

**ARKANSAS DEPARTMENT OF HEALTH & HUMAN SERVICES
DIVISION OF COUNTY OPERATIONS
APPLICATION FOR FAMILY PLANNING ASSISTANCE**

Applicant	Date of Birth	Race	Telephone No.
Address		City	State Zip
County of Residence	Social Security Number	Verified by Card Yes <input type="checkbox"/> No <input type="checkbox"/>	
Health/Hospital Insurance Yes <input type="checkbox"/> No <input type="checkbox"/>		If Yes, Name of Company	

Family Unit:				Total Number in Family Unit _____			
Name (Last, First)	Relation To You	DOB	Citizen		Social Security Number	Source of Income	Monthly Income
			Yes	No			

(Use a separate sheet if necessary)

<p>Household Resources:</p> <p>Cash on Hand \$ _____</p> <p>Bank Accounts (Checking, Savings, Credit Unions, etc.) \$ _____</p> <p>Stocks, Bonds, CD's \$ _____</p> <p>Other (specify) \$ _____</p> <p>_____ \$ _____</p> <p align="right">Total _____</p>	<p>Household Income:</p> <p>Gross Monthly Earned Income \$ _____</p> <p>Less Earned Income Deduction (\$90 per employed person) \$ _____</p> <p>Less Child Care (up to \$175 per child 2 and over. Up to \$200 per child under 2) \$ _____</p> <p>Net monthly Earned Income \$ _____</p> <p>Total Monthly Unearned Income \$ _____</p> <p>Less Unearned Income Deduction (\$50 from child support) \$ _____</p> <p>Net Monthly Unearned Income +\$ _____</p> <p>Total Net Income for Household Unit = \$ _____</p>
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<u>Resource Standard</u>				<u>Income Standard</u>			
<u>HH Size</u>	<u>MNRL</u>	<u>HH Size</u>	<u>200% FPL</u>	<u>HH Size</u>	<u>200% FPL</u>	<u>HH Size</u>	<u>200% FPL</u>
1	\$2,000	1	\$1701.66	6	\$4,601.66	2	\$5,181.66
2	3,000	2	2,281.66	7	5,761.66	3	6,341.66
3	3,100	3	2,861.66	8	6,921.66	4	7,501.66
4	3,200	4	3,441.66	9	8,081.66	5	8,161.66
5	3,300	5	4,021.66	10	9,241.66	6	9,321.66
Add \$100 for each additional person				Add \$580.00 for each additional person			

Registration/Denial Data (Do Not Complete: For DHHS County Office Use Only)

REGISTER #	APPLICATION DATE	COUNTY	CAT.	ADULTS	CHILD	WORKER #	WORKER NAME	KEY DATE	OP.INT.
WORKER #	DENIAL DATE	REASON			CATEGORY	CN	KEY DATE	OP.INT.	

READ CAREFULLY - I understand that no person may be denied benefits due to race, color, age, disability, religion, national origin, veteran status, or political affiliation.

I may request a hearing from DHHS if a decision is not made on my case within the proper time limit or if I disagree with the decision.

I understand Social Security Numbers are used in a computer match to prevent duplicate participation.

I authorize DHHS to examine all records of mine or records of those who receive or have received Medicaid benefits through me to investigate whether or not any person has committed Medicaid fraud, or for use in any legal, administrative or judicial proceedings.

ASSIGNMENT OF MEDICAL SUPPORT - I authorize any holder of medical or other information about me to release information needed for a Medicaid claim to DHHS. 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 DHHS to the full extent of any amount which is paid by DHHS for my benefit. 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 DHHS. 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.

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 DHHS, whether or not a portion of such settlement is designated for medical expenses. Any such funds received by me shall be paid to DHHS. 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 DHHS. Any assistance I receive in the future may be reduced to recover this overpayment, and I may be subject to prosecution for fraud and fined and/or imprisoned.

Applicant's Signature	Date	

ADH Worker's Signature	Phone #	Date

DHHS Worker's Signature	Date	

Instructions

Complete one DCO-64 for each female requesting family planning services. If applicant is not a U.S. citizen, ADH worker should refer her to DHHS for eligibility determination.

Enter the name of the applicant, her natural/adoptive children, and the father of those children, if in the home. Include only the income and resources of these individuals. Do not include stepchildren.

If a U-18 (minor) requests services, show her as a unit of one, with disregard of parental income/resources. If the U-18 (minor) has children in the home, include the children, the father of the children, if in the home, and all of their income/resources.

A parent may omit a child and his/her income and resources if inclusion of that child would cause the parent to be ineligible.

DHHS Routing/Retention

Upon completion, the DCO-64 will be registered to the system. If the transaction is accepted on-line, initial and date the form, file in the case record, and retain until the case record is destroyed.