



**Department of Health and Social Services
Division of Public Assistance**

Office Use Only

ELIGIBILITY REVIEW FORM

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

Check Box for Type of Program:

- Food Stamp Program
 Adult Public Assistance
 Temporary Assistance
 Medicaid

NOTE: You need to complete only one review form for all programs that are due for review this month.

Be sure the form is complete and remember to sign the statement at #15 to avoid processing delays. If you need more space for any answer, use another piece of paper. Please print clearly.

Name		Case Number
Mailing Address		
Residence Address (if different from mailing address)		
Home Phone Number	Message Phone Number	Work Phone Number

1. HOUSEHOLD INFORMATION: List all persons who live with you. List yourself first. **Disclosure of your Race and Ethnicity information is voluntary and will not affect your eligibility or level of benefits. This information will be used to assure that program benefits are distributed without regard to race, color or national origin.*

Name (First MI Last)	Relation to You If not related write NR.	Date of Birth	Social Security Number	US Citizen?	*Ethnicity (optional) Hispanic or Latino?	*Race (Optional) Select one or more: AN - Alaska Native AI - American Indian AS - Asian BL - Black/African-American PI - Native Hawaiian/Pacific Islander WH - White
	Self			Yes No	Yes No	AN AI AS BL PI WH
				Yes No	Yes No	AN AI AS BL PI WH
				Yes No	Yes No	AN AI AS BL PI WH
				Yes No	Yes No	AN AI AS BL PI WH
				Yes No	Yes No	AN AI AS BL PI WH
				Yes No	Yes No	AN AI AS BL PI WH
				Yes No	Yes No	AN AI AS BL PI WH
				Yes No	Yes No	AN AI AS BL PI WH

Is anyone in your household pregnant? Yes No If yes, who? _____

Please provide medical proof with due date.

Has anyone been convicted of a drug-related felony for an offense that occurred on or after August 22, 1996?
 Yes No If yes, who? _____

Is anyone in your household attending postsecondary education at a college or university? Yes No
 If yes, who? _____

ASSETS INFORMATION:

2. List all vehicles owned or being purchased by you or anyone in your household. *Include cars, trucks, boats, motorcycles, RVs, ATVs, snowmobiles, etc.*

Owner's Name	Type of Vehicle	Model / Year	How Used?	Amount Owed	Current Value
				\$	\$
				\$	\$
				\$	\$
				\$	\$

3. List any houses, cabins, property, stocks, bonds, or other assets you or anyone in your household owns or is buying. List any life insurance policies or burial accounts or policies you or anyone in your household owns, and the current cash value of the account or policy.

Owner	Type of Property/Asset	Value	Owner	Type of Property/Asset	Value
		\$			\$
		\$			\$
		\$			\$
		\$			\$

4. List how much money you or anyone in your household has in cash and bank accounts. *Please provide a copy of your most recent bank statement for each account.*

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

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

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

6. Do you or anyone who lives with you own a commercial fishing permit or IFQs? Yes No

If yes, Permit/IFQ Number

Value

\$

MONEY RECEIVED INFORMATION:

7. Complete if you or anyone in your household is working. *Please provide three or four most recent pay stubs. If self-employed, attach proof of income and expenses.*

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

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

8. List any other money you or anyone in your household receives. *Include Social Security, SSI, BIA, VA, retirement, unemployment insurance, Worker's Compensation, Native assistance, child support, cash gifts, etc. Please attach proof.*

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

Do you expect any changes to your income? Yes No If yes, please explain. _____

Does anyone work in exchange for food, shelter, utilities, etc.? Yes No If yes, please explain. _____

HOUSEHOLD EXPENSE INFORMATION:

9. Complete if you or anyone in your household has any of these monthly expenses. *Please provide proof of the obligated monthly rent amount, utility costs, and yearly property tax and insurance amounts.*

Expense Type	Monthly Amount	Expense Type	Monthly Amount	Expense Type	Monthly Amount
Rent/ Mortgage	\$	Telephone	\$	Heating Oil	\$
Lot or Space Rent	\$	Electricity	\$	Natural Gas	\$
Property Tax	\$	Water / Sewer	\$	Wood / Coal	\$
Home Insurance	\$	Garbage Collection	\$	Other _____	\$

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

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

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

10. Complete if anyone in your household has expenses for the care of a child, or an elderly or disabled adult. *Please provide proof of amounts paid for the last two months.*

Child / Dependent Name	Monthly Care Cost	Child / Dependent Name	Monthly Care Cost
	\$		\$
	\$		\$

