

Revised October 7, 2011

Employees' Manual  
Title 6  
Appendix

# **INCOME MAINTENANCE PROGRAMS APPENDIX**



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**ABAWD Letter, Form 470-3967 or 470-3967(S)**

Purpose	The purpose of form 470-3967, <i>ABAWD Letter</i> , is to notify each able-bodied adult without dependent (ABAWD) of the ABAWD work requirement and the consequences of failure to comply with the requirements.
Source	Complete the English version of this form on line using the template on the DHS Intranet eForms web page.  Print or photocopy the Spanish version of the form from the sample in the manual.
Completion	The IM worker issues this form to every ABAWD when: <ul style="list-style-type: none"><li>◆ The ABAWD is identified at the application review.</li><li>◆ The ABAWD is identified when a case is approved for recertification.</li><li>◆ A client loses exempt status from the ABAWD work requirement due to a change in circumstances.</li><li>◆ A new household member is an ABAWD.</li></ul>
Distribution	Give or mail a copy of the form to the client. At the application or recertification interview, give the household representative a copy of this form for each ABAWD in the household.
Data	Enter the ABAWD's name in the space provided.

**Absent Parent Information, Form 470-3773 or 470-3773(S)**

Purpose	Form 470-3773, <i>Absent Parent Information</i> , may be used to collect information for the Family Investment Program regarding the parent of a child for whom benefits are being sought when the parent is not living with that child.
Source	Complete the English or Spanish version of the form on line using the template available on the DHS Intranet eForms web page.
Completion	<p>If the household has not provided information about the absent parent in another way, the household may be asked to complete the form when it reports that:</p> <ul style="list-style-type: none"><li>◆ A parent will leave home.</li><li>◆ A parent has left home.</li><li>◆ A child or newborn has entered the home and the child has an absent parent.</li></ul> <p>Certain areas of the form populate and a due date is calculated for return of the completed form.</p> <p>Give the household assistance in completing this form if needed.</p>
Distribution	Print two copies of the form. Give one copy to the client and file one copy in the case record. The client completes the form and returns it to the assigned imaging center.
	Enter information regarding the absent parent on the ICAR system.
Data	The form requests identifying information and employment information about the absent parent and information about the parents' marriage and support obligations.

**Accident Injury Request, Form 470-0398**

Purpose	<p>Form 470-0398, <i>Accident Injury Request</i>, is used by the Iowa Medicaid Enterprise (IME) to collect information from Medicaid members or their representative when claims show they may have been involved in an accident or injury.</p> <p>The information returned on the form is used to identify claims with potential third-party liability (TPL). This form allows the IME to recover some or all of the Medicaid expenditures made on the member's behalf in connection to an accident or injury.</p>
Source	<p>The form is computer-generated by the IME OnBase system.</p>
Completion	<p>The form is prepared automatically when a Medicaid claim code indicates an accident or injury.</p> <p>The IME also generates the form when field staff, a member, a provider, an insurance company, or an attorney reports that the member has been involved in an accident and the possibility of third-party liability exists.</p>
Distribution	<p>The form is sent to the member, who returns it to the IME on completion.</p> <p>Once completed by the member or the member's representative, the form may be returned in one of the following ways:</p> <p><b>Mail:</b> Iowa Medicaid Enterprise PO Box 36446 Des Moines, IA 50315</p> <p><b>Phone:</b> Member Services <b>1-800-338-8366</b> or locally in the Des Moines area at <b>515-256-4606</b> (Monday through Friday, 8:00 am to 5:00 pm)</p> <p><b>Email:</b> <a href="mailto:RevColl_Lien@dhs.state.ia.us">RevColl_Lien@dhs.state.ia.us</a></p> <p><b>Fax:</b> 515-725-1352</p>

Data

The form requests information from the member concerning:

- ◆ When and how the injury occurred.
- ◆ Whether the recipient has filed an insurance claim or retained an attorney in connection with the injury.
- ◆ The name and address of any involved insurance companies or attorneys.

**Account Transfer Error, Form 470-5437**

Purpose	<p>Form 470-5437, <i>Account Transfer Error</i>, is a letter used to notify applicants who are ineligible for Medicaid or <b>hawk-i</b> that the state was unable to successfully transfer their application for health care coverage to the Marketplace.</p> <p>The letter informs the applicant that they need to complete a Marketplace application to see if they qualify for coverage and help paying for it. The letter also provides instructions.</p>
Source	<p>The letter is created in Central Office from a batch file that identifies applications that were not successfully transferred to the Marketplace.</p>
Completion	<p>The date, primary applicant's name, and mailing address are auto-filled on the letter through a mail merge process in Central Office.</p>
Distribution	<p>The form is sent to the primary applicant.</p>

**Addendum to Application and Review Forms for Release of Information, Form 470-4670 or 470-4670(S)**

Purpose	If signed, form 470-4670 or 470-4670(S) may be used to request information (other than protected health information) about any household member. The client is not required to sign this form.
Source	Print or photocopy the addendum from the samples in the manual or from the DHS Intranet eForms web page.
Completion	<p>The client may use this form to authorize the Department to contact other people or organizations for information needed to determine eligibility and benefits without specific contacts with the client for each request. Instead of signing this form, the client may:</p> <ul style="list-style-type: none"><li>◆ Choose to provide necessary information, or</li><li>◆ Sign another form that is specific to the source and type of information, such as an <i>Employer's Statement of Earnings</i>.</li></ul> <p>If the client chooses to use this form to authorize release of information:</p> <ol style="list-style-type: none"><li>1. Make entries in the Online Narrative to document the date this form was signed.</li><li>2. Use this form to request from other people or organizations any information that is needed to determine eligibility and benefits.</li><li>3. If the source of the information will not respond based on the client having signed this form, request the needed information from the client in writing. Help the client get information if the client asks for help.</li></ol>
Distribution	<p>If the client signs form 470-4670 or 470-4670(S):</p> <ul style="list-style-type: none"><li>◆ Send a copy to other caseworkers that have an active file for the client.</li><li>◆ File the original or copy in the case file.</li></ul>

This form is intended to collect information specified on a separate sheet. When using it to request information from other people or organizations in order to determine eligibility or benefits:

1. Fold form 470-4670 or 470-4670(S) in half and copy the "Release of Information" section of the form.
2. Fax or mail the copy to the source of information along with a form requesting specific information, such as form 470-2844, *Employer's Statement of Earnings*, or form 470-0461, *Authorization for Release of Information*.

When a signed release is in the file, requests for information may also be made by telephone.

Data

If the client chooses to use the form to authorize release of information, the client shall:

- ◆ Print the client's name, and
- ◆ Sign and date the form.

**[Addendum to Application for Help with Medicare Prescription Drug Plan Costs, Form 470-4167](#)**

Purpose	Form 470-4167, <i>Addendum to Application for Help with Medicare Prescription Drug Plan Costs</i> , is used in conjunction with the Social Security Administration application entitled, <i>Application for Help with Medicare Prescription Drug Plan Costs</i> , form SSA-1020B-OCR-SM.
Source	Print or photocopy form 470-4167 from the manual or the DHS Intranet eForms web page.
Completion	When an applicant demands that DHS process the application for extra help with Medicare prescription drug plan costs instead of the Social Security Administration, the applicant must sign and date this form.
Distribution	File the addendum and the <i>Application for Help with Medicare Prescription Drug Plan Costs</i> in the case file.
Data	The form advises the applicant of terms for DHS process.

**Adding an EBT Cardholder, Form 470-3983 or 470-3983(S)**

Purpose	<p>Form 470-3983, <i>Adding an EBT Cardholder</i>, is used by households who want a second Iowa EBT card for another member or for an authorized representative to use for shopping for the household.</p> <p>The form is also used as proof that the Department did not issue an additional Iowa EBT card on an account without permission of the household's primary cardholder.</p> <p>This form is not to be used for drug and alcohol treatment center or group living arrangement authorized representatives.</p>
Source	<p>Complete the English version of this form on line using the template on the DHS Intranet eForms web page.</p> <p>Print or photocopy the Spanish version of the form from the sample in the manual.</p>
Completion	<p>The form is completed by the IM worker, the Food Assistance head of household (the primary cardholder), and the secondary cardholder or authorized representative.</p> <p>The form must be fully completed and signed by all parties and returned to the DHS local office before a secondary cardholder or authorized representative can receive an Iowa EBT card on a Food Assistance household's EBT account.</p>
Distribution	<p>The Food Assistance household keeps the second copy when the form is given to the secondary cardholder or authorized representative. The secondary cardholder or the authorized representative keeps the third copy. File the completed original in the Food Assistance case record.</p>
Data	<p><b>Case Information.</b> To be completed by the IM worker.</p> <p><b>Case Name.</b> Enter the name of the primary cardholder (the ABC case name).</p> <p><b>Case Number.</b> Enter the DHS Food Assistance case number.</p>

**Worker's Name.** Enter name of the IM worker who is responsible for the Food Assistance case record.

**Date.** Enter the date the information is entered.

**Adding an EBT Cardholder.** These entries are completed by the primary cardholder (the ABC case name).

- ◆ **Name of Person You Want Added.** The primary cardholder enters the name of the person authorized as a secondary cardholder or authorized representative.
- ◆ **Your Signature.** The primary cardholder signs and dates the form.

**New EBT Cardholder's Section.** These entries are completed by the secondary cardholder or authorized representative.

- ◆ **Signature of New EBT Cardholder.** The person named by the primary cardholder signs to acknowledge agreement with the household.
- ◆ **Date.** The date of signature of the secondary cardholder or authorized representative.
- ◆ **Social Security Number.** The social security number of the secondary cardholder or authorized representative.
- ◆ **Birthday (mm/dd/yy).** Enter the birth date of the secondary cardholder or authorized representative.
- ◆ **Phone.** The phone number of the secondary cardholder or authorized representative.

**Adjustment to Overpayment Balance, Form 470-0010**

Purpose	Form 470-0010 is used to record payments and adjustments to debtor accounts established on the Overpayment Recovery System.
Source	Complete form 470-0010 on line using the template on the DHS Intranet eForms web page.
Completion	<p>The IM worker or PROMISE JOBS worker who receives payments from a debtor or who wants to communicate necessary adjustments to a debtor's overpayment account completes this form when:</p> <ul style="list-style-type: none"><li>◆ Payments (cash, returned warrants) are received in the local office,</li><li>◆ A monetary adjustment to a debtor's account needs to be made (e.g., credits to date were applied incorrectly), or</li><li>◆ An offset needs to be credited.</li></ul> <p>Complete one form for each transaction. Print two copies of the completed form.</p> <p>NOTE: The total amount of the claim is not adjusted with this form. Submit an updated 470-0464, <i>Overpayment Recovery Information Input</i>, or the Overpayment Recovery Information Input Summary (from the direct claim entry screen), to adjust the total owed.</p>
Distribution	<p>Send one copy with the official receipt and the payment (if applicable) to the Cashier's Office, Bureau of Purchasing, Payments, Receipts and Payroll, Hoover Building, First Floor, Room 14, 1305 E. Walnut Street, Des Moines, Iowa 50319-0114. Keep a copy in the client's case file.</p> <p>If the reduction is a result of cash payment, the check or money order must accompany this form.</p>
Data	<b>Date:</b> Enter the date the form is being submitted.

**Submitting Worker:** Enter the name of the worker preparing the form.

**Agency/Office:** Enter the department of the worker preparing the form (DHS, IWD).

**Telephone:** Enter the worker's telephone number.

**Debtor Name:** Enter the name of the debtor whose overpayment recovery account needs adjustment. Enter the name as listed on the *Overpayment Recovery Information Input*, form 470-0464, or the *Overpayment Recovery Information Input Summary* (from the direct claim entry screen).

**Identifying Number and Prefix:** Enter the prefix and the main identifier. Use the state ID number when available.

**Program:** Enter the program for the claim to which the change is being made, the offset is being credited, or the payment is being applied. If this payment could be applied to more than one claim, list all that apply.

**Date Established:** Enter the date for the claim to which the change is being made, the offset is being credited, or the payment is being applied.

**Action:** Check whether the claim balance should be increased or decreased.

**Reduce Balance:** Enter the amount by which the debtor's account balance should be reduced.

**Increase Balance:** Enter the amount by which the debtor's account balance should be increased. This occurs in case of FIP grant reduction or Food Assistance benefit reduction adjustments.

**Reason:** Check the reason for the adjustment, and identify what the "other" reason is, if "other" is checked. If more than one reason is checked, indicate a separate amount for each reason. These amounts must total to the amount entered after the action.

**Affidavit and Agreement for Issuance of Duplicate Warrant, Form 470-0005**

Purpose	Payees use the <i>Affidavit and Agreement for Issuance of Duplicate Warrant</i> to apply for another warrant when they have not received the warrant, or they have lost or inadvertently destroyed the original warrant after receipt, and it has not been cashed.
Source	Complete form 470-0005 on line using the template on the DHS Intranet eForms web page.
Completion	<p>Allow the payee to submit this form six calendar days after the scheduled mailed date when:</p> <ul style="list-style-type: none"><li>◆ The payee advises the Department of loss or non receipt of the warrant;</li><li>◆ The post office has not returned the warrant to Quality Assurance as undeliverable; and</li><li>◆ The warrant is still outstanding according to the "OUTS" system.</li></ul> <p>Fill in the required descriptive information about the warrant and have the warrant payee sign and date the form.</p>
Distribution	Send these completed documents to Quality Assurance, Division of Data Management, for processing and delivery to the Department of Administrative Services, State Accounting Enterprise, for issuance of a duplicate warrant.
Data	<p>Enter both the current address of the claimant and the address where the warrant was mailed, if they are different.</p> <p>Obtain the warrant number through the ISSV screen and use it to look up the account number, warrant amount, and issue date on the "OUTS" system. See <a href="#">14-B(4)</a>, <u>OUTS = Warrant Status Information</u>, for instructions.</p>

**Affidavit as to Forged Endorsement, Form 470-0004**

**Purpose** Form 470-0004 is used to supply the Department of Inspections and Appeals (DIA), Investigations Division, with information to determine the appropriateness of a request to replace a warrant stolen from a client's mailbox.

**Source** Complete form 470-0004 on line using the template on the DHS Intranet eForms web page.

**Completion** Complete this form when the payee reports that the warrant has not been received by the sixth day after scheduled mailing date **and**:

- ◆ The warrant has been redeemed according to the "OUTS" system.
- ◆ The payee has viewed the copy of the original check.
- ◆ The payee continues to claim that the signature on the endorsement is not that of the payee, and the payee has no knowledge of the redemption nor participated in any of the proceeds of the warrant.

If there is more than one payee, or the case is a two-parent household, both people must complete a form.

Complete the top section of the form on line from the information on the OUTS system. Then print the form for the payee signatures. The payee must complete the signature sections in front of a DHS employee, and the form must be notarized to be valid.

**Distribution** Keep the original *Affidavit* in the client's case file. Make a copy and send it to DIA Investigations Division, 321 E 12th St., Des Moines, Iowa 50319-0083.

However, if the copy is not clearly readable, send the original to DIA. If DIA cannot discern the payee's signature well enough to make an informed decision as to whether to replace the warrant, there will be a delay while the original is requested.

Data

The payee must complete the bottom section using the **exact wording and abbreviations as on the endorsement**. This includes the warrant address, not the client's current address, if different. If the payee has moved since the warrant was issued, use the address listed on the warrant when completing forms.

**[Affidavit Concerning Documentation of Citizenship, Form 470-4374 or 470-4374\(S\)](#)**

Purpose	The <i>Affidavit Concerning Documentation of Citizenship</i> is a written declaration, made under penalty of perjury, to explain why a Medicaid applicant or member does not have proof of U.S. citizenship. The form includes a cover letter to explain the affidavit.
Source	Both English and Spanish versions of this form are available on line as templates on the DHS Intranet eForms web page.
Completion	This affidavit must accompany form 470-4373, <i>Affidavit of Citizenship</i> . The income maintenance worker provides this affidavit to the applicant or member who needs to verify their U.S. citizenship.  The income maintenance worker enters the state identification number and case number on the preface page. Section 1 is populated from this information.  The applicant or member or other knowledgeable person (guardian or representative) completes Sections 2 and 3.
Distribution	You may upload the request to the electronic case file. When the original is returned, it will be scanned and uploaded.
Data	Section 1 contains the applicant or member's full name and state identification number.  Sections 2 and 3 are for the explanation and the signature of the person completing the form.

**Affidavit of Citizenship, Form 470-4373 or 470-4373(S)**

Purpose	The <i>Affidavit of Citizenship</i> is a written declaration, made under penalty of perjury, by a third party to verify that a Medicaid applicant or member who does not have proof of U.S. citizenship is a U.S. citizen. The form includes a cover letter to explain the affidavit.
Source	Both English and Spanish versions of this form are available on line as a template on the DHS Intranet eForms web page.
Completion	<p>This affidavit must accompany form 470-4374, <i>Affidavit Concerning Documentation of Citizenship</i>. The income maintenance worker provides two copies of this affidavit to applicants or members who need to verify their U.S. citizenship.</p> <p>The worker enters the person's state identification number and case number on the preface page.</p> <p>Two people must complete this affidavit for each person who needs to have citizenship verified. Only one of these people can be a relative of the applicant or member. In other words, two people unrelated to the client may complete the affidavit, or one person related to and one person unrelated to the client may complete it.</p> <p>Each person completing the affidavit must provide original proof of the person's own U.S. citizenship and identification.</p>
Distribution	You may upload the request to the electronic case file. When the original is returned, it will be scanned and uploaded.
Data	<p>Section 1 is the name of the person completing the form.</p> <p>Section 2 is the information about the applicant or recipient.</p> <p>Section 3 is any other information that may be pertinent to proving the applicant's or member's U.S. citizenship.</p> <p>Section 4 identifies if the person completing the form is a relative.</p> <p>Section 5 is the signature of the person completing the form.</p>

**Affidavit of Identity, Form 470-4386 or 470-4386(S)**

Purpose	<p>The <i>Affidavit of Identity</i> is a written declaration made under penalty of perjury by a parent, guardian, specified relative, or RCF administrator to verify the identity of a person who does not have any other proof of identity.</p> <p>NOTE: If this affidavit is used, U.S. citizenship cannot be verified by use of an affidavit.</p>
Source	<p>Both English and Spanish versions of this form are available on line as templates on the DHS Intranet eForms web page.</p>
Completion	<p>The income maintenance worker provides this affidavit to the applicant or member who needs to verify identity of a child under age 16 or a disabled person institutionalized in a residential care facility. The worker enters the person's state identification number and case number on the preface page.</p> <p>For a child under age 16, the written declaration may be made by a parent, guardian, or specified relative.</p> <p>For an institutionalized disabled person, the written declaration may be made by the director or administrator of a residential care facility.</p>
Distribution	<p>You may upload the request to the electronic case file. When the original is returned, it will be scanned and uploaded.</p>
Data	<p>Section 1 is information regarding the child or disabled person.</p> <p>Section 2 is the name of the parent, guardian, specified relative, or RCF administrator.</p> <p>Section 3 is the signature of the parent, guardian, specified relative, or RCF administrator completing the form.</p>

**Agreement for Automatic Deposit, Form 470-0261 or 470-0261(S)**

Purpose	The <i>Agreement for Automatic Deposit</i> authorizes the Department to deposit payments automatically into a participant's financial institution account.
Source	Print form 470-0261 or 470-0261(S) from the on line manual or the DHS Intranet eForms web page or photocopy the samples in the manual.
Completion	<p>Give this form to the following clients who want to start, change, or stop automated deposits:</p> <ul style="list-style-type: none"><li>◆ Family Investment Program (FIP) or Refugee Cash Assistance (RCA) clients receiving grants. (Any other cash assistance payments authorized on FIP or RCA cases will also be automatically deposited.)</li><li>◆ Facility residents who receive the state-funded payment for the difference between their countable income and the personal needs allowance.</li></ul> <p>The participant completes the form and returns it with a voided check for the account. A deposit slip should be provided for savings accounts that do not provide checks.</p>
Distribution	File the original in the case record after DIRD entries are made to start, change, or stop automated deposit. Give a copy to the client.
Data	The form indicates whether the client wants to start, stop, or change automated deposit, and gives information about the client's financial institution.

**Agreement for Telephone Hearing, Form 427-0415 or 427-0415(S)**

Purpose	Form 427-0415 is an agreement signed by the client to consent to a telephone hearing for an intentional program violation for the Food Assistance program.
Source	The Department of Inspections and Appeals sends this form to the IM worker with the <i>Notice of Hearing</i> .
Completion	The IM worker and the respondent complete this form before the telephone hearing.
Distribution	Keep the original in the client's case file. Return a copy to the Department of Inspections and Appeals.
Data	Sign and date the form and complete the appeal number and case number. Have the respondent sign and date the form in your presence.

**Agreement to Pay a Debt, Form 470-0495 or 470-0495(S)**

Purpose	Form 470-0495 or 470-0495(S) is a written agreement between a debtor and the Department for repayment when a debt exists. This form is completed by the Department of Inspections and Appeals (DIA) and is included here for information only.
Source	This form is issued by DIA.
Completion	<p>The DIA investigator sends this agreement to a debtor to seek repayment for a debt owed to the Department of Human Services.</p> <p>The investigator may also send this form when a notice of overpayment has been sent and there has been no response.</p> <p>The debtor should return this form within 10 days. When a debtor fails to respond, other collection actions are pursued.</p>
Distribution	DIA places the original in the Overpayment Recovery file and gives the copy to the debtor.
Data	The form states the amount of the debt and the repayment terms the debtor agrees to.

**Agreement to Sell Excess Property, Form 470-2909**

Purpose	Form 470-2909, <i>Agreement to Sell Excess Property</i> , is a written commitment by a State Supplementary Assistance client to make good-faith efforts to sell resources that are in excess of program limits. With this agreement and an agreement to repay conditional benefits, form 470-2835, the client can be granted conditional eligibility.
Source	Print or photocopy supplies of form 470-2909 from the sample in the manual as needed.
Completion	<p>Complete the form before granting conditional benefits to an applicant.</p> <p>For a recipient, complete the form within 10 days of learning that the person has excess property that would make the person ineligible. Do not cancel the case until the recipient has had 10 days to complete and return the form.</p> <p>The IM worker shall complete the blanks on the form. The client or representative must sign the form.</p>
Distribution	<p>Two-part NCR.</p> <p>File the yellow copy of the signed form in the case record and give the white copy to the client or representative.</p>
Data	<p>Complete Item 5 designating each program for which the client is eligible.</p> <p>Complete Item 6 by checking the number of months that is appropriate or specifying the number of months of eligibility remaining under conditional policies when SSI has already granted conditional benefits. Also enter the effective date that the property is exempt and conditional benefits are granted.</p>

If spouses' eligibility is considered together, both spouses must sign the agreement. When the client is a child, and the child or the parent has the excess resources, the parent must sign the form. If the client has a guardian, conservator, or payee, that person must sign the form.

When a sponsor's excess resources make the client ineligible, and the sponsor wishes to sell the resource, the sponsor shall also sign the form.

**Annuity Release of Information, Form 470-4699**

**Purpose** Form 470-4699 is designed to secure the client's permission for the Department to obtain annuity information needed to determine eligibility. The source of information completes the form to provide the annuity information.

**Source** Complete the form on line using the template on the DHS Intranet eForms web page.

**Completion** Workers may complete this form when it is necessary to obtain annuity information from a source other than the client. Complete a separate form for each source of required information.

The worker completes the identifying information. The client (or the person authorized to obtain information) signs the form to give the authorization. The source of information completes the remainder of the form.

**Distribution** Send one copy to the source of information.

You may upload the request to the electronic case file. When the original is returned, it will be scanned and uploaded.

**Data** Complete the following:

- ◆ State ID
- ◆ Case number
- ◆ Check the boxes to determine eligibility for Food Assistance, medical, FIP, or child care assistance
- ◆ Name and address of the source information
- ◆ Policy number
- ◆ Annuity owner
- ◆ Payment date
- ◆ Client's social security number

The client shall sign and date the form after these items have been completed. The expiration date shall be 90 days from the date the form is signed.

**Appeal and Request for Hearing, Form 470-0487 or 470-0487(S)**

Purpose	Form 470-0487 is used to initiate the appeal process and to supply information needed to proceed with an appeal.
Source	<p>Department staff may complete form 470-0487 on line using the template on the DHS Intranet eForms web page.</p> <p>Appellants may also complete this form electronically at <a href="https://dhssecure.dhs.state.ia.us/forms/">https://dhssecure.dhs.state.ia.us/forms/</a>. The request will be submitted directly to the Appeals Section to be processed.</p> <p>Print or photocopy supplies of the Spanish version of this form from the sample in the manual.</p>
Completion	<p>The form is divided into two parts. The person wishing to appeal (the appellant) or someone acting for the appellant completes the top part to initiate the appeal. The worker should assist in completing this part of the form if the appellant wishes.</p> <p>A worker who receives this form from the appellant completes the worker information section. (The worker information section is not required for appeal requests filed directly with the Appeals Section.)</p> <p>An appeal may be requested without completing this form. Any written appeal is valid. A request for a Food Assistance appeal may be expressed verbally or in writing.</p> <p>If the appellant requests an appeal verbally or in other written form, the worker shall complete the identifying information and attach the appeal request to the form.</p>
Distribution	<p>If the form is submitted to a Department office other than the Appeals section, make three copies of the completed form. Distribute them as follows:</p> <ul style="list-style-type: none"><li>◆ Give a copy to the appellant.</li><li>◆ Fax a copy to any other worker named in the "Worker Information" section, and follow up by e-mail to confirm the worker was notified.</li></ul>

- ◆ Within 24 hours of receipt, send the original and the *Notice of Decision* to:

DHS Appeals Section, 5th Fl  
1305 E Walnut Street  
Des Moines, Iowa 50319-0114

Attach a copy of the *Notice of Decision* or other notice of an adverse action that is being appealed. If no copy of the notice is attached, note why. Attach the postmarked envelope if the appeal was mailed in.

