Iowa Department of Human Services

Terry E. Branstad
Governor

Kim Reynolds
Lt. Governor

Charles M. Palmer
Director

October 28, 2016

GENERAL LETTER NO. 6-AP-121

ISSUED BY: Division of Adult, Children and Family Services

SUBJECT: Employees' Manual, Title 6, ***INCOME MAINTENANCE PROGRAMS APPENDIX***, Contents (pages 2 and 7 through 12), revised; pages 52, 53, 69, 105, 106, 137, 138, 139, 217, 291, 333, 334, 335, 396, 405, 417, 433, 439, and 456 through 465, revised; pages 290a through 290d and 466, new; and the following forms:

470-0462	*Financial Support Application*, revised
470-0462(S)	*Financial Support Application* (Spanish), revised
470-2927	*Health Services Application*, revised
470-2927(S)	*Health Services Application* (Spanish), revised
470-2845	*Notice of Health Insurance Premium Payment*, revised
470-5386	*PASRR Case Activity Report*, new
470-0643	*Request for Child and Dependent Adult Abuse Information*, renamed and revised
470-4909	*Request for Proof of Citizenship and Identity*, revised
470-4909(S)	*Request for Proof of Citizenship and Identity* (Spanish), revised
470-4858	*Request for Verification of Citizenship and Identity*, revised
470-4858(S)	*Request for Verification of Citizenship and Identity* (Spanish), revised
470-0364	*SSI Medicaid Information*, revised
470-0364(S)	*SSI Medicaid Information* (Spanish), revised
470-0364(M)	*SSI Medicaid Information* (manual), revised
470-0364(MS)	*SSI Medicaid Information* (manual Spanish), revised
Unnumbered	*Voter Registration*, revised
Comm. 2	*Facts About the Food Assistance Program*, revised
Comm. 2(S)	*Facts About the Food Assistance Program* (Spanish), revised
Comm. 24	*One-Time Payments*, revised
Comm. 24(S)	*One-Time Payments* (Spanish), revised
Comm. 180	*Medicaid for Employed People with Disabilities*, revised
Comm. 229	*Food Assistance Makes Iowa Stronger*, revised
Comm. 229(S)	*Food Assistance Makes Iowa Stronger* (Spanish), revised
Comm. 258	*Verifying Citizenship/Identity and/or Immigration Status*, renamed and revised

Comm. 258(S)	*Verifying Citizenship/Identity and/or Immigration Status* (Spanish), renamed and revised
Comm. 372	*Medicaid for Employed People with Disabilities Frequently Asked Questions*, revised
Comm. 377	*FIP Electronic Access Card*, revised
Comm. 377(S)	*FIP Electronic Access Card* (Spanish), revised
Comm. 479	*Burial Contract Frequently Asked Questions*, new
RC-0033	*Desk Aid*, revised

Summary

This chapter is revised to:

- Update the availability of form 470-3624, *Child Care Assistance Application*.
- Remove obsolete form 470-3159, *DIA Referral for Transfer of Assets*. The procedure for making referrals has been changed to entry of the referral in the WISE system.
- Revise form 470-0462, *Financial Support Application*, and its Spanish translation, 470-0462(S), to:
  - Change the page numbering due to Food Assistance federal regulations.
  - Update and clarify existing language to ensure that the policy complies with federal requirements, state law, and FIP rules.
  - Add new language that by signing the application the applicant agrees that no member of the household will use the Electronic Access Card (EAC) or their personal debit card to access FIP/RCA funds at prohibited locations.
- Update the instructions and form 470-2927, *Health Services Application*, and its Spanish translation, 470-2927(S) to:
  - Add estate recovery language.
  - Remove outdated information.
  - Revise the availability.
- Add language to form 470-2845, *Notice of Health Insurance Premium Payment*, to clarify the process of what happens when a member is approved for HIPP and has an MCO assignment for the same month.
- Add instructions and form 470-5386, *PASRR Case Activity Report*. Iowa Medicare and Medicaid certified nursing facilities are required to use the PathTracker Plus system to report individual resident admissions, transfers, and discharges. The *PASRR Case Activity Report* is electronically generated using information by the nursing facility into the PathTracker Plus system.
- Rename and revise form 470-0643 from *Request for Child Abuse Information* to *Request for Child and Dependent Adult Abuse Information*.
- Remove language that a return envelope is included on the following forms:
  - 470-4909 and 470-4909(S), *Request for Proof of Citizenship and Identity*
  - 470-4858 and 470-4858(S), *Request for Verification of Citizenship and Identity*
- Remove the case number and worker name due to a change in process for determining eligibility for SSI recipients on the following forms:

- 470-0364, *SSI Medicaid Information*
- 470-0364(S), *SSI Medicaid Information* (Spanish)
- 470-0364(M), *SSI Medicaid Information* (manual)
- 470-0364(MS), *SSI Medicaid Information* (manual Spanish)

♦ Update the availability and the *Voter Registration* sample to reflect current Secretary of State policy.

♦ Update the following with the current Food Assistance income limits and maximum allotment amounts:

- Comm. 2 and Comm. 2(S), *Facts About the Food Assistance Program*
- Comm. 229 and Comm. 229(S), *Food Assistance Makes Iowa Stronger*
- RC-0033, *Desk Aid*

♦ Remove the telephone number for the Federal Relay Service for Spanish-speaking persons with a hearing impairment or a speech disability on Comm. 24, *One-Time Payments*, and its Spanish translation, Comm. 24(S).

♦ Remove Comm. 95, *Minimum Health and Safety Requirements*, and its Spanish translation, Comm. 95(S). Comm. 95 has been:

- Renamed *Guidelines for Child Care Homes with a Child Care Assistance Provider Agreement*.
- Expanded from a two-page flier into a handbook.
- Moved to 12-F-Appendix, ***CHILD DEVELOPMENT HOME REGISTRATION APPENDIX***.

♦ Update the MEPD premium chart with the new premiums effective August 1, 2016, on the following:

- Comm. 180, *Medicaid for Employed People With Disabilities*
- Comm. 372, *Medicaid for Employed People with Disabilities (MEPD) Frequently Asked Questions*
- RC-0033, *Desk Aid*

♦ Change Comm. 258, *Verifying Citizenship/Identity and/or Immigration Status*, and its Spanish translation, Comm. 258(S), to meet federal Medicaid requirements. The following changes have been made:

- Rename the form from *Verifying Citizenship and Identity* to reflect its use for both U.S. citizens and immigrants.
- Revise the examples of common documents that customers may provide to include documents that verify immigration status.
- Remove information that is no longer needed.

♦ Update and clarify existing language to ensure that the policy complies with federal requirements, state law, and FIP rules on the following:

- Comm. 377, *FIP Electronic Access Card*
- Comm. 377(S), *FIP Electronic Access Card* (Spanish)

♦ Update the availability and distribution of Comm. 233 and Comm. 233(S), *Rights and Responsibilities*.

- Add Comm. 479, *Burial Contract Frequently Asked Questions*. Comm. 479 provides information to Medicaid applicants and recipients of how a burial contract is counted when determining Medicaid eligibility. It also answers frequently asked questions regarding funding, amounts, verification, and where to contact for questions.

Effective Date

The changes to the Medicaid for Employed People with Disabilities premium charts are effective August 1, 2016.

The Food Assistance changes are effective October 1, 2016.

The Family Investment Program changes to the *Financial Support Application* are effective January 1, 2017.

All other changes are effective upon receipt.

Material Superseded

This material replaces the following pages from Employees' Manual, Title 6, Appendix:

Page	Date
Contents (page 2)	July 3, 2015
Contents (page 7)	January 1, 2016
Contents (pages 8 and 9)	July 3, 2015
Contents (page 10)	May 20, 2016
Contents (page 11)	July 3, 2015
Contents (page 12)	October 24, 2014
52, 53	September 27, 2013
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69	October 7, 2011
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105, 106	January 3, 2014
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137-139	January 30, 2015
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405	October 24, 2014
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417	March 8, 2013
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433	January 3, 2014
Comm. 258	3/10
Comm. 258(S)	3/10
439	September 27, 2013
Comm. 372	7/15
Comm. 377	12/13
Comm. 377(S)	12/13
456-459	October 24, 2014
460	March 27, 2015
RC-0033	3/16
461-465	October 24, 2014

Additional Information

Forms 470-0462, *Financial Support Application*, and its Spanish translation, 470-0462(S):

- Use up existing supplies of applications, dated earlier than 9/16, before January 1, 2017.
- Local offices **may** start using the updated applications, dated 9/16, before January 1, 2017.
- Starting January 1, 2017, local offices **must** use the updated applications. Destroy any remaining supply of applications dated earlier than 9/16.
- A six-month supply of form 470-0462 will be shipped by central office.
- A supply of 470-0462(S) will be available before January 1, 2017.

Destroy existing supplies of form 470-2927, *Health Services Application*. Order supplies of 470-2927, dated 8/16, from Anamosa in the usual manner.

Destroy existing supplies of form 470-2927(S), *Health Services Application* (Spanish). Print or photocopy supplies, dated 8/16, from the sample in the manual as needed. Reprinting form 470-2927(S) will be re-evaluated at a later date.

Use up existing supplies of Comm. 24, *One-Time Payments,* before ordering Comm. 24, dated 10/16, from Anamosa in the usual manner.

Destroy existing supplies of Comm. 95, *Minimum Health and Safety Requirements*. Comm. 95 will no longer be printed.

Use up existing supplies of Comm. 180, *Medicaid for Employed People With Disabilities*, before ordering Comm. 180, dated 8/16, from Anamosa in the usual manner.

Destroy existing supplies of Comm. 229 and Comm. 229(S), *Food Assistance Makes Iowa Stronger*. Order supplies of Comm. 229 and Comm. 229(S), dated 10/16, from Anamosa in the usual manner.

Refer questions about this general letter to your area income maintenance administrator.

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Child Care Assistance Application, Form 470-3624 or 470-3624(S)

Purpose

The *Child Care Assistance Application*, form 470-3624 or 470-3624(S), collects information about people needing child care that is required to determine eligibility for Child Care Assistance.

Source

Central Office has a contract to provide automatic shipments of form 470-3624 to local offices. The shipments are intended to cover a six-month supply. Additional supplies of form 470-3624 are also available through Central Office.

Print supplies of the Spanish version from the sample in the manual.

Families may also fill out the application electronically through the Child Care Public Web Portal.

Completion

The applicant or someone representing the applicant prepares the form when the parent or guardian requests Child Care Assistance.

Distribution

The applicant mails the form to the Centralized Child Care Assistance Unit, Polk County River Place, 2309 Euclid Avenue, Des Moines, IA 50310.

If an applicant submits this form to a local DHS office, it must be forwarded to the Centralized Child Care Assistance Unit.

Data

Questions on the first page gather information about the family, the children needing care, and the care provider the family has chosen. Questions on the second page ask about the family's need for service. The third page asks about monthly income. The fourth page asks about the provider the family is using for care. The back of the application states appeal rights.

The applicant enters the following information:

- **Family Information:** (If two parents or guardians are in the home, the same information is needed for both.)
  - Name of the parent or guardian of the children needing care.
  - The parent or guardian's date of birth.

- The parent or guardian's social security number. Leave blank if the person does not have a social security number.
- Phone number and address, including the street, city, and ZIP code.
- The name, relationship to the parent or guardian, date of birth, social security number, sex, name of school district, race, ethnicity, citizenship and alien status for all children needing care. Leave the social security number blank if the child does not have a number.
- A check to indicate whether a child has special needs. (If so, make sure that the parent or guardian submits a statement verifying a special needs diagnosis from a doctor or other medical professional.)
- The name and relationship to the parent or guardian of all other people in the home.

♦ **Need for Service:** (If two parents or guardians are in the home, the same information is needed for both.)

- A check indicating whether each parent or guardian is working.
- If so, the number of hours per day and per week the person works.
- Each person's work schedule, with starting and ending times for the shift of work.
- A check indicating whether the parent or guardian is a full-time student, and if so, the school name.
- A check indicating whether the parent or guardian is a graduate student. (If so, that person is not eligible to receive Child Care Assistance.)
- The school's name.
- Whether the person needs child care to look for work and when they will start searching.

The applicant must attach:

- The most recent pay stubs for each employed person, or
- A copy of the class schedule if the person is a student.

Page 69 is reserved for future use.

Iowa Department of Human Services

Financial Support Application

What Kind of Help Would You Like? Part A

The Department of Human Services (DHS) has many programs that may help you and your family. Please fill out this application so that we can help you find the programs that will meet your needs.

Look at the programs listed below. Choose the programs you want to apply for and fill out those sections of the application. Pages 1 and 2 are for you to keep for your records. **Everyone must fill out Part A (pink)**.

Food Assistance Part B

The Food Assistance Program, formerly known as Food Stamps, helps you buy food for good health. You may be able to get Food Assistance by the 7th day after applying. This is called Emergency Service. If you want to apply for Food Assistance, fill out **Part A (pink)** and **Part B (green)**.

Family Investment Program (FIP) or Refugee Cash Assistance Part C

The Family Investment Program (FIP) is also known as Temporary Assistance for Needy Families (TANF). FIP provides temporary cash assistance to children and families. Refugees who do not get FIP may get Refugee Cash Assistance. If you want to apply for FIP or Refugee Cash Assistance, fill out **Part A (pink)** and **Part C (purple)**.

Child Care Assistance Part D

Child Care Assistance helps pay for the care of your child while a parent or caretaker works or attends school. It might also be used to care for children while a parent or caretaker is looking for work or is unable to care for children because of medical reasons. If you want to apply for Child Care Assistance, fill out **Part A (pink)** and **Part D (blue)**.

How Do I Get Help?

You may apply for one or more programs listed on the previous page.

Step 1. Fill out an application.

Anyone may fill out an application. You may apply on a paper application or you can apply online at www.oasis.iowa.gov. If you decide to apply using this form, answer as many questions as you can. **If you can't fill out the whole application today, fill out with at least your name, address, and signature and turn in Page 1. But, then please fill out and turn in the rest of the application as soon as you can.** If you need help filling out an application, please ask for help at your local Department of Human Services (DHS) office.

Step 2. Return the application to us.

You can take, fax or mail your application to a local DHS office. **The date we get Page 1 with your name, address, and signature is your application date. This starts the time we have to work on your application. It is also the date your Food Assistance may start.**

Step 3. Give us proof and come to an interview if asked.

You **may** be asked to show us proof:

- Of who you are and who the people are for whom you apply. Examples are a driver's license, social security card, or alien documentation card.
- That you and the people for whom you apply are U.S. citizens or nationals.
- Of the money you have gotten in the last 30 days, such as check stubs, self-employment records, or award letters.
- Of things you have, such as bank accounts, trust accounts, stocks, or bonds.

You may need to show us other proof. If you are not able to show us proof right away, you will be given time to get the information. If you can't get proof, ask DHS to help you get the information.

An interview will be set up for you, if necessary. You should come to your interview even if you do not have all the proof we need. Interviews are not needed if you are applying only for Child Care Assistance.

Information About Immigration Status

You can apply for part of your household even if some members do not have lawful immigrant status. For example, parents who do not have lawful immigrant status may apply for their children who are U.S. citizens or qualified lawful immigrants. You need to give proof of immigration status or U.S. citizenship for each person in your household for whom you apply.

Your household's alien status may be checked with the Citizenship and Immigration Service. Any information we get from the Citizenship and Immigration Service may affect your household's benefits. We will not contact the Citizenship and Immigration Service about the people you don't apply for. However, we may use their income and assets to see if the rest of the household can get help.

Addendum to Application and Review Forms for Release of Information

OPTIONAL Release of Information

Help Us Help You!

You do not have to sign this, but it will help us get information we need to help you, without having to get your signature on specific requests.

You should know that:

- We may need more information to decide if you can get assistance.
- If more information is needed from you, you will get a letter telling you what we need and the date you must get it to us.
- You are responsible to get the information or to ask us for help to get it.
- If you do not give us the information or ask for help by the due date, your application may be denied or your assistance may stop.
- We may be able to use the release below to get the information we need. **But you still have to provide information we request or ask us for help.**
- We may attach a copy of this release to a form that asks other people or organizations (like your employer) for specific information needed about you or others in your household.

Print and sign your name below to give us permission to get needed information.

RELEASE OF INFORMATION

I hereby authorize any person or organization to give the Iowa Department of Human Services requested information about me or other members of my household.

A copy of this release is as valid as the original.

This release does not apply to protected health information.

This release is good for 12 months from the date signed.

_____	_____
Your Name (please print clearly)	Other Adult Name (please print clearly)
_____	_____
Signature or Mark	Signature or Mark
_____	
Date	

Iowa Department of Human Services

Financial Support Application

What Kind of Help Would You Like? Part A

Check the box next to the programs you want to apply for. You do not need to apply for programs you already get.

☐ **Food Assistance** ☐ **Family Investment Program** ☐ **Child Care Assistance**

Tell Us About You Part A

Name	Telephone Number ( )	**Is morning or afternoon the best time to call you?**
Social Security Number	Birth Date	
Street Address	City	State Zip Code
Mailing Address (if different)	City	State Zip Code

Your Signature Part A

I certify, under penalty of perjury, that:

- The answers I am about to give are correct and complete to the best of my knowledge.
- My answer about citizenship or alien status of each person applying for assistance is correct.

Keep the cover page and Part E.

Your Signature or Mark	Today's Date
Signature of Person, If Any, Who Helped Complete the Form	Today's Date
Print Name of Person Who Helped Complete Form	Phone Number
Mailing Address of Person Who Helped Complete Form	City State Zip Code

If you need help filling out this form, call your local DHS office.

When Will I Get Help? Part A

Food Assistance in 7 days – Emergency Service

This is who can get Food Assistance in 7 days:

- Households with gross monthly income less than $150 and with assets, such as cash or bank accounts, of $100 or less; or
- Households with rent, mortgage, and utilities that are more than the household's gross monthly income and assets; or
- Households with a migrant or seasonal farm worker and with assets of $100 or less whose income is stopping or starting.

Food Assistance in 30 days

If you don't get Emergency Service, you will get Food Assistance within 30 days if you are eligible, or a letter telling you why, if you are not eligible.

All Other Programs

We will send you a letter within 30 days of the date we get your application telling you if you will get help or not.

What Do Our Terms Mean? Part A

We use these terms in the application. This is what they mean.

Alien	A person who is not a U.S. citizen.
EAC card	An electronic access card (Visa debit card) for getting your cash assistance.
EBT card	A plastic swipe card that you use at the grocery store to buy food.
Eligible	Meeting all of the program guidelines to get help from us.
Household	A group of people who live together.
PROMISE JOBS	A work and training program for the Family Investment Program (FIP).
Quality Control	A DHS unit that might review your case to see if you are getting the correct assistance. If your case is chosen, the Quality Control unit will contact you.
Refugee	A person who enters the U.S. with a refugee status.
Special needs for child care	A child with a condition diagnosed by a professional that limits major life activities.

Social Security Number Information — Part A

We can give help only to people who give us their social security number (SSN) or proof of application from the Social Security office. **You don't have to give us the SSN for people in your household who you do not want help for, but you can choose to give us their SSN**. However, we will use any SSN given to us the same way we use the SSN of people getting assistance.

We will deny assistance to the people for whom you do not give us a SSN. There are some exceptions to this. Please ask your worker.

We will not give any SSN to the Citizenship and Immigration Service.

People in Your Home — Part A

List all the people who live in your home and mark the box **yes** or **no** if you are applying for that person. If you choose no, you only need to list their name, relationship to you and their date of birth.

*Only required if applying for FIP.

We have to ask your ethnicity and race, but you don't have to answer. The reason for the information is to assure that program benefits are distributed without regard to race, color, or national origin. Your answer won't affect how much you get or how soon. If you choose to answer, use the following codes:

**Ethnicity
H = Hispanic or Latino
N = Not Hispanic or Latino

***Race (Choose all that apply)
W = White
B = Black or African American
A = Asian
I = American Indian or Alaskan Native
N = Native Hawaiian or other Pacific Islander

Apply for? Yes/No	Name (First, MI, Last)	Relationship to You	Birth Date	Birth State*	Last Grade in School*	Social Security Number	Ethnicity **	Race ***	Citizen Yes/No	If Alien, Status
		Self								

Grandparents and others applying for children that are not your own:

If you are applying for FIP **only** for the children, answer the remaining questions only about the children. If you are applying for Food Assistance, Child Care Assistance, or want FIP for yourself, answer the questions about everyone in your home.

List anyone in your home who is disabled: _____

List anyone age 18 or over who is in college or trade school: _____

List anyone getting benefits from another state: _____

Which state? _____

List anyone who is a boarder or striker: _____

Tell Us About Criminal Actions and Disqualifications — Part A

Is anyone fleeing to avoid prosecution, custody, or jail for a felony crime? ☐ Yes ☐ No

Is anyone violating a condition of probation or parole? ☐ Yes ☐ No

Is anyone in or expecting to go to jail or prison? ☐ Yes ☐ No

Has anyone been disqualified from a food assistance program in any state for fraud or a program violation? ☐ Yes ☐ No

Expenses — Part A

To get the most help you can, tell us about your expenses.

List your share of any day care for a child or a disabled adult who lives with you:

Who gets care: _____ $ _____ per month

If anyone currently pays child support, give the following information:

Who pays: _____ $ _____ per month

Income — Part A

You must tell us about all money the people in your household get. If you leave a space blank, we will take that to mean there is no money of this kind. Please use an additional sheet of paper, if needed.

List all jobs the people in your household have.

Who Works?	Employer Name?	How Much is this Person Paid Per Hour?	How Many Hours Does this Person Expect to Work Each Week?	How Often is this Person Paid?	Does this Person Get Tips?
		$_____	Regular Hours: _____ Overtime Hours: _____	☐ Weekly ☐ Every 2 Weeks ☐ Twice a Month ☐ Monthly ☐ Other (explain) _____	☐ Yes, Weekly Amount $_____ ☐ No
		$_____	Regular Hours: _____ Overtime Hours: _____	☐ Weekly ☐ Every 2 Weeks ☐ Twice a Month ☐ Monthly ☐ Other (explain) _____	☐ Yes, Weekly Amount $_____ ☐ No

Will the amount of money reported above from jobs stay about the same? ☐ Yes ☐ No

If no, explain: _____

Has anyone been hired for a job but not received a paycheck yet? ☐ Yes ☐ No

If yes, who? _____ Employer Name? _____

Has anyone reduced their work hours or ended a job in the last 30 days? ☐ Yes ☐ No

If yes, who? _____ Employer Name? _____

What Other Money Do People in Your Household Get?	Who Gets the Money?	How Much Per Month?
Self-Employment or Odd Jobs		
Unemployment Benefits or Worker's Compensation		
Social Security or SSI		
Veterans Benefits, Pensions, or Retirement		
Child Support or Alimony		
Money from Friends or Relatives		
Other: (Including irregular or one time payments) Explain:		

Will the amount of other money people in your household get stay about the same? ☐ Yes ☐ No

If no, explain: _____

Resources (Assets) Part A

Does anyone have a car, truck, boat, camper, motorcycle, or other vehicle? ☐ Yes ☐ No

If yes, list make, model, year below.

_____

List the total money anyone has in:

Checking/savings or other bank/credit union accounts $_____ Who? _____

Cash $_____ Who? _____

Stocks, bonds, savings certificates, annuities, IRAs, Keogh, or other assets $_____ Who? _____

List anyone who:

Owns land, buildings or houses other than the house you live in: _____

Owns resources with someone who does not live in your household: _____

Has a conservatorship or trust: _____

Has sold, traded or given away any resources in the past three months: _____

Food Assistance — Part B

If you do not get Food Assistance and want to apply, answer the questions in this section.

List the people in your household who are **not** applying for Food Assistance:

_____

Tell us who does not eat with you: _____

List anyone who has an Iowa EBT card: _____

Is anyone a migrant or seasonal farm worker? ☐ Yes ☐ No

Have you or any member of your household been convicted, after September 22, 1996, of:

- Buying or selling Food Assistance benefits over $500? ☐ Yes ☐ No
- Fraudulently receiving duplicate Food Assistance benefits in any state? ☐ Yes ☐ No
- Trading Food Assistance benefits for drugs, guns, ammunition or explosives? ☐ Yes ☐ No

Help With Your Food Assistance — Part B

You can have someone fill out your application, answer questions for you, give information at your interview, and buy food with an EBT card. If you choose to have someone help you, we will be able to share information with this person. You don't have to do this.

We will be able to share information with this person. Tell us about the person you want to help you.

Name	Address	Telephone Number

Food Assistance Expenses — Part B

To get the most Food Assistance you can, please tell us about your bills.

Shelter and Utilities

How much is **your share** of the following expenses:

Rent: $_____ per month

Lot Rent: $_____ per month

Mortgage: $_____ per month

If you pay taxes or insurance separate from your mortgage, list amounts below:

Property Taxes: $_____ per _____

Homeowner's Insurance: $_____ per _____

Check the boxes next to the utility bills you have to pay:

- ☐ Lights/Electricity
- ☐ Water and Sewage
- ☐ Gas
- ☐ Garbage and Trash
- ☐ Telephone
- ☐ Extra charges from your landlord
- ☐ Other, explain_____

☐ Check here if any of the utility bills you have to pay are for heating or air conditioning.

☐ Check here if you got energy assistance in the past year at your current address.

☐ Check here if you are on low rent housing. If yes, what is your part of the rent? $_____

Medical Expenses

Tell us the medical costs that are not paid by insurance for everyone who is disabled or over age 59. These could be doctor and hospital bills, medicine, transportation, health insurance premiums, or other medical services.

Who pays: _____ Amount per month: $_____

Help Paying Expenses

If you get help with your expenses tell us:

Which Expense Was Paid	Who Paid	Amount Paid

Family Investment Program (FIP) or Refugee Cash Assistance Part C

If you do not get FIP or Refugee Cash Assistance and want to apply, answer the questions in this section.

List the people in your home who are **not** applying for FIP:

_____

List anyone who has an Iowa Electronic Access Card (EAC): _____

List anyone in your home who is pregnant: _____

List anyone who is in the military, a veteran, or a spouse of a veteran: _____

Does anyone expect to get a one-time payment such as an inheritance or insurance settlement or did anyone get one in the past 30 days? ☐ Yes ☐ No

Does anyone have life or death benefit insurance? ☐ Yes ☐ No

List anyone in your household who has received TANF or other cash assistance benefits outside of Iowa since January 1, 1997: _____

Where? _____

What months? _____

Child Support

Complete this section 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	Name of This Parent's Children	County Where Court Order is Filed, if Any

Name and address of employer of parent not in the home: _____

If ever married to this parent, list the date and place of marriage: _____

Child Care Assistance — Part D

If you do not get Child Care Assistance and want to apply, answer the questions in this section.

List the children in your home who need child care: _____

List any children who are identified as having special needs: _____

List the hours of work for the adults in your household.

Name of Person Working _____			Name of Person Working _____		
Monday	_____	to _____	Monday	_____	to _____
Tuesday	_____	to _____	Tuesday	_____	to _____
Wednesday	_____	to _____	Wednesday	_____	to _____
Thursday	_____	to _____	Thursday	_____	to _____
Friday	_____	to _____	Friday	_____	to _____
Saturday	_____	to _____	Saturday	_____	to _____
Sunday	_____	to _____	Sunday	_____	to _____

Do you need child care while you attend school? ☐ Yes ☐ No

If yes, you will need to give us a copy of your class schedule.

Are you enrolled in graduate school? ☐ Yes ☐ No

Do you need child care for another reason, such as hospitalization or job search? ☐ Yes ☐ No

If yes, explain: _____

List the name of the person or agency that will be caring for your children:

Provider Name	Telephone Number	
Street Address		
City	State	Zip Code

Please answer the following questions about yourself and the other parent or caretaker if they are in the home.

Are you, or the other parent in the home, on active duty in the military? ☐ Yes ☐ No

In a national guard or reserve unit? ☐ Yes ☐ No

If yes, who? _____

Do any of the following living arrangements apply to your family?

Do you live in a: Motel, car or campsite? ☐ Yes ☐ No
Shelter or other temporary housing?
House or apartment, with friends or family members (shared housing)?

Assets are things like homes, cars, campers, stocks and bonds, or cash.
Do you have less than one million dollars in assets? ☐ Yes ☐ No

You Have the Right to Appeal — Part E

You, or the person helping you, may request an appeal hearing if you do not agree with any action taken on your case. For Food Assistance, you can appeal in person or by telephone. For all other programs, you must appeal in writing. To appeal in writing do **one** of the following:

- Fill out an appeal electronically at https://dhssecure.dhs.state.ia.us/forms/, **or**
- Write a letter telling us why you think a decision is wrong, **or**
- Fill out an Appeal and Request for Hearing form. You can get this form at your county DHS office.

Send or take your appeal to the Department of Human Services, Appeals Section, 5th Floor, 1305 E Walnut Street, Des Moines, IA 50319-0114. If you need help filing an appeal, ask your county DHS office.

You can represent yourself. Or, you can have a friend, relative, lawyer, or someone else act on your behalf.

You may contact your county DHS office about legal services. You may have to pay for these legal services. If you do, your payment will be based on your income. You may also call Iowa Legal Aid at (800) 532-1275. If you live in Polk County, call (515) 243-1193.

You Will Not Be Discriminated Against — Part E

It is the policy of the Iowa Department of Human Services (DHS) to provide equal treatment in employment and provision of services to applicants, employees and clients without regard to race, color, national origin, sex, sexual orientation, gender identity, religion, age, disability, political belief or veteran status.

If you feel DHS has discriminated against or harassed you, please send a letter detailing your complaint to: Iowa Department of Human Services, Hoover Building, 5th Floor – Policy Bureau, 1305 E Walnut, Des Moines, IA 50319-0114 or via email contactdhs@dhs.state.ia.us

Food Assistance

This institution is prohibited from discriminating on the basis of race, color, national origin, disability, age, sex, and in some cases, religion or political beliefs.

The U.S. Department of Agriculture (USDA) also prohibits discrimination based on race, color, national origin, sex, religious creed, disability, age, political beliefs or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

Persons with disabilities who require alternative means of communication for program information (e.g., Braille, large print, audiotape, American Sign Language, etc.), should contact the agency (state or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027), found online at: http://www.ascr.usda.gov/complaint_filing_cust.html, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by:

Mail: U.S. Department of Agriculture
Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue, SW
Washington, DC 20250-9410; or

Fax: (202) 690-7442; or

Email: program.intake@usda.gov

For any other information dealing with Supplemental Nutrition Assistance Program (SNAP) (Food Assistance in Iowa) issues, persons should either contact the USDA SNAP Hotline Number at (800) 221-5689, which is also in Spanish, or call the State Information/Hotline Numbers found online at: http://www.fns.usda.gov/snap/contact_info/hotlines.htm.

To file a complaint of discrimination regarding a program receiving Federal financial assistance through the U.S. Department of Health and Human Services (HHS), write: HHS Director, Office for Civil Rights, Room 515-F, 200 Independence Avenue, SW, Washington, DC 20201 or call (202) 619-0403 (voice) or (800) 537-7697 (TTY).

This institution is an equal opportunity provider.

All Programs — Part E

We Check What You Tell Us

The information you give us may be checked by federal, state, and local officials to make sure it is true. Things we might check are any listed person's: social security number, job and pay, bank account amount, alien status, and amounts received from other sources like Social Security or unemployment. If any information you give us is not correct, we may deny your application.

We may check records from other states to see if any person in your household can get benefits in Iowa. This may be because a person was disqualified from a program in another state.

We check and use computer systems like the state Income and Eligibility Verification System. If something you told us is different from what the computer system tells us, we will check to find out what is correct. We might check your information by contacting your employer, your bank, or other people. To do this kind of checking with your employer, bank, or other people, we will ask you first. Such information may affect your household's eligibility and level of benefits.

Things You Need to Know

DHS may give your answers to law enforcement officials to catch persons fleeing to avoid the law.

The Quality Control unit or Investigations unit may review your case. They may contact other people or organizations to get proof of your information. By signing this application, you give permission to release confidential information to the Quality Control unit or Investigations unit. You must cooperate with them to keep your benefits.

You will have to pay back any benefits you got or that was paid to a third party on your behalf for which you were not eligible.

Section 1128B of the Social Security Act provides federal penalties for fraudulent acts and false reporting in connection with these programs.

Anyone who gets, tries to get, or helps any other person get assistance to which they are not entitled, is guilty of violating the laws of the state of Iowa. This includes, but is not limited to, Iowa Code Chapters 239B, 243, 249, and 249A.

Your expenses may be used to figure the amount of assistance you get. You may have expenses included in your benefit calculation by reporting and giving proof of your expenses. If you do not report or give proof of your expenses, you choose not to claim the expense. You can report and give proof later, and the expense can be used for future months.

Comm. 233 will be given to you at your interview. It will tell you about any additional rights and responsibilities not covered with this application.

Food Assistance Part E

Rules of the Food Assistance Program

Follow these rules:

- **Don't** hide or give wrong information on purpose to get Food Assistance benefits.
- **Don't** use Food Assistance benefits to buy non-food items like alcohol or tobacco.
- **Don't** trade, sell, or give away Food Assistance benefits.
- **Don't** use someone else's Food Assistance benefits for yourself.
- **Don't** purchase a product with Food Assistance benefits, with a returnable container that has a return deposit, with the intent of getting cash back when the empty container is returned to the store.
- **Don't** buy food on credit and attempt to pay for it with Food Assistance.
- **Don't** buy a product with Food Assistance benefits so you can get cash or something other than eligible food by reselling that product.
- **Don't** fail to report if your household goes over its income limit.

  If you get Food Assistance, your worker will tell you what your household's income limit is. If your household's income goes over your limit in any month you must tell us by the 10th day of the next month. If you don't tell us on time, you might have to pay back the benefits.

Penalties of the Food Assistance Program

Anyone who breaks the above rules:

- **May not get Food Assistance benefits for 1 year for the first time, 2 years for the second time, and forever for the third time;**
- **May be fined up to $250,000 or jailed up to 20 years or both; and**
- **May be kept off Food Assistance for an additional 18 months, if court ordered.**

If a court finds you guilty of buying, selling, or trading more than $500 in Food Assistance benefits, you will lose benefits forever.

If a court finds you guilty of trading Food Assistance benefits for firearms, ammunition, or explosives, you will lose benefits forever.

If a court finds you guilty of trading Food Assistance benefits for controlled substances, you will lose benefits for two years the first time and forever the second time.

You will not get Food Assistance for 10 years if you are found guilty of getting or trying to get Food Assistance in more than one household at a time. This penalty happens if you give wrong information about who you are or where you live.

Giving wrong information on purpose may result in us taking legal action against you, either criminal or civil. It might also mean we reduce your benefits or take money back from you.

Things You Need to Know

Households eligible for Food Assistance may get a notice that they are eligible for the "Promoting Awareness of the Benefits of a Healthy Marriage" program and a pamphlet listing those benefits. By giving this information, DHS can use different rules that may help you get Food Assistance.

If you have a Food Assistance overpayment, DHS will give your answers to federal and state agencies as well as private claims collection agencies, to collect the overpayment.

The Food Assistance office may contact other people or organizations to get proof of your information.

By having signed this application, you agree that all members of your household will register for work and follow all of the work and training rules.

The application filing date is different if your household is in an institution and applying for Food Assistance and Supplemental Security Income at the same time. In this case, the filing date is the date of release from the institution.

You may not be denied Food Assistance benefits just because you were denied benefits from other programs. Food Assistance applications will not be delayed due to requirements of other programs you may apply for.

The collection of information on the application, including the social security number of each household member, is authorized under the Food and Nutrition Act of 2008 (formerly the Food Stamp Act of 1977), as amended, 7 U.S.C. 2011-2036. The information will be used to determine whether your household is eligible or continues to be eligible to participate in the Food Assistance program. We will verify this information through computer matching programs. This information will also be used to monitor compliance with program regulations and for program management.

Family Investment Program (FIP) or Refugee Cash Assistance Part E

Things You Need to Know

Within 10 days of the date the change happens, you must tell DHS about changes, such as:

- Income, when it starts or stops, including getting an inheritance or a one-time payment of past due child support
- Resources or assets
- Someone moving in or out of your home
- Mailing or living address
- Receipt of a SSN
- Change of school attendance of a child

If your application for FIP or Refugee Cash Assistance is approved, your Food Assistance may go down or stop.

If you are approved for FIP, you will be registered with the PROMISE JOBS program. You agree that all members of your household who must cooperate with PROMISE JOBS will do so. Talk with your worker if you feel you have a reason not to cooperate.

If you choose not to take part in PROMISE JOBS, your FIP benefits will be limited.

While you get FIP, you give up your rights to child support for the months you are on FIP. The state of Iowa will keep your child support to pay back the money you get from FIP.

Using Your FIP/RCA Electronic Access Card (EAC) or Your Debit Card to Access FIP/RCA Funds from Your Personal Bank Account

You cannot access your cash benefits with your EAC or personal debit card at a:

- Liquor store or any place that mainly sells liquor,
- Casino or other gambling or gaming establishment, or
- Business which provides adult-oriented entertainment in which performers disrobe or perform in an unclothed state (such as a strip club).

This includes these types of businesses located in Iowa, on tribal land, or in any other state.

If DHS determines that you have accessed your cash benefits with your EAC or personal debit card at one of the above places you:

- Will have committed fraud,
- Have to repay the amount of cash accessed at the location, as well as any access fees, and
- Your family will not get cash benefits for three months with the first misuse and six months for each additional misuse.

By having signed this application, you agree that no member of your household will use the EAC or your personal debit card to access FIP/RCA funds at prohibited locations.

Penalty for Getting FIP in More Than One State

You will not get FIP for 10 years if you are found guilty of getting or trying to get FIP in more than one state at a time. This penalty happens if you give wrong information about where you live.

Child Care Assistance (CCA) Part E

Things You Need to Know

Within 10 days of the date the change happens, you must tell DHS about changes, such as:

- Income, including a change in your hourly rate and when income starts or stops
- Work hours
- Mailing or living address
- Class schedule
- Someone moving in or out of the house
- Change in child care provider

Iowa Department of Human Services

Financial Support Application
(Solicitud de Ayuda Financiera)

¿Qué tipo de ayuda desea? Parte A

Department of Human Services (DHS) tiene varios programas que podrían ayudarlos a usted y a su familia. Complete este formulario para que podamos ayudarle a encontrar los programas adecuados para sus necesidades.

