ARKANSAS DEPARTMENT OF HUMAN SERVICES
LONG-TERM SERVICES AND SUPPORTS APPLICATION

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.

What services are you requesting?

☐ **Nursing Facility** — Check this if you are in a nursing facility or are planning to enter one in the next 15 days.

☐ **ALF** — Check this if you are in a Level II Assisted Living Facility or are planning to enter one.

☐ **ARChoices** — Check this if you are aged 21 to 64 with a physical disability or aged 65 or older, and you need to be in a nursing home but want to receive home and community-based services safely in your home.

☐ **PACE** — Check this if you are age 55 to 64 with a physical disability or age 65 or older, you need to be in a nursing home but want to receive home and community-based services safely in your home, and you live in an area that offers services.

☐ **DDS Waiver** — Check this if you have developmental disabilities, and you need to be in a nursing home but want to receive home and community-based services safely in your home.

For more information on any of the above programs, go to http://hs.ar.gov/daas/Pages/LTSS.aspx or call 1-866-801-3435.

Information About You

1. I am a resident of Arkansas Yes ☐ No ☐ 2. I am 65 years of age or older ☐ Blind ☐ Disabled ☐

3. My full name is _____ Race _____ Sex _____
   Last First Middle Maiden or Suffix

4. My current address is _____
   Street Address Apt/Suite/Lot No. City State Zip County

   If this is a nursing home or assisted living facility, what is the facility's name? _____

   I have lived at my current address for _____ (months, years, etc.)

   _____
   Mailing Address (P.O. Box, In Care Of, etc.) City State Zip County

   My former address was _____
   Street Address Apt/Suite No. City State Zip County

5. My telephone number is _____ My message number is _____

6. I was born on _____ I was born in _____ _____
   Month Day Year City or County State or Country

7. _____ _____ _____ _____
   Social Security Number Medicare Number Railroad Ret. Number VA Claim Number

8. I am a U.S. Citizen or National Yes ☐ No ☐ 9. I am a lawfully admitted Alien Yes ☐ No ☐

10. I am Married ☐ Separated ☐ Widowed ☐ Divorced ☐ Single (Never Married) ☐

Information About Your Spouse

Complete Questions 11 – 15 if you have a Spouse (whether Married or Separated)

11. My spouse's name is: _____ Race _____ Sex _____
Last First Middle Maiden or Suffix

12. My spouse's address is: _____
Street Address Apt/Suite/Lot No. City State Zip County

He/She lives in a nursing home or assisted living facility. Yes ☐ No ☐ If yes, which one? _____

13. My spouse's telephone number is: _____ 14. My spouse was born on _____
Month Day Year

15. _____ _____ _____ _____
Spouse's Soc. Sec. No. Spouse's Medicare No. Spouse's Railroad Ret. No. Spouse's VA Claim No.

Income

Income is the receipt of assets (cash, checks, money orders, etc.) you and/or your spouse **receive** (monthly, yearly, etc.) **Gross** means the amount **before** any deductions. See page 6 for documents that may be requested.

16. I and my spouse have income from the following: Check (√) Yes or No for **every** item. If **yes**, enter the requested information below.

	MYSELF				MY SPOUSE			
SOURCE OF INCOME	YES	NO	GROSS AMOUNT	HOW OFTEN RECEIVED	YES	NO	GROSS AMOUNT	HOW OFTEN RECEIVED
Retirement Benefits								
Social Security Benefits								
SSI								
Veteran's Benefits								
Railroad Retirement								
Civil Service Benefits								
Interest/Dividends								
Insurance Payments								
Money From Trusts								
Mineral Rights/Oil/Gas Lease Payments								
Rental Income Paid to Me or My Spouse								
Annuity Payments								
Worker's Compensation								
Employment/Work								
Farming/Self Employment								
Other not listed above (Contributions, etc.)								

17. I or my spouse have **additional** income that I was unable to list above **or** I or my spouse expect a **change** in income.
Yes ☐ No ☐ If **yes**, record your answer(s) on a separate sheet and provide verification. (See page 6.)

Resources – Real Property

Real property is land (including houses or immovable objects attached to it) which you and/or your spouse possess. It also includes burial plots and crypts. **Equity** value means the fair market value minus what you owe. Provide copies of deeds or other documentation for each property listed below. See page 6 for documents that may be requested.

18. I or my spouse own, are buying, or have legal interest in a home. Yes ☐ No ☐

_____
Location of Home (Address, City, County, State) Equity Value

How is the home titled? _____
Names on Title (e.g. your name/or your spouse's name; someone else's name; in a trust)

Does anyone live there? Yes ☐ No ☐

If yes, what is their name and relationship to you? _____

If your home in Arkansas is not occupied by you, a spouse, or a dependent relative, do you intend to return home?
Yes ☐ No ☐

19. I or my spouse own, are buying or have a legal interest in real property, (land or buildings), other than my home.
Yes ☐ No ☐ If yes, complete the following. (Use separate sheet, if necessary.)

Location of Property (Address, City, County, State) — Equity Value

Location of Property (Address, City, County, State) — Equity Value

20. I or my spouse formerly owned homes or other real property in: (Use separate sheet, if necessary.)

Location of Property (Address, City, County, State) — Date Last Owned

Location of Property (Address, City, County, State) — Date Last Owned

21. I or my spouse have sold/deeded/given away a home or other real property. To Whom and When

22. I or my spouse retain life estate, dower, curtesy, inheritance, trust, or other interest in a home or other property.

Location of Property (Address, City, County, State) — Type of Interest

23. I or my spouse own burial plots or crypts. Yes ☐ No ☐ If yes, how many do you own? _____

Name of cemetery and location _____ Value _____

Who are the plots intended for and what is their relationship to you? (Use separate sheet, if necessary.)

Resources – Personal Property

Personal property is property other than real property which you and/or your spouse possess. Some examples are: cash, checking/savings accounts, stocks, bonds, etc. See page 6 for documents that may be requested.

24. I or my spouse have the following assets. Check (√) Yes or No for **every** item. If **yes**, enter information below.

TYPE	YES	NO	AMOUNT/ VALUE	Where Held (bank name, *insurance company, etc.*)	NAME OF *JOINT OWNER*
Cash					
Checking Account					
Savings Account					
Other Savings (Certificates, etc.)					
Promissory Notes					
Stocks/Bonds					
Patient Fund Account					
Mortgage that you own					
Burial Funds/Insurance					
Life Insurance					
Trusts					
Other (Mineral/Oil/Gas Leases, Annuity, etc.)					

25. I or my spouse own or are buying personal property such as cars, trucks, tractors or farm machinery, trailers, boats, etc. (If more than three, please list on a separate sheet.)

Item (Make, Model, and Year) — Equity Value (Fair Market Value minus what you owe)

Item (Make, Model, and Year) — Equity Value

Item (Make, Model, and Year) — Equity Value

26. I or my spouse own livestock (cattle, poultry, catfish, minnows, crickets, worms, etc.) Yes ☐ No ☐
If yes, complete the following:

Type of Livestock and Number Owned	Value

27. I/my spouse have other resources (real or personal property) that are being held for me by another individual.
Yes ☐ No ☐ If yes, complete the following:

Type of Resource	Location of Resource	Amt/Value
Type of Resource	Location of Resource	Amt/Value

28. I/my spouse have **additional** resources (real or personal property) that I was unable to list under items 16 through 25 above. Yes ☐ No ☐ If yes, record your answer(s) on a separate sheet and provide verification (See page 6.)

Insurance

29. If you have hospital/medical insurance coverage, complete the following and the attached *Third Party Resource/ Medical Insurance* form (DCO-0662):

Health Insurance Company Name & Address	Type of Coverage	Effective Date	Policy or Claim #

30. Do you have Long-Term Care Insurance? Yes ☐ No ☐ If yes, complete the following:

Insurance Company Name & Address	Effective Date	Policy or Claim #

Unpaid Medical Expenses

31. I have unpaid medical expenses from the past three (3) months Yes ☐ No ☐ Which months? _____

If yes, the expenses were incurred while I was: In a hospital/rehab ☐ In a nursing home/ALF ☐ Other ☐

Rights and Responsibilities

- I understand that I must help establish my eligibility by providing as much of the requested information as I can about my circumstances.
- I authorize the Department of Human Services to make any investigation concerning me and/or my spouse necessary to establish my eligibility for assistance.
- I understand that no person may be denied long-term services and supports assistance or other Medicaid assistance on the grounds of race, color, sex, national origin or disability.
- 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 receives 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.
- **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, settlements, 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.

