Application for Medicare Savings for Qualified Beneficiaries
ARSeniors, QMB, SMB, QI-1

Si necesita este formulario en Español, llame al 1-800-482-8988 y pida la versión en Español

If you need this material in a different format, such as large print, contact your DHS county office.

Please answer all questions as completely and accurately as possible. If you do not have enough space for your answer, attach another sheet of paper to this application.

Last Name	First Name	MI	Social Security Number

Medicare Number	Railroad Retirement Number	VA Claim Number

Birth Date	Race	Sex	County of Residence	Telephone Number

Street Address	City	State	Zip Code

Mailing Address (If Different)	City	State	Zip Code

Are you 65 years or older? ☐ Yes ☐ No

Are you: ☐ Blind ☐ Disabled

Are you (check one):
☐ Married ☐ Separated
☐ Widowed ☐ Divorced
☐ Single

Are you a U.S. Citizen? ☐ Yes ☐ No Submit documentation of alien status.

Living arrangement: (check one) ☐ Own Home ☐ Renting ☐ Other's Home ☐ Assisted Living

Please complete the following section for your spouse, if you live in the same household.

Last Name	First Name	MI	Social Security Number*	Date of Birth

Medicare Number	Railroad Retirement Number	VA Claim Number

- The Social Security Number is required if your spouse is applying for benefits.

Are you applying for your spouse also? ☐ Yes ☐ No If yes, complete the following.

Is your spouse a U.S. Citizen? ☐ Yes ☐ No Submit documentation of alien status.

Is your spouse 65 years or older? ☐ Yes ☐ No

Is your spouse: ☐ Blind ☐ Disabled

Do you have children under 18 (or under 21 if attending school) living in the home? ☐ Yes ☐ No

If yes, please complete the following information on each child.

Child's Last Name	Child's First Name	MI	Date of Birth	Child's Income (Amount & Type)

INCOME: Do you or your spouse have income from the following?

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

Is food, clothing, or shelter paid for or provided free of charge for you by someone else? ☐ Yes ☐ No

REAL/PERSONAL PROPERTY:

Do you own any real estate other than your home, including property that you own with others? ☐ Yes ☐ No

If yes, complete the following for each piece of real estate. Attach additional pages if necessary. **Do not list the house you live in.**

Address or Location	Value	Amount Owed

VEHICLES:

Do you or your spouse own a car, truck, motorcycle, boat, trailer, or other vehicle? ☐ Yes ☐ No

If yes, complete the following information about each vehicle (attach additional pages as needed)

Make	Model	Year	Value	Amount Owed	Owner(s)

ASSETS: Check all assets owned by you or your spouse. Include any accounts or properties on which your name(s) appear. Include verification of trust funds. Attach additional pages if necessary.

Type of Asset	Y	N	Where held (bank, insurance co., brokerage firm, etc.)?	Account/Policy #	$ Value
Cash					
Checking Account					
Savings Account					
Certificates of Deposit					
Promissory Notes					

ASSETS: Continued

Type of Asset	Y	N	Where held (bank, insurance co., brokerage firm, etc.)?	Account/Policy #	$ Value
Stocks					
Bonds					
IRA					
Owner of a Mortgage					
Burial Plot/Crypt					
Burial Funds/Insurance					
Life Insurance					
Trusts					
Other					

HEALTH INSURANCE:

Do you have Medicare? ☐ Yes ☐ No
Does your spouse have Medicare? ☐ Yes ☐ No
Do you have other health insurance? ☐ Yes ☐ No
Does your spouse have other health insurance? ☐ Yes ☐ No

If you or your spouse have other health insurance besides Medicare, please provide the following information and attach copies (front and back) of Medicare and insurance cards.

Health Insurance Company Name	Address	Who is Insured?	Type of Coverage	Effective Date	Policy or Claim #

Would you like for someone to contact you about applying for the Supplemental Nutrition Assistance Program?
☐ Yes ☐ No

READ THE FOLLOWING INFORMATION CAREFULLY BEFORE YOU SIGN THIS APPLICATION

- I understand that I must help establish my eligibility by providing as much of the requested information as I can.
- I authorize the Department of Human Services to make any inquiry concerning me and/or my spouse necessary to establish my eligibility for assistance.
- I authorize my employer(s), any banks, savings and loans, lending institutions or other financial institutions, etc., to release to DHS any information about myself or my spouse's circumstances as necessary to verify any information contained on this application.
- I authorize DHS to obtain information from any federal, other state agencies and other sources (including electronic databases) to confirm the accuracy of my statements.
- I understand that no person may be denied assistance on the grounds of race, color, sex, age, disability, religion, national origin, or political belief.
- I understand that I may request a hearing before the state agency representative if a decision is not reached on my case within the appropriate time limit or if I disagree with the decision reached.

