

# Application/Redetermination for Elderly and Disabled Programs

## Alabama Medicaid Agency

**Important:** Answer all questions on this form. **An original signature in ink is required.** You may have someone help you complete the application. If additional space is needed, please provide information on the "notes" page at the end of the application. Anyone who makes or causes to be made a false statement, misrepresentation 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.

**Please print using dark ink.**

**1. I want to apply for Medicaid in the:**

(Check one)

- Hospital**                      Name and Address of Hospital \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
(Date of Admission)
- Nursing Home**                      Name and Address of Nursing Home \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
(Date of Admission)
- ICF/MR Program**                      Name and Address of Intermediate Care Facility for the Mentally Retarded \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
(Date of Admission)
- Home and Community Based Waiver Program**
- SSI Related Programs (Retroactive, DAC, Widow/Widower, Continuous and Grandfathered Children)**

**2. Applicant:**

Name: \_\_\_\_\_  
                    First                              Middle/Maiden                              Last

Home Address: \_\_\_\_\_  
                    Street or 911 Address  
(Note: If you are now in a nursing home, your home address prior to admission to the nursing home should be given here.)

\_\_\_\_\_  
                    City                                      State                                      Zip Code

County of Residence: \_\_\_\_\_

Telephone Number, include Area Code: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

District Office Use Only

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District Office Stamp

\_\_\_\_\_  
Medicare Number

\_\_\_\_\_  
Medicaid Number

**3. Race:**     White     Black     American Indian     Hispanic     Asian     Other \_\_\_\_\_

**4. Sex:**     Female                       Male

**5. Marital Status (Marriage Information):**

- I am Married \_\_\_\_\_ (Date Married)     I am Divorced \_\_\_\_\_ (Date Divorced)
- I am Single (Never Married)
- I am Separated \_\_\_\_\_ (Date Separated)     I am Widowed \_\_\_\_\_ (Date Widowed)

**6. 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 and should complete page 10.)

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Address: \_\_\_\_\_ Office Phone: \_\_\_\_\_  
                    Street                                      City                                      State                                      Zip

**7. Spouse Identification** (must be completed if you are married or separated):

\_\_\_\_\_

Name (First, Middle, Last)

\_\_\_\_\_

Address (Street or Box Number)

\_\_\_\_\_

(City, State, Zip Code)

\_\_\_\_\_

Telephone Number (Area Code & Number)

\_\_\_\_\_

Date of Birth \_\_\_\_\_ Social Security Number \_\_\_\_\_

**8. Former Spouse Identification** (must be completed if you are widowed or divorced) (For all previous marriages, list most recent first.):

1. Former Spouse's Name:

\_\_\_\_\_

Social Security Number \_\_\_\_\_

Date Marriage Began \_\_\_\_\_ Ended \_\_\_\_\_

Reason:  Death  Divorce  Other

2. Former Spouse's Name:

\_\_\_\_\_

Social Security Number \_\_\_\_\_

Date Marriage Began \_\_\_\_\_ Ended \_\_\_\_\_

Reason:  Death  Divorce  Other

**9. Living Arrangements:**

Check the item which describes your current living arrangement.

In your own home with husband or wife (A)

In your own home alone (A)

In your parent's household (C)

In a rented house, apartment, or room (A)  
Amount of Rent \$ \_\_\_\_\_

With someone else, not in your own home  
Do you pay any utilities or buy your own food?  
 Yes (A)  No (B)

In a Nursing Home (D)

In a Hospital (E)

Intermediate Care Facility for the Mentally Retarded (F)

Other: Please describe: \_\_\_\_\_

**10. Family Size:**

List names of anyone, excluding your spouse, living in your home:

Name	Age	Relationship	Income Source	Monthly Amount
_____	_____	_____	_____	\$ _____
_____	_____	_____	_____	\$ _____
_____	_____	_____	_____	\$ _____

**11. Residency Information:**

Are you a United States Citizen?  Yes  No

If not, when did you enter the United States? \_\_\_\_\_

\_\_\_\_\_

How long have you lived in Alabama? \_\_\_\_\_

Do you plan to remain in Alabama?  Yes  No

Where were you living prior to entering the medical institution that you are now in?

\_\_\_\_\_

City County State

**12. Veteran's Status:**

Are you a Veteran?  Yes  No

Are you a dependent of a veteran?  Yes  No

If yes to either of the above, complete the following:

Relationship to Veteran \_\_\_\_\_

Veteran's Name:

\_\_\_\_\_

First Middle Last

\_\_\_\_\_

Claim Number \_\_\_\_\_

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.

**13. Supplemental Security Income (SSI):**

Have you ever applied for or received SSI?  Yes  No

If yes, when? \_\_\_\_\_ (month/year)

**14. Medical Information:**

Did you have medical expenses in any of the three (3) months prior to application?  Yes  No

**15. Legal Status:**

Has the applicant appointed a power of attorney or has a guardian or conservator been appointed?  Yes  No

If yes, provide a copy and complete the following:

Name \_\_\_\_\_

Address \_\_\_\_\_

City, State, Zip Code \_\_\_\_\_

**16. Gross Unearned Income**

**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 child, each parent **must** also answer these questions.

NOTE: If you are applying on behalf of an adult, the spouse **must** also answer these questions.

Type of Income	Claim Number	Applicant Gross Amount	Spouse (or Parent) Gross Amount	Other (or Parent) 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. Interest on Savings					
21. Other: Specify _____					
22. Other: Specify _____					
23. Legal Settlements					
24. Sheltered Workshop Earnings					
25. Earned Income (See page 4)					
26. Self Employment (See page 4)					
27. Dividends					

**17. Gross Earned Income (25)**

**Gross Income:** (This means “money coming in” before anything is taken out) Both applicant **AND** spouse and parents of a child applicant should list the income they have.

**Wages:** If you or your spouse now receive wages or have received any wages from earned income or self-employment (such as farming, your own business, etc.) in the past year, please check:  Yes  No

If yes, list total wages (before anything was taken out of your wages) for the past three months.

	Applicant	Spouse (or Parent)	Other (or Parent)
First Month	_____	_____	_____
Second Month	_____	_____	_____
Third Month	_____	_____	_____

**18. Self-Employment\*: (26)**

Is applicant, spouse or parent currently self-employed?  Yes  No

If yes, what type of self-employment (such as own your own business, farming, etc.)? \_\_\_\_\_

**\*A copy of last year’s federal tax return must be provided (including Schedule “C” and/or “F”).**

**19. Property**

Please complete all of the information concerning property you or your spouse own, or have owned in the past, or in which you or your spouse have had an interest.

**Do you or your spouse now own or are you buying any property or do you have any interest (including life estate, heir property, joint ownership, etc.) in land, buildings or other property, including your home?**  Yes  No

If yes, Who owns the property? \_\_\_\_\_

If yes, Where is the property located? (List the full address of the property, include city, county and state: \_\_\_\_\_

Does anyone live there now? (Relative, spouse, renter, etc.)  Yes  No

If yes, What is the relationship to the applicant? \_\_\_\_\_

If you are temporarily away from your home, do you intend to return home?  Yes  No

What is the next planned use of this property? \_\_\_\_\_

County Tax Assessor’s Value of the property: \_\_\_\_\_

How much do you owe on the property? \_\_\_\_\_

**Have you or your spouse, in the past 5 years, owned or had any interest (including life estate, heir property, joint ownership, etc.) in any other property?**  Yes  No

If yes, Where was the property located? County: \_\_\_\_\_ State: \_\_\_\_\_

When did you sign a deed disposing of this property? \_\_\_\_\_

**If you answered yes to owning property now or in the past 5 years, a copy of the deed for the property must be provided.**

**Do you or your spouse own a mobile home?**  Yes  No

If yes, Send ownership (title) verification.

