Deliverable 1 - GEN 160 Daily EIS Rights and Responsibilities Notices

Gen 160 (06-3687) rev 03.24 Sample

YOUR RIGHTS AND RESPONSIBILITIES

If you need a language interpreter, call 1-800-478-7778 and we will provide one at no cost to you. If you are deaf, hard of hearing, or have a speech disability, dial 711 to reach an Alaska Relay Communications Assistant.

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. The request for Supplemental Nutrition Assistance Program (SNAP) and Medicaid 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. SNAP fair hearing requests must be made within 90 days from the effective date of the action. Fair hearing requests for all other programs must be made within 30 days from the date of the notice. 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 at (907) 272-9431 or 1-888-478-2572.

REQUEST A HEARING

You may request a hearing by filling out the following information and delivering or mailing this request to the Public Assistance office address on the front of this notice. If requested, the Division will assist you in making a hearing request. **Please fill this out only if you disagree with the action taken on your case and want to request a fair hearing. Briefly describe why you disagree:** ____________

____

____

Signature: ____ Date: ____________________________

CONTINUED/UNREDUCED ASSISTANCE

If you are currently getting cash or Medicaid benefits - If we get this request before the date your benefits are to be lowered or stopped, your benefits in most instances will stay the same until the fair hearing decision is made. *If the hearing is not decided in your favor, you will have to pay back these benefits.* If you get Temporary Assistance benefits while you wait for the fair hearing decision and you lose, the months of benefits you received may count towards your time limit.

If you are currently getting SNAP benefits – If we get this request before the date your benefits are to be lowered or stopped, your benefits will in most instances stay the same until the fair hearing decision is made, **or** your SNAP certification period ends, whichever comes first. *If the hearing is not decided in your favor, you will have to pay back these benefits.*

If you do not want to get benefits while you are waiting for a fair hearing decision – Check this box:☐

If you choose not to get benefits during this period and win your fair hearing, the Division will pay you any benefits owed.

If you do not request a fair hearing before the effective date of the action, you can still appeal but benefits will not be continued. You can always re-apply for benefits while waiting for your hearing.

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 or in writing. Each program has different rules about the kinds of changes you need to report. Please read the information below and contact your local Public Assistance office if you have any questions about what changes you need to report.

Adult Public Assistance, Interim Assistance, Senior Benefits, and Medicaid (for elderly, disabled, and long term care). You must report all changes, including changes in your medical insurance. You must also report if you will be absent from the State for more than 30 days.

Temporary Assistance and MAGI Medicaid You must report the following changes:

- Changes in employment, including when anyone starts or stops a job, has a change in rate of pay or their employment status changes from part-time to full-time or from full-time to part-time
- Changes in the source of unearned income and changes in the total amount of unearned income (*for Temporary Assistance, report if the change in unearned income is greater than $50 a month*)
- When someone moves into or out of your home *(for Temporary Assistance, report within 5 days when a child leaves your home)*
- You move or get a new mailing address
- Your household gets a vehicle or has more than $2000 total in cash and money in bank accounts (*for Temporary Assistance*)
- Changes in your legal obligation to pay child support (*for Temporary Assistance*)
- Anyone starts, stops, or has changes in health insurance coverage (*for MAGI Medicaid*)

SNAP You must report when your household's total monthly gross income goes over the income limit for your household size and if someone in your household has lottery or gambling winnings of $4,250 or more in a single game. If your household contains a member subject to ABAWD time limits, you must report when their work hours fall below 20 hours per week.

COMPUTER MATCHING AND YOUR SOCIAL SECURITY NUMBER

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.

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.

Deliverable 2- ARIES Auto Notice

Nome District Office
PO BOX 2110
Nome, Alaska 99762-

DIVISION OF PUBLIC ASSISTANCE

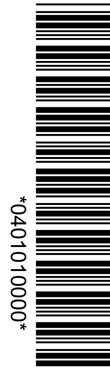
DEPARTMENT OF HEALTH

STATE OF ALASKA

Office Contact: Phone: 1-800-478-7778 Toll-Free

Fax: 1-888-269-6520 Toll-Free

Case Number: 99999999



NAME
ADDRESS
TOWN STATE ZIP

Return Forms to the Return Address Indicated Above

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

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Nome District Office
PO BOX 2110
Nome, Alaska 99762-

DIVISION OF PUBLIC ASSISTANCE
DEPARTMENT OF HEALTH

STATE OF ALASKA

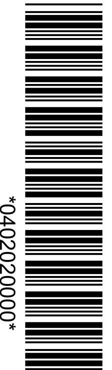
Office Contact: Phone: 1-800-478-7778 Toll-Free

Fax: 1-888-269-6520 Toll-Free

https://health.alaska.gov/dpa
Benefit Information:
907-269-5777
1-888-804-6330

Case Number: 99999999
Case Name: NAME

Document #: 99999999
Date: 99/99/9999



NAME
ADDRESS
TOWN STATE ZIP

Eligibility Notice

Dear NAME,

This letter tells you about your benefits. The information in this letter affects your legal rights so please review it carefully. If you have a question, please contact the number listed above.

We have received a report of change for your household. This change resulted in the closure of your case effective 99/99/9999. Please see the boxes below for additional details.

Eligibility Results - NAME

Date	**Determination**	**Explanation**	**Federal/State Regulations that Support the Action**
99/9999	Eligible - Pregnant Women Medicaid	Based on countable income of $0.00.	42 CFR 435.603 and 7 AAC 100.018
From 99/9999 to 99/9999	Eligible - Pregnant Women Medicaid	Based on Medicaid policy wherein no income test is required.	42 CFR 435.603 and 7 AAC 100.018
Effective 99/9999	Ineligible - Pregnant Women Medicaid	You asked to withdraw your application. You may reapply at any time.	42 CFR 435.913 and 7 AAC 100.012

Eligibility Results - NAME

Date	**Determination**	**Explanation**	**Federal/State Regulations that Support the Action**
From 99/9999 to 99/9999	Eligible - Denali KidCare	Based on Medicaid policy wherein no income test is required.	42 CFR 435.603 and 7 AAC 100.018

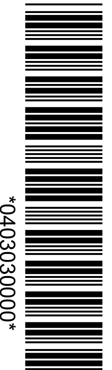
View notices online with your myAlaska account by accessing: http://aries.alaska.gov and selecting “View My Details”.

Eligibility Results - NAME			
Date	**Determination**	**Explanation**	**Federal/State Regulations that Support the Action**
Effective 99/9999	Ineligible - Denali KidCare	You asked to withdraw your application. You may reapply at any time.	42 CFR 435.913 and 7 AAC 100.012

Eligibility Results - NAME			
Date	**Determination**	**Explanation**	**Federal/State Regulations that Support the Action**
From 99/9999 to 99/9999	Eligible - Denali KidCare	Based on Medicaid policy wherein no income test is required.	42 CFR 435.603 and 7 AAC 100.018
Effective 99/9999	Ineligible - Denali KidCare	You asked to withdraw your application. You may reapply at any time.	42 CFR 435.913 and 7 AAC 100.012

Additional Information
NAME REQUESTED TO CLOSE THE MEDICAID CASE DUE TO MOVING TO SOME OTHER STATE.

Medicaid Frequently Asked Questions



Who do I call with questions?	Contact the Division of Public Assistance with Medicaid eligibility questions. Contact your medical provider or the state toll free Medicaid Recipient Helpline at 1-800-780-9972 with questions about Medicaid covered services.

How do I use Medicaid?	You will receive your benefits in the mail. If you are age 18 or older, you may be asked to pay a small co-payment when you use them. Other than this co-payment, a Provider who accepts Medicaid for a service is accepting it as payment in full. If you have other insurance, your medical provider must bill the other insurance first. Medicaid will not reimburse you or pay for any bill that you or someone else has already paid.

What if I have to travel to receive healthcare?	If you need to travel for non-emergency medical treatment, you must have your provider request authorization before you travel. If you are temporarily out of state and need medical treatment, the provider must enroll with the State of Alaska before services will be paid.

What if I have a billing problem?	If you receive a bill from your provider for services you think Medicaid should cover, contact your medical provider. If they cannot help, call the Medicaid Recipient Helpline listed above.

What if I suspect my provider is fraudulent?	If you suspect your Medicaid provider is fraudulent, please contact the Medicaid Fraud Hotline at (907)269-6279 or email your concerns to: Medfraud@alaska.gov. You can report fraud anonymously.

State of Alaska Department of Health
NOTICE OF USE OF PRIVATE HEALTH CARE INFORMATION

Effective Date September 1, 2022

FOR YOUR PROTECTION	**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

Your Health Care Information Is Private

We understand that information we collect about you and your health is personal. Keeping your health care information private is one of our most important responsibilities. We are required by law to maintain the privacy of protected health information and to provide notice of our legal duties and privacy practices with regard to your protected health information. We are committed to protecting your health care information and following all laws about its use, and we are required to abide by the terms of this notice. You have the right to discuss with the privacy officer your concerns about how your health care information is shared. The law says:

1. We must keep your health care information from others who do not need it.
2. You may ask us not to share certain health care information. Sometimes, we may not be able to agree to your request.

Who Sees And Shares My Health Care Information?

Your health caregivers, such as nurses, doctors, therapists and social workers may see, use and share your health care information to determine your plan of care. This use may cover health care services you had before now or may have later.

We review your health care information and bills (claims) to make sure that you get quality care and that all laws about providing and paying for your health care are being followed. We may also use your information to remind you about appointments or to tell you about treatment alternatives.

How Is Payment Made

We may share your health care information with health plans, insurance companies, tribal or government programs to help you get your benefits and so that we can be paid or pay for your health care services.

We may charge a small amount for copying costs.

May I See My Health Care Information?

