ARKANSAS REGISTER

Proposed Rule Cover Sheet

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Name of Department Department of Human Services

Agency or Division Name Division of County Operations

Other Subdivision or Department, If Applicable N/A

Previous Agency Name, If Applicable N/A

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Name of Rule ABLE ACT Section 103

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2271.1 Verification of a Resource

12/01/97

The countable value of a resource which is not disregarded must be verified. See TEA 2272 for disregarded resources.

2272 Resources to be Disregarded

~~12/01/97~~??/??/??

The following resources are not considered in determining the family's TEA eligibility:

1. The family's homestead~~.~~ (See TEA 2272.1 for more information regarding the homestead~~.~~);
2. One (1) motor vehicle;~~.~~
3. Household and personal goods;~~.~~
4. Income-producing real or personal property;~~.~~
5. Earmarked resources, ~~. This~~ including but not limited to~~es~~ educational grants, loans, and settlement payments that are intended and used for purposes which preclude their use for current living costs~~, etc~~;~~.~~

~~6.~~ Earned Income Credit (EIC) and other tax refunds;~~.~~

~~7.~~

~~8.~~

~~9.~~6.

~~10.~~7. Any type of life insurance policy, including the cash surrender value of the policy;~~.~~

~~11.~~8. One burial plot per TEA family member;~~.~~

~~12.~~9. Payments made under any federal, state, or local disaster assistance program;~~.~~

~~13.~~10. Any property or payment required to be disregarded for eligibility purposes according to federal or state statute~~.~~ ~~(See the Note on the following page);~~~~.~~

~~14.~~11. When the unit consists of a minor parent and ~~his or her~~their child, the resources of the minor parent's parent(s) or stepparent;~~.~~

~~15.~~12. The resources of the spouse of a non-parent relative who is included in the TEA cash assistance unit;~~.~~

NOTE: If jointly owned, the caretaker relative's pro rata share will be counted.

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~~16.~~13. Individual Development Accounts (IDA)~~.~~ (Refer to section 3445 of the DWS TEA Case Management Manual);

~~17.~~14. Funds up to ten-thousand dollars ($10,000.00) placed in an escrow account by a TEA recipient who is engaged in a micro-enterprise work activity;~~.~~

15. Savings for Education, Entrepreneurship, and Down Payment (SEED) a~~A~~ccounts; or~~.~~

~~18.~~16. Achieving a Better Life Experience a~~A~~ccounts (ABLE).

~~**NOTE**: At any timetime, there is a question as to whether a particular type of property or payment may be disregarded under Item #10 above, the worker should submit the pertinent documents, or information concerning the property or payment, to the Office of Program Planning and Development, Slot S33, for a determination. This information should include the specific federal or state statute under which it is believed the disregarded treatment is required.~~

2272.1 The Homestead

07/01/97

A homestead is a house and tract of land which a person considers his home. A mobile home or trailer used as a home will be considered as a homestead, regardless of whether the person also owns the property on which the mobile home is situated.

Only one (1) such tract will be considered a homestead. However, there is no limit to the acreage or number of lots, so long as the property is contiguous. Any other dwelling units or apartments on the property will be considered a part of the homestead.

The family must be presently residing on the property or intend to move on to it within a period of six (6) months from the date of application or date of purchase, whichever is later.

If the family ceases to live on the property, it will continue to be regarded as a homestead for a period of six (6) months from the date they left the home or the date of application, whichever was later, provided they intend to return to it. A request to extend the period beyond six (6) months may be approved by the County Administrator, if it is determined that extenuating circumstances exist in the case.

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2200 Eligibility Determination

2272 Resources to be Disregarded

Unless the period has been extended, the recipient will be advised that the homestead becomes excess property after six (6) months.

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E-610 ABLE ~~Account Application Process~~Program Trust and Account Management

Refer to Health Care Procedures Manual for more information.

MS Manual ~~10/01/17~~??/??/??

~~The Office of the Arkansas State Treasurer~~ The Achieving a Better Life Experience (ABLE) ~~Program~~ Committee will administer the ABLE program for Arkansas residents and non-residents. ~~The Committee is composed of the Secretary of the Department of Human Services, the Director of Arkansas Rehabilitation Services, the Treasurer of the State, or their designees.~~ The Office of the Arkansas State Treasurer will manage the ABLE Program Trust for the Committee. ~~The Office will:~~

- ~~determine eligibility for ABLE accounts;~~
- ~~process enrollments;~~
- ~~process account maintenance transactions;~~
- ~~maintain account payment and distribution history; and~~

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~~E-600 Achieving a Better Life Experience (ABLE) Program~~

E-600~~60~~ Achieving a Better Life Experience (ABLE) Program ~~Income~~

- ~~provide eligibility reports for Medicaid renewals.~~

Questions regarding the establishment of an ABLE account will be directed to the Office of the Arkansas State Treasurer~~, 1401 West Capitol Ave., Suite 275, Little Rock, AR 72201~~.

E-660 Income Exclusions

MS Manual ~~10/01/17~~??/??/??

Exclude all contributions to an ABLE account from the countable income of the designated beneficiary~~.~~ (See~~Re.~~ MS policy section E-630). This includes rollovers from another family member's ABLE account.

NOTE: A rollover is the distribution of all or some of the funds from an initial ~~one~~ ABLE account to the ABLE account of a member of the designated beneficiary's family. For purposes of this type of rollover, a member of the designated beneficiary's family means: siblings, ~~step-siblings~~stepsiblings, and half siblings.

However, do not deduct contributions from the countable income of the individual who makes the contribution.

EXAMPLE: Contribution: Kristie Mae has one hundred dollars ($100) automatically deducted from her paycheck and deposited into her daughter Sharon's ABLE account. The one hundred dollars ($100) will not be considered income for Sharon but will still be included as a portion of Kristie Mae's income.

EXAMPLE: Rollover: Linda is determined to no longer be disabled so she transfers all of the funds in her ABLE account to her ~~step-brother~~stepbrother Scott's ABLE account. These funds will not be considered as income to Scott.

The funds in an ABLE account can accrue interest, earn dividends, and otherwise appreciate in value. Earnings increase the account's balance. Interest accrued or dividends earned on the money in an ABLE account are excluded from the income of the designated beneficiary.

NOTE: ~~Long~~ Long-Term Supports and Services' transfer of resources rules apply to contributions made to an ABLE account (See MS policy section H-300-325).

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E-670 Resource Exclusions

MS Manual ~~10/01/17~~??/??/??

The amount of funds in an ABLE account ~~that exceeds $100,000~~ will not be counted as a resource for Health Care eligibility. ~~Only $100,000 of the balance of funds in an ABLE account can be excluded from the resources of the designated beneficiary.~~

Any distribution for a non-housing related Qualified Disability Expense (QDE), that has been retained beyond the month it was received, will be excluded from the designated beneficiary's countable resources if:

- The designated beneficiary maintains, makes contributions to, or receives distributions from the ABLE account;
- The distribution is unspent;
- The distribution is identifiable (Excluded funds commingled with non-excluded funds must be identifiable); and
- The individual still intends to use the distribution for a non-housing related QDE.

EXAMPLE: Excluded Distribution: Eric takes a distribution of five hundred dollars ($500) from his ABLE account in February 2017 to pay for a health related QDE. His health-related expense is not due until May, so Eric deposits the distribution into his checking account in February. The distribution is not income in February. Eric maintains his ABLE account at all relevant times and the distribution of ~~five hundred dollar~~five hundred dollars ($500) ~~distribution~~ remains both unspent and identifiable until Eric pays his ~~health related~~health-related expense in May. Therefore, the distribution of ~~five hundred dollar~~five hundred dollars ($500) ~~distribution~~ will be excluded from Eric's countable resources in March, April, and May.

> **NOTE:** A distribution for a ~~housing-related~~housing related QDE, or for an expense that is not a QDE, will be counted as a resource if the beneficiary retains the distribution into the month following the month of receipt. Distributions for housing-related QDEs must be spent in the month of receipt. If the beneficiary spends the distribution within the month of receipt, there is no effect on eligibility.

If distribution for a non-housing-related QDE that was retained into the following month is actually used for a non-qualified purpose or a housing-related QDE, the amount of funds used for the non-qualified purpose or a housing-related QDE will be considered a resource on the first day of the month in which the funds were spent. The caseworker will assume that the individual's intent to use the funds for a QDE changed as of the first of the month that the individual spent the funds. If the individual's intent to use the funds for a QDE changes at any other time, but the individual has not spent the funds, the retained funds will be counted as a resource the first of the following month.

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~~E-600 Achieving a Better Life Experience (ABLE) Program~~

E-600~~70~~ ~~R~~Achieving a Better Life Experience (ABLE)

EXAMPLE: Previously Excluded Distribution Used for a Non-QDE~~-~~: Sam takes a distribution of twenty ~~-~~five thousand dollars ($25,000) from his ABLE account, with the intent to modify a specially equipped van in May. He pays a deposit of ten ~~-~~thousand ~~-~~dollars~~s~~ ($10,000) ~~deposit~~ on the van modifications. While waiting for the delivery of the van, Sam takes a trip to a casino in July where he loses one thousand dollars ($1,000) of his ABLE distribution while gambling. The one thousand dollars ($1,000) he lost gambling is a countable resource in July. The other fourteen thousand dollars ($14,000) that Sam retains continues to be an excluded resource as long as it meets the requirements in this section.

