# ARKANSAS REGISTER

## Transmittal Sheet

Secretary of State
**Mark Martin**
State Capitol Room 026
Little Rock, Arkansas 72201-1094
(501) 682-3527
**www.sos.arkansas.gov**

**For Office Use Only:** Effective Date _____ Code Number _____

Name of Agency Arkansas Department of Human Services.

Department Division of Medical Services.

Contact Glenda Higgs E-mail glenda.higgs@arkansas.gov Phone 320-6425.

Statutory Authority for Promulgating Rules _____

**Rule Title: Eligibility**

| Intended Effective Date | Date |
|---|---|
| ☒ Emergency (ACA 25-15-204) | Legal Notice Published..... N/A. |
| ☐ 30 Days After Filing | Final Date for Public Comment..... N/A. |
| ☐ Other | Reviewed by Legislative Council..... |
| | Adopted by State Agency..... 10/01/13. |

☒ Electronic Copy of Rule Provided (per Act 1478 of 2003)

☒ Electronic Copy of Rule to be e-mailed from: Becky Murphy (Contact Person) becky.Murphy@arkansas.gov (Email Address)

**CERTIFICATION OF AUTHORIZED OFFICER**
I Hereby Certify That The Attached Rules Were Adopted
In Compliance with Act 434 of 1967 As Amended

Andy Allison
Signature

(501) 682-8292 (Phone Number) andy.allison@arkansas.gov (E-mail Address)

Director (Title)

Date

FILED
SECRETARY OF STATE
STATE OF ARKANSAS
13 SEP 27 PM 4:12
REGISTER DIV.

# QUESTIONNAIRE FOR FILING PROPOSED RULES AND REGULATIONS WITH THE ARKANSAS LEGISLATIVE COUNCIL AND JOINT INTERIM COMMITTEE


**DEPARTMENT/AGENCY** Department of Human Services

**DIVISION** Division of Medical Services

**DIVISION DIRECTOR** Andrew Allison, PhD

**CONTACT PERSON** Glenda Higgs

**ADDRESS** P.O. Box 1437, Slot S295, Little Rock, AR 72203-1437

**PHONE NO.** 501-320-6425 **FAX NO.** 501-682-2480 **E-MAIL** glenda.higgs@arkansas.gov

**NAME OF PRESENTER AT COMMITTEE MEETING** Marilyn Strickland

**PRESENTER E-MAIL** marilyn.strickland@arkansas.gov


## INSTRUCTIONS

**A. Please make copies of this form for future use.**
**B. Please answer each question completely using layman terms. You may use additional sheets, if necessary.**
**C. If you have a method of indexing your rules, please give the proposed citation after "Short Title of this Rule" below.**
**D. Submit two (2) copies of this questionnaire and financial impact statement attached to the front of two (2) copies of the proposed rule and required documents. Mail or deliver to:**

**Donna K. Davis**
**Administrative Rules Review Section**
**Arkansas Legislative Council**
**Bureau of Legislative Research**
**One Capitol Mall, 5th Floor**
**Little Rock, AR 72201**

**********

1. What is the short title of this rule? Eligibility

2. What is the subject of the proposed rule? To incorporate into the Medicaid State Plan eligibility for certain existing categories and new group of eligibles using the Medicaid Modified Adjusted Gross Income (MAGI) methodology effective January 1, 2014. Also, establishes the new mandatory group in accordance with Federal law.

3. Is this rule required to comply with a federal statute, rule, or regulation? Yes ☒ No ☐

If yes, please provide the federal rule, regulation, and/or statute citation. 42 CFR 431.10; Social Security Act 1902(e)(14); and 42 CFR 435.603

4. Was this rule filed under the emergency provisions of the Administrative Procedure Act? Yes ☒ No ☐

If yes, what is the effective date of the emergency rule? October 1, 2013. It is necessary to expedite the filing of these rules to ensure that the Federally Facilitated Marketplace can meet the federal

obligation of performing certain functions necessary to make correct eligibility determinations starting October 1, 2013 for individuals eligible for coverage beginning January 1, 2014 as required by Federal law.

When does the emergency rule expire? January 24, 2014

Will this emergency rule be promulgated under the permanent provisions of the Administrative Procedure Act? Yes ☒ No ☐

5. Is this a new rule? Yes ☒ No ☐
If yes, please provide a brief summary explaining the regulation. ____

Does this repeal an existing rule? Yes ☐ No ☒
If yes, a copy of the repealed rule is to be included with your completed questionnaire. If it is being replaced with a new rule, please provide a summary of the rule giving an explanation of what the rule does. ____

Is this an amendment to an existing rule? Yes ☐ No ☒
If yes, please attach a mark-up showing the changes in the existing rule and a summary of the substantive changes. **Note: The summary should explain what the amendment does, and the mark-up copy should be clearly labeled "mark-up."**

6. Cite the state law that grants the authority for this proposed rule? If codified, please give the Arkansas Code citation. Arkansas Statute 20-76-401

7. What is the purpose of this proposed rule? Why is it necessary? To develop the Medicaid State Plan amendment for determining eligibility for certain existing categories and new group of eligibles using the Medicaid Modified Adjusted Gross Income (MAGI) methodology effective January 1, 2014. Also establishing the new mandatory groups in accordance with Federal law.

8. Please provide the address where this rule is publicly accessible in electronic form via the Internet as required by Arkansas Code § 25-19-108(b).
https://www.medicaid.state.ar.us/InternetSolution/general/comment/comment.aspx

9. Will a public hearing be held on this proposed rule? Yes ☒ No ☐
If yes, please complete the following:
Date: TBD
Time: TBD
Place: TBD

10. When does the public comment period expire for permanent promulgation? (Must provide a date.)

November 5, 2014

11. What is the proposed effective date of this proposed rule? (Must provide a date.)
The rules will be implemented on October 1, 2013 to make eligibility determinations that will be effective January 1, 2014.

12. Do you expect this rule to be controversial? Yes ☒ No ☐
If yes, please explain. These rules are being implemented as required by Federal law which has been the subject of much debate.

13. Please give the names of persons, groups, or organizations that you expect to comment on these rules? Please provide their position (for or against) if known.

## FINANCIAL IMPACT STATEMENT

### PLEASE ANSWER ALL QUESTIONS COMPLETELY

**DEPARTMENT** Department of Human Services
**DIVISION** Division of Medical Services
**PERSON COMPLETING THIS STATEMENT** Thomas Carlisle
**TELEPHONE NO.** 682-0422 **FAX NO.** (501)682-2480 **EMAIL:** thomas.carlisle@arkansas.gov

To comply with Ark. Code Ann. § 25-15-204(e), please complete the following Financial Impact Statement and file two copies with the questionnaire and proposed rules.

**SHORT TITLE OF THIS RULE** Eligibility

1. Does this proposed, amended, or repealed rule have a financial impact? Yes ☒ No ☐
2. Is the rule based on the best reasonably obtainable scientific, technical, economic, or other evidence and information available concerning the need for, consequences of, and alternatives to the rule? Yes ☒ No ☐
3. In consideration of the alternatives to this rule, was this rule determined by the agency to be the least costly rule considered? Yes ☒ No ☐

   If an agency is proposing a more costly rule, please state the following:

   (a) How the additional benefits of the more costly rule justify its additional cost;

   (b) The reason for adoption of the more costly rule;

   (c) Whether the more costly rule is based on the interests of public health, safety, or welfare, and if so, please explain; and;

   (d) Whether the reason is within the scope of the agency's statutory authority; and if so, please explain.

4. If the purpose of this rule is to implement a federal rule or regulation, please state the following:

   (a) What is the cost to implement the federal rule or regulation?

| **Current Fiscal Year** | | **Next Fiscal Year** | |
|---|---|---|---|
| General Revenue | $2,620,000 | General Revenue | $11,217,000 |
| Federal Funds | $8,440,000 | Federal Funds | $37,505,000 |
| Cash Funds | | Cash Funds | |
| Special Revenue | | Special Revenue | |
| Other (Identify) | | Other (Identify) | |

| | | | |
|---|---|---|---|
| Total | $11,060,000 | Total | $48,722,000 |

(b) What is the additional cost of the state rule?

| Current Fiscal Year | | Next Fiscal Year | |
|---|---|---|---|
| General Revenue | | General Revenue | |
| Federal Funds | | Federal Funds | |
| Cash Funds | | Cash Funds | |
| Special Revenue | | Special Revenue | |
| Other (Identify) | | Other (Identify) | |
| Total | | Total | |

5. What is the total estimated cost by fiscal year to any private individual, entity and business subject to the proposed, amended, or repealed rule? Identify the entity(ies) subject to the proposed rule and explain how they are affected.

| Current Fiscal Year | Next Fiscal Year |
|---|---|
| $ 0 | $ 0 |

Implementation of new mandatory group in accordance with Federal law will have a positive impact on the State's Medicaid providers through additional medical services payments for covered beneficiaries.

6. What is the total estimated cost by fiscal year to state, county, and municipal government to implement this rule? Is this the cost of the program or grant? Please explain how the government is affected.

| Current Fiscal Year | Next Fiscal Year |
|---|---|
| $ 2,620,000 | $ 11,217,000 |

7. With respect to the agency's answers to Questions #5 and #6 above, is there a new or increased cost or obligation of at least one hundred thousand dollars ($100,000) per year to a private individual, private entity, private business, state government, county government, municipal government, or to two (2) or more of those entities combined?

Yes ☒ No ☐

If YES, the agency is required by Ark. Code Ann. § 25-15-204(e)(4) to file written findings at the time of filing the financial impact statement. The written findings shall be filed simultaneously with the financial impact statement and shall include, without limitation, the following:

(1) a statement of the rule's basis and purpose;

(2) the problem the agency seeks to address with the proposed rule, including a statement of whether a rule is required by statute;

(3) a description of the factual evidence that:

(a) justifies the agency's need for the proposed rule; and
(b) describes how the benefits of the rule meet the relevant statutory objectives and justify the rule's costs;

(4) a list of less costly alternatives to the proposed rule and the reasons why the alternatives do not adequately address the problem to be solved by the proposed rule;

(5) a list of alternatives to the proposed rule that were suggested as a result of public comment and the reasons why the alternatives do not adequately address the problem to be solved by the proposed rule;

(6) a statement of whether existing rules have created or contributed to the problem the agency seeks to address with the proposed rule and, if existing rules have created or contributed to the problem, an explanation of why amendment or repeal of the rule creating or contributing to the problem is not a sufficient response; and

(7) an agency plan for review of the rule no less than every ten (10) years to determine whether, based upon the evidence, there remains a need for the rule including, without limitation, whether:
(a) the rule is achieving the statutory objectives;
(b) the benefits of the rule continue to justify its costs; and
(c) the rule can be amended or repealed to reduce costs while continuing to achieve the statutory objectives.

## Summary of Changes

The Medicaid State Plan has been revised for determining eligibility for certain existing categories and new group of eligibles using the Medicaid Modified Adjusted Gross Income (MAGI) methodology effective January 1, 2014. Also establishes the new mandatory groups in accordance with Federal law.

