Today's Date

CHC USE ONLY	
CHC #:	
☐ Initial Application	☐ Reapplication

ARKANSAS DEPARTMENT OF HUMAN SERVICES
DIVISION OF DEVELOPMENTAL DISABILITIES SERVICES
CHILDREN WITH CHRONIC HEALTH CONDITIONS (CHC) PROGRAM

P.O. BOX 1437 - SLOT S380
LITTLE ROCK, AR 72203-1437
PHONE: 1-800-482-5850 EXT. 22277 OR (501)-682-2277 FAX: (501)-682-8247

Section 1: Child's Identification Information

Last Name	First Name	Middle Name	Date of Birth	Social Security Number	Medicaid Number

Sex	Race
☐ Female ☐ Male	☐ American Indian or Native Alaskan ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Other/Specify
	Ethnicity
	☐ Central and South American ☐ Cuban ☐ Mexican ☐ Puerto Rican ☐ Other/Specify

Language Spoken In Home:	☐ English ☐ Spanish ☐ Other/Specify	Interpreter Needed?	☐ Yes ☐ No

Mailing Address: P.O. Box or Street	City	Zip Code + 4	County
Residential Address ☐ Same as above	**City**	**Zip Code + 4**	**County**

Home Phone	Cell Phone	Father's Work Phone	Mother's Work Phone

Message Phone (List relationship to child):	
Email Address	
Current Health Insurance Coverage?	☐ Yes - Please provide insurance information ☐ No
Date of application :	
Applied for Health Insurance?	☐ Yes - Please provide insurance information ☐ No
Name of Insurance Company	
Address	
City, State Zip	
Phone	
Policy Number	
Name of Primary Person Insured	
Application Date or Coverage Date	

Section 2: Household Composition Information

Full Name	Relationship to Child	Social Security Number	Date of Birth	Employer	Disease or Disability	Gross Monthly Income

Section 3: Financial Information

Types of Income	Gross Income	Types of Resources	Amount	Expenses	Amount
Child Support		Bonds		Medical Debt	
Annual Income		CD's		Mortgage	
Rental Property		Checking		Rent	
Self-employment		IRA's		Vehicles Year/Model	
SSA		Land			
SSI		Mutual Funds			
Trust Fund		Savings			
Unemployment		Stocks			
Wages					

Section 4: Family/Social History

Why did you apply for CHC? Can you tell us things about your family that will help us serve you better? Such as inability to read or write in native language, work hours of parent/guardians, best time to contact family, family needs (such as transportation, locating services or providers, medical equipment, medical supplies, school problems, etc.) Other assistance applied for:

☐ ARKids; Date of Application _______________ ☐ Medicaid; Date of Application _______________ ☐ SSI; Date of Application _______________

☐ TEFRA; Date of Application _______________ ☐ Subsidized Adoption ☐ Child Support ☐ SNAP ☐ WIC

☐ DDS/EI ☐ HUD

Details:

Section 5: Medical History

Present Complaint/Disability	

Past/Present Treatment	
Primary Care Physician (PCP)	
PCP Address	
Date of Last Well-Child Visit	
Specialist	
Specialist Address	
Date of Last Visist with Specialist	
Medications	
Pharmacy	
Therapies	☐ Occupational ☐ Physicial ☐ peech ☐ her/Specify:
School/Day Care Child Attends and Grade	

Section 6: Parent/Guardian Agreement (please read carefully)

☐ My child has a current case manager, whose name is: ______________________

☐ I choose the Children with Chronic Health Conditions program to be my child's case manager

☐ I do not choose the Children with Chronic Health Conditions program to be my child's case manager

I hereby request that my child be accepted for services coordination, diagnosis and/or treatment as provided by the Children with Chronic Health Conditions program. I understand that I will be expected to apply for Medicaid if eligible or the Children with Chronic Health Conditions program will not be able to authorize any services. I agree to file with my insurance company for any services paid by the Children with Chronic Health Conditions program and reimburse the Children with Chronic Health Conditions program if and when insurance pays (or payment from a liability settlement.

I understand that the information contained in this application is confidential and not subject to disclosure except pursuant to law or authorized waiver. I hereby waive such confidentiality and authorize the Children with Chronic Health Conditions program staff to disclose the information herein for the purpose of obtaining services or benefits for my child.

If you need this information in a different format, such as large print or Braille, please contact the Children with Chronic Health Conditions program office or write to the Children with Chronic Health Conditions program at the above address.

______________________________ ______________________________

Signature of Parent, Legal Guardian or Responsible Party | Relationship to Child

______________________________ ______________________________

Agency Representative | Date

Arkansas Department of Human Services
CHILDREN WITH CHRONIC HEALTH CONDITIONS
P.O. Box 1437 (Slot S380)
Little Rock, Arkansas 72203-1437

INFORMATION REQUIRED TO PROCESS YOUR CHC APPLICATION

Dear Parent/Guardian:

The application for the Children with Chronic Health Conditions (CHC) program that you are completing will be mailed to the CHC office in Little Rock where eligibility for the program will be determined on your child's medical and/or developmental condition based upon certain information you must furnish. Please read the list of things below which you are required to do and the information you must mail to the CHC office address shown at the top of this page.

1. INCOME VERIFICATION – You are asked to verify your monthly gross income on the application. At that time, you must provide copies of check stubs for a complete month or the Earning Statement (DCO-97) completed by your employer. This form will be furnished to you if required by CHC. Write your child's name and your county of residence in the upper right corner and the above address across the top before giving it to your employer. Mail to CHC at the address above.

