Arkansas Dept. of Human Services

[redacted]
Pine Bluff AR 71611-8848

[redacted]

Date of Notice: 06/16/2023
Client ID: [redacted]
Case Number: [redacted]

Notice of Action

Dear [redacted],

You are getting this letter because you applied for new benefits, and a decision has been made about your eligibility.

Please read the whole notice to understand all important information about your case.

- **Each part will explain the status of your case and your household members' eligibility.**
- **The parts called "What do you need to do?" give the next steps for your case.**
- **You can also check your benefits at www.access.arkansas.gov**

If you need help understanding this notice, please call 1 (855) 372-1084.

Health Care

This table shows the full list of programs for each person in your household and our decision about your eligibility for coverage. The sections to come explain why we made this decision about your eligibility.

Approved Benefits

If a person has been approved, the person qualifies for coverage for the program listed, and we will pay for covered services that you get during the date that is listed. Changes in your household circumstances must be reported within 10 days of the change because it could affect your continued benefits.

Eligible Person	Coverage Type	Effective Date
[redacted] **Medicaid ID:** **Client ID:** [redacted]	ARHOME	06/01/2023
	Action Taken: You have been approved based on monthly household income before taxes and deductions of $0.00 and household size of 1. This decision is based on Arkansas Medical Services Policy Sections B-270.	

What do you need to do now that you have been approved?

Depending on your income, you may pay a premium for your health insurance coverage and co-payments on your health care services. If you must pay premiums or co-payments, you will get a separate notice in the mail.

Premium - A premium is money you pay every month for your health care.

Co-Pay - A co-pay is the amount of money you pay when you get a health care service, such as a doctor visit.

For [redacted]:
You must report changes to DHS within 10 days if:

- Anyone in your household is admitted to or discharged from an institution such as a nursing home.
- A change in who you file taxes for, such as a child who becomes a dependent on someone else's taxes.
- If you become pregnant, or disabled, or if a child moves into your home, call 1 (855) 372-1084 to find out if you may be eligible for another category of Medicaid.

How can you send the needed information?

You can send us the information we asked for in one of the following ways:

- **Online: -** You can send your information quickly and easily by uploading it directly to your Access Arkansas account. Follow these steps:
  1. Go to access.arkansas.gov.
  2. You will see a system upgrade screen. You will need to give us your name, date of birth, and county you live in. You can give us your Social Security number, but it is not required.
  3. Answer the Voter Registration question with "Yes" or "No."
  4. On the main Access Arkansas screen, please choose "Health Care" button to apply for Health Care, choose "SNAP" button to apply for SNAP, or choose "TEA" button to apply for TEA. You may apply for more than one program if needed.
  5. If you have created an account, you will be able to log in to update your settings and information, see letters and forms, upload documents, and more.
  6. If you need help, you can click on the Help Button at the top of the screen for step-by-step instructions.

  Having an Access Arkansas account puts your case information at your fingertips. Get started with your Access Arkansas account today to do more online!
- **Fax:** You can send your needed information to:
  - Health care (870) 534-3421
- **In Person:** You may take your needed information to your local county office:

  1603 Edison Ave
  Benton, AR, 72015-4629

How can you update your contact information?

Update your contact information if it has changed. Visit ar.gov/update to learn more.

Who can help if you have questions?

Visit our website at http://www.humanservices.arkansas.gov, call the DHS Helpline at 1 (855) 372-1084, or call your local county office at (501) 315-1600.

Where can you get this letter in a different format?

- Este aviso contiene datos sobre las prestaciones de usted.
  Si necesita la traducción en español, favor llame al 1 (855) 372-1084.
- Kojela in ebed aoleb melele kin jiban ko Nan kwe.
  Elane kwoj aikuij jiban ikijen ukok Nan kajin Majol, joij im kurtok 1 (855) 372-1084.
- To get this notice in a format that is accessible for an individual with a disability, call 1 (855) 372-1084.

What if you do not agree with the decision?

- You have the right to request an appeal hearing.
- You can find information on how to request an appeal hearing on the attached “Client Appeal Hearing Rights” sheet.

Arkansas Department of Human Services
Client Appeal Hearing Rights

What is an appeal hearing?	A hearing gives you the chance to: • Explain why you think there has been a wrong decision made about your benefits. • Ask for a fair review of the decision. The hearing officer will conduct the hearing by telephone and will call you at your telephone number.

How do I request a hearing?	To request a hearing, you can: • Check the box below. Then mail this form to the address on the front of this notice or to Appeals & Hearings at the address below. ☐ I am requesting a hearing with DHS because I disagree with the decision or planned case action. • Write a letter **or** email, including your name, case number (if you have one), the program and action that you want to request a hearing for and a copy of the front of this notice, and send it to: **Mailing address:** Office of Appeals & Hearings P.O. Box 1437 Slot 101 Little Rock, AR, 72203-1437 **Email address:** DHS.Appeals@dhs.arkansas.gov • Talk to DCO staff of any county office.

How long do I have to ask for a hearing for these health care programs?	**The following household members may ask for a hearing, but the request must be received by the date shown below**		
	[redacted]	ARHOME	07/21/2023
	• If named above, you must ask for a hearing within 30 days of the Date of Notice. • You may continue to receive Health Care benefits at your current level between now and your appeal decision if 1) you appeal within 10 days of the Date of Notice, **and** 2) you **ask** to continue benefits within 10 days of the Date of Notice. • If you **do not** ask to keep getting benefits within 10 days of the Date of Notice, DHS will assume you **do not** wish to continue your benefits pending your appeal decision.		

What are my rights if I request a hearing?	• Your hearing will be conducted by telephone unless you request a video or in-person hearing.
	• You may attend the hearing (In-person hearings are conducted in Little Rock).
	• You may be represented by a lawyer or any other person you choose.
	• You may be able to get free legal aid. If you need it:
	  • Call the 1-888-540-2941
	  • Go to www.arlawhelp.org.
	• Before the hearing, you have the right to see your hearing file and any other evidence to be presented or used at the hearing.
	• You have the right to present your own evidence.
	• You have the right to bring your own witnesses.
	• You have the right to question any witness against you.
	• Please note, if you lose your appeal, you may have to repay the amount of benefits you received during the appeal period.

Free Job Search Help
Arkansas Division of Workforce Services
Arkansas Workforce Centers

Because you get ARHOME, you can get free job search help from the Arkansas Division of Workforce Services (DWS). DWS has Arkansas Workforce Centers across the state that can tell you about job openings, how to look for a job, training programs, and more.

What kind of help can I get?

If you are unemployed or currently employed and need a better job, DWS Arkansas Workforce Centers can help by providing:

Free Job Search Help:

- Arkansas JobLink lets you post your information and skills for employers to see, search for current job openings, and more. Visit www.arjoblink.arkansas.gov.
- Free computers, telephones, fax machines, and copiers to help you find and apply for jobs.

Help from Experts:

- Identify your skills and get help finding job openings that need those skills.
- Create or update your resume to get the best results possible in your job search.
- Career counseling for step-by-step job search guidance.
- Get the facts about what kind of jobs are available and where they are in Arkansas.

Referrals for Programs for Specific Needs:

- Free GED and free English as a Second Language classes.
- Programs tailored to assist veterans with employment needs.
- Help for workers who have lost a job because of international trade.
- Temporary cash assistance for needy families (TANF/TEA).
- Vocational rehabilitation for Arkansans living with a disability.
- Programs for young people.

How do I get started?

