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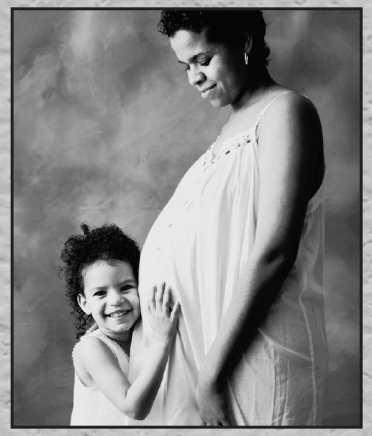
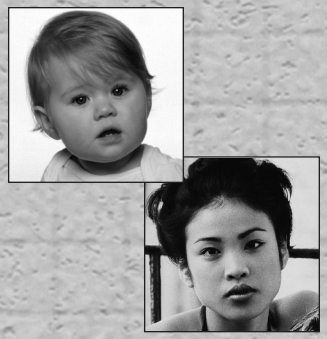
ALLKids

ALL Kids Program
PO Box 304839
Montgomery AL 36177-7280

Medicaid

for Low Income Families





SOBRA

Medicaid

ALL Kids

Insurance

The Alabama

Child Caring

Program

THIS IS YOUR APPLICATION

for free or low cost health care coverage.

These programs cover low income families with children, pregnant women, children under age 19, and females ages 19-55 for family planning/birth control service only.

Your income and family information will be the deciding factors as to which of the programs you may qualify for.

You may also apply on-line:
www.insurealabama.org

Si necesita una solicitud en español, llame gratis a ALL Kids al teléfono **1-888-373-KIDS (5437)** o a la oficina de Medicaid en Alabama al teléfono **1-800-362-1504**.

Form 291 (Revised 03/01/2009)

Please print clearly using dark ink. Please fill out all information in each section.

Do you have Medicaid in another state? Yes ☐ No ☐ If yes, you must terminate your Medicaid in that state before you can be on Medicaid in Alabama.

1. Applicant. This is the Parent, Caretaker, OR Pregnant Woman. (Children will be listed on Page 2.)

First Name of Applicant Middle/Maiden Last	Social Security Number of Applicant
Mailing Address	Home Phone: ( ) Other Phone ( ) Whose?
Street Address (911 Address) County where you live	Work Phone ( ) May we call you at work? Yes ☐ No ☐
City, State, Zip Code	Cell Phone: ( ) E-mail:
Marital Status: Married ☐ Divorced ☐ Separated ☐ Single ☐ Widowed ☐	What language do you usually speak? English ☐ Spanish ☐ Other ☐_____ Do you or a family member speak English? Yes ☐ No ☐

2. Pregnant Woman. (Please provide a statement from a doctor or an authorized clinic proving you are pregnant and the expected date your baby is due.)

Name	Date Baby is Due	Number of Babies in This Pregnancy

3. Paid or Unpaid Medical Bills. Did anyone applying have medical expenses (doctor bills, lab work, etc.) in the last 3 months? Yes ☐ No ☐

Name of Patient?	When was Care Received?	Name of Patient?	When was Care Received?

4. Health Insurance. Does anyone living in the household already have health insurance? (Such as Blue Cross, ALL Kids, Medicaid, Alabama Child Caring Program, TriCare, Champus, Medicare, other.) Yes ☐ No ☐ If yes, we need a copy of your insurance card(s), front and back.

Policyholder's Name	Insured Person's Name	Insurance Company	Policy #	Group #	Effective Date

Circle what this policy covers: Dental Doctor Visits Drugs Family Planning Hospital Maternity Other **Is it a Managed Care or HMO?** Yes ☐ No ☐

Policyholder's Name	Insured Person's Name	Insurance Company	Policy #	Group #	Effective Date

Circle what this policy covers: Dental Doctor Visits Drugs Family Planning Hospital Maternity Other **Is it a Managed Care or HMO?** Yes ☐ No ☐

Has any health insurance **ended within the last 3 months?** Yes ☐ No ☐ If yes, who _____ Why_____