- ◆ Keep a copy in the case file.

Data      Top Section      Complete all the information, including phone number, if applicable. Check the programs under appeal.

A person requesting an attribution appeal may also request an administrative hearing. An administrative hearing is a review of the record only and does not include an appearance by the worker or client.

Indicate whether the appellant:

- ◆ Wants benefits to continue while the appeal is pending.
- ◆ Requests an interpreter for the appeal hearing.
- ◆ Wishes to have a pre-hearing conference to discuss the appeal. (Explain the purpose of a pre-hearing conference.)

Explain why the appellant is appealing. The explanation may be as specific as the appellant wishes to make it.

List any other persons whom the appellant wishes to have notified of the time and place of the hearing, with their addresses. This may include an attorney or representative.

The form should be signed and dated, if possible.

Worker Information Complete the worker's name, number, telephone number, and office name, and the appellant's case number or state identification number.

Refer to the section of the manual that specifies when assistance continues in determining whether the appellant's assistance or services are continuing or being reinstated pending the outcome of the appeal. If assistance is not being continued or reinstated, check and note the reason why it is not.

Check the box and indicate if the appeal is based on a Disability Determination Services report, an IME level-of-care decision, a CSC worker action, a FIP limited benefit plan, a Quality Control report, or a DIA investigation. Include the worker office location if the appeal concerns a PROMISE JOBS, Quality Control, or DIA Investigations action.

If you have a special scheduling request in the next three months (such as a compressed work week, vacation plans, or being in training), list it on the line indicated.

Within ten days of the receipt of the appeal, forward a summary of all actions taken. The summary is a review of the facts about the situation and should include:

- ◆ Information on the household composition.
- ◆ The issue being appealed.
- ◆ A detailed explanation of actions taken that led to the appeal.
- ◆ Copies of all supporting documents, including applications, notices, any other applicable forms, and narratives.
- ◆ Manual references on the actions taken.

Provide the appellant and appellant's representatives, if any, with copies of all materials submitted to the Appeals Section. Also provide this information to any other worker involved in the appeal. Note on the materials sent to the Appeals Section that copies were sent and to whom.

Notify the Appeals Section if other agencies or staff are parties to the appeal.

**[Application for Extra Help with Medicare Prescription Drug Plan Costs, Form SSA-1020B-OCR-SM](#)**

Purpose	<p>The <i>Application for Extra Help with Medicare Prescription Drug Plan Costs</i>, form SSA-1020B-OCR-SM, is used to apply for help with Medicare prescription drug plan costs.</p> <p>A Medicare beneficiary can also apply with the state Medicaid agency for help with prescription drug plan costs and can require the state determine eligibility for this help.</p>
Source	<p>The <i>Application for Extra Help with Medicare Prescription Drug Plan Costs</i>, form SSA-1020B-OCR-SM, is issued by the Social Security Administration. Keep a supply in each local office. To order forms, contact the Social Security Administration office serving your area.</p> <p>NOTE: This form is not to be photocopied. A Medicare beneficiary who wants the Social Security Administration to determine eligibility must submit the application on an original form or apply via the Internet.</p>
Completion	<p>The applicant or the applicant's representative completes the application. To apply for state determination, the applicant or representative must also complete form 470-4167, <i>Addendum to Application for Help with Medicare Prescription Drug Plan Costs</i>.</p>
Distribution	<p>When the applicant wants the Social Security Administration to process the application, the form is to be mailed to the Social Security Administration in the pre-addressed envelope that is enclosed with the application.</p> <p>When the applicant wants the Department to process the application, the form is filed in the DHS case record with form 470-4167, <i>Addendum to Application for Help with Medicare Prescription Drug Plan Costs</i>.</p>
Data	<p>Record your action taken on this form as directed by the income maintenance supervisor 2 for your area.</p>

**Application for Health Coverage and Help Paying Costs, Form 470-5170 or 470-5170(S)**

Purpose

The *Application for Health Coverage and Help Paying Costs* is designed to assist people applying for various health-related programs, including:

- ◆ Medicaid (MAGI and non-MAGI)
- ◆ **hawk-i** (Children's Health Insurance Program or CHIP)
- ◆ Iowa Health and Wellness Plan (IHaWP)
- ◆ State Supplementary Assistance
- ◆ Help paying for health insurance costs

Source

Central Office has a contract to provide automatic shipments of form 470-5170 to local offices. The shipments are intended to cover a six-month supply. Additional supplies of form 470-5170 are also available through Central Office.

DHS staff may also complete the forms on line using the templates on the DHS Intranet eForms web page.

Completion

Give or mail the *Application for Health Coverage and Help Paying Costs* to anyone who asks for an application. Give or mail the *Voter Registration* form with the application.

Inform anyone who contacts the Department for an application of the option to submit an application in person, by mail, by fax, electronically or by telephone.

The applicant completes the form. A friend, relative or authorized representative may help. Phone numbers and a website that can be used to get help with the application are provided on the cover page of the form.

An optional release of information is included on the last page of the application. 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.

Distribution	Scan and file the completed application in the case record. Give the applicant a copy at the applicant's request.
	Enter information from the application into the Eligibility Integrated Application System (ELIAS) as appropriate.
Data	Date-stamp the application upon receipt.

**[Approval of Release of Information by Iowa Department of Human Services, Form 470-1363](#)**

Purpose	The Department of Inspections and Appeals (DIA) Investigations Division uses this form to authorize release of information to law enforcement for investigations of fraud and stolen warrants.
Source	This form is issued by DIA.
Completion	DIA Investigations Division staff complete this form when: <ul style="list-style-type: none"><li>◆ An investigation is referred to law enforcement. This includes referrals for replacement warrants.</li><li>◆ Law enforcement agencies request to view handwriting samples of possible suspects in the theft of a warrant.</li></ul>
Distribution	DIA sends this form to law enforcement (police department, sheriff, postal inspector, Division of Criminal Investigation) for every check that is sent out for investigation. The law enforcement officer will present it to the Department office when requesting information.
Data	DIA completes: <ul style="list-style-type: none"><li>◆ The client's name and case number</li><li>◆ The names and number of other related cases</li><li>◆ The information to be released</li><li>◆ The authorizing signature</li></ul>

**Attribution of Resources Appeal Summary, Form 470-3144**

Purpose	Form 470-3144 may be used as the Department's appeal summary when an appeal is filed to set aside additional resources for the community spouse.
Source	Complete the form on line using the template on the DHS Intranet eForms web page.
Completion	The IM worker completes this form as an alternative to completing an appeal summary when an appeal is filed regarding the attribution of resources.
Distribution	Send one copy to the Department of Human Services, Appeals Section, 1305 E Walnut Street, 5th Floor, Des Moines, Iowa 50319-0114. Keep a copy in the case record. Send a copy to the appellant.
Data	Enter the appeal number, if you know it, and your worker number and county number on the form. List: <ul style="list-style-type: none"><li>◆ The names and birth dates of the institutionalized spouse and the community spouse.</li><li>◆ The date of the application for attributions.</li><li>◆ The date of the application for assistance.</li><li>◆ The date of appeal.</li><li>◆ The beginning date of continuous institutionalization or the date the waiver applicant met medical institution level of care criteria.</li><li>◆ The total amount of the couple's current resources, if different from the attribution amount.</li><li>◆ Select from the drop down box the minimum monthly maintenance needs allowance (MMMNA) as of the date the appeal was filed.</li></ul>

Verify and list the community spouse's available gross income. Calculate the shortfall between the community spouse's available gross income and the MMMNA. Attach all documents listed under the attachments listing.

For people who became institutionalized on or after February 8, 2006, include the income made available to the community spouse in the client participation calculation as available to the community spouse.

**Authorization for Examination and Claim for Payment, Form 470-0502**

Purpose	Form 470-0502 is used to authorize an examination to determine if a person qualifies as an incapacitated stepparent for FIP or FMAP-related Medicaid. The form is also a billing form for the examiner to present a claim for payment.
Source	This form is available on line as a template on the DHS Intranet eForms web page.
Completion	<p>The IM worker completes the top section of the form when the Department must determine if a person who does not receive Medicaid is incapacitated, disabled, or blind. The service area manager or designee signs as "county director."</p> <p>The examiner completes and signs the claim section after the examination has been completed. Staff in Central Office complete the accounting section.</p>
Distribution	<p>Forward the form to the examiner, along with the form for the report of examination. The examiner shall return the form to the requesting DHS office.</p> <p>Make a copy to file in the client's case record. Submit the original and a copy to the Bureau of Financial, Health and Work Supports, attached to the other forms that are required for determining eligibility. If the form is used to determine incapacity of a FIP stepparent, write "FIP" across the top.</p> <p>The Bureau reviews the claim, completes the accounting section to identify the funding source, and forwards the form to the Bureau of Purchasing, Payments, Receipts and Payroll for processing. One copy of the form is returned to the examiner with the payment.</p>
Data	Indicate the DHS office name and address, the name and address of the person to be examined and the case number (when already assigned), the date of completion, the examiner's name and address, and the type of determination involved.

**Authorization for Release of Information, Form 470-0461 or 470-0461(S)**

**Purpose** Form 470-0461 is designed to secure the client's permission for the Department to investigate items of eligibility or to obtain information needed for providing services. The source of information may also use the form to furnish the requested information.

**Source** Complete the English or Spanish version of the form on line using the template on the DHS Intranet eForms web page.

**Completion** Workers may complete this form when it is necessary to obtain information from a source other than the client. Complete a separate form for each source of required information.

The worker completes the identifying information and the description of the information requested. The second page automatically populates with questions based on radio button selected on the preface page.

The client (or the person authorized to obtain the information) signs that section to give the authorization. The source of information completes the remainder of the form. Additional pages may be used if necessary.

**Distribution** Send one copy to the source of information.

You may upload the request to the electronic case file. When the original is returned, it will be scanned and uploaded.

**Data** Changes may be made to the following automatically-populated entries:

- ◆ Date
- ◆ Information due date
- ◆ The name and address of the source of information
- ◆ Your county
- ◆ Your worker number
- ◆ Your name
- ◆ Your phone number
- ◆ Your email address

In the "Information Requested" section, enter the information the source will need to respond to the request. Be as specific as possible. Include the client's name, as well as the client's address or social security number, if they are needed to identify the requested information.

The date the authorization expires automatically populates. The expiration date shall be 60 days from the date the form is signed, unless you have supervisory approval to extend the date.

The client shall sign and date the form after these items have been completed.

The source of information completes the remainder of the form.

**[Authorization to Disclose Information to the Iowa Department of Human Services, Form 470-4459 or 470-4459\(S\)](#)**

**Purpose** Form 470-4459 or 470-4459(S) is a two-way release form used to get the permission of the Medicaid applicant or the applicant's legally authorized representative to share health information needed to determine disability with the Disability Determination Services Bureau (DDSB).

**Source** The English version of this form is available on line as a template on the DHS Intranet eForms web page.  
  
The Spanish version may be printed or photocopied from the sample in the manual.

**Completion** This form should be used only in conjunction with a referral to the DDSB for a disability determination. You may either:

- ◆ Send one original form to the applicant for completion and signature, and then make a photocopy of the original for each source and complete the name and address of the source of information in the "Additional information" box before sending the forms to DDSB; or
- ◆ Send the applicants one original 470-4459 for each source of information. The name and address of the source of information must be completed in the "Additional information" box before the form is sent to the DDSB.

You may complete the identifying information. The applicant or the applicant's personal representative signs the section to give the authorization. Obtain the signature of two witnesses for an applicant who cannot sign the form due to a physical or mental disability.

Discuss the authorization and the explanation on page 3 regarding the use of this form and answer any questions raised by the applicant. Explain the consequences of failure to sign the form.

Explain that the applicant has the right to revoke the authorization at any time by completing form 470-3949, *Request to End an Authorization*. (See [1-C-Appendix](#).)

Distribution

Give the applicant a copy. Give a photocopy to the legal representative, if any. Forward the forms to DDSB with the *Disability Transmittal*, form 470-2472, and either form 470-2465, *Disability Report for Adults*, or form 470-3912, *Disability Report for Children*.

Once a disability determination has been completed, DDSB returns the authorizations to the requesting office to be filed in the case record.

If there is any appeal filed with DHS due to the denial of disability, send copies of all disability forms, including the *Authorization to Disclose Information to the Department of Human Services*, to the DHS Appeals Section, the applicant, and the applicant's representative, if any.

Data

To initiate the forms complete the:

- ◆ Applicant's name,
- ◆ Social security number,
- ◆ Date of birth, and
- ◆ Parent's or guardian's name if applicable.

Ask the applicant or the applicant's representative to sign and date the forms. Check the box indicating the relationship to the applicant of the person who signs the form.

NOTE: Only the applicant or the applicant's legally authorized representative can give consent to release or obtain mental health and AIDS/HIV related information. Only the applicant can give consent to release or obtain substance abuse information.

"Mental health information" means oral, written, or recorded information that indicates the identity of an individual receiving professional services and which relates to the diagnosis, course, or treatment of the individual's mental or emotional condition.

"Substance abuse" means the use of chemical substance by persons suffering from chemical dependency, persons who are incapacitated by a chemical substance, substance abusers, or chronic substance abusers.

"AIDS" means a medical diagnosis of acquired immunodeficiency syndrome, based on the Center for Disease Control's "Revision of the CDC Surveillance Case Definition for Acquired Immunodeficiency Syndrome." "HIV" means a medical diagnosis of human immunodeficiency virus infection based on a positive HIV-related test.

**[Authorization to Obtain or Release Health Care Information, Form 470-3951 or 470-3951\(S\)](#)**

**Purpose** Form 470-3951 or 470-3951(S) is a two-way release form used to get the permission of the client or the client's legally authorized representative to share health information.

**Source** The English version of the form is printed in pads of 25 three-part precarbonated sets. Order supplies from Iowa Prison Industries at Anamosa. DHS staff may also complete this version on line using the template on the DHS Intranet eForms web page.

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

**Completion** Complete a separate form for each source. The worker may complete the identifying information and the description of the information being obtained.

The client or the client's personal representative signs the section to give the authorization. Obtain the signature of two witnesses for clients who are incapable of signing their name due to a physical or mental disability.

**Distribution** Give the client a copy upon signature of the form. Give a photocopy to the legal representative, if any.

**Data** To initiate the form:

- ◆ Enter the client's name, state or patient identification number, social security number, date of birth, and parent's or guardian's name, if applicable.
- ◆ In the first set of agency information, enter the name and address of the provider from which information will be requested. Enter the telephone number and fax number if known.
- ◆ Enter information for DHS in the second set of agency information, as DDS will be sending the form to the provider. Use your office address and telephone number.

In the INFORMATION RELEASED OR SHARED MAY INCLUDE section, check the boxes as follows:

- ◆ For **hospitals**, mark: admission status, psychological reports, discharge summary, social history, lab results, treatment and aftercare plans, diagnosis/allergies, X-ray/imaging reports, medication history, history and physical exam, initial assessment, evaluation and recommendations, and receiving phone calls.
- ◆ For physical **doctors**, mark: lab results, treatment and aftercare plan, diagnosis/allergies, X-ray/imaging reports, medication history, history and physical exam, initial assessment, immunization record, evaluation and recommendations, receiving phone calls, and consultation reports.
- ◆ For **psychiatrists, psychologists, mental health centers**, etc., mark: admission status, psychological reports, discharge summary, social history, lab results, treatment and aftercare plans, diagnosis/allergies, team notes, medication history, initial assessment, evaluation and recommendations, receiving phone calls, and consultation reports.
- ◆ For **schools, AEAs, child care centers**, etc., mark: psychological reports, social history, treatment and aftercare plans, team notes, diagnosis/allergies, medication history, initial assessments, immunization record, school records, court documents, evaluation and recommendations, receiving phone calls, consultation reports, and other (note IEPs and teacher questionnaires).

NOTE: When in doubt, mark all boxes that you believe may apply. If the client indicates that a specific test or study was done, mark the "Other" box and list the specific study, test, or procedure performed.

State the purpose for which the information will be used.

In the SPECIFIC AUTHORIZATION FOR RELEASE section, secure the client's or the client's legal representative's initials if mental health, AIDS/HIV-related, or substance abuse is to be obtained or released.

NOTE: Only the client or the client's **legally authorized** representative can give consent to release or obtain mental health and AIDS/HIV-related information. **Only the client** can give consent to release or obtain substance abuse information.

"Mental health information" means oral, written, or recorded information that indicates the identity of an individual receiving professional services and which relates to the diagnosis, course, or treatment of the individual's mental or emotional condition.

"Substance abuse" means the use of chemical substances by persons suffering from chemical dependency, persons who are incapacitated by a chemical substance, substance abusers, or chronic substance abusers.

"AIDS" means a medical diagnosis of acquired immunodeficiency syndrome, based on the Center for Disease Control's "Revision of the CDC Surveillance Case Definition for Acquired Immunodeficiency Syndrome." "HIV" means a medical diagnosis of human immunodeficiency virus infection based on a positive HIV-related test.

Discuss the authorization and explanation paragraph regarding the use of this form and answer any questions raised. Explain the consequences of failure to sign the form. Ensure that the client understands the right to revoke the authorization at any time by completing form 470-3949, *Request to End an Authorization*. (See [1-C-Appendix](#).)

Facility workers enter the name of the facility's privacy official and the privacy official's telephone number. IM workers enter "Privacy Officer" under NAME and "1-800-803-6591" under TELEPHONE NUMBER.

Ask the client or the client's representative to sign and date the form.

Enter an expiration date that is 12 months from the date the client signs the form.

Check the box indicating the relationship of the person who signs the form to the client.

To use this form as the required documentation for the disclosure of mental health information, enter on the back of the form kept in the case record:

- ◆ The date.
- ◆ The name of recipient of information.
- ◆ The information disclosed.
- ◆ The name of the person who disclosed the information.

**Bank or Credit Union Information, Form 470-1631 or 470-1631(S)**

Purpose	Form 470-1631 is designed to secure the client's permission for the Department to investigate information that can be provided by a bank or credit union. The bank or credit union also uses the form to furnish the requested information.
Source	Complete the English or Spanish version of this form on line using the template on the DHS Intranet eForms web page.
Completion	Complete this form when it is necessary to verify interest income or resources.  The client (or the person authorized to obtain the information) shall sign and date and enter their address on the form. The bank or credit union completes the remainder of the form.
Distribution	Send one copy to the bank or credit union with a cover letter and a return envelope. Give a copy to the client.  You may upload the request to the electronic case file. When the original is returned, it will be scanned and uploaded.
Data	Complete the data items as follows:  <b>Date:</b> Enter the date the form is sent.  <b>Case #:</b> Enter client's ABC case number.  <b>Worker #:</b> Enter your worker number.  <b>Due date:</b> Enter the requested due date.  <b>Signature:</b> The client signs and dates the form and enters the address.  <b>Re:</b> Enter the names of the persons whose income or resources are being verified.

**Checking and savings accounts for the time period of:**

Enter the period of time for which the information is being requested.

**Balance in account as of:** Enter the date for which information regarding the balance in the account is being requested.

**Time certificates, . . . for the time period of:** Enter the date for which information regarding time certificates and certificates of deposits is being requested.

**Questions:** Enter the telephone number of the worker the bank or credit union representative should contact with questions.

The bank or credit union completes the remainder of the form.

**Billing Statement, Form 470-0130**

Purpose	The <i>Billing Statement</i> is sent to debtors who have received a demand letter requesting repayment of a debt. It notifies debtors of payments due and account balances. It also shows account activity including all payments or adjustments applied to an account.
Source	Form 470-0130 is generated by the Overpayment Recovery System.
Completion	<p>This form is generated:</p> <ul style="list-style-type: none"><li>◆ Monthly to debtors with a cash agreement, reflecting all payments received during the month.</li><li>◆ Quarterly to debtors on grant or benefit reduction.</li><li>◆ Periodically to debtors who have not completed a repayment agreement.</li></ul> <p>The statements are printed on the last working day of each month.</p>
Distribution	The form is mailed to the debtor.
Data	Debtors making cash payments detach the top of the statement and return it with the payment to the Department of Human Services, Cashier's Office, 1305 E. Walnut Street, Des Moines, Iowa 50319-0114.

**Cancellation of Premium Payment, Form 470-2846**

Purpose	Form 470-2846 is used to provide adequate and timely notice to the HIPP recipient that the Department will no longer pay the recipient's health insurance premium.
Source	Form 470-2846 is system-generated by the HIPP Unit.
Completion	The HIPP worker generates this form through entries on the Cancellation Notice Request Screen whenever premium payments are being terminated. Send the form at least ten days before the date that premium payments will cease.
Distribution	Separate copies are printed for: <ul style="list-style-type: none"><li>◆ The policyholder</li><li>◆ The HIPP file</li></ul>
Data	The form: <ul style="list-style-type: none"><li>◆ Specifies the reason the request for payment is denied.</li><li>◆ Provides space for additional comments regarding the denial.</li></ul>

**Care for Kids, Form 470-0365**

Purpose	The purpose of form 470-0365 is to offer EPSDT "Care for Kids" services periodically to all Medicaid members who are eligible for screening services.
Source	Form 470-0365 is issued from Central Office.
Completion	Central Office issues this form after the date of acceptance in the ABC system and periodically thereafter based on the acceptance or rejection code in the ABC system, as follows: <ul style="list-style-type: none"><li>◆ If the family refuses screening, the notice is sent annually.</li><li>◆ If the family accepts screening, it is sent based on the child's age and the periodicity schedule.</li></ul>
Distribution	One copy is sent to each child in the case at the appropriate times. The family keeps the form.
Data	Provide assistance if the family requests it. Document in the case file any response to the notice or action you take.

**Case Activity Report, Form 470-0042**

**Purpose** Form 470-0042, *Case Activity Report*, provides a mechanism for nursing facilities, ICFs/ID, mental health institutes, PMICs, and residential care facilities to report individual resident activities occurring at the facility level that may affect eligibility.

**Source** The form is available on the Iowa Medicaid Enterprise (IME) web site at: <http://dhs.iowa.gov/ime/providers/forms>

**Completion** Facility staff must complete the form when:

- ◆ A resident applies for Medicaid.
- ◆ A Medicaid member enters the facility.
- ◆ Medicare coverage for a Medicaid member residing in the facility starts or stops and the Medicaid rate is higher than the Medicare rate.
- ◆ A Medicaid member dies or is discharged.

When a Medicaid applicant or member enters the facility, the facility completes Sections 1, 2, and 3 and, if applicable, Section 4.

When a Medicaid applicant or member dies or is discharged, the facility completes Sections 1, 2, and 5.

**Distribution** Facilities must submit the form to the appropriate Department office within two business days of the action.

Nursing facilities (NF), hospice, community ICFs/ID, skilled nursing facilities (SNF), and swingbeds 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. Kaneshville Blvd.  
Council Bluffs, IA 51503-4470

Fax: 515-564-4040 email: [facilities@dhs.state.ia.us](mailto:facilities@dhs.state.ia.us)

Residential care facilities (RCFs), mental health institutes (MHIs), and state resource centers shall mail or fax a copy to the local DHS income maintenance worker and keep a copy.

Psychiatric medical institutions for children (PMICs) shall mail, email or fax the form to the address below and keep a copy.

Centralized Facility Eligibility Unit – PMIC  
Imaging Center 1  
Iowa Department of Human Services  
417 E. Kaneshville Blvd.  
Council Bluffs, IA 51503-4470

Fax: 515-564-4040 email: [CSAPMIC@dhs.state.ia.us](mailto:CSAPMIC@dhs.state.ia.us)

Program for All-Inclusive Care for the Elderly (PACE) shall email or fax the form to the appropriate Imaging Center with an attention to your DHS IM worker. Keep a copy.

Western Service Area  
Fax: 515-564-4014  
Email: [Imagingcenter1@dhs.state.ia.us](mailto:Imagingcenter1@dhs.state.ia.us)

Northern Service Area  
Fax: 515-564-4015  
Email: [Imagingcenter2@dhs.state.ia.us](mailto:Imagingcenter2@dhs.state.ia.us)

Cedar Rapids Service Area  
Fax: 515-564-4017  
Email: [Imagingcenter4@dhs.state.ia.us](mailto:Imagingcenter4@dhs.state.ia.us)

Des Moines Service Area  
Fax: 515-564-4018  
Email: [Imagingcenter5@dhs.state.ia.us](mailto:Imagingcenter5@dhs.state.ia.us)

Data

**Section 1. Member Data:** Section 1 contains resident-specific information. The resident's name should be used as it appears on the *Medical Assistance Eligibility Card*. "Date Entered Facility" is the date the resident entered the facility for the first time or was readmitted to the facility following a discharge.

**Section 2. Facility Data:** Section 2 contains information on the facility involved and the person filling out the form. The provider number or national provider identifier must correspond with the level of care indicated in Section 3. The "DHS Per Diem" is the facility's computed rate. The "Date Completed" is the date the form is completed and submitted.

**Section 3. Level of Care:** Section 3 lists the process used to determine level of care (IME Medical Services Unit, Medicare, managed care contractor, out-of-state skilled preapproval or utilization board) and the effective date of determination.