EXAMPLE: Previously Excluded Distribution Used for a Housing Related QDE~~-~~: Jennifer takes a distribution of seven ~~-~~thousand~~-~~ ~~-~~dollars~~s~~ ($7,000) ~~distribution~~ from her ABLE account in June to pay her college tuition, a qualified disability expense (QDE). Her tuition payment is due in September. However, she has to make an advance rent payment of seven ~~-~~hundred ~~-~~fifty ~~-~~dollars~~s~~ ($750) ~~advance rent payment~~ for her college apartment in August. She uses seven ~~-~~hundred ~~and~~ fifty ~~-~~dollars ($750), of the distribution she took in June, to make the rent payment which is a housing related QDE. The seven ~~-~~hundred fifty dollars ($750) is a countable resource in August. The remaining six thousand two hundred ~~and~~ fifty dollars ($6,250) continues to be an excluded resource as long as it meets the requirements in this section.

EXAMPLE: Change of Intent on the Use of a Distribution~~-~~: Jennifer takes a distribution of seven ~~-~~thousand ~~-~~dollars ($7,000) ~~distribution~~ from her ABLE account in June to pay her college tuition, a qualified disability expense (QDE). Her tuition payment is due in September. In August, Jennifer gets a job offer and decides not to return to school. Since she no longer intends to use it for tuition, the seven thousand dollars ($7,000) becomes a countable resource in September, unless Jennifer redesignates it for another QDE or returns the funds to her ABLE account prior to September.

A special rule applies when the balance of an SSI recipient's ABLE account exceeds one hundred thousand dollars ($100,000) by an amount that causes the individual to be over the resource limit, whether by those funds alone or with other resources. When this situation occurs, the Social Security Administration will place the recipient into a special SSI suspension period where:

- Social Security will suspend the recipient's SSI benefits without a time limit as long as the individual remains otherwise eligible;
- The individual retains continued eligibility for ~~Medicaid~~h~~H~~ealth c~~C~~are; and
- The individual's eligibility does not terminate after twelve (12) continuous months of suspension.

During the period SSI benefits are suspended, the designated beneficiary will be treated as if the individual continued to be receiving payment of the SSI benefits. The individual's regular SSI eligibility will be reinstated for any month in which the individual's ABLE account balance no longer causes the recipient to exceed the resource limit and the individual is otherwise eligible.

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EXAMPLE: Excess Resources-Recipient is Suspended but Retains ~~Medicaid~~ Health Care Eligibility~~:~~: Paul is the designated beneficiary of an ABLE account with a balance of one hundred ~~and~~ one thousand dollars ($101,000) on the first of the month. Paul's only other countable resource is a checking account with a balance of one thousand five hundred dollars ($1,500). Paul's countable resources are two thousand five hundred dollars ($2,500) and therefore exceed the SSI resource limit. However, since Paul's ABLE account balance is causing him to exceed the resource limit (~~i.e.~~for example, his countable resources other than the ABLE account are less than two thousand ~~dollars)~~(dollars ($2,000)), Social Security will suspend Paul's SSI eligibility and stop his cash benefits, but Paul will retain eligibility for ~~Medicaid~~h~~H~~ealth c~~C~~are.

> **NOTE:** The special suspension rule does not apply when the balance of an SSI recipient's ABLE account exceeds one hundred thousand dollars ($100,000) by an amount that causes the recipient to exceed the SSI resource limit but the resources other than the ABLE account alone would make the individual ineligible for SSI due to excess resources.

EXAMPLE: Combination of Resources-Recipient Loses SSI Eligibility: Christine is the designated beneficiary of an ABLE account with a balance of one hundred ~~and~~ one thousand dollars ($101,000) on the first of the month. Christine also has a checking account with a balance of three thousand dollars ($3,000). Christine's countable resources are four thousand dollars ($4,000) and exceed the SSI resource limit. However, because her ABLE account balance is not the cause of her excess resources, the special rule does not ~~apply~~apply, and Christine is no longer SSI eligible due to excess resources. The Social Security Administration will suspend her SSI benefits and her ~~Medicaid~~ h~~H~~ealth c~~C~~are benefits will end as well.

EXAMPLE: Sharon takes a distribution of five hundred dollars ($500) from her ABLE account in May to pay for her rent for the month of June. She deposits the five hundred dollars ($500) into her checking account in May and then withdraws five hundred dollars ($500) in cash on June 3 and pays her landlord. This distribution is a ~~housing-related~~housing related QDE and a part of Sharon's checking account balance on June 1~~st~~, which makes it a countable resource for the month of June.

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RULES SUBMITTED FOR REPEAL

Rule #1: DCO Form – 808 – Medicare Beneficiaries Application

Rule #2: Social Services Block Grant Comprehensive Services Program Plan

Application for Medicare Savings for Qualified Beneficiaries
ARSeniors, QMB, SMB, QI-1

Si necesita este formulario en Español, llame al 1-800-482-8988 y pida la versión en Español

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

Please answer all questions as completely and accurately as possible. If you do not have enough space for your answer, attach another sheet of paper to this application.

Last Name	First Name	MI	Social Security Number

Medicare Number	Railroad Retirement Number	VA Claim Number

Birth Date	Race	Sex	County of Residence	Telephone Number

Street Address	City	State	Zip Code
Mailing Address (If Different)	**City**	**State**	**Zip Code**

Are you 65 years or older? ☐ Yes ☐ No

Are you: ☐ Blind ☐ Disabled

Are you (check one):
☐ Married ☐ Separated
☐ Widowed ☐ Divorced
☐ Single

Are you a U.S. Citizen? ☐ Yes ☐ No Submit documentation of alien status.

Living arrangement: (check one) ☐ Own Home ☐ Renting ☐ Other's Home ☐ Assisted Living

Please complete the following section for your spouse, if you live in the same household.

Last Name	First Name	MI	Social Security Number*	Date of Birth

Medicare Number	Railroad Retirement Number	VA Claim Number

- The Social Security Number is required if your spouse is applying for benefits.

Are you applying for your spouse also? ☐ Yes ☐ No If yes, complete the following.

Is your spouse a U.S. Citizen? ☐ Yes ☐ No Submit documentation of alien status.

Is your spouse 65 years or older? ☐ Yes ☐ No

Is your spouse: ☐ Blind ☐ Disabled

Do you have children under 18 (or under 21 if attending school) living in the home? ☐ Yes ☐ No

If yes, please complete the following information on each child.

Child's Last Name	Child's First Name	MI	Date of Birth	Child's Income (Amount & Type)

INCOME: Do you or your spouse have income from the following?

Source of Income	Y	N	Source	Gross Pay (before deductions)	How often?	Who receives?
Retirement, Social Security, SSI, Veterans Benefits						
Employment, work, job, farming, self-employment (List all jobs for each person listed)						
Child support, alimony, unemployment benefits, worker's compensation, student loans, grants						
Miscellaneous income (part time work, babysitting, rental property, contributions from friends/relatives, roomers or boarders, insurance etc.)						

Is food, clothing, or shelter paid for or provided free of charge for you by someone else? ☐ Yes ☐ No

REAL/PERSONAL PROPERTY:

Do you own any real estate other than your home, including property that you own with others? ☐ Yes ☐ No

If yes, complete the following for each piece of real estate. Attach additional pages if necessary. **Do not list the house you live in.**

Address or Location	Value	Amount Owed

VEHICLES:

Do you or your spouse own a car, truck, motorcycle, boat, trailer, or other vehicle? ☐ Yes ☐ No

If yes, complete the following information about each vehicle (attach additional pages as needed)

Make	Model	Year	Value	Amount Owed	Owner(s)

ASSETS: Check all assets owned by you or your spouse. Include any accounts or properties on which your name(s) appear. Include verification of trust funds. Attach additional pages if necessary.

Type of Asset	Y	N	Where held (bank, insurance co., brokerage firm, etc.)?	Account/Policy #	$ Value
Cash					
Checking Account					
Savings Account					
Certificates of Deposit					
Promissory Notes					

ASSETS: Continued

Type of Asset	Y	N	Where held (bank, insurance co., brokerage firm, etc.)?	Account/Policy #	$ Value
Stocks					
Bonds					
IRA					
Owner of a Mortgage					
Burial Plot/Crypt					
Burial Funds/Insurance					
Life Insurance					
Trusts					
Other					

HEALTH INSURANCE:

Do you have Medicare? ☐ Yes ☐ No
Does your spouse have Medicare? ☐ Yes ☐ No
Do you have other health insurance? ☐ Yes ☐ No
Does your spouse have other health insurance? ☐ Yes ☐ No

If you or your spouse have other health insurance besides Medicare, please provide the following information and attach copies (front and back) of Medicare and insurance cards.

Health Insurance Company Name	Address	Who is Insured?	Type of Coverage	Effective Date	Policy or Claim #

Would you like for someone to contact you about applying for the Supplemental Nutrition Assistance Program?
☐ Yes ☐ No

READ THE FOLLOWING INFORMATION CAREFULLY BEFORE YOU SIGN THIS APPLICATION

- 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 inquiry concerning me and/or my spouse necessary to establish my eligibility for assistance.
- I authorize my employer(s), any banks, savings and loans, lending institutions or other financial institutions, etc., to release to DHS any information about myself or my spouse's circumstances as necessary to verify any information contained on this application.
- I authorize DHS to obtain information from any federal, other state agencies and other sources (including electronic databases) to confirm the accuracy of my statements.
- I understand that no person may be denied assistance on the grounds of race, color, sex, age, disability, religion, national origin, or political belief.
- 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 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, Department of Workforce Services, Internal Revenue Service, or other agencies.
- ASSIGNMENT OF MEDICAL SUPPORT. I authorize any holder of medical or other information about me to release information needed for a Medicaid 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 on 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 a Medicaid claim, be paid directly to DHS. My application for Medicaid 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 which 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 of 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.
- *The PRIVACY ACT of 1974 requires the Department of Human Services (DHS) to tell you: 1.Whether disclosure is voluntary or mandatory 2. How DHS will use your SSN; and 3.The law or regulation that allows DHS to ask you for the SSN. We are authorized to collect from your household certain information including the social security number (SSN) of each eligible household member. For the Medicaid Program, this authority is granted under Federal laws codified at 42 U.S.C. §§ 1320b-7(a)(1) and 1320b-7(b)(2). This information may be verified through computer matching programs. We will use this information to determine Program eligibility, to monitor compliance with program rules, and for program management. This information may be disclosed to other Federal and State agencies and to law enforcement officials. If a claim arises against your household, the information on this application, including all SSNs, may be provided to Federal or State officials or to private agencies for collection purposes. *EXCEPTION: In the Medicaid Program, information is disclosed without the individual's written consent only to: authorized employees of this Agency, the Social Security Administration, the U.S. Department of Health and Human Services, the individual's attorney, legal guardian, or someone with power of attorney; or an individual who the recipient has asked to serve as his representative AND who has supplied confidential information for the case record which helped to establish eligibility, or court of law when the case record is subpoenaed.

