



June 30, 2026

[Name First] [Name Last]  
[Address Line 1]  
[Address Line 2]  
[City, State Zip-Zip Extn]

Dear <<Recipient Name>>:

**We need information for your Medical Assistance (MA). You could lose MA if you do not respond.**

There will be new MA rules for some noncitizens starting October 1, 2026. We need information from you to see if you can still get MA coverage. Only people sent this letter need to respond.

Submit immigration documents by July 30, 2026 to see if you can still get healthcare with MA.

If you do not send your documents, your MA benefits may end starting October 1, 2026.

**What do I need to do?**

You must tell us if any of these things are true by submitting documents by July 30, 2026:

- If you are a U.S. citizen.
- If you are a lawful permanent resident (LPR) and have a “green card,”
- If you are a citizen of Cuba or Haiti designated a “Cuban Haitian Entrant.”
- If you are a citizen of Micronesia, the Marshall Islands, or Palau also known as a “COFA Migrant.”
- If you are lawfully present and under age 21.
- If you are lawfully present and are or were recently pregnant.

If you are any of these but need more time to get the documents, you must give us a written statement saying this.

**How do I submit documents?**

You can submit your documents in any one of the following ways:

- Online at [www.dhs.pa.gov/COMPASS](http://www.dhs.pa.gov/COMPASS);
- On the free myCOMPASS PA mobile app;
- By mail using the envelope included in this mailing; or
- In person at your local County Assistance Office.  
Find your local office at [www.dhs.pa.gov/CAO](http://www.dhs.pa.gov/CAO).

If you need help providing this information, contact the Customer Service Center at 1-877-395-8930 or 1-215-560-7226 (for Philadelphia residents).

**What do I do if I am not a U.S. Citizen, Lawful Permanent Resident (Green Card Holder), Cuban Haitian Entrant, COFA Migrant, under age 21, or pregnant?**

You could be eligible for different MA coverage if you submit additional documents to show that you are eligible for General Assistance (GA)-related MA or Emergency Medical Assistance (EMA). See #9-12 in the included Frequently Asked Questions.

**What happens if I am no longer eligible?**

If you provide verification of your immigration status and we determine that you are no longer eligible for any MA program, you will receive a notice that your MA is closing by October 1, 2026 and if we cannot determine that you are eligible for GA-related MA or EMA, you will be referred to Pennsylvania's Health Insurance Marketplace, Pennie.

**Need help?**

You can find more information about these changes by visiting [www.dhs.pa.gov/federalcuts](http://www.dhs.pa.gov/federalcuts) and clicking on the *Information for Noncitizens* link.

If you still have questions, you can call the Customer Service Center at 1-877-395-8930 or 1-215-560-7226 (for Philadelphia residents).

# House Resolution 1 (H.R. 1) Federally Funded Medical Assistance (MA) Eligibility Changes for Noncitizens Frequently Asked Questions (FAQs)

## 1. Why is this change happening?

Medicaid is a program that gets state and federal funding. In Pennsylvania, Medicaid is called Medical Assistance (MA).

A new federal law called House Resolution 1 (H.R. 1), also known as the One Big Beautiful Bill Act, was signed on July 4, 2025. Starting October 1, 2026, this law changes which noncitizens can get federally funded Medical Assistance (MA), also known as Medicaid.

Some noncitizens may still be able to get state funded MA. Keep reading for information about how noncitizens can still qualify for MA in Pennsylvania.

## 2. What changes are being made to MA eligibility for noncitizens?

Under H.R. 1, the following noncitizens will remain eligible for federally funded MA in Pennsylvania:

- Lawful Permanent Residents (LPRs)
- Cuban Haitian entrants
- Compact of Free Association migrants (those from the Marshall Islands, Micronesia, and Palau)
- Lawfully present individuals who are under age 21, or who are or were recently pregnant.

The following noncitizen statuses will no longer be eligible for federally funded MA after this change takes effect:

- Refugees who do not have LPR status
- Asylees who do not have LPR status
- Humanitarian parolees who do not have LPR status
- Victims of domestic violence or trafficking who do not have LPR status
- Individuals who have their deportation withheld

## 3. When does this change begin?

This change begins on October 1, 2026.