Take the first step today and contact DWS Arkansas Workforce Centers:

- Online: www.arjoblink.arkansas.gov
- Phone: (855) 225-4440
- Email: ADWS.Info@arkansas.gov

Arkansas Dept. of Human Services

[redacted]
Pine Bluff AR 71611-8848

[redacted]

Date of Notice: 06/04/2023
Client ID: [redacted]
Case Number: [redacted]

Notice of Action

Dear [redacted],

You are getting this letter because we received a change, and a decision has been made about your eligibility.

Please read the whole notice to understand all important information about your case.

- **Each part will explain the status of your case and your household members' eligibility.**
- **The parts called "What do you need to do?" give the next steps for your case.**
- **You can also check your benefits at www.access.arkansas.gov**

If you need help understanding this notice, please call 1 (855) 372-1084.

Health Care

This table shows the full list of programs for each person in your household and our decision about your eligibility for coverage. The sections to come explain why we made this decision about your eligibility.

Changed or Continued Benefits

If a person has been approved, the person qualifies for coverage for the program listed, and we will pay for covered services that you get during the date that is listed. Changes in your household circumstances must be reported within 10 days of the change because it could affect your continued benefits.

Eligible Person	Coverage Type	Effective Date
[redacted] **Medicaid ID:** [redacted] **Client ID:** [redacted]	ARHOME	04/01/2023
	Action Taken: You have been approved based on monthly household income before taxes and deductions of $1,000.00 and household size of 1. This decision is based on Arkansas Medical Services Policy Sections B-270.	

What do you need to do now that you have been approved?

Depending on your income, you may pay a premium for your health insurance coverage and co-payments on your health care services. If you must pay premiums or co-payments, you will get a separate notice in the mail.

Premium - A premium is money you pay every month for your health care.

Co-Pay - A co-pay is the amount of money you pay when you get a health care service, such as a doctor visit.

For [redacted]:
You must report changes to DHS within 10 days if:

- Anyone in your household is admitted to or discharged from an institution such as a nursing home.
- A change in who you file taxes for, such as a child who becomes a dependent on someone else's taxes.
- If you become pregnant, or disabled, or if a child moves into your home, call 1 (855) 372-1084 to find out if you may be eligible for another category of Medicaid.

How can you send the needed information?

You can send us the information we asked for in one of the following ways:

- **Online: -** You can send your information quickly and easily by uploading it directly to your Access Arkansas account. Follow these steps:
  1. Go to access.arkansas.gov.
  2. You will see a system upgrade screen. You will need to give us your name, date of birth, and county you live in. You can give us your Social Security number, but it is not required.
  3. Answer the Voter Registration question with "Yes" or "No."
  4. On the main Access Arkansas screen, please choose "Health Care" button to apply for Health Care, choose "SNAP" button to apply for SNAP, or choose "TEA" button to apply for TEA. You may apply for more than one program if needed.
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  6. If you need help, you can click on the Help Button at the top of the screen for step-by-step instructions.

  Having an Access Arkansas account puts your case information at your fingertips. Get started with your Access Arkansas account today to do more online!
- **Fax:** You can send your needed information to:
  - Health care (870) 534-3421
- **In Person:** You may take your needed information to your local county office:

  1105 Dr Martin Luther King Dr
  Little Rock, AR, 72202-4741

How can you update your contact information?

Update your contact information if it has changed. Visit ar.gov/update to learn more.

Who can help if you have questions?

Visit our website at http://www.humanservices.arkansas.gov, call the DHS Helpline at 1 (855) 372-1084, or call your local county office at (501) 682-9200.

Where can you get this letter in a different format?

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- Kojela in ebed aoleb melele kin jiban ko Nan kwe.
  Elane kwoj aikuij jiban ikijen ukok Nan kajin Majol, joij im kurtok 1 (855) 372-1084.
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What if you do not agree with the decision?

- You have the right to request an appeal hearing.
- You can find information on how to request an appeal hearing on the attached “Client Appeal Hearing Rights” sheet.

Arkansas Department of Human Services
Client Appeal Hearing Rights

What is an appeal hearing?	A hearing gives you the chance to: • Explain why you think there has been a wrong decision made about your benefits. • Ask for a fair review of the decision. The hearing officer will conduct the hearing by telephone and will call you at your telephone number.

How do I request a hearing?	To request a hearing, you can: • Check the box below. Then mail this form to the address on the front of this notice or to Appeals & Hearings at the address below. ☐ I am requesting a hearing with DHS because I disagree with the decision or planned case action. • Write a letter **or** email, including your name, case number (if you have one), the program and action that you want to request a hearing for and a copy of the front of this notice, and send it to: **Mailing address:** Office of Appeals & Hearings P.O. Box 1437 Slot 101 Little Rock, AR, 72203-1437 **Email address:** DHS.Appeals@dhs.arkansas.gov • Talk to DCO staff of any county office.

How long do I have to ask for a hearing for these health care programs?	**The following household members may ask for a hearing, but the request must be received by the date shown below**		
	[redacted]	ARHOME	07/07/2023
	• If named above, you must ask for a hearing within 30 days of the Date of Notice. • You may continue to receive Health Care benefits at your current level between now and your appeal decision if 1) you appeal within 10 days of the Date of Notice, **and** 2) you **ask** to continue benefits within 10 days of the Date of Notice. • If you **do not** ask to keep getting benefits within 10 days of the Date of Notice, DHS will assume you **do not** wish to continue your benefits pending your appeal decision.		

What are my rights if I request a hearing?	• Your hearing will be conducted by telephone unless you request a video or in-person hearing.
	• You may attend the hearing (In-person hearings are conducted in Little Rock).
	• You may be represented by a lawyer or any other person you choose.
	• You may be able to get free legal aid. If you need it:
	  • Call the 1-888-540-2941
	  • Go to www.arlawhelp.org.
	• Before the hearing, you have the right to see your hearing file and any other evidence to be presented or used at the hearing.
	• You have the right to present your own evidence.
	• You have the right to bring your own witnesses.
	• You have the right to question any witness against you.
	• Please note, if you lose your appeal, you may have to repay the amount of benefits you received during the appeal period.

Free Job Search Help
Arkansas Division of Workforce Services
Arkansas Workforce Centers

Because you get ARHOME, you can get free job search help from the Arkansas Division of Workforce Services (DWS). DWS has Arkansas Workforce Centers across the state that can tell you about job openings, how to look for a job, training programs, and more.

What kind of help can I get?

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Free Job Search Help:

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Referrals for Programs for Specific Needs:

- Free GED and free English as a Second Language classes.
- Programs tailored to assist veterans with employment needs.
- Help for workers who have lost a job because of international trade.
- Temporary cash assistance for needy families (TANF/TEA).
- Vocational rehabilitation for Arkansans living with a disability.
- Programs for young people.

How do I get started?

Take the first step today and contact DWS Arkansas Workforce Centers:

- Online: www.arjoblink.arkansas.gov
- Phone: (855) 225-4440
- Email: ADWS.Info@arkansas.gov

Arkansas Dept. of Human Services

[redacted]
Pine Bluff AR 71611-8848

[redacted]

Date of Notice: 06/14/2023
Client ID: [redacted]
Case Number: [redacted]

Notice of Action

Dear [redacted],

You are getting this letter because we received a change, and a decision has been made about your eligibility.

Please read the whole notice to understand all important information about your case.

- **Each part will explain the status of your case and your household members' eligibility.**
- **The parts called "What do you need to do?" give the next steps for your case.**
- **You can also check your benefits at www.access.arkansas.gov**

If you need help understanding this notice, please call 1 (855) 372-1084.