In most cases, you may see your health care information. There may be legal reasons or safety concerns that may limit the amount of information that you may see. You may ask in writing to receive a copy of your health care information.

If you think some of your health care information is wrong, you may ask in writing that we correct or add to it .You may ask that the corrected or new information be sent to others who have received your health care information from us. You may ask us for a list of where we sent your health care information unless it was disclosed for treatment, payment or operations purposes.

What If My Health Care Information Needs To Go Somewhere Else?

You may ask to have your health care information sent to others. You will be asked to sign a separate form, called an authorization form, permitting your health care information to go to them.

The authorization form tells us what, where and to whom the information must be sent. You can stop or limit the amount of information sent at any time by letting us know in writing.

Note: If you are younger than 18 years old and, by law, you are able to give consent for your own health care, then your health care information is kept private from others unless you sign an authorization form.

Could My Health Care Information Be Released Without My Authorization?

We follow laws that tell us when we have to share health care information, even if you do not sign an authorization form. We always report:

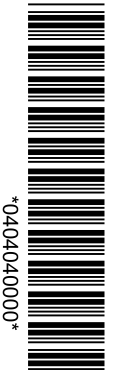
1. contagious diseases, birth defects and cancer;
2. firearm injuries and other trauma events;
3. reactions to problems with medicines or defective medical equipment;
4. to the police when required by law;
5. when the court orders us to;
6. to the government to review how our programs are working;
7. to a provider or insurance company who needs to know if you are enrolled in one of our programs;
8. to Workers Compensation for work-related injuries;
9. birth, death and immunization information;
10. to the federal government when they are investigating something important to protect our country, the President and other government workers;
11. abuse, neglect and domestic violence, if related to child protection or vulnerable adults.

We may also share health care information for permitted research purposes, for matters concerning organ donations and for serious threats to public health or safety.

Other uses and disclosures of your health care information will be made only with your written authorization, which you may revoke at any time.

To revoke an authorization, please use the second page of the GEN 150. This form can be found online at http://dpaweb.hss.state.ak.us/node/47. This form may be obtained by contacting the Department Privacy Officer. Contact information for the Privacy Officer is located at the bottom of this notice.

Most uses and disclosures of psychotherapy notes require an authorization.



Additional Rights

You have the following rights with respect to your protected health information:

1. to receive confidential communications;
2. to receive notification of a breach of your protected health information; and
3. to request that we restrict a disclosure to a health plan when you pay in full for a covered service.

May I Have A Copy Of This Notice

This notice is yours. You may ask for a copy at any time. We reserve the right to change the terms of this notice and to make the new notice provisions effective for all protected health information that we maintain. If there are important changes to this notice, you will get a new one within 60 days if you are enrolled in a health plan, such as Medicaid. An electronic version of this notice is available at:

https://health.alaska.gov/fms/Documents/DOH-Notice-of-Privacy-Practices.pdf

Questions Or Complaints

If you have questions or feel your privacy rights have been violated you can contact the Department Privacy Official by calling 907-465-2150, or by writing to State of Alaska, DOH Privacy Official, PO Box 110650, Juneau, AK 99811-0650, or by emailing PrivacyOfficial@alaska.gov. You will not be retaliated against for filing a complaint with DOH or the Secretary of Health and Human Services.

You can also file a complaint of discrimination for yourself or someone else through Health and Human Services (HHS). Complete the form online through the Office for Civil Rights (OCR) Complaint Portal at: https://ocrportal.hhs.gov/ocr/. You may also contact OCR via mail at: Centralized Case Management Operations, U.S. Department of Health and Human Services, 200 Independence Avenue, S.W., Room 509F HHH Bldg., Washington, D.C. 20201; fax: (202) 619-3818; or email: OCRmail@hhs.gov.

YOUR RIGHTS AND RESPONSIBILITIES

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. The request may be made to any employee of the Division in person, by telephone, or in writing. Fair hearing requests must be made within 30 days from the date of the notice. 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 at (907) 272-9431 or 1-888-478-2572.

Fair Hearing Request

You may request a hearing by filling out the following information and delivering or mailing this request to the Public Assistance office address on the front of this notice. If requested, the Division will assist you in making a hearing request. **Please fill this out only if you disagree with the action taken on your case and want to request a fair hearing. Briefly describe why you disagree:**

____

____

____

If we get this request before the date your benefits are to be lowered or stopped, your benefits in most instances will stay the same until the fair hearing decision is made. If the hearing is not in your favor, you will have to pay back these benefits.

If you do not want to get benefits while you are waiting for a fair hearing decision - Check this box: ☐

If you do not request a fair hearing before the effective date of action, you can still appeal but benefits will not be continued. You can always reapply for benefits while waiting for your hearing.

Signature:____ Date:__________________________

Change Reporting

REPORTING CHANGES TO YOUR HOUSEHOLD CIRCUMSTANCES

You must report changes in your household circumstances that may affect your eligibility. Changes must be reported within 10 days of when the household knows of the change. Changes can be reported in person, by telephone, or in writing.

Medicaid: You must report the following changes.

- Anyone starts or stops a job, has a change in rate of pay or their employment status changes from part-time to full-time or from full-time to part-time
- There is a change in unearned income
- A household member moves into or out of the home
- Change in residential or mailing address
- Temporary absences lasting a month or longer and the circumstances of the absence
- Change in state residency
- Anyone starts, stops, or has changes in health insurance coverage, including Medicare
- Changes in pregnancy
- Marriage or divorce
- Changes in tax filing status

Civil Rights

In accordance with federal civil rights laws and civil rights regulations and policies, institutions participating in or administering federally funded programs are prohibited from discriminating based on race, color, national origin, sex (including gender identity and sexual orientation), religious creed, disability, age, political beliefs, or reprisal or retaliation for prior civil rights activity in any program or activity.

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.

Read and keep this page (Rights and Responsibilities).

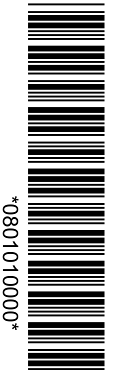
Deliverable 3- ARIES Flat Notice

Anchorage DPA Office 083
4001 Ingra Street, Suite 131
Anchorage, Alaska 99503-6089

DIVISION OF PUBLIC ASSISTANCE
DEPARTMENT OF HEALTH
STATE OF ALASKA

Office Contact: Phone: 1-800-478-7778 Toll-Free
Fax: 1-888-269-6520 Toll-Free

Case Number: 99999999



NAME
ADDRESS
CITY STATE ZIP

Return Forms to the Return Address Indicated Above

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

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Anchorage DPA Office 083
4001 Ingra Street, Suite 131
Anchorage, Alaska 99503-6089

Office Contact: Phone: 1-800-478-7778 Toll-Free

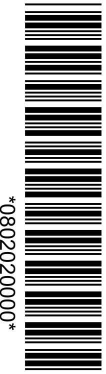
Fax: 1-888-269-6520 Toll-Free

DIVISION OF PUBLIC ASSISTANCE
DEPARTMENT OF HEALTH

STATE OF ALASKA

https://health.alaska.gov/dpa
Benefit Information:
907-269-5777
1-888-804-6330

Case Number: 99999999
Case Name: NAME
Document #: 99999999
Date: 99/99/9999



NAME
ADDRESS
CITY STATE ZIP

Eligibility Notice

Dear NAME,

This letter tells you about your benefits. The information in this letter affects your legal rights so please review it carefully. If you have a question, please contact the number listed above.

We have made a decision in regards to the renewal of Medical Assistance benefits. 99/99/9999 is the date that the Division either received an application, or a periodic review of electronic data was completed by staff. See the boxes below for the status of eligibility and the dates of coverage for each household member. Household members found eligible will have eligibility reviewed at the end of the coverage period listed below or when a change is reported that affects Medicaid eligibility.

Eligibility Results - NAME

Date	**Determination**	**Explanation**	**Federal/State Regulations that Support the Action**
From 99/9999 to 99/9999	Eligible - Denali KidCare	Based on Medicaid policy wherein no income test is required.	42 CFR 435.603 and 7 AAC 100.018

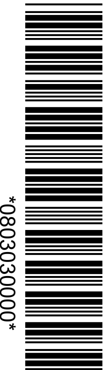
Eligibility Results - NAME

Date	**Determination**	**Explanation**	**Federal/State Regulations that Support the Action**
From 99/9999 to 99/9999	Eligible - Pregnant Women Medicaid	Based on Medicaid policy wherein no income test is required.	42 CFR 435.603 and 7 AAC 100.018

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

Additional Information
Congratulations on the birth of your CHILD, NAME on 99/99/9999. NAME has been added to your Medicaid case beginning on PERSONAL PRONOUN birth date.

Medicaid Frequently Asked Questions



Who do I call with questions?	Contact the Division of Public Assistance with Medicaid eligibility questions. Contact your medical provider or the state toll free Medicaid Recipient Helpline at 1-800-780-9972 with questions about Medicaid covered services.

How do I use Medicaid?	You will receive your benefits in the mail. If you are age 18 or older, you may be asked to pay a small co-payment when you use them. Other than this co-payment, a Provider who accepts Medicaid for a service is accepting it as payment in full. If you have other insurance, your medical provider must bill the other insurance first. Medicaid will not reimburse you or pay for any bill that you or someone else has already paid.

What if I have to travel to receive healthcare?	If you need to travel for non-emergency medical treatment, you must have your provider request authorization before you travel. If you are temporarily out of state and need medical treatment, the provider must enroll with the State of Alaska before services will be paid.

What if I have a billing problem?	If you receive a bill from your provider for services you think Medicaid should cover, contact your medical provider. If they cannot help, call the Medicaid Recipient Helpline listed above.

