Alaska Department of Health and Social Services
Division of Family and Youth Services
Division of Public Assistance

REVIEW FOR MEDICAID FOR A CHILD IN DHSS CUSTODY

(for Youth Corrections Juvenile in Custody Not living in a Youth Facility)

DPA USE ONLY - DATE RECEIVED
DPA CASE #__________

Instructions: The **Probation Officer** completes the form for a child in the custody of DHSS and in out-of-home placement within six months after Medicaid eligibility is established and every six months thereafter.

CHILD'S NAME______________________________ PROBER #_____ ____ ____ ____ ____ ____ ____ ____ ____

DATE OF BIRTH______________ SOCIALSECURITY NUMBER________________ DATE OF PLACEMENT: ______________

NAME OF PLACEMENT ____________________ CHILD'S RESIDENCE ADDRESS______________________________
Number and Street Town State Zip Code

BENEFIT MAILING ADDRESS____
Street/P O Box Town State Zip Code

1. Describe the Child's Situation: (Check all boxes that apply)

   [ ] Court Ordered Foster/Residential Care [ ] SSI Eligible Child [ ] Under-21 in Medical Institution [ ] Pregnant [ ] Voluntary Placement [ ] Other ____________

2. List the health insurance or medical services currently available to the child. If the child has multiple coverages, list each type of coverage. Provide at least the policy holder name, and insurance company name and address.

Policy Holder Name	Employer	Insurance Co. or Agency Name/Address	Policy Number or Social Security #

3. If the child had medical expenses as a result of an accident or injury during the past six months, please describe the event surrounding the accident or injury, include the names of other persons involved, insurance companies (if any), and the names of witnesses. If more space is needed, attach a separate sheet. ______________________________

4. Court ordered DHSS/Youth Corrections custody: [ ] ends within the next 60 days, extension is requested to ___/___/___. [ ] does not expire within the next 60 days
   [ ] ends within the next 60 days, no custody extension is requested because______________________________

5. Were all parental rights terminated after DFYS obtained custody of this child? [ ] Yes [ ] No

6. Child's available resources for the month of review: $____________ Month__________ Types and amount/value of these resources:______________________

   What resources changed during this review period? Specify amounts, months, and reason for the change: ______________________

7. Child's gross income for each month of review. List gross amount and month(s) of receipt: ______________________

   What income changed within this review period? Specify amounts, months, and reason for the change:______________________

8. What resources or income are anticipated during the next six months?______________________

9. What changes do you anticipate during the next six months which might affect Medicaid such as placement, deprivation, adoption, return home? Please describe______________________

Under penalty of perjury, or unsworn falsification in violation of AS 11.56.210, I certify that the information I give on this form is true, correct, and complete to the best of my knowledge.

Probation Officer Signature: ______________________ Printed Name: ______________________ Date: ____________ Location: ______________