ARKANSAS REGISTER

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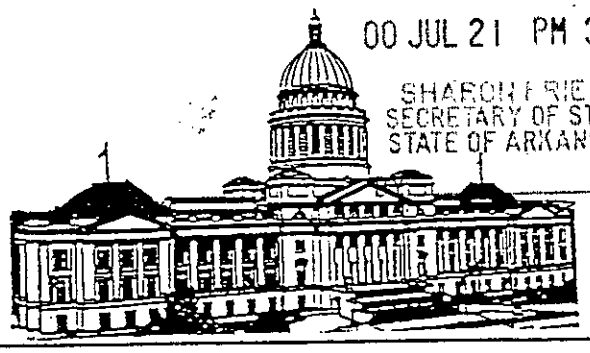

Transmittal Sheet

Sharon Priest
Secretary of State
State Capitol Rm. 026
Little Rock, Arkansas 72201-1094

For Office Use Only: Effective Date 8/4/00 Code Number 016.20.00.016

Name of Agency Department of Human Services

Department Division of County Operations

Contact Person Sandra Miller (501) 682-8251

Statutory Authority for Promulgating Rules AR Code Ann. 20-76-201 et Seq., AR Code Ann. 20-15-201 et Seq., AR Code Ann. 9-10-120

Intended Effective Date

- ☐ Emergency
- ☐ 10 Days After Filing
- ☒ Other

8/4/00

	Date
Legal Notice Published	~~06/18/00~~
Final Date for Public Comment	07/18/00
Reviewed by Legislative Council	08/03/00
Adopted by State Agency	08/04/00

CERTIFICATION OF AUTHORIZED OFFICER

I Hereby Certify That The Attached Rules Were Adopted In Compliance with Act 434 of 1967 As Amended.

Signature

(501) 682-8375
Phone Number

Director, Division of County Operations
Title

6/14/00
Date

DEPARTMENT of Human Services
DIVISION of County Operations
PERSON COMPLETING THIS STATEMENT Sandra Miller, Assistant Director
Office of Program Planning & Development
TELEPHONE: 682-8251 **FAX NO.** 682-1597

FINANCIAL IMPACT STATEMENT

***To comply* with Act 884 of 1995, please complete the following Financial Impact Statement and file with the questionnaire and proposed rules.**

SHORT TITLE OF THIS RULE – Revision to ARKids First Medicaid Application and Annual Review Form.

1. **Does this proposed, amended, or repealed rule or regulation have a financial impact?**
   No
2. **If you believe that the development of a financial impact statement is so speculative as to be cost prohibited, please explain.**
   Not Applicable.
3. **If the purpose of this rule or regulation is to implement a federal rule or regulation, please give the incremental cost for implementing the regulation.** Not Applicable.

1999-2000 Fiscal Year	2000-2001 Fiscal Year
General Revenue	General Revenue
Federal Funds	Federal Funds
Cash Funds	Cash Funds
Special Revenue	Special Revenue
Other	Other
Total	Total

4. **What is the total estimated cost by fiscal year to any party subject to the proposed, amended, or repealed rule or regulation?**

1999-2000 Fiscal Year	2000-2001 Fiscal Year
None	None

5. **What is the total estimated cost by fiscal year to the agency to implement this regulation?**

1999-2000 Fiscal Year	2000-2001 Fiscal Year
0	0

Arkansas Democrat Gazette

NOTICE
OF
RULEMAKING

Pursuant to Arkansas Code Annotated 20-76-201 et Seq., Arkansas Code Annotated 20-15-201 et Seq., and Arkansas Code Annotated 9-10-120, the Director, Division of County Operations, issues proposed changes to the Income Maintenance Forms Manual to revise the ARKids First Medicaid Application (DCO-995) and ARKids First Annual Review Form (DCO-975). This change creates a common application and Re-enrollment form for ARKids First and SOBRA Medicaid for children.

Copies of the proposed change may be obtained by writing the Division of County Operations, P.O. Box 1437, Slot 1220, Little Rock, AR 72203, Attention: Office of Program Planning & Development. All comments must be submitted in writing to the address indicated above no later than 30 days from the date of this notice.

If you need this material in a different format, such as large print, contact our Americans with Disabilities Act Coordinator at 682-8920 (voice) or 682-8933 (TDD).

The Arkansas Department of Human Services is in compliance with Titles VI and VII of the Civil Rights Act and operates, manages, and delivers services without regard to age, religion, disability, political affiliation, veteran status, sex, race, color or national origin.

