STATE OF ALABAMA
Alabama Medicaid Agency

Alabama Plan First
Section 1115 Demonstration Waiver
Renewal Application

August 7, 2014

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Section 1115 Demonstration

Section I- Program Description

This section should contain information describing the goals and objectives of the Demonstration, as well as the hypotheses that the Demonstration will test. In accordance with 42 CFR 431.412(a)(i), (v) and (vii), the information identified in this section must be included in a state's application in order to be determined complete. Specifically, this section should:

1) *Provide a summary of the proposed Demonstration program, and how it will further the objectives of title XIX and/or title XXI of the Social Security Act (the Act). (This summary will also be posted on Medicaid.gov after the application is submitted.*

2) *Include the rationale for the Demonstration.*

3) *Describe the hypotheses that will be tested/evaluated during the Demonstration's approval period and the plan by which the State will use to test them.*

4) *Describe where the Demonstration will operate, i.e., statewide, or in specific regions within the State. If the Demonstration will not operate statewide, please indicate the geographic areas/regions of the State where the Demonstration will operate.*

5) *Include the proposed timeframe for the Demonstration.*

6) *Describe whether the Demonstration will affect and/or modify other components of the State's current Medicaid and CHIP programs outside of eligibility, benefits, cost sharing or delivery systems.*

A. Summary of Proposed Demonstration

The Plan First program is designed to reduce pregnancies and improve the well-being of children and families in Alabama by extending Medicaid eligibility for family planning services to eligible women between the ages of 19-55 whose income is at or below 141% of the Federal Poverty Level (FPL). A standard income disregard of 5% of the FPL is applied if the individual is not eligible for coverage due to excess income.

Plan First was predicated on the recognized need for continued family planning once Medicaid eligibility for pregnancy ended and for those women who would not otherwise qualify for Medicaid unless pregnant. Women were able to obtain family planning services during their pregnancy related eligibility period, but often lost benefits when postpartum eligibility ended. Plan First afforded the state the ability to extend Medicaid eligibility after the birth of the baby and provided an avenue for extending eligibility to women who may not otherwise qualify for Medicaid. The program goal is to reduce unintended pregnancies.

Through Plan First, women are able to take advantage of family planning services and products that are offered through the Alabama Medicaid Agency, including smoking cessation counseling and smoking cessation products that were covered beginning October 1, 2012. Any qualified provider can enroll as a provider for the Plan First Program. Direct services are augmented with care coordination and tracking for "high risk" and "at risk" women to ensure compliance with the woman's chosen birth control method. Care coordination allows for enhanced education on appropriate use of the chosen method and further assurance of correct and continued usage.

When the program began, approximately 60,000 women were automatically enrolled. Enrollment increased steadily for the first five years of the program to over 100,000 women, after which there was a decline. The requirement to re-enroll annually, which was implemented in the beginning of the second Demonstration period, caused enrollment initially to decline, as did the requirement for citizenship and identification in 2006. Since then Alabama Medicaid has implemented a Social Security Administration data match effective January 2010 to verify citizenship, which has helped to streamline the process, and in February 2013 implemented automated Express-Lane Eligibility (ELE) renewals for Plan First women as well as children. This expedited renewal process, completed by the system, requires no participation from the case worker or recipient, enhancing the process. Enrollment numbers in the Plan First program have continued to increase since 2006, with an enrollment reaching 65% of potential eligibles in Demonstration Year (DY) 12.

By several measures, the Plan First program continues to reduce the likelihood that potentially Medicaid eligible women will become pregnant. Compared to estimates of the number of babies that would have been born to Plan First service users if their fertility rates reflected those of the general population before the start of the program, Plan First averted an estimated 11,215 births in DY10, decreasing slightly to 10,703 averted births in DY11, a result of an increase of births to Demonstration participants. Using estimated cost of $7,000 per maternity case, including the infant's first year of life, Plan First resulted in overall savings of $74,921,000 in the DY11 over what would have been spent without the program. As assessed in DY11, birth rates to Plan First met the performance target of 100 births or less per thousand per enrollee.

The Alabama Medicaid Agency will continue the Plan First Waiver in the same manner with two **anticipated** changes effective with the Waiver renewal:

- Add the removal of migrated or embedded IUD devices in an office setting or outpatient surgical facility.

- Add the coverage of vasectomies for eligible males 21 years of age or older.

The hypotheses regarding the Plan First program that will be evaluated include:

- Increase the portion of income eligible women, ages 19 –55 enrolled in Plan First and reduce race/ethnicity and geographic disparities among enrollees. Our goal is to enroll 80% of all eligible clients (based on census estimates of the eligible population) under age 40 across all race/ethnicity and geographic area groups, thereby eliminating disparities across these groups. Census data will be used to generate estimates of the eligible population.

- Maintain the high level of awareness of the Plan First program among program enrollees. Our goal is that 90% of surveyed enrollees will have heard of the program and 85% of these will be aware that they are enrolled in the program. Telephone surveys of enrollees will be used to track changes in levels of awareness of the program and enrollment in the program.

- Increase the portion of Plan First enrollees using family planning services initially after enrollment and in subsequent years of enrollment by improving access to services and increasing the rate of return visits for care. Our goal is to have 70% utilization of services by the end of the three year period, along with a 70% rate for 12 and 24 month return visits for individuals using services during the renewal period. Data will be generated from service use claims data and delivery data.

- Survey data suggest that approximately one third of Plan First enrollees are cigarette smokers, and 85% of these were advised by their family planning providers to quit smoking. Our goal is that 25% of Plan First service users (85% of the 30% who are smokers) will receive either a covered Nicotine Reduction Therapy (NRT) prescription, a referral to the Quit Line or both. Data will be generated from claims for NRT products and from client information provided by the Quit Line contractor.

- Maintain birth rates among Plan First service users that are lower than the estimated birth rates that would be occurring in the absence of the Plan First Demonstration. Our goal is to maintain the overall birth rate of about 100 births per 1000 Plan First enrollees. The eligible population counts will be based on income and insurance coverage estimates made from surveys collected by the Census Bureau annually.

- Increase the usage of the Plan First Waiver by making sterilizations available to males ages 21 years or older. This goal will be evaluated based on the number of sterilizations performed statewide.

The Plan First Demonstration will operate statewide and will not affect and/or modify other components of the current Medicaid and CHIP programs in Alabama.

The State of Alabama began the 1115(a) Research and Demonstration Waiver in October 2000 for 5 years; it was renewed in October 2005 for 3 years, and again in October 2008 for 3 years. In September 2011, the State was granted an extension until October 31, 2011, after which another temporary extension was granted until November 30, 2011. The State submitted a Waiver renewal on March 31, 2011, and was granted approval through December 31, 2013. In June 2013, the State was granted temporary extension of the Waiver until December 31, 2014. The State of Alabama requests the renewal of this Waiver for three years, beginning January 1, 2015, and ending December 31, 2017.

Section II- Demonstration Eligibility

This section should include information on the populations that will participate in the Demonstration, including income level. In accordance with 42 CFR 431.412(a)(ii), the information identified in this section must be included in a state's application in order to be determined complete. Specifically, this section should:

1) Include a chart identifying any populations whose eligibility will be affected by the Demonstration.

Eligibility groups qualified to participate in Plan First are shown in **Figure 1**.

Figure 1. Eligibility Chart for Mandatory State Plan Groups

Eligibility Group Name	Social Security Act and CFR Citations	Income Level
Women age 19 through 55 who have Poverty Level Eligible Children	1931	Does not exceed 141% of the FPL. A standard income disregard of 5% of the FPL is applied if the individual is not eligible for coverage due to excess income.
Poverty Level Pregnant Women age 19 through 55	1902(a)(10)(A)(i)(IV) 1902(1)(1)(A)	Does not exceed 141% of the FPL. A standard income disregard of 5% of the FPL is applied if the individual is not eligible for coverage due to excess income.
Other Women age 19 through 55 who are not pregnant, postpartum or not applying for a child	1902(a)(10)(E)(iv) 1905(p)(3)(A)(ii)	Does not exceed 141% of the FPL. A standard income disregard of 5% of the FPL is applied if the individual is not eligible for coverage due to excess income.

2) Describe the standards and methodologies the state will use to determine eligibility for any populations whose eligibility is changed under the Demonstration, to the extent those standards or methodologies differ from the State plan.

Applicants may apply for Plan First online at www.insurealabama.org or at Alabama Department of Public Health county health department sites with help from Public Health workers, using the regular online web application used by anyone applying for Medicaid.

Applicants may also apply for Plan First by submitting a paper application by mail. The standard Medicaid application form is utilized for Medicaid eligible females applying for pregnancy or family coverage, and a shortened application is used for the other applicants who are not pregnant and are not applying for Medicaid eligible children.

Women who have creditable insurance coverage will no longer be terminated or denied Plan First eligibility, but Plan First women with creditable coverage will still have to assign rights and provide insurance information for Third Party billing and coordination of benefits.

There are three groups of eligibles; however, there are no differences in benefits. The income limit for each of these groups does not exceed 141% of the FPL. A standard income disregard of 5% of the FPLis applied if the individual is not eligible for coverage due to excess income. The three groups are:

- Women age 19 through 55 who have eligible children (poverty level) who become eligible for family planning without a separate eligibility determination. They must answer yes to the Plan First question on the application. Income is verified at initial application and re-verified at re-certification of their children.

- Poverty level pregnant women age 19 through 55, whose pregnancy ends while she is on Medicaid. The Plan First Waiver system automatically determines Plan First eligibility for every female Medicaid member entitled to Plan First after a pregnancy has ended. Women automatically certified for the Plan First program receive a computer generated award notice by mail. If the woman does not wish to participate in the program, she can notify the caseworker to be decertified. Women who answered "no" to the Plan First question on the application and women who do not meet the citizenship requirement do not receive automatic eligibility. Income is verified at initial application and re-verified at re-certification of their children.

- Other women age 19 through 55 who are not pregnant, postpartum or who are not applying for a child may apply using a simplified shortened application. Modified Adjusted Gross Income (MAGI) eligibility determination will be completed using poverty level eligibility rules and standards. Client declaration of income will be accepted unless there is a discrepancy.

3) Specify any enrollment limits that apply for expansion populations under the Demonstration.

There are no enrollment limits for the Plan First program.

4) Provide the projected number of individuals who would be eligible for the Demonstration, and indicate if the projections are based on current state programs (i.e., Medicaid State plan, or populations covered using other waiver authority, such as 1915(c)).

The projected number of individuals who would be eligible under the renewed Demonstration Waiver is 197,552 for 2015, 223,577 for 2016 and 242,894 for 2017. The projections are based upon the average annualized enrollment between each calendar year beginning in 2009 and going to 2013. The membership as of December 2013 was 247,108.

5) To the extent that long term services and supports are furnished (either in institutions or the community), describe how the Demonstration will address post-eligibility treatment of income, if applicable. In addition, indicate whether the Demonstration will utilize spousal impoverishment rules under section 1924, or will utilize regular post-eligibility rules under 42 CFR 435.726 (SSI State and section 1634) or under 42 CFR 435.735 (209b State).

Long Term Services are not applicable to Plan First.

6) Describe any changes in eligibility procedures the state will use for populations under the Demonstration, including any eligibility simplifications that require 1115 authority (such as continuous eligibility or express lane eligibility for adults or express lane eligibility for children after 2013.

Currently, Alabama uses Express-Lane Eligibility (ELE) by relying on the income findings from the Supplemental Nutrition Assistance Program (SNAP) or Temporary Assistance for Needy Families (TANF) program to determine the eligibility for many children**.** Effective April 1, 2012, Alabama began using ELE to determine and redetermine eligibility for women ages 19 through 55 with income at or below 133% of the FPL. Effective January 1, 2014, the income amount for these women increased to 141% of the FPL. A standard income disregard of 5% of the FPL is applied if the individual is not eligible for coverage due to excess income. ELE continues to be used for Plan First women ages 19 to 55 to determine and redetermine eligibility. In addition, Plan First women will be given the opportunity to check on their initial application whether they want to renew their eligibility automatically up to 5 years using income data from tax returns.

7) If applicable, describe any eligibility changes that the state is seeking to undertake for the purposes of transitioning Medicaid or CHIP eligibility standards to the methodologies or standards applicable in 2014.

Currently, Alabama uses Express-Lane Eligibility (ELE) by relying on the income findings from the Supplemental Nutrition Assistance Program (SNAP) or Temporary Assistance for Needy Families (TANF) program to determine the eligibility for many children**.** Effective April 1, 2012, Alabama began using ELE to determine and redetermine eligibility for women age 19 through 55 with income at or below 133% of the FPL. Effective January 1, 2014, the income amount for these women increased to 141% of the FPL. A standard income disregard of 5% of the FPL is applied if the individual is not eligible for coverage due to excess income. ELE continues to be used on Plan First women age 19 to 55 to determine and redetermine eligibility. In addition, Plan First women will be given the opportunity to check on their initial application whether they want to renew their eligibility automatically up to 5 years using income data from tax returns.

