ARKANSAS DEPARTMENT OF HUMAN SERVICES
TEFRA and AUTISM WAIVER
Application for Assistance

If you need this material in a different format, such as large print, please contact your local DHS county office.
Si necesita este formulario en Espanol, llame al 1-800-482-8988 y pida la versión en Español.

What type of services are you requesting? ☐ **TEFRA** ☐ **Autism Waiver**

Child's Name:	Social Security Number	Male ☐ Female ☐	U.S. Citizen Yes ☐ No ☐
Date of Birth:	Age: _____years _____months		Race:
Parent/Guardian:			
Current Address: City:	State:	Zip:	County:
Phone:	Email:		

1. **Does the child you are applying for have income?** ☐ **Yes** ☐ **No** **If yes, list the child's income below.**

Source of Income	Gross Amount (Before deductions)	How often?
Social security		
SSI		
Veteran's benefits		
Child support		
Other		

2. **Does the child you are applying for have resources?** ☐ **Yes** ☐ **No** **If yes, list the child's resources.**

Source of Resource	Amount or Value	Location of Resource
Cash, Checking, Savings or Christmas Club Account		
Stocks, Bonds, Trust Fund, Certificate of Deposit, Mutual Fund, etc.		
Other		

3. **Does the child you are applying for have health insurance?** ☐ **Yes** ☐ **No**
   If yes, please provide a copy of the front and back of the child's insurance card.

4. **Primary Care Physician** _____

   Autism Diagnosis ☐ **Yes** ☐ **No** **Date of Diagnosis** _____

5. **Do you expect a change in any of the above?** ☐ **Yes** ☐ **No** **If yes, what?** _____
   When? _____

For TEFRA only

Information needed to determine the TEFRA premium:

- Please attach the most recent Federal Income Tax Return and Schedule A, if you itemized deductions, for the child's parent(s).
- The total number of dependents that live in your household including yourself: _____

For Autism Waiver only

If this application is for the Autism Waiver, please attach an evaluation report from each of the following indicating that the child has a diagnosis of autism. Please place a check mark beside each item that is attached.

- ☐ Physician Report
- ☐ Psychologist Report
- ☐ Speech-language Pathologist Report
- ☐ Adaptive Behavior Assessment Report (such as Vineland)

Read carefully before you sign this application

The PRIVACY ACT of 1974 requires the Department of Human Services (DHS) to tell you: (1) whether disclosure of your SSN 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 TEFRA and Autism 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 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, Department of Workforce Services, 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 Medicaid 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 Medicaid benefits through me to investigate whether or not any person has committed Medicaid 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 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 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 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 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 _____ Date_____

Arkansas Department of Human Services
Division of County Operations
THIRD PARTY RESOURCE / MEDICAL INSURANCE

A. APPLICANT INFORMATION:

1. Last Name	2. First Name	3. MI	4. Sex	5. Social Security Number

6. Applicant's Address	7. City	8. ST	9. Zip

10. Other than Medicare, do you have health insurance or some other insurance, settlement, person or group that is responsible for paying all or part of your medical expenses?

❑**Yes** If Yes, please either attach proof of coverage (such as a copy of your insurance card) **OR** complete B, C and D below.

❑**No** If No, please skip to Section F and provide a phone number, sign and date the form, and mail it to us.

B. POLICYHOLDER INFORMATION:

11. Policyholder's Last Name	12. First Name	13. MI	14. Social Security Number

15. Policyholder's Address	16. City	17. ST	18. Zip

C. INSURANCE INFORMATION:

19. Name of Insurance Company	20. Policy Number	21. Policy Effective Dates	
		From / /	To / /

22. Address of Claims Office	23. City	24. ST	25. Zip

26. Check all Type of Benefits/Coverage Applicable (at least one must be checked)

☐ 1. Medical	☐ 4. Vision	☐ 7. Indemnity/Hospital/Cancer/Heart
☐ 2. Pharmacy	☐ 5. Medicare Supplement	☐ 8. Accident Only (non-Auto)
☐ 3. Dental	☐ 6. Long Term Care	☐ 9. Automobile/Motorcycle Accident
		☐ 10. Other _____

