Arkansas Department of Human Services
Application for Health Coverage
Single Adults

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?

Single adults who:

- Don't have any dependents and can't be claimed as a dependent on someone else's tax return.

NOTE: If any of the following apply you will need to fill out form DCO-152 to make sure you get the most benefits possible:

- You're married or have dependent children.
- You were in the Foster Care system and you're under 26.
- You have items that can be deducted from your income. If your only deduction is student loan interest, you can use this form.
- You're American Indian or Alaska Native.

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're a legal immigrant).
- Employer and income information (for example, from paystubs, W-2 forms, or wage and tax statements .

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'll keep all the information you provide private and secure as required by law.** To view the Privacy Act Statement go to Access.Arkansas.gov.

What happens next?

Send your completed, signed application to the address on Page 4**. If you don't have all the information we ask for, sign and submit your application anyway.**

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.

Step 1 – Tell Us About Yourself

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 get information about this application by email? ☐ Yes ☐ No
Email address: _____

17. What is your preferred spoken or written language (if not English)?

18. Date of birth (mm/dd/yyyy)	19. Sex ☐ Male ☐ Female

20. Social Security number (SSN) ___ ___ ___-___ ___-___ ___ ___ ___
We need this if you want health coverage and have an SSN. We use SSNs to check income and other information to see if you're eligible for help with health coverage costs. If you need help getting an SSN, call 1-800-772-1213 or visit socialsecurity.gov. TTY users should call 1-800-325-0778.

21. Are you a U.S. citizen or U.S. national? ☐ Yes ☐ No

22. **If you aren't a U.S. citizen or U.S. national:** Do you have eligible immigration status?
☐ Yes. Fill in your document type and ID number below.
   a. Immigration document type_____
   b. Document ID number _____
   c. Have you lived in the in the U.S. since 1996? ☐ Yes ☐ No
   d. Are you a veteran or an active duty member of the U.S. Military? ☐ Yes ☐ No

23. Are you pregnant? ☐ Yes ☐ No
If yes, how many babies are expected during this pregnancy? _____

24. Do you have a physical, mental or emotional health condition that causes limitations in activities (like bathing, dressing, daily chores, etc.) or live in a medical facility or nursing home? ☐ Yes ☐ No

25. **If Hispanic/Latino, ethnicity (OPTIONAL – Check all that apply.)**
☐ Mexican ☐ Mexican American ☐ Chicano/a ☐ Puerto Rican ☐ Cuban ☐ Other _____

26. Race **(OPTIONAL – Check all that apply.)**

☐ White	☐ Filipino	☐ Japanese
☐ Guamanian or Chamorro	☐ Vietnamese	☐ Korean
☐ Black or African American	☐ Other Asian	☐ Native Hawaiian
☐ American Indian or Alaska Native	☐ Samoan	☐ Other _____

NEED HELP WITH YOUR APPLICATION? Call us at 1-855-372-1084. Para obtenar una 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'll get you help at no cost to you.

Step 2 – Current Job & Income Information

☐ **Employed** If you're currently employed, tell us about your income. Start with question 1.

☐ **Not employed** Skip to question 11. ☐ **Self-employed** Skip to question 10.

CURRENT JOB 1:

1. Employer Name and Address	2. Employer Phone Number

3. Wages/tips (before taxes) $ _____
☐ Hourly ☐ Weekly ☐ Every 2 Weeks ☐ Twice a Month ☐ Monthly ☐ Yearly

4. Average hours worked each **week**: _____

CURRENT JOB 2:

5. Employer Name and Address	6. Employer Phone Number

7. Wages/tips (before taxes) $ _____
☐ Hourly ☐ Weekly ☐ Every 2 Weeks ☐ Twice a Month ☐ Monthly ☐ Yearly

8. Average hours worked each week: _____

9. **In the past year, did you:** ☐ Change jobs? ☐ Stop working? ☐ Start working fewer hours?
☐ None of these?

10. **If self-employed, answer the following questions:**
a. Type of work _____
b. How much net income (profits once business expenses are paid) will you receive from this self-employment this month?
$ _____

11. **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).

☐ None
☐ Unemployment $ _____ How often? _____
☐ Pensions $ _____ How often? _____
☐ Social Security $ _____ How often? _____
☐ Other income $ _____ How often? _____
☐ Retirement Accounts $ _____ How often? _____
☐ Alimony received $ _____ How often? _____
☐ Net farming/fishing $ _____ How often? _____
☐ Net rental/royalty $ _____ How often? _____
Other type: _____

12. Do you pay student loan interest (not the amount of the loan) that can be deducted on a federal income tax return? ☐ Yes ☐ No **If yes**, how much? _____ How often? _____

13. **YEARLY INCOME:** Complete only if your income changes from month to month. If you don't expect changes in your monthly income, skip to Step 3.

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

Step 3 – Your Health Coverage

Are you enrolled in health coverage now from any of the following? ☐ Yes ☐ No
If yes, check which coverage you have:

☐ Medicaid (from another state)
☐ CHIP (from another state)
☐ Medicare
☐ TRICARE (Don't check if you have Direct Care or Line of Duty)
☐ Peace Corps
☐ VA Health Care programs
☐ Other
Name of Health insurance: _____
Policy Number: _____

Step 4 – Read & Sign This Application

I'm signing this application under penalty of perjury, which means I've 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 the federal law if I intentionally provide false or untrue information.

- I know that I must tell the Department of Human Services 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 my eligibility.
- I know that under federal law, discrimination isn't 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 calling 1-501-682-6003.
- I confirm that I'm not incarcerated (detained or jailed).
- I confirm that next year I expect to file a federal income tax return, won't claim dependents on that return and can't be claimed as a dependent on anyone else's federal income tax return.
- 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.

We need this information to check your eligibility for Medicaid, ARKids First or the Health Care Independence Program if you choose to apply. We'll 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 doesn't match, we may ask you to send us proof.

Renewal of Coverage in Future Years

To make it easier to determine my eligibility for Medicaid, ARKids First or the Health Care Independence Program coverage in future years, I agree to allow the Department of Human Services to use income data including information from tax returns. DHS will send me a notice, allow me to make any changes and I can opt out at any time.

Yes, renew 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 years ☐ Don't use tax return information to renew coverage

If I'm eligible:

If I enroll in Medicaid, ARKids First or the Health Care Independence Program, I'm giving the Department of Human Services my rights to pursue and get money from other health insurance, legal settlements or other third parties.

My right to appeal:

If I think DHS has made a mistake, I can appeal its decision. To appeal means to tell someone at the Department of Human Services that I think the action is wrong and ask for a fair review of the action. I know I can find out how to appeal an action by contacting DHS at 1-501-682-8622. I know that 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're 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 5 – Submit Completed Application

Mail your signed application to: **DHS Jefferson County**
1222 West 6th Street
P.O. Box 5670
Pine Bluff, AR 71611

Or email your signed application to: 351Jefferson@arkansas.gov

Or FAX your signed 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 has been approved or denied and provide instructions on the next steps needed to complete your health coverage. If you are not eligible for any of these programs, we will screen your application for potential eligibility for tax credits to help you 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 you.

If you want to register to vote, complete the Voter Registration packet that was given to you as a part of this application packet.