- **I understand the requirement to disclose in my application for long-term services and supports information regarding any interest that I or my spouse may have in an annuity.**
- **I understand the requirement to name the state as a remainder beneficiary in which I or my spouse is the annuitant.**
- If you have questions or problems regarding your application or care, please call your State Long-Term Care Ombudsman at **501-682-8952.**

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.

IMPORTANT ESTATE RECOVERY NOTICE

If you receive Medicaid in a nursing facility, ICF/IID facility, or under a home and community-based waiver program, the total amount of the Medicaid benefits paid on your behalf will be a debt to DHS and may be recovered from your estate 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 a claim against your estate after your death if your spouse is still living or if you have dependent children under age 21 or blind or 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. **(See PUB-428 at http://hs.ar.gov/daas/Pages/LTSS.aspx for more information.)**

CERTIFICATION: I have read the above statements, and I agree to their provisions.

- **FOR LONG-TERM CARE FACILITY RECIPIENTS/APPLICANTS ONLY:** After reviewing the alternatives to nursing facility placement available through the Department of Human Services, I understand that I am choosing to be served in a nursing facility.
- **I understand that if I am admitted to a nursing facility based on conditional Medicaid approval, and my Medicaid case is denied, I or my family will be responsible for any indebtedness while in the nursing facility.**
- 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, POA or Authorized Representative	**Date**
Guardian, POA or Authorized Representative's Address	**Telephone Number**
Name of Person Who Helped Complete Form **Date**	**Telephone Number**

This completes the Long-Term Services and Supports application process. 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 completed Medicaid application to your local Department of Human Services County Office.

Verification Needed to Complete your LTSS Application

Thank you for your application for Long-Term Services and Supports (LTSS). In order to determine your eligibility, policy requires that we verify your income, resources and other aspects of your circumstances. The following is a list of items that we must verify. The sooner you can provide these items, the sooner DHS can process your application. It is the responsibility of the client to verify all requested information. However, **DO NOT HOLD YOUR APPLICATION UNTIL YOU HAVE ALL THE INFORMATION.** You will receive a personalized notice soon informing you of exactly what DHS needs based on specific income, resources, and other circumstances in order to make a determination on your LTSS application.

Please provide copies of the following:

Cards/Certificates

- Social Security Card
- INS card, if you are not a citizen
- Medicare Card
- Health Insurance Card
- Birth Certificate (or if not available, Census Records/Baptismal Records to verify age and citizenship)
- Marriage License and/or Divorce Decree

Income – *including* ***spouse*** *if you are in a facility or if you have established an income trust*

- Copy of Paystubs
- Social Security Award Letters
- VA Award Letters – include Aid and Attendance
- Retirement Benefits Letter (APERS, Pension, OPM, etc.)
- If Rental Property – Rental Agreement
- LTC Insurance Policy
- If receive money from an insurance company or an annuity, provide proof
- Last month or quarter interest received on checking and/or savings accounts
- Trust documents (Revocable, Irrevocable, Annuity, etc.)
- Mineral Rights/Oil/Gas Lease Payments for the last 12 months and/or Form 1099 for the previous tax year
- Direct Express Accounts and/or Pay Card Statements. If you do not receive statements on your Direct Express Account, you may want to consider calling **1.888.741.1115** and request a current copy from customer service.

Resources – *including spouse*

- Bank statements showing balance as of the 1st day of month of application (three (3) prior statements)
- Savings Account Passbook or Statement from bank
- Life Insurance Policy (entire policy)
- Burial Insurance Policy – Prepaid Burial Contract
- Mortgage papers if you own a mortgage and people are paying your monthly installments
- Current year tax assessment and personal property statement
- Deeds to all property you currently own, are buying, or in which you have an ownership interest
- Deeds to all property transferred in the last 5 years
- Life estate, CD, IRA, Patient Fund Account, etc.
- Trust documents (Revocable, Irrevocable, Annuity, etc.)
- Mineral Rights/Oil/Gas Lease Form 1099 for the previous tax year

****Complete and return the attached *Disposal of Assets Disclosure* form (DHS-0727) with your application.****
If you have sold or given away anything of value within the last 60 months (5 years) prior to the date of this application, please provide verification.

If you have a trust or annuity, regardless of when it was established, provide verification.

Arkansas Department of Human Services
Division of County Operations
DISPOSAL OF ASSETS DISCLOSURE

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.

