on line

Department of Health and Social Services
Division of Public Assistance

ELIGIBILITY REVIEW FORM

Office Use Only

D.O. Date Rec'd _____

Fee Agent Date Rec'd _____

Fee Agent Signature

Check Box for All Programs Due for Review

☐SNAP (Food Stamps) ☐Adult Public Assistance ☐Temporary Assistance ☐Medicaid

NOTE: You need to complete only one review form for all programs that are due for review this month.

Be sure the form is complete and remember to sign the statement at #18 to avoid processing delays. If you need more space for any answer, use another piece of paper. Please print clearly.

Name	Case Number
Mailing Address	
Residence Address (if different from mailing address)	
Home Phone Number / Message Phone Number / Work Phone Number	

1. HOUSEHOLD INFORMATION: List all persons who live with you and use legal names. List yourself first.

**Disclosure of your Race and Ethnicity information is voluntary and will not affect your eligibility or level of benefits. This information will be used to assure that program benefits are distributed without regard to race, color or national origin.*

Name (First M I Last)	Relation to You If not related write NR.	Date Of Birth	Place of Birth	Social Security Number	US Citizen? (Yes/No)	Race	Ethnic Group
						Optional - Use codes below	
	Self						

Race: (You may select more than one race)
AN = Alaska Native **WH** = White **BL** = Black or African American
AI = American Indian **AS** = Asian **PI** = Native Hawaiian or other Pacific Islander

Ethnicity:
Y = Hispanic or Latino
N = Not Hispanic or Latino

Do you plan to file a federal income tax return NEXT YEAR? You can still apply for health insurance even if you don't file a federal income tax return.

☐YES. **If yes,** please answer questions a-c. ☐NO. **If no,** skip to question c.

a. Will you file jointly with a spouse? ☐Yes ☐No
If yes, name of spouse: _____

b. Will you claim any dependents on your tax return? ☐Yes ☐No
If yes, list name(s) of dependents: _____

c. Will you be claimed as a dependent on someone's tax return? ☐Yes ☐No
If yes, please list the name of the tax filer: _____
How are you related to the tax filer? _____

Is anyone in your household pregnant? □ Yes □ No ***Please provide medical proof with due date.***
If yes, who? _____
Has anyone in your household received assistance from the Food Distribution Program on Indian Reservations (FDPIR) in Alaska or any other state? □ Yes □ No
If yes, who and when? _____
Has anyone been convicted of any of the following types of felonies? □ Yes □ No ***List all felony household members.***
□ Drug related felony? Date of conviction: _____ Who & Where? _____
□ Making a false statement about where you live in order to receive assistance from two or more states at the same time? Date of conviction: _____ Who & Where? _____
Is any adult in your household fleeing from prosecution, custody, or confinement for a felony or class A misdemeanor from any state? □ Yes □ No
If yes, who? _____
Is anyone in your household attending postsecondary education at a college or university? □ Yes □ No
If yes, who? _____

ASSETS INFORMATION:

2. List all vehicles owned or being purchased by you or anyone in your household. *Include cars, trucks, boats, motorcycles, RVs, ATVs, snowmobiles, etc.*

Owner's Name	Type of Vehicle	Model / Year	How Used?	Amount Owed	Current Value
				$	$
				$	$
				$	$
				$	$

3. List any houses, cabins, property, stocks, bonds, or other assets you or anyone in your household owns or is buying. List any life insurance policies or burial accounts or policies you or anyone in your household owns, and the current cash value of the account or policy.

Owner	Type of Property/Asset	Value	Owner	Type of Property/Asset	Value
		$			$
		$			$
		$			$
		$			$

4. List how much money you or anyone in your household has in cash and bank accounts.

Name(s) on Account	Name of Bank/Credit Union & Branch	Account Number	Balance
			$
			$
			$
	Cash on Hand		$

5. List anyone in your household who belongs to a Native Corporation.

Shareholder Name	Native Corporation	Shares Owned	Amount/Date of Last Dividend

6. Do you or anyone who lives with you own a commercial fishing permit or IFQ (Individual Fishing Quota)?
☐ Yes ☐ No
If yes, Permit/IFQ Number _____ Value $ _____

MONEY RECEIVED INFORMATION:

7. Complete if you or anyone in your household is working.

Person Employed	Employer	Hours Worked	Hourly Wage	How often paid?
		per week		
		per week		
		per week		
		per week		

Will anyone's job, wages or hours of work change soon? ☐ Yes ☐ No If yes, please explain.

