HEALTH SYSTEMS DIVISION
Integrated Health Programs

Declaration of Intent and Agreement to Serve as a Hospital Presumptive Eligibility Site

PART I - To be completed by an authorized Hospital representative

_____ certifies that it is a participating Medicaid provider in Oregon and hereby declares its intent to perform medical eligibility determinations on behalf of the Oregon Health Authority (OHA) in order to establish presumptive eligibility for individuals who are potentially eligible for medical assistance under the Oregon Health Plan.

_____ certifies that medical eligibility determinations will be performed as follows *(select all that apply)*:

☐ By contracted entity. Contractor's name: _____

☐ By Hospital employees

_____ understands that the Hospital is responsible for the accuracy and timely reporting of any and all medical eligibility determinations made by its employees or contracted entities; and as such, the Hospital is also responsible for annual training of each person who performs medical eligibility determinations on behalf of the Hospital.

_____ understands that Hospital staff, contracted entities, or approved application assisters, must perform all duties and activities associated with the Hospital Presumptive Eligibility process, as specified in OHA's program guidelines, including:

I. Performing medical eligibility determinations consistent with OHA policies and procedures;
II. Providing applicants with an Approval or Denial Notice;
III. Reporting the results of each determination to DHS|OHA in a timely manner;
IV. Informing the applicant that a full medical assistance application must be completed by the last day of the second month following the Hospital Presumptive determination in order to determine ongoing medical assistance eligibility; and
V. Providing information on resources for assistance with the full application process.

_____ further understands that the Hospital must abide by all rules and guidelines and meet specified goals applicable to the Hospital Presumptive Eligibility process as set forth by the Oregon Health Authority.

Signed *(for Hospital)*

_____ _____
Authorized signature Date

Hospital representative name and title: _____
Hospital representative's contact information: _____
Hospital's NPI and Oregon Medicaid Provider ID _____

Part II - To be completed by an authorized OHA representative

The Oregon Health Authority (OHA) agrees that _____ is a qualified and willing entity to perform medical eligibility determinations on behalf of OHA in order to establish presumptive eligibility for individuals who are potentially eligible for medical assistance under the Oregon Health Plan.

OHA agrees to:

I. Promulgate rules and guidelines for Hospital compliance; and
II. Provide training and oversight sufficient to ensure:
    A. Quality Hospital Presumptive Eligibility services to OHP applicants and members; and
    B. Adherence to or progress toward specified goals applicable to the Hospital Presumptive Eligibility process.

Signed *(for the Oregon Health Authority)*

_____

Authorized signature

OHA representative name and title: _____

Signature date: _____

Please send the completed form by email or standard mail.

By email:
Scan the form and send to OHA at HPE.Program@dhsoha.state.or.us.

By mail:
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