If yes, Who owns the land where the mobile home or trailer is located? \_\_\_\_\_

**20. Liquid Assets**

**Accounts (including checking, savings, certificate of deposit, IRAs):**

Does applicant, spouse or parent's name now appear on an account of any kind?  Yes  No

Has applicant, spouse or parent's name appeared on a bank account of any kind in the last three years?  Yes  No

Does applicant, spouse or parent's name now appear on a safe deposit box?  Yes  No

Has applicant, spouse or parent's name appeared on a safe deposit box of any kind in the last three years?  Yes  No

If yes to any of the above questions, complete the following:

1. Name and address of Bank, Credit Union or Brokerage Firm: \_\_\_\_\_  
 Names on account: \_\_\_\_\_  
 Account Number: \_\_\_\_\_ Type of account: \_\_\_\_\_  
 If closed, what was date closed? \_\_\_\_\_ If open, what is current balance? \_\_\_\_\_
2. Name and address of Bank, Credit Union or Brokerage Firm: \_\_\_\_\_  
 Names on account: \_\_\_\_\_  
 Account Number: \_\_\_\_\_ Type of account: \_\_\_\_\_  
 If closed, what was date closed? \_\_\_\_\_ If open, what is current balance? \$ \_\_\_\_\_
3. Name and address of Bank, Credit Union or Brokerage Firm: \_\_\_\_\_  
 Names on account: \_\_\_\_\_  
 Account Number: \_\_\_\_\_ Type of account: \_\_\_\_\_  
 If closed, what was date closed? \_\_\_\_\_ If open, what is current balance? \$ \_\_\_\_\_
4. Name and address of Bank, Credit Union or Brokerage Firm: \_\_\_\_\_  
 Names on account: \_\_\_\_\_  
 Account Number: \_\_\_\_\_ Type of account: \_\_\_\_\_  
 If closed, what was date closed? \_\_\_\_\_ If open, what is current balance? \$ \_\_\_\_\_

**(Bank statements and/or cancelled or imaged checks may be requested.)**

**Do you (either alone, with your spouse, or with any other person) now have or have had:**

	Applicant	Spouse
1. An annuity or similar financial instrument: (Please describe separately under "Remarks" and provide current market value.)	\$ _____	\$ _____
2. Stocks and bonds (Please list separately under "Remarks" and provide current market value for each. Copies required). Enter total value here:	\$ _____	\$ _____
3. Patient account in institution	\$ _____	\$ _____
4. Cash not in bank	\$ _____	\$ _____
5. Trust or special funds	\$ _____	\$ _____
6. Money owed to you (including mortgages and notes in which you have an interest). List persons and amounts in "Remarks."	\$ _____	\$ _____
7. U.S. Government Savings Bonds (Copies required)	\$ _____	\$ _____

**Remarks:** \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**20. Liquid Assets** (continued)

8. Ownership interest in leases, mineral rights, timber rights or other rights to real business property. (Please list separately under "Remarks" below.)  Enter total value here:	Applicant	Spouse
	\$ _____	\$ _____
9. Other (Give details under "Remarks")	\$ _____	\$ _____

**Remarks:** \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Personal Property:**

Personal property consists of things you own that are not real property or liquid assets. Cars, boats, tools, and equipment, furniture, antiques, and collections, are examples of personal property.  
 Please complete the following sections and include your estimate of how much you would get if you sold it now.

**Do you or your spouse have:**

**1. An Automobile?**  Yes  No

	Make	Model	Value	How is it used?	How much do you owe?
a.	_____	_____	\$ _____	_____	_____
b.	_____	_____	\$ _____	_____	_____

**2. Tractor, Farm Machinery, Other Machinery and Equipment?**  Yes  No

	Type of Equipment	Year Purchased	Value	How much do you owe?
a.	_____	_____	\$ _____	\$ _____
b.	_____	_____	\$ _____	\$ _____

**3. Other Personal Property** (such as antiques, hobby collections, etc.)  Yes  No  
Professional appraisal may be required. Estimated value \$ \_\_\_\_\_

**21. Transfer of Resources:**

Has the applicant or spouse sold or given as a gift, any cash, property, vehicle, boat or other resource to any person within the past 36 months (60 months if assets placed into a trust or an annuity)?  Yes  No

Item Sold or Given Away	Person to Whom it was Sold or Given	Date Given or Sold	Amount Received or Given

