Medicaid for the Elderly and Disabled – January 2015

The Alabama Medicaid Agency has a number of programs for the elderly and disabled. Medicaid for Institutional care is for people in nursing homes, hospitals, and ICF-MR facilities. Home and Community Based Waivers are for people who are elderly, disabled, homebound, mentally retarded, or who have certain diagnoses and who live in the community. SSI Related Medicaid programs are for people who no longer receive Supplemental Security Income (SSI) payments, but have their Medicaid benefits protected under certain laws.

To be eligible for the Medicaid programs listed above, you must:

- Be living in Alabama,
- Be a U.S. citizen (You must provide proof of citizenship and identity unless you have been approved for Medicare or SSI.), or be in satisfactory immigration status (You must provide proof of immigrant status.),
- Meet certain medical criteria,
- Have a monthly income below a certain limit, and
- Have resources below a certain limit.

NOTE: Eligibility for Home and Community Based Waivers (page 5) depends on the availability of slots from the administering agency.

Nursing Home, Hospital, and ICF-MR Medicaid for an Individual:

Medical Approval. An applicant must be medically approved by Medicaid or Medicare for the nursing facility to be paid. The nursing facility must submit the medical information to Medicaid. An applicant for Nursing Home, Hospital, or ICF-MR Medicaid must also be a resident of an approved medical institution for at least 30 continuous days to be eligible for Medicaid payments. (The exception is an SSI recipient.)

Income Limit. The income limit for Nursing Home, Hospital, or ICF-MR Medicaid is $2,199 per month for an individual. (This income limit changes each January.)

Some examples of income are:

Black Lung
Social Security
Veterans Benefits (less Aid and Attendant Care, and Continuing Medical Expenses)
Railroad Retirement
Federal Civil Service
Private Pensions or Retirements

SSI and welfare checks do not count as income.

for review.

Excess Resources. The resource limit for Nursing Home, Hospital, and ICF-MR Medicaid is $2,000 before the first day of the month. This means that in order to be eligible for Medicaid you must not have more than $2,000 in resources on the first day of any given month.

To keep from going over the $2,000 limit:

- If you owe money to the nursing home, pay it before the first of the month.
- Pay any of your bills that are due before the first of the month.
- Do not let anyone else deposit money into your bank account to help pay your bills. It may be counted as income in the month of the deposit and a countable resource the following month.
- If you get a Social Security check or other pension check and it is left in your bank account at the beginning of the next month, it is counted as a resource.
- If you have a life insurance or a burial contract for more than the limit, the amount over the limit will be counted as a resource.

Remember, if you have resources in excess of $2,000 on the first day of the month, you will NOT be eligible for Medicaid that month.

Disposal of Resources. You may not be eligible for Institutional Medicaid if you sold (for less than fair market value), gave away or transferred any resource(s) that you or your spouse owned.

Nursing Home, Hospital, and ICF-MR Medicaid for a married couple:

If a couple is legally married and one spouse is a patient in a medical institution (institutionalized spouse) while the other spouse remains in the community (community spouse), special rules apply for Nursing Home, Hospital, and ICF-MR Medicaid. Some or all of the assets of the couple may be protected for the community spouse. In addition, some of the income of the institutional spouse may be allocated to the community spouse.

Income Allocation for the Community Spouse. In order to receive a portion of the institutionalized spouse's income, the community spouse cannot have more than $1,967 per month. (This income allocation amount changes each July.)

If the community spouse has gross income at or above $1,967, no additional income can be allocated from the institutionalized spouse to the community spouse. If the community spouse has gross (before anything is taken out) monthly income that is less than $1,967 per month, the institutionalized spouse may allocate income to the community spouse.

Resource Assessment for the Community Spouse.

When someone enters the nursing home and their spouse remains in the community, an assessment of the combined assets (resources) is done by the Medicaid District Office. The Medicaid worker will ask for proof of all assets owned by the couple, either solely or jointly, as of the date the institutionalized spouse entered a medical institution. (Some of the same resource exclusions apply as mentioned earlier in this handout. The home will not

at 1-800-361-4491.
To qualify for these services you have to be receiving SSI, Adoption Assistance Medicaid, Medicaid for Low Income Families, or SSI Related Medicaid Programs (listed below). Limited funds and slots are available for these waivers.

