

Presumptive Eligibility Form

My name is (please print): _____
LAST
FIRST
MI

I am: _____ the Patient _____ the Patient's Guarantor
 _____ Neither (Please state your relationship to the Patient: _____)

Please initial if category is applicable	#	Is relevant document attached?		Category
		YES	NO	
	1			Patient has received care from and/or has participated in Women's, Infants and Children's (WIC) programs.
	2			Patient is homeless and/or has received care from a homeless clinic.
	3			Patient is eligible for and is receiving food stamps.
	4			Patient's family is eligible for and is participating in subsidized school lunch programs.
	5			Patient qualifies for other state or local assistance programs that are unfunded or the patient's eligibility has been dismissed due to a technicality (i.e., Medicaid spend-down).
	6			Family or friends of a patient have provided information establishing the patient's inability to pay.
	7			The patient's street address is in an affordable or subsidized housing development.
	8			Patient/guarantor's wages are insufficient for garnishment, as defined by state law.
	9			Patient is deceased, with no known estate.
	10			Other – <u>Provide explanation:</u>

Signature _____ Date _____

Authorized by: _____ Date _____

Title: _____