

**PRESUMPTIVE ELIGIBILITY PREGNANCY**

**Patient Information Form**

Social Security Number \_\_\_\_\_  This person does not have a social security number

Name: \_\_\_\_\_

Last Name                      First Name                      Middle Initial

Date of Birth: \_\_\_\_\_ Age \_\_\_\_\_  Female

Marital Status (check one):  Single-Never Married     Divorced     Separated     Legally Separated

Widowed     Living Together Partner     Married Living Together     Married Living Apart

- Has this person received Presumptive Eligibility benefits for this pregnancy?  Yes     No
- Is this person a resident of Kentucky?  Yes     No
- Is this person a US citizen?  Yes     No
- Race: \_\_\_\_\_ Nationality: \_\_\_\_\_

• Is this person of Hispanic, Latino, or Spanish origin?  Yes     No

• Ethnicity: \_\_\_\_\_

• Preferred Written Language  English     Spanish

• Would this person like to be referred for WIC?  Yes     No

• Is this person currently incarcerated?  Yes     No

• If yes, when did this person enter prison? (mm/dd/yyyy) \_\_\_\_\_

• What date should benefits begin? \_\_\_\_\_

Address:

\_\_\_\_\_  
Street Address                      Apt/Building Number

\_\_\_\_\_  
City                      State                      Zip Code

\_\_\_\_\_  
County

Telephone Number(s):

\_\_\_\_\_  
Home/Cell Telephone Number                      Work Telephone Number                      other

How many family members does this person have? \_\_\_\_\_

When calculating family size, include the expectant mother, any unborn child/children, dependent children living in the home, and spouse. If the expectant mother is living with parents and under age 19, count the parents, step-parent, and siblings under 19 in the household size.

Expected due date (mm/dd/yyyy) \_\_\_\_\_

**FAMILY INCOME**

	Family Member's Name	Income Type*	How Much? **	How Often
1				
2				
3				
4				
	<b>TOTAL MONTHLY INCOME:</b>			

Count the income of the expectant mother, spouse, and parents' income (if the expectant mother is living with parents and claimed as a tax dependent). Include gross wages (before taxes) and other sources of income such as social security, pensions, alimony, and annuities. Do not count child support or SSI (Supplemental Security Income). Do not count income of dependent children (whether or not they live in the home with the expectant mother).

**OTHER INSURANCE**

Does this person currently have insurance that covers doctors, office visits, and hospitalization?

Yes     No

If "Yes" what is the name of this plan \_\_\_\_\_

Name of Insurance Co.                      Policy No.                      Group No.

Preferred MCO:

- Anthem Blue Cross/Blue Shield                       Aetna                       Humana CareSource
- Passport Health Plan     WellCare                       United Health Care

Primary Care Physician \_\_\_\_\_

*I certify, under penalty of perjury, the information provided by me in this statement is correct and true to the best of my knowledge. I understand that anyone who gives false information in order to receive benefits or lets someone else use their PE card or abuses PE benefits is subject to criminal action under federal law, state law, or both or may be liable for repaying in cash the value of the benefits received.*

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date Signed