SSI Related Medicaid:

Income limits. All SSI Related programs, such as Widow/Widower, Disabled Adult Child (DAC), Retroactive SSI, and Continuous (Pickle) Medicaid have an income limit that equals the Federal Benefit Rate (FBR) plus $20 per month.

The income limit for SSI Related Medicaid is $753 for an individual and $1,120 for a couple. (This income limit changes each January.)

NOTE: The couple income limit applies only if both are eligible, unless the ineligible spouse's income and resources are deemed (which means counting a portion of the income and resources) to the applicant. If only one person is eligible, the individual income limit applies.

In the Widow/Widower, DAC and Continuous cases, if the applicant otherwise qualifies, some income is not counted against the limit, such as Widow/Widower benefits, Child's benefits, or Social Security cost-of-living increases.

Resource limits. The resource limit for SSI Related Medicaid is $2,000.

Some resources do not count toward the $2,000 resource limit, they are:

1. Household goods and personal effects.
2. Life insurance (or any insurance with a cash surrender value), if the total combined face value is $1,500 or less.
3. Burial fund or prepaid burial contract of up to $1,500. (The amount excluded is reduced by life insurance. The District Office will have to have copies of the fund or contract.)
4. Burial space items (casket, vault, burial plot, marker, opening and closing of grave).
5. One automobile per household, if used by household member.

Please note: You must apply for and agree to accept any income from annuities, pensions, retirement, disability benefits, or other income to which you are entitled. Applying for these benefits is a condition of eligibility for Medicaid and failure to apply could keep you from having Medicaid eligibility.

For Veterans or Veteran's Dependents:
If you receive or are eligible to receive VA benefits, you must apply for the maximum benefit available. The amount you receive varies depending on the type of benefit. Rather than increase, some VA benefits are dropped to $90 while you are in a nursing home. You should contact VA to determine how your benefit will be affected

Some Things You Need to Know When Submitting an Application

Submitting an Application:
Complete the application to the best of your ability. The application must be completed and signed in ink, not pencil. Make sure the applicant's Name, Social Security Number, and Medicare Number are correct. If you have ever been married, include the Spouse's Name, Social Security Number, and if a veteran, the VA Claim Number.

Send the application to the appropriate District Office (see the back page of the application). A Medicaid caseworker will contact you for an interview after the application arrives in the District Office. It will be helpful if you include as many of the following items as possible when you submit the application:

1. Copies of Medicare and Social Security cards.
2. Verification of the gross (before anything is taken out) amount of Social Security, Veterans Administration, Railroad Retirement, Civil Service checks, private pension checks, rental income and annuities. (Verification should include claim and/or identification numbers.)
3. Copies of bank statements (all accounts) going back five years. First of month account balances that exceed $2,000 will require copies of cancelled/ imaged checks.
4. Verification of CDs, IRAs and Savings Bonds.
5. Verification of stocks, bonds and mutual funds.
6. Copies of deeds to property currently owned. (This includes heir property, life estate, etc.) Also, purchase and sale deeds to property which has been sold or transferred within the past five (5) years.
7. Copies of trusts, mortgages, loans, and promissory notes.
8. Copies of all insurance policies, including:
    a. Life, burial, funeral, vault, casket, cash, term and/or group.
    b. Long Term Care policies.
    c. Health, hospital, and/or cancer policies. (A copy of the card or premium notice and copy of payment method is needed.)
9. Copies of pre-need/prearranged burial contracts, including an itemized list of charges.
10. Verification of gross (before anything is taken out) wages.
11. Copy of power of attorney, guardianship papers, or curator papers.

