VIRGINIA MEDICAID HOSPITAL PRESUMPTIVE ELIGIBILITY MANUAL

Eligibility Process

Roles and Responsibilities of Hospitals

Roles and Responsibilities of DMAS

HPE Approval and Denial Notices

Cover Virginia Notices

HPE Quick Guide to Citizenship and Immigration Status

HPE Covered Services Fact Sheets

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The Hospital Provider Enrollment Agreement

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Hospital Presumptive Eligibility Process

The hospital's role

The Hospital Presumptive Eligibility (HPE) process allows qualified hospitals to act as temporary Medicaid eligibility determination sites. These sites will:

- Identify individuals who may be eligible for Medicaid health coverage and could benefit from immediate temporary medical assistance;
- Make immediate temporary Medicaid eligibility determinations for these individuals;
- Educate individuals about their responsibility to complete the full Medicaid application for health coverage within required timeframes;
- Provide the individual with Cover Virginia information about applying by telephone or online, or providing the individual with the paper Medicaid application; and
- Assist the individual with completing the Medicaid application; or
- Provide information on resources to help individuals complete the application within required timeframes.

Qualified hospitals

To be an approved HPE determination site for Virginia Medicaid, hospitals must:

- Be enrolled with the Department of Medical Assistance Services (DMAS) as a participating provider;
- Notify Cover Virginia of their decision to be a HPE determination site by completing and submitting the revised 2015 HPE Provider Agreement (page 19);
- Agree to make determinations consistent with Medicaid policies and procedures;
- Meet established quality standards; and
- Staff performing determinations must complete the HPE provider trainings.

Hospitals may not contract HPE site functions to other entities or use contracted hospital personnel to make HPE determinations. Certified Application Assisters (contracted entities and staff thereof) may assist in completing applications, gathering information, and reaching out to individuals who may be eligible for HPE. Determinations themselves, however, must be made by qualified hospital employees. Qualified hospital employees having completed the DMAS HPE provider training and be employed by a DMAS participating provider who has submitted the HPE Provider Agreement.

Who can apply for coverage?

Any individual seeking immediate Medicaid coverage may apply. There is no requirement that the individual be admitted to the hospital or be seeking hospital services in order to apply. There is no requirement for the individual to be uninsured.

How long does HPE coverage last?

HPE coverage start date:	**HPE enrollment period begins on the day that the determination is made.** **HPE start dates may not be back dated to first day of the month, or date of inpatient admission.**

HPE coverage end date:	**HPE enrollment ends with the earlier of –** **1. The day that the local Department of Social Services (LDSS) makes a decision on the application for full Medicaid or FAMIS eligibility; or** **2. The last day of the month following the month in which the determination of HPE was made, in the case where the applicant has not filed a full Medicaid application.**
HPE coverage limitations:	Only one period of presumptive eligibility coverage is allowed in any 12-month calendar year period, calculated from the last day of the most recent previous period of eligibility. Pregnant women are only allowed one presumptive eligibility coverage period per pregnancy.

What is covered?

HPE covers all services covered under Medicaid, including dental, vision and mental health. HPE allows hospitals to be reimbursed for covered services provided during the temporary coverage period even if the individual is ultimately determined ineligible for Medicaid or FAMIS.

Exception:

1. Pregnant women are covered only for ambulatory prenatal care. Labor and delivery is not covered. Pregnant woman may be determined for HPE at time of delivery; however the hospital should submit a full Medicaid application. If she is determined to be eligible for full coverage Medicaid, based on the timely submission of the Medicaid application, the period including the labor and delivery will often be covered retroactively.

2. Plan First covers only family planning services. Specific services and billing codes are available www.dmas.virginia.gov under Maternal and Child Health / Plan First.

Can newborns be covered?

A separate HPE determination is required to cover newborns.

- Newborns born to women during the HPE period are not considered as a deemed eligible newborn. They must apply for Medicaid coverage. The hospital may make a HPE determination on the infant and assist the mother in applying for full coverage Medicaid for both she and her newborn.
- If women who were presumptively eligible when pregnant are later determined to be eligible for Medicaid based on the timely submission of a Medicaid application, the newborn's status changes to a deemed eligible newborn.

