DCO-152C Step 2: Additional Household Member

Complete Step 2 for additional household members who live with you and/or anyone on your same federal income tax return if you file one and include this form with your Medicaid application.

1. First Name, Middle Name, Last Name & Suffix	2. Relationship to you?
3. Date of Birth (mm/dd/yyyy)	4. Sex ☐ Male ☐ Female

5. Social Security Number (SSN) _ _ _ - _ _ - _ _ _ _ **We need this if you want health coverage and have an SSN.**

6. Does **this person** live at the same address as you? ☐ Yes ☐ No
If no, list address:

7. Does **this person** live in Arkansas? ☐ Yes ☐ No

8. If currently out-of-state, does **this person** intend to return to Arkansas? ☐ Yes ☐ No

9. Is **this person** the main caregiver living with and taking care of at least one child under the age of 19? ☐ Yes ☐ No

10. Does **this person** currently have health coverage and want to continue with the same coverage? ☐ Yes ☐ No
If no, would **this person** like to apply for coverage? ☐ Yes ☐ No

CITIZENSHIP STATUS

11. Is **this person** a U.S. citizen or U.S. national? ☐ Yes ☐ No

12. Is this peson a citizen of the Marshall Islands, Federated States of Micronesia or Palau? ☐ Yes ☐ No

13. **If this person is not a U.S. citizen or U.S national**, do they have eligible immigration status?
☐ **Yes** Enter your document type and ID number below. ☐ **No**
a. Immigration document type:_____ Alien # _____
b. Document ID number:_____ Expiration date of document _____
c. Has this person lived in the U.S. since 1996? ☐ Yes ☐ No Date of entry into U.S._____
d. Is this person or their spouse or parent a veteran or an active duty member of the U.S. military? ☐ Yes ☐ No

14. **If Hispanic/Latino,** what is **this person**'s ethnicity and race? **(OPTIONAL – Check all that apply.)**
___ Mexican ___ Mexican-American ___ Chicano/a ___ Puerto Rican ___ Cuban ___ Other:_____

15. **Race (OPTIONAL – Mark (X) all that apply.)**

Race	X	Race	X	Race	X	Race	X	Race	X	Race	X
White		Filipino		Black/African American		Alaskan Native		Hawaiian/Pacific Islander		Samoan	
Korean		Japanese		American Indian		Asian Indian		Guamanian or Chamorro		Chinese	

16.PREGNANCY STATUS

Is **this person** pregnant? ☐ Yes ☐ No **If yes**, what is the expected due date?_____(mm/dd/yyyy)
How many babies is **this person** expecting during this pregnancy?_____ **If no**, has **this person** delivered a child in the last 90 days? ☐ Yes ☐ No **If yes**, what was the date of delivery?_____
If yes, how many babies did this person deliver?_____ Is **this person** a newborn? ☐ Yes ☐ No
If yes, What is the biological mother's name and date of birth?_____

ABSENT PARENT INFORMATION

17. Please provide **ABSENT PARENT** information: First Name: _____ Last Name: _____
Social Security Number (SSN): _ _ _-_ _-_ _ _ _ Date of birth (mm/dd/yy) _ _/_ _/ _ _ Address: _____
Phone (____) _____ Relationship to child: _____ Why is the parent absent from the home? _____
You may claim to have good cause for refusing to provide absent parent information if you believe that it would not be in the best interest of you or your child (ren) and you must provide evidence to support this good cause claim. Would you like to claim good cause for this absent parent?
Yes No **If yes,** please provide your good cause reason:

FOSTER CARE STATUS

18. Was **this person** in foster care in Arkansas at age 18 or older? Yes No
If yes, was **this person** enrolled in Medicaid when they left the Foster Care program? Yes No
Is **this person** currently enrolled in Medicaid? Yes No

TAX FILING STATUS

19. **Does this person plan to file a federal income tax return NEXT YEAR?** (You can still apply for health coverage even if you don't file a federal income tax return.)
YES If yes, please answer questions a through **NO If no**, skip to question c.
a. Will **this person** file jointly with a spouse? Yes No
If yes, name of spouse:_____
b. Will **this person** claim any dependents on his or her tax return? Yes No
If yes, list name(s) of dependents:_____
c. Will **this person** be claimed as a dependent on someone's tax return? Yes No
If yes, please list the name of the tax filer:_____
How is **this person** related to the tax filer?_____

DCO-152C

Step 2: Additional Household Member (Continued)

CURRENT JOB & INCOME INFORMATION

Employed	Not Employed	☐ Self Employed
If this person currently employed tell us about their income. Start with question 20.	Skip to Question 28.	Skip to Question 29.