D. INDICATE ALL INDIVIDUALS COVERED BY POLICY:

27. Last Name	28. First	29. MI	30. Relationship	31. SSN or Medicaid Number

E. COMMENTS _____

_____

F. TELEPHONE NUMBER WHERE YOU CAN BE REACHED BETWEEN 8:00/4:30 _____

AUTHORIZATION AND ASSIGNMENT

I authorize any holder of medical or other information about me to release information needed for this or a related Medicaid claim to the Arkansas Medicaid program. I authorize the further release of any such information to any other parties who may be liable for any of my medical expenses. I hereby authorize and request that funds, settlement or other payments made by or on behalf of third parties, including tort-feasors or insurers, arising out of this Medicaid claim be paid directly to the Arkansas Medicaid program. I also assign all rights in any settlement made by me or on my behalf and arising out of any claim of which this is a part to the extent of medical expenses paid by Medicaid whether or not a portion of such settlement is designated as being for medical expenses. Any such funds received by me shall be paid to the Arkansas Medicaid program. I permit a copy of this authorization to be used in place of the original.

_____ _____

Applicant/Recipient signature (or parent/guardian if minor) Date

DHS County Office Only below:

Fold in half or tape ends together and Mail to Third Party Liability Unit

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Division of Medical Services
Third Party Liability Unit
P.O. Box 1437, Slot S296
Little Rock, AR 72203-1437

ARKANSAS DEPARTMENT OF HUMAN SERVICES
AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Client Name: _____ **Client ID #:** _____
Mailing Address: _____ **Date of Birth:** _____
_____ **Case Head:** _____

I, _____ hereby authorize
(Client or Personal Representative)

_____ to disclose specific health information
(Name of Provider/Plan)

from the records of the above named client to: _____
_____
_____
_____
(Recipient Name/Address/Phone/Fax)

for the specific purpose(s): _____
_____
_____

Specific information to be disclosed: _____
_____

If you use "All Medical Records" this will include any and all written information DHS may have concerning your health care and any illness or injury you may have suffered, including, but not limited to, medical history, consultations, prescriptions, treatment, medical evaluations, x-rays, results of tests, and copies of hospital or medical records pertaining to you.

I understand that this authorization will expire on the following date, event or condition: _____
_____

I understand that if I fail to specify an expiration date or condition, this authorization is valid for the period of time needed to fulfill its purpose for up to one year, except for disclosures for financial transactions, wherein the authorization is valid indefinitely. I also understand that I may revoke this authorization at any time and that I will be asked to sign the *Revocation Section* on the back of this form. I further understand that any action taken on this authorization prior to the rescinded date is legal and binding.

I understand that my information may not be protected from re-disclosure by the requester of the information; however, if this information is protected by the Federal Substance Abuse Confidentiality Regulations, the recipient may not re-disclose such information without my further written authorization unless otherwise provided for by state or federal law.

I understand that if my record contains information relating to HIV infection, AIDS or AIDS-related conditions, sexually transmitted diseases, alcohol abuse, drug abuse, psychological or psychiatric conditions, genetic testing, family planning, or womens, infant, & children (WIC) this disclosure will include that information.

I also understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment for services, or my eligibility for benefits; however, if a service is requested by a non-treatment provider (e.g., insurance company) for the sole purpose of creating health information (e.g., physical exam), service may be denied if authorization is not given. If treatment is research-related, treatment may be denied if authorization is not given.

I further understand that I may request a copy of this signed authorization. A copy of this authorization shall be as binding as the original.

_____ _____ _____
(Signature of Client) *(Date)* *(Witness-If Required)*

_____ _____ _____
(Signature of Personal Representative) *(Date)* *(Personal Representative Relationship/Authority)*

NOTE: This Authorization was revoked on _____ _____
(Date) *(Signature of Staff)*

ARKANSAS DEPARTMENT OF HUMAN SERVICES
AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

REVOCATION SECTION

<u>COMPLETE ONLY</u> WHEN REVOKING THE AUTHORIZATON

I do hereby request that this authorization to disclose health information of _____
(Name of Client)

signed by _____ on _____
(*Enter Name of Person Who Signed Authorization)* *(Enter Date of Signature)*

be rescinded effective _____ I understand that any action taken on this authorization prior to the
(Date)

Rescinded date is legal and binding.

