State of Florida, Agency for Health Care Administration

NOTIFICATION OF ELIGIBILITY FOR HEALTH CARE ASSISTANCE

NOTE: THIS FORM IS NOT PROOF OF ELIGIBILITY FOR MEDICAID

Resident County: ______________________________

Name and Address of Office Making Determination:

Applicant Name

Street Address

Date Mailed

City, State, Zip Code

Case Number

Hospital Name

Patient Account Number

Only the items where there is an "X" apply to you. The action(s) checked below is being taken in accordance with Florida Statutes, Chapters 154 and/or 409, and Florida Administrative Code, Sections 59H-1.0035 through 59H-1.015.

☐ You have been found eligible for medical assistance under the Health Care Responsibility Act. This will provide payment for hospital care services provided to you for services beginning on ________________________, up to the maximum services provided by law, subject to the availability of program funds. Under the spend-down provision, your share of costs is $____________.

☐ Your application for medical assistance under the Health Care Responsibility Act has been denied for hospital care services provided to you beginning on ________________________ based on Florida Administrative Code Rule Number(s):

Reason(s):

If you have a reason to believe that this action is incorrect, your worker will be glad to discuss it with you; and, the hospital has the right to request a hearing before a hearings officer. A request for a hearing should be made within 90 days from the date at the top of this notice. The address and telephone number of your local office are shown on this form.

By: ______________________________ Telephone Number: ______________________

(Printed Name)

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that a true and correct copy of the foregoing has been furnished to the applicant at the above mentioned address via regular ground mail and to the above mentioned hospital via (place a "X" on all applicable options) ☐ fax, ☐ email and/or ☐ regular ground mail on ______________________________.

(Date)

____

(Signature)

Summary of Florida Administrative Rules Governing Eligibility Under the Health Care Responsibility Act (HCRA).

Factor	HCRA Rule	Summary
Adequate Insurance	59H-1.0035(2)	An Applicant must have no or inadequate insurance to qualify.
Application Submission Date	59H-1.008(3)	Applications must be sent to the certifying agency with 30 days of admission or treatment.
Availability of Program Funding	59H-1.0045	When all funds allocated for the program are expended, no reimbursement will be made to the hospital.
Assets	59H-1.0035(6)	Assets may not exceed specified limits.
County Residence	59H-1.009	The applicant must be a resident of the county to which the application is submitted.
Covered Services	59H-1.0065	Emergency Medical Treatment, Non-emergency if services are not available in county with funding.
Provision of Information by Applicant	59H-1.015(2)	The applicant or designated representative must provide information requested by the certifying agency and must keep scheduled appointments.
Income	59H-1.008(8)	Applicants must have gross income less than 100% of the poverty level, or spend-down less than 150%.
Other Program Eligibility	59H-1.0035(30)	Applicants must not be eligible for other government medical assistance programs.
Participating Hospitals	59H-1.0055	Reimbursement can only be made for covered services provided by a participating hospital.
Eligible Applicant	59H-1.0035(30)	An applicant must meet the income, assets, residence requirements to qualify.