State of Alaska
Department of Health
Division of Public Assistance
https://health.alaska.gov/dpa

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 apply for public assistance programs. Only your legal name, address, and signature are required on page 7 of this application form to secure a benefit start date.

For SNAP, your benefit start date begins the date we receive your completed page 7. Adult Public Assistance, Medicaid, and benefits from other programs may start on a different day

Apply for Medicaid faster online

- Visit www.healthcare.gov or www.my.alaska.gov to apply online

How long will it take?

It may take up to 45 days to process your application.

SNAP applicants may be entitled to expedited service. The following households may be eligible to receive SNAP benefits within 7 days:

- Households that have less than $100 in cash or money in the bank
- Households whose monthly gross income (before deductions) is less than $150
- Households whose costs for rent/mortgage/utilities are more than their monthly gross income, cash, money in the bank

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 — pay stubs, 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

Programs

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

Medicaid
Offers medical coverage to low-income individuals, people over 65, disabled, blind, pregnant women, and families with dependent children. Also helps with Medicare Parts A and B premiums.

Chronic & Acute Medical Assistance
Helps people with specific illnesses who don't qualify for Medicaid and have little or no income.

Supplemental Nutrition Assistance Program (SNAP)
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.

Do I have to complete an interview?

- An interview is required before we can determine if you are eligible for certain public assistance programs. You may schedule an interview at the Public Assistance office or with your local Fee Agent. Your application will be denied if you do not complete an interview.
- If you need a language interpreter, call 1-800-478-7778 and we will provide one at no cost to you. If you are deaf, hard of hearing, or have a speech disability, dial 711 to reach an Alaska Relay Communications Assistant.

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

What you may need to **give us.**

Identity: ☐ birth certificate ☐ driver's license or state identification ☐ card health benefits identification card ☐ school or work identification ☐ passport	**Earned Income:** ☐ pay stubs (for the past 30 days) ☐ employer statement of gross wages ☐ self-employment bookkeeping records ☐ income tax forms
Residency: ☐ utility bills such as electric, gas, or water ☐ rental agreement or mortgage statement that shows your address	**Unearned Income:** ☐ agency letter showing money received such as Social Security (SSI), Veteran's Affairs benefits (VA), child support, alimony, unemployment, and retirement
Immigration Status: ☐ immigration or naturalization papers (not required for U.S. citizens or for ineligible people who are applying for SNAP for their U.S. citizen children)	**Child Support:** ☐ paternity, custody and support ☐ orders divorce or dissolution decrees
Medical Expense Deductions: For households with elderly (age 60 or older), blind, or disabled members only: ☐ billing statements ☐ itemized medical receipts such as for prescription drugs ☐ Medicare card indicating Part B coverage ☐ repayment agreement with physician	**Other Documents Which May be Required:** ☐ bills or receipts for childcare or dependent adult care ☐ proof of application for Supplemental Security Income (SSI) ☐ eviction notices or utility shut off notice ☐ copy of court order showing your child support obligations and proof of payment

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

If you request a fair hearing before the effective date of the action, you may continue to receive benefits until a hearing decision is made. If you do not request a fair hearing before the effective date of the action, you can still appeal but benefits will not be continued. You can always re-apply for benefits while waiting for your hearing. At the hearing you may represent yourself or be represented by a legal representative. You may qualify for free legal advice and representation by contacting the Alaska Legal Services Corporation at (907) 272-9431 or 1-888-478-2572.

My right to appeal

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

When do I need to report changes?

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

What changes do I need to report?

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

If you receive Supplemental Nutrition Assistance Program and you do not receive benefits from any other program, you must report when your household's total gross income goes over the income limit for your household size and if someone in your household has lottery or gambling winnings of $3,500 or more in a single game. If your household contains a member subject to the ABAWD time limits, you must report when their work hours fall below 20 hours per week.

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

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

Will I need to work?

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

Read and keep this page.

What happens with my Child Support?

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

When you apply for Alaska Temporary Assistance you must:

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

When you apply for Medicaid you must:

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

Can the State of Alaska take my estate?

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

Responsibility for Overpayment

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

How are my rights protected?