_____	_____	_____	_____
(Signature of Client)	*(Date)*	*(Signature of Witness)*	*(Date)*

_____	_____	_____
(Signature of Personal Representative)	*(Date)*	*(Personal Representative Relationship/Authority)*

The Department of Human Services is in compliance with Titles VI and VII of the Civil Rights Act. This letter is available in other languages and alternate formats.

ARKANSAS DEPARTMENT OF HUMAN SERVICES
TEFRA Waiver
Physician Assessment of Eligibility

Date of Application _____

SECTION I. Patient Information:

PATIENT'S LAST NAME	FIRST	MI	SEX ☐ M ☐ F	PATIENT'S MEDICAID ID#
PHONE NUMBER	COUNTY OF RESIDENCE	DATE OF BIRTH	RACE	SOCIAL SECURITY NUMBER
MAILING ADDRESS(Street, City, State, Zip code)		RESIDENCE ADDRESS(Street, City, State, Zip code)		
PRIMARY PHYSICIAN	ADDRESS			
PARENT/GUARDIAN NAME (Primary Caregiver)		CHILD SCREENING REFERRAL ☐ Yes ☐ No		
INSURANCE COMPANY AND ADDRESS		INSURANCE POLICY NUMBER		
☐ Original	☐ Re-certification	Date		
PRIMARY DIAGNOSIS	SECONDARY DIAGNOSIS	OTHER DIAGNOSIS		
HOSPITALIZATIONS in the last year – Reason and Length of Stay				
BRIEF MEDICAL AND SURGICAL HISTORY (If available, please attach copies of clinical or hospital records)				
☐ Letter Attached ☐ Medical Records Attached				
Prognosis				
Goals				
Date Last Examined				

SECTION II. **Current Services Required for Patient Management:** ***Please attach a current medical & surgical history that includes M.D. summary, prognosis and medical follow-up requirements. Include changes since last certification, if recertification.*** **CHECK ALL THAT APPLY.**

Required Services:

☐ Close patient monitoring of _____ with frequent skilled intervention of
(specific symptom)

_____
(intervention)

☐ Hyperalimentation - parenteral or sole source enteral
☐ IV Drugs (chemotherapy, pain relief or prolonged IV antibiotics)
☐ Respiratory - Tracheostomy Care or continuous Oxygen Supplementation
☐ Ventilator-Dependent: _____ Hours per day

SECTION II. (Continued):

Needs Assessment:

- ☐ Cardiovascular System
- ☐ Digestive System
- ☐ Endocrine System
- ☐ Genito-urinary System
- ☐ Hemic and Lymphatic System
- ☐ Immune System
- ☐ Mental Disorders
- ☐ Multiple Body Systems
- ☐ Musculoskeletal System
- ☐ Neoplastic Diseases
- ☐ Neurological
- ☐ Respiratory System
- ☐ Skin
- ☐ Special Senses and Speech

Physical Abilities/Limitations:

- ☐ Ambulatory
- ☐ Ambulates with assistance
- ☐ Independent transfers bed/chair
- ☐ Transfers with assistance
- ☐ Total lift
- ☐ Sighted
- ☐ Blind
- ☐ Verbal
- ☐ Other _____
- ☐ Deaf
- ☐ Signs
- ☐ Augmentative Communication Device

Cognitive Abilities/Limitations:

- ☐ Alert, cognitive appropriate for age
- ☐ Alert, cognitive age _____
- ☐ Alert, disoriented
  - Bathing: ☐ self ☐ caregiver
  - Feedings: ☐ self ☐ caregiver
- ☐ Unresponsive
- ☐ Uncooperative
- ☐ Other _____

Skilled Nursing Needs: (frequency documented by hospital record or nurse's notes)

- ☐ Continuous O_2
- ☐ Nasopharengeal Suctioning
- ☐ Sole source enteral _____ hrs
- ☐ Trach Care
- ☐ Tracheal Suctioning
- ☐ Ventilator _____ hrs/day
- ☐ _____ (other)
- ☐ _____ (other)
- ☐ _____ (other)

