HUMAN SERVICES
DEPARTMENT
SUSANA MARTINEZ, GOVERNOR
BRENT EARNEST, SECRETARY
NANCY SMITH-LESLIE, DIRECTOR

INTERDEPARTMENTAL MEMORANDUM
MAD-MR: 18-22
DATE: November 5, 2018

TO: **ISD AND MAD STAFF**

FROM: **NANCY SMITH LESLIE, DIRECTOR, MEDICAL ASSISTANCE DIVISION**

THROUGH: **KATHY SLATER-HUFF, BUREAU CHIEF, COMMUNICATION AND EDUCATION BUREAU**

BY: **JEANELLE ROMERO, PE UNIT PROGRAM MANAGER, COMMUNICATION AND EDUCATION BUREAU**

SUBJECT: **REVISED PROCESS FOR THE SUBMISSION OF MANUAL PE ENROLLMENT FORMS AND REVISION OF THE MAD070 FORM**

GENERAL INFORMATION

The Presumptive Eligibility (PE) program has recently revised the submission process for manual PE Enrollment forms. The MAD070 form has also been updated and revised.

All PE paper forms, including the MAD008, MAD011 and MAD070, must be submitted to the Medical Assistance Division (MAD) PE Program staff via email to HSD.PEDeterminers@state.nm.us or fax at 505-827-7200, these forms will no longer be accepted by MAD's fiscal agent, Conduent.

FILING INSTRUCTION

Please make the following change:

Replace MAD070 with updated MAD070 (Revised 06/18/2018)

Please address any questions regarding this MR to Jeanelle Romero at JeanelleC.Romero@state.nm.us or call (505) 827-7713.

Attachments:
MAD070 Revised 06/18/2018
MAD008 Household Size and Income Calculation Worksheet Issued 06/25/2014
MAD011 Presumptive Eligibility (PE) Applicant Information Form Issued 05/02/2014

HUMAN SERVICES DEPARTMENT
MEDICAL ASSISTANCE DIVISION

MEDICAID PRESUMPTIVE ELIGIBILITY AUTHORIZATION

Determiner Name: _____

Determiner Fax Number: _____

Fax this form to: 505-827-7200

PE Determiner: List ONLY the individuals who are Eligible for PE. Type all information directly into this form. The PE eligibility End Date is the last day of the month following the PE approval. If an application for ongoing Medicaid eligibility is submitted on or before the PE Eligibility End Date, the PE will remain in effect until a final application determination has been

NAME – *Last, First, Middle*	Race	Sex	Date of Birth	Social Security Number (Not Required)	MCO Choice (or N/A)	PE COE	Eligibility		PE Program Unit USE ONLY	
							Begin Date	End Date		
MAILING ADDRESS – *Street, PO Box*									Added Eligibility	
City, State, Zip									YES	NO
NAME – *Last, First, Middle*	Race	Sex	Date of Birth	Social Security Number (Not Required)	MCO Choice (or N/A)	PE COE	Eligibility		PE Program Unit USE ONLY	
							Begin Date	End Date		
MAILING ADDRESS – *Street, PO Box*									Added Eligibility	
City, State, Zip									YES	NO
NAME – *Last, First, Middle*	Race	Sex	Date of Birth	Social Security Number (Not Required)	MCO Choice (or N/A)	PE COE	Eligibility		PE Program Unit USE ONLY	
							Begin Date	End Date		
MAILING ADDRESS – *Street, PO Box*									Added Eligibility	
City, State, Zip									YES	NO

TO BE COMPLETED BY PE DETERMINER

PE Determiner Name	**PE Determiner's Signature**	**PE Determiner's Number**	**Date**
PE Determiner Phone Number	**PE Determiner's Agency**	**Agency's Business Address**	
Determiner's Fax Number:	**Determiner's E-Mail:**	**Agency's Phone Number:**	
Determiner's Comments:			
PE Program Unit Comments:		**PE Program Unit Staff**	**Date**

