Applicant's Name:_____ SSN:_____

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 5 years 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 <u>MUST</u> 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