State of Alaska
Department of Health and Social Services
Division of Public Assistance

If known, please provide the following information:

_____
name of agency or nursing home

_____
name of care coord./ social worker

_____
phone fax

Application for Adults and Children with Long Term Care Needs

Please check the services you need:

☐ Home and Community-Based Services Medicaid Waiver (a.k.a. CHOICE)
☐ Child with Disabilities
☐ Nursing Home
☐ Check here if applicant is 18 years of age or older and would like to apply for the Adult Public Assistance cash program in addition to Medical Assistance.

Please read this information before completing this application form: This application is only for Medical Assistance and Adult Public Assistance for the individual named below as applicant.

If you would like Medical Assistance coverage or any other type of assistance for anyone else in the family, you may be required to complete a different application. Ask your care coordinator or a Public Assistance caseworker for information about other programs that may help you and your family members.

If you are completing the application on behalf of someone who needs the assistance, including a child, please answer all questions as if that individual was completing the form. If you have legal authority to conduct business for the applicant, such as power of attorney, guardian, etc., please attach documentation of that authority to this application.

_____/____/____ ____-_____-_____
Name of Person Needing Assistance Date of Birth Social Security Number Single or Married Gender

_____ ____/____/___ _____-_____-_____
Spouse (if applicable) Date of Birth Social Security Number (optional)

_____ _____
Applicant's Residence Address Phone Number

_____
Applicant's Mailing Address (if different)

_____ _____
Name and Daytime Phone Number of Person Completing Application (if different from applicant) Relationship to Applicant

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Please answer the following questions as completely as possible. The information is necessary to determine your eligibility for the Medicaid program.

a. Please circle your citizenship status: US Citizen Alien Alien Number: _____

Date applicant arrived in USA _____/_____/_____

b. Please circle the category that best describes your racial/ethnic heritage: (Optional) Alaska Native

Hispanic African American Caucasian American Indian Pacific Islander Asian Other

c. What date did you arrive in Alaska? _____/_____/_____

d. Where did you live before coming to Alaska? City/County/State _____ Country _____

e. Has the Social Security Administration (SSA or SSI) determined your disability? Yes___ No___ If yes, when? _____

Complete f., g., and h. only if the applicant is under 18 years old.

f. Name of Mother: _____Date of Birth: _____ Social Security Number*: _____

Address: _____Daytime Phone Number: _____

Name of Father: _____Date of Birth: _____Social Security Number*: _____

g. To determine if there is a possibility other benefits for the child, please tell us if the combined gross monthly income of the parent(s) living with the child applicant is more than $2,000 per month (optional) Yes ___ No ___

h. How many brothers and sisters live in the home with the applicant? _____

*OPTIONAL

Asset/Resource Information:

a. Check any of the following items that you or your spouse own or have your name(s) on.

___ Annuity
___ Bank/credit union savings/checking accounts
___ Bonds
___ Burial Trust/Burial Plots
___ Certificate of Deposit
___ Escrow Account
___ Individual Retirement Account
___ Joint account with someone
___ Life Estate
___ Life Insurance
___ Money Market Certificate
___ Promissory Note, Loan, Mortgage
___ Savings Bonds
___ Trust Fund

___ Home you live in
___ Property up for sale
___ Property not up for sale
___ Property for future home
___ Property jointly owned with someone other than household member
___ Land or Building
___ Mobile home (other than the home you live in)
___ Trailer (travel, utility, boat or other)
___ Camper
___ Vehicle Shell /Topper
___ Boat Motor

___ Native Corporation Stock
Which?_____
_____
Number of Shares? _____
_____
___ Farm equipment, livestock, and/or crops
___ Antiques/Coin collections
___ Fishing Permit
___ Mining Claim
___ Gold/Silver
___ Other(s) _____
_____

If you have checked any of the above, please provide a current statement or other document showing value of the items with application or bring to the interview. If no statement or other document is available please complete the following section:

Name of Owner	Asset (bank name and account/deed/registration, etc.)	Value

b. Do you receive income dividends from the sources above? Yes ___ No ___ If Yes, how often? _____ Average amount?_____

c. Are you or your spouse planning on buying any additional types of assets/resources listed above? Yes ____ No ____

If yes, please explain: _____

_____

Vehicles:

a. How many of the following vehicles do you or your spouse own?

Car _____ Truck_____ Boat_____ Snowmachine_____ Four Wheeler_____ Airplane _____

How many other type of vehicle(s) _____ List type(s)_____

b. Please complete the following information about the vehicles.

Name of Owner	Vehicle Type	Year	Make/Model	Current Value	Amount Owed	Monthly Payment

c. Are the vehicles used to: transport a person with disabilities? Yes ___ No ___ If yes, which vehicle? _____
get to medical services? Yes ___ No ___ If yes, which vehicle?_____

d. Are any of the vehicles used to perform your daily activities, including going to the bank, grocery store, church, work, or school? Yes ___ No ___ If yes, which vehicle:_____

Transfer of Assets/Resources: (needed only if applying for nursing home coverage or waiver services)

Have you or your spouse (or legal representative) sold, transferred, traded, given away, or put into trust any assets in the last 60 months (5 years)? Yes ___ No ___ If yes, please complete the following information.

Asset Description	Value of Asset	Date of transfer or trust establishment
_____	$_____	_____
_____	$_____	_____
_____	$_____	_____

Please bring documents about the transfer or trust to the interview or attach them to this application.

