

## 2200 Eligibility Determination

## 2272 Resources to be Disregarded

## 2271.1 Verification of a Resource

12/01/97

The countable value of a resource which is not disregarded must be verified. See [TEA 2272](#) for disregarded resources.

## 2272 Resources to be Disregarded

~~12/01/97??/??/??~~

The following resources are not considered in determining the family's TEA eligibility:

1. The family's homestead. (See [TEA 2272.1](#) for more information regarding the homestead.)~~;~~
2. One (1) motor vehicle~~;~~
3. Household and personal goods~~;~~
4. Income-producing real or personal property~~;~~
5. Earmarked resources~~;~~ ~~This including but not limited to~~ educational grants, loans, and settlement payments that are intended and used for purposes which preclude their use for current living costs~~;~~ ~~etc.~~~~;~~
- ~~6.~~ Earned Income Credit (EIC) and other tax refunds~~;~~
- ~~7.~~
- ~~8.~~
- ~~9-6.~~
- ~~10-7.~~ Any type of life insurance policy, including the cash surrender value of the policy~~;~~
- ~~11-8.~~ One burial plot per TEA family member~~;~~
- ~~12-9.~~ Payments made under any federal, state, or local disaster assistance program~~;~~
- ~~13-10.~~ Any property or payment required to be disregarded for eligibility purposes according to federal or state statute. ~~(See the Note on the following page).~~~~;~~
- ~~14-11.~~ When the unit consists of a minor parent and ~~his or her~~ their child, the resources of the minor parent's parent(s) or stepparent~~;~~
- ~~15-12.~~ The resources of the spouse of a non-parent relative who is included in the TEA cash assistance unit~~;~~



**NOTE:** If jointly owned, the caretaker relative's pro\_rata share will be counted.

2200 Eligibility Determination

2272 Resources to be Disregarded

~~16.13.~~ Individual Development Accounts (IDA). (Refer to section 3445 of the [DWS TEA Case Management Manual](#));

~~17.14.~~ Funds up to ~~ten-thousand dollars~~ (\$10,000.00) placed in an escrow account by a TEA recipient who is engaged in a micro-enterprise work activity;

~~15.~~ Savings for Education, Entrepreneurship, and Down Payment (SEED) ~~a~~Accounts;

~~18.16.~~ ~~Achieving a Better Life Experience a~~Accounts (ABLE).



~~**NOTE:** At any time, there is a question as to whether a particular type of property or payment may be disregarded under Item #10 above, the worker should submit the pertinent documents, or information concerning the property or payment, to the Office of Program Planning and Development, Slot S33, for a determination. This information should include the specific federal or state statute under which it is believed the disregarded treatment is required.~~

### 2272.1 The Homestead

07/01/97

A homestead is a house and tract of land which a person considers his home. A mobile home or trailer used as a home will be considered as a homestead, regardless of whether the person also owns the property on which the mobile home is situated.

Only one (1) such tract will be considered a homestead. However, there is no limit to the acreage or number of lots, so long as the property is contiguous. Any other dwelling units or apartments on the property will be considered a part of the homestead.

The family must be presently residing on the property or intend to move on to it within a period of six (6) months from the date of application or date of purchase, whichever is later.

If the family ceases to live on the property, it will continue to be regarded as a homestead for a period of six (6) months from the date they left the home or the date of application, whichever was later, provided they intend to return to it. A request to extend the period beyond six (6) months may be approved by the County Administrator, if it is determined that extenuating circumstances exist in the case.

**2200 Eligibility Determination**

**2272 Resources to be Disregarded**

Unless the period has been extended, the recipient will be advised that the homestead becomes excess property after six (6) months.

MARKUP

# MEDICAL SERVICES POLICY MANUAL, SECTION E

## ~~E-600 Achieving a Better Life Experience (ABLE) Program~~

### ~~E-6010 ABLE Achieving Account a Better Life Application~~

#### **E-610 ABLE Account Application Process** **Program Trust and Account Management**

*Refer to Health Care Procedures Manual for more information.*

MS Manual ~~10/01/17??/??/??~~

~~The Office of the Arkansas State Treasurer-The Achieving a Better Life Experience (ABLE) Program Committee will administer the ABLE program for Arkansas residents and non-residents. The Committee is composed of the Secretary of the Department of Human Services, the Director of Arkansas Rehabilitation Services, the Treasurer of the State, or their designees. The Office of the Arkansas State Treasurer will manage the ABLE Program Trust for the Committee. The Office will:~~

- ~~• determine eligibility for ABLE accounts;~~
- ~~• process enrollments;~~
- ~~• process account maintenance transactions;~~
- ~~• maintain account payment and distribution history; and~~

# MEDICAL SERVICES POLICY MANUAL, SECTION E

## ~~E-600 Achieving a Better Life Experience (ABLE) Program~~

### ~~E-60060 Achieving a Better Life Experience (ABLE) Program Income~~

- ~~• provide eligibility reports for Medicaid renewals.~~

Questions regarding the establishment of an ABLE account will be directed to the Office of the Arkansas State Treasurer, ~~1401 West Capitol Ave., Suite 275, Little Rock, AR 72201.~~

## E-660 Income Exclusions

MS Manual ~~10/01/17~~ ~~??/??/??~~

Exclude all contributions to an ABLE account from the countable income of the designated beneficiary. ~~(See Re-~~ MS policy section E-630). This includes rollovers from another family member's ABLE account.



