ARKANSAS DEPARTMENT OF HUMAN SERVICES

HOUSEHOLD HEALTH COVERAGE F.A.Q AND APPLICATION

Frequently Asked Questions

What is the fastest way to apply for coverage?

The fastest way to apply for coverage is to apply online at: https://access.arkansas.gov/

What services can I apply for with this application?

- You can apply for Medicaid, ARKids First or the Arkansas Works 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.

Who can use this application?

Use this application to apply for you or anyone in your family.

- 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.

What will I need to apply?

- Your Social Security number (or document number if you are a legal immigrant)
- Employer and income information (examples: from recent 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

Why do you need my Social Security number, employer, and income information?

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'll keep all the information you provide private and secure as required by law.** To view the Privacy Act Statement go to: https://access.arkansas.gov/.

What is I need help with my application?

You can contact or Help Center at 1-855-372-1084 or contact your local DHS county office.
En Español: Llame a nuestro centro de ayuda gratis al 1-855-372-1084.

Why is there a Voter Registration application included?

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. By applying to register or declining to register to vote will not affect the amount of assistance that you will be provided by this agency.

ARKANSAS DEPARTMENT OF HUMAN SERVICES
Division of County Operations

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 live in the State of Arkansas? ☐ Yes ☐ No	17. If you are currently out-of-state, do you intend to return to Arkansas? ☐ Yes ☐ No		
Email Address: Providing a valid email address will allow us to process your application and provide you with notice updates more efficiently. Providing an email address will allow you to receive information regarding your health coverage in real time through your email account.			
18. Email Address:		19. I do not want to provide an email address at this time. ☐	
20. Preferred spoken or written language (if not English)			

Step 2: Tell Us About Your Family

Who do you need to include on this application?

List all the people who live in your home, including yourself. If you file taxes, we need to know about everyone on your tax return. This includes your tax dependents that do not live in your home. (You don't need to file taxes to be eligible for health coverage.)

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 fill out a form DCO-152C, Additional Household Member, for each additional member of your household and attach the form(s) 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.

<u>Please proceed to Step 2, Person 1 on the following page.</u>

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

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 ☐ Male ☐ Female
4. Date of Birth (mm/dd/yyyy)	5. If you are under 18, are you emancipated? ☐ Yes ☐ No **If Yes**, how were you emancipated? ☐ Court Order ☐ 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 ssa.gov. TTY users should call 1-800-325-0778.

7. Do you currently have health coverage and want to continue with the same coverage? ☐ Yes ☐ No
If No, would you like to apply for coverage? ☐ Yes ☐ No

CITIZENSHIP STATUS
8. Are you a U.S. citizen or U.S. national? ☐ Yes ☐ No
Are you a citizen of the Marshall Islands, Federated States of Micronesia or Palau? ☐ 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. ☐ **No**
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 and race? **(OPTIONAL – Check all that apply.)**
☐ Mexican ☐ Mexican-American ☐ Chicano/a ☐ Puerto Rican ☐ Cuban ☐ Other:____________________

11. **Race (OPTIONAL – Mark (X) all that apply.)**

Race	X	Race	X	Race	X	Race	X	Race	X	Race	X
White		Filipino		Black/African American		Alaskan Native		Hawaiian/Pacific Islander		Samoan	
Korean		Japanese		American Indian		Asian Indian		Guamanian or Chamorro		Chinese	

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 student? ☐ Yes ☐ No Please mark your student status and school type.

Status				School Type					
Full Time		Half Time		Vocational		Under Graduate		Open University	
Part Time		Graduated		Equivalent Vocational/Technical		Technical		Not in School	

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
Are you currently receiving Medicaid? ☐ 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 (Continued)

CURRENT JOB & INCOME INFORMATION:

☐ **Employed**	☐ **Not Employed**	☐ **Self Employed**
If you are currently employed tell us about your income. Start with question 17.	Skip to Question 25.	Skip to Question 26.

CURRENT JOB 1:

17. Employer Name and Address	18. Employer Phone Number
19. Wages/tips (before taxes) $________________ ☐ Hourly ☐ Weekly ☐ Every 2 Weeks ☐ Twice a Month ☐ Monthly ☐ 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) $________________ ☐ Hourly ☐ Weekly ☐ Every 2 Weeks ☐ Twice a Month ☐ Monthly ☐ Yearly	
24. Average hours worked each **week**:__________Start date of employment____________(mm/dd/yyyy)	

25. **In the past year, did you:**	Change jobs?		Start working fewer hours?		Stop working?		None of these?	

If you stopped working what was the date that the job ended?

26. **If self-employed, answer the following questions:**

a. Name of Business:_______________________________________

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:** Enter the amount and how often you receive that amount for all income that is not listed above.

