Arkansas Autism Partnership

Arkansas' Autism Waiver Program

Autism Waiver Checklist for Initial Application

- ☐ Autism Waiver/ Department of Human Services Healthcare Application (Form DCO-0004)
- ☐ DHS Release of Info (Form DHS-4000)
- ☐ Medical Review Team Social Report (Form DCO-108C)
- ☐ 2 of the 3 evaluations listed below:
  - ☐ 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
- ☐ Copy of birth certificate
- ☐ Copy of social security card
- ☐ Copy of private insurance 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
- ☐ Copy of custody or guardianship papers (if applicable)

Submit Application and Supporting Documents By...

Email: rmholmes@uark.edu and lwatt@uark.edu

Mail to: Partners for Inclusive Communities
ATTN: AAP
10809 Executive Center Drive, Suite 316
Little Rock, Arkansas 72211

Fax: (479)308-0296

AAP Administration:

Renee Holmes, Director of Autism Services rmholmes@uark.edu
Shakira Gilbert, Waiver Coordinator srg02@uark.edu
Leigh Ann VanGorder, Waiver Coordinator lavangor@uark.edu
Cathy Fox, Waiver Coordinator caf002@uark.edu
Lindsay Watt, Waiver Eligibility Specialist lwatt@uark.edu

Arkansas Department of Human Services

Application for SNAP, Health Care, and TEA/RCA Benefits

This is a combined application for food, medical, and cash assistance. You can answer only the questions related to the program(s) for which you are applying. Please answer all questions if you are applying for all programs. A friend, relative, or anyone that you wish, may help you complete this application.

What sections of the application do I need to complete?

To apply for SNAP:

Check the box below and complete all the sections marked for SNAP, even if other programs are listed along with it.

If the question states that it is not required for SNAP, you are not required to complete that section.

To apply for Health Care:

Check the box below and complete all the sections marked for Health Care, even if other programs are listed along with it.

If the question states that it is not required for Health Care, you are not required to complete that section.

To apply for TEA or RCA:

Check the box below and complete all the sections marked for TEA/RCA, even if other programs are listed along with it.

If the question states that it is not required for TEA/RCA, you are not required to complete that section.

☐ **SNAP**

Supplemental Nutrition Assistance Program (SNAP): Monthly benefits to help pay for groceries.

☑ **Health Care**

Free or low-cost insurance from Medicaid to help pay for doctor visits, hospital stays, prescription medicines, lab tests, x-rays, and more.

☐ **TEA/RCA**

Transitional Employment Assistance (TEA): cash assistance to help families with children under 18 to become more independent.

Refugee Cash Assistance (RCA): cash assistance to help individuals who have recently entered the US with a certain immigration status.

Please select below if you would like to apply for any of these specific types of Health Care assistance.
(not all-inclusive)

☐ TEFRA	Helps children under 19 years old who have a disability get Health Care coverage when they might not qualify for coverage otherwise.
☑ Autism Services	Provides one-on-one treatment for eligible children from age 18 months up until the child's 8th birthday who are diagnosed with Autism Spectrum Disorder.
☐ ARChoices	Home and community-based services for adults ages 21-64 who have a physical disability or are age 65 and older.
☐ PACE (Programs of All-Inclusive Care for the Elderly)	For those age 55 to 64 with a physical disability or age 65 or older who need to be in a nursing home but want to receive home and community-based services safely in their home instead. (Must live in an area that offers services.)
☐ Assisted Living Assistance	Covers services in a Level II Assisted Living Facility if you are living in or are planning to enter one and meet the requirements.
☐ Nursing Facility Assistance	Covers services in skilled nursing facilities or nursing homes for those who meet the requirements. Must be in a nursing facility or planning to enter one.
☐ Community Employment Support (DDS Waver)	Provides services for people with developmental disabilities so they can participate as active members in their communities.
☐ Medically Needy Spend-Down	Provides short-term coverage for those whose income is above the normal limits for Health Care assistance but who have high medical bills within a 3-month period and meet the program requirements.
☐ Medicare Savings Program	Provides limited coverage to supplement Medicare recipients. Coverage ranges from payment of Medicare premiums, deductibles, and co-insurance for low-income individuals, to paying only a portion of the Medicare Part B premium for individuals with higher incomes.

Language Support

If you do not speak English, have a hearing impairment, or have a disability, let us know how we can help you (an interpreter, sign language, TDD/TTY phone number we should call, assistive listening device, etc.) or you may provide your own support. You can also call Client Assistance for free at 1-800-482-8988.

Si no habla inglés, tiene una discapacidad auditiva o tiene una discapacidad, háganos saber cómo podemos ayudarle (un intérprete, un lenguaje de señas, un número de teléfono TDD / TTY al que debemos llamar, un dispositivo de asistencia auditiva, etc.) o puede traer su propio apoyo. Llame a Asistencia al Cliente de forma gratuita al 1-800-482-8988.

What is the language that you need to read?	☐ English	☐ Spanish	☐ Marshallese	☐ Other:
In what language do you prefer for notices to be sent?	☐ English	☐ Spanish	☐ Marshallese	☐ Other:
Do you need an interpreter?	☐ Yes	☐ No	If yes, what language? _____	

STEP 1 About Your Head of Household

Head of Household Full Name:		
Physical Address:		**Unit/Apt:**
City:	**State:**	**ZIP:**
Mailing Address (*If different*):		**Unit/Apt:**
City:	**State:**	**ZIP:**
Preferred Phone:	**Alternate Phone:**	
Email:		

Do you want to receive electronic notifications and alerts for your case? If so, check: ☐ **Phone alerts** ☐ **Email alerts**

Do you currently live in Arkansas? ☐ Yes ☐ No

Has anyone in your household received assistance in another state in the last 30 days? ☐ Yes ☐ No

In which of the following settings do members of your household live?

☐ Home ☐ College Housing ☐ Transitional Housing ☐ Nursing Home ☐ Homeless
☐ Prison/Jail ☐ Mental health facility ☐ Drug/alcohol treatment facility ☐ Shelter ☐ Other

Is anyone temporarily absent from the home? (military, hospital, incarceration, school/college, etc.) ☐ Yes ☐ No

If yes, list the name(s) of those person(s):

Are you applying for anyone that is recently deceased? ☐ Yes ☐ No

If yes, list their name and date of death	Name:	Date of death:

Does the facility where you live provide you with the majority (over 50% of three meals daily) of your meals as part of its nutrition services? *(SNAP only)* ☐ Yes ☐ No

STEP 2 Interview Requirements

Households applying for SNAP and TEA/RCA are required to complete an interview to see if they are eligible. This interview can be in-person, over the phone, or virtual. Only one interview is necessary when applying for both SNAP and TEA/RCA.
If you miss your scheduled appointment for an interview, we will not schedule another one unless you ask us to do so.

1. **Would you prefer an in-person or telephone interview?** ☐ **In-person** ☐ **Telephone**

   If a telephone interview was selected, you must provide a working phone number. Be sure to have service or minutes available.

   Phone Number (if different from above): _____

FOR AGENCY USE ONLY		Case Number(s):		
		Programs Applied For	Disposition	
For SNAP Only:		☐ SNAP----------	☐ Pended	☐ Approved ☐ Denied
Expedite?		☐ TEA/RCA----------	☐ Pended	☐ Approved ☐ Denied
☐ Yes	☐ No	☐ Health Care----------	☐ Pended	☐ Approved ☐ Denied
Screen Date:	LD Date:	☐ LTSS/Nursing Facility ☐ TEFRA/Autism ☐ DDS Waiver	Received Date:	
Screener:			Disposition Date:	

STEP 3 Expedited Screening (for SNAP Only)

Most SNAP applications are processed within 30 days. However, in some cases a household may be entitled to expedited services. Please answer the questions below so we can decide if you are eligible to have your SNAP application processed sooner.

