

# Senior

## BENEFITS PROGRAM

State of Alaska  
 Department of Health and Social Services  
 Division of Public Assistance  
<http://dhss.alaska.gov/dpa/>

- ☐ New Application  
☐ Renewal Application

Alaska residents who are age 65 or older may qualify for a monthly payment from the Senior Benefits Program. Income limits are based on the Alaska Federal Poverty Guidelines and will change every year. Benefit amounts are tied to legislative funding and can change at any time.

Please complete the information below so we can determine your eligibility for these benefits. We need this information for you and your spouse if he or she is living with you, even if your spouse is under the age of 65. If you are both applying for Senior Benefits, you will both need to sign the application on page 3 and complete the Authorization for Release of Information on page 4.

- 1** Are you applying for you? ☐ Yes ☐ No  
 Are you applying for your spouse? ☐ Yes ☐ No (must be 65 years old)

**2 Applicant Information**

Name (First, Middle Initial, Last)	Social Security Number	Date of Birth
Do you intend to remain an Alaska Resident? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> US Citizen <input type="checkbox"/> Legal Alien Alien #:	<input type="checkbox"/> Male <input type="checkbox"/> Female
Mailing Address (Street or PO Box)	City	State
Residence Address	City	State
Phone Number	Message Phone	

**3 Spouse Information (required if living with you)**

Name (First, Middle Initial, Last)	Social Security Number	Date of Birth
Do you intend to remain an Alaska Resident? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> US Citizen <input type="checkbox"/> Legal Alien Alien #:	<input type="checkbox"/> Male <input type="checkbox"/> Female

**Income.** Income is any money that you or your spouse receives that can be used to meet your needs. Income includes, but is not limited to: wages and other earnings, annuity payments, pension or retirement payments, disability benefits, veteran's benefits, Social Security payments, Supplemental Security Income (SSI), Adult Public Assistance, alimony, Native corporation payments, dividends from stocks or bonds, etc.

- 4** Please list the gross annual income received by you and your spouse. Do not include the Alaska Permanent Fund Dividend. **Attach Proof.** Gross annual income is the amount before any deductions are subtracted, such as taxes or Medicare premiums

Type of Income? (Social Security, pension, retirement, wages, native dividends, etc.)	Who receives this money? (you or spouse)	Gross Annual Amount
		Total



Please return your completed application to any Division of Public Assistance office. A list of offices and their contact information can be found online at <http://dhss.alaska.gov/dpa/Pages/features/org/dpado.aspx> or you may contact us for this information at (907) 465-3347.

**Rights and Responsibilities.** I understand that:

- I have a right to request a fair hearing if I do not agree with the decision made on this application. I can make a request for a fair hearing, in writing, to any Division of Public Assistance office. The request for a fair hearing must be received within 30 days from the date of the notice.
- I am required to report changes within 10 days. Changes can be reported by phone, in writing, or in person. The Senior Benefits Office must be notified if the applicant or their spouse:
  - Leaves the State of Alaska for any reason for more than 30 days
  - Is admitted to a hospital, nursing home or Pioneer Home for more than 30 days
  - Has a new residence or mailing address
  - Passes away

**Statement of Truth**

I certify that I have checked the information on this application and that it is a true and complete statement of facts according to my best knowledge and belief.

 <b>Signature of Applicant or Authorized Representative</b>	<b>Phone/Message Number</b>
 <b>Signature of Spouse</b>	<b>Phone/Message Number</b>

**Authorized Representative**

You may authorize someone 18 years or older to help you apply for Senior Benefits. This person can also help you complete forms and report changes for you. By filling this out, you give us permission to talk to this person about your case.

<b>Name of Person Authorized to Represent You</b>	<b>Phone/Message Number</b>
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If you are not registered where you live now, would you like to apply to register to vote? ☐ Yes ☐ No

**Please complete the "Authorization for Release of Information"  
on the back of this page.**

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

Gen 36 06-3033 (Rev. 6/07)

A Copy of this Release is as Valid as the Original