ARKANSAS AUTISM PARTNERSHIP

CHECKLIST FOR INITIAL APPLICATION APPROVAL:

Please send ALL of the following to Partners for Inclusive Communities:

- ☐ Autism Waiver/TEFRA Complete Application: (9700, 108, 106, 4000, 408, 0092, 662, 9)
- ☐ Evaluation records from a medical doctor which include the Autism diagnosis
- ☐ Evaluation records from a psychologist (doctorate level) which include the Autism diagnosis
- ☐ Evaluation records from a speech pathologist which include the Autism diagnosis
- ☐ Autism Specific Testing
  - _____ CARS, ADOS, ADI-R, or
  - _____ Delineation of the DSM criteria
- ☐ Standardized assessment of intellect
- ☐ Standardized assessment of adaptive behavior
- ☐ Copy of Birth Certificate
- ☐ Copy of Social Security Card
- ☐ Copy of Private Insurance Card and/or Medicaid Card
- ☐ Copies of bank statements of any other resources/income in the child's name
- ☐ Copies of previous year's tax return

Partners for Inclusive Communities

Arkansas Autism Partnership

322 Main Street, suite 501

Little Rock, AR 72201

ARKANSAS DEPARTMENT OF HUMAN SERVICES
TEFRA and AUTISM WAIVER
Application for Assistance

If you need this material in a different format, such as large print, please contact your local DHS county office.
Si necesita este formulario en Espanol, llame al 1-800-482-8988 y pida la versión en Español.

What type of services are you requesting? ☐ **TEFRA** ☐ **Autism Waiver**

Child's Name:	Social Security Number	Male ☐ Female ☐	U.S. Citizen Yes ☐ No ☐
Date of Birth:	Age: _____years _____months		Race:
Parent/Guardian:			
Current Address: City:	State:	Zip:	County:
Phone:	Email:		

1. **Does the child you are applying for have income?** ☐ **Yes** ☐ **No** **If yes, list the child's income below.**

Source of Income	Gross Amount (Before deductions)	How often?
Social security		
SSI		
Veteran's benefits		
Child support		
Other		

2. **Does the child you are applying for have resources?** ☐ **Yes** ☐ **No** **If yes, list the child's resources.**

Source of Resource	Amount or Value	Location of Resource
Cash, Checking, Savings or Christmas Club Account		
Stocks, Bonds, Trust Fund, Certificate of Deposit, Mutual Fund, etc.		
Other		

3. **Does the child you are applying for have health insurance?** ☐ **Yes** ☐ **No**
   If yes, please provide a copy of the front and back of the child's insurance card.

4. **Primary Care Physician** _____

   Autism Diagnosis ☐ **Yes** ☐ **No** **Date of Diagnosis** _____

5. **Do you expect a change in any of the above?** ☐ **Yes** ☐ **No** **If yes, what?** _____
   When? _____

For TEFRA only

Information needed to determine the TEFRA premium:

- Please attach the most recent Federal Income Tax Return and Schedule A, if you itemized deductions, for the child's parent(s).
- The total number of dependents that live in your household including yourself: _____

For Autism Waiver only

If this application is for the Autism Waiver, please attach an evaluation report from each of the following indicating that the child has a diagnosis of autism. Please place a check mark beside each item that is attached.

- ☐ Physician Report
- ☐ Psychologist Report
- ☐ Speech-language Pathologist Report
- ☐ Adaptive Behavior Assessment Report (such as Vineland)

Read carefully before you sign this application

The PRIVACY ACT of 1974 requires the Department of Human Services (DHS) to tell you: (1) whether disclosure of your SSN is voluntary or mandatory; (2) How DHS will use your SSN; and (3) The law or regulation that allows DHS to ask you for the SSN. We are authorized to collect from your household certain information including the social security number (SSN) of each eligible household member. For the TEFRA and Autism Program, this authority is granted under Federal Laws codified at 42 U.S.C. §§1320b-7(a) (1) and 1320b-7(b) (2). This information may be verified through computer matching programs. We will use this information to determine program eligibility, to monitor compliance with program rules, and for program management. This information may be disclosed to other Federal and State agencies and to law enforcement officials. If a claim arises against your household, the information on this application, including all SSNs, may be provided to Federal or State officials or to private agencies for collection purposes. * **EXCEPTION:** In the Medicaid Program, information is disclosed without the individual's written consent only to: authorized employees of this Agency, the Social Security Administration, the U.S. Department Of Health and Human Services, the individual's attorney, legal guardian, or someone with power of attorney; or an individual who the recipient has asked to serve as his representative AND who has supplied confidential information for the case record which helped to establish eligibility, or court of law when the case record is subpoenaed.