- I agree to notify the Department of Human Services within 10 days if I or my spouse receive additional income, acquire or dispose of property or if any other changes occur in my circumstances.
- I authorize the Department of Human Services to examine all records of mine, or records of those receiving or having received Medicaid benefits through me, for the purpose of investigating whether or not any person may have committed Medicaid fraud, or for use in any legal, administrative, or judicial proceeding.
- I understand that I must provide my Social Security Number as a condition of my eligibility; and I understand that this number may be used by the Agency without my express permission in a computer match to obtain information relative to my eligibility for assistance from the Social Security Administration, Department of Workforce Services, Internal Revenue Service, or other agencies.
- ASSIGNMENT OF MEDICAL SUPPORT. 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 on 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 which 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 of 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.
- *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 Medicaid 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 have read the above statements, and I agree to the provisions. I understand that this form is signed subject to penalties for perjury. I understand that if I receive assistance to which I am not entitled as a result of withholding information or providing inaccurate information, such assistance will be subject to recovery by the Department of Human Services and I may be subject to prosecution for fraud and fined and/or imprisoned.

_____	_____
Signature of Applicant, Guardian, or Authorized Rep.	Signature of Applicant, Guardian, or Authorized Rep.
_____ _____	_____
Date Telephone Number	Guardian or Authorized Rep's Address
_____	_____
Witness (if signed by mark) Date	Address of Witness/ Telephone Number
_____	_____
Signature of County Office Worker Date	Name of Person Who Helped Complete Form Date

This completes the application process for the Medicare Savings Program. Federal law requires that each state provide the opportunity to register to vote with every application for public assistance. The remaining pages of this packet are the Arkansas Voter Registration Application. Please answer the following question regarding voter registration:

Would you like to register to vote or change your voter registration address? ☐ Yes ☐ No

If you marked **Yes**, please complete and sign the Voter Registration Application that is attached. If you marked **No**, submit your Medicare Savings Program application to the Access Arkansas Processing Center, 1095 White Drive, Batesville, AR 72501.

PLEASE PRINT AND USE BLACK INK TO COMPLETE

Rev. 7/12

ARKANSAS VOTER REGISTRATION APPLICATION

Check all that apply:
- **This is a new registration.**
- **This is a name change.**
- **This is an address change.**
- **This is a party change.**

Office Use Only

Assigned ID

1 Mr. Mrs. Miss Ms. | Last Name | Jr. Sr. II. III. IV. | First Name | Middle Name

2 Address Where You Live (See Section "C" Below) (Rural addresses must draw map.) | Apt. or Lot # | City/Town | County | State | Zip Code

3 Address Where You Receive Mail If Different From Above | Apt. or Lot # | City/Town | County | State | Zip Code

4 Date of Birth _____/_____/_____ (Month / Day / Year)

5 Home & Work Phone Numbers (Optional) (H) (W)

6 Party Affiliation (Optional)

7 E-mail Address (Optional)

8 Have you ever voted in a federal election in this State? ☐ Yes ☐ No

9 ID Number - Check the applicable box and provide the appropriate number.
- ☐ Arkansas Driver's license number _____
- ☐ **If you do not have a driver's license provide the last 4 digits of social security number** _____
- ☐ I have neither a driver's license nor social security number.

10
- **(A)** Are you a citizen of the United States of America and an Arkansas resident? ☐ Yes ☐ No
- **(B)** Will you be eighteen (18) years of age or older on or before election day? ☐ Yes ☐ No
- **(C)** Are you presently adjudged mentally incompetent by a court of competent jurisdiction? ☐ Yes ☐ No
- **(D)** Have you ever been convicted of a felony without your sentence having been discharged or pardoned? ☐ Yes ☐ No

If you checked **No** in response to either questions A or B, do not complete this form.
If you checked **Yes** in response to either questions C or D, do not complete this form.

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

_____

The information I have provided is true to the best of my knowledge. I do not claim the right to vote in another county or state. If I have provided false information, I may be subject to a fine of up to $10,000 and/or imprisonment of up to 10 years under state and federal laws.

11 **Date:** _____/_____/_____ (Month / Day / Year)

If applicant is **unable to sign his/her name,** provide name, address and phone number of the person providing assistance:
Name: _____ Address: _____
City: _____ State: _____ Phone#: _____

Please complete the sections below if:

- You were previously registered in another county or state, or
- You wish to change the name or address on your current registration.

MAIL REGISTRANTS: PLEASE SEE SECTION D.

