Alaska Department of Health
Division of Public Assistance

Medicaid Application for Adults and Children with Long Term Care Needs

Please check the program or service you need:

☐ Nursing Home ☐ Home & Community Based Medicaid Waiver ☐ Disabled Children at Home (TEFRA)

This application is only for Medicaid benefits for an individual needing Long Term Care services and supports. If you are completing the application on behalf of someone who needs the assistance, including a child, please answer all questions as if that individual was completing the form. Be sure the form is complete. If you need more space for any answer, use another piece of paper. Please print clearly.

Name		
Mailing Address		
Residence Address (if different from mailing address)		
Home Phone Number	Message Phone Number	Work Phone Number
Is English your first language? ☐ Yes ☐ No If English is not your first language, do you speak, read, and write English with sufficient proficiency to understand and properly fill out this application? ☐ Yes ☐ No		

HOUSEHOLD INFORMATION:

1. List all persons who live with you, including full-time, part-time, or temporarily, and use legal names. List yourself first.
**Disclosure of your Race and Ethnicity information is voluntary and will not affect your eligibility or level of benefits. This information will be used to assure that program benefits are distributed without regard to race, color or national origin.*

Name (First M I Last)	**Relation to You** If not related write NR.	**Date of Birth**	**Is this person a full-time or part-time member of your household?** Circle the answer. If part-time, what percentage of time does this person reside with you?	**Social Security Number**	**US Citizen?** Yes/No	**Race** / **Optional - Use codes below**	**Ethnic Group** / **Optional - Use codes below**
	Self		N/A				
			Full-time / Part-time ___%				
			Full-time / Part-time ___%				
			Full-time / Part-time ___%				
			Full-time / Part-time ___%				

Race: (You may select more than one race)
AN = Alaska Native **WH** = White **BL** = Black or African American
AI = American Indian **AS** = Asian **PI** = Native Hawaiian or other Pacific Islander

Ethnicity:
Y = Hispanic or Latino
N = Not Hispanic or Latino

What date did you arrive in Alaska? _____

Where did you live before moving to Alaska? City/County/State/Country: _____

I am: ☐ Single ☐ Married living with spouse ☐ Divorced ☐ Widowed
☐ Married living apart from spouse Name of spouse: _____

Are you or anyone in your household a sponsored alien? ☐ Yes ☐ No

Has the Social Security Administration determined your disability? ☐ Yes ☐ No If yes, when? _____

ASSETS INFORMATION:

2. Check any of the following items that you or your spouse own or have your name(s) on. You must include any asset of any kind:

☐ ABLE Account
☐ Annuity
☐ Antiques
☐ Bank Accounts
☐ Boat Motor
☐ Bonds
☐ Burial Accounts
☐ Burial Plots
☐ Cabin
☐ Camper
☐ Cash on hand
☐ Certificate of Deposit
☐ Coin Collection
☐ Credit Union Accounts
☐ Escrow Account
☐ Farm equipment/livestock/crops
☐ Fishing Permit
☐ Gold/Silver
☐ Home you do not live in
☐ Home you live in
☐ Individual Retirement Account
☐ Joint account with someone
☐ Land or Building
☐ Life Estate
☐ Life Insurance
☐ Money Market Certificate
☐ Promissory Note/Loan/Mortgage
☐ Property up for sale
☐ Reverse Mortgage
☐ Savings Bonds
☐ Trailer (travel, utility, boat, etc.)
☐ Trusts
☐ Vehicle Shell/Topper
☐ Vehicles (car, truck, boat, airplane, etc.)
☐ Virtual Currency/Cryptocurrency
☐ Other: _____

☐ Native Corporation Stock: Which? _____ Number of Shares? _____

If you have checked any of the above, please complete the following information about the assets. ***Please provide a current statement or other document showing the value of the items with this application.***

Owner	Type of Property/Asset	Value	Owner	Type of Property/Asset	Value
		$			$
		$			$
		$			$
		$			$
		$			$
		$			$
		$			$

3. Have you or your spouse (or their legal representative) sold, transferred, traded, given away, or put into trust any assets in the last 60 months (5 years)? ☐ Yes ☐ No ***If yes, please complete the following information and provide documents about the transfer with this application.***

Asset Description	Value of Asset	Date of transfer or trust establishment

MONEY RECEIVED INFORMATION:

4. Complete if you or anyone in your household is working. ***Please provide your most recent pay stubs or a work statement completed by your employer. If self-employed, describe and attach proof of income and expenses with this application.***

Person Employed	Employer	Hours Worked	Hourly Wage	How often paid?
		per week		
		per week		
		per week		
		per week		

5. List any other money you or anyone in your household receives. *Include Social Security, SSI, BIA, VA, retirement, unemployment insurance, Worker's Compensation, Native assistance, child support, Virtual Currency/Cryptocurrency, cash gifts, annuities, etc.*

Who Receives	Income Source	Amount	Who Receives	Income Source	Amount
		$			$
		$			$
		$			$
		$			$

HOUSEHOLD EXPENSE INFORMATION:

6. Complete if you or your spouse has any of these monthly expenses. ***Please provide proof of the obligated monthly rent amount, utility costs, and yearly property tax and insurance amounts***.