Lea los programas que se indican a continuación. Elija los programas que desea solicitar y complete dichas secciones del formulario. Las páginas 1 y 2 son para su archivo personal. **Todas las personas deben llenar la Parte A (rosa)**.

Food Assistance Parte B

El Programa Food Assistance (asistencia para alimentos), anteriormente conocido como Food Stamps (bonos para alimentos), le ayuda a comprar alimentos para estar saludable. Podría conseguir Food Assistance el 7mo día después de haberlo solicitado. Esto se llama Servicio de Emergencia. Si desea solicitar Food Assistance, complete la **Parte A (rosa)** y la **Parte B (verde)**.

Family Investment Program (FIP) o Refugee Cash Assistance Parte C

El Programa de Inversión Familiar (Family Investment Program, FIP) también es conocido como Asistencia Temporal para Familias Necesitadas (Temporary Assistance for Needy Families, TANF). FIP le brinda asistencia temporal en dinero en efectivo para niños y familias. Los Refugiados que no obtengan FIP pueden conseguir Refugee Cash Assistance (Asistencia en Efectivo para Refugiados). Si desea solicitar FIP o Refugee Cash Assistance, complete la **Parte A (rosa)** y la **Parte C (violeta)**.

Child Care Assistance Parte D

Child Care Assistance (asistencia para cuidado infantil) le ayuda a pagar el cuidado de su hijo mientras los padres o la persona a cargo del cuidado van a trabajar o a estudiar. También se puede usar para el cuidado de niños mientras los padres o la persona a cargo del cuidado están buscando trabajo o no pueden cuidarlos por razones de salud. Si desea solicitar Child Care Assistance, complete la **Parte A (rosa)** y la **Parte D (azul)**.

¿Qué debo hacer para conseguir ayuda?

Puede solicitar uno o más de los programas descritos en la página anterior.

Paso 1. Complete el formulario.

Todas las personas pueden completar el formulario. Puede utilizar un formulario impreso o hacer la solicitud por Internet en www.oasis.iowa.gov. Si decide hacer la solicitud utilizando este formulario, responda todas las preguntas que pueda. **Si no puede completar todo el formulario de solicitud en un solo día, complete al menos su nombre, domicilio y firma, y entregue la Página 1. Por favor, recuerde que debe completar el resto del formulario y entregarlo lo antes posible.** Si necesita ayuda para llenar el formulario, pída ayuda en la oficina local de Department of Human Services (DHS).

Paso 2. Devuélvanos el formulario.

Puede enviar la solicitud por correo o por fax, o llevarla a la oficina local de DHS. **Su fecha de solicitud será la fecha en que recibamos la Página 1 con su nombre, domicilio y firma. Ese día comienza a correr el tiempo que tenemos para gestionar su solicitud. También es la fecha en que su Food Assistance podría comenzar.**

Paso 3. Entréguenos comprobantes y venga a una entrevista si se lo pedimos.

Es posible que le pidamos:

- Comprobante de su identidad y la identidad de las personas para quienes solicita asistencia. Algunos ejemplos son: licencia de conductor, tarjeta del seguro social o su documentación como inmigrante.
- Comprobante de que usted y las personas para quienes solicita asistencia son ciudadanos estadounidenses o están nacionalizados.
- Comprobantes del dinero que recibió en los últimos 30 días, por ejemplo: recibos de sueldo, registros de trabajo por cuenta propia o cartas aprobando asignaciones.
- Comprobantes de cosas que tenga, por ejemplo: cuentas bancarias, cuentas de fideicomisos, acciones o bonos.

Podría tener que presentar otros comprobantes. Si no puede presentarlos de inmediato, se le dará tiempo para que los consiga. Si no puede conseguir los comprobantes, pídale a DHS que le ayude a conseguirlos.

Se programará una entrevista, si es necesario. Debe venir a la entrevista aunque no tenga todos los comprobantes que necesitamos. No es necesario hacer entrevistas en el caso de presentar la solicitud para Child Care Assistance únicamente.

Información sobre la situación inmigratoria

Puede presentar la solicitud para parte del grupo familiar aunque algunos integrantes sean inmigrantes ilegales. Por ejemplo, los padres que son inmigrantes ilegales pueden presentar la solicitud para los hijos que son ciudadanos estadounidenses o inmigrantes legales documentados. Debe presentar la documentación inmigratoria o de ciudadanía estadounidense de cada una de las personas para las que presenta la solicitud.

La situación inmigratoria de su grupo familiar podría ser verificada con el Servicio de Ciudadanía e Inmigración. Toda información que recibamos de dicho organismo podría afectar los beneficios de su grupo familiar. No nos comunicaremos con el Servicio de Ciudadanía e Inmigración para averiguar sobre las personas para las cuales no solicite asistencia. No obstante, podremos utilizar sus ingresos y activos para ver si el resto del grupo familiar puede obtener ayuda.

Addendum to Application and Review Forms for Release of Information
(Adenda de los Formularios de Solicitud y Revisión para Divulgación de Información)

Divulgación de Información OPCIONAL

¡Ayúdenos a ayudarle!

No es obligatorio que firme esta autorización, pero nos ayudaría a obtener la información que necesitamos para ayudarle, y no tendríamos que pedirle que firme solicitudes específicas.

Debe saber que:

- Podríamos necesitar más información para decidir si puede obtener asistencia.
- Si necesitáramos que nos proporcione más información, recibirá una carta informándole qué necesitamos y la fecha en debe entregarla.
- Es su responsabilidad conseguir dicha información o pedirnos que le ayudemos a conseguirla.
- Si no nos proporciona dicha información ni nos pide ayuda antes de la fecha de entrega de la misma, su solicitud podría ser denegada o la asistencia podría terminar.
- Podríamos utilizar la siguiente autorización para obtener la información necesaria. **Pero aún así, deberá conseguir la información que le solicitemos o pedirnos ayuda para conseguirla.**
- Podríamos adjuntar una copia del mismo a otros formularios para solicitarles a otras personas u organizaciones (como, por ejemplo, su empleador) que nos proporcionen información específica sobre usted o los miembros de su grupo familiar.

Escriba su nombre en letra de imprenta y firme debajo para autorizarnos a obtener la información necesaria.

DIVULGACIÓN DE INFORMACIÓN
(Release of Information)

Por la presente autorizo a cualquier individuo u organización a entregar a Department of Human Services de Iowa la información solicitada sobre mi persona o mi grupo familiar.
(I hereby authorize any person or organization to give the Iowa Department of Human Services requested information about me or other members of my household.)

Una copia de esta autorización es tan válida como el original.
(A copy of this release is as valid as the original.)

Esta autorización no es válida en el caso de información protegida referida a la salud.
(This release does not apply to protected health information.)

Esta autorización es válida por 12 meses a partir de la fecha de mi firma.
(This release is good for 12 months from the date signed.)

Su nombre (en imprenta legible) (Your Name – please print clearly)	Nombre de otro adulto (en imprenta legible) (Other Adult Name – please print clearly)
Firma o marca (Signature or Mark)	Firma o marca (Signature or Mark)
Fecha (Date)	

Iowa Department of Human Services

Financial Support Application
(Solicitud de Ayuda Financiera)

¿Qué tipo de ayuda desea? Parte A

Marque las casillas correspondientes a los programas que desea solicitar. No marque ningún programa que actualmente ya está recibiendo.

☐ **Food Assistance** ☐ **Family Investment Program** ☐ **Child Care Assistance**

Sus datos Parte A

Nombre	Teléfono ( )	**¿Es mejor que le llamemos a la mañana o a la tarde?**
Número de Social Security	Fecha de nacimiento	
Domicilio	Ciudad	Estado Cód. Postal
Dirección Postal (si es diferente)	Ciudad	Estado Cód. Postal

Su firma Parte A

Certifico, bajo pena de cometer perjurio, que:

- La información que estoy por dar es correcta y completa a mi leal saber y entender.
- Mi respuesta con respecto a la ciudadanía o el estado legal inmigratorio de cada una de las personas para las que solicito asistencia es correcta.

Conserve la portada y la Parte E.

Su firma o marca	Fecha de hoy
Firma de la persona que me ayudó a completar el formulario, si corresponde	Fecha de hoy
Nombre en letra de imprenta de la persona que me ayudó a completar el formulario, si corresponde	Teléfono
Dirección postal de la persona que me ayudó a completar el formulario	Ciudad Estado Cód. Postal

Si necesita ayuda para completar este formulario, llame a la oficina local de DHS.

¿Cuándo recibiré la asistencia? Parte A

Food Assistance en 7 días – Servicio de Emergencia

¿Quién puede recibir Food Assistance en 7 días?

- Grupos familiares con ingresos brutos inferiores a $150 por mes y con activos, como dinero en efectivo o cuentas bancarias, con $100 o menos;
- Grupos familiares con alquileres, hipotecas o servicios públicos que superan el ingreso bruto mensual y los activos del grupo familiar;
- Grupos familiares con trabajadores rurales por temporada y con activos de $100 o menos que dejarán de recibir ingresos o comenzarán a recibirlos.

Food Assistance en 30 días

Si no obtiene Servicio de Emergencia, recibirá Food Assistance dentro de 30 días si califica, o una carta informándole por qué no califica.

Todos los otros programas

Le enviaremos una carta dentro de los 30 días posteriores a la fecha de recepción de su solicitud, en la que le informaremos si recibirá ayuda o no.

¿Qué significan nuestros términos? Parte A

Utilizamos los siguientes términos en este formulario. Esto es lo que significan:

Extranjero	Una persona que no es ciudadana estadounidense.
Tarjeta EAC	Una tarjeta electrónica (tarjeta de débito Visa) para cobrar su asistencia en efectivo.
Tarjeta EBT	Una tarjeta magnética de plástico que usará en la tienda de comestibles para comprar alimentos.
Elegible	Que cumple con todas las normas del programa.
Grupo familiar	Un grupo de personas que viven juntas.
PROMISE JOBS	Un programa de capacitación laboral para Family Investment Program (FIP).
Control de calidad	Una unidad de DHS que podría evaluar su caso para ver si está recibiendo la asistencia correcta. Si su caso es seleccionado, la unidad de control de calidad se comunicará con usted.
Refugiado	Una persona que ingresa a los EE.UU. en condición de refugiado.
Necesidades especiales para guardería	Un menor que ha sido diagnosticado por un profesional y sufre una afección que limita las actividades más importantes de la vida diaria.

Información sobre Números de Social Security — Parte A

Podemos ayudar sólo a aquellas personas que nos den su número de Social Security (SSN) o el comprobante de solicitud expedido por la oficina de Social Security. **No tiene obligación de darnos los SSN de las personas de su grupo familiar para las que no solicita asistencia, pero puede hacerlo si lo desea**. No obstante, utilizaremos los SSN informados del mismo modo que utilizamos los SSN de las personas que reciben asistencia.

Les denegaremos asistencia a aquellas personas que no informen su número de Social Security (SSN). Existen algunas excepciones a esta regla. Pregúntele a su asistente.

No le informaremos ninguno de los SSN al Citizen and Immigration Service (Servicio de Ciudadanía e Inmigración).

Personas que viven en su hogar — Parte A

Indique los nombres de todas las personas que viven en su hogar y marque la casilla **sí** o **no** para indicar si está solicitando asistencia para dicha persona. Si elige "no", debe indicar solamente el nombre, el parentesco con usted y la fecha de nacimiento.

*Obligatorio para FIP únicamente.

Tenemos que preguntarle sobre su etnia y raza, pero no tiene obligación de responder. El motivo de estos datos es garantizar que las prestaciones del programa sean distribuidas sin tener en cuenta la raza, el color o el país de origen. Su respuesta no afectará el importe de la asistencia ni cuándo la recibirá. Si decide responder, utilice los siguientes códigos:

**Etnia
- H = Hispano o latino
- N = Ni hispano ni latino

***Raza (Elija todas las que correspondan)
- W = Blanca
- B = Negra o afroamericana
- A = Asiática
- I = Indio americano o nativo de Alaska
- N = Nativo Hawái u otra isla del Pacífico

¿Solicita asist.? Sí/No	Nombre y Apellido (Primer nombre, inicial, apellido)	Parentesco con usted	Fecha de Nac.	Estado de Nac.*	Último grado escolar*	Nº de Social Security	Etnia **	Raza ***	¿Ciuda-dano? Sí/No	Si es Extranjero, Estatus
		Yo								

Abuelos y otras personas que solicitan asistencia para menores que no son hijos propios:

Si está solicitando el programa FIP **sólo** para sus hijos, responda el resto de las preguntas refiriéndose sólo a sus hijos. Si está solicitando Asistencia Alimentaria, Asistencia para el Cuidado Infantil o desea obtener los beneficios de FIP para usted, responda las preguntas acerca de todas las personas de su hogar.

Indique el nombre de las personas discapacitadas que viven en su hogar: _____

Indique el nombre de los mayores de 18 años que cursan estudios superiores o comerciales: _____

Indique el nombre de las personas que reciben beneficios médicos de otro estado: _____

¿En qué estado? _____

Nombre a las personas que sean pensionistas o huelguistas: _____

Antecedentes penales e inhabilitaciones — Parte A

¿Alguien está huyendo para evitar que lo procesen, lo detengan o lo encarcelen por un delito grave? ☐ Sí ☐ No

¿Alguien ha violado su libertad condicional o bajo palabra? ☐ Sí ☐ No

¿Alguien está en la cárcel o prisión o espera ir a la cárcel o prisión? ☐ Sí ☐ No

¿Alguien ha sido inhabilitado para el programa Food Assistance en algún estado por fraude o infracción al programa? ☐ Sí ☐ No

Gastos — Parte A

Para recibir toda la asistencia posible, cuéntenos sobre sus gastos.

Indique la parte que paga para el cuidado diurno de niños o adultos discapacitados que viven con usted:

Quién recibe cuidado: _____ $ _____ por mes

Si alguien actualmente paga manutención de menores, indique lo siguiente:

Quién paga: _____ $ _____ por mes

Ingresos — Parte A

Debe informarnos sobre todo el dinero que reciben los integrantes de su grupo familiar. Si deja un espacio en blanco, entenderemos que no existe dinero de dicho tipo. Utilice una hoja extra si es necesario.

Indique todos los empleos que tienen los integrantes de su grupo familiar.

¿Quién trabaja?	Nombre del empleador	¿Cuánto cobra por hora?	¿Cuántas horas espera trabajar por semana?	¿Con qué frecuencia cobra?	¿Recibe propinas?
		$_____	Horas normales: _____ Horas extras: _____	☐ Semanalmente ☐ Cada 2 semanas ☐ Dos veces por mes ☐ Mensualmente ☐ Otro (explique) _____	☐ Sí, Importe semanal $_____ ☐ No
		$_____	Horas normales: _____ Horas extras: _____	☐ Semanalmente ☐ Cada 2 semanas ☐ Dos veces por mes ☐ Mensualmente ☐ Otro (explique) _____	☐ Sí, Importe semanal $_____ ☐ No

¿La cantidad de dinero informada arriba continuará siendo más o menos la misma? ☐ Sí ☐ No

Si respondió no, explique: _____

¿Alguien ha sido contratado pero aún no ha recibido paga? ☐ Sí ☐ No

Si respondió sí, ¿quién?_____ Nombre del empleador_____

¿Alguien ha reducido sus horas de trabajo o dejó su empleo en los últimos 30 días? ☐ Sí ☐ No

Si respondió sí, ¿quién?_____ Nombre del empleador_____

¿Qué otros ingresos recibe su grupo familiar?	¿Quién lo recibe?	Importe Mensual
Empleo por cuenta propia o trabajos esporádicos		
Beneficios por desempleo o indemnización por accidentes laborales (*Worker's Compensation*)		
Beneficios de Social Security o SSI		
Beneficios para Veteranos, Jubilaciones o Fondos de Retiro		
Manutención o Pensión de Alimentos		
Dinero proveniente de amigos o parientes		
Otros: (Incluyendo pagos irregulares o que se reciben una sola vez) Explique:		

¿El monto de esos otros ingresos continuará siendo más o menos el mismo? ☐ Sí ☐ No

Si respondió no, explique: _____

Recursos (Activos) Parte A

¿Alguien tiene un auto, camioneta, bote, casa rodante, motocicleta u otro vehículo? ☐ Sí ☐ No

Si respondió sí, indique la marca, el modelo y el año.

_____

Indique el total de dinero que tienen en:

Cuentas de cheques/ahorro u otras cuentas bancarias o cooperativas de crédito $_____ ¿Quién? _____

Efectivo $_____ ¿Quién? _____

Acciones, bonos, certificados de ahorro, anualidades, IRA, Keogh u otros activos $_____ ¿Quién? _____

Nombre a las personas que:

Son propietarias de terrenos, edificios o viviendas que no sea la casa en la que usted vive: _____

Son propietarias de bienes conjuntamente con alguien que no vive en su vivienda: _____

Poseen la tutela legal de un adulto o un fideicomiso: _____

Ha vendido, canjeado o regalado bienes en los últimos tres meses: _____

Food Assistance — Parte B

Si no recibe Food Assistance y desea solicitarla, responda las preguntas de esta sección.

Indique los nombres de las personas de su grupo familiar que **no** solicitan Food Assistance:

_____

Infórmenos quién no come con usted: _____

Indique quién tiene una tarjeta EBT de Iowa: _____

¿Alguien es trabajador rural estacional o itinerante? ☐ Sí ☐ No

¿Usted o algún miembro de su grupo familiar ha sido condenado, con posterioridad al 22 de septiembre de 1996, por:

- Comprar o vender beneficios de Food Assistance por más de $500? ☐ Sí ☐ No
- Actuar fraudulentamente porque recibieron beneficios duplicados de Food Assistance en cualquiera de los estados? ☐ Sí ☐ No
- Canjear beneficios de Food Assistance por drogas, armas, municiones o explosivos? ☐ Sí ☐ No

Ayuda para solicitar Food Assistance — Parte B

Puede pedirle a otra persona que complete el formulario, responda las preguntas por usted, dé información en la entrevista y compre alimentos con la tarjeta EBT. Si decide que alguien le ayude, podremos compartir información con dicha persona. No tiene obligación de hacerlo.

Podremos compartir información con esta persona. Infórmenos quién es la persona que le ayudará.

Nombre	Domicilio	Teléfono

Gastos de Food Assistance — Parte B

Para recibir toda la asistencia para alimentos que sea posible, cuéntenos sobre sus facturas.

Vivienda y servicios públicos

¿Qué parte paga de los siguientes gastos?

Alquiler: $_____ por mes

Alquiler de terreno: $_____ por mes

Hipoteca: $_____ por mes

Si paga impuestos o seguros aparte de la hipoteca, indique los montos a continuación:

Impuestos a la propiedad: $_____ por _____

Seguro de propietario: $_____ por _____

Marque las casillas correspondientes a las facturas de servicios públicos que paga:

- ☐ Luz/electricidad
- ☐ Gas
- ☐ Teléfono
- ☐ Otras, explique_____
- ☐ Agua y cloacas
- ☐ Recolección de residuos
- ☐ Otros costos cobrados por el propietario

☐ Marque esta casilla si debe pagar facturas por calefacción o aire acondicionado.

☐ Marque esta casilla si recibió asistencia para energía eléctrica el año pasado en su domicilio actual.

☐ Marque esta casilla si tiene un plan de vivienda con alquiler económico.
Si respondió sí, ¿qué parte del alquiler paga? $_____

Gastos Médicos

Infórmenos sobre los gastos médicos que el seguro no paga para personas discapacitadas o mayores de 59 años. Pueden ser facturas de médicos o del hospital, medicamentos, transporte, primas del seguro médico u otros servicios médicos.

Quién paga:_____ Importe por mes: $_____

Ayuda para pagar gastos

Si recibe ayuda para pagar sus gastos, infórmenos:

Qué gasto se pagó	Quién lo pagó	Importe pagado

Family Investment Program (FIP) o Refugee Cash Assistance — Parte C

Si no recibe FIP ni Refugee Cash Assistance y desea solicitarlos, responda las preguntas de esta sección.

Indique el nombre de las personas que viven en su hogar que **no** solicitan FIP:

_____

Nombre a las personas que tienen una tarjeta electrónica (EAC) de Iowa: _____

Indique el nombre de las embarazadas que viven en su hogar: _____

Indique el nombre de aquellos que están en las fuerzas armadas, son veteranos o cónyuges de veteranos: _____

¿Alguien espera recibir un pago por única vez, por ejemplo, una herencia o una liquidación del seguro, o alguien los recibió en los últimos 3 meses? ☐ Sí ☐ No

¿Alguien tiene seguro de vida o beneficios por fallecimiento? ☐ Sí ☐ No

Indique el nombre de quien haya recibido TANF u otros beneficios de de asistencia en efectivo fuera de Iowa desde el 1 de enero de 1997: _____

¿Dónde? _____

¿En qué meses? _____

Manutención de menores

Complete esta sección para cada uno de los progenitores que no viven en el hogar con sus hijos.

Nombre y domicilio del progenitor que no vive en el hogar	Fecha de Nac. del progenitor	Nº de Social Security Number del progenitor	Nombres de los hijos de este progenitor	Condado donde se presentó la orden judicial, si corresponde

Nombre y domicilio del empleador del progenitor que no vive en el hogar: _____

Si está/estuvo casado/a con este progenitor, indique la fecha y el lugar del casamiento: _____

Child Care Assistance — Parte D

Si no recibe Child Care Assistance y desea solicitarla, responda las preguntas de esta sección.

Indique los nombres de los niños que viven en su hogar y necesitan guardería: _____

Indique los nombres de los niños que tienen necesidades especiales: _____

Indique los horarios laborales de los adultos de su grupo familiar.

Nombre de la persona que trabaja _____	Nombre de la persona que trabaja _____
Lunes _____ a _____	Lunes _____ a _____
Martes _____ a _____	Martes _____ a _____
Miércoles _____ a _____	Miércoles _____ a _____
Jueves _____ a _____	Jueves _____ a _____
Viernes _____ a _____	Viernes _____ a _____
Sábado _____ a _____	Sábado _____ a _____
Domingo _____ a _____	Domingo _____ a _____

¿Necesita guardería mientras asiste a un establecimiento educativo? ☐ Sí ☐ No
Si respondió que sí, deberá entregarnos una copia de su horario escolar.

¿Está inscripto/a en una institución de educación superior? ☐ Sí ☐ No

¿Necesita guardería por otro motivo, por ejemplo, hospitalización o búsqueda de empleo? ☐ Sí ☐ No

Si respondió sí, explique: _____

Indique el nombre de la persona o agencia que cuidará a sus hijos:

Nombre del proveedor	Teléfono	
Domicilio		
Ciudad	Estado	Código postal

Por favor, responda las siguientes preguntas sobre usted y el otro progenitor o tutor si vive en su hogar.

¿Usted o el otro progenitor en el hogar están en servicio activo en las fuerzas armadas? ☐ Sí ☐ No

¿En una unidad de la guardia nacional o de la reserva? ☐ Sí ☐ No

Si respondió sí, ¿quién?_____

¿Su familia vive en alguno de los siguientes tipos de alojamientos?

¿Viven en: un motel, un automóvil o un campamento? ☐ Sí ☐ No
un albergue u otro tipo de vivienda temporal?
una casa o un departamento, con amigos o familiares (vivienda compartida)?

Los bienes son cosas como viviendas, automóviles, casas rodantes, acciones y bonos, o dinero en efectivo.
¿Tiene menos de un millón de dólares en bienes? ☐ Sí ☐ No

Tiene derecho a apelar — Parte E

Usted o la persona que le esté ayudando pueden solicitar una audiencia de apelación si no están de acuerdo con las acciones tomadas en su caso. En el caso de Food Assistance, puede apelar por escrito o por teléfono. Para todos los otros programas, debe apelar por escrito. Para apelar por escrito, haga **una** de las siguientes cosas:

- Complete la solicitud electrónicamente en https://dhssecure.dhs.state.ia.us/forms/, **o**
- Escriba una carta diciéndonos por qué cree que la decisión está errada, **o**
- Llene un formulario de Apelación y Solicitud de Audiencia. Puede conseguirlo en la oficina DHS del condado.

Envíe o lleve su apelación a Department of Human Services, Appeals Section, 5th Floor, 1305 E Walnut Street, Des Moines, IA 50319-0114. Si necesita ayuda para presentar la apelación, pregunte en la oficina de DHS de su condado.

Puede representarse usted mismo o pedirle a un amigo, pariente, abogado o alguien más que actúe en su nombre.

Puede comunicarse con la oficina de DHS del condado para informarse sobre servicios legales. Es posible que deba pagar dichos servicios. De ser así, el pago será proporcional a sus ingresos. También puede llamar a Iowa Legal Aid al (800) 532-1275. Si vive en el condado de Polk, llame al (515) 243-1193.

No será discriminado/a — Parte E

Es política de Iowa Department of Human Services (DHS) ofrecer trato igualitario con respecto a empleo y prestación de servicios a los solicitantes, empleados y clientes, sin importar su raza, color, país de origen, sexo, orientación sexual, identidad de género, religión, edad, incapacidad, ideología política o estatus de veterano.

Si cree que DHS le ha discriminado o acosado, le agradeceremos que envíe una carta explicando detalladamente su queja a: Iowa Department of Human Services, Hoover Building, 5th Floor – Policy Bureau, 1305 E Walnut, Des Moines, IA 50319-0114 o a través de correo electrónico a contactdhs@dhs.state.ia.us

Food Assistance

Esta institución tiene prohibido discriminar debido a raza, color, país de origen, discapacidad, edad, sexo y, en algunos casos, religión o ideología política.

El Departamento de Agricultura de los Estados Unidos (USDA) también prohíbe la discriminación debido a raza, color, país de origen, sexo, credo o religión, discapacidad, edad, ideología política, y como represalia o castigo por participación previa en movimientos de Derechos Humanos, en cualquiera de los programas o de las actividades realizadas o financiadas por USDA.

Las personas discapacitadas que requieran medios alternativos de comunicación (ej. Braille, letras grandes, grabaciones de audio, lenguaje de señas, etc.) deben comunicarse con la Agencia (estatal o local) donde presentaron la solicitud para beneficios. Las personas sordas o con problemas de audición o del habla pueden comunicarse con USDA a través del servicio federal de retransmisión: (800) 877-8339. Además, la información del programa también está disponible en otros idiomas aparte de inglés.

Para presentar una queja por discriminación, complete el Formulario *USDA Program Discrimination Complaint* (AD-3027), que se encuentra en la siguiente página de Internet: http://www.ascr.usda.gov/complaint_filing_cust.html, y en todas las oficinas de USDA, o escriba una carta dirigida a USDA e incluya toda la información solicitada en el formulario. Para solicitar el formulario de queja, llame al (866) 632-9992. Envíe el formulario completado o la carta a USDA por:

Correo: U.S. Department of Agriculture
Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue, SW
Washington, DC 20250-9410; or

Fax: (202) 690-7442; or

Email: program.intake@usda.gov

En el caso de información debido a problemas con el Programa SNAP (*Supplemental Nutrition Assistance Program*) (Food Assistance en Iowa), debe comunicarse con la línea directa de USDA SNAP al (800) 221-5689, que también está en español, o llamar a las líneas directas de información estatal por Internet en: http://www.fns.usda.gov/snap/contact_info/hotlines.htm

Para presentar una queja por discriminación de un programa que recibe asistencia económica del gobierno federal a través del Departamento de Salud y Servicios Humanos (HHS) de los Estados Unidos, escriba a: *HHS Director, Office for Civil Rights, Room 515-F, 200 Independence Avenue, SW, Washington, DC 20201*, o llame al (202) 619-0403 (teléfono de voz) o al (800) 537-7697 (teléfono de texto).

Esta institución brinda igualdad de oportunidades para todos.

Todos los programas Parte E

Verificamos lo que nos informa

La información que nos proporciona puede ser verificada por funcionarios federales, estatales y municipales para asegurarnos que es cierta. Las cosas que podemos verificar con respecto a las personas mencionadas son: número del seguro social, empleo y salario, monto de la cuenta bancaria, estado legal de inmigración, montos recibidos de otras fuentes como Social Security o el seguro de desempleo. Si la información que nos proporciona no es correcta, podremos denegar su solicitud.

Podemos verificar los registros de otros estados para ver si los miembros de su grupo familiar pueden recibir beneficios en Iowa. Esto se hace porque una persona podría haber sido inhabilitada de un programa en otro estado.

Verificamos y usamos sistemas informáticos como el State Income and Eligibility Verification System. Si algo que nos informó no coincide con la información del sistema, verificaremos para averiguar cuál es la correcta. Podríamos verificar su información comunicándonos con su empleador, su banco y otras personas. Para hacer este tipo de verificación con su empleador, su banco y otras personas, primero le preguntaremos a usted. Dicha información puede afectar la elegibilidad y el nivel de beneficios de su grupo familiar.

Cosas que debe saber

DHS puede entregarles sus respuestas a los funcionarios del orden público para que atrapen a aquellas personas que estén huyendo para eludir a la ley.

La unidad de Control de Calidad o la Unidad de Investigaciones pueden revisar su caso. Ellos pueden comunicarse con otras personas u organizaciones para obtener comprobantes de su información. Al firmar este formulario, usted nos autoriza a divulgar información confidencial a la unidad de Control de Calidad o a la unidad de Investigaciones. Debe cooperar con ellas para conservar sus beneficios.

En caso de no ser elegible para recibir beneficios, deberá reintegrar todos los beneficios que obtuvo o que hayan sido pagados a terceros en su nombre.

La sección 1128B de la Ley de Seguridad Social establece penas a nivel federal por actos fraudulentos y la presentación de información falsa relacionada con estos programas.

Toda persona que obtenga, intente obtener o ayude a otra a obtener asistencia a la cual no tiene derecho, es culpable de infracciones a las leyes del estado de Iowa. Esto incluye, entre otros, los capítulos 239B, 243, 249 y 249A del Código de Iowa.

Sus gastos pueden ser usados para calcular el monto de la asistencia que recibirá. Si informa y presenta comprobantes de sus gastos, puede pedir que los mismos se incluyan en el cálculo de sus beneficios. Si no informa ni presenta comprobantes de sus gastos, entonces se considerará que usted eligió no reclamar el gasto. Puede informar y presentar comprobantes más adelante y el gasto podrá computarse en meses futuros.

Se le entregará la Com. 233 durante la entrevista. En ella encontrará información sobre todos los otros derechos y obligaciones que no hayan sido mencionados en este formulario.

Food Assistance — Parte E

Normas del Programa Food Assistance

Cumpla estas normas:

- **NO** oculte ni proporcione información falsa a propósito para obtener Food Assistance.
- **NO** use los beneficios de Food Assistance para comprar artículos que no sean alimentos, como por ejemplo alcohol o tabaco.
- **NO** canjee, ni venda ni regale los beneficios de Food Assistance.
- **NO** utilice los beneficios de Food Assistance de otra persona para su uso personal.
- Con los beneficios de Food Assistance, **NO** compre productos con envases retornables por los que debe pagar un depósito, con la intención de obtener dinero en efectivo cuando devuelve el recipiente vacío a la tienda.
- **NO** compre alimentos en cuotas e intente pagarlos con Food Assistance.
- **NO** compre productos con beneficios de Food Assistance para revenderlos y obtener dinero en efectivo u otras cosas que no sean los alimentos aprobados.
- **NO** deje de informar si los ingresos de su grupo familiar superan el límite establecido.

  Si obtiene Food Assistance, su asistente le informará cuál es el límite de ingresos para su grupo familiar. Si los ingresos de su grupo familiar superan el límite establecido durante un mes, debe informarnos antes del 10mo día del mes siguiente. Si no nos informa a tiempo, podría tener que reintegrar los beneficios.

Sanciones del Programa Food Assistance

Toda persona que quebrante las normas mencionadas anteriormente:

- **No podrá recibir Food Assistance por 1 año la primera vez, 2 años la segunda vez, y en forma permanente la tercera vez;**
- **Podrá ser sancionada con una multa de hasta $250,000 o con prisión de hasta 20 años, o ambas; y**
- **Podrá ser excluida de Food Assistance por 18 meses adicionales, por orden judicial.**

Si un tribunal le encuentra culpable de comprar, vender o comerciar con más de $500 de Food Assistance, perderá sus beneficios para siempre.

Si un tribunal le encuentra culpable de canjear los beneficios de Food Assistance por armas, municiones o explosivos, perderá los beneficios para siempre.

Si un tribunal le encuentra culpable de canjear los beneficios de Food Assistance por sustancias controladas, perderá dichos beneficios por dos años la primera vez y para siempre la segunda vez.

No recibirá Food Assistance por 10 años si se le encuentra culpable de obtener o intentar obtener Food Assistance en más de un grupo familiar a la vez. Esta sanción se aplica si proporciona información incorrecta acerca de quién es o dónde vive.

Dar información falsa a propósito puede ocasionar que iniciemos acciones legales en su contra, ya sea acciones penales o civiles. También puede ocasionar que sus beneficios sean reducidos o que deba reintegrar el dinero que recibió.

Cosas que debe saber

Los grupos familiares elegibles para Food Assistance pueden recibir una notificación informándoles que son elegibles para el programa "Promoting Awareness of the Benefits of a Healthy Marriage" (Promoción para concientizar sobre los beneficios de un matrimonio sano) y un panfleto describiendo dichos beneficios. Al entregar esta información, DHS puede utilizar normas diferentes que podrían ayudarle a obtener Food Assistance.

Si recibe un sobrepago de Food Assistance, DHS le entregará sus respuestas a las agencias federales y estatales, así como también a agencias privadas que se encargan de cobrar reclamos, para que recuperen el sobrepago.

La oficina de Food Assistance puede comunicarse con otras personas u organizaciones para obtener comprobantes de su información.

Al firmar esta solicitud, usted acepta que todos los integrantes de su grupo familiar se registrarán para trabajar y cumplirán con todas las normativas laborales y de capacitación.

La fecha de presentación de la solicitud es diferente si su grupo familiar se encuentra en una institución y presentan la solicitud para Food Assistance y SSI (ingresos suplementarios) al mismo tiempo. En este caso, la fecha de presentación es la fecha de alta de la institución.

No se le denegarán beneficios de Food Assistance sólo porque se le denegaron beneficios de otros programas. Las solicitudes de Food Assistance no sufrirán retrasos debido a los requisitos de otros programas que haya solicitado.

La recolección de información en la solicitud, incluso los números de Social Security de todos los integrantes del grupo familiar, está autorizada por la Ley *Food and Nutrition Act* del año 2008 (llamada anteriormente *Food Stamp Act* del año 1977), con sus enmiendas, U.S.C. 7: 2011-2036. Los datos se utilizarán para determinar si su grupo familiar es elegible o continúa siendo elegible para participar en el programa Food Assistance. Verificaremos los datos mediante programas digitales que buscan datos coincidentes. También usaremos esta información para monitorear el cumplimiento con los reglamentos del programa y para la gestión del programa.

Family Investment Program (FIP) o Refugee Cash Assistance — Parte E

Cosas que debe saber

En un plazo de 10 días a partir de la fecha en que ocurra un cambio, deberá informarle a DHS acerca de cambios como:

- Ingresos, cuando comienzan y terminan, incluso si recibe una herencia o un pago por única vez por manutención de menores vencida y adeudada
- Recursos y activos
- Personas que se mudan de su hogar o van a vivir al mismo

- Cambio de domicilio residencial o dirección postal
- Recepción de un número de Social Security (SSN)
- Cambio de escuela de un menor

Si su solicitud de FIP o Refugee Cash Assistance es aprobada, su Food Assistance podría ser reducida o cancelada.

Si se le aprueba para FIP, se le inscribirá en el programa PROMISE JOBS. Usted acepta que todos los integrantes de su grupo familiar que deban cooperar con PROMISE JOBS cumplirán con esto. Hable con su asistente si cree que existen motivos para no cooperar.

Si decide no participar en PROMISE JOBS, sus beneficios FIP serán limitados.

Mientras reciba FIP, deberá renunciar a sus derechos sobre la manutención de menores durante los meses que reciba FIP. El estado de Iowa retendrá la manutención de menores para reintegrar el dinero que usted recibe de FIP.

Uso de su tarjeta de acceso electrónica (EAC) para acceder a fondos del FIP/RCA de su cuenta bancaria personal

Usted no puede acceder a sus beneficios de efectivo con su EAC ni con su tarjeta de débito personal en:

- Una licorería o cualquier otro lugar que venda principalmente bebidas alcohólicas
- Un casino u otro establecimiento de juegos y apuestas
- Un negocio que brinde servicios de entretenimiento para adultos, en el cual los artistas se desvistan o realicen un espectáculo sin ropa (como por ejemplo un local de strip tease).

Esto incluye estos tipos de negocios ubicados en Iowa, en territorios indígenas o en cualquier otro estado.

Si el DHS determina que usted ha accedido a sus beneficios de efectivo con su EAC o con su tarjeta de débito personal en uno de los lugares mencionados arriba, usted:

- Habrá cometido fraude,
- Tiene que devolver la cantidad de dinero retirada, además de cualquier cobro inherente al retiro, y
- Su familia no obtendrá beneficios de dinero en efectivo durante 3 meses luego del primer uso incorrecto de la tarjeta, y 6 meses luego de cada uso incorrecto adicional.

Al firmar esta solicitud, usted conviene en que ningún miembro de su grupo familiar usará la EAC o su tarjeta de débito personal para acceder a los fondos de FIP/RCA en lugares prohibidos.

Multa por obtener FIP en más de un estado

No recibirá FIP por 10 años si se le encuentra culpable de obtener o intentar obtener FIP en más de un estado a la vez. Esta sanción se aplica si proporciona información falsa acerca de dónde vive.

Child Care Assistance (CCA) Parte E

Cosas que debe saber

En un plazo de 10 días a partir de la fecha en que ocurra un cambio, deberá informarle a DHS acerca de cambios como:

- Ingresos, incluso cambios en la tarifa por hora y cuando los ingresos empiezan o terminan
- Horas de trabajo
- Cambio de domicilio residencial o dirección postal
- Horario de clases
- Personas que se mudan de su hogar o van a vivir al mismo
- Cambio de proveedor de cuidado infantil

Financial Support Application, Form 470-0462 or 470-0462(S)

Purpose

The *Financial Support Application* is designed to help people present the information needed for IM workers to determine eligibility for:

- Child Care Assistance
- Family Investment Program (FIP)
- Food Assistance
- Refugee Cash Assistance (RCA)

Source

Central Office has a contract to provide automatic shipments of form 470-0462 and 470-0462(S) to local offices. The shipments are intended to cover a six-month supply. Additional supplies of form 470-0462 and 470-0462(S) are also available through Central Office.