**22. Burial or Life Insurance**

**Do you or your spouse have any life insurance policies?**  Yes  No (If yes, copy of face value page required.)

If yes, 1. Name of Company \_\_\_\_\_  
Address (if known) \_\_\_\_\_  
Policy Number \_\_\_\_\_  
Person insured  Applicant  Spouse Death Benefit/Face Value of Policy \$ \_\_\_\_\_

2. Name of Company \_\_\_\_\_  
Address (if known) \_\_\_\_\_  
Policy Number \_\_\_\_\_  
Person insured  Applicant  Spouse Death Benefit/Face Value of Policy \$ \_\_\_\_\_

3. Name of Company \_\_\_\_\_  
Address (if known) \_\_\_\_\_  
Policy Number \_\_\_\_\_  
Person insured  Applicant  Spouse Death Benefit/Face Value of Policy \$ \_\_\_\_\_

4. Name of Company \_\_\_\_\_  
Address (if known) \_\_\_\_\_  
Policy Number \_\_\_\_\_  
Person insured  Applicant  Spouse Death Benefit/Face Value of Policy \$ \_\_\_\_\_

**Do you or your spouse have any burial/vault insurance policies?**  Yes  No

(If yes, copy of face value page required.)

If yes, 1. Name of Company \_\_\_\_\_  
Address (if known) \_\_\_\_\_  
Policy Number \_\_\_\_\_  
Person insured  Applicant  Spouse Death Benefit/Face Value of Policy \$ \_\_\_\_\_

2. Name of Company \_\_\_\_\_  
Address (if known) \_\_\_\_\_  
Policy Number \_\_\_\_\_  
Person insured  Applicant  Spouse Death Benefit/Face Value of Policy \$ \_\_\_\_\_

3. Name of Company \_\_\_\_\_  
Address (if known) \_\_\_\_\_  
Policy Number \_\_\_\_\_  
Person insured  Applicant  Spouse Death Benefit/Face Value of Policy \$ \_\_\_\_\_

**23. Medical Insurance**

Do you have Medicare (Social Security Health Insurance)?  Yes  No

If yes, what is your Medicare Number? \_\_\_\_\_

Are you enrolled in a Medicare Part D drug plan to cover the costs of your medicines?  Yes  No

If yes, how much do you pay for the drug plan premium each month? \_\_\_\_\_

What is the name of the drug plan you are enrolled in? \_\_\_\_\_

Do you have Long Term Care Insurance?  Yes  No

If yes, provide a copy of the policy.

Do you have any other health/accident insurance?  Yes  No

If yes, Name of Company \_\_\_\_\_ Name of Company \_\_\_\_\_

Address (if known) \_\_\_\_\_ Address (if known) \_\_\_\_\_

Type of Policy \_\_\_\_\_ Type of Policy \_\_\_\_\_

Policy Number \_\_\_\_\_ Policy Number \_\_\_\_\_

Who pays the health insurance premium?  Yourself  Other

How much is the premium? \_\_\_\_\_ How much is the premium? \_\_\_\_\_

How often do you pay? \_\_\_\_\_ How often do you pay? \_\_\_\_\_

**To keep money to pay your health insurance premiums, you must provide proof of the premium amount and that you paid it with your money.**

**24. Other Burial Fund**

Do you or your spouse have a Pre-need contract with a funeral home?  Yes  No

[If yes, copy of contract(s) required.]

If yes, Name of Funeral Home \_\_\_\_\_

Address \_\_\_\_\_

Amount \$ \_\_\_\_\_

Do you or your spouse have anything else to pay burial expenses? (For example, savings account, cash, CD, etc.)  Yes  No  
if yes, what? \_\_\_\_\_

**Notes**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



**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 understand that as a condition of receiving state medical assistance I shall disclose a description of any interest I or my spouse have in an annuity (or similar financial instrument), regardless of whether the annuity is irrevocable or is treated as an asset.
- \* I understand that as a condition of receiving state medical assistance the Alabama Medicaid Agency will become a remainder beneficiary on any annuity that I or my spouse purchased or on which we performed certain transactions on or after February 8, 2006.
- \* I certify under penalty of perjury that I am a citizen or national of the United States, or in satisfactory immigration status.
- \* 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.
- \* 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 if I am awarded nursing home benefits that part or all of my income must be applied to the nursing home bill as directed by the Alabama Medicaid Agency.
- \* 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.
- \* 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 resources that have been sold, transferred, disposed of, or given away within the past 36 months (60 months for transfers to trusts) from the month of application, may affect eligibility for Medicaid in a medical institution or a Home and Community Based Waiver Program.

**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. I agree to notify the district office if I return to work, am discharged from the nursing home, hospital or move from one to the other. I also agree to report any improvement in my medical condition if I am receiving Medicaid benefits because I am blind or disabled and I am not yet 65 years of age.

**ESTATE RECOVERY**

\* **I understand that my estate may be subject to recovery of any funds expended by Medicaid pursuant to this application and/or redetermination. My sponsor, relative, or other person who files my estate MUST notify Alabama Medicaid at ATTN: Estate Administration, P.O. Box 5624, Montgomery, Alabama 36103-5624.**

**FALSE STATEMENTS**

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

**Does the applicant and/or sponsor/representative accept the terms of the Release of Information, Affirmation and Agreement, Responsibilities, Estate Recovery, and False Statements listed above and agree to notify the Medicaid District Office of any changes?**

Yes       No

\_\_\_\_\_
Signature of Applicant    Date

\_\_\_\_\_
Signature of Spouse    Date

\_\_\_\_\_
Signature of Parent or Sponsor    Date

\_\_\_\_\_
Witness' Signature    Date

\_\_\_\_\_
Witness' Signature    Date

(Witnesses are required only if the applicant signs with an "X")

**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)

\_\_\_\_\_  
(Telephone Number)

## **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:

§ 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 thereof 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.)

§ 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 of competent 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.

## Medicaid District Offices

Address	Telephone Number	Counties served		
<b>Auburn-Opelika District Office</b> 1716 Catherine Court, Suite 1-A Auburn, AL 36830-9938	1-800-362-1504 334-887-3840 (FAX)	Bullock Chambers Clay Coosa	Lee Macon Randolph	Russell Talladega Tallapoosa
<b>Birmingham District Office</b> 468 Palisades Blvd. Birmingham, AL 35209-5154	1-800-362-1504 205-414-9335 (FAX)	Jefferson	St. Clair	
<b>Decatur District Office</b> 2119 Westmeade Dr. S.W., Suite 1 Decatur, AL 35603-1050	1-800-362-1504 256-353-1799 (FAX)	Cullman Jackson	Madison Morgan	
<b>Dothan District Office</b> 2652 Fortner Street, Suite 4 Dothan, AL 36305-3203	1-800-362-1504 334-794-3741 (FAX)	Barbour Coffee Conecuh Covington	Crenshaw Dale Geneva Henry	Houston Pike
<b>Florence District Office</b> 214 E. College Street Florence, AL 35630-5606	1-800-362-1504 256-740-0228 (FAX)	Colbert Franklin Lauderdale	Lawrence Limestone	Marion Winston
<b>Gadsden District Office</b> 200 West Meighan Blvd., Suite D Gadsden, AL 35901-3200	1-800-362-1504 256-546-4973 (FAX)	Blount Calhoun Cherokee	Cleburne Dekalb Etowah	Marshall
<b>Mobile District Office</b> 3280 Dauphin Street Suite B 100 B Mobile, AL 36606-4049	1-800-362-1504 251-471-6930 (FAX)	Baldwin Escambia	Mobile Washington	
<b>Montgomery District Office</b> 501 Dexter Avenue (P.O. Box 5624, Zip 36103-5624) Montgomery, AL 36104-3744	1-800-362-1504 334-242-3835 (FAX)	Elmore	Montgomery	
<b>Selma District Office</b> 106 Executive Park Lane Selma AL 36701-7734	1-800-362-1504 334-418-0036 (FAX)	Autauga Butler Chilton Choctaw	Clarke Dallas Lowndes Marengo	Monroe Perry Wilcox
<b>Tuscaloosa District Office</b> 907 22 <sup>nd</sup> Avenue Tuscaloosa, AL 35401-5822	1-800-362-1504 205-345-9414 (FAX)	Bibb Fayette Greene Hale	Lamar Pickens Shelby	Sumter Tuscaloosa Walker