What eligibility groups are included?

Full Benefit Eligibility Groups:

- Children Under Age 19 with income within 143% of the Federal Poverty Level (FPL);
- Parent/caretaker-relative of children under age 18 or if 18 expected to graduate high school by 19th birthday (income limit varies based on locality where individual lives);
- Former Foster Care youth under age 26 who were receiving Medicaid and foster care services in any state at the time of their 18th birthday (No Medicaid income test); and

Full Benefit Eligibility Groups continued:
- Breast and Cervical Cancer Prevention and Treatment Act participant- limited to hospitals that have the Every Woman's Life program (No Medicaid income test).

Limited Benefit Eligibility Groups
- Pregnant Women with income within 143% FPL; and
- Plan First with income within 200% FPL.

All eligibility groups have an additional MAGI 5% federal poverty level (FPL) disregard added to the income levels listed above. The HPE Income Limits Reference Chart located at www.coverva.org includes the 5% FPL disregard.

Income guidelines may change yearly. DMAS will post updated income determination guidelines at www.coverva.org. Please be sure you are using the most recent version. Hospitals are responsible for making sure to use the most recent version which may be found at www.coverva.org under Programs / Hospital Presumptive Eligibility or under Provider Services at www.dmas.virginia.gov.

Hospital responsibilities

What to do before making eligibility determinations

Check the Virginia Medicaid Web Portal or call the MediCall audio response system to see if the applicant is currently receiving Medicaid or FAMIS.

If the individual currently receives Medicaid or FAMIS, then the individual is **not eligible** for HPE.

The Virginia Medicaid Web Portal can be accessed by going to: www.virginiamedicaid.dmas.virginia.gov. The MediCall audio response system provides similar information and can be accessed by calling 1-800-884-9730 or 1-800-772-9996.

Making eligibility determinations

The hospital is responsible for making **immediate** eligibility determinations that:
- Are based on the HPE eligibility guidelines. The Cover Virginia Hospital Presumptive Eligibility screening tool is designed to guide the hospital staff in making the determinations.
- Are submitted through the HPE Online Enrollment Form. Hospital staff should submit the determination timely to ensure the individual gets enrolled to have access to necessary health care services.

Completing the HPE determination

Regardless of the eligibility decision, the hospital is responsible for ensuring completion of the HPE determination.

REQUIRED INFORMATION FOR SUBMISSION OF HPE DETERMINATION	**The following information is necessary to complete the HPE determination:** • **Decision Date for HPE determination** • **Applicant date of birth** • **Applicant's full legal name** • **Gender of applicant** • **Race of applicant (may select unknown)** • **Physical address** • **City/County of Virginia residency** • **Citizenship or Immigration status** • **Household size** • **Monthly income**
RECOMMENDED INFORMATION	• *Social security number* • *Preferred language* • *Telephone number*
SELF ATTESTION OF INDIVIDUAL NEEDED FOR DETERMINING HPE	• Household size • Household's gross monthly income • Virginia residency • U.S. citizenship or Immigration Status • Previous period of HPE within the specified time frames • Requirements related to covered group

Notifying the applicant

At the time of the presumptive determination, the hospital provides the individual immediate written notice of whether s/he is approved, or denied, coverage under this program. The hospital should also follow these requirements below:

Notification requirements	Approvals	Denials
Hospital HPE Approval Notice	X	
Hospital HPE Denial Notice		X
Covered Services Fact Sheet for Covered Group	X	
Information on how to apply for full Medicaid coverage	X	X
Help completing the Medicaid application, or information on resources to help the individual complete and submit the full Medicaid application.	X	X
Explanation that the individual must complete and submit the full Medicaid application as soon as possible (no later than the temporary coverage end date listed on the Approval Notice)	X	

Notification requirements continued	Approvals	Denials
Explanation that the denial is based on applicant statements and a simplified process which may not have the same outcome as the formal eligibility determination.		X

Submitting the HPE Online Enrollment Form

Hospitals need to submit the HPE determination approvals through the HPE Online Enrollment Form. This should be completed within 5 calendar days of the HPE determination. The HPE Online Enrollment Form is located at www.virginiamedicaid.dmas.virginia.gov through the HPE Online portal.