1. **What is your household's total monthly income before deductions?** $_____

   Deductions are amounts taken out for taxes, insurance, etc. The monthly total must include money that you and other household members get from work and money you get in the form of checks or cash. Also, you must include money that you and other members of your household have already gotten so far this month and money that you will be getting before the end of the month.

2. **How much money do you and other household members currently have in cash, checking accounts, savings accounts, etc.?** $_____

3. **How much does your household pay monthly for housing and utilities?** $_____

4. **Which utilities do you pay for separate from rent or mortgage?** (Check all that apply)

   ☐ Electricity ☐ Natural Gas ☐ Water ☐ Trash ☐ Phone ☐ Other

For Households with Migrant or Seasonal Farm Workers:

5. **Are you or anyone in your household a migrant or seasonal farm worker?** ☐ Yes ☐ No

   If so, did anyone in your household's income recently stop? ☐ Yes ☐ No

6. **Does anyone expect income from a new source this month?** ☐ Yes ☐ No

   If yes, how much will the income be? $_____

   When do you expect to get it? $_____

Right to File:

You have the right to immediately file an application for SNAP (food assistance) so long as your name and the signature of a responsible household member or authorized representative (see Appendix C) are provided on this page. SNAP benefit amounts are based on the date of application among other factors. You will not be *approved* for benefits until the full application process is complete.

By my signature, I authorize the Arkansas Department of Human Services (DHS) to get information from other state agencies, financial institutions, employers, federal agencies, and other sources to prove my statements are correct. I understand that if differences are found between what I report and information provided by the sources listed above, DHS may contact other sources for verification. I understand that I may have to provide proof that shows what I've told the Department is true. I understand that this information may affect my household's eligibility for benefits. I also understand that I must tell the Department about any changes to the information I gave on my application. I understand that if required, I must cooperate with the Office of Child Support Enforcement as a condition of eligibility. I have received, reviewed, and agree to the information about my responsibilities included in this application. I certify, under penalty of perjury, that the information I have given on this form is true and complete to the best of my knowledge.

Signature: _____ **Date:** _____

Note: An Authorized Representative may sign this document as long as you have provided the information required in Appendix C (attached).

STEP 4 EBT Card

Any SNAP or TEA/RCA benefits you get will be put on your household's Arkansas Electronic Benefit Transfer (EBT) card. If you have never had an EBT card in Arkansas, one will be mailed to you once benefits have been approved. If you need to replace a lost or stolen card, you can call the EBT Help Desk at 1-800-997-9999 or check "yes" below for assistance.

Have you ever had an EBT card in Arkansas?	☐ Yes	☐ No
If **yes**, do you need help ordering a new EBT card?	☐ Yes	☐ No

STEP 5 About Everyone in Your Household
(Even if you are not requesting benefits for them)

	EXAMPLE	Household Member #1 (YOU)	Household Member #2
1. First Name:	Maria		
Middle Name:	Denae		
Last Name:	Johnson		
2. Date of Birth:	01/23/1987		
3. Gender:	Female		
4. Race/Ethnicity (American Indian or Alaska Native, Asian Indian, Black or African American, Chinese, Chicano/a, Cuban, Filipino, Guamanian or Chamorro, Japanese, Korean, Mexican, Mexican American, Native Hawaiian, Non-Hispanic/Latino, Other Asian, Other Pacific Islander, Puerto Rican, Samoan, Spanish Origin, Vietnamese, Another Hispanic or Latino, or White):	Vietnamese		
5. Is this person a U.S. citizen? (Immigrants may be eligible for benefits)	Yes		
6. Social Security Number: (Leave blank if the person doesn't have one or isn't applying for benefits)	555-55-5555		
7. Relationship to Head of Household:	daughter		
8. Which benefits is this person applying for with your household? (List all that apply. If none, write "N/A")	SNAP, TEA		
9. Are you or your spouse the biological or adoptive parent(s) of this person?	No		
10. Is this person active duty military, a veteran, or the spouse or dependent child of someone who is active duty or a veteran? If yes, which?	Yes, veteran		
11. Is this person in foster care?	No		
12. Was this person in Arkansas foster care and enrolled in Health Care assistance when they turned 18 through 21? (Health Care only)	Yes		
13. Is this person a full-time student?	No		
14. Is this person enrolled in college or vocational school?	Yes		
If yes, name of the school/program and whether they are going full time or part-time:	McKinley Tech – Full		
15. Is this person fleeing from felony prosecution, an outstanding felony warrant, or jail? (SNAP and TEA only)	Yes		
16. Is this person currently pregnant or was pregnant in the last 90 days?	Yes		
If this person is pregnant now, when is the baby due?	MM/DD/YY		
If pregnant now, how many babies are expected during this pregnancy? (Health Care only)	1		
If this person was pregnant in the last 90 days, when did the pregnancy end?	MM/DD/YY		
Was this person enrolled in or eligible for Health Care assistance at the time of the child's birth? (Health Care only)	Yes, Not sure		
17. Has this person had high medical bills within the 7-month period including the last three, the current one, and the next three months? If so, which 3 months were they the highest? (Health Care only)	Yes, Oct-Dec		

18. Does this person have any unpaid medical bills from the last 3 months? (Health Care only)	Yes		
If **yes**, in which of the last 3 month(s) does this person have unpaid medical bills?	June, July		
Have payment arrangements been made?	No		
What was your household size in the last 3 months?	3 people		
Did this person's income change in the last 3 months?	No		
If yes, when and what changed?	Feb, lost job		
Did this person move out of the state in the last 3 months?	Yes		
If yes, when did this person move out of the state?	June/July		
Did this person's resources change in the last 3 months?	Yes		
If yes, how did they change?	New acct.		
19. Did this person have health insurance through a job and lost it in the past 3 months? (Health Care only)	Yes		
If yes, when did the coverage end? (Health Care only)	12/31/2020		
If yes, what is reason for the coverage ending? (Health Care only)	Laid off		
20. Is this person blind, disabled, or need help with daily living activities (such as bathing or walking)?	Yes, blind		
21. Is this person living in or planning to live in an Assisted Living Facility?	Yes		
If yes, what is the name of the nursing facility?	Fox Ridge		
22. Is this person living in or planning to live in a nursing home in the next 15 days?	Yes		
If yes, what is the name of the facility?	Fox Home		
23. Is this person over age 21 and have a physical disability that would require them to live in a nursing facility but would rather get home and community-based services? (Assisted Living Facilities, PACE, ARChoices, etc.)	Yes		
24. Is this person currently living in an Intermediate Care Facility for the Intellectually Disabled?	No		
25. Is this person currently living in a Human Development Center?	No		
26. Does this person have a developmental disability and want to get home and community-based services? (example: DDS Waiver, Autism Waiver)	No		
27. Is this person in an alcohol or drug treatment program?	No		
28. Has this person previously had benefits stopped for providing false information? (SNAP and TEA only)	No		
29. Do you usually buy and make meals together? (SNAP only)	Yes		
30. Is this person currently a victim of domestic violence, victim of trafficking, migrant farmworker, seasonal farmworker, or refugee/asylee? If so, which?	Yes, Refugee		
31. Is this person under 5 years of age AND not up to date on their immunizations? (TEA/RCA only)	Yes		
32. Is this person between ages 5-17 AND <u>not</u> enrolled in school now? (TEA/RCA only)	No		

