Alaska Department of Health and Social Services
Division of Public Assistance

TEFRA Initial Application Extension Request Form

Please complete the following information to request an extension to the 90-day processing timeframes for your initial TEFRA Medicaid application. All information must be completed, and the form must be signed for it to be a valid request. Attach additional information if needed.

Applicant Name: _____ Client ID: _____

Parent Name: _____ Contact Number: _____

Care Coordinator Name: _____ Contact Number: _____

TEFRA application submission date: _____ requested extension date: _____

Level of Care type being pursued (check one): ☐ IPH ☐ SNF ☐ ICF/IDD

Reason(s) for extension request: _____

With my signature below, I acknowledge and accept the delay in processing my child's TEFRA application. I am requesting an extension be granted to the 90-day initial application processing timeframes per my above reason(s).

_____ _____

Parent Signature Date

Fax to: (907) 269-3099 Attn: Division of Public Assistance, Long Term Care Coordinator

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Division of Public Assistance Use Only

Extension Request Decision: ◉ Approved ○ Denied

DPA will delay a final eligibility determination through the date of _____

Denial Reason: _____

_____ _____

Long Term Care Coordinator Signature Date

Distribution: Original to DPA case file; Copies to: Care Coordinator, TEFRA Contractor, DPA Long Term Care Coordinator, DSDS if ICF/IDD LOC