## 4. What does *lawfully present* mean?

*Lawfully present* is a broad term that includes almost everyone who is permitted to be in the United States and includes short-term and long-term stays.

**5. Do H.R. 1 changes impact federally funded MA eligibility for lawfully present noncitizen children under age 21 or pregnant women in Pennsylvania?**

No. In Pennsylvania, lawfully present noncitizens who are either under age 21 or pregnant or in their 12-month postpartum period will continue to be eligible for federally funded MA. For example:

- A victim of trafficking who is under age 21 will continue to be eligible for federally funded MA.
- A refugee who is pregnant will continue to be eligible for federally funded MA.

**6. Does H.R. 1 change the five-year wait period for noncitizens?**

Some individuals who become eligible noncitizens for federally funded MA must have their residency status for five years in the United States before they can receive MA and others will not. This is a federal requirement and H.R. 1 does not change who does and does not have this waiting period. H.R. 1 changes who an eligible noncitizen is for federally funded MA.

For example, beginning October 1, 2026, a non-pregnant, 35-year-old refugee without Cuban Haitian entrant classification is no longer an eligible noncitizen for federally funded MA. Once this individual becomes an LPR, they are an eligible noncitizen for federally funded MA and are exempt from the five-year wait period under another federal law.

There is no five-year wait period for GA-related MA or EMA.

**7. What happens if I am not currently an eligible noncitizen, and I become a Lawful Permanent Resident later?**

Lawful Permanent Residents, or green card holders, are potentially eligible for many different MA programs. If you have an immigration status that makes you ineligible on October 1, but then you get your green card after October 1, you should apply for MA at that time so we can see if you are eligible for an MA program.

**8. What if I lose MA and my circumstances change later?**

Apply again! You can apply for MA at any time. Losing MA does not mean you will not be eligible again. If your circumstances change, you may be eligible. For example, if you change citizen status, become pregnant, have a change in income, have an emergency medical condition or meet General Assistance (GA)-related MA requirements, you may be eligible for MA.

Apply online at [www.dhs.pa.gov/COMPASS](http://www.dhs.pa.gov/COMPASS).

## 9. What are the eligibility requirements for GA-related MA?

To be eligible for GA-related MA, you must be under income and resource limits and meet **one** or more of the following requirements:

- Parent or stepparent of a child under age 21;
- Age 59 or older;
- Have a verified disability or be in need of health sustaining medications;
- Caring for a child under age 13 (who is not your own) in your household;
- Caring for a person in your household who is ill or disabled;
- Getting treatment for drug or alcohol abuse that precludes any gainful employment;
- Victim of domestic violence and receiving protective services;
- Working at least 100 hours/month at minimum wage; or
- Be part of a two-parent household with your child who is either under age 13 or disabled and who does not qualify for MA in a Temporary Assistance for Needy Families category.

## 10. What documents do I need to submit to be reviewed for GA-related MA?

If your caseworker can review you for GA-related MA without additional documents based on your age and your family, your caseworker will do this.

For other common situations that may qualify you for GA-related MA, here is what you may need to provide depending on your circumstances:

If you have a disability...	→	Submit the Employability Assessment Form (PA 1663)
If you need health sustaining medication...	→	Submit the Health-Sustaining Medication Assessment Form (PA 1671)

## 11. What is Emergency Medical Assistance (EMA) and what are the eligibility requirements for it?

EMA is limited MA that covers services related to your emergency medical condition only. To be eligible for EMA, you must be under income and resource limits for federally funded MA, and you must have a verified emergency medical condition.

## 12. What documents do I need to submit to be reviewed for EMA?

We need to verify that you have an emergency medical condition. Submit the Emergency Medical Condition Information Eligibility Form (PA 1917).

**IMPORTANT INFORMATION** This notice concerns public benefits and requires immediate attention. If you need free language services, contact your county assistance office.