**Section 4. Medicare Information for Skilled Patients in Facilities:** Section 4 reflects Medicare coverage that may apply to skilled care or hospice. Complete this section when there is Medicare coverage but the Medicaid rate is higher than the Medicare rate.

**Section 5. Discharge Data:** Complete Section 5 when a resident leaves the facility or dies. The information under "Last Month in Facility" is used to recalculate client participation if the client transfers to another facility or living arrangement (not home). Remember that Medicaid does not pay for the date of discharge.

**Certificate of Enrollment, Form 470-4444**

Purpose	The <i>Certificate of Enrollment</i> , form 470-4444, is used to inform providers that a child has been approved for Child Care Assistance. This form informs the provider of the hours of care, units of service, and co-pay fee that each child in care is approved for.
Source	Form 470-4444 is generated by the KinderTrack system.
Completion	The KinderTrack system generates and completes this form for all Child Care Assistance approvals when the child has been assigned to a provider.
Distribution	This form is mailed to the provider that is assigned to the child. The form is also saved electronically in the KinderTrack system.
Data	The system completes all information on this form.

**Certification of Eligibility of SSI Applicant, Form 470-0363**

Purpose	Form 470-0363 is used to verify a person's SSI eligibility or SSI application status.
Source	<p>DHS staff may complete this form on line using the template on the DHS Intranet eForms web page.</p> <p>Supplies of the form may also be printed or photocopied from the sample in the manual as needed. Department offices located in the same county as a Social Security Administration office shall supply copies of this form to the Social Security office upon request.</p>
Completion	<p>Either the Department or the Social Security Administration may initiate the form, depending on which agency receives a complaint.</p> <p>The Department office prepares two copies of the form when the Department has not received an SDX indicating a client has been approved for SSI but the client claims:</p> <ul style="list-style-type: none"><li>◆ To have been approved for SSI for more than 60 days, or</li><li>◆ To have applied for SSI more than 60 days ago.</li></ul> <p>The Social Security office initiates the form when:</p> <ul style="list-style-type: none"><li>◆ It receives a complaint that a client who has been approved for SSI for more than 60 days has not been approved for Medicaid.</li><li>◆ A case is placed in forced pay, one-time pay, or limited period of eligibility status.</li></ul> <p>NOTE: In all situations involving forced pay, one-time pay, or a possible limited period of eligibility, the Department office should:</p> <ul style="list-style-type: none"><li>◆ Maintain a control on the case;</li><li>◆ Contact the Social Security office if no SDX information has been received on the case after six months;</li><li>◆ Cancel medical assistance if the Social Security office then indicates that the case has since been placed in a non-payment status.</li></ul>

Distribution

When the Department office initiates the form, forward the original to the Social Security office. You may upload the request to the electronic case file. When the original is returned, it will be scanned and uploaded

If the form is initiated by the Social Security office, the original is forwarded to the Department office.

Data

When the form is initiated by a Department office, complete Section A (Identification) to the best of the information you have available.

(When the form is initiated by the Social Security office, that agency completes all sections.)

**Change in Health Insurance, Form 470-3792**

Purpose	Form 470-3792, <i>Change in Health Insurance</i> , is a cover letter used to collect information for the Food Assistance and Medicaid programs.
Source	Complete the form on line using the template available on the DHS Intranet eForms web page.
Completion	Complete this form when it is reported that someone in the household has gone to work. This form is used to request information and verification regarding the new income and forward the <i>Employer's Statement of Earnings</i> form.
Distribution	Print two copies of the form. Give one copy to the client and file one copy in the case record. The client completes the form and returns it to the assigned imaging center.
Data	The form populates address and worker information areas of the form and calculates a due date for the return of the requested information.

**[Change in Medical Deduction for Food Assistance, Form 470-4487 or 470-4487\(S\)](#)**

Purpose	<p>Form 470-4487, <i>Change in Medical Deduction for Food Assistance</i>, is used in conjunction with a “warnings, informational, fatal, and summary” (WIFS) message when buy-in occurs for a Food Assistance household receiving the standard medical deduction.</p> <p>Since the state is now paying the Medicare premium, the worker uses this form to determine if the person has other medical expenses that would qualify the household for the standard medical deduction.</p>
Source	<p>Complete the English or Spanish version of this form on line using the templates on the DHS Intranet eForms web page.</p>
Completion	<p>An informational WIFS message will be sent to the worker associated with a Food Assistance case when:</p> <ul style="list-style-type: none"><li>◆ Buy-in of the Medicare premium occurs for any person active on the case, and</li><li>◆ The case is coded on BCW1 for the standard medical deduction for Food Assistance.</li></ul> <p>When you receive the WIFS message:</p> <ul style="list-style-type: none"><li>◆ Examine the case record to see if the household has any other verified medical expenses that qualify it for the Food Assistance standard medical deduction.</li><li>◆ If not, remove the coding for the standard deduction from the BCW1 screen and send this form.</li></ul>
Distribution	<p>Send one copy to the household and document that the form was issued.</p>
Data	<p>The worker completes the date, address, case number, client name, and worker phone number and name. No due date is necessary, as this form is informational to the household and the household needs respond only if it has additional expenses to report.</p>

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

Purpose	The <i>Child Care Assistance Application</i> , 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: <ul style="list-style-type: none"><li>◆ <b>Family Information:</b> (If two parents or guardians are in the home, the same information is needed for both.)<ul style="list-style-type: none"><li>• Name of the parent or guardian of the children needing care.</li><li>• The parent or guardian's date of birth.</li></ul></li></ul>

- 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.

- ◆ Monthly Family Income
  - The amount of gross wages, SSI, FIP benefits, social security, child support or alimony, and any other income. (If the children live with a guardian, only the child's income is needed.)
  - The name of the income maintenance worker if the client is receiving Food Assistance, FIP, or Medicaid.
- ◆ Provider Information
  - The child care provider's name, phone number, street address, city, state, and ZIP code.
  - A check to indicate if the provider will watch the children in the parent or guardian's home.
  - Question asking whether the provider is a backup provider.

The parent or guardian must sign and date the application.

**Child Care Assistance Billing/Attendance, Form 470-4534**

Purpose	Form 470-4534 is used by a child care provider to bill the Department for child care services provided to a child eligible for Child Care Assistance (CCA).
Source	This form is generated by the KinderTrack system and mailed to the child care provider for each CCA-eligible child.
Completion	<p>The KinderTrack system generates and completes the header information for each CCA-eligible child. This form prints and is mailed to the provider every four weeks.</p> <p>If the provider does not submit time and attendance on line through the Child Care Assistance Provider Portal, this form must be completed and returned to the Centralized Child Care Assistance Unit for processing. The provider is responsible for completing the remainder of the form, including having the parent sign it.</p>
Distribution	This form is mailed to the child care provider from DHS central office. The provider must retain a signed copy of this form. This form also is saved electronically in KinderTrack.
Data	<p>The KinderTrack system completes:</p> <p><b>Provider:</b> The provider's name.</p> <p><b>Child Name:</b> The name of the child the provider should bill for.</p> <p><b>Case#:</b> The KinderTrack case number.</p> <p><b>Billing Period:</b> The two-week billing period.</p> <p><b>Parent Name:</b> The name of the child's parent.</p> <p><b>Date:</b> Each day of the two-week billing period.</p> <p>The child care provider is responsible for:</p> <p><b>In:</b> The time the child arrived at the provider's child care.</p> <p><b>Out:</b> The time the child left the provider's care.</p>

**Absent:** Mark if a child was absent from the child care on a day that the child is normally scheduled to attend.

**Parent Signature:** The parent of the child must sign the form to certify the hours of care being billed to the Department for this child are correct.

**Provider Signature:** The provider of the child must sign the form to certify the hours of care being billed to the Department for this child are correct.

**Child Care Assistance Billing/Attendance Provider Record, Form 470-4535**

Purpose	Form 470-4535 serves as verification that an electronic bill has been submitted to the Department for child care services provided to a child eligible for Child Care Assistance (CCA).
Source	This form is generated by the KinderTrack system and is printed by the child care provider.
Completion	KinderTrack generates and completes all information for each CCA-eligible child. A provider that bills electronically is required to print this form after electronically submitting a bill for service and have the parent sign it.
Distribution	The provider must retain this form for ten years as verification that the electronic billing was correct and complete.
Data	The KinderTrack system completes all information on this form based on what the provider's electronic billing for:

**Provider Name:** The provider's name.

**Provider Address:** The provider's address.

**Parent:** The name of the child's parent.

**Child:** The name of the eligible child.

**Case #:** The KT case number.

**Billing Period:** The two-week billing period.

**Date:** Each day of the two-week billing period.

**Time In:** The time the child arrived at the provider's child care.

**Time Out:** The time the child left the provider's care.

**Absent:** Marked if the child was absent from the child care on a day that the child is normally scheduled to attend.

**Parent's Signature:** The parent of the child must sign the form to certify the hours of care being billed to the Department for this child are correct.

**Provider's Signature:** The provider of the child must sign the form to certify the hours of care being billed to the Department for this child care correct.

**Child Care Assistance Change Form, Form 470-5004**

Purpose	The <i>Child Care Assistance Change Form</i> , form 470-5004, provides a simple means for the client to report a change and submit explanatory information.
Source	This form is available to families on line from the DHS web page. It is also available from the county DHS offices as a paper form.
Completion	Clients may complete the form and mail or fax it to the Centralized Child Care Unit located in Des Moines at the River Place office address listed on the form.
Distribution	Issue the form: <ul style="list-style-type: none"><li>◆ When a client contacts a county office other than the Polk County office at River Place to report a change.</li><li>◆ When the client requests a form.</li></ul> Document the resulting action in the case record.

**Child Care Assistance Provider Agreement, Form 470-3871 or 470-3871(S)**

Purpose	The <i>Child Care Assistance Provider Agreement</i> sets the terms for payment of a child care provider by the Department of Human Services.
Source	The English version of this form is generated from KinderTrack. The English version of the form is also printed in pads of 50 sets. Order supplies from Iowa Prison Industries at Anamosa.  Print or photocopy the Spanish version of the form from the sample in the manual.
Completion	A provider selected by a Child Care Assistance client initially completes pages 1 and 2 of the form and signs and dates it to indicate understanding and agreement to all of the terms and conditions stated on the form. The provider returns pages 1 through 4 of the form to the Centralized Child Care Assistance Unit and keeps the other pages for their records.  The Child Care Assistance worker: <ul style="list-style-type: none"><li>◆ Reviews the agreement.</li><li>◆ Determines if the provider meets all of the requirements.</li><li>◆ Completes the third page with:<ul style="list-style-type: none"><li>• The provider type.</li><li>• The provider number.</li><li>• The provider's approved rates.</li><li>• The effective date of the <i>Agreement</i>.</li><li>• The termination date.</li></ul></li></ul> The <i>Agreement</i> must be renewed at least every two years, or when the provider reports changes.
Distribution	When the <i>Agreement</i> is approved and all signatures are secured, the Child Care Assistance Unit sends one copy of the <i>Agreement</i> back to the child care provider and keeps one copy.
Data	The first and second pages of the form gather provider information. The third through seventh pages set forth the terms and conditions to which both parties agree, as indicated by the signatures of the provider and Child Care Assistance worker.

On the first page, the provider chooses either Box A or Box B and:

- ◆ Enters the following identifying data:
  - Type of business
  - Social security number or employer identification number
  - Provider name
  - Address
  - Phone number

On the second page, the provider:

- ◆ Enters all of the rates the provider charges for basic and special needs care for each age group. Providers may enter half-day, full-day, hourly, or weekly rates. (If the provider does not enter half-day rates, the Child Care Assistance worker must calculate the half-day rate.)
- ◆ Signs the form to indicate the provider agrees to the terms and conditions set forth on pages 4 through 7.

On the third page, the Child Care Assistance worker:

- ◆ Enters the provider type and the provider number.
- ◆ Fills out the table with the approved half-day rates for the provider.
- ◆ Enters the effective date as follows:
  - Nonregistered: Based on the client's application or eligibility date.
  - Registered: The first date of the child care service or the registration effective date, whichever is later.
  - Licensed or exempt: The first date of the child care service or the license effective date, whichever is later.
- ◆ Enters the termination date, which can be no later than 24 months from the effective date.
- ◆ Signs the agreement.
- ◆ Sends a copy of the signed agreement to the provider.

**Child Care Assistance Review, Form 470-4377(M) or 470-4377(S)**

Purpose	The <i>Child Care Assistance Review</i> , form 470-4377(M) or 470-4377(S), collects information about people needing child care that is required to review eligibility for Child Care Assistance.
Source	<p>A review form is generated from the KinderTrack system when a family is approved with a review date that is at least 40 days in the future.</p> <p>If the system does not automatically generate the form:</p> <ul style="list-style-type: none"><li>◆ Print the English version from the sample in the manual or from the Family Summary page in the KinderTrack system.</li><li>◆ Print the Spanish version from the sample in the manual.</li></ul>
Completion	The family or someone representing the family completes the form every six months when the eligibility review is due. The parent or guardian must sign and date the review form.
Distribution	<p>The family mails the form, along with pay stubs and a school schedule if applicable, to the Centralized Child Care Assistance Unit, Polk County River Place, 2309 Euclid Avenue, Des Moines, IA 50310.</p> <p>If a family submits this form to a local DHS office, it must be forwarded to the Centralized Child Care Assistance Unit.</p> <p>Keep the completed form in the child care case file.</p>
Data	The first two pages of the review form collect information about the family, the family's need for service, and family income. The third page collects information about the family's child care provider. The fourth page gives appeal rights.

The family enters the following information:

◆ Family Information

For each person who lives in the home:

- A check to indicate whether the person needs care.
- A check to indicate whether the person has special needs.
- The person's name.
- The person's relationship to the parent or guardian.
- The person's sex.
- The person's date of birth.
- The person's social security number. (This field can be blank if the child does not have a number.)
- "Yes" or "no" whether the person is a citizen.
- Status, if the person is an alien.
- Name of the school district the child attends.

◆ Child Care Needs

- For each person working, the person's name, the number of hours worked per week, the employer's name, and the work schedule, with starting and ending times for the shift of work.
- For each person in school, checks indicating student status and a field to enter the school name.
- For each person looking for work, questions about their job search plans.

◆ Income: The amount of gross wages, SSI, social security, child support, alimony, and any other income. (If the children live with a guardian, only the child's income is needed.)

◆ Provider Information: The child care provider's name, phone number, and address.

**Child Care Claim Cover Letter, Form 470-4469 or 470-4469(S)**

Purpose	The <i>Child Care Claim Cover Letter</i> , form 470-4469 and 470-4469(S), is used to tell a provider why a Child Care Assistance claim is being returned. The cover letter tells the provider whether the claim could be processed and if not, what needs to be done to correct the errors.
Source	Complete the English or Spanish version of this form on line using the templates on the DHS Intranet eForms web page.
Completion	<p>When the worker identifies that a claim is incorrect in an area that <b>can</b> be corrected:</p> <ul style="list-style-type: none"><li>◆ Make the corrections, copy the claim form,</li><li>◆ Highlight the corrected errors, and</li><li>◆ Send this cover letter and the corrected copy of the claim back to the provider for information.</li></ul> <p>When the worker identifies that the claim is incorrect in an area that <b>cannot</b> be corrected:</p> <ul style="list-style-type: none"><li>◆ Specify on the cover letter the reasons the claim cannot be processed, and</li><li>◆ Send this cover letter along with a copy of the incorrect claim and a blank claim form back to the provider for corrections.</li></ul>
Distribution	Send one copy of this form along with a copy of the incorrect claim form to the provider along with a blank claim form, and file one copy of this form and the original claim in the DHS case record.
Data	The form includes instructions for the provider about the need to complete a new claim form (when necessary) and identifies any information that needs to be corrected.

**Child Support Information Request, Form 470-3782**

**Purpose** Form 470-3782, *Child Support Information Request*, is a cover letter used to collect information for the Family Investment Program and the Medicaid program.

This form is used with forms 470-3773, *Absent Parent Information*, and 470-0169, *Requirements of Support Enforcement*.

**Source** Complete the form on line using the template available on the DHS Intranet eForms web page.

**Completion** Complete when a household reports that a parent is leaving or has left the home.

**| Distribution** Give one copy to the client and place a copy in the case record.

**Data** Certain areas of the form populate and a due date is calculated for return of the completed form.

**Claimant's Supplemental Statement, Form 470-0006**

Purpose	Form 470-0006, <i>Claimant's Supplemental Statement</i> , is used to supply the Department of Inspections and Appeals (DIA), Investigations Division, with information to determine the appropriateness of request to replace a warrant stolen from a client's mailbox.
Supply	Print or photocopy supplies of form 470-0006 from the sample in the manual.
Completion	<p>The payee completes this form at the same time as form 470-0004, <i>Affidavit as to Forged Endorsement</i>. The affidavit must be made and signed before an officer authorized to administer oaths generally, and the officer must certify that the officer administered the oath.</p> <p>If there is more than one payee, each person must complete a form.</p>
Distribution	<p>Keep the original <i>Supplemental Statement</i> in the client's case file. Forward one copy to DIA Investigations Division, 3rd Fl, 321 E 12th St., Des Moines, Iowa 50319-0083.</p> <p>EXCEPTION: If a viable, readable copy cannot be obtained, send the original to DIA. If DIA cannot read or discern the payee's signature well enough to make an informed decision as to whether or not to replace the warrant, there will be a delay while the original is requested.</p>
Data	<p>This form must be completed in front of a DHS employee, using the <b>exact wording and abbreviations as on the endorsement</b>. This includes the warrant address, not the client's current address (if different).</p> <p>If a question is not applicable, the payee completes the line with "N/A."</p>

**Compliance with Third Party Liability (TPL), Form 470-5286**

Purpose	The Iowa Medicaid Enterprise (IME) and the Managed Care Organizations (MCOs) use the <i>Compliance with Third Party Liability (TPL)</i> to notify IM staff of the date a member cooperated with TPL.
Source	The IM worker views the form from the link that displays within the alert message in WISE.
Completion	IME or one of the MCOs sends a record to the repository (IEVS), which generates a compliance alert record to the field.  The compliance alert record is sent to IM staff to lift the member's TPL sanction.
Distribution	The repository (IEVS) sends the compliance alert to WISE. Only after the alert is worked by the IM worker is the alert indexed to the Electronic Case File (ECF).
Data	The repository (IEVS) populates the following: <ul style="list-style-type: none"><li>◆ <b>Cooperation Date:</b> The date the member cooperated.</li><li>◆ <b>Member Name:</b> The member's name.</li><li>◆ <b>Case Number:</b> The member's case number.</li><li>◆ <b>CIN or SID Number:</b> The member's state identification number.</li></ul>

**Daily Tip Record, Form 470-3777**

Purpose	Form 470-3777, <i>Daily Tip Record</i> , is used to collect information for the Family Investment Program, Food Assistance program, and Medicaid program when it is reported that someone in the household receives tip income.
Source	Complete the form on line using the template available on the DHS Intranet eForms web page.
Completion	This form is for the household to use when it is reported that someone in the household has income from tips.
Distribution	Give one copy to the client and place a copy in the case record. The client completes the form and returns it to the assigned imaging center.
Data	The template populates case and worker information areas of the form. The client completes the employer information and the dates and amounts of tips received.

**Debt Setoff Credit, Form 470-1667**

Purpose	Form 470-1667 informs a debtor of the amount that has been credited to the debtor's overpayment account from the setoff of the debtor's state tax refund. The form also serves as a receipt.
Source	Form 470-1667 is system-generated monthly in the Operations Unit in the Division of Data Management.
Completion	Once each month, the Department of Administrative Services certifies to the Department of Human Services all money taken the previous month. This money is then credited to the debtor's account.
Distribution	One copy is mailed to the debtor. The DIA investigator keeps a copy in the Public Assistance Debt Recovery Unit file.
Data	The Department of Administrative Services assesses a \$5 charge for record keeping. The charge is passed on to the debtor.

**Denial of Health Insurance Premium Payment, Form 470-2847**

Purpose	Form 470-2847 is used to provide the recipient adequate notice of the Department's decision to deny payment of the health insurance premium.
Source	Form 470-2847 is system-generated by the HIPP Unit.
Completion	The HIPP worker responsible for the eligibility determination generates the form through entries on the Denial Notice Request Screen after the decision to deny a request for premium payment is made.
Distribution	Separate copies are printed for: <ul style="list-style-type: none"><li>◆ The policyholder</li><li>◆ The HIPP file</li></ul>
Data	The form: <ul style="list-style-type: none"><li>◆ Specifies the reason the request for payment is denied.</li><li>◆ Provides space for additional comments regarding the denial.</li></ul>

**Description of Efforts to Sell Property, Form 470-2908**

Purpose	Form 470-2908, <i>Description of Efforts to Sell Property</i> , is used by conditionally eligible State Supplementary Assistance recipients to document their efforts to sell the property that they agreed to sell while being granted conditional benefits.
Source	Print or photocopy supplies of form 470-2908 from the sample in the manual as needed.
Completion	<p>Issue the form as follows:</p> <ul style="list-style-type: none"><li>◆ For personal property, issue the form every 30 days during the conditional period.</li><li>◆ For real property, issue the form 35 days after the agreement is signed and every 60 days after that during the conditional period.</li><li>◆ After the conditional period, issue the form every three months if the person continues to attempt to sell real property.</li></ul> <p>The client or designee completes all the pertinent sections and signs and dates the form. Other people that signed the agreement shall also sign the form, unless their relationship to the client has changed. If a different person now has that relationship, that person shall sign the form.</p>
Distribution	<p>Keep the yellow copy in the client's case record and mail the white copy to the client.</p> <p>When the client returns the form:</p> <ul style="list-style-type: none"><li>◆ File the completed white copy of the form in the case record.</li><li>◆ Destroy the yellow copy.</li></ul>
Data	<p>Before mailing the form, fill in the date, your name, the due date for the form's return (ten days from the issue date), and the client's name and address.</p> <p>The form lists possible efforts the client has made to sell the property and gives space for explanations.</p>

**Designation of Personal Representative, Form 470-3948**

Purpose	Clients may use form 470-3948 to designate a personal representative. A “personal representative” is someone designated by another as standing in the other’s place or representing the other’s interest for one or more purposes.
Source	Print this form from the DHS Intranet eForms web page.
Completion	<p>The client wanting to use this form to designate a personal representative completes the form and gives or sends it to:</p> <ul style="list-style-type: none"><li>◆ The income maintenance worker,</li><li>◆ The Department’s Security and Privacy Office, or</li><li>◆ A facility privacy official.</li></ul> <p>NOTE: Use of this form is not mandatory. A client may write a letter designating a personal representative.</p> <p>If you know the client, the client may also verbally inform you of the client’s choice of personal representative and you can document the client’s choice in the case file.</p>
Distribution	Give a copy of the form to anyone requesting it. File the form in the case record.
Data	The client completes the needed information and signs the form. You will not need to enter any information.

**DHS Investigative Referral Follow-Up to DIA, Form 470-5129**

Purpose	<p>Form 470-5129 is designed to inform the Department of Inspections and Appeals (DIA):</p> <ul style="list-style-type: none"><li>◆ Of the action taken by the IM worker on an applicant, participant or member's case as the result of the findings of an investigation, and</li><li>◆ To calculate any associated cost avoidance amounts.</li></ul> <p>Cost avoidance amounts determined following a referral to DIA are distinctly different than public assistance debt amounts. Recoupment will also need to be completed when a worker determines that previously issued benefits need to be recovered. See the Web-based Overpayment Recovery (WOPR) system user guide for more information.</p>
Source	<p>Workers can complete this form on line using the Forms template in the Worker Information System Exchange (WISE).</p>
Completion	<p>Complete this form in 30 days or less of acting on information received in the findings of an investigation completed by DIA.</p> <p>If the findings report indicates further investigation is needed on an application or review/recertification referral, the worker must complete the form. Select the appropriate referral type. Answer "Yes" to the question, "Application or Review/Recertification changed to Ongoing Investigation" before submitting the response to DIA.</p> <p>NOTE: WISE will open and prepopulate some fields with client case and worker information from the last case number accessed in WISE before opening the form. Change any of the prepopulated fields as needed to reflect the correct client and worker information and case number.</p>
Distribution	<p>Click the "Submit to DIA/ECF" button to forward an electronic copy of the form to DIA. WISE will upload a copy of the form to the electronic case file using the IABC or ELIAS case number.</p> <p>Child care assistance staff click on "View Submitted Form" in the 'submission was successful' popup to view and print a copy for the paper case file.</p>

Data

Review and change the following fields as needed:

- ◆ Worker number/county number
- ◆ State ID/CIN
- ◆ Case name
- ◆ IABC case number
- ◆ ELIAS case number
- ◆ KT case number

Make entries in the following fields:

- ◆ The DIA case number that is found on the DIA Investigative Report.
- ◆ Select the appropriate referral type.
- ◆ Answer the yes or no questions.
- ◆ Select the appropriate case action – benefits/eligibility.

NOTE: The following fields will auto-populate based upon the information entered into the Calculation Sheet.

- Were benefits or eligibility increased or decreased?  
(Answer Yes or No.)
- Total Amount of Cost Avoidance Increase/Decrease for all programs entered.
- Total Amount of Cost Avoidance Increase/Decrease by individual program as follows:
  - Medical
  - Food Assistance (FA)
  - Family Investment Program (FIP)
  - Child Care Assistance (CCA) – Provider or family
- ◆ Comments: Enter any additional information that applies to the cost avoidance calculations or investigation referral.
- ◆ View and complete the Calculation Sheet by entering the cost avoidance amounts, if applicable, based on the DIA Investigative Report findings.