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

INCOME	Amount	How Often	INCOME	Amount	How Often	INCOME	Amount	How Often
None			Taxable Interest			Tax Exempt Interest		
Dividends			Foreign Income			Unemployment		
Pensions/Retirement			Social Security			Net Farming/Fishing		
Retirement Accounts			Scholarship Payments			Prizes/Awards		
Capital Gains			Alimony/Maintenance			Lump Sum Amount		
Alaskan Native Income			American Indian Income			Other Income		

28. **DEDUCTIONS**: Mark all that apply, 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).

Deduction	X	Amount $	How Often	Deduction	X	Amount $	How Often
Alimony/Maintenance				Student Loan Interest			
Other Deduction:__________				Other Deduction: __________			

29. **YEARLY INCOME:** Complete only if your income changes each 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): $______________________

30. **UNPAID MEDICAL BILLS** Do you need help paying for medical bills from this month? ☐ Yes ☐ No
Do you need help paying for medical bills in the last 3 months? ☐ Yes ☐ No Are **these bills** from a Medical Emergency? ☐ Yes ☐ No
Was your household size the same during the last 3 months as it is now? ☐ Yes ☐ No
Was your household income the same during the last 3 months as it is now? ☐ Yes ☐ No
If No, What was the household size and income during those 3 months? ______________________
NOTE: Arkansas Works recipients may be eligible for retroactive coverage 30 days prior to the date of application.

31. **DISABILITY STATUS** Do you have a disability? ☐ Yes ☐ No 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 ☐ Male ☐ 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? ☐ Yes ☐ No
If No, list address:

7. Does **PERSON 2** live in Arkansas? ☐ Yes ☐ No

8. If currently out-of-state, does **PERSON 2** intend to return to Arkansas? ☐ Yes ☐ No

9. Is **PERSON 2** the main caregiver living with and taking care of at least one child under the age of 19? ☐ Yes ☐ No

10. Does **PERSON 2** currently have health coverage and want to continue with the same coverage? ☐ Yes ☐ No
If No, would **PERSON 2** like to apply for coverage? ☐ Yes ☐ No

CITIZENSHIP STATUS

11. Is **PERSON 2** a U.S. citizen or U.S. national? ☐ Yes ☐ No
12. Is PERSON 2 a citizen of the Marshall Islands, Federated States of Micronesia or Palau? ☐ Yes ☐ No

13. **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. ☐ **No**
a. Immigration document type:_______________ Alien #_______________
b. Document ID number:_______________ Expiration date of documen _______________
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

14. **If Hispanic/Latino,** what is **PERSON 2**'s ethnicity and race? **(OPTIONAL – Check all that apply.)**
☐ Mexican ☐ Mexican-American ☐ Chicano/a ☐ Puerto Rican ☐ Cuban ☐ Other:_______________

15. **Race (OPTIONAL – Mark (X) all that apply.)**

Race	X	Race	X	Race	X	Race	X	Race	X	Race	X
White		Filipino		Black/African American		Alaskan Native		Hawaiian/Pacific Islander		Samoan	
Korean		Japanese		American Indian		Asian Indian		Guamanian or Chamorro		Chinese	

PREGNANCY STATUS

16. 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?_______________ Is **Person 2** a newborn? ☐ Yes ☐ No
If Yes, What is the biological mother's name and date of birth?_______________

STUDENT STATUS

17. Is **PERSON 2** a full time student? ☐ Yes ☐ No Mark (**X**) for all that apply.

Status				School Type					
Full Time		Half Time		Vocational		Under Graduate		Open University	
Part Time		Graduated		Equivalent Vocational/Technical		Technical		Not in School	

FOSTER CARE STATUS

18. 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
Is **PERSON 2** currently enrolled in Medicaid? ☐ Yes ☐ No

TAX FILING STATUS

19. **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 (Continued)

CURRENT JOB & INCOME INFORMATION

☐ **Employed**	☐ **Not Employed**	☐ **Self Employed**
If PERSON 2 currently employed tell us about their income. Start with question 20.	Skip to Question 28.	Skip to Question 29.

CURRENT JOB 1:

20. Employer Name and Address	21. Employer Phone Number
22. Wages/tips (before taxes) $________________ ☐Hourly ☐Weekly ☐ Every 2 Weeks ☐ Twice a Month ☐Monthly ☐ Yearly	
23. Average hours worked each **week**:________________Start date of employment______________________(mm/dd/yyyy)	

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) $ ________________ ☐Hourly ☐Weekly ☐ Every 2 Weeks ☐Twice a Month ☐Monthly ☐Yearly	
27. Average hours worked each **week**:________________Start date of employment______________________(mm/dd/yyyy)	

28. **In the past year, did PERSON 2:**	Change jobs?		Start working fewer hours?		Stop working?		None of these?	
If PERSON 2 stopped working what was the date that the job ended?								

