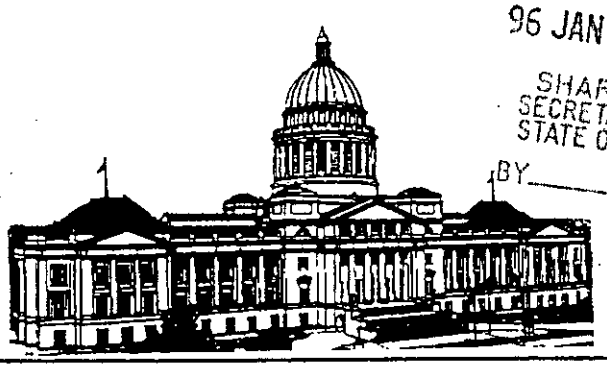
ARKANSAS REGISTER

Transmittal Sheet



Sharon Priest
Secretary of State
State Capitol Room 017
Little Rock, AR 72201-1094

For Office Use Only: Effective Date 01/26/96 Code Number 016.20.96--001

Name of Agency Department of Human Services

Department Division of County Operations

Contact Person Carol McKnight

Statutory Authority for Promulgating Rules AR Code Ann. 25-15-201 et Seq. and AR Code Ann. 20-76-201 et Seq.

Intended Effective Date

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

01-26-96

	Date
Legal Notice Published	12-14-95
Final Date for Public Comment	01-12-96
Filed With Legislative Council	12-12-95
Reviewed by Legislative Council	01-04-96
Adopted by State Agency	01-26-96

CERTIFICATION OF AUTHORIZED OFFICER

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

Signature

Director, Division of County Operations
Title

12/11/95
Date

MANUAL TRANSMITTAL

Arkansas Department of Human Services

Division of County Operations

[ ] Policy [X] Form [ ] Policy Directive

Issuance Number IMF 96-1

Income Maintenance Forms Manual

Issuance Date 2/1/96

From: Roy Hart
Director

Expiration Date Until Superseded

Subj: Revised Form

Pages to be Deleted,	Dated	Pages to be Added,	Dated
DCO-777 & Instructions	1/90	DCO-777 & Instructions	11/95

Summary

The DCO-777 & Instructions is revised to require AABD applicants to provide detailed income and resources information about their spouses. Also, a notice explaining the estate recovery process is added to page four.

A shelf supply of the revised form will be sent to counties. When this is received, counties should destroy existing supplies and begin using the revised form immediately.

Inquiries to: Carol McKnight, 682-8259
Terri Wright, 682-8258
Ann Dawson, 682-8254
Boyce Lovett, 682-1562

ARKANSAS DEPARTMENT OF HUMAN SERVICES

FOR OFFICE USE ONLY:

REG	REGISTER #	APPLICATION DATE	COUNTY	CATEGORY		MRT	WORKER #	WAIVER		KEY DATE	OP. INI.
DEN	WORKER #	DENIAL DATE	REASON	SAVINGS	TYPE	CATEGORY		CN	NHNO	KEY DATE	OP. INI.

APPLICATION FOR ASSISTANCE
LONG TERM CARE AND OTHER AABD CATEGORIES

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

YOU ARE REQUIRED TO ANSWER EACH QUESTION AS FULLY AND AS HONESTLY AS YOU CAN. WRONG, INCOMPLETE, OR WITHHELD INFORMATION COULD RESULT IN PROSECUTION FOR FRAUD.

1. I am a resident of Arkansas Yes ☐ No ☐

2. I am: 65 years of age or older ☐ Blind ☐ Disabled ☐

3. My full name is: _____ Race: _____ Sex: _____
Last First Middle

4. My current address is: _____
Street or Route No. City State Zip County

My former address was: _____
Street or Route No. City State Zip County

I have lived at my current address for: _____ years.