About Your Home:

Do you own a home? Yes ___ No___ Do you rent your home? Yes ___ No___ What is the monthly rent? $_____

Please attach proof. If you own your own home, what is the value after subtracting the amount owed? $_____

Do you live there now? Yes ____ No____ If no, are you (circle one) In the hospital? Nursing home? Assisted living? Other?

(explain) _____

If you are out of your home now, do you intend to return home? Yes____ No ____

*Does anyone else live in your home? Yes___ No___ List their relationship to you: _____

Do you receive income from this property? Yes___ No___ If Yes, please list the amount and how often_____

Only answer if applying for Adult Public Assistance

Income Information:

a. If you or your spouse receive or expect to receive income from any of the following sources, please indicate the amount and how often it is received. Reminder: if applicant is a child, your responses are about the child's income.

Please check.	*Applicant*	*Spouse*		*Applicant*	*Spouse*		*Applicant*	*Spouse*
Social Security	____	____	Other Retirement	____	____	Unemployment	____	____
Supp. Security Income	____	____	Life Insurance	____	____	Annuities	____	____
Veteran's Benefits	____	____	Indiv. Retirement Account	____	____	Loans	____	____
Payment from rent/contract	____	____	Awards/Prizes	____	____	Child Support	____	____
Military Retirement	____	____	Wages	____	____	Alimony	____	____
Pensions	____	____	Self-employment	____	____	Other Income	____	____

b. Have you or your spouse had any changes to your income during the last 90 days? Yes ___ No ___

If yes, please explain:_____

c. Do you expect any changes in your income soon? Yes ___ No ___ If yes, please explain: _____

Medical Insurance Information:

Medicaid does not pay medical expenses that a third party, such as a private insurance company would pay. When you apply for Medicaid, you must help identify other sources that could pay for your medical care. If you do not agree to allow the State to seek payment from other sources, you may not be eligible to receive Medicaid.

Do you agree to allow the State of Alaska to seek other sources to help pay for your medical costs? Yes____ No _____

Do you have Medicare Coverage? Yes ___ No ___ If yes, claim number:_____

Do you have any other medical coverage? Yes ___ No ___ If yes, please complete the following section:

Insurance Company Name, Address, or Phone Number (*This is required information if you have insurance*)

Policy and Group Number

_____ _____

_____ _____

_____ _____

Is there another person or insurance company that may pay your medical costs because of an accident? Yes____ No ____

If yes, please explain: _____

_____

Did you need help with paying any unpaid medical expenses in the last three months? Yes____ No ____

If yes, please explain:_____

Rights and Responsibilities:

I understand that:

I must report any changes in my circumstances within 10 days to the Division of Public Assistance.
If I do not agree with the decision made on this application, I have the right to ask for a fair hearing. I can make this request by phone, in writing, or in person to any Public Assistance Office.

I have the right to an equal opportunity to apply for and receive benefits administered by the Division of Public Assistance. If I believe I have been discriminated against because of my race, color, sex, age, handicap, religion, national origin, or political beliefs, I understand that I should write immediately to: Department of Health and Social Services, Civil Rights Coordinator, PO Box 110640, Juneau, AK 99811-0640. I must provide proof of eligibility for Medicaid. My situation is subject to verification by the Division of Public Assistance or other state or federal agencies.

The Social Security Number(s) I provide is required in accordance with 42 CFR 435.910 for individuals who will be receiving coverage through Medicaid. The Social Security Numbers are matched with records of other agencies such as the Social Security Administration, Internal Revenue Service, Department of Labor, etc. to verify eligibility for Medicaid. The information in this application and the case record will be kept confidential and used only for authorized purposes.

By asking for and receiving Medicaid benefits, I agree to:

- 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 myself;
- 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 myself;
- Agree to apply for all other available third-party resources that may be used to provide or pay for the cost or care or services received by myself or that may be used to reimburse the state for the cost of care or services received.
- Assign to the State of Alaska as a remainder beneficiary, or as the second remainder beneficiary after my spouse or minor or disabled child, for any interest that I may have in an annuity up to the amount of Medicaid benefits provided.

Not cooperating with Medicaid in obtaining and providing information about health insurance coverage for myself or the applicant results in not being eligible for Medicaid benefits.

By signing this application, I authorize the Department of Health and Social Services to obtain information in medical records pertaining to Medicaid services received by me.

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.

Statement of Truth and Authorization for Release of Information

I authorize the release of information requested by the Department of Health and Social Services or its agents. The requested information will be used solely in the administration of Public Assistance programs and will not be released to any other person or agency outside the Department of Health and Social services or its agents.

Under penalty of perjury, I certify that the information made on this application, including U.S. citizenship or satisfactory immigration status, are true and complete to the best of my knowledge. I have read or have had read to me and understand my rights and responsibilities.

Signature of Applicant or Applicant's Representative, Power of Attorney or Guardian/Conservator — Date	Signature of Applicant's Spouse — Date
Signature of Witness (if signed with an "X") — Date	Signature of Witness (if spouse signed with an "X") — Date

Authorized Representative (Optional)

An authorized representative is someone you name in writing who may act on behalf of your household. This person must be age 18 or older. Even though an authorized representative may sign and submit this application on your behalf, please review the application yourself. I have asked the person named here to help me with my application and case for Medicaid or other public assistance programs.

Name of Person (please print)	Daytime or Message Phone Number of Person

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