

# Arkansas Department of Human Services

## Application for Health Coverage

<b>Use this application to see what coverage you qualify for through DHS.</b>	<ul style="list-style-type: none"> <li>• Medicaid, ARKids First or the Health Care Independence Program</li> <li>• If you are not eligible for any of the above coverage, your information will be transferred to the Federally Facilitated Health Insurance Marketplace to determine your eligibility for tax credits to help pay for a Qualified Health Plan.</li> </ul>
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<b>Who can use this application?</b>	<p>Use this application to apply for you or anyone in your family.</p> <ul style="list-style-type: none"> <li>• Apply even if you or your child already has health coverage. You could be eligible for lower cost or free coverage.</li> <li>• Families that include immigrants can apply. You can apply for your children even if you are not eligible for coverage. Applying won't affect your immigration status or chances of becoming a permanent resident or citizen.</li> <li>• If someone is helping you fill out this application, you may need to complete a DCO-153, Consent for an Authorized Representative.</li> </ul>
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<b>Apply faster online.</b>	<b>Apply faster online at: <a href="https://Access.Arkansas.gov">Access.Arkansas.gov</a></b>
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<b>What you may need to apply.</b>	<ul style="list-style-type: none"> <li>• Your Social Security number (or document number if you are a legal immigrant)</li> <li>• Employer and income information (for example: from paystubs, W-2 forms, or wage and tax statements)</li> <li>• Information about any job related health insurance available to your family</li> <li>• Policy numbers for any current health insurance</li> </ul>
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<b>Why do we ask for this information?</b>	<p>We ask about income and other information to let you know what coverage you qualify for and if you can get help paying for it. <b>We will keep all the information you provide private and secure, as required by law.</b> To view the Privacy Act Statement go to <a href="https://Access.Arkansas.gov">Access.Arkansas.gov</a>.</p>
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<b>Get help with this application.</b>	<ul style="list-style-type: none"> <li>• <b>Phone:</b> Call our Help Center at <b>1-855-372-1084</b>.</li> <li>• <b>In person:</b> Contact your local DHS county office for more information.</li> <li>• <b>En Español:</b> Llame a nuestro centro de ayuda gratis al <b>1-855-372-1084</b>.</li> </ul>
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<b>Voter Registration</b>	<p>A Voter Registration packet is included with this application to provide 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.</p>
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## Step 1 Tell Us About Yourself

(We need one adult in the family to be the contact person for your application.)

1. First Name, Middle Name, Last Name & Suffix			
2. Home Address			3. Apartment or Suite Number
4. City	5. State	6. ZIP Code	7. County
8. Mailing Address (If different from home address)			9. Apartment or Suite Number
10. City	11. State	12. ZIP Code	13. County
14. Phone Number		15. Other Phone Number	
16. Do you want to receive information about this application by email? <input type="checkbox"/> Yes <input type="checkbox"/> No Email Address:			
17. Preferred spoken or written language (if not English)			

## Step 2 Tell Us About Your Family

### Who do you need to include on this application?

Tell us about all the family members that live with you. If you file taxes, we need to know about everyone on your tax return. (You don't need to file taxes to be eligible for health coverage.)

#### Do include:

- Yourself
- Your spouse
- Your children under 21 who live with you
- Your unmarried partner who needs health coverage
- Anyone you include on your tax return even if they don't live with you
- Anyone else under 21 who lives with you and you take care of

#### You don't have to include:

- Your unmarried partner who does not need health coverage
- Your unmarried partner's children
- Your parents who live with you but file their own tax return (if you are over 21)
- Other adult relatives who file their own tax return

The amount of assistance or type of program you qualify for depends on the number of people in your family and their incomes. This information helps us make sure that everyone receives the best coverage they can.

**Complete Step 2 for each person in your family.** Start with yourself, then add other adults and children. If you have more than two people in your family, you will need to make a copy of the Step 2, Person 2 pages, fill them out and attach them to this application. You don't need to provide immigration status or a Social Security Number (SSN) for family members who do not need health coverage. We will keep all the information you provide private and secure as required by law. We will only use your personal information to check if you are eligible for health coverage.

