ES-DZA 05-11-15

**Documentation of Eligibility for Issuance of Temporary Medical Card**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Medical ID Number: | | | | | | | | | | | Case Number: | | | | | | |
| Name (first, middle, last): | | | | | | | | | | | | | | | | | |
| Gender: | | Date of Birth: | | | | | | | | | | | SSN: | | | | |
| Home Address: | | | | | | | | | | | | | | | | | |
| City: | | | | | | | State: | | | | | Zip: | | | | | County: |
| Phone Number: | | | | | | | | | | | | | | | | | |
|  | Clearinghouse | | | |  | DCF Office: | | | | | | | | | | | |
| Case Head Name (first, middle, last): | | | | | | | | | | | | | | | | | |
| Responsible Person (first, middle, last): | | | | | | | | | | | | | | | | | |
| Responsible Person Address: | | | | | | | | | | | | | | | | | |
| City: | | | | | | | | State: | | | | Zip: | | | | | |
| Type of Coverage Approved: | | | | | | | | | | | | | | Start Date: | | | |
| LOC: | | | | LA: | | | | | | Effective Date: | | | | | | | |
| MCO: | | |  | Amerigroup | | | | |  | Sunflower | | | | |  | United Healthcare | |
| Reason for the temporary medical card approval/request: | | | | | | | | | | | | | | | | | |

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| The following non-financial eligibility factors have been met: | | | | | | | | | |
|  | Citizenship |  | Identity |  | Residency | |  | Categorical: | |
|  | | | | | | | | | |
| The following financial eligibility factors have been met: | | | | | | | | | |
| MAGI Determination | | | | | | Non-MAGI Determination | | | |
| Household Size: | | | | | | Household Size: | | | |
| Countable Income: | | | | | | Countable Income: | | | |
| Income Limit: | | | | | | Income Limit: | | | |
|  | | | | | | Countable Resources: | | | |
|  | | | | | | Resource Limit: | | | |
| Staff Name: | | | | | | | | | Date: |

Use the following budget/tools to determine eligibility during the Downtime. Attach completed copies of all forms used in the determination for the above individual:

ES- 3104.5, Determination of Need

PA-3103.5, MacrSSI Disregard Worksheet

Family Medical Eligibility Worksheets (use MAGI – Building Individual Budget Units and the Kansas Medical Assistance Standards (KEESM F8)