Health Care

This table shows the full list of programs for each person in your household and our decision about your eligibility for coverage. The sections to come explain why we made this decision about your eligibility.

Denials or Closures in Benefits

If a person has been denied, the person does not qualify for the Health Care program **and the period** listed. If a person is closed, the person **will not be covered for the Health Care program and the period** listed.

Who is NOT Eligible?	Effective Period	Coverage Type
[redacted] **Medicaid ID:** [redacted] **Client ID:** [redacted]	Closed [redacted]	ARHOME
	Reason For Closure: You have asked us in writing to withdraw your application, so your case has been closed/denied. This is based on Arkansas Medical Service Policy Section MS J-130.	

What do you need to do now that you have been denied or closed?

For [redacted]:

- If you have been denied, closed, or your circumstances have changed, you may reapply at any time.

How can you send the needed information?

You can send us the information we asked for in one of the following ways:

- **Online: -** You can send your information quickly and easily by uploading it directly to your Access Arkansas account. Follow these steps:

  1. Go to access.arkansas.gov.
  2. You will see a system upgrade screen. You will need to give us your name, date of birth, and county you live in. You can give us your Social Security number, but it is not required.
  3. Answer the Voter Registration question with “Yes” or “No.”
  4. On the main Access Arkansas screen, please choose "Health Care" button to apply for Health Care, choose "SNAP" button to apply for SNAP, or choose "TEA" button to apply for TEA. You may apply for more than one program if needed.
  5. If you have created an account, you will be able to log in to update your settings and information, see letters and forms, upload documents, and more.
  6. If you need help, you can click on the Help Button at the top of the screen for step-by-step instructions.

  Having an Access Arkansas account puts your case information at your fingertips. Get started with your Access Arkansas account today to do more online!

- **Fax:** You can send your needed information to:
  - Health care (870) 534-3421

- **In Person:** You may take your needed information to your local county office:

  100 Park St
  Lonoke, AR, 72086-3130

How can you update your contact information?

Update your contact information if it has changed. Visit ar.gov/update to learn more.

Who can help if you have questions?

Visit our website at http://www.humanservices.arkansas.gov, call the DHS Helpline at 1 (855) 372-1084, or call your local county office at (501) 676-5643.

Where can you get this letter in a different format?

- Este aviso contiene datos sobre las prestaciones de usted.
  Si necesita la traducción en español, favor llame al 1 (855) 372-1084.
- Kojela in ebed aoleb melele kin jiban ko Nan kwe.
  Elane kwoj aikuij jiban ikijen ukok Nan kajin Majol, joij im kurtok 1 (855) 372-1084.
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What if you do not agree with the decision?

- You have the right to request an appeal hearing.
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Arkansas Department of Human Services
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How long do I have to ask for a hearing for these health care programs?	**The following household members may ask for a hearing, but the request must be received by the date shown below**		
	[redacted]	ARHOME	07/19/2023
	• If named above, you must ask for a hearing within 30 days of the Date of Notice. • You may continue to receive Health Care benefits at your current level between now and your appeal decision if 1) you appeal within 10 days of the Date of Notice, **and** 2) you **ask** to continue benefits within 10 days of the Date of Notice. • If you **do not** ask to keep getting benefits within 10 days of the Date of Notice, DHS will assume you **do not** wish to continue your benefits pending your appeal decision.		

What are my rights if I request a hearing?	• Your hearing will be conducted by telephone unless you request a video or in-person hearing.
	• You may attend the hearing (In-person hearings are conducted in Little Rock).
	• You may be represented by a lawyer or any other person you choose.
	• You may be able to get free legal aid. If you need it:
	  • Call the 1-888-540-2941
	  • Go to www.arlawhelp.org.
	• Before the hearing, you have the right to see your hearing file and any other evidence to be presented or used at the hearing.
	• You have the right to present your own evidence.
	• You have the right to bring your own witnesses.
	• You have the right to question any witness against you.
	• Please note, if you lose your appeal, you may have to repay the amount of benefits you received during the appeal period.

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Arkansas Workforce Centers

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Help from Experts:

- Identify your skills and get help finding job openings that need those skills.
- Create or update your resume to get the best results possible in your job search.
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- Get the facts about what kind of jobs are available and where they are in Arkansas.

Referrals for Programs for Specific Needs:

- Free GED and free English as a Second Language classes.
- Programs tailored to assist veterans with employment needs.
- Help for workers who have lost a job because of international trade.
- Temporary cash assistance for needy families (TANF/TEA).
- Vocational rehabilitation for Arkansans living with a disability.
- Programs for young people.

How do I get started?

Take the first step today and contact DWS Arkansas Workforce Centers:

- Online: www.arjoblink.arkansas.gov
- Phone: (855) 225-4440
- Email: ADWS.Info@arkansas.gov

Arkansas Dept. of Human Services
Pine Bluff Scanning Center
P.O. Box 8848
Pine Bluff AR 71611-8848

[redacted]

Date of Notice: 05/01/2023
Client ID: [redacted]
Case Number: [redacted]

Benefit Renewal Form

Dear [redacted]

It is time for the annual renewal of the below program(s). We will use the information you report on this form to determine if your household can keep getting benefits.

Program/Benefit Category	Benefit Recipient(s)
TEFRA	[redacted]

What do you need to do?

- **Review your information and fill in updated information in this renewal form. Your case will be closed if you do not return this completed form by 7/10/2023.**

For [redacted]

- DMS-2602 form is attached with this renewal form. Failure to return the completed DMS-2602 form may result in closure of your TEFRA benefit.
- Parents/Guardians please attach a copy of the most recent Federal Income Tax Forms. If you itemize deductions, you must include the Schedule A.

How can you send the needed information?

You can send us the information we asked for in one of the following ways:

- **Online: -** You can send your information quickly and easily by uploading it directly to your Access Arkansas account. Follow these steps:
  1. Go to access.arkansas.gov.
  2. You will see a system upgrade screen. You will need to give us your name, date of birth, and county you live in. You can give us your Social Security number, but it is not required.
  3. Answer the Voter Registration question with “Yes” or “No.”
  4. On the main Access Arkansas screen, please choose "Health Care" button to apply for Health Care, choose "SNAP" button to apply for SNAP, or choose "TEA" button to apply for TEA. You may apply for more than one program if needed.
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  6. If you need help, you can click on the Help Button at the top of the screen for step-by-step instructions.

Having an Access Arkansas account puts your case information at your fingertips. Get started with your Access Arkansas account today to do more online!

- **Fax:** You can send your needed information to:
  - Health care (870) 534-3421

- **In Person:** You may take your needed information to your local county office:

  2612 Spruce St
  Lewisville, AR, 71845-8638

- **Mail:** You can use the enclosed envelope to send your needed information.

How can you update your contact information?

Update your contact information if it has changed. Visit ar.gov/update to learn more.

Who can help if you have questions?

Visit our website at http://www.humanservices.arkansas.gov, call the DHS Helpline at 1 (855) 372-1084, or call your local county office at (870) 921-4283.

Where can you get this letter in a different format?

- Este aviso contiene datos sobre las prestaciones de usted.
  Si necesita la traducción en español, favor llame al 1 (855) 372-1084.
- Kojela in ebed aoleb melele kin jiban ko Nan kwe.
  Elane kwoj aikuij jiban ikijen ukok Nan kajin Majol, joij im kurtok 1 (855) 372-1084.
- To get this notice in a format that is accessible for an individual with a disability, call 1 (855) 372-1084.

