

Coastal Field Office 2  
400 GAMBELL Street  
ANCHORAGE, Alaska 99501

**DIVISION OF PUBLIC ASSISTANCE<sup>3</sup>**

**DEPARTMENT OF  
HEALTH AND SOCIAL SERVICES**

Office Contact: Phone: (907) 269-6599  
(800) 478-4372 Toll-Free  
Fax: (907) 269-6520

STATE OF ALASKA

Case Number: [REDACTED] 854

[REDACTED]  
PO Box [REDACTED]  
Kodiak, Alaska 99615-3005



**Return Forms to the Return Address Indicated Above**

If you have any questions, please call the number above.

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<sup>5</sup>  
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STATE OF ALASKA

www.dhss.alaska.gov/dpa  
Benefit Information:  
907-269-5777  
1-866-804-6330

Case Number: [REDACTED] 54

Case Name: [REDACTED]

Document #: 37118788

Date: 06/18/2018

PO Box [REDACTED]  
Kodiak, Alaska 99615-3005

## Case Summary



Dear [REDACTED],

Please review the information you provided over the phone for your Medical Assistance case. If you find that any information has changed, please cross it out and write in the correct information. The Statement of Truth on the last page must be signed and returned to us. If there are any changes to the information you provided, return the entire packet to the office listed above. If there are no changes, you may submit only the Statement of Truth page. This information is due by 06/29/2018.

### Notes from Your Worker

### Basic Information

Primary Information		Gender	Date of Birth
[REDACTED]		Female	10/13/1960
Where You Live		Mailing Address	
KODIAK Alaska 99615		Kodiak Alaska 99615 3005	
In Care Of:	N/A	In Care Of:	N/A
Directions to Residence	N/A	Directions to Residence	N/A
Contact Information			
Phone Type	Phone number	Phone Comments	
N/A	N/A	N/A	
Email Type	Email Address	Email Comments	
N/A	N/A	N/A	

View notices online with your myAlaska account by accessing: <http://aries.alaska.gov> and selecting "View My Details".

6		Voter Registration		6	
Voter Registration Offered?		N/A			
Change:					

### People In Your Home

Person	Gender	Date of Birth	SSN
[REDACTED]	Female	[REDACTED]	XX-[REDACTED]
	Race	Ethnicity	
	Filipino	N/A	
	If deceased, date of death	Is there an Authorized Representative?	
	N/A	NO	
Change:			

Person	Gender	Date of Birth	SSN
[REDACTED]	Male	09/07-[REDACTED]	XXX-XX-[REDACTED]
	Race	Ethnicity	
	Filipino	N/A	
	If deceased, date of death	Is there an Authorized Representative?	
	N/A	NO	
Change:			

Person	Gender	Date of Birth	SSN
[REDACTED] F	Female	10/13-[REDACTED]	XXX-XX-[REDACTED]
	Race	Ethnicity	
	Filipino	N/A	
	If deceased, date of death	Is there an Authorized Representative?	
	N/A	NO	
Change:			

Person	Gender	Date of Birth	SSN
[REDACTED]	Female	03/ [REDACTED]	XXX-XX [REDACTED]
	Race	Ethnicity	
	Filipino	N/A	
	If deceased, date of death	Is there an Authorized Representative?	
	N/A	NO	
Change:			

### Person Alias Name

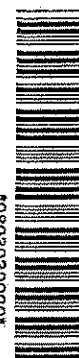
Name	First Name	Middle Name	Last Name	Suffix	Gender	Date of Birth	SSN	Primary Name?
[REDACTED] F	[REDACTED]	F	[REDACTED]	N/A	F	10/ [REDACTED]	[REDACTED]	N/A
[REDACTED]	[REDACTED]	M	[REDACTED]	N/A	F	03/ [REDACTED]	[REDACTED]	N/A
Change:								

### Individual Program Request

Person	Application Received Date	Requesting Assistance ?	Coverage Request Date
[REDACTED]	11/05/2014	YES	07/01/2015
Change:			

Person	Application Received Date	Requesting Assistance ?	Coverage Request Date
[REDACTED]	11/05/2014	YES	01/18/2018
Change:			

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Person	Application Received Date	Requesting Assistance ?	Coverage Request Date
[REDACTED]	11/05/2014	YES	01/18/2018
Change:			

Person	Application Received Date	Requesting Assistance ?	Coverage Request Date
[REDACTED]	11/05/2014	YES	07/01/2015
Change:			