Albanian	INFORMACION I RËNDËSISHËM Ky njoftim ka të bëjë me përfitimet publike dhe kërkon vëmendje të menjëhershme. Nëse keni nevojë për shërbime gjuhësore falas, kontaktoni zyrën e ndihmës së qarkut tuaj.
Amharic	አስፈላጊ መረጃ ይህ ማስታወቂያ የህዝብ ጥቅም ጥቅሞችን የሚመለከት ሲሆን አፋጣኝ ትኩረት ይፈልጋል። ነጻ የቋንቋ አገልግሎቶች ከፈለጉ የካውንቲዎን የእርዳታ ቢሮ ያነጋግሩ።
Bengali	গুরুত্বপূর্ণ তথ্য এই বজ্রপত্ৰটি জনসাধারণের সুবিধা সম্পর্কিত এবং অবিলম্বে দৃষ্টি আকর্ষণ প্রয়োজন। যদি আপনার বনিমূল্যে ভাষা পরিস্কার প্রয়োজন হয়, তখন আপনার কাউন্টি সহায়তা অফিসের সাথে যোগাযোগ করুন।
Gujarati (India)	મહત્વપૂર્ણ માહતિ આ સૂચના જાહેર લાભો સંબંધિત છે અને તાત્કાલે ધ્યાન આપવાની જરૂર છે. જો તમને મફત ભાષા સેવાઓની જરૂર હોય, તો તમારી કાઉન્ટી સહાય કચેરીનો સંપર્ક કરો.
Hebrew	מיקום ותאם. תידיימי בל תמושת תשרודו תיירוביצ תובבחה לעגונ ו העדוה: בושח עדימ. לכול ש יורחמה עויעו הסדד שממל ונפ, בניחב הפש יתורישל.
Hindi (India)	महत्वपूर्ण जानकारी यह सूचना सार्वजनिक लाभों से संबंधित है और इस पर तुरंत ध्यान देने की आवश्यकता है। यदि आपको नशिलुक भाषा सेवाओं की आवश्यकता है, तो अपने काउंटी सहायता कार्यालय से संपर्क करें।
Korean	중요한 정보 이 안내문은 공공 혜택에 관한 것이며 즉각적인 주의가 필요합니다. 무료 언어 서비스가 필요하시면 해당 카운티 지원 사무소에 문의하십시오.
Malayalam (India)	പ്രധാന വിവരങ്ങൾ ഈ അറിയിപ്പ് പൊതുജനങ്ങൾക്കുള്ള അനുകൂല്യങ്ങളുടെ സംബന്ധിച്ചതാണ്, അതിനാൽ ഉടൻ ശ്രദ്ധ അനുവശ്യമാണ്. നിങ്ങൾക്ക് സൗജന്യ ഭാഷാ സേവനങ്ങൾ അനുവശ്യമുണ്ടെങ്കിൽ, നിങ്ങളുടെ കൗൺടി സഹായ ഓഫീസുമായി ബന്ധപ്പെടുക.
Punjabi/Panjabi	ਮਹੱਤਵਪੂਰਨ ਜਾਣਕਾਰੀ: ਇਹ ਸੂਚਨਾ ਸਰਕਾਰੀ ਲਾਭਾਂ ਨਾਲ ਸੰਬੰਧਿਤ ਹੈ ਅਤੇ ਤੁਰੰਤ ਤੁਹਾਡਾ ਧਿਆਨ ਮੰਗਦੀ ਹੈ। ਜੇ ਤੁਹਾਨੂੰ ਮੁਫਤ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ ਦੀ ਲੋੜ ਹੈ, ਤਾਂ ਆਪਣੇ ਕਾਉਂਟੀ ਸਹਾਇਤਾ ਦਫ਼ਤਰ ਨਾਲ ਸੰਪਰਕ ਕਰੋ।



