Arkansas Dept. of Human Services
Pine Bluff Scanning Center
P.O. Box 8848
Pine Bluff AR 71611-8848

[redacted]

Date of Notice: 04/17/2023
Client ID: [redacted]
Case Number: [redacted]

# Benefit Renewal Form



Dear [redacted]

It is time for the annual renewal of the below program(s). We will use the information you report on this form to determine if your household can keep getting benefits.

| Program/Benefit Category | Benefit Recipient(s) |
|---|---|
| ARHOME | [redacted] |
| Parents/Caretaker Relatives Medicaid | [redacted] |

## What do you need to do?

- **Review your information and fill in updated information in this renewal form. Your case will be closed if you do not return this completed form by 3/10/2023.**

### How can you send the needed information?

You can send us the information we asked for in one of the following ways:

- **Online: -** You can send your information quickly and easily by uploading it directly to your Access Arkansas account. Follow these steps:
  1. Go to access.arkansas.gov.
  2. You will see a system upgrade screen. You will need to give us your name, date of birth, and county you live in. You can give us your Social Security number, but it is not required.
  3. Answer the Voter Registration question with “Yes” or “No.”
  4. On the main Access Arkansas screen, please choose "Health Care" button to apply for Health Care, choose "SNAP" button to apply for SNAP, or choose "TEA" button to apply for TEA. You may apply for more than one program if needed.
  5. If you have created an account, you will be able to log in to update your settings and information, see letters and forms, upload documents, and more.
  6. If you need help, you can click on the Help Button at the top of the screen for step-by-step instructions.

  **Having an Access Arkansas account puts your case information at your fingertips. Get started with your Access Arkansas account today to do more online!**
- **Fax:** You can send your needed information to:
  - Health care (870) 534-3421

- **In Person:** You may take your needed information to your local county office:

  803 Highway 64 East
  Wynne, AR, 72396
- **Mail:** You can use the enclosed envelope to send your needed information.

### How can you update your contact information?

Update your contact information if it has changed. Visit ar.gov/update to learn more.

### Why am I receiving this notice now?

- It's time for your required renewal. You may have kept your benefits without renewing during the federal Public Health Emergency (PHE) that began in 2020. However, Medicaid rules have changed, and you must provide the required information, or your case will be closed.

## Who can help if you have questions?

Visit our website at http://www.humanservices.arkansas.gov, call the DHS Helpline at 1 (855) 372-1084, or call your local county office at (870) 238-8553.

## Where can you get this letter in a different format?

- Este aviso contiene datos sobre las prestaciones de usted.
  Si necesita la traducción en español, favor llame al 1 (855) 372-1084.
- Kojela in ebed aoleb melele kin jiban ko Nan kwe.
  Elane kwoj aikuij jiban ikijen ukok Nan kajin Majol, joij im kurtok 1 (855) 372-1084.
- To get this notice in a format that is accessible for an individual with a disability, call 1 (855) 372-1084.

# Arkansas Department of Human Services
# Benefit Renewal Form

## Please complete the following sections to give us your updated information.

As you complete this form, please tell us any changes that have happened.

If there is a change in your benefits, you will get a notice explaining the change. You will not have to visit your local DHS County Office. However, you may be contacted by phone or mail if more information is needed to determine your eligibility.

## Contact Information

**This is the address we have on record for you. If you have moved to a new address, please write your address below**

**Current Address:**

[redacted]

[redacted]

**New Address:**

Street or Rural Route or P.O. Box, Apt or Lot Number

City State Zip

Phone Number Email (if available)

Please let us know if this contact information is still correct. If not please update the information.