When DIA findings result in an application or review/recertification denial, the worker must complete the:

- Cost avoidance using client-provided information to determine “projected” eligibility, and
- Number of months that would have been used for the review/recertification period had the application or review been approved.

For medical denials, use the aid code selections, as applicable:

- 001 App/Rev Denial – Adult
- 002 App/Rev denial – Child

NOTE: The system calculates the total cost avoidance amounts based on the date entered by the worker. Data is entered by program as follows:

- **Medical.** Calculate cost avoidance amounts for each individual, as applicable.
  - Select either the medical aid code or the rate type to auto-populate the capitation fee.
  - Enter the total number of months remaining in the medical review period. Tab out of the field to auto-populate the total change in medical capitation fees.
- **Food Assistance.** Enter the:
  - Current month’s benefit amount received by the household.
  - Updated payment amount as determined by the worker (SPAD).
  - Total number of months remaining in the certification period. Tab out of the field to auto-populate the total change in FA benefits.
- **FIP.** Enter the:
  - Current payment amount.
  - Current household size.
  - Earned income monthly amount.
  - Unearned income monthly amount.

- Additional adjustments, if any. Tab out of the field to auto-populate the updated monthly payment.
- Total number of months remaining in the FIP review period. Tab out of the field to auto-populate the total change in FIP benefits.
- **CCA Provider.** Enter the:
  - Current monthly payment amount.
  - Updated monthly payment.
  - Total number of months remaining in the family's certification period. Tab out of the field to auto-populate the total change provider and total CCA amounts.
- **CCA Family.** Enter the:
  - Current monthly payment amount.
  - Updated monthly payment.
  - Total number of months remaining in the family's certification period. Tab out of the field to auto-populate the total change family and total CCA amounts.

Return to the form tab to review the total cost avoidance amounts before clicking the "Submit to DIA/ECF" button.

**Example 1: Application**

Household composition: Ms. A, aged 34  
Ms. A's child, aged 10  
Mr. A, aged 35 (absent parent)

Food Assistance and medical applications are received for Ms. A and her child. Ms. A has a monthly income of \$500.

The worker has reason to believe that Mr. A is in the household and submits a referral to DIA. The investigative findings determine that Mr. A is in the household. Mr. A has monthly income of \$2,750.

The worker processes the applications based on DIA findings:

FAP: Denied, over income  
Medical: Ms. A denied, over income  
Ms. A's child is approved for *hawk-i*

Complete the *Calculation Sheet* on form 470-5129 using the results from the processed applications and the benefits that would have been received if DIA had not been involved.

Make entries in the following fields:

**FAP.** If applicable, use Scratch Pad (SPAD) located in WISE to determine the correct issuance amount.

**NOTE:** For FAP and FIP, the application month may not be a full month of benefits. To determine the amount to enter in the current monthly payment field, use the full amount of benefits that would have been issued for the month following the month of application. Use this amount for the entire certification or eligibility period.

Current payment: \$357  
Certification months remaining: 6

**Medical**

Aid code: Select 001 – App/Rev denial, adult  
(No entry for child as the child is eligible.)  
Eligibility certification months counted: 12

**Example 2: Application**

Household composition: Same household composition as Example 1:  
Application

Food Assistance and medical applications are received for Ms. A and her child. Ms. A has a monthly income of \$500.

The worker has reason to believe that Mr. A is in the household and submits a referral to DIA. The applications are processed timely as DIA needs more than 30 days to complete their investigation. The household is approved:

FAP: Eligible – \$357  
Medical: Ms. A and her child are eligible for FMAP

The investigative findings received after the approvals determine that Mr. A is in the household. Mr. A has monthly income of \$2,750.

The worker processes the applications based on DIA findings:

FAP: Denied, over income  
Medical: Ms. A denied, over income  
Ms. A's child remains eligible; no calculation needed

Complete the *Calculation Sheet* on form 470-5129 using the results from the initial application processing and the results based on the DIA findings.

Make entries in the following fields:

**FAP.** If applicable, use Scratch Pad (SPAD) located in WISE to determine the correct issuance amount.

NOTE: For FAP and FIP, the application month may not be a full month of benefits. To determine the amount to enter in the current monthly payment field, use the full amount of benefits that would have been issued for the month following the month of application. Use this amount for the entire certification or eligibility period.

Current payment: \$357  
Certification months remaining: 4

**Medical.** When medical coverage was received previously, review SSNI to find the aid code to enter on the Calculation Sheet of form 470-5129.

Aid code: 308 – FMAP  
(No entry for the child as the child is eligible.)  
Eligibility certification months counted: 10

**Example 3: Review**

Household composition: Same household composition as Example 1:  
Application

Food Assistance and medical reviews are received for Ms. A and her child. Ms. A has a monthly income of \$500.

The worker has reason to believe that Mr. A is in the household and submits a referral to DIA. The investigative finds determine that Mr. A is in the household. Mr. A has a monthly income of \$2,750.

The worker processes the reviews based on DIA findings:

FAP: Denied, over income  
Medical: Ms. A denied, over income  
Ms. A's child is approved for **hawk-i**

Complete the *Calculation Sheet* on form 470-5129 using the results from the processed reviews and the benefits that would have been received if DIA had not been involved.

FAP: Approved \$357  
Medical: Ms. A and her child are approved

Make entries in the following fields:

**FAP.** If applicable, use Scratch Pad (SPAD) located in WISE to determine the correct issuance amount.

Current payment: \$357  
Certification months remaining: 6

**Medical**

Aid code: Select 001 – App/Rev denial, adult  
(No entry for the child as the child is eligible.)  
Eligibility certification months counted: 12

**Example 4: Review**

Household composition: Same household composition as Example 1:  
Application

Food Assistance and medical reviews are received for Ms. A and her child. Ms. A has a monthly income of \$500.

The worker has reason to believe that Mr. A is in the household and submits a referral to DIA. The reviews are processed timely as DIA needs more than 30 days to complete their investigation. The household is approved:

FAP: Eligible – \$357  
Medical: Ms. A and her child are eligible for FMAP

The investigative findings received after the approvals determine that Mr. A is in the household. Mr. A has a monthly income of \$2,750.

The worker processes the reviews based on DIA findings:

FAP: Denied, over income  
Medical: Ms. A denied, over income  
Ms. A's child remains eligible

Complete the *Calculation Sheet* on form 470-5129 using the results from the initial review processing and the results based on the DIA findings.

FAP: Approved \$357  
Medical: Ms. A and Ms. A's child are approved

Make entries in the following fields:

**FAP.** If applicable, use Scratch Pad (SPAD) located in WISE to determine the correct issuance amount.

Current payment: \$357  
Certification months remaining: 4

**Medical**

Aid code: Select 001 – App/Rev denial, adult  
(No entry for child as the child is eligible.)  
Eligibility certification months counted: 10

**Example 5: Change – FAP**

Household composition: Same household composition as Example 1:  
Application

Ms. A and her child are currently receiving Food Assistance benefits of \$357 per month.

An anonymous caller reports that Mr. A lives in the home. Mr. A earns \$2,500 per month. The worker submits a referral to DIA. The investigative findings determine that Mr. A is in the household and has verified monthly income of \$2,500.

The worker processes the change based on DIA findings:

FAP: Denied, over income

Complete the *Calculation Sheet* on form 470-5129 using the results from the processed change and the benefits that would have been received if DIA had not been involved.

FAP: Approved – \$357

Make entries in the following fields:

**FAP.** If applicable, use Scratch Pad (SPAD) located in WISE to determine the correct issuance amount.

Current payment: \$357  
Certification months remaining: 3

**Example 6: Change – CCA**

Household composition: Mr. B, Ms. B, and their child, aged 1

The household was approved for Child Care Assistance (CCA). The need for service is full-time employment which averages 28 hours per week or more. The household is approved for 10 units per week (2 units per day). The certification period is July 1, 2016, through June 30, 2017.

Later it was discovered that the household failed to report that the household's employment hours fell below the required minimum beyond the 90 day temporary change or lapse in need period making the household ineligible for CCA. A referral to DIA was completed.

The DIA findings determined the family did not regain CCA eligibility after the 90 day temporary change or lapse in need period. The worker makes the adjustment entries in KinderTrack to cancel the household allowing for timely notice.

The worker process the change in KinderTrack based on DIA findings:

CCA: Canceled

Complete the *Calculation Sheet* on form 470-5129 using the results from the processed change and the benefits that would have been received if DIA had not been involved.

CCA: Canceled

Make entries in the following fields:

**CCA – Family**

\$	8.19	Provider rate per unit
x	10	Number of weekly units
x	4	Number of weeks in the month
\$	327.60	Current monthly payment
\$	.00	Updated monthly payment (leave blank)
	5	Eligible remaining months

**Example 7: DIA Non-Coop**

Household composition: Ms. C, aged 34  
Mr. C, aged 35  
Their child, aged 10

The household is currently receiving the following monthly benefits:

FIP: \$426  
FAP: \$511 per month  
Medical: All household members are eligible

An anonymous caller reports that Ms. C is working and has income. The worker submits a referral to DIA. DIA reports that the household failed to cooperate with them.

The worker completes the appropriate system entries to sanction medical, if applicable, and FIP for noncooperation. A *Request for Information* (RFI) is issued requesting income verification for Ms. C. NOTE: Food Assistance cannot be sanctioned for DIA noncooperation.

The worker processes the change based on DIA findings:

FAP: Discontinued  
Medical: Ms. C is discontinued  
The child remains eligible

Complete the *Calculation Sheet* on form 470-5129 using the results from the ongoing case benefit amounts and the DIA noncooperation sanction.

FIP: Canceled  
Medical: Canceled  
Food Assistance: Dependent on client's response to RFI

Make entries in the following fields:

**FIP**

Current monthly payment: \$426  
Current household size: 3  
Additional adjustment +/-: \$426 (When closing a case, the current benefit amount must be entered as an adjustment in order to calculate the correct updated monthly payment amount.)

Eligible months remaining: 4

**Medical.** When medical coverage was previously received, review SSNI to find the aid code to enter on the *Calculation Sheet* on form 470-5129.

Aid code: Ms. C – 308, FMAP  
Mr. C – 308, FMAP  
(No entry for the child as the child is continuously eligible until the next review.)

Eligibility certification months counted: 4

**FAP.** If applicable, use Scratch Pad (SPAD) located in WISE to determine the correct issuance amount.

**Outcome 1:** The client does not send the requested information. The Food Assistance case is canceled for failure to provide.

Current payment: \$511  
Certification months remaining: 4

**Outcome 2:** The client returns income verification showing Ms. C has a monthly income of \$1,450. The worker makes the appropriate system entries to redetermine benefits with the verified income amount.

Current payment: \$511  
Updated payment: \$210  
Certification months remaining: 4

**DHS Investigative Referral to DIA, Form 470-5130**

Purpose	Form 470-5130 is designed to make a referral to the Department of Inspections and Appeals (DIA).
Source	Workers can complete this form on line using the template in the Worker Information System Exchange (WISE).
Completion	Complete this form after receiving information that alleges fraudulent behavior.  NOTE: WISE will open and prepopulate some fields with client case and worker information for the case number last accessed in WISE before opening the form. Change any of the prepopulated fields as needed to reflect correct client and worker information and case number.
Distribution	Click the "Submit to DIA/ECF" button to forward an electronic copy of the form to DIA. WISE will upload a copy of the form to the electronic case file using the ELIAS or IABC case number.  Child care assistance staff will click "View Submitted Form" in the 'submission was successful' popup to view and print a copy for the paper case file.
Data	Review and change the following fields as needed: <ul style="list-style-type: none"><li>◆ Case number (populated initially with the last case number viewed in WISE before opening the referral form)</li><li>◆ Date referred</li><li>◆ Worker name</li><li>◆ Worker number</li><li>◆ Worker phone number and extension</li><li>◆ Worker email</li><li>◆ Client first name</li><li>◆ Client last name</li><li>◆ Date of birth</li><li>◆ State ID/CIN</li><li>◆ Client address line 1</li><li>◆ County of residence</li><li>◆ Client phone</li><li>◆ Client address line 2</li><li>◆ City</li><li>◆ State</li><li>◆ Zip</li></ul>

Complete the following fields:

- ◆ IABC, ELIAS, or KT case number
- ◆ Answer the yes and no questions
- ◆ Select all applicable programs
- ◆ Anonymous (yes or no)
- ◆ Complainant name and phone (if available)
- ◆ Select referral type
- ◆ Allegations and comments

**Disability Report for Adults, Form 470-2465**

Purpose	Form 470-2465 is used to gather information to establish disability. The Disability Determination Services Bureau (DDS), which is under contract to the Department, uses this report, along with vocational background material, contacts with medical personnel, and any information available from the Social Security Administration, to determine whether disability exists.
Source	Print this form as needed from the DHS Intranet eForms web page.
Completion	When a client who is aged 18 or over is claiming disability and the Department must make the initial determination or the disability review, the client shall complete one copy the form. Provide assistance if requested. Complete Section 11 on your observations and perceptions of the client.
Distribution	<p>Forward the form to DDS with the <i>Disability Transmittal</i>, form 470-2472. (The mailing address is on the <i>Disability Transmittal</i>.) If this is a subsequent application for Medicaid based on disability, also forward to DDS all disability forms from previous DHS determinations.</p> <p>After making a determination, DDS returns the form to the requesting worker. Upon return from DDS, file the form in the permanent forms section of the case record. Provide a copy to the client if requested.</p> <p>If the client appeals the denial of Medicaid based on the denial of disability determination, send copies of these forms to the DHS Appeals Section in Central Office, to the client, and to any representatives of the client.</p>
Data	<p>The client shall complete Sections 1 through 10. If the section does not apply, it shall be marked as "not applicable."</p> <p>Information is requested on the client's identification and characteristics; illnesses, injuries or conditions; work; medical records; medications; tests; education and training; vocational rehabilitation; additional remarks; and authorization for release of information.</p>

**Disability Report for Children, Form 470-3912**

Purpose	Form 470-3912 is used to gather information to establish disability for a child. The Disability Determination Services Bureau (DDS), which is under contract with the Department, uses this report, along with educational, medical, and other pertinent information, to determine whether disability exists.
Source	Print supplies of this form from the DHS Intranet eForms web page as needed.
Completion	When a client who is under age 18 is claiming disability and the Department must make the initial determination or the disability review, a person acting on behalf of the client shall complete one copy the form. Provide assistance if requested.
Distribution	<p>Forward the form to DDS with the <i>Disability Transmittal</i>, form 470-2472. (The mailing address is on the <i>Disability Transmittal</i>.) If this is a subsequent application for Medicaid based on disability, also forward to DDS all disability forms from previous DHS determinations.</p> <p>After making a determination, DDS returns the form to the requesting office. Upon return from DDS, file the form in the permanent forms section of the case record. Provide a copy to the client if requested.</p> <p>If the client appeals the denial of Medicaid based on the denial of disability, send copies of these forms to the DHS Appeals Section in Central Office, to the client, and to any representatives of the client.</p>
Data	<p>The client shall complete Sections 1 through 10. If the section does not apply, it shall be marked as "not applicable."</p> <p>Information is requested on the child's identification and characteristics, illnesses or injuries, medical assistance eligibility, medical treatment, medical sources, medications and tests; other sources of information, contact information, additional remarks; and authorization for release of information.</p>

**Disability Transmittal, Form 470-2472**

Purpose	The <i>Disability Transmittal</i> serves as a communication form between the Department and Disability Determination Services Bureau (DDS). The form identifies the type of disability determination needed and informs the IM worker of the results.
Source	Complete form 470-2472 on line using the template on the DHS Intranet eForms web page.
Completion	<p>The IM worker responsible for the case completes Part I of the form when:</p> <ul style="list-style-type: none"><li>◆ DDS is to complete a disability determination for the Department.</li><li>◆ The disability determination is to be terminated after the initial referral is made.</li><li>◆ The claimant's address changes while the disability determination is still pending.</li></ul> <p>The IM worker may attach comments on a separate sheet.</p> <p>DDS completes Part II of the form and returns the form when a decision regarding the disability has been made.</p>
Distribution	<p>Forward two copies to DDS. (When this form is prepared to initiate a disability determination, attach this form to the <i>Disability Report</i>, form 470-2465.) Keep a copy as a control.</p> <p>You may upload the request to the electronic case file. When DDS returns the original, it will be scanned and uploaded.</p>
Data	Part I: <b>IM Worker Name, E-mail Address, Worker Number, Office Phone, County Number, and Office Address:</b> Print the IM worker's name, email address, worker number, worker's work telephone number, county number, and address.

**Client Name, Social Security Number, Address, Birth**

**Date:** Enter the name, social security number, complete mailing address, and birth date of the person for whom a disability determination is being requested. Any change in address while the disability determination is pending must be reported to DDS.

**Disability Criteria - Check One:** Check appropriate box.

**Date of Application:** Enter the date on which the person filed an application with the Department.

**Status:** Check the box that applies to the reason for submitting the form. Promptly notify DDS of any changes in status.

Use another sheet for any comments to notify DDS of unusual circumstances (such as a deceased client).

Part II: **1. Client Disabled:**

**Disability began:** DDS determines whether disability began within the three months before the date of application.

**Disability ceased:** DDS enters the date that the disability ended. The IM worker shall take the appropriate action (partially approve, deny, or cancel). Give timely notice when applicable.

**Presumptive determination:** The six months of presumptive eligibility begins with the effective date determined by DDS.

**Diary Date:** DDS specifies when the next review of disability is due (MM YY) and the number of years (1-3, or 7) until next disability review (RSN).

**2. Client not disabled:** This section is completed when DDS determines disability does not exist. DDS also sends form 470-2463, *Explanation of Disability Determination*, to explain the reason for denial.

3. **Diagnosis:** DDS uses this field for a diagnosis entry to assist DDS at time of review or appeal.
4. **Disability Examiner:** The DDS representative signs and dates the form.  
  
**Medical Consultant:** The consultant who reviewed the disability determination signs and enters the date of review.
5. **Remarks:** DDS enters any additional information that may be helpful to the Department, such as when the next redetermination is due. On denials, a brief explanation is entered.

**Disposal of Assets Penalty Notice of Decision, Form 470-4365**

Purpose	Form 470-4365 is used to notify Medicaid applicants that a penalty has been imposed due to a transfer of assets for less than fair market value.
Source	Complete form 470-4365 on line using the template on the DHS Intranet eForms web page.
Completion	The income maintenance worker completes an original and one copy of this notice of decision when the Department has made a decision to impose a penalty because the applicant or the applicant's spouse has transferred assets for less than fair market value.
Distribution	Send one copy to the client and file another copy in the case record.
Data	<p>Press tab to access data fields.</p> <p>Enter the uncompensated amount of the transfer in dollars and cents in the appropriate fields.</p> <p>Enter the date the penalty period will begin in MM DD YY format.</p> <p>Click complete entries.</p> <p>Enter the name and address of the client or representative to be used for mailing the form.</p> <p>Enter the date of the notice.</p> <p><b>Worker's Name:</b> Enter the IM worker's name.</p> <p><b>Worker's Phone Number:</b> Enter the IM worker's phone number.</p>

**Document Verification Request, Form G-845S**

Purpose	The purpose of federal form G-845S is to obtain additional verification of alien status from the U.S. Citizenship and Immigration Services (USCIS), the former Immigration and Naturalization Service (INS).
Source	Print form G-845S from the on-line manual or the USCIS web site.
Completion	The worker responsible for the eligibility determination completes this form after submitting additional verification on the SAVE web site when the worker: <ul style="list-style-type: none"><li>◆ Is instructed to do so; or</li><li>◆ Still has questions about eligibility.</li></ul>
Distribution	Send the original form to USCIS. Attach a copy of the front and back of the original USCIS documents submitted by the client. Keep a copy for the case record.
Data	Complete only Section A of the form.  Complete the address for the USCIS as follows:  U.S. Citizenship and Immigration Services 10 Fountain Plaza, 3rd Floor Buffalo, NY 14202-2200  Complete the name and address of the submitting agency by entering the mailing address of the requesting office. Include your worker number.  USCIS supplies the verification number on Line 6.

**Documentation of Citizenship and Identity, Form 470-4381**

Purpose	Form 470-4381 is used to document that the income maintenance worker asked about a document to prove citizenship according to the prescribed hierarchy.
Source	Complete form 470-4381 on line using the template on the DHS Intranet eForms web page.
Completion	The income maintenance worker completes this form on Medicaid applicants and members to show that the worker has tried to get verification of U.S. citizenship and identification based on the levels set forth by the Centers for Medicare and Medicaid. This form is not needed for persons whose citizenship was verified by an IEVS match.
Distribution	Keep this documentation in the case file.

**Documentation of Claim Determination, Form 470-0311**

Purpose	Form 470-0311 is used to provide information on and documentation of: <ul style="list-style-type: none"><li>◆ The reason for an overissuance.</li><li>◆ The amount of overissuance.</li><li>◆ The period when the overissuance occurred.</li></ul>
Source	Complete form 470-0311 on line using the template on the DHS Intranet eForms web page.
Completion	Prepare this form: <ul style="list-style-type: none"><li>◆ When an overissuance has occurred.</li><li>◆ Each time a change occurs that affects the reason, amount, or time period covered by the overissuance.</li></ul>
Distribution	Attach the form to the corresponding copy of the Overpayment Recovery Information Input Summary (from the direct claim entry screen) and file it in the household's case file.
Data	Instructions correspond with the item number on the form.
Items 1 through 7:	Self-explanatory.
Item 8:	Documents the period of time and the application document used to determine the original basis of issuance. If the overissuance was on an adjustment allotment, do not complete this section. <ul style="list-style-type: none"><li>◆ List all the certification periods covered by the claim.</li><li>◆ List the date each certification period was established.</li><li>◆ List the date of the application document used to establish eligibility for each individual certification period.</li></ul>

- Item 9: Using worksheets completed for each month of the certification periods covered by this claim:
- ◆ For overissuances other than adjustment allotments:
    - List each month and year that an overissuance occurred.
    - For each month listed, enter the household size and net adjusted income that was used to determine the allotment, and the monthly allotment that the household originally received.
    - For each month listed, enter the household size and net adjusted income that should have been used to determine the allotment and the monthly allotment that the household should have received for that month.
  - ◆ For adjustment allotments:
    - List the month and year in which the incorrect adjustment allotment was issued.
    - Actual Issuance. The household size does not have to be completed. For "Net Income," list the ABC code used on the TD06 on Section IX, field IMM/CAN, to issue the adjustment allotment. List the amount of the adjusted allotment issued.
    - Correct Issuance. For each month listed, leave household size blank. Enter the same ABC codes that were entered under "Actual Issuance." List the amount the adjusted allotment should have been.
  - ◆ For all uses:

The amount of overissuance is the correct allotment minus the actual allotment for each month. Total:

    - The actual allotments issued in error,
    - The correct allotments that should have been issued, and
    - The amount of overissuance that occurred over the total period.

- Item 10: Explain in detail the reason the overissuance occurred. List any contacts made pertaining to the overissuance. If the Department determines that the overissuance was due to client misrepresentation or possible fraud, explain how and why this determination was made.

The documentation in this section must be detailed enough that another person will know the circumstances of the overissuance by reviewing only this document.

- Item 11: Sign and date the form. Obtain a supervisor's signature.

Attach additional pages if necessary. Indicate the order of the pages and the total number of pages for this claim.

**EBT Adjustment Request, Form 470-2574**

Purpose	<p>The <i>EBT Adjustment Request</i>, form 470-2574, is used to document and process a request for a return of Food Assistance from an EBT account. This form is used to request:</p> <ul style="list-style-type: none"><li>◆ A claims repayment.</li><li>◆ Voluntary Food Assistance program termination.</li><li>◆ The return of all benefits in an EBT account when all Food Assistance household members are deceased.</li><li>◆ The return of benefits when all household members move to a nursing facility and are unlikely to return home.</li><li>◆ A return of a monthly allotment when a household wants to receive Food Assistance benefits for the month in another state.</li><li>◆ A return of Food Assistance benefits for other reasons.</li></ul>
Source	<p>Complete this form on line using the template on the DHS Intranet eForms web page.</p>
Completion	<p>For all debit adjustments to the EBT Food Assistance account, there must be corresponding ABC entries. See <a href="#">14-B(5)</a>, <u>Recording Returned Food Assistance</u>.</p> <p>To return an authorized Food Assistance issuance for reasons other than the death of all household members or all members moving permanently to a nursing facility, there must be a written request from the household. When the household has moved to another state, the written request to return the benefits may be made by fax or mail.</p> <p>Attach the written request to the original and the copy. When a written request is attached, the client does not have to sign this form.</p> <ul style="list-style-type: none"><li>◆ For a claims repayment: When the request is to use EBT benefits to repay a claim, the written request must include the amount the client wants to apply to the claim. Attach the written request and form 470-0010, <i>Adjustment to Overpayment Balance</i>, to this form.</li></ul>

- ◆ For a voluntary Food Assistance program termination: The written request must clearly state that the household wishes to terminate Food Assistance program participation and return the balance of the EBT account. Check to see if the household has an outstanding Food Assistance claim to apply the returned benefits against.
- ◆ When all Food Assistance household members are deceased: The request to return the balance of the EBT account does not have to be in writing. Check to see if the household has an outstanding Food Assistance claim to apply the returned benefits against.
- ◆ When all household members move to a nursing facility and are unlikely to return home, the request does not need to be in writing. Check to see if the household has an outstanding Food Assistance claim to apply the returned benefits against.
- ◆ When a household requests to return a month's allotment in order to receive Food Assistance benefits in another state for the month, the full month's allotment must be available to be returned.

