State of Alaska
Department of Health & Social Services
Division of Public Assistance

# PROTECTIVE PAYEE AGREEMENT

**Check Program Choices**

☐ Adult Public Assistance or Interim Assistance
☐ Senior Benefits Program

I, ______________________________________________, agree to serve as protective payee

for ________________________________________________.

I agree to receive and use the monthly Adult Public Assistance and/or Senior Benefits payment to meet the current needs of the person listed above. If requested, I agree to provide the Division of Public Assistance with an accounting of how the payments were used. I understand the Division may end my service or I may withdraw as payee at any time.

| Signature of Payee | Printed Name | Date |
|---|---|---|

| Mail Address | Phone |
|---|---|

How do you want to receive the assistance payments? Direct Deposit ☐ Mail ☐

- If by direct deposit, please contact your local Public Assistance Office or the Direct Deposit Office at 1-888-620-1111 to request a Direct Deposit Enrollment form.
- If by mail, where should the payments be sent?

  ______________________________________________
  Mail Address
- Where should Medicaid coupons be sent?

  ______________________________________________
  Mail Address
- Please attach proof of legal guardianship and/or Power of attorney if applicable.

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I request that ______________________________________________ be my protective payee.

I understand my payee will receive my monthly Adult Public Assistance and/or Senior Benefits payment and use the money to meet my current needs. I understand I must notify the Division of Public Assistance if I want to change my protective payee.

| Signature of Recipient, Guardian, or Power of Attorney | Date |
|---|---|



Distribution: APA case file
Senior Benefits case file