Do you get money to help pay dependent care costs? Yes No If yes, how much? _____

From whom? _____

11. Complete if you or anyone in your household pays child support. *Please provide proof of your monthly obligation and the amount paid in the last two months.*

Who Pays Child Support	Who Do They Pay	How Much	When
		\$	
		\$	

12. Complete if you or anyone in your household is over age 59 or disabled, and has medical expenses. *List the person and provide proof of these expenses.*

Person with Medical Expense	Amount	Person with Medical Expense	Amount
	\$		\$

If you expect any changes in your household expenses or circumstances, please explain: _____

13. MEDICAID REVIEW: Complete if you or anyone in your household receives Medicaid

In the past twelve months, did you or anyone in your household receive treatment at a hospital because of an accident or illness for which someone else was responsible to pay? Yes No If yes, please explain what happened and who is responsible to pay for treatment. _____

Have you or anyone in your household had employer-based health insurance coverage begin or end in the last twelve months? Yes No If yes, please provide the name and address of the employer, the name and phone number of the insurance company, and a copy of the front and back of your insurance card. _____

If you or anyone in your household has health insurance please complete the following table. (*Health Insurance includes: Tricare, Medicare A&B, Worker's Compensation, IHS, Native Health, Veteran/Military, Blue Cross, Aetna, AlaskaCare, school insurance, or any employer-based health plan.*)

Covered Household Member	Insurance Company	Policy Number	Name of Policy Holder	Insured through job? Yes/No	Date Coverage Began	Check Benefits Covered					
						Hospital	Physician	Drugs	Dental	Vision	Other

14. AUTHORIZED REPRESENTATIVE:

I have asked this person to help with my public assistance case.

Name: _____ Phone Number: _____

15. STATEMENT OF TRUTH:

I have read and understand the rights and responsibilities section attached to this form. Under penalty of perjury or unsworn falsification, I certify the statements made on this review form and during any related interview for assistance regarding the persons in my home, the income, resources, property, and all other items that pertain to my possible eligibility for benefits are true and correct to the best of my knowledge.

SIGN HERE _____
 Applicant Signature Date Other Adult Applicant Signature Date

STATE OF ALASKA
DEPARTMENT OF HEALTH & SOCIAL SERVICES
DIVISION OF PUBLIC ASSISTANCE

**AUTHORIZATION
FOR RELEASE OF INFORMATION**

I authorize the release of information requested by the Department of Health & Social Services or its agents within the Department of Law. The requested information will only be used in the administration of public assistance programs, and will not be released to any other person or agency outside of the Department of Health & Social Services or its agents within the Department of Law. This release of information will be in effect while I am an applicant or recipient of public assistance, and for any later investigations of my eligibility and receipt of benefits.

Persons or organizations that may be contacted include, but are not limited to: the Department of Law, the Department of Public Safety, the Department of Fish and Game, the Department of Labor, the Department of Military & Veterans Affairs, the Department of Revenue, the Bureau of Citizenship and Immigration Services, Alaska Housing Finance Corporation, Social Security Administration, local governments, public assistance program contractors and grantees, tax assessors, financial institutions, Native corporations, stock brokerage firms, landlords, employers, school authorities, and private individuals.

A COPY OF THIS RELEASE IS AS VALID AS THE ORIGINAL.

Your Signature

Signature of Other Adult Household Member

Printed Name

Printed Name

Social Security Number

Social Security Number

Address

Address

Phone Number

Phone Number

Date

Date

STATE OF ALASKA
DEPARTMENT OF HEALTH & SOCIAL SERVICES
DIVISION OF PUBLIC ASSISTANCE

REQUEST FOR CONTACT PERSONS AND ORGANIZATIONS

We often need to contact persons or organizations that can verify your situation to determine your eligibility for public assistance. When we contact these persons or organizations, we tell them our name, title, and that we work for the Division of Public Assistance. We are prohibited by law from telling them anything about you or about your public assistance case.

The information we most often need to verify is where you live, who lives with you, and your household's income and resources. We may also ask for information about absent parents for Temporary Assistance and Medicaid applicants.

Please provide the information requested below:

NAME OF SOMEONE WHO KNOWS YOU WELL _____

MAILING ADDRESS _____

DAYTIME TELEPHONE NUMBER _____

NAME OF SOMEONE WHO KNOWS YOU WELL _____

MAILING ADDRESS _____

DAYTIME TELEPHONE NUMBER _____

NAME OF LANDLORD _____

MAILING ADDRESS _____

DAYTIME TELEPHONE NUMBER _____

FINANCIAL INSTITUTION (BANK, CREDIT UNION) _____

MAILING ADDRESS _____

DAYTIME TELEPHONE NUMBER _____

EMPLOYER _____

MAILING ADDRESS _____

DAYTIME TELEPHONE NUMBER _____

YOUR RIGHTS AND RESPONSIBILITIES

You have the right to discuss any action taken on your application or case with your caseworker or with your caseworker's supervisor.

