



State of Alaska  
Department of Health & Social Services  
Division of Public Assistance  
<http://www.hss.state.ak.us/dpa/>

# Application for Services

**If you need help filling out this form or have questions, please tell us – we can help!**

## How do I apply?

Complete page A of this application form with your name, address, and signature, and give it to us.

## What do I do next?

Fill out the whole application form.

- Attend an interview with a Public Assistance caseworker or Fee Agent.
- Provide proof of your income, expenses, and other circumstances.

You may apply for one or more program benefits with the same application.

## How long will it take?

It may take up to 30 days to process your application.

You can get food stamps within 7 days if:

- Your household's monthly gross income (income before deductions) is less than \$150 and your cash and money in the bank is not more than \$100; or,
- Your household's monthly rent/mortgage/utility payments are more than your monthly gross income, cash, and money in the bank.

If eligible, benefits for Temporary Assistance and Food Stamps start the date we receive your completed page A. Adult Public Assistance, Medicaid benefits, and benefits from other programs may start on a different date.

## Do I have to go to an interview?

Yes. A personal interview is required before the caseworker can determine if you are eligible for assistance. You may schedule an interview at the Public Assistance office or with your local Fee Agent. If you cannot attend an interview in person, contact the Public Assistance office so other arrangements can be made. Your application will be denied if you do not attend an interview within 30 days.

## Programs

### Medicaid

Offers medical coverage to families, children, elderly, disabled adults, and pregnant women. Also helps with Medicare Parts A and B premiums.

### Chronic & Acute Medical Assistance

Helps people with specific illnesses who don't qualify for Medicaid and have little or no income.

### Food Stamps

Helps people buy food.

### Temporary Assistance Program

Gives monthly cash payments to eligible families with children.

### Adult Public Assistance

Gives monthly cash payments and medical assistance to eligible elderly, blind, and disabled persons.

### General Relief Assistance

Helps eligible individuals and families with emergency rent and utility needs. Also helps with burial costs.

Information Page - Read and keep this page for your records.

# What do I need to bring to my interview?

To avoid delays, bring these items with you to your interview. Go to your interview even if you do not have all of the items. We may be able to assist if you need help getting them. For some programs, certain expenses may be allowed in determining your eligibility and benefit amounts.

## For Any Program or Service:

- Identification, such as a Driver's License, State ID card, or Certificate of Indian Blood.
- Proof of where you live, such as a rental agreement or current bill showing your residence address.
- Proof of lawful immigration status, such as an Alien Registration Card, for anyone in your household who is an immigrant and applying for benefits. Note: This information is not needed if you are applying for Medicaid for Emergency Treatment of Aliens.
- Proof of money in the bank, such as recent bank statements for checking, savings and credit union accounts for all the people in your household.
- Proof of income received by everyone in your household. This can be provided by the most recent pay stubs or a work statement from an employer. If self-employed, bring in income and expense records. Bring proof of unearned income, like unemployment benefits, SSI, Social Security, Veteran's benefits, child support, worker's compensation, school grants or loans, rental income, etc.

## For Food Stamps, Medicaid or Alaska Temporary Assistance:

- Proof of your housing costs, such as receipts or documents that show your housing costs, including rent, space rent, mortgage payments, utility bills, property tax, home insurance.
- Proof of medical expenses belonging to anyone in your household who is elderly or disabled.
- Proof of child care costs due to someone working, looking for work, attending training or school, or participating in a required work activity.
- Proof of child support paid by a person in your household. You will need to show the child support order, the amount of the monthly obligation, and the amount you currently pay.

## For Medicaid:

- Proof of U.S. citizenship, such as a birth certificate, of all persons applying for benefits.
- Proof of medical or health insurance, including a copy of the Medicare Card, if you have any.
- Proof of pregnancy and due date, if someone in your household is pregnant.

## For Adult Public Assistance:

- Proof of application for Supplemental Security Income (SSI).

## For General Relief Assistance:

- Proof of your need, such as an eviction notice or utility shut off notice.

