ARKANSAS REGISTER

Transmittal Sheet

Sharon Priest
Secretary of State
State Capitol Rm. 01
Little Rock, Arkansas 72201-1094

For Office Use Only: Effective Date _____ Code Number _____

Name of Agency: Arkansas Department of Human Services

Department: Division of County Operations

Contact Person: Sandra Miller Phone: 682-8250

Statutory Authority for Promulgating Rules: AR Code Annotated 20-76-201 et Seq.

Forms DCO-995 and DCO-975, Implementation of SCHIP Provisions to ARKids B

		Date
Intended Effective Date	Legal Notice Published	
☐ Emergency	Final Date for Public Comment	
☐ 10 Days After Filing	Filed With Legislative Council	
☒ Other	Reviewed by Legislative Council	
September 6, 2002	Adopted by State Agency	September 6, 2002

CERTIFICATION OF AUTHORIZED OFFICER

I Hereby Certify That The Attached Rules Were Adopted In Compliance with Act 434 of 1967 As Amended.

_____
Signature

Director, Division of County Operations
_____
Title

_____
Date

QUESTIONNAIRE FOR FILING PROPOSED RULES AND REGULATIONS WITH THE ARKANSAS LEGISLATIVE COUNCIL AND JOINT INTERIM COMMITTEE

DEPARTMENT/AGENCY Department of Human Services
DIVISION of County Operations
DIVISION DIRECTOR Joni Jones, Director
CONTACT PERSON Sandra Miller, Assistant Director, OPPD

ADDRESS P. O. Box 1437, Slot S-332, Little Rock, AR 72203
PHONE NO. 682- 8250 **FAX NO.** 682-1597

INSTRUCTIONS

A. Please make copies of this form for future use.
B. Please answer each question completely using layman terms. You may use additional sheets, if necessary.
C. If you have a method of indexing your rules, please give the proposed citation after "Short Title of this Rule" below.
D. Submit two (2) copies of this questionnaire attached to the front of two (2) copies of your proposed rule and mail or deliver to:

Donna K. Davis
Subcommittee on Administrative Rules and Regulations
Arkansas Legislative Council
Bureau of Legislative Research
Room 315, State Capitol
Little Rock, AR 72201

****

1. **What is the short title of this rule?**
Revision of DCO-995 and DCO-975 for Implementation of SCHIP Provisions to ARKids B.

2. **What is the subject of the proposed rule?**
Arkansas has received federal approval to claim enhanced federal funding for certain ARKids B children over 150% of poverty in our SCHIP State Plan. However, children with parents employed by Arkansas state government, state universities, public school districts or technical schools are not eligible for enhanced funding. The application form and renewal form have been revised to identify these children so that we do not claim the enhanced funding for them.

3. **Is this rule required to comply with federal statute or regulations? Yes X No**
If yes, please provide the federal regulation and/or statute citation.

42 CFR 457.310 (c) (1)

4. **Was this rule filed under the emergency provisions of the Administrative Procedure Act?**
Yes No X

If yes, what is the effective date of the emergency rule?

When does the emergency rule expire?

Will this emergency rule be promulgated under the regular provisions of the Administrative Procedure Act? Yes No

5. Is this a new rule? Yes___ No__X_

Does this repeal an existing rule? Yes___ No__X
If yes, please provide a copy of the repealed rule.

Is this an amendment to an existing rule? Yes__X_No___ If yes, please attach a markup showing the changes in the existing rule and a summary of the substantive changes.
A question has been added to the ARKids Application and ARKids Renewal Form asking if the parent is employed by Arkansas state government, state university, 2-year college or public school
to identify children not eligible for enhanced funding. The Medicaid policy has not changed.

6. What state law grants the authority for this proposed rule? If codified, please give Arkansas Code citation.

AR Code Annotated 20-76-201 et. Seq and AR Code Annotated 20-15-201 et. Seq.

7. What is the purpose of this proposed rule? Why is it necessary?
To comply with federal regulation for enhanced funding through SCHIP..

