

Arkansas Department of Human Services

Application for Health Coverage

Use this application to see what coverage you qualify for through DHS.	<ul style="list-style-type: none"> • Medicaid, ARKids First or the Health Care Independence Program • 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.
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Who can use this application?	<p>Use this application to apply for you or anyone in your family.</p> <ul style="list-style-type: none"> • Apply even if you or your child already has health coverage. You could be eligible for lower cost or free coverage. • 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. • If someone is helping you fill out this application, you may need to complete a DCO-153, Consent for an Authorized Representative.
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Apply faster online.	Apply faster online at: Access.Arkansas.gov
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What you may need to apply.	<ul style="list-style-type: none"> • Your Social Security number (or document number if you are a legal immigrant) • Employer and income information (for example: from paystubs, W-2 forms, or wage and tax statements) • Information about any job related health insurance available to your family • Policy numbers for any current health insurance
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Why do we ask for this information?	<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. We will keep all the information you provide private and secure, as required by law. To view the Privacy Act Statement go to Access.Arkansas.gov.</p>
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What happens next?	<p>Send your complete, signed application to the address on page 8. If you do not have all the information we ask for, sign and submit your application anyway.</p>
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Get help with this application.	<ul style="list-style-type: none"> • Phone: Call our Help Center at 1-855-372-1084. • In person: Contact your local DHS county office for more information. • En Español: Llame a nuestro centro de ayuda gratis al 1-855-372-1084.
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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 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 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 1 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? SELF
3. Date of Birth (mm/dd/yyyy)	4. Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
5. Social Security Number (SSN) _ _ - _ - _ _ _ _ We need this if you want health coverage and have an SSN. 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 socialsecurity.gov . TTY users should call 1-800-325-0778.	

6. **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? _____

7. Are you pregnant? Yes No If yes, how many babies are you expecting during this pregnancy? _____

8. **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 to the income questions on page 3.
Leave the rest of this page blank.

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

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

11. **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: _____ b. Document ID number: _____

c. Have you lived in the U.S. since 1996? Yes No d. Are you or your spouse or parent a veteran or an active duty member of the U.S. military? Yes No

12. Do you want help paying for medical bills from the last three months? Yes No

13. Do you live with at least one child under the age of 19 and are you the main person taking care of this child? Yes No

14. Are you a full time student? Yes No 15. Were you in foster care in Arkansas at age 18 or older? Yes No

16. **If Hispanic/Latino, what is your ethnicity? (OPTIONAL – Check all that apply.)**

Mexican Mexican American Chicano/a Puerto Rican Cuban Other: _____

17. **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: _____

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 (Continue with yourself)

Current Job & Income Information

Employed

If you're currently employed, tell us about your income. Start with question 18.

Not employed

Skip to question 28.

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 week: _____	

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 week: _____	

26. In the past year, did you: Change jobs? Stop working? 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"/> Net rental/royalty | \$ _____ | How often? _____ |
| <input type="checkbox"/> Social Security | \$ _____ | How often? _____ |
| <input type="checkbox"/> Alimony | \$ _____ | How often? _____ |
| <input type="checkbox"/> Retirement Accounts | \$ _____ | How often? _____ |
| <input type="checkbox"/> Other income | \$ _____ | How often? _____ Type: _____ |

29. 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 27b).

- | | | |
|--|----------|------------------------------|
| <input type="checkbox"/> Alimony paid | \$ _____ | How often? _____ |
| <input type="checkbox"/> Student Loan interest | \$ _____ | How often? _____ |
| <input type="checkbox"/> Other Deductions | \$ _____ | How often? _____ Type: _____ |

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

If you don't expect changes to your monthly income, skip to the next person.

Your total income this year : \$ _____	Your total income next year (if you think it will be different): \$ _____
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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 1 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) ____ - ____ - ____ We need this if you want health coverage and have an SSN.	
6. Does PERSON 2 live at the same address as you? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, list address: _____	

7. 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? _____

8. Is PERSON 2 pregnant? Yes No If yes, how many babies are expected during this pregnancy? _____

9. Does **PERSON 2** need health coverage?

YES If yes, answer all the questions below. **NO** If no, SKIP to the income questions on page 5. Leave the rest of this page blank.

10. Does PERSON 2 have a physical, mental or emotional health condition that causes limitations in activities (like bathing, dressing, daily chores, etc.) or live in a medical facility or nursing home? Yes No

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

12. If **PERSON 2** is not a U.S. citizen or U.S. national, do they have eligible immigration status?

Yes Enter their document type and ID number below.

a. Immigration document type: _____ b. Document ID number: _____

c. Has PERSON 2 lived in the U.S. since 1996? Yes No d. Is PERSON 2 or their spouse or parent a veteran or an active duty member of the U.S. military? Yes No

13. Does PERSON 2 want help paying for medical bills from the last 3 months? <input type="checkbox"/> Yes <input type="checkbox"/> No	14. Does PERSON 2 live with at least one child under the age of 19 and are they the main person taking care of this child? <input type="checkbox"/> Yes <input type="checkbox"/> No	15. Was PERSON 2 in foster care at age 18 or older? <input type="checkbox"/> Yes <input type="checkbox"/> No
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Please answer Questions 16 & 17 if PERSON 2 is 19 or younger:

16. 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: _____

17. Is PERSON 2 a full time student? Yes No

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

19. **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: _____

Step 2: Person 2 (Continue with Person 2)

Current Job & Income Information

Employed

If PERSON 2 is currently employed, tell us about their income. Start with question 20.

Not employed

Skip to question 28.

Self-employed

Skip to question 27.

CURRENT JOB 1:

20. Employer Name and Address	21. Employer Phone Number
22. 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	
23. Average hours worked each week: _____	

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

24. Employer Name and Address	25. Employer Phone Number
26. 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	
27. Average hours worked each week: _____	

28. In the past year, did PERSON 2: Change jobs? Stop working? Start working fewer hours? None of these?

29. If self-employed, answer the following questions:

a. Type of work

b. How much net income (profits once business expenses are paid) will PERSON 2 receive from self-employment this month?

\$ _____

30. OTHER INCOME THIS MONTH: Check all that apply and give the amount and how often PERSON 2 receives that amount.

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

<input type="checkbox"/> None			
<input type="checkbox"/> Unemployment	\$ _____	How often?	_____
<input type="checkbox"/> Pensions	\$ _____	How often?	_____
<input type="checkbox"/> Net farming/fishing	\$ _____	How often?	_____
<input type="checkbox"/> Net rental/royalty	\$ _____	How often?	_____
<input type="checkbox"/> Social Security	\$ _____	How often?	_____
<input type="checkbox"/> Alimony	\$ _____	How often?	_____
<input type="checkbox"/> Retirement Accounts	\$ _____	How often?	_____
<input type="checkbox"/> Other income	\$ _____	How often?	_____ Type: _____

31. DEDUCTIONS: Check all that apply and give the amount and how often PERSON 2 receives that amount.

If PERSON 2 pays 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 29b).

<input type="checkbox"/> Alimony paid	\$ _____	How often?	_____
<input type="checkbox"/> Student Loan interest	\$ _____	How often?	_____
<input type="checkbox"/> Other deductions	\$ _____	How often?	_____ Type: _____

30. YEARLY INCOME: Complete only if PERSON 2's income changes from month to month.

If you don't expect changes to PERSON 2's monthly income, skip to the next person.

PERSON 2's total income this year : \$ _____	PERSON 2's total income next year (if you think it will be different): \$ _____
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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, go to Appendix B.

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 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.
- 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, renew 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 renew my coverage.

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

Mail your signed application to:

DHS Jefferson County
1222 West 6th Street
P.O. Box 5670
Pine Bluff, AR 71611

Or email the application to: 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.

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