**Please proceed to Step 2, Person 1 on the following page.**

**NEED HELP WITH YOUR APPLICATION?** Call us at **1-855-372-1084**. Para obtener una copia de este formulario en Español, llame **1-855-372-1084**. If you need help in a language other than English, call **1-855-372-1084** and tell the customer service representative the language you need. We will get you help at no cost to you.

## Step 2: Person 1 (Start with yourself)

Complete Step 2 for yourself, your spouse/partner and children who live with you and/or anyone on your same federal income tax return if you file one. See page 2 for more information about who to include. If you don't file a tax return, remember to still add family members who live with you.

1. First Name, Middle Name, Last Name & Suffix	2. Relationship to you? <b>SELF</b>	3. Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
4. Date of Birth (mm/dd/yyyy)	5. If you are under 18, are you emancipated? <input type="checkbox"/> Yes <input type="checkbox"/> No <b>If Yes, how were you emancipated?</b> <input type="checkbox"/> Court Order <input type="checkbox"/> Common Law	
6. Social Security Number (SSN) ____ - ____ - ____ <b>We need this if you want health coverage and have an SSN.</b> Providing your SSN can be helpful if you don't want health coverage too since it can speed up the application process. We use SSNs to check income and other information to see who is eligible for help with health coverage costs. If someone wants help getting an SSN, call 1-800-772-1213 or visit <a href="http://socialsecurity.gov">socialsecurity.gov</a> . TTY users should call 1-800-325-0778.		

7. **Do you need health coverage?** (Even if you have insurance, there might be a program with better coverage or lower costs.)  
 **Yes** If yes, answer all the questions below.  **No** If no, SKIP questions 8 through 11 and begin answering questions again at # 12.

**CITIZENSHIP STATUS**

8. Are you a U.S. citizen or U.S. national?  Yes  No

9. **If you are not a U.S. citizen or U.S. national, do you have eligible immigration status?**  
 **Yes** Enter your document type and ID number below.  
 a. Immigration document type: \_\_\_\_\_ Alien # \_\_\_\_\_  
 b. Document ID number: \_\_\_\_\_ Expiration date of document \_\_\_\_\_  
 c. Have you lived in the U.S. since 1996?  Yes  No Date of entry into U.S. \_\_\_\_\_  
 d. Are you or your spouse or parent a veteran or an active duty member of the U.S. military?  Yes  No

10. **If Hispanic/Latino, what is your ethnicity? (OPTIONAL – Check all that apply.)**  
 Mexican  Mexican American  Chicano/a  Puerto Rican  Cuban  Other: \_\_\_\_\_

11. **Race (OPTIONAL – Check all that apply.)**  
 White  American Indian or Alaska Native  Filipino  Vietnamese  Guamanian or Chamorro  
 Black or African American  Asian Indian  Japanese  Other Asian  Samoan  Chinese  
 Korean  Native Hawaiian  Other Pacific Islander  Other: \_\_\_\_\_

**PREGNANCY STATUS**

12. Are you pregnant?  Yes  No **If Yes, what is your expected due date?** \_\_\_\_\_ (mm/dd/yyyy)  
 How many babies are you expecting during this pregnancy? \_\_\_\_\_  
**If No, have you delivered a child in the last 90 days?**  Yes  No **If Yes, what was the date of delivery?** \_\_\_\_\_  
**If Yes, how many babies did you deliver?** \_\_\_\_\_

**STUDENT STATUS**

13. Are you a full time student?  Yes  No

**FOSTER CARE STATUS**

14. Were you in foster care in Arkansas at age 18 or older?  Yes  No  
**If Yes, were you enrolled in Medicaid when you left the Foster Care program?**  Yes  No