Recordkeeping requirements

The hospital is responsible for maintaining the following records for three years from the date of the HPE determination:

Description	Retain on file:
Eligibility determinations completed	• Copy of completed HPE Screening Tool or other documentation to support determination
Approval Notices	• Copy of the completed Hospital HPE Approval Notice of Action • Copy of the Cover Virginia Notice of Action
Covered Services Fact Sheet	• Copy of the appropriate Covered Services Fact Sheet for the group the individual was determined eligible
Denial Notice	• Copy of the completed Hospital HPE Denial Notice
Record of applicants given information on completing the full Medicaid application how to get help completing the application	• To be determined by Hospital and approved by DMAS
Record of applicants who received assistance from the hospital completing the full Medicaid application	• To be determined by Hospital and approved by DMAS

State responsibilities

Processing Hospital Presumptive Eligibility approvals

Upon receipt of approved eligibility determinations, the State will:

- Confirm hospital is a qualified hospital;
- Enter applicants in the system;
- Not override current Medicaid/FAMIS coverage or HPE coverage with greater benefit than the submitted determination; and
- Start eligibility effective the date the Hospital completed the determination for HPE.

The State will ensure the eligible individual is not auto-enrolled in a Medicaid Managed Care Organization for the presumptive eligibility period. This means the individual will receive all covered health care services on a fee-for-service basis.

Ending Hospital Presumptive Eligibility coverage

The State will ensure coverage ends for all approved individuals as follows:

- **For individuals who submitted a Medicaid application timely**, temporary eligibility ends the date the formal determination of Medicaid/FAMIS eligibility or ineligibility is made.
- **For individuals who did not submit a Medicaid application or who submitted a Medicaid application untimely**, temporary eligibility ends at the end of the month following the month of the Hospital Presumptive Eligibility determination.

When Hospital Presumptive Eligibility ends, individuals do not receive a notice of their coverage ending. The approval notice they receive in the hospital serves as their notice that this benefit is temporary and will end, generally within two months of the approval date.

Applicant's responsibilities

When applying:

Provide true and accurate information for the Hospital Presumptive Eligibility determination.

If approved for hospital presumptive coverage:

If interested in pursuing ongoing eligibility, submit a completed Medicaid application prior to the end of the month following the month of hospital's determination.

If denied for hospital presumptive coverage:

If interested in pursuing eligibility, submit a completed Medicaid application for a full eligibility determination.

Hospital Performance Standards

The hospital must target the following performance standards for all individuals approved for HPE. Standards and criteria will be refined over time.

Proposed quality standard	Criteria
1. 85 percent of all approved applicants (specify if a. or b.)	a. Are given a Medicaid application and information on resources for assistance with the application process, or b. Are given a Medicaid application and provided assistance with completing the application.
2. 85 percent of the time	The hospital's determination that applicants do not have current Medicaid/FAMIS is correct.
3. 85 percent of the time	The hospitals' determination that applicants did not receive temporary coverage within the past 12 months (or during current pregnancy) is correct.
4. 70 percent of all approved applicants	Submit a Medicaid application within the prescribed timeframes.
5. 70 percent of all approved applicants who submit a Medicaid application	Are found eligible for Medicaid/FAMIS benefits.

Sanctions and loss of qualification

As the Virginia HPE program progresses and standards and criteria are refined, the State proposes to enforce the standards as follows:

If the prescribed standards are not met for a period of one calendar quarter, the State will establish with the hospital a written Plan of Correction (POC) that describes:

- Targets and timelines for improvement;
- Steps to be taken in order to comply with the performance standards;
- How additional staff training would be conducted, if needed;
- The estimated time it would take to achieve the expected performance standards, which would be no greater than 60 calendar days; and
- How outcomes would be measured.

The State may impose additional correction periods, as appropriate. If targets are not met after a sufficient period for improvement, as determined in discussions between the State and the hospital, the State may disqualify a hospital from making eligibility determinations under this program. Hospitals termination of HPE cannot be appealed. However a Hospital's participation with DMAS or the DMAS Managed Care Organizations will not be impacted based on participation or termination with HPE or HPE performance standards.

