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 • 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. • Apply even if you or your child already has health coverage. You could be eligible for lower cost or free coverage. • 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. • 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) • Employer and income information (for example: from paystubs, W-2 forms, or wage and tax statements) • Information about any job related health insurance available to your family • 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.

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

Voter Registration	A Voter Registration packet is included with this application to provide 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.

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 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, Person 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, Person 1 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.

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 2 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. Sex ☐ Male ☐ Female
4. Date of Birth (mm/dd/yyyy)	5. If you are under 18, are you emancipated? ☐ Yes ☐ No **If Yes**, how were you emancipated? ☐ Court Order ☐ Common Law	

6. 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.

7. **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 questions 8 through 11 and **begin answering questions again at # 12.**

CITIZENSHIP STATUS

8. Are you a U.S. citizen or U.S. national? ☐ Yes ☐ No
Are you a citizen of the Marshall Islands, Federated States of Micronesia or Palau? ☐ Yes ☐ No

9. **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:_____ Alien # _____
b. Document ID number:_____ Expiration date of document _____
c. Have you lived in the U.S. since 1996? ☐ Yes ☐ No Date of entry into U.S. _____
d. Are you or your spouse or parent a veteran or an active duty member of the U.S. military? ☐ Yes ☐ No

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

11. **Race (OPTIONAL – Mark (X) all that apply.)**

Race	X	Race	X	Race	X	Race	X	Race	X	Race	X
White		Filipino		Black/African American		Alaskan Native		Hawaiian/Pacific Islander		Samoan	
Korean		Japanese		American Indian		Asian Indian		Guamanian or Chamorro		Chinese	

PREGNANCY STATUS

12. Are you pregnant? ☐ Yes ☐ No **If Yes**, what is your expected due date?_____ (mm/dd/yyyy)
How many babies are you expecting during this pregnancy? ____ **If No**, have you delivered a child in the last 90 days? ☐ Yes ☐ No **If Yes**, what was the date of delivery? _____ **If Yes**, how many babies did you deliver? ___

STUDENT STATUS

13. Are you a student? ☐ Yes ☐ No Please mark your student status and school type.

Status				School Type					
Full Time		Half Time		Vocational		Under Graduate		Open University	
Part Time		Graduated		Equivalent Vocational/Technical		Technical		Not in School	

FOSTER CARE STATUS

14. Were you in foster care in Arkansas at age 18 or older? ☐ Yes ☐ No
If Yes, were you enrolled in Medicaid when you left the Foster Care program? ☐ Yes ☐ No
Are you currently receiving Medicaid? ☐ Yes ☐ No

15. Are you the main caregiver living with and taking care of at least one child under the age of 19? ☐ Yes ☐ No

TAX FILING STATUS

16. **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? _____

Step 2: Person 1 (Continued)

Current Job & Income Information

☐ **Employed**
If you're currently employed, tell us about your income. Start with question 17.

☐ **Not Employed**
Skip to question 25.

☐ **Self Employed**
Skip to question 26.

CURRENT JOB 1:

17. Employer Name and Address	18. Employer Phone Number
19. Wages/tips (before taxes) $_____ ☐ Hourly ☐ Weekly ☐ Every 2 Weeks ☐ Twice a Month ☐ Monthly ☐ Yearly	
20. Average hours worked each **week**:_____ Start date of employment_____(mm/dd/yyyy)	

CURRENT JOB 2: (Attach another sheet of paper to list more jobs.)

21. Employer Name and Address	22. Employer Phone Number
23. Wages/tips (before taxes) $_____ ☐ Hourly ☐ Weekly ☐ Every 2 Weeks ☐ Twice a Month ☐ Monthly ☐ Yearly	
24. Average hours worked each **week**:_____ Start date of employment_____(mm/dd/yyyy)	

25. **In the past year, did you:** ☐ Change jobs? ☐ Stop working? If so, date job ended?_____(mm/dd/yyyy) ☐ Start working fewer hours? ☐ None of these?

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

a. Name of Business:

_____

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

$ _____

27. **OTHER INCOME THIS MONTH:** Enter the amount and how often you receive that amount for all income that is not listed above.

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

INCOME	Amount	How Often	INCOME	Amount	How Often	INCOME	Amount	How Often
None			Taxable Interest			Tax Exempt Interest		
Dividends			Foreign Income			Unemployment		
Pensions/Retirement			Social Security			Net Farming/Fishing		
Retirement Accounts			Scholarship Payments			Prizes/Awards		
Capital Gains			Alimony/Maintenance			Lump Sum Amount		
Alaskan Native Income			American Indian Income			Other Income		

28. **DEDUCTIONS**: Mark all that apply, 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 26b).

