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

PROTECTIVE PAYEE AGREEMENT

Check Program Choices

☐ Adult Public Assistance or Interim Assistance
☐ Senior Benefits Program

I, _____, agree to serve as protective payee

for _____.

I agree to receive and use the monthly Adult Public Assistance and/or Senior Benefits payment to meet the current needs of the person listed above. If requested, I agree to provide the Division of Public Assistance with an accounting of how the payments were used. I understand the Division may end my service or I may withdraw as payee at any time.

_____ _____ _____
Signature of Payee | Printed Name | Date

_____ _____
Mail Address | Phone

How do you want to receive the assistance payments? Direct Deposit ☐ Mail ☐

- If by direct deposit, please contact your local Public Assistance Office or the Direct Deposit Office at 1-888-620-1111 to request a Direct Deposit Enrollment form.
- If by mail, where should the payments be sent?

  _____
  Mail Address
- Where should Medicaid coupons be sent?

  _____
  Mail Address
- Please attach proof of legal guardianship and/or Power of attorney if applicable.

I request that _____ be my protective payee.

I understand my payee will receive my monthly Adult Public Assistance and/or Senior Benefits payment and use the money to meet my current needs. I understand I must notify the Division of Public Assistance if I want to change my protective payee.

_____ _____
Signature of Recipient, Guardian, or Power of Attorney | Date

Distribution: APA case file
Senior Benefits case file