Alaska Department of Health
Division of Public Assistance

Trust Reporting Form

This form is only to be used by the Division of Public Assistance to notify the Division of Health Care Services when an individual uses a Medicaid Qualifying Trust to qualify for Medicaid benefits. Once the Policy unit has approved the trust and Medicaid benefits are authorized, the caseworker must send this completed form and a copy of the trust to dmatpl@alaska.gov.

Type of Medicaid Qualifying Trust

☐ Qualifying Income Trust (Miller Trust)

☐ Special Needs Trust

☐ Pooled Trust

Medicaid Recipient Information

Name: ______________________________ DOB: ______________

Case Number: ______________________ Client ID: ______________________

Cell Phone Number: __________________ Home Phone Number: ______________

Physical Address: ____

____

Mailing Address: ____

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Trustee Information

Trustee Name: __________________________ Relationship to Client: __________

Work Phone Number: __________________ Cell Phone Number: ______________

Home Phone Number: ______________________

Trustee Physical Address: ____

____

Trustee Mailing Address: ____

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Alaska Department of Health
Division of Public Assistance

Trust Account Information

Trust Account Bank: ______________________________

Bank Address: ______________________________

Account Number: ______________________________

Date Trust Registered: ______________________________

Other Trust Information

Attorney Name: ______________________________

Attorney Address: ______________________________

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Emergency Contact (other than Trustee): ______________________________

Relationship to Client: ______________ Work Phone Number: ______________

Cell Phone Number: ______________ Home Phone Number: ______________

Address: ______________________________

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Approval Information

Caseworker Completing Form: ______________________________

Phone: ______________ Email: ______________

Date Approved by Policy: ______________________________