Additional Services:

Medications (route and frequency): _____

Occupational Therapy (frequency, location & provider name): _____

Physical Therapy (frequency, location & provider name): _____

Speech Therapy (frequency, location & provider name): _____

Other – Specify (ex: Personal Care, Waiver Caregiver, Developmental Day Treatment Clinic Services, Mental Health, Home Health, Targeted Case Management): _____

Name of Targeted Case Manager, if applicable: _____

SECTION II. (Continued):

Equipment or Special Physical Aids In Use:

- ☐ Catheter
- ☐ CPAP/BIPAP
- ☐ Crutches/Cane
- ☐ Enteral Pump
- ☐ Hospital Bed
- ☐ Hoyer Lift
- ☐ IV Pump
- ☐ Nebulizer
- ☐ O_2
- ☐ Orthotics/Prosthetics
- ☐ Ostomy care
- ☐ Pulse OX
- ☐ Shower Chair
- ☐ Shower Chair
- ☐ Shower Chair
- ☐ Shower Chair
- ☐ Suction Machine
- ☐ Ventilator
- ☐ Walker
- ☐ Wheelchair: ☐ power ☐ manual

_____

☐ Other _____ ☐ Other _____

Daycare/Education:

Daycare/School Days & Hours, Name of School. List Start/End Dates and Vacation Dates: _____

_____

_____

_____

GOALS:

A. Patient/Family Education/Teaching Goals: _____

_____

_____

_____

B. Were previous goals met? _____

_____

_____

_____

SECTION III. Psycho-Social History:

Please include changes in psycho-social situation since last certification if re-certification.

A. Caregiver's understanding of patient's condition: _____

B. Family composition (List all residents of home by name and age. List education and occupation of Adults): _____

C. Support system: _____

D. Transportation requirements: _____

E. Number of competent caregivers in home (name & relationship to patient): _____

SECTION IV. PHYSICIAN'S CERTIFICATION:

I certify that the above named patient can be treated in a home setting with the services specified in this assessment.

The services are appropriate to the condition of the patient: ☐ Yes ☐ No

Home/Community resources are available for this assessment: ☐ Yes ☐ No

Signature of Physician: _____ Date: _____

Printed Name: _____ Phone: _____

Address: _____

City, State and Zip Code: _____

ARKANSAS DEPARTMENT OF HUMAN SERVICES

Medical Review Team (MRT)
Slot S334
Social Report for Children

Section 1: To be completed by Eligibility Worker

Child's Budget Unit ID	Cat.	Child's Name	Race	Sex	Birthdate

Application Date	County	Register #	Casehead Name

Address	City	State	Zip

Worker's Name as shown on E-Mail	Last MRT decision date	Interview Date	Date routed To MRT

Section 2: MRT use only

Date Record Added	MRT Date	Date Medical Records Request Sent Code Records Rec'd	Physician Date ID	Decision Date Code

Re-exam Date	Case Type	Key Initial	Key Date

Section 3: To be completed by Eligibility Worker, Parent or Guardian

A. List all Household Members:

Last Name	First Name	Relationship	Age
		Child	

Daytime Phone # and Area Code:	
Home/Mobile Number:	Message Number:

B. Description of Physical & Mental Condition: Please ask the parent or caretaker the following questions:

1. What is the child's height? ___ Weight?
2. When did the illness, injury, or condition begin? MM/DD/YY_____
3. Has the child ever received or applied for SSI or Social Security Disability? Yes___ (Go to 3a) No___ (go to #4)
   a. Is SSI/SSA application still pending? Yes___ (Go to #4) No___ (Go to 3b)
   b. What were the dates of approval, denial, or closure? _____
   c. What was the reason for denial or closure? Please provide a copy of letter from Social Security Administration stating the reason for denial/closure.

   d. If it has been more than 12 months since the last SSI or Social Security Disability denial/closure, is the condition with SSA last considered about the same, better, worse, or has it changed?

4. Describe any medical conditions or injuries that limit the child's daily life.

5. Describe any behavior problems, speech problems, learning problems, or attendance problems the child has had at home, in school or therapy.

