Assistance Application

DCO-0004
R. 06/25

This is a combined application for food, medical, and cash assistance. You must answer all questions in section 1 and only the questions related to the program(s) for which you are applying in section 2. A friend, relative, or anyone that you choose may help you complete this application.

1 Provide basic information about you and your family.

2 Provide relevant program-specific details.

3 Review and sign to apply!

1 *Let's get started!*

Select all the benefits for which your household is applying:

☐ **SNAP**
Supplemental Nutrition Assistance Program (SNAP): Monthly benefits to help pay for groceries
(Provide additional information requested in section 2 starting on page 9 and sign page 3.)

☐ **TEA**
Transitional Employment Assistance (TEA): Cash assistance to help families with children under 18 become more independent
(Provide additional information requested in section 2 starting on page 9 and sign page 13. Also complete the TANF Drug Assessment Tool on page 19.)

☐ **Health Care**
Free or low-cost Health Care coverage to help pay for doctor visits, hospital stays, prescription medicines, lab tests, x-rays, and more
(Provide additional information requested in section 2 starting on page 10 and sign page 13.)

→ ☐ ***Check here if you want to apply for programs to help cover community-based services, in-home care, Medicare premiums, Nursing Facility, Autism, TEFRA, etc. Make the selection on page 10.***

Select all that apply to your household and be sure to include the information requested in the relevant Appendix section.

- ☐ Someone else is filling out the application on your behalf: *Appendix 1 on page 15*
- ☐ A household member is a non-U.S. citizen: *Appendix 2 on page 16*
- ☐ A child in the household has a non-custodial or absent parent: *Appendix 3 on page 17*
- ☐ A household member has a minor who is not living at home: *Appendix 4 on page 18*
- ☐ A household member is American Indian or Alaskan Native: *Appendix 4 on page 18*
- ☐ A household member is applying for TEA: *Appendix 5 on page 19*

If you have additional information to provide, use the notes section on page 14.

Applicant Registration

Share basic information about you:

Legal Name (First and Last)

Email

Are you an Arkansas resident? ◯ Yes ◯ No Are you homeless? ◯ Yes ◯ No

Home Address *(Not a P.O. Box)*

Unit/Apt

City

State

Zip Code

Mailing Address *(If different from above)*

Unit/Apt

City

State

Zip Code

Primary Phone

Alternate Phone

Interview Phone *(If different)*

Your Preferences

SNAP and TEA applications require an interview. All interviews are completed over the phone. If you would prefer an in-office interview, please select: ◯ In-office

What language do you prefer for your interview?

◯ English ◯ Spanish ◯ Marshallese *Other:*

If you need this material in a different format or language, contact your local DHS office or Access Arkansas at 1-855-372-1084. For TDD/TTY services, please contact Arkansas Relay at 1-800-285-1131 for English or 1-866-656-1842 for Spanish.

Do you require any accommodation, such as sign language interpretation or support for a hearing impairment or disability?

◯ Interpreter ◯ Sign Language *Other:*

If you prefer a different language for written communication, specify here:

◯ English ◯ Spanish ◯ Marshallese *Other:*

If you would like to receive electronic notifications about your case, select preference(s): ◯ Text alert ◯ Email alert

We will use the primary phone # and email listed above.

Would you like to opt out of paper notices? ◯ Yes ◯ No

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Expedite: ◯ Yes ◯ No

Screen Date: / /

Screener Name:

Expedited Screening for SNAP

Most SNAP applications are processed within 30 days. However, in some cases, a household may be entitled to expedited services and receive SNAP benefits within 7 calendar days. Please answer the questions below so we can decide if you are eligible for expedited services.

What is your household's total monthly income before deductions? $

Deductions include amounts for taxes, insurance, etc. The monthly total should include all income received by you and other household members such as income from work, cash contributions, Social Security, etc. This includes money already received this month and any expected before the month's end.

How much money do you and other household members currently have in cash, checking accounts, savings accounts, etc.? $

How much does your household pay monthly for housing and utilities? $

Which utilities do you pay separately from rent or mortgage? *(Check all that apply)*

◯ Electricity ◯ Natural Gas ◯ Water ◯ Trash ◯ Phone ◯ Internet ◯ Other

Did your household's income recently stop? ◯ Yes ◯ No

If yes, how much was the last pay? $ When? / /

Does anyone expect income from a new source this month? ◯ Yes ◯ No

If yes, how much? $ When? / /

Are you or a member of your household a migrant or seasonal farm worker? ◯ Yes ◯ No

Sign Here for SNAP

Right to File

You have the right to immediately file an application for SNAP (food assistance) so long as your name, address, and the signature of a responsible household member or authorized representative (see Appendix 1) are provided. SNAP benefit amounts are based on the date of application, among other factors. You will not be approved for benefits until the full application process is complete.

By my signature, I authorize the Arkansas Department of Human Services (DHS) to get information from other state agencies, financial institutions, employers, Income and Eligibility Verification System (IEVS), federal agencies, and other sources to prove my statements are correct. I understand that this information may affect my household's eligibility for benefits. I have received, reviewed, and agree to the information about my rights and responsibilities included in this application. I certify, under penalty of perjury, that the information I have given on this form is true and complete to the best of my knowledge.

Note: An Authorized Representative may sign this document as long as you have provided the information required in Appendix 1 (attached).

Signature of Applicant | Signature of Representative | Date / /

Household Members

List everyone in your household including yourself, even if you are not requesting benefits for them. If you have more people to include, make a copy of this page and attach.