## Your appointment is on:

Date/Day \_\_\_\_\_ Time \_\_\_\_\_ Phone \_\_\_\_\_

Location/Interviewer \_\_\_\_\_ Fax \_\_\_\_\_

# Your Rights and Responsibilities

## What if I disagree with a decision made?

You have the right to discuss any action taken on your application or case with a caseworker or supervisor. If you disagree with an action taken by the Division of Public Assistance that affects the benefits or services you receive, you can ask for a fair hearing. You may do this by phone, in person, or in writing by contacting anyone in the Public Assistance office. If your disagreement has to do with medical billing or services, contact the Recipient Information Helpline at 1-800-780-9972. Usually, you must ask for a fair hearing within 30 days from the date of the notice. Food Stamp fair hearing requests must be made within 90 days from the effective date of the action. At the hearing you may represent yourself or be represented by a legal representative, friend, or relative. You may qualify for free legal advice and representation by contacting the Alaska Legal Services Corporation.

You may continue to receive Alaska Temporary Assistance, Adult Public Assistance, or Medicaid program benefits until a hearing decision is made. Food Stamps can continue until a hearing decision is made or until the certification period ends if you request the hearing before the effective date of the action or within 10 days from the date the notice was mailed. If the hearing decision is not in your favor you may be required to repay the benefits you received while you waited for the decision.

## Do I need to tell you if something changes?

It is very important that you report certain changes by contacting the Public Assistance office by phone, in person, or in writing.

## When do I need to report changes?

You must report changes in your household within 10 days of when you know of the change. If you get Alaska Temporary Assistance and a child leaves your home, you must report this within 5 days.

## What changes do I need to report?

If you receive Adult Public Assistance or Medicaid (for elderly, disabled, and long term care) you must report all changes, including changes in your medical insurance. If you receive Food Stamps and you do not receive benefits from any other program, you only need to report when your household's total gross income goes over the income limit for your household.

If you receive Alaska Temporary Assistance or Family Medicaid, you must report the following changes:

- Starting or stopping a job, change in wage rate, change from part-time to full-time, or full-time to part-time
- When money you receive from sources other than working changes by more than \$50
- Someone moves into or out of your home
- You move or get a new mailing address (you need to verify your new shelter costs or we cannot use them in calculating your benefits)
- Your household gets a vehicle
- Your household has more than \$2000 total in cash and money in bank
- Changes in your child support payment or obligation
- Changes in your medical insurance if you or anyone in your household gets Medicaid

Read and keep this page.

## Will I need to work?

To receive Alaska Temporary Assistance or Food Stamp benefits, you may have to participate in work activities. Alaska Temporary Assistance participants must prepare a Family Self-Sufficiency Plan for becoming financially independent. You must participate in approved work activities unless you qualify for an exemption. If you are an unmarried minor parent, to receive Alaska Temporary Assistance you must live with a parent or in another approved living arrangement and attend school or training. If you do not fulfill these work requirements or minor parent requirements your benefits may be reduced or ended.

## What happens with my Child Support?

Alaska must collect child support and medical support from any parent who has the duty to pay support for a child receiving Alaska Temporary Assistance or Medicaid. This includes any money owed to you at the time you apply, as well as current and future child support payments. Any child support payments given or paid to you while receiving Alaska Temporary Assistance benefits must be reported and turned over to the State immediately. To change a child support order, you must obtain a new court order or get permission from the Child Support Services Division (CSSD). If you believe you have a good reason not to cooperate with CSSD for these programs, you must tell your caseworker immediately. You may be asked to provide information to support your reason.

## When you apply for Alaska Temporary Assistance you must:

- Sign over to CSSD your right to receive and keep child support payments due to you or to a child on Alaska Temporary Assistance
- Cooperate with CSSD in establishing paternity

## When you apply for Medicaid or Chronic and Acute Medical Assistance you must:

- Assign to the State of Alaska all rights to any medical support or other third party payments to the extent the department has paid medical assistance for care and services for you or your minor children;
- Cooperate with and assist the department in identifying and providing information concerning third parties who may be liable to pay for care and services received for you or your minor children;
- Agree to apply for all other available third-party resources that may be used to provide or pay for the cost of care or services received by you or your minor children or that may be used to reimburse the state for the cost of care or services received;
- Cooperate with Child Support Services Division (CSSD) in establishing paternity;
- If applying for long-term care services, including home and community based waiver services, assign to the State of Alaska as a remainder beneficiary, or as the second remainder beneficiary after your spouse or minor or disabled child, for any interest that you may have in an annuity up to the amount of Medicaid benefits received.