- I understand that I must help establish my eligibility by providing as much information as I can and in some situations I may be required to provide proof of my circumstances.
- I authorize any banks, savings and loans, lending institutions or other financial institutions, etc., to release to DHS any information about my household's circumstances as necessary to verify any information contained on this application.
- I authorize the Department of Human Services (DHS) to obtain information from any federal agency, other state agencies and other sources (including electronic databases) to confirm the accuracy of my statements.
- I understand Social Security Numbers (SSNs) will be used in a computer match to detect and prevent duplicate participation. SSNs are also used in a match through the State Income and Eligibility Verification System to secure wage, unearned income and benefit information from the Social Security Administration, Department of Workforce Services, and Internal Revenue Service. Information received may be verified through other contacts when discrepancies are found by DHS and may affect eligibility or level of benefits.
- I understand that no person may be denied Medicaid benefits on the grounds of race, color, sex, age, disability, religion, national origin, or political belief.
- I may request a hearing from DHS if a decision is not made on my case within the proper time limit or if I disagree with the decision.
- I agree to notify the DHS county office within 10 days if I or any of my dependents cease to live in my home, if I move, or if any other changes occur in my circumstances.
- I authorize DHS to examine all records of mine or records of those who receive or have received Medicaid benefits through me to investigate whether or not any person has committed Medicaid fraud, or for use in any legal, administrative or judicial proceeding.

Assignment of Medical Support. I authorize any holder of medical or other information about me to release information needed for an Medicaid claim to DHS. I further authorize release of any information to other parties who may be liable for my medical expenses. As an eligibility condition, I automatically assign my right to any settlement, judgment, or award which may be obtained against any third party to DHS to the full extent of any amount which is paid by DHS for my behalf. I authorize and request that funds, settlement or other payments made by or on behalf of third parties, including tortfeasors or insurers arising out of an Medicaid claim, be paid directly to DHS. My application for Medicaid benefits shall in itself constitute an assignment by operation of law and shall be considered a statutory lien of any settlement, judgment, or award received by me from a third party. A third party is any person, entity, institution, organization or other source who may be liable for injury, disease, disability or death sustained by me or others named herein, including estates of said individuals. I also assign all rights in any settlement made by me or on my behalf arising out of any claim to the extent medical expenses paid by DHS, whether or not a portion of such settlement is designated for medical expenses. Any such funds received by me shall be paid to DHS. A copy of this authorization may be used in place of the original.

I DECLARE UNDER PENALTY OF PERJURY THAT THE ABOVE IS TRUE AND CORRECT. If I receive benefits to which I am not entitled because I withheld information or provided inaccurate information, such assistance will be subject to recovery by the Department of Human Services, and I may be subject to prosecution for fraud and fined and/or imprisoned.

Signature _____ Date_____

Arkansas Department of Human Services
Division of County Operations
DISABILITY WORKSHEET

Applicant:	**Budget Unit ID:**
Eligibility Worker:	**County:**

1. Have you ever applied for SSI or Social Security Disability?
   - ☐ Yes (If checked, go to #2).
   - ☐ No (If checked STOP and proceed with AD/MRT determination, but ask if individual intends to apply for SSI or Social Security Disability.) ☐ Yes ☐ No.

2. When did you apply for SSI or Social Security Disability? _____(mm/dd/yyyy)

3. Is your SSI or Social Security Disability application still pending? (Note to Worker: This question refers to a pending application, NOT to a pending appeal or reconsideration.)
   - ☐ Yes (If checked, STOP, and proceed with AD/MRT determination.)
   - ☐ No (If checked, go to #4.)

4. Has SSA approved your application?
   - ☐ Yes (If for SSI, STOP, and deny AD application. If for Social Security Disability, STOP MRT and continue processing AD application.)
   - ☐ No (If checked, go to #5.)

5. Has SSA denied your application because:
   - ☐ They found you were not disabled? (If checked, go to #6.)

     OR
   - ☐ They found you were not eligible for a reason other than disability? What was the reason?

     _____

     (If checked, proceed with AD/MRT determination unless the "other" reason would also disqualify for AD, e.g., resources. Verify the reason and deny the application if appropriate.)
     Date of denial _____

6. If SSA found you were NOT disabled, do you now have a NEW and DIFFERENT disabling condition from the one you had when SSA found you not disabled?
   - ☐ Yes (If checked, proceed with AD/MRT determination.) Describe the new or different condition:

     _____

     _____
   - ☐ No (If checked, go to #7 if the denial was within the last 12 months; to #8 if the denial was more than 12 months ago.)

7. If you still have the same condition that you had when SSA found you not disabled within the last 12 months (and answered "no" to #6), is this condition:
   ☐ about the same, ☐ better, ☐ worse, or changed? (If "about the same" or "better" is checked, STOP and deny AD. If "worse or changed" is checked, go to "a".)

(a) Have you asked SSA for a reconsideration or reopening of their previous decision?
- ☐ Yes (If checked, go to (b) below.)
- ☐ No (If checked, STOP, refer applicant to SSA for a reconsideration or reopening, and deny AD.)

(b) Did SSA agree to reconsider or reopen its determination?
- ☐ Yes (If checked, go to (c) below.)
- ☐ No (if checked, verify the reason and proceed with AD/MRT determination if appropriate.)

(c) Is the reconsideration still pending?
- ☐ Yes (If checked, verify and deny AD, and advise customer he/she may reapply for AD if Social Security Disability is approved.)
- ☐ No (If checked, go to (d) below.)

(d) When SSA reconsidered, did they:
- ☐ Again find you not disabled? (If checked here, verify and deny AD.)