Agency Code (For Official Use Only)

PA 04

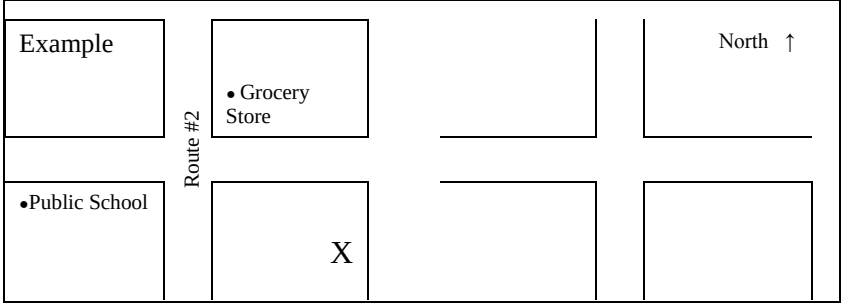
A Mr. Mrs. Miss Ms. | Previous Last Name | Jr. Sr. II. III. IV. | First Name | Middle Name(s)

Date of Birth _____/_____/_____ (Month / Day / Year)

B Previous House Number and Street Name | Apt.or Lot # | City or Town | State | Zip Code

If you live in a rural area but do not have a house or street number, or if you have no address, please show on the map where you live.

C
- Write in the names of the crossroads (or streets) nearest where you live.
- Draw an "X" to show where you live.
- Use a dot to show any schools, churches, stores or other landmarks near where you live and write the name of the landmark.



D

IDENTIFICATION REQUIREMENTS

IMPORTANT: If your voter registration application form is submitted by mail and you are registering for the first time, and you do not have a **valid Arkansas driver's license** number or **social security number**, in order to avoid the additional identification requirements upon voting for the first time you must submit with the mailed registration form: **(a)** a current and valid photo identification; or **(b)** a copy of a current utility bill, bank statement, government check, paycheck, or other government document that shows your name and address.

Arkansas Secretary of State
ATTN: Voter Registration
P.O. Box 8111
Little Rock, Arkansas 72203-8111

First Class Postage Required

From:

Deadline Information

To qualify to vote in the next election, you must apply to register to vote 30 days before the election. If you mail this form, it must be postmarked by that date. You may also present it to a voter registration agency representative by that date. If you miss the deadline you will not be registered in time to vote in that election. *Please don't delay. Make sure your vote counts*.

If you are qualified and the information on your form is complete, you will be notified of your voting precinct by your local County Clerk.

To Mail

Fold form on middle perforation, tape the form closed, stamp and mail.

Questions?

Call your local County Clerk

Or

Arkansas Secretary of State

Mark Martin
Elections Division – Voter Services
1-800-482-1127

Contact your County Clerk if you have not received confirmation of this application within two weeks.

ARKANSAS VOTER REGISTRATION INFORMATION

Section 7 of the National Voter Registration Act (NVRA) of 1993 requires that each state provide the opportunity to register to vote with every application for public assistance and every recertification, renewal and change of address. This Voter Registration packet is an opportunity for you to register to vote or change your voter registration address. Applying to register or declining to register to vote will not affect the amount of assistance that you will be provided by this agency.

If you would like help in filling out the voter registration application form, we will help you. The decision whether to seek or accept help is yours. You may fill out the voter registration application form in private.

No information relating to a declination to register to vote in connection with an application may be used for any purpose other than voter registration.

If you believe that someone has interfered with your right to: 1) Register to vote; 2) Decline to register to vote; 3) Privacy in deciding whether to register or in applying to register to vote; or 4) Choose your own political party or other political preference,

You may file a complaint with:

Secretary of State
Room 256 State Capitol
Little Rock, Arkansas 72201
1-800-482-1127

Mailing Instructions for Voter Registration

You have two options to submit your Voter Registration form.

1. You can submit the registration form in person or mail the registration form along with your SNAP or Medicaid application to your local county DHS office. The address for your county office can be found on the last page of this packet. Some applications (DCO-151 & DCO-152) must be mailed to the Jefferson County DHS office. If you are using one of these forms, you can mail the Voter Registration form with your application to that office. Upon receipt at any county office, that office will mail the form to the Secretary of State's office for you.

2. You may also mail the Voter Registration form directly to the Secretary of State's Office. To mail the form directly to the Secretary of State's office, separate the form from your application/renewal, fold the form along the middle perforation, seal the bottom with tape or staple, and mail to the address on the form. A stamp or stamped envelope is required for mailing.