## Can the State of Alaska take my estate?

The estate of an individual age 55 years of age or older who received Medicaid benefits may be subject to a claim for recovery. This is limited to the reimbursement of services received while the recipient was in a medical institution, including a nursing home or other medical institution, or was receiving home and community-based services. Under limited conditions, the State of Alaska may place a lien on a recipient's home. However, most estate recovery is conducted after the death of the recipient or the recipient's surviving spouse, if any, and only at a time when the recipient has no surviving child under age 21 and no surviving child who is blind or disabled.

## Will someone from DPA come to my home?

A Division of Public Assistance worker may visit you at home to verify your eligibility for assistance. We may also visit you to complete case management activities such as Family Self-Sufficiency Plans. If you are not completing the activities, we may visit you to determine whether you have good cause for not doing so.

Read and keep this page.

## How are my rights protected?

The Division of Public Assistance will collect information, including the Social Security Number of each household member who is applying for Food Stamps, Alaska Temporary Assistance, or Medicaid, to determine eligibility for public assistance benefits. The Division will verify this information through computer matching programs, including the Income and Earnings Verification System (IEVS). This information will be used to monitor compliance with program regulations and for program management. The Division may disclose this information to other Federal and State agencies for official examination, to law enforcement officials for the purpose of apprehending persons fleeing to avoid the law, and to private claims collection agencies for claims collection action. The Division may verify immigrant status of household members by contacting the US Citizenship and Immigration Services (USCIS). Information obtained from these agencies may affect your eligibility and level of benefits.

Providing the requested information, including the Social Security Number (SSN) of each household member for whom you are seeking benefits, is voluntary. However, failure to provide this information will result in the denial of benefits to each individual failing to provide an SSN. Any SSN provided will be used and disclosed in the same manner, regardless of the eligibility of the individual. The Division of Public Assistance can assist you in applying for a Social Security Number if you are seeking benefits and do not have one.

When you sign the application for assistance and use Medicaid or Chronic & Acute Medical Assistance coupons, you consent to release medical records and information about yourself and any other person you are applying for to the Department of Health and Social Services. Upon request, any person who has medical records and information or the custody of such records shall release those records to the Department or a representative of the department.

Health or medical information the Department of Health and Social Services (DHSS) may have about you is protected under the Health Insurance Portability and Accountability Act (HIPAA) of 1996. This federal law provides you with certain rights about how your health information is used and disclosed. The law allows you to find out how DHSS used your health information, and how DHSS has disclosed your health information outside of DHSS. The law also limits the release of information about you to the minimum amount necessary for the purpose of the disclosure and allows you to examine and obtain a copy of your own health records and to request corrections to those records.

You can get an electronic copy of the Notice of Privacy Practices at <http://www.hss.state.ak.us/das/is/hipaa/pdfs/privatehealthcareinfo.pdf>. Request a printed copy by writing to State of Alaska, DHSS Privacy Official, P. O. Box 110650, Juneau, Alaska 99811-0650 or by email at [privacyofficial@health.state.ak.us](mailto:privacyofficial@health.state.ak.us).

In accordance with Federal law and U.S. Department of Agriculture (USDA) and U.S. Department of Health & Human Services (HHS) policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age, or disability. Under the Food Stamp Act and USDA policy, discrimination is prohibited also on the basis of religion or political beliefs.

To file a complaint of discrimination, contact USDA or HHS. Write to USDA, Director, Office of Civil Rights, Room 326-W, Whitten Building, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410 or call (800) 795-3272 (voice) or (202) 720-6382 (TDD). Or write to HHS Office for Civil Rights, 2201 Sixth Avenue – Mail Stop RX-11, Seattle, WA 98121 or call (800) 368-1019 (voice) or (800) 537-7697 (TDD). USDA and HHS are equal opportunity providers and employers.

If you have questions about the Americans with Disabilities Act of 1990, contact the Division of Public Assistance Civil Rights Coordinator at (907) 465-3347.

Read and keep this page.

