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.

1. Send verification of the gross amount (before taxes) of your monthly income.

2. Sign the application.

3. Send the application to Medicaid either by email or U.S. Postal Service mail.
   Email: apply@medicaid.alabama.gov, or
   Mail: to the District Office serving your county. (Click here to find the District Office in your area.)

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 benefits from the Medicaid agency, knowing the same to be false; shall be guilty of a felony and upon conviction there of 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 ofcompetent jurisdiction to contravene federal laws or federal regulations applicable to the Medicaid program.

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

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

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 # _____

6 **FAMILY SIZE** **List names of anyone living in your home**

Name	Age	Relationship

7 **SPONSOR** (If the applicant is unable to complete the application or provide additional information, the Medicaid sponsor should be the person **most** familiar with the financial situation of the applicant.) Please complete the Appointment of Representative form on Page 6 of this application.

Relationship to Applicant _____

Name_____ Home Phone _____

Address_____ Work Phone _____

_____

_____ Cell Phone _____

City State Zip

email_____ FAX _____

8 **SPOUSE INFORMATION** **(Complete even if divorced, separated, or widowed.)**

Name_____ Phone # (_____)_____

(First, Middle, Last)

Address_____ Date of Birth _____

(Street or Box Number)

_____ SS # _____

City State Zip County

email_____ Spouse's Medicaid # _____

9 **FORMER SPOUSE INFORMATION** **(Must be completed if you are widowed or divorced.)**

(For all previous marriages, list most recent first.)

1. Former Spouse's Name_____ SS # _____

   Marriage Began_____ Ended_____ Reason ☐ Death ☐ Divorce ☐ Other

   Date Date

2. Former Spouse's Name_____ SS # _____

   Marriage Began_____ Ended_____ Reason ☐ Death ☐ Divorce ☐ Other

   Date Date

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 # _____

13 **GROSS INCOME:** (This means "money coming in" before anything is taken out). Answer the following.

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. (**A copy of most recent check stub or other verification must be provided.**)

NOTE: If you are applying on behalf of a married individual, the spouse **must** also answer these questions.

Type of Income	Claim Number	Applicant Gross Amount	Spouse Gross Amount	Minor Child 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. N/A					
21. Other: Specify _____					
22. Other: Specify _____					
23. Legal Settlements					
24. Sheltered Workshop Earnings					
25. Wages/Salary					
26. Self-Employment					

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.

Applicant's Name_____ SS # _____

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.

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

Done this the_____day of_____, 20_____.

WITNESSES

_____ _____

(Signature of Sponsor/Representative)

_____ _____

(Address)

_____

(City, State, Zip)

_____

(Telephone Number)