APPROVAL NOTICE FOR HOSPITAL PRESUMPTIVE ELIGIBILITY FOR TEMPORARY MEDICAID COVERAGE IN VIRGINIA

Patient Name: ______________________________

Patient SSN*: ____________________ Date of Birth: ______________

Date of notice: ____________

Begin date of coverage: ____________ **End date of coverage:** ____________

Issued by: ______________________________

*Social Security Number is not required for determination.

WHY YOU ARE RECEIVING THIS NOTICE

You qualify for temporary health coverage through the Virginia Hospital Presumptive Medicaid Eligibility program. This form will be your *proof of coverage* until you receive your Commonwealth of Virginia (blue & white) ID card.

TEMPORARY ELIGIBLITY GROUP (check one)

☐ Parent/Caretaker-Relative of dependent children under age 18

☐ Pregnant Women (Prenatal services only)

☐ Breast and Cervical Cancer Treatment Program (BCCTP)

☐ Child under age 19

☐ Former Foster Care Child under age 26

☐ Plan First (Coverage of family planning services only)

WHAT HAPPENS NEXT

The Virginia Department of Medical Assistance Services (DMAS) will mail you a Commonwealth of Virginia Medical Assistance ID card and letter about your health coverage. Please keep this card and coverage letter for the entire time you have coverage.

Your temporary eligibility will cover all services for which you are eligible under the Virginia Hospital Presumptive Medicaid Eligibility program, only while you are eligible. Please review the covered services fact sheet the hospital has provided you to see what services are covered for you.

HOSPITAL PRESUMPTIVE ELIGIBLITY DETERMINATIONS ARE FINAL. There is no right to appeal a hospital presumptive eligibility decision.

If you have filed a Medicaid application, your temporary eligibility will end the day on which the decision is made on that application. Your health coverage may be extended if an application for Medicaid is filed prior to the end date of coverage listed above and additional time is needed for the eligibility determination. If you do not file a Medicaid application, your temporary eligibility will end on the last day of the month following the month in which the determination of presumptive eligibility was made.

There are four easy ways to apply for Medicaid.

1. Online at www.coverva.org; **or**
2. Call the Cover Virginia at **1-855-242-8282** to apply by phone; **or**
3. Print out and complete a paper application from www.coverva.org and mail it or drop it off at your local Department of Social Services; **or**
4. Visit your local Department of Social Services in the city or county in which you live for assistance in applying.

Hospital Name: ______________________________

Hospital Authorized Signature ____________________ Date: ____________

Hospital Representative Name and Title: ______________________________
Print

Hospital Representative Telephone Number: ______________________________

rvsd03202015

DENIAL NOTICE FOR HOSPITAL PRESUMPTIVE ELIGIBILITY FOR TEMPORARY MEDICAID COVERAGE IN VIRGINIA

Patient Name: ______________________________

Patient SSN*: ______________________ Date of Birth: ______________

Date of notice: ______________

Issued by: ______________________________

*Social Security Number not required for determination.

WHY YOU ARE RECEIVING THIS NOTICE

You do **not** qualify for temporary health coverage through the Virginia Hospital Presumptive Medicaid Eligibility Program.

REASON FOR DETERMINATION (check appropriate box)

☐ Does not meet covered group

☐ Does not meet financial requirements

☐ Previous presumptive eligibility period in past calendar year

☐ Does not meet non-financial requirements

☐ Currently enrolled in full benefit Medicaid/FAMIS program

☐ Previous presumptive eligibility period during current pregnancy

☐ Other ______________________________

HOSPITAL PRESUMPTIVE ELIGIBLITY DETERMINATIONS ARE FINAL

There is no right to appeal a hospital presumptive eligibility decision.

You may still apply for a complete evaluation for health coverage by completing an application for Medicaid.

There are four easy ways to apply for Medicaid.

1. Online at www.coverva.org;**or**
2. Call the Cover Virginia at **1-855-242-8282** to apply by phone; **or**
3. Print out and complete a paper application from www.coverva.org and mail it or drop it off at your local Department of Social Services; **or**
4. Visit your local Department of Social Services in the city or county in which you live for assistance in applying.

