Autism Waiver Application / Required Document Checklist

NOTE: Applications must be received by Partners no later than October 2nd, 2012 to be included in the initial random selection.

If your child has already been approved for TEFRA, send the following documents with your submission.

- ☐ Autism Waiver/TEFRA Application (DCO-9700)
- ☐ Most recent Federal Income Tax Return and Schedule A for the child's parents.
- ☐ Report from Physician stating Autism diagnosis
- ☐ Report from Psychologist stating Autism diagnosis
- ☐ Report from Speech-Language Pathologist stating Autism diagnosis
- ☐ Adaptive Behavior Assessment (such as the Vineland)

If your child has not been approved for TEFRA, send the following documents with your submission.

- ☐ Autism Waiver/TEFRA Application (DCO-9700)
- ☐ Most recent Federal Income Tax Return and Schedule A for the child's parents. ☐
- ☐ Report from Physician stating Autism diagnosis
- ☐ Report from Psychologist stating Autism diagnosis
- ☐ Report from Speech-Language Pathologist stating Autism diagnosis
- ☐ Adaptive Behavior Assessment (such as the Vineland)
- ☐ Social Report for Children (DCO 108C)
- ☐ Disability Worksheet (DCO 106)
- ☐ Authorization to Disclose Health Information (DHS 4000)

ARKANSAS DEPARTMENT OF HUMAN SERVICES
TEFRA and AUTISM WAIVER
Application for Assistance

If you need this material in a different format, such as large print, please contact your local DHS county office.
Si necesita este formulario en Espanol, llame al 1-800-482-8988 y pida la versión en Español.

What type of services are you requesting? ☐ TEFRA ☐ Autism Waiver

Child's Name:	Social Security Number	Male ☐ Female ☐	U.S. Citizen Yes ☐ No ☐
Date of Birth:	Age: _____ years _____ months		
Parent/Guardian:			
Current Address: City:	State:	Zip:	County:
Phone:	Email:		

1. **Does the child you are applying for have income?** ☐Yes ☐No **If yes, list the child's income below.**

Source of Income	Gross Amount (Before deductions)	How often?
Social security		
SSI		
Veteran's benefits		
Child support		
Other		

2. **Does the child you are applying for have resources?** ☐Yes ☐No **If yes, list the child's resources.**

Source of Resource	Amount or Value	Location of Resource
Cash, Checking, Savings or Christmas Club Account		
Stocks, Bonds, Trust Fund, Certificate of Deposit, Mutual Fund, etc.		
Other		

3. **Does the child you are applying for have health insurance?** ☐Yes ☐No
   If yes, please provide a copy of the front and back of the child's insurance card.

4. **Primary Care Physician** _____

   Autism Diagnosis ☐Yes ☐No **Date of Diagnosis** _____

5. **Do you expect a change in any of the above?** ☐Yes ☐No **If yes, what?** _____
   When? _____

For TEFRA only

Information needed to determine the TEFRA premium:

- Please attach the most recent Federal Income Tax Return and Schedule A, if you itemized deductions, for the child's parent(s).
- The total number of dependents that live in your household including yourself: _____

For Autism Waiver only

If this application is for the Autism Waiver, please attach an evaluation report from each of the following indicating that the child has a diagnosis of autism. Please place a check mark beside each item that is attached.

- ☐ Physician Report
- ☐ Psychologist Report
- ☐ Speech-language Pathologist Report
- ☐ Adaptive Behavior Assessment Report (such as Vineland)

Read carefully before you sign this application

The PRIVACY ACT of 1974 requires the Department of Human Services (DHS) to tell you: (1) whether disclosure of your SSN 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 TEFRA and Autism 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 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, Department of Workforce Services, 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 Medicaid 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 Medicaid benefits through me to investigate whether or not any person has 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 an 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 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 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 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 _____ Date _____

ARKANSAS DEPARTMENT OF HUMAN SERVICES
DIVISION OF COUNTY OPERATIONS

Medical Review Team Slot S334
Social Report for Children

Section 1: To be completed by County Worker

Child's Social Security #	Cat.	Child's Name		Race	Sex	Birthdate
Application date	County	Reg.#	Case Number	Casehead Name		
Address		City		State	Zip	
Worker's Name as shown on E-Mail		Last MRT decision date	Interview Date	Date routed To MRT		

