Alaska Department of Health and Social Services
Division of Public Assistance

Facility Verification Form

To: _____ Date: _____

Name: _____ Date of Birth: _____

We have information indicating that the person listed above is a patient in your facility. Before we can determine this person's eligibility for Medicaid or calculate their cost-of-care obligation, we need the following information from you:

Date of Admission: _____

Expected length of stay: (check appropriate box)

☐ 90 days or less ☐ More than 90 days but less than six months ☐ More than six months

Name of Facility:	Contact Person and Phone Number:
Physician's Printed Name:	Physician's Signature:
Telephone:	Address:
Anticipated Release to: (check appropriate box) □ Home □ Assisted Living Home □ Nursing Home/Hospital	

Please return this form to:

_____

_____

_____

NOTE TO HEALTH CARE PROVIDERS ABOUT DISCLOSURES OF PROTECTED HEALTH INFORMATION TO THE DIVISION OF PUBLIC ASSISTANCE

The Division of Public Assistance encourages the use of patient authorization to release protected health information and will attempt to provide a HIPAA-compliant authorization signed by the patient to accompany this request for information. However, please be aware that if an authorization to release information does not accompany this request for information, or if you are unable to obtain an authorization from your patient, HIPAA regulation - 45 CFR §164.512(d) specifically permits disclosures of protected health information to government benefit programs for which health information is relevant to beneficiary eligibility without the patient's authorization.

If you have questions concerning disclosures of protected health information, please contact the Department of Health and Social Services Privacy Official at (907) 465-2150.