Alaska Department of Health
Division of Public Assistance

Felony Qualifying Condition Verification Form

To: Anchorage Department of Corrections (DOC): apo@alaska.gov

We have information indicating that the individual listed below was convicted of felony aggravated sexual abuse, murder, sexual exploitation and abuse of children, or sexual assault that would permanently disqualify them for Supplemental Nutrition Assistance Program (SNAP), unless they meet specific conditions.

Client's First and Last Name: _____

Date of Birth: _____

DOC Case Number: _____

Offender # (if known): _____

Please select all boxes that apply to the above referenced felony conviction:

- ☐ Satisfactorily serving or has successfully completed a period of probation or parole; or
- ☐ Successfully complying with the requirements of their reentry plan; or
- ☐ None of the above conditions have been met.

DOC Employee Name: _____

Signature: _____

Phone Number: _____

Date Completed: _____

Please return this completed form to: hss.dpa.offices@alaska.gov