State of Alaska  
 Department of Health & Social Services  
 Division of Public Assistance

## What happens if I do not follow the rules?

You may be prosecuted if you knowingly give false, incorrect, or incomplete information to get or try to get public assistance benefits you are not eligible for, or to help someone else get benefits for which they are not eligible. You must repay any benefit you wrongly receive.

Food Stamp Program	
I understand that if I...	I may...
Commit an intentional program violation of the Food Stamp Program defined in 7CFR273.16 or any of the following: <ul style="list-style-type: none"> <li>hide information or make false statements</li> <li>use electronic benefit transfer (EBT) cards that belong to someone else</li> <li>use food stamp benefits to buy alcohol or tobacco</li> <li>trade or sell benefits or EBT cards</li> </ul>	<ul style="list-style-type: none"> <li>lose food stamp benefits for 12 months for the first offense and be required to repay all benefits overpaid to me</li> <li>lose food stamp benefits for 24 months for the second offense and be required to repay all benefits overpaid to me</li> <li>lose food stamp benefits permanently for third offense and be required to repay all benefits overpaid to me</li> <li>be fined up to \$250,000.00, imprisoned up to 20 years or both</li> </ul>
<ul style="list-style-type: none"> <li>trade food stamp benefits for controlled substances, such as drugs</li> </ul>	<ul style="list-style-type: none"> <li>lose food stamp benefits for 24 months for the first offense</li> <li>lose food stamp benefits permanently for the second offense</li> </ul>
<ul style="list-style-type: none"> <li>give false information about who I am and where I live so I can get extra benefits</li> </ul>	<ul style="list-style-type: none"> <li>lose food stamp benefits for 10 years for each offense</li> </ul>
<ul style="list-style-type: none"> <li>have been convicted of trading or selling food stamps worth more than \$500, or trading food stamps for firearms, ammunition, or explosives</li> </ul>	<ul style="list-style-type: none"> <li>be barred from the Food Stamp Program permanently</li> </ul>

Alaska Temporary Assistance Program	
I understand that if I...	I may...
<ul style="list-style-type: none"> <li>commit an intentional program violation or I am convicted of fraud</li> <li>give false information about who I am and where I live so I can get extra benefits</li> </ul>	<ul style="list-style-type: none"> <li>lose benefits for 6 months for the first offense</li> <li>lose benefits for 12 months for the second offense</li> <li>lose benefits permanently for the third offense</li> <li>other penalties may also apply and I may be subject to criminal prosecution</li> </ul>

Medicaid Program	
I understand that if I...	I may...
<ul style="list-style-type: none"> <li>commit an intentional program violation or program abuse that results in misuse or overuse of Medicaid benefits or found guilty of misconduct related to Medicaid benefits</li> <li>commit Medical Assistance fraud under AS 47.05.210</li> </ul>	<ul style="list-style-type: none"> <li>be required to pay back the amount of Medicaid services that I or anyone in my household received</li> <li>be excluded from Medicaid for up to 10 years</li> <li>have to pay fines up to \$25,000 and be subject to criminal prosecution</li> </ul>

Read and keep this page.



# Application for Services

## A What kind of help do you need?

Check the programs or services you need.



- Medicaid
- Chronic & Acute Medical Assistance



- Food Stamps



- |  |  |
|--|--|
| <input type="checkbox"/> Temporary Assistance      | <b>Other Services</b>                  |
| <input type="checkbox"/> Adult Public Assistance   | <input type="checkbox"/> finding work  |
| <input type="checkbox"/> blind or disabled         | <input type="checkbox"/> child care    |
| <input type="checkbox"/> elderly assistance        | <input type="checkbox"/> child support |
| <input type="checkbox"/> General Relief Assistance | <input type="checkbox"/> prenatal care |
| <input type="checkbox"/> rent or utilities         | <input type="checkbox"/> other         |
| <input type="checkbox"/> burial expenses           | _____                                  |

## Programs

### Medicaid

Offers medical coverage to families, children, elderly, disabled adults, and pregnant women. Also helps with Medicare Parts A and B premiums.

### Chronic & Acute Medical Assistance

Helps people with specific illnesses who don't qualify for Medicaid and have little or no income.

### Food Stamps

Helps people buy food.

### Temporary Assistance Program

Gives monthly cash payments to eligible families with children.