Section III – Demonstration Benefits and Cost Sharing Requirements

This section should include information on the benefits provided under the Demonstration as well as any cost sharing requirements. In accordance with 42 CFR 431.412(a)(ii), the information identified in this section must be included in a state's application in order to be determined complete. Specifically, this section should:

1) Indicate whether the benefits provided under the Demonstration differ from those provided under the Medicaid and/or CHIP State plan:

   X Yes No

2) Indicate whether the cost sharing requirements under the Demonstration differ from those provided under the Medicaid and/or CHIP State plan:

   Yes X No

3) If changes are proposed, or if different benefit packages will apply to different eligibility group affected by the Demonstration, please include a chart specifying the benefit package that each eligibility group will receive under the Demonstration:

Figure 2. Proposed Changes for Demonstration Year 2015-2017

Example Benefit Package Chart Eligibility Group	Benefit Package
Expanding services to males by adding the coverage of vasectomies for ages 21 years or older whose income is at or below 141% of the FPL. A standard income disregard of 5% of the FPL is applied if the individual is not eligible for coverage due to excess income.	Demonstration-Only Benefit Package
Add the removal of migrated or embedded IUD devices in an office setting or outpatient surgical facility.	Demonstration-Only Benefit Package

4) *If electing benchmark-equivalent coverage for a population, please indicate which standard is being used:*

__Federal Employees Health Benefit Package
__State Employee Coverage
__Commercial Health Maintenance Organization
__Secretary Approved

Not applicable.

5) *In addition to the Benefit Specifications and Qualifications form: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/Downloads/Interim1115-Benefit-Specifications-and-Provider-Qualifications.pdf, please complete the following chart if the Demonstration will provide benefits that differ from the Medicaid or CHIP State plan.*

Benefits Chart

Benefit	Description of Amount, Duration, and Scope	Reference
Inpatient Hospital	Not covered	Mandatory 1905(a)(1), Mandatory for benchmark equivalent

		2103(c)(1)(A)
Outpatient Hospital	Only Plan First services and Plan First related services are covered. Comprehensive Hospital services are not covered.	Mandatory 1905(a)(2), Mandatory for benchmark equivalent 2103(c)(1)(A)
Rural Health Agency	Only Plan First services and Plan First related services are covered. Comprehensive rural health agency services are not covered.	Mandatory 1905(a)(2)
FQHC	Only Plan First services and Plan First related services are covered. Comprehensive FQHC services are not covered.	Mandatory 1905(a)(2)
Laboratory and X-Ray	Only Plan First services and Plan First related services are covered. Comprehensive lab & X-ray services are not covered.	Mandatory 1905(a)(3)
Nursing Facility Services age 21 & older	Not Covered	Mandatory 1905(a)(4)
EPSDT	Not Covered	Mandatory 1905(a)(4)
Family Planning Services	Covered if both the procedure code and diagnosis code are both on the approved list of Plan First covered services. This restriction does not apply to Medicaid family planning services.	Mandatory 1905(a)(4)
Tobacco Cessation for pregnant women	Not covered. Ineligible for Plan First Waiver if pregnant.	Mandatory 1905(a)(4)
Physician's Services	Only Plan First services and Plan First related services are covered. Comprehensive physician services are not covered.	Mandatory 1905(a)(5)
Medical or Surgical Services by a Dentist	Not covered	Mandatory 1905(a)(5)
Medical Care and remedial care-Podiatrist Services	Not covered	Optional 1905(a)(6)
Medical Care and	Not covered	Optional 1905(a)(6)

remedial care- Optometrists Services		
Medical Care and remedial care- Chiropractors services	Not covered	Optional 1905(a)(6)
Medical Care and remedial care- Other practitioners	Only Plan First services and Plan First related services are covered. Comprehensive services are not covered.	Optional 1905(a)(6)
Home Health Services- Intermittent or part-time	Not covered	Mandatory for certain individuals 1905(a)(7)
Home Health Services- home health aide	Not covered	Mandatory for certain individuals 1905(a)(7)
Home Health Services- Medical supplies, equipment and appliances	Not covered	Mandatory for certain individuals 1905(a)(7)
Home Health Services- Physical, occupational, & speech therapy, and audiology	Not covered	Optional 1905(a)(7), 1902(a)(10)(D), 42CFR 440.70
Private duty nursing	Not covered	Optional 1905(a)(8)
Agency services	Only Plan First services and Plan First related services are covered. Comprehensive agency services are not covered.	Optional 1905(a)(9)
Dental services	Not covered	Mandatory 2105(c)(5), Optional 1905(a)(10)
Physical Therapy	Not covered	Optional 1905(a)(11), Optional 2110(a)(22)
Occupational Therapy	Not covered	Optional 1905(a)(11), Optional 2110(a)(22)
Services for individuals with speech, hearing, and language disorders	Not covered	Optional 1905(a)(11), Optional 2110(a)(22)

Prescribed drugs	Only Plan First services and Plan First related services are covered. Comprehensive drug therapy for all diagnosis and medical needs are not covered.	Optional 1905(a)(12)
Dentures	Not covered	Optional 1905(a)(12)
Prosthetic devices	Not covered	Optional 1905(a)(12)
Eyeglasses	Not covered	Optional 1905(a)(12)
Diagnostic Services	Covered if both the procedure code and diagnosis code are both on the approved list of Plan First covered services. This restriction does not apply to Medicaid diagnostic services. Comprehensive services available to the Medicaid population are not covered under the Plan First Waiver.	Optional 1905(a)(13)
Screening Services	Covered if both the procedure code and diagnosis code are both on the approved list of Plan First covered services. This restriction does not apply to Medicaid screening services. Comprehensive services available to the Medicaid population are not covered under the Plan First Waiver.	Optional 1905(a)(13)
Preventive Services	Covered if both the procedure code and diagnosis code are both on the approved list of Plan First covered services. This restriction does not apply to Medicaid preventive services. Comprehensive services available to the Medicaid population are not covered under the Plan First Waiver.	Optional 1905(a)(13)
Rehabilitative Services	Not covered	Optional 1905(a)(13)
Services for individuals over 65 in IMDs-Inpatient hospital	Not covered	Optional 1905(a)(14)
Services for individuals over 65 in IMDs-Nursing facility	Not covered	Optional 1905(a)(14)

Intermediate Care Facility services for individuals in a public institution for the mentally retarded	Not covered	Optional 1905(a)(15)
Inpatient psychiatric service for under 22	Not covered	Optional 1905(a)(16)
Nurse-midwife services	Not covered	Mandatory 1905(a)(17)
Hospice Care	Not covered	Optional 1905(a)(18)
Targeted Case Management services	Not covered	Optional 1905(a)(19),1914(g)
Special TB related services	Not covered	Optional 1905(a)(19), 1902(z)(2)
Respiratory care services	Not covered	Optional 1905(a)(20)
Certified pediatric or family nurse practitioner's services	Covered if both the procedure code and diagnosis code are both on the approved list of Plan First covered services. This restriction does not apply to Medicaid nurse practitioner services. Comprehensive services available to the Medicaid population are not covered under the Plan First Waiver.	Mandatory 1905(a)(21)
Home and Community Care for functionally disabled elderly	Not covered	Optional 1905(a)(22)
Personal Care Services	Not covered	Optional 1905(a)(24), 42CFR 440.170
Primary Care case management	Not covered	Optional 1905(a)(25)
PACE services	Not covered	Optional 1905(a)(26)
Sickle-cell anemia related services	Not covered	Optional 1905(a)(27)
Free Standing Birth Centers	Not covered	Optional 1905(a)(28)

Transportation	Not covered	Optional 1905(a)(29)-42CFR 440.170. administrative required 42CFR 421.53
Services provided in religious non-medial health care facilities	Not covered	Optional 1905(a)(29), 42CFR 440.170(b)
Nursing facility services for patients under 21	Not covered	Optional 1905(a)(29), 42CFR 440.170(d)
Emergency Hospital services	Not covered.	Optional 1905(a)(29), 42CFR 440.170(e)
Expanded services for pregnant women-Additional pregnancy-related and postpartum services for a 60-day period after the pregnancy ends	Not covered	Optional 1905(e)(5)
Expanded services for pregnant women-Additional Services for any other medical conditions that may complicate pregnancy	Not covered	Optional 1905(e)(5)
Emergency services for certain legalized and undocumented non-citizens	Not covered	Mandatory 1903(v)(2)(A)
Home and community based services for elderly or disabled	Not covered	Optional 1915(i)
Self-directed personal assistance	Not covered	Optional 1915(k)
Community first choice	Not covered	Optional 1905(a)(29)
Well-baby and well-child care, including age appropriate	Not covered	Mandatory 2103(c)(1)(D)

immunizations		
Emergency services	Not covered	Mandatory 457.410(b)
Physicians surgical and medical services	Not covered	Mandatory for benchmark equivalent 2103(c)(1)(B)
Clinic services (including health center services) and other ambulatory health care services	Not covered	Optional 2110(a)(5)
Prenatal care and pre-pregnancy family services and supplies	Only Plan First services and Plan First related services are covered. Prenatal care is not covered.	Optional 2110(a)(9)
Inpatient mental health services	Not covered	Optional 2110(a)(10)
Outpatient mental health services	Not covered	Optional 2110(a)(11)
Durable medical equipment	Not covered	Optional 2110(a)(12)
Disposable medical supplies	Not covered	Optional 2110(a)(13)
Home and community-based health care services	Not covered	Optional 2110(a)(14)
Nursing care services	Not covered	Optional 2110(a)(15)
Abortion only if necessary to save the life of the mother or if pregnancy is the result of an act of rape or incest	Not covered	Optional 2110(a)(16)
Inpatient substance abuse treatment services	Not covered	Optional 2110(a)(18)
Outpatient substance abuse treatment	Not covered	Optional 2110(a)(19)

services		
Care coordination services	Only Plan First services and Plan First related services are covered.	Optional 2110(a)(21)
Hospice care	Not covered	Optional 2110(a)(23)
Any other medical, diagnostic, screening, preventative, restorative, remedial, therapeutic, or rehabilitative services	Not covered	Optional 2110(a)(24)
Premiums for private health insurance coverage	Not covered	Optional 2110(a)(25)
Medical transportation	Not covered	Optional 2110(a)(26)
Enabling services	Not covered	Optional 2110(a)(27)

6) *Indicate whether Long Term Services and Supports will be provided.*

__Yes (if yes, please check the services that are being offered) X No

7) *Indicate whether premium assistance for employer sponsored coverage will be available through the Demonstration.*

__Yes (if yes, please address the questions below)

_X No (if no, please skip this question)

8) If different from the State plan, provide the premium amounts by eligibility group and income level.

Not applicable.

9) *Include a table if the Demonstration will require copayments, coinsurance and/or deductibles that differ from the Medicaid State Plan.*

Not applicable.

10) Indicate if there are any exemptions from the proposed cost sharing.

Not applicable.

Section IV – Delivery System and Payment Rates for Services

This section should include information on the means by which benefits will be provided to Demonstration participants. In accordance with 42 CFR 431.412(a)(ii), a description of the proposed healthcare delivery system must be included in a state's application in order to be determined complete. Specifically, this section should:

1. *Indicate whether the delivery system used to provide benefits to Demonstration participants will differ from the Medicaid and/or CHIP State plan:*

__Yes X No (if no, please skip questions 2–7 and the applicable payment rate questions)

Section V – Implementation of Demonstration

This section should include the anticipated implementation date, as well as the approach that the State will use to implement the Demonstration. Specifically, this section should:

1) Describe the implementation schedule. If implementation is a phase-in approach, please specify the phases, including starting and completion dates by major component/milestone.

The implementation date for this renewal is January 1, 2015.

2) Describe how potential Demonstration participants will be notified/enrolled into the Demonstration; and

The Alabama Medicaid Agency will continue to use the current enrollment process and the current approach with this Waiver renewal.

3) If applicable, describe how the state will contract with managed care organizations to provide Demonstration benefits, including whether the state needs to conduct a procurement action.

Not Applicable.

Section VI – Demonstration Financing and Budget Neutrality

This section should include a narrative of how the Demonstration will be financed as well as the expenditure data that accompanies this application. The State must include 5 years of historical data, as well as projections on member month enrollment. In accordance with 42 CFR 431.412(a)(iii) and (iv), historical and projected expenditures as well as projected enrollment for the proposed Demonstration project must be included in a state's application in order to be determined complete. The additional information requested will be needed before the application can be acted upon.

Please complete the Demonstration financing and budget neutrality forms, respectively, and include with the narrative discussion. The Financing Form: http://www.medicaid.gov/Medicaid- CHIP-Program-Information/By-Topics/Waivers/1115/Downloads/Interim1115-Demo-Financing-Form.pdf includes a set of

standard financing questions typically raised in new section 1115 Demonstrations; not all will be applicable to every Demonstration application. The Budget Neutrality form and spreadsheet: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/Downloads/Interim1115-Budget-Neutrality-Form.pdf includes a set of questions with respect to historical expenditure data as well as projected Demonstration expenditures.

Please see Attachment 1 for the Financing Form and Attachment 2 for the Budget Neutrality Form.