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

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

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

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

You can get an electronic copy of the Notice of Privacy Practices at https://health.alaska.gov/fms/Documents/DOH-Notice-of-Privacy-Practices.pdf or you can request a printed copy by emailing: privacyofficial@alaska.gov or by writing to: State of Alaska, DOH Privacy Official, P.O. Box 110650, Juneau, Alaska 99811-0650.

In accordance with federal civil rights laws and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex (including gender identity and sexual orientation), religious creed, disability, age, political beliefs, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA. Programs that receive federal financial assistance from the U.S. Department of Health and Human Services (HHS), such as Temporary Assistance for Needy Families (TANF), and programs HHS directly operates are also prohibited from discrimination under federal civil rights laws and HHS regulations.

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

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

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

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

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

Release

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

We'll check your answers using information in our electronic databases and databases from the Internal Revenue Service (IRS), Social Security, the Department of Homeland Security, and/or a consumer reporting agency. If the information doesn't match, we may ask you to send us proof. We may also contact other people or organizations including, but not limited to: the Alaska Housing Finance Corporation, the Department of Fish and Game, the Department of Labor, the Department of Law, the Department of Military and Veterans Affairs, the Department of Public Safety, the Department of Revenue, U.S. Citizenship and Immigration Services, employers, financial institutions, landlords, local governments, Native corporations, private individuals, public assistance program contractors and grantees, school authorities, the Social Security Administration, stock brokerage firms, and tax assessors. We need this information to check your eligibility for public assistance services and to check your eligibility for help paying for health coverage if you choose to apply. Additionally, information obtained from this release may be used by the Department of Health in administrative proceedings against you, and/or by the Department of Law in criminal proceedings against you.

Read and keep this page.

What happens if I do not follow the rules?

You may be prosecuted if you knowingly give false, incorrect, or incomplete information to get or try to get public assistance benefits you are not eligible for, or to help someone get benefits for which they are not eligible. You must repay any benefits you wrongly receive.

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

Read and keep this page.

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.

☐ **Medicaid** Denali Care and Denali KidCare	☐ **Temporary Assistance** Monthly cash payment for eligible families with children.
☐ **Chronic & Acute Medical Assistance** Limited medical coverage for persons with a specific illness that doesn't qualify for Medicaid	☐ **Adult Public Assistance** ☐ blind or disabled ☐ elderly assistance
☐ **Supplemental Nutrition Assistance Program (SNAP)** Monthly issuance to assist with food costs. Important: You may be eligible for SNAP within seven days – answer questions below.	☐ **General Relief Assistance** Emergency assistance for eligible individuals and families. ☐ rent or utilities ☐ burial expenses
☐ **Other Services** ☐ **Senior Benefits** ☐ **Long Term Care**	

Who are you? (Please print and use legal names)

1. First name, Middle name, Last name, & Suffix

2. Other Names (maiden, nicknames, etc.)

3. Home address or directions to your house

4. Apartment or suite number

5. City

6. State

7. ZIP code

8. Mailing address (if different from home address)

9. Apartment or suite number

10. City

11. State

12. ZIP code

13. Phone number
( ) –

14. Other phone number
( ) –

15. Email address:

16. Other email address:

17. Is English your primary language? ☐ Yes ☐ No If not, what is your primary language? _____

If English is not your primary language, do you read and write in English with sufficient proficiency to understand and properly fill out this application? ☐ Yes ☐ No

If not, call 1-800-478-7778 and we will help you with this form and provide an interpreter at no cost to you.

18. Has anyone in your household received public assistance (Temporary Assistance, cash, SNAP, Medicaid, Food Distribution Program on Indian Reservations FDPIR) in Alaska or any other state? ☐ Yes ☐ No

If yes, who, when, and where? _____

19. Answer these questions to see if you can get SNAP within seven days

a. Do you have more than $100 in cash or money in the bank? ☐ Yes ☐ No

b. Is your household's monthly gross income (before deductions) less than $150? ☐ Yes ☐ No

c. Are your costs for rent/mortgage/utilities more than your monthly gross income, cash and money in the bank? ☐ Yes ☐ No

Sign here:

Date:

STEP 2 People in your household

Complete for each person in your household.
Start with yourself and then add all other members of your household, including people who reside in your household full-time and part-time. 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.