Ruth Whitney
Director, Division of County Operations
1493460f

ARKids First

Mail-In Application

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

Thank you for your interest in ARKids First. ARKids provides comprehensive health insurance to eligible Arkansas children for a small or no co-payment. ARKids offers two health coverage packages that children may qualify for based on the family's income and assets. This application will be used to determine your eligibility for either coverage package. The following provides a brief highlight of the differences between the two packages. Services must be medically necessary. Limitations may apply.

	ARKids A	ARKids B
Basic Coverage: Physician, prescription drugs, hospital, ambulance (emergency only), dental, medical equipment, medical supplies, emergency department services, eye glasses, family planning, health screens, home health services, laboratory and x-ray, mental health –outpatient only, podiatry, speech therapy and vision, chiropractor, immunizations, nurse midwife and nurse practitioner.	Yes	Yes
Additional Coverage: Audiology, child health management services, developmental day treatment clinic services, domiciliary care, end stage renal disease services, hearing aids, hospice, hyperalimentation, inpatient psychiatric, nursing facilities, orthotics, personal care, transportation (non-emergency), private duty nursing, prosthetics, therapy (occupational and physical), ventilator services, and targeted case management.	Yes	No
Screenings (through Child Health Services): If the child receives periodic Child Health Services checkups, benefits are unlimited for covered services that are medically necessary.	Yes	No
Co-payments: ARKids B requires a co-pay as follows: $5.00 per prescription drug, $10.00 per medical visit, $10.00 per emergency ambulance trip, 20% of the 1st day of inpatient hospitalization. A co-payment is not required for preventative health screens and family planning services.	No	Yes

Do you want your children considered for:

❑ Either ARKids package* ❑ ARKids A only ❑ ARKids B only

*If you choose EITHER, your child(ren) will be placed in the package with the most coverage based on their eligibility.

1 Applicant Information

You must be a PARENT, GUARDIAN or RELATED PERSON of the child(ren) who will receive ARKids

Social Security Number*	Last Name			First Name	MI
Birth Date	Race	Sex	County of Residence	Telephone or contact phone. (Home)	May we contact you at work? (Work)
Street Address				City	State / Zip Code
Mailing Address (if different)		E-mail Address		City	State / Zip Code

**Social security number of the parent, guardian or related person is not required, but it is helpful to better serve you*

FOR OFFICE USE ONLY

REG	REGISTER #	APP DATE	COUNTY	CAT	ADULTS	CHILD	WORKER #	SMN	ARKID IN	KEY DATE	OP INT
DEN	WORKER #	DENIAL DATE	REASON		SAVING	TYPE	CAT	CN	KEY DATE		OP INT

2 Household

List all children under age 19 who you want considered for ARKids. Attach copies of social security cards and birth certificates for all children applying for ARKids. Use additional sheets if needed.

Social Security Number	Last Name	First Name	Birth Date	Race	Sex	Relationship to YOU	U.S. Citizen* (Yes/No)

* *You do not have to be a U.S. citizen to qualify. If you are not a U.S. citizen, attach documentation of alien status.*

List all parents of the children listed above who live in the home.

Social Security Number	Last Name	First Name	Birth Date	Race	Sex	Children's Names	U.S. Citizen* (Yes/No)

3 Income

Does anyone listed above have income from the following? Attach additional sheets to explain, if needed.

Source of Income	Y	N	Source	Gross Pay (Before deductions)	How often?	Who receives?
Employment, work, job, farming, self-employment (List all jobs for all individuals listed above)						
Retirement, social security, SSI, veterans benefits						
Child support, alimony, unemployment benefits, worker's compensation, student loans, grants						
Miscellaneous income (part time work, babysitting, rental property, contributions from friends/relatives, roomer or boarders, insurance, etc.)						

4 Vehicles

Does anyone listed above own cars, trucks, boats, trailers or any other vehicle?

❑ Yes ❑ No If yes, complete the following. Use additional sheets as needed.

Year, Make & Model	Current Value	Amount Owed

5 Total Assets

Not counting your home or vehicles, what is the TOTAL VALUE of all assets owned by the individuals listed on page 2, including cash on hand, checking accounts, savings accounts, credit union accounts, money market accounts, certificate of deposit (CDs), stocks, bonds, mutual funds, promissory notes, trust funds, etc. $ _____

6 Child Care

Does anyone listed on page 2 of this application pay for childcare for children listed on page 2?

❑ Yes ❑ No If yes, How much? $ _____ How often? _____

7 Unpaid Medical Bills

Do any of the children listed on page 2 have unpaid medical expenses for the past 3 months?

❑ Yes ❑ No If yes, Who? _____ In which month(s)? _____

8 Health Insurance

Does anyone listed on page 2 have health insurance of any kind at this time?

❑ Yes ❑ No If yes, Who? _____ Insurance company _____

If yes, is the insurance through your employer? ❑ Yes ❑ No

Has anyone listed on page 2 had health insurance, other than Medicaid, in the last 6 months?