29. **If self-employed, answer the following questions:**
a. Name of Business:____
b. How much net income (profits once business expenses are paid) will PERSON 2 receive from this self-employment this month? $___________

30. **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).

INCOME	Amount	How Often	INCOME	Amount	How Often	INCOME	Amount	How Often
None			Taxable Interest			Tax Exempt Interest		
Dividends			Foreign Income			Unemployment		
Pensions/Retirement			Social Security			Net Farming/Fishing		
Retirement Accounts			Scholarship Payments			Prizes/Awards		
Capital Gains			Alimony/Maintenance			Lump Sum Amount		
Alaskan Native Income			American Indian			Other Income		

31**. DEDUCTIONS**: Mark all that apply, give the amount and how often you receive 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).

Deduction	X	Amount $	How Often	Deduction	X	Amount $	How Often
Alimony/Maintenance				Student Loan Interest			
Other Deduction:_________________				Other Deduction: _________________			

32. **YEARLY INCOME**: Complete only if PERSON 2's income changes each month. If you don't expect changes to PERSON 2's monthly income, skip to question 33.

Your total income **this year:** $______________________________________	Your total income **next** year (if you think it will be different): $____

33. **UNPAID MEDICAL BILLS** Does PERSON 2 need help paying for medical bills from this month? ☐ Yes ☐ No
Does PERSON 2 need help paying for medical bills in the last 3 months? ☐ Yes ☐ No
Are **these bills** from a Medical Emergency? ☐ Yes ☐ No
Was PERSON 2's household size the same during the last 3 months as it is now? ☐ Yes ☐ No
Was PERSON 2's household income the same during the last 3 months as it is now? ☐ Yes ☐ No
If No, What was the household size and income during those 3 months? ________________________________
NOTE: Arkansas Works recipients may be eligible for retroactive coverage 30 days prior to the date of application.

34. **DISABILITY STATUS** Does PERSON 2 have a disability? ☐ Yes ☐ No Or is PERSON 2 blind? ☐ Yes ☐ No
Does PERSON 2 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
Does PERSON 2 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.

Is anyone in the home eligible to receive Indian Program Services? ☐ Yes ☐ No

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.

☐	Name of Health Insurance	☐	Other Insurance
Policy Number		Name of Health Insurance	
Is this cobra coverage? ☐ Yes ☐ No		Policy Number	
Is this a retiree plan? ☐ Yes ☐ No		Is this a limited benefit plan (like a school accident policy)? ☐ Yes ☐ No	
Other Health Coverage			
☐	Medicaid	☐	ARKids First/CHIP
☐	Medicare	☐	Peace Corp
☐	VA Health Care Programs		
☐	TRICARE (Don't check if you have Direct Care or Line of Duty)		

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 the next question below	

3. Has anyone listed on the application lost health insurance coverage in the last 90 days? ☐ Yes ☐ No

If Yes, When did the coverage end? ____________________ Why did the coverage end? ____

Was the insurance a group or employer sponsored plan? ☐ Yes ☐ No

Did the insurance cover both hospital and physician charges? ☐ Yes ☐ No

4. Does anyone listed on this application use tobacco? ☐ Yes ☐ No **If Yes**, who? ____________________________

INCARCERATION STATUS

Is anyone that is listed on this application currently incarcerated with the Department of Corrections, Department of Community Correction, county jail, city jail or a Juvenile Detention Facility? ☐ Yes ☐ No

If Yes, who? ____

What is the incarcerated person's expected release date? ____________________________ (mm/dd/yyyy)

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 hhs.gov/ocr/office/file or by calling 1-501-682-6003.

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.

Step 5: Read & Sign This Application (Continued)

If anyone on this application is eligible for Medicaid, ARKids First or the Arkansas Works 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 Arkansas Works Program is not a perpetual federal or state right or a guaranteed entitlement program and it may be ended at any time upon appropriate notice.
- I understand that if I am eligible for the Arkansas Works Program my information will be shared with the Arkansas Division of Workforce Services.
- I understand that participation with the Arkansas Division of Workforce Services will not affect my eligibility for Medicaid or the Arkansas Works Program.
- 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

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 Pine Bluff Scanning Center
P.O. Box 8848
Pine Bluff, AR 71611-8848

Or email the application to: 351Jefferson@arkansas.gov
Or fax the application to: 1-870-534-3421.
Or submit the application to your local DHS Office.

What happens next? We will process your application for Medicaid, ARKids First or the Arkansas Works 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 Arkansas Works 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.