# Medicaid Eligibility

OMB Control Number 0938-1148
OMB Expiration date: 10/31/2014

## MAGI-Based Income Methodologies — S10

1902(e)(14)
42 CFR 435.603

☑ The state will apply Modified Adjusted Gross Income (MAGI)-based methodologies as described below, and consistent with 42 CFR 435.603.

In the case of determining ongoing eligibility for beneficiaries determined eligible for Medicaid on or before December 31, 2013, MAGI-based income methodologies will not be applied until March 31, 2014, or the next regularly-scheduled renewal of eligibility, whichever is later, if application of such methods results in a determination of ineligibility prior to such date.

In determining family size for the eligibility determination of a pregnant woman, she is counted as herself plus each of the children she is expected to deliver.

In determining family size for the eligibility determination of the other individuals in a household that includes a pregnant woman:

- ○ The pregnant woman is counted just as herself.
- ○ The pregnant woman is counted as herself, plus one.
- ◉ The pregnant woman is counted as herself, plus the number of children she is expected to deliver.

Financial eligibility is determined consistent with the following provisions:

When determining eligibility for new applicants, financial eligibility is based on current monthly income and family size.

When determining eligibility for current beneficiaries, financial eligibility is based on:

- ◉ Current monthly household income and family size
- ○ Projected annual household income and family size for the remaining months of the current calendar year

In determining current monthly or projected annual household income, the state will use reasonable methods to:

- ☐ Include a prorated portion of a reasonably predictable increase in future income and/or family size.
- ☐ Account for a reasonably predictable decrease in future income and/or family size.

Except as provided at 42 CFR 435.603(d)(2) through (d)(4), household income is the sum of the MAGI-based income of every individual included in the individual's household.

In determining eligibility for Medicaid, an amount equivalent to 5 percentage points of the FPL for the applicable family size will be deducted from household income in accordance with 42 CFR 435.603(d).

Household income includes actually available cash support, exceeding nominal amounts, provided by the person claiming an individual described at §435.603(f)(2)(i) as a tax dependent.

○ Yes ◉ No

# Medicaid Eligibility

☑ The age used for children with respect to 42 CFR 435.603(f)(3)(iv) is:

◉ Age 19

○ Age 19, or in the case of full-time students, age 21

## PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 40 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

# Medicaid Eligibility

OMB Control Number 0938-1148
OMB Expiration date: 10/31/2014

## AFDC Income Standards — S14

Enter the AFDC Standards below. All states must enter:

MAGI-equivalent AFDC Payment Standard in Effect As of May 1, 1988 and
AFDC Payment Standard in Effect As of July 16, 1996

Entry of other standards is optional.

### MAGI-equivalent AFDC Payment Standard in Effect As of May 1, 1988

#### Income Standard Entry - Dollar Amount - Automatic Increase Option — S13a

The standard is as follows:

- (•) Statewide standard
- ( ) Standard varies by region
- ( ) Standard varies by living arrangement
- ( ) Standard varies in some other way

The dollar amounts increase automatically each year

( ) Yes (•) No

### AFDC Payment Standard in Effect As of July 16, 1996

#### Income Standard Entry - Dollar Amount - Automatic Increase Option — S13a

The standard is as follows:

- (•) Statewide standard
- ( ) Standard varies by region
- ( ) Standard varies by living arrangement
- ( ) Standard varies in some other way

The dollar amounts increase automatically each year

( ) Yes (•) No

### Payment Standard

#### Income Standard Entry - Dollar Amount - Automatic Increase Option — S13a

The standard is as follows:

- ○ Statewide standard
- ○ Standard varies by region
- ○ Standard varies by living arrangement
- ○ Standard varies in some other way

The dollar amounts increase automatically each year

○ Yes ○ No

## AEDC Need Standard in Effect As of July 16, 1996

### Income Standard Entry - Dollar Amount - Automatic Increase Option S13a

The standard is as follows:

- ○ Statewide standard
- ○ Standard varies by region
- ○ Standard varies by living arrangement
- ○ Standard varies in some other way

The dollar amounts increase automatically each year

○ Yes ○ No

### Income Standard Entry - Dollar Amount - Automatic Increase Option S13b

The standard is as follows:

- ○ Statewide standard
- ○ Standard varies by region
- ○ Standard varies by living arrangement
- ○ Standard varies in some other way

The dollar amounts increase automatically each year

○ Yes ○ No

# Medicaid Eligibility

**MAGI-equivalent AFDC Payment Standard in Effect As of July 16, 1996, increased by no more than the percentage increase in the Consumer Price Index for urban consumers (CPI-U) since such date**

**Income Standard Entry - Dollar Amount + Automatic Increase Option** S13a

The standard is as follows:

- ○ Statewide standard
- ○ Standard varies by region
- ○ Standard varies by living arrangement
- ○ Standard varies in some other way

The dollar amounts increase automatically each year

○ Yes ○ No

**TANF payment standard**

**Income Standard Entry - Dollar Amount - Automatic Increase Option** S13a

The standard is as follows:

- ○ Statewide standard
- ○ Standard varies by region
- ○ Standard varies by living arrangement
- ○ Standard varies in some other way

The dollar amounts increase automatically each year

○ Yes ○ No

**MAGI-equivalent TANF payment standard**

**Automatic Increase Option** S13a

The standard is as follows:

- ○ Statewide standard
- ○ Standard varies by region
- ○ Standard varies by living arrangement
- ○ Standard varies in some other way

# Medicaid Eligibility

The dollar amounts increase automatically each year

○ Yes ○ No

## PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 40 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

# Medicaid Eligibility

OMB Control Number 0938-1148
OMB Expiration date: 10/31/2014

| Presumptive Eligibility by Hospitals | S21 |
|---|---|
| 42 CFR 435.1110 | |
| One or more qualified hospitals are determining presumptive eligibility under 42 CFR 435.1110, and the state is providing Medicaid coverage for individuals determined presumptively eligible under this provision.<br>○ Yes ◉ No | |

## PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 40 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

# Medicaid Eligibility

OMB Control Number 0938-1148
OMB Expiration date: 10/31/2014

## Eligibility Groups - Mandatory Coverage
## Parents and Other Caretaker Relatives

S25

42 CFR 435.110
1902(a)(10)(A)(i)(I)
1931(b) and (d)

☒ **Parents and Other Caretaker Relatives** - Parents and other caretaker relatives of dependent children with household income at or below a standard established by the state.

☑ The state attests that it operates this eligibility group in accordance with the following provisions:

☒ Individuals qualifying under this eligibility group must meet the following criteria:

☒ Are parents or other caretaker relatives (defined at 42 CFR 435.4), including pregnant women, of dependent children (defined at 42 CFR 435.4) under age 18. Spouses of parents and other caretaker relatives are also included.

The state elects the following options:

☐ This eligibility group includes individuals who are parents or other caretakers of children who are 18 years old, provided the children are full-time students in a secondary school or the equivalent level of vocational or technical training.

☐ Options relating to the definition of caretaker relative (select any that apply):

☒ Options relating to the definition of dependent child (select the one that applies):

◉ The state elects to eliminate the requirement that a dependent child must be deprived of parental support or care by reason of the death, physical or mental incapacity, or absence from the home or unemployment of at least one parent.

○ The child must be deprived of parental support or care, but a less restrictive standard is used to measure unemployment of the parent (select the one that applies):

☒ Have household income at or below the standard established by the state.

☒ MAGI-based income methodologies are used in calculating household income. Please refer as necessary to S10 MAGI-Based Income Methodologies, completed by the state.

☒ Income standard used for this group

☒ Minimum income standard

The minimum income standard used for this group is the state's AFDC payment standard in effect as of May 1, 1988, converted to MAGI-equivalent amounts by household size. The standard is described in S14 AFDC Income Standards.

☑ The state certifies that it has submitted and received approval for its converted May 1, 1988 AFDC payment standard.

An attachment is submitted.

☒ Maximum income standard

# Medicaid Eligibility

☑ The state certifies that it has submitted and received approval for its converted income standard(s) for parents and other caretaker relatives to MAGI-equivalent standards and the determination of the maximum income standard to be used for parents and other caretaker relatives under this eligibility group.

**An attachment is submitted.**

The state's maximum income standard for this eligibility group is:

◉ The state's effective income level for section 1931 families under the Medicaid state plan as of March 23, 2010, converted to a MAGI-equivalent percent of FPL or amounts by household size.

○ The state's effective income level for section 1931 families under the Medicaid state plan as of December 31, 2013, converted to a MAGI-equivalent percent of FPL or amounts by household size.

○ The state's effective income level for any population of parents/caretaker relatives under a Medicaid 1115 demonstration as of March 23, 2010, converted to a MAGI-equivalent percent of FPL or amounts by household size.

○ The state's effective income level for any population of parents/caretaker relatives under a Medicaid 1115 demonstration as of December 31, 2013, converted to a MAGI-equivalent percent of FPL or amounts by household size.

Enter the amount of the maximum income standard:

○ A percentage of the federal poverty level: [ ] %

◉ The state's AFDC payment standard in effect as of July 16, 1996, converted to a MAGI-equivalent standard. The standard is described in S14 AFDC Income Standards.

○ The state's AFDC payment standard in effect as of July 16, 1996, increased by no more than the percentage increase in the Consumer Price Index for urban consumers (CPI-U) since such date, converted to a MAGI-equivalent standard. The standard is described in S14 AFDC Income Standards.

○ The state's TANF payment standard, converted to a MAGI-equivalent standard. The standard is described in S14 AFDC Income Standards.

○ Other dollar amount

■ Income standard chosen:

Indicate the state's income standard used for this eligibility group:

○ The minimum income standard

◉ The maximum income standard

○ The state's AFDC payment standard in effect as of July 16, 1996, increased by no more than the percentage increase in the Consumer Price Index for urban consumers (CPI-U) since such date. The standard is described in S14 AFDC Income Standards.

○ Another income standard in-between the minimum and maximum standards allowed

■ There is no resource test for this eligibility group.

■ Presumptive Eligibility

# Medicaid Eligibility

The state covers individuals under this group when determined presumptively eligible by a qualified entity. The state assures it also covers individuals under the Pregnant Women (42 CFR 435.116) and/or Infants and Children under Age 19 (42 CFR 435.118) eligibility groups when determined presumptively eligible.

