June 5, 2019

To Whom It May Concern:

Enclosed is a Consent of Release Form that the DDS Medicaid Income Eligibility Unit (MIEU) will need signed and dated by the client or guardian. This consent notifies the MIEU on who can act on the behalf of the client. Hopefully, this process will eliminate any interruptions in your Medicaid Waiver and Long-Term Care Services.

If you are interested, please send the completed Consent of Release Form and the Medicaid Re-evaluation packet to the address listed above or the information can be faxed directly to (870) 673-8135.

This form is not a requirement but optional. If you as the client decide not to complete the form, please remember to always keep us informed of any residential and/or mailing address changes.

If you have any questions or concerns, please feel free to call Ashley Maier and/or Virginia Green at (870) 673-8145 or e-mail at ddsmieu.pu@dhs.arkansas.gov, thank you.

Sincerely,

Quarnicia Sloan

Quarnicia Sloan, Program Eligibility Coordinator
Quarnicia.sloan@dhs.arkansas.gov
DDS Medicaid Income Eligibility Unit
(870) 673-8145
Consent to Act as Authorized Representative & Consent of Release
Of
Information

I ______________________, legal guardian of ______________________
(SOCIAL SECURITY NUMBER)
and ______________________
(MEDICAID NUMBER)

Give permission to ______________________
(PROVIDER’S NAME)

(PROVIDER’S MAILING ADDRESS)
to act as the authorized Representative for the release of information regarding Medicaid Waiver to the Department of Human Services, Division of Developmental Disabilities Services for the Purpose of Medicaid Waiver application for eligibility determination and reevaluation for continued eligibility.

__________________________  ____________________________
Guardian                                      Date

Phone Number

*Please find attached Consent to Act as Authorized Representative & Consent of Release of Information. If you would like to give permission for another individual or Program to act as your Authorized Representative regarding your Medicaid Waiver Services application for eligibility determination and reevaluation for continued eligibility, please complete and return attached Consent of Release in the enclosed self-addressed-stamped envelope.

If you have any questions call 870-673-8145, fax 870-673-8135 or email at dds.mieu.pu@dhs.arkansas.gov

Quanicia Sloan, Program Eligibility Coordinator
Ashley Maier, Admin Spec III
Virginia Green, Admin Spec III
Donna Eddins, Program Eligibility Specialist
Julie Manis, Program Eligibility Specialist
Martha Nease, Program Eligibility Specialist
Riconda Johnson, Program Eligibility Specialist
Jennifer Gordon, Program Eligibility Specialist
Angela Simpson, Program Eligibility Specialist

“CONFIDENTIALITY NOTICE: The information contained in this fax and any attachment(s) is the property of the State of Arkansas and may be protected by state and federal laws governing disclosure of private information. It is intended solely for the use of the entity to whom this fax is addressed. If you are not the intended recipient, you are hereby notified that reading, copying or distribution of this transmission is STRICTLY PROHIBITED. The sender has not waived any applicable privilege by sending the accompanying transmission. If you have received this transmission in error, please notify the sender by return and delete the message and attachment(s) from your system.”
June 5, 2019

Dear Sir and Madam,

The Division of Developmental Disabilities Services (DDS) at the Department of Human Services (DHS) re-evaluates long term care eligibility for clients living in private Intermediate Care Facilities (ICF), Human Development Centers (HDC) and for clients served through the Community and Employment Supports (CES) Waiver under the Provider-led Arkansas Shared Savings Entity (PASSE) model. The re-evaluation is required to determine if the client's eligibility continues under the current policy and law.

Please complete the enclosed re-evaluation application forms. If the client is a child, fill-out the application for their income and resources, NOT the parents. Be sure to answer each question, even if the information has not changed since the last review. ANSWER ALL QUESTIONS AND DO NOT LEAVE ANY BLANKS. IF ALL QUESTIONS ARE NOT ANSWERED YES OR NO PAPERWORK WILL BE RETURNED TO YOU FOR COMPLETION.

If any items were answered “Yes” on the application for questions 16 (SOURCES OF INCOME) OR 25 (ASSETS/RESOURCES) please include verification by providing copies of these items. Resources included Checking and Savings accounts. Please provide CURRENT balances of all accounts with the past 30 days from the bank. If account has been closed with the past year, please provide proof of closure.

