Alaska Department of Health and Social Services
Division of Public Assistance

TEFRA Initial Application Extension Request Form

Please complete the following information to request an extension to the 90-day processing timeframes for your initial TEFRA Medicaid application. All information must be completed and the form must be signed for it to be a valid request. Attach additional information if needed.

Applicant Name: ________________________ Client ID: ________________

Parent Name: ________________________ Contact Number: ____________

Care Coordinator Name: ____________________ Contact Number: ____________

TEFRA application submission date: ________ requested extension date: ____________

Level of Care type being pursued (circle one): IPH SNF ICF/IDD

Reason(s) for extension request: ____

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With my signature below, I acknowledge and accept the delay in processing my child's TEFRA application. I am requesting an extension be granted to the 90-day initial application processing timeframes per my above reason(s).

______________________________ ____________

Parent Signature Date

Mail or fax to: Division of Public Assistance, Long Term Care Coordinator
3601 C Street Suite 460, Anchorage, AK 99524 Fax: (907) 269-3099

Division of Public Assistance Use Only

Extension Request Decision: ◯ Approved DPA will delay a final eligibility determination through the date of ____________________

◯ Denied Denial Reason: ____________________

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______________________________ ____________

Long Term Care Coordinator Signature Date

Distribution: Original to DPA case file; Copies to: Care Coordinator, TEFRA Contractor, DPA Long Term Care Coordinator, DSDS if ICF/IDD LOC