

# ARKids First

## Mail-In Application

If you need this material in a different format, such as large print, contact your DHS county office.  
Si necessita este formulario en Espanol, llame 1-800-482-8988

### Do you want your children considered for:

- Either ARKids package\*     ARKids A only     ARKids B only

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

## 1 Applicant Information

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

Social Security Number*	Last Name			First Name			MI
Birth Date	Race	Sex	County	E-mail Address			
Street Address				City	State	Zip Code	
Mailing Address (if different)				City	State	Zip Code	
Home or contact telephone		Work telephone		May we contact you at work? <input type="checkbox"/> Yes <input type="checkbox"/> No		Fax number	

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

## 2 Household

List all children living in your household under age 19 who you want considered for ARKids. Attach copies of birth certificates for all children applying for ARKids. Use additional sheets if needed.

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

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

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

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

List other children of the parents listed above that currently live in your home that you do not want covered under ARKids. These children may be included in the household size if it is to the benefit of the applicant.

Last Name	First Name	Birth Date	Relationship to YOU	U.S. Citizen (Yes/No)

### FOR OFFICE USE ONLY

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

### 3 Income

Does anyone listed on page 1 have income from the following? Attach additional sheets to explain, if needed.

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

Do you or your spouse work for Arkansas state government, state university, 2-year college, technical school or public school district?  Yes  No

### 4 Child Care

Does anyone listed on page 1 of this application pay for childcare for children listed on page 1?

Yes  No **If yes**, How much? \$ \_\_\_\_\_ How often? \_\_\_\_\_

### 5 Unpaid Medical Bills

Does any child you are applying for have unpaid medical expenses for the past 3 months?

Yes  No **If yes**, Who? \_\_\_\_\_ In which month(s)? \_\_\_\_\_

### 6 Health Insurance

Does any child you are applying for have health insurance of any kind at this time?

Yes  No **If yes**, Who? \_\_\_\_\_ Insurance company \_\_\_\_\_

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

Has any child you are applying for had health insurance, other than Medicaid, in the last 6 months?

Yes  No **If yes**, Who? \_\_\_\_\_ Insurance company \_\_\_\_\_

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

Please explain why health insurance is no longer available. \_\_\_\_\_

### 7 Chronic Illness or Disability

Does any child you are applying for have a chronic illness or disability (special health care need)?

Yes  No **If yes**, Who? \_\_\_\_\_

### 8 Primary Care Physician Selection

Indicate your 1<sup>st</sup>, 2<sup>nd</sup> and 3<sup>rd</sup> choices for the physician or clinic you want as primary care physician for each of the children for whom you are applying. ARKids allows each child covered to have only **one** primary care physician. Call toll-free 1-800-275-1131 for assistance in making your selection. Use additional sheets as needed.

Child's Name	First Choice	Second Choice	Third Choice

### 9 Other Services Available

Do you want us to mail you information about applying for Food Stamps?  Yes  No

Do you want us to mail you information about receiving child support services free of charge?  Yes  No

**Read carefully before you sign this application**

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

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

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

\_\_\_\_\_  
Signature of Parent, Guardian or Relative                              Date

\_\_\_\_\_  
Telephone number of person helping to complete form

\_\_\_\_\_  
Signature of person helping to complete form                              Date

\_\_\_\_\_

\_\_\_\_\_  
Signature of Family Support Specialist                              Date

\_\_\_\_\_  
Address of person helping to complete form

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

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

**Return This Application**, including attached pages, and copies of birth certificates for each of the children you want considered for ARKids to your local DHS office. Please use the back page for mailing.

