DIVISION OF PUBLIC ASSISTANCE
REFERRAL FOR DISABILITY DETERMINATION

Mail to: **Disability Determination Service**
619 E. Ship Creek Ave, Suite #305
Anchorage, AK 99501

Date: ____________________________

θ Initial State-Only Determination θ Review *(attached existing disability file)* θ Pre-Hearing Review

For: (check all that apply)

- ❑ Adult Public Assistance, State-only disability benefits
- ❑ Adult HCB Medicaid Waiver
- ❑ Child HCB Medicaid Waiver or Disabled Child at Home *(TEFRA)* Medicaid
- ❑ Working Disabled Medicaid Buy-In *(Disregard SGA)*

Special Notes:

❑ Prior disability allowance under SSA or SSI program *(check if yes)*
SSI application may coincide or a disability decision may already exist. If so, please explain why a state-only decision is needed: ____

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Other Information/comments: ____

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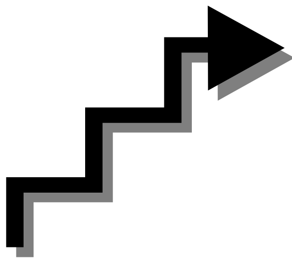
CASEWORKER INSTRUCTIONS: *Please make sure packet is complete! For adult must include GEN 141, APA 4, MED 2 and as much **current medical evidence** of person's condition as is possible to obtain. Packet for child must include GEN 141, MED 1, MED 2, and as much **current medical evidence** of child's condition as is possible to obtain. Send several medical release forms with original signatures, do not date the release of information.*

Applicant's Name: ______________________________ Date of Birth: ______________________________

SSN: ______________________________ DPA Application Date: ______________________________



Return Decision File to DPA Office at:

DPA Caseworker: ______________________ Phone: ____________________ Fax: ________________

<u>Complete if known for HCB Medicaid Waiver or TEFRA cases</u>:

Div of Mental Health & Dev Disabilities

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Case Manager

____
Location Phone # / Fax #

Care Coordination Agency

____
Provider Agency Name

____
Care Coordinator's Name Phone # / Fax #