AR WORKS REGISTERED REPORTER AUTHORIZATION FORM

Enrollee/Member Information

Enrollee/Member Name (*Last, First Middle*)	Enrollee/Member Date of Birth	Enrollee/Member Medicaid Number
Enrollee/Member Address	Enrollee/Member Phone Number	Enrollee/Member E-mail Address

Registered Reporter Information

Reporter Name (*Last, First Middle*)	Reporter Phone Number	Reporter E-mail Address

By completing this authorization form, I am consenting to the Registered Reporter identified above to act as my authorized representative for the sole purpose of reporting my Arkansas Works (AR Works) work and community engagement activities or exemption. I authorize DHS to disclose to or allow inspection/receipt of my protected health information, the protected health information of individuals included in my Medicaid case for whom I make medical decisions, and my work-related information by the individual named as the Registered Reporter above for the limited purpose of reporting the AR Works work and community engagement or exemption. The specific information that may be accessed, inspected, or disclosed includes all records contained in my Arkansas Medicaid case file.

- I understand that my information may not be protected from re-disclosure under HIPAA by the Registered Reporter accessing the information. However, if this information is protected by the Federal Substance Abuse Confidentiality Regulations or other state or federal laws, 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 I am not required to complete this form to engage in the AR Works program and that my refusal to complete this form will not affect my ability to obtain treatment, payment for services, or my eligibility for benefits.
- I understand that this authorization will expire upon my disenrollment from the Medicaid program but that I may revoke this agreement at any time in writing.
- By signing my name below, I am authorizing the Registered Reporter identified above to electronically report my work and community engagement activities or exemption through the online portal at www.access.arkansas.gov with true and correct information that I provide in accordance with the applicable laws and program policies. I understand that I may cancel this arrangement at any time with written notice to the Registered Reporter and the Arkansas Department of Human Services. I agree to provide accurate and timely information to the Reporter and to timely update the reporter with any change in circumstances that could affect my eligibility for Arkansas Works. I acknowledge that the Reporter is providing a service as a courtesy, and that I am ultimately responsible for ongoing reporting of and compliance with the work and community engagement activities.
- I acknowledge that the information reported through the portal represents a "claim" that will be presented to the Medicaid program as documentation submitted electronically to justify or help establish or determine what is to be paid for healthcare goods or services delivered to a Medicaid recipient. I understand that knowingly providing false or incomplete information could subject me to legal action, including but not limited to actions brought under the Medicaid False Claims Act or Ark. Code Ann. § 5-36-202 (Theft of Public Benefits).

________________________________ ________________________________
Enrollee/Member Signature Authorized Registered Reporter Signature

________________________________ ________________________________
Date Date

*This form should be retained by the Enrollee/Member and the Registered Reporter.