STEP 5 (continued) About ADDITIONAL Members In Your Household

	Household Member #3	Household Member #4	Household Member #5
1. First Name:			
Middle Name:			
Last Name:			
2. Date of Birth:			
3. Gender:			
4. Race/Ethnicity (American Indian or Alaska Native, Asian Indian, Black or African American, Chinese, Chicano/a, Cuban, Filipino, Guamanian or Chamorro, Japanese, Korean, Mexican, Mexican American, Native Hawaiian, Non-Hispanic/Latino, Other Asian, Other Pacific Islander, Puerto Rican, Samoan, Spanish Origin, Vietnamese, Another Hispanic or Latino or White):			
5. Is this person a U.S. citizen? (Immigrants may be eligible for benefits)			
6. Social Security Number: (Leave blank if the person doesn't have one or isn't applying for benefits)			
7. Relationship to Head of Household:			
8. Which benefits is this person applying for with your household? (List all that apply. If none, write "N/A")			
9. Are you or your spouse the biological or adoptive parent(s) of this person?			
10. Is this person active duty military, a veteran, or the spouse or dependent child of someone who is active duty or a veteran?			
11. Is this person in foster care?			
12. Was this person in Arkansas foster care and enrolled in Health Care assistance when they turned 18 through 21? (Health Care only)			
13. Is this person a full-time student?			
14. Is this person enrolled in college or vocational school?			
If yes, name of the school/program and whether they are going full time or part-time:			
15. Is this person fleeing from felony prosecution, an outstanding felony warrant, or jail? (SNAP and TEA only)			
16. Is this person currently pregnant or was pregnant in the last 90 days?			
If this person is pregnant now, when is the baby due?			
If pregnant now, how many babies are expected during this pregnancy? (Health Care only)			
If this person was pregnant in the last 90 days, when did the pregnancy end?			
Was this person enrolled in or eligible for Health Care assistance at the time of the child's birth? (Health Care only)			
17. Has this person had high medical bills within the 7-month period including the last three, the current one, and the next three months? If so, which 3 months were they the highest? (Health Care only)			

18. Does this person have any unpaid medical bills from the last 3 months? (Health Care only)			
If **yes**, in which of the last 3 month(s) does this person have unpaid medical bills?			
Have payment arrangements been made?			
What was your household size in the last 3 months?			
Did this person's income change in the last 3 months?			
If yes, when and what changed?			
Did this person move out of the state in the last 3 months?			
If yes, when did this person move out of the state?			
Did this person's resources change in the last 3 months?			
If yes, how did they change?			
19. Did this person have health insurance through a job and lost it in the past 3 months? (Health Care only)			
If yes, when did the coverage end? (Health Care only)			
If yes, what is reason for the coverage ending? (Health Care only)			
20. Is this person blind, disabled, or need help with daily living activities (such as bathing or walking)?			
21. Is this person living in or planning to live in an Assisted Living Facility?			
If yes, what is the name of the nursing facility?			
22. Is this person living in or planning to live in a nursing home in the next 15 days?			
If yes, what is the name of the facility?			
23. Is this person over age 21 and have a physical disability that would require them to live in a nursing facility but would rather get home and community-based services? (Assisted Living Facilities, PACE, ARChoices, etc.)			
24. Is this person currently living in an Intermediate Care Facility for the Intellectually Disabled?			
25. Is this person currently living in a Human Development Center?			
26. Does this person have a developmental disability and want to get home and community-based services? (example: DDS Waiver, Autism Waiver)			
27. Is this person in an alcohol or drug treatment program?			
28. Has this person previously had benefits stopped for providing false information? (SNAP and TEA only)			
29. Do you usually buy and make meals together? (SNAP only)			
30. Is this person currently a victim of domestic violence, victim of trafficking, migrant farmworker, seasonal farmworker, or refugee/asylee? If so, which?			
31. Is this person under 5 years of age AND not up to date on their immunizations? (TEA/RCA only)			
32. Is this person between ages 5-17 AND <u>not</u> enrolled in school now? (TEA/RCA only)			

STEP 6 Are Any Applicants in Your Household a Non-U.S. citizen?

☐ **Yes** – complete below ☐ **No** – (skip to step 7)

Many immigrants are eligible for benefits. Complete the immigration information for the household members who are not U.S. citizens and are seeking benefits. We must ask Immigration Services (USCIS) to verify the status of anyone who is seeking benefits for themselves. This may affect your eligibility for benefits and the amount of your benefits.

Immigration Statuses

- Lawful Permanent Resident
- Employment authorization
- Refugee
- Asylee
- Parolee
- Marshall Islander
- Amerasian
- Canadian Born American Indians
- Cuban or Haitian
- Palauan
- Iraqi and Afghan Special Immigrant
- Micronesian
- Family Unity beneficiary
- Conditional Entrant
- Battered Alien or Child of a Battered Alien
- Victim of Trafficking
- Temporary Protected Status (TPS)
- Temporary Resident Status
- Under Deferred Enforced Departure (DED)
- Administrative Stay of Removal
- Noncitizen with Withholding of Removal
- Deportation or removal withheld
- Convention Against Torture protectee
- Deferred Action status
- VISA with Adjustment of Status
- Special Immigrant Juvenile Status (SIJS), including pending applicants for SIJS
- Undocumented

Household Member Name	**Alien #**	**Immigration Status** *(use categories above)*	**Date Entered the U.S.** *(mm/dd/yy)*	**Immigration Document Type**	**Document ID Number**

Did anyone above move to the U.S. before August 22, 1996? ☐ Yes ☐ No	If yes, who?		
If you are a Lawful Permanent Resident (LPR), do you have a sponsor? ☐ Yes ☐ No	*Sponsor name:*		
Sponsor's address:	City:	State:	ZIP:
Sponsor's employer:	Sponsor's monthly income: $		
Have you, your parents, your spouse, or your sponsor ever worked in the U.S.? ☐ Yes ☐ No			

STEP 7 Tax Information (Health Care only)

1. Is anyone in your household planning to file taxes next year? ☐ Yes ☐ No
If yes, complete the section below.

Tax Filer Name	Filing Status	Tax Dependents Claimed Who Are **Living with** the Tax Flier	Tax Dependents Claimed Who Are **NOT** Living with the Tax Flier
Tax Filer 1 Name: _____	☐ Single ☐ Married (Filing Jointly) ☐ Married (Filing Separate)		
Tax Filer 2 Name: _____	☐ Single ☐ Married (Filing Jointly) ☐ Married (Filing Separate)		

2. Is anyone in your household a tax dependent of someone <u>NOT</u> living with you? ☐ Yes ☐ No
If yes, complete the section below.

Tax Dependent name	Name of Tax Filer Claiming Dependent	Tax Filer Address

STEP 8

Does your household have any income?

☐ **Yes** – complete below ☐ **No** – (skip to step 9)

Who in your household is employed? *(Include yourself and write full names)*	**Employer's Name** *(If self-employed, write "self-employed")*	**Employer's Address**	**Employer's Phone #**	**Job Start Date**	**Paycheck Amount** *(Before taxes and deductions)*	**How Often Paid?** *(example: daily, weekly, biweekly, monthly, etc.)*

What types of income does your household get other than those listed above? For example:

- Unemployment/Workers Comp
- Self-employment/Odd Jobs
- Help with Expenses
- Alimony Received
- Child Support
- Foster Care/Adoption Subsidy
- Lottery/Gambling Winnings
- Prizes/Awards
- Social Security (SSI)
- Veterans Disability
- Other VA benefit
- Net Rental/Royalty
- Social Security (Non-SSI)
- Net Farming/Fishing
- Pensions & Retirement
- Cash Gifts

Income type	**Who in your household gets this?** *(Full name)*	**Amount** *(Before taxes & deductions)*	**How often?** *(Example: daily, weekly, every two weeks, monthly, etc.)*

Has the income for anyone in your household changed in the last 30 days? ☐ Yes ☐ No

If yes, whose income changed?	How did the income change?