_____

_____

8. List any other money you or anyone in your household receives. *Include Social Security, SSI, BIA, VA, retirement, unemployment insurance, Worker's Compensation, Native assistance, child support, cash gifts, annuities, etc.*

Who Receives	Income Source	Amount	Who Receives	Income Source	Amount
		$			$
		$			$
		$			$

Do you expect any changes to your income? ☐ Yes ☐ No If yes, please explain. _____

_____

Does anyone work in exchange for food, shelter, utilities, etc.? ☐ Yes ☐ No If yes, please explain.

_____

_____

HOUSEHOLD EXPENSE INFORMATION:

9. Complete if you or anyone in your household has any of these monthly expenses. ***Please provide proof of the obligated monthly rent amount, utility costs, and yearly property tax and insurance amounts.***

Expense Type	Monthly Amount	Expense Type	Monthly Amount	Expense Type	Monthly Amount
Rent / Mortgage	$	Telephone	$	Heating Oil	$
Lot or Space Rent	$	Electricity	$	Natural Gas	$
Property Tax	$	Water / Sewer	$	Wood / Coal	$
Home Insurance	$	Garbage Collection	$	Other _____	$

Are you responsible for paying the cost of heating your home? ☐ Yes ☐ No

If yes, what fuel do you heat your home with? _____

If you share payment of these expenses with anyone, or receive assistance paying the expenses (such as rental assistance or heating assistance), please explain. _____

_____

10. Complete if anyone in your household has expenses for the care of a child, or an elderly or disabled adult. ***Please provide proof of amounts paid for the last two months.***

Child / Dependent Name	Monthly Care Cost	Child / Dependent Name	Monthly Care Cost
	$		$
	$		$

Do you get money to help pay dependent care costs? ☐ Yes ☐ No If yes, how much? _____
From whom? _____

11. Complete if you or anyone in your household pays child support. ***Please provide proof of your monthly obligation and the amount paid in the last two months.***

Who Pays Child Support	Who Do They Pay	How Much	When
		$	
		$	

12. Complete if you or anyone in your household is over age 59 or disabled, and has medical expenses. ***List the person and provide proof of these expenses.***

Person with Medical Expense	Amount	Person with Medical Expense	Amount
	$		$

If you expect any changes in your household expenses or circumstances, please explain: _____

Failure to report or verify any of the above listed expenses will be seen as a statement by your household that you do not want to receive a deduction for the unreported expense.

HEALTH COVERAGE/INSURANCE:

13. Have you or anyone in your household had employer-based health insurance coverage begin or end in the last twelve months? ☐ Yes ☐ No If yes, please provide the name and address of the employer, the name and phone number of the insurance company, and a copy of the front and back of your insurance card.

_____

_____

_____

14. If you or anyone in your household has health insurance please answer these questions

Is anyone enrolled in health coverage from the following: ☐Yes ☐No

If yes, check the type of coverage and write the person(s) name(s) next to the coverage they have.

☐Medicaid/Denali Care_____

☐Denali KidCare_____

☐Medicare_____

☐TRICARE (don't check if you have direct care or Line of duty)

_____

☐VA health care programs_____

☐Peace Corps_____

☐ Employer insurance_____

☐Name of health insurance:_____

☐Policy number: _____

Is this COBRA coverage? ☐Yes ☐No

Is this retiree health plan? ☐Yes ☐No

☐Other: Name of insured:_____

Name of health insurance:_____

Policy number:_____

Is this a limited-benefit plan (like a school accident policy)? ☐Yes ☐No

15. Is anyone listed on this application offered health coverage from a job? Check yes, even if the coverage is from someone else's job, such as a parent or spouse.

☐Yes.**If yes,** you'll need to complete and include Appendix A. ☐Yes ☐No

Is this a state employee benefit plan?

