Alabama Medicaid Agency

Application/Redetermination for Elderly and Disabled Programs

Instructions: Read this application carefully and follow all instructions given throughout the form. Answer each question completely and accurately.

You may have someone help you complete the application.

1. Send verification of the gross (before taxes) amount of your monthly income.
2. Send a copy of your Social Security card.
3. If you have Medicare, send a copy of your Medicare card.
4. Sign the application.
5. Mail the application to the Medicaid District Office serving your county. Visit www.Medicaid.Alabama.gov to see a listing of offices.

Anyone who makes, or causes to be made, a false statement, misrepresentation or omission of a material fact in an application, or for use in determining eligibility for Medicaid, commits a crime punishable under federal or state law, or both.

Notice to Applicants and Sponsors

Federal and state laws provide both criminal and civil penalties for false statements or material omissions in an application for Medicaid benefits or payments. Also, any application found to contain material misstatements or omissions will be denied.

The following statutes are excerpts from the Code of Alabama pertaining to the Medicaid program:

S 22-1-11. Making false statement or representation of material fact in claim or application for payments on medical benefits from Medicaid agency generally; kickbacks, bribes, etc.; exceptions; multiple offenses.

(a) Any person who, with intent to defraud or deceive, makes, or causes to be made or assists in the preparation of any false statement representation or omission of a material fact in any claim or application for any payment, regardless of amount, from the Medicaid agency, knowing the same to be false; or with intent to defraud or deceive, makes, or causes to be made, or assists in the preparation of any false statement, representation or omission of a material fact in any claim or application for medical benefit from the Medicaid agency, knowing the same to be false; shall be guilty of a felony and upon conviction thereof shall be fined not more than $10,000.00 or imprisoned for not less than one nor more than five years, or both.

* * *

(e) Any two or more offenses in violation of this section may be charged in the same indictment in separate counts for each offense and such offense shall be tried together, with separate sentences being imposed for each offense of which defendant is found guilty. (Acts 1980, No. 80-539, p. 837, Sections 1-5.)

S 22-6-8, Revocation of eligibility of recipient upon determination of abuse, fraud, or misuse of benefits; when eligibility may be restored.

(a) Upon determination by a utilization review committee of the designated state Medicaid agency that a Medicaid recipient has abused, defrauded, or misused the benefits of the program said recipient shall immediately become ineligible for Medicaid benefits.
(b) Medicaid recipients whose eligibility has been revoked due to abuse, fraud or other deliberate misuse of the program shall not be deemed eligible for future Medicaid services for a period of not less than one year and until full restitution has been made to the designated state Medicaid agency.
(c) The provisions of this section shall not be effective if they are found by a court of competent jurisdiction to contravene federal laws or federal regulations applicable to the Medicaid program.

(Acts 1980, No. 80-127, p.190.)

Form 204/205 **Application/Redetermination for Elderly and Disabled Programs** 3/23

Please print using dark ink.

1 Apply for or Renew Medicaid for Elderly and Disabled Programs

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

☐ **Hospital** Name of Hospital:_____

(Date of Admission)_____

Address:_____

☐ **Nursing Facility** Name of Nursing Facility: _____

(Date of Admission) _____

Address:_____

☐ **Home & Community Based Waiver Program (Application must be submitted to Waiver Agency.)**

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

2 Applicant 1st Time Applying ☐ or ☐ Renewing

Name:_____

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

Mailing Address:_____

_____

City State Zip Code

Home Address: _____

(Street or 911 Address. If you are now in a nursing home, your home address before entering nursing home.)

_____

City State Zip Code

County of Residence:_____ Medicare #:_____

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

Phone:_____ Fax:_____

Other Phone:_____ Whose?_____

Email:_____

3 Marital Status (Marriage Information)

☐ I am Married _____(Date Married)

☐ I am Divorced _____(Date Divorced)

☐ I am Single (Never Married)

☐ I am Separated _____ (Date Separated)

☐ I am Widowed_____ (Date Widowed)

District Office Use Only

District Office Stamp

Applicant's Name:_____ SSN:_____

4 Race

☐ White ☐ Black ☐ American Indian ☐ Hispanic ☐ Asian
☐ Other

5 Sex

☐ Female ☐ Male

6 Living Arrangement

Check the item which describes your current living arrangement

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

7 Residency Information

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

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

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

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

8 Supplemental Security Income (SSI):

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

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

Relationship to Applicant: _____

Name: _____ Home Phone: _____

Work Phone: _____ Address: _____

Cell Phone: _____ FAX: _____

City: _____ State: _____ Zip: _____

Email: _____

10 Legal Status

Has the applicant appointed a power of attorney or has a guardian or conservator been appointed? Yes ☐ No ☐

<u>If yes, provide a copy</u>. (This is not needed for renewal applicants if sent to the Agency previously.)

Applicant's Name:_____ SSN:_____

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

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

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

SSN:_____
City State Zip Code County

Email:_____ Spouse's Medicaid #:_____

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

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

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

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

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

13 Veteran's Status

Are you a Veteran? ☐Yes ☐ No

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

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

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

SSN:_____ VA Claim #:_____

Relationship to Veteran _____

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

If no, you must apply.

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

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

Applicant's Name:_____ SSN:_____

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

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

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

Applicant's Name:_____ SSN:_____

16 Property

Please complete all of the information concerning property you or your spouse own, or have owned in the past 5 years, or in which you or your spouse have had an interest.

