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 submiss	ion date:	reques	ted extension date:	
Level of Care type being pu	rsued (circle one)	: IPH	SNF	ICF/MR
Reason(s) for extension red	juest:			
With my signature below, I	acknowledge and	accept the d	elay in processing n	•
	acknowledge and g an extension be	accept the d	elay in processing n	ny child's TEFRA lication processing
With my signature below, I application. I am requesting timeframes per my above representations. Parent Signature Mail or fax to: Division of Public PO Box 240249, A	acknowledge and g an extension be eason(s). Assistance, Long Term Anchorage, AK 99524	accept the d granted to the Care Coordinator	elay in processing ne 90-day initial appl Dat	ny child's TEFRA lication processing
With my signature below, I application. I am requesting timeframes per my above representations. Parent Signature Mail or fax to: Division of Public PO Box 240249, A	acknowledge and g an extension be eason(s). Assistance, Long Term Anchorage, AK 99524	accept the d granted to the Care Coordinator	elay in processing ne 90-day initial appl Dat	ny child's TEFRA lication processing
With my signature below, I a application. I am requesting timeframes per my above response Parent Signature Mail or fax to: Division of Public PO Box 240249, A	Assistance, Long Term Anchorage, AK 99524 F	accept the d granted to the Care Coordinator Fax: (907) 269-309	elay in processing ne 90-day initial appl Dat	ny child's TEFRA lication processing
With my signature below, I a application. I am requesting timeframes per my above represent the signature Mail or fax to: Division of Public PO Box 240249, A Division of Public Assistance II	Assistance, Long Term Anchorage, AK 99524 F	accept the d granted to the Care Coordinator Fax: (907) 269-309 DPA will delay the date of	elay in processing ne 90-day initial appl Dat	ny child's TEFRA lication processing e
With my signature below, I a application. I am requesting timeframes per my above represent the signature Mail or fax to: Division of Public PO Box 240249, A Division of Public Assistance II	Assistance, Long Term Anchorage, AK 99524 F	accept the d granted to the Care Coordinator Fax: (907) 269-309 DPA will delay the date of	elay in processing ne 90-day initial appl Dat a final eligibility deter	ny child's TEFRA lication processing e

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