**NOTE:** A rollover is the distribution of all or some of the funds from an initial one ABLE account to the ABLE account of a member of the designated beneficiary's family. For purposes of this type of rollover, a member of the designated beneficiary's family means: siblings, ~~step-siblings~~ stepsiblings, and half siblings.

However, do not deduct contributions from the countable income of the individual who makes the contribution.

**EXAMPLE: Contribution:** Kristie Mae has one hundred dollars (\$100) automatically deducted from her paycheck and deposited into her daughter Sharon's ABLE account. The one hundred dollars (\$100) will not be considered income for Sharon but will still be included as a portion of Kristie Mae's income.

**EXAMPLE: Rollover:** Linda is determined to no longer be disabled so she transfers all of the funds in her ABLE account to her ~~step-brother~~ stepbrother Scott's ABLE account. These funds will not be considered as income to Scott.

The funds in an ABLE account can accrue interest, earn dividends, and otherwise appreciate in value. Earnings increase the account's balance. Interest accrued or dividends earned on the money in an ABLE account are excluded from the income of the designated beneficiary.



**NOTE:** ~~Long-Long~~ Term Supports and Services' transfer of resources rules apply to contributions made to an ABLE account (See MS policy section H-300-325).

# MEDICAL SERVICES POLICY MANUAL, SECTION E

## ~~E-600 Achieving a Better Life Experience (ABLE) Program~~

### ~~E-60070 R~~Achieving a Better Life Experience (ABLE)

#### E-670 Resource Exclusions

MS Manual ~~10/01/17~~ ~~??/??/??~~

The amount of funds in an ABLE account ~~that exceeds \$100,000~~ will not be counted as a resource for Health Care eligibility. ~~Only \$100,000 of the balance of funds in an ABLE account can be excluded from the resources of the designated beneficiary.~~

Any distribution for a non-housing related Qualified Disability Expense (QDE) that has been retained beyond the month it was received, will be excluded from the designated beneficiary's countable resources if:

- The designated beneficiary maintains, makes contributions to, or receives distributions from the ABLE account;
- The distribution is unspent;
- The distribution is identifiable (Excluded funds commingled with non-excluded funds must be identifiable); and
- The individual still intends to use the distribution for a non-housing related QDE.

**EXAMPLE: Excluded Distribution-** Eric takes a distribution of five hundred dollars (\$500) from his ABLE account in February 2017 to pay for a health related QDE. His health-related expense is not due until May, so Eric deposits the distribution into his checking account in February. The distribution is not income in February. Eric maintains his ABLE account at all relevant times and the distribution of five hundred dollar~~five hundred dollars (\$500) distribution~~ remains both unspent and identifiable until Eric pays his health-related~~health-related~~ expense in May. Therefore, the distribution of five hundred dollar~~five hundred dollars (\$500) distribution~~ will be excluded from Eric's countable resources in March, April, and May.



**NOTE:** A distribution for a ~~housing-related~~housing related QDE, or for an expense that is not a QDE, will be counted as a resource if the beneficiary retains the distribution into the month following the month of receipt. Distributions for housing-related QDEs must be spent in the month of receipt. If the beneficiary spends the distribution within the month of receipt, there is no effect on eligibility.

If distribution for a non-housing-related QDE that was retained into the following month is actually used for a non-qualified purpose or a housing-related QDE, the amount of funds used for the non-qualified purpose or a housing-related QDE will be considered a resource on the first day of the month in which the funds were spent. The caseworker will assume that the individual's intent to use the funds for a QDE changed as of the first of the month that the individual spent the funds. If the individual's intent to use the funds for a QDE changes at any other time, but the individual has not spent the funds, the retained funds will be counted as a resource the first of the following month.

## MEDICAL SERVICES POLICY MANUAL, SECTION E

### E-600 Achieving a Better Life Experience (ABLE) Program

#### E-60070 Achieving a Better Life Experience (ABLE)

**EXAMPLE: Previously Excluded Distribution Used for a Non-QDE:-** Sam takes a distribution of twenty-five thousand dollars (\$25,000) from his ABLE account, with the intent to modify a specially equipped van in May. He pays a deposit of ten –thousand –dollarss (\$10,000) ~~deposit~~ on the van modifications. While waiting for the delivery of the van, Sam takes a trip to a casino in July where he loses one thousand dollars (\$1,000) of his ABLE distribution while gambling. The one thousand dollars (\$1,000) he lost gambling is a countable resource in July. The other fourteen thousand dollars (\$14,000) ~~that~~ Sam retains continues to be an excluded resource as long as it meets the requirements in this section.

