State of Alaska
Division of Public Assistance
Department of Health and Social Services

DPA Use Only

ET Name _____ Phone _____

DPA Office _____ FAX _____

Client SSN_____/_____/_____ EIS Case#_____

Approved: ☐ Yes ☐ No

Preliminary Examination for Interim Assistance

Applicant's Name_____ Birth Date:_____

Dear Physician:

Your patient has applied for Interim Assistance (IA) benefits from the State of Alaska. IA provides a temporary cash benefit to individuals who have applied to the federal Social Security Administration for disability benefits. The information you provide will assist us to determine if the patient qualifies for IA.

If the patient is unable to pay for an examination or medical tests needed solely for the completion of this form, Medicaid may cover these costs. Please ask the patient to contact their local Public Assistance office to obtain a Medicaid coupon for this purpose.

Thank you for your assistance.

If the applicant has one of the following medical conditions, please check the box, and sign on the back. If the applicant does not have a condition listed below, please complete the back of this form.

☐ Amputation of a leg at the hip	☐ Down Syndrome
☐ Total deafness	☐ End stage renal disease with ongoing dialysis
☐ The individual is receiving hospice services because of a terminal illness	☐ HIV with secondary infection severe enough for the individual to be considered as disabled
☐ Spinal cord injury producing inability to ambulate without the use of a walker or crutches for more than two weeks	☐ Stroke (cerebral vascular accident) more than 3 months in the past and continued marked difficulty in walking or using a hand or arm
☐ Bed confinement or immobility without a wheelchair, walker, or crutches, due to a longstanding condition, excluding recent accident and recent surgery. Does not include simple pain (i.e., back pain).	☐ Cerebral palsy, muscular dystrophy, or muscle atrophy and marked difficulty in walking, speaking, or coordination of the hands and arms
☐ Severe mental deficiency (developmental disabilities) evidenced by dependence on others for personal needs (e.g., hygiene) and other routine daily activities). Does not include mental illness.	☐ Amyotrophic lateral sclerosis (ALS, Lou Gehrig's disease)

What is the applicant's diagnosis? _____

_____

_____

Is the applicant expected to recover from this illness or condition? ☐ Yes ☐ No

If yes, what is the expected length of time required for recovery or remission? (please circle)

Less than one month 1 2 3 4 5 6 7 8 9 10 11 12 or more months

Please provide any other information relevant to the applicant's illness or condition or the expected length of time needed for recovery or remission:

_____

_____

_____

Please attach any relevant medical records, laboratory or other test results used to confirm the applicant's diagnosis.

_____ _____

Signature of M.D. Date

_____ _____

Printed Name of M.D. Type of Practice (family practice, internal medicine, psychiatry, etc.)

_____ _____

Address Phone Number

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) 465-4722.