Arkansas Department of Human Services
Benefit Renewal Form

Please complete the following sections to give us your updated information.

As you complete this form, please tell us any changes that have happened.

If there is a change in your benefits, you will get a notice explaining the change. You will not have to visit your local DHS County Office. However, you may be contacted by phone or mail if more information is needed to determine your eligibility.

Contact Information

This is the address we have on record for you. If you have moved to a new address, please write your address below

Current Address:

[redacted]

[redacted]

New Address:

Street or Rural Route or P.O. Box, Apt or Lot Number

City State Zip

Phone Number Email (if available)

Please let us know if this contact information is still correct. If not please update the information.

[redacted] [redacted]

Primary Alternate Work

We do not have an email address on file for you. If you would like to provide an email address, please write it below:

Email Address

Would you like to get your letters and forms in a paperless format? ☐ Yes ☐ No
If you choose yes, you will need to verify your email address. Then you will start getting alerts when new information has been posted to your online account.

Absent Parent Information

If the new household member is a minor child with a parent who does not live in the home, you must provide information that you know about the absent parent:

Child's name	Absent parent name	SSN of absent parent	Date of birth of absent parent	Relationship to child	Is this parent deceased?	
					☐ Yes	☐ No
					☐ Yes	☐ No

The new household member may be excused from cooperating with the Office of Child Support Enforcement (OCSE) if it will not be in the best interest of the member or his or her child. The household member will be required to provide proof.

Please select any reasons below that apply:

- ☐ Caretaker relative in adoption counseling
- ☐ May result in physical/emotional harm
- ☐ Other
- ☐ Conception result of incest or rape
- ☐ Pending legal proceedings for adoption

Income

These are the income sources we have on record for your household. Please verify the income sources listed below. Provide an end date if this income has ended. If the income has ended, please attach proof, such as a final pay stub or a letter from your employer or income source.

Source of Income / Name of Employer	Who Receives Income	Specific Type of Income	Amount before taxes	How often Received	Income End Date
2021 Federal Income Tax	[redacted]	Earned Income	$ 12310.75	Annually	

Please list any other income sources not listed above with an end date if this income has ended. Attach another sheet of paper, if you need more space. Everyone in your household who earns money from a job or get money from other sources must give DHS proof of the money they get.

Examples of Income Sources: Retirement, Social Security, SSI, Veterans Benefits, Railroad Retirement, Civil Service Benefits, Interest/Dividends, Insurance, Mineral Rights/Oil Leases, Unemployment Benefits, Worker's Compensation, Employment/Work, Farm Income, Self-employment, Rental Income, Contributions from Family/Friends, Income from Trusts or Annuities.

Source of Income	Who receives income	Amount Before Taxes	How often Received	Income Start Date	Income End Date

Please read the below for SNAP benefits

YOU MUST SEND PROOF OF ALL INCOME RECEIVED BY ALL PEOPLE IN YOUR HOUSEHOLD. If you don't provide proof, your benefits may be delayed, or your case may be closed. For **each** person who works or gets money from another source, you must send one of the following:

1) a check stub for each pay check received in the last 30 days.
2) the attached income verification form filled out by your employer. After your employer fills out the verification form, you may return it with this form. If you need more income verification forms, contact the DHS county office.
3) an award letter or other correspondence from the person or agency that provides the unearned income.
4) other documentation that shows your current income amount.

Resource(s)

Listed below are the resources we have on record for you.

Type of Resource	Location (address, bank, insurance co., brokerage firm, etc.)?	Owner(s)	Account/ Policy#	$ Value
None	None	None	None	None

If you or your spouse obtained, sold, deeded or gave away any assets that includes those listed above, please fill out the section below and attach proof. Use another sheet of paper if you need more space.

Examples of resources: Cash, Checking Account, Savings Account, Certificates of Deposit, Promissory Notes, Real Property (land, home, rental property etc.), Trust Fund, Certificate of Deposit, Individual Retirement Account (IRA), Promissory Note, Mutual Fund, Mortgages, Stocks or Bonds, Life Insurance, Burial Funds Insurance, Burial Plot, etc.

Type of resource	Date Obtained	Date Sold, Deeded, or Gave Away (if applicable)	Location (address, bank, insurance co., brokerage firm, etc.)?	Owner(s)	Account/Policy # (Last 4 digits)	$ Value

Vehicles

Listed below are the vehicles we have on record for you.

Make	Model	Year	Value	Amount owed	Owner(s)
None	None	None	None	None	None

If you or your spouse own a car, truck, motorcycle, boat, trailer, or other vehicle not listed above, please fill in the following information about each vehicle (attach additional pages as needed). Use another sheet of paper if you need more space.

Make	Model	Year	Value	Amount owed	Owner(s)

Health Insurance

Listed below are the Health Insurance details we have on record for you.

Health Insurance Company Name and Address	Who Is Insured?	Type of Insurance	Start and End Date MM/DD/YY - MM/DD/YY	Policy or Claim #	Amount
	None	None	None	None	None

Do you have Medicare? ☐ Yes ☐ No Medicare ☐ A ☐ B

Does your spouse have Medicare? ☐ Yes ☐ No Medicare ☐ A ☐ B

Do you have other health insurance? ☐ Yes ☐ No

Does your spouse have other health insurance? ☐ Yes ☐ No

If you, your spouse, or anyone in your home, have other health insurance besides Medicare, please fill in the information below and attach copies (front and back) of Medicare and insurance cards.

Health Insurance Company Name and Address	Who is Insured?	Type of Insurance	Start and End Date MM/DD/YY - MM/DD/YY	Policy or Claim #	Amount

Medical Costs

Listed below are the medical expenses we have on record for you.

Name of Person Who Pays This Cost	Type of Cost	Start Date of the Cost	Amount Paid	How Often Paid?
None	None	None	None	None

If you have new medical costs that are not reported above, please fill in the following information about each medical cost.

Please read the below for SNAP benefits

- If you have between **$35.01** and **$138.00** in deductible medical expenses, you will be assigned the medical standard.
- If your medical expenses are more than **$138.00** , you may choose to claim the standard medical deduction or actual medical expenses.
- In order for us to consider medical expenses, you must provide proof of each expense**.**
- If your prescription costs have changed, you may wish to provide a printout from your pharmacy or a list of drugs that you take each month.
- We cannot consider actual medical expenses without proof.

Name of Person Who Pays This Cost	Type of Expense	Start Date of the Expense	Amount Paid	How Often Paid?

Cost to take care of others

Listed below are the costs to take care of others that we have on record for you.

Name of Person Who Is Cared for	Name of Person Who Pays This Cost	Name of Person Or Company Who Is Paid and Telephone Number	New Amount Paid	How Often Paid?
None	None	None	None	None

Costs to take care of others are payments for the care of someone in your household who depends on your income, like a child or an adult age 60 or older, or an individual with a disability. Paying this cost allows someone in the household to work, look for work, or attend school or a training course. You are allowed, but not required, to report changes in your costs to take care of others in the space below.

Example: child support, alimony, childcare, or adult care costs.

Name of Person Who Is Cared for	Name of Person Who Pays This Cost	Name of Person Or Company Who Is Paid and Telephone Number	New Amount Paid	How Often Paid?

Renewal of Coverage in Future Years

To make it easier to determine your eligibility for help paying for health coverage in future years, you can agree to allow DHS to use income data including information from tax returns. DHS will send you a notice, let you make any changes and you can opt out at any time.