☐No.**If no,** continue

16. MEDICAID REVIEW: Complete if you or anyone in your household receives Medicaid.

In the past twelve months, did you or anyone in your household receive treatment at a hospital because of an accident or illness for which someone else was responsible to pay? □ Yes □ No
If yes, please explain what happened and who is responsible to pay for treatment _____

_____

_____

17. AUTHORIZED REPRESENTATIVE:

I have asked this person to help with my public assistance case.

Name: _____ Phone Number: _____

18. 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 and identity of all persons under age 18 listed on this application, is true and correct to the best of my knowledge.

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

SIGN HERE _____ _____ _____ _____

Applicant Signature Date Other Adult Applicant Signature Date

19. VOTER REGISTRATION

If you want to register to vote we can help you by sending you the correct forms to complete. If you do not answer the question, it will be considered the same as a No answer. This will not stop your ability to register to vote in the future.

Do you want to register to vote? ☐Yes ☐No

Appendix A: Health Coverage from Jobs

You **DON'T** need to answer these questions unless someone in the household is eligible for health coverage from a job. Attach a copy of this page for each job that offers coverage.

Tell us about the job that offers coverage.

EMPLOYEE Information

1. Employee name (First, Middle, Last)	2. Employee Social Security number _____ - _____ - _____

EMPLOYER Information

3. Employer name		4. Employer Identification Number (EIN) _____ - _____
5. Employer address		6. Employer phone number ( ) -
7. City	8. State	9. ZIP code
10. Who can we contact about employee health coverage at this job?		
11. Phone number (if different from above) ( ) -	12. Email address	

13. **Are you currently eligible for coverage offered by this employer, or will you become eligible in the next 3 months?**

☐ **Yes** (Continue)

13a. If you're in a waiting or probationary period, when can you enroll in coverage? _____ (mm/dd/yyyy)

List the names of anyone else who is eligible for coverage from this job.

Name: _____ Name: _____ Name: _____

☐ **No**

Tell us about the health plan offered by this employer.

14. Does the employer offer a health plan that meets the minimum value standard*? ☐ Yes ☐ No

15. For the lowest-cost plan that meets the minimum value standard* offered **only to the employee** (don't include family plans):
If the employer has wellness programs, provide the premium that the employee would pay if he/ she received the maximum discount for any tobacco cessation programs, and did not receive any other discounts based on wellness programs.

a. How much would the employee have to pay in premiums for this plan? **$** _____

b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Once a month ☐ Quarterly ☐ Yearly

16. What change will the employer make for the new plan year (if known)?

☐ Employer won't offer health coverage

☐ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)

a. How much will the employee have to pay in premiums for that plan? **$** _____

b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Once a month ☐ Quarterly ☐ Yearly

Date of change (mm/dd/yyyy): _____

* An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)

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

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

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 think the Division of Public Assistance or Federally Facilitated Marketplace has made a mistake on your health insurance determination or the Division of Public Assistance has made a mistake on your benefits determination, you can appeal its decision. To appeal means to tell someone at the Division of Public Assistance or the Federally Facilitated Marketplace that you think the action is wrong, and ask for a fair hearing review of the action. The request for Supplemental Nutrition Assistance Program may be made to any employee of the Division in person, by telephone, or in writing; requests for all other programs must be made in writing. If your disagreement has to do with medical billing or services, contact the Medicaid 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. Supplemental Nutrition Assistance Program 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. 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. Supplemental Nutrition Assistance Program 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 benefits you received while you waited for the decision.

My right to appeal

I know that I can find out how to appeal by contacting the Division of Public Assistance or the Marketplace at 1-800-318-2596. I know that I can be represented in the process by someone other than myself. My eligibility and other important information will be explained to me.

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 receive 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 Health Insurance Benefits authorized by the Federally Facilitated Marketplace or Public Assistance Medicaid, you must report any and all changes to information provided in this application, including changes in your medical insurance.

If you receive Supplemental Nutrition Assistance Program 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 public assistance services, the changes you must report include, but are not limited to the following:

- 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
- Your household gets a vehicle
- Your household has more than $2250 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
- Pregnancy changes

Will I need to work?