6. Education/Therapy/Medical Treatment

a. What medical treatment has the child received for this condition? What Treatment is planned for the future?

b. Does the child attend special education classes? Yes_____ No_ List all schools/facilities that the child received behavioral, occupational, physical or speech therapy in the last year.

Attach signed DHS-4000.

****If you have copies of therapy and/or evaluation records, please attach copies.**

School/Facility Information

Name of school/facility:			Grade:
Address:	City:	State:	Zip:
Area Code & Phone #:	Teacher:		

Name of school/facility:			Grade:
Address:	City:	State:	Zip:
Area Code & Phone #:	Therapist:		

Name of school/facility:			Grade:
Address:	City:	State:	Zip:
Area Code & Phone #:	Therapist:		

Physician/Clinics/Mental Health/Hospital Information (If you have copies of medical records from the past year to present, please attach copies)

Primary Care Physician Name:		Dates: From To	
Address:	City:	State:	Zip:

Area Code & Phone #:

Physician Name/ Clinic:		Dates: From To	
Address:	City:	State:	Zip:
Area Code & Phone #:			

Physician Name/Clinic:		Dates: From To	
Address:	City:	State:	Zip:
Area Code & Phone #:			

Physician Name/Clinic:		Dates: From To	
Address:	City:	State:	Zip:
Area Code & Phone #:			

Physician Name/Clinic:		Dates: From To	
Address:	City:	State:	Zip:
Area Code & Phone #:			

Physician Name/Clinic:		Dates: From To	
Address:	City:	State:	Zip:
Area Code & Phone #:			

Please check attachments:

- ☐ DHS-4000's completed for all necessary medical record requests
- ☐ DCO-107, if applicable
- ☐ Medical records, if available

ASSIGNMENT OF RIGHTS
FOR TEA AND MEDICAID APPLICANTS

ASSIGNMENT OF MEDICAL SUPPORT (MEDICAID ONLY)

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 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 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 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.

CHILD SUPPORT ENFORCEMENT REQUIREMENTS

TRANSITIONAL EMPLOYMENT ASSISTANCE (TEA) - I understand that if I accept TEA cash assistance, by state law, I will have **assigned all rights, title, and interest in any support** that I have in my own behalf or in behalf of any other person for whom I am receiving TEA. I understand that all support payments including those received by me directly from the absent parent, are to be paid to the Office of Child Support Enforcement. I understand that this **assignment** ends when I no longer receive TEA except as to any unpaid support obligation that has accrued at the time my TEA case is closed. I also understand that as a condition of eligibility for TEA, I must cooperate with the Office of Child Support Enforcement in establishing paternity and obtaining child support.

MEDICAID - As a condition of eligibility for Medicaid, adult caretaker relatives receiving Medicaid for themselves as well as for children, must cooperate with the Office of Child Support Enforcement (OCSE) in establishing paternity and obtaining medical support for each child who has a parent absent from the home. All other OCSE services, including collection of child support payments from the absent parent, will be provided unless OCSE receives a written notice from the caretaker relative declining those services. If the adult caretaker relative is not receiving Medicaid, cooperation with OCSE is strictly voluntary.

_____ _____

Signature **Date**

IMPORTANT ESTATE RECOVERY NOTICE:

If you receive Medicaid in a nursing facility, ICF/MR facility, or under a home and community based waiver program, the total amount of the Medicaid benefits paid on your behalf will be a debt to DHS and may be recovered from your estate after your death. Your estate is the property you own at the time of your death. DHS will not make a claim against your estate while you are living. DHS will not make a claim against your estate after your death if your spouse is still living, or if you have dependent children under age 21 or blind or disabled children. DHS will collect the debt, if any, by filing a claim in your estate. Collection may not be made if it is not cost effective to DHS or if your heirs apply for a hardship waiver after your death. A hardship may exist if the estate property is the only source of income for your heirs, if that income is limited, or if there are other compelling circumstances.

I have read the Assignment of Medical Support on page 1 and the above notice on Estate Recovery.