I have read the above statements, and I agree to the 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.

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

This completes the application process for the Medicare Savings Program. Federal law requires that each state provide the opportunity to register to vote with every application for public assistance. The remaining pages of this packet are the Arkansas Voter Registration Application. Please answer the following question regarding voter registration:

Would you like to register to vote or change your voter registration address? ☐ Yes ☐ No

If you marked **Yes**, please complete and sign the Voter Registration Application that is attached. If you marked **No**, submit your Medicare Savings Program application to the Access Arkansas Processing Center, 1095 White Drive, Batesville, AR 72501.

PLEASE PRINT AND USE BLACK INK TO COMPLETE

Rev. 7/12

ARKANSAS VOTER REGISTRATION APPLICATION

Check all that apply:
- **This is a new registration.**
- **This is a name change.**
- **This is an address change.**
- **This is a party change.**

Office Use Only

Assigned ID

1	Mr. Mrs. Miss Ms.	Last Name	Jr. Sr. II. III. IV.	First Name	Middle Name

2	Address Where You Live (See Section "C" Below) (Rural addresses must draw map.)	Apt. or Lot #	City/Town	County	State	Zip Code
3	Address Where You Receive Mail If Different From Above	Apt. or Lot #	City/Town	County	State	Zip Code

4 Date of Birth _____/_____/_____ (Month / Day / Year)

5 Home & Work Phone Numbers (Optional) **(H)** **(W)**

6 Party Affiliation (Optional)

7 E-mail Address (Optional)

8 Have you ever voted in a federal election in this State? ☐ Yes ☐ No

9 ID Number - Check the applicable box and provide the appropriate number.
- ☐ Arkansas Driver's license number _____
- ☐ **If you do not have a driver's license provide the last 4 digits of social security number** _____
- ☐ I have neither a driver's license nor social security number.

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- **(A)** Are you a citizen of the United States of America and an Arkansas resident? ☐ Yes ☐ No
- **(B)** Will you be eighteen (18) years of age or older on or before election day? ☐ Yes ☐ No
- **(C)** Are you presently adjudged mentally incompetent by a court of competent jurisdiction? ☐ Yes ☐ No
- **(D)** Have you ever been convicted of a felony without your sentence having been discharged or pardoned? ☐ Yes ☐ No

If you checked **No** in response to either questions A or B, do not complete this form.
If you checked **Yes** in response to either questions C or D, do not complete this form.

Signature of elector - Please sign full name or put mark.

_____

The information I have provided is true to the best of my knowledge. I do not claim the right to vote in another county or state. If I have provided false information, I may be subject to a fine of up to $10,000 and/or imprisonment of up to 10 years under state and federal laws.

11 **Date:** _____/_____/_____ (Month / Day / Year)

If applicant is **unable to sign his/her name,** provide name, address and phone number of the person providing assistance:
Name: _____ Address: _____
City: _____ State: _____ Phone#: _____

Please complete the sections below if:

- You were previously registered in another county or state, or
- You wish to change the name or address on your current registration.

MAIL REGISTRANTS: PLEASE SEE SECTION D.

Agency Code (For Official Use Only)

PA 04

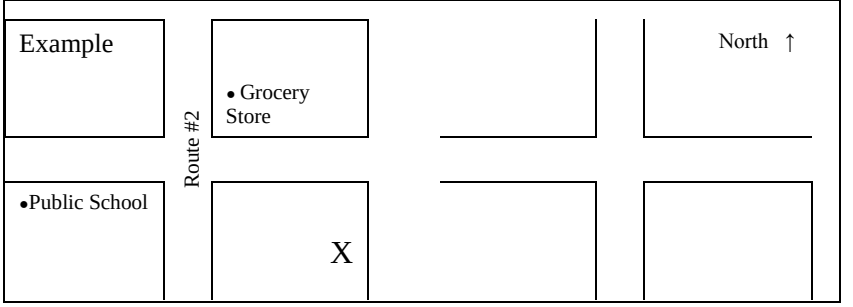
A	Mr. Mrs. Miss Ms.	Previous Last Name	Jr. Sr. II. III. IV.	First Name	Middle Name(s)

Date of Birth _____/_____/_____ (Month / Day / Year)

B	Previous House Number and Street Name	Apt.or Lot #	City or Town	State	Zip Code

If you live in a rural area but do not have a house or street number, or if you have no address, please show on the map where you live.