○ Yes ◉ No

## PRA Disclosure Statement

AR: converted thresholds
Date: June 25, 2013

| Population/Type | Citation | Unit Size | Original Standard |
|---|---|---|---|
| Family 1988 | AFDC 5/1/1988 | 1 | $81 |
| | | 2 | $162 |
| | | 3 | $202 |
| | | 4 | $238 |
| | | 5 | $271 |
| | | 6 | $302 |
| | | 7 | $329 |
| | | 8 | $354 |
| | | 9 | $376 |
| | | 10 | $376 |
| | | addon | N/A |
| Family 1996 | AFDC 7/16/1996 | 1 | $81 |
| | | 2 | $162 |
| | | 3 | $204 |
| | | 4 | $247 |
| | | 5 | $286 |
| | | 6 | $331 |
| | | 7 | $373 |
| | | 8 | $415 |
| | | 9 | $457 |
| | | 10 | $457 |
| | | addon | N/A |
| Pregnant women | 1902(a)(10)(A)(i)(IV) | | 200% FPL |
| Children 0-5 | 1902(a)(10)(A)(i) | | 133% FPL |
| Children 6-18 | 1902(a)(10)(A)(i)(VII) | | 100% FPL |
| Child 14-18 Pre-CHIP | 1902(a)(10)(A)(i)(VII) | | 18% FPL |

| | | | |
|---|---|---|---|
| Uninsured Children 0-18 | M-CHIP children 1115 Demonstration | | 200% FPL |
| Childless 19-64 | 1115 Demonstration | | 200% FPL |
| Uninsured employed parents/caretakers 19-6 | S-CHIP 1115 Demonstration | | 200% FPL |
| Family Planning | Family Planning 1115 Demonstration | | 200% FPL |

# Medicaid Eligibility

OMB Control Number 0938-1148
OMB Expiration date: 10/31/2014

## Eligibility Groups - Mandatory Coverage
## Pregnant Women

S28

42 CFR 435.116
1902(a)(10)(A)(i)(III) and (IV)
1902(a)(10)(A)(ii)(I), (IV) and (IX)
1931(b) and (d)
1920

☒ **Pregnant Women** - Women who are pregnant or post-partum, with household income at or below a standard established by the state.

☑ The state attests that it operates this eligibility group in accordance with the following provisions:

☒ Individuals qualifying under this eligibility group must be pregnant or post-partum, as defined in 42 CFR 435.4.

Pregnant women in the last trimester of their pregnancy without dependent children are eligible for full benefits under this group in accordance with section 1931 of the Act, if they meet the income standard for state plan Parents and Other Caretaker Relatives at 42 CFR 435.110.

◉ Yes ○ No

☒ MAGI-based income methodologies are used in calculating household income. Please refer as necessary to S10 MAGI-Based Income Methodologies, completed by the state.

☒ Income standard used for this group

☒ Minimum income standard (Once entered and approved by CMS, the minimum income standard cannot be changed.)

The state had an income standard higher than 133% FPL established as of December 19, 1989 for determining eligibility for pregnant women, or as of July 1, 1989, had authorizing legislation to do so.

○ Yes ◉ No

The minimum income standard for this eligibility group is 133% FPL.

☒ Maximum income standard

☑ The state certifies that it has submitted and received approval for its converted income standard(s) for pregnant women to MAGI-equivalent standards and the determination of the maximum income standard to be used for pregnant women under this eligibility group.

An attachment is submitted.

The state's maximum income standard for this eligibility group is:

◉ The state's highest effective income level for coverage of pregnant women under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified pregnant women), 1902(a)(10)(A)(i)(IV) (mandatory poverty level-related pregnant women), 1902(a)(10)(A)(ii)(IX) (optional poverty level-related pregnant women), 1902(a)(10)(A)(ii)(I) (pregnant women who meet AFDC financial eligibility criteria) and 1902(a)(10)(A)(ii)(IV) (institutionalized pregnant women) in effect under the Medicaid state plan as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.

# Medicaid Eligibility

○ The state's highest effective income level for coverage of pregnant women under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified pregnant women), 1902(a)(10)(A)(i)(IV) (mandatory poverty level-related pregnant women), 1902(a)(10)(A)(ii)(IX) (optional poverty level-related pregnant women), 1902(a)(10)(A)(ii)(I) (pregnant women who meet AFDC financial eligibility criteria) and 1902(a)(10)(A)(ii)(IV) (institutionalized pregnant women) in effect under the Medicaid state plan as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.

○ The state's effective income level for any population of pregnant women under a Medicaid 1115 demonstration as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.

○ The state's effective income level for any population of pregnant women under a Medicaid 1115 demonstration as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.

○ 185% FPL

The amount of the maximum income standard is: 209 % FPL

■ Income standard chosen

Indicate the state's income standard used for this eligibility group:

○ The minimum income standard

◉ The maximum income standard

○ Another income standard in-between the minimum and maximum standards allowed.

■ There is no resource test for this eligibility group.

■ Benefits for individuals in this eligibility group consist of the following:

○ All pregnant women eligible under this group receive full Medicaid coverage under this state plan.

◉ Pregnant women whose income exceeds the income limit specified below for full coverage of pregnant women receive only pregnancy-related services.

Pregnancy-related services, as defined at 42 CFR 440.210 (a)(2), include prenatal, delivery, postpartum and family planning services, as well as services related to conditions which may complicate pregnancy.

Full Medicaid coverage is provided only for pregnant women with income at or below the income limit described below:

■ Minimum income limit for full Medicaid coverage

The minimum income standard used for full coverage under this group is the state's AFDC payment standard in effect as of May 1, 1988, converted to MAGI-equivalent amounts by household size. The standard is described in S14 AFDC Income Standards.

☑ The state certifies that it has submitted and received approval for its converted May 1, 1988 AFDC payment standard.

An attachment is submitted.

■ Maximum income limit for full Medicaid coverage

# Medicaid Eligibility

○ The highest effective income level for coverage under section 1902(a)(10)(A)(i)(III) (qualified pregnant women) or section 1931(b) and (d) (low-income families) in effect under the Medicaid state plan as of March 23, 2010, converted to a MAGI-equivalent standard.

○ The highest effective income level for coverage under section 1902(a)(10)(A)(i)(III) (qualified pregnant women) or section 1931(b) and (d) (low-income families) in effect under the Medicaid state plan as of December 31, 2013, converted to a MAGI-equivalent standard.

○ The state's effective income level for any population of pregnant women under a Medicaid 1115 demonstration as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.

○ The state's effective income level for any population of pregnant women under a Medicaid 1115 demonstration as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.

The amount of the maximum income limit for full Medicaid coverage is:

○ A percentage of the federal poverty level: [ ] %

◉ A dollar amount

**Income Standard Entry - Dollar Amount - Automatic Increase Option** S13a

The standard is as follows:

◉ Statewide standard

○ Standard varies by region

○ Standard varies by living arrangement

○ Standard varies in some other way

Enter the statewide standard

# Medicaid Eligibility

| | Household size | Standard ($) | |
|---|---|---|---|
| + | 1 | 124 | X |
| + | 2 | 220 | X |
| + | 3 | 276 | X |
| + | 4 | 334 | X |
| + | 5 | 388 | X |
| + | 6 | 448 | X |
| + | 7 | 505 | X |
| + | 8 | 551 | X |
| + | 9 | 618 | X |
| + | 10 | 618 | X |

Additional incremental amount

○ Yes ◉ No

Increment amount $

The dollar amounts increase automatically each year

○ Yes ◉ No

☑ Income limit chosen for full Medicaid coverage:

○ The minimum income limit

◉ The maximum income limit

○ Another income limit in-between the minimum and maximum standards allowed.

☑ Presumptive Eligibility

The state covers ambulatory prenatal care for individuals under this group when determined presumptively eligible by a qualified entity.

○ Yes ◉ No

## PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 40 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

# Medicaid Eligibility

OMB Control Number 0938-1148
OMB Expiration date: 10/31/2014

## Eligibility Groups - Mandatory Coverage
## Infants and Children under Age 19

S30

42 CFR 435.118
1902(a)(10)(A)(i)(III), (IV), (VI) and (VII)
1902(a)(10)(A)(ii)(IV) and (IX)
1931(b) and (d)

☐ **Infants and Children under Age 19** - Infants and children under age 19 with household income at or below standards established by the state based on age group.

☑ The state attests that it operates this eligibility group in accordance with the following provisions:

☐ Children qualifying under this eligibility group must meet the following criteria:

☐ Are under age 19

☐ Have household income at or below the standard established by the state.

☐ MAGI-based income methodologies are used in calculating household income. Please refer as necessary to S10 MAGI-Based Income Methodologies, completed by the state.

☐ Income standard used for infants under age one

☐ Minimum income standard

The state had an income standard higher than 133% FPL established as of December 19, 1989 for determining eligibility for infants under age one, or as of July 1, 1989, had authorizing legislation to do so.

○ Yes ◉ No

The minimum income standard for infants under age one is 133% FPL.

☐ Maximum income standard

☑ The state certifies that it has submitted and received approval for its converted income standard(s) for infants under age one to MAGI-equivalent standards and the determination of the maximum income standard to be used for infants under age one.

An attachment is submitted.

The state's maximum income standard for this age group is:

◉ The state's highest effective income level for coverage of infants under age one under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified children), 1902(a)(10)(A)(i)(IV) (mandatory poverty level-related infants), 1902(a)(10)(A)(ii)(IX) (optional poverty level-related infants) and 1902(a)(10)(A)(ii)(IV) (institutionalized children), in effect under the Medicaid state plan as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.

# Medicaid Eligibility

○ The state's highest effective income level for coverage of infants under age one under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified children), 1902(a)(10)(A)(i)(IV) (mandatory poverty level-related infants), 1902(a)(10)(A)(ii)(IX) (optional poverty level-related infants) and 1902(a)(10)(A)(ii)(IV) (institutionalized children), in effect under the Medicaid state plan as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.

○ The state's effective income level for any population of infants under age one under a Medicaid 1115 demonstration as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.

○ The state's effective income level for any population of infants under age one under a Medicaid 1115 demonstration as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.

○ 185% FPL

Enter the amount of the maximum income standard: [ ] % FPL

■ Income standard chosen

The state's income standard used for infants under age one is:

◉ The maximum income standard

○ If not chosen as the maximum income standard, the state's highest effective income level for coverage of infants under age one under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified children), 1902(a)(10)(A)(i)(IV) (mandatory poverty level-related infants), 1902(a)(10)(A)(ii)(IX) (optional poverty level-related infants) and 1902(a)(10)(A)(ii)(IV) (institutionalized children), in effect under the Medicaid state plan as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.

○ If higher than the highest effective income level for this age group under the state plan as of March 23, 2010, and if not chosen as the maximum income standard, the state's highest effective income level for coverage of infants under age one under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified children), 1902(a)(10)(A)(i)(IV) (mandatory poverty level-related infants), 1902(a)(10)(A)(ii)(IX) (optional poverty level-related infants) and 1902(a)(10)(A)(ii)(IV) (institutionalized children), in effect under the Medicaid state plan as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.

○ If higher than the highest effective income level for this age group under the state plan as of March 23, 2010, and if not chosen as the maximum income standard, the state's effective income level for any population of infants under age one under a Medicaid 1115 demonstration as of March 23, 2010, converted to a percent of

○ If higher than the highest effective income level for this age group under the state plan as of March 23, 2010, and if not chosen as the maximum income standard, the state's effective income level for any population of infants under age one under a Medicaid 1115 demonstration as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.

○ Another income standard in-between the minimum and maximum standards allowed, provided it is higher than the effective income standard for this age group in the state plan as of March 23, 2010.

■ Income standard for children age one through age five, inclusive

■ Minimum income standard

# Medicaid Eligibility

The minimum income standard used for this age group is 133% FPL.