Tigrinya	ኣገዳሲ ሓበሬታ እዚ ምልክታ 'ዚ ብዛዕባ ብመገገሕቲ ዝቐርቡ ሓገዛት እዩ፣ ቕልጡፍ ትኹረት ከኣ ይደሊ። ናጻ ናይ ቋንቋ ኣገልግሎታት እንተደሊኹም ንናይ ካውንቲኹም ቤት ጽሕፈት ሓገዝ ኣዘራርቡ።
Kinyarwanda	AMAKURU Y'INGENZI Iri tangazo rirarebana n'inyungu rusange kandi rirasaba kwitabwaho byihuse. Niba ukeneye serivisi z'ururimi ku buntu, hamagara ibiro bitanga ubufasha biherereye mu karere kawe
Rohingya	ضروري معلومات، اے اعلان گان عام ماینشور فائدار متعلق، فوراً ديان دؤن ضروري۔ زؤدی تونواتتو مفت زبانور خدمت لاگے، تویلے تونوار کاؤنٹی مددور اؤفیس لوی رابطہ گؤرؤ
Oromo	ODEEFFANNOO BARBAACHISAA Beeksisni kun faayidaa uummataa kan ilaallatu yoo ta'u, xiyyeeffannoo hatattamaa barbaada. Yoo tajaajila afaanii bilisaa barbaaddan, waajjira gargaarsa kaawuntii keessanii qunnamaa.
Hakha Chin/Lai	A BIAPIMI THAWNGTHANHNAK Hi theihternak cu mizapi thathnemnak kha biapi ah a chiah i a rannak in tawlrel a herh. Man loin holh riantuanpiaknak na herh ahcun, na pengkomh bawmhnak zung kha pehtlaihnak tuah.
Polish	WAŻNA INFORMACJA To zawiadomienie dotyczy świadczeń publicznych i wymaga natychmiastowej uwagi. Jeśli potrzebujesz bezpłatnych usług językowych, skontaktuj się z biurem pomocy swojego hrabstwa.

# PLEASE READ INSTRUCTIONS BEFORE COMPLETING FORM

## COMPLETION INSTRUCTIONS - EMPLOYABILITY ASSESSMENT FORM (PA 1663)

An individual with a physical or mental disability which temporarily or permanently precludes him or her from any gainful employment may be eligible for General Assistance, GA. This form must be completed to document the disability.

To implement these requirements, we are asking you to complete this form for an applicant for public assistance.

**Who may complete assessment:** The assessment may be performed only by a licensed physician, physician's assistant, certified registered nurse practitioner, or psychologist.

**Who signs the form:** Only the individual who performed the employability assessment may sign the form. The signature must be original or the form will be invalidated. Signature or clinic stamps, labels, and other facsimilies **are not** acceptable.

**General form completion requirements:** The information on the form and attachments must be complete and legible. The inability of county staff to read your material will result in the client's application being delayed and the form being returned to you for clarification. If possible, the form and any attachments should be typed.

If all questions are not answered fully, the client's application will be delayed and the form returned to you for completion.

## EMPLOYABILITY SECTION

**Permanently Disabled:** Check this block if the client should be considered permanently disabled and, therefore, unable to work. When making this determination, you must consider whether the client is unable to engage in **any gainful employment** by reason of any medically determinable physical or mental impairments. A medically determinable physical or mental impairment is an impairment that results from anatomical, physiological, or psychological abnormalities which can be shown by medically acceptable clinical and laboratory diagnostic techniques. A physical or mental impairment must be established by medical evidence consisting of signs, symptoms, and laboratory findings, **not** only by the individual's statement of symptoms.

**Temporarily Disabled:** There are two blocks for use in evaluating a client who is **temporarily disabled** - one for a client whose disability is expected to last 12 months or more, and one for a client whose disability is expected to last less than 12 months. Check the appropriate block if the client has an injury or condition that temporarily prevents the client from working in any gainful employment. Once the injury or ailment is resolved, the client can work. The date shown is when the temporary disability is expected to end. A client whose disability is expected to last 12 or more months may be a candidate for Social Security Disability or SSI benefits.

**Employable:** Check this block if, based on your examination, it is not appropriate to check either the Permanently or Temporarily Disabled blocks.

## EXAMINATION RESULTS SECTION

This section must be fully completed so that it clearly establishes the basis for your decision that the client is either temporarily or permanently disabled. Simply providing a diagnosis is not sufficient. You must provide information about the **basis** for your diagnosis and assessment. Further, documentation sufficient to support your decision, for example medical records, X-rays, and lab reports, must be available for further review if required.