Hospital Name: ______________________________

Hospital Authorized Signature ______________________ Date: ______________

Hospital Representative Name and Title: ______________________________
Print

Hospital Representative Telephone Number: ______________________________

rvsd03202015

Notice of Presumptive Eligibility

John Doe
600 East Broad Street
Richmond, VA 23219

January 15, 2015

Dear John Doe:

The following person has been approved for presumptive Medicaid eligibility and enrolled for a limited time period indicated below:

Name	Medicaid ID	Begin Date	End Date
John Doe		01/13/2015	02/28/2015

- Coverage may be extended if an Application for Health Coverage & Help Paying Costs is filed prior to the end date of coverage above and additional time is needed for the eligibility determination. If you file a Medicaid application and you are determined to be ineligible for Medicaid coverage, your presumptive eligibility will end the date the eligibility determination is made.
- If you do not file a Medicaid application, you will no longer have presumptive eligibility Medicaid coverage after end date above.

Please use this notice as proof of coverage until you receive your ID Card.

You will receive a Commonwealth of Virginia (blue & white) ID card. Please present this card to your medical provider as proof of coverage.

There are four easy ways to apply for Medicaid.

1. Online at www.commonhelp.virginia.gov or
2. Call the Cover VA Call Center at 1-855-242-8282 to apply by phone or
3. Print out and complete a paper application from www.coverva.org and mail it to your local Department of Social Services or
4. Visit your local Department of Social Services in the city or county in which you live

You should have the following information ready when you apply, for you and anyone else in your household who needs health insurance:

- Full legal name, date of birth, Social Security number, and Citizenship or Immigration Status; Most recent federal tax filing information (if available);
- Job and income information for members of your household for the prior or the current month such as pay stubs or a letter from your employer
- Information about other taxable income for members of your household such as unemployment benefits, Social Security payments, pensions, retirement income, rental income, alimony received, etc.
- Current health insurance information

Visit www.coverva.org for more information about the Medicaid and FAMIS programs or call us toll free at 1-855-242-8282; M-F 8am to 7pm and Saturdays 9am to 12 (noon).

Cover Virginia

PO Box 1820 ~ Richmond, VA 23219
www.coverva.org ~ 1-855-242-8282
M-F 8:00am-7:00pm, Saturday 9:00am-12:00pm

Notice of Presumptive Eligibility

John Doe
600 East Broad Street
Richmond, VA 23219

April 15, 2015

Dear John Doe:

An application for Presumptive Medicaid Eligibility was recently submitted by a hospital for you.

Upon further review we show that you have active coverage.

If you have any questions, please contact **Cover Virginia** at **1-855-242-8282.**

Visit www.cover.va.org for more information about the Medicaid and FAMIS programs or call us toll free at 1-855-242-8282; M-F 8am to 7pm and Saturdays 9am to 12 (noon).

Cover Virginia
PO Box 1820 ~ Richmond, VA 23219
www.coverva.org ~ 1-855-242-8282 TDD: 1-888-221-1590
M-F 8:00am-7:00pm, Saturday 9:00am-12:00pm

Quick Guide to Citizenship and Immigration Status for Virginia Hospital Presumptive Eligibility

<table>
<tr><td rowspan="5">Eligible Individuals</td><td>All US Citizens and Nationals</td></tr>
<tr><td>Non-citizens lawfully admitted prior to 8/22/96</td></tr>
<tr><td>All Lawfully Residing Children under Age 19 and Pregnant Women</td></tr>
<tr><td>Aliens lawfully admitted for permanent residence (LPRs) who are Active Duty Military or Veterans and their spouses or dependent children</td></tr>
<tr><td>Lawfully admitted for permanent residence (LPRs) admitted on or after 8/22/96 with 5 years of residence and 40 quarters of work history under Social Security</td></tr>
<tr><td rowspan="6">Eligible for First Seven Years in US—not eligible after Seven Years</td><td>Asylees</td></tr>
<tr><td>Refugees</td></tr>
<tr><td>Cuban/Haitian Entrants</td></tr>
<tr><td>Aliens whose deportation has been withheld</td></tr>
<tr><td>Victims of a Severe Form of Trafficking</td></tr>
<tr><td>Afghan and Iraqi Special Immigrants</td></tr>
<tr><td rowspan="3">Not Eligible</td><td>Deferred Action Childhood Arrivals (DACA)</td></tr>
<tr><td>Undocumented</td></tr>
<tr><td>Lawfully admitted for permanent residence (LPRs) without 40 quarters of work history under Social Security</td></tr>
</table>