If the household used any amount of the benefits issued for the month, the household has participated in Iowa for the month. The household can either use the Iowa EBT card in the new state, or if unable to use it, can ask for a coupon conversion.

If the household has not used any of the benefits issued for the month, and the household has benefits remaining in the account after the month's benefits are returned, the household can spend down the remaining balance using the Iowa EBT card.

If the household has moved to a location in which there is no place that will accept the Iowa EBT card, the remaining balance can be converted to coupons and mailed to the new address.

- ◆ When a household requests the return of benefits for a reason not listed above, the written request must state the reason and the amount of benefits returned, or that the entire balance of the EBT account be returned.

When the amount of the adjustment request exceeds the account balance, the adjustment amount is the balance amount. This needs to be documented in the case record.

Distribution

Forward one copy to the Bureau of Purchasing, Payments, Receipts and Payroll. For claims payment, attach a copy of form 470-0464, *Overpayment Recovery Information Input*, or the *Overpayment Recovery Information Input Summary* (from the direct claim entry screen).

You may upload the request to the electronic case file. When the Bureau of Purchasing, Payments, Receipts and Payroll returns the completed form after completing the requested action, it will be scanned and uploaded to the case file.

Data

**Top Section:** Completed by the IM worker:

Enter the ABC case name and case number, and the state identification number of the case name person.

Check the applicable box under 'Debit Reason' to show the reason the account is being debited. If you check "Claims payment," you must enter the date of the claim. If you check "Other," you must enter an explanation for the debit reason.

Client Signature and Date: If the primary cardholder is not available to sign this form, a written statement must be attached. The primary cardholder or another responsible household member must sign the written statement if the primary is not available to do so.

If all household members are deceased or have moved permanently to a nursing facility, this space can be used to document this. No signature is needed.

**Central Office Section:**

Bureau of Purchasing, Payments, Receipts and Payroll staff:

- ◆ Check the applicable box and enter the date the action was taken. If "Adjustment not completed because" is checked, a description of the reason must be entered.
- ◆ Sign and date when the adjustment action is taken.

**Election of Iowa Family Planning Network, Form 470-4314**

Purpose	The <i>Election of Iowa Family Planning Network</i> , form 470-4314, documents an applicant's decision to choose the limited benefit program Iowa Family Planning Network (IFPN) when it appears that eligibility exists for another Medicaid coverage group.
Source	Staff may print supplies of this form from the sample in the manual.
Completion	Give this form to the applicant who chooses IFPN when eligibility for another Medicaid coverage group appears to exist.
Distribution	Place the signed copy in the IFPN case record. Give a copy to the client.

**Employer Verification of Insurance Coverage, Form 470-3036**

Purpose	The <i>Employer Verification of Insurance Coverage</i> is designed for employers to provide verification of health insurance enrollment for their employees.
Source	Form 470-3036 is system-generated by the HIPP Unit.
Completion	The employee signs and dates the authorization section of the form and gives the form to their employer to complete.
Distribution	The HIPP worker keeps one copy as a control copy.  Send the original to the employee with a self-addressed envelope.  When the form is returned: <ul style="list-style-type: none"><li>◆ Discard the control copy.</li><li>◆ Keep the original in the case record.</li></ul>

**Employer's Statement of Earnings, Form 470-2844 or 470-2844(S)**

Purpose	<p>The <i>Employer's Statement of Earnings</i> is designed to:</p> <ul style="list-style-type: none"><li>◆ Secure the client's permission for the Department to obtain verification of earned income.</li><li>◆ Provide a means for the employer to furnish the requested verification.</li></ul>
Source	<p>Workers can complete the English or Spanish version of this form on line using the templates on the DHS Intranet eForms web page.</p>
Completion	<p>Complete this form when it is necessary to determine earned income. Complete the identifying information on the form and check the boxes to identify the sections the employer is to complete.</p> <p>The client (or person authorized to obtain the information) shall sign and date the authorization section of the form.</p> <p>The employer completes the sections of the form that the worker has checked by and the signature line.</p>
Distribution	<p>Forward one copy of the form to the employer. Employers who want a copy of the completed form for their records should photocopy it.</p> <p>You may upload the request to the electronic case file. When the employer returns the original, it will be scanned and uploaded. Forward a copy to the local PROMISE JOBS office, if appropriate.</p>

Data

The following entries automatically populate:

- ◆ The date sent
- ◆ Your name
- ◆ Your worker number
- ◆ Your telephone number
- ◆ Your fax number
- ◆ Your mailing address
- ◆ Your e-mail address

Before sending the form:

- ◆ Enter:
  - The client's case number
  - The employee's name
  - The employer's name
  - The employee's social security number
  - Your toll free number, if applicable
- ◆ Check the box indicating each section the employer is to complete.
- ◆ Have the client sign and date the form or attach a signed generic release.

The person representing the employer shall:

- ◆ Complete the specific information requested in each section indicated.
- ◆ Sign the form.
- ◆ Indicate the name of the person completing the form, telephone number, and the date.

**Employer's Verification of Earnings, Form 470-3741**

Purpose	<p>Use form 470-3741 to comply with Internal Revenue Service safeguard procedures when you seek verification of earnings reported on an IRS IEVS report. (See <a href="#">14-G, IRS Match Report, S470X615-A: Worker Action Required</a>, for safeguard procedures.)</p> <p>Use this form to get the client's permission to obtain verification of earned income and the availability of employment-related group health insurance. The employer also uses the form to furnish the requested verification.</p>
Source	<p>Print the form as needed from the on-line manual. NOTE: This form is formatted for legal-size (8 ½" x 14") paper.</p>
Completion	<p>Complete this form when it is necessary to determine earned income and the availability of group health insurance that you identified through an IRS IEVS report. Complete one set of this form for each action.</p> <p>Complete the upper tear-off portion of the form. Check the boxes to identify the sections the employer is to complete. The client (or person authorized to obtain the information) shall complete the employee's name and social security number and sign and date the form.</p> <p>The employer completes the sections of the form that have been checked in the tear-off portion of the form and the signature line.</p>
Distribution	<p>Distribution of this form is indicated at the bottom of the form. Forward the release to the employer with a preaddressed return envelope.</p> <p>You may upload the request to the electronic case file. When the employer returns the original, it will be scanned and uploaded. Destroy the tear-off portion of the form in accordance with local IRS safeguard procedures.</p>

Employers who want a copy for their records may make a photocopy for themselves. Should the employer keep one of the copies, photocopy a copy for proper distribution.

Data

Complete the data items on the upper tear-off portion of the form as follows:

- ◆ **TO:** Enter the name and address of the employer.
- ◆ **RE:** Enter the name of the employee and the employee's social security number.
- ◆ Check the box or boxes for the verification you are seeking.
- ◆ Enter the date by which you must receive information.
- ◆ Enter the phone number the employer should use if there are questions.
- ◆ Enter your name.

The client shall enter the employee's name and social security number and sign and date the form after items on tear-off portion of the form have been completed.

Complete the data items on the form below the tear-off portion as follows:

- ◆ **Worker Name:** Enter your name.
- ◆ **Worker Phone No.:** Enter your office telephone number.
- ◆ **County:** Enter the county number.
- ◆ **Case #:** Enter the case number.

The employer or person representing the employer completes and signs the form and indicates job title, telephone number, and the date.

**Estate Recovery Notice for New Approvals, Form 470-2980**

Purpose	Form 470-2980 provides information to Medicaid members who are under the age of 55 and subject to the estate recovery program due to being in a medical institution. It explains that the member will have the opportunity to rebut the Department's presumption that the member cannot return home.
Source	Complete form 470-2980 on line using the template on the DHS Intranet eForms web page.
Completion	The IM worker is responsible for completing and sending this letter to all Medicaid members or to the person acting on the member's behalf when the member is under 55 years old at the time of initial approval for medical institution care.
Distribution	Send the original to the member or the person acting on the member's behalf. Keep a copy of the letter in the member's file.
Data	Complete all sections listed on the form.

**Estate Recovery Program Referral, Form 470-4122**

Purpose	Form 470-4122 is used to notify the Estate Recovery Program of the IME Revenue Collection Unit about the death of a Medicaid member when the deceased's estate is subject to estate recovery according to <a href="#">8-D, Estate Recovery</a> .
Source	Complete this form on line using the template on the DHS Intranet eForms web page.
Completion	Referrals should be made via the ABC referral screens for estate recovery. Use this form only when the estate recovery referral screens are unavailable. In that case, complete this form at the time of death for a Medicaid member who: <ul style="list-style-type: none"><li>◆ Was 55 years of age or older, or</li><li>◆ Was under age 55, resided in a long-term care facility, and was not expected to return home.</li></ul>
Distribution	Send an electronic copy to the Estate Recovery Program at <a href="mailto:DHS_IME_Estates@dhs.state.ia.us">DHS_IME_Estates@dhs.state.ia.us</a> . Keep a copy of the referral form and retain it in the case file.
Data	The form includes information about: <ul style="list-style-type: none"><li>◆ The deceased member.</li><li>◆ The person who is handling the member's affairs.</li><li>◆ The member's bank, funeral home, and attorney.</li><li>◆ The assets the member had at the time of death.</li></ul>

**Estate Recovery Six-Month Follow-Up, Form 470-3209**

Purpose	Form 470-3209 informs Medicaid members under age 55 years and receiving medical institution care how to rebut the Department's presumption that the member will not return home.
Source	Complete form 470-3209 on line using the template on the DHS Intranet eForms web page.
Completion	<p>The IM worker shall complete this letter and send it to all Medicaid members or to the person acting on the member's behalf when the member:</p> <ul style="list-style-type: none"><li>◆ Is under 55 years old, and</li><li>◆ Is in a medical institution six months after approval of Medicaid or has died within the six months after Medicaid coverage for institution care began.</li></ul>
Distribution	Send the original to the member or to the person acting on the member's behalf. Keep a copy of the letter in the member's file.
Data	Complete the address and identifying information listed on the form.

**Explanation of Disability Determination, Form 470-2463**

Purpose	Form 470-2463 is used to explain to the client the Department's reasons for a finding of "not disabled" on a disability determination.
Source	Form 470-2463 is issued by Disability Determination Services (DDS).
Completion	DDS prepares this form after completing a disability determination on behalf of the Department when the result of the determination is a denial. DDS shall prepare a clear concise explanation of the denial to be forwarded to the client by the DHS worker.
Distribution	DDS forwards the original and one copy of the form to the local DHS office. Send the original to the client when you issue the <i>Notice of Decision</i> . File the copy of the <i>Explanation of Disability Determination</i> in the case record with the <i>Notice of Decision</i> .
Data	The form contains a narrative explanation of the DDS decision.

**Explanation of Medicaid Benefits, Form 470-0387**

Purpose	The purpose of form 470-0387 is to verify that Medicaid-paid benefits were received. This form indicates the services paid for by the Medicaid program for the named member.
Source	This form is prepared and sent by the Iowa Medicaid Enterprise.
Completion	The Iowa Medicaid Enterprise prepares the form on a random basis for Medicaid members.
Distribution	One copy is sent to the member. The Iowa Medicaid Enterprise retains a copy in OnBase.  When a field office receives this form from a member and the member is alleging discrepancies with the services received, send the form to the Division of Medical Services for review and investigation.
Data	The form lists the provider of services, the description of the services, the date of service and the amount of Medicaid payment.

**Express Lane Medicaid for Children, Form 470-4851 or 470-4851(S)**

Purpose	Form 470-4851, <i>Express Lane Medicaid for Children</i> , is issued to parents and caretakers of children in the Food Assistance household who are eligible for Medicaid through the Mothers and Children group due to being eligible for Food Assistance.
Source	The ABC system issues the form to the Food Assistance households that include children under the age of 19 who are not already Medicaid members. When a client reports a lost form and asks for a new 470-4851, print a form from the sample in the manual.
Completion	The parent or caretaker will check off the children that the household wants to have on Medicaid and send the form to the designated Department office. The worker will use the completed form to approve eligibility for children who were requested to have Medicaid.
Distribution	One copy will be mailed to the household. The signed, returned copy will be attached to the case file.
Data	<p>The first page of form 470-4851 includes information about Express Lane Medicaid for Children. It lists the names of the children who are eligible for Express Lane Medicaid. The second page is the Insurance Questionnaire.</p> <p>The third page is issued only if there are children who have already had their reasonable period of opportunity to verify citizenship and identity. The third page lists those children as well as other persons who need to prove a qualified legal alien status. It requests information to verify citizenship and identity or to verify qualified alien status.</p>

**[Extra Help for Medicare Prescription Drug Benefits Narrative/Worksheet, Form 470-4193](#)**

Purpose	Form 470-4193, <i>Extra Help for Medicare Prescription Drug Benefits Narrative/Worksheet</i> , is used both to record information and to calculate eligibility for the extra help (subsidy) with Medicare for prescription drug costs.
Source	Complete the form on line using the template on the DHS Intranet eForms web page.
Completion	Form 470-4193 is completed when an applicant for extra help (subsidy) with Medicare prescription drug costs refuses to apply with the Social Security Administration and requires the Department to determine eligibility for the program.
Distribution	File the form in the case record.
Data	<p><b>Application Date:</b> Enter the date form 470-4167, <i>Addendum to Application for Help with Medicare Prescription Drug Plan Costs</i>, and form SSA-1020B-OCR-SM, <i>Application for Help with Medicare Prescription Drug Plan Costs</i>, is received in the local office.</p> <p><b>Interview Date:</b> Enter the date of the interview with client if an interview was conducted. Document whether the interview was conducted in person or by phone.</p> <p><b>Consumer Information Section:</b> This section is self-explanatory.</p> <p><b>Medical Benefit Questions:</b> Answer as appropriate to the individual. Deny or continue processing application based on entry.</p> <p><b>Resources:</b> Enter countable resource information as indicated on the form.</p> <p><b>Household Size:</b> Enter information as indicated.</p> <p><b>Income:</b> Enter countable income information as indicated on the form.</p>

**Calculation – Income:** Enter income as indicated and complete income calculation.

**Calculation – Resources:** Enter resource information as indicated and complete resource calculation.

**Action on Application:** Complete as indicated.

**Calculation Table Desk Aid:** Use to determine eligibility. If eligible, the level of eligibility.

**Facility Face Sheet, Form 470-5052**

Purpose	The <i>Facility Face Sheet</i> is designed to summarize the income and resources of an applicant's or member's information as submitted on the application or <i>Medicaid Review</i> form.
Source	Workers can complete the <i>Facility Face Sheet</i> on line using the template on the DHS Intranet eForms web page.
Completion	Complete this form at application and at review when determining eligibility.
Distribution	Keep a copy of the completed form in the electronic case file.
Data	Workers complete the form with information obtained from the interview with the client or based on information listed on the application or <i>Medicaid Review</i> form.

**Family Planning Medicaid Review, Form 470-4071**

Purpose	<p>The <i>Family Planning Medicaid Review</i>, form 470-4071, is designed for use as the annual recertification document for Iowa Family Planning Network (IFPN) benefits.</p> <p>This form contains instructions for completion and informs members of their rights and responsibilities.</p>
Source	<p>Form 470-4071, is generated by the Family Planning Waiver (FPW) system.</p> <p>DHS staff may also complete this form on line using the template on the DHS Intranet eForms web page.</p>
Completion	<p><i>Family Planning Medicaid Review</i>, form 470-4071, is generated 30 days before the end of the IFPN certification period.</p> <p>Give or issue form 470-4071 to the IFPN member upon request.</p> <p>The worker or the FPW system completes the top portion of page 1 before the form is sent to the member.</p> <p>The IFPN member must complete the form. A friend, relative, authorized representative, or DHS staff may help if needed. The IFPN member must sign the form.</p>
Distribution	<p>File the signed and dated <i>Family Planning Medicaid Review</i>, form 470-4071, in the case record.</p> <p>Give the member a copy at the member's request.</p>
Data	<p>The form requests information about the household's composition, income, and health insurance.</p>

**FIA Appointment, Form 470-3897 or 470-3897(S)**

**Purpose** Form 470-3897 or 470-3897(S) is used to schedule an appointment for a referred person to meet with PROMISE JOBS for the nonfinancial eligibility criterion of completing and signing a *Family Investment Agreement*. For applicants, failure to complete and sign a *Family Investment Agreement* results in denial of the family's FIP application.

**Source** Complete the English or Spanish version of the form on line using the template on the DHS Intranet eForms web page. The form can also be printed or photocopied from the sample in the manual.

**Completion** The *FIA Appointment* form is issued by the IM worker:

- ◆ During the initial face-to-face interview with the applicant to determine a family's eligibility for FIP.
- ◆ When a client has requested reconsideration of a first LBP and can be scheduled before the effective date.

For applicants, the IM worker completes the form if the family appears to meet FIP eligibility criteria and includes members of the assistance unit who are mandatory referrals to PROMISE JOBS. (When it appears that the family does not meet FIP criteria, 470-3897 will not be completed, as no involvement from PROMISE JOBS is needed.)

The IM worker schedules an appointment for applicants who appear eligible for FIP and who are mandatory referrals to the PROMISE JOBS program, to meet with PROMISE JOB to complete and sign a *Family Investment Agreement*.

Distribution

After the IM worker completes the form:

- ◆ Hand-issue or mail the form to the FIP applicant, and
- ◆ File a copy in the FIP case record.

Upon the notification of a referral, PROMISE JOBS shall:

- ◆ Ensure that the PROMISE JOBS worker's name appears in PJCcase as responsible for this particular referred individual.
- ◆ Forward the information to FaDSS if the family is currently enrolled in the FaDSS program.

Data

The form is self-explanatory. Complete all entries, ensuring that the appropriate PROMISE JOBS office is chosen from the list of PROMISE JOBS office addresses displayed as choices.

**FIA Referral for Mandatory Participants, Form 470-3105 (IWD) or 470-3106 (BRS)**

Purpose	<p>Form 470-3105 informs FIP clients that they have been referred to PROMISE JOBS as a mandatory participant and that they have ten days to contact PROMISE JOBS to schedule orientation and to write and sign a <i>Family Investment Agreement</i>.</p> <p>Form 470-3105 is identical to 470-3106, except that clients are informed that they have been referred to the Bureau of Refugee Services for their PROMISE JOBS orientation and FIA completion.</p>
Source	<p>These forms are generated from Central Office. To get a sample to use in discussions with clients, photocopy the sample in the manual or print them from the on-line manual.</p>
Completion	<p>One of these forms is sent when the IM worker changes a referral code on the ABC system for a FIP recipient from exempt to mandatory for PROMISE JOBS participation.</p>
Distribution	<p>The form is mailed to the participant from Central Office.</p>
Data	<p>The forms list the address and phone number of the office the participant should contact and the deadline for the contact.</p>

**Financial Institution Verification, Form 470-3742**

Purpose	<p>Use form 470-3742 to comply with Internal Revenue Service safeguard procedures when you seek verification of information reported on an IRS IEVS report. (See <a href="#">14-G</a>, <a href="#">IRS Match Report, S470X615-A: Worker Action Required</a>, for safeguard procedures.)</p> <p>Use this form to get the client's permission to obtain information that can be provided by a financial institution. The financial institution also uses the form to furnish the requested information.</p>
Source	<p>Print the form as needed from the sample in the manual. NOTE: This form is formatted for legal-size (8 ½" x 14") paper.</p>
Completion	<p>Complete this form when it is necessary to verify interest income or resources that you identified through an IRS IEVS report.</p> <p>Complete the upper tear-off portion of the form. Enter your worker number at the top of the form and the date the permission stops at the bottom of the form.</p> <p>The client (or the person authorized to obtain the information) shall sign and date the form. The financial institution completes the remainder of the page.</p>
Distribution	<p>Send one copy to the financial institution with a return envelope. Keep a copy as a safeguarded control copy. (See <a href="#">14-G</a> for safeguard procedures.)</p> <p>When the financial institution returns the form, destroy the control copy and the tear-off portion of the form in accordance with the local IRS safeguard procedures. (See <a href="#">14-G</a> for instructions.)</p>
Data	<p>Complete the data items on the upper tear-off portion of the form as follows:</p> <ul style="list-style-type: none"><li>◆ To: Enter the name and address of the financial institution.</li><li>◆ RE: Enter the names of the persons whose income or resources are being verified.</li></ul>

- ◆ Enter the date the information must be returned.
- ◆ Enter your phone number.
- ◆ Enter your name and number.
- ◆ Dates: Enter the period of time for which the information is being requested.

Below the tear-off portion, enter the date the authorization expires after "This permission stops on:" Except in unusual circumstances, this shall be 60 days from the date the form is signed.

The client and spouse shall sign this line after the items listed above have been completed.

The financial institution completes the remainder of the form.

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

Purpose	<p>The <i>Financial Support Application</i> is designed to help people present the information needed for IM workers to determine eligibility for:</p> <ul style="list-style-type: none"><li>◆ Child Care Assistance</li><li>◆ Family Investment Program (FIP)</li><li>◆ Food Assistance</li><li>◆ Refugee Cash Assistance (RCA)</li></ul>
Source	<p>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.</p>
Completion	<p>Give or mail one copy of the <i>Financial Support Application</i> to the applicant when assistance is requested. Mail or give the following pamphlets with the application form:</p> <ul style="list-style-type: none"><li>◆ Comm. 51, "Information Practices"</li><li>◆ Voter Registration form</li></ul> <p>A new application is not required when a new person is added to the FIP, Food Assistance, or RCA household.</p> <p>The applicant shall complete the form. A friend, relative, or local office staff may help, if needed.</p> <p>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.</p> <p>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:</p> <ul style="list-style-type: none"><li>◆ Statements of the applicant are incomplete, unclear, or inconsistent, or</li><li>◆ Circumstances indicate that further inquiry should be made and the applicant cannot clarify the situation.</li></ul>

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.

**[FMAP-Related Medically Needy Spenddown Computation Worksheet, Form 470-3088](#)**

Purpose	The <i>FMAP-Related Medically Needy Spenddown Computation Worksheet</i> is used when calculating income for the FMAP-related Medically Needy program. It provides the client with information on the manual computation and assists the worker in making an accurate computation. The form is used for both earned and unearned income.
Source	Complete form 470-3088 on line using the template on the DHS Intranet eForms web page.
Completion	The IM worker completes the form when calculating income for the retroactive or current certification period, or as otherwise needed. Attach verification to the form when required.
Distribution	Mail the original to the client. Print a copy to file the in the case record.
Data	<p>Complete a worksheet for each certification or retroactive period. You may need more than one worksheet for a period when more than two household members have income. Some modification in use may be needed to fit individual situations.</p> <p><b>Case name:</b> Enter the name of the case as it appears on agency records.</p> <p><b>Case number:</b> Enter the complete Medically Needy case number, including FBU and check digit.</p> <p><b>Retroactive period:</b> If income calculations are for the retroactive period, enter the months involved.</p> <p><b>Current certification period:</b> If income calculations are for the current certification period, enter the months involved.</p> <p><b>Household member:</b> Enter the name of the person who is employed, or has unearned income. Two boxes are available, household member A or household member B, when more than one member of the household has income.</p>

**Income source:** Enter the name of the company or the employer. If the person is self-employed, indicate the nature of the person's business. If there is unearned income, enter the source.

**Frequency:** Enter the frequency the household member is paid (weekly, biweekly, monthly, etc.).

**1. Earned income:**

**Month 1.** Enter the name of the first month of the certification period.

**Month 2.** Enter the name of the second month of the certification period.

**Month 3.** This is completed only for retroactive periods when there is a third month. Enter the name of the third month of the certification period.

**3rd check:** Check the box if the person is paid biweekly and received or is projected to receive three checks in this month. Do not check if the person is paid weekly; but started a job or ended a job; and has only received three checks this month.

**5th check:** Check the box if the person is paid weekly and received or is projected to receive five checks in this month.

The template completes the appropriate calculation based on whether there is an "x" at 3rd check or at 5th check, or if those boxes are left blank.

NOTE: If a person receiving a 3rd or 5th check also has earnings from another source, do **not** check either box. Complete the calculations manually and enter the resulting monthly amount as one payment in the amount field.

Enter the dates the gross earned income was received during the month for household member A and household member B, if applicable.

**For retroactive certification periods**, use the actual gross income received each month including third and fifth checks. Total the gross earned income per household member per month.

**For the current certification period**, use the income in the 30 days before the interview or before the date of application if this is a good indicator of future income for month one.

Enter the actual gross income received during this time period when the person received four or fewer weekly checks or two or fewer biweekly checks. Use the same gross income to project for month two if it is indicative of future income.

**Note for FMAP-related Medicaid only:** When a third or fifth check is received in the 30-day period, total the gross income and divide by the number of checks received. Multiply the total by four if the income is received weekly, or by two if the income is received biweekly.

Use this amount as the gross earned income used for both month one and month two.

2. **20% earned income deduction:** Enter the 20% earned income deduction allowed under the FMAP program.
3. **Subtotal:** Subtract the work expense from Line 2 and enter the amount on this line.
4. **Child care:** Enter the verified monthly child or dependent care expenses allowed under the FMAP program.
5. **Paid court-ordered child support:** Enter the amount of monthly court-ordered child support or alimony paid for persons outside of the home, when applicable.

NOTE: A stepparent's child support and alimony payments to persons outside of the home do not need to be court-ordered.

6. **Subtotal:** Subtract Lines 4 and 5 from Line 3 and enter the resulting amount on this line.
7. **Stepparent diversion:** Enter the appropriate stepparent diversion, if applicable.
8. **Total countable earned income:** Subtract Line 7 from Line 6 and enter the amount.
9. **Unearned income:** Enter the dates the countable unearned income was received for each month in the eligibility period. Use the countable unearned income received when paid monthly, biweekly or weekly. Complete for household member A and household member B if applicable.