☑ Maximum income standard

☑ The state certifies that it has submitted and received approval for its converted income standard(s) for children age one through five to MAGI-equivalent standards and the determination of the maximum income standard to be used for children age one through five.

**An attachment is submitted.**

The state's maximum income standard for children age one through five is:

◉ The state's highest effective income level for coverage of children age one through five under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified children), 1902(a)(10)(A)(i)(VI) (mandatory poverty level-related children age one through five), and 1902(a)(10)(A)(ii)(IV) (institutionalized children), in effect under the Medicaid state plan as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.

○ The state's highest effective income level for coverage of children age one through five under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified children), 1902(a)(10)(A)(i)(VI) (mandatory poverty level-related children age one through five), and 1902(a)(10)(A)(ii)(IV) (institutionalized children), in effect under the Medicaid state plan as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.

○ The state's effective income level for any population of children age one through five under a Medicaid 1115 demonstration as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.

○ The state's effective income level for any population of children age one through five under a Medicaid 1115 demonstration as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.

Enter the amount of the maximum income standard: 142 % FPL

☑ Income standard chosen

The state's income standard used for children age one through five is:

◉ The maximum income standard

○ If not chosen as the maximum income standard, the state's highest effective income level for coverage of children age one through five under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified children), 1902(a)(10)(A)(i)(VI) (mandatory poverty level-related children age one through five), and 1902(a)(10)(A)(ii)(IV) (institutionalized children), in effect under the Medicaid state plan as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.

○ If higher than the highest effective income level for this age group under the state plan as of March 23, 2010, and if not chosen as the maximum income standard, the state's highest effective income level for coverage of children age one through five under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified children), 1902(a)(10)(A)(i)(VI) (mandatory poverty level-related children age one through five), and 1902(a)(10)(A)(ii)(IV) (institutionalized children), in effect under the Medicaid state plan as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.

# Medicaid Eligibility

○ If higher than the highest effective income level for this age group under the state plan as of March 23, 2010, and if not chosen as the maximum income standard, the state's effective income level for any population of children age one through five under a Medicaid 1115 demonstration as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.

○ If higher than the highest effective income level for this age group under the state plan as of March 23, 2010, and if not chosen as the maximum income standard, the state's effective income level for any population of children age one through five under a Medicaid 1115 demonstration as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.

○ Another income standard in-between the minimum and maximum standards allowed, provided it is higher than the effective income standard for this age group in the state plan as of March 23, 2010.

■ Income standard for children age six through age eighteen, inclusive

■ Minimum income standard

The minimum income standard used for this age group is 133% FPL.

■ Maximum income standard

☑ The state certifies that it has submitted and received approval for its converted income standard(s) for children age six through eighteen to MAGI-equivalent standards and the determination of the maximum income standard to be used for children age six through age eighteen.

An attachment is submitted.

The state's maximum income standard for children age six through eighteen is:

○ The state's highest effective income level for coverage of children age six through eighteen under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified children), 1902(a)(10)(A)(i)(VII) (mandatory poverty level-related children age six through eighteen) and 1902(a)(10)(A)(ii)(IV) (institutionalized children), in effect under the Medicaid state plan as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.

○ The state's highest effective income level for coverage of children age six through eighteen under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified children), 1902(a)(10)(A)(i)(VII) (mandatory poverty level-related children age six through eighteen) and 1902(a)(10)(A)(ii)(IV) (institutionalized children), in effect under the Medicaid state plan as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.

○ The state's effective income level for any population of children age six through eighteen under a Medicaid 1115 demonstration as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.

○ The state's effective income level for any population of children age six through eighteen under a Medicaid 1115 demonstration as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.

◉ 133% FPL

■ Income standard chosen

The state's income standard used for children age six through eighteen is:

# Medicaid Eligibility

(●) The maximum income standard

( ) If not chosen as the maximum income standard, the state's highest effective income level for coverage of children age six through eighteen under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified children), 1902(a)(10)(A)(i)(VII) (mandatory poverty level-related children age six through eighteen) and 1902(a)(10)(A)(ii)(IV) (institutionalized children), in effect under the Medicaid state plan as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.

( ) If higher than the highest effective income level for this age group under the state plan as of March 23, 2010, and if not chosen as the maximum income standard, the state's highest effective income level for coverage of children age six through eighteen under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified children), 1902(a)(10)(A)(i)(VII) (mandatory poverty level-related children age six through eighteen) and 1902(a)(10)(A)(ii)(IV) (institutionalized children), in effect under the Medicaid state plan as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.

( ) If higher than the highest effective income level for this age group under the state plan as of March 23, 2010, and if not chosen as the maximum income standard, the state's effective income level for any population of children age six through eighteen under a Medicaid 1115 demonstration as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.

( ) If higher than the highest effective income level for this age group under the state plan as of March 23, 2010, and if not chosen as the maximum income standard, the state's effective income level for any population of children age six through eighteen under a Medicaid 1115 demonstration as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.

( ) Another income standard in-between the minimum and maximum standards allowed, provided it is higher than the effective income standard for this age group in the state plan as of March 23, 2010.

[■] There is no resource test for this eligibility group.

[■] Presumptive Eligibility

The state covers children when determined presumptively eligible by a qualified entity.

( ) Yes (●) No

## PRA Disclosure Statement

# Medicaid Eligibility

OMB Control Number 0938-1148
OMB Expiration date: 10/31/2014

| Eligibility Groups - Mandatory Coverage<br>Former Foster Care Children | S33 |
|---|---|

42 CFR 435.150
1902(a)(10)(A)(i)(IX).

☑ **Former Foster Care Children** - Individuals under the age of 26, not otherwise mandatorily eligible, who were on Medicaid and in foster care when they turned age 18 or aged out of foster care.

☑ The state attests that it operates this eligibility group under the following provisions:

☑ Individuals qualifying under this eligibility group must meet the following criteria:

☑ Are under age 26.

☑ Are not otherwise eligible for and enrolled for mandatory coverage under the state plan, except that eligibility under this group takes precedence over eligibility under the Adult Group.

☑ Were in foster care under the responsibility of the state or Tribe and were enrolled in Medicaid under the state's state plan or 1115 demonstration when they turned 18 or at the time of aging out of that state's or Tribe's foster care program.

The state elects to cover children who were in foster care and on Medicaid in any state at the time they turned 18 or aged out of the foster care system.

○ Yes ◉ No

The state covers individuals under this group when determined presumptively eligible by a qualified entity. The state assures it also covers individuals under the Pregnant Women (42 CFR 435.116) and/or Infants and Children under Age 19 (42 CFR 435.118) eligibility groups when determined presumptively eligible.

○ Yes ◉ No

## PRA Disclosure Statement

# Medicaid Eligibility

OMB Control Number 0938-1148
OMB Expiration date: 10/31/2014

| Eligibility Groups - Options for Coverage<br>Individuals above 133% FPL | S50 |
|---|---|

1902(a)(10)(A)(ii)(XX)
1902(hh)
42 CFR 435.218

**Individuals above 133% FPL** - The state elects to cover individuals under 65, not otherwise mandatorily or optionally eligible, with income above 133% FPL and at or below a standard established by the state and in accordance with provisions described at 42 CFR 435.218.

○ Yes ◉ No

## PRA Disclosure Statement

# Medicaid Eligibility

OMB Control Number 0938-1148
OMB Expiration date: 10/31/2014

| Eligibility Groups - Options for Coverage<br>Optional Coverage of Parents and Other Caretaker Relatives | S51 |
|---|---|

42 CFR 435.220
1902(a)(10)(A)(ii)(I)

**Optional Coverage of Parents and Other Caretaker Relatives** - The state elects to cover individuals qualifying as parents or other caretaker relatives who are not mandatorily eligible and who have income at or below a standard established by the state and in accordance with provisions described at 42 CFR 435.220.

○ Yes ◉ No

## PRA Disclosure Statement

# Medicaid Eligibility

OMB Control Number 0938-1148
OMB Expiration date: 10/31/2014

| Eligibility Groups - Options for Coverage<br>Reasonable Classification of Individuals under Age 21 | S52 |
|---|---|

42 CFR 435.222
1902(a)(10)(A)(ii)(I)
1902(a)(10)(A)(ii)(IV)

**Reasonable Classification of Individuals under Age 21 -** The state elects to cover one or more reasonable classifications of individuals under age 21 who are not mandatorily eligible and who have income at or below a standard established by the state and in accordance with provisions described at 42 CFR 435.222.

○ Yes ◉ No

## PRA Disclosure Statement

# Medicaid Eligibility

OMB Control Number 0938-1148
OMB Expiration date: 10/31/2014

## Eligibility Groups - Options for Coverage
## Children with Non IV-E Adoption Assistance

S53

42 CFR 435.227
1902(a)(10)(A)(ii)(VIII)

**Children with Non IV-E Adoption Assistance** - The state elects to cover children with special needs for whom there is a non IV-E adoption assistance agreement in effect with a state, who were eligible for Medicaid, or who had income at or below a standard established by the state and in accordance with provisions described at 42 CFR 435.227.

(●) Yes ( ) No

☑ The state attests that it operates this eligibility group in accordance with the following provisions:

■ Individuals qualifying under this eligibility group must meet the following criteria:

■ The state adoption agency has determined that they cannot be placed without Medicaid coverage because of special needs for medical or rehabilitative care;

■ Are under the following age (see the Guidance for restrictions on the selection of an age):

(●) Under age 21
( ) Under age 20
( ) Under age 19
( ) Under age 18

■ MAGI-based income methodologies are used in calculating household income. Please refer as necessary to S10 MAGI-Based Income Methodologies, completed by the state.

The state covered this eligibility group in the Medicaid state plan as of December 31, 2013, or under a Medicaid 1115 Demonstration as of March 23, 2010 or December 31, 2013.

(●) Yes ( ) No

The state also covered this eligibility group in the Medicaid state plan as of March 23, 2010.

(●) Yes ( ) No

■ Individuals qualify under this eligibility group if they were eligible under the state's approved state plan prior to the execution of the adoption agreement.

The state used an income standard or disregarded all income for this eligibility group either in the Medicaid state plan as of March 23, 2010 or December 31, 2013, or under a Medicaid 1115 Demonstration as of March 23, 2010 or December 31, 2013.

(●) Yes ( ) No

■ Income standard used for this eligibility group

■ Minimum income standard

The minimum income standard for this eligibility group is the AFDC payment standard in effect as of July 16, 1996, not converted to MAGI-equivalent. This standard is described in S14 AFDC Income Standards.

■ Maximum income standard

# Medicaid Eligibility

No income test was used (all income was disregarded) for this eligibility group either in the Medicaid state plan as of March 23, 2010 or December 31, 2013, or under a Medicaid 1115 Demonstration as of March 23, 2010 or December 31, 2013.

(●) Yes ( ) No

[■] No income test was used (all income was disregarded) for this eligibility group under (check all that apply):

- [☒] The Medicaid state plan as of March 23, 2010.
- [ ] The Medicaid state plan as of December 31, 2013.
- [ ] A Medicaid 1115 Demonstration as of March 23, 2010.
- [ ] A Medicaid 1115 Demonstration as of December 31, 2013.