Completion

Give or mail one copy of the *Financial Support Application* to the applicant when assistance is requested. Mail or give the following pamphlets with the application form:

- Comm. 51, "Information Practices"
- Voter Registration form

A new application is not required when a new person is added to the FIP, Food Assistance, or RCA household.

The applicant shall complete the form. A friend, relative, or local office staff may help, if needed.

Only one signature is required. If there is a guardian or conservator, this person shall participate in completing the form and shall sign for the applicant, if necessary.

Unless verification is required, accept the applicant's statements on the application, provided they are pertinent and consistent when related to other known facts and seem accurate. Help the applicant obtain verification when:

- Statements of the applicant are incomplete, unclear, or inconsistent, or
- Circumstances indicate that further inquiry should be made and the applicant cannot clarify the situation.

Staff who assist the applicant in completing the form (at the applicant's request) shall sign on the line reserved for the person who helped complete the form.

An optional release of information is included on page 3. The applicant may use this release to authorize the Department to contact other people or organizations for information needed to determine eligibility and benefits.

The applicant is not required to sign this release. See Addendum to Application and Review Forms for Release of Information, Form 470-4670 or 470-4670(S), for instructions on using the release.

Distribution

Give one copy of the form to the applicant for completion.

File one copy of the completed application in the case record. Give the applicant a copy at the applicant's request.

Enter information from the form in the eligibility system as appropriate. In addition, enter information regarding the absent parent on the ICAR system.

Data

Before FIP, RCA, Food Assistance, or Child Care Assistance can be approved, the applicant shall complete the pink section of the application and the colored sections that correspond with the programs the applicant is applying for and provide them to the local office.

When a nonparental relative applies for FIP assistance for a child living in the home, but not for needy relative assistance, the information on page 7 of the form shall relate to the relative. The remaining items shall reflect the circumstances of the child and the child's parents. The relative shall sign the form.

If additional information or documentation is obtained, note the particulars in the narrative in the case file. If information not supplied by the applicant on this form is used, record the information, the sources of the information, and the name of the worker making the decision.

Iowa Department of Human Services

Instructions for the Health Services Application

Complete this form if you live in Iowa and want to get Medical Assistance (Title 19 or Medicaid) which provides health care coverage. Other programs within the Medical Assistance Program are:

- Facility Care – helps pay your nursing home cost
- Medicaid for children in foster care or subsidized adoption
- Waiver – helps keep people at home and not in a nursing home
- Medicare Savings Program – pays all or part of your Medicare premium
- State Supplementary Assistance (State Supp) – help for people who are at least 65 or disabled
- Iowa Family Planning Network – provides limited Medicaid coverage for family planning services

If you want to get Food Assistance or cash assistance through the Family Investment Program (FIP), please complete the *Financial Support Application*, form 470-0462, or in Spanish 470-0462(S).

Please do not let fear of the U.S. Citizenship and Immigration Services (USCIS) keep you from getting help for your family. Getting help will not keep you from gaining lawful, permanent residence, U.S. citizenship, or from sponsoring relatives.

To apply for help, follow these four easy steps:

1. **Complete the Application**
   Fill out and sign the application. Use blue or black ink. Please be truthful. If you are helping someone else, answer the questions for that person.

2. **File the Application**
   To find out where to mail the application, call 877-347-5678. The date your help starts is based on the date the DHS office gets your application.

3. **Provide Any Needed Proof**
   See the table below for what is needed. Including copies of the proof will help speed up the processing of your application.

4. **An Interview May Be Needed**
   An interview may not be needed if you are applying only for a child. Adults applying for help may be asked to have an interview.

Proof You Need to Send In addition to your application, please provide any proof needed for the program(s) you are applying for.	**Medical Assistance**	**Facility or Waiver**	**Medicare Savings Program**	**Foster Care-Sub Adoption**	**State Supp Assistance**	**Iowa Family Planning Network**
Proof of who you are (ID): driver's license, birth certificate, etc.	✓	✓	✓	✓	✓	✓
Proof you are a U.S. citizen or national (birth certificate with ID, U.S. passport, etc.)	✓	✓	✓	✓	✓	✓
Proof you have applied for a Social Security Number (if you don't already have one)	✓	✓	✓	✓	✓	✓
Proof of any health insurance premium paid: bill, pay stub showing deduction, etc.		✓		✓	✓	
Proof of income* or any other money coming into your household	✓	✓	✓	✓	✓	✓
Proof of child care, dependent adult care costs, child support or alimony paid	✓		✓	✓	✓	✓
Most recent statements for any bank accounts: checking, credit union, savings, etc.**	✓	✓	✓	✓	✓	
Proof of current value of stocks/bonds, life insurance, certificates of deposit, trusts**	✓	✓	✓	✓	✓	
Proof of current living address						

* Pay stubs from the last 30 days if you are employed or federal income tax records if you are self-employed. Award letters for Social Security Benefits, Veterans Benefits, etc.

** May not be needed if just applying for a child.

RIGHTS AND RESPONSIBILITIES – READ AND KEEP THIS SHEET

INFORMATION FOR ADULTS AND CHILDREN APPLYING FOR MEDICAL ASSISTANCE

- I understand I assume full responsibility for the accuracy of the statements on this form. I understand the Department of Human Services (DHS) will use this statement to determine my eligibility for Medical Assistance.
- I understand my eligibility will not be affected by my race, creed, color, national origin, age, disability, or sex, except where this is restricted by law.
- I understand that I have the right to a hearing if this application is denied or not acted upon promptly or if services granted are terminated, reduced, or suspended. I understand that I can get a hearing by making a request in writing to my local DHS office and that I may represent myself or use a lawyer, relative, friend, or other spokesperson.
- I am aware that my case may be picked by the Department for a complete Quality Control or other review of my eligibility for assistance. If my case is selected for verification, I will cooperate fully in the verification. I hereby authorize all persons to release confidential information concerning my eligibility to a DHS reviewer. I understand that failure to cooperate with such a review can result in denial or cancellation of benefits.
- I will notify DHS within ten days of any changes in medical benefits or health insurance coverage. In addition, I understand that I am to notify my medical providers (doctors, pharmacist, etc.) if another party may be liable to pay my medical expenses. I will notify DHS within ten days if I file an insurance claim or retain an attorney to seek payment for injuries and medical expenses resulting from those injuries that otherwise would be paid by Medicaid. Failure to comply with my responsibilities can give the Department cause to deny or terminate Medicaid eligibility.
- I agree to assign medical payments from a third party to the Medicaid agency for myself and others who are eligible for Medicaid, for whom, I legally can assign benefits. I also agree to cooperate in obtaining medical payments from third parties.
- I understand that I am to reimburse the Department for any money paid to me or paid to a provider on my behalf to which I was not entitled.
- I further understand that the Department will provide documents or claim forms describing the services paid by Medicaid upon my request or the request of an attorney acting on my behalf. Such documents may also be provided to a third party when necessary to establish the extent of the Department's claim for reimbursement.
- I understand that federal and state law and rules permit access by authorized federal and state officials to Medicaid providers' records. I also fully understand that my acceptance of Medicaid is my consent for these authorized persons to have access to my medical and health care records during the time I am eligible for Medicaid, as necessary to verify appropriate Medicaid payment.
- I give my permission to tell my medical providers the status for my Medically Needy case, including the amount of my spend-down and their bills used to meet spenddown, or when a premium is due for Medicaid for Employed People with Disabilities.
- If I become enrolled in a managed health care plan, I consent to disclosure of medical information, including any clinical mental health or substance abuse information, by my medical providers to the HMO, PHP, other managed care providers or to the authorized administrative body contracted by the managed care provider to determine appropriateness, quality, or utilization of services I received while enrolled in managed health care.
- I understand that if Medical Assistance is approved, support payments intended for medical costs must be assigned and paid to DHS to the extent of the benefits I receive. I understand that the Department may intervene, according but not limited to, Iowa Code Chapters 252A, 252B, 252C, 252D, 598, and 600B, to make claim and secure support from any person or party who may be responsible for my support or that of my children. I understand that if I receive Medicaid, the Department will pursue non-medical support for myself and my children upon my request. Medical support services include the establishment of paternity and the establishment and enforcement of medical support.
- I am aware that Section 1128B of the Social Security Act provides federal penalties for fraudulent acts and false reporting. Anyone who obtains, or tries to obtain, or helps any other person to obtain public assistance to which the person is not entitled is guilty of violating the laws of the state of Iowa. These laws include, but are not limited to, Iowa Code Chapters 243, 239B, 249A, and 249A.
- I understand and agree that I will need to provide the Department with either documentation from the U.S. Citizenship and Immigration Services (USCIS) or other documents the Department considers to be proof of the immigration status of each person in my household who is not a United States citizen or national. I understand that alien status may be subject to verification with USCIS, which will require submission of certain information from this application form to USCIS. I further understand that information received from USCIS may affect my household's eligibility and level of benefits.
- If I filled out a separate application for food assistance and that application was referred to the Food Stamp Investigation Unit, I will cooperate with the investigation in order to receive Medicaid when the investigation involves income, resources, and household composition that affect my Medicaid eligibility.

MORE INFORMATION FOR ADULTS APPLYING FOR MEDICAL ASSISTANCE

- I will notify the LOCAL DHS office of any change in my information on this application, including but not limited to, anticipated income or property such as an inheritance, lump-sum payments on delinquent child support, or any change in income or living arrangements of myself or any other member of my family. If I have any doubt whether a particular change in circumstances is information that must be reported, I shall report this to my LOCAL office no later than ten days from the date the change occurs. I also understand that I am to pay back to the Department any money received by me or paid to a vendor on my behalf to which I was not entitled.
- I understand payments under the Medical Insurance Program (Part B of Medicare) will be made directly to the physicians and medical suppliers on any future unpaid bills for medical and other health services furnished me while eligible for Medicaid.
- If you made the state of Iowa a remainder beneficiary on an annuity, in order to qualify for Medicaid payment of long-term care, the state of Iowa will get any benefits remaining in the annuity, up to the amount of Medicaid benefits paid.

INFORMATION ABOUT WIC OR MATERNAL AND CHILD HEALTH SERVICES

- I understand that a declaration of income and persons in my family and living in my household is necessary to ensure that federal and state funds are directed to those persons least able to secure services from other sources.
- I understand that the Maternal and Child Health Director of the Iowa Department of Public Health, the WIC Director, or their designees shall have access to all information available from records maintained by the agency providing maternal health, child health, or WIC services.

ESTATE RECOVERY

- Federal law requires Iowa to have an estate recovery program. If you get Medicaid, you may be subject to estate recovery. This means any Medicaid funds used to pay for your healthcare, including the monthly fee paid to a Managed Care Organization (MCO), will need to be paid back from your estate after your death. Estate recovery applies if you get Medicaid and are age 55 or older or are under age 55 and live in a medical facility and cannot reasonably be expected to return home.
- For more information, call the Iowa Medicaid Estate Recovery Program at 1-877-463-7887 or go online to http://dhs.iowa.gov/sites/default/files/Comm123.pdf (English) or http://dhs.iowa.gov/sites/default/files/Comm123S.pdf (Spanish).

Iowa Department of Human Services

Health Services Application

HOUSEHOLD INFORMATION – Complete for all programs				
First Name	Middle Name	Last Name		
Home Address	City	State	County	Zip Code
Mailing Address (if different from above) OR Payee or Representative's Name & Address				
Home Phone Number ( )	Message Number ( )	Name of Message Contact Person		

Check the program(s) you would like to receive: ❑ **Medical Assistance (Title 19 or Medicaid)** ❑ **Breast and Cervical Cancer Treatment**
❑ **Facility** ❑ **Medicare Savings Program** ❑ **Waiver** ❑ **Iowa Family Planning Network (IFPN)**
❑ **Foster Care/Subsidized Adoption** ❑ **State Supplementary Assistance**

IF YOU NEED MORE ROOM TO ANSWER ANY OF THE FOLLOWING QUESTIONS, ATTACH EXTRA PAGES.

Starting with yourself, list all the people who live in your home and mark the box **yes** or **no** if you are applying for that person**.** If you choose no, you only need to list their name, relationship to you, and their date of birth.

NAME (First, Middle, Last)	Are you applying for this person?	How is this person related?	Disabled	Gender	Birth Date	Social Security Number	Medicaid State ID Number (if known)	Birth State	U.S. Citizen?	If Alien, Status	Ethnicity*	Race**	If a child, is a parent NOT living with them?	Currently on Medicaid?	Other health insurance available?
	❑ Yes ❑ No	SELF	❑ Yes ❑ No	❑ Male ❑ Female					❑ Yes ❑ No				❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
	❑ Yes ❑ No		❑ Yes ❑ No	❑ Male ❑ Female					❑ Yes ❑ No				❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
	❑ Yes ❑ No		❑ Yes ❑ No	❑ Male ❑ Female					❑ Yes ❑ No				❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
	❑ Yes ❑ No		❑ Yes ❑ No	❑ Male ❑ Female					❑ Yes ❑ No				❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
	❑ Yes ❑ No		❑Yes ❑ No	❑ Male ❑ Female					❑ Yes ❑ No				❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No

We have to ask your ethnicity and race, but you don't have to answer. Your answer won't affect how much you get or how soon. If you answer, use the following coding:
* Ethnicity: H = Hispanic or Latino; N = Not Hispanic or Latino
** Race (Choose all that apply): W = White; B = Black or African American; A = Asian; I = American Indian or Alaskan Native; N = Native Hawaiian or other Pacific Islander.

Did anyone receive medical care in the past three months? ❑ Yes ❑ No Who? _____ What months? _____

List anyone who is in the military, a veteran, or a spouse of a veteran: _____

Is anyone fleeing to avoid prosecution, custody, or jail for a felony crime? ❑ Yes ❑ No Is anyone violating a condition of probation or parole? ❑ Yes ❑ No
Is anyone in or expecting to go to jail or prison? ❑ Yes ❑ No

List pregnant persons who live in your home _____ Due Date (MMDDYY) _____

List the name of your health insurance provider _____

INCOME: List all income the people living in your home get. Include income from work, self-employment, Social Security, Veteran's Benefits, unemployment insurance, child support, worker's compensation, railroad retirement, IPERS, pensions, civil service, cash from friends or relatives, and any other income you get.

Person who received money	**Employer or income source**	**Amount before taxes or deductions**	**How often is this amount paid?**	**Is this income expected to continue? If 'NO,' explain:**
			❑ Weekly ❑ Every other week ❑ Monthly ❑ Twice a month ❑ Other _____	❑ Yes ❑ No
			❑ Weekly ❑ Every other week ❑ Monthly ❑ Twice a month ❑ Other _____	❑ Yes ❑ No
			❑ Weekly ❑ Every other week ❑ Monthly ❑ Twice a month ❑ Other _____	❑ Yes ❑ No
			❑ Weekly ❑ Every other week ❑ Monthly ❑ Twice a month ❑ Other _____	❑ Yes ❑ No

RESOURCES: A resource is cash or anything that can be changed to cash. List all resources and the amount or value. Include cash on hand, checking accounts, vehicles, life insurance, stocks, bonds, certificates of deposits (CDs), trust funds, retirement accounts, burial contracts, burial spaces, annuities, etc. If only applying for medical coverage for a child, resources may not be counted.

Person with Resource	Type of Resource	Amount or Value	Location (bank's name and address, home, etc.)

Did anyone in your home sell or give away anything of value for less than its value within the last five years? ❑ Yes ❑ No

Does anyone in your home pay child support or alimony for a person who does not live with you? ❑ Yes ❑ No
If yes, who pays? _____ Amount? _____

Does anyone in your home pay for someone to care for a child or disabled adult? ❑ Yes ❑ No
If yes, how much is paid? _____ How often? _____ To whom? _____

Is the Child Support Recovery Unit already helping you get or enforce a child support or a medical support? ❑ Yes ❑ No

If no, the Child Support Recovery Unit can help you get child support or health insurance from an absent parent. They can also help locate absent parents and their employer, establish paternity, or establish paternity or modify support orders. **Do you want help from Child Support Recovery with any of these items?** ❑ Yes ❑ No

Are you willing to cooperate with us to get medical insurance or medical support from any parent not in the home? (You are not required to cooperate if you only want Medicaid for a child.) ❑ Yes ❑ No

Name & address of parent not in the home:	Date of birth of this parent:	Social Security number of this parent:	Name of the parent's children:	County where court order is filed, if any:	Is the parent court ordered to pay cash medical support?

SOCIAL SECURITY NUMBER (SSN)

You must fill in the SSN of all persons listed on this application to get Medical Assistance. Section 1137(a) (1) of the Social Security Act and 42 CFR 435.910 requires this. If you do not want Medicaid, you do not have to give us your SSN. The SSN will be used:

- To check income, eligibility and amount of Medical Assistance payments to be made on your behalf.
- To determine another person's right to Medical Assistance.
- To comply with Federal law which requires release of information from Medicaid records.
- To match with records in other agencies such as: Social Security Administration, Internal Revenue Services, and Iowa Workforce Development. These matches may be done by computer or on an individual basis.

My rights and responsibilities were provided to me on the back of the instructions for this Health Services Application. I have read and removed the Rights and Responsibilities sheet from this Health Services Application for my future use.

I understand that if the children on this application are not eligible for Medicaid, this application may be referred to the ***hawk-i*** program to see if the children could get ***hawk-i*** health care coverage.

I CERTIFY, UNDER PENALTY OF PERJURY, THAT THESE STATEMENTS ARE CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF.

Signature or mark of applicant	Date	Signature or mark of other parent or stepparent in the home	Date	Signature of person, if any, who helped complete this form	Date

Addendum to Application and Review Forms for Release of Information

OPTIONAL Release of Information

Help Us Help You!

You do not have to sign this, but it will help us get information we need to help you, without having to get your signature on specific requests.

You should know that:

- We may need more information to decide if you can get assistance.
- If more information is needed from you, you will get a letter telling you what we need and the date you must get it to us.
- You are responsible to get the information or to ask us for help to get it.
- If you do not give us the information or ask for help by the due date, your application may be denied or your assistance may stop.
- We may be able to use the release below to get the information we need. **But you still have to provide information we request or ask us for help.**
- We may attach a copy of this release to a form that asks other people or organizations (like your employer) for specific information needed about you or others in your household.

Print and sign your name below to give us permission to get needed information.

RELEASE OF INFORMATION

I hereby authorize any person or organization to give the Iowa Department of Human Services requested information about me or other members of my household.

A copy of this release is as valid as the original.

This release does not apply to protected health information.

This release is good for 12 months from the date signed.

_____	_____
Your Name (please print clearly)	Other Adult Name (please print clearly)
_____	_____
Signature or Mark	Signature or Mark
_____	
Date	

Iowa Department of Human Services

Instructions for the Health Services Application
(Instrucciones para Solicitud de Servicios Médicos)

Complete este formulario si vive en Iowa y quiere obtener Medical Assistance (Asistencia Médica) (Título 19 o Medicaid) que provee cobertura de atención médica. Otros programas dentro del programa de Medical Assistance son:

- Facility Care – le ayuda a pagar los costos de casa para ancianos
- Medicaid para niños bajo el cuidado de un hogar adoptivo o en adopción subvencionada
- Waiver – ayuda a permanecer en sus hogares y no en casas para ancianos
- Medicare Savings Program – paga todo o parte de su prima de Medicare
- State Supplementary Assistance (State Supp) (Asistencia Estatal Complementaria) – ayuda para personas con 65 años o más o personas discapacitadas
- Iowa Family Planning Network (Red de Planificación Familiar de Iowa) – provee cobertura limitada de Medicaid para servicios de planificación familiar

Si desea obtener asistencia para alimentos (Food Assistance) o dinero en efectivo a través del programa Family Investment Program (FIP), complete la solicitud *Financial Support Application*, formulario 470-0462 (en inglés) o 470-0462(S) (en español).

Por favor no deje que el temor del U.S. Citizenship and Immigration Services (USCIS) no le permita obtener ayuda para su familia. Obtener ayuda no le quitara el poder obtener residencia permanente legalmente, ciudadanía de los E.U.A., o de poder patrocinar a sus parientes.

Para aplicar por ayuda, seguir los cuatro pasos fáciles:

1. **Completar la Solicitud**
   Complete el formulario y fírmelo. Use tinta azul o negra. Por favor, sea honesto. Si está ayudando a otra persona, responda las preguntas para dicha persona.
2. **Llene la Solicitud**
   Llame al teléfono 877-347-5678 para averiguar dónde debe enviar la solicitud. La fecha de inicio de la asistencia dependerá de la fecha en que la oficina de DHS reciba el formulario de solicitud.
3. **Proporcione Cualquier Prueba Necesaria**
   Ver la tabla a continuación para lo que se necesite. Incluyendo copias de las pruebas que ayudara a apresurar el proceso de su solicitud.
4. **Se puede Necesitar Una Entrevista**
   Una entrevista puede no ser necesario si usted está solicitando para un niño. Los adultos que soliciten ayuda se le puede pedir a tener una entrevista.

Comprobantes que debe enviar

Ademas de su solicitud, por favor proporcione cualquier prueba necesaria para el programa(s) que se estén solicitando.

	Medical Assistance	Facility or Waiver	Medicare Savings Program	Foster Care-Sub Adoption	State Supp Assistance	Iowa Family Planning Network
Prueba de quién es (I.D.) licencia de manejar, acta de nacimiento, etc.	✓	✓	✓	✓	✓	✓
Preuba de que es ciudadano(a) o nacional de los EE.UU. (certificado de nacimiento, pasaporte de los EE.UU., etc.)	✓	✓	✓	✓	✓	✓
Prueba de solicitud para Número de Social Security (si aún no tiene uno)	✓	✓	✓	✓	✓	✓
Prueba de cualquier prima pagada de seguro médico: cuenta, talón de cheque demostrando la deducción, etc.		✓		✓	✓	
Prueba de ingreso* o cualquier dinero que entre en su hogar	✓	✓	✓	✓	✓	✓
Prueba costos de cuidado para niños, adultos, manutención de niños/conyugue	✓		✓	✓	✓	✓
Reportes mensuales bancarios mas recientes; cheques, unión de crédito, ahorros, etc.**	✓	✓	✓	✓	✓	
Prueba del valor actual de valores/bonos, seguros de vida, certificados de deposito, fideicomisos**	✓	✓	✓	✓	✓	
Prueba de la presente dirección de domicilio						

* Talón de cheque de los últimos 30 días si esta trabajando o récords de impuesto de ingreso federal si se tiene negocio propio. Cartas de Beneficios de Social Security, Beneficios de Veteranos, etc.

** Pueda que no sea necesario si solo esta solicitando por un niño.

DERECHOS Y RESPONSABILIDADES - LEA Y CONSERVE ESTA HOJA

INFORMACIÓN PARA ADULTOS Y NIÑOS SOLICITANDO PARA MEDICAL ASSISTANCE

- Yo tengo entendido que yo asumo total responsabilidad por la certeza de las declaraciones en esta forma. Yo entiendo que el Department of Human Services (DHS) usara esta declaración para determinar mi elegibilidad para Medical Assistance.
- Entiendo que mi elegibilidad no se verá afectada por mi raza, credo, color, origen nacional, edad, discapacidad o sexo, excepto cuando esto sea restringido por la ley.
- Yo tengo entendido que yo tengo el derecho de una audiencia si esta solicitud es negada o no es manejada rápidamente o si los servicios otorgados son cancelados, reducidos o suspendidos. Entiendo que puedo obtener una audiencia solicitándola por escrito a la oficina local del DHS y que puedo representarme a mí mismo, pedir la ayuda de un abogado, pariente, amigo u otro portavoz.
- Yo se que mi caso puede ser escogido por el Departamento para una completa revisión de Quality Control o cualquier otra de la elegibilidad para asistencia. Si mi caso es seleccionado para verificación, yo cooperare en total para la verificación. Yo en esta forma doy mi autorización a todas las personas para divulgar información confidencial relacionada con mi elegibilidad a una persona que revise para DHS. Yo entiendo que fallar en cooperar con dicha persona puede resultar en la negación o cancelación de los beneficios.
- Le notificaré a DHS en el plazo de 10 días sobre cualquier tipo de cambio con respecto a beneficios médicos o cobertura del seguro médico. Además, entiendo que debo notificarles a mis proveedores de servicios médicos (médicos, farmacéutico, etc.) si un tercero es responsable de pagar mis gastos médicos. Le notificaré a DHS en el plazo de 10 días si presento un reclamo al seguro o contrato un abogado con el fin de presentar una demanda por lesiones o por los gastos médicos resultantes de dichas lesiones que, de lo contrario, serían pagados por Medicaid. La falta de cumplimiento con mis obligaciones será causal suficiente para que el Departamento deniegue o rescinda mi elegibilidad para Medicaid.
- Acepto entregar a la agencia Medicaid los pagos de gastos médicos realizados por terceros para mí y otras personas elegibles para Medicaid, para las cuales yo estoy legalmente autorizada a asignar beneficios. Además, acepto cooperar para obtener pagos de gastos médicos provenientes de terceros.
- Yo entiendo que yo debo reembolsar al Department por cualquier dinero pagado a mi o pagado a un proveedor a mi favor al cual yo no tenga derecho.
- Es mas yo entiendo que el Department puede proporcionar documentos o formas de demanda describiendo los servicios pagados por Medicaid cuando yo lo pida o a la petición de un abogado actuando a mi favor. Dichos documentos puedan también ser proporcionados a una tercera parte cuando sea necesario para establecer el punto en que la demanda del Department sea reembolsada.
- Yo entiendo que las leyes Federales y Estatales y las reglas permiten el acceso a oficiales Federales y Estatales autorizados para récords de Medicaid. Yo también entiendo en su totalidad que mi aceptación de Medicaid es mi consentimiento para que estas personas autorizadas tengan acceso a mis récords de atención medica durante el tiempo que yo sea elegible para Medicaid, como sea necesario para verificar los pagos apropiados de Medicaid.
- Concedo autorización para revelar a quienes me proporcionan asistencia médica el estado de mi caso de Medically Needy (Médicamente Necesitado), incluyendo el monto de mi spend-down (la parte no cubierta por Medicaid), o en los casos que deba una prima a Medicaid for Employed People with Disabilities (Medicaid por Personas Discapacitadas Empleadas).
- Si yo quedo registrado en un plan de cuidado medico manejado, yo doy consentimiento de la divulgación de información medica, incluyendo cualquier salud mental clínica o información de abuso de substancia, por mis proveedores médicos al HMO, PHP, otros proveedores de cuidado medico manejado o al cuerpo administrativo autorizado contractado por el proveedor de cuidado medico manejado para determinar aproporcion, calidad, o utilización de servicios que yo he recibido cuando estuve registrado en el cuidado medico manejado.
- Entiendo que, si se aprueba mi pedido de Ayuda Médica, los pagos de dicha ayuda para cubrir los costos médicos deben asignarse y pagarse al DHS en la medida de los beneficios que reciba. Entiendo que el Departamento puede intervenir, de acuerdo a, pero sin limitarse a, los Capítulos 252A, 252B, 252C, 252D, 598 y 600B del Código de Iowa, para presentar un reclamo y garantizar la ayuda de parte de toda persona o parte que pueda ser responsable de mi manutención o la de mis hijos. Entiendo que, si recibo Medicaid, el Departamento buscará obtener asistencia no médica para mi persona y para mis hijos, en caso de que lo pida. Los servicios de ayuda médica incluyen la determinación de la paternidad y la determinación y exigencia de la ayuda médica.
- Yo se que la Sección 1128B del Social Security Act dice que los castigos Federales por actos fraudulentos y por reportes falsos. Cualquiera que obtenga, o trate de obtener, o ayuda a otra persona a obtener asistencia publica a la cual la persona no tiene derecho es culpable de violación de las leyes del Estado de Iowa. Estas leyes incluyen, pero no están limitadas a, Código de Iowa Capitulo 243, 293B, 249 A, y 249A.
- Entiendo y acepto que necesito entregar al Departamento documentación del U.S. Citizenship and Immigration Services (USCIS) u otros documentos que el Departamento considere válidos como prueba del estatus migratorio de cada persona que vive en mi hogar, que no sea ciudadano estadounidense. Yo entiendo que la situación de extranjero puede ser sujeta a verificación con USCIS, lo cual puede requerir la entrega de cierta información de esta solicitud a USCIS. Yo además entiendo que la información recibida de USCIS puede afectar la elegibilidad de mi hogar y el nivel de beneficios.
- Si diligencio una solicitud separada para asistencia alimenticia, y dicha aplicación es remitida a la Food Stamp Investigation Unit (Unidad de Investigación de Estampillas de Alimentos), cooperaré con la investigación para recibir Medicaid cuando la investigación se refiera a ingresos recursos y composición del hogar que pueda afectar mi elegibilidad para Medicaid.

MAS INFORMACIÓN PARA ADULTOS SOLICITANDO PARA ASISTENCIA MEDICA

- Notificaré a la oficina del DHS LOCAL acerca de cualquier cambio en la información de esta aplicación, incluyendo, pero sin limitarse a ingresos anticipados o propiedad tales como una herencia, pagos integrales para el apoyo a niños delincuentes, o cualquier cambio en el ingreso o en mi vivienda o en la de cualquier otro miembro de mi familia. Si tengo alguna duda sobre si un cambio particular en las circunstancias, es información que debe ser informada, reportaré eso a mi oficina LOCAL dentro de los diez días siguientes a la fecha en que el cambio se presente. Yo también entiendo que yo debo reembolsar al Department cualquier dinero recibido por mi o pagado a un vendedor a mi nombre al cual yo no tenga derecho.
- Yo entiendo que los pagos bajo el Medical Insurance Program (Part B de Medicare) se haran directamente a los médicos y a los proveedores médicos de cualquier factura no pagada por servicios de atención medica que se me haya proporcionado cuando tenia elegibilidad de Medicaid.
- Si usted dejó al estado de Iowa como beneficiario remanente de una Anualidad, para calificar para el pago de atención médica a largo plazo de Medicaid, el estado de Iowa recibirá cualquier beneficio remanente de la anualidad, hasta el monto pagado de los beneficios de Medicaid.

INFORMACIÓN ACERCA DEL WIC O SERVICIOS MÉDICOS PARA MUJERES EMBARAZADAS

- Yo entiendo que una declaración de ingreso y personas en mi familia y viviendo en mi hogar es necesario para asegurar que fondos Federales y Estatales sean dirigídos a esas personas que tengan menos habilidad para asegurar servicios de otros recursos.
- Yo entiendo que el Maternal and Child Health Director of the Iowa Department of Public Health, el Director de WIC, o sus asignados deberán tener acceso a toda la información disponible de los récords que son mantenidos por la agencia proporcionando salud maternal, salud a niños, o servicios WIC.

RECUPERACIÓN DE PATRIMONIO

- La ley federal requiere que Iowa tenga un programa de recuperación de patrimonio. Si usted recibe Medicaid, podría estar sujeto al programa de recuperación de patrimonio. Esto significa que cualquier dinero de Medicaid usado para pagar su atención médica, incluido el cobro mensual pagado a la Managed Care Organization (MCO) (Organización de Cuidado Administrado), necesitará ser pagado de vuelta de su patrimonio después de su muerte. La recuperación de patrimonio corresponde si usted recibe Medicaid y tiene 55 años o más, o bien tiene menos de 55 años y vive en una instalación médica y se espera razonablemente que no volverá a casa.
- Para obtener más información, llame a Iowa Medicaid Estate Recovery Program al 1-877-463-7887 o visite http://dhs.iowa.gov/sites/default/files/Comm123.pdf (English) o http://dhs.iowa.gov/sites/default/files/Comm123S.pdf (Español).

Iowa Department of Human Services

Health Services Application (Solicitud de Servicios Médicos)

INFORMACIÓN DEL HOGAR - Completar para todos los programas				
Primer Nombre	Segundo Nombre	Apellido Nombre		
Dirección del Hogar	Ciudad	Estado	Condado	Código
Dirección Postal (si es diferente a la anterior) O Nombre y Dirección del Pagador				
Numero Tel. Hogar ( )	Número Mensajería ( )	Nombre del Mensaje Persona Contacto		

Marcar los programas que usted quiere recibir:
- ❑ **Medical Assistance (Title 19 or Medicaid)**
- ❑ **Facility**
- ❑ **Medicare Savings Program**
- ❑ **Waiver**
- ❑ **Foster Care/Subsidized Adoption**
- ❑ **State Supplementary Assistance** (Renuncia)
- ❑ **Breast and Cervical Cancer Treatment**
- ❑ **Iowa Family Planning Network (IFPN)**

SI USTED NECESITA MAS ESPACIO PARA CONTESTAR CUALQUIERA DE LAS SIGUIENTES PREGUNTAS, ADJUNTAR HOJAS ADICIONALES

A partir de ti mismo, una lista de todas las personas que viven en su casa y marque la casilla de sí o no, si usted está solicitando para esa persona. Si decide que no, sólo es necesario a la lista su nombre, relación con usted y su fecha de nacimiento.

NOMBRE (Primer, Segundo, Apellido)	¿Solicita por esta persona?	¿Cual relación con esta persona?	¿Disabilidad?	Sexo	Fecha Nacimiento	Nº de Social Security	Nº de Estado ID de Medicaid (si lo sabe)	Estado de nacimiento	¿Es ciudadano norte-americano?	Condi-cion de extranjo	Etnici-dad*	Raza **	¿Si es niño, los padres NO viven con el?	¿Actualmente tiene Medicaid?	¿Otro seguro médico disponible?
	❑ Si ❑ No	MISMO	❑ Si ❑ No	❑ Masc. ❑ Fem.					❑ Si ❑ No				❑ Si ❑ No	❑ Si ❑ No	❑ Si ❑ No
	❑ Si ❑ No		❑ Si ❑ No	❑ Masc. ❑ Fem.					❑ Si ❑ No				❑ Si ❑ No	❑ Si ❑ No	❑ Si ❑ No
	❑ Si ❑ No		❑ Si ❑ No	❑ Masc. ❑ Fem.					❑ Si ❑ No				❑ Si ❑ No	❑ Si ❑ No	❑ Si ❑ No
	❑ Si ❑ No		❑ Si ❑ No	❑ Masc. ❑ Fem.					❑ Si ❑ No				❑ Si ❑ No	❑ Si ❑ No	❑ Si ❑ No
	❑ Si ❑ No		❑ Si ❑ No	❑ Masc. ❑ Fem.					❑ Si ❑ No				❑ Si ❑ No	❑ Si ❑ No	❑ Si ❑ No

Debemos preguntarle su origen étnico y raza, pero usted no está obligado/a a contestar. Su respuesta no afectará cuánto reciba o con qué rapidez. Si contesta, utilice la siguiente codificación:

* Origen étnico: H = Hispano o Latino; N = No Hispano ni Latino

** Raza (Seleccione todas las que correspondan): W = Blanca; B = Negra o Afroamericana; A = Asiática; I = Amerindia o Nativas de Alaska; N = Nativas de Hawai u otras islas del Pacífico.

¿Alguien recibió atención médica en los últimos tres meses? ❑ Si ❑ No ¿Quién? _____ ¿Que meses? _____

Lista de cualquier persona que está en el ejército, un veterano o el cónyuge de un veterano _____

¿Hay alguien huyendo para evitar persecución, custodia, o en la cárcel por un delito mayor? ❑ Si ❑ No

¿Hay alguien violando una condición de libertad condicional o libertad condicional? ❑ Si ❑ No

¿Hay alguien en o esperando para ir a la cárcel o prisión? ❑ Si ❑ No

Lista de embarazadas que viven en su casa _____ Fecha de Entrega (MMDDYY) _____

_____ _____

Escriba el nombre de su proveedor de seguro médico _____

INGRESOS: Indique los ingresos de todas las personas que viven con usted. Incluya ingresos laborales en relación de dependencia, por cuenta propia, Social Security, pensión a ex combatientes (Veteran's Benefits), seguro de desempleo, manutención de menores, indemnización por accidentes laborales (Worker's Compensation), jubilación de empleados ferroviarios, IPERS, jubilación, administración pública, dinero en efectivo recibido de amigos o familiares, y cualquier otro tipo de ingresos.

Persona que recibe el dinero	**Patron o fuente de Ingreso**	**Cantidad antes de impuestos o deducciones**	**¿Qtan seguido se paga?**	**¿Se espera que este ingreso continúe? Si NO explicar:**
			❑ Semanal ❑ Semana terciada ❑ Mensual ❑ Dos al mes ❑ Otro _____	❑ Si ❑ No
			❑ Semanal ❑ Semana terciada ❑ Mensual ❑ Dos al mes ❑ Otro _____	❑ Si ❑ No
			❑ Semanal ❑ Semana terciada ❑ Mensual ❑ Dos al mes ❑ Otro _____	❑ Si ❑ No
			❑ Semanal ❑ Semana terciada ❑ Mensual ❑ Dos al mes ❑ Otro _____	❑ Si ❑ No

RECURSOS: Un recurso es dinero en efectivo o cualquier cosa que pueda canjearse por dinero. Enumerar todos los recursos y la cantidad o valor. Incluya dinero en efectivo disponible, cuentas corrientes, vehículos, seguros de vida, títulos valores, bonos, certificados de depósitos (CDs), fondos fiduciarios, cuentas de jubilación, contratos de entierro, espacios de entierro, anualidades, etc. Si solo se aplica la cobertura por un niño, los recursos no deberán contarse.

Persona con Recurso	Tipo de Recurso	Cantidad o Valor	Lugar (nombre del banco, y dirección, hogar, etc.)