**EXAMPLE: Previously Excluded Distribution Used for a Housing Related QDE:-** Jennifer takes a distribution of seven –thousand- -dollarss (\$7,000) ~~distribution~~ from her ABLE account in June to pay her college tuition, a qualified disability expense (QDE). Her tuition payment is due in September. However, she has to make an advance rent payment of seven –hundred –fifty –dollarss (\$750) ~~advance rent payment~~ for her college apartment in August. She uses seven -hundred –and-fifty-dollars (\$750), of the distribution she took in June, to make the rent payment which is a housing related QDE. The seven-hundred fifty dollars (\$750) is a countable resource in August. The remaining six thousand two hundred-and fifty dollars (\$6,250) continues to be an excluded resource as long as it meets the requirements in this section.

**EXAMPLE: Change of Intent on the Use of a Distribution:-** Jennifer takes a distribution of seven -thousand –dollars (\$7,000) ~~distribution~~ from her ABLE account in June to pay her college tuition, a qualified disability expense (QDE). Her tuition payment is due in September. In August, Jennifer gets a job offer and decides not to return to school. Since she no longer intends to use it for tuition, the seven thousand dollars (\$7,000) becomes a countable resource in September, unless Jennifer redesignates it for another QDE or returns the funds to her ABLE account prior to September.

A special rule applies when the balance of an SSI recipient's ABLE account exceeds one hundred thousand dollars (\$100,000) by an amount that causes the individual to be over the resource limit, whether by those funds alone or with other resources. When this situation occurs, the Social Security Administration will place the recipient into a special SSI suspension period where:

- Social Security will suspend the recipient's SSI benefits without a time limit as long as the individual remains otherwise eligible;
- The individual retains continued eligibility for ~~Medicaid~~ Health cCare;
- The individual's eligibility does not terminate after twelve (12) continuous months of suspension.

During the period SSI benefits are suspended, the designated beneficiary will be treated as if the individual continued to be receiving payment of the SSI benefits. The individual's regular SSI eligibility will be reinstated for any month in which the individual's ABLE account balance no longer causes the recipient to exceed the resource limit and the individual is otherwise eligible.

## MEDICAL SERVICES POLICY MANUAL, SECTION E

### ~~E-600 Achieving a Better Life Experience (ABLE) Program~~

#### ~~E-60070 R~~Achieving a Better Life Experience (ABLE)

#### **EXAMPLE:** Excess Resources-Recipient is Suspended but Retains ~~Medicaid~~ Health Care Eligibility-

Paul is the designated beneficiary of an ABLE account with a balance of one hundred and one thousand dollars (\$101,000) on the first of the month. Paul's only other countable resource is a checking account with a balance of one thousand five hundred dollars (\$1,500). Paul's countable resources are two thousand five hundred dollars (\$2,500) and therefore exceed the SSI resource limit. However, since Paul's ABLE account balance is causing him to exceed the resource limit (~~i.e. for example~~, his countable resources other than the ABLE account are less than two thousand dollars (\$2,000)), Social Security will suspend Paul's SSI eligibility and stop his cash benefits, but Paul will retain eligibility for ~~Medicaid~~ Health Care.



**NOTE:** The special suspension rule does not apply when the balance of an SSI recipient's ABLE account exceeds one hundred thousand dollars (\$100,000) by an amount that causes the recipient to exceed the SSI resource limit but the resources other than the ABLE account alone would make the individual ineligible for SSI due to excess resources.

**EXAMPLE:** Combination of Resources-Recipient Loses SSI Eligibility: Christine is the designated beneficiary of an ABLE account with a balance of one hundred and one thousand dollars (\$101,000) on the first of the month. Christine also has a checking account with a balance of three thousand dollars (\$3,000). Christine's countable resources are four thousand dollars (\$4,000) and exceed the SSI resource limit. However, because her ABLE account balance is not the cause of her excess resources, the special rule does not ~~apply~~ apply, and Christine is no longer SSI eligible due to excess resources. The Social Security Administration will suspend her SSI benefits and her ~~Medicaid~~ Health Care benefits will end as well.

**EXAMPLE:** Sharon takes a distribution of five hundred dollars (\$500) from her ABLE account in May to pay for her rent for the month of June. She deposits the five hundred dollars (\$500) into her checking account in May and then withdraws five hundred dollars (\$500) in cash on June 3 and pays her landlord. This distribution is a ~~housing-related~~ housing related QDE and a part of Sharon's checking account balance on June 1<sup>st</sup>, which makes it a countable resource for the month of June.



