Administrator of Estate Designation Form

Regarding Patient/Resident Trust

Be it known to all, that I, ____, a resident of
(Name of Medicaid Recipient)

____, hereby to declare and designate that
(Name of Facility)

____, an adult next of kin, who resides at
(Name of Primary Beneficiary)

____ shall receive
(Address of Primary Beneficiary)

all monies held in my personal trust account held at said facility, if any, at the time of my death. If the above named adult next of kin predeceases me in death, I declare and designate that ____________________________________,
(Name of Secondary Beneficiary)

an adult next of kin, who resides at ____,
(Address of Secondary Beneficiary)

receive all monies held in my patient/resident trust account.

By my signature below, I further declare that I am competent to execute this document and have done so voluntarily, free of undue influence, coercion, or duress of any kind. I further state that I have the right at any time to modify this form and designate another adult next of kin to receive the monies held in my patient/resident trust account. I understand that my estate may be subject to recovery of any funds expended by Medicaid pursuant to 42 U.S.C. § 1396p.

____________________________________ ___________________________
Medicaid Recipient *(Signature)* Date

____
Medicaid Recipient's Social Security Number

__________________________________ ___________________________
Witness Date

__________________________________ ___________________________
Witness Date

FOR FACILITY USE ONLY:

Total Funds Distributed: ____________________ Date of Distribution: _________________________

Sent to: ____

Address: ____

Fax completed form to the Alabama Medicaid Agency/Estate Recovery Unit at 334/353-4820 **and** provide a copy of this form to the beneficiary of the funds in order to inform them of potential estate recovery.