STEP 8 (continued) — Additional Income Questions

1. Please check all that can be deducted on the household's tax return: (Health Care only)

☐ Alimony paid	$_____	How often: _____
☐ Other deductions paid:	$_____	How often: _____
☐ Student loan interest paid	$_____	How often: _____
If any of these are checked; please list which household members is claiming these deductions:		Name(s):

2. Does anyone pay your household for meals or to rent a room? ☐ Yes ☐ No

If yes, person's full name: _____ *Monthly payment*: $_____

3. Does anyone in your household have an annuity? ☐ Yes, value: $_____ ☐ No (Skip to Step 9)

Is a beneficiary of the annuity a member of your household? ☐ Yes ☐ No

If yes, full name(s) of beneficiaries:

What type of annuity is it? ☐ Deferred ☐ Immediate ☐ Retirement

What kind of annuity is it? ☐ Revocable ☐ Non-Assignable ☐ Irrevocable

On what date was the annuity established? _____/_____/_____

Does the annuity provide a balloon or deferred payment? ☐ Yes ☐ No

Which entity was the annuity purchased through? ☐ Financial ☐ Insurance ☐ Other/Unknown

What is the source of the annuity funds? ☐ Annuitant ☐ Retirement Plan ☐ Other/Unknown

If funds were used to purchase the annuity, were the funds from someone in your household? ☐ Yes ☐ No

Full name of funder:

Non-Custodial Parent Information

STEP 9 Does any child on this application have a parent who lives outside the home?

☐ **Yes** –complete below ☐ **No** – (skip to step 10)

As a condition of eligibility for Health Care, SNAP, and TEA, you must tell DHS if any of the children for whom you are seeking benefits have a parent that is absent from the home. If you do not want to provide the details for the absent parent, you may provide proof that you have good cause not to cooperate.

Would you like to claim Good Cause to not cooperate with the Office of Child Support Enforcement? ☐ Yes ☐ No

If yes, select the Good Cause reason(s) that apply:

- ☐ You are working with an agency helping to decide whether to place the child for adoption.
- ☐ Court proceedings are going on for adoption of the child.
- ☐ The child was born as a result of rape or incest.
- ☐ Cooperation is anticipated to result in serious physical or emotional harm to the child.
- ☐ Cooperation is anticipated to result in physical or emotional harm to you; which is so serious, it reduces your ability to care for the child adequately.
- ☐ Other

Child One

Child's Full Name:		**Child's DOB:**
City and State where child was born:		
Tell us about the non-custodial/absent parent (*provide all information you have*)		
Parent's Full Name:		**Nickname:**
DOB:	**Place of Birth** (*city, state*)**:**	**SSN:**
Race:	**Phone:**	
Last Known Employer:	**Dates of Employment:**	
Has paternity been established? ☐ Yes ☐ No	**Has child support been ordered?** ☐ Yes ☐ No	
Child Support Hearing Court/District:	**City:**	**State:**
Date Ordered:	**Amount Ordered:**	**Date last received:**

Child Two

Child's Full Name:		**Child's DOB:**
City and State where child was born:		
Tell us about the non-custodial/absent parent (*provide all information you have*)		
Parent's Full Name:		**Nickname:**
DOB:	**Place of Birth** (*city, state*)**:**	**SSN:**
Race:	**Phone:**	
Last Known Employer:	**Dates of Employment:**	
Has paternity been established? ☐ Yes ☐ No	**Has child support been ordered?** ☐ Yes ☐ No	
Child Support Hearing Court/District:	**City:**	**State:**
Date Ordered:	**Amount Ordered:**	**Date last received:**

Child Three	**Child's Full Name:**		**Child's DOB:**
	City and State where child was born:		
	Tell us about the non-custodial/absent parent (*provide all information you have)*		
	Parent's Full Name:		**Nickname:**
	DOB:	**Place of Birth** *(city, state)*:	**SSN:**
	Race:	**Phone:**	
	Last Known Employer:	**Dates of Employment:**	
	Has paternity been established? ☐ Yes ☐ No	**Has child support been ordered?** ☐ Yes ☐ No	
	Child Support Hearing Court/District:	**City:**	**State:**
	Date Ordered:	**Amount Ordered:**	**Date last received:**
Child Four	**Child's Full Name:**		**Child's DOB:**
	City and State where child was born:		
	Tell us about the non-custodial/absent parent (*provide all information you have)*		
	Parent's Full Name:		**Nickname:**
	DOB:	**Place of Birth** *(city, state)*:	**SSN:**
	Race:	**Phone:**	
	Last Known Employer:	**Dates of Employment:**	
	Has paternity been established? ☐ Yes ☐ No	**Has child support been ordered?** ☐ Yes ☐ No	
	Child Support Hearing Court/District:	**City:**	**State:**
	Date Ordered:	**Amount Ordered:**	**Date last received:**
Child Five	**Child's Full Name:**		**Child's DOB:**
	City and State where child was born:		
	Tell us about the non-custodial/absent parent (*provide all information you have)*		
	Parent's Full Name:		**Nickname:**
	DOB:	**Place of Birth** *(city, state)*:	**SSN:**
	Race:	**Phone:**	
	Last Known Employer:	**Dates of Employment:**	
	Has paternity been established? ☐ Yes ☐ No	**Has child support been ordered?** ☐ Yes ☐ No	
	Child Support Hearing Court/District:	**City:**	**State:**
	Date Ordered:	**Amount Ordered:**	**Date last received:**

If you have more than 5 children with non-custodial parents, please list their information on an additional sheet.

Step 10 About Your Household's Resources

1. Does anyone have any financial accounts? ☐ Yes ☐ No

If yes, list all accounts owned/co-owned by you and anyone applying with you.

(Examples: Checking/Savings account, Banking Apps, 401K, IRA, Annuities, ABLE, Money Market, Stocks/Bonds/Mutual Funds, etc.)

Type	Account Owner(s)	Bank Name	Account Balance	Date Opened
			$	
			$	
			$	
			$	

2. Does anyone in your household have cash on hand or in the home? ☐ Yes ☐ No

If yes, who? _____ How much? $_____

3. Does anyone in your household have any vehicles (even if they are not registered in that person's name)? ☐ Yes ☐ No

If yes, are any of these vehicle(s) used by someone who is sick or disabled? ☐ Yes ☐ No

Please list below all vehicles owned/co-owned by you or anyone applying with you.

(Examples: Cars, Trucks, Boats, Motorcycles, Motor homes, ATVs, etc.)

Owner	Year	Make	Model	Amount Owed
				$
				$
				$

4. Does anyone in your household own any other property assets? ☐ Yes ☐ No

If yes, please complete the table below for you and anyone applying with you.

Type	Who owns this?	Fair Market Value	Amount Owed	Date Acquired
☐ Your Home		$	$	
☐ Land		$	$	
☐ Rental Home		$	$	
☐ RV/ATV		$	$	
☐ Boats		$	$	
☐ Machinery		$	$	
☐ Trailers		$	$	
☐ Livestock		$	$	
☐ Machinery		$	$	
☐ Other:		$	$	

5. Does anyone in your household have any of the following assets? ..... ☐ Yes ☐ No

If yes, complete the table below for you and anyone applying with you.

Type	Who owns this?	Cash Surrender Value	Date Acquired
☐ Life Insurance		$	
☐ Trust		$	
☐ Burial Plot		$	
☐ Burial Plan/Contract		$	

If checked, name of burial plan company: Address:

6. Has anyone in your household sold, traded, or given away assets, closed any financial accounts in the last 3 months *(SNAP only)* **or in the last 5 years** *(Health Care only)***?** ☐ Yes ☐ No

What was traded or given away?	Who owned it?	Who got it?	Fair Market Value of item
			$
			$
			$
			$

STEP 11 Tell us About Your Household's Expenses

1. How much does your household pay for the following per month? See below.
(Only list the amount you pay, not including housing assistance.)