Deduction	X	Amount $	How Often	Deduction	X	Amount $	How Often
Alimony/Maintenance				Student Loan Interest			
Other Deduction:_____				Other Deduction: _____			

29. **YEARLY INCOME**: **Complete only if your income changes each month. If you don't expect changes to your monthly income, skip to question 30.**

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

30. **UNPAID MEDICAL BILLS** Do you need help paying for medical bills from this month? ☐ Yes ☐ No
Do you need help paying for medical bills in the last 3 months? ☐ Yes ☐ No Are **these bills** from a Medical Emergency? ☐ Yes ☐ No
Was your household size the same during the last 3 months as it is now? ☐ Yes ☐ No
Was your household income the same during the last 3 months as it is now? ☐ Yes ☐ No
If No, What was the household side and income during those 3 months?_____

31. **DISABILITY STATUS** Do you have a disability or are you blind? ☐ Yes ☐ No
Do you live in a medical facility or nursing home? ☐ Yes ☐ No
What type of facility is this? ☐ Nursing Home ☐ Human Development Center ☐ Arkansas State Hospital
☐ Arkansas Health Center ☐ Intermediate Care Facility for the Intellectually Disabled
Do you have a physical, mental or emotional health condition that causes limitations in activities (like bathing, dressing, daily chores, etc.)? ☐ Yes ☐ No

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 2 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. Is **PERSON 2** the main caregiver living with and taking care of at least one child under the age of 19? ☐ Yes ☐ No

8. **Does PERSON 2 need health coverage?**
☐ **YES If yes**, answer all the questions below. ☐ **NO If no**, SKIP questions 9 through 12 and begin answering questions again at # 13.

CITIZENSHIP STATUS

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

10. Is PERSON 2 a citizen of the Marshall Islands, Federated States of Micronesia or Palau? ☐ Yes ☐ No

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

12. **If Hispanic/Latino,** what is **PERSON 2**'s ethnicity and race? **(OPTIONAL – Check all that apply.)**
☐ Mexican ☐ Mexican-American ☐ Chicano/a ☐ Puerto Rican ☐ Cuban ☐ Other:_____

13. **Race (OPTIONAL – Mark (X) all that apply.)**

Race	X	Race	X	Race	X	Race	X	Race	X	Race	X
White		Filipino		Black/African American		Alaskan Native		Hawaiian/Pacific Islander		Samoan	
Korean		Japanese		American Indian		Asian Indian		Guamanian or Chamorro		Chinese	

PREGNANCY STATUS

14. Is **PERSON 2** pregnant? ☐ Yes ☐ No **If Yes**, what is the expected due date?_____(mm/dd/yyyy)
How many babies is **PERSON 2** expecting during this pregnancy? _____ **If No**, has **PERSON 2** delivered a child in the last 90 days? ☐ Yes ☐ No **If Yes**, what was the date of delivery?_____
If Yes, how many babies did **PERSON 2** deliver?_____ Is **Person 2** is a newborn? ☐ Yes ☐ No
If Yes, What is the biological mother's name and date of birth?_____

STUDENT STATUS

15. Is **PERSON 2** a full time student? ☐ Yes ☐ No Mark (**X**) for all that apply.

Status				School Type					
Full Time		Half Time		Vocational		Under Graduate		Open University	
Part Time		Graduated		Equivalent Vocational/Technical		Technical		Not in School	

FOSTER CARE STATUS

16. Was **PERSON 2** in foster care in Arkansas at age 18 or older? ☐ Yes ☐ No
If Yes, was **PERSON 2** enrolled in Medicaid when they left the Foster Care program? ☐ Yes ☐ No
Is **PERSON 2** currently enrolled in Medicaid? ☐ Yes ☐ No

TAX FILING STATUS

17. **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?_____

Step 2: Person 2 (Continued)

CURRENT Job & Income Information

☐ **Employed** — If PERSON 2 is currently employed, tell us about their income. Start with question 18.

☐ **Not employed** — Skip to question 26.

☐ **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**:_____ Start date of employment_____(mm/dd/yyyy)

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**:_____ Start date of employment_____(mm/dd/yyyy)

26. **In the past year, did you:** ☐ Change jobs? ☐ Stop working? If so, date job ended?_____(mm/dd/yyyy) ☐ Start working fewer hours? ☐ None of these?