(e) When you requested an SSA reconsideration did they:
- ☐ Find you not eligible for SSI or Social Security Disability for a reason other than disability? What was the reason?

_____

(If reason doesn't also disqualify for AD, proceed with AD/MRT determination. If reason does disqualify, verify and deny.)

8. IF IT HAS BEEN MORE THAN 12 MONTHS since your last SSI or Social Security Disability denial, is the condition which SSA last considered ☐ about the same ☐ better ☐ worse or changed? (If the applicant's condition is the "same" or "better", deny AD application. If the condition is "worse" or "changed", go to "a" below.)

a. Have you reapplied for SSI or Social Security Disability?
- ☐ Yes (If for SSI, deny AD. If for Social Security Disability, deny AD and advise applicant he/she may reapply for AD if Social Security Disability is approved.)
- ☐ No (If checked, proceed with AD/MRT determination.)

_____ _____

Eligibility Worker Signature Date

I understand that the Department of Human Services uses the same definition of disability that SSA has defined for SSI and Social Security Disability determinations. I certify that the information I have provided regarding my disability is true and accurate.

_____ _____

Applicant/Authorized Representative Signature Date

ARKANSAS DEPARTMENT OF HUMAN SERVICES
DIVISION OF COUNTY OPERATIONS

Medical Review Team Slot S334
Social Report for Children

Section 1: To be completed by Eligibility Worker

Child's Budget Unit ID	Cat.	Child's Name	Race	Sex	Birthdate

Application Date	County	Register #	Casehead Name

Address	City	State	Zip

Worker's Name as shown on E-Mail	Last MRT decision date	Interview Date	Date routed To MRT

Section 2: MRT use only

Date Record Added	MRT Date	Date Medical Records Request Sent Code Records Rec'd	Physician Date ID	Decision Date Code

Re-exam Date	Case Type	Key Initial	Key Date

Section 3: To be completed by Eligibility Worker

A. List all Household Members:

Last Name	First Name	Relationship	Age
		Child	

Daytime Phone # and Area Code:
Home/Mobile Number: Message Number:

B. Description of Physical & Mental Condition: Please ask the parent or caretaker the following questions:

1. What is the child's height? _____ Weight? _____
2. Does the child have problems seeing or hearing? Yes ☐ No ☐
3. Does the child wear hearing aides? Yes ☐ No ☐
4. Can you understand the child's speech? Yes ☐ No ☐
5. Can other people understand the child's speech? Yes ☐ No ☐
6. When did the illness, injury, or condition begin? Month _____ Day _____ Year _____

7. Describe any speech problems the child has.

8. Does the child use: Crutches? ☐ Wheelchair? ☐ Artificial limb? ☐
9. Describe any medical conditions or injuries that limit the child's activities.

C. Daily Activities

1. Describe what the child does on an average day from the time he/she wakes up until bedtime.

2. Describe the child's sleep habits.

3. Describe any changes in the child's activities or behavior since his/her condition began.

D. Education/Therapy

1. Does the child attend special education classes? Yes ☐ No ☐ **Attach signed DHS-4000's for all schools.**

Name of school/facility:			Grade:
Address:	City:	State:	Zip:
Area Code & Phone #:	Teacher:		

2. Does the child receive occupational, physical or speech therapy? Yes ☐ No ☐

School/Facility Information **Attach signed DHS-4000's for all facilities.**

Name of school/facility:			Grade:
Address:	City:	State:	Zip:
Area Code & Phone #:	Therapist:		

Name of school/facility:			Grade:
Address:	City:	State:	Zip:
Area Code & Phone #:	Therapist:		

3. Describe any learning problems, attendance problems, or other problems the child has had in school or therapy.

D. Medical Treatment:

1. What treatment has the child received thus far for this condition?

2. What treatment is planned for the future?

3. What medication is the child taking?

Medication	Reason for Medication	Doctor who prescribed

4. Please list all the Doctors/Clinics/Mental Health Units the child has seen in the last year.
Attach signed DHS- 4000's for each Doctor, Clinic, and Mental Health Unit.

Name:		Dates: From To	
Address:	City:	State:	Zip:
Area Code & Phone #:			

Name:		Dates: From To	
Address:	City:	State:	Zip:
Area Code & Phone #:			

Name:		Dates: From To	
Address:	City:	State:	Zip:
Area Code & Phone #:			

Name:		Dates: From To	
Address:	City:	State:	Zip:
Area Code & Phone #:			

5. Has the child been in the hospital/rehabilitation facility in the last year? Yes ☐ No ☐
Attach signed DHS-4000's for all facilities.

Hospital:		Dates: From To	
Address:	City:	State:	Zip:
Area Code & Phone #:		Chart Number (if known):	
Reason for admission:		Type of Visit: Inpatient ☐ Outpatient ☐ ER ☐	

Hospital:		Dates From: To:	
Address:	City:	State:	Zip:
Area Code & Phone #:		Chart Number (if known):	
Reason for admission:		Type of Visit: Inpatient ☐ Outpatient ☐ ER ☐	

Hospital:		Dates From: To:	
Address:	City:	State:	Zip:
Area Code & Phone #:		Chart Number (if known):	
Reason for admission:		Type of Visit: Inpatient ☐ Outpatient ☐ ER ☐	

If child is applying for TEFRA, please send MRT a copy of TEFRA form DMS-2602, Physician Assessment of Eligibility, when received.