_____ _____

Signature **Date**

ARKANSAS DEPARTMENT OF HUMAN SERVICES NOTICE OF PRIVACY PRACTICES

Updated: December 08, 2016

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Department of Human Services (DHS) provides many types of services, such as health and social services. DHS staff must collect information about you to provide these services. DHS knows that information collected about you and your health is private. DHS and all associates at all locations are required by law to maintain the privacy of patients' Protected Health Information (PHI) and to provide individuals with the Notice of the legal duties and privacy practices with respect to PHI.

DHS is required to give you a notice of our privacy practices for the information we collect and keep about you. We are required to abide by the terms of this Notice. We reserve the right to change the terms of this Notice and these new term will affect all PHI that we maintain at that time.

Revised notices may be picked up at any office or online at:
http://humanservices.arkansas.gov/publicationDocs/PUB-407.pdf

In certain circumstances, DHS may use and disclose PHI without written consent.

For Treatment: We will use your health information to provide you with medical treatment or services. We will disclose PHI to doctors, nurses, technicians, students in health care training programs, or other personnel who are involved in taking care of you. For example, a doctor treating you for a broken leg may need to know if you have diabetes because that might slow the healing process. In addition, he/she may need to tell the dietitian to arrange for appropriate meals. Different departments of DHS may share health information about you in order to coordinate the services you need, such as prescriptions, lab work and x-rays. We may disclose health information to people outside DHS who provide your medical care like nursing homes or other doctors. We may tell your health insurer about treatment your doctor has recommended to obtain prior approval to determine whether your plan will cover the cost of the treatment. We may contact you to provide reminders of appointments.

For Payment: DHS will use and disclose PHI to other health care providers to assist in payment of your bills. For example, we will use it to send bills and collect payment from you, your insurance company, or other payers, such as Medicare, for the care, treatment, and other related services you receive.

For Health Care Operations: DHS may use or disclose your PHI for the purpose of our business operations. These uses and disclosures are necessary to insure our patients receive quality care. For example, we may use PHI to review the quality of our treatment and services, and to evaluate the performance of staff, contracted employees and students in caring for you.

Business Associates: We may use or disclose your PHI to an outside company that assists us in operating our health system and performs various services for us. This includes, but is not limited to, auditing, accreditation, legal services, data processing, and consulting services. These outside companies are called "business associates" and contract with us to keep PHI received confidential in the same way we do. These companies may create or receive PHI for us.

For Public Health Activities: DHS may use or disclose your PHI for public health activities that are permitted or required by law. For example, we may disclose PHI in certain circumstances to control or prevent a communicable disease; injury; disability; to report births and deaths; and for public health oversight activities or interventions. We may disclose PHI to the Food and Drug Administration (FDA) to report adverse events or product defects, to track products, to enable product recalls, or to conduct post-market surveillance as required by law or to state or federal government agencies. We may disclose PHI, if directed by a public health authority, to a foreign government agency that is collaborating with the public health authority.

For Health Oversight Activities: DHS may disclose PHI to a health oversight agency for activities authorized by law. For example, these oversight activities may include audits; investigations; inspections; licensure or disciplinary actions; or civil, administrative, or criminal proceedings or actions. Agencies seeking this information include government agencies that oversee the health care system, benefit programs, other regulatory programs, and government agencies that ensure compliance with civil rights laws.

As Required by Law and For Law Enforcement: DHS will use and disclose PHI when required or permitted by federal, state, and local laws, or by court order. Under certain conditions, we may disclose PHI to law enforcement officials for law enforcement purposes. For example, these may include (1) responding to a court order or similar process; (2) as necessary to locate or identify a suspect, fugitive, material witness, or missing person; (3) reporting suspicious wounds, burns or other physical injuries; or (4) as relating to the victim of a crime.

Lawsuits and Other Legal Proceedings: DHS may disclose PHI in the course of any judicial or administrative proceeding or in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized.) If certain conditions are met, we may disclose your PHI in response to a subpoena, a discovery request, or other lawful process.

Abuse or Neglect: We may disclose your PHI to a government authority that is authorized by law to receive reports of abuse, neglect, or domestic violence. Additionally, as required by law, if we believe you have been a victim of abuse, neglect, or domestic violence, we may disclose your PHI to a governmental entity authorized to receive it.