Expense Type	Monthly Amount	Expense Type	Monthly Amount	Expense Type	Monthly Amount
Rent/ Mortgage	$	Telephone	$	Heating Oil	$
Lot or Space Rent	$	Electricity	$	Natural Gas	$
Property Tax	$	Water / Sewer	$	Wood / Coal	$
Home Insurance	$	Garbage	$	Other _____	$

Failure to report or verify any of the above listed expenses will be seen as a statement by your household that you do not want to receive a deduction for the unreported expense.

If you share payment of these expenses with anyone or receive assistance paying the expenses (such as rental assistance or heating assistance), please explain. _____

Do you own a home? ☐ Yes ☐ No Do you rent a home? ☐ Yes ☐ No Do you live there now? ☐ Yes ☐ No

If no, do you plan on returning? ☐ Yes ☐ No If yes, when do you plan on returning? _____

Does anyone live in the home now? ☐ Yes ☐ No

If yes, list their relationship to you: _____

Do you receive income from this property? ☐ Yes ☐ No If yes, list the amount and how often: _____

Have you incurred any medical expenses that will not be reimbursed by Medicare, Medicaid, or other third parties? ☐ Yes ☐ No If yes, please provide proof.

HEALTH COVERAGE / INSURANCE:

7. Do you need help paying for medical bills from the last 3 months? ☐ Yes ☐ No
If yes, which months? _____

8. If you or anyone in your household has health insurance, check the type of coverage and write the person(s) name next to the coverage they have. please answer these questions:

☐ Medicaid _____
☐ Medicare _____
☐ TRICARE _____
☐ VA health care programs _____
☐ Employer Insurance _____
Name of health insurance: _____
Policy number: _____
Is this COBRA coverage? ☐ Yes ☐ No
Is this a retiree plan? ☐ Yes ☐ No

☐ Other _____

9. ADDITIONAL INFORMATION

Name of nursing home: _____ Phone: _____ Fax: _____

Name of Care Coordinator: _____ Phone: _____ Fax: _____

10. AUTHORIZED REPRESENTATIVE

If you would like to allow someone to represent you on all matters related to your application and case or would like the Division to share information about your application or case with someone, complete and include Appendix C.

11. 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 understand that eligibility for Public Assistance is determined in part by how many assets my household has at its disposal. To that end, I understand that this application requires that I disclose all assets possessed by myself and members of my household, including but not limited to the following types of assets: Property (regardless of whether the Property is paid for, still being paid for, or is jointly owned with someone else), all Bank Accounts (including checking and savings accounts), Cash on Hand, Certificates of Deposit, College Savings Plans, Life Insurance Policies, Pension Plans, Retirement Funds, Stocks Bonds and Annuities, Native Corporation Shares, Trust Funds, Safety Deposit Box contents, Mineral Rights, IRA Accounts, Commercial Fishing Permits, and Burial Policy Agreements.

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 Adult Applicant: _____
Signature **Date (month/day/year)**

Signature of Other Adult Applicant _____
Signature **Date (month/day/year)**

Signature of Authorized Representative: _____
Signature **Date (month/day/year)**

12. VOTER REGISTRATION

If you want to register to vote we can help you by sending you the correct forms to complete. If you do not answer the question, it will be considered the same as a No answer. This will not stop your ability to register to vote in the future.

Do you want to register to vote? ❒ Yes ❒ No

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.

Your Rights and Responsibilities

What if I disagree with a decision made?

You have the right to discuss any action taken on your application or case with a caseworker or supervisor. If you think the Division of Public Assistance or Federally Facilitated Marketplace has made a mistake on your health insurance determination or the Division of Public Assistance has made a mistake on your benefits determination, you can appeal its decision. To appeal means to tell someone at the Division of Public Assistance or the Federally Facilitated Marketplace that you think the action is wrong and ask for a fair hearing review of the action. The request for Supplemental Nutrition Assistance Program (SNAP) and Medicaid may be made to any employee of the Division in person, by telephone, or in writing; requests for all other programs must be made in writing. SNAP fair hearing requests must be made within 90 days from the effective date of the action. Fair hearing requests for all other programs must be made within 30 days from the date of the notice. If requested, the Division will assist you in making a hearing request. If your disagreement has to do with medical billing or services, contact the Medicaid Recipient Information Helpline at 1-800-780-9972.