Rent/Lease: $	Mortgage: $	Utilities: $	Escrow: $
Property Taxes: $	Real Estate Taxes: $	Homeowner's Insurance: $	Condo Fee/HOA: $
Other expense(s): $			

Who pays these expenses? _____
Amount or portion paid: _____ How often? _____

2. Check all the utilities that your household pays separate from your rent or mortgage:

☐ Electricity ☐ Natural Gas ☐ Water ☐ Trash ☐ Phone ☐ Other: _____

Who pays these expenses? _____ Amount paid? _____ How often: _____

3. Has anyone applying for SNAP received more than a $20 energy payment(s) in the last 12 months? ☐ Yes ☐ No

4. Do you pay for heating/air conditioning separately from your rent? (SNAP only) ☐ Yes ☐ No

5. Do you pay someone for a room? (SNAP only) ☐ Yes ☐ No

If yes, how much do you pay and when did you start paying for the room: Amount: $_____ Date: _____

What is the residence type? ☐ Boarding house ☐ Private Residence ☐ Other: _____

How many meals are provided by the owner each day? _____

How often do you pay for the room? (weekly, monthly, etc.) _____

6. Does anyone in your household get lower housing costs due to getting Section 8, HUD, etc.? ☐ Yes ☐ No

7. Does anyone have a minor child living outside the home? ☐ Yes ☐ No
If yes, name(s): _____

8. Does anyone in your household pay child support? ☐ Yes ☐ No
If yes, who? _____
How much do you pay each month? $_____

9. Is anyone in your household legally obligated to pay child support? ☐ Yes ☐ No
If yes, how much are you/they ordered to pay each month? $_____

10. Does anyone in your household pay dependent care expense? ☐ Yes ☐ No

If yes, is this expense for childcare costs? (daycare, after school, etc.) ☐ Yes ☐ No

Is this expense for the care of a disabled household member? ☐ Yes ☐ No

Name of dependent: _____
How much is paid $_____ How often? _____ (daily, weekly, monthly, etc.)
Name of care provider: Provider contact information:

11. Does anyone in your household who is 60 or older or disabled pay medical bills? ☐ Yes ☐ No
If yes, who? _____ How much is paid each month? $_____

STEP 12 Is Anyone Applying for Health Care?

☑ **Yes** – complete below ☐ **No** – (skip to step 14)

1. Have you ever filed a Supplemental Security Income (SSI) application with the Social Security Administration (SSA)?	☐ Yes	☐ No
If yes, when did you file your SSI application with SSA? _____		
2. Is your SSI application still in progress?	☐ Yes	☐ No
3. Have you previously been denied SSI eligibility by SSA on a prior application?	☐ Yes	☐ No
If yes, when was it filed? _____ If there were any changes to your medical condition to report since the last time you filed an application with SSA for SSI benefits, please list them: _____		

4. Is anyone in your household enrolled in health coverage now from the following?
(Check all that apply and write the person(s) name(s) next to the coverage they have.)

☐ Medicaid:	☐ CHIP:
☐ Medicare:	☐ TRICARE (do not mark if Direct Care or Line of Duty):
☐ VA Health Care Program:	☐ Peace Corps:

☐ Employer Insurance:

If yes, name of Health Insurance:	Policy Number:

Is this COBRA coverage?	☐ Yes	☐ No
Is this a retiree health plan?	☐ Yes	☐ No

To make it easier to determine your household's eligibility for help Health Care assistance in future years, we may use income data, including information from tax returns.

Yes, renew my eligibility automatically for the next:
☐ 5 years (the maximum number of years allowed)
☐ 4 years ☐ 3 years ☐ 2 years ☐ 1 year ☐ Don't use information from tax returns to renew my coverage

STEP 13 Answer if You are Applying for Health Care for a Child

1. Do you wish to participate in TEFRA if your child is eligible?		☐ Yes	☐ No
If yes, does the child have a disability or condition which would require care in an institution?		☐ Yes	☐ No
2. Has any child in your home been diagnosed with Autism?		☐ Yes	☐ No
If yes, list the name of the child and date of diagnosis:	Name:	Date:	
3. Does any child in the household have a primary care physician?		☐ Yes	☐ No
If yes, list the name of the physician and clinic:	Physician:	Clinic:	

STEP 14 Voter Registration Information

IF YOU DECLINE TO COMPLETE THIS SECTION, YOU WILL BE CONSIDERED TO HAVE DECIDED NOT TO REGISTER TO VOTE. The decision to register to vote is voluntary. Choosing to register or declining to register to vote will **not** affect the amount of assistance that you will be provided by this agency. We keep this information confidential.

We have attached a voter registration form for you. If you would like help in filling out the voter registration application form, we will help you. The decision whether to seek or accept help is yours. If you have additional people in your household that would like a voter registration application, please let us know.

Would you like to register to vote today? ☐ **Yes** ☐ **No**

Signature: _____ **Date:** _____

STEP 15 Read and Sign this Application

- **I understand I must give the Arkansas Department of Human Services complete and true information to the best of my knowledge.**
- **I understand that I may have to provide proof that what I've told the Department is true.**
- **I understand I must tell the Department about any changes to the information I gave on my application. I agree to cooperate with state or federal reviewers.**
- **I understand I will have to repay any benefits I should not have received, even if it is the Department's error.**
- **I understand that if I am admitted to a nursing facility based on conditional Health Care approval and my application is denied, I, or my family, will be responsible to repay any costs I owe from living in the nursing facility.**
- **I will use my benefits legally and will not sell, trade, or give away my benefits online or in person.**
- **I understand that if required, I must cooperate with the Office of Child Support Enforcement as a condition of receiving benefits.**
- **I authorize the Arkansas Department of Human Services (DHS) to get information from other state agencies, financial institutions, employers, federal agencies, and other sources to prove my statements are true and correct. I understand that if differences are found between what I report and information given by the sources listed above, my household's eligibility for benefits may be affected.**
- **I have received, reviewed, and agree to the information about my responsibilities included in this application.**

Under penalties of perjury, I state that I have reviewed this application, and to the best of my knowledge and belief, the answers I gave within this application are true, including household, citizenship and non-citizenship information, and I have listed all amounts and sources of income I received and property I own.

Note: An Authorized Representative may sign this document so long as you have provided the information required in Appendix C, attached.

Signature: _____ **Date:** _____

Appendix A — Health Coverage from Jobs (for Health Care applicants only)

You **DON'T** need to answer these questions unless someone in the household is eligible for health coverage from a job. Attach a copy of this page for each job that offers coverage.

Tell us about the job that offers coverage. Take the Employer Coverage Tool on the next page to the employer who offers coverage to help you answer these questions. You only need to include this page when you send in your application, not the Employer Coverage Tool.

Employee Information

Employee name (First, Middle, Last)	Social Security Number (SSN):

Employer Information

Employer name:	Employer Identification Number (EIN):	
Employer address:	Employer phone number:	
City:	State:	ZIP:

Who can we contact about employee health coverage at this job?

Phone number (if different from above):	Email address:

Are you currently eligible for coverage offered by this employer, or will you become eligible in the next 3 months?
☐ Yes (Continue) ☐ No

If you're in a waiting or probationary period, when can you enroll in coverage? (mm/dd/yyyy) _____
List the names of anyone else who is eligible for coverage from this job.

Name:_____ Name:_____ Name:_____ Name:_____

Tell us about the health plan offered by this employer

Does the employer offer a health plan that meets the minimum value standard*? ☐ Yes ☐ No

For the lowest-cost plan that meets the minimum value standard* offered **only to the employee** (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if they got the maximum discount for any tobacco cessation programs and did not get any other discounts based on wellness programs.

