



Application for Services

If you need help filling out this form or have questions, please tell us — we can help!

How do I apply?

Use this application to see what health insurance choices and public assistance programs for which you may qualify. Complete page 7 of this application form with your name, address, and signature to secure a benefit start date.

Apply faster online

- Visit my.alaska.gov to apply online.

How long will it take?

- For Health Insurance choices: Someone will contact you about which health insurance programs you might be eligible for within 1-2 weeks.
- For Public Assistance Services: It may take up to 30 days to process your application.
- For Food Stamps and Temporary Assistance services, your benefit start date begins the date we receive your completed page 7.
- Adult Public Assistance, Denali Care/Denali KidCare, and benefits from other programs may start on a different day.

What you may need to apply for health insurance

- Social Security numbers (or document numbers for any legal immigrants who need insurance)
- Birth dates
- Employer & income information for everyone in your household (for example — paystubs, W-2 tax form - Wage and Tax Statements) Your income and family size help us decide which health insurance programs you qualify for. We need to know about everyone on your tax return (you don't need to file taxes to get health coverage or public assistance services).
- Policy numbers for any current health insurance
- Information about any job-related health insurance available to your family

Do I have to go to an interview?

- For Health Insurance: No.
- For Public Assistance services: Yes. A personal interview is required before we can determine if you are eligible for assistance. You may schedule an interview at the Public Assistance office or with your local Fee Agent. If you cannot attend an interview in person, contact the Public Assistance office so other arrangements can be made. Your application will be denied if you do not attend an interview within 30 days.

Programs

Federally Facilitated Marketplace

Private health insurance plans, free or low-cost savings plan, and tax credits that pay for insurance.

Medicaid/Denali Care/Denali KidCare

Offers medical coverage to families, children, elderly, disabled adults, and pregnant women. Also helps with Medicare Parts A and B premiums.

Chronic & Acute Medical Assistance

Helps people with specific illnesses who don't qualify for Denali Care and have little or no income.

Food Stamps

Helps people buy food.

Temporary Assistance Program

Gives monthly cash payments to eligible families with children.

Adult Public Assistance

Gives monthly cash payments and medical assistance to eligible elderly, blind, and disabled persons.

General Relief Assistance

Helps eligible individuals and families with emergency rent and utility needs. Also helps with burial costs.

Information Page — Read and keep this page for your records.

What you may need to bring to your interview.

<p>Identity:</p> <ul style="list-style-type: none"> <input type="checkbox"/> birth certificate <input type="checkbox"/> driver's license or state identification card <input type="checkbox"/> health benefits identification card <input type="checkbox"/> voter registration card <input type="checkbox"/> passport 	<p>Earned Income:</p> <ul style="list-style-type: none"> <input type="checkbox"/> pay stubs <input type="checkbox"/> statement from employer as to gross wages <input type="checkbox"/> income tax forms <input type="checkbox"/> self-employment bookkeeping records
<p>Residency:</p> <ul style="list-style-type: none"> <input type="checkbox"/> utility bills such as electric, gas and water <input type="checkbox"/> rental agreement or mortgage statement that shows your address 	<p>Unearned Income:</p> <ul style="list-style-type: none"> <input type="checkbox"/> bank statement showing direct deposits <input type="checkbox"/> agency letter showing money received such as Social Security (SSI), Veteran's Affairs benefits (VA), child support, alimony, unemployment, and retirement
<p>Immigration Status:</p> <ul style="list-style-type: none"> <input type="checkbox"/> immigration or naturalization papers (not required if you are only applying for children who were born in the United States) 	<p>Child Support:</p> <ul style="list-style-type: none"> <input type="checkbox"/> paternity, custody and support orders <input type="checkbox"/> divorce or dissolution decrees
<p>Medical Expense Deductions:</p> <p>For households with elderly (age 60 or older), blind, or disabled members only:</p> <ul style="list-style-type: none"> <input type="checkbox"/> billing statements <input type="checkbox"/> itemized medical receipts such as for prescription drugs <input type="checkbox"/> Medicare card indicating Part B coverage <input type="checkbox"/> repayment agreement with physician 	<p>Other Documents Which May be Required:</p> <ul style="list-style-type: none"> <input type="checkbox"/> proof of pregnancy, and due date if someone in your household is pregnant <input type="checkbox"/> proof of application for Supplemental Security Income (SSI) <input type="checkbox"/> eviction notices or utility shut off notice <input type="checkbox"/> court orders (adoption records)

Your appointment is on:

Date/Day _____ Time _____ Phone _____

Location/Interviewer _____ Fax _____

Information Page — Keep this page for your records.

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 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. Food Stamp 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. Food Stamps can continue until a hearing decision is made or until the certification period ends if you request the hearing before the effective date of the action or within 10 days from the date the notice was mailed. If the hearing decision is not in your favor you may be required to repay benefits you received while you waited for the decision.

My right to appeal

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

When do I need to report changes?

You must report changes in your household within 10 days of when you know of the change. If you receive Alaska Temporary Assistance and a child leaves your home, you must report this within 5 days.

What changes do I need to report?

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

If you receive Food Stamps and you do not receive benefits from any other program, you only need to report when your household's total gross income goes over the income limit for your household.

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

- Starting or stopping a job, change in wage rate, change from part-time to full-time, or full-time to part-time
- When money you receive from sources other than working changes by more than \$50
- Someone moves into or out of your home
- You move or get a new mailing address
- Your household gets a vehicle
- Your household has more than \$2250 total in cash and money in bank
- Changes in your child support payment or obligation
- Changes in your medical insurance if you or anyone in your household gets Medicaid
- Pregnancy changes

Will I need to work?

To receive Alaska Temporary Assistance or Food Stamp benefits, you may have to participate in work activities. Alaska Temporary Assistance participants must prepare a Family Self-Sufficiency Plan for becoming financially independent. You must participate in approved work activities unless you qualify for an exemption. If you are an unmarried minor parent, to receive Alaska Temporary Assistance you must live with a parent or in another approved living arrangement and attend school or training. If you do not fulfill these work requirements or minor parent requirements, your benefits may be reduced or ended.

Read and keep this page.

What happens with my Child Support?

Alaska must collect child support and medical support from any parent who has the duty to pay support for a child receiving Alaska Temporary Assistance or Medicaid. This includes any money owed to you at the time you apply, as well as current and future child support payments. Any child support payments given or paid to you while receiving Alaska Temporary Assistance benefits must be reported and turned over to the State immediately. To change a child support order, you must obtain a new court order or get permission from the Child Support Services Division (CSSD). If you believe you have a good reason not to cooperate with CSSD for these programs, you must tell your caseworker immediately. You may be asked to provide information to support your reason.

When you apply for Alaska Temporary Assistance you must:

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

When you apply for Medicaid you must:

- Assign to the State of Alaska all rights to any medical support or other third party payments to the extent the department has paid medical assistance for care and services for you or your minor children.
- Cooperate with and assist the department in identifying and providing information concerning third parties who may be liable to pay for care and services received for you or your minor children.
- Agree to apply for all other available third-party resources that may be used to provide or pay for the cost of care or services received by you or your minor children or that may be used to reimburse the state for the cost of care or services received.
- Cooperate with CSSD in establishing paternity.
- If applying for long-term care services, including Home and Community Based Waiver services, assign to the State of Alaska as a remainder beneficiary, or as the second remainder beneficiary after your spouse or minor or disabled child, for any interest that you may have in an annuity up to the amount of Medicaid benefits received.

Can the State of Alaska take my estate?

The estate of an individual age 55 years of age or older who received Medicaid benefits may be subject to a claim for recovery. This is limited to the reimbursement of services received while the recipient was in a medical institution, including a nursing home or other medical institution, or was receiving home- and community-based services. Under limited conditions, the State of Alaska may place a lien on a recipient's home. However, most estate recovery is conducted after the death of the recipient or the recipient's surviving spouse, if any, and only at a time when the recipient has no surviving child under age 21 and no surviving child who is blind or disabled.

Will someone from the Division of Public Assistance come to my home?

A Division of Public Assistance worker may visit you at home to verify your eligibility for assistance. We may also visit you to complete case management activities such as Family Self-Sufficiency Plans. If you are not completing the activities, we may visit you to determine whether you have good cause for not doing so.

How are my rights protected?

The Division of Public Assistance will collect information, including the Social Security number (SSN) of each household member who is applying for Food Stamps, Alaska Temporary Assistance, or Medicaid, to determine eligibility for public assistance benefits. The Division will verify this information through computer matching programs, including the Income and Earnings Verification System (IEVS). This information will be used to monitor compliance with program regulations and for program management. The Division may disclose this information to other Federal and State agencies for official examination, to law enforcement officials for the purpose of apprehending persons fleeing to avoid the law, and to private claims collection agencies for claims collection action. The Division may verify immigrant status of household members by contacting the U.S. Citizenship and Immigration Services (USCIS). Information obtained from these agencies may affect your eligibility and level of benefits.

Providing the requested information, including the SSN of each household member for whom you are seeking benefits, is voluntary. However, failure to provide this information will result in the denial of benefits to each individual failing to provide an SSN. Any SSN provided will be used and disclosed in the same manner, regardless of the eligibility of the individual. The Division of Public Assistance can assist you in applying for a Social Security Number if you are seeking benefits and do not have one.

Read and keep this page.

When you sign the application for assistance and use Medicaid or Chronic & Acute Medical Assistance coupons, you consent to release medical records and information about yourself and any other person you are applying for to the Department of Health and Social Services (DHSS). Upon request, any person who has medical records and information or the custody of such records shall release those records to the Department or a representative of the department.

Health or medical information DHSS may have about you is protected under the Health Insurance Portability and Accountability Act (HIPAA) of 1996. This federal law provides you with certain rights about how your health information is used and disclosed. The law allows you to find out how DHSS used your health information, and how DHSS has disclosed your health information outside of DHSS. The law also limits the release of information about you to the minimum amount necessary for the purpose of the disclosure and allows you to examine and obtain a copy of your own health records and to request corrections to those records.

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

In accordance with federal law and U.S. Department of Agriculture (USDA) and U.S. Department of Health & Human Services (HHS) policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age, or disability. Under the Food Stamp Act and USDA policy, discrimination is prohibited also on the basis of religion or political beliefs.

To file a complaint of discrimination, contact USDA or HHS. Write to USDA, Director, Office of Civil Rights, Room 326-W, Whitten Building, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410 or call (800) 795-3272 (voice) or (202) 720-6382 (TDD). Or write to HHS Office for Civil Rights, 2201 Sixth Avenue – Mail Stop RX-11, Seattle, WA 98121 or call (800) 368-1019 (voice) or (800) 537-7697 (TDD). USDA and HHS are equal opportunity providers and employers.

If you have questions about the Americans with Disabilities Act of 1990, contact the Division of Public Assistance Civil Rights Coordinator at (907) 465-3347.

Responsibility for Overpayment

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

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.

Food Stamp Program	
<p>I understand that if I...</p> <p>Commit an intentional program violation of the Food Stamp Program defined in 7 CFR 273.16 or any of the following:</p> <ul style="list-style-type: none"> hide information or make false statements use electronic benefit transfer (EBT) cards that belong to someone else use Food Stamp benefits to buy alcohol or tobacco trade or sell benefits or EBT cards 	<p>I may...</p> <ul style="list-style-type: none"> lose Food Stamp benefits for 12 months for the first offense and be required to repay all benefits overpaid to me lose Food Stamp benefits for 24 months for the second offense and be required to repay all benefits overpaid to me lose Food Stamp 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
<ul style="list-style-type: none"> trade Food Stamp benefits for controlled substances, such as drugs 	<ul style="list-style-type: none"> lose Food Stamp benefits for 24 months for the first offense lose Food Stamp benefits permanently for the second offense
<ul style="list-style-type: none"> give false information about who I am and where I live so I can get extra benefits 	<ul style="list-style-type: none"> lose Food Stamp benefits for 10 years for each offense
<ul style="list-style-type: none"> have been convicted of trading or selling food stamps worth more than \$500, or trading food stamps for firearms, ammunition, or explosives 	<ul style="list-style-type: none"> be barred from the Food Stamp Program permanently
Alaska Temporary Assistance Program	
<p>I understand that if I...</p> <ul style="list-style-type: none"> 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 	<p>I may...</p> <ul style="list-style-type: none"> 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
Denali Care Program	
<p>I understand that if I...</p> <ul style="list-style-type: none"> commit an intentional program violation or program abuse that results in misuse or overuse of Denali Care benefits or are found guilty of misconduct related to Medicaid benefits commit Medical Assistance fraud under AS 47.05.210 	<p>I may...</p> <ul style="list-style-type: none"> be required to pay back the amount of Denali Care services that I or anyone in my household received be excluded from Denali Care for up to 10 years have to pay fines up to \$25,000 and be subject to criminal prosecution

Read and keep this page.



Fee Agent Date Received/Signature

DPA Date Received

Application for Services

What kind of help do you need? Check the programs or services you need.

<input type="checkbox"/> Health Insurance Including Medicaid, Denali Care, Denali KidCare, tax credit, private health insurance.	<input type="checkbox"/> Temporary Assistance Monthly cash payment for eligible families with children.
<input type="checkbox"/> Chronic & Acute Medical Assistance Limited medical coverage for persons with specific illness.	<input type="checkbox"/> Adult Public Assistance <input type="checkbox"/> blind or disabled <input type="checkbox"/> elderly assistance
<input type="checkbox"/> Food Stamps Monthly issuance to assist with food costs. Important: You may be eligible for food stamps within seven days – answer questions below.	<input type="checkbox"/> General Relief Assistance Emergency assistance for eligible individuals and families. <input type="checkbox"/> rent or utilities <input type="checkbox"/> burial expenses
<input type="checkbox"/> Other Services <input type="checkbox"/> child support <input type="checkbox"/> child care <input type="checkbox"/> finding work <input type="checkbox"/> prenatal care <input type="checkbox"/> Senior Benefits <input type="checkbox"/> other _____	

Who are you? (Please print)

1. First name, Middle name, Last name, & Suffix		2. Other Names (maiden, nicknames, etc.)	
2. Home address or directions to your house			3. Apartment or suite number
4. City	5. State	6. ZIP code	
8. Mailing address (if different from home address)			9. Apartment or suite number
10. City	11. State	12. ZIP code	
14. Phone number () -		15. Other phone number () -	
16. Do you want to get information about this application by email? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Email address: _____			
17. What is your preferred spoken or written language (if not English)? _____			
18. Answer these questions to see if you can get Food Stamps within seven days			
a. Do you have more than \$100 in cash or money in the bank?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
b. Is your household's monthly gross income (before deductions) less than \$150?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
c. Are your costs for rent/mortgage/utilities more than your monthly gross income, cash and money in the bank?		<input type="checkbox"/> Yes <input type="checkbox"/> No	

Sign here:

Date:

STEP 2

People in your household

Complete for each person in your household.

Start with yourself, and then add others. For more than four people, make a copy of the blank pages and attach. Family members who don't need health coverage or public assistance don't need to provide immigration status or a Social Security number.