1 Person

Legal Name (First and Last) | Relationship to you | Date of Birth | Sex

Self | / / | ◯ M ◯ F

U.S. Citizen ◯ Y ◯ N | Social Security # | **Requesting Benefits** ◯ **SNAP** ◯ **TEA** ◯ **Health Care** ◯ **None**

Marital Status *(optional)* ◯ Single ◯ Married ◯ Widowed ◯ Divorced/Separated

Race *(optional)*

◯ African American/Black ◯ American Indian/Alaskan Native ◯ Asian

◯ Native Hawaiian/Other Pacific Islander ◯ White *Other:*

Ethnicity *(optional)*

◯ Hispanic/Latino

◯ Not Hispanic/Latino

2 Person

Legal Name (First and Last) | Relationship to you | Date of Birth | Sex

/ / | ◯ M ◯ F

U.S. Citizen ◯ Y ◯ N | Social Security # | **Requesting Benefits** ◯ **SNAP** ◯ **TEA** ◯ **Health Care** ◯ **None**

Marital Status *(optional)* ◯ Single ◯ Married ◯ Widowed ◯ Divorced/Separated

Race *(optional)*

◯ African American/Black ◯ American Indian/Alaskan Native ◯ Asian

◯ Native Hawaiian/Other Pacific Islander ◯ White *Other:*

Ethnicity *(optional)*

◯ Hispanic/Latino

◯ Not Hispanic/Latino

3 Person

Legal Name (First and Last) | Relationship to you | Date of Birth | Sex

/ / | ◯ M ◯ F

U.S. Citizen ◯ Y ◯ N | Social Security # | **Requesting Benefits** ◯ **SNAP** ◯ **TEA** ◯ **Health Care** ◯ **None**

Marital Status *(optional)* ◯ Single ◯ Married ◯ Widowed ◯ Divorced/Separated

Race *(optional)*

◯ African American/Black ◯ American Indian/Alaskan Native ◯ Asian

◯ Native Hawaiian/Other Pacific Islander ◯ White *Other:*

Ethnicity *(optional)*

◯ Hispanic/Latino

◯ Not Hispanic/Latino

4 Person

Legal Name (First and Last) | Relationship to you | Date of Birth | Sex

/ / | ◯ M ◯ F

U.S. Citizen ◯ Y ◯ N | Social Security # | **Requesting Benefits** ◯ **SNAP** ◯ **TEA** ◯ **Health Care** ◯ **None**

Marital Status *(optional)* ◯ Single ◯ Married ◯ Widowed ◯ Divorced/Separated

Race *(optional)*

◯ African American/Black ◯ American Indian/Alaskan Native ◯ Asian

◯ Native Hawaiian/Other Pacific Islander ◯ White *Other:*

Ethnicity *(optional)*

◯ Hispanic/Latino

◯ Not Hispanic/Latino

Household Details

Is a member of your household currently living outside the home? ◯ Yes ◯ No

↳ *If yes, who?* Person 1 | Person 2

Specify where:

Person 1: ◯ College Housing ◯ Prison/Jail ◯ Nursing Home Other:

Person 2: ◯ College Housing ◯ Prison/Jail ◯ Nursing Home Other:

Are you or a member of your household blind, disabled, or in need of help with daily living activities? *Examples: Bathing, Walking, etc.* ◯ Yes ◯ No

↳ *If yes, who?* Person 1 | Person 2

Have you or a member of your household ever been in foster care? ◯ Yes ◯ No

↳ *If yes, who?* Person 1 | Person 2

Have you or a member of your household received assistance in another state in the last 30 days? ◯ Yes ◯ No

↳ *If yes, who?* Person 1 | Person 2

What state?

Household Finances: Assets/Resources

List all financial accounts owned/co-owned by you or a member of your household.
Examples: Cash, Checking/Savings Account, Mobile Banking Apps (such as: Venmo, Cash App, Chime), ABLE, Stocks/Bonds/Mutual Funds, Patient Fund Accounts, Certificate of Deposits (CD), etc.

Type	Owner(s)	Bank/Mobile App	Balance	Date Opened
			$	/ /
			$	/ /
			$	/ /
			$	/ /
			$	/ /

List all vehicles owned/co-owned by you or a member of your household even if they are not registered in the person's name. *Examples: Cars, Trucks, Boats, Motorcycles, ATVs, etc.*

Owner(s)	Year	Make/Model	Value	Amount Owed	Licensed
			$	$	◯ Yes ◯ No
			$	$	◯ Yes ◯ No
			$	$	◯ Yes ◯ No

Household Finances: Assets/Resources

List all property assets below. *Examples: All Homes, Land, Livestock, Machinery, Mineral Rights, etc.*

Type	Owner(s)	Fair Market Value	Amount Owed	Date Acquired
		$	$	/ /
		$	$	/ /
		$	$	/ /
		$	$	/ /

List other assets. *Examples: Life Insurance, Trust, Burial Plot, Burial Plan/Contract, Annuities, etc.*

Type	Owner(s)	Company	Cash Surrender Value	Current Value	Date Acquired
			$	$	/ /
			$	$	/ /
			$	$	/ /

For SNAP: Have you or a member of your household closed any financial accounts in the previous 3 months? ◯ Yes ◯ No

For Health Care: Have you or a member of your household closed any financial accounts in the previous 5 years? ◯ Yes ◯ No

If you answered yes to either question, list details below.

Type	Owner(s)	Bank/Mobile App	Date Closed
			/ /
			/ /

For SNAP: Have you or a member of your household sold, traded, or given away any assets in the previous 3 months? ◯ Yes ◯ No

For Health Care: Have you or a member of your household sold, traded, or given away any assets in the previous 5 years? ◯ Yes ◯ No

If you answered yes to either question, list details below.

Item	Date of Action	Who owned it?	Who received it?	Fair Market Value of Item	Sale Amount
	/ /			$	$
	/ /			$	$
	/ /			$	$
	/ /			$	$

Household Finances: Income

Provide all income details for all members of your household including yourself.

