ARKANSAS REHABILITATION SERVICES
REQUEST FOR ADMINISTRATIVE REVIEW

Name_____
SSN (Last 4 digits only)**:** _____

Counselor_____

Please list the decision(s) you want resolved:

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I have been advised that I can seek assistance from the Client Assistance Program.

Disability Rights Center
1100 N. University, Suite 201
Little Rock, AR 72207
Telephone: (501) 296-1775
1-800-482-1174

_____ _____
Applicant/Client Date

ARKANSAS REHABILITATION SERVICES
REQUEST FOR MEDIATION

Name_____

SSN (Last 4 digits only)**:** _____

Counselor_____

Please list the decision(s) you want resolved:

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I have been advised that I can seek assistance from the Client Assistance Program.

Disability Rights Center
1100 N. University, Suite 201
Little Rock, AR 72207
Telephone: (501) 296-1775
1-800-482-1174

_____ _____
Applicant/Client Date

APPENDIX E
FORMS AND INSTRUCTIONS

Page

System 7 form

STATE OF ARKANSAS

Mike Beebe
Governor

Bill Walker
Director

http://www.arsinfo.org
An Equal Opportunity Employer

Arkansas Career Education
Division of Rehabilitation Services
Jonathan Bibb, Interim Commissioner

APPLICATION FOR SERVICES

NAME: _____

I understand that I am responsible to help the Arkansas Rehabilitation Services (ARS) to determine my eligibility within 60 days of my application. I will be an applicant when I have:

- Signed the bottom of this form,
- Completed a ARS Intake Questionnaire, and
- Helped ARS to begin to get information that is needed to decide if I am eligible for services.

I understand that all of the information that ARS gathers about me will be confidential. This information will not be released to anyone without my informed written consent, except where allowed or required by law. It may be released if my actions cause serious concern about my safety or the safety of others. When ARS receives the information about me ARS will review it to determine if I am eligible for vocational rehabilitation services.

I understand that ARS can only pay for services if ARS writes an authorization before the services begin. I will not make promises to others that ARS will pay for any goods or services.

ARS has given me information about the Client Assistance Program (CAP) that is available in Arkansas (**see reverse**).

My counselor has explained the Order of Selection policy to me.

I understand that ARS may get information about my Social Security or Department of Social Services benefits, as well as Department of Labor employment records, for purposes of my vocational rehabilitation program.

If I disagree with any decision made by ARS (see Consumer Handbook for more information):

- I should first speak with my counselor to try to work out the problem.
- I also have the right to request an Administrative Review by the District Manager, mediation and/or Impartial Hearing.
- I must make a request for these steps within 30 days after they have notified me of the decision I disagree with.
- If I want to request an Administrative Review, I must send my request to the ARS District Manager in my area.
- If I want to request mediation or an Impartial Hearing, I must send my request to the ARS Commissioner, Arkansas Career Education, Division of Rehabilitation Services.

I am applying for ARS services because I want to work, or to keep my job if I am employed.

_____ _____

SIGNATURE **DATE**

_____ _____

SIGNATURE **DATE**

Name of Counselor | Office | Telephone

Pg 2 Application for Services

ARKANSAS REHABILITATION SERVICES

WHEN YOU HAVE QUESTIONS:

If you do not understand what is happening with your application for services, or what is expected of you, or you have any other questions, first talk to your counselor. If this does not solve your concerns or answer your questions, you are then encouraged to speak to your counselor's supervisor and/or District Manager.

You can find information about ARS services, the ARS eligibility process, and about what to do if you disagree with ARS in the ARS Consumer Handbook.

ANOTHER SOURCE OF ASSISTANCE IS:

CLIENT ASSISTANCE PROGRAM

WHAT IS THE CLIENT ASSISTANCE PROGRAM (CAP)?

CAP is a program to help you to understand your rights under the vocational rehabilitation program or help you if you have problems receiving services from the Arkansas Rehabilitation Services. CAP can provide advice, representation, or legal assistance, if appropriate.

All services are free of charge and provided on a non-discriminatory basis.

ARKANSAS REHABILITATION SERVICES
REQUEST FOR AN IMPARTIAL HEARING

Name_____

SSN (Last 4 digits only)**:** _____

Counselor_____

Please list the decision(s) you want resolved:

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1100 N. University, Suite 201
Little Rock, AR 72207
Telephone: 1-800-482-1174

_____ _____
Applicant/Client Date

SEND THIS FORM BY MAIL, FAX OR EMAIL TO:

ARS Commissioner
525 West Capitol
Little Rock, AR 72201
Fax: 1-501-296-1141
Email: ARS.Commissioner@arkansas.gov

STATE OF ARKANSAS

Mike Beebe
Governor

Bill Walker
Director

Arkansas Career Education
Division of Rehabilitation Services
Jonathan Bibb, Commissioner

http://www.arsinfo.org
An Equal Opportunity Employer

Authorization for Release/Disclosure of Personal Information

Instructions to ARS staff: Original copy to information holder. Copy to recipient of information.

Date: ____________

I authorize: (name & address of person/organization that will release the information)

Name: ______________________
Organization: ________________
Street: ________________
Suite/Apt#: ________________
City: __________
Zip: ______
State: ___

to release the information indicated below to:
(name & address of person/organization to which information is to be released)

Name: ______________________
Organization: ________________
Street: ________________
Suite/Apt#: ________________
City: __________
Zip: ______
State: ___

Purpose(s) of this release (check one):

☐ This information is being sent or requested by ARS for purposes associated with my eligibility for the provision of vocational rehabilitation services.

☐ Other purpose:

____

Additional Information:

____

___ **I also authorize shared disclosure between both parties named above for all of the information approved by this Release/Disclosure form, for purposes of coordinated planning.**

Consumer name	Date of Birth	SSN# (Last 4 digits only)
Signed (Consumer)		
If minor, signature of parent or guardian; conservator, if applicable	Relationship to consumer	

- If release is not related to my obtaining ARS services, my refusal to sign will not affect my ability to receive services from ARS.
- I understand that the information I authorize a person or entity to receive may be re-disclosed and no longer protected by privacy regulations.
- This authorization may be revoked by me at any time by notifying ARS in writing, except to the extent that action has been taken in reliance on it. Unless expressly revoked earlier, this authorization expires as noted here (box below)

SPECIFY DATE, EVENT, OR CONDITION

Information Types:

Type of Information:

Date of Authorization: Consumer's Initials:

Consumer name	Date of Birth	SSN# (Last 4 digits only)
Signed (Consumer)		
If minor, signature of parent or guardian; conservator, if applicable	Relationship to consumer	

- If release is not related to my obtaining ARS services, my refusal to sign will not affect my ability to receive services from ARS.
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SPECIFY DATE, EVENT, OR CONDITION

Note to Recipient of Information:

The confidentiality of this record is required under chapter 899 of the Connecticut general statues. This material shall not be transmitted to anyone without written consent or other authorization as provided in the aforementioned statues.

*** Alcohol and/or drug treatment records:**

This information has been disclosed to you from records protected by Federal confidentiality rules(42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

**** HIV Related Information:**

This information has been disclosed to you from records whose confidentiality is protected by state law. State law prohibits you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by state law. A general authorization for the release of medical or other information is NOT sufficient for this purpose.

ARKANSAS REHABILITATION SERVICES
REQUEST FOR AN IMPARTIAL HEARING

Name_____

SSN (Last 4 digits only)**:** _____

Counselor_____

Please list the decision(s) you want resolved:

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