What if I suspect my provider is fraudulent?	If you suspect your Medicaid provider is fraudulent, please contact the Medicaid Fraud Hotline at (907)269-6279 or email your concerns to: Medfraud@alaska.gov. You can report fraud anonymously.

State of Alaska Department of Health
NOTICE OF USE OF PRIVATE HEALTH CARE INFORMATION

Effective Date September 1, 2022

FOR YOUR PROTECTION	**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

Your Health Care Information Is Private

We understand that information we collect about you and your health is personal. Keeping your health care information private is one of our most important responsibilities. We are required by law to maintain the privacy of protected health information and to provide notice of our legal duties and privacy practices with regard to your protected health information. We are committed to protecting your health care information and following all laws about its use, and we are required to abide by the terms of this notice. You have the right to discuss with the privacy officer your concerns about how your health care information is shared. The law says:

1. We must keep your health care information from others who do not need it.
2. You may ask us not to share certain health care information. Sometimes, we may not be able to agree to your request.

Who Sees And Shares My Health Care Information?

Your health caregivers, such as nurses, doctors, therapists and social workers may see, use and share your health care information to determine your plan of care. This use may cover health care services you had before now or may have later.

We review your health care information and bills (claims) to make sure that you get quality care and that all laws about providing and paying for your health care are being followed. We may also use your information to remind you about appointments or to tell you about treatment alternatives.

How Is Payment Made

We may share your health care information with health plans, insurance companies, tribal or government programs to help you get your benefits and so that we can be paid or pay for your health care services.

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May I See My Health Care Information?

In most cases, you may see your health care information. There may be legal reasons or safety concerns that may limit the amount of information that you may see. You may ask in writing to receive a copy of your health care information.

If you think some of your health care information is wrong, you may ask in writing that we correct or add to it .You may ask that the corrected or new information be sent to others who have received your health care information from us. You may ask us for a list of where we sent your health care information unless it was disclosed for treatment, payment or operations purposes.

What If My Health Care Information Needs To Go Somewhere Else?

You may ask to have your health care information sent to others. You will be asked to sign a separate form, called an authorization form, permitting your health care information to go to them.

The authorization form tells us what, where and to whom the information must be sent. You can stop or limit the amount of information sent at any time by letting us know in writing.

Note: If you are younger than 18 years old and, by law, you are able to give consent for your own health care, then your health care information is kept private from others unless you sign an authorization form.

Could My Health Care Information Be Released Without My Authorization?

We follow laws that tell us when we have to share health care information, even if you do not sign an authorization form. We always report:

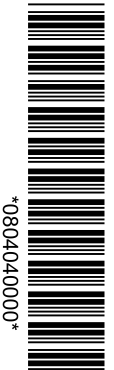
1. contagious diseases, birth defects and cancer;
2. firearm injuries and other trauma events;
3. reactions to problems with medicines or defective medical equipment;
4. to the police when required by law;
5. when the court orders us to;
6. to the government to review how our programs are working;
7. to a provider or insurance company who needs to know if you are enrolled in one of our programs;
8. to Workers Compensation for work-related injuries;
9. birth, death and immunization information;
10. to the federal government when they are investigating something important to protect our country, the President and other government workers;
11. abuse, neglect and domestic violence, if related to child protection or vulnerable adults.

We may also share health care information for permitted research purposes, for matters concerning organ donations and for serious threats to public health or safety.

Other uses and disclosures of your health care information will be made only with your written authorization, which you may revoke at any time.

To revoke an authorization, please use the second page of the GEN 150. This form can be found online at http://dpaweb.hss.state.ak.us/node/47. This form may be obtained by contacting the Department Privacy Officer. Contact information for the Privacy Officer is located at the bottom of this notice.

Most uses and disclosures of psychotherapy notes require an authorization.



Additional Rights

You have the following rights with respect to your protected health information:

1. to receive confidential communications;
2. to receive notification of a breach of your protected health information; and
3. to request that we restrict a disclosure to a health plan when you pay in full for a covered service.

May I Have A Copy Of This Notice

This notice is yours. You may ask for a copy at any time. We reserve the right to change the terms of this notice and to make the new notice provisions effective for all protected health information that we maintain. If there are important changes to this notice, you will get a new one within 60 days if you are enrolled in a health plan, such as Medicaid. An electronic version of this notice is available at:

https://health.alaska.gov/fms/Documents/DOH-Notice-of-Privacy-Practices.pdf

Questions Or Complaints

If you have questions or feel your privacy rights have been violated you can contact the Department Privacy Official by calling 907-465-2150, or by writing to State of Alaska, DOH Privacy Official, PO Box 110650, Juneau, AK 99811-0650, or by emailing PrivacyOfficial@alaska.gov. You will not be retaliated against for filing a complaint with DOH or the Secretary of Health and Human Services.

You can also file a complaint of discrimination for yourself or someone else through Health and Human Services (HHS). Complete the form online through the Office for Civil Rights (OCR) Complaint Portal at: https://ocrportal.hhs.gov/ocr/. You may also contact OCR via mail at: Centralized Case Management Operations, U.S. Department of Health and Human Services, 200 Independence Avenue, S.W., Room 509F HHH Bldg., Washington, D.C. 20201; fax: (202) 619-3818; or email: OCRmail@hhs.gov.

YOUR RIGHTS AND RESPONSIBILITIES

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. The request may be made to any employee of the Division in person, by telephone, or in writing. Fair hearing requests must be made within 30 days from the date of the notice. 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 at (907) 272-9431 or 1-888-478-2572.

Fair Hearing Request

You may request a hearing by filling out the following information and delivering or mailing this request to the Public Assistance office address on the front of this notice. If requested, the Division will assist you in making a hearing request. **Please fill this out only if you disagree with the action taken on your case and want to request a fair hearing. Briefly describe why you disagree:**

____

____

____

If we get this request before the date your benefits are to be lowered or stopped, your benefits in most instances will stay the same until the fair hearing decision is made. If the hearing is not in your favor, you will have to pay back these benefits.

If you do not want to get benefits while you are waiting for a fair hearing decision - Check this box: ☐

If you do not request a fair hearing before the effective date of action, you can still appeal but benefits will not be continued. You can always reapply for benefits while waiting for your hearing.

Signature:____ Date:________________________

Change Reporting

REPORTING CHANGES TO YOUR HOUSEHOLD CIRCUMSTANCES

You must report changes in your household circumstances that may affect your eligibility. Changes must be reported within 10 days of when the household knows of the change. Changes can be reported in person, by telephone, or in writing.

Medicaid: You must report the following changes.

- Anyone starts or stops a job, has a change in rate of pay or their employment status changes from part-time to full-time or from full-time to part-time
- There is a change in unearned income
- A household member moves into or out of the home
- Change in residential or mailing address
- Temporary absences lasting a month or longer and the circumstances of the absence
- Change in state residency
- Anyone starts, stops, or has changes in health insurance coverage, including Medicare
- Changes in pregnancy
- Marriage or divorce
- Changes in tax filing status

Civil Rights

In accordance with federal civil rights laws and civil rights regulations and policies, institutions participating in or administering federally funded programs are prohibited from discriminating based on race, color, national origin, sex (including gender identity and sexual orientation), religious creed, disability, age, political beliefs, or reprisal or retaliation for prior civil rights activity in any program or activity.

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.

Read and keep this page (Rights and Responsibilities).

Anchorage DPA Office 083
4001 Ingra Street, Suite 131
Anchorage, Alaska 99503-6089

DIVISION OF PUBLIC ASSISTANCE
DEPARTMENT OF HEALTH

STATE OF ALASKA

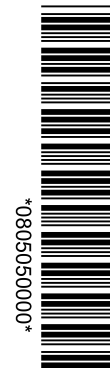
Office Contact: Phone: 1-800-478-7778 Toll-Free

Fax: 1-888-269-6520 Toll-Free

https://health.alaska.gov/dpa
Benefit Information:
907-269-5777
1-888-804-6330

Case Number: 99999999
Case Name: NAME
Document #: 99999999
Date: 99/99/9999

NAME
ADDRESS
CITY, STATE, ZIP



Request for Child Support Information

Dear NAME,

Medical Assistance rules require you to cooperate with the Child Support Services Division, unless you have good reason not to. If you have not established good cause or cooperated by the due date indicated on this notice, you will be ineligible for Medicaid benefits until you have cooperated or proven you have good cause not to cooperate.

If you agree to cooperate with the Child Support Services Division, please complete the information on the next page about the non-custodial parent of your child(ren). If you have more than one child, and they have different non-custodial parents, you must complete a new form for each non-custodial parent. You can make copies of the second page or contact the office for additional forms.

If you feel you have good cause not to cooperate with the Child Support Services Division, please complete the form on page three. On this form, you should indicate why you feel that cooperating will cause harm to you or your child. If good cause is approved, you will not be required to provide information about the non-custodial parent. You may be asked to provide documentation to support your good cause claim before it can be approved.

In some situations, you may want to cooperate by providing the information for one child but feel you have good cause not to cooperate for another child in your household. If that is the case, please complete both of the attached forms.

You must complete the information, sign the bottom of **each** completed page, and return this notice by **99/99/9999**. If you do not return the completed form(s) by this date, you will be ineligible for Medicaid.

42 CFR 435.610, 7 AAC 100.042 and 7 AAC 100.046 supports this action.

Notes from Your Worker
This form is required for Medicaid. Please complete, sign, and return by 99/99/9999. Thank you.

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

Child Support Cooperation

The information will be used to establish and/or enforce child and/or medical support.