8. Will a public hearing be held on this proposed rule?
Yes__ No_X_ If yes, please give the date, time, and place of the public hearing?

9. When does the public comment period expire?
August 31, 2002.

10. What is the proposed effective date of this proposed rule?
September 6, 2002

11. Do you expect this rule to be controversial? Yes
No_X__ If yes, please explain.

12. Please give the names of persons, groups, or organizations which you expect to comment on these rules? Please provide their position (for or against) if known.

None known.

PLEASE ANSWER ALL QUESTIONS COMPLETELY

July 28, 1995

DEPARTMENT Department of Human Services
DIVISION Division of County Operations
PERSON COMPLETING THIS STATEMENT Sandra Miller
TELEPHONE NO. 682-8250 **FAX NO.** 682-1597

FINANCIAL IMPACT STATEMENT

To comply with Act 884 of 1995, please complete the following Financial Impact statement and file with the questionnaire and proposed rules.

SHORT TITLE OF THIS RULE: Revision to forms DCO-995, ARKids First Application and DCO-975, ARKids Annual Renewal, Implementation of SCHIP Provisions to ARKids B.

1. **Does this proposed, amended, or repealed rule or regulation have a financial impact?**
   Yes ___ **No** X

   Change is to identify ARKids B children who are not eligible for the SCHIP enhanced funding. These children will continue to be funded at their current rate.

2. **If you believe that the development of a financial impact statement is so speculative as to be cost prohibited, please explain.**

   Not Applicable

3. **If the purpose of this rule or regulation is to implement a federal rule or regulation, please give the incremental cost for implementing the regulation.**

2002 Fiscal Year		**2003 Fiscal Year**	
General Revenue	$	**General Revenue**	$
Federal Funds	$	**Federal Funds**	
Cash Funds		**Cash Funds**	
Special Revenue		**Special Revenue**	
Other		**Other**	
Savings Total		**Savings Total**	

4. **What is the total estimated cost by fiscal year to any party subject to the proposed, amended, or repealed rule or regulation?**

2002 Fiscal Year	**2003 Fiscal Year**

5. **What is the total estimated cost by fiscal year to the agency to implement this regulation?**

2002 Fiscal Year	**2003 Fiscal Year**

July 28, 1995

NOTICE OF RULE MAKING

Pursuant to Arkansas Code 20-76-201 et Seq., forms DCO-995 and DCO-975 are being revised due to implementation of SCHIP provisions to ARKids B

Copies of the proposed change may be obtained by writing the Division of County Operations, P.O. Box 1437, Slot S-333, Little Rock, AR 72203. All comments must be submitted in writing to the above address no later than _____.

If you need this material in a different format, such as large print, contact our Americans with Disabilities Act Coordinator at 682-8920 (voice) or 682-8933 (TDD).

The Arkansas Department of Human Services is in compliance with Titles VI and VII of the Civil Rights Act and is operated, managed and delivers services without regard to age, religion, disability, political affiliation, veteran status, age, race, color or national origin.

_____
Joni Jones,
Director, Division of County Operations

Date:_____

MANUAL TRANSMITTAL

Arkansas Department of Human Services
Division of County Operations

☐ Policy ☒ Form ☐ Policy Directive

Issuance Number: IMF 02-12

Income Maintenance Forms Manual

Issuance Date: September 6, 2002

From: Joni Jones
Director

Expiration Date: Until Superseded

Subj: Revised Forms DCO-995
and DCO-975

Form to be Deleted	Dated	Form to be Added	Dated
DCO-995	(R 06/01)	DCO-995	(R. 09/06/02)
DCO-975	(R. 08/01)	DCO-975	(R. 09/06/02)

Summary

Form DCO-995, ARKids First Mail-In Application, and DCO-975, ARKids First Annual Renewal and Eligibility Report Form, have been revised, adding a question to identify ARKids B children not eligible for enhanced funding through SCHIP. The question, at the end of the Income section asks " Do you or your spouse work for Arkansas state government, state university, 2-year college, technical school or public school district?" Children with parents employed by these groups will continue to be eligible for ARKids B, but will not be eligible for the enhanced SCHIP funding from the federal government.