19. First name, Middle name, Last name, & Suffix			20. Relationship to you? Self
21. Social Security number ____-____-____	22. Date of birth (mm/dd/yyyy)	22a. Marital Status	23. Sex <input type="checkbox"/> Male <input type="checkbox"/> Female

We need your Social Security Number (SSN) if you want health coverage or public assistance. If you need a SSN, call 1-800-772-1213 or visit socialsecurity.gov. TTY users, call 1-800-325-0778.

24. Do you plan to file a federal income tax return NEXT YEAR? You can apply for health insurance even if you don't file a tax return. Yes. No. Skip to question C

a. Will you file jointly with a spouse? Yes No
Name of spouse: _____

b. Will you claim any dependents on your tax return? Yes No
List name(s) of dependents: _____

c. Will you be claimed as a dependent on someone's tax return? Yes No
List the name of the tax filer: _____ Relation to tax filer? _____

25. Are you pregnant? Yes No How many babies expected this pregnancy? _____ Due date: _____

26. Do you need health coverage or public assistance services for yourself? Even if you have insurance there might be a program with better coverage or lower cost. Yes. No. Skip questions 27-36.

27. Do you have a physical, mental, or emotional health condition that causes limitations (like bathing, dressing, chores) or live in a medical facility or nursing home? Yes No

28. Are you a U.S. citizen or U.S. national? Yes No

29. If you aren't a U.S. citizen or national, do you have eligible immigration status? Yes No

Fill in your document type and ID number below.

a. Immigration document type: _____ Document ID number: _____ Yes No

b. Have you lived in the U.S. since August 22, 1996? Yes No

c. Are you, your spouse, or parent a veteran or active-duty member of the U.S. military? Yes No

30. Do you want help paying for medical bills from the last 3 months? Yes No

31. Do you have medical costs due to an accident? Yes No

32. Do you live with a child under age 19, for whom you are the primary caretaker? Yes No

33. Are you a full-time student? Yes No

34. Were you in foster care at age 18 or older? Yes No

35. If Hispanic/Latino, ethnicity (OPTIONAL—check all that apply.)

Mexican Mexican American Chicano/a Puerto Rican Cuban Other _____

36. Race (OPTIONAL—check all that apply.)

<input type="checkbox"/> White	<input type="checkbox"/> American Indian	<input type="checkbox"/> Filipino	<input type="checkbox"/> Vietnamese	<input type="checkbox"/> Guamanian or Chamorro
<input type="checkbox"/> Black or African American	<input type="checkbox"/> Asian Indian	<input type="checkbox"/> Japanese	<input type="checkbox"/> Other Asian	<input type="checkbox"/> Samoan
<input type="checkbox"/> Alaska Native	<input type="checkbox"/> Chinese	<input type="checkbox"/> Korean	<input type="checkbox"/> Native Hawaiian	<input type="checkbox"/> Other Pacific Islander
				<input type="checkbox"/> Other _____

Answer the questions for the next person in your household.

37. First name, Middle name, Last name, & Suffix _____

38. Relationship to you? _____

39. Social Security number _____

40. Date of birth (mm/dd/yyyy) _____

40a. Marital Status _____

41. Sex Male Female

We need this person's Social Security Number (SSN) if they want health coverage or public assistance. If they need a SSN, call 1-800-772-1213 or visit socialsecurity.gov. TTY users, call 1-800-325-0778.

42. Does this person plan to file a federal income tax return NEXT YEAR? They can apply for health insurance even if they don't file a tax return.

 Yes. No. Skip to question C

a. Will this person file jointly with a spouse?

 Yes No

Name of spouse: _____

b. Will this person claim any dependents on their tax return?

 Yes No

List name(s) of dependents: _____

c. Will this person be claimed as a dependent on someone's tax return?

 Yes No

List the name of the tax filer: _____

Relation to tax filer? _____

43. Is this person pregnant? Yes No How many babies expected this pregnancy? _____ Due date: _____

44. Does this person need health coverage or public assistance services? Even if they have insurance there might be a program with better coverage or lower cost.

 Yes. No. Skip questions 45-54.

45. Does this person have a physical, mental, or emotional health condition that causes limitations (like bathing, dressing, chores) or live in a medical facility or nursing home?

 Yes No

46. Is this person a U.S. citizen or U.S. national?

 Yes No

47. If this person is not a U.S. citizen or national, do they have eligible immigration status?

 Yes No

Fill in their document type and ID number below.

a. Immigration document type: _____ Document ID number: _____

b. Has this person lived in the U.S. since August 22nd, 1996?

 Yes No

c. Is this person, their spouse, or parent a veteran or active-duty member of the U.S. military?

 Yes No

48. Does this person want help paying for medical bills from the last 3 months?

 Yes No

49. Does this person have medical costs due to an accident?

 Yes No

50. Does this person live with a child under age 19, for whom they are the primary caretaker?

 Yes No

51. Is this person a full-time student?

 Yes No

52. Was this person in foster care at age 18 or older?

 Yes No

53. If Hispanic/Latino, ethnicity (OPTIONAL—check all that apply.)

 Mexican Mexican American Chicano/a Puerto Rican Cuban Other _____

54. Race (OPTIONAL—check all that apply.)

 White American Indian Filipino Vietnamese Guamanian or Chamorro Black or African American Asian Indian Japanese Other Asian Samoan Alaska Native Chinese Korean Native Hawaiian Other Pacific Islander Other _____

Answer the questions for the next person in your household.

55. First name, Middle name, Last name, & Suffix _____ 56. Relationship to you? _____

57. Social Security number _____ 58. Date of birth (mm/dd/yyyy) _____ 58a. Marital Status _____ 59. Sex Male Female

We need this person's Social Security Number (SSN) if they want health coverage or public assistance. If they need a SSN, call 1-800-772-1213 or visit socialsecurity.gov. TTY users, call 1-800-325-0778.

60. Does this person plan to file a federal income tax return NEXT YEAR? They can apply for health insurance even if they don't file a tax return. Yes. No. Skip to question C

a. Will this person file jointly with a spouse? Yes No

Name of spouse: _____

b. Will this person claim any dependents on their tax return? Yes No

List name(s) of dependents: _____

c. Will this person be claimed as a dependent on someone's tax return? Yes No

List the name of the tax filer: _____ Relation to tax filer? _____

61. Is this person pregnant? Yes No How many babies expected this pregnancy? _____ Due date: _____

62. Does this person need health coverage or public assistance services? Even if they have insurance there might be a program with better coverage or lower cost. Yes. No. Skip questions 63-72.

63. Does this person have a physical, mental, or emotional health condition that causes limitations (like bathing, dressing, chores) or live in a medical facility or nursing home? Yes No

64. Is this person a U.S. citizen or U.S national? Yes No

65. If this person is not a U.S. citizen or national, do they have eligible immigration status? Yes No

Fill in their document type and ID number below.

a. Immigration document type: _____ Document ID number: _____

b. Has this person lived in the U.S. since August 22nd, 1996? Yes No

c. Is this person, their spouse, or parent a veteran or active-duty member of the U.S. military? Yes No

66. Does this person want help paying for medical bills from the last 3 months? Yes No

67. Does this person have medical costs due to an accident? Yes No

68. Does this person live with a child under age 19, for whom they are the primary caretaker? Yes No

69. Is this person a full-time student? Yes No

70. Was this person in foster care at age 18 or older? Yes No

71. If Hispanic/Latino, ethnicity (OPTIONAL—check all that apply.)

Mexican Mexican American Chicano/a Puerto Rican Cuban Other _____

72. Race (OPTIONAL—check all that apply.)

White American Indian Filipino Vietnamese Guamanian or Chamorro
 Black or African American Asian Indian Japanese Other Asian Samoan
 Alaska Native Chinese Korean Native Hawaiian Other Pacific Islander
 Other _____

Answer the questions for the next person in your household.