CURRENT JOB 1:

20. Employer Name and Address	21. Employer Phone Number
22. Wages/tips (before taxes) $_____ ☐Hourly ☐Weekly ☐ Every 2 Weeks Twice a Month ☐Monthly ☐ Yearly	
23. Average hours worked each **week**:_____Start date of employment_____(mm/dd/yyyy)	

CURRENT JOB 2: (Attach another sheet of paper to list more jobs.)

24. Employer Name and Address	25. Employer Phone Number
26. Wages/tips (before taxes) $ _____ ☐Hourly ☐Weekly ☐ Every 2 Weeks Twice a Month ☐Monthly ☐Yearly	
27. Average hours worked each **week**:_____Start date of employment_____(mm/dd/yyyy)	

28. **In the past year, did this person:**	Change jobs?		Start working fewer hours?		Stop working?		None of these?	

If this person stopped working what was the date that the job ended?

29. **If self-employed, answer the following questions:**

a. Name of Business:_____

b. How much net income (profits once business expenses are paid) will this person receive from this self-employment this month? $_____

30. **OTHER INCOME THIS MONTH:** Check all that apply and give the amount and how often you receive that amount.

NOTE: You don't need to tell us about child support, veteran's payments or Supplemental Security Income (SSI).

INCOME	Amount	How Often	INCOME	Amount	How Often	INCOME	Amount	How Often
None			Taxable Interest			Tax Exempt Interest		
Dividends			Foreign Income			Unemployment		
Pensions/Retirement			Social Security			Net Farming/Fishing		
Retirement Accounts			Scholarship Payments			Prizes/Awards		
Capital Gains			Alimony/Maintenance			Lump Sum Amount		
Alaskan Native Income			American Indian			Other Income		

31. **DEDUCTIONS**: Mark all that apply, give the amount and how often you receive that amount. If this person pays for certain things that can be deducted on a federal income tax return, telling us about them could make the cost of health coverage a little lower.

NOTE: You should not include a cost that you already considered in your answer to net self-employment (Question 29b).

Deduction	X	Amount $	How Often	Deduction	X	Amount $	How Often
Alimony/Maintenance				Student Loan Interest			
Other Deduction:_____				Other Deduction: _____			

32. **YEARLY INCOME**: Complete only if this person's income changes each month. If you don't expect changes to this person's monthly income, skip to question 33.

Your total income **this year:** $_____	Your total income **next** year (if you think it will be different): $_____

33. **UNPAID MEDICAL BILLS** Does this person need help paying for medical bills from this month? Yes ☐ No

Does this person need help paying for medical bills in the last 3 months? ☐ Yes ☐ No

Are **these bills** from a Medical Emergency? Yes ☐ No ☐

Was this person's household size the same during the last 3 months as it is now? ☐ Yes ☐ No

Was this person's household income the same during the last 3 months as it is now? ☐ Yes ☐ No

If no, What was the household size and income during those 3 months? _____

NOTE: Arkansas Works recipients may be eligible for retroactive coverage 30 days prior to the date of application.

34. **DISABILITY STATUS** Does this person have a disability? ☐ Yes ☐ No Or is this person blind? ☐ Yes ☐ No

Does this person live in a medical facility or nursing home? ☐ Yes ☐ No

What type of facility is this? ☐ Nursing Home ☐ Human Development Center ☐ Arkansas State Hospital

☐ Arkansas Health Center ☐ Intermediate Care Facility for the Intellectually Disabled

Does this person have a physical, mental or emotional health condition that causes limitations in activities(like bathing, dressing, daily chores etc.)? Yes ☐ No ☐