FAIR HEARINGS

If you disagree with an action taken by the Division of Public Assistance that affects the benefits or services you receive, you can ask for a fair hearing. You may do this by phone, in person, or in writing by contacting anyone in the Public Assistance office. Usually, you must ask for a fair hearing within 30 days from the date of the agency notice. Food Stamp fair hearing requests must be made within 90 days from the effective date of the agency action. At the hearing you may represent yourself or be represented by a legal representative, friend, or relative. You may qualify for free legal advice and representation by contacting the Alaska Legal Services Corporation.

You may continue to receive 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 agency notice was mailed. If the hearing decision is not in your favor you may be required to repay the benefits you received while you waited for the decision.

CIVIL RIGHTS

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 USDA, Director, Office of Civil Rights, Room 326-W, Whitten Building, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410 or call (202) 720-5964 (voice and TDD). Write HHS, Director, Office for Civil Rights, Room 506-F, 200 Independence Avenue, SW, Washington, D.C. 20201 or call (202) 619-0403 (voice) or (202) 619-3257 (TDD). USDA and HHS are equal opportunity providers and employers.

AMERICANS WITH DISABILITIES ACT OF 1990

The Alaska Department of Health & Social Services, Division of Public Assistance complies with Title II of the Americans with Disabilities Act of 1990. If you have questions, contact the Division's Americans with Disabilities Act Coordinator at (907) 465-3347.

SOCIAL SECURITY NUMBERS

You must provide or apply for a social security number for yourself and each household member for whom you are seeking benefits from the Alaska Temporary Assistance, Food Stamp, or Medicaid programs (42 CFR 435.910).

The collection of this information, including the social security number of each household member, is authorized under the Food Stamp Act of 1977, as amended, 7 USC 2011-2036. The information will be used to determine whether your household is eligible to participate in the Food Stamp Program. We will verify this information through computer matching programs. This information will also be used to monitor compliance with program regulations and for program management. The information may be disclosed to other Federal and State agencies for official examination, and to law enforcement officials for the purpose of apprehending persons fleeing to avoid the law. If a food stamp claim arises against your household, the information on this application, including all social security numbers, may be referred to Federal and State agencies, as well as private claims collection agencies, for claims collection action. Providing the requested information, including the social security number of each household member, is voluntary. However, failure to provide this information will result in the denial of Food Stamp benefits to your household.

MEDICAL RECORDS RELEASE

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 you and other people on whose behalf you are applying to the Department of Health and Social Services. Upon request, any person who has medical records and information or the custody of such records shall release those records to the Department or its designee.

PROTECTED HEALTH INFORMATION

Health or medical information the Department of Health and Social Services (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.
- Gives you more control over how your health information is used, allows you to find out how DHSS used your health information, and how DHSS has disclosed your health information outside of DHSS.
- Limits the release of information about you to the minimum amount necessary for the purpose of the disclosure.
- Allows you to examine and obtain a copy of your own health records and to request corrections to those records.

To obtain more information about your rights and our responsibilities regarding the use or disclosure of your protected health information you should review the DHSS notice of privacy practices. You may obtain an electronic copy of the Notice of Privacy Practices at www.hss.state.ak.us or you may request a printed copy from the DHSS Privacy Official by calling 907-465-2150, or by writing to State of Alaska, DHSS Privacy Official, PO Box 110650, Juneau, Alaska 99811-0650 or by email at PrivacyOfficial@health.state.ak.us.

MEDICAL REIMBURSEMENT AGREEMENT

If the State of Alaska makes payment for services caused by injury or illness, you must agree to include all payments made by the State in any legal claim made against a third party and to notify the Division of Medical Assistance of that claim. If you receive an insurance or court settlement, you must repay the State for the medical benefits provided as a result of the incident for which you are receiving the settlement. If married, but signing alone, you are acknowledging that benefits are for you, your spouse, or covered dependents. You and your spouse are both bound by this agreement.

MEDICAID ESTATE RECOVERY

Under Alaska law, the state has the right to seek recovery of Medicaid expenditures from certain Medicaid recipients. This may include, under limited conditions, placing a lien on a recipient's home while the recipient is still living. Estate recovery is generally limited to those who received Medicaid benefits after age 55 and is limited to the reimbursement for services provided while the recipient was in a nursing home or other medical institution, or was receiving home and community-based services. Except where a lien is enforced upon the sale of a home, most estate recovery is not conducted until 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.