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Hospital Presumptive Eligibility (HPE)
Full Benefit Coverage

The following describes the medical services available to patients (other than pregnant women) who have been determined to be presumptively eligible for Medicaid. The coverage period for presumptive eligibility begins with the day your HPE is determined by the hospital and ends the last day of the following month.

Covered services include:

- **Hospital Care – both inpatient and outpatient hospital services**
- **Pharmacy – prescription drugs ordered by a physician or other licensed medical professional**
- **Emergency Services – for serious, immediate health problems that require emergency care**
- **Physician Services – services provided by physicians or other health professionals licensed to practice medicine, osteopathy, and psychiatry**
- **Dental Care Services – routine dental services for individuals under age 21. Medically necessary oral surgery and the services used to determine the medical problem such as X-rays and surgical extractions for individuals 21 and older.**
- **Early and Periodic Screening, Diagnosis and Treatment Program (EPSDT) limited to individuals under age 21 to detect and diagnose health problems early so needed treatment can be provided**
- **Eyeglasses for individuals under age 21**
- **Laboratory Services**
- **X-ray Services**
- **Family planning services/Birth control – services that delay or prevent pregnancy**
- **Transportation for medical treatment – emergency transportation and non-emergency transportation through LogistiCare (1-866-386-8331)**

If you file a Medicaid application before the end date of your presumptive eligibility coverage, your eligibility can continue while your full Medicaid application is being processed. If you have questions about this coverage, please contact your local Department of Social Services.

DMAS 06042015

Hospital Presumptive Eligibility (HPE)
Limited Coverage for Pregnant Women

The following describes the medical services available to pregnant women who have been determined to be presumptively eligible for Medicaid. The coverage period for presumptive eligibility begins with the day your HPE is determined and ends the last day of the following month.

Presumptive eligibility medical services for pregnant women include:

- **Hospital Care – outpatient hospital services related to prenatal care**
- **Pharmacy – prescription drugs (ordered by a physician or other licensed health professional) related to prenatal care**
- **Emergency Services – for serious, immediate health problems that require emergency care related to prenatal care**
- **Physician Services – services related to prenatal care provided by doctors or other health professionals licensed to practice medicine, osteopathy, and psychiatry**
- **Laboratory Services for prenatal care**
- **X-ray Services - for prenatal care**
- **Transportation for prenatal care services – emergency transportation and non- emergency transportation through LogistiCare (1-866-386-8331)**

Pregnant women who apply for regular, full-benefit Medicaid and are found eligible, may receive additional benefits including inpatient hospital care, labor and delivery and services for conditions/illness other than pregnancy.

If you file a Medicaid application before the end date of your presumptive eligibility coverage, your eligibility can continue while your full Medicaid application is being processed. If you have questions about this coverage, please contact your local department of social services.

Failure to file a regular, full-benefit Medicaid application may result in missed coverage and/or out of pocket expenses for non-covered services received during a period of presumptive eligibility.

DMAS 06042015

Hospital Presumptive Eligibility (HPE)
Limited Coverage for Plan First

The following describes the medical services available to patients who have been determined to be presumptively eligible for Plan First, a limited Medicaid benefit for family planning coverage only. The coverage period for Plan First presumptive eligibility begins with the day your HPE is determined and ends the last day of the following month.

Presumptive eligibility medical services for Plan First include:

- **Annual family planning exams**
- **Pap smears for women to screen for cervical cancer**
- **Sexually transmitted infection (STI) testing**
- **Laboratory services for family planning and STI testing**
- **Family planning education, counseling, and preconception health**
- **Sterilization procedures (Tubal Ligation or Essure implant for women and vasectomies for men)****
- **Non-Emergency transportation (866-386-8331) to a family planning service**
- **Most Food and Drug Administration (FDA) approved prescription and over-the-counter contraceptives*****

*Services must be for preventing a pregnancy. Specific service and supply billing codes are posted online at www.planfirst.org.

