

MEDICAID PRESUMPTIVE DISABILITY

INSTRUCTIONS: The Applicant Name and Case Number are to be completed by the county or tribal Income Maintenance worker. Sections I, II and III are to be completed by a medical professional. (A medical professional is a licensed physician, physician’s assistant, nurse practitioner, licensed or registered nurse, psychologist, osteopath, podiatrist, optometrist, hospice coordinator, medical records custodian, or social worker.)

This completed form must be returned to the county or tribal agency where the applicant resides. A copy of the completed form will be retained in the applicant’s Income Maintenance case file. Applicants who have both an urgent need for services and one of the listed impairments can be determined presumptively disabled for purposes of receiving Medicaid while awaiting a final disability decision by the Disability Determination Bureau. To facilitate the final disability decision, the applicant must still complete the Medicaid Disability Application (F-10112) and Authorization to Disclose Information to Disability Determination Bureau (F-14014) forms.

Persons with an urgent need but whose impairments are not listed can still be determined presumptively disabled. This requires a different process and the decision must be made by the Disability Determination Bureau.

Applicant Name (Last, First, MI)	Case Number
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SECTION I — URGENT NEED FOR MEDICAL SERVICES

I have determined that the above named applicant (check the appropriate box or boxes):

- Is a patient in a hospital or other long term care medical institution.
- Will be admitted to a hospital or other long term care medical institution if immediate health care treatment is not provided.
- Is in need of long-term care and the nursing home or other long term care medical institution will not admit the applicant until Medicaid benefits are in effect.
- Is unable to return home from a nursing home or other long term care medical institution unless Medicaid covered in-home services or equipment is available.
- Meets none of the above.

SECTION II — IMPAIRMENTS

I have determined that the above named applicant has one or more of the following impairments (check the appropriate box or boxes):

- Amputation of a leg at the hip.
- Total deafness.
- Total blindness.
- Bed confinement or immobility without a wheelchair, walker, or crutches due to a condition that is expected to last 12 months or longer.
- Has had a stroke (cerebral vascular accident) more than three months in the past and continued marked difficulty in walking or using a hand or arm.

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- Cerebral Palsy, Muscular Dystrophy or muscle atrophy and marked difficulty in walking (e.g., use of braces), speaking, or coordination of the hands or arms.
- Down Syndrome.
- Severe mental deficiency as claimed by another individual filing on behalf of an applicant who is at least seven years of age. ('Mental deficiency' means mental retardation. This category pertains to individuals whose dependence upon others for meeting personal care needs (e.g., hygiene) and in doing other routine disability activities (e.g., fastening a seat belt) grossly exceeds age appropriate dependence as a result of mental retardation.)
- Receipt of hospice services because of a terminal condition, including but not limited to terminal cancer, as confirmed by a licensed physician or knowledgeable hospice official (hospice coordinator, staff nurse, social worker, or medical records custodian).
- Spinal cord injury producing inability to ambulate without the use of a walker or bilateral hand-held devices for more than two weeks, with confirmation of such status from an appropriate medical professional.
- End stage renal dialysis confirmed by a medical professional.
- Unable to work or return to normal functioning for at least 12 months or has a condition that will result in death within the next 12 months.
- A positive diagnosis of HIV with other serious health conditions and will be unable to work or return to normal functioning for at least 12 months or has a condition that will result in death within the next 12 months.
- Meets none of the above.

SECTION III — MEDICAL PROFESSIONAL INFORMATION

Printed Name – Medical Professional (Last, First, MI)

Address - Street	City	State	Zip Code
SIGNATURE – Medical Professional			Date Signed