Alaska Department of Health
Division of Public Assistance

ABLE Account Reporting Form

This form is only to be used by the Division of Public Assistance to notify the Division of Health Care Services when a Medicaid recipient has an ABLE account. The caseworker must send this completed form and a copy of the ABLE account enrollment paperwork to dmatpl@alaska.gov.

Medicaid Recipient Information

Case Number: _____ Client ID: _____

SSN: _____ DOB: _____

ABLE Account Information

State ABLE Account Opened: _____

ABLE Account Bank: _____

Account Number: _____

Account Balance: _____ Month/Year: _____

Date Account Opened: _____

Date Account Closed, if applicable: _____

Account Owner: _____

Street Address: _____

City, State, and Zip: _____

Phone Number: _____

Authorized Individual (if applicable): _____

Street Address: _____

City, State, and Zip: _____

Phone Number: _____

Caseworker Information

Caseworker Completing Form: _____

Phone: _____ Email: _____