Section VII – List of Proposed Waivers and Expenditure Authorities

This section should include a preliminary list of waivers and expenditures authorities related to title XIX and XXI authority that the State believes it will need to operate its Demonstration. In accordance with 42 CFR 431.412(a)(vi), this section must be included in a state's application in order to be determined complete. Specifically, this section should:

1) *Provide a list of proposed waivers and expenditure authorities; and*

2) *Describe why the state is requesting the waiver or expenditure authority, and how it will be used.*

Please refer to the list of title XIX and XXI waivers and expenditure authorities: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115 /Downloads/List-of-Waivers-and-Expenditure-Authorities.pdf that the state can reference to help complete this section.

Alabama is requesting waiver of selected Medicaid requirements to enable the operation of the Plan First Program as a Demonstration that will effectively meet the objectives as well as budget neutrality expectations. All Medicaid requirements apply, except for the following listed in Figure 4:

Figure 4. List of Proposed Waivers and Expenditures Authorities

Medicaid Requirement	Expenditure Authority	Waiver Request
Amount, Duration, and Scope of Services (Comparability)	Section 1902(a)(10)(B)	To the extent necessary to allow the State to offer the Demonstration population a benefit package consisting of family planning services and family planning-related services.
Retroactive Coverage	Section 1902(a)(34)	To the extent necessary to enable the State to not provide medical assistance to the Demonstration population for any time prior to when an

		application for the Demonstration is made.
Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)	Section 1902(a)(43)(A)	To the extent necessary to enable the State to not furnish or arrange for EPSDT services to the Demonstration population.
Eligibility Procedures and Standards	Section 1902(a)(17)	To the extent necessary to enable the State to use Express Lane eligibility determinations and redeterminations for the Demonstration population.

Section VIII – Public Notice

This section should include information on how the state solicited public comment during the development of the application in accordance with the requirements under 42 CFR 431.408.

The public comment period began on June 30, 2014, and ended on August 4, 2014.

Public notifications of the following public hearings were made via the Administrative Record for public hearings used by the Alabama Department of Human Resources. The procedures for these hearings are found in Attachment 3. A copy of the notification of the intent to apply for renewal of the 1115 Demonstration Waiver for the Plan First Waiver is included in Attachment 3 and was posted on June 30, 2014, on the following Alabama Medicaid website: http://medicaid.alabama.gov/CONTENT/4.0_Programs/4.4.0_Medical_Services/4.4.4.1_Plan_First.aspx.

The first public hearing was held on July 9, at the Alabama Medicaid Agency in Montgomery, AL. The second public hearing was held at the Alabama Medicaid Agency District Office in Birmingham, AL on July 10. The public was notified that they could attend the meetings in person, by call-in, or attend via a webinar.

The Alabama Medicaid Agency certifies that it used its email list system, including providers, provider associations, consumer advocates, and other stakeholder groups to notify the public of the Demonstration Proposal.

Figure 5. Public Hearings

Wednesday, July 9	Thursday, July 10
Alabama Medicaid Agency 4:00 p.m.-5:00 p.m. Moderator: Robin Rawls	Alabama Medicaid Agency District Office 11:00 a.m.-12:00 a.m. Moderator: Robin Rawls

Procedures for Public Hearings-At each public hearing, the Alabama Medicaid Agency Director of Communications provided introductory comments and a description of the purpose of the

public hearings. Public hearing attendees were invited to provide comments on the Demonstration Proposal. Telephone participants were also invited to provide comments via telephone. There were no comments made by attendees or telephone participants. No comments were received via mail during the public comment period.

Alabama Medicaid Agency certifies that the state provided public notice of the application in the State's Administrative Record 30 days prior to submitting the application to CMS.

Alabama Medicaid Agency further certifies that it provided public notices about the Demonstration Proposal as follows:

- Alabama Medicaid Agency published the abbreviated public notice in the Administrative Monthly on June 30, 2014.

A Screen Print of the Publication can be found on the Alabama Medicaid Agency website.

Certification that the state conducted tribal consultation more than 60 days prior to the submission of the Demonstration application is provided in Attachment 4. The Alabama Medicaid Agency sent a letter by certified mail to the Tribal Chairman of the Poarch Creek Band Indian Tribe on May 21, 2014. There were no comments received from the tribal consultation during or after sixty days from the date of notification.

Section IX – Demonstration Administration

Please provide the contact information for the state's point of contact for the Demonstration application.

Yulonda Morris, BSN, RN
501 Dexter Avenue
P.O. Box 5624
Montgomery, Alabama 36103-5624

Telephone: (334) 353-3227
Email address: Yulonda.morris@medicaid.alabama.gov

Exhibit 1: Quality Assurance

The Alabama Medicaid Agency is responsible for Quality Assurance, Complaint and Grievance Resolution, and Utilization Monitoring. In order to accomplish these Waiver requirements, the Agency will implement several monitoring functions as outlined below:

- Utilization reports from claims data to monitor trends and utilization,
- Monitor Care Coordinator activity via summary reports
- Review Summary Reports from UAB
- Coordinate complaints and grievances to acceptable resolution.

The University of Alabama at Birmingham conducts ongoing internal evaluations for this Demonstration Waiver. The primary contact person is Dr. Janet Bronstein, Associate Professor at the University of Alabama School of Public Health. Her responsibility is to evaluate the program. UAB has designed data collection tools that collect, compile and analyze data, providing feedback annually to the Alabama Medicaid Agency and the Department of Public Health on program operation and outcomes. With UAB's assistance, Dr. Bronstein compiles a yearly Demonstration progress report that illustrates progress, goal achievement, and other areas for continued improvement. UAB is not involved in direct patient care for the Plan First program.

Public Health Area supervisors audit Plan First care coordination patient records quarterly utilizing a standardized audit tool. These audits are submitted to the Public Health Central Office and are available for review by Medicaid. All care coordination patient records are documented electronically and the Central Office conducts an annual desk review of the patient records for each Care Coordinator, submitting a written report to supervisors. Six weeks after Care Coordinators complete certification training, the Central Office training staff reviews their documentation and submits a written report to their supervisor. The Public Health Program Integrity staff randomly reviews patient records in county health departments for compliance with travel reimbursement, billing of appropriate time for services, and ensuring that all time coded to Plan First has appropriate documentation to justify billing.

The Medicaid Agency provides general quality oversight for the Plan First program through direct monitoring and serves as the clearinghouse for other activities done in this area. The Agency conducts random checks on enrollment and claims data. Edits and audits are built into Medicaid's claims processes to prevent billing errors. Budgets are monitored on an on-going basis, and any areas of concern are evaluated and referred for claims review as indicated. The Agency has the responsibility for monitoring overall program performance, complaints and grievances.

Attachment 1: Demonstration Financing Form

Please complete this form to accompany Section VI of the application in order to describe the financing of the Demonstration.

The State proposes to finance the non-federal share of expenditures under the Demonstration using the following (please check all that are applicable):

_X_ State General Funds

__ Voluntary intergovernmental transfers from governmental entities. (Please specify and provide a funding diagram in the narrative section – Section VI of the application).

__Voluntary certified public expenditures from governmental entities. (Please specify and provide a funding diagram in the narrative section – Section VI of the application).

__ Provider taxes. (Provide description the narrative section – Section VI of the application).

__ other (If the State is interested in other funding or financing arrangements, please describe. Some examples could include, but are not limited to, safety net care pools, designated state health programs, Accountable Care Organization-like structures, bundled payments, etc.)

Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by States for services under the approved State Plan. To ensure that program dollars are used only to pay for Medicaid services, we are asking States to confirm to CMS that providers retain 100 per cent of the payments for services rendered or coverage provided.

Do providers receive and retain the total Medicaid expenditures claimed by the State (includes normal per diem, DRG, DSH, fee schedule, global payments, supplemental payments, enhanced payments, capitation payments, other), including the Federal and non-Federal share (NFS)?

_X_ Yes __No

If no, provide an explanation of the provider payment arrangement.

Do any providers (including managed care organizations [MCOs], prepaid inpatient health plans [PIHPs] and prepaid ambulatory health plans [PAHPs]) participate in such activities as intergovernmental transfers (IGTs) or certified public expenditure (CPE) payments, or is any portion of payments are returned to the State, local governmental entity, or other intermediary organizations?

__Yes _X_ No

If providers are required to return any portion of any payment, please provide a full description of the repayment process. Include in your response a full description of the methodology for the return of any of the payments, a complete listing of providers that return a portion of their

payments, the amount of percentage of payments that are returned, and the disposition and use of the funds once they are returned to the State (i.e., general fund, medical services account, etc.). Please indicate the period that the following data is from.

Section 1902(a) (2) provides that the lack of adequate funds from other sources will not result in the lowering of the amount, duration, scope, or quality of care and services available under the plan.

Please describe how the NFS of each type of Medicaid payment (normal per diem, DRG, fee schedule, global, supplemental, enhanced payments, capitation payments, other) is funded.

The source of funds that make up the non-Federal share of the Demonstration of each type of Medicaid payment is funded by State General fund appropriation.

Please describe whether the NFS comes from appropriations from the legislature to the Medicaid agency, through IGT agreements, CPEs, provider taxes, or any other mechanism used by the State to provide NFS. Note that, if the appropriation is not to the Medicaid agency, the source of the state share would necessarily be derived through either an IGT or CPE. In this case, please identify the agency to which the funds are appropriated.

The source of funds that make up the non-Federal share of the Demonstration of each type of Medicaid payment is funded by State General fund appropriation.

Please provide an estimate of total expenditures and NFS amounts for each type of Medicaid payment. Please indicate the period that the following data is from:

Medicaid payment for all Plan First 1115 Demonstration providers is based on the Medicaid fee schedule. An estimate of total and non-federal expenditures is provided below:

- Demonstration Year 11: $36,932,754 (total); $3,693,275 (non-federal).
- Demonstration Year 12: $39,299,089 (total); $3,929,909 (non-federal).
- Demonstration Year 13: $39,303,008 (total); $3,930,301 (non-federal).

If any of the NFS is being provided using IGTs or CPEs, please fully describe the matching arrangement, including when the state agency receives the transferred amounts from the local governmental entity transferring the funds.

Not Applicable.

If CPEs are used, please describe the methodology used by the State to verify that the total expenditures being certified are eligible for Federal matching funds is in accordance with 42 CFR 433.51(b).

Not Applicable.

For any payment funded by CPEs or IGTs, please provide the following, and indicate the period that the data is from:

Not Applicable.

Section 1902(a)(30)(A) requires that payment for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) and 2105(a)(1) provide for Federal financial participation to States for expenditures for services under an approved State Plan. If supplemental or enhanced payments are made, please provide the total amount for each type of supplemental or enhanced payment made to each provider, and indicate the time period that the data if from.

Not applicable.

Please provide a detailed description of the methodology used by the State to estimate the upper payment limit for each class of providers (State owned or operated, non-state government owned or operated, and privately owned or operated).

Inpatient Hospital UPL Description
Not applicable.

Outpatient Surgical Services
Outpatient surgical services are those covered procedures commonly performed on an inpatient basis that may be safely performed on an outpatient basis. Only those surgeries included on the Medicaid outpatient hospital fee schedule will be covered on an outpatient basis. Surgeries included on the Medicaid outpatient surgical list are reimbursable when provided on an inpatient basis if utilization review criteria are met. Hospitals may bill other procedures (within the 90000 range) if they are listed on the Outpatient Fee Schedule located on the Medicaid website: www.medicaid.alabama.gov.

Providers should refer to the fee schedule before scheduling outpatient surgeries since some procedures are restricted to recipients under age 20 and others may require prior authorization.

Surgical procedures that are not listed on Medicaid's outpatient fee schedule may be sent to the Institutional Services Unit to be considered for coverage in the outpatient setting if medically necessary and the procedure is approved by the Medical Director. Refer to the Hospital Fee Schedule on the Medicaid website for a list of covered surgical codes.

Patients who remain overnight after outpatient surgery, will be considered as an outpatient UNLESS the attending physician has written orders admitting the recipient to an inpatient bed. In such instances all outpatient charges should be combined on the inpatient claim.

Outpatient surgery reimbursement is a fee-for-service rate established for each covered surgical procedure on the Medicaid outpatient surgical list. This rate is established as a facility fee for the hospital and includes the following:
• All nursing and technician services
• Diagnostic, therapeutic and pathology services
• Pre-op and post-op lab and x-ray services
• Materials for anesthesia

• Drugs and biologicals
• Dressings, splints, casts, appliances, and equipment directly related to the surgical procedure.

In order to bill for bilateral procedures (previously identified by modifier 50), the most appropriate procedure code must be billed on two separate lines and appended by the most appropriate anatomical modifier (i.e. RT, LT, etc.). Medicaid will automatically pay the surgical procedure code with the highest reimbursement rate at 100% of the allowed amount and the subsequent surgical procedures at 50%, minus TPL and copay.