How much would the employee have to pay in premiums for this plan?	$

How often? ☐ Weekly ☐ Every two weeks ☐ Twice a month ☐ Once a month ☐ Quarterly ☐ Yearly

What change will the employer make for the new plan year (if known)?
☐ Employer won't offer health coverage
☐ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard*(Premium should reflect the discount for wellness programs.)

How much will the employee have to pay in premiums for that plan?	$

How often? ☐ Weekly ☐ Every two weeks ☐ Twice a month ☐ Once a month ☐ Quarterly ☐ Yearly

Date of change (mm/dd/yyyy):	

Employer Coverage Tool

Use this tool to help answer questions in your Health Care application, Appendix A. That part of the application asks about any employer health coverage that you're eligible for (even if it's from another person's job like a parent or a spouse). The information in the boxes below match the boxes in Appendix A. For example, you can use the answer to question 14 on this page to answer question 14 on Appendix A.

Write your name and Social Security number in boxes 1, and 2 and ask the employer to fill out the rest of the form. Complete one for each employer that offers health care coverage for which you are eligible.

Employee Information *The employee needs to fill out this section.*

1. Employee name: (First, Middle, Last)	2. Employee Social Security number (SSN):

Employer Information *Ask the employer for this information.*

3. Employer name:	4. Employer Identification Number (EIN):
5. Employer address (the Marketplace will send notices to this address)	6. Employer phone number

7. City	8. State	9. ZIP

10. Who can we contact about employee health coverage at this job?

11. Phone number (if different from above)	12. Email address

13. Is the employee currently eligible for coverage offered by this employer, or will the employee be eligible in the next 3 months?
☐ Yes (Go to question 13a).
13a. If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage(mm/dd/yyyy)? _____ (Go to question 14)

☐ No (STOP and return this form to employee)

Tell us about the **health plan** offered by this employer

14. Does the employer offer a health plan that covers an employee's spouse or dependent?
☐ Yes - Which people? ☐ Spouse ☐ Dependent(s)
☐ No (Go to question 15)

15. Does the employer offer a health plan that meets the minimum value standard*?
☐ Yes (Go to question 16) ☐ No (STOP and return this form to employee)

16. For the lowest-cost plan that meets the minimum value standard* offered only to the employee (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if they received the maximum discount for any tobacco cessation programs and didn't receive any other discounts based on wellness programs.

a. How much will the employee have to pay in premiums for this plan? $

b. How often? ☐ Weekly ☐ Every two weeks ☐ Twice a month ☐ Once a month ☐ Quarterly ☐ Yearly

If the plan year will end soon and you know that the health plans offered will change, go to question 17. If you don't know, STOP and return this form to employee.

17. What change will the employer make for the new plan year (if known)?
☐ Employer won't offer health coverage
☐ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard*. (Premium should reflect the discount for wellness programs.)

a. How much will the employee have to pay in premiums for that plan? $

b. How often? ☐ Weekly ☐ Every two weeks ☐ Twice a month ☐ Once a month ☐ Quarterly ☐ Yearly

Date of change (mm/dd/yyyy):

Appendix B American Indian or Alaska Native Information

American Indian or Alaska Native Family Member (AI/AN)

Complete this appendix if you or a family member are American Indian or Alaska Native. Submit this with your application for SNAP, Health Care, and TEA/RCA benefits.

Tell us about your American Indian or Alaska Native family member(s).

American Indians and Alaska Natives can get services from the Indian Health Services, tribal health programs, or urban Indian health programs. They also may not have to pay cost sharing and may get special monthly enrollment periods. Answer the following question to make sure your family gets the most help possible.

NOTE: If you have more people to include, make a copy of this page and attach.

	AI/AN Person 1		**AI/AN Person 2**	
1. Name (First, Middle, Last)	First	Middle	First	Middle
	Last		Last	
2. Member of a federally recognized tribe?	☐ Yes If yes, tribe name: _____ ☐ No		☐ Yes If yes, tribe name: _____ ☐ No	
3. Has this person ever gotten a service from the Indian Health Service, a tribal health program, Urban Indian Health program, or through a referral from one of these programs?	☐ Yes ☐ No If no, is this person eligible to get services from the Indian Health Service, a tribal health program, Urban Indian Health programs, or through a referral from one of these programs? ☐ Yes ☐ No		☐ Yes ☐ No If no, is this person eligible to get services from the Indian Health Service, a tribal health program, Urban Indian Health program, or through a referral from one of these programs? ☐ Yes ☐ No	
4. Certain money received may not be counted for Health Care or the Children's Health Insurance Program (CHIP). List any income (amount and how often) reported on your application that includes money from these sources: • Per capita payments from a tribe that come from natural resources, usage rights, leases, or royalties • Payments from natural resources, farming, ranching, fishing, leases, or royalties from land designated as Indian trust land by the Department of Interior (including reservations and former reservations) • Money from selling things that have cultural significance	$ How often? _____		$ How often? _____	

Appendix C — Consent for Authorized Representative

If you would like, you can give someone the right to act for you. This person can give and get facts for this application, take any action needed to enroll in benefits, and take any action needed to get benefits.

Please choose which programs you would like an authorized representative for:

☐ SNAP ☐ Health Care ☐ TEA/RCA

REPRESENTATIVE - This person can apply for benefits, provide interview assistance, get notices, report changes, and make inquiries. Your household will be held liable for any over issuance that results from the representative providing incorrect information.

Full Name (first, middle, last)**:**			**Date of Birth:**	
Phone:	**Email:**			
Address:	**Unit:**	**City:**	**State:**	**ZIP:**

By signing, I certify that the individual(s) designated above is (are) allowed to act on my behalf. **I understand my household will be held liable for any over issuance that results from the authorized representative providing incorrect information.** I understand that anyone knowingly providing false information may be prosecuted under applicable federal and state statutes. I understand that the power to act as an authorized representative is valid until I modify the authorization or notify the agency that the representative is no longer authorized to act on my behalf, or the authorized representative informs the agency that he or she is no longer acting in such capacity, or there is a change in the legal authority upon which the individual or organization's authority was based.

Applicant Signature: _____ **Date:** _____

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I agree to maintain, or be legally bound to maintain, the confidentiality of any information provided by the agency regarding the client.

(*If the authorized representative for Health Care is a provider, staff member, or volunteer of an organization*) I affirm that I will adhere to the regulations in 45 CFR part 431, subpart F and at 45 CFR §155.260(f), 45 CFR §447.10, as well as other relevant State and Federal laws concerning conflicts of interest and confidentiality of information.

Authorized Representative Signature: _____ **Date:** _____

Your Rights and Responsibilities

Please read this entire section carefully to understand your rights and responsibilities when you get Health Care benefits, Transitional Employment Assistance (TEA), or benefits from the Supplemental Nutrition Assistance Program (SNAP).

Rights and Responsibilities Across All Programs

1. You have the right to be treated courteously and with respect.
2. You have the right to apply for any public assistance program at any time.
3. You have the right to have your application processed in a timely manner.
4. You have the right not to give us any or all the information we ask for, even though that may affect our ability to process your case.
5. You have the right to be notified in writing of any changes in your benefit amount.
6. You have the right to look at your case file. If you disagree with something in your file, tell your county office worker.
7. You have the right to ask for an appeal and get an administrative hearing if a decision is not reached on your case within the appropriate time limit or if you disagree with the decision reached.
8. No person may be denied assistance on the grounds of race, color, sex, national origin, or disability.
9. You are responsible for notifying the Department of Human Services within 10 days if your personal information changes, your income or resources change, or if any other changes occur in your circumstances.

SNAP Rights and Responsibilities

SNAP helps people with low income and few resources get the food they need for good health. SNAP electronic benefits transfer (EBT) cards are used in place of cash to buy food. However, most people find they must spend some cash along with their SNAP benefits to buy enough food for a month.