**3rd check:** Check the box if the person is paid biweekly and received or is projected to receive three checks in this month. Do not check the box if the payment started or ended during the month; and the person received only three checks this month.

**5th check:** Check the box if the person is paid weekly and received or is projected to receive five checks in this month.

The template completes the appropriate calculation based on whether there is an "x" at 3rd check or at 5th check, or if those boxes are left blank.

NOTE: If a person receiving a 3rd or 5th check also has unearned income from another source, do **not** check either box. Complete the calculations manually and enter the resulting monthly amount as one payment in the amount field.

Total the unearned income per household member per month.

When a third or fifth check was received, total the countable unearned income and divide by the number of checks received. Multiply the total by four if the income is received weekly, or by two if the income is received biweekly. Use this amount as the countable unearned income.

- 10. Any remaining balance of paid court-ordered child support:** Enter any remaining balance of paid court-ordered child support not previously used on Line 5.
- 11. Total countable unearned income:** Deduct amounts found in Item 10 from the unearned income total.
- 12. Total countable unearned and earned income:** Total Lines 8 and 11 and enter the amount on this line.
- 13. Deduction:** Deduct any remaining balance of the stepparent diversion not previously used on Line 7.
- 14. Subtotal:** Deduct Line 13 from Line 12 and enter the amount on this line.
- 15. Household size:** Enter the household size for each month of the eligibility period.
- 16. Medically needy income level (MNIL):** Enter the appropriate Medically Needy Income Level for each month based on household size.
- 17. Insurance premiums:** List the insurance premium paid each month.
- 18. Medicare premiums:** List the Medicare premiums paid each month.
- 19. Total insurance:** Total Lines 17 and 18 and enter the amount on this line.
- 20. Total income for period:** Add together the total income for each month of the eligibility period (Line 14 from months 1, 2, and 3).

- 21. Total MNIL:** Add together the total Medically Needy income level for each month of the eligibility period (Line 16 from months 1, 2, and 3).
- 22. Spenddown:** Subtract the MNIL (Line 21) from the total income for the period (Line 20).
- 23. Less total insurance:** Add together the total insurance for each month of the eligibility period (Line 19 from months 1, 2, and 3).
- 24. Final spenddown:** Subtract the total insurance (Line 23) from spenddown (Line 22). This is the final spenddown amount. Enter this amount on the *Notice of Decision for Medically Needy*, form 470-2330.
- 25. Poverty level percentage:** If anyone in the eligible group receives Medicare, determine if the person is QMB-eligible using SSI income calculations. For QMB, enter the percentage of poverty on this line and in the poverty indicator field on the ABC system.

If the person is not QMB eligible, divide Line 12 by 100% of poverty for the household size and enter the percentage on this line as well as the poverty indicator field on ABC.

**Follow-Up Notice, Form MA-2126**

Purpose	The <i>Follow-Up Notice</i> is a flier printed in English on one side and Spanish on the reverse which is issued to remind a family that a child who was screened needs further medical care.
Source	The <i>Follow-Up Notice</i> is issued from Central Office.
Completion	The Iowa Medicaid Enterprise sends the <i>Follow-Up Notice</i> to the family when it receives a Care for Kids screening claim that indicates that the child needs follow-up medical care.
Distribution	The family keeps the form.  Provide assistance if the family requests it. Document in the case file any response to the notice and action you take.
Data	The flier states that Medicaid will pay for the care and includes phone numbers for requesting assistance.

**Food Assistance Complaint, Form 470-0323 or 470-0323(S)**

Purpose	Complainants or recipients of Food Assistance use forms 470-0323 or 470-0323(S) to file a written complaint.
Source	Print these forms as needed from the on-line manual or photocopy the sample in the printed manual.
Completion	A Food Assistance recipient or complainant completes this form at any time when filing a complaint. Make three copies of the submitted form. Inform the complainant that a written response will be issued within 45 days.
Distribution	<p>The person making the complaint shall leave the form at the local office.</p> <p>Provide the complainant with one copy and document that the form was issued. When the client returns the form, send the original and one copy to the Field Operations Support Unit in Central Office. Central Office will send a copy to the service area with a request for response to the complainant.</p>
Data	Completion of the <i>Food Assistance Complaint</i> form is self-explanatory.

**Food Assistance Complaint Summary, Form 470-0328**

Purpose	Form 470-0328 enables the complaint coordinator in the Field Operations Support Unit to summarize the types of complaints received in a given month concerning the Food Assistance process.
Source	Form 470-0328 is photocopied.
Completion	The complaint coordinator in the Field Operations Support Unit prepares one copy at month's end.
Distribution	The original is attached to the <i>Food Assistance Complaint</i> forms received in that particular month.
Data	Completion of this form is self-explanatory.

**Food Assistance Computation, Form 470-0330**

Purpose	The <i>Food Assistance Computation</i> , form 470-0330, is used for manual calculation of eligibility and benefits.
Source	Print form 470-0330 from the on-line manual or photocopy from the printed manual.
Completion	Complete the form at the time of certification or the processing of reported changes when manual calculation is necessary.
Distribution	File the original in the case record. Provide the household with a copy upon request.
Data	This form records income and expense information that affects benefit amounts.

**Food Assistance Work Rules, Form 470-2255 or 470-2255(S)**

Purpose	Form 470-2255, <i>Food Assistance Work Rules</i> , is used to notify each mandatory work registrant what the registrant's rights and responsibilities are and the consequences of failure to comply with the requirements.
Source	Complete the English version of this form on line using the template on the DHS Intranet eForms web page.  Print or photocopy supplies of the Spanish version from the sample in the manual.
Completion	The IM worker issues this form to every household containing a mandatory work registrant when: <ul style="list-style-type: none"><li>◆ An application is approved.</li><li>◆ A case is approved for recertification.</li></ul>
Distribution	Give or mail the one copy of the form to the household. At application or recertification, give the household representative a copy of this form listing each mandatory registrant in the household.  File the other copy of the form in the registrant's case file.
Data	Enter the names of the mandatory work registrants and the date the form was given or mailed to the household.

**Foster Care, Adoption, and Guardianship Medicaid Review, Form 470-2914 or 470-2914(S)**

Purpose	Form 470-2914 or 470-2914(S) is used for reviewing eligibility factors of children in the FMAP-related coverage groups who are in foster care, subsidized adoption, or subsidized guardianship. The service worker also uses the form for the IV-E review.
Source	<p>The English version of this form is printed with 15 forms on a pad. Order supplies from Iowa Prison Industries at Anamosa.</p> <p>The English or Spanish version of the form may also be completed on line using the template on the DHS Intranet eForms web page or in the public state-approved service folder on Outlook. You can also print or photocopy supplies of the form from the sample in the manual.</p>
Completion	<p>Initiate this form a month before the Medicaid review is due.</p> <p>The IM worker completes identifying information. The service worker, the juvenile court officer, the child in supervised apartment living, the parent of a child in subsidized adoption, or the guardian of a child in subsidized guardianship completes the rest of the form.</p> <p>The service worker may photocopy the complete form, if desired.</p>
Distribution	<p>After the service worker, juvenile court officer, child, parent, or guardian completes this form, the original form must be forwarded to the IM worker that sent the form. The service worker may file a photocopy of the completed review form in the service case record.</p> <p>Upon receipt of the form, process the review. Send an <i>Insurance Questionnaire</i>, form 470-2826 or 470-2826(S), to the birth parent of the foster child if health insurance has changed.</p> <p>If a child in subsidized adoption out of state appears to be eligible for a regular Medicaid group, notify the child's parents to apply for Medicaid in the state of residence.</p>

When eligibility is redetermined under a different coverage group, notify the service worker of the changed eligibility.

Data

The IM worker shall:

- ◆ Enter the month that represents the month in which the medical review is due.
- ◆ Complete the Medicaid worker's name and number.
- ◆ List the child being reviewed and all of the child's siblings that are in the same placement and in the same eligibility group. If one sibling is IV-E and another is CMAP, two review forms are required. Do not list siblings in other placements.
- ◆ Send the form as follows:
  - For a foster child, send the form to the service worker or juvenile court officer, unless the child is in supervised apartment living. Remove the instruction page when sending the form to the service worker.
  - When the child is in supervised apartment living, send the form with instructions to the child. Inform the service worker or juvenile court officer that the review is due.
  - For medical reviews of IV-E foster children placed in Iowa from out of state, send the review form to the service worker in the other state. Remove the instruction page.
  - For medical reviews of non-IV-E-foster children placed out of Iowa, send the form to the service worker or juvenile court officer in Iowa that is designated for the foster child. Remove the instruction page.
  - When the child is in subsidized adoption, send the form with the instruction page to the adoptive parent, including children placed out of state or placed in Iowa by another state.
  - When the child is in subsidized guardianship, send the form with the instruction page to the guardian.

- ◆ If the review is not completed in a timely manner for the child placed with the juvenile court officer or in supervised apartment living, send another review form to the service worker or chief juvenile court officer and request that the service worker or juvenile court officer complete the review.

If the form is not completed for a child in subsidized adoption, notify the service worker that the form has not been received. The service worker shall contact the adoptive parent and explain the requirements.

The service worker or juvenile court officer shall do the following when the review form is received:

- ◆ Complete the form with the information such as changes in siblings placed together, school attendance, unearned income, escrow account, resources, and list any expected changes.
- ◆ Contact the foster child's birth parents or custodial relative to ask about changes that have occurred in the child's resources or unearned income and changes in health insurance.
- ◆ Contact the foster child to ask the child to save wage stubs for the whole month before review. Ask the child if the child has any resources, recording the answer on the review form.
- ◆ Sign the form.
- ◆ At the beginning of the review month, send the review form to the IM worker with wage verification.
- ◆ If the child does not provide the wage information, obtain it and send it to the IM worker.

When siblings are in the same group, copies of this form should be filed in each of the siblings' individual service records.

### [Fraud Complaint Referral, Form 470-4768](#)

Purpose	<p>Form 470-4768, <i>Fraud Complaint Referral</i>, is used by IM Customer Service Center staff to send anonymous fraud complaints from the AWARE Hotline to income maintenance staff.</p> <p>This form replaces form 427-0578, <i>AWARE Hotline Complaint</i>.</p> <p>See <a href="#">4-G, AWARE Hotline Referrals</a>, and <a href="#">8-G, AWARE Hotline Referrals</a>, for additional information.</p>
Source	<p>Form 470-4768 is generated from the Fraud Complaint database.</p>
Completion	<p>IM Customer Service Center staff initiate this form when a complaint comes in on the AWARE Hotline and the subject of the complaint has a case on the ABC system.</p> <p>The form is generated when Customer Service Center staff have followed Step 1 through Step 3 to enter the complaint into the Fraud Complaint database. The top half of the form is filled from the information entered into the database and the bottom half will be completed by the subject's IM worker.</p> <p>The IM worker shall determine whether a referral for investigation or an overpayment claim need to be made and return the completed form to the Customer Service Center.</p>
Distribution	<p>An electronic copy is e-mailed to the subject's IM worker, the worker's supervisor, and the area IM administrator or designee.</p> <p>The worker shall make a copy of the form for the case record and e-mail the completed form back to the Customer Service Center.</p>
Data	<p>The data in the top half of the form is generated from the Fraud Complaint database, which the IM Customer Service Center worker fills out in response to an anonymous call.</p> <p>When the IM worker returns the completed form, the return date and disposition needs to be entered into the Fraud Complaint database to complete the process.</p>

**Free Lunch Notice, Form 470-4473 or 470-4473(S)**

Purpose	Forms 470-4473 and 470-4473(S) advise Food Assistance and FIP households that their school-age children are eligible for the free school lunch program. Forms are also sent to notify foster children of eligibility. The form also provides information about <b>hawk-i</b> and Medicaid.
Source	The Department of Human Services (DHS) and the Department of Education (DE) electronically match names of foster children and children receiving Food Assistance and FIP with school records. This form is generated for children who are <b>not</b> identified by the DE match.
Completion	<p>The form is mailed from Central Office by August 1 each year. Households are responsible to complete the form and provide it to the school.</p> <p>Families are also directed to sign the back of the form if they do not want their name released to the <b>hawk-i</b> program or if they currently receive health insurance through <b>hawk-i</b> or Medicaid.</p>
Distribution	<p>One copy is mailed to the household. Households should give the form to the school in order to get free lunches. If they do so at least ten days before school starts, the children listed on the form will be able to participate in the school lunch program on the first day of school.</p> <p>The schools will automatically send free lunch approval letters for children identified through the DE match. Students will receive free school lunches if:</p> <ul style="list-style-type: none"><li>◆ The student is identified by the electronic match between DHS and DE as being a foster child or as receiving Food Assistance or FIP, or</li><li>◆ The household receives form 470-4473 or 470-4473(S) for the student and provides the form to the school.</li></ul> <p>Otherwise, the household must complete an application with the school to get free meals.</p>
Data	The household completes the child's school and grade and signs the form.

**General Accounting Expenditure, Form GAX**

Purpose	IM staff use the <i>General Accounting Expenditure</i> to pay FIP benefits when the ABC system cannot issue the payment due to the age of the claim.
Source	Department staff can complete this form on line using the template in the administrative section of the public state-approved forms folder in Outlook.
Completion	<p>The worker or designated clerical staff prepare the form to issue FIP payment when an appeal decision requires the Department to issue payment for a month outside the ABC system capability (i.e., too old).</p> <p>The service area manager or designee signs the form. Make three more copies of the signed form.</p>
Distribution	Submit the original and two copies of the form to the Division of Fiscal Management, Bureau of Purchasing, Payments, Receipts and Payroll. Keep a copy in the FIP case record.
Data	<p>Note special instructions for direct payment for FIP claims.</p> <p><b>Budget FY:</b> Enter the state fiscal year when the expense is to be paid.</p> <p><b>Date:</b> Enter date the form is completed.</p> <p><b>Vendor Code:</b> For FIP claims, enter 00000041300.</p> <p><b>Agency Name:</b> Enter DHS.</p> <p><b>Vendor Name and Address:</b> Enter the name and mailing address for the FIP client.</p> <p><b>Order Approved By:</b> Enter the original signature of the authorized staff person and the date signed. If use of a stamp is authorized, the person approving the claim must initial the entry.</p>

**Quantity Received:** Enter 1.

**Unit of Measure:** Leave blank.

**Description of Item:** Enter "Appeal Decision" and attach a copy of the final decision.

**Unit Price:** Enter the dollar amount of the claim.

**Total Price:** The template does not allow entries in this field. The total price will be calculated automatically.

**Contract Number:** Leave blank.

**Document Total:** The template does not allow entries in this field. The total will be calculated automatically.

**Claimant's Signature:** The client signs the form. In other cases, leave blank.

**Fund:** Enter 0001.

**Agency:** Enter 413.

**Unit:** Enter 0101.

**Object:** Enter 4210.

**Amount:** Enter the amount of each line.

**Document Total:** The template will not allow entries in this field. The total will be calculated automatically.

To complete the form, calculate the automatic fields by double-clicking the red "Calculate" button. Double-click the "Print" button as many times as necessary to print copies of the form for distribution.

### Hardship Exemption Determination, Form 470-3876

**Purpose** Assistance from the Family Investment Program (FIP) is limited to a total of 60 months. The only way families that have received FIP for 60 months may receive FIP beyond that limit is if they request and are determined eligible for a “hardship exemption.”

The hardship exemption eligibility determination is a one- or two-step process:

1. Based on supporting evidence, the local IM worker determines whether the family has a hardship condition that affects its ability to be self-supporting. If the family does not meet the criteria, the IM worker denies the hardship exemption request at that point.
2. If the IM worker decides that the family meets hardship requirements, and there is an FIA-responsible person, the family must then meet with PROMISE JOBS to develop and sign a six-month *Family Investment Agreement* (FIA) that addresses the family’s documented hardship condition.

A family:

- ◆ Without an FIA-responsible person has to meet step 1.
- ◆ With an FIA-responsible person has to meet both steps.

All families must also meet all other FIP eligibility requirements to be approved for a hardship exemption. Refer to [4-C, Hardship Exemption](#), for more information.

Form 470-3876 is used to document approval or denial of a family’s hardship exemption request. The IM worker also uses the form to:

- ◆ Notify PROMISE JOBS of families with an FIA-responsible person that have met step one,
- ◆ Identify the FIA-responsible adults to PROMISE JOBS,
- ◆ Identify the family’s service worker, if the family has an active service case.

**Source** Complete form 470-3876 on line using the template on the DHS Intranet eForms web page. You can also print or photocopy supplies of the form from the sample in the manual.

Completion	<p>Complete this form when a family requests a hardship exemption from the FIP 60-month limit. The form consists of Parts A, B, and C.</p> <ul style="list-style-type: none"><li>◆ Complete only Part A if the family does <b>not</b> meet Step One.</li><li>◆ When the family <b>has</b> met Step One, complete Part A and later Part C. For a family with an FIA-responsible person the PROMISE JOBS worker completes Part B.</li></ul>
Distribution	<p>Copies of form 470-3876 with Parts A, B, and C completed, as applicable, may be forwarded to appropriate parties using the most expedient method, such as in person (if co-located), or by e-mail, fax, or local mail. Depending on the final hardship exemption disposition, copies of the form are distributed as described under "Data."</p> <p>If difficulties are encountered when using e-mail to exchange copies between IM and PROMISE JOBS, staff will need to use one of the other available methods for exchanging copies of the form.</p> <p>Forward a copy of form 470-3876 that reflects the final hardship exemption determination to:</p> <ul style="list-style-type: none"><li>◆ The PROMISE JOBS worker (if applicable)</li><li>◆ The family's service worker identified in form 470-3884 (if any)</li></ul> <p>Maintain the completed original of form 470-3876 in the permanent "Hardship Exemption" section of the FIP case record.</p>
Data	<p><b>Part A:</b> If you determine that the family <b>does not meet</b> hardship criteria:</p> <ul style="list-style-type: none"><li>◆ Complete the following sections of Part A:<ul style="list-style-type: none"><li>• The information about the client at the top,</li><li>• The "Hardship Does Not Exist" section, and</li><li>• The "Reason" section.</li></ul></li><li>◆ No involvement from PROMISE JOBS is needed.</li><li>◆ Forward a copy of the form to the service worker identified on form 470-3884 (if any).</li><li>◆ Process the hardship exemption denial and make corresponding entries on ETS.</li></ul>

If you determine that the family **meets** hardship criteria:

- ◆ Complete the following sections of Part A:
  - The information about the client at the top,
  - The “Hardship Exist” section, and
  - The “Reason” section.
- ◆ For a family with an FIA-responsible person, forward copies of each of the following to the local PROMISE JOBS office within one working day:
  - Form 470-3876, *Hardship Exemption Determination*.
  - Form 470-3826, *Request for FIP Beyond 60 Months*.
  - The family’s supporting hardship evidence.
  - Form 470-3884, *Hardship Exemption: Service Information*, if you received one from the family’s service worker.

This notifies PROMISE JOBS that you have determined the family with an FIA-responsible person has a hardship condition and must now develop and sign a six-month FIA before the hardship exemption request can be granted.

**Part B:** Upon receipt of these documents, PROMISE JOBS initiates procedures for the FIA-responsible adults to attend an interview to develop and sign the six-month FIA. PROMISE JOBS then documents in Part B whether the family has met the FIA requirement and returns a copy of the form to you.

**Part C:** For families with an FIA-responsible person, upon receipt of a copy of form 470-3876 from PROMISE JOBS with Part B filled in, complete Part C of the form to reflect the final determination of the family’s hardship exemption request.

- ◆ If Part B states that the family failed to attend the required interview or failed to sign the FIA, the family is not eligible for a hardship exemption. Check the “Denied – no FIA” box in Part C. Process the denial and make corresponding entries on ETS.
- ◆ If Part B states that the family has met the FIA requirement, but the family’s circumstances have changed since you completed Part A and the family no longer meets nonfinancial FIP eligibility criteria, the family is not eligible for a hardship exemption.

In that case, check the "Denied – no FIP eligibility" box in Part C. Process the denial and make corresponding entries on ETS.

- ◆ If Part B states that the family has met the FIA requirement, and the family continues to meet all nonfinancial FIP eligibility criteria, process the approval. However, do not complete Part C or make ETS entries until after the ABC system determines the family's financial eligibility for FIP.
  - If ABC determines the family is financially ineligible for FIP due to excess countable income or resources, the family is not eligible for a hardship exemption. Check the "Denied – no FIP eligibility" box in Part C.
  - If ABC determines the family is financially eligible for FIP, the family is eligible for a hardship exemption. Check the "Approved" box in Part C.

Make corresponding entries on ETS.

For families without an FIA-responsible person, complete Part C of the form to reflect the final determination of the family's hardship exemption request.

- ◆ If the family's circumstances have changed since you completed Part A and the family no longer meets nonfinancial FIP eligibility criteria, the family is not eligible for a hardship exemption.

In that case, check the "Denied – no FIP eligibility" box in Part C. Process the denial and make corresponding entries on ETS.

- ◆ If the family continues to meet all nonfinancial FIP eligibility criteria, process the approval. However, do not complete Part C or make ETS entries until after the ABC system determines the family's financial eligibility for FIP.
  - If ABC determines the family is financially ineligible for FIP due to excess countable income or resources, the family is not eligible for a hardship exemption. Check the "Denied – no FIP eligibility" box in Part C.
  - If ABC determines the family is financially eligible for FIP, the family is eligible for a hardship exemption. Check the "Approved" box in Part C.

Make corresponding entries on ETS.

**Hardship Exemption: Service Information, Form 470-3884**

Purpose

Assistance from the Family Investment Program (FIP) is limited to a total of 60 months. Families may receive FIP beyond 60 months if they have a hardship condition and they request and are determined eligible for a "hardship exemption." To request the exemption, a family must:

- ◆ Provide evidence that supports their hardship claim, and
- ◆ Complete form 470-3826, *Request for FIP Beyond 60 Months*.

The request contains an authorization for release of information that allows local income maintenance (IM), PROMISE JOBS, Service, and Family Development and Self-Sufficiency (FaDSS) program staff to share substance abuse, mental health, and AIDS/HIV-related information with each other.

The hardship exemption determination is a one- or two-step process:

1. Based on supporting evidence provided by the family, the IM worker determines whether the family has a hardship condition that keeps the family from self-sufficiency. If the family does not meet hardship criteria, the IM worker denies the hardship exemption request at this point.
2. If the IM worker determines the family meets hardship criteria, and there is an FIA-responsible person, the family must then meet with PROMISE JOBS to develop and sign a six-month *Family Investment Agreement* (FIA) that addresses the family's documented hardship condition.

A family:

- ◆ Without an FIA-responsible person has to meet step 1.
- ◆ With an FIA-responsible person has to meet both steps.

All families must also meet all other FIP eligibility requirements to be approved for a hardship exemption. Refer to [4-C, Hardship Exemption](#), for additional information.

Form 470-3884 is used to transmit relevant information from the service worker to:

- ◆ Assist PROMISE JOBS in developing an FIA with a family that has an FIA-responsible person.
- ◆ Provide the IM worker with the information on the form to use as an additional source to substantiate the family's hardship claim.

Source Complete form 470-3884 on line using the template on the DHS Intranet eForms web page.

Completion When a family requests a FIP hardship exemption, the IM worker determines whether the family's FIP case circumstances are appropriate for requesting a hardship exemption. If so, the IM worker then checks whether the family has an active service case.

If an open service case exists, the IM worker forwards to the service worker a paper copy of form 470-3826, *Request for FIP Beyond 60 Months*, and an electronic copy of form 470-3884 with Part A completed to request information about the family.

The service worker completes Part B and returns the form to IM.

Provided the family with an FIA-responsible person has met the requirements in Step 1, the IM worker forwards the completed form 470-3884, along with other pertinent documents, to PROMISE JOBS. PROMISE JOBS will then contact the family for completion of Step 2.

The IM worker notifies the service worker of the outcome of the family's request for a hardship exemption via a completed form 470-3876, *Hardship Exemption Determination*.

If the family's hardship exemption request is approved, and there is an FIA-responsible person, PROMISE JOBS will forward a copy of the *Family Investment Agreement* that the family completed to the service worker.

Distribution                      The service worker returns the completed form 470-3884 to the IM worker within five working days.

For a family that has an FIA-responsible person, the IM worker forwards a copy of the completed form to the PROMISE JOBS office for use in developing the family's FIA. Completed copies of form 470-3884 are maintained:

- ◆ In the hardship exemption section of the IM case file.
- ◆ In the PROMISE JOBS case file (if appropriate).
- ◆ In the "Other Reports" section of the service case file.

Data                                      Completion of Part A is self-explanatory.

The service worker completes Part B as follows:

- ◆ In item 1, list the family's time commitments and responsibilities, to assist PROMISE JOBS in developing a family investment agreement for an FIA-responsible person that will not conflict with appointments or responsibilities the family has.

For example, if a parent is court-ordered to attend therapy with the child every Monday, Wednesday, and Friday, the PROMISE JOBS worker needs to consider this when developing the FIA with the family.

- ◆ In item 2, write a brief assessment of the challenges, including safety issues, the family has that should be considered by the IM and addressed in the FIA for an FIA-responsible person.
- ◆ Fill in the service worker's name in the first box.
- ◆ Identify in the second box who filled out the form (this may be someone other than the assigned worker), that person's phone number, fax number, and complete e-mail address.
- ◆ Date the form.