Example Income Types:

- Employment
- Child Support
- Alimony
- Veterans Compensation
- Cash Contributions
- Foster Care/Adoption Subsidy
- Social Security or Supplemental Security Income
- Unemployment/Workers Comp

	Household Member Name	Income Type *(Examples above)*	Amount *(Before taxes and deductions)*	Frequency *(Daily, Biweekly, Monthly)*
1 Person		1	$	
	Employer's Name		Job Start Date	/ /
	If more than one source of income →	2	$	
	Employer's Name		Job Start Date	/ /
2 Person		1	$	
	Employer's Name		Job Start Date	/ /
	If more than one source of income →	2	$	
	Employer's Name		Job Start Date	/ /
3 Person		1	$	
	Employer's Name		Job Start Date	/ /
	If more than one source of income →	2	$	
	Employer's Name		Job Start Date	/ /

Are you or a member of your household self-employed or working odd jobs? If yes, list below: ◯ Yes ◯ No

Household Member Name	Type of Work	Start Date	Monthly Income *(Before expenses)*	Monthly Expenses
		/ /	$	$
		/ /	$	$
		/ /	$	$

Household Finances: Expenses

Do you or a member of your household pay for housing expense? ◯ Yes ◯ No
(Only list the amount paid, not including housing assistance.)

◯ Rent/Lease ◯ Mortgage ◯ Property Taxes ◯ Real Estate Taxes
◯ Homeowner's Insurance ◯ Escrow ◯ Condo Fee/HOA ◯ Home Repair After Disaster

Who pays? *(Household Member Name)*	Type of Expense	Amount	How Often?
		$	
		$	
		$	

Do you or a member of your household pay for utilities? *(not included in rent)* ◯ Yes ◯ No

If yes, select all that apply: ◯ Electricity ◯ Natural Gas ◯ Water ◯ Trash ◯ Phone ◯ Internet ◯ Heating/AC *Other:*

Do you or a member of your household get lower housing costs due to getting Section 8, HUD, etc.? ◯ Yes ◯ No

Have you or a member of your household received more than a $20 energy payment(s) in the last 12 months? ◯ Yes ◯ No

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Do you or a member of your household pay court-ordered child support? ◯ Yes ◯ No

If yes, who? _____ How much? *(Monthly)* $ _____

Do you or a member of your household pay dependent care expense? ◯ Yes ◯ No

If yes, select expense type: ◯ Childcare Expense *(Daycare, After School, etc.)* ◯ Disabled Person Care Expense

Do you or a member of your household who is 60 or older or disabled pay medical bills, prescription costs, health care premiums, etc.? ◯ Yes ◯ No
If yes, share details below:

Who pays? *(Household Member Name)*	Type of Expense	Amount	How Often?
		$	
		$	
		$	
		$	

Program-Specific Details

2 *Provide Additional Relevant Information*

If you are applying for SNAP and/or TEA, complete the sections below:

SNAP *(Food Assistance)* **TEA** *(Cash Assistance)*

Select all that apply for you or a member of your household. If any questions are answered as yes, specify who.

		Person 1	Person 2
○ Buys or makes food separately	○ Y ○ N		
○ Under 5 years of age and *not* up to date on their immunizations	○ Y ○ N		
○ Between ages 5-17 and *not* enrolled in school right now	○ Y ○ N		
○ Enrolled in a school, college, or vocational program	○ Y ○ N		
→ Name of School/Program:			
Enrollment Status:		○ Full-time ○ Part-time	○ Full-time ○ Part-time
○ Lives in a facility	○ Y ○ N		
→ If yes, does the facility provide more than 50% of their meals?		○ Yes ○ No	○ Yes ○ No
○ Participating in an alcohol or drug treatment program	○ Y ○ N		
→ If yes, where?			
○ A victim of domestic violence or human trafficking	○ Y ○ N		
○ An active-duty military, a veteran, the spouse or dependent child of someone who is active-duty or a veteran	○ Y ○ N		
→ *Person 1*		○ Active-duty Military ○ Veteran ○ Dependent Child ○ Spouse	
→ *Person 2*		○ Active-duty Military ○ Veteran ○ Dependent Child ○ Spouse	
○ Had benefits stopped due to providing false information	○ Y ○ N		
○ Fleeing from felony prosecution, outstanding felony warrant, or jail	○ Y ○ N		

Health Care *(Medical Assistance)*

Please select below if you would like to apply for any of these specific types of Health Care assistance. *(Select all that apply)*

**NOTE: For PACE, Assisted Living Facility, and ARChoices categories, at your Optum Independent Assessment, you may provide medical documentation that you have a primary or secondary diagnosis of Alzheimer's disease or related dementia and are cognitively impaired so as to require substantial supervision by another individual because you engage in inappropriate behaviors that pose serious health or safety hazards to yourself or others. You may also provide medical documentation that you have a diagnosed medical condition which requires monitoring or assessment at least once a day by a licensed medical professional and the condition, if untreated, would be life-threatening.*

- ☐ **ARChoices*:** *Provides home and community-based services for adults ages 21-64 who have a physical disability or adults aged 65 and older.*
- ☐ **Assisted Living Facility*:** *Provides 24-hour personal care in a congregate or community setting (assisted living facilities) to allow aging Arkansans to live in the community rather than a nursing facility.*
- ☐ **Autism Waiver:** *Provides one-on-one treatment for eligible children ages 18 months through child's 8th birthday who are diagnosed with Autism Spectrum Disorder.*
- ☐ **Community Employment Support (DDS Waiver):** *Provides in-home services for people with developmental disabilities, such as care coordination, supported living, and adaptive equipment. Available slots are limited.*
- ☐ **Medically Needy Spend-Down:** *Provides short-term coverage for those whose income is above the normal limits for Health Care assistance but who have high medical bills within a 3-month period and meet the program requirements.*
- ☐ **Medicare Savings Program:** *Provides limited coverage to supplement Medicare recipients. Coverage ranges from payment of Medicare premiums, deductibles, and co-insurance for low-income individuals, to paying only a portion of the Medicare Part B premium for individuals with higher incomes.*
- ☐ **Nursing Facility:** *Provides coverage for services in skilled nursing facilities or nursing homes for those who meet the requirements. Must be in a nursing facility or planning to enter one within 15 days.*
- ☐ **PACE (Programs of All-Inclusive Care for the Elderly)*:** *Provides comprehensive community-based health services to Arkansans age 55 or older who would otherwise need to live in a nursing facility.*
- ☐ **TEFRA:** *Provides children under 19 years old who have a disability with Medicaid services for which they might not otherwise qualify.*