E. Age Appropriateness

1. Is the child under 3 years old? Yes ☐ No ☐
If "Yes", can the child do the following?

Smile	Yes ☐ No ☐	Feed self	Yes ☐ No ☐
Roll over	Yes ☐ No ☐	Run	Yes ☐ No ☐
Sit alone	Yes ☐ No ☐	Use fork and spoon	Yes ☐ No ☐
Pull self up to stand	Yes ☐ No ☐	Help in dressing self	Yes ☐ No ☐
Walk alone	Yes ☐ No ☐	Unbutton clothing	Yes ☐ No ☐
Play with other children	Yes ☐ No ☐	Drink from cup	Yes ☐ No ☐
Is toilet trained	Yes ☐ No ☐	Say words other than "Mama & Dada"	Yes ☐ No ☐

2. Is the child age 3 or older? Yes ☐ No ☐ If "Yes", Please answer the following:
Does the child participate in sports, hobbies, school activities, scouting, clubs, or any other activities? Yes ☐ No ☐
If "Yes", list the activities and how often the child participates.

3. Does the child help with any household chores? Yes ☐ No ☐

Chores required:	How often done:	How well completed:	Amount of Supervision:

4. How does the child behave with adults (parents, other family members, teachers, neighbors)? Please give examples.

5. Describe how the child gets along with friends and playmates. How often and how well do they play together?

6. Is the child able to take care of his/her personal needs (bathing, dressing, brushing teeth, tolieting, etc.) as well as other children the same age? Yes ☐ No ☐

F. Worker's Observation/Remarks:

Please check attachments:

- ☐ DCO-106, Completed
- ☐ DHS-4000's, Completed for all necessary medical record requests
- ☐ Medical Records, if available
- ☐ If TEFRA application, copy of form DMS-2602, if available

ARKANSAS DEPARTMENT OF HUMAN SERVICES
AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Client Name: _____ **Client ID #:** _____
Mailing Address: _____ **Date of Birth:** _____
_____ **Case Head:** same

I, _____ hereby authorize
(Client or Personal Representative)

_____ to disclose specific health information
(Name of Provider/Plan)

from the records of the above named client to: DHS/TEFRA Committee- Slot S-406

DHS/MRT Slot S-334

(Recipient Name/Address/Phone/Fax)

for the specific purpose(s): establishing eligibility

Specific information to be disclosed: all medical/psychological records
"All Medical Records" includes any and all written information you may have concerning my health care and any illness or injury I may have suffered, including, but not limited to, medical history, consultations, prescriptions, treatment, medical evaluations, x-rays, results of tests, and copies of hospital or medical records pertaining to me.

I understand that this authorization will expire on the following date, event or condition: one year from signature

I understand that if I fail to specify an expiration date or condition, this authorization is valid for the period of time needed to fulfill its purpose for up to one year, except for disclosures for financial transactions, wherein the authorization is valid indefinitely. I also understand that I may revoke this authorization at any time and that I will be asked to sign the *Revocation Section* on the back of this form. I further understand that any action taken on this authorization prior to the rescinded date is legal and binding.

I understand that my information may not be protected from re-disclosure by the requester of the information; however, if this information is protected by the Federal Substance Abuse Confidentiality Regulations, the recipient may not re-disclose such information without my further written authorization unless otherwise provided for by state or federal law.

I understand that if my record contains information relating to HIV infection, AIDS or AIDS-related conditions, sexually transmitted diseases, alcohol abuse, drug abuse, psychological or psychiatric conditions, genetic testing, family planning, or womens, infant, & children (WIC) this disclosure will include that information.

I also understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment for services, or my eligibility for benefits; however, if a service is requested by a non-treatment provider (e.g., insurance company) for the sole purpose of creating health information (e.g., physical exam), service may be denied if authorization is not given. If treatment is research-related, treatment may be denied if authorization is not given.

I further understand that I may request a copy of this signed authorization. A copy of this authorization shall be as binding as the original.

_____	_____	_____
(Signature of Client)	*(Date)*	*(Witness-If Required)*
_____	_____	parent/guardian
(Signature of Personal Representative)	*(Date)*	*(Personal Representative Relationship/Authority)*

NOTE: This Authorization was revoked on _____ _____
(Date) *(Signature of Staff)*

ARKANSAS DEPARTMENT OF HUMAN SERVICES
AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

REVOCATION SECTION

I do hereby request that this authorization to disclose health information of _____
(Name of Client)

signed by _____ on _____
(Enter Name of Person Who Signed Authorization) *(Enter Date of Signature)*

be rescinded effective _____ I understand that any action taken on this authorization prior to the
(Date)

rescinded date is legal and binding.

