Alaska Department of Health
Division of Public Assistance

Office Use Only

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

Senior BENEFITS PROGRAM

☐ **New Application**
☐ **Renewal Application**

Alaska residents who are age 65 or older may qualify for a monthly payment from the Senior Benefits Program. Income limits are based on the Alaska Federal Poverty Guidelines and will change every year. Benefit amounts are tied to legislative funding and can change at any time.

Please complete the information below so we can determine your eligibility for these benefits. We need this information for you and your spouse if he or she is living with you, even if your spouse is under the age of 65. If you are both applying for Senior Benefits, you will both need to complete the Authorization for Release of information on page 3 and sign the application on page 4.

1 Are you applying for you? ☐ Yes ☐ No
Are you applying for your spouse? ☐ Yes ☐ No (must be 65 years old)

2 Applicant Information

Name (First, Middle Initial, Last)	Social Security Number		Date of Birth
Do you intend to remain an Alaska Resident? ☐ Yes ☐ No	☐ US Citizen ☐ Legal Alien Alien #:		☐ Male ☐ Female
Mailing Address (Street or PO Box)	City	State	Zip
Residence Address	City	State	Zip
Phone Number	Message Phone		

3 Spouse Information (required if living with you)

Name (First, Middle Initial, Last)	Social Security Number	Date of Birth
Do you intend to remain an Alaska Resident? ☐ Yes ☐ No	☐ US Citizen ☐ Legal Alien Alien #:	☐ Male ☐ Female

GEN 152 (06-3944) rev 12/24

Income. Income is any money that you or your spouse receives that can be used to meet your needs. Income includes, but is not limited to wages and other earnings, Virtual Currency/Cryptocurrency, annuity payments, pension or retirement payments, disability benefits, veteran's benefits, Social Security payments, Supplemental Security Income (SSI), Adult Public Assistance, alimony, Native corporation payments, dividends from stocks or bonds, etc.

4 Please list the gross annual income received by you and your spouse. Do not include the Alaska Permanent Fund Dividend. Attach Proof.

Gross annual income is the amount before any deductions are subtracted, such as taxes or Medicare premiums.

Type of Income? (Social Security, pension, retirement, wages, native dividends, etc.)	Who receives this money? (you or spouse)	Gross Annual Amount
		Total

If you are not registered where you live now, would you like to apply to register to vote? ☐ Yes ☐ No

State of Alaska
Department of Health
Division of Public Assistance

What is an 'Authorization for Release of Information'?

Your signature on this form gives the Department of Health, its agents, and the Department of Law permission to ask for information about your health, finances, family and personal history. This information is only 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 or its representatives. The Release of Information will be in effect while you are an applicant or recipient of Public Assistance, and for any later investigations of your eligibility and receipt of benefits.

Who will we ask for information?

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

I Authorize This Release of Information:

_____	_____
Signature of Adult	Signature of Other Adult
_____	_____
Printed Name	Printed Name
_____	_____
Social Security Number	Social Security Number
_____	_____
Address	Address
_____	_____
Phone Number	Phone Number
_____	_____
Date	Date

A Copy of this Release is as Valid as the Original

Rights and Responsibilities. I understand that:

- I have a right to request a fair hearing if I do not agree with the decision made on this application. I can make a request for a fair hearing, in writing, to any Division of Public Assistance office. The request for a fair hearing must be received within 30 days from the date of the notice.
- I, or a responsible person acting on my behalf, must report changes in my circumstances within 10 days after the event occurs. Changes can be reported by phone, in writing, or in person. The Division of Public Assistance must be notified if the applicant or their spouse:
  - Has a change in mailing or residence address,
  - Is absent from the state for 30 consecutive days or more,
  - Is admitted to or discharged from a hospital, nursing home, or Pioneer Home,
  - Has a change in income, or
  - Passes away
- If you receive an overpayment of Senior Benefits to which you are not entitled, you may be financially responsible for repaying the overpayment to the State of Alaska. By accepting benefits, you must understand and agree that you may have a responsibility for the repayment of benefits to which you were not entitled.

ACKNOWLEDGEMENT OF UNDERSTANDING AND STATEMENT OF TRUTH

Acknowledgements

- I understand that I must be a current Alaska resident to qualify for Public Assistance benefits administered by the Alaska Division of Public Assistance. I further understand that, if my residency status changes, I must report the change to the Alaska Division of Public Assistance within 10 days. I further understand that if I leave the state for 30 or more days, I must notify the Alaska Division of Public Assistance of my absence, regardless of whether I consider myself an Alaska resident/intend to return to Alaska, or not.
- I understand that eligibility for Public Assistance is determined in part by how much income my household has at its disposal. To that end, I understand that this application requires that I disclose all income received by myself and members of my household, including but not limited to income from the following sources: Employment (including Self-Employment), Alimony, Child Support, Unemployment, Net Rental/Royalty, Pension/Retirement, Supplemental Security Income, Veteran's Benefits, and Social Security Benefits.

I have read or had read to me the "Rights and Responsibilities" section of the application and I understand my rights and responsibilities, including fraud penalties, as described in this application.

