A Family Planning Program
for Women Ages 19-55

Application for the Medicaid Plan First Program

This application is for family planning (birth control) services only, for women 19 – 55 years of age.

If you have questions, please call Medicaid at 1-800-362-1504. The call is free.

Please print and use dark ink.

Plan First Application(Form 357)

1. Name of Recipient _____
(First Name) (Middle Name) (Maiden Name) (Last)

Social Security Number _____ **Date of Birth** _____ **Age** _____

2. Race _____ **Do you receive Medicare?** Yes ☐ No ☐

3. Are you a female? Yes ☐ No ☐ **Are you pregnant?** Yes ☐ No ☐

Have you had your tubes tied or been sterilized? Yes ☐ No ☐

4. Are you a U.S. Citizen? Yes ☐ No ☐

5. Telephone Numbers where we can call you

Cell Phone (_____)_____ Home Phone: (_____)_____

Work Phone (_____)_____ **May we contact you at work?** Yes ☐ No ☐

Other Phone (_____)_____ Whose Phone? _____

6. Address where you want your Medicaid card sent

_____
Street address or rural route number City State Zip Code County

Address where you live, if different from above

_____
Street address or rural route number City State Zip Code County

7. Name of Spouse _____

Spouse's Social Security Number _____

Spouse's Date of Birth _____ **Race** _____

8. Do you have health/hospital insurance? Yes ☐ No ☐ (Attach a copy of insurance card(s), front and back.)

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

Circle what this policy or policies cover Dental Doctor Visits Drugs Family Planning
Hospital Maternity Other

Is it a Managed Care or HMO? Yes ☐ No ☐

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Date Received at Public Health _____ Date Accepted at Medicaid _____

9. Income

If you have no income, check here ☐ If your spouse has no income, check here ☐

10. Earned Income Complete the section below if you or your spouse have income from work.

If self-employed check here ☐

Your Income How often are you paid? Weekly ____ Every 2 weeks ____ Monthly ____ Other _____

Day of week paid _____ Gross amount paid per paycheck $ _____ (include all tips)

If hourly employee, hourly rate $_____ Hours worked per week _____

Name, address and telephone number of employer _____

_____

Spouse's Income How often is he paid? Weekly ____ Every 2 weeks ____ Monthly ____ Other _____

Day of week paid _____ Gross amount paid per paycheck $_____ (include all tips)

If hourly employee, hourly rate $ _____ Hours worked per week _____

Name, address and telephone number of employer _____

_____

11. Unearned Income Complete the section below if you or your spouse have income from any of the sources listed. Please list the **GROSS AMOUNT** (amount before anything is taken out).

1. Social Security
2. SSI
3. Public Assistance
4. Railroad Retirement
5. Federal Civil Service
6. State Retirement
7. Private Pension
8. Miner's Benefits
9. Black Lung Benefits
10. Cash Contributions
11. Rental Income
12. Personal Loans
13. Unemployment Comp
14. Insurance Annuity
15. ASCS Gov't payment
16. Coal, Oil, Timber
17. Leases
18. Interest on Savings
19. Other: (Explain) _____ _____

Name of Person Receiving Payments/Benefits	What Source? From Above	Gross Amount Received	How Often are Payments Received?

Do you plan to file income taxes next year? Yes ☐ No ☐

If yes, will you claim all the individuals listed above as tax dependents? Yes ☐ No ☐

If married, will you file jointly? Yes ☐ No ☐

Do you plan to claim the individuals listed above as tax dependents? Yes ☐ No ☐

List all you do not intend to claim for tax purposes _____

_____

List any other individuals you intend to claim that are not listed above _____

_____

Will you or anyone listed above be claimed on someone else's income taxes? Yes ☐ No ☐

Who listed above will be claimed by someone else?_____

_____

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 eligibilityfor 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. 1 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.

AGREEMENT AND AFFIRMATION

* I give permission to the Alabama Medicaid Agency and the Health Insurance Marketplace to use my social security number to get information about my 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 to qualify for assistance, or to see if I have insurance.
* 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 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 part of a State or Federal Quality Control Review.
* I agree to tell the Alabama Medicaid Agency immediately or in no more than 10 days if I receive additional income, if I move or if any changes occur in my circumstances.
* I understand and agree that I and my spouse must take all necessary steps to get any benefits such as annuities, pensions, unemployment compensation or retirement disability benefits that we may be entitled to.

Renewal of coverage in future years

To make it easier to determine my eligibility for help paying for health coverage in future years, I agree to allow the Medicaid Agency to use income data, including information from tax returns. Medicaid will send me a notice, let me make any changes,and I can opt out at any time.

Yes, renew my eligibility automatically for the next (Circle one)

☐ 5 years (the maximum number of years allowed), or for a shorter number of years:

☐ 4 years ☐ 3 years ☐ 2 years ☐ 1 year Do not use information from tax returns to renew my coverage.

FALSE STATEMENTS

I know that anyone who makes or causes to be made a false statement or representation of material fact in an application or for use in determining eligibility of 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.

_____ _____

Signature Date

_____ _____

Name and phone number of person helping to fill out this form Date

Mail this form to:

Alabama Medicaid Agency
Plan First Intake Unit
501 Dexter Avenue
PO Box 5624
Montgomery, Al 36103-5624

Medicaid eligibility policies and procedures are in compliance with the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, the Federal Age Discrimination Act of 1975 and the Americans with Disabilities Act of 1990.