20. First name, Middle name, Last name, & Suffix

21. Relationship to you?
Self

22. Social Security number | 23. Date of Birth (mm/dd/yyyy) | 23a. Marital Status | 24. Sex ☐ Male ☐ Female

25. 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? _____

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

27. Do you need 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 28 - 37

28. 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

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

30. If you aren't a U.S. citizen or national, do you have eligible immigration status?Fill in your document type and ID number below. ☐ Yes ☐ No

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

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

31. Do you want help paying for medical bills from the last 3 months? Which months? _____ ☐ Yes ☐ No
If you are a tribal member and have been seen at a tribal medical facility in the last three months, you may have medical expenses that could be covered by retroactive Medicaid

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

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

34. Are you attending an institution of higher education (schooling beyond high school)? ☐ Yes ☐ No Full time or part time? _____

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

36. If Hispanic/Latino, ethnicity (OPTIONAL—check all that apply.)
☐ Mexican ☐ Mexican American ☐ Chicano/a ☐ Puerto Rican ☐ Cuban ☐ Other _____

37. 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 _____

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

Person 2 People in your household

Answer the questions for the next person in your household.

38. First name, Middle name, Last name, & Suffix

39. Relationship to you?

39a. Is this person a full-time or part-time member of your household? ☐ Full-time ☐ Part-time

If part time, what percentage of the time does this person reside with you? _____% (1 - 100)

40. Social Security number

41. Date of Birth (mm/dd/yyyy)

41a. Marital Status

42. Sex ☐ Male ☐ Female

43. 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? _____

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

45. Do you need 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 46 - 55

46. 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

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

48. 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: _____

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

49. Do you want help paying for medical bills from the last 3 months? Which months? _____ ☐ Yes ☐ No

If you are a tribal member and have been seen at a tribal medical facility in the last three months, you may have medical expenses that could be covered by retroactive Medicaid

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

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

52. Are you attending an institution of higher education (schooling beyond high school)? ☐ Yes ☐ No Full time or part time? _____

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

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

☐ Mexican ☐ Mexican American ☐ Chicano/a ☐ Puerto Rican ☐ Cuban ☐ Other _____

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

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

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

Person 3 People in your household

Answer the questions for the next person in your household.

56. First name, Middle name, Last name, & Suffix

57. Relationship to you?

57a. Is this person a full-time or part-time member of your household? ☐ Full-time ☐ Part-time

If part time, what percentage of the time does this person reside with you? _____% (1 - 100)

58. Social Security number

59. Date of Birth (mm/dd/yyyy)

59a. Marital Status

60. Sex ☐ Male ☐ Female

61. 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? _____

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

63. Do you need 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 64 - 73

64. 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

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

66. If you aren't a U.S. citizen or national, do you have eligible immigration status? Fill in your document type and ID number below. ☐ Yes ☐ No

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

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

67. Do you want help paying for medical bills from the last 3 months? Which months? _____ ☐ Yes ☐ No

If you are a tribal member and have been seen at a tribal medical facility in the last three months, you may have medical expenses that could be covered by retroactive Medicaid

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

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

70. Are you attending an institution of higher education (schooling beyond high school)? ☐ Yes ☐ No Full time or part time? _____

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

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

☐ Mexican ☐ Mexican American ☐ Chicano/a ☐ Puerto Rican ☐ Cuban ☐ Other _____

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

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

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

Person 4 People in your household

Answer the questions for the next person in your household.

