



A Family Planning Program  
Females Ages 19-55  
Males Ages 21 and older, for Vasectomies only

## **Application for the Medicaid Plan First Program**

This application is for family planning (birth control) services only, for females 19-55 years of age and males 21 and over.

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

**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 male?** Yes  No  **Have you had a vasectomy?** Yes  No

**5. Telephone Numbers where we can call you** **6. Are you a U.S. Citizen?** Yes No

Cell Phone (\_\_\_\_\_) \_\_\_\_\_ Home Phone: (\_\_\_\_\_) \_\_\_\_\_

Work Phone (\_\_\_\_\_) \_\_\_\_\_ **May we contact you at work?** Yes  No

Other Phone (\_\_\_\_\_) \_\_\_\_\_ Whose Phone? \_\_\_\_\_

**7. 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

**8. Name of Spouse** \_\_\_\_\_

**Spouse's Social Security Number** \_\_\_\_\_

**Spouse's Date of Birth** \_\_\_\_\_ **Race** \_\_\_\_\_

**9. 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 Hospital Doctor Visits Maternity Drugs Other Family Planning

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

**For Official Use Only**

Date Received at Public Health \_\_\_\_\_

Date Accepted at Medicaid \_\_\_\_\_

**10. Income**

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

**11. 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 \_\_\_\_\_

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

**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
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.