Always keep a copy of the original application you submit to Medicaid. Send copies of all other documents, do not send your original documents except for proof of citizenship or identity, if required. Proof of citizenship and identity is not needed if you are currently receiving SSI benefits or are entitled to or enrolled in Medicare. If additional information is requested, make sure you supply the information as soon as possible. If you have questions about the information requested, call the Medicaid caseworker. If you need assistance in getting the information requested, see if the nursing home social service staff or business office worker is willing to assist.

Some things that can make a claimant ineligible:

- If someone else (a family member) deposits money (income) into the claimant's bank account, this is considered a "contribution" and must be budgeted as income to the claimant, which may make the claimant ineligible..

- If the claimant's countable resources exceed $2,000 on the first day of the month, the claimant will be ineligible. (An example would be if the claimant receives their June check in May, Medicaid will not count

- Allocation to family members,
- Health Insurance Premiums (verified as being paid with claimant's money).

The Annual Review Process:
Once a claimant has been approved for Medicaid, a review of the claimant's financial circumstances will be conducted annually. This means that one year from the date of the award notice, an annual review form will be mailed to the sponsor.

It is very important that the sponsor complete the form as soon as possible and return it, along with any requested information. Make sure the review form is signed, all the questions are answered and the requested information is enclosed.

You have ten (10) days to complete and return the form. If the form is not returned, along with the requested information, the active Medicaid case will be terminated.

Between Annual Reviews:

It is the responsibility of the claimant or sponsor to report any financial changes to their Medicaid caseworker within ten (10) days of the change. Examples of changes are: if claimant receives an increase in benefits or money from another source, if claimant returns home, if the sponsor changes his or her address, if the claimant stops paying premiums for health insurance. (If you are not sure if you should report a change, contact your Medicaid caseworker.)

Form 204/205 **Application/Redetermination for Elderly and Disabled Programs** 5/2014

Please print using dark ink.

1 Apply for Medicaid

I want to apply for Medicaid in the: (Check one)

☐ Hospital Name of Hospital_____ _____
(Date of Admission)

Address:_____

☐ Nursing Facility Name of Nursing Facility_____ _____
(Date of Admission)

Address:_____

☐ Home and Community Based Waiver Program (Application must be submitted to the Waiver Agency.)

☐ SSI Related Programs (Retroactive, DAC, Widow/Widower, Continuous and Grandfathered Children)

2 Applicant

Name:_____
First Middle/Maiden Last Suffix (Jr., Sr., II, etc.)

Mailing Address:_____

_____
City State Zip Code

Home Address:_____
(Street or 911 Address. If you are now in a nursing home, your home address before you went into the nursing home.)

_____
City State Zip Code

County of Residence:_____ Medicare #:_____

Date of Birth:_____ Social Security #:_____ Medicaid #:_____

Phone:_____ Fax:_____

Other Phone:(_____)_____ Whose?_____

E-Mail:_____

3 Marital Status (Marriage Information)

☐ I am Married _____ (Date Married)

☐ I am Divorced _____ (Date Divorced)

☐ I am Single (Never Married)

☐ I am Separated _____ (Date Separated)

☐ I am Widowed _____ (Date Widowed)

District Office Use Only

District Office Stamp

Applicant's Name:_____ SSN:_____

4 Race ☐ White ☐ Black ☐ American Indian ☐ Hispanic ☐ Asian
☐ Other_____

5 Sex ☐ Female ☐ Male

6 Living Arrangement

Check the item which describes your current living arrangement.

- ☐ In your own home with husband or wife (A)
- ☐ In your own home alone (A)
- ☐ In your parent's household (C)
- ☐ In a rented house, apartment, or room (A) Amount of Rent $ _____
- ☐ With someone else, not in your own home
  Do you pay any utilities or buy your own food? ☐ Yes (A) ☐ No (B)
- ☐ In a Nursing Home (D)
- ☐ In a Hospital (E)
- ☐ Intermediate Care Facility for the Mentally Retarded (F)
- ☐ Other: Please describe: _____

7 Residency Information

Are you a United States Citizen? ☐ Yes ☐ No If not, when did you enter the United States? _____