**Questions:** Contact your local county assistance office



**CAO NAME AND ADDRESS**

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**CASE IDENTIFICATION**

CO	RECORD NUMBER	CAT	CSLD	DIST
RECORD NAME				DATE

**PENNSYLVANIA DEPARTMENT OF HUMAN SERVICES  
EMPLOYABILITY ASSESSMENT FORM**

WORKER:

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**SECTION I (Must be completed by applicant/recipient for public assistance)**

**PLEASE REVIEW ANY INFORMATION PRINTED BELOW. IF THIS INFORMATION IS INCORRECT, PLEASE STRIKE IT OUT AND WRITE IN THE CORRECT INFORMATION. PLEASE PRINT OR WRITE CLEARLY. BE SURE TO SIGN YOUR NAME AND DATE THIS FORM IN THE APPROPRIATE SPACE BELOW.**

NAME:	BIRTHDATE:	SOCIAL SECURITY NO.:
ADDRESS:	TELEPHONE NUMBER:	
CITY:	STATE:	ZIP CODE:

**BRIEFLY EXPLAIN WHY YOU BELIEVE YOU CANNOT WORK:**

<p><b>I HEREBY AUTHORIZE ALL MEDICAL PROVIDERS TO RELEASE ANY MEDICAL INFORMATION THAT IS RELATED TO MY EMPLOYABILITY TO THE PENNSYLVANIA DEPARTMENT OF HUMAN SERVICES. THE INFORMATION OBTAINED WILL BE USED ONLY FOR PURPOSES RELATED TO AN ASSESSMENT OF MY ABILITY TO WORK AND MY ELIGIBILITY FOR PUBLIC ASSISTANCE.</b></p> <p>X _____ (SIGNATURE) PUBLIC ASSISTANCE APPLICANT/RECIPIENT</p> <p>_____ PRINT NAME</p> <p>_____ DATE</p>
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**AFTER YOU HAVE COMPLETED THIS SECTION, ARRANGE FOR AN APPOINTMENT WITH A LICENSED PHYSICIAN (MEDICAL DOCTOR OR DOCTOR OF OSTEOPATHY), PHYSICIAN'S ASSISTANT, CERTIFIED REGISTERED NURSE PRACTITIONER, OR PSYCHOLOGIST. GENERAL ASSISTANCE BENEFITS CANNOT BE AUTHORIZED FOR YOU UNTIL THE FULLY-COMPLETED FORM IS RETURNED TO THE COUNTY ASSISTANCE OFFICE WORKER.**

**RETURN TO:**



**CAO NAME AND ADDRESS**

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**CASE IDENTIFICATION**

CO	RECORD NUMBER	CAT	CSLD	DIST
RECORD NAME				DATE

**PENNSYLVANIA DEPARTMENT OF HUMAN SERVICES  
HEALTH-SUSTAINING MEDICATION ASSESSMENT FORM**

APPLICANT/RECIPIENT NAME:	WORKER:
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*This form is to be completed for the applicant/recipient who requires medication that allows the person to be employable or continue with employment. All items in this section must be completed by a licensed prescriber and signed by both the physician and applicant/recipient.*

Does the applicant/recipient need health-sustaining medication? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, you do not need to enter any further information. Just sign and date. If Yes, complete the following information.
Diagnosis:
Medication(s) needed for the APPLICANT/RECIPIENT to sustain employment based on the above diagnosis:
Explain why the APPLICANT/RECIPIENT cannot work in any capacity without this medication. <i>(Please be specific)</i>

MEDICAL PROVIDER:	TELEPHONE NUMBER:	
ADDRESS:		
_____	_____	
SIGNATURE	DATE	
I HEREBY AUTHORIZE ALL MEDICAL PROVIDERS, INDIVIDUAL OR FACILITY OF WHATEVER TYPE, INCLUDING MENTAL HEALTH AND DRUG OR ALCOHOL TREATMENT TO RELEASE ALL MEDICAL/CLINICAL INFORMATION TO THE PENNSYLVANIA DEPARTMENT OF HUMAN SERVICES (DHS) WHICH RELATES TO MY ABILITY TO WORK.		
X _____	_____	_____
(SIGNATURE)	PRINTED NAME	DATE
PUBLIC ASSISTANCE APPLICANT/RECIPIENT		