I have read or heard read to me the "Acknowledgments" section of the application and understand each one.

Under penalty of perjury, I certify that all information contained in this application, including U.S. citizenship or lawful immigrant status of all persons applying for benefits, is true and correct to the best of my knowledge.

Signature of Applicant: _____ Date: _____

Signature of Spouse: _____ Date: _____

Please return your completed application to any Division of Public Assistance office. A list of offices and their contact information can be found on the last page.

APPENDIX C: Authorized Representative or Release OPTIONAL

Appointing an Authorized Representative

Would you like to allow someone to represent you on all matters related to your application and case?

You can give a trusted person or an organization permission to talk about your application and case with us, see your information, and act for you on matters related to your Public Assistance case. This person is called an "authorized representative." **An authorized representative can make changes to your Public Assistance case and has access to the information in your case file. You will be held responsible for any change that is made to your case by your appointed authorized representative, up to and including potential fraud charges.**

The Division of Public Assistance can release any information regarding your application and case to your authorized representative or any member of the organization indicated on this form. More than one person or organization can serve as your authorized representative.

You can appoint, withdraw, or change an authorized representative at any time. If you ever need to change your authorized representative, contact the Division of Public Assistance. *If you are a legally appointed representative for someone on this application and provide proof, you do not need to complete this section.*

Name of Authorized Representative (First name, Middle name, Last name) or Organization		Phone Number
Authorized Representative's Address	Apartment or suite number	Email
City	State	ZIP code

◯ New ◯ Change ◯ Addition ◯ Remove this person or organization as my authorized representative

OR

Permission to Release Information

Is there anyone that you would like us to share information with about your application and case?

By completing this section, you can give permission for the following person or organization to receive information about your Public Assistance application and benefit status, but they will not have the ability to act on your behalf like an authorized representative. You give the Division of Public Assistance permission to release information about your case status to this additional person or organization. You may cancel this release at any time by contacting the Division of Public Assistance.

Name of person (First name, Middle name, Last name) or Organization		Phone Number
Address	Apartment or suite number	Email
City	State	ZIP code

AND

Applicant / Recipient's Signature	Date (mm/dd/yyyy)
Applicant / Recipient's Printed Name	Social Security Number or Case Number

To be valid, this form must be signed by the applicant or recipient.

Public Assistance Offices

ANCHORAGE University Center 4001 Ingra Street, Suite 131 Anchorage, AK 99503 Phone: 1-800-478-7778 Fax: (907) 269-6520 or 1-888-269-6520 hss.dpa.offices@alaska.gov	**BETHEL** 460 Ridgecrest Drive, Suite 121 Mailing: P.O. Box 365 Bethel, AK 99559 Phone: 1-800-478-7778 Fax: 1-888-269-6520 hss.dpa.offices@alaska.gov	**FAIRBANKS** 675 7th Ave, Station E Fairbanks, AK 99701 Phone: 1-800-478-7778 Fax: 1-888-269-6520 hss.dpa.offices@alaska.gov
HOMER 3670 Lake Street, Suite 200 Homer, AK 99603 Phone: 1-800-478-7778 Fax: 1-888-269-6520 hss.dpa.offices@alaska.gov	**JUNEAU** 10002 Glacier Highway, Suite 201 Mailing: P.O. Box 110642 Juneau, AK 99811-0642 Phone: 1-800-478-7778 Fax: 1-888-269-6520 hss.dpa.offices@alaska.gov	**KENAI** 11312 Kenai Spur Highway, Suite 2 Kenai, AK 99611 Phone: 1-800-478-7778 Fax: 1-888-269-6520 hss.dpa.offices@alaska.gov
KETCHIKAN 2030 Sea Level Drive, Suite 301 Ketchikan, AK 99901 Phone: 1-800-478-7778 Fax: 1-888-269-6520 hss.dpa.offices@alaska.gov	**KODIAK** 211 Mission Road, Suite 101 Kodiak, AK 99615 Phone: 1-800-478-7778 Fax: 1-888-269-6520 hss.dpa.offices@alaska.gov	**LONG TERM CARE** University Center 4001 Ingra Street, Suite 131 Anchorage, AK 99503 Phone: 1-800-478-7778 Fax: (907) 269-6520 or 1-888-269-6520 hss.dpa.offices@alaska.gov
NOME 214 E. Front Street Nome, AK 99762 Mailing: 675 7th Ave, Station E Fairbanks, AK 99701 Phone: 1-800-478-7778 Fax: 1-888-269-6520 hss.dpa.offices@alaska.gov	**SITKA** 304 Lake Street, Suite 101 Sitka, AK 99835 Phone: 1-800-478-7778 Fax: 1-888-269-6520 hss.dpa.offices@alaska.gov	**WASILLA** 855 W. Commercial Drive Wasilla, AK 99654 Phone: 1-800-478-7778 Fax: 1-888-269-6520 hss.dpa.offices@alaska.gov

If you need a language interpreter, call 1-800-478-7778 and we will provide one at no cost to you. If you are deaf, hard of hearing, or have a speech disability, dial 711 to reach an Alaska Relay Communications Assistant.