Clinic Services UPL Description

FQHC services and other ambulatory services provided at the FQHC including satellite center(s) will be reimbursed by an all-inclusive encounter rate. A Medicaid prospective payment system (PPS) for Federally Qualified Health Centers (FQHCs) was enacted into law under section 702 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act (BIPA) of 2000. As described in section 1902(aa) of the Social Security Act, FQHCs will be paid under a prospective payment system effective January 1, 2001. Prior to enactment of BIPA, FQHCs were reimbursed by an established encounter rate based on 100% of reasonable allowable cost for Medicaid covered services provided by the FQHC. With the implementation of BIPA, FQHC providers that provided Medicaid covered services for the period October 1, 2000, through December 31, 2000, will file a cost report and it will be settled. For the period January 1, 2001, through September 30, 2001, Alabama Medicaid Agency will pay FQHCs 100% of the average of their reasonable costs of providing Medicaid covered services during FY 1999 and FY 2000, adjusted to take into account any increase (or decrease), see paragraph (3) below, in the scope of services furnished during FY 2001 by the FQHC (calculating the payment amount on a per visit basis). Beginning in FY 2002, and for each fiscal year thereafter, each FQHC is entitled to the payment amount (on a per visit basis) to which the FQHC was entitled to in the previous fiscal year, increased by the percentage increase in the Medicare Economic Index (MEI) for primary care services, and adjusted to take into account any increase (or decrease) in the scope of services furnished by the FQHC during that fiscal year.

Reimbursement for an enrolled out-of-state FQHC will be the lesser of the encounter rate established by the Medicaid Department of the out-of-state FQHC or the average encounter rate established by Alabama Medicaid for in-state facilities.

A new FQHC provider or a provider who constructs, leases, or purchases a facility, or has a Medicaid approved change in the scope of services, can request reimbursement based on an operating budget, subject to the ceiling established under this rule. After the actual cost report is received and desk reviewed for the budget period, an actual encounter rate will be determined. In this event, the FQHC may be subject to a retroactive adjustment based on the difference between budgeted and actual allowable costs. This difference may be subject to settlement within thirty (30) days after written notification by Medicaid to the provider of the amount of the difference. After the initial year, payment shall be set using the MEI methods used for other FQHCs. An FQHC that has a change of ownership can retain the previous owner's encounter rate if desired.

Costs Reimbursed by Other Than FQHC Encounter Rate. Costs that are reimbursed by other Alabama Medicaid Agency programs will not also be reimbursed in the FQHC Program. Examples of such reimbursements include, but are not limited to:

(a) Maternity Waiver - Primary Contractor
(b) Prescription Drugs by enrolled pharmacy providers
(c) In-patient and out-patient surgical service fee-for-service payments.

In order to keep from paying for such services twice, the payments for the programs above will be deducted from the FQHC settlements.

Encounters are face-to-face contacts between a patient and a health professional for the provision of medically necessary services. Contacts with more than one health professional and multiple contacts with the same health professional, that take place on the same day and at a single location, constitute a single encounter unless the patient, subsequent to the first encounter, suffers illness or injury requiring additional diagnosis or treatment. This does not apply to dental service; however, dental services are limited to one dental encounter per date of service. Therefore, a patient can have one dental encounter and one other encounter on the same day. Services incident-to an encounter are inclusive.

Encounters are classified as either billable or non-billable. Billable encounters are visits for face-to-face contact between a patient and a health professional in order to receive medically necessary services such as lab services, x-ray services (including ultrasound and EKG), dental services, medical services, EPSDT services, family planning services, and prenatal services. Billable encounters are forwarded to the Fiscal Agent for payment through the proper filing of claims forms. Non-billable encounters are visits for face-to-face contact between a patient and health professional for services other than those listed above (i.e., visits to social worker, LPN). Such services include, but are not limited to, administering injections only, blood pressure checked only, and Tuberculosis skin testing. Non-billable encounters cannot be forwarded to the Fiscal Agent for payment. The costs of the non-billable encounters will be included in the allowable costs; however, the non-billable encounter will not be counted as an encounter on the cost report.

Oral Contraceptives, Contraceptive Patch and Vaginal Ring

Plan First recipients who choose to use oral contraceptives (OCPs), the contraceptive patch or vaginal ring and are seeing providers at a Federally Qualified Health Center (FQHC) will have the option of obtaining these supplies from the FQHC or a Medicaid enrolled community/outpatient pharmacy. In order to fill a prescription at a community/outpatient pharmacy, the Plan First-eligible patient must have received the prescription from their Plan First provider. A 30 day supply is the maximum that may be dispensed at one time.

FQHC's will provide and bill for oral contraceptives, the contraceptive patch and the vaginal ring using their National Provider Identifier (NPI). Covered services using this NPI are limited to the following procedure codes with modifier:

- S4993 FP Oral Contraceptives
- J7304 FP Contraceptive Patch
- J7303 FP Contraceptive Ring

These services are limited to 13 units annually and should be billed for Plan First recipients only.

Effective 5/1/2012, Federally Qualified Health Centers may submit claims for Mirena®, Paragard®, and Implanon® fee-for-service outside the encounter rate. FQHC and RHCs may submit a separate medical claim using the following procedure codes:
Mirena ® - J7302
Paragard ® – J7300
Implanon ® - J7307
Skyla ®-J7301

In order for FQHC's to be eligible to bill Plan First visits, they are required to be enrolled in Plan First. The Plan First visit will be reimbursed at the encounter rate when billed.

Does any public provider or contractor receive payments (normal per diem, DRG, fee schedule, global, supplemental, enhanced, and other) that, in the aggregate, exceed its reasonable costs of providing services?

__Yes _X_ No

In the case of MCOs, PIHPs, PAHPs, are there any actual or potential payments which supplement or otherwise exceed the amount certified as actuarially sound as required under 42 CFR 438.6(c)? (These payments could be for such things as incentive arrangements with contractors, risk sharing mechanisms such as stop-loss limits or risk corridors, or direct payments to providers such as DSH hospitals, academic medical centers, or FQHCs.)

Not applicable.

If so, how do these arrangements comply with the limits on payments in §438.6(c)(5 and §438.60 of the regulations?

Not applicable.

If payments exceed the cost of services (as defined above), does the State recoup the excess and return the Federal share of the excess to CMS on the quarterly expenditure report?

Not applicable.

Use of other Federal Funds

Are other federal funds, from CMS or another federal agency, being used for the Demonstration program?
__Yes _X_ No

If yes, provide a list below of grants the State is receiving from CMS or other federal agencies. CMS must ensure these funds are not being used as a source of the non-federal share, unless such use is permitted under federal law. In addition, this will help to identify potential areas of

duplicative efforts and highlight that this demonstration is building off of an existing grant or program.

Not applicable.

Attachment 2: Budget Neutrality Calculations

Alabama's Section 1115 Plan First Demonstration Waiver
January 1, 2015-December 31, 2017
Budget Neutrality Calculations

I. Budget Neutrality Methodology Discussion

To determine projected enrollment growth, we calculated the average annualized enrollment between each calendar year beginning in 2009 and going to 2013. Per this method, the average annualized rate of growth in enrollment is 9.2%. From CY 2009 to CY 2010 enrollment via member months grew by 6.5%. From CY 2010 to CY 2011 growth was 12.4%. From CY 2011 to CY 2012 growth was 6.8%. From CY 2012 to CY 2013 growth was 11.1%. The average across these 4 years total 9.2%.

Utilization and per member per month costs: For each time period members were identified as those enrolled with aid category 50 and/or code benefit plan 'PLNF' (Plan First). To normalize the distribution of enrollees, each enrollee was multiplied by the number of months they were enrolled and projections were based on the resulting member months. To ensure the data was not skewed, member months were evaluated on an overall as well as an average quarterly enrollment.

Cost trend/growth was projected at five (5.0%) per calendar year as asserted by CMS. Costs where then broken down to reflect the Federal share at 90% and the state share at 10%.

II. Budget Neutrality Calculations

Current Costs and Recipients DY 13

PF Expenditures	$39,303,008
PF Enrollees who utilize services—Quarterly Average	61,777
Cost per Person utilization	$370.08
Cost per Person per Month	$30.84

Trend Rate

President's Budget Trend (2015-2017) 5.0%

	DY 15 CY 2015	**DY 15** CY 2016	**DY 17** CY2017
Average Quarterly Enrollment	49,388	55,894	60,723

Per Member/Per Month (PMPM) Cost (Total Computable)

	Trend	**DY 15** CY 2015	**DY 16** CY 2016	**DY 17** CY2017
Demonstration Eligibles	5.0%	$42.10	$40.48	$38.93

SAMPLE: Extension Budget Neutrality Agreement (Total computable)

This is a sample in nature only to illustrate the projected costs of the Demonstration.

	DY 15 CY 2015	**DY 16** CY 2016	**DY 17** CY 2017	Total
Without Demonstration				
Member Months	49,388	55,894	60,723	166,005
PMPM	$42.10	$40.48	$31.33	
Total Costs	$41,268,158.25	$43,331,566.17	$45,498,144.47	$130,097,868.89
With Demonstration				
Member Months	49,388	55,894	60,723	
PMPM	$42.10	$40.48	$38.93	
Total Costs	$41,268,158.25	$43,331,566.17	$45,498,144.47	$130,097,868.89

Alabama Section 1115 Family Planning Demonstration
January 1, 2015-December 31, 2017 Extension Request
Historical Enrollment and Expenditure Data

I. Enrollment

	2009	2010	2011	2012	2013
January	14,410	15,077	17,042	18,530	21,206
February	13,849	14,777	17,106	18,231	19,879
March	15,432	17,800	19,537	19,677	20,216
April	15,097	16,817	17,484	19,082	21,089
May	14,789	16,454	18,570	20,310	21,523
June	15,462	17,634	18,931	19,430	19,993
July	15,557	17,390	18,204	19,763	21,937
August	15,366	18,286	20,398	20,744	21,883
September	15,129	18,213	19,311	19,746	20,873
October	15,807	17,424	19,053	21,760	21,298
November	14,366	17,056	18,197	20,171	18,494
December	15,644	17,813	18,597	19,278	18,717
Average	15,076	17,062	18,536	19,727	20,592

II. Reported Expenditures

Total	$33,533,031	$35,828,411	$36,932,754	$39,299,089	$39,303,008
Federal	$30,179,728	$32,245,570	$33,239,478	$35,369,180	$35,372,707
Non-Federal	$ 3,353,303	$ 3,582,841	$ 3,693,275	$ 3,929,909	$ 3,930,301

Attachment 3: Abbreviated Version of the Public Notice

Alabama Medicaid Agency

501 Dexter Avenue
P.O. Box 5624
Montgomery, Alabama 36103-5624

www.medicaid.alabama.gov
e-mail: almedicaid@medicaid.alabama.gov

ROBERT BENTLEY
Governor

Telecommunication for the Deaf: 1-800-253-0799
334-242-5000 1-800-362-1504

STEPHANIE MCGEE AZAR
Acting Commissioner

PUBLIC NOTICE

SUBJECT: NOTICE OF INTENT TO SUBMIT SECTION 1115 DEMONSTRATION RENEWAL

Pursuant to 42 C.F.R. § 431.408, the Alabama Medicaid Agency (Medicaid) is required to give public notice of its intent to submit a Section 1115 Waiver Demonstration renewal to the Centers for Medicare and Medicaid Services (CMS). Medicaid is seeking renewal of the 1115 Research and Demonstration Waiver to continue a delivery model for the provision of family planning services to eligible individuals in Alabama.

This delivery care model is designed to reduce unintended pregnancies and improve the well-being of women and infants in Alabama by extending Medicaid eligibility for family planning services to eligible women between the ages of 19-55 whose income is at or below 141% of the federal poverty level. A standard income disregard of 5% of the federal poverty level is applied if the individual is not eligible for coverage due to excess income.

The care delivery model will enable the State to meet the following goals:

1. Increase the enrollment of income eligible women ages 19-55 without insurance coverage.
2. Maintain the high level of awareness of the Plan First program among program enrollees.
3. Increase the portion of enrollees using family planning services after enrollment in subsequent years.
4. Increase referrals for primary care where indicated during family planning visits.
5. Maintain birth rates among service users that are lower than estimated birth rates without Plan First.

As required by federal regulation, Medicaid is now opening a formal thirty (30) day comment period. Additional information, a copy of the draft Demonstration renewal and the full Public Notice are available to interested parties by accessing the following link:
http://medicaid.alabama.gov/CONTENT/4.0_Programs/4.4.0_Medical_Services/4.4.4.1_Plan_First.aspx
A copy of the draft Demonstration renewal will also be available upon request for public review at each county office of the Department of Human Resources and the State Office of the Alabama Medicaid Agency. Additionally, two opportunities for public comment will be held at the following locations:

Wednesday, July 9th at 4:00 p.m.
Alabama Medicaid Agency Boardroom
501 Dexter Avenue
Montgomery, AL 36104

Thursday, July 10th at 11:00 a.m.
Alabama Medicaid Agency District Office
468 Palisades Blvd.
Birmingham, AL 35209

Medicaid is providing teleconference access for both meetings. Dial- in instructions can be obtained by accessing the following link:
http://medicaid.alabama.gov/CONTENT/4.0_Programs/4.4.0_Medical_Services/4.4.4.1_Plan_First.aspx
Written comments concerning these changes should be submitted on or before 5:00 p.m. August 4, 2014, to the following e-mail address: PublicComment@medicaid.alabama.gov or mailed hardcopy to: Administrative Secretary, Alabama Medicaid Agency, 501 Dexter Avenue, P.O. Box 5624, Montgomery, Alabama 36103-5624. All written comments will be available for review by the public during normal business hours at the above address.