74. First name, Middle name, Last name, & Suffix

75. Relationship to you?

75a. Is this person a full-time or part-time member of your household? ☐ Full-time ☐ Part-time

If part time, what percentage of the time does this person reside with you? _____% (1 - 100)

76. Social Security number

77. Date of Birth (mm/dd/yyyy)

77a. Marital Status

78. Sex ☐ Male ☐ Female

79. 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? _____

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

81. Do you need 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 82 - 91

82. 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

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

84. If you aren't a U.S. citizen or national, do you have eligible immigration status? Fill in your document type and ID number below. ☐ Yes ☐ No

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

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

85. Do you want help paying for medical bills from the last 3 months? Which months? _____ ☐ Yes ☐ No
If you are a tribal member and have been seen at a tribal medical facility in the last three months, you may have medical expenses that could be covered by retroactive Medicaid

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

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

88. Are you attending an institution of higher education (schooling beyond high school)? ☐ Yes ☐ No Full time or part time? _____

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

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

☐ Mexican ☐ Mexican American ☐ Chicano/a ☐ Puerto Rican ☐ Cuban ☐ Other _____

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

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

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

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

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:

☐ Weekly ☐ Every 2 Weeks ☐ Twice Monthly ☐ Monthly ☐ Yearly ☐ Other

JOB 2

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:

☐ Weekly ☐ Every 2 Weeks ☐ Twice Monthly ☐ Monthly ☐ Yearly ☐ Other

JOB 3

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:

☐ Weekly ☐ Every 2 Weeks ☐ Twice Monthly ☐ Monthly ☐ Yearly ☐ Other

JOB 4

95. 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:

☐ Weekly ☐ Every 2 Weeks ☐ Twice Monthly ☐ Monthly ☐ Yearly ☐ Other

Please answer the following questions about income.

96. 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.

☐ B&B/Rent Rooms	☐ Crafts/Carving	☐ Odd Jobs	☐ Taxi Driving
☐ Carpenter	☐ Commercial Fishing	☐ Repair Person	☐ Trapping
☐ Child Care/Babysitting	☐ Manage Rental Property	☐ Sales Person	☐ 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

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

Name (s): _____

98. 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).

☐ Alimony	☐ Net Rental/Royalty	☐ Net Fishing/Farming
☐ Child Support	☐ Pension/Retirement Benefits	☐ Social Security Benefits
☐ Unemployment Benefits	☐ Supplemental Security Income	☐ Worker's Compensation
☐ Virtual currency/Cryptocurrency	☐ Veteran's Benefits	☐ 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

99. 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).

☐ Alimony Name(s)_____ $_____ How often?_____

☐ Student loan interest Name(s)_____ $_____ How often?_____

☐ Other deductions Name(s)_____ $_____ How often?_____

Type:

100. 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) $ _____

101. 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

102. 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.

103. 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.

☐ Medicaid _____ ☐ Employer insurance: _____

☐ Medicare _____ Name of health insurance: _____

☐ TRICARE (don't check if you have direct care or line of duty) ☐ Policy number: _____

Is this COBRA coverage? ☐ Yes ☐ No

Is this retiree health plan? ☐ Yes ☐ No RIN: _____

☐ 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

104. 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

Skip STEP 7 if you are only applying for MAGI Medicaid benefits. You must complete STEP 7 if you are applying for disability related Medicaid or any other Public Assistance program.

STEP 7 Assets, Expenses, Resources, and Other

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

105. 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

106. 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

107. 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.

- ☐ Annuities
- ☐ Burial Policy Agreement
- ☐ Cash on Hand
- ☐ Certificate of Deposit
- ☐ Checking Account
- ☐ College Savings Plan
- ☐ Credit Union Accounts
- ☐ Commercial Fishing Permit
- ☐ IRA Account
- ☐ Life Insurance Policy
- ☐ Trust or ABLE Account
- ☐ Native Corporation Shares
- ☐ Pension Plan
- ☐ Retirement Funds
- ☐ Safe Deposit Box
- ☐ Savings Account
- ☐ Stocks/Bonds
- ☐ Virtual currency/Cryptocurrency
- ☐ Other _____

108. 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

109. 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

Expenses

110. 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

111. 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 _____

112. 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 $_____

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

114. 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: _____

115. 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?_____

116. 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 $_____

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

Who pays?_____ Monthly Amount $_____

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

Who has the expense?_____ Monthly Amount $_____

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

Felony Convictions

119. Have you or any member of your household been convicted of making a false statement about where they live in order to receive assistance from two or more states at the same time? ☐ Yes ☐ No

120. Have you or any member of your household been convicted of possession, use, or distribution of a controlled substance after August 22, 1996? ☐ Yes ☐ No