Are you applying for anyone who is recently deceased? ◯ Yes ◯ No

→ If yes, list their name: _____ Date of Death: / /

Have there been any changes to your medical condition to report since the last time you filed an application with DHS or the Social Security Administration (SSA)? ◯ Yes ◯ No

Additional Household Details for Health Care

Select all that apply for you or a member of your household:

- ◯ Living or planning to live in a nursing home or assisted living facility in the next 15 days — If yes, who? ____ ◯ No
  - → Name of the facility: ____
- ◯ Was in foster care and enrolled in Health Care assistance when they turned 18 -21 — If yes, who? ____ ◯ No
  - → If yes, in what state were they residing? ____
  - If this person resided outside out of Arkansas while in Foster care, did they reach 18 years of age on or after January 01, 2023? ◯ Yes ◯ No
- ◯ Currently pregnant or was pregnant in the last 90 days — If yes, who? ____ ◯ No
  - → If this person is pregnant now:
    - Due Date: / / — How many babies are expected? ____
  - → If this person was pregnant in the last 90 days: — Pregnancy End Date: / /
  - → Was this person enrolled in or eligible for Health Care assistance at the time of the child's birth? ◯ Yes ◯ No
    - If yes, what state? ____
- ◯ Has unpaid medical bills this month or expects to have over the next 3 months — If yes, who? ____ ◯ No
- ◯ Has unpaid medical bills from the last 3 months — If yes, who? ____ ◯ No
  - → Have payment arrangements been made? ◯ Yes ◯ No
  - → Has your household size changed in the last 3 months? ◯ Yes ◯ No
  - → Has your household's income changed in the last 3 months? ◯ Yes ◯ No
  - → Has your household's resources changed in the last 3 months? ◯ Yes ◯ No
  - → Did this person move out of Arkansas in the last 3 months? ◯ Yes ◯ No
    - If yes, when? / /

Are you or a member of your household enrolled in health coverage other than Medicaid or Medicare? If yes, share details: ◯ Yes ◯ No

	Household Member Name	Name of Health Insurance	Policy Number
1			
	◯ Employer Insurance ◯ VA Health Care ◯ Supplemental	*Other:*	
2			
	◯ Employer Insurance ◯ VA Health Care ◯ Supplemental	*Other:*	

Tax Information for Health Care

Are you or a member of your household planning to file taxes next year? ◯ Yes ◯ No
If yes, complete section below:

1 Person

Tax Filer's Name

Filing Status:
◯ Single ◯ Married *(Filing Jointly)* ◯ Married *(Filing Separately)*

Tax Dependents Claimed *Who Are Living in Your Household*	Tax Dependents Claimed *Who Are NOT Living in Your Household*

If married and jointly filing, Joint Tax Filer's Name:

2 Person

Tax Filer's Name

Filing Status:
◯ Single ◯ Married *(Filing Jointly)* ◯ Married *(Filing Separately)*

Tax Dependents Claimed *Who Are Living in Your Household*	Tax Dependents Claimed *Who Are NOT Living in Your Household*

If married and jointly filing, Joint Tax Filer's Name:

Are you or a member of your household a tax dependent of someone who is NOT living with you? *If yes, complete section below:* ◯ Yes ◯ No

Tax Filer's Name	Tax Dependent Name	Tax Filer's Relationship to Dependent

Please add all that can be deducted on the household's tax return.
Examples: Alimony, Student Loan Interest, etc.

Name of Household Member Claiming the Deduction	Deduction Type	Amount Paid	Frequency *(Daily, Biweekly, Monthly)*
		$	
		$	

3 Review & Sign

Review your application and sign below:

- I understand I must give the Arkansas Department of Human Services complete and true information to the best of my knowledge.
- I understand that I may have to provide proof that what I've told the Department is true.
- I understand I must tell the Department about any changes to the information I gave on my application. I agree to cooperate with state or federal reviewers.
- I understand I will have to repay any benefits I should not have received, even if it is the Department's error.
- I understand that if I am admitted to a nursing facility based on conditional Health Care approval and my application is denied, I, or my family, will be responsible to repay any costs I owe from living in the nursing facility.
- I will use my benefits legally and will not sell, trade, or give away my benefits online or in person.
- I understand that if required, I must cooperate with the Office of Child Support Enforcement as a condition of receiving benefits.
- I authorize the Arkansas Department of Human Services (DHS) to get information from other state agencies, financial institutions, employers, federal agencies, and other sources to prove my statements are true and correct. I understand that if differences are found between what I report and information given by the sources listed above, my household's eligibility for benefits may be affected.
- I authorize the Arkansas Department of Human Services (DHS) to get information from the Immigration Services (USCIS) through the Systematic Alien Verification and Eligibility (SAVE) System to verify the status of any non-U.S. citizen who is seeking benefits for themselves.
- I have received, reviewed, and agree to the information about my responsibilities included in this application.

Do you wish to register to vote? ◯ Yes ◯ No

If you do not check any box, you will be considered to have decided to not register to vote at this time. Applying to register or declining to register to vote will not affect the amount of assistance that you will be provided, or your eligibility. Your decision to register to vote or not will be kept confidential. 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. If you have additional people in your household that would like a voter registration application, please let us know.

If you believe that someone has interfered with your right to register or to decline to register to vote, or your right to privacy in deciding whether to register; you may file a complaint with the:
Arkansas Secretary of State, Elections Division, 500 Woodlane, Ste. 26, Little Rock, AR. 72201 or
Toll free 800-482-1127.

Sign Here for Health Care and TEA

YOUR SIGNATURE: Information on this form is subject to verification by federal, state, and local officials and through the state Income and Eligibility Verification System and computer cross matching with other agencies. Information may also be submitted to the Immigration & Naturalization Service (INS) for verification. If information is found to be incorrect, your eligibility and benefit level may be affected, your benefits may be stopped, and you may be subject to criminal prosecution for knowingly providing incorrect information.