The state's maximum standard for this eligibility group is no income test (all income is disregarded).

[■] Income standard chosen

Individuals qualify under this eligibility group under the following income standard, which must be higher than the minimum for this child's age:

This eligibility group does not use an income test (all income is disregarded).

[■] There is no resource test for this eligibility group.

## PRA Disclosure Statement

# Medicaid Eligibility

OMB Control Number 0938-1148
OMB Expiration date: 10/31/2014

| Eligibility Groups - Options for Coverage<br>Optional Targeted Low Income Children | S54 |
|---|---|

1902(a)(10)(A)(ii)(XIV)
42 CFR 435.229 and 435.4
1905(u)(2)(B)

**Optional Targeted Low Income Children** - The state elects to cover uninsured children who meet the definition of optional targeted low income children at 42 CFR 435.4, who have household income at or below a standard established by the state and in accordance with provisions described at 42 CFR 435.229.

○ Yes ◉ No

# Medicaid Eligibility

OMB Control Number 0938-1148
OMB Expiration date: 10/31/2014

**Eligibility Groups - Options for Coverage**
**Independent Foster Care Adolescents** S57

42 CFR 435.226
1902(a)(10)(A)(ii)(XVII)

**Independent Foster Care Adolescents** - The state elects to cover individuals under an age specified by the state, less than age 21, who were in state-sponsored foster care on their 18th birthday and who meet the income standard established by the state and in accordance with the provisions described at 42 CFR 435.226.

○ Yes ◉ No

# Medicaid Eligibility

OMB Control Number 0938-1148
OMB Expiration date: 10/31/2014

## Non-Financial Eligibility
## State Residency

S88

42 CFR 435.403

**State Residency**

☑ The state provides Medicaid to otherwise eligible residents of the state, including residents who are absent from the state under certain conditions.

Individuals are considered to be residents of the state under the following conditions:

- ■ Non-institutionalized individuals age 21 and over, or under age 21, capable of indicating intent and who are emancipated or married, if the individual is living in the state and:
  - ■ Intends to reside in the state, including without a fixed address, or
  - ■ Entered the state with a job commitment or seeking employment, whether or not currently employed.
- ■ Individuals age 21 and over, not living in an institution, who are not capable of indicating intent, are residents of the state in which they live.
- ■ Non-institutionalized individuals under 21 not described above and non IV-E beneficiary children:
  - ■ Residing in the state, with or without a fixed address, or
  - ■ The state of residency of the parent or caretaker, in accordance with 42 CFR 435.403(h)(1), with whom the individual resides.
- ■ Individuals living in institutions, as defined in 42 CFR 435.1010, including foster care homes, who became incapable of indicating intent before age 21 and individuals under age 21 who are not emancipated or married:
  - ■ Regardless of which state the individual resides, if the parent or guardian applying for Medicaid on the individual's behalf resides in the state, or
  - ■ Regardless of which state the individual resides, if the parent or guardian resides in the state at the time of the individual's placement, or
  - ■ If the individual applying for Medicaid on the individual's behalf resides in the state and the parental rights of the institutionalized individual's parent(s) were terminated and no guardian has been appointed and the individual is institutionalized in the state.
- ■ Individuals living in institutions who became incapable of indicating intent at or after age 21, if physically present in the state, unless another state made the placement.
- ■ Individuals who have been placed in an out-of-state institution, including foster care homes, by an agency of the state.
- ■ Any other institutionalized individual age 21 or over when living in the state with the intent to reside there, and not placed in the institution by another state.
- ■ IV-E eligible children living in the state, or

# Medicaid Eligibility

☒ Otherwise meet the requirements of 42 CFR 435.403.

# Medicaid Eligibility

Meet the criteria specified in an interstate agreement.

○ Yes ◉ No

The state has a policy related to individuals in the state only to attend school.

○ Yes ◉ No

☒ Otherwise meet the criteria of resident, but who may be temporarily absent from the state.

The state has a definition of temporary absence, including treatment of individuals who attend school in another state.

○ Yes ◉ No

## PRA Disclosure Statement

# Medicaid Eligibility

OMB Control Number 0938-1148
OMB Expiration date: 10/31/2014

**Non-Financial Eligibility**
**Citizenship and Non-Citizen Eligibility** S89

1902(a)(46)(B)
8 U.S.C. 1611, 1612, 1613, and 1641
1903(v)(2),(3) and (4)
42 CFR 435.4
42 CFR 435.406
42 CFR 435.956

**Citizenship and Non-Citizen Eligibility**

☑ The state provides Medicaid to citizens and nationals of the United States and certain non-citizens consistent with requirements of 42 CFR 435.406, including during a reasonable opportunity period pending verification of their citizenship, national status or satisfactory immigration status.

■ The state provides Medicaid eligibility to otherwise eligible individuals:

■ Who are citizens or nationals of the United States; and

■ Who are qualified non-citizens as defined in section 431 of the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) (8 U.S.C. §1641), or whose eligibility is required by section 402(b) of PRWORA (8 U.S.C. §1612(b)) and is not prohibited by section 403 of PRWORA (8 U.S.C. §1613); and

■ Who have declared themselves to be citizens or nationals of the United States, or an individual having satisfactory immigration status, during a reasonable opportunity period pending verification of their citizenship, nationality or satisfactory immigration status consistent with requirements of 1903(x), 1137(d), 1902(ee) of the SSA and 42 CFR 435.406, and 956.

The reasonable opportunity period begins on and extends 90 days from the date the notice of reasonable opportunity is received by the individual.

The agency provides for an extension of the reasonable opportunity period if the individual is making a good faith effort to resolve any inconsistencies or obtain any necessary documentation, or the agency needs more time to complete the verification process.

◉ Yes ○ No

The agency begins to furnish benefits to otherwise eligible individuals during the reasonable opportunity period on a date earlier than the date the notice is received by the individual.

○ Yes ◉ No

The state provides Medicaid coverage to all Qualified Non-Citizens whose eligibility is not prohibited by section 403 of PRWORA (8 U.S.C. §1613).

◉ Yes ○ No

The state elects the option to provide Medicaid coverage to otherwise eligible individuals under 21 and pregnant women, lawfully residing in the United States, as provided in section 1903(v)(4) of the Act.

○ Yes ◉ No

# Medicaid Eligibility

☒ An individual is considered to be lawfully residing in the United States if he or she is lawfully present and otherwise meets the eligibility requirements in the state plan.

☒ An individual is considered to be lawfully present in the United States if he or she:

1. Is a qualified non-citizen as defined in 8 U.S.C. 1641(b) and (c);

2. Is a non-citizen in a valid nonimmigrant status, as defined in 8 U.S.C. 1101(a)(15) or otherwise under the immigration laws (as defined in 8 U.S.C. 1101(a)(17));

3. Is a non-citizen who has been paroled into the United States in accordance with 8 U.S.C. 1182(d)(5) for less than 1 year, except for an individual paroled for prosecution, for deferred inspection or pending removal proceedings;

4. Is a non-citizen who belongs to one of the following classes:

   ☒ Granted temporary resident status in accordance with 8 U.S.C. 1160 or 1255a, respectively;

   ☒ Granted Temporary Protected Status (TPS) in accordance with 8 U.S.C. §1254a, and individuals with pending applications for TPS who have been granted employment authorization;

   ☒ Granted employment authorization under 8 CFR 274a.12(c);

   ☒ Family Unity beneficiaries in accordance with section 301 of Pub. L. 101-649, as amended;

   ☒ Under Deferred Enforced Departure (DED) in accordance with a decision made by the President;

   ☒ Granted Deferred Action status;

   ☒ Granted an administrative stay of removal under 8 CFR 241;

   ☒ Beneficiary of approved visa petition who has a pending application for adjustment of status;

5. Is an individual with a pending application for asylum under 8 U.S.C. 1158, or for withholding of removal under 8 U.S.C.1231, or under the Convention Against Torture who -

   ☒ Has been granted employment authorization; or

   ☒ Is under the age of 14 and has had an application pending for at least 180 days;

6. Has been granted withholding of removal under the Convention Against Torture;

7. Is a child who has a pending application for Special Immigrant Juvenile status as described in 8 U.S.C. 1101(a)(27)(J);

8. Is lawfully present in American Samoa under the immigration laws of American Samoa; or

9. Is a victim of severe trafficking in persons, in accordance with the Victims of Trafficking and Violence Protection Act of 2000, Pub. L. 106-386, as amended (22 U.S.C. 7105(b));

10. Exception: An individual with deferred action under the Department of Homeland Security's deferred action for the childhood arrivals process, as described in the Secretary of Homeland Security's June 15, 2012 memorandum, shall not be considered to be lawfully present with respect to any of the above categories in paragraphs (1) through (9) of this definition.

☐ Other

# Medicaid Eligibility

☑ The state assures that it provides limited Medicaid services for treatment of an emergency medical condition, not related to an organ transplant procedure, as defined in 1903(v)(3) of the SSA and implemented at 42 CFR 440.255, to the following individuals who meet all Medicaid eligibility requirements, except documentation of citizenship or satisfactory immigration status and/or present an SSN:

- ■ Qualified non-citizens subject to the 5 year waiting period described in 8 U.S.C. 1613;
- ■ Non-qualified non-citizens, unless covered as a lawfully residing child or pregnant woman by the state under the option in accordance with 1903(v)(4) and implemented at 435.406(b).

## PRA Disclosure Statement

# Medicaid Eligibility

OMB Control Number 0938-1148
OMB Expiration date: 10/31/2014

**General Eligibility Requirements**
**Eligibility Process** S94

42 CFR 435, Subpart J and Subpart M

**Eligibility Process**

☑ The state meets all the requirements of 42 CFR 435, Subpart J for processing applications, determining and verifying eligibility, and furnishing Medicaid.

**Application Processing**

Indicate which application the agency uses for individuals applying for coverage who may be eligible based on the applicable modified adjusted gross income standard.

☒ The single, streamlined application for all insurance affordability programs, developed by the Secretary in accordance with section 1413(b)(1)(A) of the Affordable Care Act

☐ An alternative single, streamlined application developed by the state in accordance with section 1413(b)(1)(B) of the Affordable Care Act and approved by the Secretary, which may be no more burdensome than the streamlined application developed by the Secretary.

An attachment is submitted.

☐ An alternative application used to apply for multiple human service programs approved by the Secretary, provided that the agency makes readily available the single or alternative application used only for insurance affordability programs to individuals seeking assistance only through such programs.

An attachment is submitted.

Indicate which application the agency uses for individuals applying for coverage who may be eligible on a basis other than the applicable modified adjusted gross income standard:

☐ The single, streamlined application developed by the Secretary or one of the alternate forms developed by the state and approved by the Secretary, and supplemental forms to collect additional information needed to determine eligibility on such other basis, submitted to the Secretary.

An attachment is submitted.

☒ An application designed specifically to determine eligibility on a basis other than the applicable MAGI standard which minimizes the burden on applicants, submitted to the Secretary.

An attachment is submitted.