How long have you lived in Alabama? _____ Do you plan to remain in Alabama? ☐ Yes ☐ No

Before you lived in Alabama, where did you live?_____
City County State

What language do you usually speak? ☐ English ☐ Spanish ☐ Other_____

8 Supplemental Security Income (SSI) :

Have you ever applied for or received SSI? ☐ Yes ☐ No If yes, when? _____(month/year)

9 Sponsor **(If the applicant is unable to complete the application or provide additional information, the Medicaid sponsor should be the person <u>most</u> <u>familiar</u> with the financial situation of the applicant and should complete page 13.)**

Relationship to Applicant:_____

Name:_____ Home Phone:_____

Address:_____ Work Phone:_____

_____ Cell Phone:_____

_____ F AX :_____

City State Zip

E-Mail:_____

10 Legal S tatus **Has the applicant appointed a power of attorney or has a guardian or conservator been appointed?** ☐ Yes ☐ No

<u>If yes, provide a copy.</u>

Applicant's Name:_____ SSN:_____

11 Spouse Identification

(Must be completed if you are married or separated.)

Name:_____ Phone #:(_____)_____
First Middle Last Suf fix (Jr., Sr.)

Address:_____ Date of Birth:_____
(Street or Box Number)

_____ SSN:_____
City State Zip Code County

Email:_____ Spouse's Medicaid #:_____

12 Former Spouse Identification

(Must be completed if you are widowed or divorced.)
(For all previous marriages, list most recent first.)

1. Former Spouse's Name:_____ SS#:_____

   Date Marriage Began:_____ Ended:_____ Reason: ☐ Death ☐ Divorce ☐ Other

2. Former Spouse's Name:_____ SS#:_____

   Date Marriage Began:_____ Ended:_____ Reason: ☐ Death ☐ Divorce ☐ Other

13 Veteran's Status

Are you a Veteran? ☐ Yes ☐ No
Are you a dependent of a veteran? ☐ Yes ☐ No

If yes to either of the questions above, complete the following:

Veteran's Name:_____
First Middle Last Suffix (Jr., Sr.)

SSN:_____ VA Claim #:_____

Relationship to Veteran _____

Have you applied for Veteran's benefits under the new Veterans & Survivor's Improvement Act? ☐ Yes ☐ No
If yes, in which county did you apply? _____ If no, you must apply .

14 Household Members

List names of anyone under the age of 19, living in your household.

Name	Age	Relationship	Income Source	Monthly Amount
				$
				$
				$
				$
				$

Applicant's Name:_____ SSN:_____

15 Income

Gross Income (This means "money coming in" before anything is taken out.)

Do you or your spouse have "money coming in" from any of the sources listed below? ☐ Yes ☐ No
If yes, fill in the claim number and gross amount
NOTE: If you are applying on behalf of a child, each parent must also answer these questions.
NOTE: If you are applying on behalf of an adult, the spouse must also answer these questions.

Type of Income (Copy of most recent check stub or other form of verification required.)	Claim Number	Applicant Gross Amount	Spouse (or Parent) Gross Amount	Other (or Parent) Gross Amount	How Often Received? (Quarterly, Annually, etc.)
1. Social Security (include Medicare Premiums)					
2. SSI (Gold Check)					
3. Public Assistance (Welfare)					
4. Railroad Retirement					
5. Veterans Benefits, Pensions, Compensation or Insurance					
6. Federal Civil Service Annuity					
7. State Retirement/Pension					
8. Private Pension					
9. Miner's Benefits					
10. Black Lung Benefits					
11. Cash Contributions (from relatives, friends, others)					
12. Rental (land, buildings, or from roomer)					
13. Personal loans (relatives, friends, others)					
14. Unemployment Compensation					
15. Insurance Annuity or Proceeds					
16. Government Payments on land					
17. Coal, Oil, Gravel Rights and Timber Leases					
18. Royalties					
19. Court Ordered Support					
20. Interest on Savings					
21. Other: Specify _____					
22. Other: Specify _____					
23. Legal Settlements					
24. Sheltered Workshop Earnings					
25. Work Income					
(A copy of most recent check stub or some other form of verification must be provided.)					
26. Self Employment					
(A copy of last year's federal tax return must be provided (including Schedule "C" and/or "F").					
27. Dividends					

