Annual Registration Form for Medicaid Planners

Effective: July 1, 2015

Name: *(First, Middle Initial, Last)* ____

Business Name, *if applicable*: ____

	Physical Address	Mailing Address (*If different from Physical Address*)
Address Line 1		
Address Line 2		
City		
State		
Zip		

Business Telephone (____) ____ - ______ **Email:** _________________________________

Highest Educational Level: ☐ High School ☐ College ☐ College Degree ☐ Master's/Doctorate

Professional Certifications or Licenses - *Provide information, as applicable*:

	Type	Date Issued (Month/Year)	Expiration Date (Month/Year)	License Number	Issuing Agency
1					
2					
3					

Number of Years Engaged as a Medicaid Planner

☐ Less than 1 year ☐ 1 to 5 years ☐ 6 to 10 years ☐ More than 10 years

Services and Fee Scale(s) - *List services provided and fee scale(s):*

	Medicaid Planning Services Offered	Fee Scale(s)
1		
2		
3		
4		
5		

Sources used to Acquire and Maintain Medicaid Knowledge Base (experience, courses, trainings, etc.):

	Sources		Sources
1		4	
2		5	
3		6	

Sign this completed registration form, attach the required surety bond and mail to: Division of Medicaid, Office of Eligibility, 550 High Street, Suite 1000, Walter Sillers Building, Jackson, MS 39201.

I certify that the information contained herein and on any submitted documentation is true and complete to the best of my knowledge. If I become aware that any information provided on this form is no longer true or complete, I agree to immediately notify the Mississippi Division of Medicaid in order to update or correct the information. I authorize verification of this information by any federal or state entity. I understand that any falsification, omission, misrepresentation, or concealment of any material fact contained herein may lead to disapproval of my registration and may be punishable by criminal, civil, or other administrative actions, as applicable. I further attest that I will abide by all applicable state and federal law, regulations, policies, and requirements of the Mississippi Division of Medicaid.

______________________________________ ____________________

Signature of Medicaid Planner **Date**