ARKANSAS DEPARTMENT OF HUMAN SERVICES
APPLICATION FOR SOCIAL SERVICES BLOCK GRANT SERVICES

Applicant's Name ______________________ **SSN** ______________ **DOB** ____________

Client's Name (if different from applicant) ______________________ **SSN** ______________ **DOB** ____________

Mailing Address ____

Telephone (Home) ______________________ **(Work)** ______________________

FAMILY MEMBERS		FAMILY INCOME	
Name	**Relationship**	**Income Source**	**Monthly Amount**

Total Number in Family ______________ **Total Monthly Family Income** ______________

Service(s) Requested ____

Review the following and ask for clarification if necessary.

1. You will be notified if you are eligible to receive services within thirty (30) days.
2. You can choose which services you receive (if you qualify) and you may refuse any service.
3. You can request a hearing from DHS if you are unhappy with the handling of your case. Hearing requests must be filed (in writing) with the provider or the Office of Finance and Administration, Chief Fiscal Officer, P.O. Box 1437, Slot W401, Little Rock, Arkansas 72203-1437.
4. You must report the following changes within **5 days**:
   * a change of address;
   * a member of your household enters a nursing home or institution;
   * you or a member of your household has changes in income.;
   * any change in the number in the household; (ex., marriage, divorce, birth, death, or moving of a family member)
   * any other changes of information on the application form.
5. The provider will keep a case record about you and your family. It may include the reason(s) for services, the services provided, and general information such as name, address, and employment status. The provider is required to make information in your case record available to DHS and the federal government, if requested. Your signature on this form is your consent to the release of this information. You may refuse to supply any or all of this information to the provider, but your refusal may result in the denial or termination of SSBG services.
6. Your eligibility for services may be reviewed by a representative of DHS or the provider.
7. Both the provider and DHS are required to keep information about you, your family, and your case record confidential, except as stated in item five (5) above, or unless you give your written consent.

Certification:

Federal law requires that a written declaration of U.S. citizenship or lawful alien status be made for each individual applying for Social Services Block Grant funding. I declare that all service recipients named on my application are U.S. citizens, U.S. nationals, or lawfully admitted aliens.

The information I have furnished is correct and I understand my rights and responsibilities as outlined and I am in need of the services requested.

______________________________________ ______________________

Applicant's Signature (or parent/guardian's signature) **Date**

FOR PROVIDER OR DEPARTMENT USE ONLY

1. **Categorical Eligibility:** (check one)

☐ **TEA/WORK PAYS** ☐ **SSI (if checked, indicate SSI# here** ______________ **)** ☐ **Income Eligible** ☐ **Without Regard to Income** ☐ **Status Eligible**

2. Service Need Established: ☐ **Yes** ☐ **No** **3. Legal Arkansas Resident** ☐ **Yes** ☐ **No**

ELIGIBLE FOR SERVICES REQUESTED? ☐ **Yes** ☐ **No** **STATUTORY GOAL (circle one) 1 2 3 4 5**

Certification: I have given the applicant a completed copy of this form.

______________________________________ ______________________

Signature of Provider Date

Alternate formats (large print, audio, etc.) of this form will be provided upon request.

DHS-0100 (R.01/12/10)

ARKANSAS DEPARTMENT OF HUMAN SERVICES
CLIENT AND SERVICE DATA SHEET FOR
SOCIAL SERVICES BLOCK GRANT FUNDING

Name of Provider___________________________________ **Contract #**_____________________________

Billing Period________________ **through**_______________ **TIN** __________________________________
(Billing Period not to Exceed One Calendar Month)

Service Code	Number of Clients	Number of Units	Unit Rate	Total for Service

TOTAL for all services _______________________

Adjustment ________________________

Net Total for all services, with adjustment________________________

I certify that the information contained on this form is true and complete and represents services actually provided to eligible clients in accordance with the terms of our contract. If this contractual agreement involves certified expenditures, I certify that an amount sufficient to cover the required percentage of this bill has been received by the provider and utilized for allowable costs for eligible clients in compliance with applicable DHS financial guidelines.

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Signature of Provider Date Submitted

DHS-0145 (R.01/12/10)

Effective Date: January 12, 2010