Yes, review my eligibility automatically for the next:

☐ 5 years (The maximum number of years allowed) ☐ 4 years ☐ 3 years ☐ 2 years ☐ 1 year
Or for a shorter number of years:

☐ Don't use information from tax returns to review my eligibility.

Federal law requires that each state provide the opportunity to register to vote with every application for public assistance. The Arkansas Voter Registration Application begins after page 8 of this packet. Please answer the following question regarding voter registration:

- **Would you like to register to vote or change your voter registration address?**
  ☐ **Yes** ☐ **No**

If you marked **Yes**, please complete and sign the Voter Registration Application that is attached. If you marked **No**, submit your Recertification Application to your local DHS County Office.

READ THE FOLLOWING INFORMATION CAREFULLY BEFORE YOU SIGN THIS APPLICATION

- I understand that I must help establish my eligibility by providing as much of the requested information as I can.
- I authorize the Department of Human Services to make any inquiry concerning me and/or my spouse necessary to establish my eligibility for assistance.
- I authorize my employer(s), any banks, savings and loans, lending institutions or other financial institutions, etc., to release to DHS any information about myself or my spouse's circumstances as necessary to verify any information contained on this application.
- I authorize DHS to obtain information from any federal, other state agencies and other sources (including electronic databases) to confirm the accuracy of my statements.
- I understand that no person may be denied assistance on the grounds of race, color, sex, age, disability, religion, national origin, or political belief.
- I understand that I may request a hearing before the state agency representative if a decision is not reached on my case within the appropriate time limit or if I disagree with the decision reached.
- I understand that the Estate Recovery process and conditions that I agreed to with my initial application for assistance still apply.
- I agree to notify the Department of Human Services within 10 days if I or my spouse receive additional income, acquire or dispose of property or if any other changes occur in my circumstances.
- I authorize the Department of Human Services to examine all records of mine, or records of those receiving or having received Medicaid benefits through me, for the purpose of investigating whether or not any person may have committed Medicaid fraud, or for use in any legal, administrative, or judicial proceeding.
- I understand that I must provide my Social Security Number as a condition of my eligibility; and I understand that this number may be used by the Agency without my express permission in a computer match to obtain information relative to my eligibility for assistance from the Social Security Administration, Department of Workforce Services, Internal Revenue Service, or other agencies.
- ASSIGNMENT OF MEDICAL SUPPORT. I authorize any holder of medical or other information about me to release information needed for a Medicaid claim to DHS. I further authorize release of any information to other parties who may be liable for my medical expenses. As an eligibility condition I automatically assign my right to any settlement, judgment, or award which may be obtained against any third party to DHS to the full extent of any amount which is paid by DHS on my behalf. I authorize and request that funds, settlement or other payments made by or on behalf of third parties, including tortfeasors or insurers arising out of a Medicaid claim, be paid directly to DHS. My application for Medicaid benefits shall in itself constitute an assignment by operation of law and shall be considered a statutory lien of any settlement, judgment, or award received by me from a third party. A third party is any person, entity, institution, organization or other source which may be liable for injury, disease, disability or death sustained by me or others named herein, including estates of said individuals. I also assign all rights in any settlement made by me or on my behalf arising out of any claim to the extent of medical expenses paid by DHS, whether or not a portion of such settlement is designated for medical expenses. Any such funds received by me shall be paid to DHS. A copy of this authorization may be used in place of the original.
- I am also giving DHS rights to pursue and receive medical support from a spouse or parent.
- *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 Medicaid Program, this authority is granted under Federal laws codified at 42 U.S.C. §§ 1320b-7(a)(1) and 1320b-7(b)(2). This information may be verified through computer matching programs. We will use this information to determine Program eligibility, to monitor compliance with program rules, and for program management. This information may be disclosed to other Federal and State agencies and to law enforcement officials. If a claim arises against your household, the information on this application, including all SSNs, may be provided to Federal or State officials or to private agencies for collection purposes. *EXCEPTION: In the Medicaid Program, information is disclosed without the individual's written consent only to: authorized employees of this Agency, the Social Security Administration, the U.S. Department of Health and Human Services, the individual's attorney, legal guardian, or someone with power of attorney; or an individual who the recipient has asked to serve as his representative AND who has supplied confidential information for the case record which helped to establish eligibility, or court of law when the case record is subpoenaed.

- I understand that if anyone receives TEA/Work Pays cash assistance for which they are not eligible as a result of my withholding information I may have to repay that cash assistance.
- I understand that the information that I gave on this report may result in the loss of TEA/Work Pays benefits.

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 wrong and you can ask for a fair review of the action. You can find out how to appeal by contacting your local DHS office or the Office of Appeals and Hearings at 501-682-8622. Also, you can be represented in the process by someone other than yourself. Your eligibility and other important information will be explained to you

I have read the above statements, and I agree to the provisions. I understand that this form is signed subject to penalties for perjury. I understand that if I receive assistance to which I am not entitled as a result of withholding information or providing inaccurate information, such assistance will be subject to recovery by the Department of Human Services and I may be subject to prosecution for fraud and fined and/or imprisoned.

Signature of Applicant, Guardian, or Authorized Rep.

Date | Telephone Number | Guardian or Authorized Rep's Address

Witness (if signed by X) Date | Address of Witness/ Telephone Number

Signature of County Office Worker Date | Name of Person Who Helped Complete Form Date

Arkansas Department of Human Services
TEFRA Waiver / Physician Assessment of Eligibility

Date of Application 05/29/2007

SECTION I. Patient Information:

PATIENT'S LAST NAME	FIRST	MI	SEX	PATIENT'S MEDICAID ID#
[redacted]	[redacted]	[redacted]	M	[redacted]

PHONE NUMBER	COUNTY OF RESIDENCE	DATE OF BIRTH	RACE	SOCIAL SECURITY NUMBER
[redacted]	[redacted]	[redacted]	White	[redacted]

MAILING ADDRESS(Street, City, State, Zip code)	RESIDENCE ADDRESS(Street, City, State, Zip code)
[redacted]	[redacted]

PRIMARY PHYSICIAN	PRIMARY PHYSICIAN'S ADDRESS

PARENT/GUARDIAN NAME (Primary Caregiver)	CHILD SCREENING REFERRAL
	☐ Yes ☐ No

INSURANCE COMPANY AND ADDRESS	INSURANCE POLICY NUMBER

☐ Original	☐ Re-certification	Date

PRIMARY DIAGNOSIS	SECONDARY DIAGNOSIS	OTHER DIAGNOSIS

HOSPITALIZATIONS in the last year - Reason and Length of Stay

BRIEF MEDICAL AND SURGICAL HISTORY (If available, please attach copies of clinical or hospital records)

☐ Medical Records Attached

Prognosis

Goals

Date Last Examined

SECTION II. **Current Services Required for Patient Management:** ***Please attach a current medical and surgical history that includes M.D. summary, prognosis and medical follow-up requirements. Include changes since the last certification, if recertification.*** **CHECK ALL THAT APPLY.**

Required Services:

☐ Close patient monitoring of _____ with frequent skilled intervention of
(specific symptom)

_____
(intervention) _____

☐ Hyperalimentation - parenteral or sole source enteral

☐ IV Drugs (chemotherapy, pain relief or prolonged IV antibiotics)

☐ Respiratory - tracheostomy care or continuous oxygen supplementation

☐ Ventilator-Dependent: _____ hours per day

SECTION II. (Continued):

Needs Assessment:

☐ Cardiovascular System
☐ Digestive System
☐ Endocrine System
☐ Genito-urinary System
☐ Hemic and Lymphatic System
☐ Immune System
☐ Mental Disorders
☐ Multiple Body Systems
☐ Musculoskeletal System
☐ Neoplastic Diseases
☐ Neurological
☐ Respiratory System
☐ Skin
☐ Special Senses and Speech

Physical Abilities/Limitations:

☐ Ambulatory
☐ Ambulates with assistance
☐ Independent transfers bed/chair
☐ Transfers with assistance
☐ Total lift
☐ Sighted
☐ Blind
☐ Verbal
☐ Other _____
☐ Deaf
☐ Signs
☐ Augmentative Communication Device

Cognitive Abilities/Limitations:

☐ Alert, cognitive appropriate for age
☐ Alert, cognitive age _____
☐ Alert, disoriented
☐ Unresponsive
☐ Uncooperative

Bathing: ☐ self ☐ caregiver ☐ Other _____

Feedings: ☐ self ☐ caregiver _____

Skilled Nursing Needs: (frequency documented by hospital record or nurse's notes)

- ☐ Continuous O_2
- ☐ Nasopharengeal suctioning
- ☐ Sole source enteral _____ hrs
- ☐ Trach Care
- ☐ Tracheal Suctioning
- ☐ Ventilator _____ hrs/day
- ☐ _____ (other)
- ☐ _____ (other)
- ☐ _____ (other)

Additional Services:

Medications (route and frequency): _____

_____

Occupational Therapy (frequency, location and provider name): _____

_____

Physical Therapy (frequency, location and provider name): _____

_____

Speech Therapy (frequency, location and provider name): _____

_____

Other - Specify (ex: Personal Care, Waiver Caregiver, Developmental Day Treatment Clinic Services, Mental Health, Home Health, Targeted Case Management): _____

_____

Name of Targeted Case Manager, if applicable: _____

SECTION II. (Continued):

Equipment or Special Physical Aids In Use:

- ☐ Catheter
- ☐ CPAP/BIPAP
- ☐ Crutches/Cane
- ☐ Enteral Pump
- ☐ Ostomy care
- ☐ Pulse OX
- ☐ Shower Chair
- ☐ Shower Chair

- ☐ Hospital Bed
- ☐ Hoyer Lift
- ☐ IV Pump
- ☐ Nebulizer
- ☐ O_2
- ☐ Orthotics/Prosthetics
- ☐ Other _____
- ☐ Shower Chair
- ☐ Shower Chair
- ☐ Suction Machine
- ☐ Ventilator
- ☐ Walker
- ☐ Wheelchair: ☐ power ☐ manual

Daycare/Education:

Daycare/school days and hours, name of school. List start/end dates and vacation dates: _____

GOALS:

A. Patient/Family education/Teaching goals: _____

B. Were previous goals met? _____

SECTION III. PHYSICIAN'S CERTIFICATION:

Please include changes in psychosocial situation since last certification if recertification.

A. Caregiver's understanding of patient's condition: _____

B. Family composition (List all residents of home by name and age. List education and occupation of Adults): _____

C. Support system: _____

_____

_____

D. Transportation requirements: _____

_____

E. Number of competent caregivers in home (name & relationship to patient): _____

_____

I certify that the above named patient can be treated in a home setting with the services specified in this assessment. The services are appropriate to the condition of the patient: ☐ Yes ☐ No

Home/Community resources are available for this assessment: ☐ Yes ☐ No

Signature of Physician: _____ Date: _____

Printed Name: _____ Phone: _____

Address: _____

City, State and Zip Code: _____

PLEASE PRINT AND USE BLACK INK TO COMPLETE

Rev. 1-24-19

ARKANSAS VOTER REGISTRATION APPLICATION

Check all that apply:
____ **This is a new registration.**
____ **This is a name change.**
____ **This is an address change.**
____ **This is a party change.**

Office Use Only

Assigned ID

1	Mr. Mrs. Miss Ms.	Last Name	Jr. Sr. II. III. IV.	First Name	Middle Name			
2	Address Where You Live (See Section "C" Below) (Rural addresses must draw map.)		Apt. or Lot#	City/Town	County	State	ZIP Code	
3	Address Where You Receive Mail If Different From Above		Apt. or Lot#	City/Town	County	State	ZIP Code	

4 Date of Birth ____/____/____ (Month / Day / Year)

5 Home & Work Phone Numbers (Optional) **(H)** **(W)**

6 Party Affiliation (Optional)

7 E-mail Address (Optional)

8 Have you ever voted in a federal election in this State? ☐ Yes ☐ No

9 ID Number - Check the applicable box and provide the appropriate number.
☐ Arkansas Driver's license number _____
☐ **If you do not have a driver's license provide the last 4 digits of social security number** _____
☐ I have neither a driver's license nor social security number.

10
(A) Are you a citizen of the United States of America and an Arkansas resident? ☐ Yes ☐ No
(B) Will you be eighteen (18) years of age or older on or before election day? ☐ Yes ☐ No
(C) Are you presently adjudged mentally incompetent by a court of competent jurisdiction? ☐ Yes ☐ No
(D) Have you ever been convicted of a felony without your sentence having been discharged or pardoned? ☐ Yes ☐ No
If you checked No in response to either questions A or B, do not complete this form.
If you checked Yes in response to either questions C or D, do not complete this form.

Signature of elector - Please sign full name or put mark.

The information I have provided is true to the best of my knowledge. I do not claim the right to vote in another county or state. If I have provided false information, I may be subject to a fine of up to $10,000 and/or imprisonment of up to 10 years under state and federal laws.

Date: ____/____/____ (Month / Day / Year)

11 If applicant is unable to sign his/her name, provide name, address and phone number of the person providing assistance:
Name _____ Address: _____
City:_____ State:_____ Phone#:_____

Please complete the sections below if:
- You were previously registered in another county or state, or
- You wish to change the name or address on your current registration.

MAIL REGISTRANTS: PLEASE SEE SECTION D.

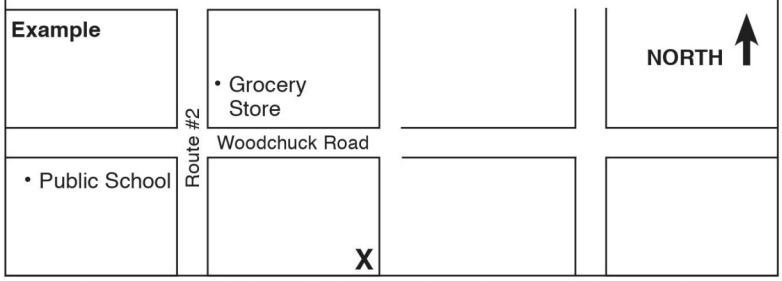
Agency Code (For Official Use Only)

Date of Birth ____/____/____ (Month / Day / Year)

A	Mr. Mrs. Miss Ms.	Previous Last Name	Jr. Sr. II. III. IV.	First Name	Middle Name			
B	Previous House Number and Street Name		Apt. or Lot#	City/Town	County	State	ZIP Code	

If you live in a rural area but do not have a house or street number, or if you have no address, please show on the map where you live.

C
- Write in the names of the crossroads (or streets) nearest where you live.
- Draw an "X" to show where you live.
- Use a dot to show any schools, churches, stores or other landmarks near where you live and write the name of the landmark.