Section 2: MRT use only

Date Record Added	MRT Date	Date Medical Records Request Sent Code Records Rec'd	Physician Date ID	Decision Date Code
Re-exam Date	Case Type	Key Initial	Key Date	

Section 3: To be completed by County Worker

A. List all Household Members:

Last Name	First Name	Relationship	Age
		Child	

Daytime Phone # and Area Code:
☐ Home phone ☐ Message Number ☐ None

B. Description of Physical & Mental Condition: Please ask the parent or caretaker the following questions:

1. What is the child's height and weight ?
2. Does the child have problems seeing or hearing? Yes ☐ No ☐
3. Does the child wear hearing aides? Yes ☐ No ☐
4. Can you understand the child's speech? Yes ☐ No ☐

5. Can other people understand the child's speech? Yes ☐ No ☐
6. Describe any speech problems the child has.

7. Does the child use: crutches ☐ wheelchair ☐ artificial limb ☐?
8. Describe any medical conditions or injuries that limit the child's activities.

C. Daily Activities

1. Describe what the child does on an average day from the time he/she wakes up until bedtime.

2. Describe the child's sleep habits.

3. Describe any changes in the child's activities or behavior since his/her condition began.

4. When did the illness, injury, or condition begin? Month Day Year

D. Education/Therapy

1. Does the child attend special education classes? Yes ☐ No ☐

School Information **Attach Signed DHS-4000's .**

Name:		Grade:	
Address:	City:	State:	Zip:
Area Code & Phone #:	Teacher:		

2. Does the child receive occupational, physical or speech therapy? Yes ☐ No ☐

Facility/School Info **Attach Signed DHS-4000's.**

Name:		Grade:	
Address:	City:	State:	Zip:
Area Code & Phone #:	Therapist:		

Name:		Grade:	
Address:	City:	State:	Zip:
Area Code & Phone #:	Therapist:		

3. Describe any learning problems, attendance problems, or other problems the child has had in school or therapy.

E. Medical Treatment:

1. What treatment has the child received thus far?

2. What treatment is planned for the future?

3. What medication is the child taking?

Medication	Reason for Medication	Doctor who prescribed

4. Please list all the Doctors/Clinics/Mental Health Units child has seen **in the last year. Attach Signed DHS- 4000's.**

Name:	Dates: From: To:		
Address:	City:	State:	Zip:
Area Code & Phone #:			

Name:	Dates: From: To:		
Address:	City:	State:	Zip:
Area Code & Phone #:			

Name:	Dates: From: To:		
Address:	City:	State:	Zip:
Area Code & Phone #:			

Name:	Dates: From: To:		
Address:	City:	State:	Zip:
Area Code & Phone #:			

5. Has the child been in the hospital/rehabilitation facility **in the last year?** **Yes** ☐ **No** ☐
(inpatient, outpatient, ER) **Attach Signed DHS-4000's for all facilities.**

Hospital:	Type of Visit:	Dates: From: To:	
Address:	City:	State:	Zip:
Area Code & Phone #:	Chart Number:		
Reason for admission:			

Hospital:	Type of Visit:	Dates: From: To:	
Address:	City:	State:	Zip:
Area Code & Phone #:	Chart Number:		
Reason for admission:			

Hospital:	Type of Visit:	Dates: From: To:	
Address:	City:	State:	Zip:
Area Code & Phone #:	Chart Number:		
Reason for admission:			

6. If child is applying for TEFRA, please send MRT a copy of TEFRA's form DMS-2602, when received.

F. Age Appropriateness

1. Is the child under 3 years old? Yes ☐ No ☐
   If Yes, can the child do the following?
   - Smile Yes ☐ No ☐
   - Roll over Yes ☐ No ☐
   - Sit alone Yes ☐ No ☐
   - Pull self up to stand Yes ☐ No ☐
   - Walk alone Yes ☐ No ☐
   - Say words other than "Mama & Dada" Yes ☐ No ☐
   - Drink from cup Yes ☐ No ☐
   - Feed self Yes ☐ No ☐
   - Run Yes ☐ No ☐
   - Use fork and spoon Yes ☐ No ☐
   - Help in dressing self Yes ☐ No ☐
   - Unbutton clothing Yes ☐ No ☐
   - Play with other children Yes ☐ No ☐
   - Is toilet trained Yes ☐ No ☐
2. Is the child age 3 or older? Yes ☐ No ☐
   If Yes, Please answer the following:
   a. Does the child participate in sports, hobbies, school activities, scouting, clubs, or any other activities? Yes ☐ No ☐

