Administrator of Estate Designation Form Regarding Patient/Resident Trust

	Be it known to all, that I,	, a resident of
(Name of Parallity)	(Name of Medicaid Recipient)	
	(Name of Facility)	, hereby to declare and designate that
(Wane of Promary Bengliciary)	(Mane of Lucardy)	
	(Name of Duiman Douofician)	, an adult next of kin, who resides at
(<i>Address of Primary Beneficiary</i>) 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 (<i>Name of Secondary Beneficiary</i>) an adult next of kin, who resides at (<i>Address of Secondary Beneficiary</i>) 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 understand that my estate may be subject to recovery of any funds expended by Medicaid pursuant to 42 U.S.C. § 1396p. Medicaid Recipient (<i>Signature</i>) Date Witness Date FOR FACILITY USE ONLY: Date Total Funds Distributed: Date of Distribution: Sent to:	(Name of Frimary Ben <u>e</u> ficiary)	shall receive
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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.