Under penalties of perjury, I state that I have reviewed this application, and to the best of my knowledge and belief, the answers I gave within this application are true, including household, citizenship and non-citizenship information, and I have listed all amounts and sources of income I received and property I own.
***Note:** An Authorized Representative may sign this document so long as you have provided the information required in Appendix 1, attached.*

Signature of Applicant	Signature of Representative	Date
		/ /

Notes

APPENDIX 1

Consent for Authorized Representative

If you would like, you can give someone the right to act for you. This person can give and get facts for this application, take any action needed to enroll in benefits, and take any action needed to get benefits.

Person requesting the Authorized Representative:

Please choose the program(s) for which you would like an authorized representative:

- ◯ SNAP (Food Assistance)
- ◯ TEA (Cash Assistance)
- ◯ Health Care (Medical Assistance)

This person can apply for benefits, provide interview assistance, get notices, report changes, and make inquiries. If the SNAP interview process is completed by the Authorized Representative, they must provide a form of identification. Your household will be held liable for any overissuance that results from the representative providing incorrect information.

Representative Name

Primary Phone

Organization Name

Email

Representative Address

Unit/Apt

City

State

Zip Code

Sign Here

By signing, I certify that the individual(s) designated above is (are) allowed to act on my behalf. ***I understand my household will be held liable for any overissuance that results from the authorized representative providing incorrect information.*** *I understand that anyone knowingly providing false information may be prosecuted under applicable federal and state statutes. I understand that the power to act as an authorized representative is valid until I modify the authorization or notify the agency that the representative is no longer authorized to act on my behalf, or the authorized representative informs the agency that they are no longer acting in such capacity, or there is a change in the legal authority upon which the individual or organization's authority was based.*

Signature of Applicant

Date / /

I agree to maintain, or be legally bound to maintain, the confidentiality of any information provided by the agency regarding the client. If the authorized representative for Health Care is a provider, staff member, or volunteer of an organization, I affirm that I will adhere to the regulations in 45 CFR part 431, subpart F and at 45 CFR §155.260(f), 45 CFR §447.10, as well as other relevant State and Federal laws concerning conflicts of interest and confidentiality of information.

Signature of Representative

Date / /

APPENDIX 2

Household Details: Non-U.S. Citizen

Many immigrants are eligible for benefits. **Complete the immigration information for the household members who are not U.S. citizens and are seeking benefits.**

List of Immigration Statuses:

Afghan Humanitarian Parolee
Amerasian
Asylee
Cuban Haitian Entrant
Lawful Permanent Resident
Marshallese
Micronesian
Palauan
Refugee
Special Immigrant Visa
Ukrainian Humanitarian Parolee
Undocumented
Victim of Trafficking

1 Person

Household Member Name | Immigration Status | Status Start Date

Document Type | Document ID # | Alien # | Date of U.S. Entry

→ Moved to the U.S. before August 22, 1996 ◯ Yes ◯ No

2 Person

Household Member Name | Immigration Status | Status Start Date

Document Type | Document ID # | Alien # | Date of U.S. Entry

→ Moved to the U.S. before August 22, 1996 ◯ Yes ◯ No

3 Person

Household Member Name | Immigration Status | Status Start Date

Document Type | Document ID # | Alien # | Date of U.S. Entry

→ Moved to the U.S. before August 22, 1996 ◯ Yes ◯ No

Have you or a member of your household ever been classified as a refugee/asylee? ◯ Yes ◯ No

Have you, your parents, your spouse, or your sponsor ever worked in the U.S.? ◯ Yes ◯ No

→ If yes, who? ◯ Self ◯ Parents ◯ Spouse ◯ Sponsor

If you or a member of your household are a Lawful Permanent Resident (LPR), do you have a sponsor? ◯ Yes ◯ No

→ If yes, share sponsor's information below.

Sponsor's Legal Name | Employer | Monthly Income $

If you have a sponsor, please include their information in the Household Finances: Assets/Resources section beginning on page 5.

APPENDIX 3

Household Details: Non-Custodial/Absent Parent

Does a child in your household have parent(s) who live outside the home?
If yes, provide non-custodial/absent parent details below:

1 Person

Absent Parent's Name	Date of Birth	Child's Legal Name	Date of Birth
	/ /		/ /

Has paternity been established? ◯ Yes ◯ No

Has child support been court ordered? ◯ Yes ◯ No Date Last Received: / /

2 Person

Absent Parent's Name	Date of Birth	Child's Legal Name	Date of Birth
	/ /		/ /

Has paternity been established? ◯ Yes ◯ No

Has child support been court ordered? ◯ Yes ◯ No Date Last Received: / /

3 Person

Absent Parent's Name	Date of Birth	Child's Legal Name	Date of Birth
	/ /		/ /

Has paternity been established? ◯ Yes ◯ No

Has child support been court ordered? ◯ Yes ◯ No Date Last Received: / /

*As a condition of eligibility for Health Care, SNAP, and TEA, you must tell DHS if any of the children for whom you are seeking benefits have a parent that is absent from the home. If you do not provide the details for the absent parent, you will be sanctioned and will be ineligible for benefits unless you can **provide proof** that you have good cause not to cooperate.*

Would you like to claim a good cause reason for not cooperating with the Office of Child Support Enforcement? ◯ Yes ◯ No

If yes, select the good cause reason(s) that apply:

- ◯ You are working with an agency helping to decide whether to place the child for adoption.
- ◯ Court proceedings are ongoing for adoption of the child.
- ◯ The child was born as a result of rape or incest.
- ◯ Cooperation is anticipated to result in serious physical or emotional harm to you or the child.

Other:

APPENDIX 4

Household Details: For a Minor Not Living at Home

Do you or a member of your household have a minor who lives outside the home? If yes, provide parent and child details below:

1 Person

Child's Legal Name | Date of Birth | Custodial Parent's Name

Household Member Name *(Child's other parent)*

Has paternity been established? ◯ Yes ◯ No

Has child support been court ordered? ◯ Yes ◯ No Date Last Paid:

2 Person

Child's Legal Name | Date of Birth | Custodial Parent's Name

Household Member Name *(Child's other parent)*

Has paternity been established? ◯ Yes ◯ No

Has child support been court ordered? ◯ Yes ◯ No Date Last Paid:

Household Details: American Indian or Alaskan Native

If you or a household member are American Indians or Alaskan Natives, you can get services from the Indian Health Services, Tribal Health programs, or Urban Indian Health programs. Also, you may not have to pay cost sharing and may get special monthly enrollment periods. Answer the following questions to make sure your family gets the most help possible.

