ARKANSAS DEPARTMENT OF HUMAN SERVICES
TEFRA
Annual Renewal Notice

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.

Date:

FROM: _____ **TO:** _____

_____ _____

_____ _____

Budget Unit ID _____ If above address has changed, please provide correct address.

ANNUAL RENEWAL INSTRUCTIONS – This report will be used to determine your child's continued eligibility for TEFRA. **You will not be required to visit your local DHS County Office.** However, you may be contacted by phone, mail or email if additional information is needed to determine your child's continued eligibility. If additional time is needed to complete and return these forms, contact the county office listed above and request an extension.

Complete each question on the DCO-7779 accurately. Your child's physician must complete the enclosed DMS-2602 form. If you do not understand a question, please call your caseworker. If you do not have enough space for your answer, attach an additional sheet of paper.

Both forms, the DCO-7779 and DCO-2602, must be returned to the county office address listed above on or before _____. **Failure to return these forms may result in closure of your child's TEFRA case.**

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1. Information needed to determine the TEFRA premium:

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

2. Telephone numbers where you can be reached if there are any questions regarding this form:

   _____

   Home Work Message

   Is there an Email address we can use to contact you? ☐ Yes ☐ No If yes, please provide.

   _____

3. Has the health insurance reported last year for the child receiving TEFRA changed? ☐ Yes ☐ No
   If yes, please provide a copy of the front and back of the child's new insurance card.

4. Has the health insurance for the TEFRA child been dropped within the last year? ☐ Yes ☐ No
   If yes, when? _____ Why was the insurance dropped? _____

5. Has the income reported last year for the child receiving TEFRA changed? ☐ Yes ☐ No
   If yes, list the child's new income information below.

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

6. Have the resources/assets reported last year for the child receiving TEFRA changed? ☐ Yes ☐ No
   If yes, list the child's new resource information below.

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		

7. Do you expect a change in any of the above? ☐ Yes ☐ No If yes, what? _____
   When? _____

PLEASE READ CAREFULLY BEFORE SIGNING THIS FORM

- I understand that if anyone receives assistance to which they are not entitled because of my withholding information, I will be liable for any overpayment.
- I understand that the information provided on this report may result in loss of my child's TEFRA Medicaid coverage.
- I declare that the information provided is correct.

The PRIVACY ACT of 1974 requires the Department of Human Services (DHS) to tell you: (1) whether disclosure of an 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 Supplemental Nutrition Assistance Program this authority is granted under the Food and Nutrition Act of 2008 as amended, 7 U.S.C. 2001-2036. For the Medicaid 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 claim arises against your household, the information on this form, including all SSNs, may be provided to Federal or State officials or to private agencies for collection purposes.

I understand that by signing this Annual Renewal Notice, I am subject to penalties for false statements.

Sign Your Name _____ Date_____