Your name:_________________________________Your SSN: ____

Address: ____City/State/Zip : ____________________________

Phone:___________Email: ____________________ Driver's License: State:___________No. ________________

Your relationship to children: ☐ Father ☐ Mother ☐ Other (explain)____

Non-custodial parent's full legal name:_______________________ and their SSN: _________________________

Child's Full Name	Date of Birth	Place of birth (City, County, State)	Child's SSN	Are both parents on birth certificate?
				Yes No
				Yes No
				Yes No

Non-custodial parent: Date of birth:________________________Place of birth:__________________________________

Address:____City/State/Zip:__________________________________

Non-custodial parent's usual occupation, current employer and location:____________________________________

Does the non-custodial parent have medical insurance for the child(ren)? Y / N Type of Policy :______________________

Union Member? Y / N

Tribe or Native Corporation member? Y / N

☐ Married:________________________Date:___________________________Where:_______________________

☐ Married and Separated: Date of separation:________________Where: _______________________

☐ Divorce pending: Date filed and what court: ____

☐ Divorced: Date final:_______________________Where: _____________________

☐ Never married: If the parents never married, has paternity been established by court or administrative order for each child listed? ☐ Yes ☐ No If no, please explain:____

Is there a custody order regarding the child(ren)? ☐ Yes ☐ No If yes, provide the following information about the order:
State/County:_____________________________________ Court/Agency:______________________Date:____________

Do you have a child support order? ☐ Yes ☐ No If yes, provide the following information about the order:
State/County:________________________________Court/Agency:_____________________Date:______________

CHILD SUPPORT COOPERATION AND ASSIGNMENT OF SUPPORT

You are required by law to help get child support for a child receiving Temporary Assistance (ATAP/TANF) payments or medical support for a child receiving medical assistance (Medicaid). This means you must help locate a non-custodial parent or establish paternity for a child with no legal father. You must sign over to the State agency any child/spousal support or medical support owed to you for any month you receive assistance. If the non-custodial parent pays support payments to you while you are receiving Temporary Assistance, you must turn the payments over to Child Support Services Division (CSSD).You must do this even if no support order is in effect.

☐ If CSSD sends a payment to you in error, they will contact you for repayment of that money. If you want to repay gradually out of future child support payments, instead of immediately in a lump sum, check this box.

SUPPLYING INFORMATION TO CSSD - CONFIDENTIALITY AND SAFETY

If you believe that cooperating with CSSD to get child or medical support will bring harm to you or your children and you can provide support for your belief, you may claim good cause for not cooperating. You will be asked by a Public Assistance caseworker to complete "good cause" claim forms. It is up to the caseworker to decide if you have good cause for not cooperating. CSSD will continue to pursue child or medical support against the non-custodial parent, even if you DO NOT cooperate, unless the Division of Public Assistance approves good cause. Please check one of the boxes and sign below.

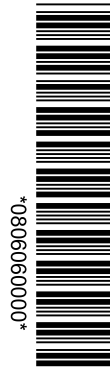
☐ I agree to cooperate with CSSD.
☐ I agree to cooperate with CSSD but I want my address kept confidential.
☐ I believe I have good cause to not cooperate with CSSD.

Signature: ____Date: _________________________________

Child Support Good Cause

If you wish to claim good cause for not cooperating with the Child Support Services Division, you must complete the following information and return this notice to the address listed on the first page by **99/99/9999** .

I do not want to cooperate with child support activities at this time because I have good cause not to. I realize I may be required to provide adequate information with this notice to support my claim, or it may be denied. I claim good cause because:



Check one:	**Person(s) Affected**
( ) Physical harm may occur to me or my child	____________________
( ) Emotional harm may occur to me or my child	____________________
( ) Child was conceived by rape or incest	____________________
( ) Legal proceedings for adoption are pending	____________________
( ) I may give up my child for adoption	____________________

Your Signature ______________________________________ Date ______________________

If you have any questions about this notice, contact our office at the phone number listed on the first page of this notice.

This action is supported by Medical Assistance Manual Section 5016, and federal and state regulations at 42 CFR 435.610 and 7 AAC 100.016

State of Alaska Department of Health
NOTICE OF USE OF PRIVATE HEALTH CARE INFORMATION

Effective Date September 1, 2022

FOR YOUR PROTECTION	**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

Your Health Care Information Is Private

We understand that information we collect about you and your health is personal. Keeping your health care information private is one of our most important responsibilities. We are required by law to maintain the privacy of protected health information and to provide notice of our legal duties and privacy practices with regard to your protected health information. We are committed to protecting your health care information and following all laws about its use, and we are required to abide by the terms of this notice. You have the right to discuss with the privacy officer your concerns about how your health care information is shared. The law says:

1. We must keep your health care information from others who do not need it.
2. You may ask us not to share certain health care information. Sometimes, we may not be able to agree to your request.

Who Sees And Shares My Health Care Information?

Your health caregivers, such as nurses, doctors, therapists and social workers may see, use and share your health care information to determine your plan of care. This use may cover health care services you had before now or may have later.

We review your health care information and bills (claims) to make sure that you get quality care and that all laws about providing and paying for your health care are being followed. We may also use your information to remind you about appointments or to tell you about treatment alternatives.

How Is Payment Made

We may share your health care information with health plans, insurance companies, tribal or government programs to help you get your benefits and so that we can be paid or pay for your health care services.

We may charge a small amount for copying costs.

May I See My Health Care Information?

In most cases, you may see your health care information. There may be legal reasons or safety concerns that may limit the amount of information that you may see. You may ask in writing to receive a copy of your health care information.

If you think some of your health care information is wrong, you may ask in writing that we correct or add to it .You may ask that the corrected or new information be sent to others who have received your health care information from us. You may ask us for a list of where we sent your health care information unless it was disclosed for treatment, payment or operations purposes.

What If My Health Care Information Needs To Go Somewhere Else?

You may ask to have your health care information sent to others. You will be asked to sign a separate form, called an authorization form, permitting your health care information to go to them.

The authorization form tells us what, where and to whom the information must be sent. You can stop or limit the amount of information sent at any time by letting us know in writing.

Note: If you are younger than 18 years old and, by law, you are able to give consent for your own health care, then your health care information is kept private from others unless you sign an authorization form.

Could My Health Care Information Be Released Without My Authorization?

We follow laws that tell us when we have to share health care information, even if you do not sign an authorization form. We always report:

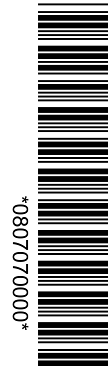
1. contagious diseases, birth defects and cancer;
2. firearm injuries and other trauma events;
3. reactions to problems with medicines or defective medical equipment;
4. to the police when required by law;
5. when the court orders us to;
6. to the government to review how our programs are working;
7. to a provider or insurance company who needs to know if you are enrolled in one of our programs;
8. to Workers Compensation for work-related injuries;
9. birth, death and immunization information;
10. to the federal government when they are investigating something important to protect our country, the President and other government workers;
11. abuse, neglect and domestic violence, if related to child protection or vulnerable adults.

We may also share health care information for permitted research purposes, for matters concerning organ donations and for serious threats to public health or safety.

Other uses and disclosures of your health care information will be made only with your written authorization, which you may revoke at any time.

To revoke an authorization, please use the second page of the GEN 150. This form can be found online at http://dpaweb.hss.state.ak.us/node/47. This form may be obtained by contacting the Department Privacy Officer. Contact information for the Privacy Officer is located at the bottom of this notice.

Most uses and disclosures of psychotherapy notes require an authorization.



Additional Rights

You have the following rights with respect to your protected health information:

1. to receive confidential communications;
2. to receive notification of a breach of your protected health information; and
3. to request that we restrict a disclosure to a health plan when you pay in full for a covered service.

May I Have A Copy Of This Notice

This notice is yours. You may ask for a copy at any time. We reserve the right to change the terms of this notice and to make the new notice provisions effective for all protected health information that we maintain. If there are important changes to this notice, you will get a new one within 60 days if you are enrolled in a health plan, such as Medicaid. An electronic version of this notice is available at:

https://health.alaska.gov/fms/Documents/DOH-Notice-of-Privacy-Practices.pdf

Questions Or Complaints

If you have questions or feel your privacy rights have been violated you can contact the Department Privacy Official by calling 907-465-2150, or by writing to State of Alaska, DOH Privacy Official, PO Box 110650, Juneau, AK 99811-0650, or by emailing PrivacyOfficial@alaska.gov. You will not be retaliated against for filing a complaint with DOH or the Secretary of Health and Human Services.

You can also file a complaint of discrimination for yourself or someone else through Health and Human Services (HHS). Complete the form online through the Office for Civil Rights (OCR) Complaint Portal at: https://ocrportal.hhs.gov/ocr/. You may also contact OCR via mail at: Centralized Case Management Operations, U.S. Department of Health and Human Services, 200 Independence Avenue, S.W., Room 509F HHH Bldg., Washington, D.C. 20201; fax: (202) 619-3818; or email: OCRmail@hhs.gov.

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YOUR RIGHTS AND RESPONSIBILITIES

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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. The request may be made to any employee of the Division in person, by telephone, or in writing. Fair hearing requests must be made within 30 days from the date of the notice. 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 at (907) 272-9431 or 1-888-478-2572.

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You may request a hearing by filling out the following information and delivering or mailing this request to the Public Assistance office address on the front of this notice. If requested, the Division will assist you in making a hearing request. **Please fill this out only if you disagree with the action taken on your case and want to request a fair hearing. Briefly describe why you disagree:**

____

____

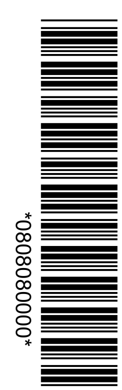
____

If we get this request before the date your benefits are to be lowered or stopped, your benefits in most instances will stay the same until the fair hearing decision is made. If the hearing is not in your favor, you will have to pay back these benefits.