The VERIFICATION OF EARNINGS form needs to be completed in detail by the employer or provide the last 8 check stubs. If the client does not work, please indicate that on the form, or provide proof of the last date of employment.

The enclosed forms and applicable verification must be returned with the allotted time. Failure to do so will result in your case being CLOSED. If you have any questions or concerns, please feel free to call Ashley Maier and/or Virginia Green at (870) 673-8145 or e-mail at ddsmieu.pu@dhs.arkansas.gov.

REMEMBER TO SIGN ALL FORMS

Sincerely,

Quarnicia Sloan, Program Eligibility Coordinator
Ashley Maier, Administrative Specialist III
DDS Medicaid Income Eligibility Unit
(870) 673-8145 Fax: (870) 673-8135
LONG TERM SERVICES AND SUPPORTS MEDICAID
ANNUAL RENEWAL NOTICE

County Office Address:
Department of Human Services - DDS
P O Box 1008 / 203 South Leslie Street
Stuttgart Arkansas 72160
dds.mieu.pu@chs.arkansas.gov

Budget Unit ID:

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

ANNUAL RENEWAL INSTRUCTIONS
It is time for the annual renewal of your Medicaid case. This report will be used to determine your continued eligibility for Nursing Home, Assisted Living Facility, or Waiver program (ARChoices, DDS) or PACE. Complete each question on this form and return it by . Failure to return this form may result in closure of your case. You will not be required to visit your local DHS County Office. However, you may be contacted by phone or mail if additional information is needed to determine your eligibility. Please provide a phone number we can contact you at:

1. Income (Attach verification, such as letter from income source.)
If you or your spouse receives income from the following sources, please complete the questions below. Attach additional sheets to explain, if needed.

<table>
<thead>
<tr>
<th>Possible Sources of Income</th>
<th>Who Receives Income</th>
<th>Specific Type of Income</th>
<th>Gross Amount</th>
<th>How Often Received</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mineral Rights/Oil Leases, Unemployment Benefits, Worker's Compensation</td>
<td></td>
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</tr>
<tr>
<td>Employment/Work, Farm Income, Self-employment</td>
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<tr>
<td>Income from Trusts or Annuities</td>
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<tr>
<td>Rental Income, Contributions from Family/Friends</td>
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<tr>
<td>Any other type of income?</td>
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</tbody>
</table>

2. Home and Household
Do you own your home? Yes ☐ No ☐ If yes, in what county is it located? ______________________
   a) If you are able, do you intend to return home? Yes ☐ No ☐
   b) Does anyone currently live in your home? Yes ☐ No ☐
   c) If yes, are they related to you? Yes ☐ No ☐ If yes, what is their relationship to you? __________
Has your marital status changed in the past year? Yes ☐ No ☐
   If yes, how? Married ☐ Divorced ☐ Death ☐

3. Assets (Attach verification, such as current bank statements, insurance policies, burial policies, etc.)
   a) What was the balance in your checking account on the first of this month? ______________________
   b) What was the balance in your savings account on the first of this month? ______________________
Assets - Continued
   c) Do you have any cash available on hand? Yes ☐ No ☐ Please list amount: ____________________________
   d) Do you have a Patient Fund account? Yes ☐ No ☐
       If yes, what was the balance in the account on the first of this month? ______________________________
   e) Do you have an irrevocable income trust? (Miller Trust) Yes ☐ No ☐
       If yes, please attach the past 12 months of bank statements for the income trust account.

Have you or your spouse obtained, sold, deeded or given away any of the Assets listed below since your last application or renewal for Medicaid coverage? Yes ☐ No ☐
If yes, please complete the section below and attach verification of the transaction.