**[Health Insurance Information for Kids With Special Needs, Form 470-4633](#)**

Purpose	Form 470-4633 is used to determine if children applying under the Medicaid for Kids With Special Needs (MKSNS) coverage group meet the health insurance enrollment requirement.
Source	Complete the form on line using the template on the DHS Intranet eForms web page.
Completion	<p>The IM worker initiates an original and one copy of this form when the Department needs to gather information about:</p> <ul style="list-style-type: none"><li>◆ The availability of employer health insurance,</li><li>◆ The employer share of the premium cost, and</li><li>◆ Enrollment of the child in the health insurance plan.</li></ul> <p>The parents:</p> <ul style="list-style-type: none"><li>◆ Check the correct box to describe their child's health insurance coverage, <b>and</b></li><li>◆ Either:<ul style="list-style-type: none"><li>• Complete form 470-2826 or 470-2826(S), <i>Insurance Questionnaire</i>, <b>or</b></li><li>• Take the second page of form 470-4633 to their employer to be completed.</li></ul></li></ul>
Distribution	Mail the original to the parents and file the copy in the case record. The parents must return the completed form to the assigned imaging center along with the information listed above.
Data	The template will populate the name, address, worker identification, and the due date.

**[Health Insurance Premium Payment Program Application, Form 470-2875 or 470-2875\(S\)](#)**

Purpose	Form 470-2875 is used to request the Department to pay for health insurance premiums on available health insurance policies.
Source	<p>Form 470-2875 is attached to Comm. 91, "The Health Insurance Premium Payment (HIPP) Program for Iowa Medicaid Recipients." Order supplies of Comm. 91 from Iowa Prison Industries at Anamosa.</p> <p>Form 470-2875(S) is attached to Comm. 91(S), "Programa de Pago de Primas del Seguro Médico para Beneficiarios de Medicaid en el Estado de Iowa." Order supplies of Comm. 91(S) from Iowa Prison Industries at Anamosa.</p> <p>The application is also available from the HIPP website, <a href="http://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp">http://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp</a>. Both versions are considered a valid application for the HIPP Program.</p>
Completion	The member or the member's representative completes the application when requesting the Department to pay for health insurance premiums.
Distribution	<p>The form goes to the HIPP Unit at Iowa Medicaid Enterprise for processing.</p> <p>The form included with Comm. 91 should be sent in the postage-paid envelope to the HIPP Unit.</p> <p>Please send applications printed from the website or contact the HIPP Unit as follows:</p> <p>Phone: 1-888-346-9562 (toll-free); (515) 974-3282 (local) Fax: (515) 725-0725 U.S. mail: HIPP Unit PO Box 36476 Des Moines, IA 50315-9907 Interoffice/IME/HIPP email: <a href="mailto:HIPP@dhs.state.ia.us">HIPP@dhs.state.ia.us</a></p>

Data

The form is self-explanatory.

Please call the HIPP Unit at 1-888-346-9562 if there are additional questions regarding this form.

**[Health Insurance Premium Payment \(HIPP\) Program Outreach Letter, Form 470-5075](#)**

Purpose	Form 470-5075 is used for outreach to provide information regarding the Health Insurance Premium Payment (HIPP) program.
Source	IME Member Services Unit staff may order printed supplies of form 470-5075 from Iowa Prison Industries at Anamosa.  HIPP unit staff use the copy stored on their computers.
Completion	The IME Member Services Unit encloses this form in the managed care packets sent to new Medicaid members.  The HIPP Unit issues the form to pregnant women and members with high Medicaid bills. The HIPP Unit adds to member's name and address.
Distribution	The form is mailed to the Medicaid member.
Data	The form includes information about: <ul style="list-style-type: none"><li>◆ What benefits the HIPP program provides</li><li>◆ How to contact the HIPP program</li></ul>

**Health Insurance Premium Payment (HIPP) Program Review, Form 470-3016**

Purpose	Form 470-3016 is used for reviewing eligibility factors of employer-sponsored health insurance policies on active HIPP cases.
Source	Form 470-3016 is system-generated by the HIPP Unit.
Completion	The member completes the form.
Distribution	Separate copies are printed through Elixir and sent to the: <ul style="list-style-type: none"><li>◆ Policyholder.</li><li>◆ HIPP file.</li></ul>
Data	The HIPP income maintenance worker shall process completed reviews to determine if it is cost-effective to continue premium payment reimbursement.

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

Purpose	<p>The <i>Health Services Application</i> 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.</p>
	<p>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.</p>
Source	<p>Form 470-2927 is printed with five sets on a pad. Order supplies of 470-2927 from Iowa Prison Industries at Anamosa.</p> <p>Print or photocopy supplies of form 470-2927(S) from the sample in the manual as needed.</p>
Completion	<p>Mail or give the <i>Health Services Application</i> to a person applying for Medicaid, Iowa Family Planning Network, Medically Needy, or State Supplementary Assistance.</p>
	<p><b>Applications:</b> The applicant completes the form. A friend, relative, authorized representative, or DHS staff may help, if needed.</p>
	<p>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.</p>
	<p>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.</p>
	<p>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 <a href="#">8-B, Who Must Sign the Application</a>.</p>

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.

**Health Services Application Narrative, Form 470-3898**

Purpose	Use form 470-3898 to document pertinent Medicaid eligibility factors when the <i>Health Services Application</i> is submitted as an application or review form.
Source	Complete form 470-3898 on line using the template on the DHS Intranet eForms web page.
Completion	The IM worker completes one copy of the form when processing a <i>Health Services Application</i> form as: <ul style="list-style-type: none"><li>◆ An application, or</li><li>◆ A SSI-related program review.</li></ul>
Distribution	File the original of the form in the case record.
Data	Complete the applicable sections on the narrative to document the client's disability information, income, and resources.  Provide additional pertinent information in the "comments" section of the form.  Sign and date the narrative at the bottom of the form.

**HIPP Medical History Questionnaire, Form 470-2868**

Purpose	Form 470-2868 is designed to secure additional information regarding specific health-related circumstances of a household for the Health Insurance Premium Payment (HIPP) Unit. The form is used to establish whether the family's Medicaid utilization may be higher than average.
Source	Form 470-2868 is system-generated or produced by the HIPP Unit.
Completion	<p>The system or the HIPP Unit shall complete the top section of the form. Upon receipt of the form, the client checks all conditions that apply. If yes is checked, list the name of the person with this condition and how often medical care is needed to treat the condition. The client is also instructed to sign, date, and provide their email address and phone numbers on the form.</p> <p>The HIPP worker refers to this form when the computer system's cost-effective recommendation is to "not buy" the health insurance policy. The computer system's cost-effective recommendation is based on the average Medicaid utilization of a family with the same demographic data. If the form indicates that the family's Medicaid utilization may be higher than average, the policy may still be cost-effective.</p>
Distribution	Send a copy of the form to the policyholder to complete and return. Keep a control copy.
Data	<p>The system or the HIPP worker enters the:</p> <ul style="list-style-type: none"><li>◆ Date.</li><li>◆ Policyholder's name.</li><li>◆ Due date for returning the form.</li><li>◆ The HIPP worker's name, phone extension, and email address.</li></ul> <p>The policyholder answers the questions about:</p> <ul style="list-style-type: none"><li>◆ Medical conditions of household members.</li><li>◆ Institutional residence.</li></ul>

**HIPP Notice of Action, Form 470-5308**

Purpose	The <i>HIPP Notice of Action</i> is issued by the HIPS system to notify clients of agency actions that affect the client's eligibility or benefit level. Each client has the right to be given information regarding eligibility and benefit determination.
Source	The HIPS system generates form 470-5308 based on worker entries or system processes.
Completion	The <i>HIPP Notice of Action</i> may be used for: <ul style="list-style-type: none"><li>◆ Cancellation notices</li><li>◆ Reinstatement notices</li><li>◆ Change notices</li></ul>
Distribution	HIPS-generated notices are mailed to the client. A copy is filed in the electronic case file.
Data	The HIPP IM worker picks the appropriate field in HIPS to complete the <i>HIPP Notice of Action</i> in HIPS. The worker may also add comments.

**HIPP Private Policy Review, Form 470-3017**

Purpose	Form 470-3017 is used for reviewing eligibility factors of private health insurance policies on active HIPP cases.
Source	Form 470-3017 is system-generated by the HIPP Unit.
Completion	The member completes the form.
Distribution	Separate copies are printed through Elixir and sent to the: <ul style="list-style-type: none"><li>◆ Policyholder.</li><li>◆ HIPP file.</li></ul>
Data	The HIPP income maintenance worker shall process completed reviews to determine if it is cost-effective to continue premium payment reimbursement.

**Household Member Questionnaire, Form 470-1630**

Purpose	Form 470-1630 is designed to secure the client's permission for the Department to investigate household composition. The source of information also uses the form to furnish the requested information.
Source	Form 470-1630 may be completed on line using the template on the DHS Intranet eForms web page.
Completion	<p>The IM worker or QC reviewer completes this form when it is necessary to investigate household composition.</p> <p>The worker completes items identifying the information requested. The client completes the release section. The source of information completes the remainder of the page.</p>
Distribution	<p>Distribution of this form is indicated at the bottom of the form. Send one copy to the source of information with a pre-addressed return envelope enclosed. Give a copy to the client.</p> <p>You may upload the request to the electronic case file. When the source of information returns the original, it will be scanned and uploaded.</p>
Data	<p>Complete the form as follows:</p> <p><b>Date:</b> Enter the date you are sending the form.</p> <p><b>To:</b> Enter the name and address of the source of information.</p> <p><b>From:</b> Enter your name, address, and phone number.</p> <p><b>Address of:</b> Enter the client's name.</p> <p><b>As of:</b> Enter the date for the period to be considered (in two places).</p> <p><b>Was:</b> Enter the client's address.</p> <p><b>List everyone living with:</b> Enter the client's name.</p>

**Signature and Date:** The client shall sign the form and complete the address and date after the items listed above have been completed.

The source of information completes the remainder of the form.

**[How Earnings May Change Your FIP, Form 470-2471, 470-2471\(S\), 470-2471\(M\), or 470-2471\(MS\)](#)**

Purpose	<i>How Earnings May Change Your FIP</i> , form 470-2471, is for informational purposes only. It explains how earnings affect FIP eligibility and the amount of benefits.
Source	<p>In most cases, the English version of form 470-2471 is issued automatically by the Automated Benefit Calculation (ABC) system. Form 470-2471(S) is also system-generated when there is an "S" in the language indicator field on the ABC TD01 screen.</p> <p>Workers may complete 470-2471(M) on line using the template on the DHS Intranet eForms web page or supplies may be printed from the sample in the manual.</p> <p>Supplies of the manually issued Spanish version, 470-2471(MS), may be printed from the sample in the manual.</p>
Completion	<p>The ABC system automatically issues form 470-2471 or 470-2471(S) to the participant the first time earnings are entered into the system for a member of the FIP eligible group.</p> <p>The worker can also issue the form manually as needed.</p>
Distribution	Mail or give the form to the participant. The worker does not keep a copy.

**ICF/ID Resident Care Agreement, Form 470-0374**

Purpose	The <i>ICF/ID Resident Care Agreement</i> is a contract between the facility, the resident, and the Department spelling out the duties, rights, and obligations of all parties concerned.
Source	Complete form 470-0374 on line using the template on the DHS Intranet eForms web page.
Completion	<p>The Department worker prepares three copies of the agreement for signatures when a resident:</p> <ul style="list-style-type: none"><li>◆ Is approved for Medicaid ICF/ID payment,</li><li>◆ Is reinstated after one month or more of ineligibility, or</li><li>◆ Transfers between intermediate care facilities for persons with intellectual disabilities.</li></ul> <p>Either the resident or the facility may sign first. A legal guardian may sign for the resident without the need for the signature of a witness.</p> <p>If a resident is unable to sign the form, a letter "X" or the resident's thumbprint shall be affixed to the line reserved for the resident's name. In such cases, the signatures of two witnesses are necessary for an "X" signature and one witness for a thumbprint.</p> <p>Review the document for completeness and revisions and sign last. Do not accept revisions in the language of the agreement. The Bureau of Long-Term Care shall sign the agreement on behalf of the Department for residents of Woodward and Glenwood State Resource Centers.</p>
Distribution	After all signatures are obtained, return one copy of the form to the facility and to the resident. File one copy in the member's case record.
Data	Enter the date of the contract (date of Medicaid eligibility in the facility), and the member's and the facility's names.

### [Important Information About Your FIP, Form 470-3851](#)

**Purpose** Beginning on January 1, 1997, families can get FIP assistance for a total of only 60 months. The 60-month period need not be consecutive. See [4-C, Limit on FIP Assistance](#), for information about the 60-month FIP limit.

Form 470-3851 is issued to families whose FIP assistance is counted toward the 60-month limit. It informs families of the number of FIP months they have used and the number of FIP months they have left to use. The purpose is to alert them to prepare for becoming self-supporting by the end of their 60-month limit.

**Source** You can generate form 470-3851 from the following sources:

- ◆ For active FIP families that have received FIP for 36 or more months, generate form 470-3851 for the family by choosing the “Active Cases That Have Used FIP For 36 or More Months” report in ETS. Using this source will:
  - Simultaneously generate Comm. 137, *60-Month Limit on FIP*. Comm. 137 provides the family with basic information about the 60-month FIP limit.
  - Automatically record in ETS the date you generate the form and the number of FIP months used at that point.
  - Fill in all items except for your name and phone number. Complete these items before issuing the form to the client.
  - Automatically generate a copy of both documents for the case record.
- ◆ For families that are not active on FIP or have received FIP for fewer than 36 months, generate form 470-3851 from the “Form History” page in ETS. This will also generate Comm. 137.

Form 470-3851 will be blank, requiring you to fill in all items before issuing the form to the client. Also, the date you generate the blank form will not be recorded in ETS.

Using the "Form History" page, you can also:

- Obtain Comm. 137 separately, without form 470-3851.
- Obtain completely filled-in duplicates of form 470-3851 you previously sent to a family from the "Active Cases That Have Used FIP For 36 or More Months" report in ETS, if there is a need. For example, the family may request a duplicate copy.
- ◆ You can complete form 470-3851 on line using the template on the DHS Intranet eForms web page. There is a button on Page 1 that links to Comm. 137. Click on the button to open and print Comm. 137.
- ◆ You can print the form from the on-line manual or photocopy it from the paper manual.

#### Completion

Issue form 470-3851, along with Comm. 137, to parents or needy specified relatives whose FIP assistance is counted toward the 60-month limit. Obtain the number of months an applicant or a participant family has received FIP from the Eligibility Tracking System (ETS).

Issue the form:

- ◆ At months 36, 42, 48, 54, 56, and 58 to families active on FIP.
- ◆ At the annual review interview, regardless of how many months the family has received FIP. Discuss the family's FIP status and the impact of the 60-month limit.
- ◆ At the application interview for families that have not received FIP for 60 months and are reapplying for FIP. Discuss the family's FIP status and the impact of the 60-month limit.
- ◆ At the family's request.

NOTE: You may also issue form 470-3851 at any other time it appears appropriate or beneficial to the family. Examples:

- ◆ You may want to issue the form in month 59 or even month 60 to help families to better understand the connection between the number of months they have received FIP and the 60-month cancellation notice.
- ◆ You may want to include the form when issuing form 470-3826, *Request for FIP Beyond 60 Months*, to families that are close to the 60-month limit. (See 6-Appendix for information on issuing form [470-3826](#) to families that have received FIP for 58 or more months.)

Distribution

Issue the completed original of the form to the family along with Comm. 137.

If the form is generated through the "Active Cases That Have Used FIP for 36 or More Months" report, the issuance will automatically be recorded in the ETS Forms History.

If a blank form is completed from the ETS Forms History or from the eForms web page or the manual, note the issuance in the On Line Narrative.

It is not necessary to keep a copy of the form in the case record.

Data

If you are generating a blank form 470-3851, fill in:

- ◆ The date.
- ◆ Your county office number.
- ◆ The FIP case number.
- ◆ The client's name and address.
- ◆ The number of FIP months the family has used.
- ◆ The number of FIP months the family has left to use.
- ◆ Your name, worker number, phone number, and e-mail address.

If you are generating form 470-3851 from the "Active Cases That Have Used FIP For 36 or More Months" report in ETS, fill in your name and phone number.

NOTE: When generating a blank form 470-3851, be sure to state the most current number of FIP months the family has used. For example, if you are completing the form so late in month 56 that it will be month 57 before the family will get the form, state "57" as the number of FIP months used.

**Important Information About Your Medicaid Benefits, Form 470-4537**

Purpose	Form 470-4537 is used to notify the member that Medicaid will stop paying for most of their prescriptions.
Source	This form is system-generated.
Completion	Central office will mail form 470-4537 to a member: <ul style="list-style-type: none"><li>◆ Two months before a member turns age 65, and</li><li>◆ When the Centers for Medicare and Medicaid Services notifies the Department that the member has Medicare benefits.</li></ul>
Distribution	One copy is mailed to the member.
Data	The form explains: <ul style="list-style-type: none"><li>◆ That Medicaid stops paying for most prescriptions when Medicare coverage begins.</li><li>◆ What Part D costs Medicare will help pay for because the member receives help from Medicaid.</li><li>◆ What will happen if the member does not enroll in a Part D plan.</li><li>◆ What the member should do if the member has drug coverage through an employer or union.</li><li>◆ Who to call if the member has questions.</li></ul>

**Inability to Find a Responsible Person, Form 470-3356**

Purpose	The <i>Inability to Find a Responsible Person</i> is completed when an individual or an organization wants to be considered a “responsible person” for a client who is physically incapacitated, incompetent, or deceased and is in need of a “responsible person” to act on their behalf and there is otherwise no person to act in that capacity.
Source	Form 470-3356 is not printed. Photocopy supplies as needed from the sample in the manual, or print the form from the on-line manual.
Completion	The person or organization requesting to be considered as a responsible person completes the form.
Distribution	The party who completed the form submits one copy to the county DHS office and should keep one copy.
Data	The form contains: <ul style="list-style-type: none"><li>◆ The name of the client.</li><li>◆ The reason that the client needs representations.</li><li>◆ The name of the person proposed to be the responsible person.</li><li>◆ The period of time for which responsibility is requested (during application, for ongoing eligibility, or both).</li><li>◆ The signature of the proposed responsible person.</li><li>◆ The date of the signature.</li><li>◆ The name of the business or organization the responsible person is from, if any.</li><li>◆ The signature of a person from that organization authorizing this designation.</li><li>◆ The position of the authorizing person.</li></ul>

**Income Documentation Tool (InDoc), Form 470-4823**

Purpose	Form 470-4823, <i>Income Documentation Tool (InDoc)</i> , is used to document what income and deductions are considered in the eligibility determination for FIP, Food Assistance, and FMAP-related Medicaid programs. The documentation is used to explain how income was calculated and to support the entries made in the ABC system.
Source	Complete the InDoc on line using the template on the DHS Intranet eForms web page.
Completion	Complete the InDoc at the time of application, RRED, or reported change.
Distribution	Upload the completed InDoc into the Electronic Case File.
Data	The InDoc contains three tabs for recording income and deduction information.

**Institutional Spouse Intent to Transfer Resources, Form 470-4888**

Purpose	Form 470-4888, <i>Institutional Spouse Intent to Transfer Resources</i> , is used to document the institutionalized spouse's intent to transfer ownership of their resources to the community spouse as a condition of ongoing Medicaid eligibility within 90 days of being approved for Medicaid facility assistance.
Source	Complete the form on line using the template on the DHS Intranet eForms web page.
Completion	After an institutionalized spouse is approved for Medicaid, the income maintenance (IM) worker issues the form to obtain: <ul style="list-style-type: none"><li>◆ The member's written statement of intent to transfer resources to the community spouse within 90 days.</li><li>◆ Proof of the resources transferred.</li></ul>
Distribution	Give one copy to the member. Upload a copy to the electronic case file.  The member signs the form and returns it. Upload the signed form into the case file.
Data	Entering the case number for the facility case will populate the name, address, and salutation of the member.  The worker profile will populate the worker address and contact information.

**Insurance Questionnaire, Form 470-2826 or 470-2826(S)**

Purpose	<p>The <i>Insurance Questionnaire</i> is used to identify clients who have health insurance or other medical resources available to them. It is also used as an input document for transmitting information to the Third-Party Liability subsystem and the Automated Benefit Calculation (ABC) system.</p>
Source	<p>The English version of form 470-2826 is printed with 100 forms on a pad. Order supplies from Iowa Prison Industries at Anamosa.</p> <p>Both the English and Spanish versions of this form are available on line as templates on the DHS Intranet eForms web page.</p>
Completion	<p>Include this form in the application packet. Also give or mail a form to the client to complete when the client reports a change in medical resources (for example, on the review form).</p> <p>The client or the client's representative completes one copy of the form at the time of application and when a change in medical resources occurs.</p>
Distribution	<p>When a completed <i>Insurance Questionnaire</i> is returned, handle it as follows:</p> <ul style="list-style-type: none"><li>◆ If the form indicates no insurance coverage, file it in the case record.</li><li>◆ If the form indicates Medicare coverage only, enter the information into the ABC system TD03 screen as directed in <a href="#">14-B-Appendix</a>. Then file the form in the case record.</li><li>◆ If the form indicates Medicare coverage plus other insurance, enter the Medicare information into the ABC system as indicated above and then send the form to Iowa Medicaid Enterprise (IME) Revenue Collection Unit.</li><li>◆ If the form indicates coverage from any source not addressed above, send the form to the IME Revenue Collection Unit.</li></ul> <p>Send forms to IME via local mail if available or mail them to IME Revenue Collection Unit, P. O. Box 310202, Des Moines, Iowa 50331-0202.</p>

When you send the form to IME, you may keep a copy of the form in the case record. However, this is not mandatory because IME will scan all forms to the workflow processing system.

- ◆ When a form is returned indicating coverage has stopped:
  - Ensure that the name of the insurance company and the client's state identification number are on the form,
  - Write TERMINATED across the top of the form, and
  - Send it to Iowa Department of Human Services, Bureau of Long Term Care, 100 Army Post Rd, Des Moines, IA 50315.

**Insurance Report, Form 470-0444**

Purpose	Form 470-0444 is used to obtain information regarding life insurance policies carried by an applicant or participant or a member of the family whose resources are considered in determining eligibility for FIP or Medicaid.
Source	Complete form 470-0444 on line using the template on the DHS Intranet eForms web page. This form is also printed in pads of 20 two-part precarboned sets. Order supplies from Iowa Prison Industries at Anamosa.
Completion	<p>The IM worker completes this form when authorized by the applicant or participant to secure information that is not otherwise available.</p> <p>Complete the cover letter. The client or authorized representative signs the authorization portion of the form. The insurance company representative completes the remainder of the form.</p>
Distribution	<p>Forward one copy to the insurance company.</p> <p>You may upload the request to the electronic case file. When the insurance company returns the original, it will be scanned and uploaded.</p>
Data	<p>Enter identifying information, sign the form as the person requesting information, and fill in the policy numbers if available.</p> <p>Enter the return address of the Department office at the bottom of the second page.</p>

**Intentional Program Violation Hearing Notice, Unnumbered**

Purpose	The <i>Intentional Program Violation Hearing Notice</i> is used to notify the client that a hearing on the referral for intentional program violation has been scheduled.
Source	This form is supplied by the Department of Inspections and Appeals (DIA), Division of Appeals.
Completion	This DIA Division of Appeals completes the form.
Distribution	DIA sends the original to the client, with copies to the client's representatives, the referring county, the service area, and the appeal file.
Data	DIA completes the following data: <ul style="list-style-type: none"><li>◆ Date issued.</li><li>◆ IPV number (the appeal number assigned to the case).</li><li>◆ Date and time of hearing.</li><li>◆ Administrative law judge scheduled to hear the referral.</li><li>◆ Reason for hearing.</li><li>◆ Administrative rules and Code of Federal Regulation citations.</li><li>◆ Explanation of intentional program violation and the client's rights.</li></ul>

**[Interview Checklist for Farmer Food Stamp Applications and Recertifications, Form 470-2326](#)**

Purpose	The purpose of form 470-2326 is to assist the IM worker during interviews with applicants who are farming.
Source	Print supplies of form 470-2326 from the on-line manual or photocopy the sample form.
Completion	At the option of the local office, the IM worker may prepare this form when interviewing an applicant who farms.
Distribution	File the form in the applicant's case record, if completed.
Data	The form suggests questions and includes explanations and reminders on: <ul style="list-style-type: none"><li>◆ Incorporation.</li><li>◆ Tax returns.</li><li>◆ Bankruptcy.</li><li>◆ Income and deductions.</li><li>◆ Capital gains.</li><li>◆ Proration.</li><li>◆ Reporting changes.</li><li>◆ Collateral sources.</li><li>◆ ABC entries.</li></ul>

**Iowa Health and Wellness Plan Billing Statement, Form 470-5285 or 470-5285(S)**

Purpose	The <i>Iowa Health and Wellness Plan Billing Statement</i> is sent to members in the Iowa Health and Wellness Plan (IHAWP) coverage group when a premium is assessed.
Source	The statement is computer-generated from the Premium Payment System at Iowa Medicaid Enterprise (IME). When a member reports non-receipt of a billing statement, advise the member to contact Member Services at IME.
Completion	The billing statement is issued directly from IME. A preaddressed envelope is included for members to remit premium payments.
Distribution	One copy of the billing statement is mailed to the member. If a copy of the billing statement is needed for an appeal, contact Member Services at IME to request a copy.
Data	The billing statement: <ul style="list-style-type: none"><li>◆ Contains the billing date, the case name and address, and the member's state identification number.</li><li>◆ Identifies the months, the amount owed per month, the payment due date, payment history, and Department contact information.</li><li>◆ Allows the member the opportunity to claim financial hardship for inability to pay the monthly premium.</li><li>◆ Instructs members to remit the bottom portion of the statement with payment, using the envelope provided.</li></ul>

**Iowa Medicaid Managed Health Care Enrollment Form, Form 470-2168 or 470-2168(S)**

Purpose	<p>Medicaid members in managed health care counties can use form 470-2168 or 470-2168(S) to register a choice of enrollment or a change in enrollment regarding their managed health care options.</p> <p>This form does not function as a notice of enrollment to the managed health care provider. The IME Member Services Unit collects this information and generates an enrollment tape monthly. The Department then notifies the managed health care providers.</p>
Source	<p>This form is a one-page self-mailer addressed to the IME Member Services Unit. The IME Member Services Unit issues this form as part of the enrollment packet mailed to each new Medicaid case approved in a managed care county.</p> <p>Make supplies of this form available to members at Department offices. (Obtain supplies from the IME Member Services Unit.) The form is also available through the Member Services call center toll-free at 1-800-338-8366 or (515) 725-1003 in the Des Moines area and at some participating managed health care providers.</p>
Completion	<p>The Medicaid member (or someone acting on the member's behalf) may complete this form to choose or change a managed health care option. (These choices can also be registered by phone to the numbers listed on the form.)</p>
Distribution	<p>A Department office or managed health care provider that receives a completed request form from a member should send the form to IME Member Services Unit.</p>
Data	<p>The member enters:</p> <ul style="list-style-type: none"><li>◆ The name or number of the county where the family resides.</li><li>◆ The date this request is signed.</li><li>◆ The last name, first name, and middle initial, birth date, and state ID number of every person in the family who is eligible to enroll in managed health care.</li></ul>

- ◆ For a choice of MediPASS, the name of the MediPASS provider chosen to serve as each person's primary care physician. (This can be different for each person in the household.)
- ◆ For a choice of HMO, the name of the HMO chosen.
- ◆ The reason for changing providers, if applicable.
- ◆ The family's address, including street, city, and zip code.
- ◆ The family's telephone number.
- ◆ The signature of the person who signed the Medicaid application.