[redacted]

Primary Alternate Work

We do not have an email address on file for you. If you would like to provide an email address, please write it below:

Email Address

## Household Composition

Listed below are the members of your household we have on file. If these members are no longer living in your home, please list the date they left your home and explain why they are no longer living with you.

| Name | Date of Birth | Still lives in your household | Does this person buy food and prepare meals separate from other household members? | Relationship to you | Date left | Explain why this person left the household |
|---|---|---|---|---|---|---|

| | | | | | | |
|---|---|---|---|---|---|---|
| [redacted] | [redacted] | ☐ [redacted] ☐ [redacted] | ☐ [redacted] ☐ [redacted] | [redacted] | | |
| [redacted] | [redacted] | ☐ [redacted] ☐ [redacted] | ☐ [redacted] ☐ [redacted] | [redacted] | | |
| [redacted] | [redacted] | ☐ Yes ☐ No | ☐ Yes ☐ No | Self | | |
| [redacted] | [redacted] | ☐ Yes ☐ No | ☐ Yes ☐ No | Child of | | |

Please list new household members below. If you want to add that household member to your case, also include that person's Social Security number and citizenship information. Attach a sheet of paper, if you need more space.

| Name | Date of Birth | Date Entered Home | Does this person buy food and prepare meals separate from other household members? | Social Security Number | Relationship to you | Citizenship | | |
|---|---|---|---|---|---|---|---|---|
| | | | | | | U.S. Citizen | Legal Alien | Other |
| | | | ☐ Yes ☐ No | | | | | |
| | | | ☐ Yes ☐ No | | | | | |
| | | | ☐ Yes ☐ No | | | | | |

## New Household Member Information

Please fill in the details for the new member added above.

| Full name | Is this person applying for benefits? | If this person had a pregnancy end in the last 3 months, when did it end? | If pregnant, what is this person's due date? | Number of babies expected |
|---|---|---|---|---|
| | | | | |
| | | | | |

| Full name | Will this person file Income taxes next year? | | Please list the name of this persons's spouse if filing jointly. | Please list anyone who may claim this person as dependent. | Please list any dependents this person may claim. |
|---|---|---|---|---|---|
| | ☐ Yes | ☐ No | | | |
| | ☐ Yes | ☐ No | | | |
| | ☐ Yes | ☐ No | | | |

## Absent Parent Information

If the new household member is a minor child with a parent who does not live in the home, you must provide information that you know about the absent parent:

| Child's name | Absent parent name | SSN of absent parent | Date of birth of absent parent | Relationship to child | Is this parent deceased? | |
|---|---|---|---|---|---|---|
| | | | | | ☐ Yes | ☐ No |
| | | | | | ☐ Yes | ☐ No |

The new household member may be excused from cooperating with the Office of Child Support Enforcement (OCSE) if it will not be in the best interest of the member or his or her child. The household member will be required to provide proof.

Please select any reasons below that apply:

- ☐ Caretaker relative in adoption counseling
- ☐ May result in physical/emotional harm
- ☐ Other
- ☐ Conception result of incest or rape
- ☐ Pending legal proceedings for adoption

## Income

These are the income sources we have on record for your household. Please verify the income sources listed below. Provide an end date if this income has ended. If the income has ended, please attach proof, such as a final pay stub or a letter from your employer or income source.

| Source of Income / Name of Employer | Who Receives Income | Specific Type of Income | Amount before taxes | How often Received | Income End Date |
|---|---|---|---|---|---|
| [redacted] | [redacted] | Earned Income | $ 716.60 | Weekly | |
| [redacted] | [redacted] | Earned Income | $ 123.28 | One-Time Only | |

Please list any other income sources not listed above with an end date if this income has ended. Attach another sheet of paper, if you need more space. Everyone in your household who earns money from a job or get money from other sources must give DHS proof of the money they get.

**Examples of Income Sources**: Retirement, Social Security, SSI, Veterans Benefits, Railroad Retirement, Civil Service Benefits, Interest/Dividends, Insurance, Mineral Rights/Oil Leases, Unemployment Benefits, Worker's Compensation, Employment/Work, Farm Income, Self-employment, Rental Income, Contributions from Family/Friends, Income from Trusts or Annuities.

| Source of Income | Who receives income | Amount Before Taxes | How often Received | Income Start Date | Income End Date |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

**Please read the below for SNAP benefits**

**YOU MUST SEND PROOF OF ALL INCOME RECEIVED BY ALL PEOPLE IN YOUR HOUSEHOLD.** If you don't provide proof, your benefits may be delayed, or your case may be closed. For **each** person who works or gets money from another source, you must send one of the following:

1) a check stub for each pay check received in the last 30 days.
2) the attached income verification form filled out by your employer. After your employer fills out the verification form, you may return it with this form. If you need more income verification forms, contact the DHS county office.
3) an award letter or other correspondence from the person or agency that provides the unearned income.
4) other documentation that shows your current income amount.