**Sterilization Consent Form (DMAS-3004-English and DMAS-3004S-Spanish) for sterilization procedures must be signed at least 30 days prior to the surgery being performed.

***Over-the-counter contraceptives require a prescription in order to be covered.

If you file a Medicaid application before the end date of your presumptive eligibility coverage, your eligibility can continue while your full Medicaid application is being processed. If you have questions about this coverage, please contact your local Department of Social Services.

Failure to file a regular, full-benefit Medicaid application may result in missed coverage and/or out of pocket expenses for non-covered services received during a period of presumptive eligibility.

DMAS 06042015

Hospital Presumptive Eligibility (HPE) Income Limits

Children Under Age 19 and Pregnant Women Statewide Income Limits *

Family Size	Monthly
1	$1,453
2	$1,966
3	$2,479
4	$2,992
5	$3,505
6	$4,018
7	$4,531
8	$5,044
Additional family member add	$514

Plan First - Family Planning Statewide Income Limits *

Family Size	Monthly
1	$2,012
2	$2,722
3	$3,433
4	$4,144
5	$4,854
6	$5,565
7	$6,276
8	$6,986
Additional family member add	$712

*Effective 1/22/2015 Income limits subject to change annually in January

Parent/Caretaker-relative of a Child Under Age 18 Income Limits by locality

Locality Group I

Accomack, Alleghany, Amelia, Amherst, Appomattox, Bath, Bedford City/County, Bland, Botetourt, Bristol, Brunswick, Buchanan, Buckingham, Buena Vista, Campbell, Caroline, Carroll, Charles City, Charlotte, Clarke, Craig, Culpeper, Cumberland Danville, Dickenson, Dinwiddie, Emporia, Essex, Fauquier, Floyd, Fluvanna, Franklin City County, Frederick, Galax, Giles, Gloucester, Goochland, Grayson, Greene, Greensville, Halifax, Hanover, Henry, Highland, Isle of Wight, James City, King and Queen, King George, King William, Lancaster, Lee, Louisa, Lunenburg, Madison, Mathews, Mecklenburg, Middlesex, Nelson, New Kent Northampton, Northumberland, Norton, Nottoway, Orange, Page, Patrick, Pittsylvania, Poquoson, Powhatan, Prince Edward, Prince George, Pulaski, Rappahannock, Richmond County, Rockbridge, Russell, Scott, Shenandoah, Smyth, Southampton, Spotsylvania, Stafford, Suffolk, Surry, Sussex, Tazewell, Washington, Westmoreland, Wise, Wythe, York

Family Size	Monthly
1	$294.00
2	$438.00
3	$556.00
4	$675.00
5	$794.00
6	$897.00
7	$1,013.00
8	$1,133.00
Additional family member add	$118

Locality Group II

Albemarle, Augusta, Chesapeake, Chesterfield, Covington, Harrisonburg, Henrico, Hopewell, Lexington, Loudoun, Lynchburg, Martinsville, Newport News, Norfolk, Petersburg, Portsmouth, Radford, Richmond City, Roanoke City, Roanoke County, Rockingham, Salem, Staunton, Virginia Beach, Warren, Williamsburg, Winchester

Family Size	Monthly
1	$369.00
2	$524.00
3	$659.00
4	$789.00
5	$927.00
6	$1,047.00
7	$1,174.00
8	$1,310.00
Additional family member add	$131

Locality Group III

Alexandria, Arlington, Charlottesville, Colonial Heights, Fairfax City, Fairfax County, Falls Church, Fredericksburg, Hampton, Manassas, Manassas Park, Montgomery, Prince William, Waynesboro

Family Size	Monthly
1	$531.00
2	$711.00
3	$872.00
4	$1,027.00
5	$1,212.00
6	$1,352.00
7	$1,507.00
8	$1,667.00
Additional family member add	$156

Parent/Caretaker Relative income limits subject to change annually on July 1.