<table>
<thead>
<tr>
<th>Asset</th>
<th>Date Purchased</th>
<th>Date Sold, Transferred or Cashed In</th>
<th>Transferred to Whom</th>
<th>Value of Asset</th>
<th>Amount that You Received</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home</td>
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</tr>
<tr>
<td>Property other than your home</td>
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<tr>
<td>Life Insurance, Burial Funds Insurance, Burial Plot / Crypt</td>
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<tr>
<td>Mortgages, Stocks or Bonds</td>
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<tr>
<td>Trust Fund, Certificate of Deposit, IRA, Promissory Note, Mutual Fund, etc.</td>
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<tr>
<td>Annuity</td>
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<td>Other</td>
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</table>

4. Vehicles
Have you or your spouse acquired any vehicles within the last year? Yes ☐ No ☐
If yes, complete the following:

<table>
<thead>
<tr>
<th>Year</th>
<th>Make</th>
<th>Model</th>
<th>Name on Title</th>
<th>Is there a co-owner?</th>
<th>Equity Value</th>
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<td>If yes, provide name</td>
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</table>

5. Insurance Other Than Medicare or Medicaid
Have you or your spouse purchased or canceled additional health insurance coverage? Yes ☐ No ☐
If coverage was canceled, what date was the coverage canceled on? ______________________________
If you have additional coverage, complete the following and provide verification of the premium amount.

<table>
<thead>
<tr>
<th>Name and address of insurance</th>
<th>Policy #</th>
<th>Premium amount</th>
</tr>
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</table>

PLEASE READ CAREFULLY BEFORE SIGNING THIS FORM
- I authorize any holder of medical, financial or other information about me to release information needed for a Medicaid claim to the Department of Human Services. I further authorize release of any information to other parties who may be liable for my medical expenses.
- I agree to notify the Department of Human Services within 10 days if I or my spouse receive additional income, acquire or dispose of property or if any other changes occur in my circumstances.
- I understand that the Estate Recovery process and conditions that I agreed to with my initial application for assistance still apply.
- I understand that the information provided on this report may result in loss of my Medicaid coverage.
- I declare that the information provided is correct.
- I understand that this form is signed subject to penalties for perjury. I understand that if I receive assistance to which I am not entitled as a result of withholding information or providing 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.

CERTIFICATION: I HAVE READ THE ABOVE STATEMENTS AND I AGREE TO THEIR PROVISIONS.

Signature ____________________________ Phone Number ____________________________ Date __________
Witness (if signed by mark) ____________________________ Date __________
Authorized Representative ____________________________ Phone Number ____________________________ Date __________
Arkansas Department of Human Services  
Division of County Operations  
THIRD PARTY RESOURCE / MEDICAL INSURANCE

A. APPLICANT INFORMATION:

<table>
<thead>
<tr>
<th>1. Last Name</th>
<th>2. First Name</th>
<th>3. MI</th>
<th>4. Sex</th>
<th>5. Social Security Number</th>
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10. Other than Medicare, do you have health insurance or some other insurance, settlement, person or group that is responsible for paying all or part of your medical expenses?

☐ Yes  If Yes, please either attach proof of coverage (such as a copy of your insurance card) OR complete B, C and D below.

☐ No  If No, please skip to Section F and provide a phone number, sign and date the form, and mail it to us.

B. POLICYHOLDER INFORMATION:

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C. INSURANCE INFORMATION:

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26. Check all Type of Benefits/Coverage Applicable (at least one must be checked)

☐ 1. Medical  ☐ 4. Vision  ☐ 7. Indemnity/Hospital/Cancer/Heart

☐ 2. Pharmacy  ☐ 5. Medicare Supplement  ☐ 8. Accident Only (non-Auto)

☐ 3. Dental  ☐ 6. Long Term Care  ☐ 9. Automobile/Motorcycle Accident

☐ 10. Other ______

D. INDICATE ALL INDIVIDUALS COVERED BY POLICY:

<table>
<thead>
<tr>
<th>27. Last Name</th>
<th>28. First</th>
<th>29. MI</th>
<th>30. Relationship</th>
<th>31. SSN or Medicaid Number</th>
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E. COMMENTS


F. TELEPHONE NUMBER WHERE YOU CAN BE REACHED BETWEEN 8:00/4:30

AUTHORIZATION AND ASSIGNMENT

I authorize any holder of medical or other information about me to release information needed for this or a related Medicaid claim to the Arkansas Medicaid program. I authorize the further release of any such information to any other parties who may be liable for any of my medical expenses. I hereby authorize and request that funds, settlement or other payments made by or on behalf of third parties, including tort-feasors or insurers, arising out of this Medicaid claim be paid directly to the Arkansas Medicaid program. I also assign all rights in any settlement made by me or on my behalf and arising out of any claim of which this is a part to the extent of medical expenses paid by Medicaid whether or not a portion of such settlement is designated as being for medical expenses. Any such funds received by me shall be paid to the Arkansas Medicaid program. I permit a copy of this authorization to be used in place of the original.