73. First name, Middle name, Last name, & Suffix _____ 74. Relationship to you? _____

75. Social Security number _____ 76. Date of birth (mm/dd/yyyy) _____ 76a. Marital Status _____ 77. Sex Male Female

We need this person's Social Security Number (SSN) if they want health coverage or public assistance. If they need a SSN, call 1-800-772-1213 or visit socialsecurity.gov. TTY users, call 1-800-325-0778.

78. Does this person plan to file a federal income tax return NEXT YEAR? They can apply for health insurance even if they don't file a tax return. Yes. No. Skip to question C

a. Will this person file jointly with a spouse? Yes No
Name of spouse: _____

b. Will this person claim any dependents on their tax return? Yes No
List name(s) of dependents: _____

c. Will this person be claimed as a dependent on someone's tax return? Yes No
List the name of the tax filer: _____ Relation to tax filer? _____

79. Is this person pregnant? Yes No How many babies expected this pregnancy? _____ Due date: _____

80. Does this person need health coverage or public assistance services? Even if they have insurance there might be a program with better coverage or lower cost. Yes. No. Skip questions 81-90.

81. Does this person have a physical, mental, or emotional health condition that causes limitations (like bathing, dressing, chores) or live in a medical facility or nursing home? Yes No

82. Is this person a U.S. citizen or U.S national? Yes No

83. If this person is not a U.S. citizen or national, do they have eligible immigration status? Yes No
Fill in their document type and ID number below.

a. Immigration document type: _____ Document ID number: _____

b. Has this person lived in the U.S. since August 22nd, 1996? Yes No

c. Is this person, their spouse, or parent a veteran or active-duty member of the U.S. military? Yes No

84. Does this person want help paying for medical bills from the last 3 months? Yes No

85. Does this person have medical costs due to an accident? Yes No

86. Does this person live with a child under age 19, for whom they are the primary caretaker? Yes No

87. Is this person a full-time student? Yes No

88. Was this person in foster care at age 18 or older? Yes No

89. If Hispanic/Latino, ethnicity (OPTIONAL—check all that apply.)

Mexican Mexican American Chicano/a Puerto Rican Cuban Other _____

90. Race (OPTIONAL—check all that apply.)

<input type="checkbox"/> White	<input type="checkbox"/> American Indian	<input type="checkbox"/> Filipino	<input type="checkbox"/> Vietnamese	<input type="checkbox"/> Guamanian or Chamorro
<input type="checkbox"/> Black or African American	<input type="checkbox"/> Asian Indian	<input type="checkbox"/> Japanese	<input type="checkbox"/> Other Asian	<input type="checkbox"/> Samoan
<input type="checkbox"/> Alaska Native	<input type="checkbox"/> Chinese	<input type="checkbox"/> Korean	<input type="checkbox"/> Native Hawaiian	<input type="checkbox"/> Other Pacific Islander
				<input type="checkbox"/> Other _____

STEP 3

Income in your household

If you need more space, attach another sheet of paper providing all information asked below. Tell us about your income.

JOB 1

91. Name (First name, Middle name, Last name)	a. Employer Name:
b. Employer Address:	
c. Employer Phone Number:	d. Supervisor's Name:
e. Wages / tips (before taxes):	f. Average hours per WEEK
g. How often are you paid: <input type="checkbox"/> Weekly <input type="checkbox"/> Every 2 Weeks <input type="checkbox"/> Twice Monthly <input type="checkbox"/> Monthly <input type="checkbox"/> Yearly <input type="checkbox"/> Other	

JOB 2

92. Name (First name, Middle name, Last name)	a. Employer Name:
b. Employer Address:	
c. Employer Phone Number:	d. Supervisor's Name:
e. Wages / tips (before taxes):	f. Average hours per WEEK
g. How often are you paid: <input type="checkbox"/> Weekly <input type="checkbox"/> Every 2 Weeks <input type="checkbox"/> Twice Monthly <input type="checkbox"/> Monthly <input type="checkbox"/> Yearly <input type="checkbox"/> Other	

JOB 3

93. Name (First name, Middle name, Last name)	a. Employer Name:
b. Employer Address:	
c. Employer Phone Number:	d. Supervisor's Name:
e. Wages / tips (before taxes):	f. Average hours per WEEK
g. How often are you paid: <input type="checkbox"/> Weekly <input type="checkbox"/> Every 2 Weeks <input type="checkbox"/> Twice Monthly <input type="checkbox"/> Monthly <input type="checkbox"/> Yearly <input type="checkbox"/> Other	

JOB 4

94. Name (First name, Middle name, Last name)	a. Employer Name:
b. Employer Address:	
c. Employer Phone Number:	d. Supervisor's Name:
e. Wages / tips (before taxes):	f. Average hours per WEEK
g. How often are you paid: <input type="checkbox"/> Weekly <input type="checkbox"/> Every 2 Weeks <input type="checkbox"/> Twice Monthly <input type="checkbox"/> Monthly <input type="checkbox"/> Yearly <input type="checkbox"/> Other	

Please answer the following questions about income.

95. For self-employed household members, please answer the following questions (if you have more jobs and need more space, attach another sheet of paper).

a. Include money from all self-employment jobs received this month or that will be received next month. Please check all boxes that apply.

<input type="checkbox"/> B&B/Rent Rooms	<input type="checkbox"/> Crafts/Carving	<input type="checkbox"/> Odd Jobs	<input type="checkbox"/> Taxi Driving
<input type="checkbox"/> Carpenter	<input type="checkbox"/> Commercial Fishing	<input type="checkbox"/> Repair Person	<input type="checkbox"/> Trapping
<input type="checkbox"/> Child Care/Babysitting	<input type="checkbox"/> Manage Rental Property	<input type="checkbox"/> Sales Person	<input type="checkbox"/> Other

For all the items checked on part a, please fill in the boxes below:

Household Member Who is Self-Employed	Type of Business	Seasonal, Year-round	Business Income This Month	Business Income Next Month	Business Expenses This Month	Business Expenses Next Month
Example: Joe Smith	Fishing	Seasonal	\$900	\$900	\$100	\$100

96. In the past 2 months, did anyone in the household: Change jobs Stop working Start working fewer hours None of these

Name (s): _____

97. OTHER INCOME: Check all that apply, and give person name, amount received, and how often it is received.

NOTE: For Health Insurance only applications, you don't need to tell us about child support, Veteran's payment or Supplemental Security Income (SSI).

<input type="checkbox"/> None	<input type="checkbox"/> Net Rental/Royalty	<input type="checkbox"/> Net Fishing/Farming
<input type="checkbox"/> Alimony	<input type="checkbox"/> Pension/Retirement Benefits	<input type="checkbox"/> Social Security Benefits
<input type="checkbox"/> Child Support	<input type="checkbox"/> Supplemental Security Income	<input type="checkbox"/> Unemployment Benefits
<input type="checkbox"/> Unemployment Benefits	<input type="checkbox"/> Veteran's Benefits	<input type="checkbox"/> Other _____

For all the items checked above, please fill in the boxes below:

Who Receives the Payment?	Type of Payment	Amount This Month	Amount Expected Next Month	How Often?
Example: Joe Smith	Unemployment	\$400	\$400	Every 2 weeks

98. DEDUCTIONS: Check all that apply, and give person name, amount received, and how often it is received.

If a household member pays for certain things that can be deducted on a federal income tax return, telling us about them could make the cost of health insurance a little lower.

