

SB

291/292

(File 3)

SFIN

FILE

Alaska Department of Health and Social Services
Division of Family and Youth Services

341 Region Kotzebue/MFR Office 023F527 Request #

REQUEST FOR SPECIAL NEEDS FUNDS FOR RESIDENTIAL CARE

Special Needs funding is assessed on an as-needed basis only and pre-authorization is required.
Limitation: This form is to used only for one time or irregular special needs expenditure on behalf of children in residential care.
Receipt and supporting documentation are required.

Child's Name: [REDACTED] DOB: 02-28-93 Prober Case Number: 402120620
Eligibility Status: (check one) Title IV-E eligible Not IV-E eligible Eligibility pending
Proposed services are for Child or Parent(s) or Sibling(s) or Other family members
Proposed services are court-ordered (please attach court order)

I. Describe the specific need and how the request is consistent with the case plan (case plan must be attached).
Child entering ARC Anchorage Student Residential Living Center, while attending school for the deaf, requires funds in an account to cover extra curricular activities and school photos etc.. He has been at Putyuk Children's Home since placement with his grandparent's failed. Grandparent's were not receiving any financial assistance.

II. TITLE IV-E FOSTER CARE MAINTENANCE

- 1. Clothing - Initial (Refer to CPS: Chapter 6.0, Section 6.2.2.8 for policy) \$ _____
 - 2. Clothing - Extraordinary & Justified by Case Plan \$ _____
 - 4. Special One-Time Items \$ 200.00
 - Special cribs, beds, mattresses
 - Other (must be explained and within allowable DFYS regulations)
- Describe: Account for extra curricular activities
- 5. Visitation with Family - Long Distance telephone cards for the child \$ _____
 - 6. Travel - Child family visitation \$ _____

IIA. SUB-TOTAL IV-E FOSTER CARE MAINTENANCE \$ 200.00

III. TITLE IV-E FOSTER CARE ADMINISTRATIVE

- 1. Travel \$ _____
 - Foster child pre-placement visit or placement with foster home
 - Other approved travel by foster child as part of case plan

Describe: _____

 - Escort Travel as justified by case plan (may require travel authorization) just and proper bill and authorize its payment
 - For Visitation
 - For Placement
- Signature: [Signature] Date: 9/10/01
- 2. Shipping & Freight Costs (Child's belongings only) \$ 200.00
 - 3. Other Services critical for completion of the case plan
 - Genetic/Paternity Testing
 - Advertising for Missing Parents
 - Birth Certificates
 - Expert Witnesses (ICWA/Non-ICWA)
 - Supervised Visitation
 - Court Teleconference Costs
- Year - Collocation - Expenditure - Amount
- 02 06213 776 773765 \$ 200.00
- Year - Collocation - Expenditure - Amount
- ARC 85280 023F527
- FIN 402120620

IIIA. SUB-TOTAL IV-E FOSTER CARE ADMINISTRATIVE \$ _____

Child's Name: _____

IV. NON-IV-E REIMBURSEMENT

- 1. Independent Living - Limited to those expenses that facilitates the transition of foster children to independent living that are not otherwise provided by the residential grant or other resources. Describe: _____ \$ _____
- 2. Medical, Dental, Diagnostic, Therapeutic, and Assessment Services As payer of last resort (no Medicaid coverage or other third party reimbursement) Refer to 7 AAC 53.320.
 - Medical Describe: _____ \$ _____
 - Dental Describe: _____
 - Diagnostic (i.e. Psych evaluations) Describe: _____
 - Therapeutic (i.e. Counseling) Describe: _____
 - Assessment Services Describe: _____
 - Medical equipment, furnishings, or discretionary devices for children with special needs Describe: _____
 - Travel Describe: _____
- 3. Other services critical for completion of the case plan of a child in foster care when no other resources are available Describe: _____ \$ _____

IV.A. SUB-TOTAL NON-IV-E REIMBURSABLE \$ _____

V. EXPLAIN HOW ALTERNATIVE SOURCES OF FUNDING FOR ALL ITEMS ABOVE HAVE BEEN EXHAUSTED: Tribe nor parent's have funds for the account required at the school.

VI. TOTAL COST: \$ 200.00

VII. one time cost short term costs (date) ____/____/____ to ____/____/____

VIII. Payee Name ARC Living Center Address Anchorage, Alaska

IX. SSN or Fed Tax ID# _____ Vendor # (PVN) _____ Reimbursement

X. Suzette M. Beaman 6MNS 08/31/01
Social Worker Signature PCN Date

XI. APPROVALS:

[Signature] 3770 8/31/01 Suzanne Arto 3016 8/31/01
S.W. IV Signature PCN Date S.W. V Signature PCN Date

_____/____/____ Date _____ Date
Children's Services Manager Family Services Program Administrator
Required for Requests exceeding \$1,500.00 and Out-of-State Travel

XII. FISCAL INFORMATION (To be filled out by fiscal)

CATEGORY	COST	CODING
IV-E Foster Care Maintenance (II.A.)	\$ _____	_____
IV-E Foster Care Administrative (III.A.)	\$ _____	_____
Non-IV-E Reimbursable (IV.A.)	\$ _____	_____
TOTAL OF REQUEST:	\$ _____	

Alaska Department of Health and Social Services
Division of Family and Youth Services

341
Region

Kotzebue/MFR
Office

023F52
Request #

PURCHASE AUTHORIZATION
(Vendor Copy)

402120620
Prober Case Number (9 digits)

TYPE OF SERVICES/GOODS REQUESTED: Funds for account to cover extra curricular activities

Notice: Copy of this authorization
must accompany the invoice.

Notice: The State of Alaska is tax exempt.
Number 92-6001185.

Within 30 days of purchase, the itemized invoice with the authorization form attached should be forwarded to the address below. The case number must be written on the invoice.

[Purchase above the amount authorized is the responsibility of the purchaser, and will not be paid by the State of Alaska.]

Division of Family and Youth Services
Northern Regional Office
751 Old Richardson Highway, Suite 300
Fairbanks, Alaska 99701-7899

Total cost of this request \$ 200.00

Payee Name ██████████ ARC of Anchorage

Address 2211 Area Dr.,

Anchorage, Alaska 99508

[X] one-time cost
\$200.00
[] short term costs
(date) 1/1 to 1/1

SS or Tax ID# 574-13-5291

Vendor # (PVN) _____

Loretta M. Greer
Worker Signature

4MNS
PCN

08/31/01
Date

AUTHORIZED PURCHASER _____

INQ-TR: TANAB - LAPSE BALANCE
CY: 2002 APPN: 24296 (2000) - FC SPECIAL NEED-GF

10/03/2001

LAPSED EXPENDITURE AUTHORIZATIONS	-336091.86
PLUS: LAPSE ADJUSTMENTS	8650.32

AVAILABLE LAPSE BALANCE	-327441.54
	=====
LESS: RESTRICTED EXPENDITURE AUTHORIZATIONS	

UNRESTRICTED AVAILABLE LAPSE BALANCE	-327441.54
	=====

Enter-PF1---PF2---PF3---PF4---PF5---PF6---PF7---PF8---PF9---PF10---PF11---PF12---				
CONT QUIT			PFKYS	HELP
4- [©]	A Sess-1	146.€3.51.196	X2EP	2/1

2/25 SPOKE TO ROD - WILL VERIFY AND CALL BACK

Situk Leasing Company

SIL93160

VEHICLE

LESSOR: SITUK LEASING COMPANY
 P.O. Box 230
 Yakutat, AK 99689
 (907) 784-3316 907-784-3232

Lessee: Name <i>Josh McClure</i>		MINIMUM RATE CHARGE — ONE DAY (24 hrs.) RATES DO NOT INCLUDE FUEL	
Driver's License No. <i>SS 99470</i>	State <i>AK</i>	Expires <i>1-21-2000</i>	Time IN
Address <i>1750 1st Dr.</i>		Time OUT <i>12-16</i>	
City/State <i>Tiara AK</i>		Vehicle Make — Body Style — Year — License #	
Insurance Company <i>State of Alaska</i>	Mileage IN		CHARGES
Company: Name <i>State of Alaska</i>	Mileage OUT		
Address <i>1750 1st Dr.</i>	Mileage Driven		Extra Hrs. @ 6.00 per hour

IF LESSEE RETURNS THE VEHICLE WITH LESS FUEL THAN WHEN LEASED, A FUEL SERVICE CHARGE WILL BE MADE.

FREE DAILY MILES		Subtotal
In	E 1/8 1/4 3/8 1/2 5/8 3/4 7/8 F	Fuel
Out	E 1/8 1/4 3/8 1/2 5/8 3/4 7/8 F	
Misc. Charges		
Subtotal		
Total Charges		
Tax		
AMOUNT DUE		

Vehicle shall NOT be operated by any person except LESSEE and the following Authorized Operators who must be validly licensed to drive and have Lessee's prior permission: persons 25 or over who are members of Lessee's immediate family and permanently reside in Lessee's household; the employer, partner, executive officer, or a regular employee of Lessee; additional authorized operator(s) approved by Lessor in writing.

THE VEHICLE IS LEASED UPON THE CONDITIONS SHOWN ON THIS PAGE AND UPON THE REVERSE HEREOF, LESSEE REPRESENTS HE OR SHE HAS READ, UNDERSTANDS AND AGREES WITH THE CONDITIONS.

Signature of Lessee
Josh McClure

LESSEE SHALL BE LIABLE FOR ALL DIRECT AND ACCIDENTAL LOSS OR DAMAGE TO VEHICLE.

LESSEE IS LIABLE FOR ALL PARKING AND DRIVING VIOLATIONS AND MUST REMIT PAYMENT DIRECTLY TO PROPER AUTHORITIES.

LESSEE MUST REPORT ALL ACCIDENTS TO LESSOR PROMPTLY, NOTIFY LOCAL POLICE AUTHORITIES AND COMPLETE AN ACCIDENT REPORT.

DEPOSITS:	Received By	Date	LESS DEPOSIT (if any)
\$			
Prepared by	Computed by	NET DUE	
Place of delivery and redelivery:			



STATE OF ALASKA

DEPT. FINANCE

TRANSPORTATION REQUEST

NO. 1105131

AGENCY						ORIGIN <i>Juneau</i>	DESTINATION <i>YAKUTAK Seabear</i>		
BILLING ADDRESS						PLACE OF ISSUE <i>Juneau</i>	DATE OF ISSUE <i>8-9</i>		
CITY		STATE		ZIP		CARRIER <i>Sitak Leasing</i>			
NAME & TITLE OF TRAVELER <i>JOHN McCLELLAN, SW III</i>						TICKET NUMBER			
FINANCIAL CODING <i>Judy Zangui 1-16-02</i>						VALUE <i>\$ 65.00</i>		NO TAX PAYABLE	
SY	CC	POM	LC	ACCT	FY	FOR AIR CHARTER		HOURS	RATE
<i>06</i>	<i>21</i>	<i>3686</i>	<i>77</i>	<i>82</i>					
SHADED BOX TO BE COMPLETED BY THE CARRIER. SEE COMPLETE INSTRUCTIONS ON REVERSE.						CERTIFICATION: The facts stated herein on supporting documents are correct and in accordance with established travel regulations.			
						SIGNATURE OF TRAVELER <i>[Signature]</i>			

02 (17 Rev 8/85)

JA 06C0981552

INQ-WD: WARRANT 25553993 DETAIL INQUIRY - REFERENCE LINES

02/25/9

REF	TYPE	NUMBER	AMOUNT	DATE	COMMENTS
1	PVN	JOM90032			
2	INV	TA06CO981552		12/16/97	
3	TA	06CO981552	33.00	12/16/97	FINAL/MCCLURE-JNU/YAK-12/16
4	STR	1105131			SITUK LEASING-65.00
5					
6					
7					
8					
9					
10					
11					
12					
13					
14					
15					
16					
17	SRD	06710		01/27/98	
18	OD	A11475030012		01/27/98	

(ENTER TO RETURN)

PF1=MAIN MENU 3=CURR BAL'S 5=BASE 6=FINANCIAL LINES 7=ADD'L REFS 8=REMIT'

INQ-TR: TANAB - LAPSE BALANCE
CY: 2002 APPN: 22546 (1998) - FC SPECIAL NEED

01/16/2002

LAPSED EXPENDITURE AUTHORIZATIONS	-77184.23
PLUS: LAPSE ADJUSTMENTS	29421.17

AVAILABLE LAPSE BALANCE	-47763.06
	=====
LESS: RESTRICTED EXPENDITURE AUTHORIZATIONS	-49536.65

UNRESTRICTED AVAILABLE LAPSE BALANCE	=====

Enter-PF1---PF2---PF3---PF4---PF5---PF6---PF7---PF8---PF9---PF10--PF11--PF12---			
CONT QUIT		PFKYS	HELP
4- ^o	A Sess-1	146.63.51.196	X2E7 2/1

INQ-CC: COLLOCATION CODE INQUIRY

01/16/2002

COLLOCATION CODE 6213663
COA YEAR 2002
SET-UP YEAR 2000

ACTIVE? YES

CREATING RSN 04985
UPDATE RSN 04985

TYPE: NON-PRIMARY
DESCRIPTION SHORT: NRO SN STATE
DESCRIPTION LONG: NRO SN STATE

/

REPORTS TO APPROPRIATION: 25408 - NRO SPECIAL NEED
REPORTS TO FUND: 11100 - GENERAL FUND
REPORTS TO ORGANIZATION: 24514 - FOSTER CARE HOME BAS
REPORTS TO PROGRAM: 25336 - FC SPECL NEED STATE

POSTING? YES
ADD PROGRAM ALLOWED? NO
LC OVERRIDE ALLOWED? YES
DEFAULT LEDGER CODE

CORRESPONDING CURR YR APPN

LAPSE COLLOCATION CODE 6213663
LAPSE CC SET-UP YEAR 2001

FOR NEXT CC ENTER==> COLLOCATION CODE _____ COA YEAR _____ SET-UP YEAR _____

Enter-PF1---PF2---PF3---PF4---PF5---PF6---PF7---PF8---PF9---PF10--PF11--PF12---

CONT QUIT LCINQ LCLST PFKYS HELP

4-0 A Sess-1 146.63.51.196 X2E7 #S 22/40

INQ-CC: COLLOCATION CODE INQUIRY

01/16/2002

COLLOCATION CODE 6213663
 COA YEAR 2002
 SET-UP YEAR 2001
 TYPE: NON-PRIMARY
 DESCRIPTION SHORT: NRO SN STATE
 DESCRIPTION LONG: NRO SN STATE
 /
 /

ACTIVE? YES

CREATING RSN 04985
 UPDATE RSN 05036

REPORTS TO APPROPRIATION: 25408 - NRO SPECIAL NEED
 REPORTS TO FUND: 11100 - GENERAL FUND
 REPORTS TO ORGANIZATION: 24514 - FOSTER CARE HOME BAS
 REPORTS TO PROGRAM: 25336 - FC SPECL NEED STATE

POSTING? YES
 ADD PROGRAM ALLOWED? NO
 LC OVERRIDE ALLOWED? YES
 DEFAULT LEDGER CODE

CORRESPONDING CURR YR APPN

LAPSE COLLOCATION CODE 6213663
 LAPSE CC SET-UP YEAR 2002

FOR NEXT CC ENTER==> COLLOCATION CODE _____ COA YEAR _____ SET-UP YEAR _____

Enter-PF1---PF2---PF3---PF4---PF5---PF6---PF7---PF8---PF9---PF10--PF11--PF12---

CONT	QUIT	LCINQ	LCLST	PFKYS	HELP
4- ^o	A Sess-1	146.63.51.196		X2E7	#5 22/40

INVOICE

TAKANA AIR SERVICE
 P.O. BOX 60713
 FAIRBANKS AK 99706
 (907) 474-3331

INVOICE NO

SOLD TO: DEPT. OF HEALTH & SOCIAL SVC
 300 DEPT. HEALTH BLDG. - 2ND FLOOR
 P.O. BOX 110550
 JUNEAU, AK 99801-0550
 (907) 485-3131

SHIP TO:

Page 1

ACCOUNT NO.	SALES PERSON	PURCHASE ORDER NO.	SHIP VIA	COL.	PPD	DATE SHIPPED	TERMS	INVOICE DATE	
AL888	WE	EXLESS	FAIR-NIE			01/08/99	NET 30	08/03/00	
QTY. ORDERED	QTY. SHIPPED	QTY. BACK ORDERED	ITEM NUMBER	DESCRIPTION			UNIT PRICE	DISC %	EXTENDED PRICE
1	1		EXCESS	EXCESS FOR [REDACTED] 12 LBS @ \$0.75/LB FAIR-NIE CHARGE ALASKA			14.25	0	14.25
<p>ARTICLE # 411E</p> <p>THIS IS AN EXCESS ITEM COPY OF INVOICE # 40004 WHICH IS IN THE ALASKA AIR TICKET # 1514.00 SEE THE DEPT. OF HEALTH BLDG. FOR THE FULL DETAILS REGARDING</p> <p>PLEASE CALL WE AT (907) 474-3331 FOR MORE INFORMATION</p>									
							SALES AMOUNT		14.25
							SALES TAX		
							FREIGHT		
							TOTAL		14.25

INVOICE

TAMANA AIR SERVICE

P. O. BOX 60713
 FAIRBANKS, AK 99706
 (907) 474-0301

INVOICE NO

100175

MONTHLY BREAK

SOLD TO: DEPT. OF HEALTH & SOCIAL SVC
 DIV. OF ADMIN. SVCS. - FAIRBANKS
 P. O. BOX 110650
 TUNEAU, AK 99811-0650
 (907) 465-3121

SHIP TO:

Page 1

ACCOUNT NO.	SALES PERSON	PURCHASE ORDER NO.	SHIP VIA	COL	PPD	DATE SHIPPED	TERMS	INVOICE DATE	
AL956	4E	EXCESS	FAI-NIB			01/08/99	NET 30	09/03/00	
QTY ORDERED	QTY SHIPPED	QTY BACK ORDERED	ITEM NUMBER	DESCRIPTION			UNIT PRICE	DISC %	EXTENDED PRICE
1	1		EXCESS	<p>EXCESS FOR [REDACTED]</p> <p>18 LBS @ \$0.75/LB</p> <p>FAI-NIB</p> <p>CHARGE ALNS6</p> <p>ATTN: DIANE</p> <p>THIS IS AN AMENDED COPY OF INVOICE # 48064 WHICH WE SPOKE ABOUT. THE TICKET (\$364.00) HAS BEEN CREDITED, BUT THE CHARGE FOR THE BAGS REMAINS UNPAID...</p> <p>IF YOU HAVE QUESTIONS, PLEASE CALL ME.</p> <p>(907) 474-0301</p> <p>THANKS,</p>			14.25	0	14.25

Dana Silva

SALES AMOUNT	14.25
SALES TAX FREIGHT	
TOTAL	14.25

PASSENGER NAME [REDACTED]		Not Transferable		PLACE OF ISSUE FAI	FARE 338.60	449 030.67	
ISSUING AGENT [REDACTED]		EXCESS Allowable Weight 40 19		ISSUING AGENT (B)	TAX 25.40		
F rom	FAI	DATE OF ISSUE 11/08/99		EXCESS 74.25	378.25	TICKET IS TO BE CHGD TO WORLD	
T o	NIB	FLY	19	DATE	11/08		FORM OF PAYMENT P.D. #017764 ACCOUNT OR VOUCHER CHG TO AIRLINE DFYS (NOT AN ACCT.)
T o	FAI						
WHITE - ORIGINAL		GREEN - ACCOUNTING		YELLOW - 1ST DESTINATION		PINK - RETURN	

FOR EXCESS ONLY

CASHER'S STAMP

INQ-TR: TANAB - LAPSE BALANCE
 CY: 2002 APPN: 22546 (1999) - FC SPECIAL NEED

01/16/2002

LAPSED EXPENDITURE AUTHORIZATIONS	-366777.64
PLUS: LAPSE ADJUSTMENTS	26238.10

AVAILABLE LAPSE BALANCE	-340539.54
	=====
LESS: RESTRICTED EXPENDITURE AUTHORIZATIONS	-75000.00

UNRESTRICTED AVAILABLE LAPSE BALANCE	-265539.54
	=====

Enter-PF1---PF2---PF3---PF4---PF5---PF6---PF7---PF8---PF9---PF10---PF11---PF12---			
CONT QUIT		PFKYS	HELP
4- ^o	A Sess-1	146.63.51.196	X2E7
			2/1

INQ-VM: VENDOR DETAIL

01/15/2002

VENDOR NUMBER: TAS94286

DATE LAST ACTIVITY: 01/03/2002

ACTIVE? YES

VENDOR CLASS: MI

VENDOR DESC SHORT: TANANA AIR SERVICE

VENDOR DESC LONG: TANANA AIR SERVICE/OWNERSHIP CHANGE IN
5/94/OLD PVN ATA91052/BUSINESS NOW A SUB
SIDIARY OF BIDZY-TA-HOT'ANNA CORPORATION

VENDOR NAME: BIDZY-TA-HOT'ANNA CORPORATION

ADDRESS: DBA TANANA AIR SERVICE
PO BOX 60713
FAIRBANKS

AK 99706-0713

VENDOR CONTACT: BETH, ACCOUNTANT

PHONE: (907)474-0301 EXT

TAX-ID NUMBER: EIN920068608

1099 REPORTABLE? NO

ENTER VENDOR NUMBER FOR NEXT DETAIL==> _____

Enter-PF1---PF2---PF3---PF4---PF5---PF6---PF7---PF8---PF9---PF10---PF11---PF12---

CONT QUIT

PFKYS

HELP

4-^o

A Sess-1 146.63.51.196 .

X325

22/42

PENINSULA AIRWAYS, INC.
 6100 BOEING AVENUE
 ANCHORAGE AK 99502

*** INVOICE ***

Sold to: 003925
 AK HEALTH & SOCIAL SERVICES
 ADMINISTRATIVE SERVICES FISCAL
 P O BOX 110650
 JUNEAU AK 99811

Ship to: 003925
 AK HEALTH & SOCIAL SERVICES
 ADMINISTRATIVE SERVICES FISCAL
 P O BOX 110650
 JUNEAU AK 99811

FY99

SECOND
 REQUEST

 Invoice # Invoice Date Terms Document Number Doc. Date
 564984-00 03/11/1999 4200126729 03/11/1999

Quantity	Um Description	Price	Amount
1.00	EA RB SNP ANC RT 11	770.00	770.00

I certify that this document is an exact copy of the original.

Signed: *Boris Buiell*
 Peninsula Airways, Inc.

Judy Zangui 1-16
 99-06213662-712

PEN AIR		ORIGINATOR		BOOKING REFERENCE		AIRLINE FORM SERIAL NUMBER	
STAPLE/CLIP/STAMP		09 MAR 99		339:4200:126:729		PENINSULA AIRWAYS STATION 65 ST. PAUL, AK	
1 12		K.S. 4850		09 MAR 99		MS 2:15P	
1 12		RV 185		10 MAR 99		7/16-28	
SAINT PAUL		ANCHORAGE		ANCHORAGE		ANCHORAGE	
SAINT PAUL		ANCHORAGE		ANCHORAGE		ANCHORAGE	
7/16-28		537.0		4200126729 1 0		* Eleanor Star	

TRAVEL AUTHORIZATION



STATE OF ALASKA

TRAVEL AUTHORIZATION NO. 115 9918 DATE 2/10/99

NAME OF TRAVELER Eleanor L. STARR TITLE Social Worker SOCIAL SECURITY NUMBER 518-62-5865
 WARRANT MAILING ADDRESS P.O. Box 293 CITY St Paul, Alaska STATE 99660 ZIP CODE
 DEPARTMENT _____ DIVISION _____ BARGAINING UNIT _____ WORK STATION _____

PURPOSE OF TRIP
I escort suicidal patient to Anchorage for evaluation

FINANCIAL CODING ESTIMATED COSTS \$ TRANSPORTATION \$ PER DIEM \$ OTHER \$ TOTAL \$

ITINERARY FROM _____ DEPARTURE DATE/TIME _____ TO _____ RETURN DATE/TIME _____

APPROVALS DIVISION _____ DATE _____ DEPARTMENT _____ DATE _____ GOV. (OUT-OF-STATE ONLY) _____ DATE _____

ACTUAL COSTS

DATE	EXPLANATION	MILES X RATE	MILEAGE OR CASH FARE	PER DIEM	OTHER
2/9/99	Depart St Paul				
3/10/01	RETURN ON RESERVE				
3/9/99	XXXXXXXXXXXXXXXXXXXX ONE WAY ON RESERVE				

I certify that this document is an exact copy of the original.
 Signed: Berta Bassett
 Peninsula Airways, Inc.

CLAIMANT'S CERTIFICATION: The facts stated herein or on supporting documents are correct and in accordance with established travel regulations, and unused ticket were returned. SUBTOTALS THIS PAGE

CLAIMANT'S SIGNATURE: Eleanor L. Starr APPROVAL SIGNATURE: _____
 PAGE 1 OF _____ PAGES TOTAL ALL PAGES \$ 1155.00

TRFV NO.	ISSUED TO	AMOUNT	DATE	LESS TRAVEL ADVANCE
				\$
				\$
				\$

IEF	TYPE	NUMBER	AMOUNT	DATE	COMMENTS
1	PVN				
2					
3					
4					

IN	AMOUNT	SY	CC	PGM	LC	ACCT	FY

INQ-TR: TANAB - LAPSE BALANCE
CY: 2002 APPN: 22546 (1999) - FC SPECIAL NEED

01/16/2002

LAPSED EXPENDITURE AUTHORIZATIONS -366777.64
PLUS: LAPSE ADJUSTMENTS 26238.10

AVAILABLE LAPSE BALANCE -340539.54
=====

LESS: RESTRICTED EXPENDITURE AUTHORIZATIONS -75000.00

UNRESTRICTED AVAILABLE LAPSE BALANCE -265539.54
=====

Enter-PF1---PF2---PF3---PF4---PF5---PF6---PF7---PF8---PF9---PF10---PF11---PF12---
CONT QUIT PFKYS HELP
4-0 A Sess-1 146.63.51.196 X2E7 2/1



Please Remit To:

PO Box 99001
Anchorage, AK 99509
(907) 777-6921



Invoice

Bill To:

State of Alaska
Dept of Health & Social Svcs/DFVS
350 Main St, Room 410
Juneau, AK 99801

Invoice #

Invoice Date

Purchase Order No.

Sales Representative

Terms

1	99-0102	3512 DSU/CSU	\$503.00	\$503.00
1		V.35 to DB25, 6' Cable	\$45.00	\$45.00

*99-6213458-75791
Judy Zangri 1-16-02*

Comments

Subtotal:

Invoice Total:

White—Original Yellow—File

GCI - SALES ORDER

COPY

SALES ORDER # 99-0102 REQUIRED DATE: 01/08/99

CUSTOMER'S NAME: State of Alaska
 CONTACT NAME: Guy Crockett
 PHONE NUMBER: 907-465-5758
 P.O. NUMBER: 02-60-0171-99

BILL TO ADDRESS (CUSTOMER)

State of Alaska Dept. of Health & Social Svcs/DHVS
350 Main Street, Room 410
Juneau, Ak 99801

SHIP TO ADDRESS

DOA/Division of Info. Svcs NSSADC
3300 Fairbanks Street
Anchorage, Ak 99503

BILL FREIGHT: y
 DROP SHIP: n
 BURN-IN: n
 CONFIGURE: n
 INSTALL: n
 DEMO:
 DEMO FROM:
 DEMO TO:

COMMENT

TODAYS DATE: 1/5/99
 SALES REP: Peter Hrst

PURCHASING DEPT. ONLY:
 REQ. REC. DATE: 1/5/99
 ORDERED DATE: 1/5/99
 VEN. SHIP DATE:
 ORDER REF #
 DATE RECEIVED: 1/11/99
 REC REPORT # 25979
 CUST DEL DATE: 1/13/99
 DELIVERY TKT # 25477
 SENT TO BILLING: 1/14/99

PART #	DESCRIPTION	QTY	SALE PRICE	TOTAL
48388	3312 DS07CSU	1	503.00	503.00
48323	V.35 to D1125, 6ft. Cable	1	45.00	45.00
				0.00
				0.00
SALE TOTAL				548.00

*Close see 99-0103
 0104
 0105*

Thursday 08 of Dec 2001, GCI

->907 465 3184

Page 2 of 3

FAX

Date : 12/06/01

Total number of pages : 3

To : FrankMiyasato

From : Colette Brooke

Company :

Department :

Fax number : 19074653184

Subject: Purchase Order 02-60-0171-99

INQ-CC: COLLOCATION CODE INQUIRY

01/16/2002

COLLOCATION CODE 6213458
COA YEAR 2002
SET-UP YEAR 2000

ACTIVE? YES

CREATING RSN 04985
UPDATE RSN 04985

TYPE: NON-PRIMARY

DESCRIPTION SHORT: CO GENERAL ADMIN

DESCRIPTION LONG: CO GENERAL ADMIN

/

06010301*

REPORTS TO APPROPRIATION: 25426 - FAM & YOUTH SVCS MGN
REPORTS TO FUND: 11100 - GENERAL FUND
REPORTS TO ORGANIZATION: 24503 - ADMINISTRATION
REPORTS TO PROGRAM: 22640 - FYS ADMINISTRATION

POSTING?	YES	CORRESPONDING CURR YR APPN
ADD PROGRAM ALLOWED?	NO	
LC OVERRIDE ALLOWED?	YES	LAPSE COLLOCATION CODE 6213458
DEFAULT LEDGER CODE		LAPSE CC SET-UP YEAR 2001
FOR NEXT CC ENTER==>	COLLOCATION CODE _____ COA YEAR _____ SET-UP YEAR _____	
Enter-PF1---PF2---PF3---PF4---PF5---PF6---PF7---PF8---PF9---PF10---PF11---PF12---		
CONT QUIT	LCINQ LCLST	PFKYS HELP
4-C	A Sess-1 146.63.51.196	X2E7 #5 22/40

INQ-CC: COLLOCATION CODE INQUIRY

01/16/2002

COLLOCATION CODE 6213458

ACTIVE? YES

CREATING RSN 04709

COA YEAR 2001

UPDATE RSN 04709

SET-UP YEAR 1999

TYPE: NON-PRIMARY

DESCRIPTION SHORT: CO GENERAL ADMIN

DESCRIPTION LONG: CO GENERAL ADMIN

/

/_____06010301*

REPORTS TO APPROPRIATION: 22550 - FMLY & YTH SVCS MGMT

REPORTS TO FUND: 11100 - GENERAL FUND

REPORTS TO ORGANIZATION: 24503 - ADMINISTRATION

REPORTS TO PROGRAM: 22640 - FYS ADMINISTRATION

POSTING? YES

CORRESPONDING CURR YR APPN

ADD PROGRAM ALLOWED? NO

LC OVERRIDE ALLOWED? YES

LAPSE COLLOCATION CODE 6213458

DEFAULT LEDGER CODE

LAPSE CC SET-UP YEAR 2000

FOR NEXT CC ENTER==> COLLOCATION CODE _____ COA YEAR _____ SET-UP YEAR _____

Enter-PF1---PF2---PF3---PF4---PF5---PF6---PF7---PF8---PF9---PF10---PF11---PF12---

CONT QUIT

LCINO LCLST

PFKYS

HELP

4-^c

A Sess-1

146.63.51.196

X2E7

#5 22/40

INQ-TR: TANAB - LAPSE BALANCE
CY: 2002 APPN: 22550 (2000) - FMLY & YTH SVCS MGMT

01/16/2002

LAPSED EXPENDITURE AUTHORIZATIONS	-139144.27
PLUS: LAPSE ADJUSTMENTS	10959.07

AVAILABLE LAPSE BALANCE	-128185.20
	=====
LESS: RESTRICTED EXPENDITURE AUTHORIZATIONS	-56800.00

UNRESTRICTED AVAILABLE LAPSE BALANCE	-71385.20
	=====

Enter-PF1---PF2---PF3---PF4---PF5---PF6---PF7---PF8---PF9---PF10---PF11---PF12---
CONT QUIT PFKYS HELP
4-^o A Sess-1 146.63.51.196 X27R 2/1

269-7815 *Melissa acct clerk*

CONTINUOUS PRINTING

2503 ARCTIC BLVD., ANCHORAGE, ALASKA 99503
OFFICE (907) 277-0446 ALASKA (800) 478-0446
FAX (907) 277-2126

FAX TRANSMITTAL SHEET

DATE: 11-20-00
TO: CECELIA
ATTENTION:
FAX NUMBER: 269-6532
PAGES TO FOLLOW: 1



4-9-01
WILL CK WITH AMY +
CALL ME BACK

HERE IS A CERTIFIED TRUE COPY OF THE INVOICE IN QUESTION. 4-9-01
CALLED
LEFT MESSAGE

THANK YOU FOR YOUR HELP.

PEGGY

3-13-01
LEFT MESSAGE

CECELIA PREZIOSE
269-6459

3-20-01 - WILL
SUBMIT TO AMY FOR
PAYMENT - CALL
AGAIN NEXT WEEK

1-31-01 -
ROBERT JACKSON
STILL WAITING
3-7-01
LEFT MESSAGE

accounts payable
Robert Jackson
269-6430
FAX 269-6329



CONTINUOUS PRINTING
OF ALASKA, INC.
(907) 277-0446
2503 Arctic Blvd
Anchorage, Alaska 99503

INVOICE

SOLD TO:

H&SS Public Assistance
400 Gambell
Suite 200
Anchorage, AK 98501

CPA 87278

INVOICE NO: W-4282

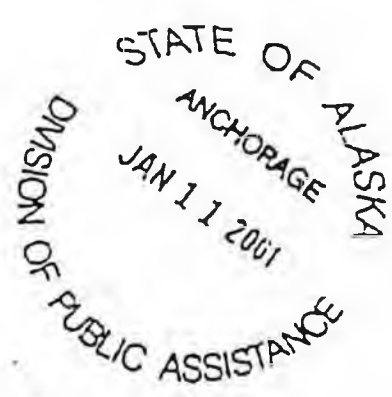
INVOICE DATE: 3/22/99

CUSTOMER P.O.# CR 077

DUE DATE: 4/21/99

CUSTOMER NUMBER 272

QUANTITY	DESCRIPTION	AMOUNT
40000	H4EALTH CARE PROVIDER INSTRUCTIONS	788.00
<i>this is a certified + true copy</i>		
<i>Peggy Colagroul 277-0446</i>		
SIGNATURE: _____		SUB-TOTAL 788.00
TERMS: 1% INTEREST ON ACCOUNTS 30 DAYS PAST DUE		TAX TOTAL 788.00
		PLEASE PAY LAST AMOUNT



*Tony Williams
7818*

I certify this bill is a true and proper bill and hereby authorize the Department Cashiers Office to effect payment of same.
Shuler 4-9-01
Signature Date
06216310 73560
6-Digit Account Code 3-Digit Object Code

\$ 788.00
FY 99

4/12 - ✓ AK SAS *not*
4/15 - ✓ *jud get*

Tony Williams

STATE OF ALASKA HEALTH AND SOCIAL SERVICES

TONY KNOWLES, GOVERNOR

Division of Administrative Services-Fiscal
P.O. Box 240249
Anchorage, AK 99524-0249

(907) 269-7818

April 20, 2001

Continuous Printing of AK
2503 Arctic Blvd
Anchorage, AK 99503

RE: Invoice # W4282 Acct# 273

To whom it may concern:

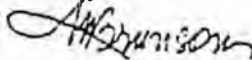
We received your fax regarding a past due invoice dated 3-22-99. Research indicates that the invoice will need to be submitted for a supplemental appropriation through the legislature.

Our Juneau fiscal office has the documents and will research for possible previous payment and then submit the invoices through the legislature for supplemental approval. Usually any supplemental requests are approved by the legislature in May of each year therefore; we are unable to pay the bill at this time.

I apologize for the delay. You may wish to suspense the invoice and contact our office in June to check the status. You can contact me directly at 269-7815.

If I can clarify the process or you need further assistance, please let me know.

Sincerely,



Marissa Brunson

Accounting Clerk II

Cc: Bobbie Fuller, Public Health
Luz Malacas, Juneau Fiscal

6-29 MESSAGE

10-29 - WILL CK W/ JUNEAU + CALL BACK

07-03 LEFT MESSAGE

07-12 - WORKING ON IT - NEED TO
~~DO THAT~~ WAIT ON JUNEAU
TINA - SUPERVISOR

6-19 Marissa
state will pay
supervisor will authorize today
she is back from vacation

Williams, Tina

From: Williams, Tina
Sent: Tuesday, July 03, 2001 2:08 PM
To: Moskito, Orlando R.
Cc: Malacas, Luzviminda
Subject: supplemental invoices

Importance: High

Orlando,

I went through the entire supplemental file we have here and have found the following do not appear on the supplemental appropriations sheet:

1. Xerox Corporation - March 6, 2001 notified, \$984.00 due for services rendered 4/20/99
2. Continuous Printing of AK - April 20, 2001 notified, \$788.00 due for services rendered 3/22/99
3. The New Printer Workshop NPW, Inc. - May 8, 2001 notified, \$7.50 due for services rendered 9-22-98

Continuous Printing continues to call and ask the status--what can I say to her? Is there a possibility that I do not have the complete list?
Please advise.

Thanks,

Tina Williams
Accounting Supervisor
(907) 269-7818 work
(907) 561-1308 fax

CONTINUOUS PRINTING

OF ALASKA, INC.

(907) 277-0446

2503 Arctic Blvd.

Anchorage, Alaska 99503

INVOICE

SOLD TO:

INVOICE NO. 2001

INVOICE DATE 7/30/01

CUSTOMER P.O.#

DUE DATE: 9-22-01
~~8/28/01~~

HEALTH & SOCIAL SERVICES
DIVISION OF PUBLIC ASSISTANCE
400 GAMBELL STREET - SUITE 200
ANCHORAGE, AK 99501

CUSTOMER NUMBER 273

QUANTITY	DESCRIPTION	AMOUNT
	ATTENTION: TINA WILLIAMS - REFERENCE INVOICE #W-4282 - YOUR P.O. #CR077 DATED 3-22-99 LATE CHARGES FOR PAST DUE INVOICE AT 1-1/2% PER MONTH, CALCULATED TO SEPTEMBER, 2001 9/22/01	429.00

SIGNATURE: _____

JUL 30 2001

TERMS: 1 1/2% INTEREST ON ACCOUNTS 30 DAYS PAST DUE.

SUB-TOTAL	
TAX	429.00
TOTAL	429.00

PLEASE PAY
LAST AMOUNT

7/27/01

talked w/ Phil Kelly - Continuous Printing

277-0446

He has been trying to collect on the
of Invoice (# W-4282) for years now.

He has repeatedly contacted the program
and just wants to be paid. He
is going to bill for Late Charges
and submit a current bill. I
wanted it paid.

I told him that I would need to
check with the finance officer
when he returns.

8/13/01 called Phil Kelly - Continuous Printing
Requested copies of earliest correspondence
on of Bill

Delayed the Late Charges would be
considered if the supplemental and

FAX COVER SHEET

STATE OF ALASKA
DEPT. OF HEALTH & SOCIAL SERVICES
DIVISION OF ADMINISTRATIVE SERVICES
FISCAL SECTION
3601 C STREET, SUITE 578
ANCHORAGE AK 99503

DATE: 9/14/01 TIME: 10:10 AM

TO: Catherine Hill PHONE # 465-3131
for Catalina. FAX # 465-3134
li

NUMBER OF PAGES TO FOLLOW: 2 - including cover page

MESSAGE: _____
Catalina

Per our conversation yesterday

analysis is the information received from

continuous printing of data change

history

FROM: Jana Williams
PHONE # 907-2515 FAX # 907-1308

STATE OF ALASKA

HEALTH AND SOCIAL SERVICES

TONY KNOWLES, GOVERNOR

Division of Administrative Services Fiscal
P.O. Box 240249
Anchorage, AK 99524-0249

(907) 269-7818

April 20, 2001

Continuous Printing of AK
2503 Arctic Blvd
Anchorage, AK 99503

RE: Invoice # W4282

Acct# 273

To whom it may concern:

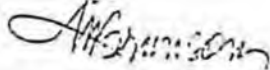
We received your fax regarding a past due invoice dated 3-22-99. Research indicates that the invoice will need to be submitted for a supplemental appropriation through the legislature.

Our Juneau fiscal office has the documents and will research for possible previous payment and then submit the invoices through the legislature for supplemental approval. Usually any supplemental requests are approved by the legislature in May of each year therefore; we are unable to pay the bill at this time.

I apologize for the delay. You may wish to suspend the invoice and contact our office in June to check the status. You can contact me directly at 269-7815.

If I can clarify the process or you need further assistance, please let me know.

Sincerely,



Marissa Brunson

Accounting Clerk II

Cc: Bobbie Fuller, Public Health
Luz Malacas, Juneau Fiscal

PLEASE
DO NOT
STAPLE
IN THIS
AREA

APPROVED GME 0300-000

AK-BCCEDP
3601 C STREET STE. #934
PO BOX 240249
ANCHORAGE AK 99524-0249

PICA

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> CHAMPUS <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN (SSN or ID) <input type="checkbox"/> FECA BLK LUNG (SSN) <input checked="" type="checkbox"/> OTHER (ID) <input type="checkbox"/>		1a. INSURED'S ID NUMBER	(FOR PROGRAM) (ITEM)
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)		3. PATIENT'S BIRTH DATE MM/DD/YY SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	
5. PATIENT'S ADDRESS (No. Street)		7. INSURED'S ADDRESS (No. Street)	
CITY ANCHORAGE STATE AK		CITY ANCHORAGE STATE AK	
ZIP CODE 99508 TELEPHONE (907) 562-4775		ZIP CODE 99508 TELEPHONE (907) 562-4775	
5. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		10. IS PATIENT'S CONDITION RELATED TO:	
a. OTHER INSURED'S POLICY OR GROUP NUMBER		a. EMPLOYMENT? (CURRENT OR PREVIOUS) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
b. OTHER INSURED'S DATE OF BIRTH MM/DD/YY SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		b. AUTO ACCIDENT? PLACE (State) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
c. EMPLOYER'S NAME OR SCHOOL NAME		c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
d. INSURANCE PLAN NAME OR PROGRAM NAME		10d. RESERVED FOR LOCAL USE	
11. INSURED'S POLICY GROUP OR FECA NUMBER		11. INSURED'S DATE OF BIRTH MM/DD/YY SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNATURE ON FILE		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier or services described below. SIGNATURE ON FILE	
SIGNED DATE		SIGNED DATE	

14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)		15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS GIVE FIRST DATE MM/DD/YY		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM/DD/YY TO MM/DD/YY	
7. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE		17a. ID NUMBER OF REFERRING PHYSICIAN 92-0047965		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM/DD/YY TO MM/DD/YY	
19. RESERVED FOR LOCAL USE 70280		20. OUTSIDE LAB? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO \$ CHARGES 0.00		22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (RELATE ITEMS 1, 2, 3 OR 4 TO ITEM 24E BY LINE) 1. V72.3 GYNECOLOGICAL E 2. 401.9 HYPERTENSION, ES		23. PRIOR AUTHORIZATION NUMBER		24. A. DATE(S) OF SERVICE FROM MM/DD/YY TO MM/DD/YY B. Place of Service C. Type of Service D. PROCEDURES, SERVICES OR SUPPLIES (Explain Unusual Circumstances) CPT/MCPCS MODIFIER E. DIAGNOSIS CODE F. \$ CHARGES G. DAYS (EPSDT OR Family Plan) H. EMG I. COB J. RESERVED FOR LOCAL USE	

24. A. DATE(S) OF SERVICE FROM MM/DD/YY TO MM/DD/YY B. Place of Service C. Type of Service D. PROCEDURES, SERVICES OR SUPPLIES (Explain Unusual Circumstances) CPT/MCPCS MODIFIER E. DIAGNOSIS CODE F. \$ CHARGES G. DAYS (EPSDT OR Family Plan) H. EMG I. COB J. RESERVED FOR LOCAL USE		25. FEDERAL TAX ID NUMBER SSN EIN 26. PATIENT'S ACCOUNT NO 27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE \$ 92.00 29. AMOUNT PAID \$ 0.00 30. BALANCE DUE \$ 92.00	
SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS certify that the statements on the reverse copy to this bill and are made a part thereof: AM ENGLE PA-C DATE 06/13/01 FDR Mam Cert# 183533		32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office): SECTION OF MATERNAL, CHILD & FAMILY HEALTH 66.03 ANCHORAGE OFFICE 66.03		33. PHYSICIAN'S SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE # Anchorage Neighborhood Hlth Ctr P.O. Box 201849 ANCHORAGE AK 99520-1849 PIN# 92-0047965 GRP# 92-0047965	

Ok to pay ANN 845831
66.03 01-06311441 06602301 73230
June 11, 2001
SECTION OF MATERNAL, CHILD & FAMILY HEALTH
66.03 ANCHORAGE OFFICE 66.03

PATIENT AND INSURED INFORMATION
PHYSICIAN OR SUPPLIER INFORMATION

PLEASE DO NOT STAPLE IN THIS AREA

APPROVED JUNE 0925 2006

AK-BCCEDP
3601 C STREET STE. #934
PO BOX 240249
ANCHORAGE AK 99524-0249

HEALTH INSURANCE CLAIM FORM

PICA

PICA

1 MEDICARE (Medicare #)	MEDICAID (Medicaid #)	CHAMPUS (Sponsor's SSN)	CHAMPVA (VA File #)	GROUP HEALTH PLAN (SSN or ID)	FECA BLK LUNG (SSN)	OTHER (ID)	13 INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)
2 PATIENT'S NAME (Last Name, First Name, Middle Initial)				3 PATIENT'S BIRTH DATE MM DD YY		4 INSURED'S NAME (Last Name, First Name, Middle Initial)	
5 PATIENT'S ADDRESS (No., Street)				6 PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		7 INSURED'S ADDRESS (No., Street)	
CITY		STATE		E PATIENT STATUS Single <input checked="" type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>		CITY	
ZIP CODE		TELEPHONE (Include Area Code)		Employed <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/>		ZIP CODE	
9 OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)				10 IS PATIENT'S CONDITION RELATED TO:		11 INSURED'S POLICY GROUP OR FECA NUMBER	
a. OTHER INSURED'S POLICY OR GROUP NUMBER				a. EMPLOYMENT? (CURRENT OR PREVIOUS) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		a. INSURED'S DATE OF BIRTH MM DD YY	
b. OTHER INSURED'S DATE OF BIRTH MM DD YY				b. AUTO ACCIDENT? PLACE (State) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		b. EMPLOYER'S NAME OR SCHOOL NAME	
c. EMPLOYER'S NAME OR SCHOOL NAME				c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		c. INSURANCE PLAN NAME OR PROGRAM NAME	
c. INSURANCE PLAN NAME OR PROGRAM NAME				10c. RESERVED FOR LOCAL USE		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If yes, return to and complete item 9 a-d	

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12 PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below: SIGNATURE ON FILE	DATE 06/13/01	13 INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefit to the undersigned physician or supplier for services described below: SIGNATURE ON FILE
---	-------------------------	---

14 DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP): ** ** *	15 IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS GIVE FIRST DATE MM DD YY 92-0047965	16 DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY
NAME OF REFERRING PHYSICIAN OR OTHER SOURCE	17a ID NUMBER OF REFERRING PHYSICIAN	18 HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY

19 RESERVED FOR LOCAL USE 70290	20 OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO 0.00
21 DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (RELATE ITEMS 1, 2, 3 OR 4 TO ITEM 24E BY LINE)	22 MEDICAID RESUBMISSION CODE ORIGINAL REF NO.
1. V72.3 GYNECOLOGICAL E	23 PRIOR AUTHORIZATION NUMBER
2. 401.9 HYPERTENSION, ES	

A		B		C		D		E		F		G		H		I		J		K	
DATE(S) OF SERVICE From		To		Place of Service		Type of Service		PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER		DIAGNOSIS CODE		\$ CHARGES		DAYS (EPSDT) OR UNITS Family Plan		EMG		COB		RESERVED FOR LOCAL USE	
06	09	99	06	09	99	50	5	88164	1	20.00	1										92-0047965
06	09	99	06	09	99	50	5	87212	1	1.15	1										

Ok to pay
\$7.15 01-06311441 06602301 73230
Justin Lusk 7-11-01

RECEIVED

JUL 10 2001

SECTION OF MATERNAL, CHILD & FAMILY HEALTH ANCHORAGE OFFICE 7.15

1 FEDERAL TAX ID NUMBER 92-0047965	25 EIN <input checked="" type="checkbox"/>	26 PATIENT'S ACCOUNT NO. 040075-01	27 ACCEPT ASSIGNMENT? (For gov't claims see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	28 TOTAL CHARGE 5 40.00	29 AMOUNT PAID 0.00	30 BALANCE DUE 40.00
SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS certify that the statements on the reverse apply to this bill and are made a part thereof. HM ENGLE PA-C				32 NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office) ANCHORAGE NEIGHBORHOOD H1TH CTR P.O. BOX 201849 ANCHORAGE AK 99520-1849		
SIGNED 06/13/01				33 PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE # ANCHORAGE NEIGHBORHOOD H1TH CTR P.O. BOX 201849 ANCHORAGE AK 99520-1849		
DATE 06/13/01				PIN# 92-0047965 GRP# 92-0047965		

PLEASE
DO NOT
STAPLE
IN THIS
AREA

APPROVED DATE 03/22/2002

AK-BCCEDP
3601 C STREET STE. #534
PO BOX 240249
ANCHORAGE AK 99524-0249

HEALTH INSURANCE CLAIM FORM

1 MEDICARE (Medicare #)				MEDICAID (Medicaid #)		CHAMPUS (Sponsor's SSN)		CHAMPVA (VA File #)		GROUP HEALTH PLAN (ISSN or ID)		FECA BLK LUNG (SSN)		OTHER (ID)		1a. INSURED'S ID NUMBER		1b. PROGRAM ITEM																									
2 PATIENT'S NAME (Last Name, First Name, Middle Initial)										3 PATIENT'S BIRTH DATE (MM DD YY)				SEX (M <input type="checkbox"/> F <input checked="" type="checkbox"/>		4 INSURED'S NAME (Last Name, First Name, Middle Initial)																											
5 PATIENT'S ADDRESS (Inc. Street)										E PATIENT RELATIONSHIP TO INSURED (Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>)				7 INSURED'S ADDRESS (Inc. Street)																													
CITY				STATE		6 PATIENT STATUS (Single <input checked="" type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>)				CITY				STATE		8 INSURED'S ADDRESS (Inc. Street)																											
ANCHORAGE				AK		Employed <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/>				ANCHORAGE				AK		521 N. KLEVIN ST. APT. 2																											
ZIP CODE				TELEPHONE (Include Area Code)		9 OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)				10 IS PATIENT'S CONDITION RELATED TO (a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> b. AUTO ACCIDENT? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> c. OTHER ACCIDENT? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 10c. RESERVED FOR LOCAL USE				11 INSURED'S POLICY GROUP OR FECA NUMBER				12 PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE (I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.) SIGNATURE ON FILE				13 INSURED'S OR AUTHORIZED PERSON'S SIGNATURE (I authorize payment of medical benefits to the undersigned physician or supplier for services described below.) SIGNATURE ON FILE																					
39508				(907)-562-4775																																							
12 PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE (I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.) SIGNATURE ON FILE				DATE				15 IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS (GIVE FIRST DATE MM DD YY)				16 DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION (FROM MM DD YY TO MM DD YY)				17a. IC NUMBER OF REFERRING PHYSICIAN				18 HOSPITALIZATION DATES RELATED TO CURRENT SERVICES (FROM ** ** ** TO ** ** **)				19 RESERVED FOR LOCAL USE				20 OUTSIDE LAB* CHARGES (YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> \$)				21 DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (RELATE ITEMS 1, 2, 3 OR 4 TO ITEM 24E BY LINE)				22 MEDICAID RESUBMISSION CODE ORIGINAL REF NO				23 PRIOR AUTHORIZATION NUMBER			
				06/13/01				32-0047965				32-0047965				70290				V76.12 MAMMOGRAM, BREAS																							
24 A DATE(S) OF SERVICE (From To)				B Place of Service		C Type of Service		D PROCEDURES SERVICES OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER				E DIAGNOSIS CODE		F CHARGES		G DAYS REPORT OR IF Family Plan		H EMG		I COB		J RESERVED FOR LOCAL USE																					
06:08:99 06:08:99				50		4		76092				1		100.00		1						32-0047965																					
15 FEDERAL TAX ID NUMBER				35N EIN		36 PATIENT'S ACCOUNT NO				27 ACCEPT ASSIGNMENT? (If for Govt. Claims, see back) YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				28 TOTAL CHARGE		29 AMOUNT PAID		30 BALANCE DUE																									
32-0047965						040075-01								100.00		0.00		100.00																									
31 SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)										32 NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)										33 PHYSICIAN'S SUPPLIER'S BILLING NAME ADDRESS ZIP CODE & PHONE #																							
AM ENGLE PA-C										06/13/01 FDR Mam Cert# 183533										Anchorage Neighborhood Hlth Ctr P.O. Box 201849 ANCHORAGE AK 99520-1849 PIN# 32-0047965 GRP# 32-0047965																							

PATIENT AND INSURED INFORMATION
PHYSICIAN OR SUPPLIER INFORMATION

PLEASE DO NOT STAPLE IN THIS AREA

APPROVED ONE 2026 022

AK-BCCEDP
3601 C STREET STE. #934
PO BOX 240249
ANCHORAGE AK 99524-0249

Handwritten signature and initials

HEALTH INSURANCE CLAIM FORM

PICA		MEDICAID		CHAMPUS		CHAMPVA		GROUP HEALTH PLAN		FECA		OTHER		INSURED'S ID NUMBER		FOR PROGRAM ITEM			
PATIENT'S NAME (Last Name, First Name, Middle Initial)		PATIENT'S BIRTH DATE		SEX		INSURED'S NAME (Last Name, First Name, Middle Initial)		INSURED'S DATE OF BIRTH		SEX		INSURED'S ADDRESS (No, Street)		CITY		STATE			
2141 WASHINGTON AVE		07/12/79		M		[Redacted]		07/12/79		M		2141 WASHINGTON AVE		ANCHORAGE		AK			
PATIENT'S ADDRESS (No, Street)		PATIENT RELATIONSHIP TO INSURED		PATIENT STATUS		INSURED'S POLICY GROUP OR FECA NUMBER		EMPLOYER'S NAME OR SCHOOL NAME		INSURANCE PLAN NAME OR PROGRAM NAME		IS THERE ANOTHER HEALTH BENEFIT PLAN?		INSURED'S OR AUTHORIZED PERSON'S SIGNATURE		DATE			
2141 WASHINGTON AVE		Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		Single <input type="checkbox"/> Married <input checked="" type="checkbox"/> Other <input type="checkbox"/>		AK-BCCEDP		AK-BCCEDP		AK-BCCEDP		NO <input checked="" type="checkbox"/> YES <input type="checkbox"/>		SIGNATURE ON FILE		06/13/01			
CITY		STATE		EMPLOYED		INSURED'S DATE OF BIRTH		EMPLOYER'S NAME OR SCHOOL NAME		INSURANCE PLAN NAME OR PROGRAM NAME		IS THERE ANOTHER HEALTH BENEFIT PLAN?		INSURED'S OR AUTHORIZED PERSON'S SIGNATURE		DATE			
ANCHORAGE		AK		Employed <input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time <input type="checkbox"/> Student <input type="checkbox"/>		07/12/79		AK-BCCEDP		AK-BCCEDP		NO <input checked="" type="checkbox"/> YES <input type="checkbox"/>		SIGNATURE ON FILE		06/13/01			
ZIP CODE		TELEPHONE (include Area Code)		10 IS PATIENT'S CONDITION RELATED TO		INSURED'S POLICY GROUP OR FECA NUMBER		EMPLOYER'S NAME OR SCHOOL NAME		INSURANCE PLAN NAME OR PROGRAM NAME		IS THERE ANOTHER HEALTH BENEFIT PLAN?		INSURED'S OR AUTHORIZED PERSON'S SIGNATURE		DATE			
99515		(907)-277-7492		a YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		AK-BCCEDP		AK-BCCEDP		AK-BCCEDP		NO <input checked="" type="checkbox"/> YES <input type="checkbox"/>		SIGNATURE ON FILE		06/13/01			
OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		OTHER INSURED'S POLICY OR GROUP NUMBER		OTHER INSURED'S DATE OF BIRTH		OTHER INSURED'S SEX		OTHER INSURED'S EMPLOYER'S NAME OR SCHOOL NAME		OTHER INSURED'S INSURANCE PLAN NAME OR PROGRAM NAME		OTHER INSURED'S IS THERE ANOTHER HEALTH BENEFIT PLAN?		OTHER INSURED'S SIGNATURE		OTHER INSURED'S DATE			
[Redacted]		[Redacted]		[Redacted]		[Redacted]		[Redacted]		[Redacted]		[Redacted]		[Redacted]		[Redacted]			
DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)		IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS GIVE FIRST DATE		DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION		HOSPITALIZATION DATES RELATED TO CURRENT SERVICES		OUTSIDE LAB? CHARGES		MEDICAID RESUBMISSION CODE ORIGINAL REF NO		PRIOR AUTHORIZATION NUMBER		FEDERAL TAX ID NUMBER		SSN EIN			
03 02 00		06/13/01		FROM MM DD YY TO MM DD YY		FROM MM DD YY TO MM DD YY		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 0.00		[Redacted]		[Redacted]		92-0047965		[Redacted]			
NAME OF REFERRING PHYSICIAN OR OTHER SOURCE		ID NUMBER OF REFERRING PHYSICIAN		RESERVED FOR LOCAL USE		DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (RELATE ITEMS 1, 2, 3 OR 4 TO ITEM 24E BY LINE)		MEDICAID RESUBMISSION CODE ORIGINAL REF NO		PRIOR AUTHORIZATION NUMBER		FEDERAL TAX ID NUMBER		SSN EIN		PATIENT'S ACCOUNT NO			
SALVADORI, GABRIEL V		32-0047965		97817-FPC		564.1 COLON, IRRITABLE		[Redacted]		[Redacted]		92-0047965		[Redacted]		062053-00			
DATE(S) OF SERVICE		Place of Service		Type of Service		PROCEDURES SERVICES OR SUPPLIES (Explain unusual circumstances) (CPT, HCPCS MODIFIER)		DIAGNOSIS CODE		CHARGES		DAYS PERIOD OR (Family Units) Plan		EMG		COB		RESERVED FOR LOCAL USE	
03 02 00		50		1		99213		1		81.00		1		[Redacted]		[Redacted]		[Redacted]	
03 02 00		50		2		57452		1		52.00		1		[Redacted]		[Redacted]		[Redacted]	
SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING OF DEGREE OR CREDENTIALS		NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (if other than home or office)		PHYSICIAN'S SUPPLIER'S BILLING NAME ADDRESS ZIP CITY STATE		TOTAL CHARGE		AMOUNT PAID		BALANCE DUE		SIGNATURE OF MATERNAL CHILD & FAMILY HEALTH ANCHORAGE OFFICE		DATE		FEDERAL TAX ID NUMBER		SSN EIN	
JOAN F HOFFMAN MD		ANCHORAGE Neighborhood Hlth Ctr P.O. Box 201849 ANCHORAGE AK 99520-1849		ANCHORAGE AK 99520-1849		5 302.00		0.00		302.00		144.09		06/13/01		92-0047965		[Redacted]	
SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING OF DEGREE OR CREDENTIALS		NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (if other than home or office)		PHYSICIAN'S SUPPLIER'S BILLING NAME ADDRESS ZIP CITY STATE		TOTAL CHARGE		AMOUNT PAID		BALANCE DUE		SIGNATURE OF MATERNAL CHILD & FAMILY HEALTH ANCHORAGE OFFICE		DATE		FEDERAL TAX ID NUMBER		SSN EIN	
JOAN F HOFFMAN MD		ANCHORAGE Neighborhood Hlth Ctr P.O. Box 201849 ANCHORAGE AK 99520-1849		ANCHORAGE AK 99520-1849		5 302.00		0.00		302.00		144.09		06/13/01		92-0047965		[Redacted]	

Ok to pay
\$ 144.09
FIRM 84523
006311441 73230
Handwritten signature 09-6-01

RECEIVED

SECTION OF MATERNAL CHILD & FAMILY HEALTH ANCHORAGE OFFICE

PLEASE DO NOT STAPLE IN THIS AREA

APPROVED OMB 0938-0001

HEALTH INSURANCE CLAIM FORM

Handwritten notes:
B, 1, 1
B, 1, 1

1 MEDICARE (Medicare #)		MEDICAID (Medicaid #)		CHAMPUS (Sponsor's SSN)		CHAMPVA (VA File #)		GROUP HEALTH PLAN (SSN or ID)		FECA BLK LUNG (SSN)		OTHER (ID)		1a INSURED'S ID NUMBER		(FOR PROGRAM USE)																																							
2 PATIENT'S NAME (Last Name, First Name, Middle Initial)								3 PATIENT'S BIRTH DATE (MM, DD, YY)				SEX (M, F)		4 INSURED'S NAME (Last Name, First Name, Middle Initial)																																									
5 PATIENT'S ADDRESS (No. Street)								6 PATIENT RELATIONSHIP TO INSURED (Self, Spouse, Child, Other)				7 INSURED'S ADDRESS (No. Street)																																											
CITY				STATE				5 PATIENT STATUS (Single, Married, Other)				CITY				STATE																																							
ZIP CODE				TELEPHONE (Include Area Code)				Employed, Full-time Student, Part-time Student				ZIP CODE				TELEPHONE (Include Area Code)																																							
9 OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)								10 IS PATIENT'S CONDITION RELATED TO (a, b, c)				11 INSURED'S POLICY GROUP OR FECA NUMBER																																											
12 PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE								13 INSURED'S OR AUTHORIZED PERSON'S SIGNATURE				14 DATE OF CURRENT ILLNESS (First Symptom) OR INJURY (Accident) OR PREGNANCY (MP)				15 IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS GIVE FIRST DATE (MM, DD, YY)				16 DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION (FROM, TO)																																			
17 NAME OF REFERRING PHYSICIAN OR OTHER SOURCE								17a ID NUMBER OF REFERRING PHYSICIAN				18 HOSPITALIZATION DATES RELATED TO CURRENT SERVICES (FROM, TO)				19 RESERVED FOR LOCAL USE				20 OUTSIDE LAB CHARGES (YES, NO)																																			
21 DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (RELATE ITEMS 1, 2, 3 OR 4 TO ITEM 24E BY LINE)								22 MEDICAID RESUBMISSION CODE				23 PRIOR AUTHORIZATION NUMBER				24 A DATE: S, OF SERVICE, To (MM, DD, YY)				B Place of Service				C Type of Service				D PROCEDURES SERVICES OR SUPPLIES (Explain Unusual Circumstances) (CPT, HCPCS, MODIFIER)				E DIAGNOSIS CODE				F CHARGES				G DAYS (P, S, D, T) OR Family Plan				H EMG				I COB				J RESERVED FOR LOCAL USE			
25 FEDERAL TAX ID NUMBER								26 PATIENT SIGNATURE				27 SIGNATURE OF PHYSICIAN OR SUPPLIER				28 TOTAL CHARGE				29 AMOUNT PAID				30 BALANCE DUE																															
31 SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREE OR CREDENTIALS								32 NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than name of office)				33 PHYSICIAN'S SUPPLIER'S BILLING NAME ADDRESS ZIP & PHONE #				34				35				36																															

PATIENT AND INSURED INFORMATION
PHYSICIAN OR SUPPLIER INFORMATION

Ok to pay
514.60
0006311441 73230
09-01

SECTION OF MATERNAL
FAMILY HEALTH
ANCHORAGE OFFICE

PLEASE DO NOT STAPLE IN THIS AREA



APPROVED CMB 0926 0005

3501 C STREET SE, ROOM 101
 ANCHORAGE, AK 99504-0005

B. 11

HEALTH INSURANCE CLAIM FORM

1 MEDICARE (Medicare #)		2 MEDICAID (Medicaid #)		3 CHAMPUS (Sponsor's SSN)		4 CHAMPVA (IVA File #)		5 GROUP HEALTH PLAN (SSN or ID)		6 FECA BLK LUNG (SSN)		7 OTHER (ID)		8 INSURED'S ID NUMBER		9 FOR PROGRAM NUMBER							
1 PATIENT'S NAME (Last Name, First Name, Middle Initial)						2 PATIENT'S BIRTH DATE (MM DD YY)			SEX		3 INSURED'S NAME (Last Name, First Name, Middle Initial)												
4 PATIENT'S ADDRESS (No. Street)						5 PATIENT RELATIONSHIP TO INSURED			6 INSURED'S ADDRESS (No. Street)														
7 CITY				STATE		8 PATIENT STATUS			9 CITY				STATE										
10 ZIP CODE				TELEPHONE (include Area Code)		11 Employed <input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time <input type="checkbox"/> Student <input type="checkbox"/>			12 ZIP CODE				TELEPHONE (include Area Code)										
13 OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)						14 IS PATIENT'S CONDITION RELATED TO			15 INSURED'S POLICY GROUP OR FECA NUMBER														
16 a OTHER INSURED'S POLICY OR GROUP NUMBER						17 a EMPLOYMENT (CURRENT OR PREVIOUS)			18 a INSURED'S DATE OF BIRTH (MM DD YY)			SEX											
19 b OTHER INSURED'S DATE OF BIRTH (MM DD YY)						20 b AUTO ACCIDENT? PLACE (State)			21 b EMPLOYER'S NAME OR SCHOOL NAME														
22 c EMPLOYER'S NAME OR SCHOOL NAME						23 c OTHER ACCIDENT?			24 c INSURANCE PLAN NAME OR PROGRAM NAME														
25 d INSURANCE PLAN NAME OR PROGRAM NAME						26 RESERVED FOR LOCAL USE			27 d IS THERE ANOTHER HEALTH BENEFIT PLAN?														
28 READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.																							
29 12 PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE												30 13 INSURED'S OR AUTHORIZED PERSON'S SIGNATURE											
31 SIGNATURE ON FILE												32 SIGNATURE ON FILE											
33 SIGNED												34 SIGNED											
35 14 DATE OF CURRENT ILLNESS (First symptoms) OR INJURY (Accident) OR PREGNANCY (M/P)						36 15 IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS GIVE FIRST DATE						37 16 DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION											
38 NAME OF REFERRING PHYSICIAN OR OTHER SOURCE						39 17 ID NUMBER OF REFERRING PHYSICIAN						40 18 HOSPITALIZATION DATES RELATED TO CURRENT SERVICES											
41 RESERVED FOR LOCAL USE						42 19 RESERVED FOR LOCAL USE						43 20 OUTSIDE LAB? \$ CHARGES											
44 21 DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (RELATE ITEMS 1, 2, 3 OR 4 TO ITEM 24E BY LINE)												45 22 MEDICAID RESUBMISSION CODE ORIGINAL REF NO											
46 23 PRIOR AUTHORIZATION NUMBER												47 24											
48 24																							
49 DATE, SI OF SERVICE				50 Place of Service		51 Type of Service		52 PROCEDURES, SERVICES OR SUPPLIES (Explain Unusual Circumstances) (CPT/HCPCS) MODIFIER				53 DIAGNOSIS CODE		54 \$ CHARGES		55 DAYS (PERSON OR Family Plan)		56 RESERVED FOR LOCAL USE					
57 03/31/00 - 03/31/00				58 50		59 1		60 99216 (60)				61 1		62 38.87		63 1		64 00-0047955					
65 Ok to pay \$ 38.87 00-06311441 73230																							
66 SECTION OF INTERNAL, CHILD & FAMILY HEALTH, ANCHORAGE OFFICE																							
67 19 FEDERAL TAX ID NUMBER						68 20 PATIENT'S ACCOUNT NO						69 21 ACCEPT ASSIGNMENT? (For govt. claims see back)											
70 00-0047955						71 050175-00						72 YES NO											
73 SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREE OR CREDENTIAL												74 22 NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than name of office)						75 23 PHYSICIAN'S SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE					
76 SIGNATURE												77 24						78 25					
79 SIGNED												80 DATE						81					

PATIENT AND INSURED INFORMATION
 PHYSICIAN OR SUPPLIER INFORMATION

RECEIVED

SECTION OF INTERNAL, CHILD & FAMILY HEALTH, ANCHORAGE OFFICE

PLEASE DO NOT STAPLE IN THIS AREA

APPROVED JUNE 1, 1992

AK-800001
3601 C STREET SE. #1034
PO BOX 240249
ANCHORAGE AK 99524-0249

Bill

HEALTH INSURANCE CLAIM FORM

1 MEDICARE		MEDICAID		CHAMPUS		CHAMPVA		GROUP HEALTH PLAN		FECA		OTHER		1a INSURED'S ID NUMBER		FOR PROGRAM/ITEM																			
2 PATIENT'S NAME (Last, First, Middle Initial)		3 PATIENT'S BIRTH DATE		SEX		4 INSURED'S NAME (Last, First, Middle Initial)		5 PATIENT'S ADDRESS (Inc. Street)		6 PATIENT RELATIONSHIP TO INSURED		7 INSURED'S ADDRESS (Inc. Street)		8 CITY		STATE																			
9 OTHER INSURED'S NAME (Last, First, Middle Initial)		10 IS PATIENT'S CONDITION RELATED TO		11 INSURED'S POLICY GROUP OR FECA NUMBER		12 PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE		13 INSURED'S OR AUTHORIZED PERSON'S SIGNATURE		14 DATE OF CURRENT ILLNESS		15 IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS		16 DATES PATIENT UNABLE TO WORK		17 NAME OF REFERRING PHYSICIAN		18 HOSPITALIZATION DATES																	
19 RESERVED FOR LOCAL USE		20 OUTSIDE LAB CHARGES		21 DIAGNOSIS OR NATURE OF ILLNESS		22 MEDICARE RESUBMISSION CODE		23 PRIOR AUTHORIZATION NUMBER		24 A DATE(S) OF SERVICE		24 B Place of Service		24 C Type of Service		24 D PROCEDURES, SERVICES OR SUPPLIES		24 E DIAGNOSIS CODE		24 F CHARGES		24 G DAYS OR UNITS		24 H EPST/ Family Plan		24 I EMG		24 J COB		24 K RESERVED FOR LOCAL USE					
25 FEDERAL TAX ID NUMBER		26 PATIENT'S ACCOUNT NO		27 ACCEPT ASSIGNMENT?		28 TOTAL CHARGE		29 AMOUNT PAID		30 BALANCE DUE		31 SIGNATURE OF PHYSICIAN OR SUPPLIER		32 NAME AND ADDRESS OF FACILITY		33 PHYSICIAN'S SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE		34 TECHNICAL		35 SIGNED		36 DATE		37 FIDM		38 NAME		39 ADDRESS		40 CITY		41 STATE		42 ZIP CODE	

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

Patient Tracking Fees - Quarter 4

Provider: PANHC

LastName	FirstName	Patient#	Service Date	CPT	Svc Fee	Tracking Fee
			5/8/2001	99396	\$145.00	\$30.00
			4/26/2001	99396	\$145.00	\$30.00
			6/11/2001	99386	\$145.00	\$30.00
			3/30/2001	88164	\$31.00	\$30.00
			4/13/2000	99214	\$117.00	\$30.00
			3/27/2001	99214	\$117.00	\$30.00
			5/22/2001	88164	\$31.00	\$30.00
			3/15/2001	99203	\$119.00	\$30.00
			5/3/2001	99396	\$145.00	\$30.00
			6/1/2001	88164	\$31.00	\$30.00
			4/18/2001	99214	\$117.00	\$30.00
			1/19/2001	88164	\$31.00	\$30.00
			6/1/2001	99214	\$117.00	\$30.00
			4/12/2001	99204	\$170.00	\$30.00
			6/27/2001	99396	\$145.00	\$30.00
			5/15/2001	99396	\$145.00	\$30.00
			5/11/2001	99396	\$145.00	\$30.00
			5/11/2001	99214	\$117.00	\$30.00
			6/6/2001	88164	\$31.00	\$30.00
			7/13/2001	99397	\$165.00	\$30.00
			2/20/2001	99386	\$175.00	\$30.00
			2/12/2001	99213	\$145.00	\$30.00
			5/31/2001	99213	\$81.00	\$30.00
			6/14/2001	88164	\$31.00	\$30.00

Patient Tracking Fees - Quarter 4

Provider: **WVHLC**

LastName	FirstName	Patient#	Service Date	CPT	Svc Fee	Tracking Fee
			6/15/2001	99204	\$170.00	\$30.00
			5/2/2001	88164	\$31.00	\$30.00
			7/11/2001	99396	\$145.00	\$30.00
			4/30/2001	99214	\$117.00	\$30.00
			5/2/2001	88164	\$31.00	\$30.00
			5/11/2001	88164	\$31.00	\$30.00
			3/14/2001	99214	\$117.00	\$30.00
			5/3/2001	99396	\$145.00	\$30.00
			5/10/2001	88164	\$31.00	\$30.00
			5/16/2001	88164	\$31.00	\$30.00
			4/16/2001	99215	\$187.00	\$30.00
			6/7/2001	99396	\$145.00	\$30.00
			5/9/2001	99213	\$81.00	\$30.00
			6/9/1999	99214	\$93.00	\$29.00
			4/5/2001	99213	\$81.00	\$30.00
			5/15/2001	88164	\$31.00	\$30.00
			7/13/2001	99213	\$81.00	\$30.00
			2/26/2001	99213	\$81.00	\$30.00
			5/31/2001	88164	\$31.00	\$30.00
			6/8/2001	99396	\$145.00	\$30.00
			5/11/2001	99214	\$117.00	\$30.00
			6/18/2001	88164	\$31.00	\$30.00
			4/18/2001	99214	\$117.00	\$30.00
			6/15/2001	99396	\$145.00	\$30.00

Patient Tracking Fees - Quarter 4

Provider: ANHC

Last Name	First Name	Patient#	Service Date	CPT	Svc Fee	Tracking Fee
			6/1/2001	99386	\$175.00	\$30.00
			3/22/2001	88164	\$31.00	\$30.00
			4/27/2001	88164	\$31.00	\$30.00
Total Patient Tracking Fees:						\$5,849.00

Ok to pay
 ANN 84583
 \$ 70.00 01-06311441 06602300 73270
Julie D. Smith 02-2-01 73270

Ok to pay
 \$ 59.00 00-06311441 06602300 73270
Julie D. Smith 02-2-01 73270

Ok to pay
 \$ 5470.00 01-06311441 06602301 73270
Julie D. Smith 02-2-01 73270

Ok to pay
 \$ 270.00 02-06311441 06602301 73270
Julie D. Smith 02-2-01 73270

HEALTH INSURANCE CLAIM FORM

MEDICARE MEDICAID CHAMPUS CHAMPVA GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER (ID)

1. (Medicare #) 2. (Medicaid #) 3. (Sponsor's SSN) 4. (VA File #) 5. PATIENT'S BIRTH DATE (MM/DD/YY) 6. SEX (M/F) 7. INSURED'S ID NUMBER 8. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No. Street) 6. PATIENT RELATIONSHIP TO INSURED (Self, Spouse, Child, Other) 7. INSURED'S ADDRESS (No. Street)

CITY STATE 8. PATIENT STATUS (Single, Married, Other) CITY STATE

ZIP CODE TELEPHONE (include Area Code) 9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) 10. IS PATIENT'S CONDITION RELATED TO (Employed, Full Time Student, Part-Time Student) 11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER b. OTHER INSURED'S DATE OF BIRTH (MM/DD/YY) SEX (M/F) 10a. EMPLOYMENT (CURRENT OR PREVIOUS) (YES/NO) 10b. AUTO ACCIDENT? (YES/NO) PLACE (State) 10c. OTHER ACCIDENT? (YES/NO) 11. INSURED'S DATE OF BIRTH (MM/DD/YY) SEX (M/F) 12. EMPLOYER'S NAME OR SCHOOL NAME 13. INSURANCE PLAN NAME OR PROGRAM NAME

c. EMPLOYER'S NAME OR SCHOOL NAME c. INSURANCE PLAN NAME OR PROGRAM NAME 10c. RESERVED FOR LOCAL USE 14. IS THERE ANOTHER HEALTH BENEFIT PLAN? (YES/NO) If yes, return to and complete item 9 a-d

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM. 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNATURE IN FILE DATE 13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNATURE IN FILE

14. DATE OF CURRENT ILLNESS (First Symptom) OR INJURY (Accident) OR PREGNANCY (LMP) 15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS GIVE FIRST DATE (MM/DD/YY) 16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM (MM/DD/YY) TO (MM/DD/YY)

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE 17a. ID NUMBER OF REFERRING PHYSICIAN 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM (MM/DD/YY) TO (MM/DD/YY)

RESERVED FOR LOCAL USE 20. OUTSIDE LAB? \$ CHARGES RESUBMISSION ORIGINAL REF NO HORIZONTAL NUMBER

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (RELATE ITEMS 1-4) Ok to pay ANN 84583 5 96.1600 0631144173230 *Judith Dutko 09-26-01*

DATE(S) OF SERVICE From MM/DD/YY To MM/DD/YY	Place of Service	Type of Service	PROCEDURES, SERVICES OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	DIAGNOSIS CODE	\$ CHARGES	DAVIS/PSO OR Family UNITS Plan	EMG	COS	RESERVED FOR LOCAL USE
03/29/00	50	E	96.16		19.60				COVERED
03/29/00	50	E	96.16						JUN 29 2001
03/29/00	50	E							SECTION OF MATERNAL & FAMILY HEALTH INSURANCE OFFICE 96.16

19. FEDERAL TAX ID NUMBER SSN EIN 26. PATIENT'S ACCOUNT NO 27. ACCEPT ASSIGNMENT? (For govt. claims see back) (YES/NO) 28. TOTAL CHARGE 29. AMOUNT PAID 30. BALANCE DUE

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) 32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office) 33. PHYSICIAN'S/SUPPLIER'S BILLING NAME ADDRESS ZIP CODE & PHONE #

34. DATE 35. PIN# 36. GPO#

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

PLEASE DO NOT STAPLE IN THIS AREA

APPROVED OMB 0935-0004



OF - 8102-04
3801 C ST
PO BOX 2002
ANCHORAGE AK 99501-0002

HEALTH INSURANCE CLAIM FORM

PIC#

1. MEDICARE		2. MEDICAID		3. CHAMPUS		4. CHAMPVA		5. GROUP HEALTH PLAN		6. FECA BLK LUNG		7. OTHER		8. INSURED'S IC NUMBER		9. (FOR PROGRAM IN USE)			
10. PATIENT'S NAME (Last Name, First Name, Middle Initial)		11. PATIENT'S BIRTH DATE		12. SEX		13. INSURED'S NAME (Last Name, First Name, Middle Initial)		14. INSURED'S BIRTH DATE		15. SEX		16. INSURED'S ADDRESS (No. Street)		17. CITY		18. STATE			
19. PATIENT'S ADDRESS (No. Street)		20. PATIENT RELATIONSHIP TO INSURED		21. PATIENT STATUS		22. INSURED'S ADDRESS (No. Street)		23. CITY		24. STATE		25. ZIP CODE		26. TELEPHONE (INCLUDE AREA CODE)		27. ZIP CODE		28. TELEPHONE (INCLUDE AREA CODE)	
29. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		30. IS PATIENT'S CONDITION RELATED TO		31. EMPLOYMENT (CURRENT OR PREVIOUS)		32. INSURED'S DATE OF BIRTH		33. SEX		34. EMPLOYER'S NAME OR SCHOOL NAME		35. INSURANCE PLAN NAME OR PROGRAM NAME		36. IS THERE ANOTHER HEALTH BENEFIT PLAN?		37. YES		38. NO	

FY 00

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE: I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNATURE ON FILE DATE 01/25/01

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE: I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNATURE ON FILE SIGNED

14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. ID NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. RELATE ITEMS TO OR PARTS THERE BY LINE.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF NO

23. PRIOR AUTHORIZATION NUMBER

A		B		C		D		E		F		G		H		I		J		K	
DATE(S) OF SERVICE		Place of Service		Type of Service		PROCEDURES SERVICES OR SUPPLIES		DIAGNOSIS CODE		CHARGES		DAYS, EPSD, OR Family Plan		EMG		COB		RESERVED FOR LOCAL USE			
03	29	00	03	29	00	50	1	75214	1 2												01-08-7555

RECEIVED

JAN 29 2001

SECTION OF MATERNAL, INFANT & FAMILY HEALTH, ANCHORAGE OFFICE

24. FEDERAL TAX ID NUMBER SSN EIN

25. PATIENT'S ACCOUNT NO

26. ACCEPT ASSIGNMENT? (For 70% claims. See back)

27. YES NO

28. TOTAL CHARGE

29. AMOUNT PAID

30. BALANCE DUE

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (if other than home or office)

33. PHYSICIAN'S SUPPLIER'S BILLING NAME ADDRESS ZIP CODE

34. PHONE #

PHYSICIAN OR SUPPLIER INFORMATION

PLEASE DO NOT STAPLE IN THIS AREA

APPROVED OMB 0938-0006



AK-BCCEDP
3501 C STREET STE. #834
PO BOX 240249
ANCHORAGE AK 99524-0249

HEALTH INSURANCE CLAIM FORM

PICA

PICA

MEDICARE		MEDICAID		CHAMPUS		CHAMPVA		GROUP HEALTH PLAN (SSN or ID)		FECA BLK LUNG (SSN)		OTHER		1a. INSURED'S I.D. NUMBER		ICR PROGRAM IN TEN	
2 PATIENT'S NAME (Last Name, First Name, Middle Initial)		3 PATIENT'S BIRTH DATE (MM DD YY)		SEX		4 INSURED'S NAME (Last Name, First Name, Middle Initial)											
5 PATIENT'S ADDRESS (No. Street)				6 PATIENT RELATIONSHIP TO INSURED				7 INSURED'S ADDRESS (No. Street)									
CITY				STATE				CITY				STATE					
ZIP CODE				TELEPHONE (Include Area Code)				ZIP CODE				TELEPHONE (INCLUDE AREA CODE)					
8 OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)				9 IS PATIENT'S CONDITION RELATED TO				10 INSURED'S POLICY GROUP OR FECA NUMBER									
a. OI				a. EMPLOYMENT* (CURRENT OR PREVIOUS)				a. INSURED'S DATE OF BIRTH (MM DD YY)				SEX					
b. OI				b. AUTO ACCIDENT? PLACE (State)				b. EMPLOYER'S NAME OR SCHOOL NAME									
c. EI				c. OTHER ACCIDENT?				c. INSURANCE PLAN NAME OR PROGRAM NAME									
d. IF				10c. RESERVED FOR LOCAL USE				d. IS THERE ANOTHER HEALTH BENEFIT PLAN?									
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.																	
SIGNATURE ON FILE								DATE 09/04/01									
13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.																	
SIGNATURE ON FILE								DATE									
14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)				15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS GIVE FIRST DATE				16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION									
NAME OF REFERRING PHYSICIAN OR OTHER SOURCE				17a. I.D. NUMBER OF REFERRING PHYSICIAN				16. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES									
19. RESERVED FOR LOCAL USE				17a. I.D. NUMBER OF REFERRING PHYSICIAN				20. OUTSIDE LAB? \$ CHARGES									
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (RELATE ITEMS 1, 2, 3 OR 4)				17a. I.D. NUMBER OF REFERRING PHYSICIAN				20. OUTSIDE LAB? \$ CHARGES									
21. 516.10 VAGINITIS AND VD				17a. I.D. NUMBER OF REFERRING PHYSICIAN				20. OUTSIDE LAB? \$ CHARGES									
21. V73.3 GYNECOLOGICAL E				17a. I.D. NUMBER OF REFERRING PHYSICIAN				20. OUTSIDE LAB? \$ CHARGES									
24. DATE(S) OF SERVICE				25. PLACE OF SERVICE				26. PROCEDURES, SER (Explain Unusual Circumstances) CPT/HCPCS MODIFIER				27. CODE					
24. 02 03 00				25. 50				26. 99213				27. 1 2					
24. 02 03 00				25. 50				26. 87490				27. 1					
24. 02 03 00				25. 50				26. 98164				27. 1					
24. 02 03 00				25. 50				26. 97210				27. 1					
28. FEDERAL TAX I.D. NUMBER				29. SSN EIN				30. PATIENT'S ACCOUNT NO				31. ACCEPT ASSIGNMENT? (For govt. claims, see back)					
32-0047965				99-9999999				063205-00				X YES [] NO					
32. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (copy that the statements on the reverse apply to this bill and are made a part hereof)				33. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)				34. PHYSICIAN'S SUPPLIER'S BILLING NAME, ADDRESS ZIP CODE & PHONE #				35. TOTAL CHARGE					
DRAYA ARAGUNDI MD				33. ANCHORAGE Neighborhood Hlth Ctr P.O. Box 201949 ANCHORAGE AK 99520-1949				34. ANCHORAGE AK 99520-1949				35. \$ 102.00					
SIGNED				DATE 09/04/01				FDA Mam Cert# 183533				35. AMOUNT PAID \$ 0.00					
												35. BALANCE DUE \$ 102.00					

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

PLEASE DO NOT STAPLE IN THIS AREA



APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88

AK-BCCEDP
3601 C STREET STE. #934
PO BOX 240249
ANCHORAGE AK 99524-0249



HEALTH INSURANCE CLAIM FORM

1. MEDICARE (Medicare #) <input type="checkbox"/>		MEDICAID (Medicaid #) <input type="checkbox"/>		CHAMPUS (Sponsor's SSN) <input type="checkbox"/>		CHAMPVA (VA File #) <input type="checkbox"/>		GROUP HEALTH PLAN (SSN or ID) <input type="checkbox"/>		FECA BLK LUNG (SSN) <input type="checkbox"/>		OTHER (ID) <input checked="" type="checkbox"/>		13. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)									
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)								3. PATIENT'S BIRTH DATE MM DD YY 11 19 64				4. INSURED'S NAME (Last Name, First Name, Middle Initial)											
5. PATIENT'S ADDRESS (No., Street) 317 STATE ST. #8								6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>				7. INSURED'S ADDRESS (No., Street) 317 STATE ST. #8											
CITY ANCHORAGE				STATE AK				8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input checked="" type="checkbox"/>				CITY ANCHORAGE				STATE AK							
ZIP CODE 99504				TELEPHONE (Include Area Code) (907)-522-1490				Employed <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/>				ZIP CODE 99504				TELEPHONE (INCLUDE AREA CODE) (907)-522-1490							
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)								10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (CURRENT OR PREVIOUS) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO b. AUTO ACCIDENT? PLACE (State) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO								11. INSURED'S POLICY GROUP OR FECA NUMBER							
a. OTHER INSURED'S POLICY OR GROUP NUMBER?								a. INSURED'S DATE OF BIRTH MM DD YY 11 19 64								SEX M <input type="checkbox"/> F <input checked="" type="checkbox"/>							
b. OTHER INSURED'S DATE OF BIRTH MM DD YY								b. EMPLOYER'S NAME OR SCHOOL NAME TRIPLE AAA SERV								c. INSURANCE PLAN NAME OR PROGRAM NAME AK-BCCEDP							
c. EMPLOYER'S NAME OR SCHOOL NAME								10c. RESERVED FOR LOCAL USE								c. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If yes, return to and complete item 9 a-c.							
c. INSURANCE PLAN NAME OR PROGRAM NAME								12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNATURE ON FILE								13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNATURE ON FILE							
SIGNED								DATE 06/13/01								SIGNED							

14. DATE OF CURRENT: <input checked="" type="checkbox"/> ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)																15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY																16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY															
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE																17a. I.C. NUMBER OF REFERRING PHYSICIAN 92-0047965																18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY															
19. RESERVED FOR LOCAL USE 105154 MT																20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO 0.00																22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.															
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1, 2, 3 OR 4 TO ITEM 21E BY LINE) 1. V72.3 GYNECOLOGICAL E																23. PRIOR AUTHORIZATION NUMBER																24. A B C D E F G H I J K L M N O P Q R S T U V W X Y Z															

A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	U	V	W	X	Y	Z
DATE(S) OF SERVICE From MM DD YY To MM DD YY	Place of Service	Type of Service	PROCEDURES, SERVICES OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	DIAGNOSIS CODE	\$ CHARGES	DAYS (EPSON OR Family Plan)	EMG	COB	RESERVED FOR LOCAL USE																
04/18/00 - 04/18/00	50	1	99201	1	70.00	1			92-0047965																
04/18/00 - 04/18/00	50	5	87252		87.00	1																			
<p>SECTION OF MATE... CHILD & FAMILY... OFFICE</p> <p>00-06311441 0060 2300 13230 46.12</p> <p>46.12</p>																									

25. FEDERAL TAX I.D. NUMBER 92-0047965				SSN EIN <input checked="" type="checkbox"/>				26. PATIENT'S HOME PHONE 073257-00				27. ACCEPT ASSIGNMENT? (If for Govt. Claims, See Back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				28. TOTAL CHARGE \$ 150.00				29. AMOUNT PAID \$ 0.00				30. BALANCE DUE \$ 150.00			
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) JDRINNE BARDLAW PA-10 SIGNED DATE 06/13/01												32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office) ANCHORAGE NEIGHBORHOOD HITH C... P.O. Box 201849 ANCHORAGE AK 99520-1849 PINA 92-0047965 GRP# 92-0047965															

PLEASE DO NOT STAPLE IN THIS AREA

APPROVED OMS-C938-0005

AK-BCCEDP
3601 C STREET STE. #934
PO BOX 240249
ANCHORAGE AK 99524-0249



HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE MEDICAID CHAMPUS CHAMPVA GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER (ID)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial) [REDACTED]

3. PATIENT'S BIRTH DATE: 12/17/80 M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial) [REDACTED]

5. PATIENT'S ADDRESS (No., Street): PO BOX 111445

6. PATIENT RELATIONSHIP TO INSURED: Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street): PO BOX 111445

CITY: ANCHORAGE STATE: AK

8. PATIENT STATUS: Single Married Other
Employed Full-Time Student Part-Time Student

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:
a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES NO
b. AUTO ACCIDENT? YES NO
c. OTHER ACCIDENT? YES NO
10c. RESERVED FOR LOCAL USE

11. INSURED'S POLICY GROUP OR FECA NUMBER: AK-BCCEDP

12. INSURED'S DATE OF BIRTH: 12/17/80 M F

13. EMPLOYER'S NAME OR SCHOOL NAME: SELF EMPLOYED

14. INSURANCE PLAN NAME OR PROGRAM NAME: AK-BCCEDP

15. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO // yes, return to and complete item 9a-d.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE: I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNATURE ON FILE 03/29/01

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE: I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNATURE ON FILE

14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (1P): ** ** *

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY: 03/29/01

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE: 31321

17a. I.D. NUMBER OF REFERRING PHYSICIAN: 92-0047965

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY

19. RESERVED FOR LOCAL USE: 31321

20. OUTSIDE LAB? YES NO \$ CHARGES: 0.00

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE): V72.3 GYNECOLOGICAL E

22. MEDICAID RESUBMISSION CODE: ORIGINAL REF ID: 00-06311441 06602300

23. PROBATION NUMBER: 75230

A		B		C		D		E		F		G		H		I		J		K		
DATE(S) OF SERVICE From		To		Place of Service	Type of Service	PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER		DIAGNOSIS CODE	\$ CHARGES	DAYS OR UNITS	EPSC Family Plan	ENG	COB	RESERVED FOR LOCAL USE								
13	27	00	03	27	00	50	1	99213	1	52.97	1											
13	27	00	03	27	00	50	5	88154	1	20.00	1											
13	27	00	03	27	00	50	5	87210	1	20.00	1											
3	27	00	03	27	00	50	5	84703	1	15.00	1											

24. FEDERAL TAX I.D. NUMBER: 3-0047965 SSN EIN: [REDACTED]

25. PATIENT'S ACCOUNT NO: 015167-00

26. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

27. TOTAL CHARGE: \$ 67.97 AMOUNT PAID: \$ 0.00 BALANCE DUE: \$ 67.97

28. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREE OR CREDENTIALS: HYLLIS DUNCKEL MD

29. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office): ANCHORAGE NEIGHBORHOOD HIGH CT P.O. BOX 201849 ANCHORAGE AK 99520-1849

30. PHYSICIAN'S SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE, CITY & PHONE: ANCHORAGE NEIGHBORHOOD HIGH CT P.O. BOX 201849 ANCHORAGE AK 99520-1849

SIGNED: 03/29/01 DATE: 03/29/01 FDA Mem Cert# 183533 PICA: 92-0047965 GRP: 92-0047965

PLEASE DO NOT STAPLE IN THIS AREA

APPROVED OMB-0938-0035
Screen

AK-BCCEDP
3601 C STREET STE. #934
PO BOX 240249
ANCHORAGE AK 99524-0249

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE <input type="checkbox"/> (Medicare #)		MEDICAID <input type="checkbox"/> (Medicaid #)		CHAMPUS <input type="checkbox"/> (Sponsor's SSN)		CHAMPVA <input type="checkbox"/> (VA File #)		GROUP HEALTH PLAN (SSN or ID) <input type="checkbox"/>		FECA BLK LUNG (SSN) <input checked="" type="checkbox"/> (ID)		OTHER <input type="checkbox"/> (ID)		1a. INSURED'S I.D. NUMBER (FOR PROGRAM ITEM)																	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)								3. PATIENT'S BIRTH DATE MM DD YY 01 19 69				SEX M <input type="checkbox"/> F <input checked="" type="checkbox"/>		4. INSURED'S NAME (Last Name, First Name, Middle Initial)																	
5. PATIENT'S ADDRESS (No., Street) 212 TAYLOR ST #1								6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>				7. INSURED'S ADDRESS (No., Street) 212 TAYLOR ST #1																			
CITY ANCHORAGE				STATE AK		8. PATIENT STATUS Single <input checked="" type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>				CITY ANCHORAGE				STATE AK																	
ZIP CODE 99508				TELEPHONE (include Area Code) (907) 278-0199				Employed <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/>				ZIP CODE 99508				TELEPHONE (INCLUDE AREA CODE) (907) 278-0199															
5. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)								10. IS PATIENT'S CONDITION RELATED TO.				11. INSURED'S POLICY GROUP OR FECA NUMBER																			
a. OTHER INSURED'S POLICY OR GROUP NUMBER								a. EMPLOYMENT? (CURRENT OR PREVIOUS) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				a. INSURED'S DATE OF BIRTH MM DD YY 01 19 69				SEX M <input type="checkbox"/> F <input checked="" type="checkbox"/>															
b. OTHER INSURED'S DATE OF BIRTH MM DD YY								b. AUTO ACCIDENT? PLACE (State) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				b. EMPLOYER'S NAME OR SCHOOL NAME																			
c. EMPLOYER'S NAME OR SCHOOL NAME								c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				c. INSURANCE PLAN NAME OR PROGRAM NAME AK-BCCEDP																			
e. INSURANCE PLAN NAME OR PROGRAM NAME								10c. RESERVED FOR LOCAL USE				d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO .. If yes, return to and complete item 9 a-d.																			
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. (also request payment of government benefits either to myself or to the party who accepts assignment.) SIGNATURE ON FILE SIGNED _____ DATE 07/06/01																13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNATURE ON FILE SIGNED _____															
14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) MM DD YY				15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY				16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY																							
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE								17a. I.D. NUMBER OF REFERRING PHYSICIAN 92-0047965				18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY																			
19. RESERVED FOR LOCAL USE 104410 MF								20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO 0.00				22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.				22. PRIOR AUTHORIZATION NUMBER															
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1, 2, 3 OR 4 TO ITEM 24E BY LINE) 1. V72.3 GYNECOLOGICAL F 2. E26.4 MENSURATION, IR 3. E16.10 VAGINITIS																															
24 A		B		C		D		E		F		G		H		I		J		K											
DATE(S) OF SERVICE From MM DD YY To MM DD YY		Place of Service		Type of Service		PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER		DIAGNOSIS CODE		\$ CHARGES		DAYS OR UNITS		EPSPD Family Plan		EMG		COB		RESERVED FOR LOCAL USE											
03 03 00 03 03 00		50		1		99201		1		46.12		1								92-0047965											
RECEIVED																															
DEC 03 2001																															
SECTION OF MATERIAL, CHILD & FAMILY HEALTH ANCHORAGE OFFICE																															
46.12																															
25. FEDERAL TAX I.D. NUMBER 92-0047965				26. PATIENT'S ACCOUNT NO. 048668-00				27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				28. TOTAL CHARGE \$ 46.12				29. AMOUNT PAID \$ 0.00				30. BALANCE DUE \$ 46.12											
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREE OR CREDENTIALS (I certify that the statements on the reverse apply in this bill and are made a part thereof.) DORINNE BARCLAY PA-1 SIGNED _____ DATE 07/06/01								32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (if other than home or office) FDR Mam Cert# 183533								33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE # Anchorage Neighborhood Hlth Ct P.O. Box 201849 ANCHORAGE AK 99520-1849 PINA 92-0047965 GRP 92-0047965															

PATIENT AND INSURED INFORMATION
PHYSICIAN OR SUPPLIER INFORMATION

PLEASE DO NOT STAPLE IN THIS AREA

AK-BCCEDP
3601 C STREET STE. #234
PO BOX 240249
ANCHORAGE AK 99524-0249
HEALTH INSURANCE CLAIM FORM

screen

PICA

PICA

1. MEDICARE <input type="checkbox"/> (Medicare #)	MEDICAID <input type="checkbox"/> (Medicaid #)	CHAMPUS <input type="checkbox"/> (Sponsor's SSN)	CHAMPVA <input type="checkbox"/> (VA File #)	GROUP HEALTH PLAN <input type="checkbox"/> (SSN or ID)	FECA BLK LUNG <input type="checkbox"/> (SSN)	OTHER <input checked="" type="checkbox"/> (ID)	1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) ████████████████████						3. PATIENT'S BIRTH DATE MM DD YY 04 10 50	SEX M <input type="checkbox"/> F <input checked="" type="checkbox"/>
5. PATIENT'S ADDRESS (No., Street) 701 HOYT APT. #4			6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>			7. INSURED'S ADDRESS (No., Street) 701 HOYT APT. #4	
CITY ANCHORAGE		STATE AK		8. PATIENT STATUS Single <input type="checkbox"/> Married <input checked="" type="checkbox"/> Other <input type="checkbox"/>		CITY ANCHORAGE	
STATE AK		STATE AK		9. EMPLOYED Employed <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/>		STATE AK	
ZIP CODE 99505		TELEPHONE (Include Area Code) (907) 277-8087		ZIP CODE 99508		TELEPHONE (INCLUDE AREA CODE) (907) 277-8087	
5. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)				10. IS PATIENT'S CONDITION RELATED TO:			
a. OTHER INSURED'S POLICY OR GROUP NUMBER				a. EMPLOYMENT? (CURRENT OR PREVIOUS) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
b. OTHER INSURED'S DATE OF BIRTH MM DD YY				b. AUTO ACCIDENT? PLACE (State) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
c. EMPLOYER'S NAME OR SCHOOL NAME				c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
c. INSURANCE PLAN NAME OR PROGRAM NAME				10c. RESERVED FOR LOCAL USE			
d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO - If yes, return to and complete item 9 a-d.				11. INSURED'S POLICY GROUP OR FECA NUMBER			

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment.

SIGNED _____ DATE 05/18/01

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)
MM DD YY

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN
92-0047965

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY

19. RESERVED FOR LOCAL USE
105751

20. OUTSIDE LAB? YES NO \$ CHARGES 0.00

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1, 2, 3 OR 4 TO ITEM 24E BY LINE)
1. 311 DEPRESSIVE DISOR
2. 076.12 MAMMOGRAM, BREAS

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24 A	B	C	D	E	F	G	H	I	J	K
DATE(S) OF SERVICE From MM DD YY To MM DD YY	Place of Service	Type of Service	PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	DIAGNOSIS CODE	\$ CHARGES	DAYS/PSOT OR Family Plan UNITS	EMG	COB	RESERVED FOR LOCAL USE	
05 24 00	50	4	76092	2	102.00	1				92-0047965
					67.81					
					00-06311441					
					06602					
					00-73230					
					67.81					

25. FEDERAL TAX I.D. NUMBER
92-0047965

25. SSN EIN

26. PATIENT'S ACCOUNT NO.
073536-00

27. ACCEPT ASSIGNMENT? (For govt. claims, see back)
 YES NO

28. TOTAL CHARGE \$ 102.00

29. AMOUNT PAID \$ 0.00

30. BALANCE DUE \$ 102.00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse copy to this bill and are made a part thereof.)
JULIAN BROWN, MD
SIGNED DATE 05/18/01

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)
ANCHORAGE NEIGHBORHOOD H1TH CT
P.O. Box 201849
ANCHORAGE AK 99520-1849
PINS 92-0047965 GRP 92-0047965

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #
ANCHORAGE NEIGHBORHOOD H1TH CT
P.O. Box 201849
ANCHORAGE AK 99520-1849
PINS 92-0047965 GRP 92-0047965

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

PLEASE DO NOT STAPLE IN THIS AREA

AK-BCCEDP
3601 C STREET STE. #934
PO. BOX 240249
ANCHORAGE AK 99524-0249
HEALTH INSURANCE CLAIM FORM

PICA

PICA

1. MEDICARE <input type="checkbox"/> (Medicare #)	MEDICAID <input type="checkbox"/> (Medicaid #)	CHAMPUS <input type="checkbox"/> (Sponsor's SSN)	CHAMPVA <input type="checkbox"/> (VA File #)	GROUP HEALTH PLAN <input type="checkbox"/> (SSN or ID)	FECA BLK LUNG <input type="checkbox"/> (SSN)	OTHER <input checked="" type="checkbox"/> (ID)	1a. INSURED'S I.D. NUMBER [REDACTED]	IFOR PROGRAM IN ITEM 1	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) [REDACTED]			3. PATIENT'S BIRTH DATE MM DD YY 04 10 50 M <input type="checkbox"/> F <input checked="" type="checkbox"/>		4. INSURED'S NAME (Last Name, First Name, Middle Initial) [REDACTED]				
5. PATIENT'S ADDRESS (No., Street) 701 HOYT APT. #4			6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		7. INSURED'S ADDRESS (No., Street) 701 HOYT APT. #4				
CITY ANCHORAGE		STATE AK	8. PATIENT STATUS Single <input type="checkbox"/> Married <input checked="" type="checkbox"/> Other <input type="checkbox"/>		CITY ANCHORAGE		STATE AK		
ZIP CODE 99508		TELEPHONE (Include Area Code) (907)-277-9037		Employed <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/>		ZIP CODE 99508		TELEPHONE (INCLUDE AREA CODE) (907)-277-3087	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)			10. IS PATIENT'S CONDITION RELATED TO:			11. INSURED'S POLICY GROUP OR FECA NUMBER			
a. OTHER INSURED'S POLICY OR GROUP NUMBER			a. EMPLOYMENT? (CURRENT OR PREVIOUS) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			a. INSURED'S DATE OF BIRTH MM DD YY 04 10 50 M <input type="checkbox"/> F <input checked="" type="checkbox"/>			
b. OTHER INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>			b. AUTO ACCIDENT? PLACE (State) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			b. EMPLOYER'S NAME OR SCHOOL NAME			
c. EMPLOYER'S NAME OR SCHOOL NAME			c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			c. INSURANCE PLAN NAME OR PROGRAM NAME AK-BCCEDP			
c. INSURANCE PLAN NAME OR PROGRAM NAME			10c. RESERVED FOR LOCAL USE			d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO ... If yes, return to and complete item 9 a-d.			

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE 05/18/01

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)
MM DD YY
** ** *

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION
FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN
92-0047965

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES
FROM MM DD YY TO MM DD YY

19. RESERVED FOR LOCAL USE
105751

20. OUTSIDE LAB? YES NO \$ CHARGES 0.00

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1, 2, 3 OR 4 TO ITEM 24E BY LINE)
1. V76.2 PAP SMEAR; CERVI

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. DATE(S) OF SERVICE		Place of Service		Type of Service	PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/MCPCS MODIFIER	DIAGNOSIS CODE	\$ CHARGES	DAYS OR UNITS	EPSTD Family Plan	EMG	COB	RESERVED FOR LOCAL USE
05 05 00	05 05 00	50	1		99204	1	170.00	1				92-0047965
							143.88					
							\$143.88					
							143.88					

25. FEDERAL TAX I.D. NUMBER 92-0047965 SSN EIN

26. PATIENT'S ACCOUNT NO. 073535-00

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE \$ 170.00 AMOUNT PAID \$ 0.00

29. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (If certify that the statements on the reverse apply to this bill and are made a part thereof.)
JULIAN GONZALEZ MD

30. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)
00-0637441-06602300-73230
12-40

31. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #
Anchorage Neighborhood Hlth Ctr
P.O. Box 201949
ANCHORAGE AK 99520-1849
PRN 92-0047965 GRP 92-0047965

PLEASE -
DO NOT
STAPLE
IN THIS
AREA

APPROVED OMB-C938-C006

AK-BCCEDP
3801 C STREET STE. #934
PO BOX 240249
ANCHORAGE AK 99524-0249
HEALTH INSURANCE CLAIM FORM

PICA

PICA

1. MEDICARE (Medicare #)		MEDICAID (Medicaid #)		CHAMPUS (Sponsor's SSN)		CHAMPVA (VA File #)		GROUP HEALTH PLAN (SSN or ID)		FECA BLK LUNG (SSN)		OTHER (ID)		1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)				3. PATIENT'S BIRTH DATE (MM DD YY)				SEX (M <input type="checkbox"/> F <input checked="" type="checkbox"/>		4. INSURED'S NAME (Last Name, First Name, Middle Initial)					
5. PATIENT'S ADDRESS (No., Street)				6. PATIENT RELATIONSHIP TO INSURED (Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>)				7. INSURED'S ADDRESS (No., Street)							
CITY ANCHORAGE STATE AK				8. PATIENT STATUS (Single <input type="checkbox"/> Married <input checked="" type="checkbox"/> Other <input type="checkbox"/>)				CITY ANCHORAGE STATE AK							
ZIP CODE 99503 TELEPHONE (Include Area Code) (907)-277-9097				Employed <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/>				ZIP CODE 99503 TELEPHONE (INCLUDE AREA CODE) (907)-277-8087							
5. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)				10. IS PATIENT'S CONDITION RELATED TO:				11. INSURED'S POLICY GROUP OR FECA NUMBER							
a. OTHER INSURED'S POLICY OR GROUP NUMBER				a. EMPLOYMENT? (CURRENT OR PREVIOUS) (YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>)				a. INSURED'S DATE OF BIRTH (MM DD YY) (04 10 50) SEX (M <input type="checkbox"/> F <input checked="" type="checkbox"/>							
b. OTHER INSURED'S DATE OF BIRTH (MM DD YY) (M <input type="checkbox"/> F <input type="checkbox"/>)				b. AUTO ACCIDENT? (YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>) PLACE (State)				c. EMPLOYER'S NAME OR SCHOOL NAME							
c. EMPLOYER'S NAME OR SCHOOL NAME				c. OTHER ACCIDENT? (YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>)				c. INSURANCE PLAN NAME OR PROGRAM NAME (AK-BCCEDP)							
d. INSURANCE PLAN NAME OR PROGRAM NAME				10c. RESERVED FOR LOCAL USE				c. IS THERE ANOTHER HEALTH BENEFIT PLAN? (YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> If yes, return to and complete item 9 and							
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.												13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.			
SIGNED _____ DATE 05/18/01												SIGNED _____			
14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)				15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE (MM DD YY)				16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION (FROM MM DD YY TO MM DD YY)							
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE				17a. I.D. NUMBER OF REFERRING PHYSICIAN (92-0047965)				18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES (FROM ** ** ** TO ** ** **)							
19. RESERVED FOR LOCAL USE (105751)				20. OUTSIDE LAB? (YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> \$ CHARGES 0.00)				22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.							
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1, 2, 3 OR 4 TO ITEM 24 BY LINE)				23. PRIOR AUTHORIZATION NUMBER				24. A B C D E F G H I J K							
1. V76.2 PAP SMEAR; CERVI				3. _____				DATE(S) OF SERVICE (From MM DD YY To MM DD YY) PLACE OF SERVICE (YY) TYPE OF SERVICE (CPT/HCPCS) PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) MODIFIER DIAGNOSIS CODE \$ CHARGES DAYS OR UNITS EPSDT OR Family Plan EMG COB RESERVED FOR LOCAL USE							
2. V20.2 ROUTINE INFANT				4. _____				05 05 00 05 05 00 50 5 87797 1 0.00 1 92-0047965							
3. _____				5. _____				05 05 00 05 05 00 50 5 88164 1 14.60 1							
4. _____				6. _____				05 05 00 05 05 00 50 5 87810 1 14.60 1							
5. _____				7. _____				00-06311441-0660230 73230 14.60							
6. _____				8. _____				SECTION OF MATERNAL CHILD & FAMILY HEALTH ANCHORAGE OFFICE							
25. FEDERAL TAX I.D. NUMBER (32-0047965) SSN EIN () (X)				26. PATIENT'S ACCOUNT NO. (273536-00)				27. ACCEPT ASSIGNMENT? (For govt. claims, see back) (YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>)							
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)				32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)				28. TOTAL CHARGE \$ 32.00 29. AMOUNT PAID \$ 0.00 30. BALANCE \$ 32.00							
JULIAN GONZALEZ MD				33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE # (Anchorage Neighborhood Hlth Ct P.O. Box 201949 ANCHORAGE AK 99520-1849)				PIN# 92-0047965 GRP# 32-0047965							
SIGNED DATE 05/19/01 FDR Mail Pert# 183533															

PLEASE DO NOT STAPLE IN THIS AREA



HEALTH INSURANCE CLAIM FORM

SCREEN
3

1a MEDICARE Medicare #		1b MEDICAID Medicaid #		1c CHAMPUS Sponsor's SSN		1d CHAMPVA IVA File #		1e GROUP HEALTH PLAN SSN or ID		1f FECA B/L LUNG SSN		1g OTHER ID		1h INSURED'S ID NUMBER [REDACTED]		1i FOR PROGRAM IN USE	
2 PATIENT'S NAME (Last Name, First Name, Middle Initial) [REDACTED]				3 PATIENT'S BIRTH DATE MM DD YY [REDACTED]				4 PATIENT'S SEX M F [REDACTED]				5 INSURED'S NAME (Last Name, First Name, Middle Initial) [REDACTED]					
6 PATIENT'S ADDRESS (No. Street) [REDACTED]				7 PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other [REDACTED]				8 INSURED'S ADDRESS (No. Street) [REDACTED]				9 INSURED'S CITY STATE [REDACTED]					
10 PATIENT'S CITY STATE [REDACTED]				11 PATIENT STATUS Single Married Other [REDACTED]				12 INSURED'S CITY STATE [REDACTED]				13 INSURED'S ZIP CODE TELEPHONE (INCLUDE AREA CODE) [REDACTED]					
14 OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) [REDACTED]				15 IS PATIENT'S CONDITION RELATED TO Employed Full-Time Student Part-Time Student [REDACTED]				16 INSURED'S POLICY GROUP OR FECA NUMBER [REDACTED]				17 INSURED'S DATE OF BIRTH MM DD YY [REDACTED]					
18 OTHER INSURED'S POLICY OR GROUP NUMBER [REDACTED]				19 AUTO ACCIDENT? PLACE (State) YES NO [REDACTED]				20 EMPLOYER'S NAME OR SCHOOL NAME [REDACTED]				21 INSURANCE PLAN NAME OR PROGRAM NAME [REDACTED]					
22 OTHER INSURED'S DATE OF BIRTH MM DD YY [REDACTED]				23 OTHER ACCIDENT? YES NO [REDACTED]				24 IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, return to and complete item 9 a-d				25 INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below [REDACTED]					
26 EMPLOYER'S NAME OR SCHOOL NAME [REDACTED]				27 RESERVED FOR LOCAL USE				28 SIGNED				29 DATE					

12 READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

13 PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the patient and accept assignment below.

14 DATE OF CURRENT ILLNESS (First symptoms) OR INJURY (Accident) OR PREGNANCY (UMP) MM DD YY		15 IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS GIVE FIRST DATE MM DD YY		16 DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY	
17 NAME OF REFERRING PHYSICIAN OR OTHER SOURCE [REDACTED]		18 NUMBER OF REFERRING PHYSICIAN [REDACTED]		19 HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY	

20 OUTSIDE LAB CHARGES YES NO \$ [REDACTED]		21 MEDICARE RESUBMISSION CODE ORIGINAL REF NO		22 PRIOR AUTHORIZATION NUMBER	
--	--	---	--	-------------------------------	--

DATE	FROM	TO	Place	Type	PROCEDURES SERVICES OR SUPPLIES (Explain Unusual Circumstances) ICD-9-CM CODE MODIFIER	DIAGNOSIS CODE	\$ CHARGES	PAYOR (Patient or Family) UNITS Plan	EMG	COB	RESERVED FOR LOCAL USE
02	19	00	02	19	00	50	1	67.57			
02	19	00	02	19	00	50	5	14.60			

Ok to pay

\$ 67.57 00-06311441 73230

Jerry [Signature] 12-7-01

67.57 67.57

23 FEDERAL TRAIL NUMBER		24 PATIENT'S ACCOUNT NO. CHILD AND ADULT IDENTIFICATION ANCHORAGE OFFICE YES NO		25 TOTAL CHARGE		26 AMOUNT PAID		27 BALANCE DUE	
28 SIGNATURE OF PHYSICIAN OR SUPPLIER		29 NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than name of office)		30 PHYSICIAN'S SUPPLIER'S BILLING NAME ADDRESS ZIP CODE PHONE #					

PLEASE
DO NOT
STAPLE
IN THIS
AREA



AK-BCEDEF
3601 D STREET STE. #33-
PO BOX 240243
ANCHORAGE AK 99524-0243



HEALTH INSURANCE CLAIM FORM

PIC#

PIC#

1 MEDICARE Medicare #	MEDICAID Medicaid #	CHAMPUS Sponsor's SSN	CHAMPVA VA File #	GROUP HEALTH PLAN SSN or ID	FEDA BLK LUNG SSN	OTHER (A, B, C, D, E, F, G, H, I, J, K, L, M, N, O, P, Q, R, S, T, U, V, W, X, Y, Z)	1a INSURED'S ID NUMBER FOR PROGRAM ITEM
2 PATIENT'S NAME (Last Name, First Name, Middle Initial)				3 PATIENT'S BIRTH DATE MM DD YY		4 INSURED'S NAME (Last Name, First Name, Middle Initial)	
5 PATIENT'S ADDRESS No. Street				6 PATIENT RELATIONSHIP TO INSURED Self, Spouse, Child, Other		7 INSURED'S ADDRESS No. Street	
CITY		STATE		8 PATIENT STATUS Single, Married, Other		CITY	
ZIP CODE		TELEPHONE (INCLUDE AREA CODE)		Employed, Full-Time, Part-Time, Student		ZIP CODE	
9 OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)				10 PATIENT'S CONDITION RELATED TO		11 INSURED'S POLICY GROUP OR FEDA NUMBER	
a OTHER INSURED'S POLICY OR GROUP NUMBER				a EMPLOYMENT (CURRENT OR PREVIOUS) YES NO		a INSURED'S DATE OF BIRTH MM DD YY	
b OTHER INSURED'S DATE OF BIRTH MM DD YY				b AUTO ACCIDENT? PLACE (State) YES NO		b EMPLOYER'S NAME OR SCHOOL NAME	
c EMPLOYER'S NAME OR SCHOOL NAME				c OTHER ACCIDENT? YES NO		c INSURANCE PLAN NAME OR PROGRAM NAME	
d INSURANCE PLAN NAME OR PROGRAM NAME				10c RESERVED FOR LOCAL USE		d IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes return to and complete item 9 a-c	
12 PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. Also request payment of government benefits either to myself or to the party who accepts assignment. SIGNATURE ON FILE 10/05/01 SIGNED DATE				13 INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier or services described below. SIGNATURE ON FILE SIGNED			
14 DATE OF CURRENT ILLNESS (First symptom or injury, accident or pregnancy/LMP)		15 IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS GIVE FIRST DATE		16 DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION			
NAME OF REFERRING PHYSICIAN OR OTHER SOURCE		17A ID NUMBER OF REFERRING PHYSICIAN		16 HOSPITALIZATION DATES RELATED TO CURRENT SERVICES			
19 RESERVED FOR LOCAL USE		17B ID NUMBER OF REFERRING PHYSICIAN		20 OUTSIDE LAB CHARGES YES NO			
21 DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. RELATE ITEMS 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20 TO ITEM USE BY LINE				22 MEDICAL RESUBMISSION CODE ORIGINAL REF NO		23 PRIOR AUTHORIZATION NUMBER	
24 A DATE(S) OF SERVICE		B PROCESSED SERVICES OR SUPPLIES		C DIAGNOSIS CODE		D CHARGES	
33 10 00 03 10 00 11 15		33164		3		33-0047888	
Ok to pay				RECEIVED		DEC 21 2001	
s14.60 00-06311441 73230				SECTION OF MATERNAL, CHILD & FAMILY HEALTH ANCHORAGE OFFICE		1460 7460	
25 FEDERAL TAX ID NUMBER		26 PATIENT ACCOUNTING		27 ACCEPT ASSIGNMENT?		28 TOTAL CHARGE	
33-0047888		006003-00		YES NO		29 AMOUNT PAID	
29 SIGNATURE OF PHYSICIAN, SUPPLIER, OR OTHER PROVIDER		30 NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED		31 PHYSICIAN'S SUPPLIER'S BILLING NAME ADDRESS ZIP CODE		32 BALANCE DUE	
33-0047888		33-0047888		33-0047888		33-0047888	

PLEASE PRINT OR TYPE

FORM 100-100 (REV. 10/01)

PHYSICIAN OR SUPPLIER INFORMATION

PLEASE DO NOT STAPLE IN THIS AREA

STATE: STATE OF ALASKA - ECCCJP
ALBUX 2+0244
ANCHORAGE AK 995240244

(1501)
(PRI)JP(LINE)J
DP: LJ

APPROVED OMB-0938-0008 HEALTH INSURANCE CLAIM FORM

1. MEDICARE MEDICAID CHAMPUS CHAMPVA GROUP HEALTH PLAN FECA BLK LUNG OTHER
(Medicare #) (Medicaid #) (Sponsor's SSN) (VA File #) (SSN or ID) (SSN) (ID)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial) 3. PATIENT'S BIRTH DATE MM DD YY 4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street) 6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other 7. INSURED'S ADDRESS (No., Street) SAME AS PATIENT

CITY STATE 8. PATIENT STATUS Single Married Other

ZIP CODE TELEPHONE (include Area Code) EMPLOYED Full-Time Student Part-Time Student

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) 10. IS PATIENT'S CONDITION RELATED TO 11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES NO b. AUTO ACCIDENT? PLACE (State) YES NO c. OTHER ACCIDENT? YES NO

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F c. EMPLOYER'S NAME OR SCHOOL NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME 10d. RESERVED FOR LOCAL USE c. INSURANCE PLAN NAME OR PROGRAM NAME STATE OF ALASKA - ECCCJP

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, return to and complete item 9 a-d

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNATURE ON FILE SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNATURE ON FILE SIGNED

14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) 15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS GIVE FIRST DATE MM DD YY 16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE 17a. I.D. NUMBER OF REFERRING PHYSICIAN 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY

19. RESERVED FOR LOCAL USE 20. OUTSIDE LAB? CHARGES YES NO

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1, 2, 3 OR 4 TO ITEM 24E BY LINE) 22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER

From MM	DATE(S) OF SERVICE DD YY	To MM DD YY	Part of Service	Type of Service	PROCEDURES SERVICES OR SUPPLIES (Include Universal CPT/HCPCS CODES)	DIAGNOSIS CODE	\$ CHARGES	DAYS OR UNITS	EPSDT Family Plan	EMG	COB	RESERVED FOR LOCAL USE
01	05	00	02	05	00	11	4	75002+27	1	21.69		707

Ok to pay
21.69
00-06311441 73230
09-10-01

SECTION OF MATERNAL CHILD HEALTH
ANCHORAGE OFFICE
21.69
SEP 08 2001

25. FEDERAL TAX ID NUMBER SSN EIN 26. PATIENT'S ACCOUNT NO 27. ACCEPT ASSIGNMENT? (For Govt claims see back) YES NO 28. TOTAL CHARGE ANCHORAGE OFFICE BALANCE DUE

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREE(S) OR CREDENTIALS (If family, the relationship to the insured must be stated and the insured's date of birth must be stated) 32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office) 33. PHYSICIAN'S SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE

PLEASE
PRINT
STAPLE
IN THIS
AREA



Signature

HEALTH INSURANCE CLAIM FORM

1. PATIENT'S NAME: [REDACTED] OTHER INSURED'S NAME: [REDACTED]

2. PATIENT'S BIRTH DATE: 07 07 1964 SEX: M - INSURED'S HOME ADDRESS: Same as Patient

3. PATIENT'S ADDRESS: PO Box 772472 CITY: Earle River STATE: AL

4. EMPLOYER'S NAME: [REDACTED] EMPLOYER'S ADDRESS: [REDACTED]

5. EMPLOYER'S PHONE NUMBER: 338 8715

6. OTHER INSURED'S POLICY OR GROUP NUMBER: [REDACTED]

7. EMPLOYMENT: CURRENT OR PREVIOUS: YES / NO

8. OTHER INSURED'S DATE OF BIRTH: [REDACTED]

9. EMPLOYER'S NAME: Ok to pay

10. INSURANCE POLICY NUMBER: S608.01 00-06311412 06602100 77610

11. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE: P. Vinnier 8/9/01

12. SIGNED: Signature on file

RECEIVED
SECTION OF MATERNAL
CHILD & FAMILY HEALTH
ANCHORAGE OFFICE

13. DATE OF CURRENT ILLNESS: [REDACTED]

14. PATIENT HAS HAD SAME OR SIMILAR ILLNESS: NO

15. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION: FROM [REDACTED] TO [REDACTED]

16. NAME OF REFERRING PHYSICIAN: Ok to pay

17. RECEIVED FOR CLAIM: S 9.51 01-06311412 06602101 77610

18. DIAGNOSIS OR ICD-9 CODE: V26.52 / V26.51

19. SIGNED: P. Vinnier 8/9/01

DATE OF SERVICE	PLACE OF SERVICE	PROCEDURES	SERVICES OR SUPPLIES	DIAGNOSIS CODE	CHARGES	RESERVED FOR LOCAL USE
05 10 001	50	99202		2	91 001	✓
06 14 001	50	55230		1	607 001 \$1,517.01	
11 06 001	50	89300		1	700 001 9.51	

SECTION OF MATERNAL
CHILD & FAMILY HEALTH
ANCHORAGE OFFICE

20. PATIENT'S SIGNATURE: [Signature]

21. DATE: 8/9/01

22. PHYSICIAN'S SIGNATURE: [Signature]

23. DATE: 8/9/01

24. PHYSICIAN'S NAME: Dr. [Name]

25. PHYSICIAN'S ADDRESS: [Address]

26. PHYSICIAN'S PHONE NUMBER: [Phone]

27. PHYSICIAN'S LICENSE NUMBER: [License]

Patient Tracking Fees - Quarter 4

Provider: Aurora Clinic

69

LastName	FirstName	Patient#	Service Date	CPT	Svc Fee	Tracking Fee
			5/29/2001	99215	\$100.00	\$30.00
			3/5/2000	99215	\$121.35	\$30.00
			5/15/2001	99215	\$100.00	\$30.00
			3/24/2001	99215	\$100.00	\$30.00
			4/28/2001	99213	\$60.00	\$30.00
			6/8/2001	99215	\$100.00	\$30.00
			6/20/2001	99215	\$100.00	\$30.00
			6/9/2001	99215	\$100.00	\$30.00
			1/9/2001	99215	\$20.00	\$30.00
			5/19/2001	99205	\$110.00	\$30.00
			6/22/2001	99215	\$100.00	\$30.00
			5/1/2001	99205	\$110.00	\$30.00
			5/19/2001	99215	\$100.00	\$30.00
			5/11/2001	99204	\$75.00	\$30.00
			6/6/2001	99215	\$100.00	\$30.00
			6/9/2001	99215	\$100.00	\$30.00
			4/13/2001	99215	\$100.00	\$30.00
			5/22/2001	99205	\$110.00	\$30.00
			6/16/2001	99205	\$110.00	\$30.00
			5/19/2001	99205	\$110.00	\$30.00
			6/19/2001	99205	\$110.00	\$30.00
			5/11/2001	99215	\$100.00	\$30.00
			5/19/2001	99215	\$100.00	\$30.00
			5/19/2001	99215	\$100.00	\$30.00

Patient Tracking Fees - Quarter 4

Provider: Aurora Clinic 69

LastName	FirstName	Patient#	Service Date	CPT	Svc Fee	Tracking Fee
			6/9/2001	99215	\$100.00	\$30.00
			5/8/2001	99215	\$100.00	\$30.00
			4/20/2001	99205	\$110.00	\$30.00
			7/7/2001	99205	\$110.00	\$30.00
			7/7/2001	99215	\$100.00	\$30.00
			5/15/2001	99215	\$100.00	\$30.00
Total Patient Tracking Fees:						\$900.00

Ok to pay

\$60.00 03-06311441 06602301 73250

[Signature] 03-2-01

Bill Review							
U	Done	QuickNotes	Claim Hist	?			
Visit Dt	Bill Typ	FeeNum	Off Dr. Plan	Charge	Payment	Adjmnt	
01/19/00	207900	011	009102 of jg	95.00	0.00	0.00	
Operator ATP							
First Form Printed For				On **/**/** For	0.00	E? n	
Last Form Printed For				On **/**/** For	0.00	E? n	
Last Tracer Printed For				On **/**/** Susp? n	Suprs Str?	n	
Notes For: [REDACTED]				07097000	Plnt Paid	0.00	
				07097000	Plan Paid	0.00	
					Balance	95.00	
Visit Dt	Procedure	Dr. Diagnosis	S POS	Charge	Credit		
01/19/00	00 - New Patient - L	jg Throat Pain	50	75.00			
06/06/01	Pd 06/06/01	Adj:0-D Agency Placene			-75.00		
01/19/00	Streptococcus, Group	jg Throat Pain	50	20.00			
06/06/01	Pd 06/06/01	Adj:0-D Agency Placene			-20.00		
06/27/01	Adj:0-D Agency Place	jg Throat Pain		0.00			
06/27/01	Pd 06/27/01	RRW Adj:0-D Agency Placene			95.00		
Enter Function Key:							

406034718

REQUEST# 002AE2226
 CODE EN# 0603438-LIN#9
 PVN# FAS00349
 AMOUNT \$95.00
 AUTHORIZATION (b)(6) (b)(7)(C)

6-29-01

deleted

~~4469070-26~~

Fairview Health Center
1217 E. 10th Avenue
Anchorage, AK 99501
(907) 257-4600 Phone

□ (907) 257-4625 Fax
Dr. Madeleine Grant
John Riley, PA-C

□ (907) 257-4620 Fax
Dr. Bruce Chandler
Dr. Brad Gessner
Dr. Tom Hunt
Jill Johnson, PA-C

□ (907) 257-4092 Fax
Dr. Sharon Smith
Dr. Soraya Aragundi
Pam Engle, PA-C
Charlotte Gardner, PA-C

□ (907) 257-4844 Fax
Medical Records

□ (907) 257-4654 Fax
Special Programs

□ (907) 257-4681 Phone
□ (907) 257-4687 Fax
ANHC Pharmacy

□ (907) 257-4881 Phone
□ (907) 257-4654 Fax
ANHC Dental Clinic

NHS - 257-4665

Mid View Health Center
3521 Air View Drive
Anchorage, AK 99508
(907) 792-2300 Phone
□ (907) 792-2390 Fax
Dr. Phyllis Dunckel
Colinne Barclay, PA-C

Administrative Office
903 W. N. Light Street, #218
Anchorage, AK 99503
(907) 792-6330 Phone
(907) 792-6324 Ext. Fax
(907) 792-6344 Bus. Fax
(907) 792-6324 Billing Mgr.



Facsimile transmittal

To: ANNA Fax: 261-3902
From: Richard Date: 6/27/01
Re: [REDACTED] Pages: 2
cc:

Urgent For Review Please Comment Please Reply Please Recycle

Anna -

I took care out of Collections
Please call me and let me
know if you are resp. for
Bill
792-6511

The information contained in this transmission is privileged and confidential. It is intended only for the use of the individual or entity named above. IF THE READER OF THIS MESSAGE IS NOT THE INTENDED RECIPIENT, YOU ARE HEREBY NOTIFIED THAT YOU ARE NOT AUTHORIZED TO REVIEW THE FOLLOWING PAGES AND THAT ANY DISSEMINATION, DISTRIBUTION OR COPY OF THIS COMMUNICATION IS STRICTLY PROHIBITED. If you have received this communication in error, please notify us immediately by telephone (collect) and destroy the original message. Thank you.

JUN 27 2001 4:35PM

NO 2001 11 11

REQUEST FOR SPECIAL NEEDS FUNDS FOR FOSTER CARE

Special Needs funding is assessed on an as-needed basis only and pre-authorization is required.

Limitation: This form is to be used only for one time or irregular special needs expenditures on behalf of children in foster care. Receipts and supporting documentation are required.

Child's Name: [REDACTED] DOB: 04-11-87 Prober Case Number: 406034718

Eligibility Status: (check one) Title IV-E eligible Not IV-E eligible Eligibility pending

Proposed services are for Child or Parent(s)/legal guardian/Indian custodian or Sibling(s) or Other family members

Proposed services are court-ordered (please attach court order)

I Describe the specific need and how the request is consistent with the case plan (case plan must be attached): Child was in foster care and needed medical attention.

II TITLE IV-E FOSTER CARE MAINTENANCE

- 1. Clothing - Initial (Refer to CPS Chapter 6.0, Section 6.2.2.8 for policy) = \$
- 2. Clothing - Extraordinary & Justified by Case Plan = \$
- 3. Food - Special Diet = \$
- 4. Extraordinary Laundry (Must have medical or psychological)
Describe: = \$
- 5. Personal Incidentals
Describe: = \$
- 6. Special One-Time Items = \$
 - Special cribs, beds, mattresses
 - Other (must be explained and within allowable DFYS regulations)Describe:
- 7. Visitation with Family - Long Distance telephone cards for the child = \$
- 8. Licensed Child Care (Please provide DFYS license number:) = \$
Licensed Child Care for foster child:
 - during foster parent's employment when the foster child is not in school
 - during the foster parent's attendance at mandatory foster parent training
 - during foster parents attendance at case conference, case reviews, court hearing, without foster child
 - which facilitate the foster parent's attendance at Division approved activities which are beyond the scope of "ordinary parental duties"
- 9. Travel - Child family visitation = \$

II.A SUB TOTAL IV-E FOSTER CARE MAINTENANCE	= \$
---	------

III. TITLE IV E FOSTER CARE ADMINISTRATIVE

- I. Travel = \$
 - Miles over 50 per week for foster child's attendance at administrative case or judicial reviews
 - Foster child pre-placement visit or placement with foster home
 - Foster Parents attendance at administrative case/judicial reviews and mandatory case conferences/team meetings
 - Other approved travel by foster child as part of case plan

Describe:

 - Escort Travel as justified by case plan (may require travel authorization)
 - For visitation
 - For placement
- 2. Foster Parent Damages and loss = \$

Refer to CPS Adm. Chapter 6.0, section 6.2.2.7 (4) (b)
Please attach form 06-9440 and police report if applicable.
- 3. Shipping & Freight Costs (Child's belongings only) = \$
- 4. Other-Services critical for completion of the case plan = \$
 - Genetic/Paternity Testing
 - Advertising for Missing Parents
 - Birth Certificates
 - Expert Witnesses (ICWA/Non-ICWA)
 - Supervised Visitation
 - Court Teleconference Costs

III A SUB-TOTAL IV-E FC ADMINISTRATIVE = \$

IV. NON IV-E REIMBURSEMENT

- 1. Independent Living - limited to those expenses that facilitates the transition of foster children to independent living that are not otherwise reimbursable under maintenance or administration or other resource. = \$

Describe:
- 2. Medical, Dental, Diagnostic, Therapeutic, and Assessment Services = \$95.00

As payer of last resort (no Medicaid coverage or other third party reimbursement)
Refer to 7 AAC 53.320.

 - Medical Describe: Dr. Visit
 - Dental Describe:
 - Diagnostic (i.e. Psych evaluations) Describe:
 - Therapeutic (i.e. Counseling) Describe:
 - Assessment Services Describe:
 - Medical equipment, furnishings, or discretionary devises for children with special needs

Describe:

 - Travel Describe:
- 3. Unlicensed Child Care for Foster Child = \$
 - during foster parent's employment when the foster child is not in school
 - during the foster parent's attendance at mandatory foster parent training
 - during foster parents attendance at case conference, case reviews, court hearing, without foster child
 - which facilitate the foster parent's attendance at Division approved activities which are beyond the scope of "ordinary parental duties"
- 4. Other services critical for completion of the case plan of a child in foster care when no other resources are available = \$

Describe:

IV.A. SUBTOTAL NON-IV-E REIMBURSABLE = \$95.00

V. EXPLAIN HOW ALTERNATIVE SOURCES OF FUNDING FOR ALL ITEMS ABOVE HAVE BEEN EXHAUSTED: Medicaid did not cover.

VI TOTAL COST: \$95.00

VII one time cost short term costs (date) to

VIII Payee Name: Fairview Health Center Address: 1217 E. 10th Ave. Anchorage, AK 99501

IX SSN or Fed Tax ID#: Vendor # (PVN): Reimbursement

X for Jarrin Munoz 6/27/01
Social Worker Signature PCN Date

XI APPROVALS:

[Signature] 3256, 2701
S.W. IV Signature PCN Date S.W. V Signature PCN Date

_____ 1/1 _____ 1/1
Children's Service Manager Date Family Services Program Administrator Date
Required For Requests exceeding \$1,500.00 and all Out-of-State Travel

FISCAL INFORMATION (To be filled out by fiscal)

XII	CATEGORY	COST	CODING
	IV-E Foster Care Maintenance (II. A)	\$ _____	_____
	IV-E Foster Care Administrative (III. A)	\$ _____	_____
	Non IV-E Reimbursable (IV)	\$ _____	_____
	TOTAL OF REQUEST:	\$ _____	

This form must be completed in full

7 AAC 53.070, 100-110 and 300-370

Patient Tracking Fees - Quarter 4

Provider: INEC

LastName	FirstName	Patient#	Service Date	CPT	Svc Fee	Tracking Fee
			5/8/2001	99396	\$143.00	\$30.00
			4/17/2001	99396	\$143.00	\$30.00
			3/20/2001	99396	\$143.00	\$30.00
			4/10/2001	99396	\$143.00	\$30.00
			5/25/2001	88164	\$22.90	\$30.00
			5/21/2001	99386	\$190.00	\$30.00
			5/25/2001	88164	\$22.90	\$30.00
			4/26/2001	99202	\$97.00	\$30.00
			4/24/2001	99396	\$143.00	\$30.00
			12/5/2000	99214	\$137.00	\$30.00
			5/9/2001	88164	\$22.90	\$30.00
			5/2/2001	99396	\$143.00	\$30.00
			5/18/2001	99212	\$65.00	\$30.00
			5/9/2001	99386	\$190.00	\$30.00
			5/15/2001	99396	\$143.00	\$30.00
			4/6/2001	88164	\$22.90	\$30.00
			4/10/2001	88164	\$22.90	\$30.00
			4/27/2001	88164	\$22.90	\$30.00
			4/17/2001	99212	\$65.00	\$30.00
			4/26/2001	99396	\$143.00	\$30.00
			5/29/2001	88164	\$22.90	\$30.00
			5/24/2001	99213	\$83.00	\$30.00
			4/9/2001	99214	\$130.00	\$30.00
			4/24/2001	99396	\$143.00	\$30.00

Patient Tracking Fees - Quarter 4

Provider: INHC

Last Name	First Name	Patient#	Service Date	CPT	Svc Fee	Tracking Fee
			4/6/2001	99386	\$190.00	\$30.00
			5/7/2001	99396	\$143.00	\$30.00
			4/30/2001	99212	\$65.00	\$30.00
			4/6/2001	99396	\$143.00	\$30.00
			4/6/2001	99386	\$190.00	\$30.00
			12/18/2000	99213	\$83.00	\$30.00
			5/7/2001	99396	\$80.90	\$30.00
			5/23/2001	99214	\$130.00	\$30.00
			4/26/2001	99386	\$190.00	\$30.00
			5/9/2001	99202	\$97.00	\$30.00
			4/10/2001	99213	\$83.00	\$30.00
			4/30/2001	88164	\$22.90	\$30.00
			5/8/2001	99386	\$190.00	\$30.00
			4/3/2001	99396	\$143.00	\$30.00
			4/4/2001	88164	\$22.90	\$30.00
			4/10/2001	99214	\$130.00	\$30.00
Total Patient Tracking Fees:						\$1,920.00

Ok to pay

11495180

5 70 00 00-06311441 06602300 73230

[Signature] 07-2-01 70

Ok to pay

51870 01-06311441 06602301 73230

[Signature] 07-2-01 70

Patient Tracking Fees - Quarter 4

Provider: NTN 9

LastName	FirstName	Patient#	Service Date	CPT	Svc Fee	Tracking Fee
<i>NEIGHBOR TO NEIGHBOR</i>			4/23/2001	99214	\$88.10	\$30.00
			5/15/2001	99214	\$88.10	\$30.00
			5/16/2001	99205	\$186.20	\$30.00
			4/26/2001	99204	\$148.04	\$30.00
			5/31/2001	99215	\$130.38	\$30.00
			3/22/2001	99214	\$88.10	\$30.00
			6/8/2001	99212	\$40.43	\$30.00
			5/21/2001	99214	\$88.10	\$30.00
			6/22/2001	99214	\$88.10	\$30.00
			5/17/2001	99203	\$102.21	\$30.00
			6/22/2001	99215	\$130.38	\$30.00
			5/27/2001	99204	\$148.04	\$30.00
			5/15/2000	99204	\$143.88	\$30.00
			4/13/2001	99214	\$88.10	\$30.00
			4/30/2001	99214	\$88.10	\$30.00
			6/14/2001	99215	\$100.38	\$30.00
			3/30/2001	99214	\$88.10	\$30.00
			7/11/2001	99214	\$88.10	\$30.00
			6/22/2001	99215	\$130.38	\$30.00
			4/24/2001	99213	\$56.63	\$30.00
			3/21/2001	99204	\$148.04	\$30.00
			6/8/2001	99205	\$186.20	\$30.00
			3/27/2001	99202	\$69.36	\$30.00
			4/2/2001	99204	\$148.04	\$30.00

Patient Tracking Fees - Quarter 4

Provider: NTN

LastName	FirstName	Patient#	Service Date	CPT	Svc Fee	Tracking Fee
			3/28/2001	99214	\$88.10	\$30.00
			5/18/2001	99215	\$130.38	\$30.00
			3/26/2001	99204	\$148.04	\$30.00
			3/30/2001	99202	\$69.36	\$30.00
			5/9/2001	99214	\$88.10	\$30.00
			6/27/2001	99203	\$102.21	\$30.00
			6/20/2001	99203	\$102.21	\$30.00
			6/15/2001	99204	\$148.04	\$30.00
			5/23/2001	99204	\$148.04	\$30.00
			5/23/2001	99204	\$148.04	\$30.00
			4/2/2001	99204	\$148.04	\$30.00

Number of Patients 107

Total Patient Tracking Fees: \$3,210.00

Ok to pay

NTN 1182

\$30.00 01-06311441 06602300 73230

Quinn D. Smith 08-2-01 *TC*

Ok to pay

\$30.00 01 06311441 06602300 73230

Quinn D. Smith 08-2-01 *TC*

Ok to pay

\$297.00 01-06311441 06602301 73230

Quinn D. Smith 08-2-01 *TC*

Ok to pay

\$130.00 02-06311441 06602301 73230

Quinn D. Smith 08-2-01 *TC*

Network Business Systems, Inc.
 1577 C Street
 Suite 205
 Anchorage AK 99501

021001352

Invoice 34597
 Date (11/29/99)
 Page: 1
 P.O. No. 99-466

Bill To: *Health*
 SOAHSS Div Public Assistance
 3601 C Street Suite 434
 PO Box 240249
 Anchorage AK 99524-0249

Ship To:
 SOAHSS Div Public Assistance
 3601 C Street Suite 434
 PO Box 240249
 Anchorage AK 99524-0249 *269-7435*

FAX 562-7802 *Heater*

DORA
269-78557
269-7830

Customer ID	Salesperson ID	Shipping Method	Payment Terms	Req Ship Date	Master No.	
XHSS8000	JAB100		Net 30	11/30/99	2,112	
Ord'd	Sho'd	Item Number	Description	Unit Price	Disc.	Ext. Price
1	1	*NVL555	INTRANETWARE: INTEGRATING WINDOWS NT Larry Bowles <u>Course Kit Only</u> <i>Did Not go to Training - Books Only!</i>	\$375.00		\$375.00

7/13/01

This invoice is a certified copy of the original

Valenta A Anderson
Dir of Administration
Network Business Systems

Accepted for purchase and payment by and authorize us
Heater, BOA 7/13/01
OR 063114074222 \$375.00

10/8/01 -

NBS does not guarantee or warrant
 in any way expressed or implied
 YR 2000 compliance of any products
 or services provided on this invoice.

Subtotal	\$375.00
Misc	\$0.00
Freight	\$0.00
Trade Discount	\$0.00
Total	\$375.00
Pymnt Rec'd	\$0.00
Balance Due	\$375.00

PLEASE
DO NOT
STAPLE
IN THIS
AREA

Family Planning Program
3601 'C' St. #934- PO Box 240249
Anchorage AK 995240249

HEALTH INSURANCE CLAIM FORM

1 MEDICARE MEDICAID CHAMPUS CHAMPVA GROUP HEALTH PLAN FECA BLK LUNG OTHER 1a INSURED'S ID NUMBER (FOR PROGRAM IN ITEM 1)

2 PATIENT'S NAME (Last Name, First Name, Middle Initial) 3 PATIENT'S BIRTH DATE MM DD YY SEX 4 INSURED'S NAME (Last Name, First Name, Middle Initial)

5 PATIENT'S ADDRESS (No. Street) 6 PATIENT RELATIONSHIP TO INSURED 7 INSURED'S ADDRESS (No. Street)

8 CITY STATE 9 PATIENT STATUS 10 INSURED'S CITY STATE

11 ZIP CODE TELEPHONE (Include Area Code) 12 EMPLOYED FULL-TIME PART-TIME STUDENT 13 ZIP CODE TELEPHONE (INCLUDE AREA CODE)

14 OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) 15 IS PATIENT'S CONDITION RELATED TO 16 INSURED'S POLICY GROUP OR FECA NUMBER

17 a OTHER INSURED'S POLICY OR GROUP NUMBER b OTHER INSURED'S DATE OF BIRTH MM DD YY SEX 18 a EMPLOYMENT? (CURRENT OR PREVIOUS) YES NO b AUTO ACCIDENT? PLACE (State) YES NO c OTHER ACCIDENT? YES NO

19 c EMPLOYER'S NAME OR SCHOOL NAME d INSURANCE PLAN NAME OR PROGRAM NAME 20c RESERVED FOR LOCAL USE 21 IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, return to and complete item 9 a-c

12 PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

13 INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED Signature On File DATE SIGNED Signature On File

14 DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) 15 IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS GIVE FIRST DATE MM DD YY 16 DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY

17 NAME OF REFERRING PHYSICIAN OR OTHER SOURCE 17a ID NUMBER OF REFERRING PHYSICIAN 18 HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY

19 RESERVED FOR LOCAL USE 20 OUTSIDE LAB? CHARGES YES NO

21 DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1, 2, 3 OR 4 TO ITEM 24E BY LINE) 22 MEDICAID RESUBMISSION CODE ORIGINAL RE: NO

23 PRIOR AUTHORIZATION NUMBER

24	A	B	C	D	E	F	G	H	I	J	K
DATE(S) OF SERVICE	To	Place of Service	Type of Service	PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	DIAGNOSIS CODE	\$ CHARGES	DAYS (SPD) OR UNITS	Family Plan	ENG	COB	RESERVED FOR LOCAL USE
02:16:00	02:16:00			99401		53.98	1	N			
02:16:00	02:16:00			99070	N	10.50	3	N			
02:16:00	02:16:00			4260A		7.50	30	N			
02:16:00	02:16:00			1STFT		0.00	1	N			

25 FEDERAL TAX ID NUMBER SSN EIN 26 PATIENT'S ACCOUNT NO 27 ACCEPT ASSIGNMENT? (For gov't claims, see back) YES NO 28 TOTAL CHARGE \$ 71.98 29 AMOUNT PAID \$ 30 BALANCE DUE \$ 71.98

31 SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) 32 NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office) 33 PHYSICIAN'S SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE

Planned Parenthood of Alaska
3401 E. 42nd Avenue
Anchorage AK 99508

3401 East 42nd Ave, Suite 200
Anchorage AK 99508
(907) 565-7526

JO FORTIER FNP 07 03 01 SIGNED DATE

PP0144

PLEASE
DO NOT
STAPLE
IN THIS
AREA

(293)
1001 JPL (11-12) P
JP: LJ

APPROVED OMB-0935-0006 HEALTH INSURANCE CLAIM FORM

1 MEDICARE (Medicare #)	MEDICAID (Medicaid #)	CHAMPUS (Sponsor's SSN)	CHAMPVA (IVA File #)	GROUP HEALTH PLAN (ISSN or ID)	FECA BY LUNG (SSN)	OTHER (ID)	16 INSURED'S ID NUMBER (IF OF PROGRAM IN ITEM 1)			
2 PATIENT'S NAME (Last Name, First Name, Middle Initial)				3 PATIENT'S BIRTH DATE (MM DD YY) SEX (M F)		4 INSURED'S NAME (Last Name, First Name, Middle Initial)				
5 PATIENT'S ADDRESS (Inc. Street)				6 PATIENT RELATIONSHIP TO INSURED (Self, Spouse, Child, Other)		7 INSURED'S ADDRESS (Inc. Street)				
CITY		STATE		8 PATIENT STATUS (Single, Married, Other)		CITY		STATE		
ZIP CODE		TELEPHONE (Include Area Code)		Employment (Full-Time Student, Part-Time Student)		ZIP CODE		TELEPHONE (INCLUDE AREA CODE)		
5. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)				10 IS PATIENT'S CONDITION RELATED TO:		11 INSURED'S POLICY GROUP OR FECA NUMBER				
a OTHER INSURED'S POLICY OR GROUP NUMBER				a EMPLOYMENT? (CURRENT OR PREVIOUS) (YES NO)		b INSURED'S DATE OF BIRTH (MM DD YY) SEX (M F)				
c OTHER INSURED'S DATE OF BIRTH (MM DD YY) SEX (M F)				b AUTO ACCIDENT? (YES NO) PLACE (State)		b EMPLOYER'S NAME OR SCHOOL NAME				
c EMPLOYER'S NAME OR SCHOOL NAME				c OTHER ACCIDENT? (YES NO)		c INSURANCE PLAN NAME OR PROGRAM NAME				
c INSURANCE PLAN NAME OR PROGRAM NAME				RESERVED FOR LOCAL USE		d IS THERE ANOTHER HEALTH BENEFIT PLAN? (YES NO) If yes, return to and complete item 9 a-c.				
12 PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment.						13 INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.				
SIGNATURE ON FILE						SIGNATURE ON FILE				
14 DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)				15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS GIVE FIRST DATE		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION				
17 NAME OF REFERRING PHYSICIAN OR OTHER SOURCE				17a. I.D. NUMBER OF REFERRING PHYSICIAN		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES				
19 RESERVED FOR LOCAL USE				20. OUTSIDE LAB? (YES NO) \$ CHARGES		22 MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.				
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)				23. PRIOR AUTHORIZATION NUMBER		24. TABLE OF SERVICES				
25 FEDERAL TAX ID NUMBER SSN EIN				26 PATIENT'S ACCOUNT NO.		27 ACCEPT ASSIGNMENT? (For govt. claims, see back) (YES NO)		28 TOTAL CHARGE	29 AMOUNT PAID	30 BALANCE DUE
31 SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREE OR CREDENTIALS (If copy of the statement on the reverse copy to this box and file made a part thereof.)				32 NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)		33 PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #				

Ok to pay PIC 87104
\$46.12 00-06311441 78230
J... 09-16-01

RECEIVED

SEP 06 2001

SECTION OF MATERNAL, CHILD & ADOLESCENT HEALTH ANCHORAGE OFFICE 46.12

Patient Tracking Fees - Quarter 4

Provider: PSMC *P. Seward* 24

LastName	FirstName	Patient#	Service Date	CPT	Svc. Fee	Tracking Fee
			5/21/2001	88164	\$34.00	\$30.00
			4/11/2001	99396	\$160.00	\$30.00
			7/12/2001	88164	\$34.00	\$30.00
			2/6/2001	99214	\$133.00	\$30.00
			5/16/2001	99214	\$133.00	\$30.00
			3/13/2001	99214	\$133.00	\$30.00
			5/2/2001	88164	\$34.00	\$30.00
			4/17/2001	99396	\$160.00	\$30.00
			2/24/2000	99214	\$127.00	\$30.00
Total Patient Tracking Fees:						\$270.00

Number of Patients 9

5400

Ok to pay PSM 99250
 \$210.00 01-06311441 06602301 73230
Juli D. Smith 08-2-01

Ok to pay
 \$30.00 02-06311441 06602301 73230
Juli D. Smith 08-3-01

Ok to pay
 \$30.00 02-06311441 06602301 73230
Juli D. Smith 08-3-01

PLEASE
DO NOT
STAPLE
IN THIS
AREA

Alaska BCCEDP - Billing
3601 C STREET, SUITE 934
Anchorage, AK 99503

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) CHAMPUS (Sponsors SSN) CHAMPVA (VA File #) GROUP HEALTH PLAN (ISSN or ID) FECA BLK LUNG (SSN, X (ID)) OTHER

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): [REDACTED]

3. PATIENT'S BIRTH DATE: MM DD YY 06 05 1969 M SEX F X

4. INSURED'S NAME (Last Name, First Name, Middle Initial): [REDACTED]

5. PATIENT'S ADDRESS (Inc., Street): P.O. BOX 812

6. PATIENT RELATIONSHIP TO INSURED: Self X Spouse Child Other

7. INSURED'S ADDRESS (Inc., Street): P.O. BOX [REDACTED]

CITY STATE: TALKEETNA AK

8. PATIENT STATUS: Single X Married Other

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP): MM DD YY

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS: GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION: FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

18. I.C. NUMBER OF REFERRING PHYSICIAN

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO X

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1, 2, 3 OR 4 TO ITEM 24E BY LINE): V72.3

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A B C D E F G H I J K

MM	DD	YY	MM	DD	YY	Service	Type of Service	Place of Service	PROCEDURES SERVICES OR SUPPLIES (Explain Unusual Circumstances)	DIAGNOSIS CODE	\$ CHARGES	DAYS TPST OR Family UNITS, Plan	EMG	COB	RESERVED FOR LOCAL USE
05	30	2000	05	30	2000	OF	1		99204	1	184.00				
05	30	2000	05	30	2000	OF	1		88164	1	143.85				

25. FEDERAL TAX I.D. NUMBER: 92-0117838

26. PATIENT'S ACCOUNT NO.: 700200

27. ACCEPT ASSIGNMENT? (For gov. claims, see back) YES NO X

28. TOTAL CHARGE: \$ 197.00

29. AMOUNT PAID: \$ 0.00

30. BALANCE DUE: \$ 197.00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (If certify that the statements on the reverse apply to this bill and are made a part thereof):
Ok to pay
\$156.88
SAC 86237
06311441 78230
Jenni D. Smith 10-12-01

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office):
Sunshine Community Health Center
P.O. Box 787 (Mile 4.4 Talkeetna Spur Rd)
Talkeetna, AK 99676 (907) 733-2273

33. PHYSICIANS, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

RECEIVED
OCT 15 2001
SECTION OF MATERNAL, CHILD & FAMILY HEALTH
ANCHORAGE OFFICE
156.88
197.88

JESSICA B. STEVENS, 10/08/2001
SIGNED DATE

PLEASE
DO NOT
STAPLE
IN THIS
AREA

Alaska BCCEDP - Billing
3601 C STREET, SUITE 934
Anchorage, AK 99505

HEALTH INSURANCE CLAIM FORM

1. MEDICARE (Medicare #)	MEDICAID (Medicaid #)	CHAMPUS (Sponsors SSN)	CHAMPVA (VA File #)	GROUP HEALTH PLAN (ISSN or ID)	FED. BLK. LUNG (ISSN)	OTHER (ID)	16. INSURED'S I.D. NUMBER (For Program Use Only)			
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE (MM DD YY)	SEX (M F X)	4. INSURED'S NAME (Last Name, First Name, Middle Initial)	5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED (Self, Spouse, Child, Other)	7. INSURED'S ADDRESS (No., Street)	8. INSURED'S DATE OF BIRTH (MM DD YY)			
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER	12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.	13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.	14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS: GIVE FIRST DATE (MM DD YY)	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION (FROM MM DD YY TO MM DD YY)			
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE	17a. I.C. NUMBER OF REFERRING PHYSICIAN	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES (FROM MM DD YY TO MM DD YY)	19. RESERVED FOR LOCAL USE	20. OUTSIDE LAB? (YES X NO)	21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)	22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.	23. PRIOR AUTHORIZATION NUMBER			
24. A DATE(S) OF SERVICE (From MM DD YY To MM DD YY)	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) (CPT/MCPCS MODIFIER)	E DIAGNOSIS CODE	F CHARGES	G DAYS TPSDT	H OP Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
25. FEDERAL TAX I.D. NUMBER	SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For gov. claims, see back) (YES X NO)	28. TOTAL CHARGE	29. PAYMENT	30. BALANCE DUE	31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)	33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #	34. PIN #

SIGNED SARAH Y. WALTERS, DATE 10/08/2001

Ok to pay
\$65.97
06311441 73230
10-1201

RECEIVED

OCT 10 2001

SECTION OF MATERNAL, CHILD & FAMILY HEALTH ANCHORAGE OFFICE

Sunshine Community Health Center
P.O. Box 787 (Mile 4.4 Talkeetna Spur Rd)
Talkeetna, AK 99676 (907) 733-2273

PRIMARY REBILL

MISCELLANEOUS INSKEY

PLEASE DO NOT STAPLE IN THIS AREA

PICA MISCELLANEOUS INSKEY

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE (Medicare #) <input type="checkbox"/>		MEDICAID (Medicaid #) <input type="checkbox"/>		CHAMPUS (Sponsor's SSN) <input type="checkbox"/>		CHAMPVA (VA File #) <input type="checkbox"/>		GROUP HEALTH PLAN (SSN or ID) <input type="checkbox"/>		FECA (ISSN) <input checked="" type="checkbox"/>		OTHER <input checked="" type="checkbox"/>		12. INSURED'S I.C. NUMBER (FOR PROGRAM IN ITEM 1)			
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)								3. PATIENT'S BIRTH DATE (MM DD YY)				4. INSURED'S NAME (Last Name, First Name, Middle Initial)					
5. PATIENT'S ADDRESS (No., Street)								6. PATIENT RELATIONSHIP TO INSURED				7. INSURED'S ADDRESS (No., Street)					
CITY				STATE		8. PATIENT STATUS				CITY				STATE			
ZIP CODE				TELEPHONE (Include Area Code)				Employed <input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time <input type="checkbox"/>				ZIP CODE				TELEPHONE (INCLUDE AREA CODE)	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)								10. IS PATIENT'S CONDITION RELATED TO:				11. INSURED'S POLICY GROUP OR FECA NUMBER					
a. OTHER INSURED'S POLICY OR GROUP NUMBER								b. EMPLOYMENT? (CURRENT OR PREVIOUS)				a. INSURED'S DATE OF BIRTH					
b. OTHER INSURED'S DATE OF BIRTH								c. AUTO ACCIDENT? PLACE (State)				d. EMPLOYER'S NAME OR SCHOOL NAME					
c. EMPLOYER'S NAME OR SCHOOL NAME								c. OTHER ACCIDENT?				c. INSURANCE PLAN NAME OR PROGRAM NAME					
d. INSURANCE PLAN NAME OR PROGRAM NAME								102. RESERVED FOR LOCAL USE				d. IS THERE ANOTHER HEALTH BENEFIT PLAN?					

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNATURE ON FILE DATE 04 30 2001

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNATURE ON FILE

14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY/ACCIDENT OR RESONANCE (MRI) DATE 07 5 01

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS GIVE DATE (MM DD YY)

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM TO

17. NAME OF REFERRING PHYSICIAN: PRYOR, M.D. Signature Date 193.00

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM TO

19. RESERVED FOR LOCAL USE: Collocation - Expenditure - Amount

20. OUTSIDE LAB CHARGES YES NO

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (RELATE ITEMS 1, 2, 3 OR 4 TO ITEM 24E BY LINE): 84500 .NF213 7 S

22. MEDICAID RESUBMISSION CODE ORIGINAL REF NO

23. PRIOR AUTHORIZATION NUMBER: E927 FMA 89104 023F1052

DATE OF SERVICE	Place of Service	Type of Service	PROCEDURES (ICD-9-CM)	DIAGNOSIS CODE	CHARGES	DAYS (EPSDT OR Family Plan)	EMG	CCR	RESERVED FOR LOCAL USE
09271999	23	01	99283, LEV 3, EXP. HIST, EXAM, LOW-MOD CO	12	193 00	1	X		4295

24. FEDERAL ID NUMBER: 920085972

25. PATIENT'S ACCOUNT ID: 00001765301X01

26. ACCEPT ASSIGNMENT? YES NO

27. TOTAL CHARGE: 193 00

28. AMOUNT PAID: 5

29. BALANCE DUE: 193 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER: SUSAN A. ... DATE 04 30 2001

32. NAME AND ADDRESS OF PHYSICIAN WHERE SERVICES WERE PERFORMED: FAIRBANKS MEMORIAL HOSP 1650 COWLES STREET FAIRBANKS AK 99701 5925

33. PHYSICIAN'S SUPPLIER'S BILLING NAME ADDRESS ZIP CODE: EMERGENCY MEDICINE ASSOCIATES PO BOX 74000 FAIRBANKS AK 99707 4000 4295 1517205-

REQUEST FOR SPECIAL NEEDS FUNDS FOR FOSTER CARE

Special Needs funding is assessed on an as-needed basis only and pre-authorization is required.
Limitation: This form is to used only for one time or irregular special needs expenditures on behalf of children in foster care.
Receipts and supporting documentation are required.

Child's Name: [REDACTED] DOB: 7/7/82 Prober Case Number: 401405262
Eligibility Status: (check one) Title IV-E eligible Not IV-E eligible Eligibility pending
Proposed services are for Child or Parent(s)/legal guardian/Indian custodian or Sibling(s) or Other family members
Proposed services are court-ordered (please attach court order)

I. Describe the specific need and how the request is consistent with the case plan (case plan must be attached). This is a request for the Division to pay for Dr. Appointment. This was an appointment that was not covered by Medicaid.

II. TITLE IV-E FOSTER CARE MAINTENANCE

1. Clothing - Initial (Refer to CPS Chapter 6.0, Section 6.2.2.8 for policy) S _____
2. Clothing - Extraordinary & Justified by Case Plan S _____
3. Food - Special Diet S _____
4. Extraordinary Laundry (Must have medical or psychological) S _____
Describe: _____
5. Personal Incidentals S _____
Describe: _____
6. Special One-Time Items S _____
 Special cribs, beds, mattresses
 Other (must be explained and within allowable DFYS regulations)
Describe: _____
7. Visitation with Family - Long Distance telephone cards for the child S _____
8. Licensed Child Care (Please provide DFYS license number _____) S _____
Licensed Child Care for foster child:
 during foster parent's employment when the foster child is not in school
 during the foster parent's attendance at mandatory foster parent training
 during foster parents attendance at case conference, case reviews, court hearing, without foster child
 which facilitate the foster parent's attendance at Division approved activities which are beyond the scope of "ordinary parental duties"
9. Travel - Child family visitation S _____

II.A. SUB-TOTAL - IV-E FOSTER CARE MAINTENANCE	S _____
--	---------

III. TITLE IV-E FOSTER CARE ADMINISTRATIVE

1. Travel S _____
 Miles over 50 per week for foster child's attendance at administrative case or judicial reviews
 Foster child pre-placement visit or placement with foster home
 Foster Parents attendance at administrative case/judicial reviews and mandatory case conferences/team meetings
 Other approved travel by foster child as part of case plan
Describe: _____
 Escort Travel as justified by case plan (may require travel authorization)
 For Visitation
 For Placement

Child's Name: _____

- 2. Foster Parent Damages and loss \$ _____
Refer to CPS Adm. Chapter 6.0. section 6.2.2.7 (4) (b)
Please attach form 06-9440 and police report if applicable.
- 3. Shipping & Freight Costs (Child's belongings only) \$ _____
- 4. Other-Services critical for completion of the case plan \$ _____
 - Genetic/Paternity Testing
 - Advertising for Missing Parents
 - Birth Certificates
 - Expert Witnesses (ICWA/Non-ICWA)
 - Supervised Visitation
 - Court Teleconference Costs

III.A. SUB-TOTAL IV-E FOSTER CARE ADMINISTRATIVE	\$ _____
---	-----------------

IV. NON-IV-E REIMBURSEMENT

- 1. Independent Living - Limited to those expenses that facilitates the transition of foster children to independent living that are not otherwise reimbursable under maintenance or administration or other resource. \$ _____
Describe: _____
- 2. Medical, Dental, Diagnostic, Therapeutic, and Assessment Services \$ 193.00
As payer of last resort (no Medicaid coverage or other third party reimbursement)
Refer to 7 AAC 53.320.
 - Medical Describe: Dr. Appointment
 - Dental Describe: _____
 - Diagnostic (i.e. Psych evaluations) Describe: _____
 - Therapeutic (i.e. Counseling) Describe: _____
 - Assessment Services Describe: _____
 - Medical equipment, furnishings, or discretionary devises for children with special needs Describe: _____
 - Travel Describe: _____
- 3. Unlicensed Child Care for Foster Child \$ _____
 - during foster parent's employment when the foster child is not in school
 - during the foster parent's attendance at mandatory foster parent training
 - during foster parents attendance at case conference, case reviews, court hearing, without foster child
 - which facilitate the foster parent's attendance at Division approved activities which are beyond the scope of "ordinary parental duties"
- 4. Other services critical for completion of the case plan of a child in foster care when no other resources are available \$ _____
Describe: _____

IV.A. SUB-TOTAL NON-IV-E REIMBURSABLE	\$ _____
--	-----------------

V. EXPLAIN HOW ALTERNATIVE SOURCES OF FUNDING FOR ALL ITEMS ABOVE HAVE BEEN EXHAUSTED: Child emancipated; no other resources.

VI. TOTAL COST: \$ 193.00

VII. one time cost short term costs (date) _____ / _____ / _____ to _____ / _____ / _____

Child's Name: _____

VIII. Payee Name FMH Address Cowles Street. 00701

IX. SSN or Fed Tax ID# _____ Vendor # (PVN) _____ Reimbursement

X. Judy Ringstad
Social Worker Signature _____ PCN _____ Date 1/1

XI. APPROVALS:

S.W. IV Signature PCN _____ Date 1/1 Shel Arde
S.W. V Signature PCN 5014 Date 11/1/01

Children's Services Manager Date _____
Family Services Program Administrator Date _____
Required for Requests exceeding \$1,500.00 and Out-of-State Travel

FISCAL INFORMATION (To be filled out by fiscal)

XII. CATEGORY	COST	CODING
IV-E Foster Care Maintenance (II.A.)	\$ _____	_____
IV-E Foster Care Administrative (III.A.)	\$ _____	_____
Non-IV-E Reimbursable (IV.A.)	\$ _____	_____
TOTAL OF REQUEST:	\$ _____	_____

PVN
NIMS 98041

Breast & Cervical Health Check (BCHC)

2001 Billing and Service Form
2000

Clinic/Provider Name: Northern Medical Services
Mailing Address: 4101 Arctic Blvd Suite 206
Anchorage AK 99503

Woman's Last Name: [REDACTED] First: [REDACTED]
Date of Birth: 4 19 69
SSN: [REDACTED]

New Patient Office Visits						Radiological Procedures					
	Rate	CPT Code	Service Date(s)	Qty	Cost		Rate	CPT Code	Service Date(s)	Qty	Cost
Problem focused (usually 10 minutes)	\$39.98	99201				Screening mammogram	\$64.23	76042			
Expanded problem focused (usually 20 minutes)	\$69.36	99202				Diagnostic/Followup - Unilateral Mammogram	\$83.85	76041			
Medical decision making, low complexity (usually 30 minutes)	99.84 99.84	99203	6/29/00	1	109.84	Diagnostic/Followup - Bilateral Mammogram	\$102.31	76091			
Medical decision making, moderate complexity (usually 45 minutes)	\$148.04	99204				Ultrasound - Echography, Breast (unilateral or bilateral) scan and/or real time image documentation	\$83.12	76645			
Medical decision making, high complexity (usually 60 minutes)	\$186.20	99205				Laboratory Procedures					
Established Patient Office Visits						Rate	CPT Code	Service Date(s)	Qty	Cost	
Minimal presenting problem(s) (usually 5 minutes)	\$25.69	99211				Pap smear (read by a cytotechnologist)	\$14.60	88164			
Problem focused (usually 10 minutes)	\$40.43	99212				Pap smear, cytopathology, cervical or vaginal collected in preservative fluid, automated thin layer preparation.	\$14.60	88142			
Expanded problem focused history/exam medical decision making, low complexity (usually 15 minutes)	\$56.63	99213				Colposcopy Biopsy Interpretation	\$100.84	88305			
Detailed history/exam medical decision making, moderate complexity (usually 25 minutes)	\$88.10	99214				Cervical Diagnostic Procedures					
Comprehensive history/exam medical decision making, high complexity (usually 40 minutes)	\$130.38	99215				Colposcopy directed cervical biopsy	\$130.69	57454			
Consultation						Colposcopy without biopsy	\$105.17	57452			
Consultation (15 minutes)	\$55.94	99241				Other					
Consultation, problem focused (usually 30 minutes)	\$100.25	99242									
Consultation, problem focused (usually 40 minutes)	\$132.17	99243									
Preventive Medicine											
New Patient-Initial Preventive Medicine Visit, 18-39 Years	\$103.00	99385									
New Patient-Initial Preventive Medicine Visit, 40-64 Years	\$143.00	99386									
New Patient-Initial Preventive Medicine Visit, 65 - Years	\$142.00	99387									
Established Patient-Periodic Preventive Medicine Visit, 18-39 Years	\$92.00	99395									
Established Patient-Periodic Preventive Medicine Visit, 40-64 Years	\$114.00	99396									
Established Patient-Periodic Preventive Medicine Visit, 65 - Years	\$130.00	99397									
						Total					99.84

Please submit to:
BCHC
3601 C Street, Suite 934
PO Box 240249
Anchorage, Alaska 99524-0249

I certify this information is true, accurate and complete.

State of Alaska
Women & At
934, PO Box
Ok to pay
\$ 99.84 906-6311441 73230
Julie [Signature] 12/26/01

Christy Stogor
Signed
12-19-01
Date

STATE OF ALASKA

HEALTH AND SOCIAL SERVICES

TONY KNOWLES, GOVERNOR

Division of Administrative Services/Fisc
P.O. Box 240249
Anchorage, AK 99524-0249

(907) 269-7818

March 6, 2001

Xerox Corporation
PO Box 7405
Pasadena, CA 91109-7405

RE: Invoice # 168587459

Acct# 691857908

To whom it may concern:

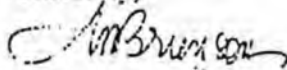
We received your fax regarding a past due invoice dated 4-20-99. Research indicates that the invoice will need to be submitted for a supplemental appropriation through the legislature.

Our Juneau fiscal office has the documents and will research for possible previous payment and then submit the invoices through the legislature for supplemental approval. Usually any supplemental requests are approved by the legislature in May of each year therefore; we are unable to pay the bill at this time.

I apologize for the delay. You may wish to suspense the invoice and contact our office in June to check the status. You can call Marissa at 269-7815 or you can contact me directly at 269-7818.

If I can clarify the process or you need further assistance, please let me know.

Sincerely,



Marissa Brunson

Accounting Clerk II

Cc: Cheryl Karasch, Human Resources
Luz Malacas, Juneau Fiscal

Please Remit To:

RECEIVED
MAR 16 2001

INVOICE

PVN

FBM 91029

Frontier Business Systems, Inc.
105 Trading Bay Drive # 105
Kenai, AK 99611

Invoice Number: 8981
P.O. Number: INV

Invoice Date: 12/22/1999
Invoice Terms: Net 10



K-PPA-075

Bill To: 003050

SOA-H&SS/DIV PUBLIC ASSIS-KENAI
3601 C St. Suite 410 P.O.Box 240249

Anchorage, AK 99524

Attn: Shannon Hall JILL KILPECK 283-2950 * (907) 283-2900

Ship To:

SOA-H&SS/PUBLIC ASSIS-KENAI
11312 KENAI SPUR HWY #2

KENAI, AK 99611

JILL KIOPECKY * (907) 283-2950

99501-5434

SOA-H&SS/PUBLIC ASSIS-KENAI * SHARP * FO3850 * Ser # 6010335X * * Non Contract * Chargeable * Mrx: N/A

Service

Service Problem	Technician	Qty	Ext Price
Supply Delivery	TBL		

Supplies

Product Code	Order	BO	Ship	Make	Model	Discount	Unit Price	Ext Price
FO48DR	1	0	1	Sharp	FO4800	0.00%	\$206.00	\$206.00
DRUM CART.								

"Copy of original" (written)

I certify that this is a just and proper invoice for the Department of Social Services for payment of same.

[Signature] Date: 6/1/01

06-21-C-330-74225

6-Digit Account Code 3-Digit Object

[Signature]

1/ ✓ AKSAS not pd.
✓ supplemental list. *

Telephone: (907) 283-2880
Facsimile: (907) 283-6495

Sub Total: \$206.00
Shipping & Handling: \$0.00
Applicable Sales Tax: \$0.00
Payment: \$0.00

Customer Signature

Balance Due: \$206.00

This Invoice Is Due and Payable By 01/01/2000

The customer guarantees payment within the specified terms and agrees to reimburse seller for all expenses incurred in collecting the amount of this invoice. A service charge of 1.5 % per month will be added to all past due amounts.

Thank You For Choosing Frontier Business Systems, Inc.

STATE OF ALASKA
HEALTH AND SOCIAL SERVICES

TONY KNOWLES, GOVERNOR

Division of Administrative Services/Fiscal
P.O. Box 240249
Anchorage, AK 99524-0249

(907) 269-7818

May 8, 2001

The New Printer Workshop NPW, Inc.
605 Barrow Street, Ste 2
Anchorage, AK 99501

RE: Invoice # 032098

Acct# 5060

To whom it may concern:

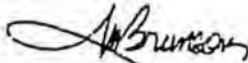
We received your fax regarding a past due invoice dated 09-22-98. Research indicates that the invoice will need to be submitted for a supplemental appropriation through the legislature.

Our Juneau fiscal office has the documents and will research for possible previous payment and then submit the invoices through the legislature for supplemental approval. Usually any supplemental requests are approved by the legislature in May of each year therefore; we are unable to pay the bill at this time.

I apologize for the delay. You may wish to suspense the invoice and contact our office in June to check the status. You can contact me directly at 269-7815.

If I can clarify the process or you need further assistance, please let me know.

Sincerely,



Marissa Brunson

Accounting Clerk II

Cc: Leanne Gunter, Public Health, Nursing
Luz Malacas, Juneau Fiscal

CC 06311 020

74225

Printing, Rubber Stamps, Stencils, Notary & Corporate Seals, Name Plates

INVOICE NUMBER

the new **printer's workshop**

NPW, Inc.

605 BARROW STREET, SUITE 2
ANCHORAGE, ALASKA 99501
(907) 279-4501 • FAX (907) 276-0329
FED I.D. #92-0126897

RECEIVED
MAR - 8 2001
DE 30 98 032098
SCR NURSING

SOLD TO: State of Alaska		ACCT. NO. 5060	DATE WRITTEN 9-22-98	BY DB
Dept. of Health & Social Services So. Central Regional Nursing		CONTACT PERSON Carol Stricklin		
		PHONE 562-5454	CUSTOMER P. O. NUMBER 06152-99-99002	

QUANTITY	DESCRIPTION	PRICE	AMOUNT
1	Nametag		7.50
I CERTIFY THIS TO BE A TRUE AND ACCURATE COPY OF THE ORIGINAL. <i>Carol Stricklin</i> 2/28/01 Signature Date			
INVOICE			
PAST DUE			
			TOTAL \$ 7.50

PLEASE PAY FROM THIS INVOICE. NO STATEMENT SENT UNLESS REQUESTED.

STATE OF ALASKA

HEALTH AND SOCIAL SERVICES

TONY KNOWLES, GOVERNOR

Division of Administrative Services/Fiscal
P.O. Box 240249
Anchorage, AK 99524-0249

(907) 269-7818

June 1, 2001

Builders Industrial Supply, Inc.
Box 947
Nome, AK 99762

RE: Invoice # 79216

To whom it may concern:

We received your fax regarding a past due invoice dated 09/16/99. Research indicates that the invoice will need to be submitted for a supplemental appropriation through the legislature.

Our Juneau fiscal office has the documents and will research for possible previous payment and then submit the invoices through the legislature for supplemental approval. Usually any supplemental requests are approved by the legislature in May of each year therefore; we are unable to pay the bill at this time.

I apologize for the delay. You may wish to suspense the invoice and contact our office in June to check the status. You can contact me directly at 269-7815.

If I can clarify the process or you need further assistance, please let me know.

Sincerely,



Marissa Brunson

Accounting Clerk II

Cc: Kathy Tenney, Division of Juvenile Justice
Luz Malacas, Juneau Fiscal

FY00

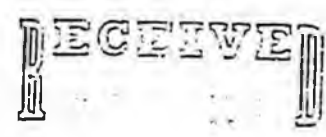
BUILDERS INDUSTRIAL SUPPLY, INC.

P.O. BOX 947
NOME, AK 99762

Statement

Date
3/31/2001

To:
NOME YOUTH FACILITY
BOX 1750
NOME, AK 99762



BY:

Amount Due	Amount Enc.
\$457.06	

Date	Transaction	Amount	Balance
06/30/1999	Balance forward		8.00
07/15/1999	PMT - 76942	-8.00	0.00
09/16/1999	INV #79216	316.00	316.00
10/19/1999	INV #79982	500.00	816.00
11/16/1999	INV #80519	500.00	1,316.00
11/24/1999	INV #80652	85.00	1,401.00
12/02/1999	PMT - 80519	-500.00	901.00
01/04/2000	PMT - 79982/80652	-585.00	316.00
02/25/2000	INV #81984	40.00	356.00
03/06/2000	INV #82145	68.00	424.00
03/25/2000	PMT - 81984	-40.00	384.00
05/31/2000	PMT	-68.00	316.00
06/20/2000	INV #83708	126.44	442.44
09/07/2000	INV #85331	68.50	510.94
09/30/2000	PMT - 83708	-126.44	384.50
10/02/2000	INV #86144	31.87	416.37
10/30/2000	INV #86763	20.88	437.25
11/10/2000	PMT - 85331	-68.50	368.75
11/27/2000	INV #87220	128.98	497.73
12/06/2000	PMT - 86763/86144	-52.75	444.98
12/27/2000	INV #87666	11.50	456.48
01/13/2001	PMT - 87220	-128.98	327.50
02/05/2001	PMT - 87666	-11.50	316.00
03/23/2001	INV #88998	83.24	399.24
03/23/2001	INV #88995	39.82	439.06
03/23/2001	INV #88984	18.00	457.06

[Handwritten signature]

CURRENT	1-30 DAYS PAST DUE	31-60 DAYS PAST DUE	61-90 DAYS PAST DUE	OVER 90 DAYS PAST DUE	Amount Due
0.00	41.06	0.00	0.00	316.00	\$457.06

STATE OF ALASKA

TONY KNOWLES, GOVERNOR

DEPT. OF HEALTH AND SOCIAL SERVICES


*DIVISION OF JUVENILE JUSTICE
NORTHERN REGION YOUTH CORRECTIONS*

1502 WILBUR STREET
FAIRBANKS, AK 99701
PHONE (907) 451-2150
FAX (907) 451-5152

MEMORANDUM

DATE: May 24, 2001

TO: Tina Williams, Anchorage Fiscal

FROM:  Kathy Tenney
Administrative Assistant

SUBJECT: Unpaid Bill - Builders Industry Supply ?

Per our conversation, I'm enclosing an invoice that the vendor has indicated is unpaid. Since AKSAS has been purged for this time period, the invoice will need to be verified against microfiche.

I'm coding the invoice in case it is verified to be outstanding. Please process the bill once this information is obtained. If it is verified that it has been paid, please provide us with information that we can return to the vendor (cancelled check preferably). Thanks.

Attachment

*Builders Industry Supply, Inc. Invoice #79216, dated 9/16/1999.

D. W. ...

00

OK per
Kach
BR

- COPY OF PHYSICIAN BILL
- PHYSICIAN BILL BREAKDOWN
- PHYSICIAN'S NOTICE AND CERTIFICATION

\$ 159.⁰⁰ PHYSICIAN SERVICES 100% 06338820-77290

\$ 159.⁰⁰ TOTAL PAID

PVN: WHA 84118
 William H. ANTHES, MD.

PLEASE DO NOT STAPLE IN THIS AREA



RECEIVED FEB HEALTH INSURANCE CLAIM FORM DMHDD

SELF PAY WRITING DATE STAMP JAN 13 2000 RECEIVED

1 MEDICARE MEDICAID CHAMPUS CHAMPVA GROUP HEALTH PLAN FECA OTHER INSURED'S ID NUMBER

2 PATIENT'S NAME (Last Name, First Name, Middle Initial) 3 PATIENT'S DATE OF BIRTH MM DD YY SEX

4 PATIENT'S ADDRESS (No. Street) 6 PATIENT RELATIONSHIP TO INSURED Self X Spouse Child Other

5 CITY STATE 7 INSURED'S ADDRESS CITY

8 ZIP CODE TELEPHONE (include Area Code) 9 PATIENT STATUS Single Married Other X

10 IS PATIENT'S CONDITION RELATED TO EMPLOYMENT CURRENT OR PREVIOUS YES NO

11 INSURED'S POLICY OR GROUP NUMBER 12 INSURED'S DATE OF BIRTH MM DD YY SEX

13 OTHER INSURED'S DATE OF BIRTH MM DD YY SEX 14 EMPLOYER'S NAME OR SCHOOL NAME

15 EMPLOYER'S NAME OR SCHOOL NAME 16 IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO

17 INSURANCE PLAN NAME OR PROGRAM NAME 18 RESERVED FOR LOCAL USE

19 PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE 20 INSURED'S OR AUTHORIZED PERSON'S SIGNATURE

21 DATE OF CURRENT ILLNESS First symptoms of INJURY Accident or PREGNANCY/CHP 22 IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS GIVE FIRST DATE MM DD YY

23 NAME OF REFERRING PHYSICIAN OR OTHER SOURCE 24 NUMBER OF REFERRING PHYSICIAN

25 RESERVED FOR LOCAL USE 26 HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM TO

27 DIAGNOSIS OR NATURE OF ILLNESS OR INJURY RELATE ITEMS 1 AND 4 TO ITEM 27 BY LINE

28 OUTSIDE LAB CHARGES YES NO

29 MEDICAID RESUBMISSION CODE ORIGINAL REF NO

30 PRIORITY AUTHORIZATION NUMBER

Table with 6 columns: A DATE S OF SERVICE, B PROC, C TYPE, D PROCEDURES SERVICES OF SUPPLIER, E DIAGNOSIS CODE, F CHARGES

Table with 6 columns: A DATE S OF SERVICE, B PROC, C TYPE, D PROCEDURES SERVICES OF SUPPLIER, E DIAGNOSIS CODE, F CHARGES

Table with 6 columns: A DATE S OF SERVICE, B PROC, C TYPE, D PROCEDURES SERVICES OF SUPPLIER, E DIAGNOSIS CODE, F CHARGES

Table with 6 columns: A DATE S OF SERVICE, B PROC, C TYPE, D PROCEDURES SERVICES OF SUPPLIER, E DIAGNOSIS CODE, F CHARGES

Table with 6 columns: A DATE S OF SERVICE, B PROC, C TYPE, D PROCEDURES SERVICES OF SUPPLIER, E DIAGNOSIS CODE, F CHARGES

Table with 6 columns: A DATE S OF SERVICE, B PROC, C TYPE, D PROCEDURES SERVICES OF SUPPLIER, E DIAGNOSIS CODE, F CHARGES

Table with 6 columns: A DATE S OF SERVICE, B PROC, C TYPE, D PROCEDURES SERVICES OF SUPPLIER, E DIAGNOSIS CODE, F CHARGES

Table with 6 columns: A DATE S OF SERVICE, B PROC, C TYPE, D PROCEDURES SERVICES OF SUPPLIER, E DIAGNOSIS CODE, F CHARGES

Table with 6 columns: A DATE S OF SERVICE, B PROC, C TYPE, D PROCEDURES SERVICES OF SUPPLIER, E DIAGNOSIS CODE, F CHARGES

Table with 6 columns: A DATE S OF SERVICE, B PROC, C TYPE, D PROCEDURES SERVICES OF SUPPLIER, E DIAGNOSIS CODE, F CHARGES

Please do cover sheet. We will pay KF 9-17-01

Carrs Quality Centers

6411 A Street, Anchorage, Alaska 99518 • Ph: 561-1944

D 94396 INVOICE
No 930181

- No. 2 Gambell
- No. 5 Aurora Village
- No. 6 Sears Mall
- No. 7 Eagle River
- No. 8 Kena
- No. 9 Eastgate
- No. 10 Diamond
- No. 11 Wasilla
- No. 12 Jewel Lake
- No. 13 Huffman
- No. 14 Palmer
- No. 16 Fairbanks
- No. 17 Muldoon
- No. 18 Kelchikan
- No. 20 Juneau
- Video Return
- Other

SOLD TO State of Alaska Dept. of Health & Social Services Prenatal Care II program DATE 8-3-99
1231 Gambel Street Anch. AK 99501 SOLD BY KRIS

CUSTOMER # 31216118

PAID ON ACCOUNT CHARGE
 RECEIPT

QUANTITY	DESCRIPTION	UNIT PRICE	AMOUNT
100	Prenatal Vit. Lx # 842217		18.60
100	Hum. Ins NPtt # 842216		20.80
100	Hum. Ins Regular Lx # 842215		20.80
100	one touch test strips Lx # 842214		68.80

TERMS. NET. 30 DAYS (FROM DATE ABOVE)
 RECEIVED BY: [Signature] TOTAL 128.30

White - Office Yellow - Customer Pink - Store

SAFEWAY, INC.
 HEREBY STATES THIS
 TO BE A CERTIFIED COPY
 OF THE ORIGINAL INVOICE
 ACCTS. REC. SUPERVISOR

[Signature]

okay to pay ATN 32618
 #128,30 0006311408 77590
 P. J. J. 1/30/02

Remit to: CARR'S c/o SAFEWAY INC.
FILE #72905
P.O. BOX 60000
SAN FRANCISCO, CA 94160-2905

094396

STORE SALES INVOICE

SOLD TO: St. of Alaska

Dept. of Health + Social Services

ATTN OF: Prenatal Care II Program

ADDRESS: 1231 Gambell Street

Anchorage, AK 99501-4621

Store Number 1-14	1816
Cust. No. 15-20	E10437
Inv. No. 21-20	100308
Date (*) 27-32	091999
Accounting Use Only 33-34	0 1

QUANTITY	DESCRIPTION	PRICE	AMOUNT
1	Rx 9312265 (30 Tablets)		8.60
	Auth. # 27350		
	OPag to pay ATN 27350		
	*P.O. No. 02311408 77590		
	② Summary 1/30/02		
	SAFEWAY, INC. HEREBY STATES THIS TO BE A CERTIFIED COPY OF THE ORIGINAL INVOICE ACCTS. REC. SUPERVISOR		

THIS ACKNOWLEDGES RECEIPT OF MERCHANDISE AND SERVES AS CUSTOMER RECORD OF PURCHASES STATEMENT WILL REFER TO THE INVOICE NUMBER.

TOTAL 35-40	8.60
Cust. P.O. No. 41-48	

STORE MGR'S APPROVAL *[Signature]*

CARR'S CHECKER *[Signature]*

AUTHORIZED SIGNATURE *[Signature]*

Customer to Initial Cash Register Top if Requested and Received.

Form Number 71-B CARR'S (new 9-99) 3-95-1A-10

COPY WHITE MINK YELLOW -ACCTG ONLY -STORE -CUSTOMER

Printed in U.S.A.

Carrs Quality Centers

6111 A Street, Anchorage, Alaska 99518 • Ph: 561-1944

INVOICE

№ 947208

- No. 2 Gambell No. 8 Kenal No. 12 Jewel Lake No. 17 Muldoon
- No. 5 Aurora Village No. 9 Eastgate No. 13 Huffman No. 18 Ketchikan
- No. 6 Scars Mall No. 10 Dimond No. 14 Palmer No. 20 Juneau
- No. 7 Eagle River No. 11 Wasilla No. 16 Fairbanks Video Return
- Oil*

094396-11-99

SOLD TO State of Alaska Prenatal Care Program
1231 Gambell St
ANCHORAGE AK 99501-4627

DATE 11-11-99

SOLD BY Kay... ..

CUSTOMER # 1104137 Auth# 12793

PAID ON ACCOUNT		CHARGE	
-----------------	--	--------	--

RECEIPT

QUANTITY	DESCRIPTION	UNIT PRICE	AMOUNT
1	Prenatal VITS		8.60

TERMS: NET. 30 DAYS (FROM DATE ABOVE)

RECEIVED BY: [Signature] TOTAL 8.60

White - Charge Yellow - Customer Pink - Store

SAFEWAY, INC.
 HEREBY STATES THIS
 TO BE A CERTIFIED COPY
 OF THE ORIGINAL INVOICE.
 ACCTS. REC. SUPERVISOR

[Signature]

ok to pay ATN 12793
 # 8.60 00 66311408 77590
 P. Finnesen 1/30/02

WAY INC.

0000
SAN FRANCISCO, CA 94160-2905

INVOICE

State of Alaska
ATTN: Friendal Care
ADDRESS: 1231 Campbell St
Anch AK 99501

Store Number 11-14	1805
Cust. No. 15-20	
Inv. no. 21-26	105353
Date (M) 27-32	10/20/99
Accounting Use Only 33-34	0 1

QUANTITY	DESCRIPTION	PRICE	AMOUNT
	14 650999 - strips (not covered on Ins)		61.40
	14 650998 - syringes (not covered on Ins)		22.70
	14 650997 - insulin (Ins copay)		15.00
	14 650996 - insulin (Ins copay)		15.00
	[REDACTED] 6/10/99 (charge correction)		

SAFEMAY, INC.
HEREBY STATES THIS
TO BE A CERTIFIED COPY
OF THE ORIGINAL INVOICE
ACCTS. REC. SUPERVISOR

THIS ACKNOWLEDGES RECEIPT OF MERCHANDISE AND
SERVES AS CUSTOMER RECORD OF PURCHASES. STATE-
MENT WILL REFER TO THE INVOICE NUMBER

TOTAL 35-40	114.10
Cust. P.O. No. 41-48	

STORE MGR'S
APPROVAL _____

CARR'S
CHECKER CT

AUTHORIZED
SIGNATURE _____

Customer to Initial if Cash Register Tape
is Requested and Received.

Form Number 71-B SALLPS
(new 6-92) 6-92-15 10

COPY
WHITE
PINK
YELLOW
ACCTG. DEPT.
STORE
CUSTOMER

Printed in U.S.A.

okay to pay ATN 30048
#114.10 99 06 311 405 77590
P. Simmen 1/30/02.

CARRS

NOBODY DOES IT BETTER FOR LESS
YOUR FRIENDLY AUPURA WILLING WORKS

01	PHARMACY	11	40
	PHARMACY	22	70
	PHARMACY	15	00
	PHARMACY	12	00
----	TAX	03	84
	Misc. Tender	119	11

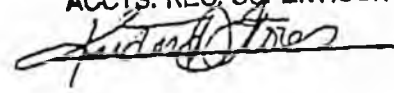
TOTAL NUMBER OF ITEMS SOLD - 4
10/20 14 08 12 1604 29 0023 101

JOIN THE CARRS CLUB MEMBERSHIP IS
FREE AND INSTANT

SEE CARRS BRO TO THE CARRS

PLEASE CALL TO ORDER OR USE THE
CARRS APP TO ORDER YOUR CARRS

SAFEWAY, INC.
HEREBY STATES THIS
TO BE A CERTIFIED COPY
OF THE ORIGINAL INVOICE
ACCTS. REC. SUPERVISOR



ATN 304F

SAFeway INC.

5000
SAN FRANCISCO, CA 94160-2905

SALES INVOICE

State of AK
ATTN: OF: Prenatal Care
ADDRESS:

Store Number 11-14	1805
Cust. No. 15-20	
Inv. No. 21-25	105354
Date (M) 27-32	10/20/99
Accounting Use Only 33-34	0 1

(MM-DD-YY)

QUANTITY	DESCRIPTION	PRICE	AMOUNT
17	660888 - insulin (Ins copay)		15.00
17	660887 - strips (Not covered on Ins)		61
	for [redacted] 7/13/99 (charge correction)		

SAFeway, INC.
HEREBY STATES THIS
TO BE A CERTIFIED COPY
OF THE ORIGINAL INVOICE
ACCTS. REC. SUPERV. 301
Sharon L. Jones

THIS ACKNOWLEDGES RECEIPT OF MERCHANDISE AND SERVES AS CUSTOMER RECORD OF PURCHASES. STATEMENT WILL REFER TO THE INVOICE NUMBER.

TOTAL 35-40	76.40
Cust. P.O. No. 41-46	

STORE MGR'S APPROVAL _____

CARR'S CHECKER *[Signature]*

AUTHORIZED SIGNATURE _____

Customer to Initial if Cash Register Tape is Requested and Received.

Form Number 71-B CANYS
(rev 5 02) 6-99-15-10

COPY
WHITE
PINK
YELLOW
ACCTG. DEPT
-STORE
-CUSTOMER

Printed in U.S.A

ok to pay ATN 30107
7640 00 063 11 408 77590
[Signature] 1/30/02

SAFEGWAY INC.

50000
SAN FRANCISCO, CA 94160-2905

SALES INVOICE

State of AK
ITEM OF: Prenatal Care

ADDRESS:

Store Number 11-14	1805
Cust. No. 15-20	
Inv. no. 21-26	105354
Date (*) 27-32	10/20/99
Accounting Use Only 33-34	0 1

QUANTITY	DESCRIPTION	PRICE	AMOUNT
74	6608868-insulin (Ins copy)		15.00
74	6608867-Strips (Not cov)		
	for XXXX (change a		

CARRS

NOBODY DOES IT BETTER FOR YOU.
YOUR FRIENDLY AURORA VILLAGE STORE

PHARMACY	15.00
UP PHARMACY	61.40
*** TAX	16.40
MIS. FEE	16.40

TOTAL NUMBER OF ITEMS SOLD: 2
10-20-99 TO 10-20-99 29 0000 100

THIS ACKNOWLEDGES RECEIPT OF ME
SERVES AS CUSTOMER RECORD OF PAY-
MENT WILL REFER TO THE INVOICE NUMBER

STORE MGR'S
APPROVAL _____

AUTHORIZED
SIGNATURE _____

Requested and Received

Form Number 71-D CARRS
(Rev. 5-97) 5-93 16-10

COPY
WHITE
PINK
YELLOW
ACCOUNT DEPT
STORE
CUSTOMER

Price in U.S.A.

SAFEGWAY, INC.
HEREBY STATES THIS
TO BE A CERTIFIED COPY
OF THE ORIGINAL INVOICE
ACCTS. REC. SUPERVISOR

Kurtis D. Hines

SAFeway, INC. HEREBY STATES THIS TO BE A CERTIFIED COPY OF THE ORIGINAL INVOICE ACCTS. REC. SUPERVISOR

[Signature]

29

CO, CA 94160-2905

SALES INVOICE

TO: ~~XXXXXXXXXX~~
STATE OF ALASKA DEPT OF
HEALTH AND SOCIAL SERVICES
SFA MATERNAL CHILD FAM HEALTH
ADDRESS:
1231 GAMBELL ST. #302
ANCHORAGE, AK 99501

Store Number 11-14	1806
Cust. No. 15-20	094397
Inv. No. 21-26	418561
Date (*) 27-32	102699
Accounting Use Only 33-34	0 1

QUANTITY	DESCRIPTION	PRICE	AMOUNT
50.	Rx # 6307674		4549
	Voucher 22170		
	okay to pay ATM 22170		
	\$45.49 00 06.311420	77590	
	P. J. J. 1/30/02		

THIS ACKNOWLEDGES RECEIPT OF MERCHANDISE AND SERVICES AS CUSTOMER RECORD OR PURCHASES STATEMENT WILL REFER TO THE INVOICE NUMBER.

TOTAL 35-40	4549
Cust. P.O. No. 41-48	22170

STORE MGR'S APPROVAL

SAFEWAY CHECKER

AUTHORIZED SIGNATURE ~~XXXXXXXXXX~~

Customer to Initial in Cash Register Tape & Reconciled and Received.

Form No 718 (Rev. 5-97) 2-09-300-10

COPY WHITE -ACCTG DEPT YELLOW -CUSTOMER PINK -STORE

Printed in USA

Auth # 22170 ds 1/29/02

Nanuaq Manor
PO Box 850/400 Bering Street
Nome, AK 99762

Account Statement

PVN- NAM97056

Account Number	38
Statement Date	01/04/02
Balance Due	409.00
Last Payment	
Existing Credit	0.00

State Of Alaska- Public Assist
Coastal Reg. Office
3601 C Street
Anchorage, AK 99524
Attn: Shannon Hall

Net 30 days.
Your account is currently closed.

Open Balance:	31-60 days	61-90 days	91-120 days	Over 120 days:
0.00	0.00	0.00	0.00	409.00

Inv Date	Check In/Out	Voucher	Invoice	Reference	Original Amount	Payments Received	Finance Charges	Open Amount
06/06	06/05-06/06	[REDACTED]	F 813	LYDIA	160.00	0.00	0.00	160.00
06/06	06/05-06/06	[REDACTED]	F 814	LYDIA	160.00	0.00	0.00	160.00
06/06	06/05-06/06	[REDACTED]	F 815	LYDIA	89.00	0.00	0.00	89.00

Fix Assets

Spoke to LeAnn 11 Jan 02

Please call

907-443-5296

I certify that this is a full and proper bill and hereby authorize the Department Certifying Officer to effect payment of same.

[Signature]
Signature _____ Date *11 Jan 02*

06-21-6-330-71280 409.00
Budget Account Code 3-Digit Object Code

15

Nauyas Minor

Page 1 of 1

PO Box 850/400 Bering Street
Nome, AK 99762
907-443-5296

Bernice Rookok

*Old SCC 01976
Bernice 1967 xid/idea*

Room	Folio	Checkin	CheckOut	Balance
2/14	813	06/05/2000	06/06/2000	0.00
Master Folio		Weekday: 180.00 Weekend: 180.00		

Date	Room	Description/Voucher	Charges	Credits	Balance
06/05/2000	2/14	Room Non-Taxable	180.00	0.00	180.00
06/06/2000	2/14	City Ledger - Rookok, Bernice	0.00	180.00	0.00
		* [REDACTED]			
		* [REDACTED]			

Certified copy

LON
01/11/02 11:53 AM

Thank you for staying with us!

*Internal System - Room Not Paid - per Se Ann. & N.B. King.
1/13/02 - NO 90) found, NO piece print found.*

Nanuaq Manor
PO Box 850/400 Bering Street
Nome, AK 99762
907-443-5296

Page 1 of 1

Alice Anagick

Room	Folio	CheckIn	CheckOut	Balance
(414)	B14	06/05/2000	06/06/2000	0.00
Master Folio		Weekday: 160.00 Weekend: 160.00		

Date	Room	Description/Voucher	Charges	Credits	Balance
06/05/2000	414	Room Non-Taxable	160.00	0.00	160.00
06/06/2000	414	City Ledger - Anagick Alice	0.00	160.00	0.00
		* [REDACTED]			
		* [REDACTED]			
<u>Certified copy</u>					

LOH
01/11/02 11:58 AM

Thank you for staying with us!

1/11/02 - NO ENSURED AKA PRIOR Pymt Forward.

Nanaaq Manor
 PO Box 850/400 Bering Street
 Nome, AK 99762
 907-443-5296

██████████
 Elim, AK

Room	Folio	CheckIn	CheckOut	Balance
(3/14)	015	06/05/2000	06/06/2000	0.00
Master Folio		Weekday: 89.00 Weekend: 89.00		

Date	Room	Description / Voucher	Charges	Credits	Balance
06/05/2000	3/14	Room Non-Taxable	89.00	0.00	89.00
06/05/2000	3/14	Room Non-Taxable	89.00	0.00	178.00
06/06/2000	3/14	City Ledger - ██████████	0.00	89.00	89.00
06/06/2000	3/14	City Ledger - ██████████	0.00	89.00	0.00

Certified copy

LO1
 01/11/02 12:02 PM

Thank you for staying with us!

VA ?N - NO EN Final, NO PRIOR permit found,

Patient Tracking Fees - Quarter 2

Provider: Interior Neighborhood Health Clinic 3

LastName	FirstName	Patient#	Service Date	CPT	Svc Fee	Tracking Fee
			11/5/01	99385	\$171.00	\$40.00
			9/4/01	99396	\$143.00	\$40.00
			10/4/01	99396	\$143.00	\$40.00
			11/13/01	88141	\$35.00	\$40.00
			10/23/01	99202	\$97.00	\$40.00
			10/19/01	99396	\$143.00	\$40.00
			11/1/01	99395	\$147.00	\$40.00
			12/7/01	99386	\$190.00	\$40.00
			10/25/01	99386	\$190.00	\$40.00
			10/24/01	99396	\$143.00	\$40.00
			10/26/01	99396	\$143.00	\$40.00
			11/8/01	99396	\$143.00	\$40.00
			5/21/01	99212	\$83.00	\$30.00
			10/27/99	99214	\$137.00	\$30.00
			10/29/01	99396	\$143.00	\$40.00
			11/5/01	99386	\$190.00	\$40.00
			10/4/01	99386	\$190.00	\$40.00
			11/14/01	99396	\$143.00	\$40.00
			12/14/01	99203	\$136.00	\$40.00
			10/12/01	99386	\$190.00	\$40.00
			11/26/01	99395	\$147.00	\$40.00
			11/24/01	99396	\$90.00	\$40.00
			10/5/01	99395	\$147.00	\$40.00
			10/9/01	99396	\$143.00	\$40.00

*
Suppl

~~10/27/99 99214 \$137.00 \$30.00 *~~

Patient Tracking Fees - Quarter 2

Provider: Interior Neighborhood Health Clinic 3

LastName	FirstName	Patient#	Service Date CPT	Svc Fee	Tracking Fee
			11/16/01 99396	\$143.00	\$40.00
			11/30/01 99396	\$143.00	\$40.00
			12/27/01 99395	\$147.00	\$40.00
			12/7/01 99396	\$143.00	\$40.00
			12/21/01 99212	\$65.00	\$40.00

Number of Patients: 101

Total Patient Tracking Fees: \$4,010.00

Summary by State FY Coding

00 - 03611441 73270	\$30.00
01 - 03611441 73270	\$60.00
02 - 03611441 73270	\$3,920.00

Supplemental

pd
2-5-02
1526462-73

John D'Amico
2/1/02

11711975180

Patient Tracking Fees - Quarter 2

Provider: Anchorage Neighborhood Health Center 5

LastName	FirstName	Patient#	Service Date	CPT	Svc Fee	Tracking Fee
			10/30/01	88164	\$31.00	\$40.00
			8/1/01	88164	\$31.00	\$40.00
			10/8/01	88164	\$31.00	\$40.00
			10/9/01	99395	\$133.00	\$40.00
			3/3/00	99201	\$61.00	\$30.00 *
			2/18/00	99213	\$62.00	\$30.00 *
			10/1/01	99395	\$133.00	\$40.00
			10/4/01	88164	\$31.00	\$40.00
			11/5/01	99396	\$145.00	\$40.00
			10/1/01	99395	\$133.00	\$40.00
			10/4/01	88164	\$31.00	\$40.00
			3/27/00	99213	\$81.00	\$30.00 *
			10/10/01	88164	\$31.00	\$40.00
			10/9/01	88164	\$31.00	\$40.00
			7/28/00	99214	\$117.00	\$30.00
			11/7/01	99213	\$81.00	\$40.00
			9/17/01	99204	\$170.00	\$40.00
			10/18/01	99386	\$175.00	\$40.00
			10/23/01	99385	\$160.00	\$40.00
			10/9/01	88164	\$31.00	\$40.00
			10/29/01	88164	\$31.00	\$40.00
			11/9/01	99395	\$133.00	\$40.00
			10/3/01	99396	\$145.00	\$40.00
			11/6/01	99396	\$145.00	\$40.00

(*)
(*)

(*)

Patient Tracking Fees - Quarter 2

Provider: Anchorage Neighborhood Health Center 5

LastName	FirstName	Patient#	Service Date	CPT	Svc Fee	Tracking Fee
			10/24/01	99396	\$145.00	\$40.00
			10/5/01	99385	\$160.00	\$40.00
			11/7/01	99396	\$145.00	\$40.00
			10/25/01	88164	\$31.00	\$40.00

Number of Patients: 100

Total Patient Tracking Fees: \$3,920.00

Summary by State FY Coding

00 - 03611441	73270	\$180.00
01 - 03611441	73270	\$60.00
02 - 03611441	73270	\$3,680.00

⊕ Supplemental -

PP
2-15-02
1526462-74

Juni Domet 2/1/02
ANN 8/15/83

Section 19

Miscellaneous Claims and Stale-dated Warrants

Department of Law

Change Record Detail With Description

Department of Law

Scenario: LAW FY2002 Supplemental - Governor's (2483)

Component: Administrative Services (2164)

BRU: Administration and Support (280)

Change Record Title	Trans Type	Totals	Personal Services	Travel	Contractual	Supplies	Equipment	Land/ Buildings	Grants Claims	Misc.	Positions		
											PFT	PPT	NP
Sec 19 Miscellaneous Claims													
	Suppl	27.1	0.0	0.0	27.1	0.0	0.0	0.0	0.0	0.0	0	0	0
1004 Gen Fund	27.1												
Miscellaneous Claims: \$27.1 in GF's to pay two vendor invoices related to prior fiscal years that were not received in time to process prior to funds lapsing.													
Totals		27.1	0.0	0.0	27.1	0.0	0.0	0.0	0.0	0.0	0	0	0

Audit Findings Sheet
State of Alaska

Name: Alaska Department of Law

Calculation of Back Maintenance For Contract Period: July 1, 1998 - June 30, 1999
(Our Current Contract Period is July 1, 2000 - June 30, 2001)

Date: 8-29-01

Discount:

Licenses

Enter the findings from the "Technical Data Sheet" in this table:

	*Licenses Purchased	Licenses In Use	List Price	Discounted Price	Licenses Added	Total
NetWare (Nodal)	574	574	\$ 158 00	\$ 104 25	0	\$ -
GroupWise	477	477	\$ 130 00	\$ 85 80	0	\$ -
Total Licenses to Purchase						\$ -

*Licenses Purchased based on Maintenance History

Back Maintenance

If you can determine the month in which new licenses listed above, were installed, then use that number of months prior to the Co-Term to calculate back-maintenance.

	Back-Maintenance Owed	List - Yearly	Discounted - Yearly	Discounted - Monthly	# of Months	Total
NetWare (Nodal) (7/1/98-6/30/99)	460	\$ 40 00	\$ 26 40	\$ 2 20	12	\$ 12 144 00
GroupWise (7/1/98-6/30/99)	450	\$ 32 00	\$ 21 12	\$ 1 76	12	\$ 9 504 00
Total Back-Maintenance to Purchase						\$ 21,648.00

Total Purchases for Compliance	\$ 21,648.00
---------------------------------------	---------------------

Technical Process Agreement

By signing below, I agree with the audit process used during the audit of Novell software and the results of the process as shown above.

Signature _____

Date _____

Name (printed): _____

Facilities Agreement

By signing below, I accept the results of the Novell audit and agree to complete a purchase order and schedule C for the above licenses and maintenance, and submit to Novell within 30 calendar days of the signature date below.

Signature _____

Date _____

Name (printed): _____

INVOICE

Civil Division
Nelson Deschene
P. O. Box 110300
Juneau, AK 99811-0300
LAW\CIVIL

Invoice No. 0003714
Date: 07/06/2001
Acct: 3\138\82
Account PO#:
From: 06/01/2001 to 06/30/2001

Page: 2

	RATE	QTY	TOTAL
CHARGES/CREDITS			
19,480 lbs @ .17/lb Destruction of Non-Confidential Materials (Code 130)			3,311.60
			<hr/>
			3,311.60

Total Amount Due 5,485.99

Paid 7/25/01 wrnt# 20077287

- 73.50

5412.49

Remit Payment to:
AAA MOVING & STORAGE
717 E. SHIP CREEK AVE
ANCHORAGE, AK 99501
(907) 276-3506

Billing Inquiries:
AAA ARCHIVES
5344 SHAUNE DR.
JUNEAU, AK 99801
(907) 780-3671

AAA RECORD ARCHIVES

INVOICE

TO: Barbara H.
- 5419

204

Civil Division
Nelson Deschene
P. O. Box 110300
Juneau, AK 99811-0300
LAW\CIVIL

Invoice No. 0003714
Date: 07/06/2001
Acct: 3\138\82
Account PO#:
From: 06/01/2001 to 06/30/2001

Page: 1

		RATE	QTY	TOTAL
STORAGE: 06/01/2001 through 06/30/2001				
STD FILE BOX QTY/EA (CODE 131)	(0.2700/30 days)	0.2700	3,905.00	1,054.35
Odd Size Box/Tube QTY/EA (CODE 131)	(0.2700/30 days)	0.2700	22.00	5.94
			<u>3,927.00</u>	<u>1,060.29</u>

OTHER SERVICES

Input Data Qty/Mins (CODE 129)	WO #0004136 06/20/2001	62.5000	180.00	62.50
Refilling Qty/Mins (CODE 126)	WO #0004111 06/12/2001	17.7000	50.00	17.70
Pull Ctn/File. Qty/Mins. (CODE 126)	WO #0004112 06/12/2001	17.7000	50.00	17.70
Pull Ctn/File. Qty/Mins. (CODE 126)	WO #0004115 06/13/2001	62.5000	168.00	62.50
Pull Ctn/File. Qty/Mins. (CODE 126)	WO #0004115 06/13/2001	104.1700	286.00	104.17
Pull Ctn/File. Qty/Mins. (CODE 126)	WO #0004115 06/13/2001	161.4600	465.00	161.46
Pull Ctn/File. Qty/Mins. (CODE 126)	WO #0004115 06/13/2001	151.0400	421.00	151.04
Pull Ctn/File. Qty/Mins. (CODE 126)	WO #004115 06/13/2001	151.0400	430.00	151.04
Pull Ctn/File. Qty/Mins. (CODE 126)	WO #0004146 06/21/2001	88.5400	247.00	88.54
Pull Ctn/File. Qty/Mins. (CODE 126)	WO #0004146 06/21/2001	88.5400	255.00	88.54
Pull Ctn/File. Qty/Mins. (CODE 126)	WO #0004146 06/21/2001	88.5400	248.00	88.54
STANDARD PICK UP (CODE 127)	WO #0004136 06/20/2001	26.0400	1.00	26.04
				<u>1,019.77</u>

PRIORITY SERVICES

NORMAL DELIVERY (CODE 128)	WO #0004146 06/21/2001	20.8300	1.00	20.83
				<u>20.83</u>

MATERIALS

Std Stg Box (CODE 124)	WO #0004103 06/11/2001	1.4700	50	73.50
				<u>73.50</u>

Approved for Payment

Date: 7/6/01

Signed: [Signature]

Acct: 13807003

Remit Payment to:
AAA MOVING & STOR. INC
717 E. SHIP CREEK AVE
ANCHORAGE, AK 99501
(907) 276-3506

Billing Inquiries:
AAA ARCHIVES
5344 SHAUNE DR.
JUNEAU, AK 99801
(907) 780-3671

AAA RECORD ARCHIVES

ASAB3000-03 RRN: 0189141
 RSN: 05045 CPD: 07/25/01

DISTRB RD: 03304 D01

STATE OF ALASKA
 STATEWIDE ACCOUNTING SYSTEM
 FINANCIAL TRANSACTION REGISTER

PAGE: 13
 DATE: 07/25/01

SELECTION INPUT RD: SOURCE RD: 03304 N STATUS: B TRANS CODES:
 CERT RD: AUTH RD: SSI:

TRANSACTION CODE, NAME AND DESCRIPTIONS	BATCH/SEQUENCE	DOCUMENT	RD CODES	DATE	TIME	TERMINAL	RSN
310-10 WARRANT REQUEST EXP	AA1468641 0156	AA14686410156	INPUT 03304	07/24/01	13:38:57	X25U	05045
	FPC COA	TRANS AMOUNT	SOURCE 03304	07/25/01	18:37:50:84		
			CERT 03300	07/25/01	14:18:30	X3MC	STATUS
	A 01	91.20	AUTH	00/00/00	00:00:00		A
			AUTH	00/00/00	00:00:00		
			LAST 03304	07/25/01	07:56:28	X2A8	

WRNT NUM	CLASS	ROUTING	NEW	OLD	DATES	PRINT AMOUNT	REISSUE	NAME AND ADDRESS
20077287	GN	M			SCHED 07/24/01 PRINT 00/00/00 REDEM 00/00/00 RECON 00/00/00	91.20		
								00000-0000

DOC	ACT	LINE	TYPE	NUMBER	AMOUNT	DATE	COMMENTS
001	001	PVN	AMS84356		0.00	00/00/00	AAA MOVING & STORAGE
002	002	ARD	03000		0.00	00/00/00	LAW
003	003	ACC	3\138\82		0.00	00/00/00	
004	004	INV	0003714		73.50	07/06/01	
005	005	ACC	3\138\81		0.00	00/00/00	
006	006	INV	0003713		17.70	07/06/01	

DOC	ACT	LINE	AMOUNT	SY	CC	PGM	LC	ACCT	FY	NMRTR	PT	OPEN	ITEM	LIQN	IEAX	DESCRIPTION
001	001		91.20	01	03201003			73857	01							

DOC	ACT	LINE	AMOUNT	SY	CC	PCM	LC	ACCT	FY	NMRTR	PT	MO	OPEN	ITEM	LIQN	COA	DESCRIPTION	SRCE
001	001		91.20	01	03201003			73857	01			01				01		UD
001	001		91.20-	02	90011100			22600	01			01				02		EX
001			91.20-	01	90011100			21331	01			01				01		EX
001			91.20	01	90011100			21331	01			01				02		EX

Short paid in error INV. 0003714 total is \$5485.99
 This Payment < 73.50 >
 Balance Due 5412.49

BSA 9/21/01

Section 19

Miscellaneous Claims and Stale-dated Warrants

Department of Military and Veterans' Affairs

Change Record Detail With Description

Department of Military and Veterans Affairs

Scenario: FY2002 Supplemental - Governor's (2454)
 Component: Alaska Military Youth Academy (1969)
 BRU: Alaska National Guard (130)

Change Record Title	Trans Type	Totals	Personal Services	Travel	Contractual	Supplies	Equipment	Land/ Buildings	Grants Claims	Misc.	Positions			
											PFT	PPT	NP	
Sec 19 Miscellaneous Claim														
	Suppl	0.3	0.0	0.0	0.3	0.0	0.0	0.0	0.0	0.0	0	0	0	
1004 Gen Fund	0.3													
See back-up memo.														
Totals		0.3	0.0	0.0	0.3	0.0	0.0	0.0	0.0	0.0	0	0	0	

MEMORANDUM


DEPARTMENT OF MILITARY & VETERANS AFFAIRS

STATE OF ALASKA

ADMINISTRATIVE SERVICES

TO: Annalee McConnell
Director, OMB

DATE: January 17, 2002

FROM:  Carol Carroll
Director, Administrative Services

TELEPHONE: 465-4730

SUBJECT: FY02 Miscellaneous Claim
AK Military Youth
Academy

The Department of Military & Veterans Affairs requests approval of a miscellaneous claim for inclusion in the FY02 supplemental funding legislation.

The miscellaneous claim in the amount of \$274.00 is to pay a bill submitted to the Alaska Military Youth Academy (AMYA) by the Doctors Collection Service in July, 2001. The bill was presented on behalf of the Providence Alaska Medical Center, for services provided to the AMYA in July, 1995. The original bill was inadvertently not paid, resulting in this late billing.

If you have any questions please call Jean Davis at 465-2422.

cc: Tim Jones, AMYA Director
Denise Liccioli, DMVA Finance Officer

Jeremiah Hamilton

Bill: \$274⁰⁰

Acct #: 192242

ADDRESS

Doctors Collection Service
605 Barrow St.
Ste 1
Anchorage, AK 99501

Attn: Annie

ASSI- D/R	EST- -YCN	SUP ANCH	FMO	KULIS	TAG
SEC	Department of Military and Veterans Affairs				DGP
ACCT	JUL 23 2001				ADCC
TERS	Admin. Inhab. & Support Services Division (A2-SD)				VETS
NOTE:					

TAX ID #

92-0138120

Payment Approved:

R. Lasher

Date:

JUL 20 2001

Amount:

\$274.00

Coding:

09602010 / 9420

↓ cannot code to TW:
7/26/01

HCI # A

PROVIDENCE ALASKA MEDICAL CENTER
PO BOX 196604
ANCHORAGE, AK
907 261-3005
FEI # 920016429N

PAGE N

TYPE OF BILL	DATE OF BILL	DATE OF PREV BILL
CYCLE	07/20/95	
OUTP.		

99519-6604

BIRTH-DATE

07/09/78

HOSP I.

061

PATIENT NAME	PATIENT NUMBER	SEX	AGE	ADMISSION DATE	DISCHARGE DATE	DAYS
HAMILTON, JERMAH S	52827359	M		07/14/95		

GUARANTOR NAME AND ADDRESS	GLEN HAMILTON HC33B3197 WASILLA, AK 99654	C.O.B.	INSURANCE COMPANY NAME	GROUP NUMBER	POLICY NUMBER
		1	[REDACTED]		
		HANLEY MD JOHN R			

AMOUNT OF PAYMENT \$

DATE OF SERVICE	DESCRIPTION OF HOSPITAL SERVICES	CPT CODE	TOTAL CHARGES	EST. COVERAGE INS. CO. NO. 1	EST. COVERAGE INS. CO. NO. 2	EST. COVERAGE INS. CO. NO. 3	EST. COVERAGE INS. CO. NO. 4	PATIENT AMOUNT
DETAIL OF CURRENT CHARGES, PAYMENTS AND ADJUSTMENTS								
07/14	CERVICAL COLLA		12.40	12.40				
001	03600202							
07/14	C-SP AP LAT	72040	103.60	103.60				
001	53006953							
07/14	LIMITED CARE	99283	90.00	90.00				
001	08624256							
07/14	LOW SEVERITY	99282	68.00	68.00				
001	08900052							
SUMMARY OF CURRENT CHARGES								
	CAST ROOM		12.40	12.40				
	RADIOLOGY		103.60	103.60				
	ER PHY FEE		68.00	68.00				
	EMERGENCY ROOM		90.00	90.00				
SUB-TOTAL OF CURR. CHARGES			274.00	274.00				

Where
Did this
Name come
from

What
is this for,

AH: Col Fleming

Dr. Collection
605 Barrow
\$9224.2

IT IS OUR PLEASURE TO SERVE YOU
THANK YOU FOR SELECTING PROVIDENCE

PAY THIS AMOUNT

ADDITIONAL PATIENT BILLING MAY BE NECESSARY FOR ANY CHARGES NOT POSTED WHEN THIS BILL WAS PREPARED, OR IF INSURANCE CARRIERS DO NOT PAY ANY PART OF THE AMOUNT SHOWN UNDER ESTIMATED INSURANCE COVERAGE.

7/17/01 \$382.08

PROVIDENCE ALASKA MEDICAL CENTER
ANCHORAGE AK

TOTALS

274.00 | 274.00

PATIENT NUMBER PLEASE REFER TO PATIENT NUMBER ON ALL INQUIRIES AND CORRESPONDENCE.
52827359

Subject: RE: 6-year old bill from Providence Medical
Date: Thu, 20 Sep 2001 13:05:58 -0800
From: Richard Lasher <rlasher@ngchak.org>
To: 'Jeanmarie Davis' <jeand@dnr.state.ak.us>
CC: Irene Lee <Irene_Lee@ngchak.org>, Denise Liccioli <denise_liccioli@ak-prepared.com>, nicob@dnr.state.ak.us

\$274.00

Collection Service as noted.

-----Original Message-----

From: Jeanmarie Davis [mailto:jeand@dnr.state.ak.us]
Sent: Thursday, September 20, 2001 9:35 AM
To: Dick Lasher
Cc: Irene Lee; Denise Liccioli; nicob@dnr.state.ak.us
Subject: 6-year old bill from Providence Medical

Hi Dick,

The 6-year old bill for Providence Medical Center that you submitted for payment on July 23, 2001 will require an appropriation from the legislature as a "Miscellaneous Claim" against a prior year. These usually get approved in the supplemental bills that pass in May. Once we have approval for that, then we can cut the check.

I need to verify the following information for the appropriation request:

1. AMOUNT - the actual bill shows \$274.00, but there is a handwritten amount at the bottom dated 7/17/01 for \$383.08. Please confirm the correct amount.
2. Providence Alaska Medical Center provided the service, but it looks like you'll need to pay the bill to the "Doctors Collection Service". Please confirm.

Please let me know no later than Monday morning as OMB has requested this information now.

Thanks.

Jean

Section 19

Miscellaneous Claims and Stale-dated Warrants

Department of Public Safety

Change Record Ignoring Included Scenarios

Department of Public Safety

Scenario: FY2002 Supplemental - Governor's (2454)

Component: Administrative Services (525)

BRU: Statewide Support (165)

Scenario/ Change Record Title	Trans Type	Totals	Personal Services	Travel	Contractual	Supplies	Equipment	Land/ Buildings	Grants Claims	Misc.	Positions		
											PFT	PPT	NP
Sec 19 Miscellaneous Claims													
	Suppl	0.3	0.0	0.0	0.0	0.3	0.0	0.0	0.0	0.0	0	0	0
1004 Gen Fund	0.3												
This request is to fund miscellaneous claims of \$293.88 for expenses incurred by FWP Enforcement/ISU in FY99.													
Totals		0.3	0.0	0.0	0.0	0.3	0.0	0.0	0.0	0.0	0	0	0

MEMORANDUM


State of Alaska

TO: Annalee McConnell, Director
Office of Management & Budget
Office of the Governor

DATE: January 9, 2002

FILE NO:

TELEPHONE NO: 465-4336


FROM: Ken Bischoff, Director
Division of Administrative Services
Department of Public Safety

SUBJECT: FY02 Misc. Claims
Supplemental

The Department of Public Safety requests approval of an FY2002 Miscellaneous Claims Supplemental Appropriation in the amount of \$293.88 for the following items:

Sitka True Value - Invoice 141979	\$283.70
Sitka True Value - Invoice 141919	<u>10.18</u>
Total	\$293.88

Your approval of this request is greatly appreciated.

Attachments: Copy of Invoices
Copy of AKSAS FY99 AR showing lapse balance is available

CC: FWP, Karen Allam
Budget Section

True Value

SITKA TRUE VALUE
 P.O. BOX 1609
 815 HALIBUT POINT ROAD
 SITKA ALASKA 99835
 PHONE: (907) 747-6292

PAGE NO 1

PVN - SIE 84823

Payment researched, not paid
 per Matt.

SAVE YOUR RECEIPT
 RECEIPT REQUIRED FOR REFUND OR EXCHANGE

AK DEPT. OF PUBLIC SAFETY - FISH
 FISH AND WILDLIFE PROTECTION
 P.O. BOX 1062
 SITKA AK 99835

CUST # 11012
 TERMS: NET 10TH

INV # 141979
 DATE: 10/23/98
 CLERK: DI

REF. # P/V MINKE

TIME :10:13

 * INVOICE *

*certify this
 to be a true
 copy of the
 original
 Steve Dean*

QUANTITY	UM	ITEM	DESCRIPTION	PRICE / PER	EXTENSION
1	EA	265405	REDDY HEATER - 35,000 BTU - R35B	233.99 /EA	233.99 N
2	EA	207837	2-PAK 9" ROLLER COVER - TP6915	4.19 /EA	8.38 N
1	EA	265637	SILVER DUCT TAPE - PROFESSIONAL	7.49 /EA	7.49 N
1	EA	217158	9" ROLLER FRAME - RFE900	2.19 /EA	2.19 N
1	EA	217455	2" X 60-YD MASKING TAPE - 1217EP	2.99 /EA	2.99 N
1	EA	195299	1007 1-1/2" VARNISH/ENAMEL BRUSH	4.19 /EA	4.19 N
1	EA	670265	FIRM PAINT TRAY - PRT-90	2.49 /EA	2.49 N
1	EA	248948	8' X 10' POLY TARP - 700810	6.99 /EA	6.99 N
1	EA	248649	10' X 20' POLY TARP - 701020	14.99 /EA	14.99 N

to pay *d*
 Mary Folger
 Date 1-16-00 BY 98 BY 98
 Location Code: 12 10.0.405 74786 = 49.71
12.10.0.405, 74820 = 233.99

*** AMOUNT CHARGED TO ACCOUNT *** 283.70 TAXABLE 0.00
 NON-TAXABLE 283.70
 SUB-TOTAL 283.70
 TAX AMOUNT 0.00
 TOTAL INVOICE 283.70

Matt Mah
 RECEIVED BY

JAN 17 2000

True Value

SITKA TRUE VALUE
 P.O. BOX 1689
 815 HALIBUT POINT ROAD
 SITKA ALASKA 99835
 PHONE: (907) 747-6292

PAGE NO 1

attn Carol

PVY-51E84823

SAVE YOUR RECEIPT
 RECEIPT REQUIRED FOR REFUND OR EXCHANGE

*Payment researched
 not paid per Matt.*

AK DEPT. OF PUBLIC SAFETY - FISH
 FISH AND WILDLIFE PROTECTION
 P.O. BOX 1662
 SITKA AK 99835

CUST # 11812
 TERMS: NET 10TH

INV # 141919
 DATE : 10/22/98
 CLERK: FS

TIME : 8:25

 * INVOICE *

*I identify this
 to be a
 true copy
 of the
 original*

Sherrill Helmer

QUANTITY	UM	ITEM	DESCRIPTION	PRICE / PER	EXTENSION
1	EA	678995	6-PK ASSORTED STEEL WOOL - 1129	1.79 /EA	1.79 N
1	EA	192815	LFS-3 RUST INHIBITER - 88316	8.39 /EA	8.39 N
				74759 = 8.39	
P/V MINKE				12-10 0.405	74756 = 1.79

OK to pay 9 Gary Folger

Date 1-16-01 CY 98 SY 99

Collection Code: 12-10-0.405 ~~79559~~

** AMOUNT CHARGED TO ACCOUNT **

16.18 TAXABLE
 NON-TAXABLE 18.18
 SUB-TOTAL 18.18
 TAX AMOUNT 0.00
 TOTAL INVOICE 18.18

Matt Mahan
 RECEIVED BY

*Here are your request invoices
 if you have further questions
 please call us
 Thank you
 Sherrill*

JAN 17 2001

PAGE: 1

True Value.

SITKA TRUE VALUE
P.O. BOX 1809
815 HALIBUT POINT ROAD
SITKA ALASKA 99835
(907) 747-6292

STATEMENT

CLOSING DATE: 6/30/00

ACCT: 11012

AK DEPT. OF PUBLIC SAFETY - FISH
FISH AND WILDLIFE PROTECTION
2760 SHERWOOD LANE
JUNEAU AK 99901

DATE	REFERENCE NO.	ST	C	DESCRIPTION	DEBIT	CREDIT	
				YOUR SUMMER TIME HEADQUARTERS			
10/22/98	141919	1	I	INVOICE	10.18		
10/23/98	141979	1	I	P/V MINKE	283.70		
				NEW BALANCE	293.88		
<div data-bbox="982 1102 1169 1168" data-label="Text"><p>JAN 17 2001</p></div>							
CURRENT		1-30 DAYS		31-60 DAYS		61-90 DAYS	
0.00		0.00		0.00		0.00	
						OVER 90 DAYS	
						293.88	

TERMS: NET 10TH

011012

INQ-TR: TANAB AND UNOBLIGATED BALANCE CALCULATIONS
CY: 2002 APPN: 46508 (1999) - ENFORCEMENT & ISU

01/02/2002

	AVAILABLE BALANCE	UNOBLIGATED BALANCE
NET CONTINUING EXPENDITURE AUTHORIZATION (PF2)	11069954.57	11069954.57
NET CONTINUING RESTRICTED REVENUE ESTIMATE (PF3)	-711609.99	
LESS: ALLOWABLE RECEIPTS (PF4)	-711609.99	
ACTUAL EXPENDED	11069954.57	11069954.57
ENCUMBRANCES (PF5)	N/A	
NET BALANCE	-----	-----
TOLERANCE ADJUSTMENT (PF6)		=====
TOLERANCE ADJUSTED NET AVAILABLE BALANCE	=====	

INQ-TR: TANAB - LAPSE BALANCE
CY: 2002 APPN: 46508 (1999) - ENFORCEMENT & ISU

01/02/2002

LAPSED EXPENDITURE AUTHORIZATIONS	-7555.42
PLUS: LAPSE ADJUSTMENTS	1585.50
AVAILABLE LAPSE BALANCE	----- -5969.92 =====
LESS: RESTRICTED EXPENDITURE AUTHORIZATIONS	
UNRESTRICTED AVAILABLE LAPSE BALANCE	----- -5969.92 =====



Section 19

Miscellaneous Claims and Stale-dated Warrants

Department of Transportation and Public Facilities

Sec 19

MEMORANDUM

State of Alaska
Department of Transportation & Public Facilities
Administrative Services Division

TO: Dianna Blair
Budget Analyst

DATE: 1/28/02

TEXT NO: (907) 465-3652

FAX NO: (907) 465-3124

TELEPHONE NO: (907) 465-3911

FROM: Liz Blecker *LB*
Finance Officer

SUBJECT: Miscellaneous Claims

The Department of Transportation and Public Facilities has one miscellaneous claim for FY 2002, a payment to Hoonah Trading Company for \$32.96 dated January 2, 1999. The Highway and Aviation section purchased 32 gallons of diesel fuel. A search of Hoonah Trading payments did not prove that this invoice had already been paid.

Unfortunately, the company did not bring the unpaid invoice to our attention until after the 24 month period for which to pay outstanding State obligations.

Sec 19

Certified true original copy

J. H. ...

Office Manager

01-28-02

11058122 NY

444085775

NR 52501

19

2586313P-58139-34101461-70751

CA 29890658E

Miss ...

... & ...

... & ...

... & ...

HOONAH TRADING CO.
 P.O. BOX 117
 HOONAH, ALASKA 99822
 (907) 846-3211 FAX (907) 846-3000
 EMail: 81-0818782

DELIVERY INVOICE No. 26266

145

1 12 199

DATE	PRODUCT QUANTITIES	AMOUNT	PRICE	AMOUNT
207	Unbleached Cotton	32	1.03	32.96
	Heckling Fuel Inc.			
	Wood Fuel Inc.			
				32.96

1/15/02 spoke of ...

Laura ... still outstanding bill

Sec 20(a)

MEMORANDUM

State of Alaska


Department of Transportation & Public Facilities
Commissioner's Office

TO: Annalee McConnell, Director
Office of Management and Budget

DATE: February 8, 2002

FAX NO: (907) 586-8365

TELEPHONE NO: (907) 465-3900


FROM: Joseph L. Perkins, P.E.
Commissioner

SUBJECT: Supplemental request
for FY2002

In addition to the FY2002 operating and capital budget supplemental requests submitted via ABS, the Department of Transportation and Public Facilities (DOT&PF) is requesting the following capital budget supplemental items:

The Department is also requesting the following ratifications:

- | | | |
|--|--|--------------|
| (1) Department of Transportation and Public Facilities | | |
| (A) AR 64790-15 Reimbursable Projects | | \$34,614.23 |
| (B) AR 58904-01 Reimbursable Authority | | \$96,773.16 |
| (C) AR 61669-01 Reimbursable Authority | | \$165,066.62 |

Explanation:

(A) and (B): The Southeast Region Design and Construction section developed plans and specifications for Kake city streets with the understanding that the costs would be reimbursed by Kake Tribal Corporation. BIA paid for on-site construction administration, project inspection and materials testing. Unfortunately, preliminary engineering costs were not included in the project budget. Attempts were made to receive the funding from Kake Tribal Corporation and the Bureau of Indian Affairs, but were unsuccessful. Since then Kake Tribal Corporation has filed Chapter 11 which places the State among the other unsecured creditors. Reimbursement of these funds has been determined to be highly unlikely.

(C): The Federal Highway Administration allows the use of in-kind match on construction projects. The Municipality of Anchorage used in-kind match for projects and requested the federal portion from the Department. The FHWA requires for reporting purposes the total project costs to include the in-kind match. Prior to FY96 an adjusting journal entry was done in the state accounting system to reflect this match both on the expenditure and revenue sides. The procedures for completing this transaction were not documented well, nor were they always followed correctly. This request cleans up the errors from this in-kind match accounting process.

The Department is also requesting \$32.96 in general funds for a miscellaneous claim. The Southeast Region Highways and Aviation section purchased 32 gallons of diesel fuel on January 2, 1999. Only recently did Hoonah Trading Company notify the Department

that this invoice had not been paid. Research has determined that it has not been paid and it is past the 24-month period for processing State obligations thus requiring a supplemental.

If you have any questions or need further information, please contact Nancy Slagle at 465-3911.

CC: Nancy Slagle, Administrative Services Director
Kurt Parkan, Deputy Commissioner
Liz Blecker, Finance Officer

MEMORANDUM
DEPARTMENT OF NATURAL RESOURCES

State of Alaska
SUPPORT SERVICES DIVISION

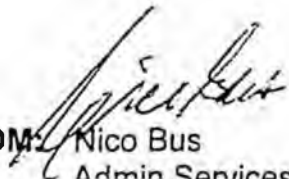
Sec 20(b)

TO: Annalee McConnell
Director, OMB

DATE: January 18, 2002

FILE NO: 03 ratification memo

TELEPHONE NO.: 465-2406


FROM: Nico Bus
Admin Services Manager

SUBJECT: Ratification request
FY01 Fire Suppression

The Department of Natural Resources submits a request for one ratification item to be included in SLA02 legislation. The ratification amount is \$4,730,000, for FY01 authorization posted in the Statewide Fire Suppression Program BRU, Fire Suppression component.

The authorization to expend was obtained through the "Declaration of a Disaster Emergency" process, during the time period after the regular FY01 supplemental process. Emergency funding in the amount of \$2,000,000 was posted on June 13, 2001, and \$3,000,000 was posted on June 29, 2001. Unused authorization in the amount of \$270,000 was removed from AKSAS on September 10, 2001 (ADN#1014056), resulting in the need to ratify the balance.

June 13, 2001	\$2,000,000.00
June 29, 2001	\$3,000,000.00
ADN#1014056 Reduction	<u>(\$270,000.00)</u>
Balance to Ratify	<u>\$4,730,000.00</u>

Copies of the Emergency Declaration and the general fund reduction are attached. If you have any questions, please call Jean Davis at 465-2422.

Attachments

cc: Jean Davis, Budget Analyst
Lex McKenzie, Forestry

Sec 20(b)

B 1491346 5 0001

FDE 520-50: APPROPRIATION BUDGET

TRANS CODE MINOR 50 ADDITIONAL AUTH RD 120

DOCUMENT NUMBER 10/31-1-4056

SOURCE RD CODE 10064

TOTAL AMOUNT _____ SPREAD AMT (Y/N) N

DESCRIPTION LONG FY01 FIRE SUPPRESSION _____ AR 37313

REDUCE GENERAL FUND NOT NEEDED FROM _____

EMERGENCY DISASTER DECLARATIONS _____

FISCAL PERIOD CODE P BUDGET TYPE SUP DENOMINATOR _____ POSTING MONTH _____

FIN	AMOUNT	SY	CC	PGM	LC	ACCT	FY	NMR	MORE	FINS	N
1	-117549.76	01	10310130			71000	01				
	LINE DESC										
2	-96404.15	01	10310130			72000	01				
	LINE DESC										
3	-56046.09	01	10310130			75000	01				
	LINE DESC										
4	270000.00	01	10310130			68515	01				
	LINE DESC										

Enter-PF1---PF2---PF3---PF4---PF5---PF6---PF7---PF8---PF9---PF10--PF11--PF12--
 UPDAT QUIT SUBMT ERRS BASE FINS PFKYS HELP

OFFICE OF
MANAGEMENT DIRECT

SEP 19 2001

[Signature] 9/7/01
[Signature]
[Signature]

OMB APPROVED

9-10-01

150
141

TONY KNOWLES
GOVERNOR
GOVERNOR@STATE.AL.US



STATE OF ALASKA
OFFICE OF THE GOVERNOR
JUNEAU

Sec 20(b)

P.O. Box 110001
Juneau, Alaska 99811-0001
(907) 465-3506
Fax (907) 465-3532
www.gov.state.ak.us

DECLARATION OF A DISASTER EMERGENCY

WHEREAS, the Department of Natural Resources must provide fire suppression activities (AS 41.15.010-41.15.170) to prevent continuing and new fires from threatening life and property; and,

WHEREAS, the appropriation to the Department of Natural Resources, Statewide Fire Suppression Program by sec. 1, ch. 133, SLA 2000, page 24, line 12, for fiscal year 2001 is totally obligated and not sufficient to cover fire suppression costs for fiscal year 2001; and,

WHEREAS, the disasters declared on September 22, 2000; October 20, 2000; November 17, 2000; December 15, 2000; January 12, 2001; February 9, 2001; and March 9, 2001, were limited to 30 days under AS 26.23.020(c); however, continued fire suppression operations are needed;

NOW, THEREFORE, on this 6th day of April 2001, I find insufficient funds were regularly appropriated for fiscal year 2001 fire suppression operations and activities, and find it necessary to implement funding via the disaster declaration process. Because money from the disaster relief fund is not available to cope with the disaster, I authorize under AS 26.23.020(j), and AS 26.23.050, that additional funds be made available to the Department of Natural Resources for continued wildland fire fighting needs for fiscal year 2001. To the extent that additional fire suppression authorization is needed for the remainder of fiscal 2001, this funding mechanism will be used again.

FURTHER, the commissioner of the Department of Natural Resources is hereby authorized to utilize funds made available for these purposes, in the amounts considered necessary for fire protection and suppression.

By Tony Knowles
Tony Knowles
Governor

SEL 20(6)
B 1468239 S 0002

FDE 520-50: APPROPRIATION BUDGET

TRANS CODE MINOR 50 ADDITIONAL AUTH RD _____
DOCUMENT NUMBER 10/31-1-4053_
SOURCE RD CODE 10064
TOTAL AMOUNT _____ SPREAD AMT (Y/N) N
DESCRIPTION LONG FX01 FIRE SUPPRESSION _____
EMERGENCY DECLARATION _____

FISCAL PERIOD CODE C BUDGET TYPE SUP DENOMINATOR _____ POSTING MONTH _____

FIN	AMOUNT	SY	CC	PGM	LC	ACCT	FY	NMR	MORE	FINS	Y
1	1500000.00	01	10310130			71000	01				
	LINE DESC _____										
2	150000.00	01	10310130			72000	01				
	LINE DESC _____										
3	1100000.00	01	10310130			73000	01				
	LINE DESC _____										
4	75000.00	01	10310130			74000	01				
	LINE DESC _____										

Enter-PF1---PF2---PF3---PF4---PF5---PF6---PF7---PF8---PF9---PF10---PF11---PF12---
 UPDAT QUIT SUBMT ERRS BASE FINS PFKYS HELP

FDE 520-50: APPROPRIATION BUDGET

B 1468239 S 0001
OVERFLOW N

DOC NUM 10/31-1-4053

DENOM

N	AMOUNT	SY	CC	PGM	LC	ACCT	FY	NMR
1	1500000.00	01	10310130			71000	01	
	LINE DESC _____							
2	150000.00	01	10310130			72000	01	
	LINE DESC _____							
3	1100000.00	01	10310130			73000	01	
	LINE DESC _____							
4	75000.00	01	10310130			74000	01	
	LINE DESC _____							
5	175000.00	01	10310130			75000	01	
	LINE DESC _____							
6	-3000000.00	01	10310130			68515	01	
	LINE DESC _____							
7								
	LINE DESC _____							
8								
	LINE DESC _____							
9								
	LINE DESC _____							

Handwritten signature and date: 6/29/01

110
1
4053

Enter-PF1---PF2---PF3---PF4---PF5---PF6---PF7---PF8---PF9---PF10---PF11---PF12---
UPDAT QUIT SUBMT ERRS BASE FINS PFKYS HELP

OFFICE OF
MANAGEMENT & BUDGET

Handwritten signature: Carl Meszola
OMB APPROVED

JUN 29 2001

6-29-01

1500
1400
1

STATE OF ALASKA

OFFICE OF THE GOVERNOR

OFFICE OF MANAGEMENT AND BUDGET

TONY KNOWLES, GOVERNOR

P.O. BOX 110020
JUNEAU, ALASKA 99811-0020
PHONE: (907) 465-4660
FAX: (907) 465-3008

February 28, 2002

The Honorable Dave Donley
The Honorable Pete Kelly
The Honorable Eldon Mulder
The Honorable Bill Williams
Alaska State Legislature
State Capitol
Juneau, AK 99801

Dear Finance Committee Co-Chairs:

Please consider the following amendments to the regular supplemental bills, SB 292 and HB 415:

Amend section 3(c), Department of Corrections, to read as follows:

(c) The sum of ~~\$85,000~~ [\$100,000] is appropriated from the general fund to the Department of Corrections, parole board, for operating costs for the fiscal year ending June 30, 2002.

Amend section 11, Judgments and Claims, to read as follows:

Sec. 11. JUDGMENTS AND CLAIMS. The sum of ~~\$785,500~~ [\$816,500] is appropriated to the Department of Law to pay judgments and claims against the state for the fiscal year ending June 30, 2002, from the following sources in the amounts listed:

SOURCE	AMOUNT
General fund	600,500 [631,500]
Public Employees Retirement Trust Fund	185,000

Amend section 15(a)(9), Department of Public Safety, to read as follows:

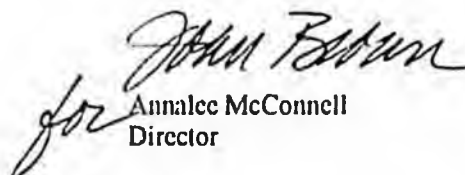
(a)(9) the sum of ~~\$87,500~~ [\$30,000] is appropriated from the general fund to the Department of Public Safety, Alaska state troopers detachments, for medical examination costs of victims of sexual assault and sexual abuse:

Amend section 17, Department of Transportation and Public Facilities, by deleting 17(e)(3):

(e)(3) [THE SUM OF \$150,000 FROM GENERAL FUND PROGRAM RECEIPTS FOR HILLCREST BRIDGE REPAIR:]

Back-up information on the amendments is attached. If you have any questions, please call me (465-4660) or Joan Brown (465-4681).

Sincerely,


Annalee McConnell
Director

Attachments

cc: David Teal
Legislative Finance

FY2002 SUPPLEMENTALS

	A	B	C	D	E	F	G	H	I
1	Sec. No.	Department	BRU or Component	Supplemental Need	General Funds	Federal Funds	Other Funds	Fund Source	Total Funds
2	FAST TRACK SUPPLEMENTAL								
3	1	Court System	Judicial Conduct	Legal fees in excess of FY2001 supplemental. Actual amount is \$6829.77.	6.8				6.8
4	2(a)	Comm & Ec Dev	Alaska Science & Technology Foundation	Idaho National Engineering and Environmental Laboratory Grant Contract for Alaska Business Research. Funds are available March 1, 2002.			25.0	Statutory Designated Prog Rcpts	25.0
5	2(b)	Comm & Ec Dev	International Trade & Business Development	International Trade and Business Endowment - replace unrealized FY02 Investment Earnings - Fund Source Change	230.4		-230.4	Internal'l Trade and Dev. Fund Earnings Reserve	0.0
6	3	Corrections	Palmer Correctional Center	New well including pump and wellhouse as primary water well has failed and is nonrepairable. Statutory designated program receipts (SDPR) are from interest earnings of Northern Tobacco Securitization Corporation (NTSC).			172.2	Statutory Designated Prog Rcpts	172.2
7	4(a)	Health & Soc Svcs	Medicaid Services	Medicaid Services - Projected to run out April 16. \$4.57m GF is for FY2001 bills paid in FY2002; 1.8m GF is from underfunding last year below low case scenario; 6.34m GF is for caseload at mid-case range and cost increases, particularly for seniors and d	12,712.5	106,618.0	23,903.3	Statutory Designated Prog Rcpts	143,233.8
8	4(b)	Health & Soc Svcs	Subsidized Adoptions & Guardianship	Formula program caseload growth	2,529.6				2,529.6
9	5	Transportation	Marine Highway Stabilization Fund	Marine Highway Stabilization Fund FY02 deficit due to Columbia fire and fuel cost increases. If not funded, Spring/Summer service would need to be drastically cut, reducing revenues during highest revenue season. Ships would be put into lay-up status fo	2,876.9				2,876.9
10	6	Military & Vets	Disaster Planning & Control	Costs to maintain 24-hour State Emergency Coordination Center (SECC), the agency that coordinates all federal, state and local jurisdictional responses associated with any disaster or event.	100.0				100.0
11	7	Natural Resources	CIP	Scope change for SLA97, CH50, Sec 15(k), P9, L13 - from prepare and administer the Kalgin Island II, Caribou Hills, S. Ninilchik-Dome View, South Ninilchik Blck timber sales in Kenai Peninsula to Kenai Peninsula to reduce risks from wildfire.					0.0
12	8	Governor	Elections	Costs for printing and mailing a Primary Election Voter Education Guide in time to explain the new law (shifted from FY2003 budget which will be amended)	25.0				25.0
13	9(a)	Comm & Ec Dev	Power Cost Equalization & Rural Electrification Fund	Technical correction to add the inadvertently omitted FY02 appropriation from the Power Cost Equalization Endowment fund to the Power Cost Equalization and Rural Electclification Fund			7,062.2	PCE EF	7,062.2
14	9(b)	Comm & Ec Dev	Power Cost Equalization & Rural Electrification Fund	Fully fund the statutory formula in the PCE statute. Cost increase is due to higher fuel costs.	1,100.0				1,100.0

FY2002 SUPPLEMENTALS

	A	B	C	D	E	F	G	H	I
1	Sec. No.	Department	BRU or Component	Supplemental Need	General Funds	Federal Funds	Other Funds	Fund Source	Total Funds
15	9(c)	Comm & Ec Dev	Power Cost Equalization	Fully fund PCE statute. Increase due to higher fuel costs.			1,100.0	PCE	1,100.0
16	9(d)(1)	Comm & Ec Dev	Power Cost Equalization	Delete sufficient authorization from FY02 to pay FY01 late bills			-56.8	PCE	-56.8
17	9(d)(2)	Comm & Ec Dev	Power Cost Equalization	Add authorization to pay power cost equalization program FY01 late bills			56.8	PCE	56.8
18	10(a)(1)	Transportation	Northern Region Highways & Aviation	Chandalar (James Dalton Hwy) Maintenance Station Replacement- Temporary rental and other costs of vacating the maintenance station due to imminent structural failure.	127.8				127.8
19	10(a)(2)	Transportation	Central Region Highways & Aviation	East Fork (Parks Hwy- S of Cantwell) Maintenance Station Replacement- Temporary rental and other costs of vacating the maintenance station due to imminent structural failure.	21.9				21.9
20	10(a)(3)	Transportation	Central Region Highways & Aviation	Willow (Parks Hwy) Maintenance Station Replacement- Temporary rental and other costs of vacating the maintenance station due to imminent structural failure.	45.5				45.5
21	10(a)(4)	Transportation	Northern Region Highways & Aviation	Nome Maintenance Station Imminent Structural Failure - Temporary rental and other costs of vacating the maintenance station to due imminent failure.	72.0				72.0
22	10(b)	Transportation	Northern Region CIP	Chandalar Maintenance Station Replacement Design Costs (SDPR from NTSC - see line 6)			456.8	Statutory Designated Prog Rcpts	456.8
23	10(c)	Transportation	Southeast Region CIP	Title change from West Douglas Highway Extension to Gastineau Channel Second Crossing to match federal project name change					0.0
24	11(a)	University	Systemwide Small Planning, Design and Construction	Funding authority needed in excess of the FY02 small project non-gf receipt authority for Lena Point fisheries and ocean sciences facility for simultaneous excavation with NOAA to prevent disruption and damage to the facility at a later date.			800.0	UA Rcpts	800.0
25	11(b)	University	CIP	Scope Change for Sec 3, Ch 61, SLA 2001 to include UAA Heating, Ventilation, and Air Conditioning Piping Replacement Phases 1-4					
26	12			Lapse Provisions					
27	13			Retroactivity					
28	14			Effective Date					
29	FAST TRACK BILL TOTAL				19,848.4	106,618.0	33,289.1	0.0	159,755.5
30	[REDACTED]								
31	[REDACTED]								
32	REGULAR SUPPLEMENTALS								
33	1(a)(1)	Administration	Finance	Contractual costs for maintenance of the State payroll system (AKPAY) core database	150.0				150.0
34	1(a)(2)	Administration	General Relief	Shortfunding for projected caseload	273.0				273.0
35	1(a)(3)	Administration	Leasing	Shortfunding of the amount required to pay leases with the private sector	1,300.0				1,300.0
36	1(a)(4)	Administration	Leasing	FY02 appropriation for the Anchorage Jail lease is short \$4,784.38	4.8				4.8
37	1(a)(5)	Administration	Office of Public Advocacy	Shortfunding of current year exacerbated by increased costs	1,865.0				1,865.0
38	1(a)(6)	Administration	Public Defender	Shortfunding of current year need and fiscal notes	600.0				600.0
39	1(a)(7)	Administration	Public Defender	Mental Health Court attorney approved by the Mental Health Trust			73.0	MHTAAR	73.0

FY2002 SUPPLEMENTALS

	A	B	C	D	E	F	G	H	I
1	Sec. No.	Department	BRU or Component	Supplemental Need	General Funds	Federal Funds	Other Funds	Fund Source	Total Funds
40	1(b)-(c)	Administration	Senior Services	Senior Services Employment Program hold harmless -- Federal regulations not promulgated so funds not needed.	-120.0				-120.0
41	2(a)	Comm & Ec Dev	Alaska Aerospace Development Corporation	Replace \$311.9 of unrealized FY02 Alaska Science & Technology Foundation Investment Earnings with AADC receipts.			0.0		0.0
42	2(a)	Comm & Ec Dev	Alaska Aerospace Development Corporation Facilities Maintenance	Replace \$69.2 of unrealized Alaska Science & Technology Foundation FY02 Investment Earnings with AADC receipts.			0.0		0.0
43	2(b)	Comm & Ec Dev	Power Project Fund	Denali Commission Appropriation to the Power Project Fund		4,900.0			4,900.0
44	2(c)	Comm & Ec Dev	Alaska Aerospace Development Corporation	Grant from the U.S. Department of Defense for Kodiak Launch Complex Improvements- Infrastructure Safety Upgrades, Range Safety System, and Road Improvements		20,000.0			20,000.0
45	3(a)	Corrections	Facility-Capital Improvement Unit	The \$160.5 general fund fiscal note funding Ch. 32, SLA 2001 (HB 149 Private Prison in Kenai) is no longer needed since Kenai voters rejected the proposal. Funds are reappropriated to Inmate Health Care.					0.0
46	3(b)	Corrections	Inmate Health Care	Shortfunding in health care costs resulting from continued inflation of pharmacy costs, staff salaries (includes \$676.0 for health care worker/nurses salary costs), contract physician costs and hospital care.	1,839.5				1,839.5
47	3(c)	Corrections	Parole Board	Shortfunding in operations due to increased prisoner hearings and Parole Board activity AMD Feb 28 Decrease GF by 15.0 from 100.0 to 85.0	85.0				85.0
48	3(d)	Corrections	CIP	Offender Tracking Information System Development		762.0			762.0
49	4	Military & Veterans' Affairs	Disaster Relief Fund	The Disaster Relief Fund directly funds the core services of the Division of Emergency Services, 10 full-time positions and the match for another 10 positions. Fund capitalization to cover the core services costs has been done in the supplemental for sev	680.0				680.0
50	5(a)(1)	Education	Pupil Transportation	Cost for new bus routes approved in current year	541.6				541.6
51	5(a)(2)	Education	Schools for the Handicapped	Education costs for children in state custody who require out-of-state placement	165.5				165.5
52	5(b)	Education	Foundation	Use balance in foundation program resulting from the October student count to fund supplemental needs.	-1,975.9				-1,975.9
53	5(c)	Education	CIP	Federal School Renovation, Individuals with Disabilities Education Act (IDEA) and Technology grants for local school districts		5,400.0			5,400.0
54	5(d)(1)-(2)	Education		Along with a reappropriation of \$198.6 from the Department of Law, this will fund the McGraw-Hill assessment contract increase of \$498.9.	300.3				300.3
55	6	Environ Cons		Amend the FY02 appropriation made by Sec. 89, Ch. 61 for implementation of the cruise ship bill to correct the fund source from statutory designated program receipts to the Commercial Passenger Vessel Environmental Compliance Fund.					0.0
56	7	Natural Resources	Fire Suppression	Fixed costs and fire suppression costs incurred to date. Updated costs for spring fire suppression will be provided as needed	7,235.0				7,235.0

FY2002 SUPPLEMENTALS

	A	B	C	D	E	F	G	H	I
1	Sec. No.	Department	BRU or Component	Supplemental Need	General Funds	Federal Funds	Other Funds	Fund Source	Total Funds
	8(a) - (b)	Fish & Game	CIP	Change fund source on \$26.2 due to shortfall in Commercial Fisheries Limited Entry Commission (CFEC) collections - Dock replacement in King Salmon. (SDPR from NTSC - see line 6)				Rcpt Supp Svcs to Statutory Designated Prog Rcpts	0.0
57								same	0.0
58	8(a) - (b)	Fish & Game	CIP	Change fund source on \$78.8 due to CFEC shortfall - Statewide facilities repair & maintenance. (SDPR from NTSC - see line 6)				same	0.0
	8(a) - (b)	Fish & Game	CIP	Change fund source on \$145.0 due to CFEC shortfall - Upper Cook Inlet and Kuskokwim River Coho projects. (SDPR from NTSC - see line 6)				same	0.0
59								same	0.0
60	8(a) - (b)	Fish & Game	CIP	Change fund source on \$63.0 on FY01 CIP project due to CFEC shortfall - Copper River (Miles Lake) Sonar. (SDPR from NTSC - see line 6)				same	0.0
61	8(a) - (b)	Fish & Game	CIP	Change fund source on \$88.5 due to CFEC shortfall - Mariculture development program. (SDPR from NTSC - see line 6)				same	0.0
62	8(a) - (b)	Fish & Game	CIP	Change fund source on \$200.0 due to CFEC shortfall - Vessel and aircraft repair and maintenance. (SDPR from NTSC - see line 6)				same	0.0
63	9(a)	Governor	Elections	Redistricting: add carryforward language for the remaining balance of the \$947.4 appropriation made in Sec. 20, Ch. 60, SLA 2001					0.0
64	9(b)	Governor		Correct a drafting error in Sec. 36(c), Ch. 61 by adding reference to fiscal year 2001.					0.0
65	9(c)	Governor	Governmental Coordination	Change RPL 01-2-8022 Coastal Impact Assistance Program from Operating to Capital					0.0
66	9(d)	Governor	CIP Governmental Coordination	Additional authorization for the Coastal Impact Assistance Program			3,335.7		3,335.7
67	10(a)(1)	Health & Soc Svcs	Adult Public Assistance	Formula program caseload growth	541.0				541.0
68	10(a)(2)	Health & Soc Svcs	Board on Alcohol & Drug Abuse	Cost of co-locating with AK Mental Health Board			40.9	MHTAAR	40.9
69	10(a)(3)	Health & Soc Svcs	Bureau of Vital Statistics	Increased receipt supported services authority so general funds can be transferred to Community Health/Emergency Medical Services for two-way radio costs			75.0	Rcpt Supp Svcs	75.0
70	10(a)(4)	Health & Soc Svcs	Foster Care Special Needs	Shortfunding of formula program from caseload growth projections	304.6				304.6
71	10(a)(5)	Health & Soc Svcs	General Relief Assistance	Formula program growth	190.7				190.7
72	10(b)	Health & Soc Svcs	Comm Health/EMS	Correct HB 228 Sale of Tobacco Products fiscal note fund source from Tobacco Settlement to Tobacco Use Cessation and Education Fund	-487.9		487.9	Tobacco Use Cessation & Ed Fund	0.0
73	11	Law		Judgments and Claims \$810,486.85 AMD Feb 28 Decrease GF by 31.5 from 631.5 to 600.5	600.5		185.0	PERS Fund	785.5
74	12(a)	Law		Law Office Assistant reclassification costs		1.7	129.4	Inter-Agency Rcpts	131.1
75	12(b)	Law		Fund the \$214.4 general fund portion of the Law Office Assistant reclassification costs with the reappropriation of funds within the Department of Law					0.0

FY2002 SUPPLEMENTALS

	A	B	C	D	E	F	G	H	I
1	Sec. No.	Department	BRU or Component	Supplemental Need	General Funds	Federal Funds	Other Funds	Fund Source	Total Funds
	13	Military & Vets	Army Guard Facilities Maintenance	Federal funds for increased telecommunications costs for the Distance Learning project		350.0			350.0
76									
77	14(1)	Natural Resources	Geological Development	Federal grant awards for geological projects		493.4			493.4
78	14(2)	Natural Resources	Parks Mgmt	Increased fuel costs	20.2				20.2
79	14(3)	Natural Resources	Parks Mgmt	Increased costs for two-way radio circuits	40.7				40.7
80	14(4)	Natural Resources	Recorder's Office	Costs of title records for new title companies. Title insurance laws require companies to have duplicate records for the past 25 years.			300.0	Statutory Designated Prog Rcpts Rcpt Supp Svcs	300.0
81	14(4)	Natural Resources	Recorder's Office	Assume recording duties in Valdez, Glennallen, and Seward that were previously done by the Courts System without charge. Increased costs to process heavy volume of mortgage refinance activity and implement completed classification study.			235.0		235.0
82	15(a)(1)	Public Safety	AST	Increased fuel costs	106.1				106.1
83	15(a)(2)	Public Safety	AST- Prisoner Transport	Increased prisoner transports based on higher volume of cases	172.9				172.9
84	15(a)(3)	Public Safety	AST Detachments	Increased fuel costs	125.3				125.3
85	15(a)(4)	Public Safety	AST Detachments	Recruitment Academy Training	81.0				81.0
86	15(a)(5)	Public Safety	AST Detachments	Standby pay due to heightened security	67.5				67.5
87	15(a)(6)	Public Safety	AST	Standby pay due to heightened security	15.7				15.7
88	15(a)(7)	Public Safety	VPSO	Standby pay due to heightened security	11.8				11.8
89	15(a)(8)	Public Safety	AST Detachments	Emergency guard hires needed to guard offenders in areas with no jails.	59.0				59.0
90	15(a)(9)	Public Safety	AST Detachments	Medical examination costs for sexual assault/abuse cases AMD Feb 28 Increase GF by 57.5 from 30.0 to 87.5	87.5				87.5
91	15(a)(10)	Public Safety	AST Detachment's	Increased costs for two-way radio circuits	102.4				102.4
92	15(a)(11)	Public Safety	Fish & Wildlife	Increased fuel costs	247.4				247.4
93	15(b)	Public Safety	Batterers Intervention Program	Fund source change to correct the overallocation of PFD felon funds in FY2002.	63.9		-63.9	PFD Fund	0.0
94	16(a)(1)	Revenue	Alcohol Beverage Control Board	Contractual costs for a hearing officers to conduct formal hearings on liquor licenses	20.0			General Fund Program Rcpts	20.0
95	16(a)(2)	Revenue	Permanent Fund Dividend Division	Legal costs awarded by state Supreme Court in a class-action suit filed on behalf of applicants denied dividends.			89.9	PFD Fund	89.9
96	16(a)(3)	Revenue	Permanent Fund Dividend Division	Overtime costs to resolve eligibility review and appeal case backlog.			31.9	PFD Fund	31.9
97	16(b)	Revenue	Child Support Enforcement	Recover cost of increased number of paternity testings required by court orders.	43.0				43.0
98	16(c)	Revenue	Child Support Enforcement	Appropriation of interest earned on reserve account balance	60.0				60.0
99	16(d)	Revenue	Treasury Division	Correct fund source for Ch 60, SLA 2000 PCE Fund/Sale of 4 Dam Pool/Energy (HB 446) fiscal note.					0.0

FY2002 SUPPLEMENTALS

	A	B	C	D	E	F	G	H	I
1	Sec. No.	Department	BRU or Component	Supplemental Need	General Funds	Federal Funds	Other Funds	Fund Source	Total Funds
	16(e)	Revenue	Treasury Division	Repeal fiscal note funding for Ch. 32, SLA 2001 (HB 149 Kenai Private Prison) since Kenai voters did not approve the private prison development.	-20.0				-20.0
100									
101	17(a)	Transportation	Central Region Highways & Aviation	Whittier Tunnel Maintenance and Operations for June 7-30 (current contract expires)			178.0	Rcpt Supp Svcs	178.0
102	17(b)(1)	Transportation	Central Region Facilities	Fuel and Utility Cost Increases	240.9				240.9
103	17(b)(2)	Transportation	Northern Region Facilities	Fuel and Utility Cost Increases	230.6				230.6
104	17(b)(3)	Transportation	Southeast Region Facilities	Fuel and Utility Cost Increases	140.3				140.3
105	17(b)(4)	Transportation	Central Region Highways & Aviation	Fuel and Utility Cost Increases	381.0				381.0
106	17(b)(5)	Transportation	Northern Region Highways & Aviation	Fuel Cost Increases	569.2				569.2
107	17(b)(6)	Transportation	Southeast Region Highways & Aviation	Fuel Cost Increases	39.2				39.2
108	17(c)(1)	Transportation	Ted Stevens Anchorage International Airport (TSAIA) Administration	Utility Cost Increases			10.0	Internat'l Airports Rev Fund	10.0
109	17(c)(2)	Transportation	TSAIA Facilities	Utility Cost Increases			467.0	Internat'l Airports Rev Fund	467.0
110	17(c)(3)	Transportation	TSAIA Field & Equipment Maintenance	Utility Cost Increases			60.0	Internat'l Airports Rev Fund	60.0
111	17(c)(4)	Transportation	TSAIA Safety	Utility Cost Increases			8.0	Internat'l Airports Rev Fund	8.0
112	17(d)	Transportation	State Equipment Fleet Administration	Add authority for increased usage of fuel credit card system			250.0	Highway Working Capital Fund	250.0
113	17(e)(1)	Transportation		Glenn Highway Rut Repair from McCarrey St to Highland Rd.		6,000.0			6,000.0
114	17(e)(2)	Transportation		Dimond Boulevard Rut Repair		6,000.0			6,000.0
115	17(e)(3)	Transportation		Hillcrest (Anchorage) Bridge Repair- 3rd party repayment for damages. AMD Feb 28 Deleted request for \$150.0 GFPR				General Fund Program Rcpts	0.0
116	17(e)(4)	Transportation		Northern Region Materials Lab Worker Safety Compliance Upgrade. (SDPR from NTSC - see line 6)			600.0	Statutory Designated Prog Rcpts	600.0

FY2002 SUPPLEMENTALS

	A	B	C	D	E	F	G	H	I
1	Sec. No.	Department	BRU or Component	Supplemental Need	General Funds	Federal Funds	Other Funds	Fund Source	Total Funds
	18(a)-(d)	University	CIP	Eliminate federal receipts since funding source was changed to university receipts via RPL 45-2-0007 for Arctic Supercomputer purchase.		-32,000.0			-32,000.0
117									
118	18 (e)	University		Replace unrealized investment earnings from the Alaska Science and Technology Foundation	1,753.3		-1,753.3	ASTF	0.0
119	19	Misc Claims	Administration	Miscellaneous Claims: -0-, State-dated warrants: 23,744.07	23.7				23.7
120	19	Misc Claims	Corrections	Miscellaneous claims: \$3,204.11	3.2				3.2
121	19	Misc Claims	Fish & Game	Miscellaneous claims: \$3,761 00	3.8				3.8
122	19	Misc Claims	Health & Soc Srvc	Miscellaneous claims: \$21,499.91	21.5				21.5
123	19	Misc Claims	Law	Miscellaneous claims: \$27,060.49	27.1				27.1
124	19	Misc Claims	Military & Veterans' Affairs	Miscellaneous claims: \$274.00	0.3				0.3
125	19	Misc Claims	Public Safety	Miscellaneous claims: \$293.88	0.3				0.3
126	19	Misc Claims	Transportation	Miscellaneous claims: \$32.96					0.0
127				REGULAR SUPPLEMENTAL BILL TOTAL	18,831.5	15,242.8	1,403.8		35,478.1
128									
129	TOTAL FOR BOTH BILLS MINUS THE \$16.5m GF PLACEHOLDER IN FISCAL SUMMARY				22,179.9	121,860.8	34,692.9		178,733.5
130									
131				Ratifications:					
132	20(a)(1)	Transportation		AR 61669-2001 Reimbsble Authority	165,066.62				
133	20(a)(2)	Transportation		AR 64790-2015 Reimbursable Authority	34,614.23				
134	20(a)(3)	Transportation		AR 58904-2001 Reimbursable Proj.	96,773.16				
135	20(b)	Natural Resources	Fire Suppression	FY2001 Fire suppression costs AR 37313-01 Fire Suppression	4,730,000.00				
136	21			Lapse Provisions					
137	22			Retroactivity					
138	23			Effective Dates					
139	24			Immediate Effective Date					

STATE OF ALASKA /

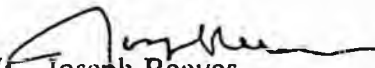
DEPARTMENT OF CORRECTIONS

MEMORANDUM

Division of Administrative Services
Budget and Finance
P.O. Box 112000
Juneau, Alaska 99811-2000
Phone (907) Fax (907)

TO: Annalee McConnell, Director
Office of Management and Budget

DATE: February 26, 2002

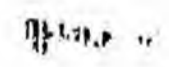
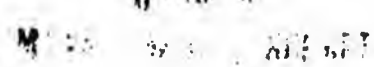
FROM:  Joseph Reeves
Deputy Director
Division of Administrative Services

PHONE:
SUBJECT: *FY2002 Parole Board
Supplemental - Amendment*

Current projections for the Parole Board component indicate that the supplemental request of \$100.0 can be reduced to \$85.0.

The reduction of \$15.0 in contractual line is due to the Board being one member short. There have been only four board members for a period of time and that has reduced board member compensation.

cc: Dwayne Peeples, Director, Division of Administrative Services
Sharleen Griffin, Budget and Finance Manager, Division of Administrative Services



FEB 27 2002

MEMORANDUM

State of Alaska
Department of Law
Division of Administrative Services

TO: Annalee McConnell, Director
Office of Management and Budget

DATE: 20 February, 2002

FROM: Kathryn Daughhete, Director *Kad*
Division of Administrative Services

PHONE: 465-3673

SUBJECT: FY 2002 Supplemental Items

FY 2002 Judgments and Claims

The attached schedules, totaling \$785,440.55 reflects the current level of judgments and claims awaiting legislative appropriation. The funds for this request are as follows:

\$600,440.55 General Fund
\$185,000.00 PERS Fund

While the latest version of the schedule of items to be paid from the general fund does contain recently submitted judgments and claims, the amount overall has been reduced to reflect our withdrawal of the attorney's fees and costs awarded by the Ninth Circuit Court of Appeals in re: Doe v. Otte – the appeal challenging the application of the sex offender registration law to sex offenders who committed their offenses before the effective date of the statute. As you are now most certainly aware, the Supreme Court has granted our request for certiorari in this case. As a result, the Appeals Court award is not ripe for payment at this time.

cc: Bruce Botelho, Attorney General
Barbara Pitchie, Deputy Attorney General, Civil Division
Cynthia Cooper, Deputy Attorney General, Criminal Division
Dean Guaneli, Chief Assistant Attorney General, Criminal Division

Department of Law

FY2002 Judgments & Claims - General Funds

Case #	Case Name	Description	Date	Amount	Interest	Total	Cumulative Total
1	ACLU Planned Parenthood of Alaska, et al v. Commissioner Perdue/DHSS	Challenge to legislative elimination of funding for the General Relief Medical Program	10/9/99 01/05/01 - 09/20/01	\$236,026.16	\$33,882.51	\$269,908.67	
2	Foster Pepper Rubini & Reeves ACLU v. State	Challenge to 1996 campaign finance reform legislation	4/27/00 08/30/01	\$107,954.28	\$23,706.39	\$131,660.67	
3	Steven D. Smith, P.C. CSED v. Ragula	Child support lien and withholding lien vs. attorney's lien	6/30/00 9/27/01	\$2,344.08	\$268.48	\$2,612.56	
4	Michael Gershel, Esq. Brooker v. Brooker	Agreements between private parties not involving CSED	10/30/01	\$525.00	\$31.46	\$556.46	
5	Hagans, Ahearn, McLaughlin & Webb Herold v. State	Wrongful termination	1/2/02	\$80,000.00	\$0.00	\$80,000.00	
6	Alaska Legal Services Corporation Quinagak v. U.S.	Subsistence jurisdiction over navigable rivers	9/30/96 10/24/00	\$82,525.07	\$16,955.56	\$99,480.63	
7	Marston & Cole Trust Fund Thomas Brown v. DMV	Right to due process re: telephonic testimony in driver's license revocation administrative hearing	1/7/02	\$414.43	\$52.81	\$467.24	
8	Kasmar & Stone JTF Peter T. Knight Peter T. Knight v. DMV	Right to due process re: telephonic testimony in driver's license revocation administrative hearing	1/7/02	\$873.20	\$17.69	\$890.89	
9	Randall Luffberry, Esq. ITF Donald A. Ryall Donald Ryall v. DMV	Challenge to administrative revocation of driver's license	10/31/01	\$1,262.14	\$75.31	\$1,337.45	
10	Ingaldson Maassen, P.C. ITF Nicholas Digel Nicholas Digel v. DMV	Reversal of administrative revocation of driver's license due to supreme court striking down "use it and lose it" law	5/7/01	\$229.01	\$23.66	\$252.67	
11	Larry L. Caudle Brandon Garrett v. DMV	Reversal of administrative revocation of driver's license due to supreme court striking down "use it and lose it" law	5/7/01	\$536.50	\$64.55	\$601.05	

Department of Law

FY2002 Judgments & Claims - General Funds

Item #	Case Name	Description	Date	Amount	Interest	Total	Cumulative Total
12	Bankston, Gronning et.al, P.C. ITF for Melissa Witteveen Melissa Witteveen v. DMV	Reversal of administrative revocation of driver's license due to supreme court striking down "use it and lose it" law	5/11/01	\$500.00	\$51.16	\$551.16	
13	Richard Brandon v. Corrections	Ambiguity as to filing fee deadline in inmate civil case	9/4/01	\$87.00	\$7.48	\$94.48	
14	Foster, Pepper, Rubini & Reeves Ulmer v. Alaska Restaurant and Beverages	Challenge to ballot initiative increasing state's liquor taxes	11/9/01	\$1,595.67	\$91.67	\$1,687.34	
15	Volland & Taylor, P.C. Cleary v. Smith	Monitoring, compliance and enforcement of the Final Order in prisoner class action	1/24/02	\$9,892.48	\$446.79	\$10,339.27	\$600,440.55

Department of Law

FY 2002 Judgments - Other Fund Sources

Item #	Case Name	Description	Date	Amount	Interest	Total	Fund Source
1	Dennis Bailey, Esq. ITF Terri Hale Terri Hale v. State, PERS	Settlement in occupational disability case	10/11/01	\$185,000.00	\$0.00	\$185,000.00	PERS Fund

Department of Law

JUDGMENTS/CLAIMS/SETTLEMENTS FOR PAYMENT

(Please Type)

**This form will be used for the purpose of standardizing the submission of claims to the Legislature. Complete and accurate information will expedite payment to the claimants, thereby reducing the amount of interest required to be paid by the state. If any of the information changes, please immediately advise the Director, Administrative Services Division, P.O. Box 110300, Juneau, AK 99811, or call (907) 465-3673.

PART ONE

1. **Case Name:** Cleary v. Smith
2. **Case Number:** 3AN-81-5274 Civil
3. **Judge/Justices:** Elaine Andrews
4. **Date Judgment entered:** January 24, 2002
5. **Did the date of the cause of action accrue on or after August 7, 1997?** No.
6. **Amount to be paid:** \$9,892.48
7. **Interest Rate:** 10.5% **Effective Date:** January 24, 2002
8. **Requested hourly rate and total compensation of attorneys to be paid:**
64.1 hours at \$145/hr = \$ 9,294.50

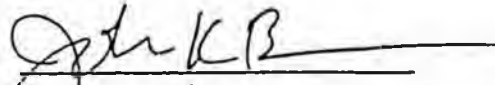
Costs	\$ 597.98
Total fees and costs	\$ 9,892.48
9. **Court approved/ordered hourly rate and total compensation of attorneys to be paid:**
As requested, above.
10. **Payable to:** Volland & Taylor, P.C.
211 H Street
Anchorage, AK 99501
11. **EIN:** 92-0076898 **or** **SSN:**

12. Send check to: _____ above address

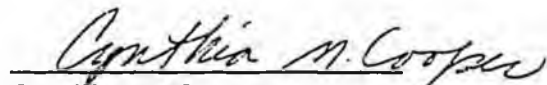
Departmental contact: XX

Departmental attorney contact:

Departmental Approval:



John K. Bodick
Assistant Attorney General



Cynthia M. Cooper
Deputy Attorney General

(907)269-6379

Telephone Number

2/3/02

Date

Department of Law

JUDGMENT/SETTLEMENT FUNDING REQUEST
QUESTIONNAIRE

PART TWO

The following information needs to be provided on all judgment awards and/or settlements made against the State.

Case Name: Cleary v. Smith

Case No.: 3AN-81-5274 Civil

1. Describe the circumstances or events resulting in this case and ultimately this judgment/settlement against the State.

The trial court found that the Final Order in this prisoner class action required payment of attorney's fees and costs incurred by counsel in monitoring compliance and enforcement of the Final Order. This particular attorney fee is for work performed on behalf of Subclasses A and B to enforce compliance with the Final Order, to determine the effect the Alaska Prison Litigation Reform Act (PLRA), AS 09.19.200, has on the Final Order, and in regard to the end of court monitoring and the role of counsel.

2. Describe issues of State policy or law involved in this case, if they are relevant to and resulted in substantial effort and expense for the department to bring or defend this case.

The case involves issues regarding conditions of confinement of male prisoners which resulted in a Final Order and is still subject to court overview and enforcement. Most recently, the case included issues regarding the extent to which legislation, specifically the Alaska PLRA, can override existing court judgments.

3. Did the State prevail on any issues? If so, describe.

Yes. The state moved to dismiss this case under the Alaska PLRA and the court issued a preliminary order upholding the constitutionality of the statute. The court has not yet entered a full opinion so the extent to which the state prevailed remains unclear. The court did end all court monitoring of Department affairs and dismissed class counsel.

4. Did we challenge plaintiffs' request for costs and fees or in other ways seek to reduce the costs to the State? If so, describe to what extent we were successful.

No grounds existed to challenge plaintiff's fees and costs which were necessary to secure the dismissal of class counsel and the end to court monitoring.

5. What was the source of the State's liability in this case?

The Department of Corrections entered into a Final Settlement Agreement and Order to settle prisoner class action claims in 1990 which is still binding on the state but limited in application by the Alaska PLRA.

6. What, if any, preventative action has been taken by the involved agency to prevent or reduce the potential for such liability in the future?

The Department of Corrections has worked to attain full compliance with the Final Order and the Department of Law has moved to terminate the Final Order under the Alaska PLRA.

7. If the information is available to you, has the agency involved taken any corrective action as a result of this case? If the information is not protected from publication by statute, privilege, or right to privacy, indicate what the corrective action was.

This case is now inactive as court oversight has ended. To achieve this result, the Department of Corrections managed its state-wide prison population to remain below court-imposed capacities and contracted with the Corrections Corporation of America to house Alaska prisoners at a facility located in Arizona.

8. Any recommendations concerning cases of this type in the future?

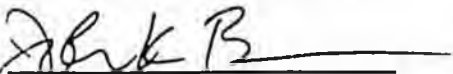
Cases regarding injunctive relief for prisoners should be reviewed and evaluated with reference to the Alaska PLRA, AS 09.19.200.

9. Any recommendations for changes in statutes, regulations or policy? Cite any applicable statutes or regulations.

Not at this time. The legislature passed the PLRA in 1999.

Attorney completing form:

Date: 1-31-02


John K. Bodick
Assistant Attorney General

Phone Number : (907)269-6379

IN THE SUPERIOR COURT FOR THE STATE OF ALASKA
THIRD JUDICIAL DISTRICT AT ANCHORAGE

MICHAEL CLEARY, *et al.*,

Plaintiffs,

vs.

ROBERT SMITH,

Defendants.

Case No. 3AN-81-5274 CI

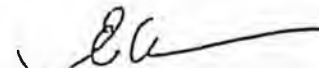
ORDER

Upon review of Plaintiffs' Motion for Attorneys' Fees and Costs, defendants' opposition, if any, and the record on file herein, and good cause appearing therefor,

IT IS HEREBY ORDERED that plaintiffs are awarded the sum of \$9,892.48 from defendants for full payment of attorneys' fees and costs incurred by the offices of Volland & Taylor, P.C., in representing plaintiffs from January 1, 2001, through November 20, 2001.

DATED at Anchorage, Alaska this 24 day of Jan, 2001.

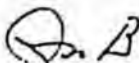
BY THE COURT


Elaine Andrews
Judge of the Superior Court

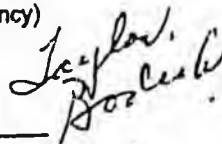
LAW OFFICES
VOLLAND & TAYLOR
A PROFESSIONAL CORPORATION
211 H STREET
ANCHORAGE, AK 99501
(907) 276-5231

I certify that on 1/25/01 a copy
of the above was mailed to each of the following at
their addresses of record (list names if not an agency)

CSED AG PD DA



Administrative Assistant



IN THE SUPERIOR COURT FOR THE STATE OF ALASKA
THIRD JUDICIAL DISTRICT AT ANCHORAGE

MICHAEL C'LEARY, *et al.*,

Plaintiffs,

vs.

ROBERT SMITH, *et al.*,

Defendants.

Case No. 3AN-81-5274 CI

JUDGMENT

IT IS HEREBY ORDERED that judgment is entered against defendant State of Alaska for the sum of \$9,892.48 for full payment of attorneys' fees and costs incurred by the offices of Volland & Taylor, P.C., in representing plaintiffs from January 1, 2001, through November 20, 2001.

This judgment shall bear interest entered at the rate of 10.5% per annum.

DATED at Anchorage, Alaska this 21 day of Jan, 2002

BY THE COURT

(Elaine Andrews)
Elaine Andrews
Judge of the Superior Court

LAW OFFICES
VOLLAND & TAYLOR
A PROFESSIONAL CORPORATION
211 H STREET
ANCHORAGE, AK 99501
(907) 276-5231

I certify that on 1/31/02 a copy
of the above was mailed to each of the following at
their addresses of record (list names if not an agency)

CSED AG PD DA

(Signature)
Administrative Assistant

(Signature)
Taylor
Boeck

MEMORANDUM

STATE OF ALASKA

*Department of Public Safety
Division of Administrative Services*

To: Annalee McConnell
Director
Office of Management & Budget
Office of the Governor

Date: February 26, 2002

From: Karen Morgan *Karen R. Morgan*
Director
Division of Administrative Services
Department of Public Safety

Phone: 465-5488

Subject: FY02 Supplemental
Budget Request

The Department of Public Safety respectfully requests that the FY 2002 Supplemental Budget Request be amended from \$30.0 to \$87.5 to fully fund forensic examinations related to sexual assault and sexual abuse of minors in the Alaska State Trooper Detachment BRU.

This \$57.5 increase is expected to fund unanticipated costs as a result of implementing Chapter 57, SLA 2000. This legislation states that sexual assault victims will not be required to pay for the costs associated with examinations. Prior to its enactment, the State of Alaska did not receive bills from some hospitals for the costs associated with these exams. Since the Department did not receive bills in the past, it was not possible to anticipate the total costs associated with these examinations.

cc: Commissioner Glenn G. Godfrey
Department of Public Safety

MEMORANDUM


State of Alaska
Department of Transportation & Public Facilities
Commissioner's Office

TO: Annalee McConnell, Director
Office of Management and Budget

DATE: February 21, 2002

FAX NO: (907) 586-8365

TELEPHONE NO: (907) 465-3900


FROM: Joseph L. Perkins, P.E.
Commissioner

SUBJECT: Amend Supplemental
request for FY2002

The Department of Transportation and Public Facilities (DOT&PF) is requesting an amendment to an FY2002 capital budget supplemental item contained in HB 415 and SB 292. The \$150,000 general fund program receipts request for Hillcrest Bridge repair, contained in Section 17 (e)(3) can be deleted. This appropriation is no longer needed. The insurance company representing the driver of the vehicle causing the bridge damage will be dealing directly with the contractor regarding the necessary repair work.

If you have any questions or need further information, please contact Nancy Slagle at 465-3911.

cc: Nancy Slagle, Administrative Services Director
Kurt Parkan, Deputy Commissioner
Dave Eberle, Regional Director, Central Region
Tom Brigham, Statewide Planning

STATE OF ALASKA

OFFICE OF THE GOVERNOR

OFFICE OF MANAGEMENT AND BUDGET

TONY KNOWLES, GOVERNOR

P.O. BOX 110020
JUNEAU, ALASKA 99811-0020
PHONE: (907) 465-4660
FAX: (907) 465-3008

March 5, 2002

The Honorable Dave Donley
The Honorable Pete Kelly
The Honorable Eldon Mulder
The Honorable Bill Williams
Alaska State Legislature
State Capitol
Juneau, AK 99801

Dear Finance Committee Co-Chairs:

Please consider the following amendment to the regular supplemental bills, SB 292 and HB 415:


Amend section 11, Judgments and Claims, to read as follows:

Sec. 11. JUDGMENTS AND CLAIMS. The sum of 792,000 [\$785,500] is appropriated to the Department of Law to pay judgments and claims against the state for the fiscal year ending June 30, 2002, from the following sources in the amounts listed:

SOURCE	AMOUNT
General fund	607,000 [600,500]
Public Employees Retirement Trust Fund	185,000

Back-up information on the amendment is attached along with an updated spreadsheet. If you have any questions, please call me (465-4660) or Joan Brown (465-4681).

Sincerely,


for Annalee McConnell
Director

Attachments

cc: David Teal
Legislative Finance

FY2002 SUPPLEMENTALS

	A	B	C	D	E	F	G	H	I
1	Sec. No.	Department	BRU or Component	Supplemental Need	General Funds	Federal Funds	Other Funds	Fund Source	Total Funds
2	FAST TRACK SUPPLEMENTAL								
3	1	Court System	Judicial Conduct	Legal fees in excess of FY2001 supplemental. Actual amount is \$6829.77.	6.8				6.8
4	2(a)	Comm & Ec Dev	Alaska Science & Technology Foundation	Idaho National Engineering and Environmental Laboratory Grant Contract for Alaska Business Research. Funds are available March 1, 2002.			25.0	Statutory Designated Prog Rcpts	25.0
5	2(b)	Comm & Ec Dev	International Trade & Business Development	International Trade and Business Endowment - replace unrealized FY02 Investment Earnings - Fund Source Change	230.4		-230.4	Internal'l Trade and Dev. Fund Earnings Reserve	0.0
6	3	Corrections	Palmer Correctional Center	New well including pump and wellhouse as primary water well has failed and is nonrepairable. Statutory designated program receipts (SDPR) are from interest earnings of Northern Tobacco Securitization Corporation (NTSC).			172.2	Statutory Designated Prog Rcpts	172.2
7	4(a)	Health & Soc Svcs	Medicaid Services	Medicaid Services - Projected to run out April 16. \$4.57m GF is for FY2001 bills paid in FY2002; 1.8m GF is from underfunding last year below low case scenario; 6.34m GF is for caseload at mid-case range and cost increases, particularly for seniors and disabled.	12,712.5	106,618.0	23,903.3	Statutory Designated Prog Rcpts	143,233.8
8	4(b)	Health & Soc Svcs	Subsidized Adoptions & Guardianship	Formula program caseload growth	2,529.6				2,529.6
9	5	Transportation	Marine Highway Stabilization Fund	Marine Highway Stabilization Fund FY02 deficit due to Columbia fire and fuel cost increases. If not funded, Spring/Summer service would need to be drastically cut, reducing revenues during highest revenue season. Ships would be put into lay-up status for extended periods.	2,876.9				2,876.9
10	6	Military & Vets	Disaster Planning & Control	Costs to maintain 24-hour State Emergency Coordination Center (SECC), the agency that coordinates all federal, state and local jurisdictional responses associated with any disaster or event.	100.0				100.0
11	7	Natural Resources	CIP	Scope change for SLA97, CH50, Sec 15(k), P9, L13 - from prepare and administer the Kalgin Island II, Caribou Hills, S. Ninilchik-Dome View, South Ninilchik Bldg timber sales in Kenai Peninsula to Kenai Peninsula to reduce risks from wildfire.					0.0
12	8	Governor	Elections	Costs for printing and mailing a Primary Election Voter Education Guide in time to explain the new law (shifted from FY2003 budget which will be amended)	25.0				25.0
13	9(a)	Comm & Ec Dev	Power Cost Equalization & Rural Electrification Fund	Technical correction to add the inadvertently omitted FY02 appropriation from the Power Cost Equalization Endowment fund to the Power Cost Equalization and Rural Electrification Fund			7,062.2	PCE EF	7,062.2
14	9(b)	Comm & Ec Dev	Power Cost Equalization & Rural Electrification Fund	Fully fund the statutory formula in the PCE statute. Cost increase is due to higher fuel costs.	1,100.0				1,100.0

FY2002 SUPPLEMENTALS

	A	B	C	D	E	F	G	H	I
1	Sec. No.	Department	BRU or Component	Supplemental Need	General Funds	Federal Funds	Other Funds	Fund Source	Total Funds
15	9(c)	Comm & Ec Dev	Power Cost Equalization	Fully fund PCE statute. Increase due to higher fuel costs.			1,100.0	PCE	1,100.0
16	9(d)(1)	Comm & Ec Dev	Power Cost Equalization	Delete sufficient authorization from FY02 to pay FY01 late bills			-56.8	PCE	-56.8
17	9(d)(2)	Comm & Ec Dev	Power Cost Equalization	Add authorization to pay power cost equalization program FY01 late bills			56.8	PCE	56.8
18	10(a)(1)	Transportation	Northern Region Highways & Aviation	Charidalar (James Dalton Hwy) Maintenance Station Replacement- Temporary rental and other costs of vacating the maintenance station due to imminent structural failure.	127.8				127.8
19	10(a)(2)	Transportation	Central Region Highways & Aviation	East Fork (Parks Hwy- S of Cantwell) Maintenance Station Replacement- Temporary rental and other costs of vacating the maintenance station due to imminent structural failure.	21.9				21.9
20	10(a)(3)	Transportation	Central Region Highways & Aviation	Willow (Parks Hwy) Maintenance Station Replacement- Temporary rental and other costs of vacating the maintenance station due to imminent structural failure.	45.5				45.5
21	10(a)(4)	Transportation	Northern Region Highways & Aviation	Nome Maintenance Station Imminent Structural Failure - Temporary rental and other costs of vacating the maintenance station to due imminent failure.	72.0				72.0
22	10(b)	Transportation	Northern Region CIP	Chandalar Maintenance Station Replacement Design Costs (SDPR from NTSC - see line 6)			456.8	Statutory Designated Prog Rcpts	456.8
23	10(c)	Transportation	Southeast Region CIP	Title change from West Douglas Highway Extension to Gastineau Channel Second Crossing to match federal project name change					0.0
24	11(a)	University	Systemwide Small Planning, Design and Construction	Funding authority needed in excess of the FY02 small project non-gf receipt authority for Lena Point fisheries and ocean sciences facility for simultaneous excavation with NOAA to prevent disruption and damage to the facility at a later date.			800.0	UA Rcpts	800.0
25	11(b)	University	CIP	Scope Change for Sec 3, Ch 61, SLA 2001 to include UAA Heating, Ventilation, and Air Conditioning Piping Replacement Phases 1-4					
26	12			Lapse Provisions					
27	13			Retroactivity					
28	14			Effective Date					
29	FAST TRACK BILL TOTAL				19,848.4	106,618.0	33,289.1	0.0	159,755.5
30	[REDACTED]								
31	[REDACTED]								
32	REGULAR SUPPLEMENTALS								
33	1(a)(1)	Administration	Finance	Contractual costs for maintenance of the State payroll system (AKPAY) core database	150.0				150.0
34	1(a)(2)	Administration	General Relief	Shortfunding for projected caseload	273.0				273.0
35	1(a)(3)	Administration	Leasing	Shortfunding of the amount required to pay leases with the private sector	1,300.0				1,300.0
36	1(a)(4)	Administration	Leasing	FY02 appropriation for the Anchorage Jail lease is short \$4,784.38	4.8				4.8
37	1(a)(5)	Administration	Office of Public Advocacy	Shortfunding of current year exacerbated by increased costs	1,865.0				1,865.0
38	1(a)(6)	Administration	Public Defender	Shortfunding of current year need and fiscal notes	600.0				600.0
39	1(a)(7)	Administration	Public Defender	Mental Health Court attorney approved by the Mental Health Trust			73.0	MHTAAR	73.0

FY2002 SUPPLEMENTALS

	A	B	C	D	E	F	G	H	I
1	Sec. No.	Department	BRU or Component	Supplemental Need	General Funds	Federal Funds	Other Funds	Fund Source	Total Funds
40	1(b)-(c)	Administration	Senior Services	Senior Services Employment Program hold harmless -- Federal regulations not promulgated so funds not needed.	-120.0				-120.0
41	2(a)	Comm & Ec Dev	Alaska Aerospace Development Corporation	Replace \$311.9 of unrealized FY02 Alaska Science & Technology Foundation Investment Earnings with AADC receipts.			0.0		0.0
42	2(a)	Comm & Ec Dev	Alaska Aerospace Development Corporation Facilities Maintenance	Replace \$69.2 of unrealized Alaska Science & Technology Foundation FY02 Investment Earnings with AADC receipts.			0.0		0.0
43	2(b)	Comm & Ec Dev	Power Project Fund	Denali Commission Appropriation to the Power Project Fund		4,900.0			4,900.0
44	2(c)	Comm & Ec Dev	Alaska Aerospace Development Corporation	Grant from the U.S. Department of Defense for Kodiak Launch Complex Improvements- Infrastructure Safety Upgrades, Range Safety System, and Road Improvements		20,000.0			20,000.0
45	3(a)	Corrections	Facility-Capital Improvement Unit	The \$160.5 general fund fiscal note funding Ch. 32, SLA 2001 (HB 149 Private Prison in Kenai) is no longer needed since Kenai voters rejected the proposal. Funds are reappropriated to Inmate Health Care.					0.0
46	3(b)	Corrections	Inmate Health Care	Shortfunding in health care costs resulting from continued inflation of pharmacy costs, staff salaries (includes \$676.0 for health care worker/nurses salary costs), contract physician costs and hospital care.	1,839.5				1,839.5
47	3(c)	Corrections	Parole Board	Shortfunding in operations due to increased prisoner hearings and Parole Board activity AMD Feb 28 Decrease GF by 15.0 from 100.0 to 85.0	85.0				85.0
48	3(d)	Corrections	CIP	Offender Tracking Information System Development		762.0			762.0
49	4	Military & Veterans' Affairs	Disaster Relief Fund	The Disaster Relief Fund directly funds the core services of the Division of Emergency Services, 10 full-time positions and the match for another 10 positions. Fund capitalization to cover the core services costs has been done in the supplemental for several years.	680.0				680.0
50	5(a)(1)	Education	Pupil Transportation	Cost for new bus routes approved in current year	541.6				541.6
51	5(a)(2)	Education	Schools for the Handicapped	Education costs for children in state custody who require out-of-state placement	165.5				165.5
52	5(b)	Education	Foundation	Use balance in foundation program resulting from the October student count to fund supplemental needs.	-1,975.9				-1,975.9
53	5(c)	Education	CIP	Federal School Renovation, Individuals with Disabilities Education Act (IDEA) and Technology grants for local school districts		5,400.0			5,400.0
54	5(d)(1)-(2)	Education		Along with a reappropriation of \$198.6 from the Department of Law, this will fund the McGraw-Hill assessment contract increase of \$498.9.	300.3				300.3
55	6	Environ Cons		Amend the FY02 appropriation made by Sec. 89, Ch. 61 for implementation of the cruise ship bill to correct the fund source from statutory designated program receipts to the Commercial Passenger Vessel Environmental Compliance Fund.					0.0
56	7	Natural Resources	Fire Suppression	Fixed costs and fire suppression costs incurred to date. Updated costs for spring fire suppression will be provided as needed.	7,235.0				7,235.0

FY2002 SUPPLEMENTALS

	A	B	C	D	E	F	G	H	I
1	Sec. No.	Department	BRU or Component	Supplemental Need	General Funds	Federal Funds	Other Funds	Fund Source	Total Funds
	8(a) - (b)	Fish & Game	CIP	Change fund source on \$28.2 due to shortfall in Commercial Fisheries Limited Entry Commission (CFEC) collections - Dock replacement in King Salmon. (SDPR from NTSC - see line 6)				Rcpt Supp Svcs to Statutory Designated Prog Rcpts	0.0
57								same	0.0
58	8(a) - (b)	Fish & Game	CIP	Change fund source on \$78.8 due to CFEC shortfall - Statewide facilities repair & maintenance. (SDPR from NTSC - see line 6)				same	0.0
59	8(a) - (b)	Fish & Game	CIP	Change fund source on \$145.0 due to CFEC shortfall - Upper Cook Inlet and Kuskokwim River Coho project (SDPR from NTSC - see line 6)				same	0.0
60	8(a) - (b)	Fish & Game	CIP	Change fund source on \$63.0 on FY01 CIP project due to CFEC shortfall - Copper River (Miles Lake) Sonar. (SDPR from NTSC - see line 6)				same	0.0
61	8(a) - (b)	Fish & Game	CIP	Change fund source on \$88.5 due to CFEC shortfall - Mariculture development program. (SDPR from NTSC - see line 6)				same	0.0
62	8(a) - (b)	Fish & Game	CIP	Change fund source on \$200.0 due to CFEC shortfall - Vessel and aircraft repair and maintenance. (SDPR from NTSC - see line 6)				same	0.0
63	9(a)	Governor	Elections	Redistricting: add carryforward language for the remaining balance of the \$947.4 appropriation made in Sec. 20, Ch. 60, SLA 2001					0.0
64	9(b)	Governor		Correct a drafting error in Sec. 36(c), Ch. 61 by adding reference to fiscal year 2001.					0.0
65	9(c)	Governor	Governmental Coordination	Change RPL 01-2-8022 Coastal Impact Assistance Program from Operating to Capital					0.0
66	3(d)	Governor	CIP Governmental Coordination	Additional authorization for the Coastal Impact Assistance Program		3,335.7			3,335.7
67	10(a)(1)	Health & Soc Svcs	Adult Public Assistance	Formula program caseload growth	541.0				541.0
68	10(a)(2)	Health & Soc Svcs	Board on Alcohol & Drug Abuse	Cost of co-locating with AK Mental Health Board			40.9	MHTAAR	40.9
69	10(a)(3)	Health & Soc Svcs	Bureau of Vital Statistics	Increased receipt supported services authority so general funds can be transferred to Community Health/Emergency Medical Services for two-way radio costs			75.0	Rcpt Supp Svcs	75.0
70	10(a)(4)	Health & Soc Svcs	Foster Care Special Needs	Shortfunding of formula program from caseload growth projections	304.6				304.6
71	10(a)(5)	Health & Soc Svcs	General Relief Assistance	Formula program growth	190.7				190.7
72	10(b)	Health & Soc Svcs	Comm Health/EMS	Correct HB 228 Sale of Tobacco Products fiscal note fund source from Tobacco Settlement to Tobacco Use Cessation and Education Fund	-487.9		487.9	Tobacco Use Cessation & Ed Fund	0.0
73	11	Law		Judgments and Claims \$816,486.85 AMD Feb 28 Decrease GF by 31.5 from 631.5 to 600.5 AMD Mar 5 Increase GF by 6.5 from 600.5 to 607.0	607.0		185.0	PERS Fund	792.0
74	12(a)	Law		Law Office Assistant reclassification costs		1.7	129.4	Inter-Agency Rcpts	131.1

FY2002 SUPPLEMENTALS

	A	B	C	D	E	F	G	H	I
1	Sec. No.	Department	BRU or Component	Supplemental Need	General Funds	Federal Funds	Other Funds	Fund Source	Total Funds
	12(b)	Law		Fund the \$214.4 general fund portion of the Law Office Assistant reclassification costs with the reappropriation of funds within the Department of Law					0.0
75									
	13	Military & Vets	Army Guard Facilities Maintenance	Federal funds for increased telecommunications costs for the Distance Learning project		350.0			350.0
76									
	14(1)	Natural Resources	Geological Development	Federal grant awards for geological projects		493.4			493.4
77									
	14(2)	Natural Resources	Parks Mgmt	Increased fuel costs	20.2				20.2
78									
	14(3)	Natural Resources	Parks Mgmt	Increased costs for two-way radio circuits	40.7				40.7
79									
	14(4)	Natural Resources	Recorder's Office	Costs of title records for new title companies. Title insurance laws require companies to have duplicate records for the past 25 years.			300.0	Statutory Designated Prog Rcpts	300.0
80									
	14(4)	Natural Resources	Recorder's Office	Assume recording duties in Valdez, Glennallen, and Seward that were previously done by the Courts System without charge. Increased costs to process heavy volume of mortgage refinance activity and implement completed classification study.			235.0	Rcpt Supp Svcs	235.0
81									
	15(a)(1)	Public Safety	AST	Increased fuel costs	106.1				106.1
82									
	15(a)(2)	Public Safety	AST- Prisoner Transport	Increased prisoner transports based on higher volume of cases	172.9				172.9
83									
	15(a)(3)	Public Safety	AST Detachments	Increased fuel costs	125.3				125.3
84									
	15(a)(4)	Public Safety	AST Detachments	Recruitment Academy Training	81.0				81.0
85									
	15(a)(5)	Public Safety	AST Detachments	Standby pay due to heightened security	67.5				67.5
86									
	15(a)(6)	Public Safety	AST	Standby pay due to heightened security	15.7				15.7
87									
	15(a)(7)	Public Safety	VPSO	Standby pay due to heightened security	11.8				11.8
88									
	15(a)(8)	Public Safety	AST Detachments	Emergency guard hires needed to guard offenders in areas with no jails.	59.0				59.0
89									
	15(a)(9)	Public Safety	AS Detachments	Medical examination costs for sexual assault/abuse cases AMD Feb 28 Increase GF by 57.5 from 30.0 to 87.5	87.5				87.5
90									
	15(a)(10)	Public Safety	AST Detachments	Increased costs for two-way radio circuits	102.4				102.4
91									
	15(a)(11)	Public Safety	Fish & Wildlife	Increased fuel costs	247.4				247.4
92									
	15(b)	Public Safety	Batterers Intervention Program	Fund source change to correct the overall allocation of PFD felon funds in FY2002.	63.9		-63.9	PFD Fund	0.0
93									
	16(a)(1)	Revenue	Alcohol Beverage Control Board	Contractual costs for a hearing officers to conduct formal hearings on liquor licenses	20.0			General Fund Program Rcpts	20.0
94									
	16(a)(2)	Revenue	Permanent Fund Dividend Division	Legal costs awarded by state Supreme Court in a class-action suit filed on behalf of applicants denied dividends.			89.9	PFD Fund	89.9
95									
	16(a)(3)	Revenue	Permanent Fund Dividend Division	Overtime costs to resolve eligibility review and appeal case backlog.			31.9	PFD Fund	31.9
96									
	16(b)	Revenue	Child Support Enforcement	Recover cost of increased number of paternity testings required by court orders.	43.0				43.0
97									
	16(c)	Revenue	Child Support Enforcement	Appropriation of interest earned on reserve account balance	60.0				60.0
98									

FY2002 SUPPLEMENTALS

	A	B	C	D	E	F	G	H	I
1	Sec. No.	Department	BRU or Component	Supplemental Need	General Funds	Federal Funds	Other Funds	Fund Source	Total Funds
	16(d)	Revenue	Treasury Division	Correct fund source for Ch 60, SLA 2000 PCE Fund/Sale of 4 Dam Pool/Energy (HB 446) fiscal note.					0.0
99									
	16(e)	Revenue	Treasury Division	Repeal fiscal note funding for Ch. 32, SLA 2001 (HB 149 Kenai Private Prison) since Kenai voters did not approve the private prison development.	-20.0				-20.0
100									
	17(a)	Transportation	Central Region Highways & Aviation	Whittier Tunnel Maintenance and Operations for June 7-30 (current contract expires)			178.0	Rcpt Supp Svcs	178.0
101									
	17(b)(1)	Transportation	Central Region Facilities	Fuel and Utility Cost Increases	240.9				240.9
102									
	17(b)(2)	Transportation	Northern Region Facilities	Fuel and Utility Cost Increases	230.6				230.6
103									
	17(b)(3)	Transportation	Southeast Region Facilities	Fuel and Utility Cost Increases	140.3				140.3
104									
	17(b)(4)	Transportation	Central Region Highways & Aviation	Fuel and Utility Cost Increases	381.0				381.0
105									
	17(b)(5)	Transportation	Northern Region Highways & Aviation	Fuel Cost Increases	569.2				569.2
106									
	17(b)(6)	Transportation	Southeast Region Highways & Aviation	Fuel Cost Increases	39.2				39.2
107									
	17(c)(1)	Transportation	Ted Stevens Anchorage International Airport (TSAIA) Administration	Utility Cost Increases			10.0	Internat'l Airports Rev Fund	10.0
108									
	17(c)(2)	Transportation	TSAIA Facilities	Utility Cost Increases			467.0	Internat'l Airports Rev Fund	467.0
109									
	17(c)(3)	Transportation	TSAIA Field & Equipment Maintenance	Utility Cost Increases			60.0	Internat'l Airports Rev Fund	60.0
110									
	17(c)(4)	Transportation	TSAIA Safety	Utility Cost Increases			8.0	Internat'l Airports Rev Fund	8.0
111									
	17(d)	Transportation	State Equipment Fleet Administration	Add authority for increased usage of fuel credit card system			250.0	Highway Working Capital Fund	250.0
112									
	17(e)(1)	Transportation		Glenn Highway Rut Repair from McCarrey St. to Highland Rd.		6,000.0			6,000.0
113									
	17(e)(2)	Transportation		Dimond Boulevard Rut Repair		6,000.0			6,000.0
114									
	17(e)(3)	Transportation		Hillcrest (Anchorage) Bridge Repair- 3rd party repayment for damages. AMD Feb 28 Deleted request for \$150.0 GFPR				General Fund Program Rcpts	0.0
115									

FY2002 SUPPLEMENTALS

	A	B	C	D	E	F	G	H	I
1	Sec. No.	Department	BRU or Component	Supplemental Need	General Funds	Federal Funds	Other Funds	Fund Source	Total Funds
116	17(e)(4)	Transportation		Northern Region Materials Lab Worker Safety Compliance Upgrade. (SDPR from NTSC - see line 6)			600.0	Statutory Designated Prog Rcpts	600.0
117	18(a)-(d)	University	CIP	Eliminate federal receipts since funding source was changed to university receipts via RPL 45-2-0007 for Arctic Supercomputer purchase.		-32,000.0			-32,000.0
118	18 (e)	University		Replace unrealized investment earnings from the Alaska Science and Technology Foundation	1,753.3		-1,753.3	ASTF	0.0
119	19	Misc Claims	Administration	Miscellaneous Claims: -0-, State-dated warrants: 23,744.07	23.7				23.7
120	19	Misc Claims	Corrections	Miscellaneous claims: \$3,204.11	3.2				3.2
121	19	Misc Claims	Fish & Game	Miscellaneous claims: \$3,761.00	3.8				3.8
122	19	Misc Claims	Health & Soc Svcs	Miscellaneous claims: \$21,499.91	21.5				21.5
123	19	Misc Claims	Law	Miscellaneous claims: \$27,060.49	27.1				27.1
124	19	Misc Claims	Military & Veterans' Affairs	Miscellaneous claims: \$274.00	0.3				0.3
125	19	Misc Claims	Public Safety	Miscellaneous claims: \$293.88	0.3				0.3
126	19	Misc Claims	Transportation	Miscellaneous claims: \$32.96					0.0
127				REGULAR SUPPLEMENTAL BILL TOTAL	18,838.0	15,242.8	1,403.8		35,484.6
128									
129	TOTAL FOR BOTH BILLS MINUS THE \$16.5m GF PLACEHOLDER IN FISCAL SUMMARY				22,186.4	121,860.8	34,692.9		178,740.0
130									
131				Ratifications:					
132	20(a)(1)	Transportation		AR 61669-2001 Reimbsble Authority	165,066.62				
133	20(a)(2)	Transportation		AR 64790-2015 Reimbursable Authority	34,614.23				
134	20(a)(3)	Transportation		AR 58904-2001 Reimbursable Proj.	96,773.16				
135	20(b)	Natural Resources	Fire Suppression	FY2001 Fire suppression costs AR 37313-01 Fire Suppression	4,730,000.00				
136	21			Lapse Provisions					
137	22			Retroactivity					
138	23			Effective Dates					
139	24			Immediate Effective Date					

MEMORANDUM

State of Alaska
Department of Law
Division of Administrative Services

TO: Annalee McConnell, Director
Office of Management and Budget

DATE: 28 February, 2002

FROM: Kathryn Daughetee, Director *KAD*
Division of Administrative Services

PHONE: 465-3673

SUBJECT: FY 2002 Supplemental Items

FY 2002 Judgments and Claims

The attached schedules, totaling \$791,953.21 reflect the current level of judgments and claims awaiting legislative appropriation. The funds for this request are as follows:

\$606,953.21 General Fund
\$185,000.00 PERS Fund

Please contact me if you need further information regarding this request.

cc: Bruce Botelho, Attorney General
Barbara Ritchie, Deputy Attorney General, Civil Division
Cynthia Cooper, Deputy Attorney General, Criminal Division
Dean Guaneli, Chief Assistant Attorney General, Criminal Division

Department of Law

2002 Judgments & Claims - General Funds

Item #	Case Name	Description	Date	Amount	Interest	Total	Cumulative Total
1	ACLU Planned Parenthood of Alaska, et al v. Commissioner Perdue/DHSS	Challenge to legislative elimination of funding for the General Relief Medical Program	10/9/99 01/05/01 09/20/01	\$236,026.16	\$33,882.51	\$269,908.67	
2	Foster Pepper Rubini & Reeves ACLU v. State	Challenge to 1996 campaign finance reform legislation	4/27/00 08/30/01	\$107,954.28	\$23,706.39	\$131,660.67	
3	Steven D. Smith, P.C. CSED v. Ragula	Child support lien and withholding lien vs. attorney's lien	6/30/00 9/27/01	\$2,344.08	\$268.48	\$2,612.56	
4	Michael Gershel, Esq. Brooker v. Brooker	Agreements between private parties not involving CSED	10/30/01	\$525.00	\$31.46	\$556.46	
5	Hagans, Ahearn, McLaughlin & Webb Herold v. State	Wrongful termination	1/2/02	\$80,000.00	\$0.00	\$80,000.00	
6	Alaska Legal Services Corporation Quinhagak v. U.S.	Subsistence jurisdiction over navigable rivers	9/30/96 10/24/00	\$82,525.07	\$16,955.56	\$99,480.63	
7	Marston & Cole Trust Fund Thomas Brown v. DMV	Right to due process re: telephonic testimony in driver's license revocation administrative hearing	1/7/02	\$414.43	\$52.81	\$467.24	
8	Kasmar & Slone ITF Peter T. Knight Peter T. Knight v. DMV	Right to due process re: telephonic testimony in driver's license revocation administrative hearing	1/7/02	\$873.20	\$17.69	\$890.89	
9	Randall Luffberry, Esq. ITF Donald A. Ryall Donald Ryall v. DMV	Challenge to administrative revocation of driver's license	10/31/01	\$1,262.14	\$75.31	\$1,337.45	
10	Ingaldson Maassen, P.C. ITF Nicholas Digel Nicholas Digel v. DMV	Reversal of administrative revocation of driver's license due to supreme court striking down "use it and lose it" law	5/7/01	\$229.01	\$23.66	\$252.67	
11	Larry L. Caudle Brandon Garrett v. DMV	Reversal of administrative revocation of driver's license due to supreme court striking down "use it and lose it" law	5/7/01	\$536.50	\$64.55	\$601.05	

Department of Law

2002 Judgments & Claims - General Funds

Item #	Case Name	Description	Date	Amount	Interest	Total	Cumulative Total
12	Bankston, Gronning et.al, P.C. ITF for Melissa Witteveen Melissa Witteveen v. DMV	Reversal of administrative revocation of driver's license due to supreme court striking down "use it and lose it" law	5/11/01	\$500.00	\$51.16	\$551.16	
13	Richard Brandon v. Corrections	Ambiguity as to filing fee deadline in inmate civil case	9/4/01	\$87.00	\$7.48	\$94.48	
14	Foster, Pepper, Rubini & Reeves Ulmer v. Alaska Restaurant and Beverages	Challenge to ballot initiative increasing state's liquor taxes	11/9/01	\$1,595.67	\$91.67	\$1,687.34	
15	Volland & Taylor, P.C. Cleary v. Smith	Monitoring, compliance and enforcement of the Final Order in prisoner class action	1/24/02	\$9,892.48	\$446.79	\$10,339.27	
16	Keesal, Youong & Logan State, ex rel, Jaylen Cromety v. John Shivers	Paternity issue	2/23/02	\$273.88	\$4.05	\$277.93	
17	Alaska Law Center Albert Rivera v. State, CSED	Paternity issue	2/14/02	\$6,000.00	\$234.74	\$6,234.74	\$606,953.21

Department of Law

2002 Judgments - Other Fund Sources

Item #	Case Name	Description	Date	Amount	Interest	Total	Fund Source
1	Dennis Bailey, Esq. ITF Terri Hale Terri Hale v. State, PERS	Settlement in occupational disability case	10/11/01	\$185,000.00	\$0.00	\$185,000.00	PERS Fund

Department of Law

JUDGMENTS/CLAIMS/SETTLEMENTS FOR PAYMENT

(Please Type)

**This form will be used for the purpose of standardizing the submission of claims to the Legislature. Complete and accurate information will expedite payment to the claimants, thereby reducing the amount of interest required to be paid by the state. If any of the information changes, please immediately advise the Director, Administrative Services Division, P.O. Box 110300, Juneau, AK 99811, or call (907) 465-3673.

PART ONE

1. Case Name: Albert Rivera v. State of Alaska, Dept. of Revenue, Child Support Enforcement Division

2. Case Number: 3AN-99-9264 CI

3. Judge/Justices: Judge Gregory Motyka

4. Settlement entered: 2/14/02

5. Did the date of the cause of action accrue on or after August 7, 1997? No

6. Amount to be paid: \$6,000

Interest Rate: 10.5%

Effective Date: 2/14/02

8. Requested hourly rate and total compensation of attorneys to be paid: None. The claim for attorney's fees was included in the overall settlement amount (\$6,000).

9. Court approved/ordered hourly rate and total compensation of attorneys to be paid: none

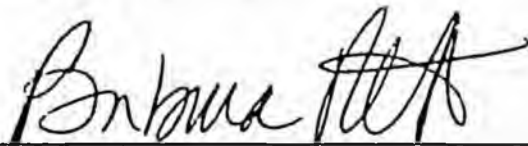
10. Payable to: Albert Rivera, c/o Alaska Law Center, 211 E. 5th Avenue, Anchorage, AK 99501

11. EIN: or SSN: 552-15-9834

12. Send check to: above address Departmental contact: _____

Departmental attorney contact: Departmental Approval:

Diane L. Wendlandt
Assistant Attorney General



Barbara J. Ritchie
Deputy Attorney General

(907) 269-5228
Telephone Number

2/27/02
Date

Department of Law

JUDGMENT/SETTLEMENT FUNDING REQUEST
QUESTIONNAIRE

PART TWO

The following information needs to be provided on all judgment awards and/or settlements made against the State.

Case Name: *Albert Rivera v. State of Alaska, Dept. of Revenue, Child Support Enforcement Div.*

Case No.: 3AN-99-9264 CI

1. Describe the circumstances or events resulting in this case and ultimately this judgment/settlement against the State.

In 1993, CSED issued an order for Albert Rivera to pay child support for Linda Rivera. CSED did not establish paternity because he was named as the father on the child's birth certificate. Upon receiving the support order, Rivera requested an informal conference. He requested a blood test to determine whether he was the child's father and sought custody of the child. CSED told Rivera that he would have to go to court to address paternity and custody. Rivera immediately filed a court action for custody, claiming that he was Linda's father. Eventually, the parties agreed that Rivera could have custody of Linda. Once Rivera had custody of Linda, he did paternity testing, which excluded him as the father. In October 1998, he obtained a court order that he was not Linda's father.

CSED collected \$19,149.95 in child support from Rivera from late 1994 into 1998. Of that amount, \$9,117.76 was distributed to the child's custodian, and \$5,109.59 was sent to the federal government. The State of Alaska retained \$4,008.17 for welfare reimbursement, and \$502.14 was returned to Mr. Rivera.

In the custody action (to which CSED was not a party), Rivera obtained a judgment ordering CSED to refund the money collected from him. His lawyer wrote to this office and demanded payment of the judgment. With limited knowledge of the case, we declined payment on the grounds that the judgment was void because CSED was not a party to the action. Therefore, the court had no jurisdiction to require anything of CSED regarding the matter.

In November 1999, Rivera filed an action against the State for reimbursement of the \$19,000 collected from him by CSED. On November 6, 2001, the court granted CSED's motion for partial summary judgment, finding that the State was only liable for the amount that it actually retained as public assistance reimbursement. The court denied Rivera's cross-motions for summary judgment. At that point, CSED offered to settle all claims, including any claim for attorney's fees, for \$6,000. The settlement and release was signed on February 14, 2002, and the stipulation for dismissal was filed with the court a week later.

2. Describe issues of State policy or law involved in this case, if they are relevant to and resulted in substantial effort and expense for the department to bring or defend this case.

The Alaska Supreme Court and CSED have since resolved the legal issue presented by this case. CSED issued a child support order because Mr. Rivera was identified as the child's legal father on her birth certificate. The Alaska Supreme Court has since held that the fact that a man's name is on a child's birth certificate is not conclusive on the question of paternity. Instead, it only creates a rebuttable presumption of paternity. In such cases, a putative father must be given an opportunity to rebut the presumption when a support order is established. If CSED refused to allow a putative father to rebut the presumption (as was its policy a number of years ago), the court will find the support order to be void (based on a violation of the putative father's right to due process) and will require CSED to refund some or all of the support collected from the putative father.

3. Did the State prevail on any issues? If so, describe.

Yes. Rivera sought to recover the entire \$19,000 that CSED had collected from him, plus costs and attorney's fees. A portion of this amount had already been disbursed to the child's custodian. In addition, a portion of the welfare reimbursement was paid to the federal government as the "federal share" under applicable federal regulations. CSED filed a motion for partial summary judgment, asking the court to limit the State's liability to the amount actually retained by the state (*i.e.*, not disbursed to the custodian or the federal government). The court granted this motion which made the settlement of this case for \$6,000 possible.

4. Did we challenge plaintiffs' request for costs and fees or in other ways seek to reduce the costs to the State? If so, describe to what extent we were successful.

This matter was settled, as described in response to question 3, above. The settlement did not specify the amount designated as costs and fees, as opposed to other damages. However, CSED conceded that approximately \$4,000 was owed to Rivera as state reimbursement for public assistance. Thus, at most, \$2,000 could be attributed to costs and fees and other damages, including interest on the reimbursement. If the matter had not been settled and additional litigation had been necessary, plaintiff's claim for costs and fees (in addition to prejudgment interest on the reimbursement amount) would likely have exceeded this amount by a substantial amount.

5. What was the source of the State's liability in this case?

As explained in response to question 2, CSED refused to allow the plaintiff to raise paternity when it established an administrative support order against him. CSED believed that the birth certificate created an irrebuttable presumption of paternity. The Alaska Supreme Court has since held that the refusal to allow a putative father to rebut the presumption of paternity violates

the putative father's right to due process. Therefore, the support order was void and CSED was required to refund the amounts it retained, under a theory of restitution and unjust enrichment.

6. What, if any, preventative action has been taken by the involved agency to prevent or reduce the potential for such liability in the future?

CSED has developed several new policies under which it now allows a putative father to rebut the presumption of paternity in the context of a proceeding to establish a support order. In such cases, CSED will provide paternity testing if the putative father challenges paternity either when the support order is originally issued or within a certain period of time after the order is established. As a result, this situation should not arise in the future.

7. If the information is available to you, has the agency involved taken any corrective action as a result of this case? If the information is not protected from publication by statute, privilege, or right to privacy, indicate what the corrective action was.

As explained in response to question 6, CSED has adopted procedures that should prevent such a case from arising again.

8. Any recommendations concerning cases of this type in the future?

No. CSED has fully remedied the problem which gave rise to this case.

9. Any recommendations for changes in statutes, regulations or policy? Cite any applicable statutes or regulations.

No. CSED has already adopted the necessary policies and procedures which will prevent this situation from arising in the future.

Attorney completing form:

Date:

Diane L. Wendlandt

Assistant Attorney General

(907) 269-5228

SETTLEMENT AND RELEASE

For and in consideration of the sum of \$6,000 (Six Thousand Dollars), Albert Rivera (hereinafter referred to as "releasor") does hereby release, agree not to sue, and forever discharge the State of Alaska, its agencies, agents, representatives, employees, servants, successors in interest, and assigns (hereinafter referred to as "releasees"), from any and all actions, causes of actions, suits, controversies, claims and damages of every kind and nature accrued, or to accrue, arising out of his interaction with the Child Support Enforcement Division, which became the subject of *Albert Rivera vs. State of Alaska, Department of Revenue, Child Support Enforcement Division*, Superior Court Case No. 3AN-99-9264 Civil, (hereinafter, the "events").

By virtue of this settlement and release the releasor hereby unequivocally releases the releasees from any and all claims which were raised or could have been raised arising from the above-referenced events, including but not limited to damages arising out of any and all monetary damages, pain and suffering, and any and all other expenses, and releasor hereby covenants and agrees that he will not, either by himself or in concert with others, or by virtue of judicial proceedings of any kind whatsoever, make or cause to be made, acquiesce in or assist in the bringing of any further claims or actions for damages against releasees arising out of the events above described.

It is the intent of releasor to unequivocally release and discharge releasees from any and all claims accrued or which may accrue in the future, as a result of any change

in the nature or extent of the injuries or damages claimed or as a result of discovery of new injuries or damages. In this connection, the releasor has discussed this matter with his attorney and other advisors and experts as releasor has deemed appropriate, has been advised of and is familiar with the case of *Witt v. Watkins*, 579 P.2d 1065 (Alaska 1978), and still desires to settle this matter in accord with the settlement amount set forth in this release.

Releasor further states that no promise or inducement which is not herein expressed has been made to his to secure this settlement and release. Releasor represents that the settlement which led to the execution of this release was not secured under duress or in haste at the instigation of releasees and that releasor is not, in agreeing to this settlement and to this release, at a bargaining disadvantage because of the nature of the suit, or any injury, loss or damage or for any other reason, and that the undersigned has been represented by an attorney throughout the course of negotiations which led to this settlement.

Releasor agrees to dismiss with prejudice the State of Alaska and its agencies and employees from the above-referenced litigation.

Releasor hereby agrees through his attorney to execute the appropriate stipulation for dismissal with prejudice with each party to bear its own costs and attorney's fees. Releasor declares that each of the terms of this settlement and release have been carefully read and that the terms of this Settlement and Release are fully understood and voluntarily accepted for the purpose of making a full and final compromise.

It is expressly agreed by Releasor that at the time of the signing of this release no assignment of any claim stated or otherwise, has been made or executed to any other individual, firm or corporation, or any other entity as a result of the incident hereinabove mentioned. It is further agreed that Releasor is to satisfy any and all attorney liens, medical liens, and/or government liens, insurance liens, or any other types of liens presently asserted or to be asserted.

It is understood that this agreement represents the final settlement of a disputed claim; releasees do not by reason of this release and settlement admit any liability, negligence, or responsibility on the part of releasees by reason of the "events." Nothing contained herein should be deemed to be an admission of liability, negligence, or responsibility on the part of the State of Alaska or any of its employees.

I HAVE READ EACH PAGE OF THIS RELEASE AND HAVE OBTAINED EXPLANATIONS FROM MY ATTORNEY OF ANY MATERIAL IN THIS AGREEMENT WHICH I DID NOT UNDERSTAND WHEN I READ IT.

Date: 2-14-02

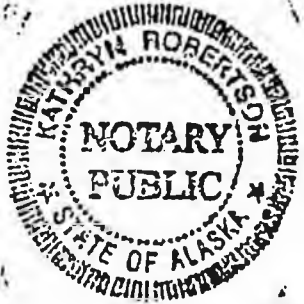
By: Albert Rivera
Albert F. Rivera

STATE OF ALASKA)
) ss.
THIRD JUDICIAL DISTRICT)

THIS IS TO CERTIFY that on the 14 day of February, 2002, before me, the undersigned, a Notary Public in and for the State of Alaska, duly commissioned as such,

this day personally appeared Albert Rivera, known to me and to me known to be the person named in and who executed the foregoing instrument, and he acknowledged to me that he executed the same freely and voluntarily, with knowledge of its contents, for the uses and purposes therein set forth.

Witness my hand and seal the day and year last above written.



Kathryn Robertson

NOTARY PUBLIC for Alaska

My commission expires: _____

My Commission Expires
June 26, 2002

Department of Law

JUDGMENT/SETTLEMENT FUNDING REQUEST
QUESTIONNAIRE

PART TWO

The following information needs to be provided on all judgment awards and/or settlements made against the State.

Case Name: *State, ex rel, Jaylen Cromery v. John Shivers*

Case No.: 3AN-01-8689 Civil

1. Describe the circumstances or events resulting in this case and ultimately this judgment/settlement against the State.

This claim arose in the context of a paternity action filed by CSED to establish that John Shivers is the father of the child, Jaylen Cromery. Mr. Shivers is a member of the military. Therefore, under the Soldiers and Sailors Civil Relief Act, 50 U.S.C. § 520, a default judgment cannot be entered against him until counsel has been appointed. The appointed counsel must contact the defendant, determine whether the defendant's active military service would have a material effect on the defendant's ability to respond to the action, and advise the defendant on the possibility of a default if the defendant does not answer or obtain a stay. Appointed counsel is entitled to recover attorney's fees at the rate of \$40 per hour under Administrative Rule 12(e)(5), but not to exceed a total of \$500.

Attorney Douglas Davis was appointed as Mr. Shivers' counsel on October 23, 2001. *See* Order Appointing Attorney, attached. Mr. Davis performed his statutory duties from November 2, 2001 through November 30, 2001. On January 23, 2002, he sent a bill to this office for his attorney's fees. In his bill, he used a billing rate of \$225 per hour, plus paralegal work at the rate of \$95 per hour and costs of \$3.88, for a total bill of \$1,457.63. *See* Invoice, attached. The assistant attorney general handling the case responded to the bill, explaining the restrictions on fees set forth in the administrative rule and stating that she would submit the claim for the amount required under the rule (\$273.88). *See* Letter, attached.

2. Describe issues of State policy or law involved in this case, if they are relevant to and resulted in substantial effort and expense for the department to bring or defend this case.

No issues of state policy or law were involved in this case. This was a routine paternity case. Because of the defendant's military service, appointment of counsel was required before a default

could be entered. This expense is required by both state and federal law, as described more fully in answer to question 1.

3. Did the State prevail on any issues? If so, describe.

Yes. Paternity was established.

4. Did we challenge plaintiffs' request for costs and fees or in other ways seek to reduce the costs to the State? If so, describe to what extent we were successful.

Yes. As explained in response to question 1, the attorney sought \$1,453.75 in attorney's fees. This request, however, was based on a billing rate of \$225 per hour. Under Administrative Rule 12(e)(5), reimbursement for attorney's fees is limited to \$40 per hour. For this reason, the claim is being submitted for only \$270 in attorney's fees, plus costs of \$3.88.

5. What was the source of the State's liability in this case?

The Soldiers and Sailors Civil Relief Act, 50 U.S.C. § 520, requires the appointment of counsel before a default judgment may be entered against a member of the military. The state (CSED) is required to pay the attorney's fees related to that appointment.

6. What, if any, preventative action has been taken by the involved agency to prevent or reduce the potential for such liability in the future?

There is no preventative action needed. Payment of attorney's fees in cases involving appointment of counsel under the Soldiers and Sailors Civil Relief Act is required by state and federal law. Short of changing the federal law, there is nothing the agency can do to prevent this liability in appropriate cases. CSED is required to establish paternity where paternity is contested in its open cases. To do so, CSED must file actions against putative fathers. If the putative father is properly served but fails to respond, CSED must ask that a default judgment be entered. If the putative father is a member of the military, appointment of counsel is required. Thus, the expense cannot be avoided.

7. If the information is available to you, has the agency involved taken any corrective action as a result of this case? If the information is not protected from publication by statute, privilege, or right to privacy, indicate what the corrective action was.

Please see answer to question 6 above.

8. Any recommendations concerning cases of this type in the future?

Please see answer to question 6 above.

9. Any recommendations for changes in statutes, regulations or policy? Cite any applicable statutes or regulations.

Please see answer to question 6 above.

Attorney completing form:

Diane L. Wendlandt
Assistant Attorney General

Date:

February 20, 2002

(907) 269-5228

Phone Number

STATE OF ALASKA

TONY KNOWLES, GOVERNOR

DEPARTMENT OF LAW
OFFICE OF THE ATTORNEY GENERAL

1031 WEST 4TH AVENUE, SUITE 200
ANCHORAGE, ALASKA 99501-5903
PHONE: (907)269-6616
FAX: (907)276-3456

February 12, 2002

Douglas R. Davis
Law Offices of Keesal, Young & Logan
1029 W. 3rd Avenue, 6th Floor
Anchorage, AK 99501

Re: State, ex rel. Cromery v. Shivers
Case No. 3AN-01-8689 CI
CSED No. 001106815

Dear Mr. Davis:

This letter is in response to the invoice that you provided to the Office of the Attorney General requesting payment for the services you provided in the above referenced case. I have submitted your invoice for payment, but not at the amount stated on the invoice. We are not questioning your billing and we realize that you provided a valuable service in this case. However, the order appointing you as counsel to this case limited the rate of reimbursement to \$40 per hour. For that reason I forwarded the invoice with the request that reimbursement be limited to \$270 for attorney's fees (for 6.75 hours work) and the costs. Thank you.

Sincerely,

BRUCE M. BOTELHO
ATTORNEY GENERAL

By:


Terisia K. Chleborad
Assistant Attorney General

TKC:eag

TKC/EAG/OTHER/LETTERS/DAVISI.LTR

LAW OFFICES
KEESAL, YOUNG & LOGAN
A CORPORATION

SIXTH FLOOR
1029 WEST THIRD AVENUE
ANCHORAGE, ALASKA 99501-1954
(907) 279-9698

FACSIMILE:
(907) 279-4239
www.kyl.com

BETH A. MARINO
THOMAS M. McCALLISTER
DEVINA DONOHUE
CARA L. FITZAN
JENNIFER M. HONG
JAMES ROBERT GREENE
ZARA SANTOS
ESTHER E. CHO
MUCKEY V. COLBY
MAURICIO J. RAULD
JULIE A. KOLE
OLEN R. PIPER
JAMES E. FOSLER*
DARRELL C. MARTIN
DAVID D. PIPER

THEODORE H. ADKINSON
BARBARA A. SYLVESTER
JENNIFER J. OHRENBERGER
DANIELLE J. TARASEN
TODD C. ATKINS
KELLY M. McINTYRE
JEFFREY A. FEASBY
DAVID B. STARKS*
CATHERINE M. MORISSET*
CHRISTOPHER A. STECHER
R. AUDETTE PAUL
STELIOS A. CHRISOPoulos
THOMAS R. TRAINOR
DIANA J. COBURN
BRIAN A. CALIHOUN

CL A. KEESAL, JII.
HEN YOUNG
ROBERT H. LOGAN
MICHAEL M. GLESS
PETER K. DOUTIN
SCOTT T. PRATT
TERRY ROSS
JOHN D. GIFFIN
WILLIAM H. COLLIER, JR.
PHILIP A. McLEOD
NEAL S. ROBB
HEN SUTER
DAWN M. SCHOCK
ALBERT E. PEACOCK III
CAMERON STOLT
JOHN R. LOFTUS
DAVID M. BARTHOLOMEW
ROBERT J. STENLER
LISA M. BERTAIN
JANET SIMMONS STEMLER

ROBERT J. BOCKO**
MICHELE R. FRON
ROBERT B. ERICSON
ELIZABETH P. BEAZLEY
PAUL J. SCHUNACHER
JOSEPH A. WALSH II
HERBERT H. RAY, JR.**
JODI S. COHEN
PHILIP R. LEMPRIERE*
JULIE L. TAYLOR
STACEY MYERS GARRETT
JON W. ZINICK*
DOUGLAS R. DAVIS**
GORDON C. YOUNG
ELIZABETH H. LINDH
KELLY J. MOYNIHAN
KIMBERLY WONG
JOHN M. WHELAN
DENA L. MURPHY
SARAH TONG SANGMEISTER

OF COUNSEL
MICHAEL H. WOODDELL**
HEESE H. TAYLOR, JR.
RICHARD A. APPELBAUM*
NEAR ANNUAL, U.S.C.G. (RET.)

SCOTT R. MAGEE
ERIC R. ADLER
ELIZABETH A. KENDRICK

January 23, 2002

* ADMITTED IN ALASKA
† ADMITTED IN WASHINGTON
‡ ADMITTED IN WASHINGTON & CALIFORNIA
§ ADMITTED IN ALASKA & CALIFORNIA
¶ ADMITTED IN DISTRICT OF COLUMBIA & FLORIDA
** REGISTERED FOREIGN LAWYER WITH THE LAW SOCIETY
OF HONG KONG & ADMITTED IN NEW YORK
ALL OTHERS ADMITTED IN CALIFORNIA

RECEIVED

JAN 24 2002

Department of Law
Office of Attorney General
3rd Judicial District
Anchorage, Alaska

Via Mail

Department of Law
Attn: Terisia K. Chleborad
1031 W. Fourth Avenue
Suite 200
Anchorage, AK 99501

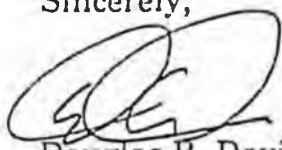
Re: *State of Alaska, Department of Revenue, Child Support
Enforcement Division, ex rel, Jaylen E. Cronety v. Shivers*
Case No.: 3AN-01-8689 CV
Our File No.: 5905-1

Dear Ms. Chleborad:

In accordance with the Court's order of October 15, 2001, we enclose a copy of our invoice for fees and costs which we understand will be paid for by the State in accordance with the Court's order.

If there are any questions, please advise

Sincerely,


Douglas R. Davis

DRD:ab (121442)
Enclosure

LAW OFFICES
KEESAL, YOUNG & LOGAN
 A CORPORATION

SIXTH FLOOR
 1029 WEST THIRD AVENUE
 ANCHORAGE, ALASKA 99501-1954

(907) 279-9696

FACSIMILE:
 (907) 279-4239

www.kyl.com

BETH A. MARINO
 THOMAS M. McCALLISTER
 DEVIN A. DONOHUE
 CARA L. FINAN
 JENNIFER M. HONG
 JAMES ROBERT GREENE
 ZARA SANTOS
 ESTHER E. CHO
 NICKY Y. COLBY
 MAURICIO J. RAULD
 JULIE A. KOLE
 GLEN R. PIPER
 JAMES E. FOSLER*
 DARRELL C. MARTIN
 DAVID D. PIPER

THEODORE H. ADKINSON
 BARBARA A. SYLVESTER
 JENNIFER J. OHRENBERGER
 DANIELLE J. TARASEN
 TODD C. ATKINS
 KELLY M. MCINTYRE
 JEFFREY A. FEASBY
 DAVID B. STARKS*
 CATHARINE M. MORUSSET*
 CHRISTOPHER A. STECHER
 R. AUDETTE PAUL
 STELIOS A. CHRUSOPOLLOS
 THOMAS R. TRAINOR
 DIANA J. COBURN
 BRIAN A. CALHOUN

* ADMITTED IN ALASKA
 † ADMITTED IN WASHINGTON
 ‡ ADMITTED IN WASHINGTON & CALIFORNIA
 § ADMITTED IN ALASKA & CALIFORNIA
 ¶ ADMITTED IN DISTRICT OF COLUMBIA & FLORIDA
 ** REGISTERED FOREIGN LAWYER WITH THE LAW SOCIETY
 OF HONG KONG & ADMITTED IN NEW YORK
 ALL OTHERS ADMITTED IN CALIFORNIA

EL A. KEESAL, JR.
 HEN YOUNG
 ROBERT H. LOGAN
 MICHAEL M. GLESS
 PETER R. BOLTIN
 SCOTT T. PRATT
 TERRY ROSS
 JOHN D. GIFFIN
 WILLIAM H. COLLIER, JR.
 PHILIP A. McLEOD
 NEAL S. ROBB
 HEN ELTER
 DAWN M. SCHOCK
 ALBERT E. PEACOCK III
 CAMERON STOUT
 JOHN R. LOFTUS
 DAVID M. BARTHOLOMEW
 ROBERT J. STEINLEK
 LISA M. HERTAIN
 JANET SIMMONS STEINLEK

ROBERT J. BOCKO**
 MICHELE R. FRON
 ROBERT B. ERICSON
 ELIZABETH F. BEAZLEY
 PAUL J. SCHUMACHER
 JOSEPH A. WALSH II
 HERBERT H. RAY, JR.**
 JODI S. COHEN
 PHILIP R. LEMPRIERE*
 JULIE L. TAYLOR
 STACEY MYERS GARRETT
 JON W. ZINKE*
 DOUGLAS R. DAVIS**
 GORDON C. YOUNG
 ELIZABETH H. LINDH
 KELLY J. MOYNIHAN
 KIMBERLY WONG
 JOHN M. WIELAN
 DENA L. MURPHY
 SARAH TONG SANGMEISTER

OF COUNSEL

MICHAEL H. WOODDELL**
 HESE H. TAYLOR, JR.
 RICHARD A. APPELBAUM*
 REAR ADMIRAL, U.S.G. (RET.)
 SCOTT R. MAGEE
 ERIC R. ADLEN
 ELIZABETH A. KENDRICK

DEPARTMENT OF LAW
 ATTN: TERISIA K. CHLEBORAD
 ASSISTANT ATTORNEY GENERAL
 1031 W. FOURTH AVE., SUITE 200
 ANCHORAGE, AK. 99501

JANUARY 23, 2002
 5905-1

INVOICE: 149255

FOR PROFESSIONAL SERVICES RENDERED
Please remit within 15 days

RE: JAYLEN CROMETY, STATE OF ALASKA V.
 RE: STATE V. SHIVERS
 CHILD SUPPORT ENFORCEMENT DIVISION
 CASE #3AN-01-8689

SERVICES

Nov 02, 01	DRD	EFFORTS TO LOCATE DEFENDANT; REVIEW SOLDIERS' AND SAILORS' RELIEF ACT.	.25
Nov 02, 01	JJL	CONDUCT BACKGROUND INVESTIGATION ON JOHN SHIVERS FOR LOCATION INFORMATION OBTAINED BY DATABASES.	.50

DEPARTMENT OF LAW
JANUARY 23, 2002
INVOICE: 149256

Page2

Nov 27, 01	DRD	REVIEW STATUS; LEGAL RESEARCH REQUIREMENTS OF SOLDIERS' AND SAILORS' RELIEF ACT; EFFORTS TO LOCATE CLIENT.	2.50
Nov 28, 01	DRD	EFFORTS TO LOCATE CLIENT; REVIEW CASE STATUS.	1.00
Nov 29, 01	DRD	EFFORTS TO LOCATE CLIENT; ATTEMPT TO LOCATE HOME NUMBER AND ADDRESS; TELEPHONE CONFERENCE WITH CLIENT'S COMMANDING OFFICER.	1.25
Nov 30, 01	DRD	TELEPHONE CONFERENCE WITH CLIENT'S COMMANDING OFFICER; PREPARE LETTER TO CLIENT.	1.25

DEPARTMENT OF LAW
JANUARY 23, 2002
INVOICE: 149256

Page3

RECAP OF HOURS:

DAVIS, DOUGLAS R.	6.25	HOURS AT \$ 225.00 EFFECTIVE RATE PER HOUR =	\$ 1,406.25
LEWIS, JOHN J.	.50	HOURS AT \$ 95.00 EFFECTIVE RATE PER HOUR =	\$ <u>47.50</u>

TOTAL HOURS 6.75

TOTAL FEES \$ 1,453.75

DISBURSEMENTS

OVERNIGHT DELIVERY	2.34
POSTAGE & MAILING	.34
PHOTOCOPY	<u>1.20</u>

TOTAL DISBURSEMENTS 3.88

TOTAL STATEMENT \$ 1,457.63

Please remit within 15 days

FEES & DISBURSEMENTS UNPAID (INCLUDING THIS STATEMENT): \$ 1,457.63
(DOES NOT INCLUDE PAYMENTS RECEIVED AFTER 01/23/02)

1 IN THE SUPERIOR COURT FOR THE STATE OF ALASKA

2 THIRD JUDICIAL DISTRICT AT ANCHORAGE

3 STATE OF ALASKA, DEPARTMENT)
4 OF REVENUE, CHILD SUPPORT)
5 ENFORCEMENT DIVISION, ex rel,)
6 JAYLEN E. CROMETY,)

6 Plaintiff,)

7 vs.)

8 JOHN W. SHIVERS, JR.)

9 Defendant.)

RECEIVED

OCT 23 2001

Department of Law
Office of Attorney General
3rd Judicial District
Anchorage, Alaska

Case No. 3AN-01-8689 CIV

10 ORDER

11
12 Having considered the Motion for Appointment of Counsel
13 by the State of Alaska, Department of Revenue, Child Support
14 Enforcement Division (CSED);

15 IT IS HEREBY ORDERED that Douglas R. Davis is
16 appointed counsel for defendant, John W. Shivers, Jr., pursuant
17 to and for the limited purposes contemplated by 50 U.S.C. § 520.

18 Plaintiff shall compensate the above-named attorney at
19 the rates stated in Administrative Rule 12(e)(5)(B) and (D). If
20 necessary to prevent manifest injustice, the undersigned judge
21 may authorize payment of compensation or expenses in excess of
22 the amounts provided therein. These fees and costs may later be
23 included in plaintiff's cost bill under Civil Rule 79. For that
24 reason, the above-named attorney shall submit a request for
25 payment to the state before the action is concluded.
26

Lecroy, Young & Logan
1024 W 3rd Ave 6th FL
A/1 99501

DEPARTMENT OF LAW
OFFICE OF THE ATTORNEY GENERAL
ANCHORAGE BRANCH
1031 W. FOURTH AVENUE, SUITE 200
ANCHORAGE, ALASKA 99501
PHONE: (907) 269-5100

1 IT IS ALSO ORDERED that within 21 days of the date of
2 this order, appointed counsel file with the court an affidavit
3 setting forth what efforts under this appointment have been
4 taken. This appointment does not extend to preparation of a
5 defense on the merits of the lawsuit. The appointment and
6 compensation for same, is limited to those duties set forth
7 below, as required by the federal act:

8 (a) Appointed counsel shall determine whether or not
9 defendant John W. Shivers, Jr., whose last know address is 8222
10 Marymont Dr. #23, Laurel, MD 20707, (home phone no. 301-725-1835,
11 work phone no. 301-677-5675), is in the active military service
12 of the United States.

13 (b) Appointed counsel shall notify defendant John W.
14 Shivers, Jr. of these proceedings against him and advise
15 defendant of the protections of the Soldiers' and Sailors' Civil
16 Relief Act.

17 (c) Appointed counsel shall determine whether defendant
18 John W. Shivers' active military service has a material effect on
19 his ability to proceed in this action such that an application to
20 stay proceedings may be appropriate.

21 (d) Appointed counsel shall advise the defendant John W.
22 Shivers that if no stay is granted, the State of Alaska has the
23 right to move for a default against him if no answer to
24
25
26

1 the complaint is filed. Appointed counsel will advise the
2 defendant of the consequences of such a judgment.

3 IT IS SO ORDERED.

4 DATED: 10/15/01

5
6 
7 _____
8 SUPERIOR COURT JUDGE

9 I certify that on 10/23/01
10 a copy of the above was mailed/delivered
11 to each of the following at their addresses

12 of record: T. Chelvard - Ag / J. Shivers / D. Douglas /
13 M. Lucas Admin Accty
14 _____
15 Secretary/Deputy Clerk

IN THE DISTRICT/SUPERIOR COURT FOR THE STATE OF ALASKA
AT _____

STATE OF ALASKA DEPARTMENT OF REVENUE,
CHILD SUPPORT ENFORCEMENT DIVISION,
BY TOL, JAYLEN E CROMETY, Plaintiff(s),

vs.

JOHN W. SHIVERS, JR.,
Defendant(s).

CASE NO. 3AN-01-8689 CI

ORDER APPOINTING ATTORNEY
UNDER SOLDIERS' AND SAILORS'
CIVIL RELIEF ACT

It is ordered that Douglas R. Davis, attorney, is appointed under the Soldiers' and Sailors' Civil Relief Act of 1940, 50 U.S.C. Appendix §§ 510, 520 and 521, to represent and protect the interests of defendant, John W. Shivers, Jr.

Unless the box below is checked, plaintiff shall compensate the above-named attorney at the rates stated in Administrative Rule 12(e)(5)(B) and (D). If necessary to prevent manifest injustice, the undersigned judge may authorize payment of compensation or expenses in excess of the amounts provided therein. These fees and costs may later be included in plaintiff's cost bill under Civil Rule 79.

Plaintiff has shown an inability to pay for such representation. Therefore, counsel will be paid by the Alaska Court System as provided in Administrative Rule 12(e)(5). All claims for compensation must be submitted on court form ADM-121 within 30 days following disposition of the case.

This appointment, and compensation for same, is limited to those duties set forth below, as required by the federal act. This appointment does not extend to preparation of a defense on the merits of the lawsuit.


Counsel shall

1. contact the defendant and assure that defendant has actual notice of the lawsuit,
2. advise defendant of the protections of the Soldiers' and Sailors' Civil Relief Act,
3. advise defendant of the possibility of entry of default judgment and of the consequences of such a judgment, and
4. ascertain whether the defendant's ability to appear and defend his or her legal interests is affected in any way by defendant's military status and,
5. if the defendant wishes, move for a stay of the proceedings to enable defendant to obtain counsel or to prepare a defense on the merits of the case.

Upon completion of counsel's duties, counsel shall file an affidavit with the court setting forth the efforts made under this appointment.

It is further ordered that the time for opposition to plaintiff's motion for entry of default judgment is extended 40 days from the date of distribution of this order to enable appointed counsel to complete the above duties.

Effective Date 10/23/01


Judge
John Reese
Type or Print Judge's Name

I certify that on 10/23/01
a copy of this order was sent to:

Plaintiff counsel: T. Chelborad - AG
Defendant: John W. Shivers JR.
Appointed counsel: Douglas & Davis
Administrative Accounting

Clerk: M. Lucas