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

REPORT OF CLAIM DETERMINATION

Complete this form online, print two copies, one for case record, and send one to Benefit Issuance & Recovery Unit in Juneau.

Case Name _____ Date _____

Case Number _____ District Office _____

PLEASE DO NOT COMBINE PROGRAM OVERPAYMENTS. IF AN OVERPAYMENT EXISTS FOR MORE THAN ONE PROGRAM, USE BOTH SIDES OF THIS FORM.

CHECK SPECIFIC PROGRAM: ATAP _____ SNAP _____ APA _____ SB _____ GRA _____

BENEFIT MONTH	ERROR CAUSE AG = Agency Caused CL = Client Caused Circle One	AMOUNT OF BENEFIT ISSUED	AMOUNT OF BENEFIT ENTITLED TO	OVERPAYMENT OR UNDERPAYMENT AMOUNT
	AG CL			
	AG CL			
	AG CL			
	AG CL			
	AG CL			
	AG CL			
	AG CL			

EXPLAIN HOW AND WHY THE OVERPAYMENT OCCURRED: Include names, **DATES**, resource, income, deduction amounts, and other relevant information. Also include the program manual section(s) supporting the reason benefits are being recouped.

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PRINTED NAME OF CASEWORKER SIGNATURE OF SUPERVISOR

_____ _____

SIGNATURE OF CASEWORKER DATE REVIEWED BY SUPERVISOR

Case Name _____ Case Number _____

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