_____	_____	_____	_____
(Signature of Client)	*(Date)*	*(Signature of Witness)*	*(Date)*

_____	_____	_____
(Signature of Personal Representative)	*(Date)*	*(Personal Representative Relationship/Authority)*

The Department of Human Services is in compliance with Titles VI and VII of the Civil Rights Act. This letter is available in other languages and alternate formats.

ARKANSAS DEPARTMENT OF HUMAN SERVICES
Division of County Operations

DECLARATION OF U.S. CITIZENSHIP OR SATISFACTORY IMMIGRATION STATUS

If you need this material in a different format such as large print, contact your DHS county office.

Casehead _____ Case No. _____ County _____

Federal law requires that a written declaration of U.S. citizenship or lawful alien status be made for each individual applying for or receiving Transitional Employment Assistance (TEA), Medicaid, or Food Stamps.

Please check the appropriate box and list names as requested.

☐ **I declare that the persons listed on page 1 of my application form are U.S. Citizens or Nationals.**

☐ **I declare that I am a U.S. Citizen or National.**

☐ **I declare that the following persons are aliens who are:**

1) lawfully admitted for permanent residence; or 2) refugees; or (3) asylees; or 4) parolees with status granted for at least one year; or 5) individuals whose deportation is withheld; or 6) conditional entrants

_____ INS # _____

_____ INS # _____

_____ INS # _____

☐ **I declare that the following persons are lawfully admitted aliens who are 1) U.S. military veterans with an honorable discharge; or 2) active duty servicepersons; or 3) spouses or children of #1 or #2.**

_____ Form # _____

_____ Form # _____

☐ **Other Specify INS Status** _____

_____ INS # _____

INS #

I declare under penalty of perjury that the foregoing is true and correct. (28 USC 1746)

_____ _____
Signature Date

If you have any questions regarding this form, please contact:

_____ _____
County Office Representative Phone Number

DCO-9 (R. 7/97)

ARKANSAS DEPARTMENT OF HUMAN SERVICES

IMPORTANT NOTICE

PLEASE READ BEFORE COMPLETING APPLICATION FOR BENEFITS

The PRIVACY ACT of 1974 requires the Department of Human Services (DHS) to tell you three (3) things about your Social Security Number (SSN). DHS must tell you: (1) whether disclosure is voluntary or mandatory; (2) how DHS will use your SSN; and, (3) the law or regulation that allows DHS to ask you for the SSN. If a household member does not have a Social Security Number, DHS will help the person apply for a number. A parent may refuse to disclose his or her SSN without affecting the benefits of an eligible child.

Please sign and date this notice at the bottom. Also, please initial in the space provided before each type of benefit for which you are applying.

_____ **Supplemental Nutrition Assistance Program** (SNAP): As a condition of eligibility for benefits, each household member must furnish his or her Social Security Number to DHS. Federal laws 7 U.S.C. § 2025 (e) and 42 U.S.C. § 1320b-7(b) (4) and DHS Food Stamp Certification Manual § 2100 make DHS collect your number before approving your SNAP application.* Disclosure of your Social Security Number is voluntary. However, a person who does not provide the number, or apply for one, will not be eligible to receive benefits.

_____ **Medicaid**: As a condition of eligibility, each applicant for or recipient of Medicaid must furnish his or her Social Security Number to DHS. Federal laws 42 U.S.C. §§ 1320b-7(a) (1) and 1320b-7(b) (2) and DHS Medical Services Policy Manual § 1390 make DHS collect your number before approving your Medicaid application.*. Disclosure of your Social Security Number is voluntary. However, a person who does not provide the number, or apply for one, will not be eligible to receive benefits.

_____ **TEA** (TANF): As a condition of eligibility, each applicant for or recipient of TEA (TANF), benefits must furnish DHS his or her Social Security Number. Federal laws 42 U.S.C. §§ 1320b-7(a) (1) and 1320b-7(b) (2) and DHS Transitional Employment Assistance Manual § 2110 make DHS collect your SSN before approving your application.* Disclosure of your Social Security Number is voluntary. However, a person who does not provide the number, or apply for one, will not be eligible to receive benefits.

* If someone does not have an SSN, DHS will help the person apply for one. As long as an SSN application is filed with the Social Security office, the DHS application may be approved.

In all of the above programs, DHS uses Social Security Numbers for program applicants and participants:

- To access information
- To determine eligibility
- To verify wages, unearned income, and other information
- To prevent duplicate participation
- To facilitate mass changes in Federal benefits
- To determine the accuracy and reliability of information

In addition, SSN's are used for matters related to collection of child support for TEA program participants.

Printed Name _____

Signature _____ **Date**_____

Address _____

City _____ **State** _____ **Zip** _____

ARKANSAS DEPARTMENT OF HUMAN SERVICES NOTICE OF PRIVACY PRACTICES

Updated: December 08, 2016

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Department of Human Services (DHS) provides many types of services, such as health and social services. DHS staff must collect information about you to provide these services. DHS knows that information collected about you and your health is private. DHS and all associates at all locations are required by law to maintain the privacy of patients' Protected Health Information (PHI) and to provide individuals with the Notice of the legal duties and privacy practices with respect to PHI.

