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

# ADULT PUBLIC ASSISTANCE PROTECTIVE PAYEE AGREEMENT

I, ______________________________________________, agree to serve as protective payee

for ________________________________________________.

I agree to receive and use the monthly Adult Public Assistance payment to meet the current needs of the person listed above. If requested, I agree to provide the Division of Public Assistance with an accounting of how the payments were used. I understand the Division may end my service or I may withdraw as payee at any time.

_________________________ _________________________ __________
Signature Printed Name Date

______________________________________________________________
Mail Address

How do you want to receive the assistance payments? Direct Deposit ☐ Mail ☐

- If by direct deposit, please call our Direct Deposit Office at 1-888-620-1111.
- If by mail, where should the payments be sent?

  ______________________________________________________________
  Mail Address

- Where should Medicaid coupons be sent?

  ______________________________________________________________
  Mail Address

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I request that _____________________________________________ be my protective payee.

I understand my payee will receive my monthly Adult Public Assistance payment and use the money to meet my current needs. I understand I must notify the Division of Public Assistance if I want to change my protective payee.

__________________________________________________ __________________
Signature of Recipient, Guardian, or Power of Attorney Date