NEWBORN SCREENING BENEFITS
PRESUMPTIVE ELIGIBILITY INSTRUCTIONS
(For Immediate Medical Services)

PURPOSE

The Presumptive Eligibility Form should be completed when an applicant is in need of immediate medical services AND cannot fulfill initial screening or application requirements at that time. The form will also document that an applicant appears to be eligible for benefits. The eligibility determination process will be completed as soon as the applicant is able, and within 60 days following the delivery of services.

INSTRUCTIONS FOR COMPLETING THE FORM

- Enter applicant name, name of legally responsible adult if applicant is a child, address and phone number where applicant (legally responsible adult) can be reached, date of birth, mailing address;
- Enter contracted provider's name and phone number;
- Enter the type of benefits requested (i.e. metabolic food or medication);
- Print name of the contractor (i.e., metabolic specialist, endocrinologist or hematologist responsible for providing services to the individual).
- Applicant completes numbers 1 through 7;
- Applicant and contracted provider signs and dates the Presumptive Eligibility Form.

INSTRUCTIONS FOR COMPLETING THE PROCESS

- Applicant and contractor (i.e., nutritionist, nurse, or social worker) sign the Statement of Applicant's Rights and Responsibilities;
- Complete the Immediate Medical Need Prescription Request and Waiver of Ineligibility;
- Fax or Email:
  - Presumptive Eligibility Form;
  - Statement of Applicant's Rights and Responsibilities Form;
  - Waiver of Eligibility; and
  - Immediate Medical Needs Prescription Form.
- Copies of the signed forms are provided to the applicant;
- The original signed forms and documentation are kept in the applicant's record for four state fiscal years after services are rendered.

Send completed form to NBS Benefits
FAX - 512-776-7593 *OR* **Email** - irma.hernandez@dshs.state.tx.us
Questions? Call (512) 776-2983 or 800-252-8023 ext. 2983

NEWBORN SCREENING BENEFITS PRESUMPTIVE ELIGIBILITY FORM

Applicant Name / Nombre de Solicitante	**Home Telephone** Número de teléfono de la casa **(If no telephone, give number of person who can reach applicant.** De no tener teléfono, proporcione el teléfono de la persona que pueda ponerse en contacto con el solicitante.)
Mailing Address (Street or P.O. Box) Dirección Postal (Calle o Apdo.)	**Date of Birth** Fecha de Nacimiento
Home Address, if different from above. Domicilio particular, si es diferente a la dirección de arriba	**City** Ciudad **ZIP** Código postal
Physician Specialist Name Nombre de Médico Especialista	**Telephone Number** Numero de Teléfono
What benefits are you requesting? ¿Qué beneficios se le solicita?	

I am in need of immediate medical benefits (medical foods, medications) from Newborn Screening Benefits. I understand that within 60 days following the delivery of services, I will submit a completed application for eligibility determination. The information below is true, correct, and complete to the best of my knowledge.
(Estoy en necesidad inmediata de beneficios del Programa de Examen Médico de Recién Nacidos (alimentos, medicamentos). Yo entiendo y acepto que dentro de 60 días después de recibir los servicios yo entregaré una solicitud completamente llena, para que se lleve a cabo la determinación de elegibilidad. La siguiente información es verdadera, correcta y completa según mi leal saber y entender.

1. **I am and/or the person applying for services are residents of Texas?** ☐**Yes/Si** ☐**No**
   (Yo o la persona que solicita servicios somos residentes de Texas)
2. **I am eligible for Medicaid (if under age 21 yrs.)** ☐ **Yes/Si** ☐**No**
   (Soy elegible para Medicaid (si es menor de 21 años de edad)
3. **I am eligible for Children's Health Insurance Program (CHIP).** ☐ **Yes/Si** ☐ **No**
   (Soy elegible para el Programa de Seguro Médico para Niños) (CHIP)
4. **I am eligible for Children with Special Health Care Needs (CSHCN).** ☐ **Yes/Si** ☐ **No**
   (Soy elegible para el Programa de Niños con Necesidades Especiales de Salud) (CSHCN)
5. **I have insurance (or HMO/PPO) coverage for formula.** ☐ **Yes/Si** ☐ **No**
   (Tengo seguro (o HMO / PPO) para la cobertura de formula)
6. **I have a gross family income at or below 350% of the most current Federal Poverty Level guidelines.** ☐**Yes/Si** ☐**No**
   (Tengo un ingreso familiar bruto igual o inferior al 350% de los más reciente lineamientos del Nivel Federal de Pobreza)
7. **I was not able to complete the standard eligibility determination process for NBS Benefits at this time.**
   (En este momento, no me fue posible completar el proceso de determinación de elegibilidad para el NBS Benefits).
   ☐**Yes/Si** ☐**No**

I understand that I will be contacted by the Texas Department of State Health Services Newborn Screening Program within 60 days to complete a *NBS Benefits Application for Services.*
(Yo entiendo que seré contactado por el Programa de Examen Médico de Recién Nacidos del Departamento Estatal de Servicios de Salud dentro de 60 días para completar un formulario de selección y elegibilidad para servicios de asistencia.)

Signature – Applicant / Firma – Solicitante	**Date** / Fecha
Print Name of Contractor:	**Date**:
Signature – Contractor:	
Phone:	**Fax:**

Approved by NBS Staff:_____ Date:_____

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