Applicant's Name:_____ SSN:_____

16 Property

Please complete all of the information concerning property you or your spouse own, or have owned in the past 5 years, or in which you or your spouse have had an interest.
If additional space is needed, please report on the last page of this application or attach a separate sheet of paper

Do you or your spouse now own or are you buying any property or do you have any interest (including life estate, heir pr operty, joint ownership, etc.) in land, buildings or other pr operty, including your home?

☐ Yes ☐ No

If yes, who owns the property? _____

If yes, where is the property located? (List the full address of the propertyinclude city, county and state:

Parcel 1:_____

Parcel 2:_____

Parcel 3:_____

Parcel 4:_____

Parcel 5:_____

Does anyone live there now? ☐ Yes ☐ No Which Parcel?_____

If yes, what is the persons name and relationship to the applicant? _____

If you are temporarily away from your home, do you intend to return home and live on this property in the future? ☐ Yes ☐ No

Do you owe money on the property? ☐ Yes ☐ No

If yes, send amortization schedule showing payment schedule and amount owed.

Do you have a r everse mortgage? ☐ Yes ☐ No

If yes, send verification of the payments you have received and the remaining balance.

Have you or your spouse owned or had any interest in any other property (including life estate, heir property, joint ownership, etc.) within 5 years of the month in which you filed a Medicaid application? ☐ Yes ☐ No

If yes, where was the property located? County:_____ State:_____

When did you sign a deed disposing of this property? _____

If you answered yes to owning property now or in the past 5 years, send copies of the deed(s) showing you pur chased the pr operty. If sold, copies of the deed(s) showing you transferr ed the property and a copy of the settment statement.

Do you or your spouse own a mobile home? ☐ Yes ☐ No If yes, send ownership (title) verification.

If yes, who owns the land where the mobile home or trailer is located? _____

Applicant's Name:_____ SSN:_____

17 Resources

Accounts (including checking, savings, certificate of deposit, IRAs)

Does applicant, spouse or parent's name now appear on an account of any kind? ☐ Yes ☐ No
Has applicant, spouse or parent's name appeared on a bank account of any kind in the last 5 years?
☐ Yes ☐ No
Does applicant, spouse or parent's name now appear on a safe deposit box? ☐ Yes ☐ No
Has applicant, spouse or parent's name appeared on a safe deposit box of any kind in the last 5 years?
☐ Yes ☐ No
If yes to any of the above questions, complete the following:

1. Name and address of Bank, Credit Union or Brokerage Firm: _____
Names on account: _____
Account Number:_____ Type of account: _____
If closed, what was date closed?_____ If open, what is current balance?_____

2. Name and address of Bank, Credit Union or Brokerage Firm: _____
Names on account: _____
Account Number:_____ Type of account: _____
If closed, what was date closed?_____ If open, what is current balance?_____

3. Name and address of Bank, Credit Union or Brokerage Firm: _____
Names on account: _____
Account Number:_____ Type of account: _____
If closed, what was date closed?_____ If open, what is current balance?_____

4. Name and address of Bank, Credit Union or Brokerage Firm: _____
Names on account: _____
Account Number:_____ Type of account: _____
If closed, what was date closed?_____ If open, what is current balance?_____

Bank statements and/or cancelled or imaged checks may be requested.