Medicaid rules require the complete disclosure of all asset transfers (real or personal property transfers) including the establishment of trusts and/or annuities made by yourself or your spouse within the last 5 years (60 months). Also, currently valid trusts or annuities established outside the last 5 years (60 months) must be disclosed. All such transfers must be documented by the local Human Services Office to determine your eligibility for Medicaid assistance. Read each part of this form carefully to determine parts which apply to you. You must complete and sign Part A **or** Part B. **Please complete another form to report additional transfers.**

PART A. ASSETS TRANSFERRED

☐ I (or my spouse) established a trust or annuity on _____. Please provide a copy of your trust and/or annuity documents.
(Date)

☐ I (or my spouse) have sold, transferred, assigned, or given away the following assets (cash, checking accounts, savings accounts, securities, real or personal property, etc.) within the last 60 months. (Please verify any transfers with copies of deeds, bank statements, etc.)

	Item	Transferred to (Name)	Relationship to you	Transfer Date	Location (County, State)	Value of item	Payment Received
1.							
2.							
3.							
4.							
5.							

Provide the address and telephone number below for the person that received the item.

Name _____ Address _____

Telephone Number _____ **(Please use an additional sheet of paper if needed).**

This statement is true to the best of my knowledge, and I understand that should I give a false statement, I may be subject to criminal prosecution. I also understand that I will be liable for any overpayments made on my behalf by the Arkansas Medicaid program due to my misrepresentation of fact(s).

_____ _____
Signature Date

PART B. NO ASSETS TRANSFERRED

☐ I (or my spouse) have not established a trust or annuity, and have not sold, transferred, assigned, or given away any assets (cash, checking accounts, savings accounts, securities, real or personal property, etc.) within the last 5 years (60 months). This statement is true to the best of my knowledge, and I understand that should I give a false statement, I may be subject to criminal prosecution. I also understand that I will be liable for any overpayments made on my behalf by the Arkansas Medicaid program due to my misrepresentation of fact(s).

_____ _____
Signature Date

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

A. APPLICANT INFORMATION:

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

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

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

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

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

B. POLICYHOLDER INFORMATION:

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

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

C. INSURANCE INFORMATION:

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

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

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

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

D. INDICATE ALL INDIVIDUALS COVERED BY POLICY:

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

E. COMMENTS _____

_____

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

AUTHORIZATION AND ASSIGNMENT

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

_____ _____

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

Arkansas Department of Human Services
Division of County Operations
Collateral Statement

Dept of Human Services
Garland County
115 Stover Lane
Hot Springs AR 71913
Phone: (501) 321-2583
TDD: (501) 321-4709

IF YOU NEED THIS MATERIAL IN A DIFFERENT FORMAT SUCH AS LARGE PRINT, CONTACT YOUR LOCAL DHS OFFICE.

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

Casehead Name _____ SSN _____

☐ TRANSITIONAL EMPLOYMENT ASSISTANCE (TEA)
☐ SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM (SNAP)
☐ MEDICAID

To The Casehead: Please have a friend or neighbor complete this form. This person cannot be a relative or any of your household members and should be someone with a telephone who can be reached between 8:00 and 4:30. They should be familiar enough with your household to be able to answer every question. This form is used to verify residency and household composition, which are requirements of eligibility. **NOTE: For SNAP Applicants, Only The Questions With The Stars (*) Must Be Completed.**

To The Person Completing This Form: The above named individual has applied for assistance. In order for us to determine his eligibility, we need a statement from a person who is not a relative and who knows the applicant and his circumstances.

* 1. What is the family's home (where they live) address?

_____

* 2. What are the names of the adults living in the home?

_____ _____ _____

_____ _____ _____

* 3. What are the names of the children who are living in the home?

_____ _____ _____

_____ _____ _____

*4. How do you know that all these persons are living in the home?

_____

_____

*5. Does anyone living in the home work? _____ If yes, who is working and where do they work?

_____

6. Has anyone moved into this home during the past six months? _____ If yes, who has moved in?

_____

7. Has anyone moved out of this home during the past six months ? _____ If yes, who moved out?

_____

The State of Arkansas provides penalties including fines and/or imprisonment for persons providing false information in order to receive or aid others in receiving Public Assistance.

Signed: _____
Address: _____

_____

_____

Telephone No: _____
Date Signed: _____