If you request a fair hearing before the effective date of the action, you may continue to receive benefits until a hearing decision is made. If you do not request a fair hearing before the effective date of the action, you can still appeal but benefits will not be continued. You can always re-apply for benefits while waiting for your hearing. At the hearing you may represent yourself or be represented by a legal representative. You may qualify for free legal advice and representation by contacting the Alaska Legal Services Corporation at (907) 272-9431 or 1-888-478-2572.

My right to appeal

I know that I can find out how to appeal by contacting the Division of Public Assistance or the Marketplace at 1-800-318-2596. I know that I can be represented in the process by someone other than myself. My eligibility and other important information will be explained to me.

When do I need to report changes?

You must report changes in your household within 10 days of when you know of the change. If you receive Alaska Temporary Assistance and a child leaves your home, you must report this within 5 days.

What changes do I need to report?

If you receive Health Insurance Benefits authorized by the Federally Facilitated Marketplace or Public Assistance Medicaid, you must report any and all changes to information provided in this application, including changes in your medical insurance.

If you receive Supplemental Nutrition Assistance Program and you do not receive benefits from any other program, you must report when your household's total gross income goes over the income limit for your household size and if someone in your household has lottery or gambling winnings of $4,500 or more in a single game. If your household contains a member subject to the ABAWD time limits, you must report when their work hours fall below 20 hours per week.

If you receive other public assistance programs, the changes you must report include, but are not limited to the following:

- Starting or stopping a job, change in wage rate, change from part-time to full-time, or full-time to part- time
- When money you receive from sources other than working changes by more than $50
- Someone moves into or out of your home
- You move or get a new mailing address
- Your household gets a vehicle
- Your household has more than $2,000 total in cash and money in bank
- Changes in your child support payment or obligation
- Changes in your medical insurance if you or anyone in your household gets Medicaid
- Pregnancy changes

Will I need to work?

To receive Alaska Temporary Assistance or Supplemental Nutrition Assistance Program, you may have to participate in work activities. Alaska Temporary Assistance participants must prepare a Family Self-Sufficiency Plan for becoming financially independent. You must participate in approved work activities unless you qualify for an exemption. If you are an unmarried minor parent, to receive Alaska Temporary Assistance you must live with a parent or in another approved living arrangement and attend school or training. If you do not fulfill these work requirements or minor parent requirements, your benefits may be reduced or ended.

Read and keep this page.

What happens with my Child Support?

Alaska must collect child support and medical support from any parent who has the duty to pay support for a child receiving Alaska Temporary Assistance or Medicaid. This includes any money owed to you at the time you apply, as well as current and future child support payments. Any child support payments given or paid to you while receiving Alaska Temporary Assistance benefits must be reported and turned over to the State immediately. To change a child support order, you must obtain a new court order or get permission from the Child Support Services Division (CSSD). If you believe you have a good reason not to cooperate with CSSD for these programs, you must tell your caseworker immediately. You may be asked to provide information to support your reason.

When you apply for Alaska Temporary Assistance, you must:

- Sign over to CSSD your right to receive and keep child support payments due to you or a child on Alaska Temporary Assistance.
- Cooperate with CSSD in establishing paternity.
- Agree not to make purchases with or to access the cash benefits on your EBT card at ATMs that are located in bars, liquor stores, gambling or adult entertainment establishments.

When you apply for Medicaid, you must:

- Assign to the State of Alaska all rights to any medical support or other third party payments to the extent the department has paid medical assistance for care and services for you or your minor children.
- Cooperate with and assist the department in identifying and providing information concerning third parties who may be liable to pay for care and services received for you or your minor children.
- Agree to apply for all other available third-party resources that may be used to provide or pay for the cost of care or services received by you or your minor children or that may be used to reimburse the state for the cost of care or services received.
- Cooperate with CSSD in establishing paternity.
- If applying for long-term care services, including Home and Community Based Waiver services, assign to the State of Alaska as a remainder beneficiary, or as the second remainder beneficiary after your spouse or minor or disabled child, for any interest that you may have in an annuity up to the amount of Medicaid benefits received.

Can the State of Alaska take my estate?

The estate of an individual age 55 years of age or older who received Medicaid benefits may be subject to a claim for recovery. This is limited to the reimbursement of services received while the recipient was in a medical institution, including a nursing home or other medical institution, or was receiving home- and community-based services. Under limited conditions, the State of Alaska may place a lien on a recipient's home. However, most estate recovery is conducted after the death of the recipient or the recipient's surviving spouse, if any, and only at a time when the recipient has no surviving child under age 21 and no surviving child who is blind or disabled.

Responsibility for Overpayment

If you receive an overpayment of Public Assistance benefits or receive services to which you are not entitled, you may be financially responsible for repaying the overpayment or cost of services to the State of Alaska. This may be true even if the overpayment or improper authorization of services is due to an error on the part of the Department of Health. By accepting benefits or services, you must understand and agree that you may have a responsibility for the repayment of benefits or services to which you were not entitled.

How are my rights protected?

The Division of Public Assistance will collect information, including the Social Security number (SSN) of each household member who is applying for Supplemental Nutrition Assistance Program, Alaska Temporary Assistance, or Medicaid, to determine eligibility for public assistance benefits. The Division will verify this information through computer matching programs, including the Income and Earnings Verification System (IEVS). This information will be used to monitor compliance with program regulations and for program management. The Division may disclose this information to other Federal and State agencies for official examination, to law enforcement officials for the purpose of apprehending persons fleeing to avoid the law, and to private claims collection agencies for claims collection action. The Division may verify immigrant status of household members by contacting the U.S. Citizenship and Immigration Services (USCIS). Information obtained from these agencies may affect your eligibility and level of benefits.

Providing the requested information, including the SSN of each household member for whom you are seeking benefits, is voluntary. However, failure to provide this information will result in the denial of benefits to each individual failing to provide an SSN. Any SSN provided will be used and disclosed in the same manner, regardless of the eligibility of the individual. The Division of Public Assistance can assist you in applying for a Social Security Number if you are seeking benefits and do not have one.

When you sign the application for assistance and use Medicaid, you consent to release medical records and information about yourself and any other person you are applying for to the Department of Health (DOH). Upon request, any person who has medical records and information or the custody of such records shall release those records to the Department or a representative of the department.

Health or medical information DOH may have about you is protected under the Health Insurance Portability and Accountability Act (HIPAA) of 1996. This federal law provides you with certain rights about how your health information is used and disclosed. The law allows you to find out how DOH used your health information, and how DOH has disclosed your health information outside of DOH. The law also limits the release of information about you to the minimum amount necessary for the purpose of the disclosure and allows you to examine and obtain a copy of your own health records and to request corrections to those records.

You can get an electronic copy of the Notice of Privacy Practices at https://health.alaska.gov/fms/Documents/DOH-Notice-of-Privacy-Practices.pdf or you can request a printed copy by emailing: privacyofficial@alaska.gov or by writing to: State of Alaska, DOH Privacy Official, P.O. Box 110650, Juneau, Alaska 99811-0650.

In accordance with federal civil rights laws and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex (including gender identity and sexual orientation), religious creed, disability, age, political beliefs, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA. Programs that receive federal financial assistance from the U.S. Department of Health and Human Services (HHS), such as Temporary Assistance for Needy Families (TANF), and programs HHS directly operates are also prohibited from discrimination under federal civil rights laws and HHS regulations.

Persons with disabilities who require alternative means of communication for program information (e.g., Braille, large print, audiotape, American Sign Language), should contact the agency (state or local) where they applied for benefits. Individuals who are deaf, hard of hearing or who have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

USDA provides federal financial assistance for many food security and hunger reduction programs such as the Supplemental Nutrition Assistance Program (SNAP), the Food Distribution Program on Indian Reservations (FDPIR) and others. To file a program complaint of discrimination, complete the Program Discrimination Complaint Form, (AD-3027) (found online at: https://www.usda.gov/sites/default/files/documents/ad-3027.pdf and at any USDA office) or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by:

1. mail: Food and Nutrition Service, USDA
   1320 Braddock Place, Room 334, Alexandria, VA 22314; or
2. fax: (833) 256-1665 or (202) 690-7442; or
3. phone: (833) 620-1071; or
4. email: FNSCIVILRIGHTSCOMPLAINTS@usda.gov.

For any other information regarding SNAP issues, persons should either contact the USDA SNAP hotline number at (800) 221-5689, which is also in Spanish, or call the state information/hotline numbers (click the link for a listing of hotline numbers by state); found online at: https://www.fns.usda.gov/snap/state-directory.