For Government Programs: DHS may use and disclose PHI for public benefits under other government programs. For example, DHS may disclose PHI for the determination of Supplemental Security Income (SSI) benefits.

To Avoid Harm: DHS may disclose PHI to law enforcement in order to avoid a serious threat to the health and safety of a person or the public.

For Research: DHS may use and share your health information for certain kinds of research. For example, a research project may involve comparing the health and recovery of patients who received one medication to those who received another for the same condition. All research projects, however, are subject to a special approval process. In some instances, the law allows us to do some research using your PHI without your approval.

Family Members and Friends: If you agree, do not object, or we reasonably infer that there is no objection, DHS may disclose PHI to a family member, relative, or other person(s) whom you have identified to be involved in your health care or the payment of your health care. If you are not present, or are incapacitated, or it is an emergency or disaster relief situation, we will use our professional judgment to determine whether disclosing limited PHI is in your best interest. We may disclose PHI to a family member, relative, or other person(s) who was involved in the health care or the payment for health care of a deceased individual if not inconsistent with prior expressed preferences of the individuals known to DHS. You also have the right to request a restriction on our disclosure of your PHI to someone who is involved in your care.

Coroners, Medical Examiners, and Funeral Directors: DHS may release your PHI to a coroner or medical examiner. For example, this may be necessary to identify a deceased person or to determine cause of death. We may also release your PHI to a funeral director, as necessary, to carry out his/her duties.

Organ Donations: We will disclose PHI to organizations that obtain, bank, or transplant organs or tissues.

National Security and Protection of the President: DHS may release your PHI to an authorized federal official or other authorized persons for purposes of national security, for providing protection to the President, or to conduct special investigations, as authorized by law.

Correctional Institution: If you are an inmate of a correctional institution or under the custody of a law enforcement officer, DHS may release your PHI to them. The PHI released must be necessary for the institution to provide you with health care, protect your or other's health and safety, or for the safety and security of the correctional institution.

Military: If you are a veteran or a current member of the armed forces, DHS

may release your PHI as required by military command or veteran administration authorities.

Workers' Compensation: DHS will disclose your health information that is reasonably related to a worker's compensation illness or injury following written request by your employer, worker's compensation insurer, or their representative.

Employer Sponsored Health and Wellness Services: We maintain PHI about employer sponsored health and wellness services we provide our patients, including services provided at their employment site. We will use the PHI to provide you medical treatment or services and will disclose the information about you to others who provide you medical care.

Shared Medical Record/Health Information Exchanges: We maintain PHI about our patients in shared electronic medical records that allow the DHS associates to share PHI. We may also participate in various electronic health information exchanges that facilitate access to PHI by other health care providers who provide you care. For example, if you are admitted on an emergency basis to another hospital that participates in the health information exchange, the exchange will allow us to make your PHI available electronically to those who need it to treat you.

Sponsor of the Plan: DHS may disclose PHI to the sponsor of a group health plan or a health insurance issuer.

Other Uses and Disclosures of PHI

Other uses and disclosures of your PHI that are not described above will be made only with your written authorization. If you provide DHS with an authorization, you may revoke it in writing, and this revocation will be effective for future uses and disclosures of PHI. The revocation will not be effective for information that we have used or disclosed in reliance on the authorization.

For example, most uses and disclosures of psychotherapy notes, uses and disclosures of PHI for marketing purposes, and disclosures that constitute the sale of PHI require your written authorization.

Your PHI Privacy Rights

Right to Revoke Permission: If you are asked to sign an authorization to use or disclose PHI, you can cancel that authorization at any time. You must make the request in writing. This will not affect PHI that has already been shared.

The Right to Access to Your Own Health Information: You have the right to inspect and copy most of your protected health information for as long as we maintain it as required by law. We may require that you make this request in writing. We may charge you a nominal fee for each page copied and postage if applicable. You also have the right to ask for a summary of this information. If you request a summary, we may charge you a nominal fee.