## Resource(s)

Listed below are the resources we have on record for you.

| Type of Resource | Location (address, bank, insurance co., brokerage firm, etc.)? | Owner(s) | Account/ Policy# | $ Value |
|---|---|---|---|---|
| None | None | None | None | None |

If you or your spouse obtained, sold, deeded or gave away any assets that includes those listed above, please fill out the section below and attach proof. Use another sheet of paper if you need more space.

Examples of resources: Cash, Checking Account, Savings Account, Certificates of Deposit, Promissory Notes, Real Property (land, home, rental property etc.), Trust Fund, Certificate of Deposit, Individual Retirement Account (IRA), Promissory Note, Mutual Fund, Mortgages, Stocks or Bonds, Life Insurance, Burial Funds Insurance, Burial Plot, etc.

| Type of resource | Date Obtained | Date Sold, Deeded, or Gave Away (if applicable) | Location (address, bank, insurance co., brokerage firm, etc.)? | Owner(s) | Account/Policy # (Last 4 digits) | $ Value |
|---|---|---|---|---|---|---|
| | | | | | | |
| | | | | | | |
| | | | | | | |



## Vehicles

Listed below are the vehicles we have on record for you.

| Make | Model | Year | Value | Amount owed | Owner(s) |
|---|---|---|---|---|---|
| None | None | None | None | None | None |

If you or your spouse own a car, truck, motorcycle, boat, trailer, or other vehicle not listed above, please fill in the following information about each vehicle (attach additional pages as needed). Use another sheet of paper if you need more space.

| Make | Model | Year | Value | Amount owed | Owner(s) |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |

## Health Insurance

Listed below are the Health Insurance details we have on record for you.

| Health Insurance Company Name and Address | Who Is Insured? | Type of Insurance | Start and End Date MM/DD/YY - MM/DD/YY | Policy or Claim # | Amount |
|---|---|---|---|---|---|
| | None | None | None | None | None |

Do you have Medicare? ☐ Yes ☐ No Medicare ☐ A ☐ B

Does your spouse have Medicare? ☐ Yes ☐ No Medicare ☐ A ☐ B

Do you have other health insurance? ☐ Yes ☐ No

Does your spouse have other health insurance? ☐ Yes ☐ No

If you, your spouse, or anyone in your home, have other health insurance besides Medicare, please fill in the information below and attach copies (front and back) of Medicare and insurance cards.

| Health Insurance Company Name and Address | Who is Insured? | Type of Insurance | Start and End Date MM/DD/YY - MM/DD/YY | Policy or Claim # | Amount |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |



## Medical Costs

Listed below are the medical expenses we have on record for you.

| Name of Person Who Pays This Cost | Type of Cost | Start Date of the Cost | Amount Paid | How Often Paid? |
|---|---|---|---|---|
| [redacted] | Doctor Visit | 01/05/2023 | $0.00 | One-Time Only |

If you have new medical costs that are not reported above, please fill in the following information about each medical cost.

**Please read the below for SNAP benefits**

- If you have between **$35.01** and **$138.00** in deductible medical expenses, you will be assigned the medical standard.
- If your medical expenses are more than **$138.00** , you may choose to claim the standard medical deduction or actual medical expenses.
- In order for us to consider medical expenses, you must provide proof of each expense.
- If your prescription costs have changed, you may wish to provide a printout from your pharmacy or a list of drugs that you take each month.
- We cannot consider actual medical expenses without proof.

| Name of Person Who Pays This Cost | Type of Expense | Start Date of the Expense | Amount Paid | How Often Paid? |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |

## Cost to take care of others

Listed below are the costs to take care of others that we have on record for you.

| Name of Person Who Is Cared for | Name of Person Who Pays This Cost | Name of Person Or Company Who Is Paid and Telephone Number | New Amount Paid | How Often Paid? |
|---|---|---|---|---|
| None | None | None | None | None |

Costs to take care of others are payments for the care of someone in your household who depends on your income, like a child or an adult age 60 or older, or an individual with a disability. Paying this cost allows someone in the household to work, look for work, or attend school or a training course. You are allowed, but not required, to report changes in your costs to take care of others in the space below.