C
- Write in the names of the crossroads (or streets) nearest where you live.
- Draw an "X" to show where you live.
- Use a dot to show any schools, churches, stores or other landmarks near where you live and write the name of the landmark.



D

IDENTIFICATION REQUIREMENTS

IMPORTANT: If your voter registration application form is submitted by mail and you are registering for the first time, and you do not have a **valid Arkansas driver's license** number or **social security number**, in order to avoid the additional identification requirements upon voting for the first time you must submit with the mailed registration form: **(a)** a current and valid photo identification; or **(b)** a copy of a current utility bill, bank statement, government check, paycheck, or other government document that shows your name and address.

Arkansas Secretary of State
ATTN: Voter Registration
P.O. Box 8111
Little Rock, Arkansas 72203-8111

First Class Postage Required

From:

Deadline Information

To qualify to vote in the next election, you must apply to register to vote 30 days before the election. If you mail this form, it must be postmarked by that date. You may also present it to a voter registration agency representative by that date. If you miss the deadline you will not be registered in time to vote in that election. *Please don't delay. Make sure your vote counts*.

If you are qualified and the information on your form is complete, you will be notified of your voting precinct by your local County Clerk.

To Mail

Fold form on middle perforation, tape the form closed, stamp and mail.

Questions?

Call your local County Clerk

Or

Arkansas Secretary of State

Mark Martin
Elections Division – Voter Services
1-800-482-1127

Contact your County Clerk if you have not received confirmation of this application within two weeks.

ARKANSAS VOTER REGISTRATION INFORMATION

Section 7 of the National Voter Registration Act (NVRA) of 1993 requires that each state provide the opportunity to register to vote with every application for public assistance and every recertification, renewal and change of address. This Voter Registration packet is an opportunity for you to register to vote or change your voter registration address. Applying to register or declining to register to vote will not affect the amount of assistance that you will be provided by this agency.

If you would like help in filling out the voter registration application form, we will help you. The decision whether to seek or accept help is yours. You may fill out the voter registration application form in private.

No information relating to a declination to register to vote in connection with an application may be used for any purpose other than voter registration.

If you believe that someone has interfered with your right to: 1) Register to vote; 2) Decline to register to vote; 3) Privacy in deciding whether to register or in applying to register to vote; or 4) Choose your own political party or other political preference,

You may file a complaint with:

Secretary of State
Room 256 State Capitol
Little Rock, Arkansas 72201
1-800-482-1127

Mailing Instructions for Voter Registration

You have two options to submit your Voter Registration form.

1. You can submit the registration form in person or mail the registration form along with your SNAP or Medicaid application to your local county DHS office. The address for your county office can be found on the last page of this packet. Some applications (DCO-151 & DCO-152) must be mailed to the Jefferson County DHS office. If you are using one of these forms, you can mail the Voter Registration form with your application to that office. Upon receipt at any county office, that office will mail the form to the Secretary of State's office for you.

2. You may also mail the Voter Registration form directly to the Secretary of State's Office. To mail the form directly to the Secretary of State's office, separate the form from your application/renewal, fold the form along the middle perforation, seal the bottom with tape or staple, and mail to the address on the form. A stamp or stamped envelope is required for mailing.