¿Alguna de las personas que viven con usted vendió o cedió algo de valor por menos de su valor en los últimos 5 años? ❑ Si ❑ No

¿Alguien en el hogar paga manutención para niños o conyugue para una persona que no viva con ustedes? ❑ Si ❑ No
Si es si, ¿quién paga? _____ ¿Cantidad? _____

Alguien en el hogar paga a alguien para que cuide a un niño o aun adulto incapacitado? ❑ Si ❑ No
Si es si, ¿quién paga? _____ Que tan seguido? _____ ¿A quien? _____

¿La Unidad de Recuperación de Apoyo Infantil ya le está ayudando a obtener o exigir pagos de manutención infantil o ayuda médica? ❑ Sí ❑ No

Si respondió que no, Child Support Recovery Unit (Unidad de recuperación de manutención de menores) puede ayudarle a conseguir que el padre ausente abone manutención o seguro médico. También pueden ayudarle a localizar al padre ausente y a su empleador, a determinar la paternidad o a modificar órdenes judiciales de manutención. **¿Desea que Child Support Recovery le ayude con alguno de estos temas?** ❑ Sí ❑ No

¿Está dispuesto a cooperar con nosotros para obtener cobertura o ayuda médica de parte del padre que no vive en el hogar? (No tiene la obligación de cooperar si sólo desea obtener Medicaid para un menor) ❑ Sí ❑ No

Nombre y domicilio del padre que no vive en el hogar:	Fecha de nacimiento de este padre:	Número de seguro social de este padre:	Nombre de los hijos de este padre:	Condado en el cual se presentó la orden del tribunal, si la hubiere:	¿El padre tiene la orden de un tribunal de pagar dinero para la ayuda médica?

NUMERO DE SOCIAL SECURITY (SSN)

Debe poner el SSN de todas las personas mencionadas en esta solicitud para obtener Medical Assistance. La Sección 1137(a)(1) del Social Security Act y el 42 CFR 435.910 requiere esto. Si usted no quiere Medicaid, usted no tiene que darnos su SSN. El SSN será utilizado:

- Para checar el ingreso, elegibilidad y la cantidad de pagos de Medical Assistance que se harán a su favor.
- Para determinar el derecho de otras personas a Medical Assistance.
- Para cumplir con las leyes Federales que requieren divulgación de información para récords de Medicaid.
- Para comparar con récords en otras agencias tales como: Social Security Administration, Internal Revenue Services, y Iowa Workforce Development. Estas comparaciones de pueden hacer por una computadora e un base individual.

Mis derechos y responsabilidades me serán proporcionados en la parte de atrás de las instrucciones de esta Health Services Application. He leído y quitado la hoja de Derechos y Responsabilidades de la Solicitud de Servicios de Salud para mi uso futuro.

Entiendo que, si los niños que están en esta solicitud no son elegibles para recibir Medicaid, esta solicitud puede ser enviada al programa ***hawk-i*** para ver si pueden obtener la cobertura de salud ***hawk-i***.

YO CERTIFICO QUE ESTAS DECLARACIONES SON CORRECTAS A LO MEJOR DE MI CONOCIMIENTO Y CREENCIA.

Firma o marca del solicitante Fecha

Firma o marca de otro padre o padrastro en el hogar Fecha

Firma de la persona, si hay que haya ayudado a completar esta forma Fecha

Addendum to Application and Review Forms for Release of Information (Anexo a los Formularios de Solicitud y Revisión para Divulgar Información)

Divulgación de Información - OPCIONAL

¡Ayúdenos a ayudarle!

No tiene obligación de firmar esta autorización, pero nos ayudaría a obtener la información que necesitamos para ayudarle y no tendríamos que pedirle que firme ciertas solicitudes.

Debe saber que:

- Podríamos necesitar más información para decidir si puede obtener asistencia.
- Si necesitáramos que nos proporcione más información, recibirá una carta informándole qué necesitamos y la fecha en que debe entregarla.
- Es su responsabilidad conseguir dicha información o pedirnos que le ayudemos a conseguirla.
- Si no nos proporciona dicha información ni nos pide ayuda antes de la fecha de entrega de la misma, su solicitud podría ser denegada o la asistencia podría terminar.
- Podríamos utilizar esta autorización para obtener la información necesaria. **Pero aún así, deberá conseguir la información que le solicitemos o pedirnos ayuda para conseguirla.**
- Podríamos adjuntar una copia de la autorización a otros formularios para solicitarles a otras personas u organizaciones (como, por ejemplo, su empleador) que nos proporcionen determinada información sobre usted o su grupo familiar.

Escriba su nombre en letra de imprenta y firme para autorizarnos a obtener la información necesaria.

DIVULGACIÓN DE INFORMACIÓN

Por la presente autorizo a cualquier individuo u organización a entregar a Department of Human Services de Iowa la información solicitada sobre mi persona o mi grupo familiar.
(I hereby authorize any person or organization to give the Iowa Department of Human Services requested information about me or other members of my household.)

Una copia de esta autorización es tan válida como el original.
(A copy of this release is as valid as the original.)

Esta autorización no es válida en el caso de información médica protegida.
(This release does not apply to protected health information.)

Esta autorización es válida por 12 meses a partir de la fecha de mi firma.
(This release is good for 12 months from the date signed.)

Su nombre (en imprenta legible) (Your Name – please print clearly)	Nombre de otro adulto (en imprenta legible) (Other Adult Name – please print clearly)
Firma o marca (Signature or Mark)	Firma o marca (Signature or Mark)
Fecha (Date)	

Health Services Application, Form 470-2927 or 470-2927(S)

Purpose

The *Health Services Application* is designed to assist people applying for various health-related programs, including SSI-related coverage groups, Iowa Family Planning Network, Medically Needy, and State Supplementary Assistance.

It is designed to be a brief and easily understood form. With this form, an applicant does not have to provide identical information to several different agencies in order to apply for the programs each agency administers.

Source

Form 470-2927 is printed with five sets on a pad. Order supplies of 470-2927 from Iowa Prison Industries at Anamosa.

Print or photocopy supplies of form 470-2927(S) from the sample in the manual as needed.

Completion

Mail or give the *Health Services Application* to a person applying for Medicaid, Iowa Family Planning Network, Medically Needy, or State Supplementary Assistance.

Applications: The applicant completes the form. A friend, relative, authorized representative, or DHS staff may help, if needed.

The applicant must sign the form unless mentally or physically unable to do so. If the applicant is mentally competent but unable to sign the application form, an "X" or a thumbprint may be used if witnessed by two people who know the applicant.

If the applicant is mentally incompetent, the form may be completed by a legal guardian, a relative, a person in whose home the applicant resides, or by the IM worker if there is no other person able or willing to file the application.

When both parents or spouses are in the home, one must sign the application. If there is a guardian or conservator, this person shall participate in completing the form and shall sign for the applicant, if necessary. See 8-B, Who Must Sign the Application.

See 8-B, Information Provided, for a list of pamphlets to provide with the *Health Services Application*.

Medically Needy Recertifications: Recipients shall complete a new application when the Medically Needy certification period has expired.

The client shall complete the form or enlist the help of some interested party in preparing it. If there is a guardian, the guardian shall participate in completing the form and sign for the client.

Distribution

If the client wants a copy of the application, photocopy the form for the client.

When a person does not file the application at a DHS office, and the person also requests Medicaid, the originating agency shall route the original to the DHS office responsible for the applicant's county of residence within two working days of receipt. The originating agency shall photocopy the application for their files.

Data

Date-stamp the original application before faxing or mailing the photocopy of the form to another agency.

For the purpose of Medicaid, the application date is the date the originating agency received the application.

Page 139 is reserved for future use.

Distribution

The Centralized Child Care Provider Registration Unit sends this form to the unregistered home along with:

- Comm. 95, *Guidelines for Child Care Homes with a Child Care Assistance Provider Agreement*.
- Form 470-2890, *Payment Application for Nonregistered Providers*.
- Form 595-1489 or 595-1489(S), *Non-Law Enforcement Record Check Request Form A* (one form for each person over age 13 who lives in the household or has access to the children in care).
- Form 470-3871, *Child Care Assistance Provider Agreement*.
- A pre-addressed return envelope.

When the provider returns the form, the Unit checks each person's records using the Single Contact Repository (SING) system. If no criminal records are found, the form is filed in the provider's file.

When SING indicates criminal or abuse records, the Unit sends form 470-2310, *Record Check Evaluation*, to the subject of the record to get more information for the purpose of evaluating the conviction or abuse.

Data

Before mailing the form:

- Enter the requesting worker's name, work address, fax number and telephone number in the "From:" spaces.
- Enter the name, maiden name, sex, social security number, and birth date of the person whose records are requested.

The person being checked signs the "waiver" section.

Iowa Medicaid Enterprise-HIPP Unit
PO Box 36476
Des Moines, IA 50315-9907

Date:

HIPP Worker:
Local Calls:
Toll Free: 1-888-346-9562
Fax: (515) 725-0725
E-mail: HIPP@dhs.state.ia.us

Notice of Health Insurance Premium Payment

You are approved to receive Health Insurance Premium Payment (HIPP) benefits because the Iowa Department of Human Services has determined that this is a cost-effective way to pay for your medical care. **PAYMENTS WILL CONTINUE AS LONG AS YOUR CASE IS DETERMINED TO BE COST-EFFECTIVE FOR THE MEDICAID ELIGIBLE MEMBERS OF YOUR HOUSEHOLD.** Your case will be re-evaluated periodically for cost-effectiveness. The decision to pay premiums is based upon a review of the coverage provided by the policy, premium rates, average utilization history and the specific health related circumstances of the Medicaid-eligible persons covered under the policy. [IAC 441-75.21(249A)] Any questions or concerns you may have regarding this action should be referred to the HIPP worker listed above. For any months that you received a HIPP reimbursement, your Medicaid coverage will be retroactively transferred from the Managed Care Organization (MCO) back to Medicaid Fee-for-Service (FFS). Your providers will need to re-file claims with the Iowa Medicaid Enterprise for any months affected by HIPP reimbursement.

PAYMENT INFORMATION

Report all changes regarding your health insurance coverage to this office within 10 days of the change. See the back side of this notice for details.

Policyholder Name:

Employers Name:

Health Insurance Carrier:

Health Insurance Policy Number:

Health Insurance Premium Amount: $

Frequency of payroll deduction for insurance:

Health Insurance Deductible: Single $ Family $

Effective Date of Health Insurance Premium Payment:

Premiums will be paid in the following manner:

RECIPIENTS COVERED UNDER THIS POLICY

Report all changes regarding members in your household to this office within 10 days of the change. See the back side of this notice for details.

Name	Date of Birth	Name	Date of Birth

Comments:

PLEASE READ IMPORTANT NOTICE ON OTHER SIDE

IMPORTANT NOTICE

Please read the following information regarding your participation in the HIPP program. Questions should be referred to the HIPP worker listed on the front of this form.

Medicaid (Title 19) Eligibility

In order to be eligible for the HIPP program, some or all of the persons covered under the insurance policy must be eligible for Medicaid. If all of the persons covered under the policy lose Medicaid eligibility, HIPP payments will stop as of the date eligibility ends. If some of the persons covered under the policy lose Medicaid eligibility, we will reevaluate the policy to see if it is still cost-effective for the Department to pay the premiums.

Reporting Changes

Report all changes regarding your health insurance coverage to this office within 10 days of the change. The quickest way to report changes is to:

- Call us toll-free **1-888-346-9562**
- Call the number on the front of this notice
- E-mail: **HIPP@dhs.state.ia.us**
- Fax: **1-515-725-0725**

Changes that should be reported include, but are not limited to, the following:

- Address change
- New job
- Insurance premium or deductible change
- Other insurance is available
- **If you lose your job or your hours of employment are reduced**
- Medicaid ends
- Baby born
- You are not living with a family member who is on Medicaid
- Job ends
- Health insurance ends
- Insurance carrier or coverage change

If you are enrolled in a group health plan through your employer and you lose your job or you are working fewer hours, health insurance may still be available through your employer. If it is cost-effective, the HIPP program will continue to pay for the insurance coverage.

Under the Consolidated Omnibus Budget Reconciliation Act of 1985 (often referred to as COBRA), some employers must continue to make health insurance available for a limited time to persons after employment ends or hours of work are reduced (such as going from full-time to part-time). However, the employer may no longer share in the cost of the premiums. If you are eligible for insurance coverage under the COBRA provisions, your employer must give you a written notice informing you of your right to continue the coverage. **DO NOT SIGN THE FORM SAYING YOU DON'T WANT COBRA COVERAGE UNTIL WE CAN DETERMINE WHETHER THE POLICY IS COST-EFFECTIVE.**

You Have the Right to Appeal

What is an appeal?

An **appeal** is asking for a hearing because you do not like a decision the Department of Human Services (DHS) makes. You have the right to file an appeal if you disagree with a decision. You do not have to pay to file an appeal. [441 Iowa Administrative Code Chapter 7].

How do I appeal?

Filing an appeal is easy. You can appeal in person, by telephone or in writing for Food Assistance or Medicaid. You must appeal in writing for all other programs. To appeal in writing, do **one** of the following:

- Complete an appeal electronically at https://dhssecure.dhs.state.ia.us/forms/, **or**
- Write a letter telling us why you think a decision is wrong, **or**
- Fill out an Appeal and Request for Hearing form. You can get this form at your county DHS office.

Send or take your appeal to the Department of Human Services, Appeals Section, 5th Floor, 1305 E Walnut Street, Des Moines, Iowa 50319-0114. If you need help filing an appeal, ask your county DHS office.

How long do I have to appeal?

For Food Assistance or Medicaid, you have 90 calendar days to file an appeal from the date of a decision. For all other programs, you must file an appeal:

- Within 30 calendar days of the date of a decision or
- Before the date a decision goes into effect

If you file an appeal more than 30 but less than 90 calendar days from the date of a decision, you must tell us why your appeal is late. If you have a good reason for filing your appeal late, we will decide if you can get a hearing.

If you file an appeal 90 days after the date of a decision, we cannot give you a hearing.

Can I continue to get benefits when my appeal is pending?

You may keep your benefits until an appeal is final or through the end of your certification period if you file an appeal:

- Within 10 calendar days of the date the notice is received. A notice is considered to be received 5 calendar days after the date on the notice or
- Before the date a decision goes into effect

Any benefits you get while your appeal is being decided may have to be paid back if the Department's action is correct.

How will I know if I get a hearing?

You will get a hearing notice that tells you the date and time a telephone hearing is scheduled. You will get a letter telling you if you do not get a hearing. This letter will tell you why you did not get a hearing. It will also explain what you can do if you disagree with the decision to not give you a hearing.

Can I have someone else help me in the hearing?

You or someone else, such as a friend or relative can tell why you disagree with the Department's decision. You may also have a lawyer help you, but the Department will not pay for one. Your county DHS office can give you information about legal services. The cost of legal services will be based on your income. You may also call Iowa Legal Aid at 1-800-532-1275. If you live in Polk County, call 243-1193.

Policy Regarding Discrimination, Harassment, Affirmative Action and Equal Employment Opportunity

It is the policy of the Iowa Department of Human Services (DHS) to provide equal treatment in employment and provision of services to applicants, employees, and clients without regard to race, color, national origin, sex, sexual orientation, gender identity, religion, age, disability, political belief or veteran status.

If you feel DHS has discriminated against or harassed you, please send a letter detailing your complaint to:

Iowa Department of Human Services, Hoover Building, 5th Floor – Policy Bureau, 1305 E Walnut, Des Moines, IA 50319-0114 or via email contactdhs@dhs.state.ia.us

Iowa Medicaid Enterprise-HIPP Unit
PO Box 36476
Des Moines, IA 50315-9907

Date:

HIPP Worker:
Local Calls:
Toll Free: 1-888-346-9562
Fax: (515) 725-0725
E-mail: HIPP@dhs.state.ia.us

Notice of Health Insurance Premium Payment

You are approved to receive Health Insurance Premium Payment (HIPP) benefits because the Iowa Department of Human Services has determined that this is a cost-effective way to pay for your medical care. **PAYMENTS WILL CONTINUE AS LONG AS YOUR CASE IS DETERMINED TO BE COST-EFFECTIVE FOR THE MEDICAID ELIGIBLE MEMBERS OF YOUR HOUSEHOLD.** Your case will be re-evaluated periodically for cost-effectiveness. The decision to pay premiums is based upon a review of the coverage provided by the policy, premium rates, average utilization history and the specific health related circumstances of the Medicaid-eligible persons covered under the policy. [IAC 441-75.21(249A)] Any questions or concerns you may have regarding this action should be referred to the HIPP worker listed above. For any months that you received a HIPP reimbursement, your Medicaid coverage will be retroactively transferred from the Managed Care Organization (MCO) back to Medicaid Fee-for-Service (FFS). Your providers will need to re-file claims with the Iowa Medicaid Enterprise for any months affected by HIPP reimbursement.

PAYMENT INFORMATION

Report all changes regarding your health insurance coverage to this office within 10 days of the change. See the back side of this notice for details.

Policyholder Name:

Employers Name:

Health Insurance Carrier:

Health Insurance Policy Number:

Health Insurance Premium Amount: $

Frequency of payroll deduction for insurance:

Health Insurance Deductible: Single $ Family $

Effective Date of Health Insurance Premium Payment:

Premiums will be paid in the following manner:

MEDICAID RECIPIENTS COVERED UNDER THIS POLICY

Report all changes regarding members in your household to this office within 10 days of the change. See the back side of this notice for details.

Name	Date of Birth	Name	Date of Birth

Comments:

PLEASE READ IMPORTANT NOTICE ON OTHER SIDE

HIPP File

IMPORTANT NOTICE

Please read the following information regarding your participation in the HIPP program. Questions should be referred to the HIPP worker listed on the front of this form.

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Reporting Changes

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- Call us toll-free **1-888-346-9562**
- Call the number on the front of this notice
- E-mail: **HIPP@dhs.state.ia.us**
- Fax: **1-515-725-0725**

Changes that should be reported include, but are not limited to, the following:

- Address change
- New job
- Insurance premium or deductible change
- Other insurance is available
- Medicaid ends
- Baby born
- You are not living with a family member who is on Medicaid
- Job ends
- Health insurance ends
- Insurance carrier or coverage change
- **If you lose your job or your hours of employment are reduced**

If you are enrolled in a group health plan through your employer and you lose your job or you are working fewer hours, health insurance may still be available through your employer. If it is cost-effective, the HIPP program will continue to pay for the insurance coverage.

Under the Consolidated Omnibus Budget Reconciliation Act of 1985 (often referred to as COBRA), some employers must continue to make health insurance available for a limited time to persons after employment ends or hours of work are reduced (such as going from full-time to part-time). However, the employer may no longer share in the cost of the premiums. If you are eligible for insurance coverage under the COBRA provisions, your employer must give you a written notice informing you of your right to continue the coverage. **DO NOT SIGN THE FORM SAYING YOU DON'T WANT COBRA COVERAGE UNTIL WE CAN DETERMINE WHETHER THE POLICY IS COST-EFFECTIVE.**

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- Complete an appeal electronically at https://dhssecure.dhs.state.ia.us/forms/, **or**
- Write a letter telling us why you think a decision is wrong, **or**
- Fill out an Appeal and Request for Hearing form. You can get this form at your county DHS office.

Send or take your appeal to the Department of Human Services, Appeals Section, 5th Floor, 1305 E Walnut Street, Des Moines, Iowa 50319-0114. If you need help filing an appeal, ask your county DHS office.

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For Food Assistance or Medicaid, you have 90 calendar days to file an appeal from the date of a decision. For all other programs, you must file an appeal:

- Within 30 calendar days of the date of a decision or
- Before the date a decision goes into effect

If you file an appeal more than 30 but less than 90 calendar days from the date of a decision, you must tell us why your appeal is late. If you have a good reason for filing your appeal late, we will decide if you can get a hearing.

If you file an appeal 90 days after the date of a decision, we cannot give you a hearing.

Can I continue to get benefits when my appeal is pending?

You may keep your benefits until an appeal is final or through the end of your certification period if you file an appeal:

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- Before the date a decision goes into effect

Any benefits you get while your appeal is being decided may have to be paid back if the Department's action is correct.

How will I know if I get a hearing?

You will get a hearing notice that tells you the date and time a telephone hearing is scheduled. You will get a letter telling you if you do not get a hearing. This letter will tell you why you did not get a hearing. It will also explain what you can do if you disagree with the decision to not give you a hearing.

Can I have someone else help me in the hearing?

You or someone else, such as a friend or relative can tell why you disagree with the Department's decision. You may also have a lawyer help you, but the Department will not pay for one. Your county DHS office can give you information about legal services. The cost of legal services will be based on your income. You may also call Iowa Legal Aid at 1-800-532-1275. If you live in Polk County, call 243-1193.

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If you feel DHS has discriminated against or harassed you, please send a letter detailing your complaint to:

Iowa Department of Human Services, Hoover Building, 5th Floor – Policy Bureau, 1305 E Walnut, Des Moines, IA 50319-0114 or via email contactdhs@dhs.state.ia.us

Iowa Department of Human Services

PASRR Case Activity Report

☐ Corrected

This form is generated electronically with information received through PathTracker.

1. Member Data

Name	Date Entered Facility	PASRR Date
Social Security Number	State ID	Medicaid Case Number

2. Facility Data

Medicaid Provider Number	Facility Type ☐ Nursing Facility (NF/ICF) ☐ Skilled Nursing Facility (SNF) ☐ Nursing Facility for Persons with Mental Illness (NF/MI)		
NPI Number			
Facility Name			
Street Address	City	State	ZIP
Person Completing Form		Date Completed	
Contact Phone Number		Contact Email	

3. Level of Care

Level of Care	Level of Care Process	Effective Date
☐ NF/ICF ☐ NF/MI ☐ Skilled ☐ Other	☐ IME Medical Services ☐ Managed Care ☐ Medicare ☐ Non-Medicaid	

4. Medicare Information for Skilled Patients in Facilities

Note: Dates in this section are populated when Medicare is marked in Section 3.

Expected Dates of Medicare Coverage through

5. Discharge Data

Reason for Discharge: ☐ Died ☐ Hospital (Less than 10 days, form is not required) ☐ Transferred to another facility ☐ Moved home ☐ Moved to other living arrangement	Date of Discharge	Per Diem at Discharge	
	Address Discharged to:		
	Facility Name (if applicable)		
	Street		
	City	State	ZIP

6. Hospice or PACE Provider Information

Note: Only complete this section if individual residing in your facility has elected hospice or is enrolled with PACE.

Elected/Enrolled Program Information	Medicaid Provider Number	NPI Number
☐ Hospice ☐ PACE	Hospice PACE	Hospice PACE
Name of Hospice or PACE Provider	Date of Election/Enrollment	Date of Revocation/Disenrollment
Contact Name for Hospice or PACE	Contact Phone Number	Contact Email

Instructions for Preparing the PASRR Case Activity Report

- When a current resident applies for Medicaid, complete sections 1, 2, and 3 and if applicable, sections 4 and 6. If the individual is already in PathTracker, their name will populate when the SSN is entered. If not in PathTracker, enter the resident's first name, middle initial and last name as they appear on the *Medical Assistance Eligibility Card*. The state ID number is assigned by the Iowa Department of Human Services and consists of seven digits plus one letter, e.g., 1100234G.
- When a Medicaid applicant or member enters the facility, complete sections 1, 2, and 3 and if applicable, sections 4 and 6.
- When a Medicaid applicant or member changes level of care, complete sections 1, 2, and 3 and if applicable, sections 4 and 6.
- When there is Medicare coverage and the Medicaid rate is higher than the Medicare rate, complete sections 1, 2, and 4 and if applicable, section 6.
- When a Medicaid applicant or member dies or is discharged or transferred, complete sections 1, 2, and 5 and if applicable, section 6.
- The administrator or designee responsible for the accuracy of this information should complete section 2.
- If the Medicaid member is receiving benefits through a hospice or PACE provider, please refer to bullets 1 through 5 above and also complete section 6.

Distribution Instructions for Hospice, NFs, NF/MIs, and SNFs

This form is generated electronically with information received through Ascend Database PathTracker Plus.

If this form is to be submitted via paper, the facility should keep a copy for their records and also mail, email or fax a copy to:

Centralized Facility Eligibility Unit
Imaging Center 1
Iowa Department of Human Services
417 E. Kanesville Blvd.
Council Bluffs, IA 51503-4470
Fax: 515-564-4040 Email: facilities@dhs.state.ia.us

Distribution Instructions for PACE

This form is generated electronically with information received through Ascend Database PathTracker Plus.

If this form is to be submitted via paper and the member is enrolled with a PACE program, the facility should keep a copy for their records and also email or fax a copy to the appropriate Imaging Center with an attention to your DHS IM:

Western Service Area
Fax: 515-564-4014
Email: Imagingcenter1@dhs.state.ia.us

Northern Service Area
Fax: 515-564-4015
Email: Imagingcenter2@dhs.state.ia.us

Des Moines Service Area
Fax: 515-564-4018
Email: Imagingcenter5@dhs.state.ia.us

Cedar Rapids Service Area
Fax: 515-564-40147
Email: Imagingcenter4@dhs.state.ia.us

PASRR Case Activity Report, Form 470-5386

Purpose

Form 470-5386, *PASRR Case Activity Report*, provides a mechanism for nursing facilities (NFs), skilled nursing facilities (SNFs), and nursing facilities for people with mental illness (NFMIs) to report individual resident activities occurring at the facility level that may affect eligibility.

Source

The form is electronically generated using information entered by the facility provider into the PathTracker Plus system. The form is available on the Iowa Medicaid Enterprise (IME) website at http://dhs.iowa.gov/ime/providers/forms.

Completion

Facility staff must complete entries in PathTracker Plus when a resident:

- Enters the facility.
- Transfers out of the facility.
- Is discharged.
- Died.
- Has a change in level of care.
- Has a change in payment source. (I.e., Medicare coverage, newly approved for Medicaid, private pay, etc.)

Distribution

NFs, SNFs, and NFMIs must enter all resident information into PathTracker Plus. PathTracker Plus transmits this data electronically to the Department daily. When the transmitted data matches to a Medicaid member, the *PASRR Case Activity Report* (CAR) form is created. The PASRR CAR form is uploaded to Electronic Case File (ECF) nightly.

If a paper PASRR CAR is requested, NFs, SNFs, and NFMIs shall mail, email or fax the form to the address below and keep a copy.

Centralized Facility Eligibility Unit
Imaging Center 1
Iowa Department of Human Services
417 E. Kanesville Blvd.
Council Bluffs, IA 51503-4470
Fax: 515-564-4040
Email: facilities@dhs.state.ia.us

For NF, SNF, or NFMI residents enrolled in the Program for All-Inclusive Care for the Elderly (PACE) mail, email or fax the form to the address below and keep a copy.

Woodbury Adult Intake Team
Imaging Center 1
Iowa Department of Human Services
417 E. Kanesville Blvd.
Council Bluffs, IA 51503-4470
Fax: 515-564-4014
Email: 97cmz2@dhs.state

Data

Section 1. Member Data

This section contains resident specific information.

- **Name**: First and last name of the resident. Enter name as it appears on the *Medical Assistance Eligibility Card*.
- **Date Entered Facility**: The date the resident entered the facility for the first time or was readmitted to the facility following a discharge.
- **PASRR Date**: The date of the most recent PASRR approval.
- **State ID**: The member's Medicaid identification number. It contains seven numbers and one alphabetically character.

Section 2. Facility Data

This section contains information on the facility involved and the person making the entries in PathTracker Plus.

- **Medicaid Provider or National Provider Identifier (NPI) Number**: The provider number of the facility where the member resides. This must correspond with the level of care indicated in Section 3.
- **Facility Type**: The type of facility where the member resides.
- **Facility Name**: The name of the facility where the member resides.

- **Street Address, City, State, ZIP**: The street address, city, state, and ZIP code of the facility where the member resides.
- **Person Completing Form**: The facility staff person who completed the entries into PathTracker Plus.
- **Date Completed**: The date the information was entered into PathTracker Plus.
- **Contact Phone Number and Contact Email**: The phone number and email of the facility staff person who completed the entries into PathTracker Plus.

Section 3. Level of Care

This section identifies the member's level of care information.

- **Level of Care**: Select the level of care the member is receiving.
- **Level of Care Process**: Select who will be determining level of care. Select:
  - "IME Medical Services" if Medicaid eligibility is pending or if this is a new admission.
  - "Medicare" if this is a Medicare qualified stay.
  - "Managed Care" if this is a continued stay review.
  - "Non-Medicaid" if the member is private pay.
- **Effective Date**: Enter the effective date of level of care determination.

Section 4. Medicare Information for Skilled Patients in Facilities

Complete this section when there is Medicare coverage that may apply to skilled care by entering the expected dates of Medicare coverage.

Section 5. Discharge Data

Complete Section 5 when a resident leaves the facility or dies. Remember that Medicaid does not pay for the date of discharge.

- **Reason for Discharge**: Select from the list of reasons why the member was discharged from the facility.
- **Date of Discharge**: The date the member was discharged from the facility.
- **Per Diem at Discharge**: The computed rate for the facility.
- **Address Discharged to**: The facility name, street address, city, state, and ZIP where the member discharged to. This section should be completed if the reason for discharge was something other than "died."

Section 6. Hospice or PACE Provider Information

Complete Section 6 when a resident has elected hospice or is enrolled in the PACE program.

- **Elected/Enrolled Program Information**: Select the appropriate program that the member has elected or enrolled.
- **Medicaid Provider Number and NPI Number**: The provider number of the hospice or PACE provider.
- **Name of Hospice or PACE Provider**: The name of the hospice or PACE provider.
- **Date of Election/Enrollment**: The date the member elected the hospice benefit or signed the PACE enrollment form.
- **Date of Revocation/Disenrollment**: The date the member revoked their hospice benefit or disenrolled from the PACE program.
- **Contact Name for Hospice or PACE**: The staff person's name at the hospice or PACE who can assist with questions regarding the member's election or enrollment.
- **Contact Phone Number and Email**: The phone number and email of the hospice or PACE facility staff person.

Payment Application for Nonregistered Providers, Form 470-2890 or 470-2890(S)

Purpose	Nonregistered and in-home providers apply for Child Care Assistance payment by completing the *Payment Application for Nonregistered Providers*, form 470-2890 or 470-2890(S).
Source	The English version of form 470-2890 is printed with 100 forms on a pad. Order supplies from Iowa Prison Industries at Anamosa. The Spanish version can be printed or photocopied from the sample in the manual.
Completion	The provider completes the application when: ♦ Applying for payment for the first time; or ♦ Applying for a two-year renewal; or ♦ Applying after the expiration of a previous agreement; or ♦ There is a change of name, care, living or mailing address, or household composition. The provider shall complete the form after reading all the instructions and the minimum requirements in Comm. 95, *Guidelines for Child Care Homes with a Child Care Assistance Provider Agreement*.
Distribution	The provider returns the application to the Centralized Child Care Provider Registration Unit. The Unit files the application in the child care case record.
Data	The applicant-provider shall: ♦ Indicate whether this is a new application or a renewal. ♦ Carefully print the name (and maiden name and other last names, if any) and addresses. ♦ Enter the birth date, last four digits of the social security number, and telephone numbers with area codes. ♦ Nonregistered providers add the names of other adults and children living in the home with birth dates and the last four digits of the social security number, if available.

Iowa Department of Human Services

Request for Child and Dependent Adult Abuse Information

Persons or agencies with authorized access to child or dependent adult abuse information must use this form to request information about a child or dependent adult abuse report. **Complete a separate form for each family or individual** and email to dhsabuseregistry@dhs.state.ia.us, or fax to (515) 564-4112, or mail to the Iowa Department of Human Services, Central Abuse Registry, P.O. Box 4826, Des Moines, IA 50305.

Please specify your type of request by checking the appropriate box below:

☐ Child abuse request ☐ Dependent adult abuse request ☐ Both

Please specify your preferred **method of response** by checking a box and completing the information in Section 1.

☐ Address ☐ Fax ☐ Email

Section 1: ***To be completed by the person or agency requesting the information.***

Requester: Last	First	Agency Name	Telephone Number ( )
Address			Fax Number ( )
City	State	Zip Code	Email
Relationship to the persons listed in Section 2 or 3:			
Purpose for request:			
State the Iowa Code section that allows access to the child **or** dependent adult abuse information requested:			
I have read and understand the legal provisions for handling child or dependent adult abuse information which is printed on the second page of this form. I understand that this request will not be approved unless I have authorized access.			
Signature of Requester		Date	

Complete Section 2 if the purpose of this record check is employment, licensing or registration, or payment approval.

Section 2: ***List the name and address of the person whose record is being checked.***

Last	First	Middle	Birth Date	Social Security Number	
Address		City	County	State	Zip Code
List maiden name, any previous married names, and any alias:					

Complete Section 3 if the request is for a copy of the written summary of the abuse investigation or assessment.

Section 3: ***List the name of the persons for whom you are requesting information. Attach pages for additional family members.***

Last	First	Middle	County	Birth Date	Social Security #
Address			City	State	Zip Code
List maiden name, any previous married names, and any alias:					

Section 4: ***Registry or designee decision.***

☐ This request for information is approved.

☐ This request for information is denied because:

Signature of Registry or Designee	Date

LEGAL PROVISIONS FOR HANDLING CHILD AND DEPENDENT ADULT ABUSE INFORMATION

Redissemination of Child and Dependent Adult Abuse Information (Iowa Code sections 235A.17 and 235B.8)

A person, agency, or other recipient of child or dependent adult abuse information shall not redisseminate (release) this information, except that redissemination is permitted when **ALL** of the following conditions apply:

- The redissemination is for official purposes in connection with prescribed duties or, in the case of a health practitioner, pursuant to professional responsibilities.
- The person to whom such information would be redisseminated would have independent access to the same information under Iowa Code sections 235A.15 or 235B.6.
- A written record is made of the redissemination, including the name of the recipient and the date and purpose of the redissemination.
- The written record is forwarded to the Central Abuse Registry within 30 days of the redissemination.

Criminal Penalties (Iowa Code sections 235A.21 and 235B.12)

A person is guilty of a criminal offense when the person:

- Willfully requests, obtains, or seeks to obtain child or dependent adult abuse information under false pretenses, or
- Willfully communicates or seeks to communicate child or dependent adult abuse information to any agency or person except in accordance with Iowa Code sections 235A.15, 235A.17, 235B.6, and 235B.8, or
- Is connected with any research authorized pursuant to Iowa Code sections 235A.15 and 235B.6 and willfully falsifies child or dependent adult abuse information or any records relating to child or dependent adult abuse.

Upon conviction for each offense, the person is guilty of a serious misdemeanor punishable by a fine or imprisonment.

Any person who knowingly, but without criminal purposes, communicates or seeks to communicate child or dependent adult abuse information except in accordance with Iowa Code sections 235A.15, 235A.17, 235B.6, and 235B.8 is guilty of a simple misdemeanor punishable, upon conviction for each offense, by a fine or imprisonment.

Any reasonable grounds for belief that a person has violated any provision of Iowa Code Chapters 235A or 235B shall be grounds for the immediate withdrawal of any authorized access that person might otherwise have to child or dependent adult abuse information.

REQUESTS FOR CORRECTION OR EXPUNGEMENT OF A CHILD OR DEPENDENT ADULT ABUSE REPORT

To request an administrative appeal hearing of a child or dependent adult abuse report, please submit a request in writing to: Department of Human Services, Appeals Section, 5th Fl, 1305 E Walnut St, Des Moines, Iowa 50319-0114. You will be notified in writing acknowledging receipt of your request; time, date, and place of your hearing; and any decisions regarding your request. If you disagree with this decision, the written notice will explain how you may request an administrative hearing about the report and its conclusions per Iowa Code sections 235A.19 or 235B.10.

Request for Child and Dependent Adult Abuse Information, Form 470-0643

Purpose

Form 470-0643 is used to request information from the Central Abuse Registry:

- To determine whether there is record of a founded abuse report on a person in the child care provider's household.
- To assist in verifying a minor parent's claim of good cause for not living with an adult parent or legal guardian because of abuse.
- To record the dissemination of child abuse information.

Source

IM staff can complete this form on line using the template on the DHS Intranet eForms web page.

Completion

The form is initiated by any person wishing to obtain child abuse information that is placed on the Central Abuse Registry. IM staff complete the form when:

- A nonregistered provider wishes to receive Child Care Assistance funds.
- A minor parent claims good cause for not living with an adult parent or legal guardian because of abuse.

Complete Section 1 with information about the person making the request (the worker).

Complete Section 2 with information about the person whose records are being requested (the minor parent or child care provider).

Section 4 is completed by the Central Abuse Registry staff or the local office staff person designated as approved to relay founded child abuse information to any authorized requester.

All local offices are authorized to release information to the subjects of a child abuse investigation or assessment (or to a subject's legal representative) upon verification of identity and subject status.

Distribution

For internal DHS requests from licensing, registration or payment approval record checks, send one copy of the form to the person doing the registry checks in your area. Keep a copy of the form until the original is returned.

For requests involving a minor parent, attach a copy of form 470-0461, *Authorization for Release of Information*, completed by the minor parent. The release shall:

- State that you are authorized to obtain information from the child abuse registry.
- Request that the status of the child abuse report and the worker number of the service worker be provided, for the purpose of FIP payment.

If the name is not found on the Registry, the person doing the check attaches a label saying this and returns the forms to you. File the original in the registration file or eligibility file, and discard the rest.

If the name is found on the registry as the person responsible for a founded incident, the person making the check:

- Labels it as such with the Iowa Code reference.
- Sends one copy to the Registry to record dissemination of the information.
- Keeps one copy of the completed form for the local office records.
- Sends one copy to the requester with the result of the check.

Data

Complete Part 1 as follows:

- Enter your name, telephone number, and office address.
- Enter “income maintenance worker” under relationship.
- Sign your name and enter the date.

In Section 2:

- Enter the complete name of the minor parent or the child care provider with birth date and social security number, if available.
- Enter the person's address and the county of residence.
- Enter any other names previously used by this person.

Complete separate forms for:

- The provider's spouse.
- Other adults living in the home.
- People with access to a child when the child is alone.
- The child care provider's children.

The person authorized to access information in the child abuse registry for that area completes Section 4 of the form to verify the status of the child abuse report and, for minor parents, the worker number of the service worker.

Iowa Department of Human Services

Request for Proof of Citizenship and Identity

County Number Worker

Case Number Date

Questions? Call your worker at .
We will accept collect calls if you live outside the local calling area.

Dear

We need proof of citizenship and/or identity for the person(s) listed below.

You have until to provide proof of citizenship and/or identity for the person(s) listed above. To do this you can:

- ✓ **Call your worker at to**:
  - Ask if we can do a birth records check (for anyone born in Iowa).
- ✓ **Give us another type of verification.** On the back of this letter is Comm. 258, *Verifying Citizenship/Identity and/or Immigration Status,* that tells you other types of verification we can use. Send or bring proof to your worker.