If you do not want to get benefits while you are waiting for a fair hearing decision - Check this box: ☐

If you do not request a fair hearing before the effective date of action, you can still appeal but benefits will not be continued. You can always reapply for benefits while waiting for your hearing.

Signature:______________________________ Date:____________________



Change Reporting

REPORTING CHANGES TO YOUR HOUSEHOLD CIRCUMSTANCES

You must report changes in your household circumstances that may affect your eligibility. Changes must be reported within 10 days of when the household knows of the change. Changes can be reported in person, by telephone, or in writing.

Medicaid: You must report the following changes.

- Anyone starts or stops a job, has a change in rate of pay or their employment status changes from part-time to full-time or from full-time to part-time
- There is a change in unearned income
- A household member moves into or out of the home
- Change in residential or mailing address
- Temporary absences lasting a month or longer and the circumstances of the absence
- Change in state residency
- Anyone starts, stops, or has changes in health insurance coverage, including Medicare
- Changes in pregnancy
- Marriage or divorce
- Changes in tax filing status

Civil Rights

In accordance with federal civil rights laws and civil rights regulations and policies, institutions participating in or administering federally funded programs are prohibited from discriminating based on race, color, national origin, sex (including gender identity and sexual orientation), religious creed, disability, age, political beliefs, or reprisal or retaliation for prior civil rights activity in any program or activity.

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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.

Read and keep this page (Rights and Responsibilities).

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Deliverable 4 - GEN 72 Eligibility Review Form

