

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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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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Voter Registration	<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? SELF	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 If Yes, how were you emancipated? <input type="checkbox"/> Court Order <input type="checkbox"/> Common Law	
6. 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.		

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 week : _____ 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 week : _____ 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

<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: _____	

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).

<input type="checkbox"/> Alimony paid	\$ _____ How often? _____	<input type="checkbox"/> Student Loan interest	\$ _____ How often? _____
<input type="checkbox"/> 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 this year : \$ _____	Your total income next year (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) ___ - ___ - _____ 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. Is PERSON 2 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 week : _____ 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 week : _____ 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 this year : \$ _____	Your total income next year (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 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, 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 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.

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.

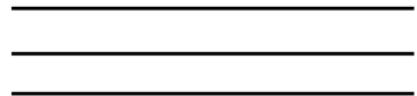
This completes the application process for Medicaid, ARKids First and the Health Care Independence Program. Federal law requires that each state provide the opportunity to register to vote with every application for public assistance. The remaining pages of this packet are the Arkansas Voter Registration 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 Secretary of State
ATTN: Voter Registration
P.O. Box 8111
Little Rock, Arkansas 72203-8111

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.

ARKANSAS VOTER REGISTRATION INFORMATION

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. 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.

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: 1) Register to vote; 2) Decline to register to vote; 3) Privacy in deciding whether to register or in applying to register to vote; or 4) 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 two options to submit your Voter Registration form.

1. You can submit the registration form in person or mail the registration form along with your SNAP or Medicaid application to your local county DHS office. The address for your county office can be found on the last page of this packet. 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.
2. You may also mail the Voter Registration form directly to the Secretary of State's Office. To mail the form directly to the Secretary of State's office, separate the form from your application/renewal, fold the form along the middle perforation, seal the bottom with tape or staple, and mail to the address on the form. A stamp or stamped envelope is required for mailing.

DHS County Office Mailing Addresses

County	Address	City	Zip	County	Address	City	Zip	County	Address	City	Zip
Arkansas	100 Court Square	DeWitt	72042	Grant	PO Box 158	Sheridan	72150	Ouachita	PO Box 718	Camden	71711
Arkansas	PO Box 1008	Stuttgart	72160	Greene	809 Goldsmith Rd	Paragould	72450	Perry	213 Houston Ave	Perryville	72126
Ashley	PO Box 190	Hamburg	71646	Hempstead	116 N. Laurel	Hope	71802	Phillips	PO Box 277	Helena	72342
Baxter	PO Box 408	Mt. Home	72654	Hot Spring	2505 Pine Bluff St	Malvern	72104	Pike	PO Box 200	Murfreesboro	71958
Benton	900 SE 13 th Court	Bentonville	72712	Howard	PO Box 1740	Nashville	71852	Poinsett	PO Box 526	Harrisburg	72432
Boone	PO Box 1096	Harrison	72602	Independence	100 Weaver Ave	Batesville	72501	Polk	PO Box 1808	Mena	71953
Bradley	PO Box 509	Warren	71671	Izard	PO Box 65	Melbourne	72556	Pope	701 N Denver	Russellville	72801
Calhoun	PO Box 1068	Hampton	71744	Jackson	PO Box 610	Newport	72112	Prairie	PO Box 356	DeValls Bluff	72041
Carroll	PO Box 425	Berryville	72616	Jefferson	PO Box 5670	Pine Bluff	71611	Pulaski East	PO Box 8083	Little Rock	72203
Chicot	PO Box 71	Lake Village	71653	Johnson	PO Box 1636	Clarksville	72830	Pulaski Jax.	PO Box 626	Jacksonville	72078
Clark	PO Box 969	Arkadelphia	71923	Lafayette	2612 Spruce St.	Lewisville	71845	Pulaski No.	PO Box 5791	N. Little Rock	72119
Clay	PO Box 366	Piggott	72454	Lawrence	PO Box 69	Walnut Ridge	72476	Pulaski So.	PO Box 2620	Little Rock	72203
Cleburne	PO Box 1140	Heber Springs.	72543	Lee	PO Box 309	Marianna	72360	Pulaski Sw.	PO Box 8916	Little Rock	72219
Cleveland	PO Box 465	Rison	71665	Lincoln	101 W. Wiley St.	Star City	71667	Randolph	1408 Pace Rd	Pocahontas	72455
Columbia	PO Box 1109	Magnolia	71754	Little River	90 Waddell St.	Ashdown	71822	Saline	PO Box 608	Benton	72018
Conway	PO Box 228	Morrilton	72110	Logan-1	#17 W. McKeen	Paris	72855	Scott	PO Box 840	Waldron	72958
Craighead	PO Box 16840	Jonesboro	72403	Logan-2	398 East 2 nd St.	Booneville	72927	Searcy	106 School St	Marshall	72650
Crawford	704 Cloverleaf Circle	Van Buren	72956	Lonoke	PO Box 260	Lonoke	72086	Sebastian	616 Garrison Ave	Ft. Smith	72901
Crittenden	401 S. College Blvd	W. Memphis	72301	Madison	PO Box 128	Huntsville	72740	Sevier	PO Box 670	DeQueen	71832
Cross	803 Hwy 64E	Wynne	72396	Marion	PO Box 447	Yellville	72687	Sharp	1467 Hwy 62/412 Ste. B	Cherokee Village	75229
Dallas	1202 W. 3 rd St.	Fordyce	71742	Miller	3809 Airport Plaza	Texarkana	71854	St Francis	PO Box 899	Forrest City	72336
Desha	PO Box 1009	McGehee	71654	Mississippi 1	1104 Byrum Rd.	Blytheville	72315	Stone	1821 E Main	Mountain View	72560
Drew	PO Box 1350	Monticello	71657	Mississippi 2	437 S Country Club	Osceola	72370	Union	123 W 18 th St.	El Dorado	71730
Faulkner	1000 East Siebenmorgan Road	Conway	72032	Monroe-1	PO Box 354	Clarendon	72029	Van Buren	449 Ingram Street	Clinton	72031
Franklin	800 W Commercial	Ozark	72949	Monroe-2	301½ N New Orleans	Brinkley	72021	Washington	4044 Frontage	Fayetteville	72703
Fulton	PO Box 650	Salem	72576	Montgomery	PO Box 445	Mount Ida	71957	White	608 Rodgers Drive	Searcy	72143
Garland	115 Stover Lane	Hot Springs	71913	Nevada	PO Box 292	Prescott	71857	Woodruff	PO Box 493	Augusta	72006
				Newton	PO Box 452	Jasper	72641	Yell	PO Box 277	Danville	72833

***If you live in Pulaski County please check the zip code listing below to ensure that you mail or return your application to the appropriate Pulaski County DHS Office.**

Pulaski East : 72016, 72053, 72126, 72135, 72201, 72202, 72203, 72205, 72207, 72212, 72223, 72227

Pulaski North: 72046 (England), 72113, 72114, 72115, 72117, 72118, 72119, 72142 (Scott), 72190, 72231

Pulaski Jacksonville: 72023 (Cabot), 72076, 72078, 72099, 72106, 72116, 72120, 72124

Pulaski South: 72204, 72206 (Shared with Southwest)

Pulaski Southwest: 72002, 72065, 72103, 72208, 72209, 72210, 72211, 72164, 72180, 72183, 72206 (Shared with South)