The agency's procedures permit an individual, or authorized person acting on behalf of the individual, to submit an application via the internet website described in 42 CFR 435.1200(f), by telephone, via mail, and in person.

The agency also accepts applications by other electronic means:

◉ Yes ○ No

# Medicaid Eligibility

Indicate the other electronic means below:

| | Name of Method | Description | |
|---|---|---|---|
| | On-line | www.access.arkansas.gov | X |

☑ The agency has procedures to take applications, assist applicants and perform initial processing of applications for the eligibility groups listed below at locations other than those used for the receipt and processing of applications for the title IV-A program, including Federally-qualified health centers and disproportionate share hospitals.

Parents and Other Caretaker Relatives

Pregnant Women

Infants and Children under Age 19

**Redetermination Processing**

☑ Redeterminations of eligibility for individuals whose financial eligibility is based on the applicable modified adjusted gross income standard are performed as follows, consistent with 42 CFR 435.916:

■ Once every 12 months

■ Without requiring information from the individual if able to do so based on reliable information contained in the individual's account or other more current information available to the agency

■ If the agency cannot determine eligibility solely on the basis of the information available to it, or otherwise needs additional information to complete the redetermination, it provides the individual with a pre-populated renewal form containing the information already available.

■ Redeterminations of eligibility for individuals whose financial eligibility is not based on the applicable modified adjusted gross income standard are performed, consistent with 42 CFR 435.916 (check all that apply):

☒ Once every 12 months

☐ Once every 6 months

☐ Other, more often than once every 12 months

**Coordination of Eligibility and Enrollment**

☑ The state meets all the requirements of 42 CFR 435, Subpart M relative to coordination of eligibility and enrollment between Medicaid, CHIP, Exchanges and other insurance affordability programs. The single state agency has entered into agreements with the Exchange and with other agencies administering insurance affordability programs.

## PRA Disclosure Statement

# Arkansas Department of Human Services
# Application for Health Coverage
# Single Adults

## Use this application to see what coverage you qualify for through DHS

- 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.

## Who can use this application?

Single adults who:

- Don't have any dependents and can't be claimed as a dependent on someone else's tax return.

**NOTE:** If any of the following apply, you need to fill out a form DCO-152 to make sure you get the most benefits possible:

- You're married or have dependent children.
- You were in the foster care system and you're under age 26.
- You have items that can be deducted from your income. If your only deduction is student loan interest, you **can** use this form.
- You're American Indian or Alaska Native.

## Apply faster online

Apply faster online at Access.Arkansas.gov.

## What you may need to apply

- Your Social Security number (or document number if you're a legal immigrant).
- Employer and income information (for example, from paystubs, W-2 forms, or wage and tax statements).

## Why do we ask for this information?

We ask about income and other information to let you know what coverage you qualify for and if you can get any 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 Access.Arkansas.gov

## What happens next?

Send your complete, signed application to the address on page 4. **If you don't have all the information we ask for, sign and submit your application anyway.**

## Get help with this application

- **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 ruestro centro de ayuda gratis al 1-855-372-1084.
- Text

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 representative the language you need. We'll get you help at no cost to you. TTY users should call **1-855-372-1084.**

# Step 1 Tell Us About Yourself

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 get information about this application by email? ☐ Yes ☐ No

Email address: _____

17. What is your preferred spoken or written language (if not English)?

| 18. Date of birth (mm/dd/yyyy) | 19. Sex ☐ Male ☐ Female |
|---|---|

20. Social Security number (SSN) ___ ___ ___ - ___ ___ - ___ ___ ___ ___

**We need this if you want health coverage and have an SSN.** We use SSNs to check income and other information to see if you're eligible for help with health coverage costs. If you need help getting an SSN, call 1-800-772-1213 or visit socialsecurity.gov, TTY users should call 1-800-325-0778.

21. Are you a U.S. citizen or U.S. national? ☐ Yes ☐ No

22. **If you aren't a U.S. citizen or U.S. national,** do you have eligible immigration status?

☐ Yes Fill in your document type and ID number below.

a. Immigration document type _____

b. Document ID number _____

c. Have you lived in the U.S. since 1996? ☐ Yes ☐ No

d. Are you a veteran or an active duty member of the U.S. Military? ☐ Yes ☐ No

23. Are you pregnant? ☐ Yes ☐ No

**If yes,** how many babies are expected during this pregnancy? _____

24. Do you have a physical, mental, or emotional health condition that causes limitations in activities (like bathing, dressing, daily chores, etc.) or live in a medical facility or nursing home? ☐ Yes ☐ No

25. **If Hispanic/Latino, ethnicity (OPTIONAL—check all that apply.)**

☐ Mexican ☐ Mexican American ☐ Chicano/a ☐ Puerto Rican ☐ Cuban ☐ Other _____

26. **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 _____ |

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 that English, call **1-855-372-1084** and tell the customer service representative the language you need. We'll get you the help at no cost to you. TTY users should call **1-855-372-1084.**

# Step 2 Current Job & Income Information

☐ **Employed** If you're currently employed, tell us about your income. Start with question 1.

☐ **Not Employed** – Skip to question 11. ☐ **Self Employed** – Skip to question 10.

## CURRENT JOB 1:

| 1. Employer name and address | 2. Employer phone number | 3. Average hours worked each week |
|---|---|---|
| | ( ) – | |

4. Wages/tips (before taxes) ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly

$ _____

## CURRENT JOB 2: If you have more jobs and need more space, attach another sheet of paper.

| 5. Employer name and address | 6. Employer phone number | 7. Average hours worked each week |
|---|---|---|
| | ( ) – | |

8. Wages/tips (before taxes) ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly

$ _____

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

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

a. Type of work

_____

b. How much net income (profits once business expenses are paid) will you get from this self-employment this month?

$ _____

11. **OTHER INCOME THIS MONTH:** Check all that apply, and give the amount and how often you get it.

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

☐ None

☐ Unemployment $ _____ How often? _____

☐ Pensions $ _____ How often? _____

☐ Social Security $ _____ How often? _____

☐ Retirement accounts $ _____ How often? _____

☐ Alimony received $ _____ How often? _____

☐ Net farming/fishing $ _____ How often? _____

☐ Other income $ _____ How often? _____

Type: _____

12. Do you pay student loan interest (not the amount of the loan) that can be deducted on a federal income tax return?

☐ YES. **If yes,** how much $ _____ How often? _____ ☐ NO.

13. **YEARLY INCOME:** Complete only if your income changes from month to month. If you don't expect changes to your monthly income, skip to Step 3.

| Your total income **this year** | Your total income **next year** (if you think it will be different) |
|---|---|
| $ | $ |

# Step 3 Your Health Coverage

1. **Are you enrolled in health coverage now from any of the following?**

☐ YES. **If yes,** check which coverage you have. ☐ NO.

☐ Medicaid (from another state)
☐ CHIP (from another state)
☐ Medicare
☐ TRICARE (Don't check if you have Direct Care or Line of Duty)
☐ Peace Corps
☐ VA health care programs
☐ Other

Name of health insurance

_____

Policy number

_____

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'll get you help at no cost to you. TTY users should call **1-855-372-1084**.

# Step 4 Read & Sign This Application

I'm signing this application under penalty of perjury, which means I've 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 the federal law if I intentionally provide false or untrue information.

- I know that I must tell the Department of Human Services 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 my eligibility.
- I know that under federal law, discrimination isn't 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 calling 1-501-682-6003.
- I confirm that I'm not incarcerated (detained or jailed).
- I confirm that next year I expect to file a federal income tax return, won't claim dependents on that return, and can't be claimed as a dependent on anyone else's federal income tax return.
- I understand that the Health Care Independence Program is not an entitlement program.

We need this information to check your eligibility for Medicaid, ARKids or the Health Care Independence Program if you choose to apply. We'll 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 doesn't match, we may ask you to send us proof.

**Renewal of coverage in future years**

To make it easier to determine my eligibility for Medicaid, ARKids or the Health Care Independence Program coverage in future years, I agree to allow the Department of Human Services to use income data, including information from tax returns. DHS will send me a notice, allow me to make any changes and I can opt out at any time.

Yes, renew 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 renew my coverage.

**If I'm eligible**

If I enroll in Medicaid, ARKids First, or the Health Care Independence Program, I'm giving the Department of Human Services my rights to pursue and get money from other health insurance, legal settlements, or other third parties.

**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 the Department of Human Services 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 an action by contacting DHS at 1-501-682-8622. I know that 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're an authorized representative, you may sign here as long as you have provided the information required in the DCO-153.

| Signature | Date (mm/dd/yyyy) |
|---|---|
| | |

# Step 5 Submit Completed Application

Mail your signed application to: **DHS Jefferson County**
**1222 West 6th Street**
**P.O. Box 5670**
**Pine Bluff, AR 71611**

**Or you can email** your signed application to: 351Jefferson@arkansas.gov

**Or you can fax** your signed 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 has been approved or denied and provide instructions on the next steps needed to complete your health coverage. 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.

If you want to register to vote, complete the Voter Registration packet that was given to you as a part of this application packet.

# Arkansas Department of Human Services
# Application for Health Coverage

| | |
|---|---|
| **Use this application to see what coverage you qualify for through DHS** | • Medicaid, ARKids First or the Health Care Independence Program<br>• 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.<br>• Apply even if you or your child already has health coverage. You could be eligible for lower cost or free coverage.<br>• 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.<br>• If someone is helping you fill out this application, you may need to complete a DCO-153, Consent for an Authorized Representative. |

| | |
|---|---|
| **Apply faster online** | Apply faster online at: Access.Arkansas.gov |

| | |
|---|---|
| **What you may need to apply** | • Your Social Security number (or document number if you are a legal immigrant)<br>• Employer and income information (for example: from paystubs, W-2 forms, or wage and tax statements)<br>• Information about any job related health insurance available to your family<br>• Policy numbers for any current health insurance |

| | |
|---|---|
| **Why do we ask for this 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 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. |

| | |
|---|---|
| **What happens next?** | Send your complete, signed application to the address on page 8. **If you do not have all the information we ask for, sign and submit your application anyway.** |

| | |
|---|---|
| **Get help with this application** | • **Phone:** Call our Help Center at **1-855-372-1084.**<br>• **In person:** Contact your local DHS county office for more information.<br>• **En Español:** Llame a nuestro centro de ayuda gratis al **1-855-372-1084.** |

## 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? ☐ Yes ☐ No<br>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 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 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. TTY users should call **1-855-372-1084.**

## 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 1 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. 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.** 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.

6. **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?_____

7. Are you pregnant? ☐ Yes ☐ No **If yes,** how many babies are you expecting during this pregnancy? _____

8. **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 to the income questions on page 3. Leave the rest of this page blank.