## **RULES SUBMITTED FOR REPEAL**

**Rule #1: DCO Form – 808 – Medicare  
Beneficiaries Application**

**Rule #2: Social Services Block Grant Comprehensive  
Services Program Plan**

# ***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 a U.S. Citizen? ☐ Yes ☐ No Submit documentation of alien status.

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

Are you (check one):

☐ Married ☐ Separated  
☐ Widowed ☐ Divorced  
☐ Single

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.

<b>Check all that apply:</b> - 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? <input type="checkbox"/> Yes <input type="checkbox"/> No			
9	ID Number - Check the applicable box and provide the appropriate number. <input type="checkbox"/> Arkansas Driver's license number <input type="checkbox"/> If you do not have a driver's license provide the last 4 digits of social security number <input type="checkbox"/> I have neither a driver's license nor social security number.				Signature of elector - Please sign full name or put mark.				
10	(A) Are you a citizen of the United States of America and an Arkansas resident? <input type="checkbox"/> Yes <input type="checkbox"/> No (B) Will you be eighteen (18) years of age or older on or before election day? <input type="checkbox"/> Yes <input type="checkbox"/> No (C) Are you presently adjudged mentally incompetent by a court of competent jurisdiction? <input type="checkbox"/> Yes <input type="checkbox"/> No (D) Have you ever been convicted of a felony without your sentence having been discharged or pardoned? <input type="checkbox"/> Yes <input type="checkbox"/> No If you checked <b>No</b> in response to either questions A or B, do not complete this form. If you checked <b>Yes</b> in response to either questions C or D, do not complete this form.				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.				
				Date:    /    / Month    Day    Year					
				11 If applicant is <b>unable to sign his/her name</b> , provide name, address and phone number of the person providing assistance: Name:    Address:    City:    State:    Phone#:					

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

Agency Code (For Official Use Only)

PA 04

<b>A</b>	Mr.	Previous Last Name	Jr.	Sr.	First Name	Middle Name(s)
	Mrs. Miss Ms.		II. III. IV.			

Date of Birth \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Month Day Year

<b>B</b>	Previous House Number and Street Name	Apt. or Lot #	City or Town	State	Zip Code
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**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.

Example

• Grocery Store

North ↑

•Public School

X

**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

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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:

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

# DHS ADMINISTRATIVE PROCEDURES MANUAL

## Chapter 904

### Title: Social Services Block Grant Pre-expenditure Report

- I. **PURPOSE:** To assure compliance with federal regulations for the Social Services Block Grant (SSBG) program relating to a required plan of service and expenditures.

II. **POLICY:**

- A. Before a State receives a SSBG allotment, it must submit an annual pre-expenditure report that describes how the State plans to administer its SSBG funds for the coming year. This report must be submitted 30 days prior to the start of the fiscal year (i.e., June 1). States must report on the intended use of SSBG funds, including the types of activities (or services) to be supported, and the categories and characteristics of individuals to be served (such as children, adults 59 and younger, adults 60 and older, and the disabled) (42 U.S.C. §1397c). While no specific format is required for the pre-expenditure report, States typically provide a narrative of the proposed activities and individuals to be served or a chart with this information by service area. States are also required to submit a revised pre-expenditure report if the planned uses of SSBG funds change during the year.
- B. If the deadline cannot be met, Office of Finance and Administration, Contract Support Section (CSS) must request and receive a waiver from the federal government for delayed submission.
- C. Reports and waiver requests shall be submitted to:

Social Services Block Grant Program  
U.S. Department of Health and Human Services  
Administration for Children and Families  
Office of Community Services  
370 L'Enfant Promenade, S.W. 5<sup>th</sup> Floor West  
Washington, DC 20447

III. **PROCEDURES:**

- A. Coordination with Program Agencies

Upon notification of allocations made by the DHS Chief Fiscal Officer, CSS shall execute the following steps:

1. Discuss the changes with, and meet with as necessary, the representative(s) from each program division and outside agency receiving SSBG funds;
2. Incorporate changes as necessary, and prepare a draft revision to the

**Report**, tracking changes;

3. Compare the revision to the most recent **SSBG Post-expenditure Report** for significant discrepancies;
4. Finalize the revision to the **Report**, tracking the changes.

B. Promulgation

1. Upon completion of an annual or interim **Report**, CSS shall submit the draft to Policy and Administrative Program Management Unit (PAPM) for promulgation in accordance with DHS Policy 1052, Administrative Procedure, Rules Promulgation, to include Executive Staff review, a thirty day public review period and final review and approval by the Legislative Council, Administrative Rules and Regulations Subcommittee.
2. CSS shall then forward a copy to the U.S. Department of Health and Human Services, Administration for Children and Families, Office of Community Services, Washington D.C.

REPEAL