120a. Are they satisfactorily serving or successfully completed a period of probation or parole? ☐ Yes ☐ No

120b. Are they in the process of serving or successfully completed mandatory participation in a drug or alcohol treatment program? ☐ Yes ☐ No

120c. Have they taken action towards rehabilitation, including participation in a drug or alcohol treatment program? ☐ Yes ☐ No

120d. Are they successfully complying with the requirements of their re-entry plan? ☐ Yes ☐ No

121. Are you or any member of your household fleeing from prosecution, custody, or confinement for a felony or class A misdemeanor from any State, or currently violating conditions of parole or probation? ☐ Yes ☐ No

122. Have you or any member of your household been convicted of trading SNAP benefits for drugs after September 22, 1996? ☐ Yes ☐ No

123. Have you or any member of your household been convicted of buying or selling SNAP benefits over $500 after September 22, 1996? ☐ Yes ☐ No

124. Have you or any member of your household been convicted of fraudulently receiving duplicate SNAP benefits in any State after September 22, 1996? ☐ Yes ☐ No

125. Have you or any member of your household been convicted of trading SNAP benefits for guns, ammunitions, or explosives after September 22, 1996? ☐ Yes ☐ No

126. Have you or any member of your household been convicted of aggravated sexual abuse, murder, sexual exploitation and abuse of children, or sexual assault after February 7, 2014? ☐ Yes ☐ No

126a. Are they serving or have they successfully completed a period of probation or parole? ☐ Yes ☐ No

126b. Are they successfully complying with the requirements of their re-entry plan? ☐ Yes ☐ No

STEP 8 Release of Information

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

We'll check your answers using information in our electronic databases and databases from the Internal Revenue Service (IRS), Social Security, the Department of Homeland Security, and/or a consumer reporting agency. If the information doesn't match, we may ask you to send us proof. We may also contact other people or organizations including, but not limited to: the Alaska Housing Finance Corporation, the Department of Fish and Game, the Department of Labor, the Department of Law, the Department of Military and Veterans Affairs, the Department of Public Safety, the Department of Revenue, U.S. Citizenship and Immigration Services, employers, financial institutions, landlords, local governments, Native corporations, private individuals, public assistance program contractors and grantees, school authorities, the Social Security Administration, stock brokerage firms, and tax assessors. We need this information to check your eligibility for public assistance services and to check your eligibility for help paying for health coverage if you choose to apply. Additionally, information obtained from this release may be used by the Department of Health in administrative proceedings against you, and/or by the Department of Law in criminal proceedings against you.

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 Medicaid:

- I am giving the State Medicaid 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 Medicaid 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 ☐	No ☐
I agree to cooperate with child support requirements.	**Yes** ☐	No ☐

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 page 7 (the applicant) should sign this application. If you're an authorized representative, you may sign here as long as the applicant has completed the required information in Appendix C.

Sign this application: _____

Signature Date (month/day/year)

Printed name: _____

Sign this application: _____

Signature Date (month/day/year)

Printed name: _____

STEP 9 Acknowledgement of Understanding and Statement of Truth

Acknowledgements

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

I have read or 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.

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

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

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

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

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

Authorized Representative, if applicable: _____ _____
Signature Date (month/day/year)

SNAP Subsistence Hunting and/or Fishing OPTIONAL

Does your household live in a rural community in which access to retail stores is difficult and you intend to rely on subsistence hunting and/or fishing for substantial portion of your food? If so, you may be able to use SNAP benefits to buy subsistence hunting and fishing items such as nets, lines, hooks, fishing rods, and knives.

Do you want to use SNAP to buy subsistence hunting and fishing items? ☐ Yes ☐ No

I agree not to use the items purchased for commercial purposes. ☐ Yes ☐ No

Adult Applicant: _____ _____
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? _____ (mm/dd/yyyy)

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

Name:_____ Name:_____ Name: _____

☐ No

Tell us about the health plan offered by this employer.

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

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

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

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

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

☐ Employer won't offer health coverage

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

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

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

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

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

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 of 1986)

APPENDIX B: American Indian or Alaska Native Family Member

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
1. Name (First name, Middle name, Last name)	First Middle Last	First Middle Last
2. Member of a federally recognized tribe?	☐ Yes If yes, tribe name _____ ☐ No	☐ Yes If yes, tribe name _____ ☐ 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?	☐ Yes ☐ 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? ☐ Yes ☐ No	☐ Yes ☐ 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? ☐ Yes ☐ No
4. Certain money received may not be counted for Medicaid. List any income (amount and how often) reported on your application that includes money from these sources: • 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: Appointing an Authorized Representative OPTIONAL

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

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

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

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

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

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

OR

Permission to Release Information

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

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

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

AND

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

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

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 and 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? Yes / No Union member? Yes / No

Tribe or Native Corporation member? Yes / No Type/Policy: _____

☐ 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 may be asked by a Public Assistance caseworker to provide documentation to support your good cause claim. 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 involving moral turpitude, or having been so convicted, 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.

1. **You MUST complete this section for registration:**

☐ Yes ☐ No I am a citizen of the United States.

☐ Yes ☐ No I am at least 18 years old or will be within 90 days of completing this application.

If you checked NO to either question, do not complete this form as you are not eligible to register to vote.

2. **Last Name** **First Name** **Middle Initial** **Suffix**

3. **Former Name**: (If your name has changed)

4. You **MUST** provide the **Alaska** residence address where you claim residency. Do not use PO, PSC, HC or RR.

House No. **Street Name** **Apt No.** **City** **Alaska** **State**

*❑ Keep my residence address confidential. **(Your mailing address in section 5 must be DIFFERENT from your residence address in section 4 to remain confidential.)**

5. **Mailing Address:** (Address where you receive your mail if different from above)

6. *AK Voter Number: (If known)

7. ❑ I am a voter with a disability and would like information on alternative voting methods.

8. ❑ I am interested in serving as an election official. (Provide your phone number and/or email address in section 9.)

9. Daytime Phone No.:

Evening Phone No.:

Email Address:

10. **Identifiers –** You **MUST** provide at least one:

*SSN or Last 4 of SSN: *Alaska Driver's License or State ID Number

❑ I have not been issued a Social Security Number, Alaska Driver's License or State ID number.

11. You **MUST** provide:

***Date of Birth** Month Day Year

12. **Gender** ❑ Male ❑ Female

13. **Political Affiliation** For political affiliation choices in Alaska, see instruction number 4 on the reverse side.

Write political affiliation:

14 I am registered to vote in another state, cancel my registration in:

City: **State:** **County:** **Zip:**

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 involving moral turpitude, or having been so convicted, have been unconditionally discharged from incarceration, probation and/or parole.

WARNING: If you provide false information on this application you can be convicted of a misdemeanor AS 15.56.050.

***SIGNATURE:** **DATE:**

Your signature must be a handwritten signature. A typed or digital signature is not valid.

Registrar/Agency/Official – Check ID and complete this section

Registrar Name **Voter No or SSN** OR **Agency Name** NVRA Agency

*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 in Alaska 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 be denied if you do not provide an Alaska residence address or you provide a PO Box, HC No. and Box, PSC Box, Rural Route No., Commercial Address or Mail Stop Address or a residence address outside of Alaska on Line 4 of the application.

     If your residence has been assigned a street name and house number, provide this information or 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 rural 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.

     *If you are temporarily out of state and have intent to return***,** 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. Active military and military spouses are exempt from intent requirement.
   - **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 10 of the application. If you have never been issued one of the identification numbers, please indicate so by checking the box on Line 10.
   - **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
   - Driver's license
   - Passport
   - State identification card
   - Birth certificate
   - Hunting and Fishing license
3. **Have you been convicted of a felony involving moral turpitude?** 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.
4. **Political Affiliation.** Write your political affiliation. Recognized political parties are parties who have gained recognized political party status under Alaska Statute. Political groups are parties who have applied for recognized political party status but have not met the qualifications. Alaska political affiliations are as follows:

Recognized Political Parties:
- Alaska Democratic Party
- Alaska Republican Party
- Alaskan Independence Party