Gen 72 (06-3670) rev 07.27

X004 SNAP Recertification (GEN 72)

```
EIS - PRODUCTION
File  Edit  Session  Options  Transfer  View  Script  Help

Record displayed
TE056NM1          Notice Definition Table Maintenance               092324 12:30
NOTICEDF                                                            KARLA K
ENTER ACTION CODE (A,C)      Notice ID            X004              page 1 of 3
                             Effective Date From  20231001          lines: 34
                             Effective Date To    99999999

Notice Title  SNAP RECERTIFICATION                      Denial/Closure    (?)

Line   N o t i c e   D e f i n i t i o n   T e x t   (PF1: Keyword)    I/D
  1  >>
  2  Your certification period for Supplemental Nutrition Assistance
  3  Program (SNAP) ends on the last day of %%%%%%%%%%%%%%%%%%%@@
  4  >>
  5  If you want to continue to get SNAP benefits, you will need to fill
  6  out the enclosed Eligibility Review Form and return it to the Division
  7  of Public Assistance (DPA) as soon as possible. To reapply for SNAP
  8  benefits, check the "SNAP" box at the top of the form. Fill out the
  9  form completely, reporting all changes, and attach all needed proof.@@
 10  >>
 11  To avoid a delay in benefits, we must receive the completed enclosed
 12  form no later than the 15th of %%%%%%%%%%%%%%%%%%% Your SNAP case will
 13  close %%%%%%%%%%%%%%%%%%%%% if you do not submit this recertification
 14  form.@@
 15  >>
 16  DPA will contact you if we determine that an interview is needed. If
 17  you fail to attend the interview, your SNAP benefits may be delayed or
 18  denied. You are responsible for rescheduling a missed interview and
 19  for providing required proof.@@
 20  >>
 21  If you live in a community with no Public Assistance office, you can
 22  mail, fax, or email this application to any DPA office or meet with a
 23  Fee Agent in your community. If you apply through a Fee Agent, bring
 24  the completed review form with you. Do this by the first week of the
 25  month to give the Fee Agent time to send the Eligibility Review Form
 26  to our office by the 15th of the month.@@
 27  >>
 28  You have the right to receive an application upon request and have it
 29  accepted as long as it contains a legible name, signature, and
 30  address. If you have any questions, please contact the Division of
 31  Public Assistance at 1-800-478-7778.@@
 32  >>
 33  This action is supported by regulations at 7 CFR 273.14 and SNAP
 34  manual section 604-2.@@

Enter-PF1---PF2---PF3---PF4---PF5---PF6---PF7---PF8---PF9---PF10--PF11--PF12---
      Help        Quit        Cnfrm       Up    Down  FIN

S1/A  Ready (1)  146.63.51.196  X380  12:31:16 9/23/2024  NUM  03:54:57  04, 026
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Department of Health
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 ☐ Adult Public Assistance ☐ Temporary Assistance ☐ Medicaid ☐ Senior Benefits

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 acknowledgment and statement of truth 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

Is English your primary language? ☐ Yes ☐ No If not, what is your primary language?____________
If English is not your primary language, do you read and write English with sufficient proficiency to understand and properly fill out this application? ☐ Yes ☐ No
If not, call 1-800-478-7778 and we will help you with this form and provide an interpreter at no cost to you.

HOUSEHOLD INFORMATION:

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

Race and Ethnic background information is voluntary and will not affect eligibility or benefit amounts. This information is used to assure program benefits are distributed without regard to race, color, or national origin. For Food Assistance/SNAP the United States Department of Agriculture (USDA) requires us to answer for you if no information is provided.

Name (First M I Last)	**Relation to You** If not related write NR.	**Date of Birth**	**Is this person a full-time or part-time member of your household?** Circle the answer. If part-time, what percentage of time does this person reside with you?	**Social Security Number**	**US Citizen?** Yes/No	**Race** (Optional - Use codes below)	**Ethnic Group** (Optional - Use codes below)
	Self		N/A				
			Full-time / Part-time ___%				
			Full-time / Part-time ___%				
			Full-time / Part-time ___%				
			Full-time / Part-time ___%				
			Full-time / Part-time ___%				
			Full-time / Part-time ___%				

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

2. Do you plan to file a federal income tax return NEXT YEAR?

☐ 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 names 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? ____________

3. Is anyone in your household pregnant? ☐ Yes ☐ No If yes, who? Due date? ____________________________
4. Is anyone in your household attending an institution of higher education (schooling beyond high school)?
   ☐Yes ☐No If yes, who? ____Full time or part time? ____________
5. 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?____
6. Have you or any member of your household been convicted of making a false statement about where they live in order to receive assistance from two or more states at the same time? ☐ Yes ☐ No
7. Have you or any member of your household been convicted of possession, use, or distribution of a controlled substance after August 22, 1996? ☐ Yes ☐ No If yes, please answer questions a – d.
   a. Are they satisfactorily serving or successfully completed a period of probation or parole? ☐ Yes ☐ No
   b. Are they in the process of serving or successfully completed mandatory participation in a drug or alcohol treatment program? ☐ Yes ☐ No
   c. Have they taken action towards rehabilitation, including participation in a drug or alcohol treatment program? ☐ Yes ☐ No
   d. Are they successfully complying with the requirements of their re-entry plan? ☐ Yes ☐ No
8. Are you or any member of your household fleeing from prosecution, custody, or confinement for a felony or class A misdemeanor from any State, or currently violating conditions of parole or probation? ☐ Yes ☐ No
9. Have you or any member of your household been convicted of trading SNAP benefits for drugs after September 22, 1996? ☐ Yes ☐ No
10. Have you or any member of your household been convicted of fraudulently receiving duplicate SNAP benefits in any State after September 22, 1996? ☐ Yes ☐ No
11. Have you or any member of your household been convicted of buying or selling SNAP benefits over $500 after September 22, 1996? ☐ Yes ☐ No
12. Have you or any member of your household been convicted of trading SNAP benefits for guns, ammunitions, or explosives after September 22, 1996? ☐ Yes ☐ No
13. Have you or any member of your household been convicted of aggravated sexual abuse, murder, sexual exploitation and abuse of children, or sexual assault after February 7, 2014? ☐ Yes ☐ No If yes, please answer a & b.
   a. Are they serving or have successfully completed a period of probation or parole? ☐ Yes ☐ No
   b. Are they successfully complying with the requirements of their re-entry plan? ☐ Yes ☐ No

ASSETS INFORMATION:

14. 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
				$	$
				$	$
				$	$
				$	$

15. 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
		$			$
		$			$
		$			$
		$			$

16. List how much money you or anyone in your household has in cash and bank accounts. Include Virtual Currency/Cryptocurrency, Trusts, and ABLE accounts.
Please provide a copy of your most recent statement for each account.

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

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

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

18. 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:

19. Complete if you or anyone in your household is working. ***Please provide your most recent pay stubs or a work statement completed by your employer. If self-employed, attach proof of income and expenses.***

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

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

21. 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, Virtual Currency /Cryptocurrency, cash gifts, annuities, etc.*

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

22. Do you expect any changes to your income? ☐ Yes ☐ No If yes, please explain: ______________________________
____

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

HOUSEHOLD EXPENSE INFORMATION:

24. 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	$

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

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

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

27. 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
	$		$
	$		$

28. Do you get money to help pay dependent care costs? ☐ Yes ☐ No If yes, how much? ________________

From whom? ______________________________

29. 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
		$	
		$	

30. 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
	$		$
	$		$

31. 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:

32. 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.

____

33. 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 ______________________________

☐ Medicare______________________________

☐ TRICARE ______________________________

☐ VA health care programs ______________________________

☐ Employer Insurance ______________________________
Name of health insurance: ______________________________
Policy number: ______________________________
Is this COBRA coverage? ☐ Yes ☐ No Is this a retiree plan? ☐ Yes ☐ No RIN: ____________
☐ Other ______________________________

34. 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 ☐ No If yes, complete and include Appendix A.

MEDICAID REVIEW:

35. 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 ______________________________

AUTHORIZED REPRESENTATIVE:

If you would like to allow someone to represent you on all matters related to your application and case or would like the Division to share information about your application or case with someone, complete and include Appendix C.

ACKNOWLEDGEMENT OF UNDERSTANDING AND STATEMENT OF TRUTH:

Acknowledgements

- I understand that I must be a current Alaska resident to qualify for Public Assistance benefits administered by the Alaska Division of Public Assistance. I further understand that, if my residency status changes, I must report the change to the Alaska Division of Public Assistance within 10 days. I further understand that if I leave the state for 30 or more days, I must notify the Alaska Division of Public Assistance of my absence, regardless of whether I consider myself an Alaska resident/intend to return to Alaska, or not.
- I understand that eligibility for Public Assistance is determined in part by how much income my household has at its disposal. To that end, I understand that this application requires that I disclose all income received by myself and members of my household, including but not limited to income from the following sources: Employment (including Self-Employment), Alimony, Child Support, Unemployment, Net Rental/Royalty, Pension/Retirement, Supplemental Security Income, Veteran's Benefits, and Social Security Benefits.
- I understand that eligibility for Public Assistance is determined in part by how many assets my household has at its disposal. To that end, I understand that this application requires that I disclose all assets possessed by myself and members of my household, including but not limited to the following types of assets: Property (regardless of whether the Property is paid for, still being paid for, or is jointly owned with someone else), all Bank Accounts (including checking and savings accounts), Cash on Hand, Certificates of Deposit, College Savings Plans, Life Insurance Policies, Pension Plans, Retirement Funds, Stocks Bonds and Annuities, Native Corporation Shares, Trust Funds, Safety Deposit Box contents, Mineral Rights, IRA Accounts, Commercial Fishing Permits, and Burial Policy Agreements.

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.

I have read or heard read to me the "Acknowledgments" section of the application and understand each one.

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.

Signature of Adult Applicant: ______________________________
Signature **Date (month/day/year)**

Signature of Other Adult Applicant ______________________________
Signature **Date (month/day/year)**

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

State of Alaska
Department of Health
Division of Public Assistance

Contact People and Organizations

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

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, MI, 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? ____________________
List the names of anyone else who is eligible for coverage from this

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)

APPENDIX C: Appointing an Authorized Representative OPTIONAL

Would you like to allow someone to represent you on all matters related to your application and case?

You can give a trusted person or an organization permission to talk about your application and case with us, see your information, and act for you on matters related to your Public Assistance case. This person is called an "authorized representative." **An authorized representative can make changes to your Public Assistance case and has access to the information in your case file. You will be held responsible for any change that is made to your case by your appointed authorized representative, up to and including potential fraud charges.**

The Division of Public Assistance can release any information regarding your application and case to your authorized representative or any member of the organization indicated on this form. More than one person or organization can serve as your authorized representative.

You can appoint, withdraw, or change an authorized representative at any time. If you ever need to change your authorized representative, contact the Division of Public Assistance. *If you are a legally appointed representative for someone on this application and provide proof, you do not need to complete this section.*

Name of Authorized Representative (First name, Middle name, Last name) or Organization		Phone Number
Authorized Representative's Address	Apartment or suite number	Email
City	State	ZIP code

○ New ○ Change ○ Addition ○ Remove this person or organization as my authorized representative

OR

Permission to Release Information

Is there anyone that you would like us to share information with about your application and case?

By completing this section, you can give permission for the following person or organization to receive information about your Public Assistance application and benefit status, but they will not have the ability to act on your behalf like an authorized representative. You give the Division of Public Assistance permission to release information about your case status to this additional person or organization. You may cancel this release at any time by contacting the Division of Public Assistance.

Name of person (First name, Middle name, Last name) or Organization		Phone Number
Address	Apartment or suite number	Email
City	State	ZIP code

AND

Applicant / Recipient's Signature	Date (mm/dd/yyyy)
Applicant / Recipient's Printed Name	Social Security Number or Case Number

To be valid, this form must be signed by the applicant or recipient.

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 (SNAP) and Medicaid 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. SNAP fair hearing requests must be made within 90 days from the effective date of the action. Fair hearing requests for all other programs must be made within 30 days from the date of the notice. If requested, the Division will assist you in making a hearing request. If your disagreement has to do with medical billing or services, contact the Medicaid Recipient Information Helpline at 1-800-780-9972.

If you request a fair hearing before the effective date of the action, you may continue to receive benefits until a hearing decision is made. If you do not request a fair hearing before the effective date of the action, you can still appeal but benefits will not be continued. You can always reapply for benefits while waiting for your hearing. 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 at (907) 272-9431 or 1-888-478-2572.

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 must report when your household's total gross income goes over the income limit for your household size and if someone in your household has lottery or gambling winnings of $4,250 or more in a single game. If your household contains a member subject to the ABAWD time limits, you must report when their work hours fall below 20 hours per week.

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 $2,250 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.

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. 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.

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.

When you sign the application for assistance and use Medicaid, you consent to release medical records and information about yourself and any other person you are applying for to the Department of Health (DOH). 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.

Read and keep this page.

Health (DOH) or medical information DOH 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 DOH used your health information, and how DOH has disclosed your health information outside of DOH. 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 https://health.alaska.gov/fms/Documents/DOH-Notice-of-Privacy-Practices.pdf or you can request a printed copy by emailing: privacyofficial@alaska.gov or by writing to: State of Alaska, DOH Privacy Official, P.O. Box 110650, Juneau, Alaska 99811-0650.

In accordance with federal civil rights laws 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 (including gender identity and sexual orientation), 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. Programs that receive federal financial assistance from the U.S. Department of Health and Human Services (HHS), such as Temporary Assistance for Needy Families (TANF), and programs HHS directly operates are also prohibited from discrimination under federal civil rights laws and HHS regulations.

USDA provides federal financial assistance for many food security and hunger reduction programs such as the Supplemental Nutrition Assistance Program (SNAP), the Food Distribution Program on Indian Reservations (FDPIR) and others. To file a program complaint of discrimination, complete the Program Discrimination Complaint Form, (AD-3027) (found online at: How to File a Complaint, and at any USDA office) or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by:

1. mail: Food and Nutrition Service, USDA
   1320 Braddock Place, Room 334, Alexandria, VA 22314; or
2. fax: (833) 256-1665 or (202) 690-7442; or
3. phone: (833) 620-1071; or
4. email: FNSCIVILRIGHTSCOMPLAINTS@usda.gov.

For any other information regarding SNAP issues, persons should either contact the USDA SNAP hotline number at (800) 221-5689, which is also in Spanish, or call the state information/hotline numbers (click the link for a listing of hotline numbers by state); found online at: SNAP hotline.

HHS provides federal financial assistance for many programs to enhance health and well-being, including TANF, Head Start, the Low Income Home Energy Assistance Program (LIHEAP), and others. If you believe that you have been discriminated against because of your race, color, national origin, disability, age, sex (including pregnancy, sexual orientation, and gender identity), or religion in programs or activities that HHS directly operates or to which HHS provides federal financial assistance, you may file a complaint with the Office for Civil Rights (OCR) for yourself or for someone else.

To file a complaint of discrimination for yourself or someone else regarding a program receiving federal financial assistance through HHS, complete the form online through OCR's Complaint Portal at https://ocrportal.hhs.gov/ocr/. You may also contact OCR via mail at: Centralized Case Management Operations, U.S. Department of Health and Human Services, 200 Independence Avenue, S.W., Room 509F HHH Bldg., Washington, D.C. 20201; fax: (202) 619-3818; or email: OCRmail@hhs.gov. For faster processing, we encourage you to use the OCR online portal to file complaints rather than filing via mail. Persons who need assistance with filing a civil rights complaint can email OCR at OCRMail@hhs.gov or call OCR toll-free at 1-800-368-1019, TDD 1-800-537-7697. For persons who are deaf, hard of hearing, or have speech difficulties, please dial 7-1-1 to access telecommunications relay services. We also provide alternative formats (such as Braille and large print), auxiliary aids and language assistance services free of charge for filing a complaint. This institution is an equal opportunity provider.

Release

Your signature on this application gives the Federally Facilitated Marketplace, the Department of Health, its agents, and the Department of Law permission to ask for information about your health, finances, family, and personal history. This information may be used to determine your eligibility for public assistance programs and, if a fraud investigation is launched, in administrative or criminal investigations of your eligibility for benefits. Your information will not be released for any other reason or to any other person or agency outside of the Federally Facilitated Marketplace, Department of Health, or its representatives except as required by law. 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.

We'll check your answers using information in our electronic databases and databases from the Internal Revenue Service (IRS), Social Security, the Department of Homeland Security, and/or a consumer reporting agency. If the information doesn't match, we may ask you to send us proof. We may also contact other people or organizations including, but 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. We need this information to check your eligibility for public assistance services and to check your eligibility for help paying for health coverage if you choose to apply. Additionally, information obtained from this release may be used by the Department of Health in administrative proceedings against you, and/or by the Department of Law in criminal proceedings against you.

Read and keep this page.

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… 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	**I may…** • 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… • 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	**I may…** • 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… • 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	**I may…** • 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.

Deliverable 5: Denali Care Renewal Notice Sample

NOTICE: X037
       1234567890123456789012345678901234567890
TITLE: DENALI CARE/KIDCARE RENEWAL DUE

1234567890123456789012345678901234567890123456789012345678901234567890

1 >>
2 Your Medicaid benefits are due for renewal. There is an eligibility
3 renewal form and renewal appendix in this envelope. Please fill these
4 out with all requested information and return it to our office.@@
5 >>
6 Here is what you need to do:@@
7 >>
8   1. Read this form and make sure this information is correct.@@
9 >>
10   2. Cross out any old information and write in your new@@
11   information.@@
12 >>
13   3. If you have any questions about your benefits, please call@@
14   us at 1-888-804-6330 outside of Anchorage or 269-5777 in@@
15   Anchorage.@@
16 >>
17 You may be able to speed up this process by also providing proof of
18 money that your household receives.@@
19 >>
20 The renewal form and renewal appendix must be turned into our agency
21 by the 5th day of next month. If we get them after that date but
22 before the end of the month, your Medicaid benefits for the next month
23 may be delayed.@@
24 >>
25 If we do not get your renewal form by the last day of next month and
26 we do not have enough information to redetermine your eligibility,
27 your Medicaid benefits will end on that date.@@
28 >>
29 This action is supported by regulations at 42 CFR 435.916, 7 AAC
30 100.020, and Medical Assistance Manual Sections 5005-7, 5006-3, and
31 5007.@@
32
33
34

Deliverable 6 - GEN 152 Senior Benefits Renewal Form

Gen 152 (06-3944) rev 07.24 Sample