Your Rights

1. You have the right to ask for help from your worker to get the information you need to establish your eligibility.
2. Participation in the SNAP is not time-limited. You can continue to get SNAP if you are eligible under SNAP rules. This is true even if someone in your home gets TEA cash assistance. If someone in your home does get TEA cash assistance, participation in SNAP not count against their TEA time limits
3. You have the right to know the SNAP rules.
4. You have the right to know how we worked your SNAP benefit case.

Your Responsibilities

1. **Penalty Warnings**

   If you get SNAP you must follow the rules listed below:

   - **DO NOT** give false (wrong) information or hide information to get SNAP.
   - **DO NOT** give false (wrong) information to help someone else get SNAP.
   - **DO NOT** put your money or property in someone else's name in order to get SNAP benefits.
   - **DO NOT** sell or trade or try to sell or trade your SNAP.
   - **DO NOT** use your SNAP to buy items like alcoholic drinks or tobacco.
   - **DO NOT** use a SNAP Electronic Benefits Transfer (EBT) card that belongs to someone else to buy food for your household.
   - **DO NOT** use SNAP benefits or allow someone else to use these benefits if you know that the benefits have been received illegally, given to someone other than the legal owner, or are to be used in any illegal manner.

   Any member of your household who admits to breaking any of these rules or who is found guilty of breaking any of these rules may be disqualified to get SNAP
   benefits for:

   - One year for the first violation
   - Two years for the second violation
   - Permanently for the third violation

   This person may also be fined up to $25,000, sent to jail for up to 20 years, or both. They may be subject to federal prosecution. Federal penalties may include an additional disqualification period of 18 months or, for second and subsequent felony convictions for SNAP fraud, a mandatory jail sentence.

   Additional Disqualifications

   - A person found guilty in a Federal, State, or local court of trading SNAP for controlled substances (illegal drugs or prescriptions that were not written for you) will be barred from receiving SNAP for 24 months for the first violation and permanently for the second violation.
   - A person found guilty by a court of trading SNAP for firearms, ammunition, or explosives will be permanently barred from getting SNAP.
   - A person who is a fleeing felon or a parole or probation violator is barred from getting SNAP while they are fleeing to avoid custody.

2. **Requirement to Work**

   Unless they are exempt, people between the ages of 18 and 50 who get SNAP must meet the Requirement to Work. Anyone who is not exempt must work at least 20 hours per week at a job or self-employment; or attend an approved job training course at least 20 hours per week.

3. What Can I Buy with SNAP benefits?

A person may buy only eligible foods with their SNAP benefits. Eligible foods include, but are not limited to, plants and seeds that can be used to grow food. You **cannot** buy the following items with SNAP benefits:

- Paper goods
- Cleaning products
- Household items
- Alcoholic beverages
- Tobacco products
- Vitamins, medicine, or personal care items like toothpaste
- Foods prepared to be eaten in the store
- Hot food prepared in the store to be "carried out" and eaten

TEA Rights and Responsibilities

The Transitional Employment Assistance (TEA) program is intended to help needy families with children to become more responsible for their own support and less dependent on public assistance. Assistance from the TEA program is intended to help needy families become economically self-sufficient by providing opportunities to get and keep employment that will sustain the family. There is a limit to the number of months you can get TEA. It is your responsibility to work toward achieving self-sufficiency before your time-limited assistance ends.

Your Rights

1. To be advised in writing of your work requirements.
2. If personal or family problems are keeping you from going to work, your case manager may be able to refer you to an agency that may be able to help you.
3. You may apply for an extension of your TEA cash benefits at the end of your time limit due to circumstances beyond your control, if more time will help you to become fully independent.

Your Responsibilities

1. **Meetings**
   Attend all meetings your case manager schedules for you.
2. **Personal Responsibility Agreement**
   The Personal Responsibility Agreement (PRA) is an agreement stating what you will have to do for us to help you. Your case manager will go over these responsibilities with you. If you fail to do these things, it may cause a decrease in or loss of your cash assistance payment.
   - You must cooperate with Child Support Enforcement unless you have good cause, work requirements, and certain responsibilities to your family.
   - You must make sure your school-age child is going to school and that your preschooler gets their immunizations (shots).
   - Fulfill all the requirements of your Personal Responsibility Agreement and Employment Plan.
3. **Work Participation Activities**
   Adults who get TEA must complete work activities as described in their Employment Plans for a minimum number of hours per week. Allowable activities are:
   - Employment with a private or public employer
   - Micro-Enterprise (Self-Employment)
   - On-the-Job Training
   - Job Search and Job Readiness
   - Work Experience
   - Community Service
   - Career and Technical Education
   - Providing Childcare Services for a Community Service Participant
   - Education Directly Related to Employment
   - Job Skills Training
   - Attendance at Secondary School

   Your case manager will explain each activity and the participation requirements to you.
   You must give DHS true information and not withhold information for the purpose of getting TEA without following the rules.
4. **Penalty Warnings**
   - If you do not participate in your work activities, your TEA case manager will decide if you have a good reason and whether you are getting all the support services you need. If you do not have a good reason for not participating, your cash payment may be reduced, or your case may be closed until you do participate.
   - If you get benefits to which you or your household are not entitled because you gave false information or hid information assistance will be subject to recovery by DHS, any assistance you get in the future may be reduced to recover this overpayment, and you may be subject to prosecution for fraud and/or fined or imprisoned.
   - **DO NOT** give false information or hide information in order to become eligible for benefits.
   - **DO NOT** put your money or property in someone else's name in order to get TEA benefits.

5. **Fraud**
   Fraud consists of giving false (wrong) information or withholding information for the purpose of getting assistance that a person is not entitled to under the program rules and regulations. Committing fraud can result in criminal fines, penalties, and paying back benefits.

6. **Intentional Program Violation**
   An Intentional Program Violation (IPV) in the TEA Program occurs when a person gives incorrect information for the purpose of falsely maintaining the family's eligibility for TEA. If you are found guilty of an IPV you cannot participate in the program for:
   (a) the first offense, one (1) year.
   (b) the second offense, two (2) years.
   (c) more than two, permanently.

Health Care Rights and Responsibilities

Health Care reimburses providers for covered medical services that are provided to eligible needy individuals through the Medicaid program. Eligibility is determined based on income, resources, Arkansas residency, and other requirements. Covered services also vary among Medicaid categories. The Arkansas Works Program is not a perpetual federal or state right or a guaranteed entitlement program and it may be ended at any time upon appropriate notice.

Your Rights

1. You have the right to seek job search and job training services from the Arkansas Division of Workforce Services but it is not a requirement to receive Medicaid or the Arkansas Works Program.
2. You do not have the perpetual federal or state right or a guaranteed entitlement to Arkansas Works, and it may be ended at any time upon appropriate notice.
3. You are giving DHS your rights to seek and get money from other health insurance, legal settlements, or other third parties.
4. You are giving the Medicaid agency rights to pursue and get medical support from a spouse or parent.

Your Responsibilities

1. **General Responsibilities**
   - You have the responsibility to notify the Department of Human Services of any changes of household members who get additional income, acquire, or dispose of property (or if any other changes occur in your circumstances).
   - You have the responsibility to give as much of the needed information as you can about your circumstances.
   - You have the responsibility to fully complete forms with true information to the best of your knowledge.
   - If receiving Healthcare in a nursing facility, Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID), or under a home/community-based waiver, you have the responsibility to have the amount of health care benefits that DHS paid on your behalf to be recovered from your estate or grantee of a beneficiary deed after your death.
   - You have the responsibility to cooperate with the Office of Child Support Enforcement (OCSE) in establishing paternity and getting medical support for each child who has a parent absent from the home if the program you have applied for asks you to do so.