NOTE: You shouldn't include a cost that you already considered in your answers to net self-employment (question 29).

<input type="checkbox"/> Alimony	Name(s) _____	\$ _____	How often? _____
<input type="checkbox"/> Student loan interest	Name(s) _____	\$ _____	How often? _____
<input type="checkbox"/> Other deductions	Name(s) _____	\$ _____	How often? _____

Type: _____

99. YEARLY INCOME: Complete only if the income you listed changes from month to month.

Name of person(s) _____ Total income this year \$ _____ Next year (if different) \$ _____

Name of person(s) _____ Total income this year \$ _____ Next year (if different) \$ _____

100. Does any person applying for health insurance or public assistance services expect any changes in any of their income or employment (new income or employment not provided)? Yes No

If yes, please explain: _____

STEP 4 Alaska Native or American Indian (AN/AI) family members

101. Are you or is anyone in your family Alaska Native or American Indian?

No, skip to Step 5. Yes, please complete Appendix B.

STEP 5 Your Family's Health Coverage

Answer these questions for anyone who needs health coverage.

102. Is anyone enrolled in health coverage from the following? Yes No

Check the type of coverage and write the person(s) name(s) next to the coverage they have.

Denali Care _____ Employer insurance _____
 Denali KidCare _____ Name of health insurance _____
 Medicare _____ Policy number: _____
 TRICARE (don't check if you have direct care or line of duty) Is this COBRA coverage? Yes No
Is this retiree health plan? Yes No
 Other: Name of insured: _____ Peace Corps _____
Policy number: _____ VA health care _____
Name of health insurance: _____ Is this a limited-benefit plan (like a school accident policy)? Yes No

103. 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. Please complete and include Appendix A.
 No.

STEP 6 Stop if applying only for Health Insurance

Stop here if applying **ONLY** for health insurance, then **CONTINUE** to Steps 8 & 9 to read, sign and return application. If you are applying for other public assistance services then continue to Step 7.



STEP 7 Assets, Expenses, Resources, and Other

If you need more space, attach another sheet of paper providing all information asked below.

104. Does any person applying for health insurance or other public assistance services own any property such as a house, land, apartment, mobile home, duplex, condo, camper or cabin? Yes No

If yes, complete the information below. Include any property that is paid for, you are still paying for, or that is owned with someone else.

Who Owns the Property?	Type of Property Owned	Estimated Value	Amount Owed
Example: Joe Smith	Condo	\$75,000	\$70,000

105. Do you, or anyone who lives with you, own any vehicles such as a car, truck, motorcycle, boat, snowmobile, personal watercraft, aircraft, recreational vehicle (RV) or all-terrain vehicle (ATV)? Yes No

Please complete the information below. Include any vehicles that are paid for, you are paying for, or are owned with someone else. Also include vehicles that are not running or that you are not using.

Who Owns the Vehicle?	Vehicle Type, Model and Year	What is Vehicle Used for?	Estimated Value	Amount Still Owed
Example: Joe Smith	1987 Ford Escort	Work	\$800	\$200

106. Do you, or anyone who lives with you, have any of the items below? Yes No

Check the boxes that apply. Include items owned with someone else and accounts with no money in them right now.

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> Annuities | <input type="checkbox"/> College Savings Plan | <input type="checkbox"/> Mineral Rights | <input type="checkbox"/> Savings Account |
| <input type="checkbox"/> Burial Policy Agreement | <input type="checkbox"/> Credit Union Accounts | <input type="checkbox"/> Native Corporation Shares | <input type="checkbox"/> Stocks/Bonds |
| <input type="checkbox"/> Cash on Hand | <input type="checkbox"/> Commercial Fishing Permit | <input type="checkbox"/> Pension Plan | <input type="checkbox"/> Trust Funds |
| <input type="checkbox"/> Certificate of Deposit | <input type="checkbox"/> IRA Account | <input type="checkbox"/> Retirement Funds | <input type="checkbox"/> Other |
| <input type="checkbox"/> Checking Account | <input type="checkbox"/> Life Insurance Policy | <input type="checkbox"/> Safe Deposit Box | _____ |

107. For all items checked above, please fill in the boxes below:

Who Owns the Item?	Type of Item	Where Held?	Account Number	Total Value/ Balance
Example: Jane Smith	Checking Account	Frontier Bank	452231	\$300

108. Have you, or anyone in your household, sold, given away, or transferred any property, vehicles or other resources in the past five years? Yes, please complete the information below. No

Who Owned It?	Vehicle, Property, or Resource	Sold, Gave Away, or Transferred?	When?	Estimated Value
Example: Joe Smith	Truck	Gave Away	May 2005	\$4,000

109. What are your shelter expenses? Check the boxes that apply and fill in the amount that you are required to pay.

Do not enter amounts paid by housing assistance such as HUD, ASHA, AHFC or Section 8.

Rent \$ _____ per month Mobile Home Lot or Space Rent \$ _____ per month
 Mortgage \$ _____ per month

110. What shelter expenses are billed separately from your rent or mortgage?

Home/Renters Insurance \$ _____ per _____ Property Taxes \$ _____ per _____
 Condo/Association Fees \$ _____ per _____ Other (such as deposits) \$ _____ per _____

111. Check the boxes next to the utility bills your household is responsible for paying monthly:

Heat (such as gas, electric, propane, wood, etc.) \$ _____ Sewer \$ _____ Telephone \$ _____
 Water \$ _____ Electricity \$ _____ Garbage \$ _____ Other \$ _____

112. Does your household receive LIHEAP or does your household expect to receive LIHEAP ? Yes No

113. Does any person work for or get help with food, shelter, utilities, or other expenses that are not paid in cash? Yes No

Please explain: _____

114. Does a person or agency help pay all or part of your shelter costs (like housing or heating assistance)? Yes No

Who pays? _____ What expense? _____ Amount paid? _____

115. Does anyone in your household have child care, elderly or disabled adult care expenses? Yes No

Who is responsible for paying? _____

Who is it for? _____ Monthly Amount \$ _____

116. Does anyone in your household pay child support? Yes No

Who pays? _____ Monthly Amount \$ _____

117. Does anyone in your household who is disabled or age 60 or older, have medical expenses? Yes No

Who has the expense? _____ Monthly Amount \$ _____

118. Has anyone in your household received public assistance (Temporary Assistance, cash, food stamps, Medicaid, Food Yes No

Distribution Program on Indian Reservations FDPIR) in Alaska or any other state?

If yes, who, when and where? _____

Felony Convictions

119. Has anyone been convicted of any of the following types of felonies? Yes No

Drug-related felony? Date of conviction: _____ Who and where? _____

Making a false statement about where you live in order to receive assistance from two or more states at the same time.

Date of conviction: _____ Who and where? _____

120. Is any adult in your household fleeing from prosecution, custody, confinement for a felony or class A misdemeanor Yes No

from any state? If yes, who? _____

121. Have you or any member of your household been convicted of trading Food Stamp benefits for drugs after Yes No

September 22, 1996? If yes, who and when? _____

122. Have you or any member of your household been convicted of buying or selling Food Stamp benefits over \$500 Yes No

after September 22, 1996? If yes, who and when? _____

123. Have you or any member of your household been convicted of fraudulently receiving duplicate Food Stamp Yes No

benefits in any State after September 22, 1996? If yes, who and when? _____

124. Have you or any member of your household been convicted of trading Food Stamp benefits for guns, ammunitions, Yes No

or explosives after September 22, 1996? If yes, who and when? _____

Do you live in areas where getting to food stores is difficult and often rely on subsistence hunting and fishing for your food needs? If you are in this situation, you may use food stamp benefits to buy subsistence hunting and fishing items. These items include nets, lines, hooks, fishing rods, harpoons, and knives, but not firearms, ammunition, clothing, shelter, or fuel. Do you want to use food stamps to buy subsistence hunting and fishing items? Yes No

If yes, sign here: _____
Signature of Adult Household Member Date

STEP 8

Release of Information

Your signature gives the Federally Facilitated Marketplace, the Department of Health and Social Services, its agents, and the Department of Law permission to ask for information about your health, finances, family and personal history. This information is only used in the administration of public assistance programs and will not be released to any other person or agency outside of the Federally Facilitated Marketplace, Department of Health and Social Services 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 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. 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.