❑ Yes ❑ No If yes, Who? _____ Insurance company _____

If yes, was the insurance through your employer? ❑ Yes ❑ No

Please explain why health insurance is no longer available. _____

9 Chronic Illness or Disability

Do any of the children listed on page 2 have a chronic illness or disability (special health care need)?

❑ Yes ❑ No If yes, Who? _____

10 Primary Care Physician Selection

Select the physician or clinic you want as primary care physician for each of the children listed on page 2. Indicate your 1st, 2nd and 3rd choices. ARKids allows each child covered to have only <u>one</u> primary care physician. If you do not know whom to select as your primary care physician, call toll-free 1-800-275-1131 for assistance. Attach additional sheets, if needed.

Child's Name	First Choice	Second Choice	Third Choice

Read carefully before you sign this application

Assignment of Medical Support. I authorize any holder of medical or other information about me to release information needed for an ARKids claim to DHS. I further authorize release of any information to other parties who may be liable for my medical expenses. As an eligibility condition, I automatically assign my right to any settlement, judgment, or award which may be obtained against any third party to DHS to the full extent of any amount which is paid by DHS for my behalf. I authorize and request that funds, settlement or other payments made by or on behalf of third parties, including tortfeasors or insurers arising out of an ARKids claim, be paid directly to DHS. My application for ARKids benefits shall in itself constitute an assignment by operation of law and shall be considered a statutory lien of any settlement, judgment, or award received by me from a third party. A third party is any person, entity, institution, organization or other source who may be liable for injury, disease, disability or death sustained by me or others named herein, including estates of said individuals. I also assign all rights in any settlement made by me or on my behalf arising out of any claim to the extent medical expenses paid by DHS, whether or not a portion of such settlement is designated for medical expenses. Any such funds received by me shall be paid to DHS. A copy of this authorization may be used in place of the original.

Continued on next page

Read carefully before you sign this application (continued)

- I understand that I must help establish my eligibility by providing as much information as I can and in some situations I may be required to provide proof of my circumstances.
- I authorize the Department of Human Services (DHS) to obtain information from other state agencies and other sources to confirm the accuracy of my statements.
- I understand Social Security Numbers (SSNs) will be used in a computer match to detect and prevent duplicate participation. SSNs are also used in a match through the State Income and Eligibility Verification System to secure wage, unearned income and benefit information from the Social Security Administration, Employment Security Division, and Internal Revenue Service. Information received may be verified through other contacts when discrepancies are found by DHS and may affect eligibility or level of benefits.
- I understand that no person may be denied ARKids benefits on the grounds of race, color, sex, age, disability, religion, national origin, or political belief.
- I may request a hearing from DHS if a decision is not made on my case within the proper time limit or if I disagree with the decision.
- I agree to notify the DHS county office within 10 days if I or any of my dependents cease to live in my home, if I move, or if any other changes occur in my circumstances.
- I authorize DHS to examine all records of mine or records of those who receive or have received ARKids benefits through me to investigate whether or not any person has committed ARKids fraud, or for use in any legal, administrative or judicial proceeding.

Assignment of Support. As a condition of eligibility for ARKids, each applicant or recipient must cooperate with the Office of Child Support Enforcement (OCSE) in establishing paternity and obtaining medical support for each child who has a parent absent from the home. All other OCSE services, including collection of child support payments from the absent parent, will be provided unless OCSE is notified by me in writing that I do not want these services.

I DECLARE UNDER PENALTY OF PERJURY THAT THE ABOVE IS TRUE AND CORRECT. If I receive benefits to which I am not entitled because I withheld information or provided inaccurate information, such assistance will be subject to recovery by the Department of Human Services, and I may be subject to prosecution for fraud and fined and/or imprisoned.

Signature of Parent, Guardian or Relative	Date	Telephone number of person helping to complete form
Signature of person helping to complete form	Date	
Signature of Family Support Specialist	Date	Address of person helping to complete form

A decision on your application should be made within 45 days.

Questions? If you have questions about eligibility for ARKids, call your local DHS county office. If you have questions about medical services covered by either ARKids A or ARKids B, call toll-free 1-888-474-8275. TDD# (501) 682-0102.

Return This Application, including attached pages, and copies of social security cards and birth certificates for each of the children you want considered for ARKids to your local DHS office.

RETURN TO:

Your local DHS office

ARKids First

Annual Renewal Notice and Eligibility Report Form

If you need this material in a different format, such as large print, please call 1-888-543-7890.

County Office Address

Complete this report for the previous full month.
REPORT DATE: Return this report to the address to the left by:

If above address has changed, please provide corrected address.