Benefits will end for the person(s) listed above if proof is not received by the due date. After that date, the person(s) listed above will not be able to get Medicaid, ***hawk-i***, or family planning benefits until citizenship and identity is verified. If retroactive Medicaid was requested, it will be denied for the person(s) listed above if citizenship and identity is not verified by the due date.

Department of Human Services

Verifying Citizenship/Identity and/or Immigration Status

Examples of How to Prove U.S. 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, 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	
Proves both Citizenship and Identity	**Part 1**	**Part 2**
	Proves only Citizenship	**Proves only Identity**
• U.S. passport • Certification of Naturalization • Documentation of membership or affiliation issued by a federally recognized Indian Tribe	• Official birth certificate issued by the county or state • Medical record showing U.S. place of birth • Other acceptable proof of citizenship	• Driver's license or ID card from the Department of Transportation • School photo ID • School, day care or medical records (for children) • Military ID or dependent card • Other acceptable proof of ID

Examples of How to Prove Immigration Status

- Arrival Departure Record in foreign passport (I-94)
- Arrival/Departure Record
- Certificate of Citizenship
- Certificate of Eligibility for Exchange Visitor
- Certificate of Eligibility for Nonimmigrant Student Status
- Employment Authorization Card
- Foreign passport
- Machine Readable Immigrant Visa (with temporary I-551 language)
- Permanent Resident Card
- Reentry permit
- Refugee travel document
- Temporary I-551 Stamp (on passport or I-94/I-94a)
- Other acceptable proof immigration status

Questions or Need Help?

- Call our toll-free number 1-877-937-3663.
- Contact your worker.

Iowa Department of Human Services

Request for Proof of Citizenship and Identity
(Solicitud de Comprobante de Ciudadanía e Identidad)

Número del Condado Asistente

Número del Caso Fecha

¿Preguntas? Llame a su asistente al teléfono .
Aceptaremos llamadas por cobrar si vive fuera del área de llamadas locales.

Estimado/a

Hemos necesita los comprobantes de ciudadanía y/o identidad de las personas nombradas a continuación.

Tiene tiempo hasta el para entregarnos los comprobantes de ciudadanía y/o identidad de la(s) persona(s) nombrada(s) anteriormente. Para hacerlo, puede:

- ✓ **Llamar a su asistente al teléfono para**:
  - Preguntarnos si podemos revisar las partidas de nacimiento (de personas que hayan nacido en Iowa).
- ✓ **Darnos otro tipo de verificación.** Al dorso de esta carta está la Com. 258, *Verifying Citizenship/ Identity and/or Immigration Status* (Verificación de ciudadanía/identidad o estatus migratorio), en la cual hemos le informa qué otros tipos de verificación puede utilizar. Envíe o traiga el comprobante a tu asistente.

Los beneficios para la(s) persona(s) mencionada(s) anteriormente finalizarán el si no recibimos los comprobantes antes de la fecha de vencimiento. Después de esa fecha, la persona (s) antes mencionadas no podrá recibir Medicaid, ***hawk-i***, o beneficios de planificación familiar hasta que la ciudadanía y la identidad es verificada. Si retroactiva de Medicaid se solicitó, se le negará a la persona(s) mencionada(s) anteriormente, si la ciudadanía y la identidad no se verifica(n) la fecha de vencimiento.

Department of Human Services

Verifying Citizenship/Identity and/or Immigration Status
(Verificación de ciudadanía/identidad o estatus migratorio)

Ejemplos de cómo probar su ciudadanía estadounidense e identidad

La prueba debe ser un documento original. No envíe sus documentos originales por correo. Tráigalos a la oficina.

- La Columna A prueba ciudadanía e identidad al mismo tiempo.

Si no tiene un documento de la Columna A, necesitará proveer documentos de la Columna B.

- La Columna B requiere un documento de la Parte 1 y otro de la Parte 2 para cumplir con el requisito.

Columna A	**Columna B**	
	Parte 1	**Parte 2**
Prueba ciudadanía e identidad al mismo tiempo	**Prueba ciudadanía solamente**	**Prueba identidad solamente**
• Pasaporte estadounidense • Certificado de naturalización • Documentación de acreditación y afiliación emitida por una Tribu Indígena reconocida por el gobierno federal	• Certificado de nacimiento oficial emitido por el país o el estado • Registro médico que muestre el lugar de nacimiento en EE. UU. • Otra prueba de ciudadanía aceptable	• Licencia de conducir o tarjeta de identificación del Departamento de Transporte • Identificación escolar con fotografía • Comprobantes de escuela, guardería o registros médicos (para menores) • Tarjeta de identificación militar o de persona dependiente • Otra prueba de identificación aceptable

Ejemplos de cómo probar el estatus migratorio

- Registro de llegadas y salidas en pasaporte extranjero (I-94)
- Registro de llegada/salida
- Certificado de ciudadanía
- Certificado de elegibilidad como visitante de intercambio
- Certificado de elegibilidad como estudiante no inmigrante
- Tarjeta de autorización de empleo
- Pasaporte extranjero
- Visa de inmigrante automatizada (con texto explícito de I-551 temporal)
- Tarjeta de residente permanente
- Permiso de reingreso
- Documento de viaje para refugiado
- Sello de I-551 temporal (en pasaporte o I-94/I-94a)
- Otra prueba aceptable de estatus migratorio

¿Tiene alguna pregunta o necesita ayuda?

- Llame gratis al 1-877-937-3663.
- Comuníquese con su trabajador(a).

Iowa Department of Human Services

Request for Verification of Citizenship and Identity

County Number Worker

Case Number Date

Questions? Call your worker at .
We will accept collect calls if you live outside the local calling area.

Dear

We have not been able to verify citizenship and/or identity using the information you gave us for the person(s) listed below. The verification is done through a match with the Social Security Administration (SSA) and is based on name, social security number, and birth date.

You have until to get us verification of citizenship and/or identity for the person(s) listed above. To do this you can:

- ✓ **Call your worker at to**:
  - Make sure we have the correct name, social security number, and birth date.
  - Ask if we can do a birth records check (for anyone born in Iowa).
- ✓ **Call the SSA** at 1-800-772-1213 to make sure they have the correct name, social security number, and date of birth in their records. Ask SSA to send you verification of your citizenship/identity. Once you get this from SSA, give it to your worker.
- ✓ **Give us another type of verification.** On the back of this letter is Comm. 258, *Verifying Citizenship/Identity and/or Immigration Status,* that tells you other types of verification we can use. Send or bring proof to your worker.

Benefits will end for the person(s) listed above if verification is not received by the due date. After that date, the person(s) listed above will not be able to get Medicaid, ***hawk-i***, or family planning benefits until citizenship and identity is verified. If retroactive Medicaid was requested, it will be denied for the person(s) listed above if citizenship and identity is not verified by the due date.

Department of Human Services

Verifying Citizenship/Identity and/or Immigration Status

Examples of How to Prove U.S. 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, 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	
Proves both Citizenship and Identity	**Part 1**	**Part 2**
	Proves only Citizenship	**Proves only Identity**
• U.S. passport • Certification of Naturalization • Documentation of membership or affiliation issued by a federally recognized Indian Tribe	• Official birth certificate issued by the county or state • Medical record showing U.S. place of birth • Other acceptable proof of citizenship	• Driver's license or ID card from the Department of Transportation • School photo ID • School, day care or medical records (for children) • Military ID or dependent card • Other acceptable proof of ID

Examples of How to Prove Immigration Status

- Arrival Departure Record in foreign passport (I-94)
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- Certificate of Citizenship
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- Certificate of Eligibility for Nonimmigrant Student Status
- Employment Authorization Card
- Foreign passport
- Machine Readable Immigrant Visa (with temporary I-551 language)
- Permanent Resident Card
- Reentry permit
- Refugee travel document
- Temporary I-551 Stamp (on passport or I-94/I-94a)
- Other acceptable proof immigration status

Questions or Need Help?

- Call our toll-free number 1-877-937-3663.
- Contact your worker.

Iowa Department of Human Services

Request for Verification of Citizenship and Identity
(Solicitud de Verificación de Ciudadanía e Identidad)

Número del Condado Asistente

Número del Caso Fecha

¿Preguntas? Llame a su asistente al teléfono .
Aceptaremos llamadas por cobrar si vive fuera del área de llamadas locales.

Estimado/a

No hemos verificar la ciudadanía y/o la identidad utilizando la información que nos dio para la(s) persona(s) que se indica(n) a continuación. La verificación se realiza buscando registros de Social Security Administration (SSA) que coincidan con el nombre, el número de seguro social y la fecha de nacimiento.

Tiene tiempo hasta el para conseguirnos la verificación de ciudadanía y/o identidad de la(s) persona(s) nombrada(s) anteriormente. Para hacerlo, puede:

- ✓ **Llamar a su asistente al teléfono para**:
  - Confirmar que tenemos el nombre, el número de seguro social y la fecha de nacimiento correctos.
  - Preguntarnos si podemos revisar las partidas de nacimiento (de personas que hayan nacido en Iowa).
- ✓ **Llamar a SSA** al teléfono 1-800-772-1213 para confirmar que tienen el nombre, el número de seguro social y la fecha de nacimiento correctos en sus registros. Pídale a SSA que le envíen su verificación de ciudadanía o de identidad. Una vez que reciba dicho formulario de SSA, entrégueselo a su asistente.
- ✓ **Darnos otro tipo de verificación.** Al dorso de esta carta está la Com. 258, *Verifying Citizenship/ Identity and/or Immigration Status* (Verificación de ciudadanía/identidad o estatus migratorio), en la cual hemos le informa qué otros tipos de verificación puede utilizar. Envíe o traiga el comprobante a tu asistente.

Los beneficios para la(s) persona(s) mencionada(s) anteriormente finalizarán el
si no recibimos la verificación antes de la fecha de vencimiento. Después de esa fecha, la persona (s) antes mencionadas no podrá recibir Medicaid, ***hawk-i***, o beneficios de planificación familiar hasta que la ciudadanía y la identidad es verificada. Si retroactiva de Medicaid se solicitó, se le negará a la persona(s) mencionada(s) anteriormente, si la ciudadanía y la identidad no se verifica(n) la fecha de vencimiento.

Department of Human Services

Verifying Citizenship/Identity and/or Immigration Status
(Verificación de ciudadanía/identidad o estatus migratorio)

Ejemplos de cómo probar su ciudadanía estadounidense e identidad

La prueba debe ser un documento original. No envíe sus documentos originales por correo. Tráigalos a la oficina.

- La Columna A prueba ciudadanía e identidad al mismo tiempo.

Si no tiene un documento de la Columna A, necesitará proveer documentos de la Columna B.

- La Columna B requiere un documento de la Parte 1 y otro de la Parte 2 para cumplir con el requisito.

Columna A	**Columna B**	
	Parte 1	**Parte 2**
Prueba ciudadanía e identidad al mismo tiempo	**Prueba ciudadanía solamente**	**Prueba identidad solamente**
• Pasaporte estadounidense • Certificado de naturalización • Documentación de acreditación y afiliación emitida por una Tribu Indígena reconocida por el gobierno federal	• Certificado de nacimiento oficial emitido por el país o el estado • Registro médico que muestre el lugar de nacimiento en EE. UU. • Otra prueba de ciudadanía aceptable	• Licencia de conducir o tarjeta de identificación del Departamento de Transporte • Identificación escolar con fotografía • Comprobantes de escuela, guardería o registros médicos (para menores) • Tarjeta de identificación militar o de persona dependiente • Otra prueba de identificación aceptable

Ejemplos de cómo probar el estatus migratorio

- Registro de llegadas y salidas en pasaporte extranjero (I-94)
- Registro de llegada/salida
- Certificado de ciudadanía
- Certificado de elegibilidad como visitante de intercambio
- Certificado de elegibilidad como estudiante no inmigrante
- Tarjeta de autorización de empleo
- Pasaporte extranjero
- Visa de inmigrante automatizada (con texto explícito de I-551 temporal)
- Tarjeta de residente permanente
- Permiso de reingreso
- Documento de viaje para refugiado
- Sello de I-551 temporal (en pasaporte o I-94/I-94a)
- Otra prueba aceptable de estatus migratorio

¿Tiene alguna pregunta o necesita ayuda?

- Llame gratis al 1-877-937-3663.
- Comuníquese con su trabajador(a).

Iowa Department of Human Services

SSI Medicaid Information

IMPORTANT: Your Medicaid cannot start until you return this form.

County Number

State ID

Worker Number

Worker Phone

SSI Application Date

Please send this form back in the enclosed envelope by
so we can decide if you can get Medicaid.

If you need help filling out this form, call your worker at the number listed above. Please answer all questions. **If you are filling out this form for someone else**, please answer the questions as if you were that person.

Please give the phone number where we can reach you: (_____)_____

1. Do you live in a nursing facility? If yes, what is the name of the facility? ❑ Yes ❑ No
   _____
2. Have you or your spouse given away, traded, or sold resources or assets for less than fair market value within the last 60 months (including setting up a trust)? ❑ Yes ❑ No
3. Do you or your spouse have a trust? ❑ Yes ❑ No
4. **Only if you are under the age of 18.** Are both of your parents living with you? If no, list the name(s) and social security number(s) of the parent(s) not living with you. ❑ Yes ❑ No
   Name(s) _____ SSN(s)_____
5. **Only if you recently moved to Iowa**, is the SSI application date the correct date of when you moved to Iowa? If not, then fill in the correct date. ❑ Yes ❑ No
   _____
6. **Only if you are under the age of 23.** Are you a student? ❑ Yes ❑ No
7. **Only if you have a spouse, child or parent who lives with you and that you support**. Do you want to apply for medical and cash assistance for that person? ❑ Yes ❑ No

Retroactive Medicaid Coverage

Only if you want help to pay medical bills you have for the three months before the month you applied for SSI, complete this section. REMEMBER: If you are filling out the form for some one else, fill in the answers for the person who is getting SSI.

If you receive SSI as a disabled person, fill in the date that your disability began: _____

Income

List all income you and your spouse had (or your parents had if you are under age 18) for each of these months and **provide proof of the amount**. Attach a separate sheet if you need more space.

	First month before SSI application			Second month before SSI application			Third month before SSI application		
Type of income received in each month	You	Your Spouse	Parents or Dependents	You	Your Spouse	Parents or Dependents	You	Your Spouse	Parents or Dependents
	Amount	Amount	Amount	Amount	Amount	Amount	Amount	Amount	Amount
Gross earnings									
Veteran's benefits									
Social security									
Private pension									
Disability insurance									
Unemployment benefits									
Dividends and interest									
Income from property									
Workers' compensation									
Railroad retirement									
Gifts									
Accelerated life insurance									
Alimony/ Child support									
Black lung									
Civil service									
In-kind support									
Income insurance									
IPERS									
Life estate									
Self employment									
Trusts									
Student income									
Other (list)									

Resources or Assets

List all resources/assets available to you and your spouse (and your parents if you are under age 18) for each of these months and **provide proof**. Attach a separate sheet if you need more space.

	First month before SSI application			Second month before SSI application			Third month before SSI application		
Type of resource or asset	You	Your Spouse	Parents or Dependents	You	Your Spouse	Parents or Dependents	You	Your Spouse	Parents or Dependents
	Amount	Amount	Amount	Amount	Amount	Amount	Amount	Amount	Amount
Cash on hand									
Checking account									
Savings account									
Stocks or bonds									
Certificates of deposit									
Trust fund									
Value of safety deposit box contents									
IRA/Keogh									
Money market									
Annuities									
Burial funds									
Burial plots									
Home you're not living in									
Home you are living in									
Real estate (not your home)									
Contracts for sale of real estate									
Life estate									
Resources used for self employment									
Life insurance									
Deferred compensation									
Other (identify)									
Vehicles owned by you or your spouse, and if you are under 18 years include your parents' vehicles.	Year _____ Make _____ Model _____ Market value _____			Year _____ Make _____ Model _____ Market value _____			Year _____ Make _____ Model _____ Market value _____		

Health Insurance Information

Remember: If you are filling the form out for some one else, fill in the questions for that person.

1. Do you have Medicare? ❑ Yes ❑ No
   If yes, do you have Part A? ❑ Yes ❑ No Part B? ❑ Yes ❑ No Drug Plan? ❑ Yes ❑ No
2. Do you currently have other health insurance policies? ❑ Yes ❑ No
3. Do you have or could you get health insurance through your job or your spouse's job? ❑ Yes ❑ No
4. If you are under 18, do you have or could you get health insurance through your parent's job? ❑ Yes ❑ No
5. Do you have court ordered medical support? ❑ Yes ❑ No
6. Do you have a lawsuit from an accident? ❑ Yes ❑ No
7. Did you have health insurance that ended since your SSI eligibility began? ❑ Yes ❑ No
   If **yes**, fill in the date it ended: _____
8. Can you get health insurance free of charge? ❑ Yes ❑ No

If you have other health benefits or if you answered Yes to any question about health insurance, complete the following:

Type of policy_____

Name policy holder_____ Relationship to you_____

Address_____

_____

Insurance company name_____

Claims office address_____

_____

Policy number_____ Group number_____

What does the policy cover? (Check all that apply) ❑ Hospital ❑ Physician ❑ Drugs ❑ Dental

If you are covered by more than one health insurance, give us the information on a separate sheet of paper.

Things You Must Agree to If You Get Medicaid

If we need more information, we will contact you after you send this form to the Department of Human Services (DHS). You may call the phone number on the first page if you need Medicaid right away. If you qualify for Medicaid, we will let you know in writing. **You, or someone acting for you, must sign that you agree to the statements on the page titled "Important Statements" before you will get Medicaid.**

I believe the information I give is true, correct, and complete. I know there is a penalty for hiding or giving false information. I understand this and agree to get proof of what I say when asked to by DHS. I certify under penalty of perjury that all answers I give are correct and complete to the best of my knowledge.

Signature or mark of application payee (or legal guardian)		Date	
Signature or person, if any, who helped complete the form		Date	
Name of representative payee		Phone number	
Street address	City	State	Zip code

Important Statements

If I am responsible for a child who is under the age of 18 and has a parent who is not living with this child, I know that I must cooperate to get medical support and to establish paternity when it has not been established for this child. Also, DHS can take action to get medical support for the child from anyone who must provide medical support. When medical support payments for medical expenses have been ordered, they must go to DHS to help pay for medical bills.

I must not let someone else use my medical card.

A medical review is needed before I can get Medicaid if I am living in a nursing home or wanting services that help me to stay at home. The Iowa Medicaid Enterprise (IME) will do this review. I give my permission to DHS, IME, the nursing home and anyone who gives me medical care to share information about my health and information needed to do this review.

The Social Security law requires that DHS use my social security number to check facts with other federal and state government agency computer matching systems like the Internal Revenue Service system. If DHS finds that I gave false information, I will have to pay back what I got incorrectly. I may also face criminal or civil action for giving false information.

Payments made by all health insurance including Medicare must be paid directly to the doctors and health care providers while I get Medicaid. I will cooperate in refunding to DHS payment of any settlement that I get that is to pay for medical bills when Medicaid paid the bill.

The law says DHS does not need permission to recover medical payments. DHS can ask for payment from any person or company who is responsible for paying medical bills for a person who gets Medicaid. I will cooperate with DHS in getting needed information.

Federal and state law allows persons from the federal and state governments to look at records of Medicaid payments. I know that by accepting Medicaid, I am giving my permission for these persons to look at my medical or health care records for the time I am getting Medicaid so these persons can make sure the provider was paid correctly by Medicaid.

I agree to assign medical payments from a third party to the Medicaid agency for myself and others who are eligible for Medicaid for whom I legally can assign benefits. I also agree to cooperate in obtaining payments from third parties.

If I am put in a managed health care plan, I will allow release of medical information, including any clinical mental health information, by persons providing medical care to me. This information will be given to the health maintenance organization, or another managed care plan that is giving me service if I am in managed health care. Also, information may be given to the people who are working for the managed health care plan to determine if provided services are correct, are of good quality, or are used correctly.

If I am the person getting SSI and I am under age 21, I can take part in a program called Care for Kids that promotes my health. The worker has more details.

If you don't agree with any action taken on your Medicaid case, you or your representative may ask for a hearing. This request has to be in writing. Any person you choose may present your case at the hearing.

Your local Department of Human Services will assist in filing an appeal if you ask them. If you disagree with any action taken on your Medicaid, you may contact **Iowa Legal Aid at 1-800-532-1275** or, if you live in **Polk County, call 243-1193** if you need help with an appeal.

We look at your request for Medicaid without considering your race, creed, color, sex, age, physical or mental disability, religion, national origin or political belief. (There are rules about getting Medicaid depending on your age and disability.)

What You Should Know

Reporting Changes

When you get Medicaid you must report some changes to your Department of Human Services county office and other changes to the Social Security Administration. Report your income, resources, and living arrangements to the Social Security Administration.

Report the following changes to your county DHS office within 10 days of the date that you know about the change:

- Health insurance coverage
- The cost of health insurance if you live in a nursing facility
- Entering a nursing facility
- Giving away resources or assets
- Making a trust with your resources or assets
- Staying in a hospital for 15 days or more if you get waiver services
- Moving to a new address

If you get other help from our Department, such as Food Assistance or State Supplementary Assistance, there is more information that you must report. Ask your worker about that.

Your Rights

You have the right to:

- Have Medicaid decided for certain months before you get SSI benefits, if you have medical bills. Your worker will tell you if DHS can help pay those bills.
- Ask for help from programs other than Medicaid.
- Have your questions answered.
- To have information kept confidential, unless it is needed to correctly pay your medical bills.

Your Responsibilities

You must provide proof of the facts we ask about in order to receive Medicaid. (*This is only a guide*.)

Your income maintenance worker may ask you for more information or for more facts on information that you have already given. If you cannot get the information, ask your worker for help. You must give written permission for your worker to contact others for that information. You must show us:

- A trust set up with your resources or assets.
- The value of resources or income that you gave away, sold, traded for less than fair market value or did not take possession of.
- Resources of your spouse if you have a spouse at home and you live in a nursing facility.
- Income and resource facts for you or your spouse, if you want Medicaid for the time before your SSI benefits began.
- We may need more facts regarding your health insurance.
- We may need more facts concerning an absent parent of a child under the age of 18.
- Income and resource facts for you and for your parents if you want Medicaid before your SSI began and you are under the age of 18 and lived at home before your SSI benefits began.

"Income" means earned income, income from self-employment, rental income, social security benefits, veteran's benefits, railroad retirement benefits, child support, interest and dividend income, pensions, and cash from property sold on contract, unemployment benefits, or worker's compensation benefits.

"Resources" or assets, means cash, money in the bank, certificates of deposit, IRAs, Keogh accounts, stocks and bonds, licensed and unlicensed vehicles, land, property sold on contract, burial contracts, real property other than your homestead, burial plots, recreational vehicles, property, life insurance or money market accounts.

Important Notice to Property Owners and Renters

Your property taxes may be suspended or reduced, under Iowa law. You may be eligible if you are elderly or disabled.

What is Tax Suspension?

Tax suspension means that you will not have to pay your property taxes until the property is sold or transferred to another person.

Can My Property Taxes Be Suspended?

Your property taxes may be suspended if:

- You get either Supplemental Security Income (SSI) or State Supplementary Assistance (SSA), or
- You live in a nursing home and the Department of Human Services is paying for all or part of the cost for your care.

You will not have to pay a penalty while your taxes are suspended. The suspended taxes will need to be paid when the property is sold or transferred. If you want to, you can still pay your taxes while they are suspended.

The County Board of Supervisors runs the tax suspension program. You must give the County Board of Supervisors proof that you qualify for property tax suspension. You do this in the county where your property is located.

You will get a Notice of Decision that tells you if you are eligible for tax suspension. This notice will be proof that you qualify. This notice will say:

> "You get SSI, State Supplementary Assistance or you live in a facility in which the Department of Human Services is paying some or all of the cost. You may not have to pay property taxes at this time. Take this notice to your County Board of Supervisors to discuss having your property taxes delayed."

Take your notice to the County Board of Supervisors for the county where your property is located. You can find the address and phone number for the County Board of Supervisors in the government section of your phone book.

What is a Tax Credit?

A tax credit lowers or gets rid of the amount of tax to be paid when property is sold or transferred.

Can I Get a Tax Credit?

You may be able to get an extra tax credit of up to $1,000. You must own your homestead property and be responsible for the taxes due on the property.

The amount of the tax credit is based on your income. You may be able to get the extra tax credit if your household's income is less than $22,360.00 and you:

- Were 65 years of age or older as of December 31 of last year, or
- Were totally disabled as of December 31 of last year.

Note: A claim for tax credit may be filed on behalf of an eligible deceased person by the deceased person's spouse, attorney, guardian, or administrator.

To get a tax credit, you must file with your county treasurer.

Can I Get Both?

Yes, it is better for you to file for both a tax suspension and a tax credit.

What if I Am Renting My Home?

If you rent your home, and your home is subject to taxes, you may get up to $1,000 of the total rent you pay each year back. If you live in a nursing home, you are considered to be a renter for this purpose.

You may be eligible for the rent reimbursement if your household's income is less than $22,360.00 and you:

- Were 65 years of age or older as of December 31 of last year, or
- Were totally disabled as of December 31 of last year.

Note: A claim for rent reimbursement may be filed on behalf of an eligible deceased person by the deceased person's spouse, attorney, guardian, or administrator.

Rent reimbursement forms are available at your county treasurer's office.

Iowa Department of Human Services

SSI Medicaid Information
(Recordatorio de Medicaid SSI)

IMPORTANTE: Su Medicaid no comenzará hasta que devuelva este formulario.

Número del condado

Identificación del Estado

Número del trabajador

Teléfono del trabajador

Fecha de solicitud de SSI

Por favor, envíe este formulario en el sobre que se adjunta antes del para que podamos decidir si usted puede obtener Medicaid.

Si necesita ayuda para completar este formulario, llame a su asistente social al número que aparece arriba. Por favor, conteste todas las preguntas. **Si está completando este formulario para otra persona,** conteste las preguntas como si fuera esa persona.

Por favor, indique el número de teléfono al que podemos llamarlo/a: (_____)_____

1. ¿Vive en un centro de cuidados especializados? Si respondió sí, ¿cuál es el nombre del centro? _____ ❑ Sí ❑ No
2. ¿Usted o su cónyuge donaron, canjearon o vendieron recursos o activos a un valor menor que el normal de mercado en los últimos 60 meses (incluida la constitución de un fideicomiso)? ❑ Sí ❑ No
3. ¿Tienen usted o su cónyuge un fideicomiso? ❑ Sí ❑ No
4. **Solo si es menor de 18 años.** ¿Viven sus padres con usted? Si respondió no, indique el/los nombre(s) y número(s) de seguro social de su padre y/o madre que no vive con usted. Nombre(s) _____ SSN(s)_____ ❑ Sí ❑ No
5. **Sólo si usted se mudó recientemente a Iowa**, ¿la fecha de solicitud para SSI es decir, el , es la fecha correcta de cuando usted se mudó a Iowa? Si respondió no, entonces indique la fecha correcta. _____ ❑ Sí ❑ No
6. **Solo si es menor de 23 años.** ¿Es usted estudiante? ❑ Sí ❑ No
7. **Solo si tiene un cónyuge, hijo/a o padre/madre que vive con usted y usted lo/la mantiene**. ¿Desea solicitar asistencia médica y económica para dicha persona? ❑ Sí ❑ No

Cobertura de Medicaid Retroactivo

Complete esta sección solamente si usted desea ayuda para pagar facturas médicas de los tres meses anteriores al mes en que solicitó SSI. RECUERDE: Si está completando este formulario para otra persona, complete las respuestas con la información de la persona que desea obtener SSI.

Si recibe SSI como discapacitado/a, indique la fecha de inicio de su incapacidad: _____

Ingreso

Indique todos los ingresos que usted y su cónyuge tenían (o sus padres tenían, si es menor de 18 años) en cada uno de estos meses y **proporcione comprobantes de los importes**. Adjunte la información en una hoja por separado si necesita más espacio.

	Primer mes antes de solicitud SSI			Segundo mes antes de solicitud SSI			Tercer mes antes de solicitud SSI		
Tipo de ingreso recibido cada mes	Usted	Su cónyuge	Padres o Dependientes	Usted	Su cónyuge	Padres o Dependientes	Usted	Su cónyuge	Padres o Dependientes
	Cantidad	Cantidad	Cantidad	Cantidad	Cantidad	Cantidad	Cantidad	Cantidad	Cantidad
Salario bruto									
Beneficios de Veteranos									
Seguro social									
Jubilación privada									
Seguro por incapacidad									
Beneficios de desempleo									
Dividendos e intereses									
Ingresos por propiedades									
Indemnización de trabajadores									
Retiro ferroviario									
Donativos									
Seguro de vida anticipado									
Pensión alimenticia Manutención de hijos									
Pulmón negro									
Administración pública									
Pagos en especies									
Seguro de ingresos									
IPERS									
Propiedad vitalicia									
Trabajo independiente									
Fideicomisos									
Ingresos para estudiantes									
Otros (liste)									

Recursos o Activos

Nombre todos los recursos/activos de que disponían usted y su cónyuge (y sus padres si es menor de 18 años en cada mes y **proporcione comprobantes**. Adjunte la información en una hoja por separado si necesita más espacio.

	Primer mes antes de solicitud SSI			Segundo mes antes de solicitud SSI			Tercer mes antes de solicitud SSI		
Tipo de recurso o activo	Usted	Su cónyuge	Padres o Dependientes	Usted	Su cónyuge	Padres o Dependientes	Usted	Su cónyuge	Padres o Dependientes
	Cantidad	Cantidad	Cantidad	Cantidad	Cantidad	Cantidad	Cantidad	Cantidad	Cantidad
Efectivo en mano									
Cuenta corriente									
Caja de ahorros									
Acciones o bonos									
Certificados de depósito									
Fondo de inversión									
Valor de los contenidos de la caja de seguridad									
IRA/Keogh									
Mercado de dinero									
Rentas anuales									
Fondos de sepultura									
Lotes de sepultura									
Vivienda en la que no reside									
Vivienda en la que reside									
Bienes raíces (no su vivienda familiar)									
Contratos para venta de bienes raíces									
Propiedades vitalicias									
Recursos usados para trabajo independiente									
Seguro de vida									
Compensaciones diferidas									
Otros (especifique)									
Vehículos de su propiedad o de su cónyuge, y si es menor de 18 años incluya los vehículos de sus padres.	Año _____ Marca _____ Modelo _____ Valor de mercado _____			Año _____ Marca _____ Modelo _____ Valor de mercado _____			Año _____ Marca _____ Modelo _____ Valor de mercado _____		

Información sobre Seguro Médico

Recuerde: Si completa este formulario para otra persona, conteste las preguntas con la información de dicha persona.

1. ¿Tiene Medicare? ❑ Sí ❑ No
   Si respondió sí, ¿tiene Parte A? ❑Sí ❑ No ¿Parte B? ❑Sí ❑ No ¿Plan de medicamentos? ❑ Sí ❑ No
2. ¿Tiene otras pólizas de seguros médico en este momento? ❑ Sí ❑ No
3. ¿Tiene o puede obtener seguro médico a través de su empleo o del de su cónyuge? ❑ Sí ❑ No
4. Si es menor de 18 años, ¿tiene o puede conseguir seguro médico a través del empleo de sus padres? ❑ Sí ❑ No
5. ¿Recibe ayuda médica por orden judicial? ❑ Sí ❑ No
6. ¿Tiene una demanda judicial debido a un accidente? ❑ Sí ❑ No
7. ¿Tenía un seguro médico que finalizó desde que el proceso de elegibilidad para SSI se inició? Si respondió **sí**, indique la fecha en que finalizó: _____ ❑ Sí ❑ No
8. ¿Puede obtener seguro médico gratis? ❑ Sí ❑ No

Si tiene otras prestaciones médicas o si respondió "Sí" a alguna de las preguntas sobre seguro médico, complete lo siguiente:

Tipo de póliza _____

Nombre del titular de la póliza _____ Su parentesco con Ud _____

Domicilio _____

_____

Nombre de la compañía de seguros _____

Domicilio de la oficina de reclamos _____

_____

Número de póliza _____ Número de grupo _____

¿Qué cubre la póliza? (Marque todo lo que corresponda) ❑Hospital ❑ Médico ❑ Medicamentos ❑ Dentista

Si tiene cobertura de más de un seguro médico, entréguenos la información en una hoja por separado.

Si obtiene Medicaid, deberá aceptar lo siguiente

Si necesitáramos más información, nos comunicaremos con usted después que envíe este formulario al Department of Human Services (DHS). Si necesita utilizar Medicaid inmediatamente, puede llamar al teléfono que aparece en la primera página. Si usted califica para Medicaid, se lo comunicaremos por escrito. **Usted, o la persona que actúe en su representación, debe firmar aceptando las declaraciones de la página titulada "Important Statements" antes de obtener Medicaid.**

Creo que la información que entrego es verdadera, correcta y completa. Sé que existen sanciones por esconder o dar información falsa. Lo comprendo y acepto conseguir pruebas de lo que digo cuando DHS me lo pida. Certifico bajo pena de cometer perjurio que todas las respuestas que presento son correctas y están completas en mi opinión.

Firma o marca del beneficiario (o tutor legal)		Fecha	
Firma de la persona que ayudó a completar el formulario, si corresponde.		Fecha	
Nombre del representante del beneficiario		Teléfono	
Domicilio	Localidad	Estado	Código postal

Declaraciones Importantes

Si soy responsable de un(a) menor de 18 años y uno de sus padres no vive con él/ella, sé que debo cooperar para conseguirle ayuda médica y para establecer la paternidad si ésta no hubiera sido establecida para dicho(a) menor. Además, con el fin de obtener ayuda médica para el/la menor, DHS puede iniciar acciones legales contra cualquier persona que tenga la obligación de proporcionar ayuda médica. En el caso que se hubiera ordenado el pago de ayuda médica por gastos médicos, dichas personas deben dirigirse a DHS para colaborar con el pago de las facturas médicas.

No debo permitir que otra persona use mi tarjeta médica.

Si estoy viviendo en un una residencia geriátrica o deseo obtener servicios que me ayuden a quedarme en mi hogar, es necesario que me haga un examen médico antes de obtener Medicaid. El examen lo realizará la empresa Iowa Medicaid Enterprise (IME). Autorizo a DHS, IME, a la residencia geriátrica y a cualquier persona que me brinda atención médica a compartir información sobre mi salud y otra información necesaria para realizar dicho examen.

La ley de Seguridad Social requiere que DHS utilice mi número de seguro social para verificar y comparar datos con los sistemas informáticos de otras agencias federales y gubernamentales, como por ejemplo el sistema de Internal Revenue Service (Servicio de Recaudación de Impuestos). Si DHS descubriera que presenté información falsa, deberé devolver lo que conseguí indebidamente. También podría afrontar acciones legales civiles o penales por presentar información falsa.

Todos los seguros médicos, incluido Medicare, deberán realizar los pagos directamente a los médicos y a los proveedores de atención médica mientras obtengo Medicaid. Yo cooperaré para devolverle a DHS el pago de cualquier beneficio que consiga y que esté destinado al pago de facturas médicas, si Medicaid hubiera pagado las facturas.

La ley dice que DHS no necesita autorización para recuperar los pagos por prestaciones médicas. DHS puede solicitar el pago a cualquier persona o compañía que sea responsable de pagar las facturas médicas de una persona que obtenga Medicaid. Yo cooperaré con DHS en la obtención de la información necesaria.

La ley federal y estatal autoriza que los agentes de los gobiernos federal y estatal vean los registros de pagos de Medicaid. Sé que al aceptar Medicaid, estoy autorizando a dichos agentes a ver mi historia clínica y mis expedientes de atención médica durante el período en que obtengo Medicaid, con el fin que dichos agentes puedan comprobar que Medicaid le pagó correctamente al proveedor.

Acepto entregar a la agencia Medicaid los pagos de gastos médicos realizados por terceros para mí y otras personas elegibles para Medicaid, para las cuales yo estoy legalmente autorizado/a a asignar beneficios. Además, acepto cooperar para obtener pagos de gastos médicos provenientes de terceros.

Si me ponen en un plan de medicina prepaga (managed health care plan), autorizaré a las personas que me brindan atención médica a que divulguen mi información médica, incluyendo cualquier tipo de información clínica sobre salud mental. Dicha información será entregada a la organización para el mantenimiento de la salud (HMO), o a otro plan managed care que me brinde servicios, si correspondiera. Además, dicha información podrá ser entregada a los empleados del plan managed care para que determinen si los servicios provistos son adecuados, son de buena calidad o son usados correctamente.

Si soy la persona que desea obtener SSI y soy menor de 21 años, puedo participar del programa llamado “Care for Kids” que promueve la salud. El/La asistente social me dará más información.

Si no está de acuerdo con alguna de las decisiones tomadas sobre su caso Medicaid, usted o su representante pueden solicitar una audiencia. Dicha solicitud debe ser hecha por escrito. Usted puede elegir a otra persona para que presente su caso en la audiencia.

Su Department of Human Services local le prestará ayuda para que presente una apelación si se los solicita. Si usted no está de acuerdo con alguna de las decisiones tomadas sobre su Medicaid, puede comunicarse con **Iowa Legal Aid** (Asistencia Legal de Iowa) **al teléfono 1-800-532-1275** o, si vive en **Polk County, llame al teléfono 243-1193** si necesita ayuda con la apelación.

Examinamos su solicitud de Medicaid sin tener en cuenta su raza, credo, color, sexo, edad, incapacidad física o mental, religión, país de procedencia o creencias políticas. (Existen normas con respecto a su edad e incapacidad para la obtención de Medicaid).

Lo que debe saber

Cómo informar cambios

Cuando obtenga Medicaid, deberá informar algunos cambios a la oficina del condado del Department of Human Services y otras modificaciones a Social Security Administration. Informe sus ingresos, recursos y arreglos de alojamiento a Social Security Administration.