Inquiries to: Jack Tiner, 501-682-8259
Diana Teal, 501-682-1562
Carmen Brown, 501-682-8258
Cindy Gray, 501-682-8254

ARKids First

Mail-In Application

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

Do you want your children considered for:

❑ Either ARKids package* ❑ ARKids A only ❑ ARKids B only

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

1 Applicant Information

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

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

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

2 Household

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

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

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

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

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

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

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

FOR OFFICE USE ONLY

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

3 Income

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

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

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

4 Child Care

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

❑ Yes ❑ No **If yes**, How much? $ _____ How often? _____

5 Unpaid Medical Bills

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

❑ Yes ❑ No **If yes**, Who? _____ In which month(s)? _____

6 Health Insurance

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

❑ Yes ❑ No **If yes**, Who? _____ Insurance company _____

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

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

❑ Yes ❑ No **If yes**, Who? _____ Insurance company _____

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

Please explain why health insurance is no longer available. _____

7 Chronic Illness or Disability

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

❑ Yes ❑ No If yes, Who? _____

8 Primary Care Physician Selection

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

Child's Name	First Choice	Second Choice	Third Choice

9 Other Services Available

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

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

Read carefully before you sign this application

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

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

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

_____ _____

Signature of Parent, Guardian or Relative Date Telephone number of person helping to complete form

_____ _____

Signature of person helping to complete form Date

_____ _____

Signature of Family Support Specialist Date Address of person helping to complete form

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

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

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

DHS County Office Mailing Addresses

County	Address	City	Zip
Arkansas	100 Court Square	DeWitt	72042
Arkansas	PO Box 270	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	72601
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 968	Arkadelphia	71923
Clay-1	PO Box 366	Piggott	72454
Clay-2	1007 Ada St.	Corning	72422
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	2920 McClellan Drive	Jonesboro	72401
Crawford	704 Cloverleaf Circle	Van Buren	72956
Crittenden	401 S. Airport Rd.	W. Memphis	72301
Cross	PO Box 572	Wynne	72396
Dallas	1202 W. 3rd St.	Fordyce	71742
Desha	PO Box 1009	McGehee	71654
Drew	PO Box 1350	Monticello	71657
Faulkner	PO Box 310	Conway	72033
Franklin	800 W.Commercial	Ozark	72949
Fulton	PO Box 650	Salem	72576
Garland	115 Market St.	Hot Springs	71901
Grant	PO Box 158	Sheridan	72150
Greene	PO Box 839	Paragould	72451
Hempstead	116 N. Laurel	Hope	71802
Hot Spring	PO Box 813	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 E. 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 Plz.	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	301 ½ N New Orlean	Brinkley	72021
Montgomery	PO Box 445	Mt. 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	606 Pine St.	Mena	71953
Pope	701 N. Denver	Russellville	72801
Prarie	PO Box 356	DeValls Bluff	72041
Pulaski East	PO Box 8083	Little Rock	72203
Pulaski Jax.	PO Box 626	Jacksonville	72078
Pulaski North	PO Box 5791	No. Little Rock	72119
Pulaski South	PO Box 2620	Little Rock	72203
Puluaski 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	350 School	Marshall	72650
Sebastian	616 Garrison #231	Ft. Smith	72901
Sevier	108 Tn N, Prof Bldg A	DeQueen	71832
Sharp	PO Box 159	Ash Flat	72513
St Francis	PO Box 899	Forrest City	72336
Stone	HC 71 Box 180	Mountain View	72560
Union	123 W. 18th St.	El Dorado	71730
Van Buren	362 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

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

Return Address

_____

_____

_____

Place Stamp Here

Mail to your local DHS county office

ARKids First

Annual Renewal Notice and Eligibility Report Form

If you need this material in a different format, such as large print, please call 1-888-543-7890.

County Office Address

Complete this report for the previous full month.
REPORT DATE: Return this report to the address to the left by:

If above address has changed, please provide corrected address.

