

## Express Lane Medicaid for Children

County number:

Worker name and number:

Case number:

Worker phone number:

**NEW** rules make it easy to get Medicaid for the children in your home who already get Food Assistance. You will not have to fill out an application.

If you want Medicaid for your children:

1. Check "Yes" for each child named below that needs help with paying medical bills.
2. Sign and mail this form to your DHS office or bring it to the DHS office by

Yes	No	Name of Child
<input type="checkbox"/>	<input type="checkbox"/>	

Your Signature	Date
----------------	------

**Health Insurance**

Do the children have other health insurance?  Yes  No

If your children have health insurance, send back or bring to the DHS office form 470-2826, *Insurance Questionnaire* (enclosed).

**Medical Care**

Did any of the children receive medical care in the past three months?  Yes  No

Do you want help with paying medical bills for the past three months for the children?

Yes  No

**Child Support Recovery**

Do you want to get help from Child Support Recovery for the children named on this form?

Yes  No

Do any of the children named on this form get court-ordered medical support from an absent parent?  Yes  No

If "yes" to either question, give information for each parent who does not live in the home with the children.

Name and Address of Parent Not Living in the Home	Date of Birth of This Parent	Social Security Number of This Parent	Names of This Parent's Children	County Where Court Order is Filed, if Any

For each parent not in the home, please give the following information, if you know:

Name of Parent Not Living in the Home	Name of Employer	Employer's Address	If ever married to this parent, date and place of marriage

If you need more room to give this information, attach another sheet.

## Insurance Questionnaire

To ensure that your bills are paid as quickly as possible, please fill out this form and return to your local Department of Human Services (DHS) office.

Your Name: \_\_\_\_\_ Your State ID number, if any: \_\_\_\_\_

Do you, your children or others in your home have health insurance coverage?  Yes  No, then stop here.

If yes, who carries this health insurance?

- You  A parent who does not live with you  
 Someone else in your home  Someone else not in your home

Please fill out the information below. The boxes with this mark \* must be filled in. Use the next page if you have another policy to tell us about.

### Information About First Policy

Choose **all** that apply to this policy:

- Major Medical  Drug  Medicare Supplement  
 Dental  Vision

*Policyholder (Last Name, First Name, Middle Initial)		Phone number (     )
Mailing address (House #, Street, Apt, OR PO Box, City, State, Zip)		
*Social Security number	*Date of birth	*State ID #
*Insurance company name		Phone number (     )
Insurance claims office mailing address (#, Street, OR PO Box, City, State, Zip)		
If the insurance is through an employer, employer's name		
*Policy number	Group number	Date policy is effective

### People covered by the policy above:

Fill out the information below and tell us if each person is currently covered or if they are being added or dropped from the insurance.

Currently Covered	Choose One:		Effective Date	Last Name, First Name, Middle Initial	Date of Birth	State ID	Relationship to Policyholder
	Add	Drop					
	<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"/>	<input type="checkbox"/>					

## Information About Second Policy

Choose **all** that apply to this policy:

- Major Medical                       Drug                                       Medicare Supplement  
 Dental                                       Vision

*Policyholder (Last Name, First Name, Middle Initial)		Phone number (     )
Mailing address (House #, Street, Apt, OR PO Box, City, State, Zip)		
*Social Security number	*Date of birth	*State ID #
*Insurance company name		Phone number (     )
Insurance claims office mailing address (#, Street, OR PO Box, City, State, Zip)		
If the insurance is through an employer, employer's name		
*Policy number	Group number	Date policy is effective

### People covered by the policy above:

Fill out the information below and tell us if each person is currently covered or if they are being added or dropped from the insurance.

Currently Covered	Choose One:		Effective Date	Last Name, First Name, Middle Initial	Date of Birth	State ID	Relationship to Policyholder
	Add	Drop					
	<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"/>	<input type="checkbox"/>					

Is there anything else about the insurance information you gave that you want to tell about? If yes, please use this space.

---



---



---

For office use only:  
 County # \_\_\_\_\_  
 Worker # \_\_\_\_\_  
 Date Rec'd \_\_\_\_\_

**Are the children United States citizens?**

Everyone who gets Medicaid must provide proof that they are a U.S. citizen. See Comm. 258, *Verifying Citizenship and Identity*, on the back of this page for types of verification DHS can use. Please provide proof that the children named below are U.S. citizens by

DHS may be able to help by doing an Iowa birth records check for any child born in Iowa. To find out more about this call your worker.

**Are the children qualified aliens?**

Qualified alien children may also get Medicaid. Please provide proof that the children named below are qualified aliens by

To find out more about this call your worker.

## Verifying Citizenship and Identity

# Important Notice!

## Federal Medicaid Law Requires Proof of U.S. Citizenship and Identification

U.S. citizens who apply for or get Medicaid will need to show proof of citizenship and identity.

**Note:** In most cases, if you were born in the United States you are a U.S. citizen.

### Questions or Need Help?

- Call our toll-free number 1-877-937-3663.
- Contact your worker.
- Visit the website at <http://www.dhs.state.ia.us/>.
- Visit the website at [www.cdc.gov/nchs/w2w.htm](http://www.cdc.gov/nchs/w2w.htm) if you need to get a birth certificate from another state.

### Examples of How to Prove U.S. Citizenship and Identity

Everyone in your home who gets Medicaid\* will need to turn in proof of citizenship and identity.

**Proof must be an original document. Do not mail original documents. Bring them to the office.**

- **Column A** proves both citizenship and identity.

If you don't have a document from column A, then you will need to provide documents from column B.

- **Column B** requires a document from both Part 1 and Part 2 to meet the requirement.

Column A	Column B	
	Part 1	Part 2
<b>Proves both Citizenship &amp; Identity</b>	<b>Proves only Citizenship</b>	<b>Proves only Identity</b>
<ul style="list-style-type: none"><li>• U.S. passport, even if expired</li><li>• Certification of Naturalization (Form N-550 or N-570)</li><li>• Certification of Citizenship (Form N-560 or N-561)</li><li>• Documentation of membership or affiliation issued by a federally recognized Indian Tribe</li></ul>	<ul style="list-style-type: none"><li>• Official birth certificate issued by the county or state</li><li>• Letter from hospital of birth</li><li>• Other acceptable proof of citizenship</li></ul>	<ul style="list-style-type: none"><li>• Drivers license or ID card from the Department of Transportation</li><li>• School photo ID</li><li>• School, day care or medical records (for children)</li><li>• Military ID or dependent card</li><li>• Other acceptable proof of ID</li></ul>

**Important:** You must do this for every U.S. citizen in your family who gets Medicaid.

Eligibility will not be affected by race, creed, color, national origin, age, disability, political beliefs, religion, or sex, except where it is required by law.

\*People who get SSI, Medicare, or Social Security Disability benefits, people who are in foster care or some subsidized adoptions or guardianships, people who had newborn status from a Medicaid-eligible mother, and people whose citizenship was verified by an automated match with the Social Security Administration do not have to turn in proof.