For persons who will receive health care authorized by the Federally Facilitated Marketplace:

To make it easier to determine my eligibility for help paying for health coverage in future years, I agree to allow the Marketplace to use income data, including information from tax returns. The Marketplace will send me a notice, let me make any changes, and I can opt out at any time.

Yes, renew my eligibility automatically for the next: 5 years (max allowed) 4 years 3 years 2 years 1 year
 Don't use tax return information to renew my coverage.

If anyone on this application is eligible for Denali Care:

- I am giving the State Denali Care agency the rights to pursue and get any money from other health insurance, legal settlements, or other third parties. I am also giving to the Denali Care agency rights to pursue and get medical support from a spouse or parent.
- I know that I must tell the Health Insurance Marketplace and or the Public Assistance office by phone, in person or in writing if anything changes and if anything is different than what I wrote on this application I understand that a change in my information could affect the eligibility for the member(s) of my household.
- I know that under federal law, discrimination isn't permitted on the basis of race, color, national origin, sex, age, sexual orientation, gender identity, or disability. I can file a complaint of discrimination by visiting www.hhs.gov/ocr/office/file.
- If yes, I know I will be asked to cooperate with the agency that collects medical and temporary assistance support from an absent parent. If I think that cooperating to collect medical support will harm me or my children, I can tell the Division of Public Assistance and I may not have to cooperate. Please see Appendix D.

Does any child on this application have a parent living outside of the home?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
I agree to cooperate with child support requirements.	Yes <input type="checkbox"/>	No <input type="checkbox"/>

I confirm that no one applying for health insurance on this application is incarcerated (detained or jailed).

If this is incorrect, who is incarcerated? _____

The person who filled out step 1 should sign this application. If you're an authorized representative, you may sign here, as long as you have provided the information required in Appendix C.

Sign this application: _____
Signature Date (month/day/year)

Sign this application: _____
Signature Date (month/day/year)

STEP 9

Statement of Truth

Under penalty of perjury, I certify that all information contained in this application, including U.S. citizenship or lawful immigrant status of all persons applying for benefits, is true and correct to the best of my knowledge.

I have read or heard 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.

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

Signature of Other Adult Applicant: _____
Signature Date (month/day/year)

Signature of Witness, if signed with an 'X': _____
Signature Date (month/day/year)

STEP 10

Contact People and Organizations

Why do you need to complete this form?

To determine your eligibility for assistance, we may need to contact people or organizations that can answer questions about your situation. By completing this form, you are allowing us to contact the people and organizations you provide.

What questions do we ask?

We often ask questions about where you live, who lives with you, and your household's income and resources. We may also ask for information about a child's parent not living in the home.

What information do we provide them?

When we contact these people or organizations, we tell them our name and title. We also tell them that we work for the Division of Public Assistance. We do not give them any information about you or your public assistance services.

Information about two people who know you well:

Name and Relation to You	Mailing Address	Daytime Phone

Information about your landlord:

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.

Take the Employer Coverage Tool on the next page to the employer who offers coverage to help you answer these questions. You only need to include this page when you send in your application, not the Employer Coverage Tool.

EMPLOYEE Information

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

EMPLOYER Information

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

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

Yes (Continue)

13a. If you're in a waiting or probationary period, when can you enroll in coverage? _____
List the names of anyone else who is eligible for coverage from this job. (mm/dd/yyyy)

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 A: Employer Coverage Tool

Use this tool to help answer questions in Appendix A about any employer health coverage that you're eligible for (even if it's from another person's job, like a parent or spouse). The information in the numbered boxes below match the boxes on Appendix A. For example, the answer to question 14 on this page should match question 14 on Appendix A.

Write your name and Social Security number in boxes 1 and 2 and ask the employer to fill out the rest of the form. Complete one tool for each employer that offers health coverage.



EMPLOYEE Information

The employee needs to fill out this section.

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



EMPLOYER Information

Ask the employer for this information.

3. Employer name	4. Employer Identification Number (EIN) ____ - _____	
5. Employer address (the Marketplace will send notices to this 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. Is the employee currently eligible for coverage offered by this employer, or will the employee be eligible in the next 3 months?

Yes (Continue)

13a. If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage? _____ (mm/dd/yyyy) (Continue)

No (STOP and return this form to employee)

Tell us about the health plan offered by this employer.

Does the employer offer a health plan that covers an employee's spouse or dependent?

Yes. Which people? Spouse Dependent(s)

No

(Go to question 14)

14. Does the employer offer a health plan that meets the minimum value standard*?

Yes (Go to question 15) No (STOP and return form to employee)

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 didn't 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

If the plan year will end soon and you know that the health plans offered will change, go to question 16. If you don't know, STOP and return form to employee.

16. What change will the employer make for the new plan year?

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)

APPENDIX B

American Indian or Alaska Native Family Member (AI/AN)

Complete this appendix if you or a family member are American Indian or Alaska Native. Submit this with your application for services.

Tell us about your American Indian or Alaska Native family member(s).

American Indians and Alaska Natives can get services from the Indian Health Services, tribal health programs, or urban Indian health programs. They also may not have to pay cost sharing and may get special monthly enrollment periods. Answer the following questions to make sure your family gets the most help possible.

NOTE: If you have more people to include, make a copy of this page and attach.

	AI/AN PERSON 1		AI/AN PERSON 2	
	First	Middle	First	Middle
1. Name (First name, Middle name, Last name)	Last		Last	
2. Member of a federally recognized tribe?	<input type="checkbox"/> Yes If yes, tribe name _____ <input type="checkbox"/> No		<input type="checkbox"/> Yes If yes, tribe name _____ <input type="checkbox"/> No	
3. Has this person ever gotten a service from the Indian Health Service, a tribal health program, or urban Indian health program, or through a referral from one of these programs?	<input type="checkbox"/> Yes <input type="checkbox"/> No If no, is this person eligible to get services from the Indian Health Service, tribal health programs, or urban Indian health programs, or through a referral from one of these programs? <input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No If no, is this person eligible to get services from the Indian Health Service, tribal health programs, or urban Indian health programs, or through a referral from one of these programs? <input type="checkbox"/> Yes <input type="checkbox"/> No	
4. Certain money received may not be counted for Denali Care or the Children's Health Insurance Program (DKC). List any income (amount and how often) reported on your application that includes money from these sources: <ul style="list-style-type: none"> Per capita payments from a tribe that come from natural resources, usage rights, leases, or royalties Payments from natural resources, farming, ranching, fishing, leases, or royalties from land designated as Indian trust land by the Department of Interior (including reservations and former reservations) Money from selling things that have cultural significance 	\$ _____ How often? _____		\$ _____ How often? _____	

APPENDIX C

Assistance with Completing this Application

You can choose an authorized representative.

You can give a trusted person permission to talk about this application with us, see your information, and act for you on matters related to this application, including getting information about your application and signing your application on your behalf. This person is called an “authorized representative.” If you ever need to change your authorized representative, contact the Marketplace. If you’re a legally appointed representative for someone on this application, submit proof with the application.