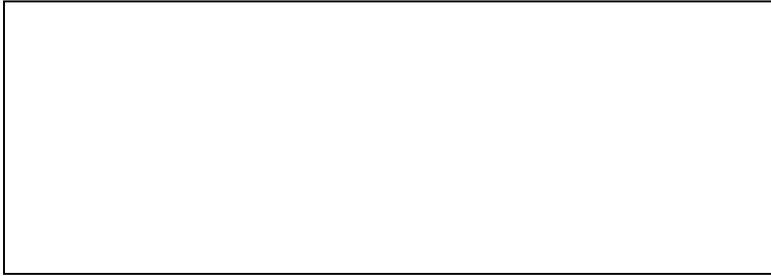
## DHS County Office Mailing Addresses

County	Address	City	Zip	County	Address	City	Zip	County	Address	City	Zip
Arkansas	100 Court Square	DeWitt	72042	Grant	PO Box 158	Sheridan	72150	Ouachita	PO Box 718	Camden	71711
Arkansas	PO Box 1008	Stuttgart	72160	Greene	PO Box 839	Paragould	72451	Perry	213 Houston Ave.	Perryville	72126
Ashley	PO Box 190	Hamburg	71646	Hempstead	116 N. Laurel	Hope	71802	Phillips	PO Box 277	Helena	72342
Baxter	PO Box 408	Mt. Home	72654	Hot Spring	PO Box 813	Malvern	72104	Pike	PO Box 200	Murfreesboro	71958
Benton	900 SE 13 <sup>th</sup> Court	Bentonville	72712	Howard	PO Box 1740	Nashville	71852	Poinsett	PO Box 526	Harrisburg	72432
Boone	PO Box 1096	Harrison	72601	Independence	100 Weaver Ave	Batesville	72501	Polk	606 Pine St.	Mena	71953
Bradley	PO Box 509	Warren	71671	Izard	PO Box 65	Melbourne	72556	Pope	701 N. Denver	Russellville	72801
Calhoun	PO Box 1068	Hampton	71744	Jackson	PO Box 610	Newport	72112	Prarie	PO Box 356	DeValls Bluff	72041
Carroll	PO Box 425	Berryville	72616	Jefferson	PO Box 5670	Pine Bluff	71611	Pulaski East	PO Box 8083	Little Rock	72203
Chicot	PO Box 71	Lake Village	71653	Johnson	PO Box 1636	Clarksville	72830	Pulaski Jax.	PO Box 626	Jacksonville	72078
Clark	PO Box 968	Arkadelphia	71923	Lafayette	2612 Spruce st.	Lewisville	71845	Pulaski North	PO Box 5791	No. Little Rock	72119
Clay-1	PO Box 366	Piggott	72454	Lawrence	PO Box 69	Walnut Ridge	72476	Pulaski South	PO Box 2620	Little Rock	72203
Clay-2	1007 Ada St.	Corning	72422	Lee	PO Box 309	Marianna	72360	Pulaski SW	PO Box 8916	Little Rock	72219
Cleburne	PO Box 1140	Heber Springs.	72543	Lincoln	101 W. Wiley St.	Star City	71667	Randolph	1408 Pace Rd.	Pocahontas	72455
Cleveland	PO Box 465	Rison	71665	Little River	90 Waddell St.	Ashdown	71822	Saline	PO Box 608	Benton	72018
Columbia	PO Box 1109	Magnolia	71754	Logan-1	#17 W. McKeen	Paris	72855	Scott	PO Box 840	Waldron	72958
Conway	PO Box 228	Morrilton	72110	Logan-2	398 E. 2 <sup>nd</sup> St.	Booneville	72927	Searcy	350 School	Marshall	72650
Craighead	2920 McClellan Drive	Jonesboro	72401	Lonoke	PO Box 260	Lonoke	72086	Sebastian	616 Garrison #231	Ft. Smith	72901
Crawford	704 Cloverleaf Circle	Van Buren	72956	Madison	PO Box 128	Huntsville	72740	Sevier	108 Tn N, Prof Bldg A	DeQueen	71832
Crittenden	401 S. Airport Rd.	W. Memphis	72301	Marion	PO Box 447	Yellville	72687	Sharp	PO Box 159	Ash Flat	72513
Cross	PO Box 572	Wynne	72396	Miller	3809 Airport Plz.	Texarkana	71854	St Francis	PO Box 899	Forrest City	72336
Dallas	1202 W. 3 <sup>rd</sup> St.	Fordyce	71742	Mississippi – 1	1104 Byrum Rd.	Blytheville	72315	Stone	1821 E. Main	Mountain View	72560
Desha	PO Box 1009	McGehee	71654	Mississippi – 2	437 S Country Club	Osceola	72370	Union	123 W. 18 <sup>th</sup> St.	El Dorado	71730
Drew	PO Box 1350	Monticello	71657	Monroe-1	PO Box 354	Clarendon	72029	Van Buren	362 Ingram Street	Clinton	72031
Faulkner	PO Box 310	Conway	72033	Monroe-2	301 ½ N New Orlean	Brinkley	72021	Washington	4044 Frontage	Fayetteville	72703
Franklin	800 W.Commercial	Ozark	72949	Montgomery	PO Box 445	Mt. Ida	71957	White	608 Rodgers Drive	Searcy	72143
Fulton	PO Box 650	Salem	72576	Nevada	PO Box 292	Prescott	71857	Woodruff	PO Box 493	Augusta	72006
Garland	115 Market St.	Hot Springs	71901	Newton	PO Box 452	Jasper	72641	Yell	PO Box 277	Danville	72833

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 Fold in half, staple or tape ends together, and mail to your local DHS County Office  
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**Return Address**

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