### Adult Public Assistance

Gives monthly cash payments and medical assistance to eligible elderly, blind, and disabled persons.

### General Relief Assistance

Helps eligible individuals and families with emergency rent and utility needs. Also helps with burial costs.

## B Who are you? (Please print)

Name (First, Middle, Last)		Social Security Number (optional)		
Home Address or Directions to Your Home		City	State	Zip Code
Mailing Address		City	State	Zip Code
Home Phone	Message Phone	Other Names (maiden, nicknames, etc)		
Answer these questions to see if you can get food stamps within seven days:				
• Do you have more than \$100 in cash or money in the bank?				<input type="checkbox"/> yes <input type="checkbox"/> no
• Is your household's monthly gross income (income before deductions) less than \$150?				<input type="checkbox"/> yes <input type="checkbox"/> no
• Are your costs for rent/mortgage/utilities more than your monthly gross income, cash and money in the bank?				<input type="checkbox"/> yes <input type="checkbox"/> no
Sign Here		Date	E-mail	
X				

## Notes



# People in your household



## 1 Tell us about yourself and the people living in your home.

Race and ethnicity information is optional. It is requested to assure benefits are given without regard to race, color or national origin. Your answers will not affect your eligibility or benefit amount. If you need more space, use page 8.

Household Members (Enter name)	Relation (NR = Not Related)	Birth Date	Social Security Number	Sex (M/F)	US Citizen? (Yes/No)	Education (Last Grade Completed GED, College)	Race	Ethnic Group
							Optional-Use codes below	
Complete these sections only for those who need benefits.								
Example: Joe Smith	NR	2/10/74	555-55-5555	M	Yes	12th	WH	N
	Self							
<b>Race:</b> (You may select more than one race) <b>AN</b> = Alaskan Native <b>WH</b> = White <b>BL</b> = Black or African American <b>AI</b> = American Indian <b>AS</b> = Asian <b>PI</b> = Native Hawaiian or other Pacific Islander						<b>Ethnicity:</b> <b>Y</b> = Hispanic or Latino <b>N</b> = Not Hispanic or Latino		

**2** Has anyone in your household received public assistance (Temporary Assistance, cash, food stamps, Medicaid, Food Distribution Program on Indian Reservations FDPIR) in Alaska or any other state?  yes  no

If yes, who, when and where? \_\_\_\_\_

**3** Are you requesting assistance for anyone in your household who is pregnant?  yes  no

If yes, who? \_\_\_\_\_ When is baby due? \_\_\_\_\_

**4** Have you or anyone in your household been convicted of a drug-related felony for an offense that occurred on or after August 22, 1996?  yes  no

If yes, who, when and where? \_\_\_\_\_

**5** Is any adult in your household fleeing from prosecution, custody, confinement for a felony or class A misdemeanor from any state?  yes  no

If yes, who? \_\_\_\_\_

**6** Is anyone in your household attending a college or university?  yes  no

If yes, who? \_\_\_\_\_

# Income in your household



**7** Do you, or anyone who lives with you, receive money from employment?  yes  no  
 Include money from all jobs received this month or that will be received next month.  
 If yes, check all boxes that apply.

- Full-time Work   
  Seasonal Work   
  Vacation Pay   
  Contract Income   
  Tips  
 Part-time Work   
  Sick Pay   
  Bonuses   
  Other (day labor, on-call, commissions)

For all the items checked above, please fill in the boxes below:

Household Member Who Works	Employer	Full-time, Part-time, or Seasonal	Number of Hours Worked per Week	Hourly Wage or Monthly Salary	Amount Paid This Month	Amount To Be Paid Next Month	How Often Paid?
Example: Joe Smith	XYZ Company	Part	10	\$10	\$400	\$400	Weekly

**8** Has anyone in your household had a job end in the last 60 days?  yes  no  
 If yes, who? \_\_\_\_\_

**9** Do you, or anyone who lives with you, receive money from self-employment?  yes  no

Include money from all jobs received this month or that will be received next month.  
 If yes, check all boxes that apply.