Do you (either alone, with your spouse, or with any other person) now have or have had in the past 5 years:

	Applicant	Spouse
1. An annuity or similar financial instrument: (Please describe separately under "Remarks" and provide current market value.)	$_____	$_____
Remarks:_____		
2. Stocks and bonds (Please list separately under "Remarks" and provide current market value for each. Copies required). Enter total value here:	$_____	$_____
Remarks:_____		
3. Cash not in bank	$_____	$_____

Applicant's Name:_____ SSN:_____

17 Resources (continued)

	Applicant	Spouse
4. Trust or special funds	$_____	$_____
5. Money owed to you (including mortgages and notes in which you have an interest). List persons and amounts in "Remarks."	$_____	$_____

Remarks:_____

_____

6. U.S. Government Savings Bonds (Copies required) $_____

$_____

7. Ownership interest in leases, mineral rights, timber rights or other rights to real business property . (For mineral rights, provide copy of Lease Agreement and verify income received.) (Please list separately under "Remarks" below.)

Enter total value here: $_____ $_____

Remarks:_____

_____

8. Other (Give details under "Remarks") $_____ $_____

Remarks:_____

_____

If you have additional resources, please report on the last page of the application or on a separate sheet of paper and attach to application.

18 Transfer of Resour ces

Has the applicant or spouse sold or given as a gift, any cash, property, vehicle, boat or other resource to any person within the past 5 years? ☐ Yes ☐ No

Item Sold or Given Away	Person to Whom it was Sold or Given	Date Given or Sold	Amount Received or Given

Applicant's Name:_____ SSN:_____

19 Life Insurance

Do you or your spouse have any life insurance policies? ☐ Yes ☐ No
(If yes, copy of face value page is required.)

1. Name of Company _____
   Address (if known) _____
   Policy Number _____
   Person insured ☐ Applicant ☐ Spouse Death Benefit/Face Value of Policy $_____

2. Name of Company _____
   Address (if known) _____
   Policy Number _____
   Person insured ☐ Applicant ☐ Spouse Death Benefit/Face Value of Policy $_____

3. Name of Company _____
   Address (if known) _____
   Policy Number _____
   Person insured ☐ Applicant ☐ Spouse Death Benefit/Face Value of Policy $_____

4. Name of Company _____
   Address (if known) _____
   Policy Number _____
   Person insured ☐ Applicant ☐ Spouse Death Benefit/Face Value of Policy $_____

5. Name of Company _____
   Address (if known) _____
   Policy Number _____
   Person insured ☐ Applicant ☐ Spouse Death Benefit/Face Value of Policy $_____

6. Name of Company _____
   Address (if known) _____
   Policy Number _____
   Person insured ☐ Applicant ☐ Spouse Death Benefit/Face Value of Policy $_____

Applicant's Name:_____ SSN:_____

20 Burial or Vault Insurance

Do you or your spouse have any burial or vault insurance policies? ☐ Yes ☐ No (If yes, copy of face value page is required.)

1. Name of Company _____
Address (if known) _____
Policy Number _____
Person insured ☐ Applicant ☐ Spouse Death Benefit/Face V alue of Policy $_____

2. Name of Company _____
Address (if known) _____
Policy Number _____
Person insured ☐ Applicant ☐ Spouse Death Benefit/Face V alue of Policy $_____

3. Name of Company _____
Address (if known) _____
Policy Number _____
Person insured ☐ Applicant ☐ Spouse Death Benefit/Face V alue of Policy $_____

21 Other Burial Fund

Do you or your spouse have a Pre-need contract with a funeral home? ☐ Yes ☐ No (If yes, copy of contract(s) is required.)

Name of Funeral Home _____

Address _____

Amount $_____

Do you or your spouse have anything else to pay burial expenses? (For example, savings account, cash, CD, etc.) ☐ Yes ☐ No

If yes, What? _____

_____

_____

Applicant's Name:_____ SSN:_____

22 Personal Property

Personal property consists of things you own that are not real property or liquid assets: cars, boats, tools, and equipment, furniture, antiques, and collections, ar e examples of personal pr operty.