   If Yes, list the activities and how often the child participates.

b. Does the child help with any household chores? Yes ☐ No ☐

Chores	How often done	How well done	Amount of Supervision required

c. How does the child behave with adults (parents, other family members, teachers, neighbors)? Please give examples.

d. Describe how the child gets along with friends and playmates. How often and how well do they play together?

e. Is the child able to take care of his/her personal needs (bathing, dressing, brushing teeth, tolieting, etc.) as well as other children the same age? Yes ☐ No ☐

G. Worker's Observation/Remarks:

Please check attachments:

- ☐ DCO-106, Completed
- ☐ DHS-4000's, Signed
- ☐ Medical Records, if available
- ☐ If TEFRA application, copy of form DMS-2602, if available

Arkansas Department of Human Services
Division of County Operations
DISABILITY WORKSHEET

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

County _____ Applicant _____

Caseworker _____ SSN _____

1. Have you ever applied for SSI or Social Security Disability?
   ☐ Yes (If checked, go to #2).
   ☐ No (If checked STOP and proceed with AD/MRT determination, but ask if individual intends to apply for SSI or Social Security Disability.) ☐ Yes ☐ No.

2. When did you apply for SSI or Social Security Disability? _____
   Month Year

3. Is your SSI or Social Security Disability application still pending? (Note to Worker: This question refers to a pending application, NOT to a pending appeal or reconsideration.)
   ☐ Yes (If checked, STOP, and proceed with AD/MRT determination.)
   ☐ No (If checked, go to #4.)

4. Has SSA approved your application?
   ☐ Yes (If for SSI, STOP, and deny AD application. If for Social Security Disability, STOP MRT and continue processing AD application.)
   ☐ No (If checked, go to #5.)

5. Has SSA denied your application because:
   ☐ They found you were not disabled? (If checked, go to #6.)
   OR
   ☐ They found you were not eligible for a reason other than disability? What was the reason? _____ (If checked, proceed with AD/MRT determination unless the "other" reason would also disqualify for AD, e.g., resources. Verify the reason and deny the application if appropriate.)
   Date of denial _____.

6. If SSA found you were NOT disabled, do you now have a NEW and DIFFERENT disabling condition from the one you had when SSA found you not disabled?
   ☐ Yes (If checked, proceed with AD/MRT determination.) Describe the new or different condition:
   _____
   _____
   ☐ No (If checked, go to #7 if the denial was within the last 12 months; to #8 if the denial was more than 12 months ago.)

7. If you still have the same condition that you had when SSA found you not disabled within the last 12 months (and answered "no" to #6), is this condition:
   ☐ about the same, ☐ better, ☐ worse, or changed? (If "about the same" or "better" is checked, STOP and deny AD. If "worse or changed" is checked, go to "a".)

   a. Have you asked SSA for a reconsideration or reopening of their previous decision?
      ☐ Yes (If checked, go to (1) below.)
      ☐ No (If checked, STOP, refer applicant to SSA for a reconsideration or reopening, and deny AD.)

(1) Did SSA agree to reconsider or reopen its determination?
- ☐ Yes (If checked, go to (2) below.)
- ☐ No (if checked, verify the reason and proceed with AD/MRT determination if appropriate.)

(2) Is the reconsideration still pending?
- ☐ Yes (If checked, verify and deny AD, and advise customer he/she may reapply for AD if Social Security Disability is approved.)
- ☐ No (If checked, go to (3) below.)

(3) When SSA reconsidered, did they:
- ☐ Again find you not disabled? (If checked here, verify and deny AD.)

(4) When you requested an SSA reconsideration did they:
- ☐ Find you not eligible for SSI or Social Security Disability for a reason other than disability? What was the reason?