15. Are you the main caregiver living with and taking care of at least one child under the age of 19?  Yes  No

**TAX FILING STATUS**

16. **Do you plan to file a federal income tax return NEXT YEAR?** (You can still apply for health coverage even if you don't file a federal income tax return.)  
 **YES** If yes, please answer questions a through c.  **NO** If no, skip to question c.  
 a. Will you file jointly with a spouse?  Yes  No  
**If yes, name of spouse:** \_\_\_\_\_  
 b. Will you claim any dependents on your tax return?  Yes  No  
**If yes, list name(s) of dependents:** \_\_\_\_\_  
 c. Will you be claimed as a dependent on someone's tax return?  Yes  No  
**If yes, please list the name of the tax filer:** \_\_\_\_\_  
 How are you related to the tax filer? \_\_\_\_\_

## Step 2: Person 1 (Continue with yourself)

### Current Job & Income Information

**Employed**

If you're currently employed, tell us about your income. Start with question 17.

**Not employed**

Skip to question 25.

**Self-employed**

Skip to question 26.

#### CURRENT JOB 1:

17. Employer Name and Address _____	18. Employer Phone Number _____
19. Wages/tips (before taxes) \$ _____ <input type="checkbox"/> Hourly <input type="checkbox"/> Weekly <input type="checkbox"/> Every 2 Weeks <input type="checkbox"/> Twice a Month <input type="checkbox"/> Monthly <input type="checkbox"/> Yearly	
20. Average hours worked each <b>week</b> : _____ Start date of employment _____ (mm/dd/yyyy)	

#### CURRENT JOB 2: (Attach another sheet of paper to list more jobs.)

21. Employer Name and Address _____	22. Employer Phone Number _____
23. Wages/tips (before taxes) \$ _____ <input type="checkbox"/> Hourly <input type="checkbox"/> Weekly <input type="checkbox"/> Every 2 Weeks <input type="checkbox"/> Twice a Month <input type="checkbox"/> Monthly <input type="checkbox"/> Yearly	
24. Average hours worked each <b>week</b> : _____ Start date of employment _____ (mm/dd/yyyy)	

25. **In the past year, did you:**    Change jobs?    Stop working? If so, date job ended? \_\_\_\_\_ (mm/dd/yyyy)  
 Start working fewer hours?    None of these?

#### 26. If self-employed, answer the following questions:

a. Type of work \_\_\_\_\_

b. How much net income (profits once business expenses are paid) will you receive from this self-employment this month?  
 \$ \_\_\_\_\_

#### 27. OTHER INCOME THIS MONTH: Check all that apply and give the amount and how often you receive that amount.

**NOTE:** You don't need to tell us about child support, veteran's payments or Supplemental Security Income (SSI).

None

Unemployment   \$ \_\_\_\_\_   How often? \_\_\_\_\_    Pensions   \$ \_\_\_\_\_   How often? \_\_\_\_\_

Net farming/fishing   \$ \_\_\_\_\_   How often? \_\_\_\_\_    Social Security   \$ \_\_\_\_\_   How often? \_\_\_\_\_

Retirement Accounts   \$ \_\_\_\_\_   How often? \_\_\_\_\_    Alimony   \$ \_\_\_\_\_   How often? \_\_\_\_\_

Other income   \$ \_\_\_\_\_   How often? \_\_\_\_\_   Type: \_\_\_\_\_

#### 28. DEDUCTIONS: Check all that apply and give the amount and how often you receive that amount.

If you pay for certain things that can be deducted on a federal income tax return, telling us about them could make the cost of health coverage a little lower.

**NOTE:** You should not include a cost that you already considered in your answer to net self-employment (Question 26b).