Please complete the following sections and include your estimate of how much you would get if you sold it now

Do you or your spouse have:

1. An Automobile? ☐ Yes ☐ No

	Make	Model	Value	How is it used?	How much do you owe?
a.	_____	_____	$_____	_____	_____
b.	_____	_____	$_____	_____	_____
c.	_____	_____	$_____	_____	_____
d.	_____	_____	$_____	_____	_____
e.	_____	_____	$_____	_____	_____
f.	_____	_____	$_____	_____	_____
g.	_____	_____	$_____	_____	_____
h.	_____	_____	$_____	_____	_____

2. Tractor, Farm Machinery, Other Machinery and Equipment? ☐ Yes ☐ No

	Type of Equipment	Year Purchased	Value	How much do you owe?
a.	_____	_____	$_____	$_____
b.	_____	_____	$_____	$_____

3. Antiques, Hobby collections, etc. ☐ Yes ☐ No

a._____ Estimated value $_____

b._____ Estimated value $_____

Professional appraisal(s) may be required.

Applicant's Name:_____ SSN:_____

23 Medical Insurance

1. **Do you have any other health/accident/disability/hospital insurance?** ☐ Yes ☐ No

   Name of Company _____

   Address (if known)_____

   Type of Policy_____

   Who pays the health insurance premium? ☐ Yourself ☐ Other

   How much is the premium?_____

   How often do you pay?_____

   Name of Company _____

   Address (if known)_____

   Type of Policy_____

   Who pays the health insurance premium? ☐ Yourself ☐ Other

   How much is the premium?_____

   How often do you pay?_____

2. **Are you enrolled in a Medicare Part D drug plan to cover the costs of your medicines?**
   ☐ Yes ☐ No

   Name of Company_____

   Policy #_____ Premium Amount _____

Provide copies of all health insurance cards, including Part D.

<u>To keep money to pay yourhealth insurance premiums, you must provide proof of the premium amount and that you paid it with youmoney.</u>

3. **Do you have Long Term Care Insurance?** ☐ Yes ☐ No
   If yes, provide a copy of the policy and verification from the company of the total amount of benefits that have been paid.

   Plan Name_____

   Contract #_____

Applicant's Name:_____ SSN:_____

RELEASE OF INFORMATION

* I hereby authorize and give my consent for the Alabama Medicaid Agency to obtain information from any source for the purpose of determining my eligibility for Medicaid benefits. I authorize this release form to be in effect for as long as I am on Medicaid regardless of the date that it is signed. I further authorize copies of this document to be used in place of the original. I give my consent for the release of information for those purposes directly related to the administration of the Medicaid program. These purposes include, but are not limited to, establishing eligibility for benefits, determination of the amount of medical assistance received, the provision of services, and investigation of program violations.

AFFIRMATION AND AGREEMENT

* I understand that as a condition of receiving state medical assistance I shall disclose a description of any interest I or my spouse have in an annuity (or similar financial instrument), regardless of whether the annuity is irrevocable or is treated as an asset.
* I understand that as a condition of receiving state medical assistance the Alabama Medicaid Agency will become a remainder beneficiary on any annuity that I or my spouse purchased or on which we performed certain transactions on or after February 8, 2006.
* I certify under penalty of perjury that I am a citizen or national of the United States, or in satisfactory immigration status .
* I give permission to the Alabama Medicaid Agency to use my social security number to get information about my resources and income from banks, financial institutions, employers, and other county, state and federal agencies, and/or to see if I qualify for assistance or to see if I have insurance.
* I understand that if this application or other information shows that I may be eligible for payments or benefits from other sources, I am required to apply for them.
* I understand that if I am awarded nursing home benefits that part or all of my income must be applied to the nursing home bill as directed by the Alabama Medicaid Agency.
* I understand that my case is subject to review by State and Federal Quality Control and that I must cooperate in completing the application process or in any subsequent reviews of my eligibility, including reviews resulting from reported changes, recertification, or as a part of a State or Federal Quality Control Review.
* If I am approved for Medicaid, I assign all insurance and medical support benefits to Medicaid. If Medicaid pays my bills, then my insurance or other benefits (such as lawsuit settlements) must be used to pay Medicaid back. I agree to help and cooperate with Medicaid in identifying and collecting this money, or I may lose my Medicaid benefits. I give permission for my insurance company, employer, and others to give needed information to Medicaid in order to administer the Medicaid program.
* I understand that resources that have been sold, transferred, disposed of, or given away within the past 5 years from the month of application, may affect eligibility for Medicaid in a medical institution or a Home and Community Based Waiver Program.