DHS County Office Mailing Addresses

County	Address	City	Zip
Arkansas	100 Court Square	DeWitt	72042
Arkansas	PO Box 1008	Stuttgart	72160
Ashley	PO Box 190	Hamburg	71646
Baxter	PO Box 408	Mt. Home	72654
Benton	900 SE 13th Court	Bentonville	72712
Boone	PO Box 1096	Harrison	72602
Bradley	PO Box 509	Warren	71671
Calhoun	PO Box 1068	Hampton	71744
Carroll	PO Box 425	Berryville	72616
Chicot	PO Box 71	Lake Village	71653
Clark	PO Box 969	Arkadelphia	71923
Clay	PO Box 366	Piggott	72454
Cleburne	PO Box 1140	Heber Springs.	72543
Cleveland	PO Box 465	Rison	71665
Columbia	PO Box 1109	Magnolia	71754
Conway	PO Box 228	Morrilton	72110
Craighead	PO Box 16840	Jonesboro	72403
Crawford	704 Cloverleaf Circle	Van Buren	72956
Crittenden	401 S. College Blvd	W. Memphis	72301
Cross	803 Hwy 64E	Wynne	72396
Dallas	1202 W. 3rd St.	Fordyce	71742
Desha	PO Box 1009	McGehee	71654
Drew	PO Box 1350	Monticello	71657
Faulkner	1000 East Siebenmorgan Road	Conway	72032
Franklin	800 W Commercial	Ozark	72949
Fulton	PO Box 650	Salem	72576
Garland	115 Stover Lane	Hot Springs	71913
Grant	PO Box 158	Sheridan	72150
Greene	809 Goldsmith Rd	Paragould	72450
Hempstead	116 N. Laurel	Hope	71802
Hot Spring	2505 Pine Bluff St	Malvern	72104
Howard	PO Box 1740	Nashville	71852
Independence	100 Weaver Ave	Batesville	72501
Izard	PO Box 65	Melbourne	72556
Jackson	PO Box 610	Newport	72112
Jefferson	PO Box 5670	Pine Bluff	71611
Johnson	PO Box 1636	Clarksville	72830
Lafayette	2612 Spruce St.	Lewisville	71845
Lawrence	PO Box 69	Walnut Ridge	72476
Lee	PO Box 309	Marianna	72360
Lincoln	101 W. Wiley St.	Star City	71667
Little River	90 Waddell St.	Ashdown	71822
Logan-1	#17 W. McKeen	Paris	72855
Logan-2	398 East 2nd St.	Booneville	72927
Lonoke	PO Box 260	Lonoke	72086
Madison	PO Box 128	Huntsville	72740
Marion	PO Box 447	Yellville	72687
Miller	3809 Airport Plaza	Texarkana	71854
Mississippi 1	1104 Byrum Rd.	Blytheville	72315
Mississippi 2	437 S Country Club	Osceola	72370
Monroe-1	PO Box 354	Clarendon	72029
Monroe-2	301½ N New Orleans	Brinkley	72021
Montgomery	PO Box 445	Mount Ida	71957
Nevada	PO Box 292	Prescott	71857
Newton	PO Box 452	Jasper	72641
Ouachita	PO Box 718	Camden	71711
Perry	213 Houston Ave	Perryville	72126
Phillips	PO Box 277	Helena	72342
Pike	PO Box 200	Murfreesboro	71958
Poinsett	PO Box 526	Harrisburg	72432
Polk	PO Box 1808	Mena	71953
Pope	701 N Denver	Russellville	72801
Prairie	PO Box 356	DeValls Bluff	72041
Pulaski East	PO Box 8083	Little Rock	72203
Pulaski Jax.	PO Box 626	Jacksonville	72078
Pulaski No.	PO Box 5791	N. Little Rock	72119
Pulaski So.	PO Box 2620	Little Rock	72203
Pulaski Sw.	PO Box 8916	Little Rock	72219
Randolph	1408 Pace Rd	Pocahontas	72455
Saline	PO Box 608	Benton	72018
Scott	PO Box 840	Waldron	72958
Searcy	106 School St	Marshall	72650
Sebastian	616 Garrison Ave	Ft. Smith	72901
Sevier	PO Box 670	DeQueen	71832
Sharp	1467 Hwy 62/412 Ste. B	Cherokee Village	72529
St Francis	PO Box 899	Forrest City	72336
Stone	1821 E Main	Mountain View	72560
Union	123 W 18th St.	El Dorado	71730
Van Buren	449 Ingram Street	Clinton	72031
Washington	4044 Frontage	Fayetteville	72703
White	608 Rodgers Drive	Searcy	72143
Woodruff	PO Box 493	Augusta	72006
Yell	PO Box 277	Danville	72833

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

Pulaski East: 72016, 72053, 72126, 72135, 72201, 72202, 72203, 72205, 72207, 72212, 72223, 72227
Pulaski North: 72046 (England), 72113, 72114, 72115, 72117, 72118, 72119, 72142 (Scott), 72190, 72231
Pulaski Jacksonville: 72023 (Cabot), 72076, 72078, 72099, 72106, 72116, 72120, 72124
Pulaski South: 72204, 72206 (Shared with Southwest)
Pulaski Southwest: 72002, 72065, 72103, 72208, 72209, 72210, 72211, 72164, 72180, 72183, 72206 (Shared with South)

DHS ADMINISTRATIVE PROCEDURES MANUAL

Chapter 904

Title: Social Services Block Grant Pre-expenditure Report

I. PURPOSE: To assure compliance with federal regulations for the Social Services Block Grant (SSBG) program relating to a required plan of service and expenditures.

II. POLICY:

A. Before a State receives a SSBG allotment, it must submit an annual pre-expenditure report that describes how the State plans to administer its SSBG funds for the coming year. This report must be submitted 30 days prior to the start of the fiscal year (i.e., June 1). States must report on the intended use of SSBG funds, including the types of activities (or services) to be supported, and the categories and characteristics of individuals to be served (such as children, adults 59 and younger, adults 60 and older, and the disabled) (42 U.S.C. §1397c). While no specific format is required for the pre-expenditure report, States typically provide a narrative of the proposed activities and individuals to be served or a chart with this information by service area. States are also required to submit a revised pre-expenditure report if the planned uses of SSBG funds change during the year.

B. If the deadline cannot be met, Office of Finance and Administration, Contract Support Section (CSS) must request and receive a waiver from the federal government for delayed submission.

