

# ARKANSAS DEPARTMENT OF HUMAN SERVICES

## TEFRA and AUTISM WAIVER

### Application for Assistance

If you need this material in a different format, such as large print, please contact your local DHS county office.  
 Si necesita este formulario en Espanol, llame al 1-800-482-8988 y pida la versión en Español.

What type of services are you requesting?    TEFRA       Autism Waiver

Child's Name:		Social Security Number:		Male <input type="checkbox"/>	U.S. Citizen	
				Female <input type="checkbox"/>	Yes	No
Date of Birth:	Age: _____ years _____ months			Race:		
Parent/Guardian:						
Residence Address: (Street, Apt./Lot #)			City:	State:	County:	Zip:
Mailing Address: (P.O. Box, Street, Apt./Lot #)			City:	State:	County:	Zip:
Phone:			Email:			

1. Does the child you are applying for have income?    Yes    No    If yes, list the child's income below.

Source of Income	Gross Amount (Before deductions)	How often?
Social security		
SSI		
Veteran's benefits		
Child support		
Other		

2. Does the child you are applying for have resources?    Yes    No    If yes, list the child's resources.

Source of Resource	Amount or Value	Location of Resource
Cash, Checking, Savings or Christmas Club Account		
Stocks, Bonds, Trust Fund, Certificate of Deposit, Mutual Fund, etc.		
Other		

3. Does the child you are applying for have health insurance?    Yes    No  
 If yes, please provide a copy of the front and back of the child's insurance card.

4. Primary Care Physician \_\_\_\_\_

Autism Diagnosis    Yes    No    Date of Diagnosis \_\_\_\_\_

5. Do you expect a change in any of the above?    Yes    No    If yes, what? \_\_\_\_\_

When? \_\_\_\_\_

**For TEFRA only**

Information needed to determine the TEFRA premium:

- Please attach the most recent Federal Income Tax Return and Schedule A, if you itemized deductions, for the child's parent(s).
- The total number of dependents that live in your household including yourself: \_\_\_\_\_

**For Autism Waiver only**

If this application is for the Autism Waiver, please attach an evaluation report from each of the following indicating that the child has a diagnosis of autism. Please place a check mark beside each item that is attached.

- Physician Report
- Psychologist Report
- Speech-language Pathologist Report
- Adaptive Behavior Assessment Report (such as Vineland)

**Read carefully before you sign this application**

**The PRIVACY ACT of 1974** requires the Department of Human Services (DHS) to tell you: (1) whether disclosure of your SSN 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 TEFRA and Autism 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 I must help establish my eligibility by providing as much information as I can and in some situations I may be required to provide proof of my circumstances.
- I authorize any banks, savings and loans, lending institutions or other financial institutions, etc., to release to DHS any information about my household's circumstances as necessary to verify any information contained on this application.
- I authorize the Department of Human Services (DHS) to obtain information from any federal agency, other state agencies and other sources (including electronic databases) to confirm the accuracy of my statements.
- I understand Social Security Numbers (SSNs) will be used in a computer match to detect and prevent duplicate participation. SSNs are also used in a match through the State Income and Eligibility Verification System to secure wage, unearned income and benefit information from the Social Security Administration, Department of Workforce Services, and Internal Revenue Service. Information received may be verified through other contacts when discrepancies are found by DHS and may affect eligibility or level of benefits.
- 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 may request a hearing from DHS if a decision is not made on my case within the proper time limit or if I disagree with the decision.
- I agree to notify the DHS county office within 10 days if I or any of my dependents cease to live in my home, if I move, or if any other changes occur in my circumstances.
- I authorize DHS to examine all records of mine or records of those who receive or have received Medicaid benefits through me to investigate whether or not any person has committed Medicaid fraud, or for use in any legal, administrative or judicial proceeding.

**Assignment of Medical Support.** I authorize any holder of medical or other information about me to release information needed for an 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 for 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 an 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 who 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 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 DECLARE UNDER PENALTY OF PERJURY THAT THE ABOVE IS TRUE AND CORRECT.** If I receive benefits to which I am not entitled because I withheld information or provided 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 \_\_\_\_\_

Date \_\_\_\_\_