# Alabama Medicaid Agency

## Application for Medicare Savings Programs

This is NOT an application for full Medicaid.

These programs cover Medicare premiums and deductibles. Medicaid's drug coverage is limited to the drugs covered under Medicare Part D only. Medicaid will not pay for any excluded drugs under Medicare Part D.

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

- ☐ Send verification of the gross amount (before taxes) of your monthly income.
- ☐ Sign the application.
- ☐ Send the application to the Medicaid District Office serving your county. (Click here to find your District Office)

Form 211

# Application for Medicare Savings Programs

3-2023

**Please print clearly using dark ink.**

## 1 APPLICANT

Name _____
First Middle/Maiden Last Suffix

Mailing Address _____
Street or 911 Address

_____
City State Zip Code

Phone # (_____)_____ Other Phone (_____)_____ Whose? _____

email _____ Fax _____

Current Resident Address _____
(If different from Mailing Address)

_____
City State Zip Code

County of Residence _____ Date of Birth _____

Social Security # _____ Medicaid # _____

## 2 MARITAL STATUS

**Marriage Information**

☐ I am Married _____ (Date Married)
If married, does your spouse have Medicare? ☐ Yes ☐ No

☐ I am Divorced _____ (Date Divorced) ☐ I am Single (NeverMarried)

☐ I am Separated _____ (Date Separated) ☐ I am Widowed _____ (Date Widowed)

## 3 MEDICARE

**Do you have Medicare Part A(Hospital) Coverage?** ☐ Yes ☐ No

Name on Medicare card _____

Medicare # _____

## 4 RACE

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

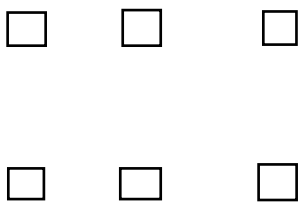
## 5 SEX

☐ Female ☐ Male

**District Office Use Only**

Date Received _____ Date Accepted _____

Medicare Card Received ☐ Yes ☐ No Income Verification Received ☐ Yes ☐ No



Applicant's Name_____ SS # _____

## 10 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 Name _____
First Middle Last

Veteran Claim Number_____Relationship to Veteran _____

Have you applied for Veteran's benefits under the new Veterans & Survivor's Improvement Act? ☐ Yes ☐ No If no, you must apply and send verification.

## 11 RESIDENCY INFORMATION

Are you a United States Citizen? ☐ Yes ☐ No Are you a lawfully admitted alien? ☐ Yes ☐ No

Where were you born?_____
City County State Country

Do you live in Alabama and plan to stay? ☐ Yes ☐ No
**What language do you usually speak?** ☐ English ☐ Spanish ☐ Other_____
**Do you or a family member speak English?** ☐ Yes ☐ No
**Have you ever applied for or received SSI?** ☐ Yes ☐ No

If yes, were you terminated from SSI? When? _____
Month/Year

## 12 OTHER INSURANCE

Do you have medical insurance other than Medicare? ☐ Yes, ☐ No If yes, provide information below:

**1. Name/Address of Health Insurance Company**

_____
_____
_____

Policy #_____
Group #_____

**2. Name/Address of Health Insurance Company**

_____
_____
_____

Policy # _____
Group # _____

**3. Name/Address of Health Insurance Company**

_____
_____
_____

Policy #_____
Group #_____

**4. Name/Address of Health Insurance Company**

_____
_____
_____

Policy # _____
Group # _____

(You may list other policies on a separate sheet(s) and attach to this application, if needed.)

Applicant's Name_____ SS # _____

**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 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.
* 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 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 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.
* I understand that resources that have been sold, transferred, disposed of, or given away within the past 60 months will not affect my application for Medicaid for the Medicare Savings Programs, but may affect eligibility for Medicaid in a medical institution.

**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.

**FALSE STATEMENTS**

I know that anyone who makes or causes to be made a false statement, representation 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.

_____ Date_____

Signature of Applicant or Representative

_____ Date_____

Signature of Applicant's Spouse or Representative

**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 Medicaid 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 five years without completing a renewal.**

If you do not want your eligibility renewed automatically for 5 years, you must check
4 years ☐ 3 years ☐ 2 years ☐ 1 year ☐

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