DHS is required to give you a notice of our privacy practices for the information we collect and keep about you. We are required to abide by the terms of this Notice. We reserve the right to change the terms of this Notice and these new term will affect all PHI that we maintain at that time.

Revised notices may be picked up at any office or online at:
http://humanservices.arkansas.gov/publicationDocs/PUB-407.pdf

In certain circumstances, DHS may use and disclose PHI without written consent.

For Treatment: We will use your health information to provide you with medical treatment or services. We will disclose PHI to doctors, nurses, technicians, students in health care training programs, or other personnel who are involved in taking care of you. For example, a doctor treating you for a broken leg may need to know if you have diabetes because that might slow the healing process. In addition, he/she may need to tell the dietitian to arrange for appropriate meals. Different departments of DHS may share health information about you in order to coordinate the services you need, such as prescriptions, lab work and x-rays. We may disclose health information to people outside DHS who provide your medical care like nursing homes or other doctors. We may tell your health insurer about treatment your doctor has recommended to obtain prior approval to determine whether your plan will cover the cost of the treatment. We may contact you to provide reminders of appointments.

For Payment: DHS will use and disclose PHI to other health care providers to assist in payment of your bills. For example, we will use it to send bills and collect payment from you, your insurance company, or other payers, such as Medicare, for the care, treatment, and other related services you receive.

For Health Care Operations: DHS may use or disclose your PHI for the purpose of our business operations. These uses and disclosures are necessary to insure our patients receive quality care. For example, we may use PHI to review the quality of our treatment and services, and to evaluate the performance of staff, contracted employees and students in caring for you.

Business Associates: We may use or disclose your PHI to an outside company that assists us in operating our health system and performs various services for us. This includes, but is not limited to, auditing, accreditation, legal services, data processing, and consulting services. These outside companies are called "business associates" and contract with us to keep PHI received confidential in the same way we do. These companies may create or receive PHI for us.

For Public Health Activities: DHS may use or disclose your PHI for public health activities that are permitted or required by law. For example, we may disclose PHI in certain circumstances to control or prevent a communicable disease; injury; disability; to report births and deaths; and for public health oversight activities or interventions. We may disclose PHI to the Food and Drug Administration (FDA) to report adverse events or product defects, to track products, to enable product recalls, or to conduct post-market surveillance as required by law or to state or federal government agencies. We may disclose PHI, if directed by a public health authority, to a foreign government agency that is collaborating with the public health authority.

For Health Oversight Activities: DHS may disclose PHI to a health oversight agency for activities authorized by law. For example, these oversight activities may include audits; investigations; inspections; licensure or disciplinary actions; or civil, administrative, or criminal proceedings or actions. Agencies seeking this information include government agencies that oversee the health care system, benefit programs, other regulatory programs, and government agencies that ensure compliance with civil rights laws.

As Required by Law and For Law Enforcement: DHS will use and disclose PHI when required or permitted by federal, state, and local laws, or by court order. Under certain conditions, we may disclose PHI to law enforcement officials for law enforcement purposes. For example, these may include (1) responding to a court order or similar process; (2) as necessary to locate or identify a suspect, fugitive, material witness, or missing person; (3) reporting suspicious wounds, burns or other physical injuries; or (4) as relating to the victim of a crime.

Lawsuits and Other Legal Proceedings: DHS may disclose PHI in the course of any judicial or administrative proceeding or in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized.) If certain conditions are met, we may disclose your PHI in response to a subpoena, a discovery request, or other lawful process.

Abuse or Neglect: We may disclose your PHI to a government authority that is authorized by law to receive reports of abuse, neglect, or domestic violence. Additionally, as required by law, if we believe you have been a victim of abuse, neglect, or domestic violence, we may disclose your PHI to a governmental entity authorized to receive it.

For Government Programs: DHS may use and disclose PHI for public benefits under other government programs. For example, DHS may disclose PHI for the determination of Supplemental Security Income (SSI) benefits.

To Avoid Harm: DHS may disclose PHI to law enforcement in order to avoid a serious threat to the health and safety of a person or the public.

For Research: DHS may use and share your health information for certain kinds of research. For example, a research project may involve comparing the health and recovery of patients who received one medication to those who received another for the same condition. All research projects, however, are subject to a special approval process. In some instances, the law allows us to do some research using your PHI without your approval.

Family Members and Friends: If you agree, do not object, or we reasonably infer that there is no objection, DHS may disclose PHI to a family member, relative, or other person(s) whom you have identified to be involved in your health care or the payment of your health care. If you are not present, or are incapacitated, or it is an emergency or disaster relief situation, we will use our professional judgment to determine whether disclosing limited PHI is in your best interest. We may disclose PHI to a family member, relative, or other person(s) who was involved in the health care or the payment for health care of a deceased individual if not inconsistent with prior expressed preferences of the individuals known to DHS. You also have the right to request a restriction on our disclosure of your PHI to someone who is involved in your care.

Coroners, Medical Examiners, and Funeral Directors: DHS may release your PHI to a coroner or medical examiner. For example, this may be necessary to identify a deceased person or to determine cause of death. We may also release your PHI to a funeral director, as necessary, to carry out his/her duties.