   If you or your spouse is self-employed, you must furnish a copy of last year's Federal Income Tax Return, complete with attachments. In addition to this, you may be asked to supply other more current income information.

2. BIRTH CERTIFICATE – You will need to supply a copy of the birth certificate and/or proof of US citizenship for the child for whom you are seeking CHC benefits.

3. HEALTH INSURANCE – You must supply CHC with a copy of both sides of your child's insurance card. All covered medical services must be billed to your insurance company before being billed to CHC. You will also be asked to complete a Third Party Resource form (DCO-662).
   - If your child does not have health insurance coverage but is eligible for health insurance through your employment, CHC requires documentation that you have begun the process to get coverage. If you do not have access to health insurance through your employment, CHC requires documentation that you have begun the process to get insurance coverage under the Arkansas Health Insurance Marketplace. Visit the website at https://myarinsurance.com/ .

4. MEDICAID FOR YOUR CHILD – Because of limited funding, CHC will not make payment for medical care that is covered by Medicaid. You may be asked to apply for Medicaid to maintain CHC coverage if it appears that you are potentially eligible for Medicaid in any category.

5. SOCIAL SECURITY NUMBER FOR YOUR CHILD – For purposes of record keeping, CHC requires a Social Security Number for all children covered by this program. If they already have a number, CHC will need a copy of your child's Social Security Card. If they have never obtained a Social Security Number, please be sure to ask the caseworker for a Social Security Number application form for your child. You should complete this form at the time you fill out the CHC application. Notify CHC of your child's Social Security Number as soon as you receive it.

6. IMMUNIZATION RECORD – CHC will need a copy of your child's immunization record.

7. PUB-408 – ARKANSAS DEPARTMENT OF HUMAN SERVICES NOTICE OF PRIVACY PRACTICES: Please sign and return for our records.

If you have any questions about the Children with Chronic Health Conditions program or the information needed for your application, call toll free at 1-800-482-5850, extension 2-2277 (Voice). If you need this information in a different format, such as large print or Braille, please contact your CHC office or write to CHC at the above address.

CHC-882 (Rev. 09/2019)

Arkansas Department of Human Services
Verification of Earnings

TO EMPLOYER:
To determine eligibility and correct benefits for your employee we need the information requested below. **This will enable us to ensure that the public funds are used only for the actual and correct benefits to which a household is entitled.**
PLEASE COMPLETE THE ITEMS CIRCLED AS WELL AS THE SIGNATURE SECTION AT THE BOTTOM OF THIS FORM.
If you need this material in a different format such as large print, contact your local DHS office.

Caseworker

Address: Department of Human Services
Children with Chronic Health Condition Services

Telephone Number   Fax Number

Employee   Casehead (Child's Name)

SSN of Employee   Case Number (CHC Number)

1. The above employee began work ________ and earns $________ per hour. He/she works an average of ________ hours per week. Date first pay to be received ________.
Anticipated gross amount of 1st pay $ ________.

Employee is paid: ☐ Weekly ☐ Monthly ☐ Other – Please indicate how often ____________________
☐ Every 2 weeks ☐ Twice monthly

2. Please show GROSS EARNINGS (before any deduction) PAID TO this employee as indicated. Please list each pay check separately **including vacation pay and bonuses.**

☐ REC'D in the Month of January

4 For the Past 4 consecutive pay periods.

Pay Period Ending	Date Received	Hours Worked	Gross Wages	Tips	Housing/Utilities Paid above wages

3. **Earnings:** Are any of the earnings funded by JTPA – On The Job Training Program? ☐ Yes or ☐ No
4. **Termination:** If employee is no longer employed by you, what was the date and reason for leaving this job?

Date last check will be received ______________ And gross amount ______________

5. Additional information/Expected changes: (such as layoffs, raises, increased or reduced hours, vacation pay, bonuses, and Sick pay).

6. **Insurance:** If employee has insurance through this job, what is the name and address of the insurance carrier?

Claims processing address if different than insurance carrier ______________
Policy Number ______________ Effective date of policy ______________

Type of Coverage ______________ Policy: ☐ Individual or ☐ group
Policyholder and covered individuals ______________
I do hereby certify that the above information is factual and correct to the best of my knowledge.

Employer/Payroll Clerk Signature   Date   Telephone

Place of Business   Address

DCO-97 (R.2/91)-100970

Instructions for DCO-97

Purpose

Form DCO-97 will be used to obtain verification of earned income and insurance coverage from the applicant or recipient's employer.

Completion

The following items will be completed by the caseworker before the DCO-97 is issued.

Caseworker – Enter the caseworker's name.

Telephone Number – Enter the telephone number at which the caseworker may be reached at the county office. Include extension numbers when applicable.

Address – Using the county office stamp, enter the name and address of the county office.

Employee – Enter the name of the individual for whom the income verification is being requested.

SSN of Employee – Enter the Social Security number of the individual for whom the income verification is being requested.

Casehead – Enter the name of the head of the food stamp household or the name of the TEA casehead.

Case Number – Enter the Tea case number of the Social Security number of the head of the food stamp household.

Circle the items to be completed by the employer. If number two (2) is circled, one of the two boxes in number three (3) must be checked and the appropriate information entered. For example, 'Received in the month of June" or "For the past four consecutive pay periods."

Routing

This form may be given to the client or mailed directly to the employer.

Only an original must be completed. When the completed form is returned to the county office, it will be filed in the case record and retained for at least three (3) years from the month of completion.

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

DHS County Office Only below:

Fold in half or tape ends together and Mail to Third Party Liability Unit

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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: ____

(Recipient Name/Address/Phone/Fax)

for the specific purpose(s): ____

Specific information to be disclosed: ____

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.