RESPONSIBILITIES

* I agree to notify the Medicaid District Office within ten (10) days, if there is a change in my address, living arrangements, family size, income or resources. I agree to notify the district office if I return to work, am discharged from the nursing home, hospital or move from one to the other. I also agree to report any improvement in my medical condition if I am receiving Medicaid benefits because I am blind or disabled and I am not yet 65 years of age.

ESTATE RECOVERY

* I understand that my estate may be subject to recovery of any funds expended by Medicaid pursuant to this application and/or redetermination. My sponsor, relative, or other person who files my estate MUST notify Alabama Medicaid at ATTN: Estate Administration, P.O. Box 5624, Montgomery, Alabama 36103-5624.

FALSE STATEMENTS

* I know that anyone who makes or causes to be made a false statement, misrepresentation or omission of a material fact in an application or for use in determining eligibility for Medicaid commits a crime punishable under Federal or State law or both. I affirm under penalty of perjury that all information I give in this document or in support of it is true.

Does the applicant and/or sponsor/representative accept the terms of the Release of Information, Affirmation and Agreement, Responsibilities, Estate Recovery, and False Statements listed above and agree to notify the Medicaid District Office of any changes?

☐ Yes ☐ No

_____ _____

Signature of Applicant Date Signature of Spouse Date

_____

Signature of Parent or Sponsor Date

_____ _____

Witness' Signature Date Witness' Signature Date

Applicant's Name:_____ SSN:_____

APPOINTMENT OF REPRESENTATIVE

I hereby appoint: _____ (Sponsor 's Name) as my legal representative to act in my stead and on my behalf to apply , reapply and make claim for Medicaid benefits under Title XIX of the Social Security Act from the Alabama Medicaid Agency, hereby ratifying and confirming the acts of my said representative on my behalf. This appointment authorizes my said representative to fully act in my stead in connection with al l Medicaid matters involving me, including, but not limited to, making applications, reapplications and claims of all kinds, accepting and giving notice in connection with eligibility determinations and Fair Hearings, requesting information, and presenting and eliciting evidence. This appointment shall remain in full force and ef fect until I have notified the Alabama Medicaid Agency in writing that this authority has been withdrawn.

Done this the _____ day of _____, 20 _____.

WITNESSES:

_____ _____

(Signature of Medicaid Claimant)

_____ _____

(Social Security Number)

If claimant cannot sign his/her name but can make a mark; this is acceptable if witnessed by two adults.
The mark may be labeled. Example: X (Her mark) Jane Doe .

If claimant cannot sign his/her name or make a mark and there is no one legally designated as guardian, conservator , etc., representative must answer the questions below:

What is your relationship to claimant? _____

Why can't claimant sign? _____

To what extent are you responsible for claimant? _____

If claimant has a legally appointed guardian, conservator or someone with durable power of attorney who will represent him/her for Medicaid purposes, claimant's signature on this form is not required. Representative should sign the Representative portion of the form only and attach to this form a copy of evidence of legal authority to act on claimant' s behalf (Letter of Conservatorship/Guardianship or Durable Power of Attorney).

ACCEPTANCE OF APPOINTMENT

I hereby accept the foregoing appointment. I certify that I have not been suspended or prohibited from practice before the Alabama Medicaid Agency and am not otherwise disqualified from acting as an appointed representative. I acknowledge that representations and applications made by me on behalf of the claimant are made under an affirmation which subjects me to penalties for perjury and that false statements may subject me to penalties or fraud.
My relationship to the above is _____ (Attorney , relative, etc.)

Done this the _____ day of _____, 20 _____.

WITNESSES:

_____ _____

(Signature of Sponsor/Representative)

_____ _____

(Address)

_____

(City, State)

_____

(Telephone Number)

Applicant's Name:_____ SSN:_____

Additional Information