



Hospital Presumptive Eligibility Statement of Interest

Please indicate your agency's interest in becoming a Qualified Entity for Hospital Presumptive Eligibility for the KanCare Hospital Presumptive Eligibility Program by completing this form and submitting the required information as indicated below.

Indicating your interest does not obligate you to, preclude you from, or guarantee participation in the Hospital Presumptive Eligibility Program.

Hospital Name: _____

Contact Name: _____

Street Address 1: _____

Street Address 2: _____

City, State, Zip: _____

Telephone Number: _____

Fax Number: _____

Email Address: _____

Indicate below the names, phone numbers and email addresses of hospital staff that will participate in the Implementation of Hospital Presumptive Eligibility. These individuals shall include executive-level staff permitted to make decisions on behalf of the hospital. It is suggested that legal staff also participate to ease the process of approving and signing the Memorandum of Understanding.

Name	Job Title	Phone Number	Email Address



Medicaid ID#			
Contracts with MCOs:			
Amerigroup	<input type="checkbox"/> Yes <input type="checkbox"/> No	Provider #	
Sunflower	<input type="checkbox"/> Yes <input type="checkbox"/> No	Provider #	
United	<input type="checkbox"/> Yes <input type="checkbox"/> No	Provider #	
Estimate the number of patients your hospital sees each month that are not covered by health insurance or Medicaid at the time of their visit			
How many staff positions do you anticipate will be assigned to determine presumptive eligibility?			
Are you able to send staff to Topeka for one day of Instructor-Led Training?			

We will conduct several pre and post-meetings as part of the implementation of presumptive eligibility at your facility. Please identify by 1st and 2nd choice the meeting block that works best for your agency and implementation team members.

Mondays 1 – 2 pm	<input type="checkbox"/> 1 st Choice	<input type="checkbox"/> 2 nd Choice
Tuesdays 1 – 2 pm	<input type="checkbox"/> 1 st Choice	<input type="checkbox"/> 2 nd Choice
Wednesdays 9 – 10 am	<input type="checkbox"/> 1 st Choice	<input type="checkbox"/> 2 nd Choice
Thursdays 1 – 2 pm	<input type="checkbox"/> 1 st Choice	<input type="checkbox"/> 2 nd Choice
Fridays 9 – 10 am	<input type="checkbox"/> 1 st Choice	<input type="checkbox"/> 2 nd Choice

Anticipated Implementation Plan: As part of the process, we will ask you to submit an Implementation Plan. We will discuss all aspects of this plan during our information calls. For your reference, your plan shall document how you anticipate implementing Hospital Presumptive Eligibility in your facility. This should include details such as:

- Organizational Structure of Presumptive Eligibility staff
- Types and number of staff positions assigned to presumptive eligibility
- Methods used to identify potential eligibles
- Process of obtaining the presumptive eligibility application
- Assistance in completion of the complete Medicaid application
- Follow-up assistance for application completion

We will mutually agree on a timeline for implementation at your facility which will include a date by which we can expect your Implementation Plan. Your plan is not required to be submitted at this time.

Please return a copy of this form to:
 KDHE – Division of Health Care Finance
 Attn: Medicaid Eligibility Unit
 900 SW Jackson, Suite 900
 Topeka, KS 66612 66612
 Or via Fax to (785) 296-4813