

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

³
DIVISION OF PUBLIC ASSISTANCE
DEPARTMENT OF HEALTH

STATE OF ALASKA

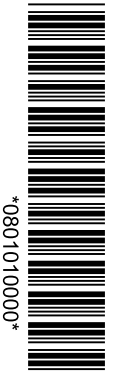
Office Contact: Phone: 1-800-478-7778 Toll-Free
Fax: 1-888-269-6520 Toll-Free

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.



Page intentionally left blank

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

NAME
ADDRESS
CITY STATE ZIP

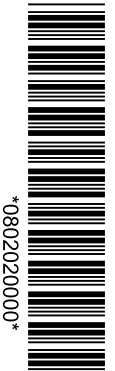
Case Number: 99999999

Case Name: NAME

Document #: 99999999

Date: 99/99/9999

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?

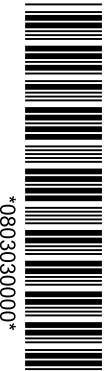
If you need to travel for non-emergency medical treatment, you must have your provider request authorization before you travel. If you are temporarily out of state and need medical treatment, the provider must enroll with the State of Alaska before services will be paid.

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.



8

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:

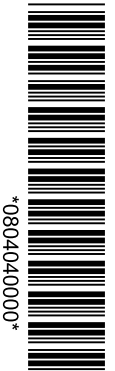
1. contagious diseases, birth defects and cancer;
2. firearm injuries and other trauma events;
3. reactions to problems with medicines or defective medical equipment;
4. to the police when required by law;
5. when the court orders us to;
6. to the government to review how our programs are working;
7. 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	<p>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.</p>			
Fair Hearing Request	<p>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:</p> <hr/> <hr/> <hr/>			
	<p>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.</p> <p>If you do not want to get benefits while you are waiting for a fair hearing decision - Check this box: <input type="checkbox"/></p> <p>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.</p> <p>Signature: _____ Date: _____</p>			
Change Reporting	<p>REPORTING CHANGES TO YOUR HOUSEHOLD CIRCUMSTANCES</p> <p>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.</p>			
	<p>Medicaid: You must report the following changes.</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 33%; padding: 5px; vertical-align: top;"> <ul style="list-style-type: none"> ● 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 </td><td style="width: 33%; padding: 5px; vertical-align: top;"> <ul style="list-style-type: none"> ● 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 </td><td style="width: 33%; padding: 5px; vertical-align: top;"> <ul style="list-style-type: none"> ● Anyone starts, stops, or has changes in health insurance coverage, including Medicare ● Changes in pregnancy ● Marriage or divorce ● Changes in tax filing status </td></tr> </table>	<ul style="list-style-type: none"> ● 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 	<ul style="list-style-type: none"> ● 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 	<ul style="list-style-type: none"> ● Anyone starts, stops, or has changes in health insurance coverage, including Medicare ● Changes in pregnancy ● Marriage or divorce ● Changes in tax filing status
<ul style="list-style-type: none"> ● 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 	<ul style="list-style-type: none"> ● 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 	<ul style="list-style-type: none"> ● 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	<p>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.</p>			
Your SSN	<p>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.</p>			
Well Child Checkups	<p>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.</p>			
Family Planning Services	<p>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.</p>			

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

NAME
ADDRESS
CITY, STATE, ZIP

Case Number: 99999999

Case Name: NAME

Document #: 99999999

Date: 99/99/9999

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.

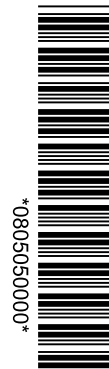
In some situations, you may want to cooperate by providing the information for one child but feel you have good cause not to cooperate for another child in your household. If that is the case, please complete both of the attached forms.

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

<input type="checkbox"/> Married:	Date: _____	Where: _____
<input type="checkbox"/> Married and Separated:	Date of separation: _____	Where: _____
<input type="checkbox"/> Divorce pending:	Date filed and what court: _____	
<input type="checkbox"/> Divorced:	Date final: _____	Where: _____
<input type="checkbox"/> Never married: If the parents never married, has paternity been established by court or administrative order for each child listed? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, please explain: _____		
Is there a custody order regarding the child(ren)? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, provide the following information about the order: State/County: _____ Court/Agency: _____ Date: _____		
Do you have a child support order? <input type="checkbox"/> Yes <input type="checkbox"/> 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

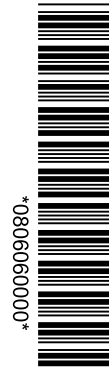
☐ Legal proceedings for adoption are pending

☐ 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



14

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.

0807070000



**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.

Page intentionally left blank

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	<p>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.</p>			
Fair Hearing Request	<p>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:</p> <hr/> <hr/> <hr/>			
	<p>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.</p> <p>If you do not want to get benefits while you are waiting for a fair hearing decision - Check this box: <input type="checkbox"/></p> <p>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.</p> <p>Signature: _____ Date: _____</p>			
Change Reporting	<p>REPORTING CHANGES TO YOUR HOUSEHOLD CIRCUMSTANCES</p> <p>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.</p>			
	<p>Medicaid: You must report the following changes.</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 33%; vertical-align: top;"> <ul style="list-style-type: none"> ● 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 </td> <td style="width: 33%; vertical-align: top;"> <ul style="list-style-type: none"> ● 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 </td> <td style="width: 33%; vertical-align: top;"> <ul style="list-style-type: none"> ● Anyone starts, stops, or has changes in health insurance coverage, including Medicare ● Changes in pregnancy ● Marriage or divorce ● Changes in tax filing status </td> </tr> </table>	<ul style="list-style-type: none"> ● 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 	<ul style="list-style-type: none"> ● 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 	<ul style="list-style-type: none"> ● Anyone starts, stops, or has changes in health insurance coverage, including Medicare ● Changes in pregnancy ● Marriage or divorce ● Changes in tax filing status
<ul style="list-style-type: none"> ● 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 	<ul style="list-style-type: none"> ● 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 	<ul style="list-style-type: none"> ● 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	<p>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.</p>			
Your SSN	<p>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.</p>			
Well Child Checkups	<p>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.</p>			
Family Planning Services	<p>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.</p>			

0808080800



Read and keep this page (Rights and Responsibilities).

Page intentionally left blank