To receive Alaska Temporary Assistance or Supplemental Nutrition Assistance Program, 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.

Read and keep this page.

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 a child on Alaska Temporary Assistance.
- Cooperate with CSSD in establishing paternity.
- Agree not to make purchases with or to access the cash benefits on your EBT card at ATMs that are located in bars, liquor stores, gambling or adult entertainment establishments.

When you apply for Medicaid 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 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 the Division of Public Assistance 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.

How are my rights protected?

The Division of Public Assistance will collect information, including the Social Security number (SSN) of each household member who is applying for Supplemental Nutrition Assistance Program, 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 U.S. Citizenship and Immigration Services (USCIS). Information obtained from these agencies may affect your eligibility and level of benefits.

Providing the requested information, including the 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.

Read and keep this page.

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 (DHSS). 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 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://dhss.alaska.gov/Documents/Pdfs/DHSS_Notice_of_Privacy_Practices.pdf. You can get an electronic copy of the Notice of Privacy Practices at Request a printed copy by writing to State of Alaska, DHSS Privacy Official, and P. O. Box 110650, Juneau, Alaska 99811-0650 or by email at privacyofficial@alaska.gov.

In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, religious creed, disability, age, political beliefs, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

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. The USDA Program Discrimination Complaint form can be found online at http://www.ascr.usda.gov/filing-program-discrimination-complaint-usda-customer or a copy of the form may be requested by calling (866) 632-9992. You may also 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.

Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

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.

Responsibility for Overpayment

If you receive an overpayment of Public Assistance benefits or receive services to which you are not entitled, you may be financially responsible for repaying the overpayment or cost of services to the State of Alaska. This may be true even if the overpayment or improper authorization of services is due to an error on the part of the Department of Health and Social Services . By accepting benefits or services, you must understand and agree that you may have a responsibility for the repayment of benefits or services to which you were not entitled.

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 get benefits for which they are not eligible. You must repay any benefits you wrongly receive.

Supplemental Nutrition Assistance Program (SNAP)	
I understand that if I...	**I may...**
Commit an intentional program violation of the Supplemental Nutrition Assistance Program defined in 7 CFR 273.16 or any of the following: • hide information or make false statements • use electronic benefit transfer (EBT) cards that belong to someone else • use SNAP benefits to buy alcohol or tobacco • trade or sell benefits or EBT cards	• lose SNAP benefits for 12 months for the first offense and be required to repay all benefits overpaid to me • lose SNAP benefits for 24 months for the second offense and be required to repay all benefits overpaid to me • lose SNAP benefits permanently for third offense and be required to repay all benefits overpaid to me • be fined up to $250,000.00, imprisoned up to 20 years or both
• trade SNAP benefits for controlled substances, such as drugs	• lose SNAP benefits for 24 months for the first offense • lose SNAP benefits permanently for the second offense
• give false information about who I am and where I live so I can get extra benefits	• lose SNAP benefits for 10 years for each offense
• have been convicted of trading or selling SNAP benefits worth more than $500, or trading SNAP benefits for firearms, ammunition, or explosives	• be barred from receiving SNAP benefits permanently
Alaska Temporary Assistance Program	
I understand that if I...	**I may...**
• commit an intentional program violation or I am convicted of fraud • give false information about who I am and where I live so I can get extra benefits • use my ATAP cash benefits or access them at any ATMs located in bars, liquor stores, gambling or adult entertainment establishments	• lose benefits for 6 months for the first offense • lose benefits for 12 months for the second offense • lose benefits permanently for the third offense • other penalties may also apply and I may be subject to criminal prosecution • have to pay back amount received if there is an overpayment
Medicaid Program	
I understand that if I...	**I may...**
• commit an intentional program violation or program abuse that results in misuse or overuse of Medicaid benefits or are found guilty of misconduct related to Medicaid benefits • commit Medical Assistance fraud under AS 47.05.210	• be required to pay back the amount of Medicaid services that I or anyone in my household received • be excluded from Medicaid for up to 10 years • have to pay fines up to $25,000 and be subject to criminal prosecution

Read and keep this page.