### Living Situation- Details

Name	Household Status	Absence Reason	Intend to Return?	Estimated date of Return	# of days in a month the individual resides in the household
[REDACTED]	In the Household	N/A	N/A	N/A	30
Emancipation Status	Living Situation Type		Date This Living Situation Started		Is there a plan for this individual to return to their parent's home?
N/A	Dormitory (College Housing)		08/01/2014		N/A
Change:					

Name	Household Status	Absence Reason	Intend to Return?	Estimated date of Return	# of days in a month the individual resides in the household
[REDACTED]	In the Household	N/A	N/A	N/A	30
Emancipation Status	Living Situation Type		Date This Living Situation Started		Is there a plan for this individual to return to their parent's home?
N/A	In Home		08/01/2014		N/A
Change:					

9 Name	Household Status	Absence Reason	Intend to Return?	Estimated date of Return	# of days in a month the individual resides in the household 9
[REDACTED]	In the Household	N/A	N/A	N/A	30
Emancipation Status	Living Situation Type	Date This Living Situation Started	Is there a plan for this individual to return to their parent's home?		
N/A	In Home	08/01/2014	N/A		
Change:					

Name	Household Status	Absence Reason	Intend to Return?	Estimated date of Return	# of days in a month the individual resides in the household
[REDACTED] F	In the Household	N/A	N/A	N/A	30
Emancipation Status	Living Situation Type	Date This Living Situation Started	Is there a plan for this individual to return to their parent's home?		
N/A	In Home	08/01/2014	N/A		
Change:					



### Person Demographics

Person	Citizenship	Alaska Resident	Does this person live in Alaska now?
[REDACTED]	U.S. Citizen	YES	YES
	Has this person recently moved to Alaska?	Date Moved	State Moved From
	NO	N/A	N/A
	Does this person plan to remain in Alaska?	Marital Status	Are you expecting to file taxes this year?
	YES	Single-Never Married	YES
Change:			

<sup>10</sup> Person	Citizenship	Alaska Resident	Does this person live in <sup>10</sup> Alaska now?
[REDACTED]	U.S. Citizen	YES	YES
	Has this person recently moved to Alaska?	Date Moved	State Moved From
	NO	N/A	N/A
	Does this person plan to remain in Alaska?	Marital Status	Are you expecting to file taxes this year?
	YES	Married	YES
Change:			

Person	Citizenship	Alaska Resident	Does this person live in Alaska now?
[REDACTED]	U.S. Citizen	YES	YES
	Has this person recently moved to Alaska?	Date Moved	State Moved From
	NO	N/A	N/A
	Does this person plan to remain in Alaska?	Marital Status	Are you expecting to file taxes this year?
	YES	Married	YES
Change:			

Person	Citizenship	Alaska Resident	Does this person live in Alaska now?
[REDACTED] F	U.S. Citizen	YES	YES
	Has this person recently moved to Alaska?	Date Moved	State Moved From
	NO	N/A	N/A
	Does this person plan to remain in Alaska?	Marital Status	Are you expecting to file taxes this year?
	YES	Single-Never Married	NO
Change:			



<sup>11</sup>  
Education Details

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Name	Education Level	Enrollment Status	Education Institution Level
[REDACTED]	Completed High School /GED program	Not Enrolled	
Change:			

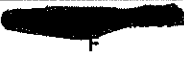
Earned Income Details & Payments


Name	Earned Income Type	Earned Income Begin Date	Earned Income End Date	Pay Frequency	Do you expect the income to continue?	Combat Pay Amount
[REDACTED]	Wages	12/01/2017	N/A	Bi-Weekly	YES	N/A
Pass account amount	Is income seasonal?	# of Monthly payments received on an annual basis	Source	Final Pay Reason	Final Pay Amount	Final Payment Date
N/A	N/A	N/A	uaa	N/A	N/A	N/A
Change:						


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Name	Earned Income Type	Earned Income Begin Date	Earned Income End Date	Pay Frequency	Do you expect the income to continue?	Combat Pay Amount
[REDACTED]	Wages	12/01/2017	N/A	Bi-Weekly	NO	N/A
Pass account amount	Is income seasonal?	# of Monthly payments received on an annual basis	Source	Final Pay Reason	Final Pay Amount	Final Payment Date
N/A	YES	YES	International Seafoods	Time Limited	N/A	12/01/2017
Change:						

<sup>12</sup> Name	Earned Income Type	Earned Income Begin Date	Earned Income End Date	Pay Frequency	Do you expect the income to continue?	<sup>12</sup> Combat Pay Amount
 F	Wages	11/01/2017	N/A	Weekly	YES	N/A
Pass account amount	Is income seasonal?	# of Monthly payments received on an annual basis	Source	Final Pay Reason	Final Pay Amount	Final Payment Date
N/A	YES	YES	Alaska Pacific Seafoods	N/A	N/A	N/A
Change:						

Name	Earned Income Type	Earned Income Begin Date	Earned Income End Date	Pay Frequency	Do you expect the income to continue?	Combat Pay Amount
 F	Wages	11/01/2017	N/A	Twice Monthly	NO	N/A
Pass account amount	Is income seasonal?	# of Monthly payments received on an annual basis	Source	Final Pay Reason	Final Pay Amount	Final Payment Date
N/A	NO	NO	Alzheimars Disease Resource Center of Alaska	Time Limited	N/A	11/01/2017
Change:						

Name	Earned Income Type	Earned Income Begin Date	Earned Income End Date	Pay Frequency	Do you expect the income to continue?	Combat Pay Amount
 F	Wages	08/01/2014	N/A	Twice Monthly	YES	N/A
Pass account amount	Is income seasonal?	# of Monthly payments received on an annual basis	Source	Final Pay Reason	Final Pay Amount	Final Payment Date
N/A	YES	YES	NORTH PACIFIC SEAFOODS INC	N/A	N/A	N/A
Change:						

13 Name	Earned Income Type	Earned Income Begin Date	Earned Income End Date	Pay Frequency	Do you expect the income to continue?	13 Combat Pay Amount
[REDACTED] F	Wages	11/01/2017	N/A	Bi-Weekly	YES	N/A
Pass account amount	Is income seasonal?	# of Monthly payments received on an annual basis	Source	Final Pay Reason	Final Pay Amount	Final Payment Date
N/A	N/A	N/A	Alzheimer	N/A	N/A	N/A
Change:						

### Unearned Income Details & Payments

Name	Unearned Income Type	Unearned Income Begin Date	Unearned Income End Date	Pay Frequency
[REDACTED]	Permanent Fund Dividend (PFD)	08/01/2014	N/A	Annually
Combat Pay Amount	Source	Amount	Final Pay Reason	Final Pay Amount
N/A	N/A	N/A	Time Limited	\$900.00
Change:				

Name	Unearned Income Type	Unearned Income Begin Date	Unearned Income End Date	Pay Frequency
[REDACTED]	Permanent Fund Dividend (PFD)	12/01/2017	N/A	Annually
Combat Pay Amount	Source	Amount	Final Pay Reason	Final Pay Amount
N/A	2017pfd	N/A	N/A	N/A
Change:				

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<sup>14</sup> Name	Unearned Income Type	Unearned Income Begin Date	Unearned Income End Date	<sup>14</sup> Pay Frequency
[REDACTED]	Permanent Fund Dividend (PFD)	08/01/2014	N/A	Annually
Combat Pay Amount	Source	Amount	Final Pay Reason	Final Pay Amount
N/A	N/A	N/A	Time Limited	\$900.00
Change:				

Name	Unearned Income Type	Unearned Income Begin Date	Unearned Income End Date	Pay Frequency
[REDACTED]	Permanent Fund Dividend (PFD)	12/01/2017	N/A	Annually
Combat Pay Amount	Source	Amount	Final Pay Reason	Final Pay Amount
N/A	2017pfd	N/A	N/A	N/A
Change:				

Name	Unearned Income Type	Unearned Income Begin Date	Unearned Income End Date	Pay Frequency
[REDACTED]	SSA	12/01/2017	N/A	Monthly
Combat Pay Amount	Source	Amount	Final Pay Reason	Final Pay Amount
N/A	SSA	N/A	N/A	N/A
Change:				

Name	Unearned Income Type	Unearned Income Begin Date	Unearned Income End Date	Pay Frequency
[REDACTED]	Permanent Fund Dividend (PFD)	08/01/2014	N/A	Annually
Combat Pay Amount	Source	Amount	Final Pay Reason	Final Pay Amount
N/A	N/A	N/A	Time Limited	\$900.00
Change:				

15 Name	Unearned Income Type	Unearned Income Begin Date	Unearned Income End Date	15 Pay Frequency
[REDACTED]	Permanent Fund Dividend (PFD)	12/01/2017	N/A	Annually
Combat Pay Amount	Source	Amount	Final Pay Reason	Final Pay Amount
N/A	2017pfd	N/A	N/A	N/A
Change:				

Name	Unearned Income Type	Unearned Income Begin Date	Unearned Income End Date	Pay Frequency
[REDACTED] F	Permanent Fund Dividend (PFD)	08/01/2014	N/A	Annually
Combat Pay Amount	Source	Amount	Final Pay Reason	Final Pay Amount
N/A	N/A	N/A	Time Limited	\$900.00
Change:				

Name	Unearned Income Type	Unearned Income Begin Date	Unearned Income End Date	Pay Frequency
[REDACTED]	Permanent Fund Dividend (PFD)	12/01/2017	N/A	Annually
Combat Pay Amount	Source	Amount	Final Pay Reason	Final Pay Amount
N/A	2017pfd	N/A	N/A	N/A
Change:				



## Statement of Truth

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Please remember that changes must be reported. If you find that any information in this entire packet has changed, cross out the incorrect information and provide the new information under the "Change" box in each section.

If you do not have any changes to report, you may submit only this page. If you have changes, return the entire packet.

Under penalty of perjury, I certify that all of the information contained in this application, including U.S. citizenship or lawful immigration 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.

Printed Name of Adult Applicant	Signature of Adult Applicant	Date
Printed Name of Other Adult Applicant	Signature of Other Adult Applicant	Date
Printed Name of Witness, if signed with an "X"		
Signature of Witness, if signed with an "X"	Date	



You have the right to discuss any action taken on your application or case with your caseworker or with your caseworker's supervisor

## Fair Hearings

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. For the Medicaid program, you may request a fair hearing by phone, in person, or in writing by contacting anyone in Public Assistance office. You must ask for a fair hearing within 30 days from the date of the agency notice. 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 Medicaid program benefits until a hearing decision is made.

## Fair Hearing Request

You may request a hearing by filling out the following information and delivering or mailing it to the address on the front of this notice. Please fill this out if you want to request a fair hearing.

Reason for Fair Hearing Request:

You may be eligible for continued benefits pending the outcome of your fair hearing. However, if the hearing decision is not in your favor, you are responsible for paying back any extra benefits you receive while waiting for a hearing decision. Please check a box to let us know if you wish to receive continued benefits while waiting for the outcome of your hearing:

☐ Continue my benefits at the level received before this notice until the hearing decision is made. I understand that if the hearing decision is not in my favor, I am responsible for paying back any extra benefits I receive while waiting for the hearing decision.

☐ Do not continue my benefits at the level received before this notice. I accept the amount stated in this notice, knowing that if the hearing decision is in my favor I will be paid for any benefits wrongly denied me.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

## Change Reporting

### REPORTING CHANGES IN YOUR HOUSEHOLD CIRCUMSTANCES

You must report changes in your household within 10 days of when you know of the change. You may do this by contacting the Public Assistance office by phone, in person, in writing or online.

Please read the information below and contact your local Public Assistance office if you have any questions about what changes you need to report.

### Medicaid: You must report the following changes.

- Changes in employment status, starting or stopping a job, change in wage rate, change from part-time to full-time or full-time to part-time
- Changes in the source of unearned income,
- You move or get a new mailing address.
- Changes in medical insurance
- Changes in state residency status
- When someone moves into or out of your household.
- Pregnancy Changes.

## Civil Rights

The Civil Rights Act of 1974 states, "No person in the United States, on the grounds of race, color, age, sex, handicap, religious creed, political beliefs or national origin shall be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program receiving federal assistance." If you feel you have been discriminated against, a complaint requesting a hearing on the matter may be filed with the Division of Public Assistance, PO Box 110640, Juneau, Alaska 99811-0640.

## Your SSN

Your Social Security Number will be used to obtain information from various state and federal agencies through computer matching. This information may be used to determine your eligibility. You are not required to provide a Social Security Number (SSN) or citizenship information for anyone in your household who will not receive benefits from a public assistance program.

## Well Child Checkups

Medicaid pays for well child checkups, dental care, and other services for children through their 21st birthday. Ask your local Public Health Nurse, clinic, or health care provider for more information.

## Family Planning Services

If Medicaid coverage ends and you need help finding low cost or free family planning services, call your local Public Health Center or AK Info at 1 800-478-2221.

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Read and keep this page (Rights and Responsibilities).

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