Stephanie McGee Azar
Acting Commissioner

LEGISLATIVEREFSERVICE
REC'D & FILED
JUN 20 2014

JUN 20 2014
REC'D & FILED
JUN 20 2014
LEGISLATIVEREFSERVICE

Attachment 4: Notification for Tribal Consultations

91 7108 2133 3935 0283 2303

Alabama Medicaid Agency

501 Dexter Avenue
P.O. Box 5624
Montgomery, Alabama 36103-5624

www.medicaid.alabama.gov
e-mail: almedicaid@medicaid.alabama.gov

ROBERT BENTLEY
Governor

Telecommunication for the Deaf: 1-800-253-0799
334-242-5000 1-800-362-1504

STEPHANIE MCGEE AZAR
Acting Commissioner

May 21, 2014

Mr. Buford L. Rolin
Tribal Chairman
Poarch Band Indian Health Department
5811 Jack Springs Road
Atmore, Alabama 36502

Dear Mr. Rolin:

As directed by the Tribal Consultation section 1902(a) (73) of the Social Security Act and Federal Regulation, this notice to the Tribal Government is hereby given for the anticipated submission of the 1115 (b) Waiver which governs the operations of the Plan First Program. The Agency is considering a request to expand Plan First services to include coverage of vasectomies for males, coverage of complications secondary to insertion and placement of Intrauterine Devices and care coordination to women with adverse pregnancy outcomes with this waiver renewal.

The intent of this letter is to keep you informed of changes and to allow an opportunity for recommendations, comments, and input regarding the Waiver renewal. You have 30 days from the date of this letter to provide written comments. If you have any questions or concerns, please contact me at (334) 353-4599 or Jerri Jackson, Director of the Managed Care Division at (334) 242-5630.

Comments/concerns may be submitted to the attention of:

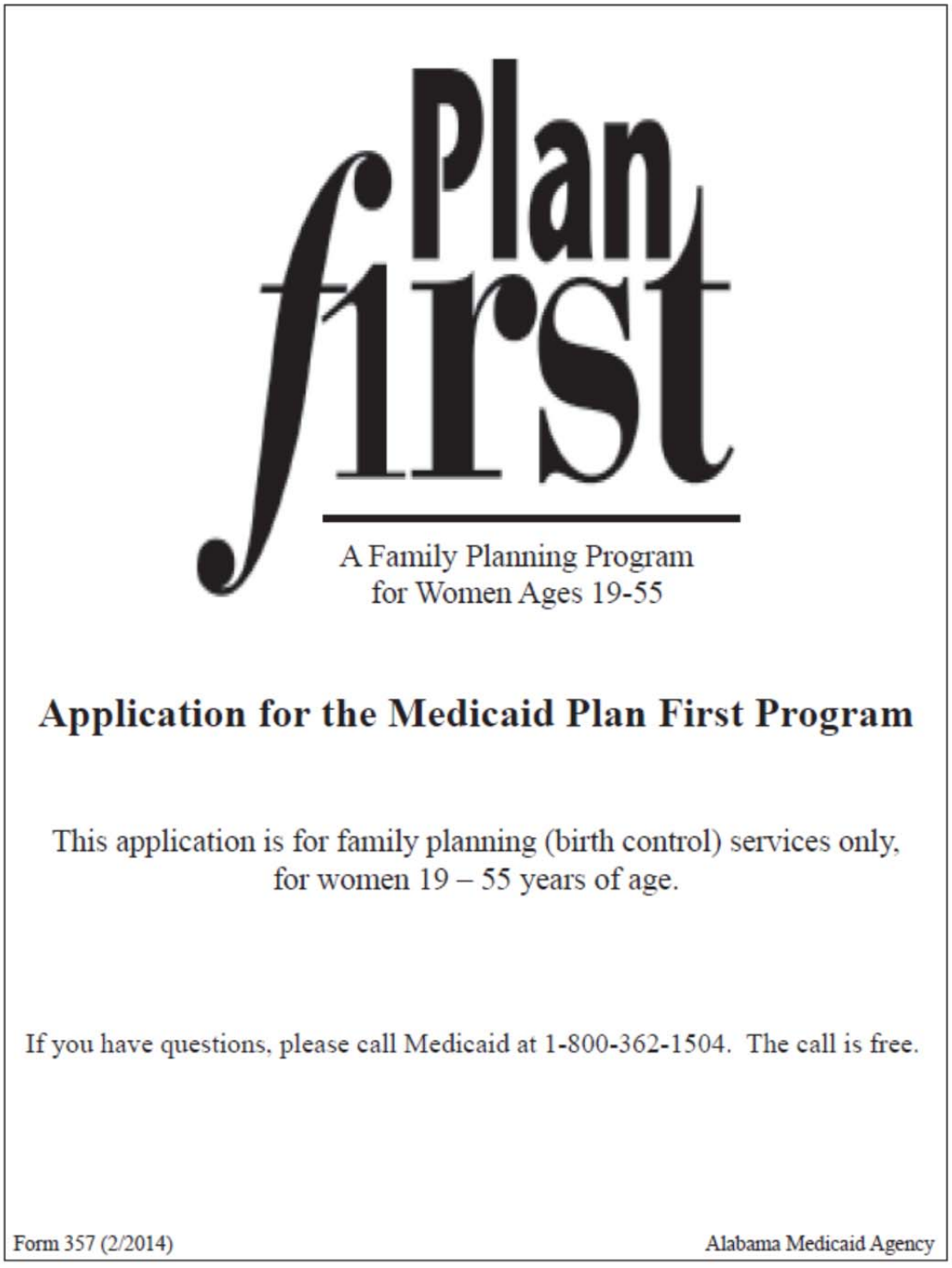
Sylisa Lee-Jackson R.N.
Associate Director
Maternity, Family Planning/Plan First and Nurse Midwife Programs
Managed Care Division
Alabama Medicaid Agency
501 Dexter Avenue
Montgomery, Alabama 36103-5624

Sincerely,

Sylisa Lee-Jackson
Associate Director
Maternity, Family Planning/Plan First and Nurse Midwife Programs
Alabama Medicaid Agency

Our Mission - to provide a system of financing health care for eligible Alabamians in accordance with established statutes and Executive Orders.

Attachment 5: Plan First Shortened Application For Women Without Children



Plan first

A Family Planning Program
for Women Ages 19-55

Application for the Medicaid Plan First Program

This application is for family planning (birth control) services only, for women 19 – 55 years of age.

If you have questions, please call Medicaid at 1-800-362-1504. The call is free.

Form 357 (2/2014) Alabama Medicaid Agency

Please print and use dark ink.

Plan First Application(Form 357)

1. **Name of Recipient** _____
(First Name) (Middle Name) (Maiden Name) (Last)

Social Security Number _____ **Date of Birth** _____ **Age** _____

2. **Race** _____ **Do you receive Medicare?** Yes ☐ No ☐

3. **Are you a female?** Yes ☐ No ☐ **Are you pregnant?** Yes ☐ No ☐
Have you had your tubes tied or been sterilized? Yes ☐ No ☐

4. **Are you a U.S. Citizen?** Yes ☐ No ☐

5. **Telephone Numbers where we can call you**

Cell Phone (_____)_____ Home Phone: (_____)_____

Work Phone (_____)_____ **May we contact you at work?** Yes ☐ No ☐

Other Phone (_____)_____ Whose Phone? _____

6. **Address where you want your Medicaid card sent**

_____
Street address or rural route number City State Zip Code County

Address where you live, if different from above

_____
Street address or rural route number City State Zip Code County

7. **Name of Spouse** _____

Spouse's Social Security Number _____

Spouse's Date of Birth _____ **Race** _____

8. **Do you have health/hospital insurance?** Yes ☐ No ☐ (Attach a copy of insurance card(s), front and back.)

Policyholder's Name	Insured Person's Name	Insurance Company & Address	Group # Policy #	Effective Date of Policy

Circle what this policy or policies cover Dental Doctor Visits Drugs Family Planning
Hospital Maternity Other

Is it a Managed Care or HMO? Yes ☐ No ☐

For Official Use Only

Date Received at Public Health _____ Date Accepted at Medicaid _____

9. Income

If you have no income, check here ☐ If your spouse has no income, check here ☐

10. Earned Income Complete the section below if you or your spouse have income from work.

If self-employed check here ☐

Your Income How often are you paid? Weekly ____ Every 2 weeks ____ Monthly ____ Other _____

Day of week paid _____ Gross amount paid per paycheck $ _____ (include all tips)

If hourly employee, hourly rate $_____ Hours worked per week _____

Name, address and telephone number of employer _____

_____

Spouse's Income How often is he paid? Weekly ____ Every 2 weeks ____ Monthly ____ Other _____

Day of week paid _____ Gross amount paid per paycheck $_____ (include all tips)

If hourly employee, hourly rate $ _____ Hours worked per week _____

Name, address and telephone number of employer _____

_____

11. Unearned Income Complete the section below if you or your spouse have income from any of the sources listed. Please list the **GROSS AMOUNT** (amount before anything is taken out).

1. Social Security	6. State Retirement	11. Rental Income	16. Coal, Oil, Timber
2. SSI	7. Private Pension	12. Personal Loans	17. Leases
3. Public Assistance	8. Miner's Benefits	13. Unemployment Comp	18. Interest on Savings
4. Railroad Retirement	9. Black Lung Benefits	14. Insurance Annuity	19. Other: (Explain) _____
5. Federal Civil Service	10. Cash Contributions	15. ASCS Gov't payment	_____

Name of Person Receiving Payments/Benefits	What Source? From Above	Gross Amount Received	How Often are Payments Received?

Do you plan to file income taxes next year? Yes ☐ No ☐

If yes, will you claim all the individuals listed above as tax dependents? Yes ☐ No ☐

If married, will you file jointly? Yes ☐ No ☐

Do you plan to claim the individuals listed above as tax dependents? Yes ☐ No ☐

List all you do not intend to claim for tax purposes _____

_____

List any other individuals you intend to claim that are not listed above _____

_____

Will you or anyone listed above be claimed on someone else's income taxes? Yes ☐ No ☐

Who listed above will be claimed by someone else?_____

_____

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 eligibilityfor 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. 1 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.

AGREEMENT AND AFFIRMATION

* I give permission to the Alabama Medicaid Agency and the Health Insurance Marketplace to use my social security number to get information about my 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 to qualify for assistance, or to see if I have insurance.
* 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 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 part of a State or Federal Quality Control Review.
* I agree to tell the Alabama Medicaid Agency immediately or in no more than 10 days if I receive additional income, if I move or if any changes occur in my circumstances.
* I understand and agree that I and my spouse must take all necessary steps to get any benefits such as annuities, pensions, unemployment compensation or retirement disability benefits that we may be entitled to.

Renewal of coverage in future years

To make it easier to determine my eligibility for help paying for health coverage in future years, I agree to allow the Medicaid Agency to use income data, including information from tax returns. Medicaid will send me a notice, let me make any changes,and I can opt out at any time.

Yes, renew my eligibility automatically for the next (Circle one)

☐ 5 years (the maximum number of years allowed), or for a shorter number of years:

☐ 4 years ☐ 3 years ☐ 2 years ☐ 1 year Do not use information from tax returns to renew my coverage.

FALSE STATEMENTS

I know that anyone who makes or causes to be made a false statement or representation of material fact in an application or for use in determining eligibility of 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.

_____ _____

Signature Date

_____ _____

Name and phone number of person helping to fill out this form Date

Mail this form to:

Alabama Medicaid Agency
Plan First Intake Unit
501 Dexter Avenue
PO Box 5624
Montgomery, Al 36103-5624

Medicaid eligibility policies and procedures are in compliance with the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, the Federal Age Discrimination Act of 1975 and the Americans with Disabilities Act of 1990.

Attachment 6: Regular Application For Women With Children

Application for Health Coverage & Help Paying Costs

THINGS TO KNOW

Use this application to see what coverage choices you qualify for

- Affordable private health insurance plans that offer comprehensive coverage to help you stay well
- A new tax credit that can immediately help pay your premiums for health coverage
- Free or low-cost insurance from Alabama Medicaid or ALL Kids.

You may qualify for a free or low-cost program even if you earn as much as $94,000 a year (for a family of 4).

Who can use this application?

- Use this application to apply for anyone in your family.
- Apply even if you or your child already has health coverage. You could be eligible for lower-cost or free coverage.
- If you're single, you may be able to use a short form. If you do not need help with cost, go to **HealthCare.gov**.
- Families that include immigrants can apply. You can apply for your child even if you aren't eligible for coverage. Applying won't affect your immigration status or chances of becoming a permanent resident or citizen.
- If someone is helping you fill out this application, you may need to complete Appendix C.

What you may need to apply

- Social Security Numbers (or document numbers for any legal immigrants who need insurance)
- Employer and income information for everyone in your family (for example, from paystubs, W-2 forms, or wage and tax statements)
- Policy numbers for any current health insurance
- Information about any job-related health insurance available to your family

Why do we ask for this information?

We ask about income and other information to let you know what coverage you qualify for and if you can get any help paying for it. **We'll keep all the information you provide private and secure, as required by law.** To view the Privacy Act Statement, go to HealthCare.gov/placeholder.