Informe los siguientes cambios a la oficina DHS del condado en un plazo de 10 días a partir de la fecha en que se entere de la modificación:

- La cobertura del seguro médico.
- El costo del seguro médico si vive en un centro de cuidados especializados.
- El ingreso a un centro de cuidados especializados.
- La donación de recursos o activos.
- La creación de un fideicomiso con sus recursos o activos.
- Su permanencia en un hospital por 15 días o más si obtiene servicios de exención (waiver services).
- Su mudanza a un nuevo domicilio.

Si obtiene otro tipo de asistencia de nuestro Departamento, como Food Assistance (Asistencia para Alimentos) o State Supplementary Assistance (Asistencia Estatal Suplementaria), también deberá informar estos datos. Pregúntele a su asistente social sobre este tema.

Sus derechos

Usted tiene derecho a:

- Tener Medicaid algunos meses antes de obtener los beneficios SSI, si usted tuviera facturas médicas que pagar. Su asistente social le dirá si DHS puede ayudarle a pagar dichas facturas.
- Solicitar la ayuda de otros programas que no sean Medicaid.
- Que le respondan sus preguntas.
- Que la información sea confidencial, a menos que sea necesaria para pagar sus facturas médicas correctamente.

Sus responsabilidades

Usted debe proporcionar pruebas de los datos sobre los que le preguntamos para recibir Medicaid. (*Ésta es solamente una guía*.)

Su asistente social de Income Maintenance podría pedirle más información o más datos con respecto a la información que ya nos ha entregado. Si no puede conseguir la información, pídale a su asistente social que le preste ayuda. Su asistente social necesitará su autorización para comunicarse con otras personas y conseguir dicha información. Usted debe mostrarnos:

- Un fideicomiso creado con sus recursos o activos.
- El valor de los recursos o ingresos que usted donó, vendió o canjeó por menos del valor normal de mercado o de los que nunca tomó posesión.
- Los recursos de su cónyuge, si su cónyuge vive en su hogar y usted vive en un centro de cuidados especializados
- Los datos de sus ingresos y recursos o los de su cónyuge, si desea recibir Medicaid durante el período anterior a que comiencen los beneficios SSI.
- Podríamos necesitar más datos con respecto a su seguro médico.
- Podríamos necesitar más datos con respecto al padre ausente de un menor de 18 años.
- Los datos de sus ingresos y recursos, y los de sus padres si desea recibir Medicaid antes que comiencen los beneficios SSI, y si usted es menor de 18 años y vivía en su hogar antes del inicio de los beneficios SSI.

"Ingresos" significa: sueldo, ingresos por trabajo independiente, ingresos por rentas, beneficios de seguridad social, beneficios para veteranos, beneficios por retiro ferroviario, manutención de hijos, ingresos por intereses y dividendos, jubilaciones, y dinero en efectivo proveniente de propiedades vendidas por contrato, subsidios de desempleo, o beneficios de Workers´ Compensation.

"Recursos" o activos significa: dinero en efectivo, dinero en el banco, certificados de depósito, IRA (cuentas de jubilación particular), cuentas Keogh (plan de jubilación para profesionales autónomos o propietarios de microempresas), acciones y bonos, vehículos con o sin licencia, tierras o terrenos, propiedades vendidas por contrato, contratos funerarios, bienes inmuebles que no sean su vivienda familiar, lotes de sepultura, vehículos recreativos, propiedades, seguros de vida, o cuentas en el mercado de dinero.

Important Notice to Property Owners and Renters
(Aviso Importante para Propietarios y Arrendatarios)

Bajo las leyes de Iowa, sus impuestos sobre la propiedad pueden suspenderse o reducirse. Usted puede ser elegible si es anciano(a) o incapacitado(a).

¿Qué es la suspensión de impuestos?

La suspensión de impuestos significa que usted no tendrá que pagar sus impuestos sobre la propiedad hasta que ésta se venda o se transfiera a otra persona.

¿Pueden ser suspendidos mis impuestos sobre la propiedad?

Sus impuestos sobre la propiedad pueden suspenderse si:

- Usted recibe Supplemental Security Income (SSI) o State Supplementary Assistance (SSA), ó
- Si usted vive en un ancianato y el Department of Human Services paga la totalidad o parte del costo de la atención que usted recibe.

Usted no tendrá que pagar ninguna multa mientras sus impuestos estén suspendidos. Deberán pagarse los impuestos suspendidos cuando la propiedad se venda o transfiera. Si lo desea, puede aún pagar sus impuestos mientras están suspendidos.

La Junta de Supervisores del Condado dirige el programa de suspensión de impuestos. Usted debe brindarle pruebas a la Junta de Supervisores del Condado acerca de que usted califica para la suspensión de impuestos sobre la propiedad. Este trámite debe ser realizado en el condado donde está ubicada la propiedad.

Usted recibirá un Aviso de Decisión que le dirá si es elegible para la suspensión del impuesto. Este aviso será prueba de que usted califica. Este aviso dirá lo siguiente:

> "Usted recibe SSI, Asistencia Estatal Suplementaria, o vive en una vivienda cuyo costo es pagado parcial o totalmente por el Department of Human Service. Es posible que no deba pagar impuestos inmobiliarios en este momento. Lleve esta notificación al Consejo del Condado (Board of Supervisors) para plantear la posibilidad de que sus impuestos inmobiliarios sean demorados."

Lleve su aviso a la Junta de Supervisores del Condado del condado donde está ubicada su propiedad. Puede encontrar la dirección y número telefónico de la Junta de Supervisores del Condado en la sección de gobierno de su directorio telefónico.

¿Qué es el crédito de impuestos?

Un crédito de impuestos elimina o reduce el monto de impuestos que deberá pagar cuando venda o transfiera la propiedad.

¿Yo puedo obtener un crédito de impuestos?

Usted puede obtener un crédito de impuestos adicional hasta de $1.000. Usted debe ser dueño de su hogar y ser el responsable de pagar los impuestos sobre la propiedad.

El monto del crédito de impuestos se basa en su ingreso. Usted puede obtener crédito de impuestos adicional si el ingreso de su hogar es menor a $22.360,00, y usted:

- Tenía 65 años de edad o más al 31 de diciembre del año pasado, o
- Estaba totalmente incapacitado/a al 31 de diciembre del año pasado.

Nota: El cónyuge, el abogado, el tutor o el administrador de una persona elegible fallecida pueden radicar un reclamo de crédito fiscal a nombre de la persona fallecida.

Para obtener crédito de impuestos, debe solicitarlo ante el tesorero del condado.

¿Puedo obtener ambos?

Sí, es mejor si usted solicita tanto una suspensión de impuestos y un crédito de impuestos.

¿Qué pasa si estoy arrendando mi hogar?

Si usted arrienda su hogar y éste está sujeto a impuestos, usted puede recibir una devolución de hasta $1.000 del total de la renta que paga cada año. Si usted vive en un ancianato, usted se considera un arrendador para estos propósitos.

Usted puede ser elegible para un crédito de impuestos adicional si el ingreso de su hogar es menor a $22.360,00, y usted:

- Tenía 65 años de edad o más al 31 de diciembre del año pasado, o
- Estaba totalmente incapacitado/a al 31 de diciembre del año pasado.

Nota: El cónyuge, el abogado, el tutor o el administrador de una persona elegible fallecida pueden radicar un reclamo de reembolso de alquiler a nombre de la persona fallecida.

Los formularios de reembolso de renta están disponibles en la oficina del tesorero de su condado.

Iowa Department of Human Services

SSI Medicaid Information

IMPORTANT: Your Medicaid cannot start until you return this form.

Date:

County Number

State ID

Worker Number

Worker Phone

SSI Application Date

Please send this form back in the enclosed envelope by , so we can decide if you can get Medicaid.

If you need help filling out this form, call your worker at the number listed above. Please answer all questions. **If you are filling out this form for someone else**, please answer the questions as if you were that person.

Please give the phone number where we can reach you: _____

1. Do you live in a nursing facility? If yes, what is the name of the facility? ❑ Yes ❑ No
   _____
2. Have you or your spouse given away, traded, or sold resources or assets for less than fair market value within the last 60 months (including setting up a trust)? ❑ Yes ❑ No
3. Do you or your spouse have a trust? ❑ Yes ❑ No
4. **Only if you are under the age of 18.** Are both of your parents living with you? If no, list the name(s) and social security number(s) of the parent(s) not living with you. ❑ Yes ❑ No
   Name(s) _____ SSN(s)_____
5. **Only if you recently moved to Iowa**, is the SSI application date , the correct date of when you moved to Iowa? If not, then fill in the correct date. ❑ Yes ❑ No
   _____
6. **Only if you are under the age of 23.** Are you a student? ❑ Yes ❑ No
7. **Only if you have a spouse, child or parent who lives with you and that you support**. Do you want to apply for medical and cash assistance for that person? ❑ Yes ❑ No

Retroactive Medicaid Coverage

Only if you want help to pay medical bills you have for the three months before the month you applied for SSI, complete this section. REMEMBER: If you are filling out the form for some one else, fill in the answers for the person who is getting SSI.

If you receive SSI as a disabled person, fill in the date that your disability began: _____

Income

List all income you and your spouse had (or your parents had if you are under age 18) for each of these months and **provide proof of the amount**. Attach a separate sheet if you need more space.

	First month before SSI application			Second month before SSI application			Third month before SSI application		
Type of income received in each month	You	Your Spouse	Parents or Dependents	You	Your Spouse	Parents or Dependents	You	Your Spouse	Parents or Dependents
	Amount	Amount	Amount	Amount	Amount	Amount	Amount	Amount	Amount
Gross earnings									
Veteran's benefits									
Social security									
Private pension									
Disability insurance									
Unemployment benefits									
Dividends and interest									
Income from property									
Workers' compensation									
Railroad retirement									
Gifts									
Accelerated life insurance									
Alimony/ Child support									
Black lung									
Civil service									
In-kind support									
Income insurance									
IPERS									
Life estate									
Self employment									
Trusts									
Student income									
Other (List)									

Resources or Assets

List all resources/assets available to you and your spouse (and your parents if you are under age 18) for each of these months and **provide proof**. Attach a separate sheet if you need more space.

	First month before SSI application			Second month before SSI application			Third month before SSI application		
Type of resource or assets	You	Your Spouse	Parents or Dependents	You	Your Spouse	Parents or Dependents	You	Your Spouse	Parents or Dependents
	Amount	Amount	Amount	Amount	Amount	Amount	Amount	Amount	Amount
Cash on hand									
Checking account									
Savings account									
Stocks or bonds									
Certificates of deposit									
Trust fund									
Value of safety deposit box contents									
IRA/Keogh									
Money market									
Annuities									
Burial funds									
Burial plots									
Home you're not living in									
Home you are living in									
Real estate (not your home)									
Contracts for sale of real estate									
Life estate									
Resources used for self employment									
Life insurance									
Deferred compensation									
Other (Identify)									
Vehicles owned by you or your spouse, and if you are under 18 years include your parents' vehicles.	Year _____ Make _____ Model _____ Market value _____			Year _____ Make _____ Model _____ Market value _____			Year _____ Make _____ Model _____ Market value _____		

Health Insurance Information

Remember: If you are filling the form out for some one else, fill in the questions for that person.

1. Do you have Medicare? ❑ Yes ❑ No
   If yes, do you have Part A? ❑ Yes ❑ No Part B? ❑ Yes ❑ No Drug Plan? ❑ Yes ❑ No
2. Do you currently have other health insurance policies? ❑ Yes ❑ No
3. Do you have or could you get health insurance through your job or your spouse's job? ❑ Yes ❑ No
4. If you are under 18, do you have or could you get health insurance through your parent's job? ❑ Yes ❑ No
5. Do you have court ordered medical support? ❑ Yes ❑ No
6. Do you have a lawsuit from an accident? ❑ Yes ❑ No
7. Did you have health insurance that ended since your SSI eligibility began? ❑ Yes ❑ No
   If **yes**, fill in the date it ended: _____
8. Can you get health insurance free of charge? ❑ Yes ❑ No

If you have other health benefits or if you answered Yes to any question about health insurance, complete the following:

Type of policy_____

Name policy holder_____ Relationship to you_____

Address_____

_____

Insurance company name_____

Claims office address_____

_____

Policy number_____ Group number_____

What does the policy cover? (Check all that apply) ❑ Hospital ❑ Physician ❑ Drugs ❑ Dental

_____

If you are covered by more than one health insurance, give us the information on a separate sheet of paper.

Things You Must Agree to If You Get Medicaid

If we need more information, we will contact you after you send this form to the Department of Human Services (DHS). You may call the phone number on the first page if you need Medicaid right away. If you qualify for Medicaid, we will let you know in writing. **You, or someone acting for you, must sign that you agree to the statements on the page titled "Important Statements" before you will get Medicaid.**

I believe the information I give is true, correct, and complete. I know there is a penalty for hiding or giving false information. I understand this and agree to get proof of what I say when asked to by DHS. I certify under penalty of perjury that all answers I give are correct and complete to the best of my knowledge.

Signature or mark of application payee (or legal guardian)		Date	
Signature or person, if any, who helped complete the form		Date	
Name of representative payee		Phone number	
Street address	City	State	Zip code

Important Statements

If I am responsible for a child who is under the age of 18 and has a parent who is not living with this child, I know that I must cooperate to get medical support and to establish paternity when it has not been established for this child. Also, DHS can take action to get medical support for the child from anyone who must provide medical support. When medical support payments for medical expenses have been ordered, they must go to DHS to help pay for medical bills.

I must not let someone else use my medical card.

A medical review is needed before I can get Medicaid if I am living in a nursing home or wanting services that help me to stay at home. The Iowa Medicaid Enterprise (IME) will do this review. I give my permission to DHS, IME, the nursing home and anyone who gives me medical care to share information about my health and information needed to do this review.

The Social Security law requires that DHS use my social security number to check facts with other federal and state government agency computer matching systems like the Internal Revenue Service system. If DHS finds that I gave false information, I will have to pay back what I got incorrectly. I may also face criminal or civil action for giving false information.

Payments made by all health insurance including Medicare must be paid directly to the doctors and health care providers while I get Medicaid. I will cooperate in refunding to DHS payment of any settlement that I get that is to pay for medical bills when Medicaid paid the bill.

The law says DHS does not need permission to recover medical payments. DHS can ask for payment from any person or company who is responsible for paying medical bills for a person who gets Medicaid. I will cooperate with DHS in getting needed information.

Federal and state law allows persons from the federal and state governments to look at records of Medicaid payments. I know that by accepting Medicaid, I am giving my permission for these persons to look at my medical or health care records for the time I am getting Medicaid so these persons can make sure the provider was paid correctly by Medicaid.

I agree to assign medical payments from a third party to the Medicaid agency for myself and others who are eligible for Medicaid for whom I legally can assign benefits. I also agree to cooperate in obtaining payments from third parties.

If I am put in a managed health care plan, I will allow release of medical information, including any clinical mental health information, by persons providing medical care to me. This information will be given to the health maintenance organization, or another managed care plan that is giving me service if I am in managed health care. Also, information may be given to the people who are working for the managed health care plan to determine if provided services are correct, are of good quality, or are used correctly.

If I am the person getting SSI and I am under age 21, I can take part in a program called Care for Kids that promotes my health. The worker has more details.

If you don’t agree with any action taken on your Medicaid case, you or your representative may ask for a hearing. This request has to be in writing. Any person you choose may present your case at the hearing.

Your local Department of Human Services will assist in filing an appeal if you ask them. If you disagree with any action taken on your Medicaid, you may contact **Iowa Legal Aid at 1-800-532-1275** or, if you live in **Polk County, call 243-1193** if you need help with an appeal.

We look at your request for Medicaid without considering your race, creed, color, sex, age, physical or mental disability, religion, national origin or political belief. (There are rules about getting Medicaid depending on your age and disability.)

What You Should Know

Reporting Changes

When you get Medicaid you must report some changes to your Department of Human Services county office and other changes to the Social Security Administration. Report your income, resources, and living arrangements to the Social Security Administration.

Report the following changes to your county DHS office within 10 days of the date that you know about the change:

- Health insurance coverage
- The cost of health insurance if you live in a nursing facility
- Entering a nursing facility
- Giving away resources or assets
- Making a trust with your resources or assets
- Staying in a hospital for 15 days or more if you get waiver services
- Moving to a new address

If you get other help from our Department, such as Food Assistance or State Supplementary Assistance, there is more information that you must report. Ask your worker about that.

Your Rights

You have the right to:

- Have Medicaid decided for certain months before you get SSI benefits, if you have medical bills. Your worker will tell you if DHS can help pay those bills.
- Ask for help from programs other than Medicaid.
- Have your questions answered.
- To have information kept confidential, unless it is needed to correctly pay your medical bills.

Your Responsibilities

You must provide proof of the facts we ask about in order to receive Medicaid. (*This is only a guide*.)

Your income maintenance worker may ask you for more information or for more facts on information that you have already given. If you cannot get the information, ask your worker for help. You must give written permission for your worker to contact others for that information. You must show us:

- A trust set up with your resources or assets.
- The value of resources or income that you gave away, sold, traded for less than fair market value or did not take possession of.
- Resources of your spouse if you have a spouse at home and you live in a nursing facility.
- Income and resource facts for you or your spouse, if you want Medicaid for the time before your SSI benefits began.
- We may need more facts regarding your health insurance.
- We may need more facts concerning an absent parent of a child under the age of 18.
- Income and resource facts for you and for your parents if you want Medicaid before your SSI began and you are under the age of 18 and lived at home before your SSI benefits began.

"Income" means earned income, income from self-employment, rental income, social security benefits, veteran's benefits, railroad retirement benefits, child support, interest and dividend income, pensions, and cash from property sold on contract, unemployment benefits, or worker's compensation benefits.

"Resources" or assets, means cash, money in the bank, certificates of deposit, IRAs, Keogh accounts, stocks and bonds, licensed and unlicensed vehicles, land, property sold on contract, burial contracts, real property other than your homestead, burial plots, recreational vehicles, property, life insurance or money market accounts.

Important Notice to Property Owners and Renters

Your property taxes may be suspended or reduced, under Iowa law. You may be eligible if you are elderly or disabled.

What is Tax Suspension?

Tax suspension means that you will not have to pay your property taxes until the property is sold or transferred to another person.

Can My Property Taxes Be Suspended?

Your property taxes may be suspended if:

- You get either Supplemental Security Income (SSI) or State Supplementary Assistance (SSA), or
- You live in a nursing home and the Department of Human Services is paying for all or part of the cost for your care.

You will not have to pay a penalty while your taxes are suspended. The suspended taxes will need to be paid when the property is sold or transferred. If you want to, you can still pay your taxes while they are suspended.

The County Board of Supervisors runs the tax suspension program. You must give the County Board of Supervisors proof that you qualify for property tax suspension. You do this in the county where your property is located.

You will get a Notice of Decision that tells you if you are eligible for tax suspension. This notice will be proof that you qualify. This notice will say:

> "You get SSI, State Supplementary Assistance or you live in a facility in which the Department of Human Services is paying some or all of the cost. You may not have to pay property taxes at this time. Take this notice to your County Board of Supervisors to discuss having your property taxes delayed."

Take your notice to the County Board of Supervisors for the county where your property is located. You can find the address and phone number for the County Board of Supervisors in the government section of your phone book.

What is a Tax Credit?

A tax credit lowers or gets rid of the amount of tax to be paid when property is sold or transferred.

Can I Get a Tax Credit?

You may be able to get an extra tax credit of up to $1,000. You must own your homestead property and be responsible for the taxes due on the property.

The amount of the tax credit is based on your income. You may be able to get the extra tax credit if your household's income is less than $22,360.00 and you:

- Were 65 years of age or older as of December 31 of last year, or
- Were totally disabled as of December 31 of last year.

Note: A claim for tax credit may be filed on behalf of an eligible deceased person by the deceased person's spouse, attorney, guardian, or administrator.

To get a tax credit, you must file with your county treasurer.

Can I Get Both?

Yes, it is better for you to file for both a tax suspension and a tax credit.

What if I Am Renting My Home?

If you rent your home, and your home is subject to taxes, you may get up to $1,000 of the total rent you pay each year back. If you live in a nursing home, you are considered to be a renter for this purpose.

You may be eligible for the rent reimbursement if your household's income is less than $22,360.00 and you:

- Were 65 years of age or older as of December 31 of last year, or
- Were totally disabled as of December 31 of last year.

Note: A claim for rent reimbursement may be filed on behalf of an eligible deceased person by the deceased person's spouse, attorney, guardian, or administrator.

Rent reimbursement forms are available at your county treasurer's office.

Iowa Department of Human Services

SSI Medicaid Information
(Recordatorio de Medicaid SSI)

IMPORTANTE: Su Medicaid no comenzará hasta que devuelva este formulario.

Número del condado

Identificación del estado

Número del trabajador

Teléfono del trabajador

Fecha de solicitud de SSI

Por favor, envíe este formulario en el sobre que se adjunta antes del _____ para que podamos decidir si usted puede obtener Medicaid.

Si necesita ayuda para completar este formulario, llame a su asistente social al número que aparece arriba. Por favor, conteste todas las preguntas. **Si está completando este formulario para otra persona,** conteste las preguntas como si fuera esa persona.

Por favor, indique el número de teléfono al que podemos llamarlo/a: (_____)_____

1. ¿Vive en un centro de cuidados especializados? Si respondió sí, ¿cuál es el nombre del centro? _____ ❑ Sí ❑ No
2. ¿Usted o su cónyuge donaron, canjearon o vendieron recursos o activos a un valor menor que el normal de mercado en los últimos 60 meses (incluida la constitución de un fideicomiso)? ❑ Sí ❑ No
3. ¿Tienen usted o su cónyuge un fideicomiso? ❑ Sí ❑ No
4. **Solo si es menor de 18 años.** ¿Viven sus padres con usted? Si respondió no, indique el/los nombre(s) y número(s) de seguro social de su padre y/o madre que no vive con usted. Nombre(s) _____ SSN(s)_____ ❑ Sí ❑ No
5. **Sólo si usted se mudó recientemente a Iowa**, ¿la fecha de solicitud para SSI es decir, el _____, es la fecha correcta de cuando usted se mudó a Iowa? Si respondió no, entonces indique la fecha correcta. _____ ❑ Sí ❑ No
6. **Solo si es menor de 23 años.** ¿Es usted estudiante? ❑ Sí ❑ No
7. **Solo si tiene un cónyuge, hijo/a o padre/madre que vive con usted y usted lo/la mantiene**. ¿Desea solicitar asistencia médica y económica para dicha persona? ❑ Sí ❑ No

Cobertura de Medicaid Retroactivo

Complete esta sección solamente si usted desea ayuda para pagar facturas médicas de los tres meses anteriores al mes en que solicitó SSI. RECUERDE: Si está completando este formulario para otra persona, complete las respuestas con la información de la persona que desea obtener SSI.

Si recibe SSI como discapacitado/a, indique la fecha de inicio de su incapacidad: _____

Ingreso

Indique todos los ingresos que usted y su cónyuge tenían (o sus padres tenían, si es menor de 18 años) en cada uno de estos meses y **proporcione comprobantes de los importes**. Adjunte la información en una hoja por separado si necesita más espacio.

	Primer mes antes de solicitud SSI			Segundo mes antes de solicitud SSI			Tercer mes antes de solicitud SSI		
Tipo de ingreso recibido cada mes	Usted	Su cónyuge	Padres o Dependientes	Usted	Su cónyuge	Padres o Dependientes	Usted	Su cónyuge	Padres o Dependientes
	Cantidad	Cantidad	Cantidad	Cantidad	Cantidad	Cantidad	Cantidad	Cantidad	Cantidad
Salario bruto									
Beneficios de Veteranos									
Seguro social									
Jubilación privada									
Seguro por incapacidad									
Beneficios de desempleo									
Dividendos e intereses									
Ingresos por propiedades									
Indemnización de trabajadores									
Retiro ferroviario									
Donativos									
Seguro de vida anticipado									
Pensión alimenticia Manutención de hijos									
Pulmón negro									
Administración pública									
Pagos en especies									
Seguro de ingresos									
IPERS									
Propiedad vitalicia									
Trabajo independiente									
Fideicomisos									
Ingresos para estudiantes									
Otros (liste)									

Recursos o Activos

Nombre todos los recursos/activos de que disponían usted y su cónyuge (y sus padres si es menor de 18 años en cada mes y **proporcione comprobantes**. Adjunte la información en una hoja por separado si necesita más espacio.

	Primer mes antes de solicitud SSI			Segundo mes antes de solicitud SSI			Tercer mes antes de solicitud SSI		
Tipo de recurso o activo	Usted	Su cónyuge	Padres o Dependientes	Usted	Su cónyuge	Padres o Dependientes	Usted	Su cónyuge	Padres o Dependientes
	Cantidad	Cantidad	Cantidad	Cantidad	Cantidad	Cantidad	Cantidad	Cantidad	Cantidad
Efectivo en mano									
Cuenta corriente									
Caja de ahorros									
Acciones o bonos									
Certificados de depósito									
Fondo de inversión									
Valor de los contenidos de la caja de seguridad									
IRA/Keogh									
Mercado de dinero									
Rentas anuales									
Fondos de sepultura									
Lotes de sepultura									
Vivienda en la que no reside									
Vivienda en la que reside									
Bienes raíces (no su vivienda familiar)									
Contratos para venta de bienes raíces									
Propiedades vitalicias									
Recursos usados para trabajo independiente									
Seguro de vida									
Compensaciones diferidas									
Otros (especifique)									
Vehículos de su propiedad o de su cónyuge, y si es menor de 18 años incluya los vehículos de sus padres.	Año _____ Marca _____ Modelo _____ Valor de mercado _____			Año _____ Marca _____ Modelo _____ Valor de mercado _____			Año _____ Marca _____ Modelo _____ Valor de mercado _____		

Información sobre Seguro Médico

Recuerde: Si completa este formulario para otra persona, conteste las preguntas con la información de dicha persona.

1. ¿Tiene Medicare? ❑ Sí ❑ No
   Si respondió sí, ¿tiene Parte A? ❑ Sí ❑ No ¿Parte B? ❑ Sí ❑ No ¿Plan de medicamentos? ❑ Sí ❑ No
2. ¿Tiene otras pólizas de seguros médico en este momento? ❑ Sí ❑ No
3. ¿Tiene o puede obtener seguro médico a través de su empleo o del de su cónyuge? ❑ Sí ❑ No
4. Si es menor de 18 años, ¿tiene o puede conseguir seguro médico a través del empleo de sus padres? ❑ Sí ❑ No
5. ¿Recibe ayuda médica por orden judicial? ❑ Sí ❑ No
6. ¿Tiene una demanda judicial debido a un accidente? ❑ Sí ❑ No
7. ¿Tenía un seguro médico que finalizó desde que el proceso de elegibilidad para SSI se inició? Si respondió **sí**, indique la fecha en que finalizó: _____ ❑ Sí ❑ No
8. ¿Puede obtener seguro médico gratis? ❑ Sí ❑ No

Si tiene otras prestaciones médicas o si respondió "Sí" a alguna de las preguntas sobre seguro médico, complete lo siguiente:

Tipo de póliza _____

Nombre del titular de la póliza _____ Su parentesco con Ud _____

Domicilio _____

_____

Nombre de la compañía de seguros _____

Domicilio de la oficina de reclamos _____

_____

Número de póliza _____ Número de grupo _____

¿Qué cubre la póliza? (Marque todo lo que corresponda) ❑ Hospital ❑ Médico ❑ Medicamentos ❑ Dentista

Si tiene cobertura de más de un seguro médico, entréguenos la información en una hoja por separado.

Si obtiene Medicaid, deberá aceptar lo siguiente

Si necesitáramos más información, nos comunicaremos con usted después que envíe este formulario al Department of Human Services (DHS). Si necesita utilizar Medicaid inmediatamente, puede llamar al teléfono que aparece en la primera página. Si usted califica para Medicaid, se lo comunicaremos por escrito. **Usted, o la persona que actúe en su representación, debe firmar aceptando las declaraciones de la página titulada "Important Statements" antes de obtener Medicaid.**

Creo que la información que entrego es verdadera, correcta y completa. Sé que existen sanciones por esconder o dar información falsa. Lo comprendo y acepto conseguir pruebas de lo que digo cuando DHS me lo pida. Certifico bajo pena de cometer perjurio que todas las respuestas que presento son correctas y están completas en mi opinión.

Firma o marca del beneficiario (o tutor legal)		Fecha	
Firma de la persona que ayudó a completar el formulario, si corresponde.		Fecha	
Nombre del representante del beneficiario		Teléfono	
Domicilio	Localidad	Estado	Código postal

Declaraciones Importantes

Si soy responsable de un(a) menor de 18 años y uno de sus padres no vive con él/ella, sé que debo cooperar para conseguirle ayuda médica y para establecer la paternidad si ésta no hubiera sido establecida para dicho(a) menor. Además, con el fin de obtener ayuda médica para el/la menor, DHS puede iniciar acciones legales contra cualquier persona que tenga la obligación de proporcionar ayuda médica. En el caso que se hubiera ordenado el pago de ayuda médica por gastos médicos, dichas personas deben dirigirse a DHS para colaborar con el pago de las facturas médicas.

No debo permitir que otra persona use mi tarjeta médica.

Si estoy viviendo en un una residencia geriátrica o deseo obtener servicios que me ayuden a quedarme en mi hogar, es necesario que me haga un examen médico antes de obtener Medicaid. El examen lo realizará la empresa Iowa Medicaid Enterprise (IME). Autorizo a DHS, IME, a la residencia geriátrica y a cualquier persona que me brinda atención médica a compartir información sobre mi salud y otra información necesaria para realizar dicho examen.

La ley de Seguridad Social requiere que DHS utilice mi número de seguro social para verificar y comparar datos con los sistemas informáticos de otras agencias federales y gubernamentales, como por ejemplo el sistema de Internal Revenue Service (Servicio de Recaudación de Impuestos). Si DHS descubriera que presenté información falsa, deberé devolver lo que conseguí indebidamente. También podría afrontar acciones legales civiles o penales por presentar información falsa.

Todos los seguros médicos, incluido Medicare, deberán realizar los pagos directamente a los médicos y a los proveedores de atención médica mientras obtengo Medicaid. Yo cooperaré para devolverle a DHS el pago de cualquier beneficio que consiga y que esté destinado al pago de facturas médicas, si Medicaid hubiera pagado las facturas.

La ley dice que DHS no necesita autorización para recuperar los pagos por prestaciones médicas. DHS puede solicitar el pago a cualquier persona o compañía que sea responsable de pagar las facturas médicas de una persona que obtenga Medicaid. Yo cooperaré con DHS en la obtención de la información necesaria.

La ley federal y estatal autoriza que los agentes de los gobiernos federal y estatal vean los registros de pagos de Medicaid. Sé que al aceptar Medicaid, estoy autorizando a dichos agentes a ver mi historia clínica y mis expedientes de atención médica durante el período en que obtengo Medicaid, con el fin que dichos agentes puedan comprobar que Medicaid le pagó correctamente al proveedor.

Acepto entregar a la agencia Medicaid los pagos de gastos médicos realizados por terceros para mí y otras personas elegibles para Medicaid, para las cuales yo estoy legalmente autorizado/a a asignar beneficios. Además, acepto cooperar para obtener pagos de gastos médicos provenientes de terceros.

Si me ponen en un plan de medicina prepaga (managed health care plan), autorizaré a las personas que me brindan atención médica a que divulguen mi información médica, incluyendo cualquier tipo de información clínica sobre salud mental. Dicha información será entregada a la organización para el mantenimiento de la salud (HMO), o a otro plan managed care que me brinde servicios, si correspondiera. Además, dicha información podrá ser entregada a los empleados del plan managed care para que determinen si los servicios provistos son adecuados, son de buena calidad o son usados correctamente.

Si soy la persona que desea obtener SSI y soy menor de 21 años, puedo participar del programa llamado “Care for Kids” que promueve la salud. El/La asistente social me dará más información.

Si no está de acuerdo con alguna de las decisiones tomadas sobre su caso Medicaid, usted o su representante pueden solicitar una audiencia. Dicha solicitud debe ser hecha por escrito. Usted puede elegir a otra persona para que presente su caso en la audiencia.

Su Department of Human Services local le prestará ayuda para que presente una apelación si se los solicita. Si usted no está de acuerdo con alguna de las decisiones tomadas sobre su Medicaid, puede comunicarse con **Iowa Legal Aid** (Asistencia Legal de Iowa) **al teléfono 1-800-532-1275** o, si vive en **Polk County, llame al teléfono 243-1193** si necesita ayuda con la apelación.

Examinamos su solicitud de Medicaid sin tener en cuenta su raza, credo, color, sexo, edad, incapacidad física o mental, religión, país de procedencia o creencias políticas. (Existen normas con respecto a su edad e incapacidad para la obtención de Medicaid).

Lo que debe saber

Cómo informar cambios

Cuando obtenga Medicaid, deberá informar algunos cambios a la oficina del condado del Department of Human Services y otras modificaciones a Social Security Administration. Informe sus ingresos, recursos y arreglos de alojamiento a Social Security Administration.

Informe los siguientes cambios a la oficina DHS del condado en un plazo de 10 días a partir de la fecha en que se entere de la modificación:

- La cobertura del seguro médico.
- El costo del seguro médico si vive en un centro de cuidados especializados.
- El ingreso a un centro de cuidados especializados.
- La donación de recursos o activos.
- La creación de un fideicomiso con sus recursos o activos.
- Su permanencia en un hospital por 15 días o más si obtiene servicios de exención (waiver services).
- Su mudanza a un nuevo domicilio.

Si obtiene otro tipo de asistencia de nuestro Departamento, como Food Assistance (Asistencia para Alimentos) o State Supplementary Assistance (Asistencia Estatal Suplementaria), también deberá informar estos datos. Pregúntele a su asistente social sobre este tema.

Sus derechos

Usted tiene derecho a:

- Tener Medicaid algunos meses antes de obtener los beneficios SSI, si usted tuviera facturas médicas que pagar. Su asistente social le dirá si DHS puede ayudarle a pagar dichas facturas.
- Solicitar la ayuda de otros programas que no sean Medicaid.
- Que le respondan sus preguntas.
- Que la información sea confidencial, a menos que sea necesaria para pagar sus facturas médicas correctamente.

Sus responsabilidades

Usted debe proporcionar pruebas de los datos sobre los que le preguntamos para recibir Medicaid. (*Ésta es solamente una guía*.)

Su asistente social de Income Maintenance podría pedirle más información o más datos con respecto a la información que ya nos ha entregado. Si no puede conseguir la información, pídale a su asistente social que le preste ayuda. Su asistente social necesitará su autorización para comunicarse con otras personas y conseguir dicha información. Usted debe mostrarnos:

- Un fideicomiso creado con sus recursos o activos.
- El valor de los recursos o ingresos que usted donó, vendió o canjeó por menos del valor normal de mercado o de los que nunca tomó posesión.
- Los recursos de su cónyuge, si su cónyuge vive en su hogar y usted vive en un centro de cuidados especializados.
- Los datos de sus ingresos y recursos o los de su cónyuge, si desea recibir Medicaid durante el período anterior a que comiencen los beneficios SSI.
- Podríamos necesitar más datos con respecto a su seguro médico.
- Podríamos necesitar más datos con respecto al padre ausente de un menor de 18 años.
- Los datos de sus ingresos y recursos, y los de sus padres si desea recibir Medicaid antes que comiencen los beneficios SSI, y si usted es menor de 18 años y vivía en su hogar antes del inicio de los beneficios SSI.

"Ingresos" significa: sueldo, ingresos por trabajo independiente, ingresos por rentas, beneficios de seguridad social, beneficios para veteranos, beneficios por retiro ferroviario, manutención de hijos, ingresos por intereses y dividendos, jubilaciones, y dinero en efectivo proveniente de propiedades vendidas por contrato, subsidios de desempleo, o beneficios de Workers' Compensation.

"Recursos" o activos significa: dinero en efectivo, dinero en el banco, certificados de depósito, IRA (cuentas de jubilación particular), cuentas Keogh (plan de jubilación para profesionales autónomos o propietarios de microempresas), acciones y bonos, vehículos con o sin licencia, tierras o terrenos, propiedades vendidas por contrato, contratos funerarios, bienes inmuebles que no sean su vivienda familiar, lotes de sepultura, vehículos recreativos, propiedades, seguros de vida, o cuentas en el mercado de dinero.

Important Notice to Property Owners and Renters
(Aviso Importante para Propietarios y Arrendatarios)

Bajo las leyes de Iowa, sus impuestos sobre la propiedad pueden suspenderse o reducirse. Usted puede ser elegible si es anciano(a) o incapacitado(a).

¿Qué es la suspensión de impuestos?

La suspensión de impuestos significa que usted no tendrá que pagar sus impuestos sobre la propiedad hasta que ésta se venda o se transfiera a otra persona.

¿Pueden ser suspendidos mis impuestos sobre la propiedad?

Sus impuestos sobre la propiedad pueden suspenderse si:

- Usted recibe Supplemental Security Income (SSI) o State Supplementary Assistance (SSA), ó
- Si usted vive en un ancianato y el Department of Human Services paga la totalidad o parte del costo de la atención que usted recibe.

Usted no tendrá que pagar ninguna multa mientras sus impuestos estén suspendidos. Deberán pagarse los impuestos suspendidos cuando la propiedad se venda o transfiera. Si lo desea, puede aún pagar sus impuestos mientras están suspendidos.

La Junta de Supervisores del Condado dirige el programa de suspensión de impuestos. Usted debe brindarle pruebas a la Junta de Supervisores del Condado acerca de que usted califica para la suspensión de impuestos sobre la propiedad. Este trámite debe ser realizado en el condado donde está ubicada la propiedad.

Usted recibirá un Aviso de Decisión que le dirá si es elegible para la suspensión del impuesto. Este aviso será prueba de que usted califica. Este aviso dirá lo siguiente:

> "Usted recibe SSI, Asistencia Estatal Suplementaria, o vive en una vivienda cuyo costo es pagado parcial o totalmente por el Department of Human Service. Es posible que no deba pagar impuestos inmobiliarios en este momento. Lleve esta notificación al Consejo del Condado (Board of Supervisors) para plantear la posibilidad de que sus impuestos inmobiliarios sean demorados."

Lleve su aviso a la Junta de Supervisores del Condado del condado donde está ubicada su propiedad. Puede encontrar la dirección y número telefónico de la Junta de Supervisores del Condado en la sección de gobierno de su directorio telefónico.

¿Qué es el crédito de impuestos?