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

a. Name of Business: _____

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).

INCOME	Amount	How Often	INCOME	Amount	How Often	INCOME	Amount	How Often
None			Taxable Interest			Tax Exempt Interest		
Dividends			Foreign Income			Unemployment		
Pensions/Retirement			Social Security			Net Farming/Fishing		
Retirement Accounts			Scholarship Payments			Prizes/Awards		
Capital Gains			Alimony/Maintenance			Lump Sum Amount		
Alaskan Native Income			American Indian			Other Income		

29. **DEDUCTIONS**: Mark all that apply, 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).

Deduction	X	Amount $	How Often	Deduction	X	Amount $	How Often
Alimony/Maintenance				Student Loan Interest			
Other Deduction:_____				Other Deduction: _____			

30. **YEARLY INCOME**: **Complete only if your income changes each month. If you don't expect changes to your monthly income, skip to question 31.**

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

31. **UNPAID MEDICAL BILLS** Do you need help paying for medical bills this month? ☐ Yes ☐ No
Do you need help paying for medical bills in the last 3 months? ☐ Yes ☐ No Are **these bills** from a Medical Emergency? ☐ Yes ☐ No
Was your household size the same during the last 3 months as it is now? ☐ Yes ☐ No
Was your household income the same during the last 3 months as it is now? ☐ Yes ☐ No
If No, What was the household size and income during those 3 months? _____

32. **DISABILITY STATUS** Do you have a disability or are you blind? ☐ Yes ☐ No
Do you live in a medical facility or nursing home? ☐ Yes ☐ No Name of the facility _____
What type of facility is this? ☐ Nursing Home ☐ Human Development Center ☐ Arkansas State Hospital
☐ Arkansas Health Center ☐ Intermediate Care Facility for the Intellectually Disabled
Do you have a physical, mental or emotional health condition that causes limitations in activities (like bathing, dressing, daily chores, etc.)? ☐ Yes ☐ No

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, please obtain and complete an Appendix B to the DCO-151/152 and submit it with this application.

Is anyone in the home eligible to receive Indian Program Services? ☐ Yes ☐ No

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 the next question.

3. Has anyone listed on the application lost health insurance coverage in the last 90 days? ☐ Yes ☐ No
   If Yes, When did the coverage end?_____
   Why did the coverage end? _____
   Was the insurance a group or employer sponsored plan? ☐ Yes ☐ No
   Did the insurance cover both hospital and physician charges? ☐ Yes ☐ No
4. Does anyone listed on this application use tobacco? ☐ Yes ☐ No
   If Yes, Who?_____

INCARCERATION STATUS

1. Is anyone that is listed on this application currently incarcerated with the Department of Corrections, Department of Community Correction, county jail, city jail or a Juvenile Detention Facility? ☐ Yes ☐ No
   If Yes, Who? _____
2. What is the expected release date? _____(mm/dd/yyyy)

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.

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, review 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 review my eligibility.

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 a federal or state entitlement program and that it may be ended at any time upon appropriate notice.
- 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

Send your complete, signed application to the address below. If you do not have all the information we ask for, sign and submit your application anyway.

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.

This completes the application process for Medicaid, ARKids First and the Health Care Independence 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 and submit it with your application.

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

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

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.

The information I have provided is true to the best of myknowledge. I do not claim the right to vote in another county or state. If I have provided false information, I may be subject to afineofupto$10,000and/orimprisonmentofupto10yearsunderstateandfederallaws.

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

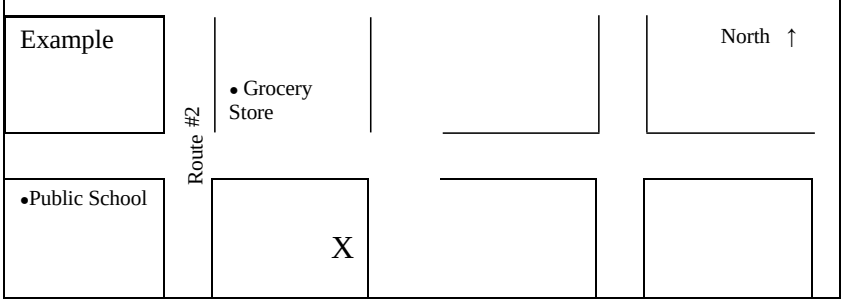
A	Mr. Mrs. Miss Ms.	Previous Last Name	Jr. Sr. II. III. IV.	First Name	Middle Name(s)

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	75229
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)