_____

(If reason doesn't also disqualify for AD, proceed with AD/MRT determination. If reason does disqualify, verify and deny.)

8. IF IT HAS BEEN MORE THAN 12 MONTHS since your last SSI or Social Security Disability denial, is the condition which SSA last considered ☐ about the same ☐ better ☐ worse or changed? (If the applicant's condition is the "same" or "better", deny AD application. If the condition is "worse" or "changed", go to "a" below.)

a. Have you reapplied for SSI or Social Security Disability?
- ☐ Yes (If for SSI, deny AD. If for Social Security Disability, deny AD and advise customer he/she may reapply for AD if Social Security Disability is approved.)
- ☐ No (If checked, proceed with AD/MRT determination.)

_____ _____

County Worker Signature Date

I understand that the Department of Human Services uses the same definition of disability that SSA used for SSI and Social Security Disability determinations. I certify that the information I have provided regarding my disability is true and accurate.

_____ _____

Applicant/Authorized Representative Signature Date

ARKANSAS DEPARTMENT OF HUMAN SERVICES
AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Client Name: _____ **Client ID #:** _____
Mailing Address: _____ **Date of Birth:** _____
_____ **Case Head:** _____

I, _____ hereby authorize
(Client or Personal Representative)

_____ to disclose specific health information
(Name of Provider/Plan)

from the records of the above named client to: _____
_____
_____
_____
(Recipient Name/Address/Phone/Fax)

for the specific purpose(s): _____
_____
_____

Specific information to be disclosed: _____
"All Medical Records" includes any and all written information you may have concerning my health care and any illness or injury I may have suffered, including, but not limited to, medical history, consultations, prescriptions, treatment, medical evaluations, x-rays, results of tests, and copies of hospital or medical records pertaining to me.

I understand that this authorization will expire on the following date, event or condition: _____
_____

I understand that if I fail to specify an expiration date or condition, this authorization is valid for the period of time needed to fulfill its purpose for up to one year, except for disclosures for financial transactions, wherein the authorization is valid indefinitely. I also understand that I may revoke this authorization at any time and that I will be asked to sign the *Revocation Section* on the back of this form. I further understand that any action taken on this authorization prior to the rescinded date is legal and binding.

I understand that my information may not be protected from re-disclosure by the requester of the information; however, if this information is protected by the Federal Substance Abuse Confidentiality Regulations, the recipient may not re-disclose such information without my further written authorization unless otherwise provided for by state or federal law.

I understand that if my record contains information relating to HIV infection, AIDS or AIDS-related conditions, sexually transmitted diseases, alcohol abuse, drug abuse, psychological or psychiatric conditions, genetic testing, family planning, or womens, infant, & children (WIC) this disclosure will include that information.

I also understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment for services, or my eligibility for benefits; however, if a service is requested by a non-treatment provider (e.g., insurance company) for the sole purpose of creating health information (e.g., physical exam), service may be denied if authorization is not given. If treatment is research-related, treatment may be denied if authorization is not given.

I further understand that I may request a copy of this signed authorization. A copy of this authorization shall be as binding as the original.

_____ _____ _____
(Signature of Client) *(Date)* *(Witness-If Required)*

_____ _____ _____
(Signature of Personal Representative) *(Date)* *(Personal Representative Relationship/Authority)*

NOTE: This Authorization was revoked on _____ _____
(Date) *(Signature of Staff)*

ARKANSAS DEPARTMENT OF HUMAN SERVICES
AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

REVOCATION SECTION

I do hereby request that this authorization to disclose health information of _____
(Name of Client)

signed by _____ on _____
(Enter Name of Person Who Signed Authorization) *(Enter Date of Signature)*

be rescinded effective _____ I understand that any action taken on this authorization prior to the
(Date)

rescinded date is legal and binding.

_____	_____	_____	_____
(Signature of Client)	*(Date)*	*(Signature of Witness)*	*(Date)*

_____	_____	_____
(Signature of Personal Representative)	*(Date)*	*(Personal Representative Relationship/Authority)*

The Department of Human Services is in compliance with Titles VI and VII of the Civil Rights Act. This letter is available in other languages and alternate formats.