**Trust Reporting Form**

This form is only to be used by the Division of Public Assistance to notify the Division of Health Care Services when an individual uses a Medicaid Qualifying Trust to qualify for Medicaid benefits. Once the policy unit has approved the trust document and Medicaid benefits are authorized, the Eligibility Technician sends this completed form and a copy of the trust to [dmatpl@alaska.gov](mailto:dmatpl@alaska.gov).

**Type of Medicaid Qualifying Trust**

Qualifying Income Trust (Miller Trust)

Special Needs Trust

Pooled Trust

**Medicaid Recipient Information**

Name:       DOB:

Case Number:       Client Id:

Phone Numbers: Cell

Home

Residence Address:

Mailing Address:

**Trustee Information**

Trustee Name:

Relationship to Client:

Trustee Phone Numbers: Work

Cell

Home

Trustee Residence Address:

Trustee Mailing Address:

**Trust Account Information**

Trust Account Bank:

Bank Address:

Account Number:

Date trust registered:

**Other Trust Information**

Attorney Name:

Attorney Address:

Emergency Contact (other than Trustee):

Relationship to Client:

Phone numbers: Work

Cell

Home

Address:      

**Approval Information**

Eligibility Technician completing this form:

DPA Office:       Phone:       Email:

Date approved by Policy:       Approved by: