CHILDREN ENTERING INSTITUTIONAL TREATMENT

☐ Denali KidCare
3601 C Street, Suite 120
P.O. Box 240047
Anchorage, AK 99524-00047
(907) 269-6529 phone
(907) 269-0986 fax

☐ Division of Public Assistance
_____
_____
_____
(907) _____(phone)
(907) _____(fax)

Date: _____

To: _____

We have information indicating that _____is a patient in your treatment facility. Before we can determine this person's eligibility for Denali KidCare or other Medicaid, we need the following information from you:

Date of admission: _____

Expected discharge date: _____

Where did child reside before entering facility? _____

Is child expected to return home after released from this facility? ☐ Yes ☐ No

If no, where will the child be going upon discharge? _____
_____

Name of Institution:	Contact Person and Phone Number:
Telephone/Fax Number:	Address:
Admitting Physician, Clinical Psychologist, or LCSW Printed Name	Admitting Physician, Clinical Psychologist, or LCSW Signature

Return the completed form to the address checked above.