DIVISION OF PUBLIC ASSISTANCE

Referral to the Division of Senior and Disability Services

Home and Community Based Medicaid Waiver

Caseworker Instructions: Complete the form and fax to DSDS and Care Coordinator (if one has been selected).

Applicant/Recipient Name:		Address:	City/Zip:
Phone Number:	Social Security Number:	DOB:	Case Number/Client ID:
DPA Medicaid Application Date or Ongoing Medicaid:		Applicant Requested Retro Med for Months Listed:	
Parent/Guardian Name (if applicable):		Day Phone Contact Numbers:	

- Older Alaskans Waiver (65 and over)
- Adults with Physical Disabilities Waiver (21 and over)

Division of Senior and Disability Services
"CHOICE" Program
3601 C Street, Ste 310
Anchorage, AK 99503
Phone: 269-3666 Fax: 269-3688

☐ 1. The individual is currently eligible for Medicaid. Medicaid will pay for screening and assessment. Please request Medicaid coupon from waiver applicant if needed.

☐ 2. Application for Medicaid has been made and eligibility is pending. Medicaid will pay for screening and assessment. Please ask me for the special screening and assessment Medicaid coupon(s) for month(s) needed.

☐ 3. Not eligible for Medicaid, even under the LTC standards. Medicaid will not pay for screening and assessment.

Public Assistance Office Address

DPA Caseworker's Printed Name:
Phone Number/Fax Number:
Date: