

State of Alaska • Department of Health and Social Services • Senior and Disabilities Services
STAR Grant Program
Discretionary Funds Application

Applicant:		Date of Birth:	
Address:			
City:	State:	Zip code:	
Telephone:	Email address:		
Person completing form:			Telephone:
Relationship to applicant:			
Date of Request:		Amount of request: \$	
Describe items, services, or payments requested. <i>Attach supporting documentation, e.g., estimate from vendor, catalog page/order, written recommendation of health care professional, or copies of bills</i>			
Vendor or service provider name:			
Address:			
Telephone number:			
STAR agency:			
Request reviewed by <input type="checkbox"/> STAR Coordinator <input type="checkbox"/> STAR Advisory Board			
<input type="checkbox"/> Approved	Date:	Amount: \$	
Approved by:			
Comments/Plan:			
<input type="checkbox"/> Denied	Date:	Amount: \$	
Denied by:			
Reason for denial:			