Will any health insurance end in the next 2 months? Yes ☐ No ☐ If yes, who _____ End date:_____

Please explain why this insurance will end._____

Is anyone in the household a state or public school employee? Yes ☐ No ☐ If Yes, who: _____

5. Females Age 19 - 55 May be Eligible for Family Planning (Birth Control) Services. (NOTE: You will not be eligible for this program if you have had your tubes tied, been sterilized, or are on Medicare.) Do You Want to Apply for or Continue to Receive Family Planning? Yes ☐ No ☐

ALL Kids Date Rec'd _____	Medicaid Date Rec'd _____	Plan First Date Rec'd _____
Date Accepted_____	Date Accepted_____	Date Accepted_____

6. Do You Receive Family Assistance From DHR? Yes ☐ No ☐ Do You Get Food Stamps? Yes ☐ No ☐ Case Number _____

7. Are You or Anyone in Your Household Interested in Information About Getting Free Food From the WIC Program? Yes ☐ No ☐

8. Household Members.

On Line A, list parent, caretaker, or pregnant woman from Item 1. on page 1.

On Line B, list the spouse of the person on Line A

On Lines C - H, list all the children who are under 19 years of age that you take care of and who live in your home.

NOTE: List the name of the child as it appears on their birth certificate.

NOTE: If there is a legal parent to the child(ren) listed, who lives in the home, **please include that parent in this section.**

	** First Name	Middle or Maiden	Last Name(s)	Social Security Number (required for those seeking assistance)	Relationship to person on line A. Son/ Daughter (C) Grandchild (I) Husband (H) Wife (W) Parent (P) Brother/ Sister (S) Niece/ Nephew (N) Cousin (E) Other (O)	Are you a U. S. Citizen? Yes or No (Citizens must provide proof of citizenship and identity for Medicaid. See Citizenship and Identity Handout.) (Noncitizens may still receive services.)	Date of Birth	Age	Sex	Race Black (B) White (W) Asian (A) Hispanic (H) American Indian/ Native Alaskan (I) Native Hawaiian/ Pacific Islander (NP) Other (O) Not Known (U)
A					**Self**					
B					**Spouse**					
C										
D										
E										
F										
G										
H										

** If your name is Fulana de Tal Vista Hermosa enter your name like this: **First Name** as Fulana, **Middle** or **Maiden Name** as deTal, and **Last Name(s)** as Vista-Hermosa.

If you have more family members in your home, please attach an additional sheet of paper listing those family members and the above information for them (SS#, DOB, etc.)

9. Stepparents. Is there a stepparent living in the home? Yes ☐ No ☐

If yes, _____ is a Stepparent to _____
Name of Stepparent Name of Child(ren)

_____ is a Stepparent to _____
Name of Stepparent Name of Child(ren)

10. If Your Household Has No Income, Check Here _____.

11. Work Income For You and Your Household. For Medicaid eligibility, attach proof of gross wages. (This means work income before anything is taken out, such as taxes, retirement, Medicare premiums, garnishments, etc.). You may send check stubs or a signed statement from employer for the most recent month.
NOTE: Remember to include any overtime pay.
Only the income from a legal parent of a child you are applying for will be considered.

Name of Person Working	**Number of Hours Worked Each Week**	**Hourly Pay Rate**	**Day of Week Paid**	**How Often Paid?** Weekly Every two weeks Twice a month Other (specify)	**Gross Amount Paid** (Before anything is taken out) **Include Tips and Overtime**	**Name of the Person or Company that You Work for, as well as the Address and Phone Number**

Are You Self-employed? Yes ☐ No ☐ If self-employed, you must attach a copy of your most recent Income Tax Return and Schedule C.

Do You Receive Income From Farming? Yes ☐ No ☐ You must attach a copy of your most recent Income Tax Return and Schedule F.

12. Day Care. If you are working, does anyone in your household pay for care of a child or an incapacitated adult living in the home? Yes ☐ No ☐

Name of Person Who Pays	Amount Paid?	How Often Paid?	Name and Age of Person(s) in Care

13. Other Income. For Medicaid eligibility, attach proof of income such as a benefits award letter, a copy of the check, or a statement from the Income Source. Tell us if you or any family members receive other income from the types listed below. For child support, list the child's name as the person who gets the payment.