9. Do you have a physical, mental or emotional health condition that causes limitations in activities (like bathing, dressing, daily chores, etc.) or live in a medical facility or nursing home? ☐ Yes ☐ No

10. Are you a U.S. citizen or U.S. national? ☐ Yes ☐ No

11. **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:_____ b. Document ID number:_____
   c. Have you lived in the U.S. since 1996? ☐ Yes ☐ No d. Are you or your spouse or parent a veteran or an active duty member of the U.S. military? ☐ Yes ☐ No

12. Do you want help paying for medical bills from the last three months? ☐ Yes ☐ No

13. Do you live with at least one child under the age of 19 and are you the main person taking care of this child? ☐ Yes ☐ No

14. Are you a full time student? ☐ Yes ☐ No 15. Were you in foster care in Arkansas at age 18 or older? ☐ Yes ☐ No

16. **If Hispanic/Latino,** what is your ethnicity? **(OPTIONAL – Check all that apply.)**
☐ Mexican ☐ Mexican American ☐ Chicano/a ☐ Puerto Rican ☐ Cuban ☐ Other:_____

17. **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:_____

**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. TTY users should call **1-855-372-1084.**

## 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 18.

☐ **Not employed**
Skip to question 28.

☐ **Self-employed**
Skip to question 27.

### CURRENT JOB 1:

| 18. Employer Name and Address | 19. Employer Phone Number |
|---|---|
| 20. Wages/tips (before taxes) $ _____ ☐ Hourly ☐ Weekly ☐ Every 2 Weeks ☐ Twice a Month ☐ Monthly ☐ Yearly | |
| 21. Average hours worked each **week**: _____ | |

### 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) $ _____ ☐ Hourly ☐ Weekly ☐ Every 2 Weeks ☐ Twice a Month ☐ Monthly ☐ Yearly | |
| 25. Average hours worked each **week**: _____ | |

26. **In the past year, did you:** ☐ Change jobs? ☐ Stop working? ☐ 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
☐ Unemployment $ _____ How often? _____
☐ Pensions $ _____ How often? _____
☐ Net farming/fishing $ _____ How often? _____
☐ Net rental/royalty $ _____ How often? _____
☐ Social Security $ _____ How often? _____
☐ Alimony $ _____ How often? _____
☐ Retirement Accounts $ _____ How often? _____
☐ Other income $ _____ How often? _____ Type: _____

29. **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 27b).

☐ Alimony paid $ _____ How often? _____
☐ Student Loan interest $ _____ How often? _____
☐ Other Deductions $ _____ How often? _____ Type: _____

30. **YEARLY INCOME: Complete only if your income changes from month to month.**
**If you don't expect changes to your monthly income, skip to the next person.**

| Your total income this year: | Your total income **next** year (if you think it will be different): |
|---|---|
| $ _____ | $ _____ |

## 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 1 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 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? _____

8. Is PERSON 2 pregnant? ☐ Yes ☐ No **If yes**, how many babies are expected during this pregnancy? _____

9. **Does PERSON 2 need health coverage?**

☐ **YES If yes**, answer all the questions below. ☐ **NO If no**, SKIP to the income questions on page 5. Leave the rest of this page blank.

10. Does PERSON 2 have a physical, mental or emotional health condition that causes limitations in activities (like bathing, dressing, daily chores, etc.) or live in a medical facility or nursing home? ☐ Yes ☐ No

11. Is PERSON 2 a U.S. citizen or U.S. national? ☐ Yes ☐ No

12. **If PERSON 2 is not a U.S. citizen or U.S national**, do they have eligible immigration status?
☐ Yes Enter their document type and ID number below.
a. Immigration document type: _____ b. Document ID number: _____
c. Has PERSON 2 lived in the U.S. since 1996? ☐ Yes ☐ No d. Is PERSON 2 or their spouse or parent a veteran or an active duty member of the U.S. military? ☐ Yes ☐ No

| 13. Does PERSON 2 want help paying for medical bills from the last 3 months? ☐ Yes ☐ No | 14. Does PERSON 2 live with at least one child under the age of 19 and are they the main person taking care of this child? ☐ Yes ☐ No | 15. Was PERSON 2 in foster care at age 18 or older? ☐ Yes ☐ No |
|---|---|---|

**Please answer Questions 16 & 17 if PERSON 2 is 19 or younger:**

16. 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: _____

17. Is PERSON 2 a full time student? ☐ Yes ☐ No

18. **If Hispanic/Latino**, what is your ethnicity? **(OPTIONAL – Check all that apply.)**
☐ Mexican ☐ Mexican-American ☐ Chicano/a ☐ Puerto Rican ☐ Cuban ☐ Other: _____

19. **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: _____

## Step 2: Person 2 (Continue with Person 2)

### Current Job & Income Information

☐ **Employed**
If PERSON 2 is currently employed, tell us about their income. Start with question 20.

☐ **Not employed**
Skip to question 28.

☐ **Self-employed**
Skip to question 27.

**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**: _____ | |

**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**: _____ | |

28. **In the past year, did PERSON 2:** ☐ Change jobs? ☐ Stop working? ☐ Start working fewer hours? ☐ None of these?

29. **If self-employed, answer the following questions:**
a. Type of work _____

b. How much net income (profits once business expenses are paid) will PERSON 2 receive from self-employment this month?
$ _____

30. **OTHER INCOME THIS MONTH:** Check all that apply and give the amount and how often PERSON 2 receives that amount.
**NOTE:** You don't need to tell us about child support, veteran's payments or Supplemental Security Income (SSI).

☐ None
☐ Unemployment $ _____ How often? _____
☐ Pensions $ _____ How often? _____
☐ Net farming/fishing $ _____ How often? _____
☐ Net rental/royalty $ _____ How often? _____
☐ Social Security $ _____ How often? _____
☐ Alimony $ _____ How often? _____
☐ Retirement Accounts $ _____ How often? _____
☐ Other income $ _____ How often? _____ Type: _____

31. **DEDUCTIONS:** Check all that apply and give the amount and how often PERSON 2 receives 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).

☐ Alimony paid $ _____ How often? _____
☐ Student Loan interest $ _____ How often? _____
☐ Other deductions $ _____ How often? _____ Type: _____

30. **YEARLY INCOME: Complete only if PERSON 2's income changes from month to month.**
**If you don't expect changes to PERSON 2's monthly income, skip to the next person.**

| PERSON 2's total income **this year:** | PERSON 2's total income **next** year (if you think it will be different): |
|---|---|
| $ _____ | $ _____ |

## 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, go to Appendix B.

## 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.

☐ Medicaid_____
☐ ARKids First/CHIP_____
☐ Medicare_____
☐ TRICARE
(Don't check if you have Direct Care or Line of Duty)
_____
☐ VA Health Care Programs_____
☐ Peace Corps_____

☐ Employer insurance_____
Name of health insurance_____
Policy number_____
Is this COBRA coverage? ☐ Yes ☐ No
Is this a retiree health plan? ☐ Yes ☐ No

☐ Other
Name of health insurance_____
Policy number_____
Is this a limited benefit plan (like a school accident policy)?
☐ Yes ☐ 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**, renew 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 renew my coverage.

### 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 an entitlement 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 (mm/dd/yyyy) |
|---|---|
| | |

## Step 6 Mail Completed Application

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. TTY users should call **1-855-372-1084.**

# APPENDIX A for DCO-151/152

## Health Coverage from Jobs

You **DON'T** need to answer these questions unless someone in the household is eligible for health coverage from a job.
Attach a copy of this page for each job that offers coverage.

Tell us about the **job** that offers coverage.

**Take the Employer Coverage Tool on the next page to the employer who offers coverage to help you answer these questions. You only need to include this page when you send in your application, not the Employer Coverage Tool.**

### EMPLOYEE Information

| 1. Employee name (First, Middle, Last) | 2. Employee Social Security number<br>___-__-____ |
|---|---|

### EMPLOYER Information

| 3. Employer name | 4. Employer Identification Number (EIN)<br>__-_____ |
|---|---|
| 5. Employer address | 6. Employer phone number<br>(  )  - |

| 7. City | 8. State | 9. ZIP code |
|---|---|---|

10. Who can we contact about employee health coverage at this job?

| 11. Phone number (if different from above)<br>(  )  - | 12. Email address |
|---|---|

**13. Are you currently eligible for coverage offered by this employer, or will you become eligible in the next 3 months?**

☐ Yes (Continue)

13a. If you're in a waiting or probationary period, when can you enroll in coverage? _____
(mm/dd/yyyy)

List the names of anyone else who is eligible for coverage from this job.
Name: _____ Name: _____ Name: _____

☐ No (Stop here and go to Step 5 in the application)

Tell us about the **health plan** offered by this employer.

**14. Does the employer offer a health plan that meets the minimum value standard*?** ☐ Yes ☐ No

**15. For the lowest-cost plan that meets the minimum value standard* offered only to the employee (don't include family plans):**
**If the employer has wellness programs, provide the premium that the employee would pay if he/ she received the maximum discount for any tobacco cessation programs, and did not receive any other discounts based on wellness programs.**

a. How much would the employee have to pay in premiums for this plan? $_____

b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Once a month ☐ Quarterly ☐ Yearly

16. What change will the employer make for the new plan year (if known)?

☐ Employer won't offer health coverage

☐ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)

a. How much will the employee have to pay in premiums for that plan? $_____

b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Once a month ☐ Quarterly ☐ Yearly

Date of change (mm/dd/yyyy): _____

* An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)

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# EMPLOYER COVERAGE TOOL

Use this tool to help answer questions in Appendix A about any employer health coverage that you're eligible for (even if it's from another person's job, like a parent or spouse). The information in the numbered boxes below match the boxes on Appendix A. For example, the answer to question 14 on this page should match question 14 on Appendix A.

Write your name and Social Security number in boxes 1 and 2 and ask the employer to fill out the rest of the form. Complete one tool for each employer that offers health coverage.

## EMPLOYEE Information

The **employee** needs to fill out this section.

| 1. Employee name (First, Middle, Last) | 2. Employee Social Security number<br>___-__-____ |
|---|---|

## EMPLOYER Information

Ask the **employer** for this information.

| 3. Employer name | 4. Employer Identification Number (EIN)<br>__-_____ |
|---|---|
| 5. Employer address | 6. Employer phone number<br>(  )  - |

| 7. City | 8. State | 9. ZIP code |
|---|---|---|

10. Who can we contact about employee health coverage at this job?

| 11. Phone number (if different from above)<br>(  )  - | 12. Email address |
|---|---|

13. Is the employee currently eligible for coverage offered by this employer, or will the employee be eligible in the next 3 months?

☐ Yes (Continue)

13a. If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible?
_____ (mm/dd/yyyy) (Continue)

☐ No (Stop here and return this form to employee)

Tell us about the **health plan** offered by this employer.

Does the employer offer a health plan that covers an employee's spouse or dependent?

☐ Yes. Which people? ☐ Spouse ☐ Dependent(s)

☐ No
(Go to question 14)

14. Does the employer offer a health plan that meets the minimum value standard*?
☐ Yes (Go to question 15) ☐ No (STOP and return form to employee)

15. For the lowest-cost plan that meets the minimum value standard* offered **only to the employee** (don't include family plans):
If the employer has wellness programs, provide the premium that the employee would pay if he/ she received the maximum discount for any tobacco cessation programs, and did not receive any other discounts based on wellness programs.

a. How much would the employee have to pay in premiums for this plan? $_____

b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Once a month ☐ Quarterly ☐ Yearly

If the plan year will end soon and you know that the health plans offered will change, go to question 16. If you don't know, STOP and return form to employee.