5. My telephone no. is: _____

6. I was born on: _____
Month Day Year

7. _____ _____
Social Security Number Medicare Number

I was born in: _____
City or County

_____ _____
Railroad Ret. Number VA Claim Number

_____
State or Country

8. I am a U.S. Citizen: Yes ☐ No ☐

9. I am a lawfully admitted Alien: Yes ☐ No ☐

10. I am: Married ☐ Separated ☐ Widowed ☐ Divorced ☐ Single ☐

COMPLETE QUESTIONS 11-15 **ONLY** IF YOU HAVE A SPOUSE.

11. My spouse's name is: _____
Last First Middle

12. My spouse's address is: _____
Street or Route No. City State Zip County

13. My spouse's telephone no. is: _____

14. My spouse was born on: _____
Month Day Year

15. _____ _____ _____ _____
Spouse's Soc. Sec. No. Spouse's Medicare No. Spouse's Railraod Ret. No. Spouse's VA Claim No.

16. I and my spouse have income from the following: (Check (✓) Yes or No. If yes, enter the amount and how often the income is received.)

	MYSELF				MY SPOUSE			
SOURCE OF INCOME	YES	NO	AMOUNT	HOW OFTEN	YES	NO	AMOUNT	HOW OFTEN
Retirement Benefits								
Social Security Benefits								
SSI								
Veteran's Benefits								
Railroad Retirement								
Civil Service Benefits								
Interest/Dividends								
Insurance								
Money From Trusts								
Mineral Rights/Oil Leases								
Rental								
Cash Contributions								
Unemployment Benefits								
Worker's Compensation								
Employment/Work								
Farming/Self Employment								
Deposits by Others for Me								
Other								

17. I or my spouse expect a change in income: Yes ☐ No ☐ If Yes, Explain _____

_____

18. I or my spouse own a home. Yes ☐ No ☐
If yes, my home is occupied by my spouse and/or dependent relatives. Yes ☐ No ☐

_____
Address of Home Equity Value

I or my spouse formerly owned homes in: _____
City, County and State

_____
City, County and State

19. I or my spouse own real property other than my home (land or buildings). Yes ☐ No ☐
If yes, complete the following:

_____
Address of Property Equity Value

_____
Address of Property Equity Value

I or my spouse formerly owned Real property other than my home in: _____

_____
City, County and State

20. I or my spouse have sold/deeded/given a home or other real property: _____
To Whom

_____
Location of Property (City, County, State) Month/Year Amount Received

21. I or my spouse retain life estate, dower, curtesy, inheritance or other interest in a home or other property:

_____
Location of Property (City, County, State) Type of Interest Value

22. I or my spouse own personal property such as cars, trucks, tractors or other farm machinery, trailers, boats, etc. (If more than three, please list on a separate sheet).

Item (Make, Model, and Year)	Equity Value
Item (Make, Model, and Year)	Equity Value
Item (Make, Model, and Year)	Equity Value

23. I or my spouse own livestock (cattle, poultry, catfish, minnows, crickets, worms, etc.)
Yes ☐ No ☐ If yes, complete the following:

Type of Livestock and Number Owned	Value

24. I or my spouse have the following assets. (Check (✓) Yes or No. If yes, enter the amount/value, location of the asset, and name of joint owner, if any.)

TYPE	YES	NO	AMT/VALUE	LOCATION OF ASSET	NAME OF JOINT OWNER
Cash					
Checking Account					
Savings Account					
Other Savings (Certificates, etc.)					
Promissory Notes					
Stocks					
Bonds					
Patient Fund Account					
Mortgage					
Burial Plot/Crypt					
Burial Funds/Insurance					
Life Insurance					
Trusts					
Other					

25. I or my spouse have additional income and/or property (real or personal) that I was unable to list under items 16 through 23. Yes ☐ No ☐ If yes, record your answer(s) on a separate sheet.

26. I or my spouse have other resources (real or personal property) that are being held for me by another individual. Yes ☐ No ☐ If yes, complete the following:

Type of Resource	Location of Resource	Amt/Value
Type of Resource	Location of Resource	Amt/Value

27. I or my spouse have hospital/medical insurance coverage. Yes ☐ No ☐ If yes, complete the following:

Name and Address of Insurance Company	Policy No.