	Household Member Name	Member of a Federally Recognized Tribe	Eligible for Services *(Programs listed above)*	Has Received Services *(Programs listed above)*
1 Person		◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No
	If yes, Tribe Name:			
2 Person		◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No
	If yes, Tribe Name:			
3 Person		◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No
	If yes, Tribe Name:			

APPENDIX 5

TANF Drug Assessment Tool

Effective January 1, 2016, in accordance with Act 1205 of 2015, all adult (above 18) TANF applicants/recipients who are otherwise eligible for TANF programs are required to be assessed for illegal use of a controlled substance. If the applicant or recipient is suspected of illegal drug usage, they will have to undergo a drug test and potentially a substance abuse treatment. If the applicant or recipient fails to comply with any of these requirements, the TANF case will be denied/closed, or the case will be approved with a protective payee in place. Illegal use of a controlled substance (illegal drug) means:

- The use of a drug that is against the law, or
- The use of a prescription drug which is a controlled substance that is not prescribed for you.

Each person in your household who is not exempt from drug screening and testing must answer the following questions before TANF eligibility can be determined. Each eligible adult will receive a form to complete.

I understand the drug assessment procedures as detailed in this form and will answer each question listed below truthfully.

In the past 30 days, have you used any illegal drugs? ◯ Yes ◯ No

In the past 30 days, have you lost or been denied a job due to current illegal drug use? ◯ Yes ◯ No

		/ /
Signature of Applicant/Recipient	Name of Applicant/Recipient	Date

Important Information for You

If you do not fill out this form your application will be denied. If you are a recipient, your case will be closed. ***We will send you a separate notice if we take this action.***

- While getting cash assistance, adult household members may have to complete a drug test if there is reasonable cause to believe they are using illegal drugs.
- If you test positive for illegal drugs, you must cooperate with drug testing requirements and your Plan of Action, or your case will be denied/closed or processed with a protective payee in place.

DHS is an equal opportunity provider/employer Under Titles VI and VII of the Civil Rights Act of 1964, and the Americans with Disabilities Act of 1990 (ADA), Section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975. DHS prohibits discrimination in admissions, programs, services, activities, or employment based on race, color, religion, sex, national origin, age, and disability. DHS must make a reasonable accommodation to allow a person with a disability to take part in a program, service or activity. For example, this means, if necessary, DHS must provide sign language interpreters for people who are deaf, a wheelchair accessible location, or enlarged print materials. It also means that DHS will take any other reasonable action that allows you to take part in and understand a program or activity, including making reasonable changes to an activity. If you believe that you will not be able to understand or take part in a program or activity because of your disability, please let us know of your disability needs in advance if at all possible. To request this document in alternative format or for further information about this policy, contact your county office.

Note: If you have additional adult household members, make a copy of this page and attach.

Your Rights and Responsibilities

Please read this entire section carefully to understand your rights and responsibilities when you get Health Care benefits, Transitional Employment Assistance (TEA), or benefits from the Supplemental Nutrition Assistance Program (SNAP).

Rights and Responsibilities Across All Programs

1. You have the right to be treated courteously and with respect.
2. You have the right to apply for any public assistance program at any time.
3. You have the right to have your application processed in a timely manner.
4. You have the right not to give us any or all the information we ask for, even though that may affect our ability to process your case.
5. You have the right to be notified in writing of any changes in your benefit amount.
6. You have the right to look at your case file. If you disagree with something in your file, tell your county office worker.
7. You have the right to ask for an appeal and get an administrative hearing if a decision is not reached on your case within the appropriate time limit or if you disagree with the decision reached.
8. No person may be denied assistance on the grounds of race, color, sex, national origin, or disability.
9. You are responsible for notifying the Department of Human Services within 10 days if your personal information changes, your income or resources change, or if any other changes occur in your circumstances.
10. You have the right to receive interpreter services when requested.
11. You have the right to not be discriminated against on the basis of race, color, national origin, age, disability, religion, or sex including pregnancy, sexual orientation, and gender identity.

SNAP Rights and Responsibilities

SNAP helps people with low income and few resources get the food they need for good health. SNAP electronic benefits transfer (EBT) cards are used in place of cash to buy food. However, most people find they must spend some cash along with their SNAP benefits to buy enough food for a month.

Your Rights

1. You have the right to ask for help from your worker to get the information you need to establish your eligibility.
2. Participation in SNAP is not time-limited. You can continue to get SNAP if you are eligible under SNAP rules. This is true even if someone in your home gets TEA cash assistance. If someone in your home does get TEA cash assistance, participation in SNAP does not count against their TEA time limits.
3. You have the right to know SNAP rules.
4. You have the right to know how we worked your SNAP benefit case.

Your Responsibilities

1. **Penalty Warnings:** If you get SNAP, you must follow the rules listed below:
    - **DO NOT** give false (wrong) information or hide information to get SNAP.
    - **DO NOT** give false (wrong) information to help someone else get SNAP.
    - **DO NOT** put your money or property in someone else's name in order to get SNAP benefits.
    - **DO NOT** sell or trade or try to sell or trade your SNAP.
    - **DO NOT** use your SNAP to buy items like alcoholic drinks or tobacco.
    - **DO NOT** use a SNAP Electronic Benefits Transfer (EBT) card that belongs to someone else to buy food for your household.
    - **DO NOT** use SNAP benefits or allow someone else to use these benefits if you know that the benefits have been received illegally, given to someone other than the legal owner, or are to be used in any illegal manner.

