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

Declaration Of Identity For A Disabled Individual In Institutional Care

This form meets the Medicaid photo identity requirement for a disabled individual in institutional care.

Please Print:

1. Applicant's Full Name: _____
2. Applicant's Date of Birth: _____
3. Applicant's Place of Birth: _____
   (city, state, country)

I hereby swear and affirm, under penalty of perjury, that the information provided above is true and correct to the best of my knowledge.

_____ _____
Signature of Director or Administrator Date

_____
Printed Name of Director or Administrator

_____
Name of Residential Care Facility

_____ _____
Mailing Address Phone Number

_____ _____
City State Zip