STATE OF ALASKA
DEPARTMENT OF HEALTH AND SOCIAL SERVICES
DIVISION OF PUBLIC ASSISTANCE

To: **Division of Public Assistance**
Claims Unit
P.O. Box 110640
Juneau, Alaska 99811

From: _____
(DPA Office)

_____
(Date Mailed)

PUBLIC ASSISTANCE CLAIM REMITTANCE

Complete this section for each payment received in a DPA office. A separate form is required for each payment. Refer to Administrative Procedures Manual for instructions. Send the completed form and payment to the Claims Unit using certified mail.

Enclosed is a payment in the amount of $_____ for the public assistance case belonging to:

_____ _____
(Case Name) (Case Number)

Circle Form of Payment: Check Money Order

Circle Program Type: ATAP APA FS MED GA

Circle Reason for Payment: Overpayment Claim Voluntary Return

Client Deceased Other:_____

_____ _____
(DPA Signature #1) (Date) (DPA Signature #2) (Date)