Organ Donations: We will disclose PHI to organizations that obtain, bank, or transplant organs or tissues.

National Security and Protection of the President: DHS may release your PHI to an authorized federal official or other authorized persons for purposes of national security, for providing protection to the President, or to conduct special investigations, as authorized by law.

Correctional Institution: If you are an inmate of a correctional institution or under the custody of a law enforcement officer, DHS may release your PHI to them. The PHI released must be necessary for the institution to provide you with health care, protect your or other's health and safety, or for the safety and security of the correctional institution.

Military: If you are a veteran or a current member of the armed forces, DHS

may release your PHI as required by military command or veteran administration authorities.

Workers' Compensation: DHS will disclose your health information that is reasonably related to a worker's compensation illness or injury following written request by your employer, worker's compensation insurer, or their representative.

Employer Sponsored Health and Wellness Services: We maintain PHI about employer sponsored health and wellness services we provide our patients, including services provided at their employment site. We will use the PHI to provide you medical treatment or services and will disclose the information about you to others who provide you medical care.

Shared Medical Record/Health Information Exchanges: We maintain PHI about our patients in shared electronic medical records that allow the DHS associates to share PHI. We may also participate in various electronic health information exchanges that facilitate access to PHI by other health care providers who provide you care. For example, if you are admitted on an emergency basis to another hospital that participates in the health information exchange, the exchange will allow us to make your PHI available electronically to those who need it to treat you.

Sponsor of the Plan: DHS may disclose PHI to the sponsor of a group health plan or a health insurance issuer.

Other Uses and Disclosures of PHI

Other uses and disclosures of your PHI that are not described above will be made only with your written authorization. If you provide DHS with an authorization, you may revoke it in writing, and this revocation will be effective for future uses and disclosures of PHI. The revocation will not be effective for information that we have used or disclosed in reliance on the authorization.

For example, most uses and disclosures of psychotherapy notes, uses and disclosures of PHI for marketing purposes, and disclosures that constitute the sale of PHI require your written authorization.

Your PHI Privacy Rights

Right to Revoke Permission: If you are asked to sign an authorization to use or disclose PHI, you can cancel that authorization at any time. You must make the request in writing. This will not affect PHI that has already been shared.

The Right to Access to Your Own Health Information: You have the right to inspect and copy most of your protected health information for as long as we maintain it as required by law. We may require that you make this request in writing. We may charge you a nominal fee for each page copied and postage if applicable. You also have the right to ask for a summary of this information. If you request a summary, we may charge you a nominal fee.

Right to Request Restrictions: You have the right to request certain restrictions of our use or disclosure of your PHI. We are not required to agree to your request in most cases. But if DHS agrees to the restriction, we will comply with your request unless the information is needed to provide you emergency treatment. DHS will agree to restrict disclosure of PHI about an individual to a health plan if the purpose of the disclosure is to carry out payment or health care operations and the PHI pertains solely to a service for which the individual, or a person other than the health plan, has paid DHS for in full. For example, if a patient pays for a service completely out of pocket and asks DHS not to tell his/her insurance company about it, we will abide by this request. A request for restriction should be made in writing. To request a restriction you must contact the DHS Privacy Officer. We reserve the right to terminate any previously agreed-to restrictions (other than a restriction we are required to agree to by law). We will inform you of the termination of the agreed-to restriction and such termination will only be effective with respect to PHI created after we inform you of the termination.

Right to Request Confidential Communications: You may request in writing that we communicate with you in an alternative manner or at an alternative location. For example, you may ask that all communications be sent to your work address. Your request must specify the alternative means or location for communication with you. It also must state that the disclosure of all or part of the PHI in a manner inconsistent with your instructions would put you in danger. We will accommodate a request for confidential communications that is reasonable and that states that the disclosure of all or part of your protected health information could endanger you.

Right to Inspect and Copy: You have the right to inspect and receive a copy of PHI about you that may be used to make decisions about your health. A request to inspect your records may be made to your nurse or doctor while you are an inpatient or to the DHS Privacy Officer while an outpatient. For copies of your PHI, requests must go to the DHS Privacy Officer. For PHI in a designated record set that is maintained in an electronic format, you can request an electronic copy of such information. There may be a charge for these copies.

Right to Amend: You may ask us to amend the information, for as long as DHS maintains the information. Requests for amending your PHI should be made to the DHS Privacy Officer. The DHS personnel who maintain the information will respond to your request within 60 days after you submit the written amendment request form. If we deny your request, we will provide you a written explanation. You may respond with a statement of disagreement to be appended to the information you wanted amended. If we accept your request to amend the information, we will make reasonable efforts to inform others, including people you name, of the amendment and to include the changes in any future disclosures of that information.

Right to Get a List of Disclosures: You have the right to ask DHS for a list of disclosures made after April 14, 2003. You must make the request in writing. With some exceptions, you have the right to receive an accounting of certain disclosures of your PHI. A nominal fee will be charged for the record search.

Right to Get a Paper Copy of this Notice: You have the right to ask for a paper copy of this notice at any time

Right to File a Complaint: You have the right to file a complaint if you feel DHS has violated your rights. To do so, contact the Privacy Officer by using the information below. You can file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights by using the contact information below. We will not retaliate against you for filing a complaint.