Right to Request Restrictions: You have the right to request certain restrictions of our use or disclosure of your PHI. We are not required to agree to your request in most cases. But if DHS agrees to the restriction, we will comply with your request unless the information is needed to provide you emergency treatment. DHS will agree to restrict disclosure of PHI about an individual to a health plan if the purpose of the disclosure is to carry out payment or health care operations and the PHI pertains solely to a service for which the individual, or a person other than the health plan, has paid DHS for in full. For example, if a patient pays for a service completely out of pocket and asks DHS not to tell his/her insurance company about it, we will abide by this request. A request for restriction should be made in writing. To request a restriction you must contact the DHS Privacy Officer. We reserve the right to terminate any previously agreed-to restrictions (other than a restriction we are required to agree to by law). We will inform you of the termination of the agreed-to restriction and such termination will only be effective with respect to PHI created after we inform you of the termination.

Right to Request Confidential Communications: You may request in writing that we communicate with you in an alternative manner or at an alternative location. For example, you may ask that all communications be sent to your work address. Your request must specify the alternative means or location for communication with you. It also must state that the disclosure of all or part of the PHI in a manner inconsistent with your instructions would put you in danger. We will accommodate a request for confidential communications that is reasonable and that states that the disclosure of all or part of your protected health information could endanger you.

Right to Inspect and Copy: You have the right to inspect and receive a copy of PHI about you that may be used to make decisions about your health. A request to inspect your records may be made to your nurse or doctor while you are an inpatient or to the DHS Privacy Officer while an outpatient. For copies of your PHI, requests must go to the DHS Privacy Officer. For PHI in a designated record set that is maintained in an electronic format, you can request an electronic copy of such information. There may be a charge for these copies.

Right to Amend: You may ask us to amend the information, for as long as DHS maintains the information. Requests for amending your PHI should be made to the DHS Privacy Officer. The DHS personnel who maintain the information will respond to your request within 60 days after you submit the written amendment request form. If we deny your request, we will provide you a written explanation. You may respond with a statement of disagreement to be appended to the information you wanted amended. If we accept your request to amend the information, we will make reasonable efforts to inform others, including people you name, of the amendment and to include the changes in any future disclosures of that information.

Right to Get a List of Disclosures: You have the right to ask DHS for a list of disclosures made after April 14, 2003. You must make the request in writing. With some exceptions, you have the right to receive an accounting of certain disclosures of your PHI. A nominal fee will be charged for the record search.

Right to Get a Paper Copy of this Notice: You have the right to ask for a paper copy of this notice at any time

Right to File a Complaint: You have the right to file a complaint if you feel DHS has violated your rights. To do so, contact the Privacy Officer by using the information below. You can file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights by using the contact information below. We will not retaliate against you for filing a complaint.

Right to be notified of a Breach: You have the right to be notified in the event that we (or one of our Business Associates) discover a breach of unsecured protected health information involving your medical information.

See the contact information below:
To View, Inspect, Copy, or Amend your PHI,
To Request Confidential Communications,
To Request an accounting (list) of disclosures, To Request Restrictions,
To Revise Authorizations, or
To File a Complaint.

This privacy notice is also available at:
http://humanservices.arkansas.gov/publicationDocs/PUB-407.pdf

You may contact your local DHS office or the DHS Privacy Officer at the address listed below.

DHS Privacy Officer
Arkansas Department of Human Services
P.O. Box 1437, Slot S260
Little Rock, Arkansas 72203-1437 Telephone: 1-855-283-0835
TDD: (501) 682-8933
Email: DHSPrivacyOfficer@dhs.arkansas.gov

Office for Civil Rights
U.S. Department of Health & Human Services
1301 Young Street-Suite 1169
Dallas, TX 75202
(800) 368-1019; (800) 537-7697(TDD)
(202) 619-3818 Fax
www.hhs.gov/ocr/privacy/hipaa/complaints/

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____ (print name of client or legal representative) have been given a copy of DHS's Notice of Privacy Practices and have had a chance to ask questions about how my PHI will be used.

_____ _____
Client's Signature **Date**

_____ _____
Legal or Personal Representative of Client (if applicable) **Date**

File the original signed copy in the case record; give the recipient of this notice a copy of this document.