See Reverse Side For Instructions

COMPLETION INSTRUCTIONS

# HEALTH–SUSTAINING MEDICATION ASSESSMENT FORM

*READ INSTRUCTIONS CONTAINING SPECIFIC DEFINITIONS AND REQUIREMENTS BEFORE COMPLETING THE FORM*

Medical information is required by the Department of Human Services (DHS) in determining whether an applicant qualifies for a certain category of public assistance benefits as well as his or her employability. Your medical assessment and documentation are necessary to help the CAO make these decisions.

- Who may complete the assessment:** The assessment may only be completed by the following licensed medical providers: physician, physician-assistant, certified registered nurse practitioner, or psychologist.
- Who signs the form:** Only the individual who completed the employability assessment may complete and sign the form. Signature or clinic stamps, labels, and other facsimiles **are not** acceptable. The signature must be original or the form will be invalidated.
- General form completion requirements:** The information on the form and attachments must be legible. The inability of county staff to read your material will result in the client's application being delayed and the form being returned to you for clarification. If at all possible, the form and any attachments should be typed.  
If all questions are not answered fully, the client's application will be delayed and the form returned to you for completion.
- Diagnosis:** Record your diagnosis of the applicant/recipient's condition. The explanation should indicate whether or not the condition is chronic or temporary. Attach documentation sufficient to support your decision such as medical records, X-rays, and lab reports that support your conclusion must be attached. Simply providing a diagnosis is not sufficient. Without this documentation, the client will be determined ineligible for benefits.
- Medication Needed:** List the medication(s) needed by the applicant/recipient that address his medical condition thus enabling him/her to be able to work.
- Explanation:** Explain in detail what the consequences to the applicant/recipient would be if the medication(s) listed above were not available to him/her. Document in this section whether the medication is for a chronic condition such as diabetes that the person will be required to take for life. Also indicate if the medication will be needed for a limited time period. If that is the case, show the date the person is expected to no longer need the medication.
- Questions:** Contact your local county assistance office at:

CAO NAME AND ADDRESS

CASE IDENTIFICATION				
CO	RECORD NUMBER	CAT	CSLD	DIST
RECORD NAME				DATE
WORKER				

Pennsylvania Department of Human Services

## EMERGENCY MEDICAL CONDITION INFORMATION ELIGIBILITY FORM

Certain noncitizens may be eligible to receive Medical Assistance (MA) to cover medical expenses necessary to treat an emergency medical condition. For purposes of MA eligibility for certain noncitizens, an emergency medical condition is defined as:

A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention is reasonably expected to result in serious jeopardy to the patient's health; or serious impairment to bodily functions; or serious dysfunction of any body part or organ. 42 U.S.C. 1396b(v)(3)

Please note that care and services related to an organ transplant procedure is not considered to be an emergency medical condition.

### HOW TO COMPLETE THE FORM:

**Section I:** Select any of the medical conditions which apply.

**NOTE:** There are many emergency medical conditions that are not listed in Section I. If the emergency medical condition is not listed, please select option I. "Any condition not described above" and list the condition. These applications will be reviewed by the department's clinical evaluation team.

**Section II:** State the beginning and expected end date of the treatment of the emergency medical condition.

**Section III:** State the treatment that is needed for each diagnosis listed.

**Section IV:** Certification and signature of medical provider.

APPLICANT'S INFORMATION		
NAME	BIRTHDATE	RECIPIENT I.D. NUMBER
ADDRESS (Include street, city, state & ZIP code)		TELEPHONE NUMBER

### TO BE COMPLETED BY MEDICAL PROVIDER (Must be a licensed physician, physician's assistant or certified nurse practitioner)

**NOTE TO PROVIDER:** Certain noncitizens may be eligible to receive Medical Assistance (MA) to cover medical expenses necessary to treat an emergency medical condition. For purposes of MA eligibility for certain noncitizens, an emergency medical condition is defined as a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of **immediate** medical attention is reasonably expected to result in serious jeopardy to the patient's health; or serious impairment to bodily functions; or serious dysfunction of any body part or organ. Please note that care and services related to an organ transplant procedure are not considered to be an emergency medical condition 42 U.S.C. 1396b(v)(2)(c) & (v)(3).