Right to be notified of a Breach: You have the right to be notified in the event that we (or one of our Business Associates) discover a breach of unsecured protected health information involving your medical information.

See the contact information below:
To View, Inspect, Copy, or Amend your PHI,
To Request Confidential Communications,
To Request an accounting (list) of disclosures, To Request Restrictions,
To Revise Authorizations, or
To File a Complaint.

This privacy notice is also available at:
http://humanservices.arkansas.gov/publicationDocs/PUB-407.pdf

You may contact your local DHS office or the DHS Privacy Officer at the address listed below.

DHS Privacy Officer
Arkansas Department of Human Services
P.O. Box 1437, Slot S260
Little Rock, Arkansas 72203-1437 Telephone: 1-855-283-0835
TDD: (501) 682-8933
Email: DHSPrivacyOfficer@dhs.arkansas.gov

Office for Civil Rights
U.S. Department of Health & Human Services
1301 Young Street-Suite 1169
Dallas, TX 75202
(800) 368-1019; (800) 537-7697(TDD)
(202) 619-3818 Fax
www.hhs.gov/ocr/privacy/hipaa/complaints/

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____ (print name of client or legal representative) have been given a copy of DHS's Notice of Privacy Practices and have had a chance to ask questions about how my PHI will be used.

_____ _____
Client's Signature **Date**

_____ _____
Legal or Personal Representative of Client (if applicable) **Date**

File the original signed copy in the case record; give the recipient of this notice a copy of this document.

Arkansas Department of Human Services
Division of County Operations
THIRD PARTY RESOURCE / MEDICAL INSURANCE

A. APPLICANT INFORMATION:

1. Last Name	2. First Name	3. MI	4. Sex	5. Social Security Number

6. Applicant's Address	7. City	8. ST	9. Zip

10. Other than Medicare, do you have health insurance or some other insurance, settlement, person or group that is responsible for paying all or part of your medical expenses?

☐ **Yes** If Yes, please either attach proof of coverage (such as a copy of your insurance card) **OR** complete B, C and D below.

☐ **No** If No, please skip to Section F and provide a phone number, sign and date the form, and mail it to us.

B. POLICYHOLDER INFORMATION:

11. Policyholder's Last Name	12. First Name	13. MI	14. Social Security Number

15. Policyholder's Address	16. City	17. ST	18. Zip

C. INSURANCE INFORMATION:

19. Name of Insurance Company	20. Policy Number	21. Policy Effective Dates	
		From / /	To / /

22. Address of Claims Office	23. City	24. ST	25. Zip

26. Check all Type of Benefits/Coverage Applicable (at least one must be checked)

☐ 1. Medical	☐ 4. Vision	☐ 7. Indemnity/Hospital/Cancer/Heart
☐ 2. Pharmacy	☐ 5. Medicare Supplement	☐ 8. Accident Only (non-Auto)
☐ 3. Dental	☐ 6. Long Term Care	☐ 9. Automobile/Motorcycle Accident
		☐ 10. Other _____

D. INDICATE ALL INDIVIDUALS COVERED BY POLICY:

27. Last Name	28. First	29. MI	30. Relationship	31. SSN or Medicaid Number

E. COMMENTS _____

_____

F. TELEPHONE NUMBER WHERE YOU CAN BE REACHED BETWEEN 8:00/4:30 _____

AUTHORIZATION AND ASSIGNMENT

I authorize any holder of medical or other information about me to release information needed for this or a related Medicaid claim to the Arkansas Medicaid program. I authorize the further release of any such information to any other parties who may be liable for any of my medical expenses. I hereby authorize and request that funds, settlement or other payments made by or on behalf of third parties, including tort-feasors or insurers, arising out of this Medicaid claim be paid directly to the Arkansas Medicaid program. I also assign all rights in any settlement made by me or on my behalf and arising out of any claim of which this is a part to the extent of medical expenses paid by Medicaid whether or not a portion of such settlement is designated as being for medical expenses. Any such funds received by me shall be paid to the Arkansas Medicaid program. I permit a copy of this authorization to be used in place of the original.

_____ _____

Applicant/Recipient signature (or parent/guardian if minor) Date

1. **DCO-108C** form suggests that it is to be filled out by the "county worker"...disregard...this form is to be completed by the parent/guardian and returned to Partners
2. **DCO-106**...same issue...leave the line blank for county worker signature...complete the info and return to Partners
3. **DHS-4000**...the space where you indicate to whom the records can be released ("Recipient/Name/Address/Phone/Fax") please indicate both DHS and Partners for Inclusive Communities

RETURN TO:
PARTNERS FOR INCLUSIVE COMMUNITIES
Attention: AAP
322 Main Street, Suite 501
Little Rock, AR 72201

AAP Administration:

- Karan Burnette, Director

*Renee Holmes, Regional Waiver Coordinator
rmholmes@uark.edu;

*Vickie Tankersley, Regional Waiver Coordinator
vctanker@uark.edu;

*Shakira Gilbert, Regional Waiver Coordinator
srg02@uark.edu;