What happens next?

Send your complete, signed application to the address on page 11. **If you don't have all the information we ask for, sign and submit your application anyway.** We'll follow-up with you. You'll get instructions on the next steps to complete your health coverage. If you don't hear from us, call the Alabama Medicaid Agency at **1-800-362-1504** or call ALL Kids at **1-888-373-KIDS (5437)**. Filling out this application doesn't mean you have to buy health coverage.

NEED HELP WITH YOUR APPLICATION? If you have any questions, please call **ALL Kids** at our toll-free number **1-888-373-KIDS (5437)** Monday through Friday from 7:30 am to 5:00 pm CST to speak to a Customer Service representative. Or you may call the **Alabama Medicaid Agency** at **1-800-362-1504**. You may also leave a message at anytime or email us at **ALLKids@adph.state.al.us.**

STEP 1 Tell us about yourself.

(We need one adult in the family to be the contact person for your application.)

1. First name, Middle name, Last name, & Suffix

2. Mailing address			3. Apartment or suite number
4. City	5. State	6. ZIP code	7. County
8. Home address (if different from mailing address)			9. Apartment or suite number
10. City	11. State	12. ZIP code	13. County
14. Phone number ( ) –		15. Other phone number ( ) –	

16. Do you want to get information by email? ☐ Yes ☐ No

Email address: _____

17. What is your preferred spoken or written language (if not English)?

18. Marital Status: (Married, Divorced, Separated, Single, Widowed) **CIRCLE ONE**

STEP 2 Tell us about your family.

Who do you need to include on this application?

Tell us about all the family members who live with you. If you file taxes, we need to know about everyone on your tax return. (You don't need to file taxes to get health coverage).

DO Include:

- Yourself
- Your spouse
- Your children under 21 who live with you
- Your unmarried partner who needs health coverage
- Anyone you include on your tax return, even if they don't live with you
- Anyone else under 21 who you take care of and lives with you

You DON'T have to include:

- Your unmarried partner who doesn't need health coverage
- Your unmarried partner's children
- Your parents who live with you, but file their own tax return (if you're over 21)
- Other adult relatives who file their own tax return

The amount of assistance or type of program you qualify for depends on the number of people in your family and their incomes. This information helps us make sure everyone gets the best coverage they can.

Complete Step 2 for each person in your family. Start with yourself, then add other adults and children. **If you have more people in your family, you'll need to make a copy of the pages and attach them.** You don't need to provide immigration status or a Social Security Number (SSN) for family members who don't need health coverage. We'll keep all the information you provide private and secure as required by law. We'll use personal information only to check if you're eligible for health coverage.

NEED HELP WITH YOUR APPLICATION? If you have any questions, please call **ALL Kids** at our toll-free number **1-888-373-KIDS (5437)** Monday through Friday from 7:30 am to 5:00 pm CST to speak to a Customer Service representative. Or you may call the **Alabama Medicaid Agency** at **1-800-362-1504**. You may also leave a message at anytime or email us at **ALLKids@adph.state.al.us.**

STEP 2: PERSON 1 (Start with yourself)

Complete Step 2 for yourself, your spouse/partner and children who live with you and/or anyone on your same federal income tax return if you file one. See page 1 for more information about who to include. If you don't file a tax return, remember to still add family members who live with you.

1. First name, Middle name, Last name, & Suffix | 2. Relationship to you? **SELF**

3. Date of birth (mm/dd/yyyy) | 4. Sex ☐ Male ☐ Female

5. Social Security Number (SSN) ___ ___ ___ - ___ ___ - ___ ___ ___ ___

We need this if you want health coverage and have an SSN. Providing your SSN can be helpful if you don't want health coverage too since it can speed up the application process. We use SSNs to check income and other information to see who's eligible for help with health coverage costs. If someone wants help getting an SSN, call 1-800-772-1213 or visit **socialsecurity.gov.** TTY users should call 1-800-325-0778.

6. **Do you plan to file a federal income tax return NEXT YEAR?**
(You can still apply for health insurance even if you don't file a federal income tax return.)

☐ **YES. If yes,** please answer questions a–c. ☐ **NO. If no,** skip to question c.

a. Will you file jointly with a spouse? ☐ Yes ☐ No
If yes, name of spouse: _____

b. Will you claim any dependents on your tax return? ☐ Yes ☐ No
If yes, list name(s) of dependents: _____

c. Will you be claimed as a dependent on someone's tax return? ☐ Yes ☐ No
If yes, please list the name of the tax filer: _____
How are you related to the tax filer? _____

7. Are you pregnant? ☐ Yes ☐ No a. **If Yes,** how many babies are expected during this pregnancy? _____ **Due Date:** _____

Females Ages 19-55 May be eligible for Family Planning (Birth Control) Services. (NOTE: You will not be eligible for this program if you have had your tubes tied, been sterilized, or are on Medicare) **Do you want to apply for or continue to receive Family Planning?** ☐ **Yes** ☐ **No**

If you are interested in applying for WIC (for pregnant or breast-feeding women and children under age five) you can apply at your local County Health Department.

8. **Do you need health coverage?** *(Even if you have insurance, there might be a program with better coverage or lower costs).*

☐ **YES. If yes**, answer all the questions below. ⬇ ☐ **NO. If no,** SKIP to the income questions on page 3. Leave the rest of this page blank. ➡

9. Do you have a physical, mental, or emotional health condition that causes limitations in activities (like bathing, dressing, daily chores, etc) or live in a medical facility or nursing home? ☐ Yes ☐ No

10. Are you a U.S. citizen or U.S. national? ☐ Yes ☐ No **If No, Answer #11**

11. **If you aren't a U.S. citizen or U.S. national,** do you have eligible immigration status?
☐ Yes. Fill in your document type and ID number below.
a. Immigration document type _____ b. Document ID number _____
c. Have you lived in the U.S. since 1996? ☐ Yes ☐ No d. Are you, or your spouse or parent a veteran or an active-duty member of the U.S. military? ☐ Yes ☐ No

12. Do you want help paying for medical bills from the last three months? ☐ Yes ☐ No

13. Do you live with at least one child under the age of 19, and are you the main person taking care of this child? ☐ Yes ☐ No

14. Are you a full-time student? ☐ Yes ☐ No | 15. Were you in foster care at age 18 or older? ☐ Yes ☐ No

16. **If Hispanic/Latino, ethnicity (OPTIONAL—check all that apply.)**
☐ Mexican ☐ Mexican American ☐ Chicano/a ☐ Puerto Rican ☐ Cuban ☐ Other _____

17. **Race (OPTIONAL—check all that apply.)**

☐ White	☐ American Indian or Alaska Native	☐ Filipino	☐ Vietnamese	☐ Guamanian or Chamorro
☐ Black or African American	☐ Asian Indian	☐ Japanese	☐ Other Asian	☐ Samoan
	☐ Chinese	☐ Korean	☐ Native Hawaiian	☐ Other Pacific Islander
				☐ Other _____

NEED HELP WITH YOUR APPLICATION? If you have any questions, please call **ALL Kids** at our toll-free number **1-888-373-KIDS (5437)** Monday through Friday from 7:30 am to 5:00 pm CST to speak to a Customer Service representative. Or you may call the **Alabama Medicaid Agency** at **1-800-362-1504**. You may also leave a message at anytime or email us at **ALLKids@adph.state.al.us.**

STEP 2: PERSON 1 (Continue with yourself)

Current Job & Income Information

☐ **Employed**
If you're currently employed, tell us about your income. Start with question 18.

☐ **Not employed**
Skip to question 28.

☐ **Self-employed**
Skip to question 27.

CURRENT JOB 1:

18. Employer name and address

19. Employer phone number
( ) –

20. Wages/tips (before taxes) ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly

$ _____

21. Average hours worked each WEEK

CURRENT JOB 2: (If you have more jobs and need more space, attach another sheet of paper.)

22. Employer name and address

23. Employer phone number
( ) –

24. Wages/tips (before taxes) ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly

$ _____

25. Average hours worked each WEEK

26. **In the past year, did you:** ☐ Change jobs ☐ Stop working ☐ Start working fewer hours ☐ None of these

27. **If self-employed, answer the following questions:**

a. Type of work

_____

b. How much net income (profits once business expenses are paid) will you get from this self-employment this month?

$ _____

28. **OTHER INCOME THIS MONTH:** Check all that apply, and give the amount and how often you get it.

NOTE: You don't need to tell us about child support, veteran's payment, or Supplemental Security Income (SSI).

☐ None

☐ Unemployment $ _____ How often? _____

☐ Pensions $ _____ How often? _____

☐ Social Security $ _____ How often? _____

☐ Retirement accounts $ _____ How often? _____

☐ Alimony received $ _____ How often? _____

☐ Net farming/fishing $ _____ How often? _____

☐ Net rental/royalty $ _____ How often? _____

☐ Other income $ _____ How often? _____

Type: _____

29. **DEDUCTIONS:** Check all that apply, and give the amount and how often you get it.

If you pay for certain things that can be deducted on a federal income tax return, telling us about them could make the cost of health coverage a little lower.

NOTE: You shouldn't include a cost that you already considered in your answer to net self-employment (question 27b).

☐ Alimony paid $ _____ How often? _____

☐ Student loan interest $ _____ How often? _____

☐ Other deductions $ _____ How often? _____

Type: _____

30. **YEARLY INCOME: Complete only if your income changes from month to month.**

If you don't expect changes to your monthly income, skip to the next person.

Your total income **this year**	Your total income **next** year (if you think it will be different)
$	$

THANKS! This is all we need to know about you.

NEED HELP WITH YOUR APPLICATION? If you have any questions, please call **ALL Kids** at our toll-free number **1-888-373-KIDS (5437)** Monday through Friday from 7:30 am to 5:00 pm CST to speak to a Customer Service representative. Or you may call the **Alabama Medicaid Agency** at **1-800-362-1504**. You may also leave a message at anytime or email us at **ALLKids@adph.state.al.us.**

STEP 2: PERSON 2

Complete Step 2 for yourself, your spouse/partner, and children who live with you and/or anyone on your same federal income tax return if you file one. See page 1 for more information about who to include. If you don't file a tax return, remember to still add family members who live with you.

1. First name, Middle name, Last name, & Suffix | 2. Relationship to you?

3. Date of birth (mm/dd/yyyy) | 4. Sex ☐ Male ☐ Female

5. Social Security number (SSN) ___ ___ ___ - ___ ___ - ___ ___ ___ ___
We need this if you want health coverage and have an SSN.

6. Does PERSON 2 live at the same address as you? ☐ Yes ☐ No

If no, list address: _____

7. **Does PERSON 2 plan to file a federal income tax return NEXT YEAR?**
(You can still apply for health insurance even if you don't file a federal income tax return.)

☐ **YES. If yes**, please answer questions a–c. ☐ **NO. If no**, skip to question c.

a. Will PERSON 2 file jointly with a spouse? ☐ Yes ☐ No
If yes, name of spouse: _____

b. Will PERSON 2 claim any dependents on his or her tax return? ☐ Yes ☐ No
If yes, list name(s) of dependents: _____

c. Will PERSON 2 be claimed as a dependent on someone's tax return? ☐ Yes ☐ No
If yes, please list the name of the tax filer: _____
How is PERSON 2 related to the tax filer? _____

8. Is PERSON 2 pregnant? Yes No (circle one) a. **If yes**, how many babies are expected? _____ Due Date: _____

Females Ages 19-55 May be eligible for Family Planning (Birth Control) Services. (NOTE: You will not be eligible for this program if you have had your tubes tied, been sterilized, or are on Medicare) **Do you want to apply for or continue to receive Family Planning?** ☐ Yes ☐ No

If you are interested in applying for WIC (for pregnant or breast-feeding women and children under age five) you can apply at your local County Health Department.

9. **Does PERSON 2 need health coverage?**
(Even if they have insurance, there might be a program with better coverage or lower costs.)

☐ **YES. If yes**, answer all the questions below. ☐ **NO. If no**, SKIP to the income questions on page 5. Leave the rest of this page blank.

10. Does PERSON 2 have a physical, mental, or emotional health condition that causes limitations in activities (like bathing, dressing, daily chores, etc) or live in a medical facility or nursing home? ☐ Yes ☐ No

11. Is PERSON 2 a U.S. citizen or U.S. national? ☐ Yes ☐ No **If No, Answer #12**

12. **If PERSON 2 isn't a U.S. citizen or U.S. national,** do they have eligible immigration status?