HOME VISITS

A Division of Public Assistance worker may visit your home and may contact other people to verify your eligibility for assistance. We may also do a home visit if you are under a Temporary Assistance penalty.

REPORTING CHANGES IN YOUR HOUSEHOLD CIRCUMSTANCES

You must report changes in your household within 10 days of when you know of the change. You may do this by contacting the Public Assistance office by phone, in person or in writing.

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

Adult Public Assistance and Medicaid (for elderly, disabled, and long term care). You must report all changes, including changes in your medical insurance.

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

- Changes in employment - starting or stopping a job, change in wage rate, change from part-time to full-time or full-time to part-time
- Changes in the source of unearned income and changes in the total amount of unearned income greater than \$50 a month
- When someone moves into or out of your home (*report within 5 days when a child leaves your home, if you get Temporary Assistance*)
- You move or get a new mailing address (you need to verify your new shelter costs or we cannot use them in calculating your benefits)
- Your household gets a vehicle
- Your household has more than \$2000 total in cash and money in bank accounts
- Changes in your legal obligation to pay child support
- Changes in medical insurance if your household gets Medicaid

Food Stamps You only need to report when your household's total monthly gross income goes over the income limit for your household.

CHILD SUPPORT INFORMATION AND COOPERATION

Alaska must collect child support and medical support from any parent who has the duty to pay support to a Temporary Assistance or Medicaid recipient. 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 Temporary Assistance benefits must be reported and turned over to the State immediately. If you wish to change a child support order, you must obtain a new court order or get permission from CSED.

Note: If you believe you have a good reason not to cooperate with CSED for either the Temporary Assistance or Medical Assistance programs, you must tell your caseworker immediately. You may be asked to provide information to support your reason.

When you apply for Temporary Assistance you must:

- Sign over to the State your right to receive and keep child support payments due to you or to a child on Temporary Assistance.
- Cooperate with the Child Support Enforcement Division (CSED) by providing information to establish paternity, help locate an absent parent, and enforce a child support obligation.

When you apply for Medicaid or Chronic & Acute Medical Assistance for you or your minor children you must:

- Assign to the State your right to any medical support or other payment for medical care.
- Agree to cooperate with the State in establishing paternity.
- Cooperate with the State in obtaining any available third party payments such as an insurance payment or court settlement.

WORK REQUIREMENTS

To receive Temporary Assistance or Food Stamp benefits, you may have to participate in work activities. Temporary Assistance participants must prepare a family self-sufficiency plan that lists steps you will take to become financially independent. You must participate in approved work activities unless you qualify for an exemption. If you are an unmarried minor parent, to receive 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.

FRAUD PENALTY WARNINGS

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 else get benefits for which they are not eligible. You must repay any benefit you wrongly receive.

If you misrepresent your residence or identity to receive multiple benefits, you can be barred from receiving Temporary Assistance and Food Stamps for 10 years.

Under Temporary Assistance program rules, if you are convicted of fraud in court or an administrative hearing, you may not be able to get benefits for 6 months for the first time, 12 months for the second time, and permanently for the third time. Other penalties may also apply.

Under Medicaid rules, if you are found to have committed an intentional program violation or program abuse, or if you are convicted of a criminal offense related to medical assistance, the state has the right to seek reimbursement for the amount of Medicaid services you or anyone in your household received. There are penalties for kickbacks, bribes, or rebates in furnishing Medicaid benefits. Penalties include fines up to \$25,000 and imprisonment for up to five years. Conviction of an offense could cause loss of Medicaid benefits for up to one year.

Under Food Stamp rules if you are convicted of fraud or otherwise found to have intentionally broken the rules, you will be disqualified from the Food Stamp Program for one year for a first offense, two years for a second and permanently for a third. You may also be fined up to \$250,000, imprisoned up to 20 years, or both. You may not use Food Stamps benefits to buy items such as alcohol or tobacco. You may not sell or trade Food Stamp benefits, or use someone else's Food Stamp benefits. If you are convicted of using Food Stamp benefits to get drugs, you will be disqualified from the program for two years for a first offense and permanently for a second offense. If convicted of trading or selling Food Stamps benefits worth more than \$500, or trading Food Stamp benefits for firearms, ammunition, or explosives, you will be permanently disqualified from the Food Stamp Program. Individuals convicted of drug-related felonies are barred from the Food Stamp Program.