Example: child support, alimony, childcare, or adult care costs.

| Name of Person Who Is Cared for | Name of Person Who Pays This Cost | Name of Person Or Company Who Is Paid and Telephone Number | New Amount Paid | How Often Paid? |
|---|---|---|---|---|
| | | | | |
| | | | | |



## Renewal of Coverage in Future Years

To make it easier to determine your eligibility for help paying for health coverage in future years, you can agree to allow DHS to use income data including information from tax returns. DHS will send you a notice, let you make any changes and you can opt out at any time.

Yes, review my eligibility automatically for the next:

☐ 5 years (The maximum number of years allowed) ☐ 4 years ☐ 3 years ☐ 2 years ☐ 1 year
Or for a shorter number of years:

☐ Don't use information from tax returns to review my eligibility.

Federal law requires that each state provide the opportunity to register to vote with every application for public assistance. The Arkansas Voter Registration Application begins after page 8 of this packet. 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 Recertification Application to your local DHS County Office.

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 understand that the Estate Recovery process and conditions that I agreed to with my initial application for assistance still apply.
- 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.
- I am also giving DHS rights to pursue and receive medical support from a spouse or parent.
- *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 understand that if anyone receives TEA/Work Pays cash assistance for which they are not eligible as a result of my withholding information I may have to repay that cash assistance.
- I understand that the information that I gave on this report may result in the loss of TEA/Work Pays benefits.

## Your Right to Appeal

If you think that DHS has made a mistake, you can appeal its decision. To appeal means to tell someone at DHS that you think the action was wrong and you can ask for a fair review of the action. You can find out how to appeal by contacting your local DHS office or the Office of Appeals and Hearings at 501-682-8622. Also, you can be represented in the process by someone other than yourself. Your eligibility and other important information will be explained to you

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.

_____ _____ _____
Date Telephone Number Guardian or Authorized Rep's Address

_____ _____
Witness (if signed by X ) Date Address of Witness/ Telephone Number

_____ _____
Signature of County Office Worker Date Name of Person Who Helped Complete Form Date

# Free Job Search Help
# Arkansas Division of Workforce Services
# Arkansas Workforce Centers

ARKANSAS WORKFORCE CENTERS
Bringing People and Jobs Together.℠
A proud partner of the americanjobcenter network

Because you get ARHOME, you can get free job search help from the Arkansas Division of Workforce Services (DWS). DWS has Arkansas Workforce Centers across the state that can tell you about job openings, how to look for a job, training programs, and more.

## What kind of help can I get?

If you are unemployed or currently employed and need a better job, DWS Arkansas Workforce Centers can help by providing:

**Free Job Search Help:**

- Arkansas JobLink lets you post your information and skills for employers to see, search for current job openings, and more. Visit www.arjoblink.arkansas.gov.
- Free computers, telephones, fax machines, and copiers to help you find and apply for jobs.

**Help from Experts:**

- Identify your skills and get help finding job openings that need those skills.
- Create or update your resume to get the best results possible in your job search.
- Career counseling for step-by-step job search guidance.
- Get the facts about what kind of jobs are available and where they are in Arkansas.

**Referrals for Programs for Specific Needs:**

- Free GED and free English as a Second Language classes.
- Programs tailored to assist veterans with employment needs.
- Help for workers who have lost a job because of international trade.
- Temporary cash assistance for needy families (TANF/TEA).
- Vocational rehabilitation for Arkansans living with a disability.
- Programs for young people.



## How do I get started?

Take the first step today and contact DWS Arkansas Workforce Centers:

- Online: www.arjoblink.arkansas.gov
- Phone: (855) 225-4440
- Email: ADWS.Info@arkansas.gov

PLEASE PRINT AND USE BLACK INK TO COMPLETE

Rev. 1-24-19

# ARKANSAS VOTER REGISTRATION APPLICATION

Check all that apply:
____ 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? ☐ Yes ☐ No

**9** ID Number - Check the applicable box and provide the appropriate number.
☐ Arkansas Driver's license number ____
☐ **If you do not have a driver's license provide the last 4 digits of social security number** ____
☐ I have neither a driver's license nor social security number.