```
NOTICE: X034
       1234567890123456789012345678901234567890
TITLE: Senior Benefits Program Review Due

1234567890123456789012345678901234567890123456789012345678901234567890

 1  >>
 2  It's time to review your eligibility for the Senior Benefits
 3  Program.@@
 4  >>
 5  There is a renewal application enclosed with this letter.  Please
 6  complete and return this form to our office by the 5th of next month.
 7  If we do not get your completed form by the 5th of next month, your
 8  Senior Benefits payment may be delayed.@@
 9  >>
10  When you turn in the review form, be sure to:@@
11  >>
12     1.  Answer each question on the form;@@
13  >>
14     2.  Send proof of any income you get, and if married and living@@
15         with your spouse, any income that your spouse gets; and@@
16  >>
17     3.  Be sure to sign the form.  If you are married and living with@@
18         your spouse, your spouse should also sign the form.@@
19  >>
20  Please call the Senior Benefits Office at 352-4150 (in Mat-Su) or
21  1-888-352-4150 (toll-free) if you have any questions about this
22  letter.@@
23  >>
24  If you are not currently enrolled in the direct deposit program and
25  would like to be, you can get a Direct Deposit Enrollment form at your
26  local Public Assistance office, or by calling our direct deposit
27  enrollment office at 1-888-620-1111 or online at
28  www.hss.state.ak.us/dpa/forms/ddeposit.html.@@
29  >>
30  This action is supported by state regulations at 7 AAC 47.563.@@
31  >>
32
33
34
```

Alaska Department of Health
Division of Public Assistance

Office Use Only

D.O. Date Rec'd ________________
Fee Agent Date Rec'd ________________
Fee Agent Signature ________________

Senior BENEFITS PROGRAM

☐ **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 complete the Authorization for Release of information on page 3 and sign the application 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? ☐ Yes ☐ No	☐ US Citizen ☐ Legal Alien Alien #:		☐ Male ☐ Female
Mailing Address (Street or PO Box)	City	State	Zip
Residence Address	City	State	Zip
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? ☐ Yes ☐ No	☐ US Citizen ☐ Legal Alien Alien #:	☐ Male ☐ 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, Virtual Currency/Cryptocurrency, 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

If you are not registered where you live now, would you like to apply to register to vote? ☐ Yes ☐ No

State of Alaska
Department of Health
Division of Public Assistance

What is an 'Authorization for Release of Information'?

Your signature on this form gives the Department of Health, 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 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

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, or a responsible person acting on my behalf, must report changes in my circumstances within 10 days after the event occurs. Changes can be reported by phone, in writing, or in person. The Division of Public Assistance must be notified if the applicant or their spouse:
  - Has a change in mailing or residence address,
  - Is absent from the state for 30 consecutive days or more,
  - Is admitted to or discharged from a hospital, nursing home, or Pioneer Home,
  - Has a change in income, or
  - Passes away
- If you receive an overpayment of Senior Benefits to which you are not entitled, you may be financially responsible for repaying the overpayment to the State of Alaska. By accepting benefits, you must understand and agree that you may have a responsibility for the repayment of benefits to which you were not entitled.

ACKNOWLEDGEMENT OF UNDERSTANDING AND STATEMENT OF TRUTH

Acknowledgements

- I understand that I must be a current Alaska resident to qualify for Public Assistance benefits administered by the Alaska Division of Public Assistance. I further understand that, if my residency status changes, I must report the change to the Alaska Division of Public Assistance within 10 days. I further understand that if I leave the state for 30 or more days, I must notify the Alaska Division of Public Assistance of my absence, regardless of whether I consider myself an Alaska resident/intend to return to Alaska, or not.
- I understand that eligibility for Public Assistance is determined in part by how much income my household has at its disposal. To that end, I understand that this application requires that I disclose all income received by myself and members of my household, including but not limited to income from the following sources: Employment (including Self-Employment), Alimony, Child Support, Unemployment, Net Rental/Royalty, Pension/Retirement, Supplemental Security Income, Veteran's Benefits, and Social Security Benefits.

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.

I have read or heard read to me the "Acknowledgments" section of the application and understand each one.

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.

Signature of Applicant: ____ Date: _____________

Signature of Spouse: ____ Date: _____________

Please return your completed application to any Division of Public Assistance office.
A list of offices and their contact information can be found on the last page.

Appointing an Authorized Representative

Would you like to allow someone to represent you on all matters related to your application and case?

You can give a trusted person or an organization permission to talk about your application and case with us, see your information, and act for you on matters related to your Public Assistance case. This person is called an "authorized representative." **An authorized representative can make changes to your Public Assistance case and has access to the information in your case file. You will be held responsible for any change that is made to your case by your appointed authorized representative, up to and including potential fraud charges.**

The Division of Public Assistance can release any information regarding your application and case to your authorized representative or any member of the organization indicated on this form. More than one person or organization can serve as your authorized representative.

You can appoint, withdraw, or change an authorized representative at any time. If you ever need to change your authorized representative, contact the Division of Public Assistance. *If you are a legally appointed representative for someone on this application and provide proof, you do not need to complete this section.*

Name of Authorized Representative (First name, Middle name, Last name) or Organization		Phone Number
Authorized Representative's Address	Apartment or suite number	Email
City	State	ZIP code

○ New ○ Change ○ Addition ○ Remove this person or organization as my authorized representative

OR

Permission to Release Information

Is there anyone that you would like us to share information with about your application and case?

By completing this section, you can give permission for the following person or organization to receive information about your Public Assistance application and benefit status, but they will not have the ability to act on your behalf like an authorized representative. You give the Division of Public Assistance permission to release information about your case status to this additional person or organization. You may cancel this release at any time by contacting the Division of Public Assistance.

Name of person (First name, Middle name, Last name) or Organization		Phone Number
Address	Apartment or suite number	Email
City	State	ZIP code

AND

Applicant / Recipient's Signature	Date (mm/dd/yyyy)
Applicant / Recipient's Printed Name	Social Security Number or Case Number

To be valid, this form must be signed by the applicant or recipient.

Public Assistance Offices

ANCHORAGE University Center 4001 Ingra Street, Suite 131 Anchorage, AK 99503 Phone: 1-800-478-7778 Fax: (907) 269-6520 or 1-888-269-6520 hss.dpa.offices@alaska.gov	**BETHEL** 460 Ridgecrest Drive, Suite 121 Mailing: P.O. Box 365 Bethel, AK 99559 Phone: 1-800-478-7778 Fax: 1-888-269-6520 hss.dpa.offices@alaska.gov	**FAIRBANKS** 675 7th Ave, Station E Fairbanks, AK 99701 Phone: 1-800-478-7778 Fax: 1-888-269-6520 hss.dpa.offices@alaska.gov
HOMER 3670 Lake Street, Suite 200 Homer, AK 99603 Phone: 1-800-478-7778 Fax: 1-888-269-6520 hss.dpa.offices@alaska.gov	**JUNEAU** 10002 Glacier Highway, Suite 201 Mailing: P.O. Box 110642 Juneau, AK 99811-0642 Phone: 1-800-478-7778 Fax: 1-888-269-6520 hss.dpa.offices@alaska.gov	**KENAI** 11312 Kenai Spur Highway, Suite 2 Kenai, AK 99611 Phone: 1-800-478-7778 Fax: 1-888-269-6520 hss.dpa.offices@alaska.gov
KETCHIKAN 2030 Sea Level Drive, Suite 301 Ketchikan, AK 99901 Phone: 1-800-478-7778 Fax: 1-888-269-6520 hss.dpa.offices@alaska.gov	**KODIAK** 211 Mission Road, Suite 101 Kodiak, AK 99615 Phone: 1-800-478-7778 Fax: 1-888-269-6520 hss.dpa.offices@alaska.gov	**LONG TERM CARE** University Center 4001 Ingra Street, Suite 131 Anchorage, AK 99503 Phone: 1-800-478-7778 Fax: (907) 269-6520 or 1-888-269-6520 hss.dpa.offices@alaska.gov
NOME 214 E. Front Street Nome, AK 99762 Mailing: 675 7th Ave, Station E Fairbanks, AK 99701 Phone: 1-800-478-7778 Fax: 1-888-269-6520 hss.dpa.offices@alaska.gov	**SITKA** 304 Lake Street, Suite 101 Sitka, AK 99835 Phone: 1-800-478-7778 Fax: 1-888-269-6520 hss.dpa.offices@alaska.gov	**WASILLA** 855 W. Commercial Drive Wasilla, AK 99654 Phone: 1-800-478-7778 Fax: 1-888-269-6520 hss.dpa.offices@alaska.gov

If you need a language interpreter, call 1-800-478-7778 and we will provide one at no cost to you. If you are deaf, hard of hearing, or have a speech disability, dial 711 to reach an Alaska Relay Communications Assistant.

Deliverable 7 - Example Auto Roll Letter

Medicaid Auto Roll Review in Progress Letter

THE STATE
of ALASKA
GOVERNOR MIKE DUNLEAVY

Department of Health

DIVISION OF PUBLIC ASSISTANCE
Director's Office

P.O. Box 110640
Juneau, Alaska 99811-0640
Main: 907.465.3347
Fax: 907.465.5154

Medicaid recipient,

Your household's Medicaid eligibility renewal is in progress. Members of your household that currently receive Medicaid benefits will continue to have Medicaid coverage until the Division of Public Assistance (DPA) makes a decision about continued eligibility. A notice will be sent to you when a decision has been made.