D

IDENTIFICATION REQUIREMENTS

IMPORTANT: Applicants will be required to verify their registration when voting in person or by absentee ballot by providing a required document or identification card as provided in Arkansas Constitution, Amendment 51, Section 13. If your voter registration application form is submitted by mail and you are registering for the first time, and you do not have a valid Arkansas driver's license number or social security number, in order to avoid the additional identification requirements upon voting for the first time you must submit with the mailed registration form: (a) a current and valid photo identification; or (b) a copy of a current utility bill, bank statement, government check, paycheck, or other government document that shows your name and address.

Arkansas Secretary of State
ATTN:Voter Registration
P.O. BOX 8111
Little Rock, Arkansas 72203-8111

First Class Postage Required

From:

Deadline Information

To qualify to vote in the next election, you must apply to register to vote 30 days before the election. If you mail this form, it must be postmarked by that date. You may also present it to a voter registration agency representative by that date. If you miss the deadline you will not be registered in time to vote in that election. *Please don't delay. Make sure your vote counts*.

If you are qualified and the information on your form is complete, you will be notified of your voting precinct by your local County Clerk.

To Mail

Fold form on middle perforation, remove plastic strip, seal at bottom, stamp and mail.

Questions?

Call your local County Clerk

Or

Arkansas Secretary of State
John Thurston
Elections Division - Voter Services
1-800-482-1127

Contact your County Clerk if you have not received confirmation of this application within two weeks.

ARKANSAS VOTER REGISTRATION INFORMATION

Section 7 of the National Voter Registration Act (NVRA) of 1993 requires that each state provide the opportunity to register to vote with every application for public assistance and every recertification, renewal and change of address. This Voter Registration packet is an opportunity for you to register to vote or change your voter registration address. Applying to register or declining to register to vote will not affect the amount of assistance that you will be provided by this agency.

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. You may fill out the voter registration application form in private.

No information relating to a declination to register to vote in connection with an application may be used for any purpose other than voter registration.

If you believe that someone has interfered with your right to: 1) Register to vote;
2) Decline to register to vote; 3) Privacy in deciding whether to register or in applying to register to vote; or 4) Choose your own political party or other political preference,

You may file a complaint with:

Secretary of State
Room 256 State Capitol
Little Rock, Arkansas 72201
1-800-482-1127

Mailing Instructions for Voter Registration

You have two options to submit your Voter Registration form.

1. You may mail or drop off your completed Voter Registration form to any DHS office. When the county office receives your form, that office will mail the form to the Secretary of State's office for you.

2. You may also mail the Voter Registration form directly to the Secretary of State's Office. To mail the form directly to the Secretary of State's office, separate the form from your application/renewal, fold the form along the middle perforation, seal the bottom with tape or staple, and mail to the address on the form. A stamp or stamped envelope is required for mailing.

DHS County Office Mailing Addresses											
County	Address	City	Zip	County	Address	City	Zip	County	Address	City	Zip
Arkansas	PO Box 1008	Stuttgart	72160	Grant	PO Box 158	Sheridan	72150	Perry	213 Houston Ave	Perryville	72126
Arkansas Processing Center	1095 White Dr	Batesville	72501	Greene	809 Goldsmith Rd	Paragould	72450	Phillips	PO Box 277	Helena	72342
Ashley	PO Box 190	Hamburg	71646	Hempstead	116 N Laurel St	Hope	71801	Pike	PO Box 200	Murfreesboro	71958
Baxter	PO Box 408	Mountain Home	72654	Hot Spring	2505 Pine Bluff St	Malvern	72104	Poinsett	PO Box 526	Harrisburg	72432
Benton	900 SE 13th Ct	Bentonville	72712	Howard	PO Box 1740	Nashville	71852	Polk	PO Box 1808	Mena	71953
Boone	PO Box 1096	Harrison	72602	Independence	100 Weaver Ave	Batesville	72501	Pope	701 N Denver Ave	Russellville	72801
Bradley	PO Box 509	Warren	71671	Izard	PO Box 65	Melbourne	72556	Prairie	PO Box 356	Devalls Bluff	72041
Calhoun	PO Box 1068	Hampton	71744	Jackson	PO Box 610	Newport	72112	Pulaski Jacksonville	PO Box 626	Jacksonville	72078
Carroll	PO Box 425	Berryville	72616	Jefferson	PO Box 5670	Pine Bluff	71611	Pulaski North	PO Box 5791	North Little Rock	72119
Chicot	PO Box 71	Lake Village	71653	Johnson	PO Box 1636	Clarksville	72830	Pulaski South	PO Box 2620	Little Rock	72203
Clark	PO Box 969	Arkadelphia	71923	Lafayette	2612 Spruce St	Lewisville	71845	Pulaski Southwest	PO Box 8916	Little Rock	72219
Clay	PO Box 366	Piggott	72454	Lawrence	PO Box 69	Walnut Ridge	72476	Randolph	1408 Pace Rd	Pocahontas	72455
Cleburne	PO Box 1140	Heber Springs	72543	Lee	PO Box 309	Marianna	72360	Saint Francis	PO Box 899	Forrest City	72336
Cleveland	PO Box 465	Rison	71665	Lincoln	101 W Wiley Ave	Star City	71667	Saline - 1	PO Box 608	Benton	72018
Columbia	PO Box 1109	Magnolia	71754	Little River	90 Waddell St	Ashdown	71822	Scott	PO Box 840	Waldron	72958
Conway	PO Box 228	Morrilton	72110	Logan	17 W McKeen St	Paris	72855	Searcy	106 School St	Marshall	72650
Craighead	PO Box 16840	Jonesboro	72403	Lonoke	PO Box 260	Lonoke	72086	Sebastian	616 Garrison Ave	Fort Smith	72901
Crawford	704 Cloverleaf Cir	Van Buren	72956	Madison	PO Box 128	Huntsville	72740	Sevier	PO Box 670	De Queen	71832
Crittenden	401 S College Blvd	West Memphis	72301	Marion	PO Box 447	Yellville	72687	Sharp	1467 Highway 62 412 Ste B	Cherokee Village	72529
Cross	803 Highway 64 E	Wynne	72396	Miller	3809 Airport Plaza Dr	Texarkana	71854	Stone	1821 E Main St	Mountain View	72560
Dallas	1202 W 3rd St	Fordyce	71742	Mississippi	1104 Byrum Rd	Blytheville	72315	Union	123 W 18th St	El Dorado	71730
Desha	PO Box 1009	McGehee	71654	Monroe	301 1/2 N New Orleans Ave	Brinkley	72021	Van Buren	449 Ingram St	Clinton	72031
Drew	PO Box 1350	Monticello	71657	Montgomery	PO Box 445	Mount Ida	71957	Washington - 1	4201 N Shiloh Drive Suite 110	Fayetteville	72703
Faulkner	1000 E Siebenmorgen Rd	Conway	72032	Nevada	PO Box 292	Prescott	71857	White	608 Rodgers Dr	Searcy	72143
Franklin	800 W Commercial St	Ozark	72949	Newton	PO Box 452	Jasper	72641	Woodruff	PO Box 493	Augusta	72006
Fulton	PO Box 650	Salem	72576	Ouachita	PO Box 718	Camden	71711	Yell	PO Box 277	Danville	72833
Garland	115 Stover St	Hot Springs	71913								

***If you live in Pulaski County please check the zip code listing below to ensure that you mail or return your application to the appropriate Pulaski County DHS Office.**

Pulaski North: 72046 (England), 72113, 72114, 72115, 72116 (Shared with Jax), 72117, 72118, 72119, 72142 (Scott), 72190, 72231
Pulaski Jacksonville: 72023 (Cabot), 72076, 72078, 72099, 72106, 72116, 72120, 72124
Pulaski South: 72204, 72206 (Shared with Southwest), 72016, 72053, 72126, 72135, 72201, 72202, 72203, 72205, 72207, 72212, 72223, 72227
Pulaski Southwest: 72002, 72065, 72103, 72164, 72208, 72209, 72210, 72211, 72164, 72180, 72183, 72206 (Shared with South)

Arkansas Dept. of Human Services

[redacted]
Pine Bluff AR 71611-8848

[redacted]

Date of Notice: 06/16/2023
Client ID: [redacted]
Case Number: [redacted]

Request for Information

Dear [redacted],

We do not have enough information to determine if you or your household can continue to get benefits.