**10**
(A) Are you a citizen of the United States of America and an Arkansas resident? ☐ Yes ☐ No
(B) Will you be eighteen (18) years of age or older on or before election day? ☐ Yes ☐ No
(C) Are you presently adjudged mentally incompetent by a court of competent jurisdiction? ☐ Yes ☐ No
(D) Have you ever been convicted of a felony without your sentence having been discharged or pardoned? ☐ Yes ☐ No
If you checked No in response to either questions A or B, do not complete this form.
If you checked Yes in response to either questions C or D, do not complete this form.

Signature of elector - Please sign full name or put mark.

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 unable to sign his/her name, provide name, address and phone number of the person providing assistance:
Name ____ Address: ____
____ State: ____ Phone#: ____

**Please complete the sections below if:** ***MAIL REGISTRANTS: PLEASE SEE SECTION D.***
- 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)

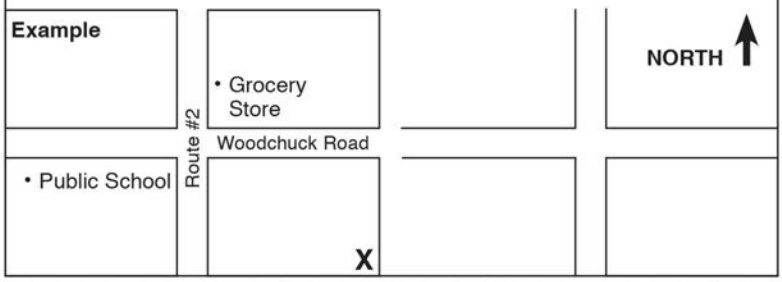
Date of Birth ____/____/____ (Month / Day / Year)

**A** Mr. Mrs. Miss Ms. | Previous Last Name | Jr. Sr. II. III. IV. | First Name | Middle Name

**B** Previous House Number and Street Name | Apt. or Lot# | City/Town | County | State | ZIP Code

**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.




**D**

## IDENTIFICATION REQUIREMENTS

**IMPORTANT:** Applicants will be required to verify their registration when voting in person or by absentee ballot by providing a required document or identification card as provided in Arkansas Constitution, Amendment 51, Section 13. 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

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, remove plastic strip, seal at bottom, stamp and mail.

Questions?

Call your local County Clerk

Or

Arkansas Secretary of State
John Thurston
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:

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 may mail or drop off your completed Voter Registration form to any DHS office. When the county office receives your form, 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 - 2 | PO Box 1008 | Stuttgart | 72160 | Grant | PO Box 158 | Sheridan | 72150 | Perry | 213 Houston Avenue | Perryville | 72126 |
| Arkansas Processing Center | 1095 White Drive | Batesville | 72501 | Greene | 809 Goldsmith Road | Paragould | 72450 | Phillips | PO Box 277 | Helena | 72342 |
| Ashley | PO Box 190 | Hamburg | 71646 | Hempstead | 116 North Laurel | Hope | 71801 | Pike | PO Box 200 | Murfreesboro | 71958 |
| Baxter | PO Box 408 | Mtn Home | 72654 | Hot Spring | 2505 Pine Bluff Street | Malvern | 72104 | Poinsett | PO Box 526 | Harrisburg | 72432 |
| Benton | 900 Southeast 13th Court | Bentonville | 72712 | Howard | PO Box 1740 | Nashville | 71852 | Polk | PO Box 1808 | Mena | 71953 |
| Boone | PO Box 1096 | Harrison | 72601 | Independence | 100 Weaver Avenue | Batesville | 72501 | Pope | 701 North Denver | Russellville | 72801 |
| Bradley | PO Box 509 | Warren | 71671 | Izard | PO Box 65 | Melbourne | 72556 | Prairie | PO Box 356 | DeValls Bluff | 72041 |
| Calhoun | PO Box 1068 | Hampton | 71744 | Jackson | PO Box 610 | Newport | 72112 | Pulaski Jacksonville | PO Box 626 | Jacksonville | 72078 |
| Carroll | PO Box 425 | Berryville | 72616 | Jefferson | PO Box 5670 | Pine Bluff | 71611 | Pulaski North | PO Box 5791 | North Little Rock | 72119 |
| Chicot | PO Box 71 | Lake Village | 71653 | Johnson | PO Box 1636 | Clarksville | 72830 | Pulaski South | PO Box 2620 | Little Rock | 72203 |
| Clark | PO Box 969 | Arkadelphia | 71923 | Lafayette | 2612 Spruce Street | Lewisville | 71845 | Pulaski Southwest | PO Box 8916 | Little Rock | 72209 |
| Clay | PO Box 366 | Piggott | 72454 | Lawrence | PO Box 69 | Walnut Ridge | 72476 | Randolph | 1408 Pace Road | Pocahontas | 72455 |
| Cleburne | PO Box 1140 | Heber Springs | 72543 | Lee | PO Box 309 | Marianna | 72360 | Saint Francis | PO Box 899 | Forrest City | 72335 |
| Cleveland | PO Box 465 | Rison | 71665 | Lincoln | 101 West Wiley Street | Star City | 71667 | Saline - 1 | PO Box 608 | Benton | 72018 |
| Columbia | PO Box 1109 | Magnolia | 71754 | Little River | 90 Waddell Street | Ashdown | 71822 | Scott | PO Box 840 | Waldron | 72958 |
| Conway | PO Box 228 | Morrilton | 72110 | Logan - 1 | #17 West McKeen | Paris | 72855 | Searcy | 106 School Street | Marshall | 72650 |
| Craighead | PO Box 16840 | Jonesboro | 72403 | Lonoke | PO Box 260 | Lonoke | 72086 | Sebastian | 616 Garrison Avenue | Fort Smith | 72901 |
| Crawford | 704 Cloverleaf Circle | Van Buren | 72956 | Madison | PO Box 128 | Huntsville | 72740 | Sevier | PO Box 670 | DeQueen | 71832 |
| Crittenden | 401 South College Boulevard | West Memphis | 72301 | Marion | PO Box 447 | Yellville | 72687 | Sharp | 1467 Highway 62/412 Suite B | Cherokee Village | 72529 |
| Cross | 803 Highway 64 East | Wynne | 72396 | Miller | 3809 Airport Plaza | Texarkana | 71854 | Stone | 1821 East Main | Mtn View | 72560 |
| Dallas | 1202 West 3rd Street | Fordyce | 71742 | Mississippi - 1 | 1104 Byrum Road | Blytheville | 72315 | Union | 123 West 18th Street | El Dorado | 71730 |
| Desha | PO Box 1009 | McGehee | 71654 | Monroe - 2 | 301 1/2 North New Orleans | Brinkley | 72021 | Van Buren | 449 Ingram Street | Clinton | 72031 |
| Drew | PO Box 1350 | Monticello | 71657 | Montgomery | PO Box 445 | Mount Ida | 71957 | Washington - 1 | 4201 N Shiloh Drive Suite 110 | Fayetteville | 72703 |
| Faulkner | 1000 East Siebenmorgan | Conway | 72032 | Nevada | PO Box 292 | Prescott | 71857 | White | 608 Rodgers Drive | Searcy | 72143 |
| Franklin | 800 West Commercial | Ozark | 72949 | Newton | PO Box 452 | Jasper | 72641 | Woodruff | PO Box 493 | Augusta | 72006 |
| Fulton | PO Box 650 | Salem | 72576 | Ouachita | PO Box 718 | Camden | 71711 | Yell | PO Box 277 | Danville | 72833 |
| Garland | 115 Stover Lane | Hot Springs | 71913 | | | | | | | | |



***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 North:** 72046 (England), 72113, 72114, 72115, 72116 (Shared with Jax), 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), 72016, 72053, 72126, 72135, 72201, 72202, 72203, 72205, 72207, 72212, 72223, 72227
**Pulaski Southwest:** 72002, 72065, 72103, 72164, 72208, 72209, 72210, 72211, 72164, 72180, 72183, 72206 (Shared with South)