Although Medicaid covered services will continue to be paid while a decision is being made, new Medicaid Recipient Identification Cards will not be sent until the renewal process is complete and continued Medicaid eligibility has been determined. Medical providers should continue to verify eligibility using the Alaska Medicaid Health Enterprise Portal or by calling Healthcare Management Solutions (HMS) at (907) 644-6800 or (800) 770-5650 if located outside of the Anchorage area.

You must tell us when you have changes in your household's situation. Medicaid recipients must report any information that may affect their eligibility including:

1. A household member moves into or out of the home,
2. A change in state residency,
3. Anyone starts or stops a job, has a change in rate of pay, or their employment status changes from part-time to full-time or from full-time to part-time,
4. Anyone starts, stops, or has changes in health insurance coverage, including Medicare,
5. There is a change in unearned income,
6. Changes in pregnancy,
7. Changes in tax filing status,
8. Marriage or divorce,
9. Temporary absences lasting a month or longer, and
10. Changes in mailing and/or residential address.

You need to report changes to DPA within 10 days of when you know of the change. It is best to report changes in writing, but you can report in person or by phone. If you have any questions about this letter or have any changes to report, please contact your local office. A list of offices and their contact information is printed on the back of this letter.

This action is supported by regulations at 42 CFR 435.916 and 7 AAC 100.020.

Public Assistance Offices

ANCHORAGE University Center 4001 Ingra Street, Suite 131 Anchorage, AK 99503 Phone: 1-800-478-7778 Fax: (907) 269-6520 or 1-888-269-6520 hss.dpa.offices@alaska.gov	**BETHEL** 460 Ridgecrest Drive, Suite 121 Mailing: P.O. Box 365 Bethel, AK 99559 Phone: 1-800-478-7778 Fax: 1-888-269-6520 hss.dpa.offices@alaska.gov	**FAIRBANKS** 675 7th Ave, Station E Fairbanks, AK 99701 Phone: 1-800-478-7778 Fax: 1-888-269-6520 hss.dpa.offices@alaska.gov
HOMER 3670 Lake Street, Suite 200 Homer, AK 99603 Phone: 1-800-478-7778 Fax: 1-888-269-6520 hss.dpa.offices@alaska.gov	**JUNEAU** 10002 Glacier Highway, Suite 201 Mailing: P.O. Box 110642 Juneau, AK 99811-0642 Phone: 1-800-478-7778 Fax: 1-888-269-6520 hss.dpa.offices@alaska.gov	**KENAI** 11312 Kenai Spur Highway, Suite 2 Kenai, AK 99611 Phone: 1-800-478-7778 Fax: 1-888-269-6520 hss.dpa.offices@alaska.gov
KETCHIKAN 2030 Sea Level Drive, Suite 301 Ketchikan, AK 99901 Phone: 1-800-478-7778 Fax: 1-888-269-6520 hss.dpa.offices@alaska.gov	**KODIAK** 211 Mission Road, Suite 101 Kodiak, AK 99615 Phone: 1-800-478-7778 Fax: 1-888-269-6520 hss.dpa.offices@alaska.gov	**LONG TERM CARE** University Center 4001 Ingra Street, Suite 131 Anchorage, AK 99503 Phone: 1-800-478-7778 Fax: (907) 269-6520 or 1-888-269-6520 hss.dpa.offices@alaska.gov
NOME 214 E. Front Street Nome, AK 99762 Mailing: 675 7th Ave, Station E Fairbanks, AK 99701 Phone: 1-800-478-7778 Fax: 1-888-269-6520 hss.dpa.offices@alaska.gov	**SITKA** 304 Lake Street, Suite 101 Sitka, AK 99835 Phone: 1-800-478-7778 Fax: 1-888-269-6520 hss.dpa.offices@alaska.gov	**WASILLA** 855 W. Commercial Drive Wasilla, AK 99654 Phone: 1-800-478-7778 Fax: 1-888-269-6520 hss.dpa.offices@alaska.gov

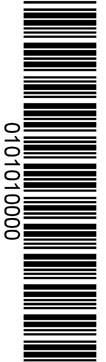
If you need a language interpreter, call 1-800-478-7778 and we will provide one at no cost to you. If you are deaf, hard of hearing, or have a speech disability, dial 711 to reach an Alaska Relay Communications Assistant.

Deliverable 8 - Heating Assistance Letter

LIHEAP Client Notice – Denial-Sample

State of Alaska
Department of Health
Division of Public Assistance
http://dhss.alaska.gov/dpa/

Date: 8/7/2024
Application ID:
Application Date: 5/7/2024



NOTICE OF DENIAL

Your application for the Heating Assistance Program received on 5/7/2024 is denied.

Your application is not timely because it wasn't received, or postmarked by April 30. The deadline, set by regulation, is noted on the application. This action is supported by Heating Assistance Policy Manual Section 3001-2J and state regulations at 7 AAC 44.020(c).

Application has been denied due to application date being after 04/30/24.

If your situation changes, you may reapply before May 1, 2024. To reapply, you must complete a new application and provide proof of income for the month prior to the date you sign your application. You can obtain a new application by calling 1-800-478-7778, at any local DPA office, at your vendor's place of business, through your local fee agent, or on-line at www.heatinghelp.alaska.gov. Your case cannot be redetermined after the April 30, 2024 filing deadline.

If you have additional questions, feel free to contact us by phone at 1-800-478-7778 or by email at hss.dpa.offices@alaska.gov

State of Alaska
Heating Assistance Program

State of Alaska
Department of Health
Division of Public Assistance
http://dhss.alaska.gov/dpa/

YOUR RIGHTS AND RESPONSIBILITIES

You have the right to discuss any action taken on your application or case with a caseworker or 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. The request for SNAP (formerly known as Food Stamps) 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. SNAP 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. SNAP 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 is 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.

FAIR HEARING REQUEST

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

Reason for Fair Hearing Request: ____

____

____

[ ] Continue my benefits at the level received before this notice until the hearing decision is made, or my SNAP certification period ends. 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 on this notice, knowing that if the hearing decision is in my favor I will be paid for any benefits wrongly denied me.

Signature____ Date: _____________________

WHEN DO I NEED TO REPORT CHANGES?

You must report changes in your household within 10 days of which 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 Alaska Temporary Assistance, Adult Public Assistance, or Medicaid Program benefits, you must report any and all changes to information provided on your application, including changes in your medical insurance. If you receive SNAP benefits and you do not receive benefits for 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 form 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 $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
- Pregnancy changes

CIVIL RIGHTS

The Civil Rights Act of 1974 states, "No person in the United States, on the grounds of race, color, age, sec, handicap, religious creed, political belief 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."

COMPUTER MATCHING AND YOUR SOCIAL SECURITY NUMBER

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 AND FAMILY PLANNING SERVICES

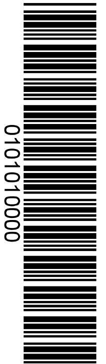
Medicaid pays for well child checkups, dental care, and other services for children through their 21st birthday. Ask your local Public Health Nurse, clinic, or health care provider for more information. If Medicaid coverage ends and you need help find low cost or free family planning services, call your local Public Health Center or AK Info at 1-800-478-2221.

Deliverable 9 - Water Assistance Letter

LIWAP Client Notice-Denial Notice-Special Mailing Sample

State of Alaska Water Assistance Program
PO Box 110642
Juneau, Alaska 99811-0642

Date: 11/25/2022
Application ID:
Application Date: 11/21/2022



NOTICE OF DENIAL

Your application for the Water Assistance Program received on 11/21/2022 is denied.

You do not meet the income eligibility requirement. A household must have income at or below 150% of the federal poverty income guidelines for Alaska. Your household is above the threshold. This action is supported by Water Assistance Policy Manual Section 7000.

If your situation changes, your case may reapply. To reapply, you must complete a new application and provide proof of income for the month prior to the date you sign your application. You can obtain a new application by calling our main office at 800-470-3058, at any local DPA office, at your vendor's place of business, through your local fee agent, or on-line at www.heatinghelp.alaska.gov.

Sincerely,

Water Assistance Program
liheap@alaska.gov

State of Alaska Water Assistance Program
PO Box 110642
Juneau, Alaska 99811-0642

YOUR RIGHTS AND RESPONSIBILITIES

You have the right to discuss any action taken on your application or case with a caseworker or 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. The request for SNAP (formerly known as Food Stamps) 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. SNAP 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. SNAP 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 is 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.

FAIR HEARING REQUEST

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

Reason for Fair Hearing Request: ____

____

____

[ ] Continue my benefits at the level received before this notice until the hearing decision is made, or my SNAP certification period ends. 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 on this notice, knowing that if the hearing decision is in my favor I will be paid for any benefits wrongly denied me.

Signature____ Date: _________________________

WHEN DO I NEED TO REPORT CHANGES?

You must report changes in your household within 10 days of which 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 Alaska Temporary Assistance, Adult Public Assistance, or Medicaid Program benefits, you must report any and all changes to information provided on your application, including changes in your medical insurance. If you receive SNAP benefits and you do not receive benefits for 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 form 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 $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
- Pregnancy changes

CIVIL RIGHTS

The Civil Rights Act of 1974 states, "No person in the United States, on the grounds of race, color, age, sec, handicap, religious creed, political belief 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."

COMPUTER MATCHING AND YOUR SOCIAL SECURITY NUMBER

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 AND FAMILY PLANNING SERVICES

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

Date: 11/25/2022