Un crédito de impuestos elimina o reduce el monto de impuestos que deberá pagar cuando venda o transfiera la propiedad.

¿Yo puedo obtener un crédito de impuestos?

Usted puede obtener un crédito de impuestos adicional hasta de $1.000. Usted debe ser dueño de su hogar y ser el responsable de pagar los impuestos sobre la propiedad.

El monto del crédito de impuestos se basa en su ingreso. Usted puede obtener crédito de impuestos adicional si el ingreso de su hogar es menor a $22.360,00, y usted:

- Tenía 65 años de edad o más al 31 de diciembre del año pasado, o
- Estaba totalmente incapacitado/a al 31 de diciembre del año pasado.

Nota: El cónyuge, el abogado, el tutor o el administrador de una persona elegible fallecida pueden radicar un reclamo de crédito fiscal a nombre de la persona fallecida.

Para obtener crédito de impuestos, debe solicitarlo ante el tesorero del condado.

¿Puedo obtener ambos?

Sí, es mejor si usted solicita tanto una suspensión de impuestos y un crédito de impuestos.

¿Qué pasa si estoy arrendando mi hogar?

Si usted arrienda su hogar y éste está sujeto a impuestos, usted puede recibir una devolución de hasta $1.000 del total de la renta que paga cada año. Si usted vive en un ancianato, usted se considera un arrendador para estos propósitos.

Usted puede ser elegible para un crédito de impuestos adicional si el ingreso de su hogar es menor a $22.360,00, y usted:

- Tenía 65 años de edad o más al 31 de diciembre del año pasado, o
- Estaba totalmente incapacitado/a al 31 de diciembre del año pasado.

Nota: El cónyuge, el abogado, el tutor o el administrador de una persona elegible fallecida pueden radicar un reclamo de reembolso de alquiler a nombre de la persona fallecida.

Los formularios de reembolso de renta están disponibles en la oficina del tesorero de su condado.

Voter Registration, Unnumbered

Purpose

The *Voter Registration* form:

- Gives clients information about registering to vote.
- Records a client's decision whether to register.
- Provides a detachable card that clients can use to register.

This process is required by the National Voter Registration Act of 1993 and Iowa Code Section 48A.19.

Source

Central Office has a contract to provide automatic shipments of the *Voter Registration* form to local offices. The shipments are intended to cover a six-month supply. Additional supplies are also available through Central Office.

Completion

Give this form to the client every time you give out an application, recertification, review, or address change form for FIP, Food Assistance, Medicaid, or Child Care Assistance.

At each application, recertification, or review interview, ask if the client wants to register to vote. If the client has not answered the voter registration question on the form, have the client complete the question at the interview.

Offer the client assistance in completing the voter registration form if the client wants to register to vote. Date-stamp each voter registration form. This verifies that the form is timely for voter registration purposes.

Distribution

Keep the declination section in the local office. Give the voter registration information section to the client.

Send or deliver all completed voter registration forms to the county election office every Friday. When Friday is a holiday, send the forms the last working day of that week. EXCEPTION: Deliver registration forms received on the tenth day before the general election to the election office on that day.

Things You Need to Know on Election Day

Your Ballot, Your Vote

Don't panic if you registered to vote but your name is not on the list. Get help from a poll worker to make sure your vote is counted. You may be directed to another polling place or given a provisional ballot.

ID – Don't Go Without It

You may need to show an ID. To be safe, bring your driver's license, paycheck, utility bill, bank statement, government check, or other government document that includes your name and current street address.

Writing on the Wall

Look at the signs at the polling place for directions on how to use the voting machines, a list of your voting rights and instructions for filing a complaint if your rights have been violated.

When in Doubt, Ask

Poll workers are there to help you. They'll show you how to use the machines and give you a provisional ballot if you need one.

Election Day Registration

Iowa law allows you to register to vote on election day at the polling place for the precinct in which you currently live. To do so, you must show proof of identity and proof of residency. The best way to do this is using your non-expired Iowa driver's license or non-operator ID card with your current address printed on it.

Voting with Assistance

If you need help marking your ballot because of a disability or because you cannot read English, any person you choose may help you, except your employer or your employer's agent or an officer or agent of your union. If you want help from the poll workers, one person from each political party will help you. You will be asked to sign a form to show that you asked for assistance.

Deadlines for Registering to Vote

The voter registration deadline is 10 days before primary and general elections and 11 days before any other election.

Voter Registration Card

You will receive a voter registration card within 14 days. If you do not, call your county auditor. Be ready to tell the auditor when and where you completed the registration form and to whom you gave the voter registration form to.

Voter Registration is Permanent

After you register to vote, you do not have to register again unless you move to a new address. However, your registration will be canceled if you are convicted of a felony or judged to be incompetent to vote by a court.

Privacy

If you register to vote, the name of the office where you turned in the registration form will be kept private. If you do not register to vote, this fact will also be kept private. The information provided on this form will be used only for voter registration purposes.

Questions

For more information or if you have questions about voter registration, contact your county auditor or the Secretary of State's Office.

Elections Division……515-281-0145
Toll Free …… …1-888-SOS-VOTE
1-888-767-8683

Complaints

If you believe that someone has interfered with your right to:

- Register or to decline to register to vote,
- Privacy in deciding whether to register,
- Privacy in applying to register to vote,
- Choose your own political party or other political preference.

You may file a complaint with:

Voter Registration Commission
Lucas State Office Building
321 E. 12th Street
Des Moines, IA 50319
1-888-SOS-VOTE

Iowa Voter Registration

Form and Instructions

Voting is Your Right

If you are not registered to vote where you live now, would you like to apply to register to vote here today?

☐ **YES, I want to register to vote.** (Complete the voter registration form to the right.)

☐ **NO, I do not want to register to vote** (Sign and date this part only.)

If you do not check either box, you will be considered to have decided not to register to vote at this time.

Signature: _____

Print Your Name: _____

Date: ____/____/____

Voter Registration Information

You may apply to register to vote when you apply for assistance. This agency is required to offer you an opportunity to register to vote.

To register to vote in Iowa, you must:

- Be a citizen of the United States,
- Be a resident of Iowa,
- Be at least 17 ½ years old (must be 18 on election day),
- Not have been convicted of a felony (or have had your rights restored),
- Not currently be judged by a court to be "incompetent to vote," and
- Give up your right to vote in any other place.

Assistance

If you would like assistance in filling out the voter registration form, we will help you. The decision whether to seek or accept help is yours. You may fill out the application form in private. You may take the registration form with you or fill it out later and return it to this office or your County Auditor.

Benefits

Applying to register or declining to register to vote will not affect the amount of assistance that you will be provided by this agency.

Use this form to apply to register to vote or to make changes to your current voter registration. Use a pen and print neatly.

Required Information:

- ID number,
- Date of birth,
- Gender,
- Name,
- Address,
- Signature

If you do not include the required information, your registration cannot be processed.

ID Number

Your Iowa driver's license number is required if you have one. If you don't have one, put the number of your Iowa non-driver ID card. If you have neither of these, put the last 4 digits of your Social Security number. Iowa Code section 48A.11 requires the state to ask for these numbers on this form.

If your ID number cannot be verified, you will be required to show identification before voting.

Driver's license, non-operator ID, and Social Security numbers are not printed on voter registration lists sold to candidates and others.

Read the form carefully before you sign it.

Mail the completed form to your county auditor.

(03)

STATE OF IOWA OFFICIAL VOTER REGISTRATION FORM

Revised 4/7/2016

In Iowa, you are not qualified to vote if you have been convicted of a felony and have not received a restoration of voting rights. You may apply to the Governor to restore your voting rights.

Qualifications

1. Are you a citizen of the United States? ☐ Yes ☐ No
2. Will you be 18 years of age on or before Election Day? ☐ Yes ☐ No

If you answered "No" to either of these questions, do not complete this form.

ID Number
Provide your Iowa driver's license, non-operator ID number, or the last 4 digits of your Social Security number if you have one.

☐ **IA driver's license #:** ____ ____ ____ ____ ____ ____ ____ ____ ____

☐ **IA non-operator ID #:** ____ ____ ____ ____ ____ ____ ____ ____ ____

☐ **Last 4 digits of Social Security number:** XXX – XX – ____ ____ ____ ____

☐ **I do not have an IA driver's license, non-operator ID, or Social Security number.**

Additional Information
Date of birth and sex are required.

Date of Birth (month, day, year) ____ ____ / ____ ____ / ____ ____ ____ ____

Sex ☐ Male ☐ Female

Phone and/or Email (optional)

Your Name

Last

First

Middle **Suffix**

Address Where You Live

Street Address
(include apt., lot, etc.)

City **Zip** **County**

If homeless or you do not have an established residence, describe where you reside:

Where You Receive Mail
(if different)

Address/P.O. Box

City **State** **Zip**

Previous Voter Registration Information

Your name was

Your address was

Your city and state were **Your zip was**

Political Affiliation
(check only one)

Political Parties: ☐ No Party ☐ Democratic ☐ Republican

Non-Party Political Organizations: ☐ Green ☐ Libertarian

WARNING
If you sign this form and you know the information is not true, you may be convicted of perjury and fined up to $7,500 and/or jailed for up to 5 years.

Registrant Affidavit

I swear or affirm under penalty of perjury that:

- I am the person named above.
- I am a citizen of the United States.
- I have not been convicted of a felony (or I have received a restoration of rights).
- I am at least 17 ½ years old.
- I live at the address listed above.
- I am not currently judged by a court to be "incompetent to vote."
- I do not claim the right to vote anywhere else.

Signature **Date**

Iowa Department of Human Services

Facts About the Food Assistance Program

INCOME GUIDELINES

Gross monthly income is the amount before taxes or other deductions are taken out. Net monthly income is what is left of gross income after certain allowable expenses are subtracted.

Income Guidelines

Household Size	1	2	3	4	5	6	7	8	Each Extra Person
Gross Monthly Limit	$1,287	$1,736	$2,184	$2,633	$3,081	$3,530	$3,980	$4,430	+$451
Net Monthly Limit	$990	$1,335	$1,680	$2,025	$2,370	$2,715	$3,061	$3,408	+$347

To be eligible, a household's monthly income must be within the above limits for its size. **Exceptions:**

- Households with an elderly (age 60 or over) or disabled person do not have to meet gross income limits.
- If everyone gets SSI or FIP, the household does not have to meet the gross or net monthly income limits.
- Some households that do not meet the above income guidelines might be eligible if monthly income is not more than the amount below (160% of the federal poverty level).

160% of Federal Poverty Level

Household Size	1	2	3	4	5	6	7	8	Each Extra Person
Monthly Limit	$1,584	$2,136	$2,688	$3,240	$3,792	$4,344	$4,898	$5,453	+$556

MAXIMUM FOOD ASSISTANCE BENEFIT AMOUNT

Households of the same size do not all get the same amount of Food Assistance. The benefit amount depends on both the household's size and income. Only households with very little or no income get the maximum benefit amount.

Household Size	1	2	3	4	5	6	7	8	Each Extra Person
Maximum Monthly Benefit	$194	$357	$511	$649	$771	$925	$1,022	$1,169	+$146

WHERE TO APPLY

You can apply online at https://secureapp.dhs.state.ia.us/oasis/. You can also apply at the Human Services office. The address and phone number is in the county government listing of your telephone book under "Human Services." (A few counties have the listing under "Social Services.")

Iowa Department of Human Services

Facts About the Food Assistance Program
(Datos sobre el Programa de Asistencia Alimentaria)

PAUTAS GENERALES SOBRE EL INGRESO

El ingreso mensual bruto es el monto que se recibe antes de impuestos u otras deducciones. El ingreso mensual neto es lo que queda del ingreso mensual bruto luego de que se restan ciertos gastos deducibles.

Pautas generales sobre el ingreso

Número de personas en el hogar	1	2	3	4	5	6	7	8	Cada persona adicional
Límite mensual bruto	$1287	$1736	$2184	$2633	$3081	$3530	$3980	$4430	+$451
Límite mensual neto	$990	$1335	$1680	$2025	$2370	$2715	$3061	$3408	+$347

Para resultar elegible, el ingreso mensual de un hogar debe encontrarse dentro de los límites fijados más arriba según la cantidad de personas que viven en él. **Excepciones:**

- Los hogares en los que vive una persona anciana (de 60 años o más) o discapacitada no deben cumplir con ningún límite de ingresos brutos.
- Si todos reciben SSI o FIP, el hogar no debe cumplir con los límites de ingresos mensuales brutos o netos.
- Algunos hogares que no cumplen con las pautas sobre ingreso que se especifican arriba pueden ser elegibles si el ingreso mensual no supera el monto que se encuentra debajo (160% del nivel de pobreza federal).

160% del Nivel de pobreza federal

Número de personas en el hogar	1	2	3	4	5	6	7	8	Cada persona adicional
Límite mensual	$1584	$2136	$2688	$3240	$3792	$4344	$4898	$5453	+$556

MONTO MÁXIMO DEL BENEFICIO DE ASISTENCIA ALIMENTARIA

No todos los hogares con igual cantidad de personas reciben la misma cantidad de Asistencia Alimentaria. El monto del beneficio depende tanto de la cantidad de personas en el hogar como de sus ingresos. Sólo los hogares con muy pocos ingresos o sin ingresos reciben el monto máximo del beneficio.

Número de personas en el hogar	1	2	3	4	5	6	7	8	Cada persona adicional
Máximo beneficio mensual	$194	$357	$511	$649	$771	$925	$1022	$1169	+$146

DÓNDE PRESENTAR LA SOLICITUD

Usted puede presentar su solicitud en línea en https://secureapp.dhs.state.ia.us/oasis/. También puede hacerlo en la oficina del Department of Human Services. La dirección y el número de teléfono se encuentran en el listado de organismos gubernamentales del condado en su guía telefónica, debajo de “Human Services”. (Algunos condados poseen el listado debajo de “Social Services”)

Remember...

- Contact us as soon as you think that you may get a one-time payment.
- If you get a one-time payment while you are applying for or getting FIP, you must use the money to live on until your period of ineligibility has ended.

Statement on Nondiscrimination

It is the policy of the Iowa Department of Human Services (DHS) to provide equal treatment in employment and provision of services to applicants, employees, and clients without regard to race, color, national origin, sex, sexual orientation, gender identity, religion, age, disability, political belief or veteran status.

If you feel DHS has discriminated against or harassed you, please send a letter detailing your complaint to:

Iowa Department of Human Services
Hoover Building, 5th Floor
Policy Bureau
1305 E Walnut Street
Des Moines, IA 50319-0114
Email: contactdhs@dhs.state.ia.us

(*Food Assistance only*)
USDA – Director, Office of Adjudication
1400 Independence Ave SW
Washington, DC 20250-9410
or call **1-866-632-9992** (voice)

Individuals who are hearing impaired or have speech disabilities may contact USDA through the Federal Relay Service at **800-877-8339**.

Iowa Department of Human Services

Comm. 24 (Rev. 10/16)

One-Time Payments

What is a one-time payment?

A one-time payment is when you get money that you do not expect to get on a regular basis. We call this a nonrecurring lump-sum.

One-time payments can include:

- Insurance death benefits
- Lottery winnings
- Lawsuit settlements
- Inheritances
- Gifts

This can also include back payments that you get from:

- Social Security
- Worker's compensation
- Child support
- Unemployment benefits
- Veteran's benefits

What do I do if I get a one-time payment?

Tell us if you get or expect to get a one-time payment. We will tell you how the one-time payment will affect any benefits you get from us.

If you don't know in advance that you will be getting a one-time payment, tell us within ten days after you get the money. **It would be best for you and your family if you talk to us before you spend any of the money.**

How is a one-time payment counted?

We count one-time payments as income. This money is added to the other income that you get in a month. We use your income to decide if you can get Family Investment Program (FIP) or Medicaid.

FIP

If you are applying for the Family Investment Program (FIP) when you get a one-time payment, you might not be eligible to get FIP for a period of time.

If you are receiving FIP and the amount of your one-time payment plus your other income is too high, your FIP payments may stop for a period of time. We will tell you how long you will have to wait before you can get FIP again. This is called a period of ineligibility. If you want FIP after the period of ineligibility ends, you may reapply.

You cannot get FIP during your period of ineligibility even if you spend all of the money. This includes if you use the money to pay back bills or buy things you need, like a car or household items.

Medicaid

Effective January 1, 2014, if you are getting Medicaid when you get a one-time payment, we may count it as income in the month it is received. We will not prorate the lump sum for Medicaid.

Are there any payments that are not counted?

Some payments are not counted, like a property settlement from a divorce or gifts that are less than $30 in a three-month period. We will not count payments that you get and spend for:

- Medical expenses
- Funeral and burial expenses
- Repair or replacement of a house, car or other personal property
- Costs of getting the lump sum, such as attorney fees

We do not count the one-time payment if you get the money when you are not applying for or getting FIP.

For example, if you think you will get a one-time payment in October and you ask to stop your FIP before October 1, there will not be a period of ineligibility or period of proration.

- For FIP, if you get a FIP check in October, you must return the actual FIP check or we will have to figure a period of ineligibility.
- You can reapply for FIP in November. We will not count the one-time payment as income. Any part of the one-time payment you will have left will be counted as a resource.

How is my period of ineligibility for FIP figured?

To decide how long we will count the one-time payment for FIP, we divide your income in the month you get the one-time payment by the FIP standard of need. The standard of need chart is on the next panel.

Number of People in Your Group							
1	2	3	4	5	6	7	8
$365	$719	$849	$986	$1092	$1216	$1335	$1457
This chart increases if you have more than 8 people.							

Find the number of people in your FIP group in the chart. We will divide your one-time payment plus your other income by that amount.

Here is an example:

Ms. A and her two children get FIP. In October, the family gets $2,250 from a one-time insurance payment. Ms. A reports getting the money within ten days. The family has $300 in other income. The total income for October is $2,550 ($2,250 + $300 = $2,550). The period of ineligibility is figured by dividing the income by the standard of need for three people ($849). $2,550 ÷ $849 = 3. There is $3 left over. The period of ineligibility is October, November, and December. The extra $3 will be counted as income in January if Ms. A reapplies for FIP. Because Ms. A reported the one-time payment within ten days she will not have to repay the November FIP.

Can my period of ineligibility or period of proration be reduced?

Your period of ineligibility or period of proration can be reduced if you no longer have the money because of the following:

- The money is lost or stolen and you report this to the police.
- The person with the money no longer lives with your family and you cannot get the money.
- The money is spent on any of the following bills which are not covered by your insurance:
  - Medical services for members of your family
  - Home repairs over $25 if they are needed to keep your home livable and you own or are buying your home
  - Costs for replacing a home or household goods damaged in a natural disaster, such as a fire, flood or tornado
  - Funeral and burial expenses

When these things happen, the loss or expense may be deducted from the one-time payment. This would shorten the period of ineligibility or period of proration.

If you tell us the one-time payment is no longer available to you, you will have to show us proof. This proof can include a copy of a police report or a receipt that shows what you bought.

Here is an example:

Ms. A gives proof that she spent $500 of the one-time payment she received in October on medical expenses. She reported getting the lump sum within ten days. The $500 is deducted from her total income of $2,550. This leaves $2,050 as income. $2,050 divided by $849 equals a two-month period with $352 left over.

For FIP: Ms. A's family's period of ineligibility is October and November. The remaining $352 will be counted as income in December if she reapplies. Because she reported the one-time payment within ten days she will not have to repay the November FIP.

Can I continue to get other help?

You will not be able to get FIP during your period of ineligibility; however, you may be able to get other help. Some people can still get Medicaid and we will check to see if you can.

You may also be able to get more Food Assistance when your FIP stops.

Ask us about other types of help that may be available in your community.

What happens if I don't report a one-time payment?

If you don't report a one-time payment, you will risk:

- Having to pay back FIP benefits you should not have gotten.
- Having to pay some of your family's medical expenses.
- Losing a choice to have the one-time payment treated in a way that's better for you and your family.

What if I have questions?

If you have questions, contact your worker in your local Human Services office. You may also contact Iowa Legal Aid for assistance. The toll free number is: **1-800-532-1275**.

Recuerde…

- Contáctenos tan pronto como crea que puede recibir un pago único.
- Si recibe un pago único mientras esté solicitando u obteniendo FIP, deberá usar el dinero para vivir o hasta que su periodo de no-elegibilidad haya terminado.

Declaración de no discriminación

Es política del Iowa Department of Human Services (DHS) ofrecer trato igualitario en cuanto a empleo y ofrecimiento de servicios a los solicitantes, empleados y clientes, sin importar su raza, color, nacionalidad, sexo, orientación de sexual, identidad de género, religión, edad, incapacidad, creencia política o estatus de veterano.

Si cree que DHS le ha discriminado o acosado, le agradeceremos que envíe una carta explicando detalladamente su queja a:

Iowa Department of Human Services
Hoover Building, 5th Floor
Policy Bureau
1305 E Walnut Street
Des Moines, IA 50319-0114
Correo electrónico: contactdhs@dhs.state.ia.us

(*Únicamente para Food Assistance*)
USDA – Director, Office of Adjudication
1400 Independence Ave SW
Washington, DC 20250-9410
o llamar al **1-866-632-9992** (voz)

Las personas que tengan problemas de audición o de habla, pueden contactarse a la USDA a través de Federal Relay Services al **800-877-8339**.

Iowa Department of Human Services

Comm. 24(S) (Rev. 10/16)

One-Time Payments

(Pagos únicos o de una sola vez)

¿Qué es un pago único?

Un pago único es cuando usted recibe dinero que no espera recibir en forma regular. Nosotros le llamamos cantidad global no recurrente.

Los pagos únicos pueden incluir:

- Beneficios por seguro de muerte
- Ganancias de lotería
- Conciliaciones por demandas
- Herencias
- Regalos

Esto también puede incluir pagos atrasados que reciba de:

- Seguridad social
- Indemnización del trabajador
- Manutención infantil (child support)
- Beneficios de desempleo
- Beneficios de veteranos

¿Qué hago si recibo un pago único?

Infórmenos si recibe o espera recibir un pago único. Nosotros le informaremos cómo el pago único afectará los beneficios que recibe de nosotros.

Si no sabe con anticipación que recibirá un pago único, infórmenos dentro de los diez días siguientes a la recepción del dinero. **Sería mejor para usted y su familia si hablan con nosotros antes de gastar el dinero.**

¿Cómo se cuenta un pago único?

Nosotros contamos los pagos únicos como ingresos. Este dinero se suma a los otros ingresos que reciban durante el mes. Nosotros usamos su ingreso para decidir si puede recibir Family Investment Program (Programa de Inversión Familiar - FIP) or Medicaid.

FIP

Si está solicitando el Family Investment Program (FIP) cuando reciba un pago único, puede no ser elegible para recibir FIP durante un tiempo.

Si está recibiendo FIP y el monto de su pago único más sus otros ingresos es demasiado alto, sus pagos por FIP podrán suspenderse por un tiempo. Nosotros le informaremos qué tanto deberá esperar antes de recibir FIP nuevamente. Esto se llama un período de no-elegibilidad. Si desea el FIP después de la terminación del período de no-elegibilidad, puede volver a solicitarlo.

Usted no puede recibir FIP durante su período de no-elegibilidad, aún si gastó todo el dinero. Esto incluye si usted usó el dinero para pagar facturas vencidas, o para comprar cosas que necesitaba, como un auto o elementos para el hogar.

Medicaid

Si recibe prestaciones de Medicaid, a partir del 1 de enero de 2014 no prorratearemos los pagos que reciba por única vez, sino que los contabilizaremos como ingresos de dicho mes.

¿Hay algunos pagos que no se cuentan?

Algunos pagos no se cuentan, como una conciliación de propiedad de un divorcio o regalos que sumen menos de $30 en un periodo de tres meses. No contaremos pagos que usted recibe y los gasta en:

- Gastos médicos
- Gastos funerarios y de entierro
- Reparación o reemplazo de una casa, auto u otras propiedades personales
- Costos de recibir la suma global, como honorarios de abogado

No contamos el pago único si usted recibe el dinero cuando no está haciendo la solicitud u obteniendo FIP.

Por ejemplo, si usted cree que obtendrá un pago único en octubre, y pide que se suspenda su FIP antes del 1 de octubre, no habrá periodo de no-elegibilidad ni periodo de asignación o distribución.

- Para FIP, si usted recibe un cheque FIP en octubre, debe regresar el cheque FIP o tendremos que imponer un período de no-elegibilidad.
- Puede volver a solicitar FIP en noviembre. No contaremos el pago único como ingreso. Cualquier parte del pago único que le quede, será contada como un recurso.

¿Cómo se determina mi período de no-elegibilidad para FIP?

Para decidir por cuánto tiempo contaremos el pago único para FIP, dividimos su ingreso en el mes en que recibe el pago único por el estándar FIP de necesidad. La tabla con los importes estándar para cubrir las necesidades básicas se encuentra en el panel siguiente.

Número de personas en su grupo							
1	2	3	4	5	6	7	8
$365	$719	$849	$986	$1092	$1216	$1335	$1457
Este cuadro se aumenta si tiene más de 8 personas en su grupo.							

Encuentre el número de personas en su grupo FIP en el cuadro. Dividiremos su pago único más sus otros ingresos por esa cantidad.

Aquí hay un ejemplo:

La Sra. A y sus dos hijos reciben FIP. En octubre, la familia recibe $2.250 por un pago único de un seguro. La Sra. A reporta haber recibido el dinero dentro de los diez días siguientes. La familia tiene $300 en otros ingresos. El ingreso total para octubre es $2.550 ($2.250 + $300 = $2.550). El período de no-elegibilidad se obtiene dividiendo el ingreso por el estándar de necesidad para tres personas ($849). $2.550 ÷ $849 = 3. Hay un sobrante de $3. El período de no-elegibilidad es octubre, noviembre y diciembre. Los $3 adicionales se contarán como ingreso en enero si la Sra. A solicita nuevamente el FIP. Como la Sra. A reportó el pago único dentro de los diez días siguientes, ella no tendrá que hacer el repago del FIP de noviembre.

¿Pueden reducirse mis períodos de no-elegibilidad o de asignación?

Sus períodos de no-elegibilidad o de asignación pueden reducirse si ya no tiene el dinero por las siguientes causas:

- El dinero se perdió o fue robado y usted reportó el hecho a la policía.
- La persona que tiene el dinero ya no vive con su familia y usted no puede obtener el dinero.
- El dinero se gastó para pagar cualquiera de las siguientes facturas y no fueron cubiertas por su seguro:
  - Servicios médicos para miembros de su familia
  - Reparaciones domésticas por más de $25 si se requerían para mantener su hogar habitable y usted es el dueño o está comprando su hogar
  - Costos para remplazar un hogar o bienes del hogar dañados por un desastre natural, como un incendio, inundación o tornado
  - Gastos funerarios y de entierro

Cuando estas cosas ocurren, la pérdida o gasto pueden deducirse del pago único. Esto acortará el período de no-elegibilidad o el de asignación.

Si usted nos informa que el pago único ya no está disponible para usted, tendrá que mostrarnos una prueba. Esta prueba puede incluir una copia de un reporte policial o un recibo que muestre lo que compró.

Aquí hay un ejemplo:

La Sra. A ofrece una prueba de que ella gastó $500 del pago único recibido en octubre, en gastos médicos. Ella reportó haber recibido la suma global dentro de los diez días siguientes. Los $500 se deducen de su ingreso total de $2.550. Esto deja un ingreso de $2.050. $2.050 dividido por $849 igual a un período de dos meses con un sobrante de $352.

Para FIP: El período de no-elegibilidad de la familia de la Sra. A es octubre y noviembre. Los $352 restantes se contarán como ingreso en diciembre si ella vuelve a hacer la solicitud. Como ella reportó el pago único dentro de los diez días siguientes, no tendrá que repagar el FIP de noviembre

¿Puedo seguir recibiendo otras ayudas?

No podrá obtener FIP durante su período de no-elegibilidad; sin embargo, podrá recibir otras ayudas. Algunas personas aún pueden recibir Medicaid y nosotros verificaremos si usted puede.

Usted también puede obtener más Food Assistance (Asistencia Alimenticia) cuando su FIP esté suspendido.

Pregúntenos sobre otros tipos de ayuda que pueda haber en su comunidad.

¿Qué pasa si no reporto un pago único?

Si no reporta un pago único, arriesgará:

- Tener que repagar los beneficios FIP que no debió haber recibido.
- Tener que pagar algunos de los gastos médicos de su familia.
- Perder la opción de que el pago único sea tratado en la mejor forma para usted y su familia.

¿Qué pasa si tengo preguntas?

Si tiene preguntas, contacte a su trabajado en la oficina local de Human Services. También puede contactar a Iowa Legal Aid para asistencia. El número gratuito es: **1-800-532-1275**.

Comm. 24 or Comm. 24(S), One-Time Payments

Purpose	Brochures Comm. 24 and Comm. 24(S) explain how receipt of a non-recurring lump sum may affect Medicaid or FIP eligibility.
Source	Printed supplies of Comm. 24 may be ordered from Iowa Prison Industries at Anamosa. Print or photocopy the Spanish version from the sample in the manual.
Distribution	Provide this brochure to: ♦ Each applicant for FIP or MAGI-related Medicaid, and ♦ Each FIP or MAGI-related Medicaid member: • Who reports receipt or possible receipt of a nonrecurring lump sum, or • Whom you believe may receive a nonrecurring lump sum.
Data	The brochure instructs clients what to do if they receive a lump sum, how one-time payments are counted, and how a period of ineligibility is determined.

Page 417 is reserved for future use.

How much will I have to pay?

Look at the chart below to find the monthly premium that you may have to pay. Add your gross earned income and your gross unearned income together. Then find the total of your income on the chart and look for the premium on the same line.

PREMIUM SCHEDULE

If the monthly gross income of the disabled person is:	The monthly premium is:
$ 1,485 or less	**$ 0**
More than: $ 1,485	$ 33
1,634	46
1,782	55
1,980	64
2,228	76
2,475	88
2,970	110
3,465	135
3,960	158
4,455	183
5,445	228
6,435	276
7,425	324
8,415	383
9,900	460
11,385	539
12,870	622
14,652	718
15,147	735
$ 15,741 and above	767

This chart is a guide only. Federal poverty levels may be updated each year. Changes in the poverty levels will change the income range for premiums.

When are premium payments due?

A billing statement will be sent to you that lists the months for which you have been approved and for which a premium is due. Generally, premiums should be paid by the last day of the month for the next month's coverage.

IMPORTANT: When you are first approved, the bill may be for more than one month and the premium amount or due dates may vary. **Please read the billing statement carefully.**

What happens when I do not pay the premiums?

If you do not pay the premium by the due date, your MEPD will be canceled. You may have to file a new application to get MEPD again.

If you make a late payment:

- MEPD can be reinstated if your ongoing month's payment is received by the last working day of the month it is due.
- MEPD coverage can be reopened if the payment is late but is received in the month after the month it is due.

Questions?

Call the DHS office in your county.

PRINTED ON RECYCLED PAPER

Iowa Department of Human Services

Comm. 180 (Rev. 8/16)

MEDICAID FOR EMPLOYED PEOPLE WITH DISABILITIES (MEPD)

MOVING ON UP WITH MEPD

Medicaid for Employed People with Disabilities

Medicaid for Employed People with Disabilities (MEPD) is a program for people with disabilities who work.

Are you eligible?

To qualify you must:

- Be under age 65.
- Be disabled. You are disabled if:
  - You are determined to be disabled by the Social Security Administration.
  - The Department of Human Services (DHS) has made a determination that you are disabled.
- Have income from work or be self-employed.
- Have monthly **net family income** less than 250% of the federal poverty level for your family size. Net income is your gross family income after deductions and disregards. The DHS office will tell you about the disregards and deductions you can get and if your family's net income is below 250% of the poverty level.
- Have countable assets that are less than:
  - $12,000 for one person
  - $13,000 for a couple

Some assets held by the MEPD applicant or member do not count for the MEPD program. They are:

- **Retirement accounts.** Examples are:
  - Simplified employee pension plans
  - Self-employment pension plans
  - Keogh plans
  - Individual retirement accounts
  - Roth individual retirement accounts
  - Savings incentive matched plans for employees and similar plans for retirement
- **Funds in assistive technology accounts.** This is money saved to get assistive technology to help you do your work. A physician, certified vocational rehabilitation counselor, licensed physical therapist, licensed speech therapist, or licensed occupational therapist must state that the assistive technology is needed to help you in your employment.
- **Funds in an exempt medical savings account.** This money is exempt from federal income taxation as stated in Section 220 of the United States Internal Revenue Code (26 U.S.C. § 220).

- Pay a monthly premium when **your** monthly **gross income** is above 150% of the federal poverty level. **Premiums are based only on the gross income of the disabled person (see MEPD Premium Chart).**
- Meet all other eligibility rules for the program.

How do I find out if I can get MEPD?

To find out if you can get MEPD:

- Complete an application from your local DHS office, or
- Use your computer to apply at this web site: https://dhsservices.iowa.gov/apspssp/ssp.portal

What happens when I have to pay a premium?

You will get a Notice of Decision telling you the amount of your monthly premium for the 12-month enrollment period.

- Your monthly premium will not go up during your 12-month enrollment period.
- The monthly premium may go down if you report that your income goes down.

How much income can we have?

Gross income means income before any deductions. *Net* income means gross income after deductions. For October 1, 2016, through September 30, 2017, the monthly income guidelines are:

People in Household	Gross Monthly Income	Net Monthly Income
1	$1,287	$ 990
2	1,736	1,335
3	2,184	1,680
4	2,633	2,025
5	3,081	2,370
6	3,530	2,715
7	3,980	3,061
8	4,430	3,408
More people	$ 451	$ 347

To be eligible, a household's monthly income must be within the above amounts for its size.
Exceptions:

- Households with an elderly (age 60 or over) or disabled person do not have to meet gross income guidelines.
- If everyone gets SSI or FIP, the household does not have to meet the gross or net monthly income guidelines.
- Some households that do not meet the above income guidelines might be eligible if monthly income is not more than the amount below (160% of the federal poverty level).

People in Household	Monthly Income 160% of Federal Poverty Level
1	$1,584
2	2,136
3	2,688
4	3,240
5	3,792
6	4,344
7	4,898
8	5,453
More people	$ 556

What are the allowable deductions?

To determine how much you can get, we use the following deductions:

▲ 20 percent of earned income;

▲ A standard deduction of $157 or more;

▲ Medical expenses over $35 a month for elderly (age 60 or over) or disabled persons;

▲ Certain dependent-care costs when needed for training, education, or work;

▲ Legally owed child support; and

▲ A percentage of shelter costs.

Choose foods to promote a healthy future at every stage of life.

▲ Food Assistance helps you to be able to buy and eat a variety of foods.

▲ Let the Plate guide your food choices.

▲ Aim for a healthy weight.

▲ Be physically active each day – at least 30 minutes for adults and 60 minutes for children.

▲ Choose a variety of grains (especially whole grains), fruits, and vegetables daily.

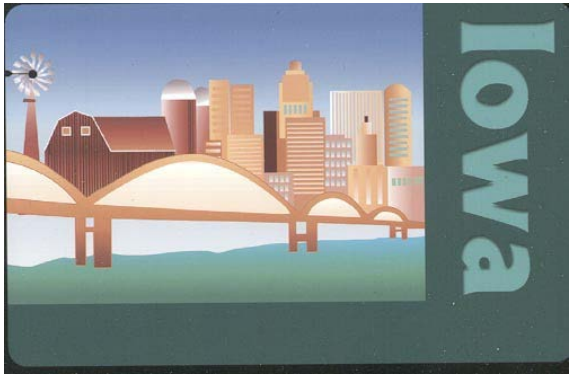
Food Assistance is a program under the United States Department of Agriculture's Food and Nutrition Service.

USDA is an equal opportunity provider and employer.

Iowa Department of Human Services

Comm. 229 (Rev. 10/16)

Food Assistance Makes Iowa Stronger



What is Food Assistance?

The program helps people with little or no income to buy food for a healthy diet.

There is enough Food Assistance for everyone who is eligible.

Food Assistance helps your local economy. The Food Assistance spent in local grocery stores helps to provide jobs for people.

How do I get Food Assistance?

You must fill out a Food Assistance application and turn it in to your Department of Human Services office. You can call toll free 1-877-DHS-5678 to find out where your Department of Human Services office is located. You may also apply online at https://secureapp.dhs.state.ia.us/oasis/.

You will be given an appointment for an interview. You will be asked to give us some things like ID, pay stubs for people in your household who work, and child-support orders.

Will I have to get a social security number?

You can choose to give us the Social Security Number of each person in your household. We can give Food Assistance only to the people who give us their Social Security Number.

You don't have to give us the Social Security Number for the people you do not want Food Assistance for.

Can legal noncitizens get Food Assistance?

Many can get Food Assistance. Even if you can't, your family members born in this country can.

Getting Food Assistance won't stop you if you want to become a citizen.

Can I get help if I'm not working?

If you can work, you must not quit a job unless you have a good reason. In some areas of the state, we have a program that can help you search for a job or get training.

If you can't work because of a mental or physical reason, tell your Food Assistance worker.

How many assets can we have?

Most households do not have to meet an asset test. If you do have to meet an asset test, your home and the value of at least one vehicle will not count.

If my household is eligible, how much will we get?

For October 1, 2016, through September 30, 2017, the table below shows the most you could get if you have no income. As your income goes up, the amount of Food Assistance you will get goes down.

People in Household	Maximum Monthly Allotment
1	$ 194
2	357
3	511
4	649
5	771
6	925
7	1,022
8	1,169
More people	$146 for each

Is Food Assistance cash?

Food Assistance comes through Electronic Benefit Transfer (EBT). You use a plastic EBT swipe card to buy food. Once your eligible food items have been totaled at the cash register, you will pass your EBT card through a point-of-sale (POS) terminal in the check out line. The cost of the food you purchase is subtracted from the amount in your Food Assistance EBT account.

What if I have more questions?

Please call your local Department of Human Services office. If you don't know where the office is, call the toll-free number, 1-877-DHS-5678 to find out.

You can also visit **"Food Assistance"** on Iowa's web site at http://dhs.iowa.gov/

¿Qué ingresos podemos tener?