ANNUAL RENEWAL INSTRUCTIONS – It is time for the annual review of your children's eligibility for ARKids First insurance. COMPLETE EACH QUESTION ON THIS REPORT AND RETURN IT BY THE REPORT DATE SHOWN ABOVE. THIS REPORT WILL BE USED TO DETERMINE YOUR CONTINUING ELIGIBILITY FOR ARKIDS. You will not be required to visit your local DHS County Office.

ARKids offers two health insurance coverage packages that children may qualify for based on the family's income and assets. This form will be used to determine eligibility for either coverage package. Services must be medically necessary. Limitations may apply.

Coverage	ARKids A	Arkids B
Basic Coverage: Physician, prescription drugs, hospital, ambulance (emergency only), dental, medical equipment, medical supplies, emergency department services, eye glasses, family planning, health screens, home health services, laboratory and x-ray, mental health –outpatient only, podiatry, speech therapy and vision, chiropractor, immunizations, nurse midwife and nurse practitioner.	Yes	Yes
Additional Coverage: Audiology, child health management services, developmental day treatment clinic services, domiciliary care, end stage renal disease services, hearing aids, hospice, hyperalimentation, inpatient psychiatric, nursing facilities, orthotics, personal care, transportation (non-emergency), private duty nursing, prosthetics, therapy (occupational and physical), ventilator services, and targeted case management.	Yes	No
Screenings (through Child Health Services): If the child receives periodic Child Health Services checkups, benefits are unlimited for covered services that are medically necessary.	Yes	No
Co-payments: ARKids B requires a co-pay as follows: $5.00 per prescription drug, $10.00 per medical visit, $10.00 per emergency ambulance trip, 20% of the 1st day of inpatient hospitalization. A co-payment is not required for preventative health screens and family planning services.	No	Yes

Do you want your children considered for:

❑ Either ARKids package* ❑ ARKids A only ❑ ARKids B only

*If you choose EITHER, your child(ren) will be placed in the package with the most coverage based on their eligibility.

1 Household (Attach additional sheets if needed.)

Complete if there are any children living in your home that you would like to add to your ARKids coverage.

Social Security Number	Last Name	First Name	Birthdate (MM-DD-YY)	Race	Sex	Relationship to you	U.S. Citizen Yes	No

Provide a copy of their birth certificate and social security number.

Has a parent of any ARKids child moved into the home in the last 12 months? ❑ Yes ❑ No If yes, complete:

Social Security Number	Last Name	First Name	Birthdate (MM-DD-YY)	Race	Sex	Relationship to you	U.S. Citizen Yes	No

Has any child covered by ARKids or their parent moved out of the home in the last 12 months? ❑ Yes ❑ No If yes, who?

Name(s)	Social Security Number(s)	Date Moved

2 Income

Does anyone receive income from the following? Attach additional sheets to explain, if needed.

Source of Income	Y	N	Source	Gross Pay (Before deductions)	How often?	Who receives?
Employment, work, job, farming, self-employment (List all jobs for all individuals listed above)						
Retirement, social security, SSI, veterans benefits						
Child support, alimony, unemployment benefits, worker's compensation, student loans, grants						
Miscellaneous income (part time work, babysitting, rental property, contributions from friends/relatives, roomer or boarders, insurance, etc.)						

3 Vehicles

Does anyone own cars, trucks, boats, trailers or any other vehicle? ❑ Yes ❑ No If yes, complete the following. Use additional sheets as needed.

Year, Make & Model	Current Value	Amount Owed	Who Owns

4 Total Assets

Not counting your home or vehicles, what is the **TOTAL VALUE** of all assets owned, including cash on hand, checking accounts, savings accounts, credit union accounts, money market accounts, certificate's of deposit (CDs), stocks, bonds, mutual funds, promissory notes, trust funds, etc.

$ _____

5 Child Care

Does any parent pay childcare for any child(ren) receiving ARKids coverage? ❑ Yes ❑ No
If yes, How much? $_____ How often? _____

6 Health Insurance

Did a child receiving or added to ARKids have health insurance during the last 6 months? ❑ Yes ❑ No If yes, please provide:

Children's Names	Insurance Company	Date Coverage Began

7 Primary Care Physician Selection:

Complete only if you are adding a child or changing a primary care physician.

Child's Name	1st Choice	2nd Choice	3rd Choice

PLEASE READ CAREFULLY BEFORE SIGNING THIS FORM

- I understand that if any of my children receive assistance to which they are entitled as a result of withholding information, I will be liable for any overpayment.
- I understand that the information provided on this report may result in loss of my ARKids coverage.
- I declare that the information provided is correct.

I understand that by signing this annual report I am subject to penalties for false statements.

Sign Your Name_____ Date _____