471-000-303 Description of the Use of Form MS-91, "Presumptive Application for Pregnant Women"

Form MS-91 is used by a qualified provider to determine eligibility for Presumptive Eligibility for a pregnant woman. A qualified provider is a provider who meets the requirements of 471 NAC 28001.01. Form MS-91 is a temporary eligibility document issued to clients at the time they are determined to be presumptively eligible for Nebraska Medicaid by a qualified presumptive eligibility provider.

Presumptive eligibility may begin or end on any day of the month. When presented with the Nebraska Medicaid Presumptive Eligibility Application as proof of Medicaid eligibility, the provider must verify eligibility through the Nebraska Medicaid Eligibility System using the client's Social Security Number.

Form MS-91 may also be used as a pregnancy verification.

Page 1: The fields on this page are self-explanatory. The "Date of PE Determination" is the date presumptive eligibility for Nebraska Medicaid begins.

Page 2: The shaded field marked "For Agency Use Only" is completed by the qualified provider. The shaded field marked "Completed By Office" is completed by the HHS worker. Page 2 includes a space for the client's signature and date signed, and a release of information. Number Prepared: MS-91 is prepared in triplicate on NCR paper.

Disposition: The provider forwards the white copy to the HHSS local office within 5 days, gives the yellow copy to the applicant, and retains the pink copy for his/her record.

Presumptive Application for Pregnant Women

NEBRASKA HEALTH AND HUMAN SERVICES SYSTEM

Instructions: Read carefully. Please write clearly.
This is not a valid application until it contains your name, address and signature

Name of Applicant	Social Security Number
Address (Number, Street, City, Zip Code)	Telephone Home/Work

Did anyone in your household get services through Department of Health and Human Services this month or last month?
☐ Yes ☐ No If yes, explain under what name, where, when and type of services:

My Family's Current Physician(s) is (are):

List everyone in your family who lives with you (parents & children): (Give the information listed. Use more paper if you need to.)

Name: (First Name, Middle Initial, Last Name)	U.S. Citizen Y/N	Social Security Number	Race	Birthdate	Sex M/F	Pregnant Y/N	If, Pregnant What is Expected Date of Delivery
(Adults in Home)							
(Children)							

I certify that the above woman is eligible for Presumptive Eligibility. Individuals on this form who ARE NOT pregnant, ARE NOT Presumptively Eligible.

Sign Here_____ _____
Provider Representative Name of Provider

_____ _____ _____
Date of PE Determination Provider Address Provider Phone Number

NOTICE TO PROVIDERS: Please accept this form as proof of temporary Medical coverage for pregnant women. To check Medical presumptive eligibility, in most instances, use the woman's social security number with a two digit suffix when calling the Nebraska Medicaid Eligibility (NMES) line at 1-800-642-6092.

NOTICE TO APPLICANT: Show this form to providers of services as proof of medical coverage for children and outpatient prenatal coverage for pregnant women.

NOTICE & APPEAL RIGHTS!
Presumptive
1. If you are found ineligible for Presumptive Eligibility, this form is your notice and no further action is required. You cannot appeal this decision.
2. If you are found eligible for Presumptive Eligibility and do not provide the additional information requested, presumptive eligibility will end. No further notice is required.

Medicaid
1. This is also an application for continuing Medical Assistance. If the Medicaid application is denied, you have the right to appeal this action.
2. If the local Department of Health and Human Services office does not make a timely decision (within 45 days) on your Medicaid application and send you notice of the reason, you may appeal this action.

Does any Person Currently Receive any Money From:	Yes	No	If Yes, Who Is It?	Gross Amount	How Often Received?
Salaries, Wages, Tips, Commissions, etc., (Include Income from Self-Employment)					
Salaries, Wages, Tips Commissions, etc., (Include Income from Self-Employment)					
Unearned Income Such As: Child Support/Alimony Spousal Support					
Unearned Income Such As: Workman's Compensation, Unemployment Compensation, Social Security					

Does anyone pay child care costs, please give names of the children and the monthly amount you pay for each child.

Name of Child	Monthly Amount	Name and Address of Provider

Income Computation: (FOR AGENCY USE ONLY)

1. Total Monthly **Gross** Earned Income $_____
2. Total **Net** Self-Employment Income $_____
3. Total Earned Income (Add lines 1 & 2) $_____
4. Subtract $100 (For each employed adults from earned income only) $_____
5. Total Child Care Costs $_____
6. Total Monthly Unearned Income $_____
7. Total Countable Income (Line 4 Minus 5 Plus 6) $_____

SOCIAL SECURITY NUMBER:

I understand that the Nebraska Department of Health and Human Services will require Social Security numbers for each individual in my family who receives assistance. The Social Security number for each person in your household will be computer matched with the following programs to assist in determination of eligibility:

Department of Health and Human Services - Vital Statistics
Social Security Benefits - Social Security Administration
Supplemental Security Income (SSI) - Social Security Administration
Unemployment Compensation Benefits - State Department of Labor
Department of Health and Human Services - Block Grants
Child Support - Clerk of District Court
Resources and Income - Internal Revenue Service

The information received from these agencies will be used and verified and could affect your food stamp, public assistance and Medicaid eligibility and benefits. I authorize the release of my Social Security number to the Nebraska Department of Health and Human Services to use for the purposes mentioned above. The use of my Social Security number will also be used in computer matching and program reviews or audits to make sure my household is eligible for assistance. This may result in criminal or civil action or administrative claims against persons fraudulently participating.

Sign Here_____ Date_____
Signature or Mark of Applicant (Witness if mark)

I certify that the information I have provided is true to the best of my knowledge and I give permission for the State of Nebraska to make any necessary contacts to check my statements. I have read the list of my rights and responsibilities. I know that I could be penalized if I knowingly give false information.

COMPLETED BY LOCAL HHS OFFICE:_____

Request Date/Date of P.E. Determination_____ Date_____