Political Groups:
- Alaska Constitution Party
- Alaska Libertarian Party
- Alliance Party of Alaska
- FreedomReform Party
- Moderate Party of Alaska
- Green Party of Alaska
- OWL Party
- Patriot's Party of Alaska
- Progressive Party of Alaska
- UCES' Clowns Party
- Veterans Party of Alaska

Other:
- Nonpartisan (not affiliated with a political party or group)
- Undeclared (do not wish to declare a political affiliation)

Mail, fax or email (as a PDF, TIFF or JPEG attachment) your completed application to one of the offices listed below:

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
electionsr1@alaska.gov

Region II Elections Office
Anchorage Office
2525 Gambell St Ste 100
Anchorage, AK 99503-2838
(907) 522-8683 – Telephone
(907) 522-2341 – Fax
Toll Free 1-866-958-8683
electionsr2a@alaska.gov

Matanuska-Susitna Office
North Fork Professional Building
1700 E Bogard Rd Ste B102
Wasilla AK 99654-6565
(907) 373-8952 – Telephone
(907) 373-8953 – Fax
electionsr2m@alaska.gov

Region III Elections Office
675 7th Ave Ste H3
Fairbanks, AK 99701-4542
(907) 451-2835 – Telephone
(907) 451-2832 – Fax
Toll Free 1-866-959-8683
electionsr3@alaska.gov

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
electionsr4@alaska.gov

Native Language Assistance
Toll Free 1-866-954-8683

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

Public Assistance Offices

ANCHORAGE University Center 4001 Ingra Street, Suite 131 Anchorage, AK 99503 Phone: 1-800-478-7778 Fax: (907) 269-6520 or 1-888-269-6520 hss.dpa.offices@alaska.gov	**BETHEL** 460 Ridgecrest Drive, Suite 121 Mailing: P.O. Box 365 Bethel, AK 99559 Phone: 1-800-478-7778 Fax: 1-888-269-6520 hss.dpa.offices@alaska.gov	**FAIRBANKS** 675 7th Ave, Station E Fairbanks, AK 99701 Phone: 1-800-478-7778 Fax: 1-888-269-6520 hss.dpa.offices@alaska.gov
HOMER 3670 Lake Street, Suite 200 Homer, AK 99603 Phone: 1-800-478-7778 Fax: 1-888-269-6520 hss.dpa.offices@alaska.gov	**JUNEAU** 10002 Glacier Highway, Suite 201 Mailing: P.O. Box 110642 Juneau, AK 99811-0642 Phone: 1-800-478-7778 Fax: 1-888-269-6520 hss.dpa.offices@alaska.gov	**KENAI** 11312 Kenai Spur Highway, Suite 2 Kenai, AK 99611 Phone: 1-800-478-7778 Fax: 1-888-269-6520 hss.dpa.offices@alaska.gov
KETCHIKAN 2030 Sea Level Drive, Suite 301 Mailing: P.O. Box 5560 Ketchikan, AK 99901 Phone: 1-800-478-7778 Fax: 1-888-269-6520 hss.dpa.offices@alaska.gov	**KODIAK** 211 Mission Road, Suite 101 Kodiak, AK 99615 Phone: 1-800-478-7778 Fax: 1-888-269-6520 hss.dpa.offices@alaska.gov	**LONG TERM CARE** University Center 4001 Ingra Street, Suite 131 Anchorage, AK 99503 Phone: 1-800-478-7778 Fax: (907) 269-6520 or 1-888-269-6520 hss.dpa.offices@alaska.gov
NOME 214 E. Front Street Nome, AK 99762 Mailing: 675 7th Ave, Station E Fairbanks, AK 99701 Phone: 1-800-478-7778 Fax: 1-888-269-6520 hss.dpa.offices@alaska.gov	**SITKA** 304 Lake Street, Suite 101 Sitka, AK 99835 Phone: 1-800-478-7778 Fax: 1-888-269-6520 hss.dpa.offices@alaska.gov	**WASILLA** 855 W. Commercial Drive Wasilla, AK 99654 Phone: 1-800-478-7778 Fax: 1-888-269-6520 hss.dpa.offices@alaska.gov

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