ANNUAL RENEWAL INSTRUCTIONS – It is time for the annual review of your children's eligibility for ARKids First insurance. COMPLETE EACH QUESTION ON THIS REPORT AND RETURN IT BY THE REPORT DATE SHOWN ABOVE. THIS REPORT WILL BE USED TO DETERMINE YOUR CONTINUING ELIGIBILITY FOR ARKIDS. You will not be required to visit your local DHS County Office.

ARKids offers two health insurance coverage packages that children may qualify for based on the family's income and assets. This form will be used to determine eligibility for either coverage package. Services must be medically necessary. Limitations may apply.

Coverage	ARKids A	Arkids B
Basic Coverage: Physician, prescription drugs, hospital, ambulance (emergency only), dental, medical equipment, medical supplies, emergency department services, eye glasses, family planning, health screens, home health services, laboratory and x-ray, mental health –outpatient only, podiatry, speech therapy and vision, chiropractor, immunizations, nurse midwife and nurse practitioner.	Yes	Yes
Additional Coverage: Audiology, child health management services, developmental day treatment clinic services, domiciliary care, end stage renal disease services, hearing aids, hospice, hyperalimentation, inpatient psychiatric, nursing facilities, orthotics, personal care, transportation (non-emergency), private duty nursing, prosthetics, therapy (occupational and physical), ventilator services, and targeted case management.	Yes	No
Screenings (through Child Health Services): If the child receives periodic Child Health Services checkups, benefits are unlimited for covered services that are medically necessary.	Yes	No
Co-payments: ARKids B requires the following co-payments: $5.00 per prescription drug, $10.00 per medical visit, $10.00 per emergency ambulance trip, 20% of the 1st day of inpatient hospitalization, 20% of the Medicaid allowed amount for each item of Durable Medical Equipment. A co-payment is not required for preventive health screens, dental check-ups and family planning services. American Indians and Alaskan Natives (AI/AN) are exempt from co-pays (please indicate if you are AI/AN). There is a 5% cap on co-pays based on the families gross annual income.	No	Yes

Do you want your children considered for:

❑ Either ARKids package* ❑ ARKids A only ❑ ARKids B only

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

1 Household (Attach additional sheets if needed.)

Complete if there are any children living in your home that you would like to add to your ARKids coverage.

Social Security Number	Last Name	First Name	Birthdate (MM-DD-YY)	Race	Sex	Relationship to you	U.S. Citizen Yes	No

Provide a copy of their birth certificate and social security card.

Has a parent of any ARKids child moved into the home in the last 12 months? ❑ Yes ❑ No If yes, complete:

Social Security Number	Last Name	First Name	Birthdate (MM-DD-YY)	Race	Sex	Relationship to you	U.S. Citizen Yes	No

Has any child covered by ARKids or their parent moved out of the home in the last 12 months? ❑ Yes ❑ No If yes, who?

Name(s)	Social Security Number(s)	Date Moved

2 Income

Does anyone receive income from the following? Attach additional sheets to explain, if needed.

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

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

3 Child Care

Does any parent pay childcare for any child(ren) living in the home? ❑ Yes ❑ No

If yes, How much? $ _____ How often? _____ For Whom? _____

4 Health Insurance

Did a child receiving or added to ARKids have health insurance during the last 6 months? ❑ Yes ❑ No If yes, please provide:

Children's Names	Insurance Company	Date Coverage Began

5 Primary Care Physician Selection:

Complete only if you are adding a child or changing a primary care physician.

Child's Name	1st Choice	2nd Choice	3rd Choice

PLEASE READ CAREFULLY BEFORE SIGNING THIS FORM

- I understand that if any of my children receive assistance to which they are not entitled as a result of withholding information, I will be liable for any overpayment.
- I understand that the information provided on this report may result in loss of my ARKids coverage.
- I declare that the information provided is correct.

I understand that by signing this annual eligibility report I am subject to penalties for false statements.

Sign Your Name_____ Date _____