16. What change will the employer make for the new plan year?

☐ Employer won't offer health coverage

☐ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)

a. How much will the employee have to pay in premiums for that plan? $_____

b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Once a month ☐ Quarterly ☐ Yearly

Date of change (mm/dd/yyyy): _____

* An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)

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# APPENDIX B for DCO-151/152

## American Indian or Alaska Native Family Member (AI/AN)

Complete this appendix if you or a family member are an American Indian or Alaska Native. Submit this with your Application for Health Coverage.

**Tell us about your American Indian or Alaska Native family member(s).**
American Indians and Alaska Natives can get services from the Indian Health Services, tribal health programs or urban Indian health programs. They also may not have to pay cost sharing and may get special monthly enrollment periods. Answer the following questions to make sure your family gets the most help possible.

**NOTE:** If you have more people to include, make a copy of this page and attach.

| | AI/AN PERSON 1 | AI/AN PERSON 2 |
|---|---|---|
| 1. Name (First, Middle, Last) | First Middle<br>Last | First Middle<br>Last |
| 2. Member of a federally recognized tribe? | ☐ Yes<br>**If Yes**, tribe name: _____<br>☐ No | ☐ Yes<br>**If Yes**, tribe name: _____<br>☐ No |
| 3. Has this person ever received a service from the Indian Health Service, a tribal program, or the urban Indian health program or through a referral from one of these programs? | ☐ Yes<br>☐ No<br>**If No**, is this person eligible to receive services from the Indian Health Service, a tribal program, or the urban Indian health program or through a referral from one of these programs?<br>☐ Yes ☐ No | ☐ Yes<br>☐ No<br>**If No**, is this person eligible to receive services from the Indian Health Service, a tribal program, or the urban Indian health program or through a referral from one of these programs?<br>☐ Yes ☐ No |
| 4. Certain money received may not be counted for Medicaid or ARKids First. List any income (amount and how often) reported on your application that includes money from these sources:<br>• Per captia payments from a tribe that come from natural resources, usage rights, leases or royalties<br>• Payments from natural resources, farming, ranching, fishing, leases or royalties from land designated as Indian trust land by the Department of the Interior (including reservations and former reservations)<br>• Money from selling things that have cultural significance | $ _____<br>How often? _____ | $ _____<br>How often? _____ |

**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. TTY users should call **1-855-372-1084.**

# CHIP Eligibility

OMB Control Number: 0938-1148
Expiration date: 10/31/2014

| Eligibility for Medicaid Expansion Program | CS3 |
|---|---|

42 CFR 457.320(a)(2) and (3)

Income eligibility for children under the Medicaid Expansion is determined in accordance with the following income standards:

There should be no overlaps or gaps for the ages entered.

Age and Household Income Ranges

| | From Age | To Age | Above (% FPL) | Up to & including (% FPL) | |
|---|---|---|---|---|---|
| + | 0 | 19 | 142 | 211 | X |

## PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 50 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

# CHIP Eligibility

OMB Control Number: 0938-1148
Expiration date: 10/31/2014

**Separate Child Health Insurance Program**
**Eligibility - Coverage From Conception to Birth** **CS9**

42 CFR 457.10

☒ **Coverage From Conception to Birth** - Coverage from conception to birth when the mother is not eligible for Medicaid.

☑ The CHIP Agency operates this covered group in accordance with the following provisions:

Age Standard

From conception through birth.

Does the state have an additional age definition or other age-related conditions? No

Income Standards

Income standards are applied statewide. Yes

Are there any exceptions, e.g. populations in a county which may qualify under either a statewide income standard or a county income standard? No

Statewide Income Standard

The statewide income standard is: From zero up to 209 % FPL

☒ Exempted from requirement of providing or applying for a Social Security Number.

☒ Exempted from requirement of verifying citizenship status.

## PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 50 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

State: **ARKANSAS**

| Citation | Condition or Requirement |
|---|---|

42 CFR 435.914

11. Effective Date of Eligibility

a. Groups Other Than Qualified Medicare Beneficiaries

(1) For the prospective period.

Coverage is available for the full month if the following individuals are eligible at any time during the month.

___ Aged, blind, disabled.
___ ~~AFDC-related.~~
_X_ MAGI Household.

Coverage is available only for the period during the month for which the following individuals meet the eligibility requirements.

_X_ Aged, blind, disabled.
___ AFDC-related.

(2) For the retroactive period.

Coverage is available for three months before the date of application if the following individuals would have been eligible had they applied:

_X_ Aged, blind, disabled.
_X_ AFDC-related.

Coverage is available beginning the first day of the third month before the date of application if the following individuals would have been eligible at any time during that month, had they applied.

___ Aged, blind, disabled.
___ AFDC-related.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: **ARKANSAS**

ELIGIBILITY CONDITIONS AND REQUIREMENTS

| Citation | Condition or Requirement |
|---|---|
| 1920(b)(1) of the Act | ~~X~~ (3) For a presumptive eligibility period for pregnant women only.<br><br>Coverage is available for ambulatory prenatal care for the period that begins on the day a qualified provider determines that a woman meets any of the income eligibility levels specified in ATTACHMENT 2.6-A of this approved plan. If the woman files an application for Medicaid by the last day of the month following the month in which the qualified provider made the determination of presumptive eligibility, the period ends on the day that the State agency makes the determination of eligibility based on that application. If the woman does not file an application for Medicaid by the last day of the month following the month in which the qualified provider made the determination, the period ends on that last day. |
| 1902(e)(8) and 1905(a) of the Act | X b. For qualified Medicare beneficiaries defined in section 1905(p)(1) of the Act coverage is available beginning with the first day of the month after the month in which the individual is first determined to be a qualified Medicare beneficiary under section 1905(p)(1). The eligibility determination is valid for –<br><br>X 12 months<br><br>___ 6 months<br><br>___ ___ months (no less than 6 months and no more than 12 months) |

**Revised: September 30, 2003**

State/Territory: [Arkansas]

| Citation | | | |
|---|---|---|---|
| 42 CFR 435.914 1902(a)(34) of the Act | 2.1(b) | (1) | Except as provided in items 2.1(b)(2) and (3) below, individuals are entitled to Medicaid services under the plan during the three months preceding the month of application, if they were, or on application would have been, eligible. The effective date of prospective and retroactive eligibility is specified in Attachment 2.6-A. |
| 1902(e)(8) and 1905(a) of the Act | | (2) | For individuals who are eligible for Medicare cost-sharing expenses as qualified Medicare beneficiaries under section 1902(a)(10)(E)(i) of the Act, coverage is available for services furnished after The end of the month which the individual is first Determined to be a qualified Medicare beneficiary. Attachment 2.6-A specifies the requirements for Determination of eligibility for this group. |
| 1902(a)(47) and | X | (3) | Pregnant women are entitled to ambulatory prenatal care under the plan during a presumptive eligibility period in accordance with section 1920 of the Act. Attachment 2.6-A specifies the requirements for Determination of eligibility for this group. |

State/Territory: ARKANSAS

## AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

21. Ambulatory prenatal care for pregnant women furnished during a presumptive eligibility period by an eligible provider (in accordance with section 1920 of the Act).

☒ Provided: ☐ No limitations ☒ With limitations*

☒ Not provided.

22. Respiratory care services (in accordance with section 1902(e)(9)(A) through (C) of the Act).

☒ **Provided:** ☐ No limitations ☒ With limitations* **with Prior Authorization**

☐ Not provided.

23. Certified pediatric or family nurse practitioners' services.

☒ Provided: ☐ No limitations ☒ With limitations*

*Description provided on attachment.

21. ~~Ambulatory prenatal care for pregnant women furnished during a presumptive eligibility period by an eligible provider (in accordance with Section 1920 of the Act).~~

~~Services are limited to the same benefit limits as other pregnancy related services. i.e., outpatient hospital, physician, lab and X-ray, etc.~~

RESERVED

22. Respiratory care services (in accordance with Section 1902(e)(9)(A) through (C) of the Act).

**Respiratory care for ventilator-dependent individuals means services that are not otherwise available under the State's Medicaid plan, provided on a part-time basis in the recipient's home by a respiratory therapist or other health care professional trained in respiratory therapy to an individual who---**

**a. Is medically dependent on a ventilator for life support at least 6 hours per day;**
**b. Has been so dependent for at least a number of consecutive days (number is based on maximum number of days authorized under the State plan, whichever is less) as an inpatient in one or more hospitals, NFs, or ICFs/MR;**
**c. Except for the availability of respiratory care services, would require respiratory care as an inpatient in a hospital, NF, or ICF/MR and would be eligible to have payment made for inpatient care under the State plan;**
**d. Has adequate social support services to be cared for at home;**
**e. Wishes to be cared for at home; and**
**f. Receives services under the direction of a physician who is familiar with the technical and medical components of home ventilator support, and who has medically determined that in-home care is safe and feasible for the individual.**

1. Ventilator Equipment (i.e., ventilator, suction pump, oxygen concentrator, liquid oxygen, liquid oxygen walker and reservoir, ventilator supplies and hospital bed) including 24-hour availability of respiratory therapy and equipment maintenance, with prior authorization.

2. **Respiratory therapy/treatment services for ventilator-dependent recipients under age 21, with prior authorization.**

**METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - OTHER TYPES OF CARE**

**Revised: August 1, 2009**

~~21. Ambulatory prenatal care for pregnant women furnished during a presumptive eligibility period by a qualified provider (in accordance with section 1920 of the Act.)~~

~~Reimbursement for these services is described in Attachment 4.19-B, e.g. outpatient hospital, physician services, etc.~~

RESERVED

~~22.~~21. Respiratory care services (in accordance with section 1920(e)(9)(A) through (C) of the Act).

1. See reimbursement methodology for respiratory therapy services for ventilator-dependent recipients under age 21 on Attachment 4.19-B, Page 1j.

2. Ventilator equipment - Reimbursement is based on the lower of the amount billed or the Title XIX maximum charge allowed.

   The Title XIX maximum is based on the following:

   (a) The **volume control** ventilator and accessories are based on the LP-6 manufacturer's price (Aequitron Medical - October 1, 1986) for new equipment and 75% of the LP-6 manufacturer's price (Aequitron Medical - October 1, 1986) for used equipment.

   (b) The suction pump is based on Medicare's rate in effect in August 1987 for new equipment. Used equipment is based on 75% of Medicare's rate.

   (c) The negative pressure ventilator and accessories are based on the manufacturer's price plus 10% for the maintenance, delivery, set up, emergency call, 24/hr/day, 7 day/week availability.

   (d) The oxygen concentrator, liquid oxygen, liquid oxygen walker and reservoir, hospital bed and nebulizer are based on the DME Fiscal Year 1981 Medicare median.

   (e) The ventilator supplies are based on the manufacturer's price.

   **(f) The pressure support ventilator is based on the 2007 Medicare rate.**

   The reimbursement methodology includes a provision for adjustments based on **legislative committee review, as required.**