HHS provides federal financial assistance for many programs to enhance health and well-being, including TANF, Head Start, the Low Income Home Energy Assistance Program (LIHEAP), and others. If you believe that you have been discriminated against because of your race, color, national origin, disability, age, sex (including pregnancy, sexual orientation, and gender identity), or religion in programs or activities that HHS directly operates or to which HHS provides federal financial assistance, you may file a complaint with the Office for Civil Rights (OCR) for yourself or for someone else.

To file a complaint of discrimination for yourself or someone else regarding a program receiving federal financial assistance through HHS, complete the form on line through OCR's Complaint Portal at https://ocrportal.hhs.gov/ocr/. You may also contact OCR via mail at: Centralized Case Management Operations, U.S. Department of Health and Human Services, 200 Independence Avenue, S.W., Room 509F HHH Bldg., Washington, D.C. 20201; fax: (202) 619-3818; or email: OCRmail@hhs.gov. For faster processing, we encourage you to use the OCR online portal to file complaints rather than filing via mail. Persons who need assistance with filing a civil rights complaint can email OCR at OCRMail@hhs.gov or call OCR toll-free at 1-800-368-1019, TDD 1-800-537-7697. For persons who are deaf, hard of hearing, or have speech difficulties, please dial 7-1-1 to access telecommunications relay services. We also provide alternative formats (such as Braille and large print), auxiliary aids and language assistance services free of charge for filing a complaint. This institution is an equal opportunity provider.

Release

Your signature on this application gives the Federally Facilitated Marketplace, 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 may be used to determine your eligibility for public assistance programs and, if a fraud investigation is launched, in administrative or criminal investigations of your eligibility for benefits. Your information will not be released for any other reason or to any other person or agency outside of the Federally Facilitated Marketplace, Department of Health or its representatives except as required by law. 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.

We'll check your answers using information in our electronic databases and databases from the Internal Revenue Service (IRS), Social Security, the Department of Homeland Security, and/or a consumer reporting agency. If the information doesn't match, we may ask you to send us proof. We may also contact other people or organizations including, but 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. We need this information to check your eligibility for public assistance services and to check your eligibility for help paying for health coverage if you choose to apply. Additionally, information obtained from this release may be used by the Department of Health in administrative proceedings against you, and/or by the Department of Law in criminal proceedings against you.

Read and keep this page.

What happens if I do not follow the rules?

You may be prosecuted if you knowingly give false, incorrect, or incomplete information to get or try to get public assistance benefits you are not eligible for, or to help someone get benefits for which they are not eligible. You must repay any benefits you wrongly receive.

Supplemental Nutrition Assistance Program (SNAP)	
I understand that if I… Commit an intentional program violation of the Supplemental Nutrition Assistance Program defined in 7 CFR 273.16 or any of the following: • hide information or make false statements • use electronic benefit transfer (EBT) cards that belong to someone else • use SNAP benefits to buy alcohol or tobacco • trade or sell benefits or EBT cards	**I may…** • lose SNAP benefits for 12 months for the first offense and be required to repay all benefits overpaid to me • lose SNAP benefits for 24 months for the second offense and be required to repay all benefits overpaid to me • lose SNAP benefits permanently for third offense and be required to repay all benefits overpaid to me • be fined up to $250,000.00, imprisoned up to 20 years or both
• trade SNAP benefits for controlled substances, such as drugs	• lose SNAP benefits for 24 months for the first offense • lose SNAP benefits permanently for the second offense
• give false information about who I am and where I live so I can get extra benefits	• lose SNAP benefits for 10 years for each offense
• have been convicted of trading or selling SNAP benefits worth more than $500, or trading SNAP benefits for firearms, ammunition, or explosives	• be barred from receiving SNAP benefits permanently
Alaska Temporary Assistance Program	
I understand that if I… • commit an intentional program violation or I am convicted of fraud • give false information about who I am and where I live so I can get extra benefits • use my ATAP cash benefits or access them at any ATMs located in bars, liquor stores, gambling or adult entertainment establishments	**I may…** • lose benefits for 6 months for the first offense • lose benefits for 12 months for the second offense • lose benefits permanently for the third offense • other penalties may also apply and I may be subject to criminal prosecution • have to pay back amount received if there is an overpayment
Medicaid Program	
I understand that if I… • commit an intentional program violation or program abuse that results in misuse or overuse of Medicaid benefits or are found guilty of misconduct related to Medicaid benefits • commit Medical Assistance fraud under AS 47.05.210	**I may…** • be required to pay back the amount of Medicaid services that I or anyone in my household received • be excluded from Medicaid for up to 10 years • have to pay fines up to $25,000 and be subject to criminal prosecution

Read and keep this page.

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.