Any member of your household who admits to breaking any of these rules or who is found guilty of breaking any of these rules may be disqualified to get SNAP benefits for:

- **One year for the first violation**
- **Two years for the second violation**
- **Permanently for the third violation**

This person may also be fined up to $250,000, sent to jail for up to 20 years, or both. They may be subject to federal prosecution. Federal penalties may include an additional disqualification period of 18 months or, for second and subsequent felony convictions for SNAP fraud, a mandatory jail sentence.

SNAP Rights and Responsibilities Continued

Additional Disqualifications

- **A person found to have made a fraudulent statement or representation with respect to the identity or place of residence of the individual in order to receive multiple SNAP benefits simultaneously shall be ineligible to participate in the SNAP program for a period of 10 years.**
- **A person found guilty in a Federal, State, or local court of having trafficked benefits for an aggregate amount of $500 or more shall be permanently ineligible to participate in the SNAP program upon the first occurrence of such violation.**
- **A person found guilty in a Federal, State, or local court of trading SNAP for controlled substances (illegal drugs or prescriptions that were not written for you) will be barred from receiving SNAP for 24 months for the first violation and permanently for the second violation.**
- **A person found guilty by a court of trading SNAP for firearms, ammunition, or explosives will be permanently barred from getting SNAP.**
- **A person who is a fleeing felon or a parole or probation violator is barred from getting SNAP while they are fleeing to avoid custody.**

2. **Requirement to Work:** Unless they are exempt, people between the ages of 18 and 54 who get SNAP must meet the Requirement to Work. Anyone who is not exempt must work at least 20 hours per week at a job or self-employment; or attend an approved job training course at least 20 hours per week.
3. **What Can I Buy with SNAP benefits?** A person may buy only eligible foods with their SNAP benefits. Eligible foods include, but are not limited to, plants and seeds that can be used to grow food. You cannot buy the following items with SNAP benefits:
   - Paper goods
   - Cleaning products
   - Household items
   - Alcoholic beverages
   - Tobacco products
   - Vitamins, medicine, or personal care items like toothpaste
   - Foods prepared to be eaten in the store
   - Hot food prepared in the store to be "carried out" and eaten

SNAP Non-Discrimination Statement

In accordance with federal civil rights law and USDA civil rights regulations and policies, the USDA, its agencies, offices, employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, religion, sex, disability, age, marital status, family/parental status, income derived from a public assistance program, political beliefs, or reprisal or retaliation for prior civil rights activity, in any program or activity conducted or funded by USDA (not all bases apply to all programs). Remedies and complaint filing deadlines vary by program or incident.

Persons with disabilities who require alternative means of communication for program information (e.g., Braille, large print, audiotape, American Sign Language, etc.) should contact their local county office or Access Arkansas at 855-372-1084. Individuals who are deaf, hard of hearing, or have speech disabilities may contact Arkansas Relay at 800-285-1131 or USDA through the Telecommunications Relay Service at 711 (voice and TTY). Additionally, program information may be made available in languages other than English.

To file a complaint of discrimination, contact:
Office of Program and Grant Management
P.O. Box 1437 Slot-S335
Little Rock, AR 72203-1437
Call (501) 534-4119
DCOCivilRightsComplaints@dhs.arkansas.gov

To file a program discrimination complaint, complete the USDA Program Discrimination Complaint Form, AD-3027, found online at How to File a Program Discrimination Complaint and at any USDA office or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by:
Mail: USDA Food and Nutrition Service, 1320 Braddock Place, Room 334 Alexandria, VA 22314; or
Email: FNSCIVILRIGHTSCOMPLAINTS@usda.gov.

USDA is an equal opportunity provider, employer, and lender.

TEA Rights and Responsibilities

The Transitional Employment Assistance (TEA) program is intended to help needy families with children to become more responsible for their own support and less dependent on public assistance. Assistance from the TEA program is intended to help needy families become economically self-sufficient by providing opportunities to get and keep employment that will sustain the family. There is a limit to the number of months you can get TEA. It is your responsibility to work toward achieving self-sufficiency before your time-limited assistance ends.

Your Rights

1. To be advised in writing of your work requirements.
2. If personal or family problems are keeping you from going to work, your case manager may be able to refer you to an agency that may be able to help you.
3. You may apply for an extension of your TEA cash benefits at the end of your time limit due to circumstances beyond your control if more time will help you to become fully independent.

Your Responsibilities

1. **Meetings:** Attend all meetings your case manager schedules for you.
2. **Personal Responsibility Agreement:** The Personal Responsibility Agreement (PRA) is an agreement stating what you will have to do for us to help you. Your case manager will go over these responsibilities with you. If you fail to do these things, it may cause a decrease in or loss of your cash assistance payment.
   - You must cooperate with Child Support Enforcement unless you have good cause, work requirements, and certain responsibilities to your family.
   - You must make sure your school-age child is going to school and that your preschooler gets their immunizations (shots).
   - Fulfill all the requirements of your Personal Responsibility Agreement and Employment Plan.
3. **Work Participation Activities:** Adults who get TEA must complete work activities as described in their Employment Plans for a minimum number of hours per week. Allowable activities are:
   - Employment with a private or public employer
   - Self-Employment
   - On-the-Job Training
   - Job Search and Job Readiness
   - Work Experience
   - Community Service
   - Career and Technical Education
   - Providing Childcare Services for a Community Service Participant
   - Education Directly Related to Employment
   - Job Skills Training
   - Attendance at Secondary School

   Your case manager will explain each activity and the participation requirements to you. You must give DHS true information and not withhold information for the purpose of getting TEA without following the rules.
4. **Assignment of Rights for TEA (Child Support Enforcement Requirements):** You understand that if you accept TEA cash assistance, by state law, you will have assigned all rights, title, and interest in any support that you have in your own behalf or in behalf of any other person for whom you are receiving TEA. You understand that all support payments, including those received by you directly from the absent parent, are to be paid to the Office of Child Support Enforcement. You understand that this assignment ends when you no longer receive TEA, except as to any unpaid support obligation that has accrued at the time your TEA case is closed. You also understand that as a condition of eligibility for TEA, you must cooperate with the Office of Child Support Enforcement in establishing paternity and obtaining child support.
5. **Penalty Warnings**
   - If you do not participate in your work activities, your TEA case manager will decide if you have a good reason and whether you are getting all the support services you need. If you do not have a good reason for not participating, your cash payment may be reduced, or your case may be closed until you do participate.
   - If you get benefits to which you or your household are not entitled because you gave false information or hid information assistance will be subject to recovery by DHS, any assistance you get in the future may be reduced to recover this overpayment, and you may be subject to prosecution for fraud and/or fined or imprisoned.
   - **DO NOT** give false information or hide information in order to become eligible for benefits.
   - **DO NOT** put your money or property in someone else's name in order to get TEA benefits.