C. Reports and waiver requests shall be submitted to:

Social Services Block Grant Program
U.S. Department of Health and Human Services
Administration for Children and Families
Office of Community Services
370 L'Enfant Promenade, S.W. 5th Floor West
Washington, DC 20447

III. PROCEDURES:

A. Coordination with Program Agencies

Upon notification of allocations made by the DHS Chief Fiscal Officer, CSS shall execute the following steps:

1. Discuss the changes with, and meet with as necessary, the representative(s) from each program division and outside agency receiving SSBG funds;

2. Incorporate changes as necessary, and prepare a draft revision to the

Report, tracking changes;

3. Compare the revision to the most recent **SSBG Post-expenditure Report** for significant discrepancies;

4. Finalize the revision to the **Report**, tracking the changes.

B. Promulgation

1. Upon completion of an annual or interim **Report**, CSS shall submit the draft to Policy and Administrative Program Management Unit (PAPM) for promulgation in accordance with DHS Policy 1052, Administrative Procedure, Rules Promulgation, to include Executive Staff review, a thirty day public review period and final review and approval by the Legislative Council, Administrative Rules and Regulations Subcommittee.

2. CSS shall then forward a copy to the U.S. Department of Health and Human Services, Administration for Children and Families, Office of Community Services, Washington D.C.

FINANCIAL IMPACT STATEMENT

PLEASE ANSWER ALL QUESTIONS COMPLETELY.

DEPARTMENT Department of Human Services
BOARD/COMMISSION Division of County Operations
PERSON COMPLETING THIS STATEMENT Jason Callan
TELEPHONE NO. (501) 320-6540 **EMAIL** Jason.Callan@dhs.arkansas.gov

To comply with Ark. Code Ann. § 25-15-204(e), please complete the Financial Impact Statement and email it with the questionnaire, summary, markup and clean copy of the rule, and other documents. Please attach additional pages, if necessary.

TITLE OF THIS RULE ABLE Act Section 103

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 no, please explain:

   (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 reason for adoption of the more costly rule is based on the interests of public health, safety, or welfare, and if so, how; and

   (d) whether the reason for adoption of the more costly rule is within the scope of the agency's statutory authority, and if so, how.

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	0	General Revenue	0
Federal Funds	0	Federal Funds	0
Cash Funds		Cash Funds	
Special Revenue		Special Revenue	
Other (Identify)		Other (Identify)	
Total	$ 0.00	Total	$ 0.00

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

Current Fiscal Year		**Next Fiscal Year**	
General Revenue	0	General Revenue	0
Federal Funds	0	Federal Funds	0
Cash Funds		Cash Funds	
Special Revenue		Special Revenue	
Other (Identify)		Other (Identify)	
Total	$ 0.00	Total	$ 0.00

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

Current Fiscal Year	**Next Fiscal Year**
$ 0.00	$ 0.00

6. What is the total estimated cost by fiscal year to a state, county, or 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**
$ 0.00	$ 0.00

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.

NOTICE OF RULE MAKING

The Department of Human Services (DHS) announces for a public comment period of thirty (30) calendar days a notice of rulemaking for the following proposed rule under one or more of the following chapters, subchapters, or sections of the Arkansas Code: §§20-76-201, 20-76-401, 20-77-107, and 25-10-129. The proposed effective date is January 1, 2024.

The Director of the Division of County Operations (DCO) amends Sections E-610, E-660, and E-670 of the Medical Services Policy Manual and Section 2272 of the TEA Manual to comply with the ABLE ACT, Pub. L. No 113-295 (as amended Pub. L No. 114-113), as detailed in guidance from the Centers for Medicare and Medicaid Services (CMS). All funds in ABLE accounts will be excluded as income and resources for the Supplemental Nutrition Assistance Program (SNAP). DCO also removed business processes, revised terminology, and updated formatting and date references in the above sections. The proposed rule has no estimated financial impact.

Pursuant to the Governor's Executive Order 23-02, DHS repeals the following two rules as part of this promulgation: (1) DCO Form - 808 - Medicare Beneficiaries Application, and (2) Social Services Block Grant Comprehensive Services Program Plan.

The proposed rule is available for review at the Department of Human Services (DHS) Office of Rules Promulgation, 2nd floor Donaghey Plaza South Building, 7th and Main Streets, P. O. Box 1437, Slot S295, Little Rock, Arkansas 72203-1437. You may also access and download the proposed rule at ar.gov/dhs-proposed-rules. Public comments must be submitted in writing at the above address or at the following email address: ORP@dhs.arkansas.gov. All public comments must be received by DHS no later than September 25, 2023. Please note that public comments submitted in response to this notice are considered public documents. A public comment, including the commenter's name and any personal information contained within the public comment, will be made publicly available and may be seen by various people.

If you need this material in a different format, such as large print, contact the Office of Rules Promulgation at (501) 320-6428.

The Arkansas Department of Human Services is in compliance with Titles VI and VII of the Civil Rights Act and is operated, managed and delivers services without regard to religion, disability, political affiliation, veteran status, age, race, color or national origin. 4502100209

Mary Franklin

Mary Franklin, Director
Division of County Operations