- B&B/Rent Rooms   
  Crafts/Carving   
  Odd Jobs   
  Taxi Driving  
 Carpenter   
  Commercial Fishing   
  Repair Person   
  Trapping  
 Child Care/Babysitting   
  Manage Rental Property   
  Sales Person   
  Other

For all the items checked above, please fill in the boxes below:

Household Member Who is Self-Employed	Type of Business	Seasonal, Year-round	Business Income This Month	Business Income Next Month	Business Expenses This Month	Business Expenses Next Month
Example: Joe Smith	Fishing	Seasonal	\$900	\$900	\$100	\$100

# Questions about your household



**10** Do you, or anyone who lives with you, receive money from any other source (not from working)?  yes  no

If yes, check all the boxes that apply.

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Alimony                                     | <input type="checkbox"/> Insurance/Lawsuit Settlement | <input type="checkbox"/> Permanent Fund Dividend      |
| <input type="checkbox"/> Annuities                                   | <input type="checkbox"/> Interest/Dividends           | <input type="checkbox"/> Social Security Benefits     |
| <input type="checkbox"/> Bingo/Gambling Winnings                     | <input type="checkbox"/> Military Benefits            | <input type="checkbox"/> Subsidized Adoption Payments |
| <input type="checkbox"/> Child Support                               | <input type="checkbox"/> Money from Friends/Relatives | <input type="checkbox"/> Supplemental Security Income |
| <input type="checkbox"/> Education Assistance                        | <input type="checkbox"/> Native Corporation Dividends | <input type="checkbox"/> Unemployment Benefits        |
| <input type="checkbox"/> Foster Care Payments                        | <input type="checkbox"/> Oil/Mineral Royalties        | <input type="checkbox"/> Veteran's Benefits           |
| <input type="checkbox"/> General Assistance from Native Corporations | <input type="checkbox"/> Pension/Retirement Benefits  | <input type="checkbox"/> Workers' Compensation        |
|  |   | <input type="checkbox"/> Other _____                  |

For all the items checked above, please fill in the boxes below:

Who Receives the Payment?	Type of Payment	Amount This Month	Amount Expected Next Month	How Often?
Example: Joe Smith	Unemployment	\$400	\$400	Every 2 weeks

**11** Do you expect any changes in any of the income or employment you listed above, or do you expect any new income or employment not listed above?  yes  no

If yes, please explain: \_\_\_\_\_

**12** Do you work for or get help with food, shelter, utilities, or other expenses that are not paid in cash?  yes  no

If yes, please explain: \_\_\_\_\_

**13** Do you, or anyone who lives with you, own any property such as a house, land, apartment, mobile home, duplex, condo, camper or cabin?  yes  no

If yes, complete the information below. Include any property that is paid for, you are still paying for, or that is owned with someone else.

Who Owns the Property?	Type of Property Owned	Estimated Value	Amount Owed
Example: Joe Smith	Condo	\$75,000	\$70,000

# Questions about your household



**14** Do you, or anyone who lives with you, own any vehicles such as a car, truck, motorcycle, boat, snowmobile, recreational vehicle (RV) or all-terrain vehicle (ATV)?  yes  no

If yes, please complete the information below. Include any vehicles that are paid for, you are paying for, or are owned with someone else. Also include vehicles that are not running or that you are not using.

Who Owns the Vehicle?	Vehicle Type, Model and Year	What is Vehicle Used for?	Estimated Value	Amount Still Owed
Example: Joe Smith	1987 Ford Escort	Work	\$800	\$200

**15** Do you, or anyone who lives with you, have any of the items below?  yes  no

If yes, check all the boxes that apply. Include items owned with someone else and accounts with no money in them right now.

- |  |  |  |  |
|--|--|--|--|
| <input type="checkbox"/> Annuities               | <input type="checkbox"/> College Savings Plan      | <input type="checkbox"/> Mineral Rights            | <input type="checkbox"/> Savings Account |
| <input type="checkbox"/> Burial Policy Agreement | <input type="checkbox"/> Credit Union Accounts     | <input type="checkbox"/> Native Corporation Shares | <input type="checkbox"/> Stocks/Bonds    |
| <input type="checkbox"/> Cash on Hand            | <input type="checkbox"/> Commercial Fishing Permit | <input type="checkbox"/> Pension Plan              | <input type="checkbox"/> Trust Funds     |
| <input type="checkbox"/> Certificate of Deposit  | <input type="checkbox"/> IRA Account               | <input type="checkbox"/> Retirement Funds          | <input type="checkbox"/> Other           |
| <input type="checkbox"/> Checking Account        | <input type="checkbox"/> Life Insurance Policy     | <input type="checkbox"/> Safe Deposit Box          |  |