1. Name of authorized representative (First name, Middle name, Last name)		
2. Address		3. Apartment or suite number
4. City	5. State	6. ZIP code
7. Phone number () -		
8. Organization name		9. ID number (if applicable)
By signing, you allow this person to sign your application, get official information about this application, and act for you on all future matters with this agency.		
10. Your signature		11. Date (mm/dd/yyyy)

For certified application counselors, navigators, agents, and brokers only.

Complete this section if you’re a certified application counselor, navigator, agent, or broker filling out this application for somebody else.

1. Application start date (mm/dd/yyyy)	
2. First name, Middle name, Last name, & Suffix	
3. Organization name	4. ID number (if applicable)

APPENDIX D: Child Support Information

APPENDIX D: CHILD SUPPORT INFORMATION PLEASE PRINT IN INK.

Complete a form for each noncustodial parent. The information will be used to establish and/or enforce child 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	Absent Parent Full name	Are both parents on birth certification?
					Yes No
					Yes No
					Yes No

Non-custodial parents: 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 children?
 _____ Type/Policy: ___ Union member? ___ Tribe or Native Corporation member? ___

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 children? 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 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 _____

Voter Registration

You may register to vote in Alaska if:

1. You are a United States citizen.
2. You are a resident of Alaska.
3. You are at least 18 years of age or will be 18 within 90 days of completing the registration application.
4. You are not a convicted felon, unless you have been unconditionally discharged.
5. You are not registered in another state, unless you cancel that registration. (There is an area on the Alaska registration application for you to cancel if needed).

Important Notices

1. Applying to register or declining to register to vote will not affect the services or the amount of benefits that you will be provided by this agency.
2. If you would like help filling out the voter registration form, we will help you. The decision whether to seek or accept help is yours. You may fill out the registration form in private.
3. If you decline to register to vote, your decision will be confidential. If you choose to register to vote, the office at which your voter registration application is submitted will remain confidential and will be used only for your voter registration purposes.
4. If you believe that someone has interfered with your right to register or to decline to register to vote, your right to privacy in deciding whether to register or in applying to register to vote, or your right to choose your own political party or other political preference, you may file a complaint with the Director of the Division of Elections by calling 907-465-4611, or toll-free at 866-952-8683 or you may write to: Director, Division of Elections, PO Box 110017, Juneau, AK 99811-0017.

If you are not registered where you live now, would you like to apply to register to vote here today? (Check one)

- Yes. I would like to register to vote. (Please fill out the attached registration application.)
- No. I do not want to register to vote.

Note: If you do not check either box, you will be considered to have decided NOT to register to vote at this time.

Name of Applicant

Date

This form will be retained with this agency.

Completed voter registration applications will be mailed to the Division of Elections.

STATE OF ALASKA VOTER REGISTRATION APPLICATION

Refer to instructions on the reverse side for specific information and identification requirements.

Please print clearly in blue or black ink.

<p>1. You MUST complete this section for registration.</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No I am a citizen of the United States.</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No I am at least 18 years old or will be within 90 days of completing this application.</p> <p>If you checked NO to either question, do not complete this form as you are not eligible to register to vote.</p>					
<p>2. Last Name</p>		<p>First Name</p>		<p>Middle Initial</p>	<p>Suffix (Sr., Jr., etc.)</p>
<p>3. Former Name: (If your name has changed)</p>					
<p>4. You MUST provide the Alaska residence address where you claim residency. Do not use PO, PSC, HC or RR.</p>					
				ALASKA	
House #	Street Name		Apt #	City	State
<p>*<input type="checkbox"/> Keep my residence address confidential. (Your mailing address in section 5 must be DIFFERENT from your residence address in section 4 to remain confidential.)</p>					
<p>5. Mailing Address:</p> <p>_____</p> <p>_____</p> <p>_____</p>		<p>10. <input type="checkbox"/> I am a voter with a disability and would like information on alternative voting methods.</p>			
		<p>11. <input type="checkbox"/> I am interested in serving as an election official. (Provide your phone number and/or email address in section 12.)</p>			
		<p>12. *Daytime Phone No. _____</p> <p>*Evening Phone No. _____</p> <p>*Email Address _____</p>			
<p>6. You MUST provide at least ONE</p> <p>*Social Security No. _____/_____/_____</p> <p>*Last 4 Digits of Social Security No. _____</p> <p>*Alaska Driver's License No. _____</p> <p>*Alaska State ID Card No. _____</p> <p><input type="checkbox"/> I have not been issued a Social Security, Alaska Driver's License or State ID number.</p>		<p>13. Political Affiliation For information on political types see reverse No. 5.</p> <p><u>Select only ONE Below</u></p> <p>Political Parties:</p> <p><input type="checkbox"/> Alaska Democratic Party</p> <p><input type="checkbox"/> Alaska Libertarian Party</p> <p><input type="checkbox"/> Alaska Republican Party</p> <p><input type="checkbox"/> Alaskan Independence Party</p> <p>or Political Groups:</p> <p><input type="checkbox"/> Green Party of Alaska</p> <p><input type="checkbox"/> Alaska Constitution Party</p> <p><input type="checkbox"/> Veterans Party of Alaska</p> <p>or Other:</p> <p><input type="checkbox"/> Nonpartisan (no party affiliation)</p> <p><input type="checkbox"/> Undeclared (no party declared)</p> <p><input type="checkbox"/> _____</p>			
<p>7. You MUST provide</p> <p>*Date of Birth _____/_____/_____</p> <p style="text-align: center;"><small>Month Day Year</small></p>					
<p>8. *AK Voter Number _____</p> <p style="text-align: center;"><small>(If known)</small></p>					
<p>9. Sex <input type="checkbox"/> Male <input type="checkbox"/> Female</p>					
<p>14. If you are registered to vote in another state, you MUST cancel that registration by providing the following:</p> <p>City: _____ State: _____ County: _____ Zip Code: _____</p>					
<p>Voter Certificate. Read and Sign: I certify, under penalty of perjury, that the above information I provided on this document is true and correct. I am not registered to vote in another state, or I have provided information to cancel that registration. I further certify that I am a resident of Alaska and I have not been convicted of a felony, or having been so convicted, have been unconditionally discharged from incarceration, probation and/or parole.</p> <p>WARNING: If you provide false information on this application you can be convicted of a misdemeanor AS 15.56.050.</p>					
<p>*SIGNATURE: _____</p>		<p>DATE: _____</p>			
<p>Registrar/Agency/Official – Check ID and complete this section</p>			<p>For Office Use Only</p>		
<p>Registrar Name _____</p> <p>OR</p> <p>Agency Name _____</p>	<p style="font-size: 24pt; font-weight: bold;">NVRA Agency</p>		<p>VN _____</p>	<p>D/P _____</p>	

*Items are kept confidential by the Division of Elections and are not available for public inspection except that confidential addresses may be released to government agencies or during election processes as set out in state law.



State of Alaska Division of Elections

Voter Registration Application

To register to vote in Alaska you must be a U.S. Citizen, a resident of Alaska, and at least 18 years old or will be 18 years old within 90 days of completing this application.

Initial registration or registration changes must be made at least 30 days prior to an election. Once your application is processed, a notice will be mailed to you within 3 to 4 weeks.

1. When Completing This Application You **MUST** Provide:

♦ **Alaska Residence Address Where You Claim Residency** – A complete physical residence address must be included on your application. The residence address you provide will be used to assign your voter record to a voting district and precinct. Your application will not be processed if you leave the residence address blank or if you provide a PO Box, HC No. and Box, PSC Box, Rural Route No., Commercial Address or Mail Stop Address on Line 4 of the application.