Ingreso *Bruto* significa el ingreso antes de efectuar retenciones. Ingreso *Neto* significa el ingreso bruto después de efectuar retenciones. Desde el 1 de octubre de 2016, hasta el 30 de septiembre de 2017, el ingreso mensual establecido es:

Personas en el grupo familiar	Ingreso Mensual Bruto	Ingreso Mensual Neto
1	$1287	$ 990
2	1736	1335
3	2184	1680
4	2633	2025
5	3081	2370
6	3530	2715
7	3980	3061
8	4430	3408
Más personas	$ 451	$ 347

Para calificar, el ingreso mensual del grupo familiar no debe superar el importe indicado de acuerdo al tamaño del mismo. **Excepciones:**

- Los grupos familiares con una persona anciana (60 años o más) o discapacitada no tienen obligación de cumplir las normas sobre ingresos.
- Si todos reciben SSI o FIP, el grupo familiar no tiene obligación de cumplir las normas sobre ingresos brutos o netos.
- Algunos grupos familiares que no reúnan los requisitos indicados arriba podrían calificar si el ingreso mensual no supera los siguientes importes (160% del índice de pobreza a nivel federal).

Personas en el grupo familiar	Ingreso Mensual 160% del índice de pobreza a nivel federal
1	$1584
2	2136
3	2688
4	3240
5	3792
6	4344
7	4898
8	5453
Más personas	$ 556

¿Cuáles son las retenciones deducibles?

Para determinar los beneficios que puede recibir, se utilizan las siguientes retenciones:

- ▲ 20% de ingresos laborales;
- ▲ Una retención estándar de $157 o más;
- ▲ Gastos médicos superiores a $35 por mes correspondientes a personas ancianas (60 años o más) o discapacitadas;
- ▲ Determinados costos por cuidado de dependientes cuando sean necesarios por razones de capacitación, educación o trabajo;
- ▲ Manutención de menores por orden judicial; y
- ▲ Un porcentaje de los costos de la vivienda.

Elija alimentos que promuevan un futuro saludable en cada etapa de la vida.

- ▲ Food Assistance le ayuda a comprar y comer una amplia variedad de alimentos.
- ▲ Secciones los alimento usando el plato como guia.

- ▲ Manténgase en un peso saludable.
- ▲ Haga ejercicio físico todos los días – al menos 30 minutos los adultos y 60 minutos los niños.
- ▲ Consuma cereales variados (especialmente cereales integrales), frutas y vegetales diariamente.

Food Assistance es un programa del Servicio de Alimentos y Nutrición del Departamento de Agricultura de EE.UU.

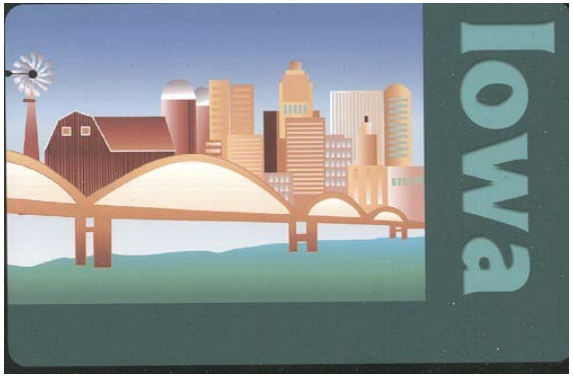
USDA es un empleador y proveedor de igualdad de oportunidades.

Iowa Department of Human Services

Comm. 229(S) (Rev. 10/16)

Food Assistance Makes Iowa Stronger

(Food Assistance Hace que Iowa Sea Más Fuerte)



¿Qué es Food Assistance?

El programa ayuda a las personas con ingresos bajos o sin ingresos a comprar alimentos sanos.

Tenemos suficiente Food Assistance para todas aquellas personas que sean elegibles.

Food Assistance ayuda a la economía local. Al comprar alimentos con Food Assistance en las tiendas locales, ayuda a crear empleos.

¿Cómo consigo Food Assistance?

Debe llenar un formulario de solicitud de Food Assistance y entregarlo en la oficina local de Department of Human Services. Puede llamar de forma gratuita al 1-877-DHS-5678 para averiguar dónde está ubicada la oficina local de Department of Human Services. Además, puede solicitar Food Assistance por Internet: https://secureapp.dhs.state.ia.us/oasis/.

Se programará una entrevista. Se le preguntará que nos dé algunas cosas como identificación, los recibos de sueldo de los integrantes de su grupo familiar que estén trabajando y las órdenes de manutención de menores.

¿Tendré que conseguir mi número de Social Security?

Tendrá que darnos el número de Social Security de cada una de las personas que soliciten Food Assistance. Podemos darles Food Assistance únicamente a aquellas personas que nos den su número de Social Security.

No tiene obligación de darnos los números de Social Security de las personas que no soliciten Food Assistance.

¿Pueden recibir Food Assistance las personas que no son ciudadanos legales?

Muchas personas pueden recibir Food Assistance. Aunque usted no pueda, los integrantes de su familia que hayan nacido en este país pueden recibirla.

Recibir Food Assistance no le impedirá convertirse en ciudadano.

¿Puedo recibir ayuda si no tengo trabajo?

Si puede trabajar, no debe renunciar a su empleo a menos que tenga una buena razón para hacerlo. En algunas zonas del estado, tenemos un programa que le puede ayudar a buscar empleo o recibir capacitación.

Si no puede trabajar por un problema mental o físico, dígaselo a su asistente de Food Assistance.

¿Qué bienes podemos tener?

La mayoría de los grupos familiares no tienen obligación de cumplir con los requisitos del análisis de bienes. Si usted no está obligado cumplir dichos requisitos, no se tendrá en cuenta el valor de su vivienda y de un vehículo por lo menos.

Si mi grupo familiar es elegible, ¿cuánto recibiremos?

Desde el 1 de octubre de 2016, hasta el 30 de septiembre de 2017, los beneficios que puede recibir si no tiene ingresos son los que se indican en la siguiente tabla. A medida que sus ingresos aumenten, el monto de Food Assistance se reducirá.

Personas en el grupo familiar	Máxima asignación mensual
1	$ 194
2	357
3	511
4	649
5	771
6	925
7	1.022
8	1.169
Más personas	$146 cada una

¿Food Assistance es en efectivo?

Food Assistance se recibe a través de transferencia electrónica (*Electronic Benefit Transfer*, EBT). Puede usar la tarjeta plástica EBT para comprar alimentos. Una vez que la cajera sume el importe total de los alimentos que compró, podrá pasar su tarjeta EBT por el lector de tarjetas que se encuentra en la caja. El costo de los alimentos que compró se debitará automáticamente de su cuenta EBT de Food Assistance.

¿Y si deseo hacer otras preguntas?

Por favor, llame a la oficina local de Department of Human Services. Si no sabe dónde está la oficina, llame de forma gratuita al 1-877-DHS-5678 para averiguar.

Además, puede consultar **"Food Assistance"** en la página electrónica de Iowa: http://dhs.iowa.gov/

Comm. 233 or Comm. 233(S), Rights and Responsibilities

Purpose	The *Rights and Responsibilities* brochure explains the client's rights and responsibilities when receiving FIP, Food Assistance or Medicaid.
Source	Comm. 233 is printed with 50 copies per pad. Order supplies from Iowa Prison Industries at Anamosa.
	Comm. 233 is also available online at http://dhs.iowa/gov/sites/default/files/Comm233/pdf.
	Supplies of Comm. 233(S) can be printed or photocopied from the sample in the manual. Comm. 233(S) is available online at http://dhs.iowa/gov/sites/default/files/Comm233S/pdf.
Distribution	Give or mail Comm. 233 to the applicant household when an applicant files form 470-0462 or 470-0462(S), *Financial Support Application*.
	Also give or mail Comm. 233 or Comm. 233(S) to individuals upon request.

Department of Human Services

Verifying Citizenship/Identity and/or Immigration Status

Examples of How to Prove U.S. 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, 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	
Proves both Citizenship and Identity	**Part 1**	**Part 2**
	Proves only Citizenship	**Proves only Identity**
• U.S. passport • Certification of Naturalization • Documentation of membership or affiliation issued by a federally recognized Indian Tribe	• Official birth certificate issued by the county or state • Medical record showing U.S. place of birth • Other acceptable proof of citizenship	• Driver's license or ID card from the Department of Transportation • School photo ID • School, day care or medical records (for children) • Military ID or dependent card • Other acceptable proof of ID

Examples of How to Prove Immigration Status

- Arrival Departure Record in foreign passport (I-94)
- Arrival/Departure Record
- Certificate of Citizenship
- Certificate of Eligibility for Exchange Visitor
- Certificate of Eligibility for Nonimmigrant Student Status
- Employment Authorization Card
- Foreign passport
- Machine Readable Immigrant Visa (with temporary I-551 language)
- Permanent Resident Card
- Reentry permit
- Refugee travel document
- Temporary I-551 Stamp (on passport or I-94/I-94a)
- Other acceptable proof immigration status

Questions or Need Help?

- Call our toll-free number 1-877-937-3663.
- Contact your worker.

Department of Human Services

Verifying Citizenship/Identity and/or Immigration Status
(Verificación de ciudadanía/identidad o estatus migratorio)

Ejemplos de cómo probar su ciudadanía estadounidense e identidad

La prueba debe ser un documento original. No envíe sus documentos originales por correo. Tráigalos a la oficina.

- La Columna A prueba ciudadanía e identidad al mismo tiempo.

Si no tiene un documento de la Columna A, necesitará proveer documentos de la Columna B.

- La Columna B requiere un documento de la Parte 1 y otro de la Parte 2 para cumplir con el requisito.

Columna A	Columna B	
	Parte 1	Parte 2
Prueba ciudadanía e identidad al mismo tiempo	**Prueba ciudadanía solamente**	**Prueba identidad solamente**
• Pasaporte estadounidense • Certificado de naturalización • Documentación de acreditación y afiliación emitida por una Tribu Indígena reconocida por el gobierno federal	• Certificado de nacimiento oficial emitido por el país o el estado • Registro médico que muestre el lugar de nacimiento en EE. UU. • Otra prueba de ciudadanía aceptable	• Licencia de conducir o tarjeta de identificación del Departamento de Transporte • Identificación escolar con fotografía • Comprobantes de escuela, guardería o registros médicos (para menores) • Tarjeta de identificación militar o de persona dependiente • Otra prueba de identificación aceptable

Ejemplos de cómo probar el estatus migratorio

- Registro de llegadas y salidas en pasaporte extranjero (I-94)
- Registro de llegada/salida
- Certificado de ciudadanía
- Certificado de elegibilidad como visitante de intercambio
- Certificado de elegibilidad como estudiante no inmigrante
- Tarjeta de autorización de empleo
- Pasaporte extranjero
- Visa de inmigrante automatizada (con texto explícito de I-551 temporal)
- Tarjeta de residente permanente
- Permiso de reingreso
- Documento de viaje para refugiado
- Sello de I-551 temporal (en pasaporte o I-94/I-94a)
- Otra prueba aceptable de estatus migratorio

¿Tiene alguna pregunta o necesita ayuda?

- Llame gratis al 1-877-937-3663.
- Comuníquese con su trabajador(a).

Comm. 258 or Comm. 258(S), Verifying Citizenship/Identity and/or Immigration Status

Purpose	*Verifying Citizenship/Identity and/or Immigration Status* is an informational notice about federal Medicaid requirements.
Source	The English and Spanish versions are available on line on the DHS Intranet eForms web page.
Distribution	Give this notice to applicants and members when requested or needed.
Data	The notice includes examples of common documents that customers may provide to verify U.S. citizenship/identity and/or immigration status.

Iowa Department of Human Services

Medicaid for Employed People with Disabilities (MEPD)
Frequently Asked Questions

Medicaid for Employed People with Disabilities (MEPD) is a program for people with disabilities who are employed.

What are the eligibility requirements for MEPD?

People who are disabled and have earned income can get Medicaid when the person:

- Is under age 65.
- Is still considered to be disabled based on SSI medical criteria for disability.
- Has earned income from employment or self-employment.
- Meets general SSI-related Medicaid eligibility requirements.
- Is not eligible for any other Medicaid coverage group other than QMB, SLMB, or Medically Needy.
- Have resources less than $12,000 for an individual and $13,000 for a couple.
- Has net family income less than 250% of the federal poverty level.
- Pays any premium due for the month of eligibility.

How do I find out if I can get MEPD?

To find out if you can get MEPD, you must fill out a Medicaid application and send it to your local Department of Human Services (DHS) office. The application may be mailed, faxed or delivered to the DHS office. **Or**, you may apply on-line at https://dhsservices.iowa.gov/apspssp/ssp.portal

Do I have to pay a premium for MEPD?

If your monthly gross income is over 150% of the federal poverty level, you will have to pay a premium. You will get a Notice of Decision telling you the amount of your monthly premium. See the premium chart on the next page.

Note: Your monthly premium will not go up during the 12-month enrollment period. The premium may go down if you report that your income has decreased.

How much will I have to pay each month?

You will get an MEPD Billing Statement telling you the amount of the premium. The chart on the next page can help you figure out the amount of your premium. This chart is a guide only, and the premium amount is updated annually in August.

To find your premium, add your gross earned income and your gross unearned income together. Then find the total of your monthly gross income on the chart. The premium you will have to pay will be on the same line.

If the monthly gross income of the disabled person is:	The monthly premium is:
$1,485 or less	**$0**
More than: $1,485	$33
$1,634	$46
$1,782	$55
$1,980	$64
$2,228	$76
$2,475	$88
$2,970	$110
$3,465	$135
$3,960	$158
$4,455	$183
$5,445	$228
$6,435	$276
$7,425	$324
$8,415	$383
$9,900	$460
$11,385	$539
$12,870	$622
$14,652	$718
$15,147	$735
$15,741 and above	**$767**

When are premiums due?

A billing statement will be sent to you that shows the month a premium is due. To get Medicaid on the first day of next month, premiums should be received by DHS by the last day of the month. Your MEPD will be canceled if you do not pay the premium by the 14th of the month.

Note: When you are first approved, the first billing statement may be for more than one month and the premium amount or due dates may vary. **Please read your billing statements carefully.**

What happens if I am late paying my premium?

If you do not pay the premium by the due date, your MEPD will be canceled. If you make a premium payment late:

- MEPD can be reinstated if your ongoing month's payment is received by the last day of the month it is due. For example, the payment for the July Medicaid was due July 14, but DHS received by July 31.
- MEPD coverage can be reopened if the payment is late but is received in the month after the month in which it was due. For example, the payment for July Medicaid was due July 14, but DHS received by August 31.

Note: If your payment is more than 3 months late, it will not be accepted and you will not be able to get Medicaid for that month. It is **very** important that you make your premium payment on time or early if possible.

How are my payments applied?

Payments are always applied to pay the current month premium, if unpaid. If the payment is received **after** the 14th of the month and the current month is already paid, it will be held to pay for the next month. See the last page for examples.

How do I pay my premium?

A postage-paid envelope is included with your bill. If you lose your MEPD Billing Statement, you can call your local DHS office to get a new one mailed to you. If you lose your envelope, you may mail your payment to the address below:

Iowa Medicaid Enterprise
MEPD Premium
PO Box 10339
Des Moines, IA 50306-9948

Please write your name and your member ID number on the check or money order. If this information is not included, your payment may not be credited to the right account.

Where can I go to get services?

Members enrolled with MEPD may see any provider who agrees to be paid by Iowa Medicaid. You may contact Iowa Medicaid Member Services to find out who these providers are by:

- Phone: Monday through Friday 8:00 AM to 5:00 PM at 1-800-338-8366 or in Des Moines at 515-256-4606.
- E-mail at: IMEMemberServices@dhs.state.ia.us.

Or, search on Iowa Medicaid's website at: http://dhs.iowa.gov/ime/.

What services are covered?

MEPD members have all Iowa Medicaid benefits. This includes medical, dental, vision, and chiropractic services. Prescription services are included for members who do not have Medicare.

For those members enrolled with Medicare as well as MEPD, prescription coverage will go through a Medicare Part D plan. MEPD will pay for your Medicare premiums.

If you would like to know if a specific service is covered, you must work with your physician. Your physician will need to contact Provider Services to explain the service that you need to see if that service can be paid for by Medicaid.

Will I have to pay any co-payments?

Yes, the following is a breakdown of your co-payment amounts:

Co-payment Amount	Service
$1.00 per visit	Services from a podiatrist, chiropractor, and physical therapy.
$2.00 per visit	Ambulance services, audiology services, hearing aid dealer services, medical equipment, optical services, prosthetic devices, psychology services, and rehabilitation services.
$3.00 per visit	Dental services, hearing aides, physician office visits and lab services.

How can MEPD help me to stop smoking?

Counseling plus medication has proven to be the best way to help people stop smoking. If you follow these steps, Medicaid will pay the costs of these services:

- First, you will be asked to visit your physician and explain that you want to stop smoking. Your doctor will work with you to decide which program is best for you.
- You could also get:
  - A prescription for Chantix or Buproprion (but Medicaid will only pay for these prescriptions if you do not have Medicare).
  - Over-the-counter nicotine patches and gum.
- You will also have to participate in counseling through Quitline Iowa. This counseling is done over the phone while you are taking a drug to stop smoking. Together, the drug and counseling help you stop smoking.

Will I get an MEPD ID card?

Yes. It is the same card that all Medicaid members get. You will get a plastic card that says Iowa Department of Human Services Medical Assistance Eligibility Card. Keep this card. If your card becomes lost, damaged, or stolen, contact Iowa Medicaid Member Services to get a new card. Call **1-800-338-8366** or locally in the Des Moines area **515-256-4606.**

Is there anything else I need to know?

Yes. Be sure to report the following changes to your Income Maintenance Worker at your local DHS office if you:

- Stop working,
- Earn more money,
- Earn less money,
- Move to a new address, or
- Are no longer disabled according to the Social Security Administration.

Who can I call if I still have questions about MEPD?

Your local DHS office is a good source of information about the program. You can also call the Iowa Medicaid Enterprise Member Services at **1-800-338-8366** or in Des Moines area at **515-256-4606.**

How premium payments are applied?

This is the order that payments are applied to your account:

1. To the current month, if the current month is unpaid.
2. If the payment is received **before** the 14th, after paying the current month, any extra money will be applied to old unpaid months, in this order:
    a. To the month before the current calendar month, if unpaid.
    b. To the oldest unpaid month and forward until all old unpaid months have been paid.
3. If the payment is received **after** the 14th of the month, it will be held to pay to the next month.
4. When all unpaid months have been paid, any extra money will be held as a credit and used to pay future months.

Examples:

The member has a monthly premium of $64.00. The member has not made their first two premium payments and also owes for current month.

Example 1: The member mails in a payment for $128.00 and it is received on the 10th of the month.

- $64.00 will be applied towards the current month and,
- $64.00 will be applied towards the previous month, leaving a past due balance on the first month.

Example 2: The member mails in a payment for $128.00 and it is received on the 18th of the month.

- $64.00 will be applied towards current month and,
- $64.00 will be applied towards the following month.
- No payments will be applied towards the past due months.

Example 3: The member mails in a payment of $192.00 and it is received on the 10th of the month.

- $64.00 will be applied towards current month,
- $64.00 will be applied towards the previous month and,
- $64.00 will be applied towards the oldest unpaid month.

Example 4: The member mails in a payment of $192.00 and it is received on the 18th of the month.

- $64.00 will be applied towards current month,
- $64.00 will be applied towards the following month and
- $64.00 will be applied towards the previous month, leaving a past due amount for the oldest unpaid month.

Example 5: The member mails in a payment of $256.00 and it is received on the 10th of the month.

- $64.00 will be applied towards current month,
- $64.00 will be applied towards the previous month,
- $64.00 will be applied towards the oldest unpaid month and,
- $64.00 will be applied to the second oldest undpaid month.

Example 6: The member mails in a payment of $256.00 and it is received on the 18th of the month.

- $64.00 will be applied towards current month,
- $64.00 will be applied towards the following month,
- $64.00 will be applied towards the previous month and,
- $64.00 will be applied towards the oldest unpaid month.

FIP ELECTRONIC ACCESS CARD

If you are approved for FIP, you will soon get the *Iowa Electronic Access Visa Prepaid Debit Card* (pictured) in the mail. The Iowa Department of Human Services (DHS) will put your monthly FIP benefits on this card.

When you get the card, **keep it**. It is not junk mail. Keep this card even if your benefits stop, just in case you need to reapply for future benefits.

The letter *D* after your name is to remind you that this is your DHS card. **This card is <u>only</u> for FIP benefits.** Any other state services you receive like Food Assistance, child support or unemployment benefits will not be on this card.

You cannot access your cash benefits with your electronic access card (EAC) or your personal debit card at a:

- Liquor store or any place that mainly sells liquor,
- Casino or other gambling or gaming establishment, or
- Business which provides adult-oriented entertainment in which performers disrobe or perform in an unclothed state (such as a strip club).

This includes these types of businesses located in Iowa, on tribal land, or in any other state.

If the Department determines that you have accessed your cash benefits with your EAC or your personal debit card at one of the above places you:

- Will have committed fraud,
- Have to repay the amount of cash accessed at the location, as well as any access fees, and
- Your family will not get cash benefits for three months with the first misuse and six months for each additional misuse.

Make sure to **read the papers that come with the card**. The papers will tell you how to:

- Activate your card,
- Ways to avoid fees,
- Contact the toll-free customer service number, **1-866-899-5611**, and
- Check your account balance and find participating free ATM locations via the website, **<u>www.EPPICard.com</u>**.

For questions about the card, call customer service at 1-866-899-5611. You will never be charged for calls to:

- Report a lost, stolen or damaged card;
- Request a replacement card;
- Report problems using your card; or
- Ask for help to fix a problem with your account.

You will get 6 free customer service calls per month for all other services; after that each call costs $0.40.

How to Avoid Fees:

- **Use your three (3) free cash withdrawals** each month at an Alliance One, Money Pass, or Wells Fargo ATM.
- **Make withdrawals at any Visa member bank teller window.**
- **Ask for cash back with purchases.** There are no fees on purchases or on cash back from purchases. The store may have a cash back limit.
- **Check your account balance using the www.EPPICard.com website.**

FIP ELECTRONIC ACCESS CARD

(TARJETA DE ACCESO ELECTRÓNICO DE FIP)

Si su solicitud de FIP es aprobada, muy pronto recibirá por correo la *Iowa Electronic Access Visa Prepaid Debit Card* (Tarjeta Visa de débito prepago con acceso electrónico de Iowa) (ver imagen). Iowa Department of Human Services (DHS) depositará sus beneficios de FIP mensualmente en esta tarjeta.

Cuando reciba la tarjeta, **consérvela**. No es correo basura. Conserve esta tarjeta aunque sus beneficios hayan finalizado, en caso de que necesite volver a solicitar estos beneficios en el futuro.

La letra *D* después de su nombre es para recordarle que ésta es su tarjeta DHS. **Esta tarjeta es <u>únicamente</u> para los beneficios FIP.** Cualesquier otros servicios estatales que reciba, por ejemplo, Food Assistance, manutención de menores o beneficios de desempleo no estarán en esta tarjeta.

Usted no puede acceder a sus beneficios de efectivo con su tarjeta de acceso electrónica (EAC) o su tarjeta de débito personal en los siguientes lugares:

- Licorerías o cualquier lugar donde se vendan bebidas alcohólicas principalmente.
- Casinos u otros establecimientos de juegos o apuestas.
- Locales de entretenimiento para adultos donde los artistas se desnuden o actúen desnudos (como locales de strip-tease).

Esto incluye a todos estos tipos de negocios en Iowa, en reservaciones indígenas o en cualquier otro estado.

Si el Departamento determina que usted ha accedido a beneficios de efectivo con su EAC o su tarjeta de débito personal en uno de los lugares anteriores, usted:

- Habrá cometido un fraude;
- Tendrá que pagar el monto de dinero accedido en el lugar, al igual que los cobros de acceso, y
- Su familia no recibirá beneficios en efectivo por 3 meses la primera vez que utilice la tarjeta incorrectamente y por 6 meses cada vez que vuelva a hacerlo.

No deje de **leer los papeles que acompañan a la tarjeta**. En dichos papeles encontrará información sobre cómo:

- Activar su tarjeta,
- Evitar comisiones bancarias,
- Comunicarse con el teléfono gratuito de servicios al cliente, **1-866-899-5611**, y
- Controlar el saldo de su cuenta y encontrar la ubicación de los cajeros automáticos gratuitos a través de Internet en **<u>www.EPPICard.com</u>**.

Si desea hacer preguntas con respecto a la tarjeta, llame al servicio de atención al cliente al teléfono 1-866-899-5611. No se le cobrarán las llamadas que realice para:

- Informar sobre una tarjeta perdida, robada o dañada;
- Solicitar la sustitución de la tarjeta;
- Informar sobre problemas al utilizar su tarjeta; o
- Solicitar ayuda para solucionar un problema con su cuenta.

Para todos los demás servicios, podrá hacer 6 llamadas gratuitas por mes a servicios de atención al cliente; posteriormente, cada llamada tendrá un costo de $0.40.

Cómo evitar comisiones bancarias:

- **Realice sus tres (3) retiros gratuitos de dinero en efectivo** por mes en los cajeros electrónicos de Alliance One, Money Pass, o Wells Fargo.
- **Retire dinero por ventanilla en cualquier banco que trabaje con Visa.**
- **Pida devolución de efectivo cuando haga compras.** No se cobran comisiones cuando paga sus compras o recibe efectivo con sus compras. Los comercios pueden tener un límite de devolución de efectivo.
- **Controle el saldo de su cuenta por Internet en www.EPPICard.com.**

Comm. 479, Burial Contract Frequently Asked Questions

Purpose	The flier *Burial Contract Frequently Asked Questions* gives information to Medicaid applicants and recipients of how a burial contract is counted when determining Medicaid eligibility. It also answers frequently asked questions regarding funding, amounts, verification, and where to contact for questions.
Source	Print or photocopy supplies of Comm. 438 from the sample in the manual as needed.
Distribution	Give Comm. 479 to Medicaid applicants and recipients.
Data	Medicaid applicants and recipients should read through the *Burial Contract Frequently Asked Questions* to determine: ♦ If this information pertains to them or ♦ If they need to contact DHS for further information relating to burial contracts.

Iowa Department of Human Services

Comm. 479 (12/15)

Burial Contract Frequently Asked Questions

What is a burial contract?

A burial contract is an agreement with a funeral home in which a person pre-pays for funeral expenses.

How is a burial contract counted in determining eligibility for Medicaid?

There are some circumstances in which a burial contract is not counted as a resource for Medicaid. In order to be excluded as a resource a prepaid burial contract must be an irrevocable contract and the applicant or member must be unable to access the funds.

In addition there must be a contract with a funeral home. In other words, you must purchase something for your money. You may not simply put money in an irrevocable account. This would be considered a transfer of assets for less than fair market value which results in a period of ineligibility for Medicaid.

How can a burial contract be funded?

A burial contract can be funded a number of ways. The most common ways include assigning ownership of a life insurance policy to a funeral home, setting up a trust at a bank which can be funded by a certificate of deposit or another type of account.

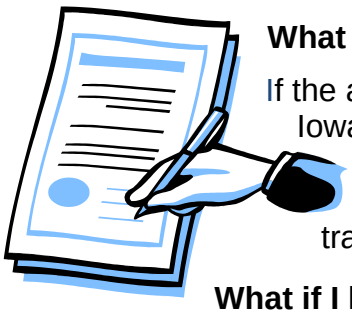
If I have a burial contract, what information do I need to provide?

If you have a burial contract, you will be asked to provide verification of the contract to your Department of Human Services IM worker.

If you have a life insurance policy funding a burial contract, you will need to provide verification of the face value and cash value of the life insurance policy as well as verification of the owner and beneficiary of the policy.

If you have burial trusts, CDs, or other funds set aside for your burial, you will need to provide verification of the value.

You must also provide a complete copy of your burial contract that indicates whether the contract is revocable or irrevocable.



What amount can be funded for burial?

If the amount funding your burial contract exceeds the average cost of a funeral in Iowa, you will need to provide a statement of goods and services verifying what was purchased. The current average cost can be found at www.iafda.org. The Department will also need to review the contract for any possible transfer of assets.

What if I have questions?

If you have questions about Facility Medicaid or what to provide, you can call the DHS Facility Unit at 877-344-9628.

RC-0002, Schedule of Needs

Purpose

Title IV-A of the Social Security Act requires states administering a cash assistance program (known as FIP in Iowa) to establish standards of assistance. These standards, expressed in money amounts, are for the purpose of determining financial need and the amount of assistance on an equitable basis.

The *Schedule of Living Costs* and the *Schedule of Basic Needs* are provided to comply with 1991 Iowa Acts, Chapter 267.

The instructions governing the use of the schedules are contained in 4-F, Applying Income Tests and Calculating the Amount of Assistance.

Chart of Basic Needs Components:

Below the *Schedule of Needs* is the *Chart of Basic Needs Components*. The total of the amounts of basic needs components does not exactly equal the amount shown on the corresponding *Schedule of Basic Needs*. This difference arises from many factors, but occurs primarily by reason of the "rounding off" procedures that are employed throughout the process culminating in the *Schedule of Basic Needs*.

This chart is used in determining applicant's or participant's net profit from renting out apartments in the applicant's or participant's own home. Note that the amounts set forth on the chart for each budgetary item are computed on a per-person basis.

For example, the two-person allowance for shelter is $131.62 ($65.81 x 2); the two-person allowance for utilities is $32.90 ($16.45 x 2).

Allowances for Special Needs:

A summary of the allowances for special needs is printed on the reverse for quick reference.

RC-0008, Overpayment Recovery Codes

Purpose

RC-0008 explains the meaning of codes in the Overpayment Recovery System.

RC-0018, Supplemental Security Income Payment Standards

Purpose	The RC-0018 is a chart of SSI and State Supplementary Assistance payment standards. It may be used as a reference in determining eligibility and the amount of payment in SSI-related Medicaid and State Supplementary Assistance cases.
Source	This chart is available on line on the DHS Intranet eForms web page. No supplies are printed.
Data	Payment standards for the various categories of State Supplementary Assistance are found under the headings listed on the chart.

RC-0023 or RC-0023(S), Things You Need to Give Us for Food Assistance

Purpose	RC-0023 and RC-0023(S) are fliers used to inform applicants of the verification requirements in the application and recertification processes.
Source	The English version of the flier is printed with 50 sheets on a pad. Order supplies from Iowa Prison Industries at Anamosa. The Spanish version can be printed or photocopied from the sample in the manual.
Distribution	Give one document to each household filing an initial application for Food Assistance or an application for recertification.
Data	The flier explains what documents clients need to produce to verify their identity, alien status, social security number, residency, expenses, earnings and other income, and assets.

Iowa Department of Human Services

Desk Aid

COVERAGE GROUP	RESOURCE LIMIT	MONTHLY INCOME LIMITS							
Food Assistance	$3,250 if one or more age 60 or older or disabled $2,250 all other households	Household Size							
			1	2	3	4	5	6	7
		Gross	$ 1,287	$ 1,736	$ 2,184	$ 2,633	$ 3,081	$ 3,530	$ 3,980
		Net	$ 990	$ 1,335	$ 1,680	$ 2,025	$ 2,370	$ 2,715	$ 3,061
		Max Allotment	$ 194	$ 357	$ 511	$ 649	$ 771	$ 925	$ 1,022
Expanded FA Cat Elig	None	Household Size							
		1	2	3	4	5	6	7	
		$ 1,584	$ 2,136	$ 2,688	$ 3,240	$ 3,792	$ 4,344	$ 4,898	
FIP	$2,000 per applicant household $5,000 per recipient household	Household Size							
			1	2	3	4	5	6	7
		Test 1	$ 675.25	$1,330.15	$1,570.65	$1,824.10	$2,020.20	$2,249.60	$2,469.75
		Test 2	$ 365	$ 719	$ 849	$ 986	$ 1,092	$ 1,216	$ 1,335
		Test 3	$ 183	$ 361	$ 426	$ 495	$ 548	$ 610	$ 670
Medically Needy Medicaid *	$10,000 per household	Medically Needy Income Level (MNIL) by Household Size							
		1	2	3	4	5	6	7	
		$ 483	$ 483	$ 566	$ 666	$ 733	$ 816	$ 891	

100% Poverty Level	1	2	3	4	5	6	7
	$ 990	$ 1,335	$ 1,680	$ 2,025	$ 2,370	$ 2,715	$ 3,061
	For each additional household member add $347						

300% Poverty Level Medicaid for Kids with Special Needs (MKSN)	1	2	3	4	5	6	7
	$ 2,970	$ 4,005	$ 5,040	$ 6,075	$ 7,110	$ 8,145	$ 9,183
	For each additional household member add $1,040.						

COVERAGE GROUP	RESOURCE LIMIT	MONTHLY INCOME LIMITS
SSI-Related Medicaid *	$2,000 for one person $3,000 for a couple	Household Size (couple in own home): 1 — $ 733; 2 — $ 1,100
QMB * (A Medicare Savings Program)	$7,280 for one person $10,930 for a couple	Effective 3/1/16 — Poverty Level 100%; Household Size: Individual $ 990; Couple $ 1,335
SLMB * (A Medicare Savings Program)	$7,280 for one person $10,930 for a couple	Poverty Level: Effective 3/1/16 Over 100% but less than 120% Household Size: Individual; Couple Income Over: Individual $ 990; Couple $ 1,335 But Less Than: Individual $ 1,188; Couple $ 1,602
Expanded SLMB * (QI-1) (A Medicare Savings Program)	$7,280 for one person $10,930 for a couple	Poverty Level: Effective 3/1/16 120% but less than 135% Household Size: Individual; Couple Income: Individual $ 1,188; Couple $ 1,602 But Less Than: Individual $ 1,337; Couple $ 1,803
QDWP Medicaid * (A Medicare Savings Program)	$4,000 for one person $6,000 for a couple	Effective 3/1/16 — Poverty Level 200%; Household Size: Individual $ 1,980; Couple $ 2,670
MEPD Medicaid for Employed People with Disabilities	$12,000 for one person $13,000 for a couple	Net countable income is less than 250% FPL Eff. 3/1/16

MEPD Income Limit Household Size

1	2	3	4	5	6	7	8
$ 2,475	$ 3,338	$ 4,200	$ 5,063	$ 5,925	$ 6,788	$ 7,653	$ 8,519

* Note: Compare net countable income to the income limits.

Monthly Medicare Part B Premium
(Effective 1-1-2015)
$104.90

MEPD Premiums Effective August 1, 2016

If the gross monthly income of the person getting MEPD is:	FPL	Premium Amount
$ 1,485 or less	At or below 150%	**$ 0**
Above: $ 1,485	**Above:** 150%	$ 33
1,634	165%	46
1,782	180%	55
1,980	200%	64
2,228	225%	76
2,475	250%	88
2,970	300%	110
3,465	350%	135
3,960	400%	158
4,455	450%	183
5,445	550%	228
6,435	650%	276
7,425	750%	324
8,415	850%	383
9,900	1000%	460
11,385	1150%	539
12,870	1300%	622
14,652	1480%	718
15,147	1530%	735
$ 15,741 and above	1590%	767

RC-0033, Desk Aid

Purpose

The RC-0033 is a chart of Food Assistance, FIP, and Medicaid income and resource limits. Workers can use it as a reference in determining eligibility and the amount of payment in these cases.

Source

Print RC-0033 from the manual or the DHS Intranet eForms web page.

Data

The chart lists:

- Income and resource limits for:
  - Food Assistance
  - FIP
  - Medically Needy Medicaid
  - Medicaid for Kids with Special Needs (MKSN) (no resource limit)
  - SSI-related Medicaid
  - QMB (Medicare savings)
  - SLMB (Medicare savings)
  - Expanded SLMB (Medicare savings)
  - QDWP (Medicare savings)
  - Medicaid for Employed People with Disabilities
- Income limits and premium levels for Medicaid for Employed People with Disabilities
- The Medicare Part B premium

RC-0064, Unearned Income Desk Aid

Purpose

The *Unearned Income Desk Aid* is designed as an immediate reference about unearned income for income maintenance staff. It:

- Gives information on the documents that verify child support, unemployment benefits, SSI benefits, and social security benefits.
- Explains how to determine the receipt date for these income sources when determining initial and ongoing eligibility for the Food Assistance, FIP, and Medicaid programs.
- Lists the child support account codes to distinguish between payments that are forwarded to the client and those that are kept by the state.

Source

Print or photocopy RC-0064 from the sample in the manual if needed.

RC-0085, Guide for Citizenship and Identification

Purpose	The *Guide for Citizenship and Identification* is a tool to help ensure that each Medicaid applicant and member provides documentation of identity and citizenship with the highest level of reliability that is readily available.
Source	Print the guide from the DHS Intranet eForms web page as needed.

RC-0103, Disability Determination Checklist

Purpose	RC-0103 is used to assist income maintenance workers in submitting complete disability determination referrals to the Disability Determination Services Bureau (DDSB). It may be used as a checklist for each determination or as a general guide to ensure that all required information is included in the referral.
Source	Print RC-0103 from the manual or the DHS Intranet eForms web page.
Distribution	The worker may retain the form in the case file, but it is not required.
Data	The front of the form lists the required documentation to provide with disability referrals. The back of the form gives helpful tips for: ♦ Continuing disability reviews (CDRs). ♦ Disability referrals based on worsened conditions or new conditions. ♦ The use of form 470-0363, *Certification of Eligibility of SSI Applicant*. ♦ Concurrent determinations for Medicaid and Social Security benefits.

RC-0128, Suspending Medicaid to Limited Benefits for Incarcerated Individuals Procedure Guide

Purpose	RC-0128 is used to assist income maintenance workers in determining the correct procedure for suspending Medicaid benefits to limited services for individuals who have been incarcerated for more than 30 consecutive days. It should be used as general guide to make sure all the required steps are completed.
Source	Print RC-0128 from the sample in the manual.

RC-0130, Desk Aid for MAGI, MIYA, IHAWP, and *hawk-i*

Purpose	RC-0130 is a chart of monthly income limits. Workers can use it as a reference in determining eligibility in these cases.
Source	Print RC-0130 from the manual or the DHS Intranet eForms web page.
Data	The chart lists income limits for: ♦ Modified adjusted gross income (MAGI) ♦ Medicaid for Independent Young Adults (MIYA) ♦ Iowa Health and Wellness Plan (IHAWP) ♦ Healthy and Well Children in Iowa (***hawk-i***)