

# APPENDIX B

## American Indian or Alaska Native Family Member (AI/AN)

Complete this appendix if you or a family member are American Indian or Alaska Native. Submit this with your Application for Health Coverage & Help Paying Costs.

### Tell us about your American Indian or Alaska Native family member(s).

American Indians and Alaska Natives can get services from the Indian Health Services, tribal health programs, or urban Indian health programs. They also may not have to pay cost sharing and may get special monthly enrollment periods. Answer the following questions to make sure your family gets the most help possible.

**NOTE:** If you have more people to include, make a copy of this page and attach.

	AI/AN PERSON 1	AI/AN PERSON 2	AI/AN PERSON 3	AI/AN PERSON 4
1. Name (First name, Middle name, Last name)	First	First	First	First
	Middle	Middle	Middle	Middle
	Last	Last	Last	Last
2. Member of a federally recognized tribe?	<input type="checkbox"/> Yes <b>If yes, tribe name</b> _____	<input type="checkbox"/> Yes <b>If yes, tribe name</b> _____	<input type="checkbox"/> Yes <b>If yes, tribe name</b> _____	<input type="checkbox"/> Yes <b>If yes, tribe name</b> _____
	<input type="checkbox"/> No	<input type="checkbox"/> No	<input type="checkbox"/> No	<input type="checkbox"/> No
3. Has this person ever gotten a service from the Indian Health Service, a tribal health program, or urban Indian health program, or through a referral from one of these programs?	<input type="checkbox"/> Yes <input type="checkbox"/> No <b>If no, is this person eligible to get services from the Indian Health Service, tribal health programs, or urban Indian health programs, or through a referral from one of these programs?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No <b>If no, is this person eligible to get services from the Indian Health Service, tribal health programs, or urban Indian health programs, or through a referral from one of these programs?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No <b>If no, is this person eligible to get services from the Indian Health Service, tribal health programs, or urban Indian health programs, or through a referral from one of these programs?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No <b>If no, is this person eligible to get services from the Indian Health Service, tribal health programs, or urban Indian health programs, or through a referral from one of these programs?</b>
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Certain money received may not be counted for Medicaid or the Children's Health Insurance Program (CHIP). List any income (amount and how often) reported on your application that includes money from these sources: • Per capita payments from a tribe that come from natural resources, usage rights, leases, or royalties • Payments from natural resources, farming, ranching, fishing, leases, or royalties from land designated as Indian trust land by the Department of Interior (including reservations and former reservations) • Money from selling things that have cultural significance	\$ _____ How often? _____	\$ _____ How often? _____	\$ _____ How often? _____	\$ _____ How often? _____
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Does this person have an active user letter from the Indian Tribe Service <b>(please check one)</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No



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**.