TEA Rights and Responsibilities Continued

6. **Fraud:** Fraud consists of giving false (wrong) information or withholding information for the purpose of getting assistance that a person is not entitled to under the program rules and regulations. Committing fraud can result in criminal fines, penalties, and paying back benefits.
7. **Intentional Program Violation:** An Intentional Program Violation (IPV) in the TEA Program occurs when a person gives incorrect information for the purpose of falsely maintaining the family's eligibility for TEA. If you are found guilty of an IPV, you cannot participate in the program for:
   - the first offense, one (1) year.
   - the second offense, two (2) years.
   - more than two, permanently.

Health Care Rights and Responsibilities

Health Care reimburses providers for covered medical services that are provided to eligible needy individuals through the Medicaid program. Eligibility is determined based on income, resources, Arkansas residency, and other requirements. Covered services also vary among Medicaid categories. The Arkansas Health and Opportunity for Me (ARHome) Program is not a perpetual federal or state right or a guaranteed entitlement program, and it may be ended at any time upon appropriate notice.

Your Rights

1. You have the right to seek job search and job training services from Arkansas Workforce Connections (AWC), but it is not a requirement to receive Medicaid or the Arkansas Health and Opportunity for Me (ARHome) Program.
2. You do not have the perpetual federal or state right or a guaranteed entitlement to ARHome, and it may be ended at any time upon appropriate notice.
3. You are giving DHS your rights to seek and get money from other health insurance, legal settlements, or other third parties.
4. You are giving the Medicaid agency rights to pursue and get medical support from a spouse or parent.

Your Responsibilities

1. **General Responsibilities**
   - You have the responsibility to notify the Department of Human Services of any changes that occur in your circumstances, including, but not limited to, the addition of new household members who get additional income, acquire, or dispose of property.
   - You have the responsibility to give as much of the needed information as you can about your circumstances.
   - You have the responsibility to fully complete forms with true information to the best of your knowledge.
   - If receiving healthcare in a nursing facility, Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID), or under a home/community-based waiver, you have the responsibility to have the amount of Health Care benefits that DHS paid on your behalf to be recovered from your estate or grantee of a beneficiary deed after your death.
   - You have the responsibility to cooperate with the Office of Child Support Enforcement (OCSE) in establishing paternity and getting medical support for each child who has a parent absent from the home if the program you have applied for asks you to do so.
2. **Penalty Warnings:** If you get Health Care benefits, you must follow the rules listed below:
   - **DO NOT** give false information or hide information in order to become eligible for benefits.
   - **DO NOT** put your money or property in someone else's name in order to get Health Care benefits.
   - If you get benefits to which you or your household are not entitled because you gave false information or hid information, assistance will be subject to recovery by DHS, any assistance you get in the future may be reduced to recover this overpayment, and you may be subject to prosecution for fraud, fined or imprisoned.

Under the Department of Human Services (DHS) policy, Medicaid cannot deny you eligibility or benefits based on your race, age, sex, disability, national origin, or political or religious beliefs.

Privacy Notice

The PRIVACY ACT of 1974 requires the Department of Human Services (DHS) to tell you:

1. Whether disclosure 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 Supplemental Nutrition Assistance Program this authority is granted under the Food and Nutrition Act of 2008 as amended, 7 U.S.C. 2001-2036. For both the Medicaid Program and the TEA 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 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.

Important Estate Recovery Notice

If you receive Health Care assistance in a nursing facility, ICF/IID facility, or under a home and community-based waiver program, the total amount of the Health Care benefits paid on your behalf will be owed to DHS and may be recovered from your estate or from the grantee of a beneficiary deed 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 claim against your estate after your death if your spouse is still living or if you have dependent minor children under age 21 or blind or have children with disabilities. 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 and are granted 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.

Quality Control

Your case may be selected for a Quality Control (QC) review. If so, the QC worker will check your case to see if you have given us the correct information. They will also check to make sure the DHS county office processed your case correctly. If your case is selected for a QC review, the QC worker will contact you for an interview. You are required to give information to prove your statements are true and correct. The QC worker may contact your employer, your bank, other agencies, your landlord, etc., for information. If you do not cooperate during a QC review, your SNAP case will close. You will not be eligible to get SNAP benefits until you cooperate with QC or until February of the following year, whichever comes first.

Your Right to Appeal

If you think that DHS has made a mistake, you can appeal its decision. To appeal means to tell someone at DHS that you think the action was incorrect and that you want a fair review of the action. You can be represented in the process by someone other than yourself.
You can request an appeal in the following ways:

- In person: Talk to staff of any DHS county office.
- By phone: You can call the Office of Appeals and Hearings at (501) 682-8622, or you may call your local county office.
- By email: DHS.Appeals@dhs.arkansas.gov
- By mail: Arkansas Department of Human Services

  Office of Appeals and Hearings
  Slot S101
  P.O. Box 1437
  Little Rock, AR 72203-1437

How to File a Complaint

You have the right to make a complaint if the Department of Human Services has discriminated against you. You can make a complaint orally or in writing by contacting the Office of Program and Grant Management-Civil Rights Unit, P.O Box 1437 Slot S335, Little Rock, AR 72203-1437, by emailing DCOCivilRightsComplaints@dhs.arkansas.gov or by calling (501) 534-4119.