**I. MEDICAL CONDITION:** Please select any of the medical conditions that apply. **If conditions A through H are not applicable, select condition "I. Any condition not described above."** These applications will be reviewed by the department's clinical evaluation team.

- A. High risk pregnancy (if any of the following conditions are present) – Expected Due Date:** \_\_\_\_\_
- Preeclampsia (confirmed diagnosis with current pregnancy)
  - Diabetes (gestational DM requiring medication, type 1, or type 2 DM)
  - Current active medical conditions - hypertension (high blood pressure), HIV infection, sickle cell disease, lupus
  - Serious mental illness (uncontrolled) - (any of the following)
    - Psychosis
    - Bipolar
    - Schizophrenia
    - Major Depressive Disorder
  - Substance use disorder, excluding tobacco.
  - Multiple gestations (expecting twins, triplets, etc.)
  - Having had 5 or more births or pregnancy < 1 year since prior delivery.
  - Teenage pregnancy (age 18 and younger at first prenatal visit)
  - Advanced maternal age: 35 yrs or older at expected delivery date
  - A past pregnancy with pre-term delivery (before 37 weeks gestation)

**B. Diabetic emergencies:**

- Diabetic ketoacidosis - (which includes all of the following conditions)
  - Plasma glucose > 200 mg/dl
  - Serum bicarbonate level < 18 mEq/l
  - Arterial pH < 7.30
  - Ketonuria and/or ketonemia present
- Hyperglycemic hypersmolar state - (which includes all of the following conditions)
  - Impaired mental status
  - Plasma glucose >600mg/dl
  - Elevated serum osmolality > 320 mOsm/kg

**C. Renal failure requiring ongoing dialysis**

**D. Fracture of a bone in the skull, arm, leg, neck, spine, or pelvis that occurred within the past two months**

**E. Unstable seizure disorder: (if any of the following conditions are present)**

- Person has ≥ 5 minutes of continuous seizures
- Person has ≥ 2 discrete seizures between which there is incomplete recovery of consciousness

**F. Ventilator dependency**

**G. Labor and delivery – Delivery Date:** \_\_\_\_\_

**H. Acute inpatient psychiatric hospitalization**

**I. Any condition not described above:** \_\_\_\_\_

Attach medical documentation to verify the condition is/was an emergency medical condition, such as:

- Hospital admission history and physical and discharge summaries, including rehab hospitals, clinic, or ER notes
- Results of pathology reports or biopsies, especially when for a diagnosis of cancer
- Results of other diagnostic testing that supports the diagnosis and presence of an emergency medical condition (e.g. CT, labs, ultrasound)

<b>II. TREATMENT DATES:</b> Date(s) of Emergency Medical Treatment	BEGIN DATE	EXPECTED END DATE
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**III. EMERGENCY MEDICAL TREATMENT:** Please list the medical treatment needed for each diagnosis, including any hospitalization dates for treatment.

**IV. CERTIFICATION:** As a medical provider, I certify that all of the information provided on this form is true and correct to the best of my professional knowledge. I further certify that the care rendered is for an emergency medical condition and that the absence of immediate medical treatment could reasonably be expected to result in placing the patient's health in serious jeopardy, OR serious impairment to a bodily function, OR serious dysfunction of a bodily organ or part. I certify that the emergency is not an organ transplant or related to an organ transplant procedure. I understand and agree that the diagnosis and supporting documentation may be subjected to review by the Department of Human Services. I certify that submission of this form complies with all applicable privacy and security laws.

\_\_\_\_\_  
MEDICAL PROVIDER SIGNATURE

MEDICAL PROVIDER (Please print)	DATE	MA PROVIDER ID	NPI	TELEPHONE NUMBER
ADDRESS (Include street, city, state & ZIP code)				