State of Alaska • Department of Health and Social Services • Senior and Disabilities Services

Short Term Assistance & Referral (STAR) Grant Program
Discretionary Funds Application

Applicant:		Date of Birth:
Address:		
City:	State:	Zip code:
Telephone:	Email address:	
Have you received a STAR discretionary funds award before? Yes ☐ No ☐		
Person Completing Form:		Contact:

Certification statement:
I have no funds personally to make this purchase. I verify that there are no other programs available to fund this request, and acknowledge that SDS may request verification in the form of denied applications. I also give permission for the STAR agency to contact me and/or the person completing the form, as indicated above.
Signature: _____ **Date:** _____

Amount of request: $_____ Date of request: _____

Describe items, services or payments requested. *Attach supporting documentation, e.g., estimate from a vendor, catalog page/order, or copies of bills, and a written recommendation of health care professional, if appropriate.*

Vendor or service provider name: _____
Address: _____
Telephone number: _____

STAR Agency:	Telephone:
Request reviewed by ☐ STAR Coordinator	☐ SDS Program Manager

☐ APPROVED BY_____	Date: _____	Amount: _____
Comments/Plan:		
☐ DENIED BY _____	Date: _____	Amount: _____
Reason for Denial:		