DHS County Office Mailing Addresses

County	Address	City	Zip
Arkansas	100 Court Square	DeWitt	72042
Arkansas	PO Box 1008	Stuttgart	72160
Ashley	PO Box 190	Hamburg	71646
Baxter	PO Box 408	Mt. Home	72654
Benton	900 SE 13th Court	Bentonville	72712
Boone	PO Box 1096	Harrison	72602
Bradley	PO Box 509	Warren	71671
Calhoun	PO Box 1068	Hampton	71744
Carroll	PO Box 425	Berryville	72616
Chicot	PO Box 71	Lake Village	71653
Clark	PO Box 969	Arkadelphia	71923
Clay	PO Box 366	Piggott	72454
Cleburne	PO Box 1140	Heber Springs.	72543
Cleveland	PO Box 465	Rison	71665
Columbia	PO Box 1109	Magnolia	71754
Conway	PO Box 228	Morrilton	72110
Craighead	PO Box 16840	Jonesboro	72403
Crawford	704 Cloverleaf Circle	Van Buren	72956
Crittenden	401 S. College Blvd	W. Memphis	72301
Cross	803 Hwy 64E	Wynne	72396
Dallas	1202 W. 3rd St.	Fordyce	71742
Desha	PO Box 1009	McGehee	71654
Drew	PO Box 1350	Monticello	71657
Faulkner	1000 East Siebenmorgan Road	Conway	72032
Franklin	800 W Commercial	Ozark	72949
Fulton	PO Box 650	Salem	72576
Garland	115 Stover Lane	Hot Springs	71913
Grant	PO Box 158	Sheridan	72150
Greene	809 Goldsmith Rd	Paragould	72450
Hempstead	116 N. Laurel	Hope	71802
Hot Spring	2505 Pine Bluff St	Malvern	72104
Howard	PO Box 1740	Nashville	71852
Independence	100 Weaver Ave	Batesville	72501
Izard	PO Box 65	Melbourne	72556
Jackson	PO Box 610	Newport	72112
Jefferson	PO Box 5670	Pine Bluff	71611
Johnson	PO Box 1636	Clarksville	72830
Lafayette	2612 Spruce St.	Lewisville	71845
Lawrence	PO Box 69	Walnut Ridge	72476
Lee	PO Box 309	Marianna	72360
Lincoln	101 W. Wiley St.	Star City	71667
Little River	90 Waddell St.	Ashdown	71822
Logan-1	#17 W. McKeen	Paris	72855
Logan-2	398 East 2nd St.	Booneville	72927
Lonoke	PO Box 260	Lonoke	72086
Madison	PO Box 128	Huntsville	72740
Marion	PO Box 447	Yellville	72687
Miller	3809 Airport Plaza	Texarkana	71854
Mississippi 1	1104 Byrum Rd.	Blytheville	72315
Mississippi 2	437 S Country Club	Osceola	72370
Monroe-1	PO Box 354	Clarendon	72029
Monroe-2	301½ N New Orleans	Brinkley	72021
Montgomery	PO Box 445	Mount Ida	71957
Nevada	PO Box 292	Prescott	71857
Newton	PO Box 452	Jasper	72641
Ouachita	PO Box 718	Camden	71711
Perry	213 Houston Ave	Perryville	72126
Phillips	PO Box 277	Helena	72342
Pike	PO Box 200	Murfreesboro	71958
Poinsett	PO Box 526	Harrisburg	72432
Polk	PO Box 1808	Mena	71953
Pope	701 N Denver	Russellville	72801
Prairie	PO Box 356	DeValls Bluff	72041
Pulaski East	PO Box 8083	Little Rock	72203
Pulaski Jax.	PO Box 626	Jacksonville	72078
Pulaski No.	PO Box 5791	N. Little Rock	72119
Pulaski So.	PO Box 2620	Little Rock	72203
Pulaski Sw.	PO Box 8916	Little Rock	72219
Randolph	1408 Pace Rd	Pocahontas	72455
Saline	PO Box 608	Benton	72018
Scott	PO Box 840	Waldron	72958
Searcy	106 School St	Marshall	72650
Sebastian	616 Garrison Ave	Ft. Smith	72901
Sevier	PO Box 670	DeQueen	71832
Sharp	1467 Hwy 62/412 Ste. B	Cherokee Village	72529
St Francis	PO Box 899	Forrest City	72336
Stone	1821 E Main	Mountain View	72560
Union	123 W 18th St.	El Dorado	71730
Van Buren	449 Ingram Street	Clinton	72031
Washington	4044 Frontage	Fayetteville	72703
White	608 Rodgers Drive	Searcy	72143
Woodruff	PO Box 493	Augusta	72006
Yell	PO Box 277	Danville	72833

***If you live in Pulaski County please check the zip code listing below to ensure that you mail or return your application to the appropriate Pulaski County DHS Office.**

Pulaski East: 72016, 72053, 72126, 72135, 72201, 72202, 72203, 72205, 72207, 72212, 72223, 72227
Pulaski North: 72046 (England), 72113, 72114, 72115, 72117, 72118, 72119, 72142 (Scott), 72190, 72231
Pulaski Jacksonville: 72023 (Cabot), 72076, 72078, 72099, 72106, 72116, 72120, 72124
Pulaski South: 72204, 72206 (Shared with Southwest)
Pulaski Southwest: 72002, 72065, 72103, 72208, 72209, 72210, 72211, 72164, 72180, 72183, 72206 (Shared with South)