28. I have unpaid medical expenses from the past three (3) months. Yes ☐ No ☐

29. I, or someone in my household, would like to learn to read, or to read better. Yes ☐ No ☐

30. I am pregnant. Yes ☐ No ☐
Someone else in my household is pregnant. Yes ☐ No ☐

- I understand that I must help establish my eligibility by providing as much of the requested information as I can.
- I authorize the Department of Human Services to make any investigation concerning me and/or my spouse necessary to establish my eligibility for assistance.
- I understand that no person may be denied long term care assistance or other Medicaid assistance on the grounds of race, color, sex, national origin or disability.
- I understand that I may request a hearing before the state agency representative if a decision is not reached on my case within the appropriate time limit or if I disagree with the decision reached.
- I agree to notify the Department of Human Services within 10 days if I or my spouse receive additional income, acquire or dispose of property or if any other changes occur in my circumstances.
- I understand that by applying for Medicaid I automatically assign my right to any settlement, judgement or award which may be obtained against any third party to the Arkansas Department of Human Services to the full extent of any amount which may be paid by Medicaid for my benefit. I also understand that this assignment is required by Act 463 of 1987.
- Assignment of Medical Support includes the rights to benefits from hospital/medical insurance, workers compensation, etc.
- I authorize the Department of Human Services to examine all records of mine, or records of those receiving or having received Medicaid benefits through me, for the purpose of investigating whether or not any person may have committed Medicaid fraud, or for use in any legal, administrative or judicial proceeding.
- I understand that I must provide my Social Security Number as a condition of my eligibility; and I understand that this number may be used by the Agency without my express permission in a computer match to obtain information relative to my eligibility for assistance from the Social Security Administration, Employment Security Division, Internal Revenue Services, or other agencies.

- IMPORTANT ESTATE RECOVERY NOTICE:

  If you receive Medicaid in a nursing facility, ICF/MR facility, or under a home and community based waiver program, the total amount of the Medicaid benefits paid on your behalf will be a debt to DHS and may be recovered from your estate after your death. Your estate is the property you own at the time of your death.

  DHS will not make a claim against your estate while you are living. DHS will not make a claim against your estate after your death if your spouse is still living, or if you have dependent children under age 21 or blind or disabled children.

  DHS will collect the debt, if any, by filing a claim in your estate. Collection may not be made if it is not cost effective to DHS or if your heirs apply for a hardship waiver after your death. A hardship may exist if the estate property is the only source of income for your heirs, if that income is limited, or if there are other compelling circumstances.

  CERTIFICATION: I HAVE READ THE ABOVE STATEMENTS; AND I AGREE TO THEIR PROVISIONS.

- I UNDERSTAND THAT THIS FORM IS SIGNED SUBJECT TO PENALTIES FOR PERJURY, I UNDERSTAND THAT IF I RECEIVE ASSISTANCE TO WHICH I AM NOT ENTITLED AS A RESULT OF WITHHOLDING INFORMATION OR PROVIDING 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.

Witness (if signed by mark)/Date	Applicant, Guardian, or Authorized Rep.'s Signature
Address of Witness/Telephone Number	Date / Telephone Number
Name of Person Who Helped Complete Form/Date	Guardian or Authorized Rep.'s Address
Signature of County Office Worker/Date	

Arkansas Democrat Gazette

12F • THURSDAY, DECEMBER 14, 1995

NOTICE OF RULE MAKING

Pursuant to AR Code Ann. 25-15-201 et seq. and AR Code Ann. 20-76-201 et seq., the Director, Division of County Operations, issues proposed changes to the Application for Assistance with Long Term Car and other AABD Categories.

Copies of the proposed changes may be obtained by writing the Division of County Operations, P.O. Box 1437 - Slot 1223, Little Rock, Arkansas 72203-1437. All comments must be submitted in writing to the address above no later than thirty days from the date of this publication.

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.

Roy Hart, Director

PO #6000004492EL

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