Alimony paid   \$ \_\_\_\_\_   How often? \_\_\_\_\_

Student Loan interest   \$ \_\_\_\_\_   How often? \_\_\_\_\_

Other Deductions   \$ \_\_\_\_\_   How often? \_\_\_\_\_   Type: \_\_\_\_\_

#### 29. YEARLY INCOME: Complete only if your income changes from month to month.

**If you don't expect changes to your monthly income, skip to question 30.**

Your total income <b>this year</b> : \$ _____	Your total income <b>next year</b> (if you think it will be different): \$ _____
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30. **UNPAID MEDICAL BILLS** Do you want help paying for medical bills from the last three months?    Yes    No

31. **DISABILITY STATUS** Do you have a disability or are you blind?    Yes    No

Do you live in a medical facility or nursing home?    Yes    No

What type of facility is this?    Nursing Home    Human Development Center    Arkansas State Hospital

Arkansas Health Center    Intermediate Care Facility for the Intellectually Disabled

Do you have a physical, mental or emotional health condition that causes limitations in activities (like bathing, dressing, daily chores, etc.)?    Yes    No

## Step 2: Person 2

Complete Step 2 for your spouse/partner and children who live with you and/or anyone on your same federal income tax return if you file one. See page 2 for more information about who to include. If you don't file a tax return, remember to still add family members who live with you.

1. First Name, Middle Name, Last Name & Suffix	2. Relationship to you?
3. Date of Birth (mm/dd/yyyy)	4. Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
5. Social Security Number (SSN) ___ - ___ - _____ <b>We need this if you want health coverage and have an SSN.</b>	
6. Does <b>PERSON 2</b> live at the same address as you? <input type="checkbox"/> Yes <input type="checkbox"/> No <b>If No</b> , list address: _____	
7. Is <b>PERSON 2</b> the main caregiver living with and taking care of at least one child under the age of 19? <input type="checkbox"/> Yes <input type="checkbox"/> No	

8. Does **PERSON 2** need health coverage?  
 **YES** If yes, answer all the questions below.  **NO** If no, SKIP questions 9 through 12 and begin answering questions again at # 13.

### CITIZENSHIP STATUS

9. Is **PERSON 2** a U.S. citizen or U.S. national?  Yes  No

10. If **PERSON 2** is not a U.S. citizen or U.S. national, do they have eligible immigration status?  
 Yes Enter your document type and ID number below.  
 a. Immigration document type: \_\_\_\_\_ Alien # \_\_\_\_\_  
 b. Document ID number: \_\_\_\_\_ Expiration date of document \_\_\_\_\_  
 c. Has **PERSON 2** lived in the U.S. since 1996?  Yes  No Date of entry into U.S. \_\_\_\_\_  
 d. Is **PERSON 2** or their spouse or parent a veteran or an active duty member of the U.S. military?  Yes  No

11. If **Hispanic/Latino**, what is **PERSON 2's** ethnicity? (OPTIONAL – Check all that apply.)  
 Mexican  Mexican American  Chicano/a  Puerto Rican  Cuban  Other: \_\_\_\_\_

12. Race (OPTIONAL – Check all that apply.)  
 White  American Indian or Alaska Native  Filipino  Vietnamese  Guamanian or Chamorro  
 Black or African American  Asian Indian  Japanese  Other Asian  Samoan  Chinese  
 Korean  Native Hawaiian  Other Pacific Islander  Other: \_\_\_\_\_

### PREGNANCY STATUS

13. Is **PERSON 2** pregnant?  Yes  No If Yes, what is the expected due date? \_\_\_\_\_ (mm/dd/yyyy)  
 How many babies is **PERSON 2** expecting during this pregnancy? \_\_\_\_\_  
 If No, has **PERSON 2** delivered a child in the last 90 days?  Yes  No If Yes, what was the date of delivery? \_\_\_\_\_  
 If Yes, how many babies did **PERSON 2** deliver? \_\_\_\_\_

### STUDENT STATUS

14. Is **PERSON 2** a full time student?  Yes  No

### FOSTER CARE STATUS

15. Was **PERSON 2** in foster care in Arkansas at age 18 or older?  Yes  No  
 If Yes, was **PERSON 2** enrolled in Medicaid when they left the Foster Care program?  Yes  No

### TAX FILING STATUS

16. Does **PERSON 2** plan to file a federal income tax return NEXT YEAR? (You can still apply for health coverage even if you don't file a federal income tax return.)  
 **YES** If yes, please answer questions a through c.  **NO** If no, skip to question c.  
 a. Will **PERSON 2** file jointly with a spouse?  Yes  No  
 If yes, name of spouse: \_\_\_\_\_  
 b. Will **PERSON 2** claim any dependents on his or her tax return?  Yes  No  
 If yes, list name(s) of dependents: \_\_\_\_\_  
 c. Will **PERSON 2** be claimed as a dependent on someone's tax return?  Yes  No  
 If yes, please list the name of the tax filer: \_\_\_\_\_  
 How is **PERSON 2** related to the tax filer? \_\_\_\_\_

## Step 2: Person 2 (Continue with Person 2)

17. Did PERSON 2 have insurance through a job and lose it within the past 3 months?  Yes  No  
 a. If Yes, insurance end date: \_\_\_\_\_ b. Reason insurance ended: \_\_\_\_\_

### Current Job & Income Information

**Employed**

If PERSON 2 is currently employed, tell us about their income. Start with question 18.

**Not employed**

Skip to question 26.

**Self-employed**

Skip to question 27.

### CURRENT JOB 1:

18. Employer Name and Address	19. Employer Phone Number
20. Wages/tips (before taxes) \$ _____ <input type="checkbox"/> Hourly <input type="checkbox"/> Weekly <input type="checkbox"/> Every 2 Weeks <input type="checkbox"/> Twice a Month <input type="checkbox"/> Monthly <input type="checkbox"/> Yearly	
21. Average hours worked each <b>week</b> : _____ Start date of employment _____ (mm/dd/yyyy)	

### CURRENT JOB 2: (Attach another sheet of paper to list more jobs.)

22. Employer Name and Address	23. Employer Phone Number
24. Wages/tips (before taxes) \$ _____ <input type="checkbox"/> Hourly <input type="checkbox"/> Weekly <input type="checkbox"/> Every 2 Weeks <input type="checkbox"/> Twice a Month <input type="checkbox"/> Monthly <input type="checkbox"/> Yearly	
25. Average hours worked each <b>week</b> : _____ Start date of employment _____ (mm/dd/yyyy)	

26. In the past year, did you:  Change jobs?  Stop working? If so, date job ended? \_\_\_\_\_ (mm/dd/yyyy)  
 Start working fewer hours?  None of these?

### 27. If self-employed, answer the following questions:

a. Type of work

\_\_\_\_\_

b. How much net income (profits once business expenses are paid) will you receive from this self-employment this month?  
 \$ \_\_\_\_\_

28. **OTHER INCOME THIS MONTH:** Check all that apply and give the amount and how often you receive that amount.

**NOTE:** You don't need to tell us about child support, veteran's payments or Supplemental Security Income (SSI).

None

<input type="checkbox"/> Unemployment	\$ _____	How often? _____	<input type="checkbox"/> Pensions	\$ _____	How often? _____
<input type="checkbox"/> Net farming/fishing	\$ _____	How often? _____	<input type="checkbox"/> Social Security	\$ _____	How often? _____
<input type="checkbox"/> Retirement Accounts	\$ _____	How often? _____	<input type="checkbox"/> Alimony	\$ _____	How often? _____
<input type="checkbox"/> Other income	\$ _____	How often? _____	Type: _____		

29. **YEARLY INCOME:** Complete only if your income changes from month to month.

If you don't expect changes to your monthly income, skip to question 30.

Your total income <b>this year</b> : \$ _____	Your total income <b>next year</b> (if you think it will be different): \$ _____
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30. **UNPAID MEDICAL BILLS** Do you want help paying for medical bills from the last three months?  Yes  No

31. **DISABILITY STATUS** Do you have a disability or are you blind?  Yes  No

Do you live in a medical facility or nursing home?  Yes  No Name of the facility \_\_\_\_\_

What type of facility is this?  Nursing Home  Human Development Center  Arkansas State Hospital

Arkansas Health Center  Intermediate Care Facility for the Intellectually Disabled

Do you have a physical, mental or emotional health condition that causes limitations in activities (like bathing, dressing, daily chores, etc.)?  Yes  No

## Step 3 American Indian or Alaskan Native (AI/AN) Family Members

### Are you or is anyone in your family an American Indian or an Alaskan Native?

- No If No, skip to Step 4.  
 Yes If Yes, please obtain and complete an Appendix B to the DCO-151/152 and submit it with this application.

## Step 4 Your Family's Health Coverage

Answer these questions for anyone who needs health coverage.

1. Is anyone enrolled in health coverage now from the following?  Yes  No

If Yes, check the type of coverage and write the person(s)' name(s) next to the coverage they have.

- |  |   |
|--|---|
| <input type="checkbox"/> Medicaid _____                | <input type="checkbox"/> Employer insurance _____                                       |
| <input type="checkbox"/> ARKids First/CHIP _____       | Name of health insurance _____  |
| <input type="checkbox"/> Medicare _____                | Policy number _____   |
| <input type="checkbox"/> TRICARE _____                 | Is this COBRA coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No        |
| (Don't check if you have Direct Care or Line of Duty)  | Is this a retiree health plan? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| _____  | <input type="checkbox"/> Other _____  |
| <input type="checkbox"/> VA Health Care Programs _____ | Name of health insurance _____  |
| <input type="checkbox"/> Peace Corps _____             | Policy number _____   |
|  | Is this a limited benefit plan (like a school accident policy)?                         |
|  | <input type="checkbox"/> Yes <input type="checkbox"/> No                                |

2. Is anyone listed on this application offered health coverage from a job? Check Yes even if the coverage is from someone else's job, such as a parent or spouse.

- Yes If Yes, you will need to complete and include Appendix A. Is this a state employee benefit plan?  Yes  No  
 No If No, continue to Step 5.

## Step 5 Read & Sign This Application

- I am signing this application under penalty of perjury which means I have provided true answers to all the questions on this form to the best of my knowledge. I know that I may be subject to penalties under federal law if I provide false or untrue information.
- I know that I must tell the Department of Human Services (DHS) if anything changes (and is different than) what I wrote on this application. I can visit [access.arkansas.gov](http://access.arkansas.gov) or call **1-855-372-1084** to report any changes. I understand that a change in my information could affect the eligibility for members of my household.
- I know that under federal law, discrimination is not permitted on the basis of race, color, national origin, sex, age, sexual orientation, gender identity or disability. I can file a complaint of discrimination by visiting [www.hhs.gov/ocr/office/file](http://www.hhs.gov/ocr/office/file).
- I confirm that no one applying for health insurance on this application is incarcerated (detained or jailed). If not, \_\_\_\_\_ (name of person) is incarcerated.

We need this information to check your eligibility for help paying for health coverage if you choose to apply. We will check your answers using information in our electronic databases and databases from the Internal Revenue Service (IRS), Social Security, the Department of Homeland Security and/or a consumer reporting agency. If the information does not match, we may ask you to send us proof.

### Renewal of coverage in future years

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

Yes, review my eligibility automatically for the next:  5 years (The maximum number of years allowed)

Or for a shorter number of years:

- 4 years  3 years  2 years  1 year  
 Don't use information from tax returns to review my eligibility.

**If anyone on this application is eligible for Medicaid, ARKids First or the Health Care Independence Program**

- I am giving to the Department of Human Services our rights to pursue and receive money from other health insurance, legal settlements or other third parties. I am also giving to the Medicaid agency rights to pursue and receive medical support from a spouse or parent.
- I understand that the Health Care Independence Program is not a federal or state entitlement program and that it may be ended at any time upon appropriate notice.
- Does any child on this application have a parent living outside the home?  Yes  No  
**If yes,** I know I will be asked to cooperate with the agency that collects medical support from an absent parent. If I think that cooperating to collect medical support will harm me or my children, I can tell DHS and I may not have to cooperate.

**My right to appeal**

If I think that DHS has made a mistake, I can appeal its decision. To appeal means to tell someone at DHS that I think the action is wrong and ask for a fair review of the action. I know that I can find out how to appeal by contacting Medicaid at **1-501-682-8622**. I know I can be represented in the process by someone other than myself. My eligibility and other important information will be explained to me.

**Sign this application.** The person who filled out Step 1 should sign this application. If you are an Authorized Representative you may sign here, as long as you have provided a signed copy of the DCO-153, Consent for an Authorized Representative.

Signature	Date (mm/dd/yyyy)
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**Step 6 Mail Completed Application**

Send your complete, signed application to the address below. If you do not have all the information we ask for, sign and submit your application anyway.

Mail your signed application to:

**DHS Jefferson County  
1222 West 6<sup>th</sup> Street  
P.O. Box 5670  
Pine Bluff, AR 71611**

Or email the application to: [351Jefferson@arkansas.gov](mailto:351Jefferson@arkansas.gov)

Or you can fax the application to: 1-870-534-3421.

**What happens next?** We will process your application for Medicaid, ARKids First or the Health Care Independence Program and send you a notice to tell you if your application for coverage has been approved or denied and provide instructions on the next steps needed to complete your health coverage application. If you are not eligible for any of these programs, we will screen your application for potential eligibility for tax credits to help pay for health insurance premiums and then transfer your information to the Health Insurance Marketplace. We will provide instructions on how to complete the application process on the notice we send to you.

**NEED HELP WITH YOUR APPLICATION?** Call us at **1-855-372-1084**. Para obtener una copia de este formulario en Español, llame **1-855-372-1084**. If you need help in a language other than English, call **1-855-372-1084** and tell the customer service representative the language you need. We will get you help at no cost to you.

This completes the application process for Medicaid, ARKids First and the Health Care Independence Program. Federal law requires that each state provide the opportunity to register to vote with every application for public assistance. The remaining pages of this packet are the Arkansas Voter Registration Application. 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 and submit it with your application.

## ARKANSAS VOTER REGISTRATION INFORMATION

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.

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. Attached is a Voter Registration form. Please review the information below and answer "Yes" or "No" to the voter registration question.

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

Voter registration forms completed in the DHS office may be submitted to the county office today. You may also return the Voter Registration form with your application, renewal, or change form. You can also mail your completed Voter Registration form to the Arkansas Secretary of State at the address listed below.

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:

- Register to vote,
- Decline to register to vote,
- Privacy in deciding whether to register or in applying to register to vote, or
- 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 three options to submit your Voter Registration form.

1. You can submit the registration form in person to the county DHS office along with your SNAP or Medicaid application/renewal. If you choose this option, we will mail your Voter Registration form to the Secretary of State for you.
2. You can mail the registration form along with your SNAP or Medicaid application to the appropriate county DHS office. The address for this office may be different than your local county office. Some applications (DCO-151 & DCO-152) must be mailed to the Jefferson County DHS office. If you are using one of these forms, you can mail the Voter Registration form with your application to that office. Upon receipt at any county office, that office will mail the form to the Secretary of State's office for you.
3. You may also mail the Voter Registration form directly to the Secretary of State's Office. If the form is mailed directly to the Secretary of State's office, detach the last page of this packet, fold the form along the middle dotted line, seal the bottom with tape or staple, and mail to the address on the form. A stamp or stamped envelope is required for mailing.

# ARKANSAS VOTER REGISTRATION APPLICATION

<b>Check all that apply:</b> <input type="checkbox"/> This is a new registration. <input type="checkbox"/> This is a name change. <input type="checkbox"/> This is an address change. <input type="checkbox"/> This is a party change.			Office Use Only			Assigned ID			
<b>1</b>	Mr. Mrs. Miss Ms.	Last Name	Jr.	Sr.	First Name	Middle Name			
<b>2</b>	Address Where You Live (See Section "C" Below) (Rural addresses must draw map.)				Apt. or Lot #	City/Town	County	State	Zip Code
<b>3</b>	Address Where You Receive Mail If Different From Above				Apt. or Lot #	City/Town	County	State	Zip Code
<b>4</b>	Date of Birth _____ / _____ / _____ Month Day Year			<b>5</b>	Home & Work Phone Numbers (Optional) (H) (W)			<b>6</b>	Party Affiliation (Optional)
<b>7</b>	E-mail Address (Optional)				<b>8</b>	Have you ever voted in a federal election in this State? <input type="checkbox"/> Yes <input type="checkbox"/> No			
<b>9</b>	ID Number - Check the applicable box and provide the appropriate number. <input type="checkbox"/> Arkansas Driver's license number _____ <input type="checkbox"/> <b>If you do not have a driver's license provide the last 4 digits of social security number</b> _____ <input type="checkbox"/> I have neither a driver's license nor social security number.				Signature of elector - Please sign full name or put mark.				
<b>10</b>	(A) Are you a citizen of the United States of America and an Arkansas resident? <input type="checkbox"/> Yes <input type="checkbox"/> No (B) Will you be eighteen (18) years of age or older on or before election day? <input type="checkbox"/> Yes <input type="checkbox"/> No (C) Are you presently adjudged mentally incompetent by a court of competent jurisdiction? <input type="checkbox"/> Yes <input type="checkbox"/> No (D) Have you ever been convicted of a felony without your sentence having been discharged or pardoned? <input type="checkbox"/> Yes <input type="checkbox"/> No If you checked <b>No</b> in response to either questions A or B, do not complete this form. If you checked <b>Yes</b> in response to either questions C or D, do not complete this form.				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.				
					<b>11</b>	Date: _____ / _____ / _____ Month Day Year If applicant is <b>unable to sign his/her name</b> , provide name, address and phone number of the person providing assistance: Name: _____ Address: _____ City: _____ State: _____ Phone#: _____			

**Please complete the sections below if:** **MAIL REGISTRANTS: PLEASE SEE SECTION D.**

- You were previously registered in another county or state, or
- You wish to change the name or address on your current registration.

	Agency Code (For Official Use Only) <b>PA 04</b>
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<b>A</b>	Mr. Mrs. Miss Ms.	Previous Last Name	Jr.	Sr.	First Name	Middle Name(s)		
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Date of Birth \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Month Day Year

<b>B</b>	Previous House Number and Street Name	Apt. or Lot #	City or Town	State	Zip Code
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**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.**

<b>C</b>	<ul style="list-style-type: none"> <li>• Write in the names of the crossroads (or streets) nearest where you live.</li> <li>• Draw an "X" to show where you live.</li> <li>• Use a dot to show any schools, churches, stores or other landmarks near where you live and write the name of the landmark.</li> </ul>			
Example	Route #2	North ↑		
	• Grocery Store			
• Public School	X			

<b>D</b>	<p><b>IDENTIFICATION REQUIREMENTS</b></p> <p><b>IMPORTANT:</b> If your voter registration application form is submitted by mail and you are registering for the first time, and you do not have a <b>valid Arkansas driver's license number or social security number</b>, in order to avoid the additional identification requirements upon voting for the first time you must submit with the mailed registration form: <b>(a)</b> a current and valid photo identification; or <b>(b)</b> a copy of a current utility bill, bank statement, government check, paycheck, or other government document that shows your name and address.</p>
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Little Rock, Arkansas 72203-8111

P.O. Box 8111

ATTN: Voter Registration

Arkansas Secretary of State

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, tape the form closed, stamp and mail.

Questions?

Call your local County Clerk

Or

Arkansas Secretary of State

Mark Martin

Elections Division – Voter Services

1-800-482-1127

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