Applicant/Recipient signature (or parent/guardian if minor)

Date

DCO-662 (rev. 01/14)
Arkansas Department of Human Services
DISPOSAL OF ASSETS DISCLOSURE

Si necesita este formulario en Español, llame al 1-800-482-8988 y pida la versión en Español

If you need this material in a different format, such as large print, contact your DHS county Office.

Medicaid rules require the complete disclosure of all asset transfers (real or personal property transfers) including the establishment of trusts and/or annuities made by yourself or your spouse within the last 5 years (60 months). Also, currently valid trusts or annuities established outside the last 5 years (60 months) must be disclosed. All such transfers must be documented by the local Human Services Office to determine your eligibility for Medicaid assistance. Read each part of this form carefully to determine parts which apply to you. You must complete and sign Part A or Part B. Please complete another form to report additional transfers.

PART A. ASSETS TRANSFERRED

☐ I (or my spouse) established a trust or annuity on _________________. Please provide a copy of your trust and/or annuity documents. (Date)

☐ I (or my spouse) have sold, transferred, assigned, or given away the following assets (cash, checking accounts, savings accounts, securities, real or personal property, etc.) within the last 60 months. (Please verify any transfers with copies of deeds, bank statements, etc.)

<table>
<thead>
<tr>
<th>Item</th>
<th>Transferred to (Name)</th>
<th>Relationship to you</th>
<th>Transfer Date</th>
<th>Location (County, State)</th>
<th>Value of item</th>
<th>Payment Received</th>
</tr>
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<td>1.</td>
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Provide the address and telephone number below for the person that received the item.

Name _______________________________ Address _______________________________

Telephone Number _______________________________ (Please use an additional sheet of paper if needed).

This statement is true to the best of my knowledge, and I understand that should I give a false statement, I may be subject to criminal prosecution. I also understand that I will be liable for any overpayments made on my behalf by the Arkansas Medicaid program due to my misrepresentation of fact(s).

Signature __________________________ Date __________________________

PART B. NO ASSETS TRANSFERRED

☐ I (or my spouse) have not established a trust or annuity, and have not sold, transferred, assigned, or given away any assets (cash, checking accounts, savings accounts, securities, real or personal property, etc.) within the last 5 years (60 months). This statement is true to the best of my knowledge, and I understand that should I give a false statement, I may be subject to criminal prosecution. I also understand that I will be liable for any overpayments made on my behalf by the Arkansas Medicaid program due to my misrepresentation of fact(s).

Signature __________________________ Date __________________________
DISPOSAL OF ASSETS DISCLOSURE

DHS-0727

PURPOSE

The Disposal of Assets disclosure, Form DHS-0727, is used to obtain a report from the Long Term Care applicant/recipient (Facility or HCBW) of all resource transfers, including transfers to trusts or annuities, within the last 5 years (60 months). Form DHS-0727 must be completed for all applications in these categories and for all reevaluations of such cases.

COMPLETION

Form DHS-0727 is completed by the Long Term Care applicant/recipient (Facility or HCBW) or his designated representative. Completion of the form is self-explanatory. Form DHS-0727 must be signed by the applicant/recipient unless he/she is legally incompetent or physically unable to do so.

ROUTING

Form DHS-0727 will be retained in the applicant/recipient’s record and a copy of the form will be given to the client for his/her records.

RETENTION

The form will be retained (5) years from the date of signature.
REMINDER: TO BE INCLUDED WITH YOUR REVIEW PACKET

• PLEASE INCLUDE PROOF OF EARNINGS THE LAST 8 CURRENT CHECK STUBS OR EMPLOYERS STATEMENT.

• PLEASE INCLUDE THE CURRENT BANK STATEMENT(S) THAT HAS BEEN RECEIVED WITH THE LAST 30 DAYS. IF THE ACCOUNT HAS BEEN CLOSED WE NEED PROOF THAT IT HAS BEEN CLOSED.

• IF YOU HAVE HAD ANY CHANGES BE SURE TO FURNISH PROOF OF THE CHANGE.