What do you need to do?

You must send the following information by the due date, or your Case will be closed.

Please note, there may be different due dates for each type of information we are requesting.

The sooner you provide all the information, the sooner your case can be processed.

Please send a copy of the documents. Do not send the original documents. If you need more time, contact your local county office at (501) 315-1600.

Please send this information for **Randall Rainwater:**		
Type: [redacted]	**Program:** [redacted]	**Due date:** 06/26/2023
Information Needed (Please provide one of the following): Social Security award letters, Veteran's Administration award letters (must include aid and attendance), retirement benefits letters, rental property rental agreement, any monies received from insurance companies, trust documents (revocable, irrevocable, annuity, special needs, etc.), mineral rights/oil lease payments (including all checks received in last 12 months), any interest payments, worker's compensation, cash contributions for: Railroad Retirement - RR for the period 06/16/2023-Present		

Are You Having Trouble Getting This Information?

- If you cannot get the information you need or if you have trouble getting it before 06/26/2023, let your case worker know as soon as possible. The case worker must help you get the requested information if your household is cooperating with the State agency. Although you must provide the requested information on or before 06/26/2023, if you provide this information sooner we may be able to process your paperwork more quickly. Please return this form with your requested information.

How can you send the needed information?

To avoid delays in your benefits please give us your documents with a copy of this notice.

- **Online:-** You can send your information quickly and easily by uploading it directly to your Access

Arkansas account. Follow these steps:

1. Go to access.arkansas.gov.
2. You will see a system upgrade screen. You will need to give us your name, date of birth, and county you live in. You can give us your Social Security number, but it is not required.
3. Answer the Voter Registration question with “Yes” or “No.”
4. On the main Access Arkansas screen, please choose "Health Care" button to apply for Health Care, choose "SNAP" button to apply for SNAP, or choose "TEA" button to apply for TEA. You may apply for more than one program if needed.
5. If you have created an account, you will be able to log in to update your settings and information, see letters and forms, upload documents, and more.
6. If you need help, you can click on the Help Button at the top of the screen for step-by-step instructions.

Having an Access Arkansas account puts your case information at your fingertips. Get started with your Access Arkansas account today to do more online!

- **Fax:** You can send your needed information to:
  - Health care: (870) 534-3421
- **In Person:** You may take your needed information to your local county office:

  1603 Edison Ave
  Benton, AR, 72015-4629
- **Mail:** You can use the enclosed envelope to send your needed information.

How can you update your contact information?

Update your contact information if it has changed. Visit ar.gov/update to learn more.

Who can help if you have questions?

Visit our website at http://www.humanservices.arkansas.gov, call the DHS Helpline at 1 (855) 372-1084, or call your local county office at (501) 315-1600.

Where can you get this letter in a different format?

- Este aviso contiene datos sobre las prestaciones de usted.
  Si necesita la traducción en español, favor llame al 1 (855) 372-1084.
- Kojela in ebed aoleb melele kin jiban ko Nan kwe.
  Elane kwoj aikuij jiban ikijen ukok Nan kajin Majol, joij im kurtok 1 (855) 372-1084.
- To get this notice in a format that is accessible for an individual with a disability, call 1 (855) 372-1084.

Arkansas Department of Human Services
Client Appeal Hearing Rights

What is an appeal hearing?	A hearing gives you the chance to: • Explain why you think there has been a wrong decision made about your benefits. • Ask for a fair review of the decision. The hearing officer will conduct the hearing by telephone and will call you at your telephone number.

How do I request a hearing?	To request a hearing, you can: • Check the box below. Then mail this form to the address on the front of this notice or to Appeals & Hearings at the address below. ☐ I am requesting a hearing with DHS because I disagree with the decision or planned case action. • Write a letter **or** email, including your name, case number (if you have one), the program and action that you want to request a hearing for and a copy of the front of this notice, and send it to: **Mailing address:** Office of Appeals & Hearings P.O. Box 1437 Slot 101 Little Rock, AR, 72203-1437 **Email address:** DHS.Appeals@dhs.arkansas.gov • Talk to DCO staff of any county office.

How long do I have to ask for a hearing for these health care programs?	**The following household members may ask for a hearing, but the request must be received by the date shown below**		
	[redacted]	ARHOME	07/21/2023
	• If named above, you must ask for a hearing within 30 days of the Date of Notice. • You may continue to receive Health Care benefits at your current level between now and your appeal decision if 1) you appeal within 10 days of the Date of Notice, **and** 2) you **ask** to continue benefits within 10 days of the Date of Notice. • If you **do not** ask to keep getting benefits within 10 days of the Date of Notice, DHS will assume you **do not** wish to continue your benefits pending your appeal decision.		

What are my rights if I request a hearing?	• Your hearing will be conducted by telephone unless you request a video or in-person hearing.
	• You may attend the hearing (In-person hearings are conducted in Little Rock).
	• You may be represented by a lawyer or any other person you choose.
	• You may be able to get free legal aid. If you need it:
	  • Call the 1-888-540-2941
	  • Go to www.arlawhelp.org.
	• Before the hearing, you have the right to see your hearing file and any other evidence to be presented or used at the hearing.
	• You have the right to present your own evidence.
	• You have the right to bring your own witnesses.
	• You have the right to question any witness against you.
	• Please note, if you lose your appeal, you may have to repay the amount of benefits you received during the appeal period.

Free Job Search Help
Arkansas Division of Workforce Services
Arkansas Workforce Centers

Because you get ARHOME, you can get free job search help from the Arkansas Division of Workforce Services (DWS). DWS has Arkansas Workforce Centers across the state that can tell you about job openings, how to look for a job, training programs, and more.

What kind of help can I get?

If you are unemployed or currently employed and need a better job, DWS Arkansas Workforce Centers can help by providing:

Free Job Search Help:

- Arkansas JobLink lets you post your information and skills for employers to see, search for current job openings, and more. Visit www.arjoblink.arkansas.gov.
- Free computers, telephones, fax machines, and copiers to help you find and apply for jobs.

Help from Experts:

- Identify your skills and get help finding job openings that need those skills.
- Create or update your resume to get the best results possible in your job search.
- Career counseling for step-by-step job search guidance.
- Get the facts about what kind of jobs are available and where they are in Arkansas.

Referrals for Programs for Specific Needs:

- Free GED and free English as a Second Language classes.
- Programs tailored to assist veterans with employment needs.
- Help for workers who have lost a job because of international trade.
- Temporary cash assistance for needy families (TANF/TEA).
- Vocational rehabilitation for Arkansans living with a disability.
- Programs for young people.

How do I get started?

Take the first step today and contact DWS Arkansas Workforce Centers:

- Online: www.arjoblink.arkansas.gov
- Phone: (855) 225-4440
- Email: ADWS.Info@arkansas.gov