☐ Yes. Fill in their document type and ID number below.

a. Document type _____ b. Document ID number _____

c. Has PERSON 2 lived in the U.S. since 1996? ☐ Yes ☐ No d. Is PERSON 2, or their spouse or parent a veteran or an active-duty member in the U.S. military? ☐ Yes ☐ No

13. Does PERSON 2 want help paying for medical bills from the last 3 months? ☐ Yes ☐ No

14. Does PERSON 2 live with at least one child under the age of 19, and are they the main person taking care of this child? ☐ Yes ☐ No

15. Was PERSON 2 in foster care at age 18 or older? ☐ Yes ☐ No

Please answer the following questions if PERSON 2 is 22 or younger:

16. Did PERSON 2 have insurance through a job and lose it within the past 3 months? ☐ Yes ☐ No

a. **If yes**, end date: _____ b. Reason the insurance ended: _____

17. Is PERSON 2 a full-time student? ☐ Yes ☐ No

18. **If Hispanic/Latino, ethnicity (OPTIONAL—check all that apply.)**

☐ Mexican ☐ Mexican American ☐ Chicano/a ☐ Puerto Rican ☐ Cuban ☐ Other _____

19. **Race (OPTIONAL—check all that apply.)**

☐ White
☐ Black or African American
☐ American Indian or Alaska Native
☐ Asian Indian
☐ Chinese
☐ Filipino
☐ Japanese
☐ Korean
☐ Vietnamese
☐ Other Asian
☐ Native Hawaiian
☐ Guamanian or Chamorro
☐ Samoan
☐ Other Pacific Islander
☐ Other _____

Now, tell us about any income from PERSON 2 on the back.

NEED HELP WITH YOUR APPLICATION? If you have any questions, please call **ALL Kids** at our toll-free number **1-888-373-KIDS (5437)** Monday through Friday from 7:30 am to 5:00 pm CST to speak to a Customer Service representative. Or you may call the **Alabama Medicaid Agency** at **1-800-362-1504**. You may also leave a message at anytime or email us at **ALLKids@adph.state.al.us**

STEP 2: PERSON 2 Continue with person 2

Current Job & Income Information

☐ **Employed**
If you're currently employed, tell us about your income. Start with question 20.

☐ **Not employed**
Skip to question 30.

☐ **Self-employed**
Skip to question 29.

CURRENT JOB 1:

20. Employer name and address

21. Employer phone number
( ) –

22. Wages/tips (before taxes) ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly

$ _____

23. Average hours worked each WEEK

CURRENT JOB 2: (If you have more jobs and need more space, attach another sheet of paper.)

24. Employer name and address

25. Employer phone number
( ) –

26. Wages/tips (before taxes) ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly

$ _____

27. Average hours worked each WEEK

28. **In the past year, did PERSON 2:** ☐ Change jobs ☐ Stop working ☐ Start working fewer hours ☐ None of these

29. **If self-employed, answer the following questions:**

a. Type of work

_____

b. How much net income (profits once business expenses are paid) will you get from this self-employment this month?

$ _____

30. **OTHER INCOME THIS MONTH:** Check all that apply, and give the amount and how often you get it.

NOTE: You don't need to tell us about child support, veteran's payment, or Supplemental Security Income (SSI).

☐ None

☐ Unemployment $ _____ How often? _____

☐ Pensions $ _____ How often? _____

☐ Social Security $ _____ How often? _____

☐ Retirement accounts $ _____ How often? _____

☐ Alimony received $ _____ How often? _____

☐ Net farming/fishing $ _____ How often? _____

☐ Net rental/royalty $ _____ How often? _____

☐ Other income $ _____ How often? _____
Type: _____

31. **DEDUCTIONS:** Check all that apply, and give the amount and how often you get it.

If PERSON 2 pays for certain things that can be deducted on a federal income tax return, telling us about them could make the cost of health coverage a little lower.

NOTE: You shouldn't include a cost that you already considered in your answer to net self-employment (question 29b).

☐ Alimony paid $ _____ How often? _____

☐ Student loan interest $ _____ How often? _____

☐ Other deductions $ _____ How often? _____
Type: _____

32. **YEARLY INCOME: Complete only if PERSON 2's income changes from month to month.**

If you don't expect changes to PERSON 2's monthly income, add another person or skip to the next section.

PERSON 2's total income **this year**	PERSON 2's total income **next year** (if you think it will be different)
$	$

THANKS! This is all we need to know about PERSON 2.

If you have more people to include, make a copy of Step 2: Person 2 (pages 4 and 5) and complete.

NEED HELP WITH YOUR APPLICATION? If you have any questions, please call **ALL Kids** at our toll-free number **1-888-373-KIDS (5437)** Monday through Friday from 7:30 am to 5:00 pm CST to speak to a Customer Service representative. Or you may call the **Alabama Medicaid Agency** at **1-800-362-1504**. You may also leave a message at anytime or email us at **ALLKids@adph.state.al.us.**

STEP 2: PERSON 3

Complete Step 2 for yourself, your spouse/partner, and children who live with you and/or anyone on your same federal income tax return if you file one. See page 1 for more information about who to include. If you don't file a tax return, remember to still add family members who live with you.

1. First name, Middle name, Last name, & Suffix | 2. Relationship to you?

3. Date of birth (mm/dd/yyyy) | 4. Sex ☐ Male ☐ Female

5. Social Security number (SSN) ___ ___ ___ - ___ ___ - ___ ___ ___ ___
We need this if you want health coverage and have an SSN.

6. Does PERSON 3 live at the same address as you? ☐ Yes ☐ No
If no, list address: _____

7. **Does PERSON 3 plan to file a federal income tax return NEXT YEAR?**
(You can still apply for health insurance even if you don't file a federal income tax return.)

☐ **YES. If yes,** please answer questions a–c. ☐ **NO. If no,** skip to question c.

a. Will PERSON 3 file jointly with a spouse? ☐ Yes ☐ No
If yes, name of spouse: _____

b. Will PERSON 3 claim any dependents on his or her tax return? ☐ Yes ☐ No
If yes, list name(s) of dependents: _____

c. Will PERSON 3 be claimed as a dependent on someone's tax return? ☐ Yes ☐ No
If yes, please list the name of the tax filer: _____
How is PERSON 3 related to the tax filer? _____

8. Is PERSON 3 pregnant? Yes No (circle one) a. **If yes,** how many babies are expected? _____ Due Date: _____

Females Ages 19-55 May be eligible for Family Planning (Birth Control) Services. (NOTE: You will not be eligible for this program if you have had your tubes tied, been sterilized, or are on Medicare) **Do you want to apply for or continue to receive Family Planning?** ☐ Yes ☐ No

If you are interested in applying for WIC (for pregnant or breast-feeding women and children under age five) you can apply at your local County Health Department.

9. **Does PERSON 3 need health coverage?**
(Even if they have insurance, there might be a program with better coverage or lower costs.)

☐ **YES. If yes**, answer all the questions below. ☐ **NO. If no,** SKIP to the income questions on page 5. Leave the rest of this page blank.

10. Does PERSON 3 have a physical, mental, or emotional health condition that causes limitations in activities (like bathing, dressing, daily chores, etc) or live in a medical facility or nursing home? ☐ Yes ☐ No

11. Is PERSON 3 a U.S. citizen or U.S. national? ☐ Yes ☐ No **If No, Answer #12**

12. **If PERSON 3 isn't a U.S. citizen or U.S. national,** do they have eligible immigration status?

☐ Yes. Fill in their document type and ID number below.

a. Document type _____ b. Document ID number _____

c. Has PERSON 2 lived in the U.S. since 1996? ☐ Yes ☐ No d. Is PERSON 3, or their spouse or parent a veteran or an active-duty member in the U.S. military? ☐ Yes ☐ No

13. Does PERSON 3 want help paying for medical bills from the last 3 months? ☐ Yes ☐ No

14. Does PERSON 3 live with at least one child under the age of 19, and are they the main person taking care of this child? ☐ Yes ☐ No

15. Was PERSON 3 in foster care at age 18 or older? ☐ Yes ☐ No

Please answer the following questions if PERSON 3 is 22 or younger:

16. Did PERSON 3 have insurance through a job and lose it within the past 3 months? ☐ Yes ☐ No

a. **If yes**, end date: _____ b. Reason the insurance ended: _____

17. Is PERSON 3 a full-time student? ☐ Yes ☐ No

18. **If Hispanic/Latino, ethnicity (OPTIONAL—check all that apply.)**

☐ Mexican ☐ Mexican American ☐ Chicano/a ☐ Puerto Rican ☐ Cuban ☐ Other _____

19. **Race (OPTIONAL—check all that apply.)**

☐ White
☐ Black or African American
☐ American Indian or Alaska Native
☐ Asian Indian
☐ Chinese
☐ Filipino
☐ Japanese
☐ Korean
☐ Vietnamese
☐ Other Asian
☐ Native Hawaiian
☐ Guamanian or Chamorro
☐ Samoan
☐ Other Pacific Islander
☐ Other _____

Now, tell us about any income from PERSON 3 on the back.

NEED HELP WITH YOUR APPLICATION? If you have any questions, please call **ALL Kids** at our toll-free number **1-888-373-KIDS (5437)** Monday through Friday from 7:30 am to 5:00 pm CST to speak to a Customer Service representative. Or you may call the **Alabama Medicaid Agency** at **1-800-362-1504**. You may also leave a message at anytime or email us at **ALLKids@adph.state.al.us.**

STEP 2: PERSON 3 Continue with person 3

Current Job & Income Information

☐ **Employed**
If Person 3 is currently employed, tell us about your income. Start with question 20.

☐ **Not employed**
Skip to question 30.

☐ **Self-employed**
Skip to question 29.

CURRENT JOB 1:

20. Employer name and address

21. Employer phone number
( ) –

22. Wages/tips (before taxes) ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly

$ _____

23. Average hours worked each WEEK

CURRENT JOB 2: (If Person 3 has more jobs and need more space, attach another sheet of paper.)

24. Employer name and address

25. Employer phone number
( ) –

26. Wages/tips (before taxes) ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly

$ _____

27. Average hours worked each WEEK

28. **In the past year, did PERSON 3:** ☐ Change jobs ☐ Stop working ☐ Start working fewer hours ☐ None of these

29. **If self-employed, answer the following questions:**

a. Type of work

_____

b. How much net income (profits once business expenses are paid) will you get from this self-employment this month?

$ _____

30. **OTHER INCOME THIS MONTH:** Check all that apply, and give the amount and how often you get it.

NOTE: You don't need to tell us about child support, veteran's payment, or Supplemental Security Income (SSI).

☐ None

☐ Unemployment $ _____ How often? _____

☐ Pensions $ _____ How often? _____

☐ Social Security $ _____ How often? _____

☐ Retirement accounts $ _____ How often? _____

☐ Alimony received $ _____ How often? _____

☐ Net farming/fishing $ _____ How often? _____

☐ Net rental/royalty $ _____ How often? _____

☐ Other income $ _____ How often? _____
Type: _____

31. **DEDUCTIONS:** Check all that apply, and give the amount and how often you get it.

If PERSON 3 pays for certain things that can be deducted on a federal income tax return, telling us about them could make the cost of health coverage a little lower.

NOTE: You shouldn't include a cost that you already considered in your answer to net self-employment (question 29b).

☐ Alimony paid $ _____ How often? _____

☐ Student loan interest $ _____ How often? _____

☐ Other deductions $ _____ How often? _____
Type: _____

32. **YEARLY INCOME: Complete only if PERSON 3's income changes from month to month.**

If you don't expect changes to PERSON 3's monthly income, add another person or skip to the next section.

PERSON 3's total income **this year**	PERSON 3's total income **next year** (if you think it will be different)
$	$

THANKS! This is all we need to know about PERSON 3.

If you have more people to include, make a copy of Step 2: Person 2 (pages 4 and 5) and complete.

NEED HELP WITH YOUR APPLICATION? If you have any questions, please call **ALL Kids** at our toll-free number **1-888-373-KIDS (5437)** Monday through Friday from 7:30 am to 5:00 pm CST to speak to a Customer Service representative. Or you may call the **Alabama Medicaid Agency** at **1-800-362-1504**. You may also leave a message at anytime or email us at **ALLKids@adph.state.al.us.**

STEP 2: PERSON 4

Complete Step 2 for yourself, your spouse/partner, and children who live with you and/or anyone on your same federal income tax return if you file one. See page 1 for more information about who to include. If you don't file a tax return, remember to still add family members who live with you.

1. First name, Middle name, Last name, & Suffix | 2. Relationship to you?

3. Date of birth (mm/dd/yyyy) | 4. Sex ☐ Male ☐ Female

5. Social Security number (SSN) ___ ___ ___ - ___ ___ - ___ ___ ___ ___
We need this if you want health coverage and have an SSN.

6. Does PERSON 4 live at the same address as you? ☐ Yes ☐ No

If no, list address: _____

7. **Does PERSON 4 plan to file a federal income tax return NEXT YEAR?**
(You can still apply for health insurance even if you don't file a federal income tax return.)

☐ **YES. If yes,** please answer questions a–c. ☐ **NO. If no,** skip to question c.

a. Will PERSON 4 file jointly with a spouse? ☐ Yes ☐ No
If yes, name of spouse: _____

b. Will PERSON 4 claim any dependents on his or her tax return? ☐ Yes ☐ No
If yes, list name(s) of dependents: _____

c. Will PERSON 4 be claimed as a dependent on someone's tax return? ☐ Yes ☐ No
If yes, please list the name of the tax filer: _____
How is PERSON 3 related to the tax filer? _____

8. Is PERSON 4 pregnant? Yes No (circle one) a. **If yes,** how many babies are expected? _____ Due Date: _____

Females Ages 19-55 May be eligible for Family Planning (Birth Control) Services. (NOTE: You will not be eligible for this program if you have had your tubes tied, been sterilized, or are on Medicare) **Do you want to apply for or continue to receive Family Planning?** ☐ Yes ☐ No

If you are interested in applying for WIC (for pregnant or breast-feeding women and children under age five) you can apply at your local County Health Department.