1. Social Security (include Medicare prem.)
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, others)
12. Rental Income (land, buildings or from roomer)
13. Personal Loans (from relatives, others)
14. Unemployment Compensation
15. Insurance Annuity or Proceeds
16. Government Payments on Land
17. Coal, Oil, Gravel Rights & Timber Leases
18. Royalties
19. Child Support
20. Interest on Savings
21. Other: Specify _____
22. Other: Specify_____
23. Legal Settlements
24. Sheltered Workshop Earnings
25. Lump Sums
26. Dividends
27. School Grants or Loans

Name of Person Receiving the Payments	What Type (From Above)	Gross Amount (before anything is taken out)	How Often are Payments Received?

For ALL Kids Use Only

Screen ck	All Kids ck	MCD ck	LF/NF ck	Fee pd ck	Date wk

For Medicaid Use Only

ID# _____ ID# _____ ID# _____ ID# _____

Alabama Medicaid Agency/Alabama Department of Public Health 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 Americans With Disabilities Act of 1990.

This page is for Medicaid for Low Income Families (MLIF) only.

If you do not wish to apply for MLIF for yourself, leave this page blank.

Medicaid for Low Income Families (MLIF) is for families with very low income. MLIF will allow an adult to be included in Medicaid, however, information regarding absent parents is required for this program. If you want to apply for MLIF for yourself, you must give us the absent parent information below to allow Medicaid to send a medical support referral to the Child Support Enforcement Unit of the Department of Human Resources (DHR).

If you are applying for MLIF and there is a child in your home whose parent(s) are not living in the home, you must complete the information below about each parent not living in the home, unless you can provide Medicaid with a good reason. A good reason may be that the child was conceived through rape or incest, or that cooperating or providing information would result in harm or injury to you, your family or your child(ren). If you do not want to apply for MLIF or do not want to complete the absent parent information or cooperate with the Child Support Unit, your child(ren) may still be eligible for Medicaid.

Will you cooperate with the Child Support Unit for medical support enforcement? Yes ☐ No ☐
If you feel you have a good reason not to cooperate, check here _____.

Does the adult or adults living in the home wish to apply for MLIF? Yes ☐ No ☐

For MLIF only, fill out as much information as you have for each child that has one or both parents not living in the home.

Name of child who has an absent parent _____				
Name of the absent parent	Social Security Number	Date of Birth	Sex Male ☐ Female ☐	Race
Address	Reason for not living in the household			
Have you already applied for medical support for this child? Yes ☐ No ☐	Has paternity been established for this child? Yes ☐ No ☐			

Name of child who has an absent parent _____				
Name of the absent parent	Social Security Number	Date of Birth	Sex Male ☐ Female ☐	Race
Address	Reason for not living in the household			
Have you already applied for medical support for this child? Yes ☐ No ☐	Has paternity been established for this child? Yes ☐ No ☐			

Name of child who has an absent parent ________________________________

Name of the absent parent	Social Security Number	Date of Birth	Sex Male ☐ Female ☐	Race
Address		Reason for not living in the household		
Have you already applied for medical support for this child? Yes ☐ No ☐		Has paternity been established for this child? Yes ☐ No ☐		

Name of child who has an absent parent ________________________________

Name of the absent parent	Social Security Number	Date of Birth	Sex Male ☐ Female ☐	Race
Address		Reason for not living in the household		
Have you already applied for medical support for this child? Yes ☐ No ☐		Has paternity been established for this child? Yes ☐ No ☐		

Name of child who has an absent parent ________________________________

Name of the absent parent	Social Security Number	Date of Birth	Sex Male ☐ Female ☐	Race
Address		Reason for not living in the household		
Have you already applied for medical support for this child? Yes ☐ No ☐		Has paternity been established for this child? Yes ☐ No ☐		

Name of child who has an absent parent ________________________________

Name of the absent parent	Social Security Number	Date of Birth	Sex Male ☐ Female ☐	Race
Address		Reason for not living in the household		
Have you already applied for medical support for this child? Yes ☐ No ☐		Has paternity been established for this child? Yes ☐ No ☐		

If you need more room, please attach additional sheets.

RELEASE OF INFORMATION

* I hereby authorize and give my consent for the Alabama Medicaid Agency, the Alabama Department of Public Health and the Alabama Child Caring Program to obtain information from any source for the purpose of determining my eligibility for the Medicaid, ALL Kids or Alabama Child Caring Program. I authorize this release form to be in effect for as long as I am on Medicaid, ALL Kids or the Alabama Child Caring program 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, ALL Kids or the Alabama Child Caring programs. 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.

I UNDERSTAND AND AGREE

* This application is only for ALL Kids, Alabama Child Caring Program, Medicaid for pregnant women, Medicaid for females ages 19-55 (for family planning/birth control services only), Medicaid for children under age 19, and Medicaid for Low Income Families (MLIF) with children.
* I give permission to the Alabama Medicaid Agency, the Alabama Department of Public Health and the Alabama Child Caring Program to use my social security number and the social security numbers of persons on whose behalf I am applying to get information about anyone's income from banks, financial institutions, employers, and other county, state and federal agencies, and/or to see if anyone qualifies for assistance or to see if anyone has insurance.
* To be eligible for MLIF, I must cooperate in establishing paternity and getting medical support, unless I provide Medicaid with good reason not to cooperate.
* If I am approved for either Medicaid or ALL Kids, I assign all insurance and medical support benefits to the program I am enrolled in. If Medicaid or ALL Kids pays my bills, then my insurance or other benefits (such as lawsuit settlements) must be used to pay Medicaid or ALL Kids back. I agree to help and cooperate with Medicaid or All Kids in identifying and collecting this money, or I may lose my Medicaid or ALL Kids benefits. I give permission for my insurance company, employer, and others to give needed information to Medicaid or ALL Kids in order to administer the Medicaid or ALL Kids program.
* I (and my spouse) must apply for any benefits (such as unemployment compensation) that we may be entitled to in order for me, my spouse, or my family members to become eligible for Medicaid.
* I agree to let the above named agencies know, at annual renewal, if anything in my household changes. However, if I am on MLIF, I must report any changes within ten (10) days. (The kinds of changes to report are: someone moves into or out of my home, my address changes, I/we get or lose insurance, or someone's income changes.)
* If I am approved, I agree to cooperate if I am reviewed by State and/or Federal Quality Control.
* I understand that medical information acquired in the administration of the Medicaid/ALL Kids/Alabama Child Caring programs is subject to health oversight activities, and that such information may be disclosed for program oversight purposes to the State of Alabama (or those engaged as its business associates) without the need for individual consent by me or my family members, as allowed by HIPAA privacy regulations.

SIGN HERE:

I affirm under penalty of perjury that all information entered on this application is true, to the best of my knowledge, including the identity of all persons under age 16 listed on this application. I also understand that I may be asked to provide additional proof, as needed. If I knowingly entered any false statements or left out information asked for on this application, such as income or household members, I commit a crime that is punishable under Federal and/or State law.

_____ _____ _____ _____

Signature of applicant Date Signature of Spouse Date

NOTE: If you are applying for Family Planning Services for your spouse, who is a female aged 19-55, she must sign on "Signature of Spouse" line.

_____ _____ _____

Signature of person helping to fill out this form Relationship to applicant Date

_____ _____ _____

Name of interviewer helping to fill out this form Date **I certify that I have completed the initial interview**

You may mail this application to any one of the programs you are applying for. Mail to:

ALL Kids Program
P.O. Box 304839
Montgomery, AL 36130-4839
1-888-373-KIDS (5437) Toll free

Alabama Medicaid Agency (SOBRA, MLIF)
P.O. Box 5624
Montgomery, AL 36103-5624
1-800-362-1504 Toll free

The Alabama Child Caring Program
P. O. Box 830870
Birmingham, AL 35283-0870
1-877-220-5929 Toll free