



**Arkansas Department of Human Services
Division of Children and Family Services
Application for Title IV-E Payments/Medicaid**

Register #	Application Date	County	Category	Child	Worker #	Key Date	Oper Init

Worker #	Denial Date	Reason	Savings	Type	Category	Key Date	Oper Init

1. The Family Service Worker will enter the following information on the child for whom Title IV-E/Medicaid benefits are being requested.

Child's Name: _____ DOB: _____ SSN: _____
 Race: _____ Sex: ____ County of Residence: _____ Custody Date: _____
 Name of Placement: _____ Date of Placement: _____
 Placement Address: _____ City: _____ State: ____ Zip: _____
 Mailing Address: _____ City: _____ State: ____ Zip: _____

2. The Family Service Worker will complete all of the information for each person in the home from which the child was removed:

Name	Relation To Child	SS#	DOB	Race	Sex	U.S. Citizen

3. Was the child in receipt of AFDC in the month the petition was filed or in one of the six months prior to the month the petition was filed? Yes No

Name: _____ Case # _____

If the child was in receipt of AFDC, do not answer questions 4 – 5 and questions 6 – 13 apply to the child only.

4. If the child was not removed from the home of a relative, the Family Service Worker Should list the child's living arrangements for the six months prior to the month the petition was filed.

From	To	Name/Relationship/Address

5. Is the child deprived of parental support of one or both parents?

	Yes	No	If Yes,	Mother	Father
Continued Absence	<input type="checkbox"/>	<input type="checkbox"/>	If Yes,	<input type="checkbox"/>	<input type="checkbox"/>
Death	<input type="checkbox"/>	<input type="checkbox"/>	If Yes,	<input type="checkbox"/>	<input type="checkbox"/>
Disabled	<input type="checkbox"/>	<input type="checkbox"/>	If Yes,	<input type="checkbox"/>	<input type="checkbox"/>
Unemployment	<input type="checkbox"/>	<input type="checkbox"/>	If Yes,	<input type="checkbox"/>	<input type="checkbox"/>

6. If the child is age 15 or older is he/she attending school: Yes No NA;
 School attended _____ Grade _____
 Full-time or part-time _____.

7. If the child is age 18 and in school, is he/she expected to graduate age 19? Yes No NA
 Graduation date _____

8. **Income:** Does anyone listed in question #2 receive any of the following income?

Source of Income	Yes or No	Amount	Frequency	Person Receiving
Employment	<input type="checkbox"/> (Yes) <input type="checkbox"/> (No)			
SSA	<input type="checkbox"/> (Yes) <input type="checkbox"/> (No)			
SSI	<input type="checkbox"/> (Yes) <input type="checkbox"/> (No)			
VA	<input type="checkbox"/> (Yes) <input type="checkbox"/> (No)			
Child Support	<input type="checkbox"/> (Yes) <input type="checkbox"/> (No)			
Unemployment Comp	<input type="checkbox"/> (Yes) <input type="checkbox"/> (No)			
Loans/Grants	<input type="checkbox"/> (Yes) <input type="checkbox"/> (No)			
Other	<input type="checkbox"/> (Yes) <input type="checkbox"/> (No)			
Other	<input type="checkbox"/> (Yes) <input type="checkbox"/> (No)			

9. **Resources:** Does anyone listed in question #2 own any of the following?

Resources	Yes or No	Amount	Where	Name of Person
Checking	<input type="checkbox"/> (Yes) <input type="checkbox"/> (No)			
Savings	<input type="checkbox"/> (Yes) <input type="checkbox"/> (No)			
Life Insurance	<input type="checkbox"/> (Yes) <input type="checkbox"/> (No)			
Hospital Insurance	<input type="checkbox"/> (Yes) <input type="checkbox"/> (No)			
Mortgages	<input type="checkbox"/> (Yes) <input type="checkbox"/> (No)			
Stocks/Bonds	<input type="checkbox"/> (Yes) <input type="checkbox"/> (No)			
Other	<input type="checkbox"/> (Yes) <input type="checkbox"/> (No)			

Vehicles	Yes or No	Make/Year	Money Owed	Owner
Car	<input type="checkbox"/> (Yes) <input type="checkbox"/> (No)			
Truck	<input type="checkbox"/> (Yes) <input type="checkbox"/> (No)			
Motorcycle	<input type="checkbox"/> (Yes) <input type="checkbox"/> (No)			
Boats	<input type="checkbox"/> (Yes) <input type="checkbox"/> (No)			

10. Does the relative own or is he/she buying his/her house? Yes No
11. Does the relative own or is he/she buying any other real property? Yes No
12. Is the home from which the child was removed or is currently residing receiving adoption support payments? Yes No
13. Does the child receive or expect an inheritance or settlement? Yes No
If yes, attach information about suit or estate.

14. Absent Parent(s) Name	Absent Parent #	Sex	DOB	Soc. Sec. #
1.				
2.				

Street Address	City/State/Zip	Telephone #
----------------	----------------	-------------

--	--	--

Employer's Name:	Employer's Address/City/State/Zip:	Telephone #
------------------	------------------------------------	-------------

--	--	--

Health Insurance Name:	Policy Number
------------------------	---------------

Date of Order	Order Number	Amount	Freq.	Pay To	Date	Amount

15. Statement of Rights and Responsibilities

Please read this section very carefully before you sign this form.

I understand that I must help establish the eligibility for the child by providing as much information as I can about the child's circumstances.

I authorize the Department of Human Services to obtain information from other State Agencies, banks, and savings institutions, employers, Federal agencies and other sources to confirm the accuracy of my statements.

I understand that the Social Security number of the child and Social Security of other persons in the child's household may be submitted to the Employment Security Division to verify the employment status, amount of wages and eligibility for unemployment benefits of the child and other persons in the household. It may also be submitted to the Social Security Administration, Internal Revenue Service and other agencies and organizations to obtain information relative to the child's eligibility for assistance.

I understand that no person may be denied Medicaid benefits on the grounds of race, color, sex, age, disability, religion, national origin, or political belief.

I understand that I may request a hearing before the State Agency Representative if a decision is not reached on the child's case within the proper time limit or if I disagree with the decision reached.

I agree to notify the eligibility worker of the Division of Children and Family Services within 10 days if the child receives additional income, acquires or disposes of property, if the child moves, or any other changes in the child's circumstances.

I authorize the Department of Human Services to examine all records of the child for the purpose of investigating whether or not Medicaid fraud may have been committed, or for use in any legal, administrative or judicial proceeding.

I understand that this form is signed subject to penalties for perjury. I understand that if I knowingly withhold or provide 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.

Assignment of medical support. I understand that by applying for Medicaid for the child, I assign the child's rights to any settlement, judgment or award which may be obtained against any third party to the Arkansas Department of Human Services to the full extent of any amount which may be paid by Medicaid for the benefit of the child. I also understand that this agreement is required by Act 463 of 1987.

Assignment of Medical Support includes the rights to benefits from hospital/medical insurance, workers compensation, etc.

Family Service Worker _____ Date _____

Attach Appropriate Court Orders and All Other Pertinent Information