If your residence has been assigned a street number, provide that number. If not, indicate exactly where you live such as, highway name and milepost number, boat harbor, pier and slip number, subdivision name with lot and block or trailer park name and space number. If you live in a rural village in Alaska, you may provide the community name as your residence address.

If you have a different mailing address than your residence address, you may choose to keep your residence address confidential. Confidential addresses are not released to the general public, but may be released to government agencies or during election processes as set out in state law.

Are you temporarily out of State? If so, and you have intent to return (active military and military spouses are exempt from intent requirements), you may maintain your Alaska residence as it appears on your current record. If you provide a new residence address, it must be within Alaska.

♦ **Proof of Identity** – Your identity must be verified. If you have been issued a Social Security number, Alaska Driver’s License, or Alaska State ID card, you **MUST** provide at least one number on Line 6 of the application. If you have never been issued one of the identification numbers, please indicate so by checking the box on Line 6.

♦ **Date of Birth** – You **MUST** provide your date of birth.

2. **Are you submitting this application by mail, by fax, or email?** If so, and if you are not already registered to vote in Alaska, your identity must be verified either at the time you register or the first time you vote. If you would like to ensure that your identity is verified at the time you register, submit a copy of one of the below:

- Current and valid photo identification
- Passport
- Birth certificate
- Driver’s license
- State identification card
- Hunting and Fishing license

3. **Are you registering from outside the State of Alaska?** If so, you must provide proof of Alaska residency, such as a copy of your Alaska driver’s license, Alaska hunting or fishing license, student loan or college tuition documents showing Alaska as state of residence, proof of employment in Alaska, military leave and earnings statement that identifies Alaska as the state of legal residence or other documentation that supports your claim as an Alaska resident. If you do not provide proof of Alaska residency, your application will not be processed.

4. **Have you been convicted of a felony?** If so, you may register to vote only if you have been unconditionally discharged. Provide a copy of your discharge papers with this application if available.

5. **Political Affiliation.** Those parties that have gained recognized political party status under Alaska Statutes 15.60.010(25) are listed under **Political Parties**. Those groups that have applied for party status but have not met the qualifications to be a recognized political party under Alaska Statutes 15.60.010(25) are listed under **Political Groups**. Under **Other**, nonpartisan means you are not affiliated with any recognized political party or group and undeclared means you do not wish to declare a political affiliation. If you do not check a political affiliation, you will be registered as undeclared unless you are already registered under an affiliation.

Mail, fax or email (as a pdf, tiff or jpg attachment) your completed application to one of the offices below:

Visit our website at: www.elections.alaska.gov

Region I Elections Office
PO Box 110018
Juneau, AK 99811-0018
(907) 465-3021 – Telephone
(907) 465-2289 – Fax
Toll Free 1-866-948-8683

Region II Elections Office
Anchorage Office
2525 Gambell Street Suite 100
Anchorage, AK 99503-2838
(907) 522-8683 – Telephone
(907) 522-2341 – Fax
Toll Free 1-866-958-8683
Matanuska-Susitna Office
North Fork Professional Building
1700 E. Bogard Road, Suite B102
Wasilla, AK 99654-6565
(907) 373-8952 – Telephone
(907) 373-8953 – Fax

Region III Elections Office
675 7th Avenue Suite H3
Fairbanks, AK 99701-4594
(907) 451-2835 – Telephone
(907) 451-2832 – Fax
Toll Free 1-866-959-8683

Region IV Elections Office
PO Box 577
Nome, AK 99762-0577
(907) 443-5285 – Telephone
(907) 443-2973 – Fax
Toll Free 1-866-953-8683

Yup’ik Language Assistance
Toll Free 1-866-954-8683

Public Assistance Offices

<p>ANCHORAGE DISTRICT OFFICE</p> <p>400 Gambell Street</p> <p>Anchorage, AK 99501</p> <p>(907) 269-6599 - Phone</p> <p>(907) 269-6450 - Fax</p>	<p>COASTAL FIELD OFFICE</p> <p>3601 C Street, Suite 410</p> <p>P.O. Box 240249</p> <p>Anchorage, AK 99524</p> <p>(907) 269-8950 - Phone 1-800-478-4372</p> <p>(907) 562-1619 - Fax</p>	<p>HOMER DISTRICT OFFICE</p> <p>Homer District Office</p> <p>3670 Lake Street, # 200</p> <p>Homer, AK 99603</p> <p>(907) 226-3040 - Phone</p> <p>(907) 235-6176 - Fax</p>
<p>EAGLE RIVER JOB CENTER</p> <p>11723 Old Glenn Highway, Sp. B-4</p> <p>Eagle River, AK 99577-7595</p> <p>(907) 694-7008</p> <p>(907) 694-1490 - Fax</p>	<p>JUNEAU FIELD OFFICE</p> <p>10002 Glacier Hwy, Suite 200</p> <p>Juneau, AK 99801</p> <p>(907) 465-3537 - Phone (1-800-478-3537)</p> <p>(907) 465-4657 - Fax</p>	<p>BETHEL DISTRICT OFFICE</p> <p>P.O. Box 365</p> <p>Bethel, AK 99559</p> <p>(907) 543-2686 - Phone (1-800-478-2686)</p> <p>(907) 543-5912 - Fax</p>
<p>FAIRBANKS DISTRICT OFFICE</p> <p>675 7th Avenue, Station D</p> <p>Fairbanks, AK 99701</p> <p>(907) 451-2850 - Phone (1-800-478-2850)</p> <p>(907) 451-2923 - Fax</p>	<p>KENAI PENINSULA JOB CTR</p> <p>11312 Kenai Spur Hwy, Suite #2</p> <p>Kenai, AK 99611</p> <p>(907) 283-2900 - Phone (1-800-478-9032)</p> <p>(907) 283-6619 - Fax</p>	<p>KETCHIKAN DISTRICT OFFICE</p> <p>2030 Sea Level Dr., Suite 301</p> <p>Ketchikan, AK 99901</p> <p>(907) 225-2135 - Phone (1-800-478-2135)</p> <p>(907) 247-2135 - Fax</p>
<p>KODIAK DISTRICT OFFICE</p> <p>211 Mission Road, Suite 101</p> <p>Kodiak, AK 99615</p> <p>(907) 486-3783 - Phone (1-888-480-3783)</p> <p>(907) 486-3116 - Fax</p>	<p>KOTZEBUE DISTRICT OFFICE</p> <p>P.O. Box 1210</p> <p>Kotzebue, AK 99752</p> <p>(907) 442-3451 - Phone</p> <p>(907) 442-2151 - Fax</p>	<p>MAT-SU DISTRICT OFFICE</p> <p>855 W. Commercial Drive</p> <p>Wasilla, AK 99654</p> <p>(907) 376-3903 - Phone (1-800-478-7778)</p> <p>(907) 373-1136 - Fax</p>
<p>MULDOON DISTRICT OFFICE</p> <p>1251 Muldoon Rd, Suite 111B</p> <p>Anchorage, AK 99504</p> <p>(907) 269-0001 - Phone</p> <p>(907) 269-0070 - Fax</p>	<p>NOME DISTRICT OFFICE</p> <p>P.O. Box 2110</p> <p>Nome, AK 99762</p> <p>(907) 443-2237 - Phone (1-800-478-2236)</p> <p>(907) 443-2307 - Fax</p>	<p>SITKA DISTRICT OFFICE</p> <p>201 Katlian Street, Suite 107</p> <p>Sitka, AK 99835</p> <p>(907) 747-8234 - Phone (1-800-478-8234)</p> <p>(907) 747-8224 - Fax</p>