9. **Does PERSON 4 need health coverage?**
(Even if they have insurance, there might be a program with better coverage or lower costs.)

☐ **YES. If yes,** answer all the questions below. ☐ **NO. If no,** SKIP to the income questions on page 5. Leave the rest of this page blank.

10. Does PERSON 4 have a physical, mental, or emotional health condition that causes limitations in activities (like bathing, dressing, daily chores, etc) or live in a medical facility or nursing home? ☐ Yes ☐ No

11. Is PERSON 4 a U.S. citizen or U.S. national? ☐ Yes ☐ No **If No, Answer #12**

12. **If PERSON 4 isn't a U.S. citizen or U.S. national,** do they have eligible immigration status?

☐ Yes. Fill in their document type and ID number below.

a. Document type _____ b. Document ID number _____

c. Has PERSON 4 lived in the U.S. since 1996? ☐ Yes ☐ No d. Is PERSON 4, or their spouse or parent a veteran or an active-duty member in the U.S. military? ☐ Yes ☐ No

13. Does PERSON 4 want help paying for medical bills from the last 3 months? ☐ Yes ☐ No	14. Does PERSON 4 live with at least one child under the age of 19, and are they the main person taking care of this child? ☐ Yes ☐ No	15. Was PERSON 4 in foster care at age 18 or older? ☐ Yes ☐ No

Please answer the following questions if PERSON 3 is 22 or younger:

16. Did PERSON 4 have insurance through a job and lose it within the past 3 months? ☐ Yes ☐ No

a. **If yes,** end date: _____ b. Reason the insurance ended: _____

17. Is PERSON 4 a full-time student? ☐ Yes ☐ No

18. **If Hispanic/Latino, ethnicity (OPTIONAL—check all that apply.)**

☐ Mexican ☐ Mexican American ☐ Chicano/a ☐ Puerto Rican ☐ Cuban ☐ Other _____

19. **Race (OPTIONAL—check all that apply.)**

☐ White	☐ American Indian or Alaska Native	☐ Filipino	☐ Vietnamese	☐ Guamanian or Chamorro
☐ Black or African American	☐ Asian Indian	☐ Japanese	☐ Other Asian	☐ Samoan
	☐ Chinese	☐ Korean	☐ Native Hawaiian	☐ Other Pacific Islander
				☐ Other _____

Now, tell us about any income from PERSON 4 on the back.

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STEP 2: PERSON 4 Continue with person 4

Current Job & Income Information

☐ **Employed**
If Person 4 is currently employed, tell us about your income. Start with question 20.

☐ **Not employed**
Skip to question 30.

☐ **Self-employed**
Skip to question 29.

CURRENT JOB 1:

20. Employer name and address

21. Employer phone number
( ) –

22. Wages/tips (before taxes) ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly

$ _____

23. Average hours worked each WEEK

CURRENT JOB 2: (If Person 4 has more jobs and need more space, attach another sheet of paper.)

24. Employer name and address

25. Employer phone number
( ) –

26. Wages/tips (before taxes) ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly

$ _____

27. Average hours worked each WEEK

28. **In the past year, did PERSON 4:** ☐ Change jobs ☐ Stop working ☐ Start working fewer hours ☐ None of these

29. **If self-employed, answer the following questions:**

a. Type of work

_____

b. How much net income (profits once business expenses are paid) will you get from this self-employment this month?

$ _____

30. **OTHER INCOME THIS MONTH:** Check all that apply, and give the amount and how often you get it.

NOTE: You don't need to tell us about child support, veteran's payment, or Supplemental Security Income (SSI).

☐ None

☐ Unemployment $ _____ How often? _____

☐ Pensions $ _____ How often? _____

☐ Social Security $ _____ How often? _____

☐ Retirement accounts $ _____ How often? _____

☐ Alimony received $ _____ How often? _____

☐ Net farming/fishing $ _____ How often? _____

☐ Net rental/royalty $ _____ How often? _____

☐ Other income $ _____ How often? _____
Type: _____

31. **DEDUCTIONS:** Check all that apply, and give the amount and how often you get it.

If PERSON 4 pays for certain things that can be deducted on a federal income tax return, telling us about them could make the cost of health coverage a little lower.

NOTE: You shouldn't include a cost that you already considered in your answer to net self-employment (question 29b).

☐ Alimony paid $ _____ How often? _____

☐ Student loan interest $ _____ How often? _____

☐ Other deductions $ _____ How often? _____
Type: _____

32. **YEARLY INCOME: Complete only if PERSON 2's income changes from month to month.**

If you don't expect changes to PERSON 4's monthly income, add another person or skip to the next section.

PERSON 4's total income **this year**	PERSON 4's total income **next year** (if you think it will be different)
$	$

THANKS! This is all we need to know about PERSON 4.

If you have more people to include, make a copy of Step 2: Person 2 (pages 4 and 5) and complete.

NEED HELP WITH YOUR APPLICATION? If you have any questions, please call **ALL Kids** at our toll-free number **1-888-373-KIDS (5437)** Monday through Friday from 7:30 am to 5:00 pm CST to speak to a Customer Service representative. Or you may call the **Alabama Medicaid Agency** at **1-800-362-1504**. You may also leave a message at anytime or email us at **ALLKids@adph.state.al.us.**

STEP 3 American Indian or Alaska Native (AI/AN) family member(s)

1. **Are you or is anyone in your family American Indian or Alaska Native?**

☐ If **No**, skip to Step 4.

☐ **Yes. If yes**, Be sure to complete Appendix B.

STEP 4 Your Family's Health Coverage

Answer these questions for anyone who needs health coverage.

1. **Is anyone enrolled in health coverage now from the following?**

☐ **YES. If yes**, check the type of coverage and write the person(s)' name(s) next to the coverage they have. ☐ **NO.**

- ☐ Medicaid _____
- ☐ CHIP _____
- ☐ Medicare _____
- ☐ TRICARE (Don't check if you have direct care or Line of Duty) _____
- ☐ VA health care programs _____
- ☐ Peace Corps _____
- ☐ Employer insurance _____
  - Name of health insurance: _____
  - Policy number: _____
  - Is this COBRA coverage? ☐ Yes ☐ No
  - Is this a retiree health plan? ☐ Yes ☐ No
- ☐ Other
  - Name of health insurance: _____
  - Policy number: _____
  - Is this a limited-benefit plan (like a school accident policy)? ☐ Yes ☐ No

2. **Is anyone listed on this application offered health coverage from a job?** Check yes even if the coverage is from someone else's job, such as a parent or spouse.

☐ **YES. If yes**, you'll need to complete and include Appendix A. Is this a state employee benefit plan? ☐ Yes ☐ No

☐ **NO. If no, continue to Step 5.**

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STEP 5 Read & sign this application.

- I'm signing this application under penalty of perjury which means I've provided true answers to all the questions on this form to the best of my knowledge. I know that I may be subject to penalties under federal law if I provide false and or untrue information.
- I know that I must tell the Health Insurance Marketplace if anything changes (and is different than) what I wrote on this application. I can visit **HealthCare.gov** or call **1-800-318-2596** to report any changes. I understand that a change in my information could affect the eligibility for member(s) of my household.
- I know that under federal law, discrimination isn't permitted on the basis of race, color, national origin, sex, age, sexual orientation, gender identity, or disability. I can file a complaint of discrimination by visiting **www.hhs.gov/ocr/office/file**.
- I confirm that no one applying for health insurance on this application is incarcerated (detained or jailed). If not, _____ is incarcerated.
  (name of person)

We need this information to check your eligibility for help paying for health coverage if you choose to apply. We'll check your answers using information in our electronic databases and databases from the Internal Revenue Service (IRS), Social Security, the Department of Homeland Security, and/or a consumer reporting agency. If the information doesn't match, we may ask you to send us proof.

If anyone on this application is eligible for Medicaid

- I am giving to the Medicaid agency our rights to pursue and get any money from other health insurance, legal settlements, or other third parties. I am also giving to the Medicaid agency rights to pursue and get medical support from a spouse or parent.
- Does any child on this application have a parent living outside of the home? ☐ Yes ☐ No
- If yes, I know I will be asked to cooperate with the agency that collects medical support from an absent parent. If I think that cooperating to collect medical support will harm me or my children, I can tell Medicaid and I may not have to cooperate.

My right to appeal

If I think the Health Insurance Marketplace or Medicaid/Children's Health Insurance Program (CHIP) has made a mistake, I can appeal its decision. To appeal means to tell someone at the Health Insurance Marketplace or Medicaid/CHIP that I think the action is wrong, and ask for a fair review of the action. I know that I can find out how to appeal by contacting the Marketplace at **1-800-318-2596**. I know that I can be represented in the process by someone other than myself. My eligibility and other important information will be explained to me.

Renewal of coverage in future years

To make it easier to determine my eligibility for help paying for health coverage in future years, I agree to allow the Marketplace to use income data, including information from tax returns. The Marketplace will send me a notice, let me make any changes, and I can opt out at any time.

Yes, renew my eligibility automatically for the next

☐ 5 years (the maximum number of years allowed), or for a shorter number of years:

☐ 4 years ☐ 3 years ☐ 2 years ☐ 1 year ☐ Don't use information from tax returns to renew my coverage.

Sign this application. The person who filled out Step 1 should sign this application. If you're an authorized representative you may sign here, as long as you have provided the information required in Appendix C.

Signature	Date (mm/dd/yyyy)

STEP 6 Mail completed application.

Mail your signed application to:

ALL Kids Program
P.O. Box 304839
Montgomery, AL 36130-4839
1-888-373-KIDS (5437)
334-206-3783 (Fax Number)

If you need assistance from the Health Insurance Marketplace you can contact them at **Healthcare.gov** or by calling the numbers listed below.

Available 24/7 1-800-318-2596
TTY: 1-855-889-4325

If you would like to register to vote, you may complete a voter registration form by going to The Secretary of State website, **www.alabamavotes.gov.**
If you do not have the ability to use a computer to complete your voter registration form we can mail you a form.
Please check here ____ to have a form sent to you.

NEED HELP WITH YOUR APPLICATION? If you have any questions, please call **ALL Kids** at our toll-free number **1-888-373-KIDS (5437)** Monday through Friday from 7:30 am to 5:00 pm CST to speak to a Customer Service representative. Or you may call the **Alabama Medicaid Agency** at **1-800-362-1504**. You may also leave a message at anytime or email us at **ALLKids@adph.state.al.us.**

Attachment 7: Medicaid Family Planning Services Consent Form

Medicaid Family Planning Services Consent Form

Name: ______________________________
Medicaid Number: ______________________
Date of Birth: _________________________

I give my permission to ______________________________ to provide family planning services to me. I understand that I will be given a physical exam that will include a pelvic (female) exam, Pap smear, tests for sexually transmitted diseases (STDs), tests of my blood and urine and any other tests that I might need. I have been told that birth control methods that I can pick from may include oral contraceptives (pills), Depo-Provera shots, intrauterine devices (IUDs), Norplant implant, diaphragms, foams, jellies, condoms, natural family planning or sterilization.

Signature: ____________________ Date: ____________________	Signature: ____________________ Date: ____________________
Signature: ____________________ Date: ____________________	Signature: ____________________ Date: ____________________
Signature: ____________________ Date: ____________________	Signature: ____________________ Date: ____________________
Signature: ____________________ Date: ____________________	Signature: ____________________ Date: ____________________
Signature: ____________________ Date: ____________________	Signature: ____________________ Date: ____________________
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Signature: ____________________ Date: ____________________	Signature: ____________________ Date: ____________________
Signature: ____________________ Date: ____________________	Signature: ____________________ Date: ____________________

Form 138 (Formerly MED-FP9106)
Revised 2/99

Attachment 8: Plan First Program Participation Agreement Form

AGREEMENT FOR PARTICIPATION IN THE PLAN FIRST PROGRAM

I _____ hereby enter into an agreement with the Alabama Medicaid Agency for participation in the Plan First.

I agree to provide services as described in the family Planning section of the Alabama Medicaid Provider Manual and in accordance with the terms and conditions expressed in the Medicaid State Plan for Medical Assistance, the Administrative Code, the approved 1115 Research and Demonstration Waiver and all other federal and state laws and regulations as they pertain to my performance under this agreement. I understand that these requirements are incorporated by reference into this agreement. I understand that I am bound to follow all specifications, terms and conditions expressed in these manuals and documents, and that my failure to do so may result in termination of this agreement and recoupment of any or all funds paid under this agreement.

Executed this _____ day of_____,200___.

_____
Signature

_____ _____
Title Typed / Printed Name

Enrollment Information

Name: _____

Address (including street address and county) _____

City _____ Zip:_____Provider #:_____

Office Phone: _____ FAX#: _____

Type of Enrollment: _____Group _____ Individual

Group or Clinic Name:_____

Group/Payee Number : _____ Contact Name: _____

FOR EDS USE ONLY

Date Accepted: _____ By: _____ Indicator Added: _____