2. **Penalty Warnings**

If you get Health Care benefits, you must follow the rules listed below:

- **DO NOT** give false information or hide information in order to become eligible for benefits.
- **DO NOT** put your money or property in someone else's name in order to get Health Care benefits.
- If you get benefits to which you or your household are not entitled because you gave false information or hid information, assistance will be subject to recovery by DHS, any assistance you get in the future may be reduced to recover this overpayment, and you may be subject to prosecution for fraud, fined or imprisoned.

Department Responsibilities

The U.S. Department of Agriculture prohibits discrimination based on race, color, national origin, sex, religious creed, disability, age, political beliefs, or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

The Arkansas Department of Workforce Services and the Arkansas Department of Human Services are Equal Opportunity Providers / Employers | Under Titles VI and VII of the Civil Rights Act of 1964 (Title VI & the Americans with Disabilities Act of 1990 (ADA), Section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975, the Department prohibits discrimination in admissions, programs, services, activities, or employment based on race, color, religion, sex, national origin age, and disability. The Department must make a reasonable accommodation to allow a person with a disability to take part in a program, service or activity. For example, this means if necessary, the Department must provide sign language interpreters for people who are deaf, a wheelchair accessible location, or enlarged print materials. It also means that the Department will take any other reasonable action that allows you to take part in and understand a program or activity, including making reasonable changes to an activity. If you believe that you will not be able to understand or take part in a program or activity because of your disability, please let us know of your disability needs in advance if at all possible.

Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

For any other information dealing with Supplemental Nutrition Assistance Program (SNAP) issues, persons should either contact the USDA SNAP Hotline Number at (800) 221-5689, which is also in Spanish or call the State Information/Hotline Numbers (click the link for a listing of hotline numbers by State); found online at: http://www.fns.usda.gov/snap/contact_info/hotlines.htm.

To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027), found online at: http://www.ascr.usdRIgha.gov/complaint_filing_cust.html, and at any USDA office, or write a letter addressed to USDA and provide in the letter all the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by:

- Mail: U.S. Department of Agriculture Office of the Assistant Secretary for Civil Rights 1400 Independence Avenue, SW Washington, D.C. 20250-9410
- Fax: (202) 690-7442; or
- Email: program.intake@usda.gov.

To file a complaint of discrimination regarding a program receiving federal financial assistance through the U.S. Department of Health and Human Services (HHS), write: HHS Director, Office for Civil Rights, Room 515-F, 200 Independence Avenue, S.W., Washington, D.C. 20201 or call (202) 619-0403 (voice) or (800)537-7697 (TTY).

Under the Department of Human Services (DHS) policy, Medicaid cannot deny you eligibility or benefits based on your race, age, sex, disability, national origin, or political or religious beliefs. To report Medicaid eligibility or provider discrimination, call the Department of Human Services Office of Employee Relations/Office of Equal Opportunity at 501-682-6003.

You may also file a complaint of discrimination by contacting the DHS Office of Employee Relations/Office of Equal Opportunity, P.O. Box 1437 – Slot N250 Little Rock, AR 72203-1437 or call (501) 682-6003 or fax (501) 682-8926.

Privacy Notice

The PRIVACY ACT of 1974 requires the Department of Human Services (DHS) to 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. We are authorized to collect from your household certain information including the social security number (SSN) of each eligible household member. For the Supplemental Nutrition Assistance Program this authority is granted under the Food and Nutrition Act of 2008 as amended, 7 U.S.C. 2001-2036. For both the Medicaid Program and the TEA 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 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.

Important Estate Recovery Notice

If you receive Health Care assistance in a nursing facility, ICF/IID facility, or under a home and community-based waiver program, the total amount of the Health Care benefits paid on your behalf will be owed to DHS and may be recovered from your estate or from the grantee of a beneficiary deed after your death. Your estate is the property you own at the time of your death. DHS will not make a claim against your estate while you are living. DHS will not make claim against your estate after your death if your spouse is still living or if you have dependent minor children under age 21 or blind or have children with disabilities. DHS will collect the debt, if any, by filing a claim in your estate. Collection may not be made if it is not cost-effective to DHS or if your heirs apply and are granted a hardship waiver after your death. A hardship may exist if the estate property is the only source of income for your heirs, if that income is limited, or if there are other compelling circumstances.

Quality Assurance

Your case may be selected for a Quality Assurance (QA) review. If so, the QA worker will check your case to see if you have given us the correct information. They will also check to make sure the DHS county office processed your case correctly. If your case is selected for a QA review, the QA worker will contact you for an interview. You are required to give information to prove your statements are true and correct. The QA worker may contact your employer, your bank, other agencies, your landlord, etc. for information. If you do not cooperate during a QA review, your SNAP case will close. You will not be eligible to get SNAP benefits until you cooperate with QA or until February of the following year, whichever comes first.

Your Right to Appeal

If you think that DHS has made a mistake, you can appeal its decision. To appeal means to tell someone at DHS that you think the action was incorrect and that you want a fair review of the action. You can be represented in the process by someone other than yourself.

You can request an appeal in the following ways:

- In person: Talk to staff of any county DHS office.
- By phone: You can call the Office of Appeals and Hearings at 501-682-8622 or you may call your local county office.
- By email: DHS.Appeals@dhs.arkansas.gov
- By mail: Arkansas Department of Human Services
  Appeals and Hearings Section
  Slot N401
  P.O. Box 1437
  Little Rock, AR 72203-1437

ARKANSAS DEPARTMENT OF HUMAN SERVICES
AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

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

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: Arkansas DHS Medical Review Team
P.O. Box 1437 Slot S334, Little Rock, AR 72203
DHS / TEFRA P.O. Box 1437 Slot S406
Partners for Inclusive Communities fax: 479-308-0296
(Recipient Name/Address/Phone/Fax)

for the specific purpose(s): Initial & Continuing Eligibility for the Arkansas Autism Waiver & Services

Specific information to be disclosed: any / all health records

If you use "All Medical Records" this will include any and all written information DHS may have concerning your health care and any illness or injury you 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 you.

I understand that this authorization will expire on the following date, event or condition: _____

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)*
_____	_____	_____
(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

COMPLETE ONLY WHEN REVOKING THE AUTHORIZATON

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

Medical Review Team (MRT)
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 Parent or Guardian

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. When did the illness, injury, or condition begin? MM/DD/YY_____
3. Has the child ever received or applied for SSI or Social Security Disability? Yes___ (Go to 3a) No___ (go to #4)
   a. Is SSI/SSA application still pending? Yes___ (Go to #4) No___ (Go to 3b)
   b. What were the dates of approval, denial, or closure? _____
   c. What was the reason for denial or closure? Please provide a copy of letter from Social Security Administration stating the reason for denial/closure.

   d. If it has been more than 12 months since the last SSI or Social Security Disability denial/closure, is the condition with SSA last considered about the same, better, worse, or has it changed?

4. Describe any medical conditions or injuries that limit the child's daily life.

5. Describe any behavior problems, speech problems, learning problems, or attendance problems the child has had at home, in school or therapy.

6. Education/Therapy/Medical Treatment

a. What medical treatment has the child received for this condition? What Treatment is planned for the future?

b. Does the child attend special education classes? Yes_____ No_ List all schools/facilities that the child received behavioral, occupational, physical or speech therapy in the last year.

Attach signed DHS-4000.

****If you have copies of therapy and/or evaluation records, please attach copies.**

School/Facility Information

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

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:		

Physician/Clinics/Mental Health/Hospital Information (If you have copies of medical records from the past year to present, please attach copies)

Primary Care Physician Name:		Dates: From To	
Address:	City:	State:	Zip:

Area Code & Phone #:

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

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

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

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

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

Please check attachments:

- ☐ DHS-4000's completed for all necessary medical record requests
- ☐ DCO-107, if applicable
- ☐ Medical records, if available