



Iowa Department of Human Services  
**Referral to the *hawk-i* Program**

Denied Application/Individual (provide Medicaid application date)

Canceled Case/Individual

Date:					Case Name:								
Worker Name:			Worker Number:		Case Number:								
Worker County:		Worker Phone:			Case Phone:		County of Residence:						
People in Household	Social Security Number	Birth Date	Sex		Citizen (If No, explain alien status in Comments)		How Related to Case Name (spouse, parent, child, etc.)	Medicaid End Date (only on canceled cases or individuals)	Language Preference			If child, do they have health insurance coverage?	
			M	F	Yes	No			English	Spanish	Other	Yes	No
1.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**This case is being referred to *hawk-i* because:**

- The children must meet a spenddown under the Medically Needy program.
- The following children have been voluntarily excluded from the Medicaid eligible group because the **child's income** creates Medicaid ineligibility for the remaining household members. **Indicate the income of the voluntarily excluded child below in the next section. Also, attach an NOD showing the Medicaid eligibility calculation for the other family members.** (Note: Children voluntarily excluded for non-financial reasons are not eligible for *hawk-i*.)
  1. \_\_\_\_\_
  2. \_\_\_\_\_
  3. \_\_\_\_\_
  4. \_\_\_\_\_

**Income**

- Family members are employed at the following companies:
- Family members have unearned income from the following sources:

**This case has (check all that apply):**

- Non-recurring lump sum income:  
Amount prorated monthly (Standard of Need): \$ \_\_\_\_\_  
Last month and year of period of proration: \_\_\_\_\_ (MM/YYYY)
  - Income of voluntarily excluded child:  
\$ \_\_\_\_\_ per \_\_\_\_\_ (week, month, etc.)
    - Income has been verified (attach verification to referral)
    - Income has not been verified
  - Self-employment income:  
Amount of depreciation (from Schedule C or F): \$ \_\_\_\_\_  
(or attach a copy of Schedule C or F)
  - Unemployment benefits:  
Name of person(s) receiving UIB: \_\_\_\_\_
- Attachments:**  Copy of Notice of Decision showing Medicaid ineligibility (Required)

**Comments**

**REMINDER – Only refer children who are over income for Medicaid.**

**Do not refer children to the *hawk-i* program who:**

- ◆ Are age 19 or older; or
- ◆ Are ineligible for Medicaid due to a non-cooperation issue.

**Send via local mail to:**

Iowa Medicaid Enterprise  
Attn: MAXIMUS/*hawk-i* Program  
100 Army Post Road  
Des Moines, IA 50315    **OR**    **Fax:** 877-457-7701