Income limits include the MAGI 5% federal poverty level (FPL) disregard

DMAS 070915

Virginia Qualified Entity Agreement for Hospital Presumptive Eligibility

This is an agreement to become a Qualified Entity for Hospital Presumptive Eligibility (HPE) for the purposes of conducting Presumptive Eligibility determinations. You must participate as a Virginia Medicaid provider to perform Hospital Presumptive Eligibility determinations. Please complete, sign, and return this agreement to the Virginia Department of Medical Assistance Services (DMAS) at the contact below:

Email: HPE@dmas.virginia.gov
Fax: (866) 292-6422

If you have questions about this application or the Hospital Presumptive Eligibility program, please email: HPE@dmas.virginia.gov

Name of hospital	
Other name (if any used for provider services)	National Provider Identifier number (NPI)
Telephone number	FAX number
Mailing address (no P.O. Box) for Site	City, State, Zip
Primary HPE Contact Person	
Telephone number	FAX number
( )	( )
Email Address	

Hospital Presumptive Eligibility (HPE) Qualified Entity Responsibilities and Agreement

I understand that the responsibilities as an HPE Qualified Entity include:

1. Providing the Department of Medical Assistance Services (DMAS) HPE training to all hospital staff members who will perform HPE determinations before they begin conducting them.
2. Offering the HPE program to patients who have an immediate medical need and are without current, confirmed Medicaid or FAMIS coverage;
3. Screening interested patients for income eligibility using HPE forms and guidelines;
4. Ensuring that all individuals performing HPE determinations are direct employees of the hospital and do not work as contractors or vendors of the hospital;
5. Accurately determining HPE;
6. Submitting completed HPE enrollment forms with the required information on those patients eligible for HPE to the DMAS designee within recommended time frame of five (5) calendar days;
7. Providing in writing (and orally if appropriate), notification to the patient about the outcome of the HPE determination, including approvals or denials;
8. Informing patients at the time of the HPE determination that they must file a Medicaid application in order to obtain regular Medicaid coverage beyond the HPE period, including information regarding all ways to apply and providing to the individual a Medicaid application form;
9. Informing patients that they may file a Medicaid application regardless of eligibility for HPE;
10. Facilitating patients with the completion of an application for Medicaid;
11. Keeping current with changes affecting HPE through provider memos, manuals, bulletins, notices, and/or further training;
12. Maintaining criteria to continue participation as an HPE provider based on the expectation of meeting the following standards: (1) the proportion of individuals determined presumptively eligible by the hospital who submit a full application; and (2) the proportion of individuals who are determined eligible for Medicaid based on the full application. The state may disqualify an HPE provider if (1) less than 85% of HPE submissions result in a full Medicaid application; or (2) less than 70% of individuals are determined eligible for Medicaid based on a full application. These standards will be assessed and may be revised by DMAS based on the results.
13. Participating in additional training by DMAS or other corrective action measures if the HPE provider does not meet the established standards after the data collection period has ended. HPE providers will not be immediately disqualified; rather, DMAS will conduct additional training as part of a 60 -day plan for improved performance. HPE providers may be disqualified for failure to meet standards if performance does not improve after implementation of a 60-day plan for improvement and retraining.
14. Not participating in any unfair, unequal, or discriminatory treatment of applicants or recipients.

15. Maintain HPE records for a minimum of three years following the determination date.

The Department may revoke, suspend, or deny a qualified provider's authorization to make HPE determinations at any time for any reason deemed sufficient (including failing to meet the above requirements); such revocation, suspension or denial is not subject to appeal.

I, (print name) ____, agree to cooperate with the Department of Medical Assistance Services in complying with the above Qualified Entity responsibilities. I am aware that if I do not comply with these responsibilities and the PE guidelines as outlined in §1902(a)(47)(B) of the Social Security Act and 42 C.F.R. 435.1110, I may lose status as a Qualified Entity. I agree to notify DMAS in writing of any changes in application information at least ten (10) days prior to the effective date of the change. This agreement may be terminated by either DMAS or the qualified provider within thirty (30) days of notice.

Signature	Title of Authorized Agent	Date