For all items checked above, please fill in the boxes below:

Who Owns the Item?	Type of Item	Where Held?	Account Number	Total Value/Balance
Example: Jane Smith	Checking Account	Frontier Bank	452231	\$400

**16** Have you, or anyone in your household, sold, given away, or transferred any property, vehicles or other resources in the past five years?  yes  no

If yes, please complete the information below:

Who Owned It?	Vehicle, Property, or Resource	Sold, Gave Away, or Transferred?	When?	Estimated Value
Example: Joe Smith	Truck	Gave Away	May 2005	\$4,000

# House and Shelter Expenses



**17** What are your shelter expenses? Check the boxes that apply and fill in the amount. Do not enter amounts paid by housing assistance such as HUD, AHFC or Section 8.

- Rent \$ \_\_\_\_\_ per month
- Mortgage \$ \_\_\_\_\_ per month
- Mobile Home Lot or Space Rent \$ \_\_\_\_\_ per month

**18** What shelter expenses are billed separately from your rent or mortgage?

- Home/Rent Insurance \$ \_\_\_\_\_ per \_\_\_\_\_
- Property Taxes \$ \_\_\_\_\_ per \_\_\_\_\_
- Condo/Association Fees \$ \_\_\_\_\_ per \_\_\_\_\_
- Other (such as deposits) \$ \_\_\_\_\_ per \_\_\_\_\_

**19** Check the boxes next to the utility bills your household is responsible for paying:

- Heat (such as gas, electric, propane, wood, etc.)
- Water
- Telephone
- Electricity
- Sewer
- Garbage
- Other \_\_\_\_\_

**20** Does another person or agency help you pay all or part of your shelter costs (including energy or heating assistance)?  yes  no

If yes, who pays? \_\_\_\_\_ What expense? \_\_\_\_\_ Amount paid? \_\_\_\_\_

# Other Household Expenses



**21** Does anyone in your household have child care or elderly or disabled adult care expenses?  yes  no

If yes, who is responsible for paying? \_\_\_\_\_

Who is it for? \_\_\_\_\_ Monthly Amount \$ \_\_\_\_\_

**22** Does anyone in your household pay child support?  yes  no

If yes, who pays? \_\_\_\_\_ Monthly Amount \$ \_\_\_\_\_

**23** Does anyone in your household who is disabled or age 60 or older, have medical expenses?  yes  no

If yes, who has the expense? \_\_\_\_\_ Monthly Amount \$ \_\_\_\_\_

# Medical Information



Answer the questions on this page if you are applying for medical assistance.

**24** Does anyone in your household need help paying for any unpaid medical bills from the past three months? If yes, we may be able to help. You must provide proof of income and resources for each month.  yes  no

Who? \_\_\_\_\_ What months? \_\_\_\_\_

**25** Does anyone in your household have medical costs due to an accident?  yes  no  
If yes, who? \_\_\_\_\_ Accident date? \_\_\_\_\_

**26** List household members who have health insurance such as Medicare, Indian Health Services, VA, TRICARE, Worker's Compensation, private, employer-provided insurance, etc.

Household Member	Insurance Name and Address	Date Coverage Begins	Policy/Group/Claim Numbers	Benefits Covered					
				Hospital	Physician	Rx Drugs	Dental	Vision	Other
Example: Joe Smith	Acme, 123 F St. Palmer, AK 99555	3/4/2007	78910	X		X		X	

**27** Do any household members expect changes in health insurance coverage?  yes  no  
If yes, who and why? \_\_\_\_\_

**28** Did anyone in your household have health insurance cancelled or stopped within the past 12 months?  yes  no  
If yes, who and why? \_\_\_\_\_

**29** List the name and place of birth of children under age 16 in your household.

Child's Name	Child's Place of Birth

# Signature Page



**30** You may authorize someone 18 years or older to help you apply for public assistance benefits. This person can also speak for you at the interview, help you complete forms, and report changes for you. You will have to repay any benefits you may get by mistake because of information this person gives us.

