

**PRESUMPTIVE ELIGIBILITY WORK SHEET**

1. PE Applicant Last Name \_\_\_\_\_ First Name \_\_\_\_\_ M.I. \_\_\_\_\_
2. PE Applicant Date of Birth \_\_\_\_\_
3. Do you have a Medical Assistance Card? Yes \_\_\_\_\_ No \_\_\_\_\_
4. Are you a resident of Pennsylvania? Yes \_\_\_\_\_ No \_\_\_\_\_
5. Are you a U.S. citizen, national or in satisfactory immigration status? Yes \_\_\_\_\_ No \_\_\_\_\_
6. How many family members are in the tax household, including the applicant? \_\_\_\_\_  
(Include unborn child or children in household.)
7. What is the household's monthly gross income (before taxes)? \_\_\_\_\_
8. Does the household have the following tax deductions from their Federal Tax Form 1040?
  - Student Loan interest deduction. Monthly Amount \_\_\_\_\_
  - Self-employed health insurance deduction. Monthly Amount \_\_\_\_\_
  - Deductible part of self-employment tax. Monthly Amount \_\_\_\_\_
  - Health Savings Account deduction. Monthly Amount \_\_\_\_\_
  - Other. Monthly Amount \_\_\_\_\_

**Total Monthly Tax Deductions** \_\_\_\_\_

**Comparison of Household Income to Income Limit**  
(Use Attachment A.)

Household Size	
Gross Monthly Income	
-Tax Deductions	
Monthly Income After Deductions	
-5% FPL Disregard	
Net Income	
Income Limit	

Is the applicant eligible? Yes \_\_\_\_\_ No \_\_\_\_\_

PE Begin Date: \_\_\_\_\_

Estimated Date of Delivery (pregnant woman): \_\_\_\_\_

PE Provider Name (printed) \_\_\_\_\_

Staff Name (printed) \_\_\_\_\_ Signature \_\_\_\_\_

Date \_\_\_\_\_