HUMAN SERVICES DEPARTMENT
MEDICAL ASSISTANCE DIVISION

HOUSEHOLD SIZE AND INCOME CALCULATION WORKSHEET

STEP 1: Identify the Head of Household (HOH) and who is part of that household	STEP 2: Identify individual's relationship to Head of Household	STEP 3: Identify individual's income	STEP 4: Identify individual's tax status	STEP 5: Refer to "How to Determine a Household Size" flow chart and mark a "1" if the individual is included in the budget group						STEP 6: List the number of unborn children for all pregnant women included in the Budget Group	STEP 7: Add number of individuals in Budget Group (Add figures in STEP 5 to figure in STEP 6)
Individuals in Household	Relationship	Monthly Gross Income	Tax Filer, Dependent, Non-Filer	HOH	Ind. 2	Ind. 3	Ind. 4	Ind. 5	Ind. 6	Number of Unborn Children	Total Individuals in Budget Group
HOH	SELF										0
Ind. 2											0
Ind. 3											0
Ind. 4											0
Ind. 5											0
Ind. 6											0

STEP 8: List all individuals requesting assistance	STEP 9: List individual's age	STEP 10: List household Budget Group size from STEP 7	STEP 11: Add monthly gross income for each individual included in the household/Budget Group	STEP 12: Refer to the MAD 222 to determine the category of eligibility	STEP 13: Apply disregard if applicable	STEP 14: Subtract disregard from total monthly gross income based on household size (if applicable)
Name	Age	Household Size (Budget Group)	Total Monthly Gross Income for Budget Group*	Medicaid Category of Eligibility**	Subtract 5% Disregard (if applicable)	Total Monthly Gross Income for Budget Group with 5% Disregard (if Applicable)
		0				
		0				
		0				
		0				
		0				
		0				

*Subtract Federal Pre-Tax Deductions (dependent care accounts, health insurance premiums, flexible spending accounts, retirement accounts and/or commuter expenses) from Monthly Gross Income.

** Refer to MAD 222 for Categories of Eligibility and income guidelines.

HUMAN SERVICES DEPARTMENT
MEDICAL ASSISTANCE DIVISION

PRESUMPTIVE ELIGIBILITY (PE) APPLICANT INFORMATION FORM

Person Supplying Information on Behalf of Applicants and/or Household Members Listed Below

First Name ____________________ Middle ____________________ Last ____________________

Home Address ____________________ City ____________________ State ________ Zip ________

Phone ____________________ Email ____________________

Mailing Address (if different than above)

Address ____________________ City ____________________ State ________ Zip ________

Family Members in the Household

Name (First, Middle, Last)	**Applying** For PE?	**Relationship** to Person Supplying Information	**Date of Birth**	**SSN** (not required)	**US Citizen, US National or Eligible Immigrant?** (not required)	**Living in New Mexico?**	**Pregnant?**	**Receiving Income from Work or Job?**	**How Often?**	**Enrolled in Medicaid or Medicare?**
	Y☐ N☐				Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐		Y☐ N☐
	Y☐ N☐				Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐		Y☐ N☐
	Y☐ N☐				Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐		Y☐ N☐
	Y☐ N☐				Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐		Y☐ N☐
	Y☐ N☐				Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐		Y☐ N☐
	Y☐ N☐				Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐		Y☐ N☐
	Y☐ N☐				Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐		Y☐ N☐
	Y☐ N☐				Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐		Y☐ N☐

Total Household Job Income per Month (before taxes): ____________________

Other Household Income per Month (before taxes): ____________________
DO Include: Unemployment, Alimony, and Disability from the Social Security Administration
DO NOT Include: SSI Payments, or Child Support Received

MAD 011 Revised 5/2/14

By signing below, you are swearing that all information you have supplied for the completing of this Presumptive Eligibility application is true and correct to the best of your knowledge.

All information supplied will be kept secure and private.

____
Signature of Person Supplying Info on Behalf of This Household