If additional space is needed, please report on the last page of this application or attach a separate sheet of paper

Do you or your spouse now own or are you buying any property or do you have any interest (including life estate, heir property, joint ownership, etc.) in land, buildings or other property, including your home?
Yes ☐ No ☐

If yes, who owns the property? _____

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

Parcel 1:_____

Parcel 2:_____

Parcel 3:_____

Parcel 4:_____

Parcel 5:_____

Does anyone live there now? ☐ **Yes** ☐ **No**

Which Parcel?_____

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

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

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

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

Do you have a reverse mortgage? Yes ☐ No ☐
If yes, send verification of the payments you have received and the remaining balance.

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

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

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

If you answered yes to owning property now or in the past 5 years, send copies of the deed(s) showing you purchased the property. If sold, copies of the deed(s) showing you transferred the property and a copy of the settlement statement.

Do you or your spouse own a mobile home? Yes ☐ No ☐
If yes, send ownership (title) verification. If yes, who owns the land where the mobile home or trailer is located? _____

Applicant's Name:_____ SSN:_____

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

Does applicant, spouse or parent's name now appear on an account of any kind?
Yes ☐ No ☐

Has applicant, spouse or parent's name appeared on a bank account of any kind in the last 5 years? Yes ☐ No ☐

Does applicant, spouse or parent's name now appear on a safe deposit box? Yes ☐ No ☐
Has applicant, spouse or parent's name appeared on a safe deposit box of any kind in the last 5 years?
Yes ☐ No ☐

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

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

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

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

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

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

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

1. An annuity or similar financial instrument:
   Applicant Spouse (Please describe separately under "Remarks" and provide current market value. $_____
   Remarks:_____

2. Stocks and bonds (Please list separately under "Remarks" and provide current market value for each. Copies required). <u>Enter total value here</u>: $_____ $_____
   Remarks: _____

3. Cash not in bank $_____ $_____

Applicant's Name:_____ SSN:_____

17 Resources (continued)

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

Remarks: _____

_____

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

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

Enter total value here:	$_____	$_____

Remarks:_____

_____

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

Remarks:_____

_____

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

Transfer of Resources

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

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

Applicant's Name:_____ SSN:_____

Life Insurance

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

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

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

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

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

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

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

Applicant's Name:_____ SSN:_____

20 Burial or Vault Insurance

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

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

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

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

21 Other Burial Fund

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

Name of Funeral Home _____

Address _____

Amount $_____

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

If yes, What? _____

Applicant's Name:_____ SSN:_____

22 Personal Property

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

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

Do you or your spouse have:

1. An Automobile? ☐ **Yes** ☐ **No**

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

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

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

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

a._____ Estimated value $_____

b._____ Estimated value $_____

Professional appraisal(s) may be required.

23 Medical Insurance

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

Name of Company _____

Address (if known)_____

Type of Policy_____

Who pays the health insurance premium? Yourself ☐ Other ☐

How much is the premium?_____

How often do you pay?_____

Name of Company _____

Address (if known) _____

Type of Policy_____

Who pays the health insurance premium? Yourself ☐ Other ☐

How much is the premium?_____

How often do you pay?_____

2. **Are you enrolled in a Medicare Part D drug plan to cover the costs of your medicines?**

Yes ☐ **No** ☐

Name of Company_____

Policy #_____ Premium Amount _____

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

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

3. **Do you have Long Term Care Insurance?** ☐ **Yes** ☐ **No**

If yes, provide a copy of the policy and verification from the company of the total amount of benefits that have been paid.

Plan Name_____

Contract #_____

Applicant's Name:_____ SSN:_____

RELEASE OF INFORMATION

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

AFFIRMATION AND AGREEMENT

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

RESPONSIBILITIES

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

ESTATE RECOVERY

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

FALSE STATEMENTS

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

Does the applicant and/or sponsor/representative accept the terms of the Release of Information, Affirmation and Agreement, Responsibilities, Estate Recover y, and False Statements listed above and agree to notify the Medicaid District Office of any changes? ☐ Yes ☐ No

_____ _____

Signature of Applicant Date Signature of Spouse Date

_____

Signature of Parent or Sponsor Date

_____ _____

Witness' Signature Date Witness' Signature Date

Applicant's Name:_____ SSN:_____

APPOINTMENT OF REPRESENTATIVE

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

Done this the _____ day of _____, 20 _____.

WITNESSES:

_____ _____

(Signature of Medicaid Claimant)

_____ _____

(Social Security Number)

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

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

What is your relationship to claimant? _____

Why can't claimant sign? _____

To what extent are you responsible for claimant? _____

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

ACCEPTANCE OF APPOINTMENT

I hereby accept the foregoing appointment. I certify that I have not been suspended or prohibited from practice before the Alabama Medicaid Agency and am not otherwise disqualified from acting as an appointed representative. I acknowledge that representations and applications made by me on behalf of the claimant are made under an affirmation which subjects me to penalties for perjury and that false statements may subject me to penalties or fraud. As an Authorized Representative, I agree to the following:

- Maintain the confidentiality of any information regarding the Medicaid client provided by the Alabama Medicaid Agency,
- Comply with state and federal laws and regulations concerning the protection of Medicaid client confidentiality and avoiding conflicts of interest,
- Comply with federal safeguard provisions in regards to Medicaid client information, and,
- Comply with federal prohibitions against the reassignment of claims against the Medicaid client.

My relationship to the above is _____ (Attorney, relative, etc.)

Done this the _____ day of _____, 20 _____.

WITNESSES:

_____ _____

(Signature of Sponsor/Representative)

_____ _____

(Address)

_____

(City, State)

_____

(Telephone Number)

Additional Information