Hospital Presumptive Eligibility (PE) Program
Provider Election Form and Agreement

IMPORTANT:
1. **Type or print legibly.**
2. **Return this completed form to:**
   DHCS Hospital PE Program
   Attn: Xerox State Health Care, LLC
   P.O. Box 15508
   Sacramento, CA 95852-1508
3. **If you have any questions regarding this Hospital PE Program Provider Election Form and Agreement, please call 1-800-541-5555.**

Official Use Only

Reviewer Name:

_____

Date Received:

_____

Date Review Completed:

_____

Part 1. Hospital Contact Information and Participation Identification Information

Legal Name of Provider			
Business Name of Provider if different from legal name			
Service Address (number & street)	**City**	**State**	**ZIP Code**
Contact Phone number	**Contact Fax number**	**Contact Email address**	
Contact Person and Title			
Federal Employer ID Number or Taxpayer Identification Number	**Hospital License Number**	**National Provider Identifier**	

Part 2. Pay-to Information

Pay-to Name of Business or Person to which payment should be issued			
Pay-to Address	**City**	**State**	**ZIP Code**
Pay-to Phone number	**Pay-to Fax number**	**Pay-to Email address**	

Part 3. List Entities Providing Services with your Hospital License

Entity Name	Entity Address	Physician Name	Professional License Number

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Part 4. Hospital PE Program Provider Election Form and Agreement

By signing this participation agreement, [***insert the name of the applying hospital provider***]_____ elects to participate as a qualified entity in the Medi-Cal Hospital Presumptive Eligibility (PE) Program and agrees to comply with all applicable requirements and policies of the Hospital PE Program. The Hospital PE Program provides temporary Medi-Cal coverage to low-income individuals without health coverage pending completion of an insurance affordability program application and determination of eligibility for insurance affordability programs in California.

Hospital Participation Requirements:

- Be an enrolled Medi-Cal Provider with a National Provider Identifier (NPI) number and Provider Identification Number (PIN).
- Only Hospital employees shall perform PE eligibility determinations for PE applicants.
- Log onto the Hospital PE web-based application using NPI and PIN to electronically submit the Hospital PE application on behalf of the applicant.
- Assist the individual who is seeking services in completing the Hospital PE application.
- Provide the Hospital PE applicant a paper copy of his or her Hospital PE eligibility determination generated from the on-line Hospital PE Program application system. If the applicant is eligible, confirmation will allow the individual to access temporary no-cost Medi-Cal coverage for up to 60 days.
- If the applicant has been found eligible for PE, provide the applicant with a written explanation, and an oral explanation if appropriate, that:
  - The 60-day PE period will begin on the first day of the month in which the Hospital PE application is approved and ends on the last day of the following month if an Insurance Affordability Application is not filed by that date.
  - If the patient's first date of treatment is within one month of the date that the Hospital PE application is submitted, the PE period will begin the first day of the month the treatment began, so long as the Hospital PE application is submitted during the hospital stay and the application was not completed earlier because of one of the following circumstances:
    - Applicant Unavailable: Applicant unable to complete/sign application.
    - Authorized Representative Unavailable: Applicant did not have representative or authorized representative to sign on his/her behalf.
    - Hospital Staff Unavailable: Designated hospital employee not available.
    - Application Portal Not Available: Online application portal not available.
  - If an Insurance Affordability Application is filed by the last day of the following month, the PE period will end on the day that a decision is made on the applicant's Medi-Cal eligibility.
  - The applicant must submit a completed Insurance Affordability Application before their PE period terminates in order to be eligible for continued coverage beyond the 60-day PE period and/or coverage back to 3 months from the date of the Insurance Affordability Application.

- If the Hospital PE applicant is not determined to be presumptive eligible, inform the applicant in writing, and orally if appropriate, of the reason for that determination and that he or she may file an Insurance Affordability Application for medical coverage under an insurance affordability program.

- Provide the Hospital PE applicant a paper copy of the Insurance Affordability Application prior to release from the hospital.

- Provide assistance to the Hospital PE applicant, if assistance is requested, in completing the Insurance Affordability Application.

Records Management Requirements:

- Hospital PE Program participants shall maintain organized records of Hospital employee PE training and of the Hospital PE applications for three years from the last date of billing. Hospitals are allowed to store scanned copies of the completed Hospital PE applications only if the scanning system has the capability to store confidential documents securely.

- Hospital PE Program participants shall make Hospital PE records available to DHCS for periodic review within 30 days of DHCS's request.

Training Requirements

- Each hospital employee that will submit Hospital PE applications must complete and pass the Hospital PE training program.

- Each hospital employee that will submit Hospital PE applications must stay current with any changes to the program. The Hospital PE changes will be sent out through provider bulletins, notices and/or additional training programs.

Performance Standards

- Hospital PE Providers must provide at least 95 percent of the beneficiaries a copy of the insurance affordability application prior to release from the hospital.

- Hospital PE Providers must provide 100 percent of the Hospital PE applicants a paper copy of their Hospital PE eligibility determination.

- Hospital PE Providers must meet all Hospital PE determination performance standards as specified in DHCS provider instructions or regulations.

Corrective Action

- In the event that performance standards are <u>not</u> met, the hospital provider must submit to DHCS a corrective action plan:

    1. The plan shall describe how additional staff training will be conducted.
    2. The plan shall describe an estimated time to achieve improved performance standards (no greater than three months).
    3. The plan shall describe how outcomes will be measured.

- DHCS will review and approve the corrective action plan within 30 days.

Disqualification

- Hospital PE Providers will be disqualified from participating in the Hospital PE Program if the hospital fails to meet the conditions specified in the corrective action plan.

Part 5. Hospital PE Program Provider Election Form and Agreement - Certification and Signature

The Hospital PE Provider Enrollee agrees to be bound by all governing Federal and State laws and regulations. Any provision of this Election which is in conflict with current or future applicable Federal or State law or regulation will be amended to conform to the provisions of those laws and regulations. Due to the scope and complexity of this program, the Hospital PE Provider Enrollee further acknowledges that the terms and conditions of this Election are subject to change by DHCS. Any amendment of this Election shall be effective as of the effective date of the applicable statute, regulation, term, or condition and shall be binding on the Enrollee even though such amendment may not have been reduced to writing and formally agreed upon and executed by the Enrollee. The Hospital PE Provider Enrollee hereby agrees to execute such documents, amendments, or agreements as necessary to effect its continued Election, if so required by law or regulatory authority or requested by DHCS.

By signing below, I represent that I have the authority to bind the Hospital stated below to this Election.

Printed name and title of Provider Applicant *(first)* *(middle initial)* *(last)* *(title)*	
Provider Applicant signature ***IN BLUE INK ONLY***	Date
Hospital Name	Address