Alabama Medicaid Agency's Recipient Change Report Form

Name_____ Medicaid #_____

Address_____ Home Phone_____

City/County/State/Zip_____ Other Phone_____

Is this a new address? ☐ Yes ☐ No If Yes, Date Moved_____

Check the items that you have changes for. (There are more items listed on the back of this form.)
NOTE: Your signature is required on the back of this form.

☐ **Marital Status Changes**. Date of change_____

New marital status: ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

If you checked Married, please complete the following:

Name of Spouse_____

Spouse's SSN_____ Spouse's DOB_____

Spouse's Address_____

City, State, Zip_____ Phone_____

☐ **Sponsor Address and Phone Changes**. Date of change _____

New Sponsor Address_____

City, State, Zip_____ Phone_____

NOTE: To change your sponsor to another person, you will need to complete a Form 202 and mail to your caseworker or call 1-800-362-1504 to request a Form 202 be mailed to you.

☐ **Family Changes.** Date of change _____

☐ **I Had a Baby.** Baby's Name is_____ ☐ Male ☐ Female

Baby's SSN_____

Baby was Born on_____(date) in _____(city/state/zip)

☐ **Someone in My Household is Having a Baby.** Her Name is_____

Date Baby is Due_____ Number of Babies in Pregnancy_____

☐ **Person(s) Moved Into My Home.** Date of change _____

Name	Relationship to You	Income	Date of Birth	SSN	Receiving SSI, Yes/No

☐ **Person(s) Moved Out of My Home.** Date of change _____

Name	Relationship to You	Income	Date of Birth	SSN

☐ **Income Changes**. Date of change _____

☐ **New Income.**

Name	Employer Name and Address	Gross Amount of Pay (before deductions)	Hourly Pay Rate	Hours Worked a Week	How Often Paid	Day Paid
(Attach verification of income.)						

☐ **Loss of Income.** Person Who No Longer Has Income is_____

Date of Last Pay Received_____.

☐ **Expense changes.** Date of change _____

☐ **I Now Pay for Day/Night Care.**

Name of Person Who Pays_____

Name and Age of Person(s) in Care_____

Amount Paid_____ How Often_____

☐ **I No Longer Pay for Day/Night Care**.

☐ **Insurance Changes**. Complete the "Report Insurance Coverage Change Form" which is located on the Medicaid Website at www.medicaid.alabama.gov.

☐ **Report of Death**.

Name of Recipient_____ Date of death_____

☐ **I wish to close my Medicaid case.** Date _____

Reason for closing case _____

☐ **I wish to withdraw my application**. Date _____

☐ **Other Changes**. Date of change_____

Explain_____

_____

☐ By checking this box, I declare under penalty of perjury, that the information I have entered is true and correct.

_____ _____

Signature of Recipient Date

_____ _____

Person Helping to Fill Out Form Daytime Phone Number

I am an Application Assister ☐ Yes ☐ No

You may Fax this form to 334-353-5689, or Mail to: Alabama Medicaid Agency, Attn: Eligibility Change Unit, 501 Dexter Avenue, P O Box 5624, Montgomery, AL 36103-5624.