Do you want someone to help you with your public assistance case?  yes  no

\_\_\_\_\_  
Name of Person (Authorized Representative)

\_\_\_\_\_  
Phone/Message Number

**31** Do you want another person to receive or spend your benefits on behalf of your household?  yes  no

If yes, which benefits? \_\_\_\_\_  cash  food

\_\_\_\_\_  
Name of Person (Alternate Payee)

\_\_\_\_\_  
Phone/Message Number

\_\_\_\_\_  
Address

\_\_\_\_\_  
City and State

\_\_\_\_\_  
Zip Code

**32** Some people in Alaska live in areas where getting to food stores is difficult. They often rely on subsistence hunting and fishing for their food needs. If you are in this situation, you may use food stamp benefits to buy subsistence hunting and fishing items. These items include nets, lines, hooks, fishing rods, harpoons, and knives, but not firearms, ammunition, clothing, shelter, or fuel.

Do you want to use food stamps to buy subsistence hunting and fishing items?  yes  no

If yes, sign here.

X \_\_\_\_\_  
Signature of Adult Household Member

\_\_\_\_\_  
Date

## **33** Statement of Truth

Under penalty of perjury, I certify that all information contained in this application, including U.S. citizenship or lawful immigrant status of all persons applying for benefits, is true and correct to the best of my knowledge.

I have read or had read to me the "Rights and Responsibilities" section of the application and I understand my rights and responsibilities, including fraud penalties, as described in this application.

X \_\_\_\_\_  
Signature of Adult Applicant

\_\_\_\_\_  
Date

X \_\_\_\_\_  
Signature of Other Adult Applicant

\_\_\_\_\_  
Date

X \_\_\_\_\_  
Signature of Witness, if signed with an "X"

\_\_\_\_\_  
Date



## Notes

State of Alaska  
Department of Health & Social Services  
Division of Public Assistance

## Authorization for Release of Information

### What is an 'Authorization for Release of Information'?

Your signature on this form gives the Department of Health and Social Services, its agents, and the Department of Law permission to ask for information about your health, finances, family and personal history. This information is only used in the administration of public assistance programs and will not be released to any other person or agency outside of the Department of Health and Social Services or its representatives. The Release of Information will be in effect while you are an applicant or recipient of Public Assistance, and for any later investigations of your eligibility and receipt of benefits.

### Who will we ask for information?

The people or organizations that may be contacted include, but are not limited to: the Alaska Housing Finance Corporation, the Department of Fish and Game, the Department of Labor, the Department of Law, the Department of Military and Veterans Affairs, the Department of Public Safety, the Department of Revenue, U. S. Citizenship and Immigration Services, employers, financial institutions, landlords, local governments, Native corporations, private individuals, public assistance program contractors and grantees, school authorities, the Social Security Administration, stock brokerage firms, and tax assessors.

### I Authorize This Release of Information:

\_\_\_\_\_  
Signature of Adult

\_\_\_\_\_  
Signature of Other Adult

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Printed Name

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

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

\_\_\_\_\_  
Address

\_\_\_\_\_  
Address

\_\_\_\_\_  
Phone Number

\_\_\_\_\_  
Phone Number

\_\_\_\_\_  
Date

\_\_\_\_\_  
Date

A Copy of this Release is as Valid as the Original



State of Alaska  
Department of Health & Social Services  
Division of Public Assistance

## Contact People and Organizations

### Why do you need to complete this form?

To determine your eligibility for assistance, we may need to contact people or organizations that can answer questions about your situation. By completing this form, you are allowing us to contact the people and organizations you provide.

### What questions do we ask?

We often ask questions about where you live, who lives with you, and your household's income and resources. We may also ask for information about a child's parent not living in the home.

### What information do we provide them?

When we contact these people or organizations, we tell them our name and title. We also tell them that we work for the Division of Public Assistance. We do not give them any information about you or your public assistance case.

**1** Information about two people who know you well:

Name and Relation to You	Mailing Address	Daytime Phone

**2** Information about your landlord:

Name	Mailing Address	Daytime Phone

**3** Information about your employer:

Name	Mailing Address	Daytime Phone

**4** Information about your bank account(s):

Name of Financial Institution	Mailing Address	Daytime Phone