**IPV Referral Cover Sheet, Form 470-3035**

Purpose	Form 470-3035 transmits a request for an administrative disqualification hearing to determine if a client has committed an intentional program violation (IPV) under the Food Assistance program.
Source	Complete the form on line using the template available on the DHS Intranet eForms web page.
Completion	<p>The IM worker responsible for submitting the IPV referral completes the form. When requesting administrative disqualification on more than one member of the same household, complete a separate form and documentation for each referral. Attach:</p> <ul style="list-style-type: none"><li>◆ A summary of the alleged violation.</li><li>◆ Copies of documentary evidence supporting the allegation.</li><li>◆ A copy of form 470-0464, <i>Overpayment Recovery Information Input</i>, or the <i>Overpayment Recovery Information Input Summary</i> (from the direct claim entry screen), if applicable.</li></ul> <p>Each referral shall contain a summary and supporting evidence. Do not send in multiple referrals with one set of evidence. You need to attach a summary and evidence for each referral.</p>
Distribution	<p>The worker forwards the referral packet to the worker's supervisor (or designee) for approval and signature.</p> <p>Submit the signed original with the rest of the referral information to the DHS Appeals Section, 5th Floor, 1305 E. Walnut Street, Des Moines, IA 50319-0114. Keep a copy of the entire referral packet in the case file.</p>
Data	<p><b>Name:</b> Enter the first name, middle name (if known), and last name of the person being referred for fraud. If appellant has changed names, indicate previous names in this section also.</p> <p><b>Date:</b> Enter the date of the referral.</p> <p><b>Address:</b> Enter the complete address of the person being referred. If the person is no longer receiving benefits, list the last known address.</p>

**Case number:** Enter the complete ABC case number of the person being referred. If the case is not active, list the closed case number.

**Food Assistance Status:** Check the box to indicate whether the person is receiving benefits (active) or not (closed).

**State Identification Number:** List the state identification number of the person being referred.

**Birthdate:** List the birth date of the person being referred.

**Social Security Number:** List the social security number of the person being referred.

**Previous Disqualifications:** List any known previous IPV disqualifications of the person being referred. Include the appeal number or the date of the criminal order, if available.

**IM Worker Name, Worker Number, and Telephone Number:** List the name, number, and telephone number of the person completing the form.

**IM Supervisor or Designee Signature:** The worker's supervisor or the supervisor's designee shall review the information being submitted and sign the form to indicate approval.

Pages 165 through 170 are reserved for future use.

**Level of Care Certification for HCBS Waiver Program, Form 470-4392**

Purpose	<p>Form 470-4392, <i>Level of Care Certification for HCBS Waiver Program</i>, provides a mechanism for a medical professional to report a Medicaid member's admission, change in condition, or annual assessment for level of care.</p> <p>Providers are encouraged to conduct the level of care process during a routine or preventative office visit.</p>
Source	<p>This form is available on the DHS website under provider forms. Department staff can issue the form on line using the template on the DHS Intranet eForms web page.</p>
Completion	<p>A medical professional (MD, DO, ARNP, or PA) must complete the form when:</p> <ul style="list-style-type: none"><li>◆ A Medicaid member is going to receive services provided in their home or community.</li><li>◆ A Medicaid member has a significant change in condition.</li><li>◆ A Medicaid member has an annual assessment.</li></ul> <p>The IME Medical Services Unit will make a level of care determination upon receipt of the form.</p>
Distribution	<p>The medical professional completing the form or others involved in assisting in arranging the services (i.e., facility staff, hospital discharge planner, case manager, or family member) shall:</p> <ul style="list-style-type: none"><li>◆ Fax the form to the IME Medical Services Unit at 515-725-1349 or</li><li>◆ Email the form to <a href="mailto:imeltc@dhs.state.ia.us">imeltc@dhs.state.ia.us</a> and</li><li>◆ Provide a copy to the Medicaid member.</li></ul>
Data	<p><b>Today's Date:</b> The actual date the form is completed in MM/DD/YY format.</p> <p><b>Iowa Medicaid Member Name:</b> The Medicaid member's first, middle initial, and last name as it appears on the eligibility card.</p>

**State ID or Social Security Number:** The member's state identification number or social security number as it appears on the eligibility card.

**Birth Date:** The Medicaid member's birth date in MM/DD/YY format.

**Provider Name and Telephone Number with Area Code:** The specific information for the medical professional filling out the form.

**HCBS Waiver:** Contains the specific Medicaid home- and community-based (HCBS) waiver type.

**Diagnoses and Medications:** The member-specific health information related to diagnoses and medications. The healthcare practitioner may submit supporting documentation and a medication list along with the form in order to complete the review.

**Level of Care Criteria:** Mandatory criterion sections. Please review each category and check all applicable criteria. Please check all that apply, as well as additional comments the medical professional may want or need to add.

**Signature with Title of Healthcare Professional (MD/DO/ARNP/PA):** The signature of the medical professional completing the form.

### [Lost Form Request, Form 470-0272](#)

Purpose	Form 470-0272 is used to request certain system-generated forms that are not received or are received and misplaced. A replacement document has the sequence number of the last document.
Source	Complete form 470-0272 on line using the template on the DHS Intranet eForms web page.
Completion	<p>When you do not receive a form, determine if sufficient time for processing has elapsed before submitting a <i>Lost Form Request</i>.</p> <p>Complete this form to request replacement of the following forms from the MMIS Medically Needy Subsystem:</p> <ul style="list-style-type: none"><li>◆ The <i>Eligibility Status Turnaround Document (ESTD)</i>,</li><li>◆ The <i>Bill Status Turnaround Document (BSTD)</i>, or</li><li>◆ The <i>Notice of Spenddown Status (NOSS)</i>, for cases that have a spenddown.</li></ul> <p>If screens LF01 and IEV2 are not available, you can also use this form to request forms from:</p> <ul style="list-style-type: none"><li>◆ The Automated Benefit Calculation (ABC) system.</li><li>◆ The Income and Eligibility Verification System (IEVS).</li></ul>
Distribution	<p>For forms from the Medically Needy subsystem, send the form to the IME Medically Needy Unit using the 'send' button on the template. Enter the e-mail address listed on the form.</p> <p>For IEVS or ABC system forms, submit the form to the Quality Assurance Unit in the Division of Data Management, Hoover State Office Building.</p>
Data	<p>Mark the box indicating the form requested. For each request for replacement, complete the:</p> <ul style="list-style-type: none"><li>◆ Identifying numbers</li><li>◆ Worker number</li><li>◆ Date</li><li>◆ County</li><li>◆ Signature</li></ul>

Page 174 is reserved for future use.

Page 175 is reserved for future use.

**MAIT Facility Worksheet, Form 470-4678**

Purpose	Form 470-4678 is used to calculate client participation for a member who resides in a medical institution and has a medical assistance income trust (MAIT or Miller trust).
Source	Complete the form on line using the template on the DHS Intranet eForms web page.
Completion	IM workers use this form when calculating client participation for members who reside in a medical institution and have a medical assistance income trust (MAIT or Miller trust). Complete a worksheet for each initial determination and annual review.
Distribution	File the original in the case file.
Data	<p>Some modification in use may be needed to fit individual situations.</p> <p>Enter the facility <b>case number</b>, including FBU. Entering the case number automatically populates the <b>case name</b>.</p> <ol style="list-style-type: none"><li>1. <b>Central office/local office approval date:</b> Enter the date the trust met the criteria for a medical assistance income trust (MAIT).</li><li>2. <b>Execution date:</b> Enter the date that the trust was signed and notarized.</li><li>3. <b>Date trust was established:</b> Enter the first day of the month that income is used to fund the trust. This will be the effective date of eligibility.</li><li>4. <b>Member's facility type:</b> Select ICF/ID, mental health institute, nursing facility, or PMIC from the dropdown box.</li><li>5. <b>Charge for care:</b> The worksheet defaults to the current state fiscal year and enters the amount based on the member's facility type. Select the other button to enter amounts based on the member's facility type for the previous state fiscal year.</li></ol>

6. **Gross income:** Enter the source and gross amount of unearned and earned income used to fund the trust. The worksheet calculates the total gross income.
7. **Is member's adjusted gross income greater than 125 percent of the statewide average charge for care?**

If 125 percent of the statewide average charge for care is less than the total gross income, the worksheet enters "Yes, deny facility eligibility and approve Medicaid only under Medically Needy."

If 125 percent of the statewide average charge for care is greater than the total gross income, the worksheet enters "No, calculate client participation."

8. **Months:** Enter the months that the client participation calculation is to cover.
9. **Diversion to community spouse?** Check "Yes" if there is a community spouse. Check "No" if there is no community spouse.
10. **Client participation:** Enter the dependent diversion, unmet medical expenses, aid and attendance, and nursing facility insurance payments. The worksheet calculates the adjusted gross income, client participation, and maximum client participation.
11. **Vendor name:** Enter the name of the medical institution where the member resides.

**Per diem:** Enter the per diem rate of the medical institution where the member resides. The maximum Medicaid rates automatically populate.

Entries for the second page (Sys Entries & Spouse tab) include:

**Year:** The worksheet defaults to the current year. Select the other button if you are calculating the client participation for the previous year.

**Community spouse diversion:** Enter the income source and the gross unearned and earned income of the community spouse.

**Total income for community spouse:** The worksheet calculates the total gross unearned and earned income of the community spouse.

**Maximum diversion amount:** The worksheet enters the amount based on the minimum monthly maintenance needs allowance (MMMNA) for the year selected.

**Deficit:** The worksheet calculates the community spouse's income shortfall and enters the amount in the "spousal diversion" field under Item 10.

**System entries:** Use these case actions to enter the Miller Trust information into the ABC system.

**MAIT Waiver Worksheet, Form 470-4679**

Purpose	Form 470-4679 is used to calculate client participation for members who are eligible for a home- and community-based services (HCBS) waiver and have a medical assistance income trust (MAIT or Miller trust).
Source	Complete the form on line using the template on the DHS Intranet eForms web page.
Completion	The IM worker uses this form when calculating client participation for a member who has been approved for a HCBS waiver and has a medical assistance income trust (MAIT or Miller trust). Complete a worksheet for each initial determination and annual review.
Distribution	File the original in the case file.
Data	<p>Some modification in use may be needed to fit individual situations.</p> <p>Enter the facility <b>case number</b>, including FBU. Entering the case number automatically populates the <b>case name</b>.</p> <ol style="list-style-type: none"><li>1. <b>Central office/local office approval date:</b> Enter the date the trust met the criteria for a medical assistance income trust (MAIT).</li><li>2. <b>Execution date:</b> Enter the date that the trust was signed and notarized.</li><li>3. <b>Date trust was established:</b> Enter the first day of the month that income is used to fund the trust. This will be the effective date of eligibility.</li><li>4. <b>Member's level of care:</b> Select ICF/MD, mental health institute, or nursing facility from the dropdown box.</li><li>5. <b>Charge for care:</b> The worksheet defaults to the current state fiscal year and enters the amount based on the level of care selected in Item 4. Select the other button to enter amounts based on the level of care for the previous state fiscal year.</li></ol>

6. **Gross income:** Enter the source and gross amount of unearned and earned income used to fund the trust. The worksheet calculates the total gross income. The worksheet calculates the adjusted gross income after deducting the \$10 trust administrative fee.

7. **Is member's adjusted gross income greater than 125 percent of the statewide average charge for care?**

If 125 percent of the statewide average charge for care is less than the adjusted gross income, the worksheet enters "Yes, deny facility eligibility and approve Medicaid only under Medically Needy."

If 125 percent of the statewide average charge for care is greater than the adjusted gross income, the worksheet enters "No, calculate client participation."

8. **Waiver type:** Enter the HCBS waiver type the member has been approved for.

9. **Months:** Enter the months that the client participation calculation is to cover.

10. **Client participation:**

The worksheet enters the maintenance allowance based on the year selected. The worksheet defaults to the current year. Select the other button if you are calculating the client participation for the previous year.

Enter the needs allowance for spouse or spouse and dependents, unmet medical expenses, aid and attendance, and nursing facility insurance payments. The worksheet calculates the client participation and total client participation.

**System entries:** Waiver cases require manual system entries. Use these case actions to manually enter the Miller trust information into the ABC system.

**Medicaid Claim Denial Notice, Form 470-0385**

Purpose	The purpose of form 470-0385 is to notify Medicaid members that the Iowa Medicaid Enterprise has denied a claim for service rendered to the member.
Source	This form is issued only by the IME Core Services Unit (the unit that processes and pays Medicaid claims).
Completion	<p>The IME Core Services Unit prepares the form when a claim for ambulance service or rehabilitation agency services is denied because the criteria for payment are not met.</p> <p>The form is included in the manual for information only.</p>
Distribution	The IME Core Services Unit sends the original to the member and keeps one copy for its files.
Data	Self-explanatory.

**Medicaid EPSDT Enrollees, Report Number X161C5A**

Purpose	The <i>Medicaid EPSDT Enrollees</i> report notifies workers that the local office is responsible for providing the EPSDT “Care for Kids” oversight. Responsibilities under this program are covered in 8-M.
Source	The Iowa Medicaid Enterprise generates this printout monthly.
Completion	This report is for information only. It identifies the children on the worker’s caseload that are eligible for “Care for Kids” screenings.
Distribution	The report is issued to the IM workers for children in foster care and persons who are eligible for Medically Needy with a spenddown. Oversight for other cases is provided by local public health agencies under contract to the Department.
Data	The “LAST” screening date is the last screening paid by Medicaid in the last two years. The “NEXT” screening date is based upon the enrollee’s age and the screening periodicity schedule.

**Medicaid EPSDT Enrollees Due Screening by Periodicity, Report Number X1612C34**

Purpose	The purpose of the <i>Medicaid EPSDT Enrollees Due Screening by Periodicity</i> report is to notify workers of children on their caseload due for "Care for Kids" screening.
Source	The Iowa Medicaid Enterprise generates this report monthly for each IM worker whose caseload includes children in foster care and persons who are eligible for Medically Needy with a spenddown, based on payment records for screening services.
Distribution	When you receive the new <i>Screening Due by Periodicity List</i> , you may discard the previous month's report.
Data	<p>This list indicates the prior and next screening dates. The "PRIOR" screening date is the last screening paid by Medicaid in the last two years.</p> <p>The "NEXT" screening date is based upon the member's age and the Screening Periodicity schedule. A date will appear if:</p> <ul style="list-style-type: none"><li>◆ The member is due for a screening in the current or next two months.</li><li>◆ The member has not received a screening in the last year and the member is under seven years of age.</li></ul> <p>The column labeled "OVER 1 YEAR" will contain a "YES" if it has been more than 12 months since this child has had a screening exam paid by Medicaid. A double asterisk (**) also identifies these same members. EXCEPTION: These indicators do not apply to anyone on the two-year screening schedule (i.e., 8-year, 10-year, etc.).</p>

**Medicaid for Independent Young Adults Change Report, Form 470-4376**

Purpose	Form 470-4376 is a reminder to members in the Medicaid for independent young adults (MIYA) coverage group that changes in addresses and health insurance must be reported to the income maintenance worker whenever they occur. It provides a simple means for the member to report a change.
Source	Complete form 470-4376 on line using the template on the DHS Intranet eForms web page.
Completion	When changes in addresses or health insurance occur, the member completes and submits the form to the assigned income maintenance worker.
Distribution	<p>Issue the form:</p> <ul style="list-style-type: none"><li>◆ At the time of the automatic redetermination for Medicaid for independent young adults following the foster care exit.</li><li>◆ At the time of application.</li><li>◆ When Medicaid for independent young adults eligibility is established.</li><li>◆ At the annual review.</li><li>◆ When the member submits the form to report a change.</li><li>◆ When the member requests a form.</li></ul> <p>File the submitted form in the case record after the required action is completed. Document the resulting action in the case record.</p>

**Medicaid for Kids With Special Needs Income Worksheet, Form 470-4632**

Purpose	Form 470-4632 is used to calculate countable income for the SSI-related coverage group Medicaid for kids with special needs (MKSNS). It can be used to provide the applicant or member with information on the computation and assists the worker in making an accurate income determination.
Source	Complete the form on line using the template on the DHS Intranet eForms web page.
Completion	The IM worker completes an original and one copy when calculating income. Enter the number of children applying for MKSN. The health insurance information may be completed at the end of the form, but it is not required.
Distribution	Mail the original to the applicant or member and file the copy in the case record.
Data	<p><b>Item 1. Case name:</b> Enter the name of the child with disabilities who will be the eligible person on the case. NOTE: When there is more than one child per family who qualifies for MKSN, select one to enter here.</p> <p><b>Item 2. Case number:</b> Enter the MKSN case number.</p> <p><b>Item 3. Unearned income:</b> Enter the average monthly unearned income for each source for the disabled child. Enter the full amount of child support received for children under 18 years of age.</p> <p>Enter the average monthly unearned income for each source for the other family members who are included in the family size. When there are more than five family members, add the income of all other members and enter it in the last column.</p> <p><b>Items 4 through 6</b> are calculated by the template.</p> <p><b>Item 7. Earned income:</b> Enter the average monthly earned income from each source for the disabled child. Enter the average monthly earned income from each source for other members included in the family size.</p>

**Items 8 through 11** are calculated by the template.

**Item 12.** Enter impairment-related work expense, if applicable.

**Items 13 through 15** are calculated by the template.

**Item 16.** Enter work expenses for the blind, if applicable.

**Items 17 and 18** are calculated by the template.

**Items 19.** Enter the monthly amount of the Plan for Achieving Self-Support (PASS).

**Item 20. Family size:** Enter the number in the household.

**Item 21. Number of eligible children in the family:** Enter the number of children with disabilities who are included in the MSKN case.

Answer the following questions:

- ◆ Does the employer pay at least half of the annual cost of the health insurance premiums?
- ◆ If yes, is the child enrolled in health insurance?

After you have made entries and double-clicked on the "Calculate" button at the end of the form, the template performs the income calculation. The calculation will populate the following fields:

- ◆ Total Countable Family Income,
- ◆ Income for Your Family Size Must Be No More Than (the dollar amount of 300% of the federal poverty level for the family size),
- ◆ Medicaid for Kids With Special Needs Poverty Level (the percentage of the federal poverty level represented by the family's countable income), and
- ◆ Eligible or Not Eligible.

If you have made an error in entering data, correct the data and double click on the "Calculate" button again.

**Medicaid Notice of Sanction, Form 470-0409**

Purpose	The <i>Medicaid Notice of Sanction</i> transmits information and instructions from the HIPP Unit to the IM worker.
Source	Form 470-0409 is generated by the HIPP Unit.
Completion	The HIPP Unit prepares the form when the HIPP worker determines that a Medicaid member (or someone acting on the member's behalf) has failed to cooperate in providing information or enrolling in a health insurance plan or by disenrolling in a plan that HIPP has determined cost effective.
Distribution	Send a copy to the IM worker responsible for the case via e-mail. File a copy in the HIPP Unit's files as permanent verification of the action taken. Upon receipt, the IM worker: <ul style="list-style-type: none"><li>◆ Cancels the member's Medicaid benefits effective the first of the month following the expiration of the ten-day notice period.</li><li>◆ Issues a <i>Notice of Decision</i>, 470-0485 or 470-0486, informing the member of the action to be taken.</li><li>◆ Files form 470-0409 in the case record.</li></ul>
Data	The HIPP worker enters: <ul style="list-style-type: none"><li>◆ The current date.</li><li>◆ The name of the office to which the form is being sent.</li><li>◆ The number of the IM worker responsible for the case.</li><li>◆ The name of the HIPP worker preparing the form.</li><li>◆ The name of the member whose benefits are to be canceled.</li><li>◆ The case number of the member's Medicaid case.</li><li>◆ A check in the box for the reason that Medicaid benefits are being canceled.</li><li>◆ The effective date of cancellation of the Medicaid benefits.</li></ul>

**Medicaid Review, Form 470-3118, 470-3118(S), 470-3118(M), or 470-3118(MS)**

Purpose	The <i>Medicaid Review</i> is designed for review and recertification of various Medicaid and State Supplementary Assistance coverage groups.
Source	<p>The ABC system automatically generates form 470-3118. Form 470-3118(S) is generated instead when there is an "S" in the language indicator field on the ABC TD01 screen.</p> <p>The manually issued English version, form 470-3118(M), is available on line as a template on the DHS Intranet eForms web page.</p> <p>The manually issued Spanish version, form 470-3118(MS), can be printed or photocopied from the sample in the manual.</p>
Completion	<p>The <i>Medicaid Review</i> is sent for a member whose case is due for a review or recertification of SSI-related Medicaid, Medically Needy, or State Supplementary Assistance.</p> <p>If the worker initiates the form, complete the top portion of page 1 before giving or mailing the form to the member.</p> <p>The member shall complete and sign the form or enlist the help of someone else in preparing it. If the member has a guardian, the guardian shall participate in completing the form and shall sign for the member.</p> <p>Date-stamp the original form when it is returned.</p>
Distribution	If the member wants a copy of the form after it has been completed, photocopy it for the member. Keep the original form in the case record.

Data

The member's address, the worker's name, telephone number, and county number, the case number, and the due date for returning the form are entered on the form before the form is system-generated.

If the worker initiates the form, the worker should enter this information before the form is mailed or given to the member.

**Medicaid/*hawk-i* Review, Form 470-5168, 470-5168(S), 470-5168(M), or 470-5168(MS)**

**Purpose** The *Medicaid/hawk-i* Review is designed for use as the annual review document for MAGI-related Medicaid.

This form contains instructions for completion and informs clients of their rights and responsibilities.

**Source** Usually, the ELIAS system generates form 470-5168 automatically. Form 470-5168(S) is generated when the Medicaid member has indicated that Spanish is their preferred language.

DHS staff may issue a manual version of the form, 470-5168(M) or 470-5168(MS), using the templates available on the DHS Intranet eForms web page.

**Completion** The ELIAS system produces form 470-5168 or 470-5168(S) at the end of the month for *hawk-i* and MAGI-related Medicaid when a case is active for Medicaid in the ELIAS system and due for an annual review.

Give or issue the form to the member upon request.

The worker or the ELIAS system completes the top portion of page 1 before the form is sent or issued to the participant.

The member must complete the answers to all applicable questions. The participant may obtain help in completing the report from friends, relatives, advocate groups, or Department staff, if needed.

**Distribution** Give or mail one copy of the form to the client for completion.

The completed form is scanned and filed in the case record.

## Data

Whenever the form is issued manually, provide a pre-addressed return envelope. Prepare the form as follows:

- ◆ Enter the Imaging Center name and address in the upper left hand corner of the form.
- ◆ Enter the case name and current mailing address.
- ◆ **Due Date.** Enter the date the renewal form is due back to the Department.
- ◆ **Case Number.** Enter the complete case number.
- ◆ **County Number.** Enter the county number.
- ◆ **Worker Name.** Enter the worker or team name.
- ◆ **What do I do with this form?** Enter the date the renewal form is due back to the Department.
- ◆ **What if I have questions?** Enter the telephone number of the worker or team.

**Medical Assistance Debt Notice, Form 470-4342**

Purpose	The Estate Recovery section of the IME Revenue Collection Unit uses form 470-4342 to notify interested parties, including family members, that a deceased Medicaid member incurred a debt to repay for paid Medicaid claims.
Source	Form 470-4342 is issued by the Iowa Medicaid Enterprise Estate Recovery Unit.
Completion	Form 470-4342 is issued in conjunction with form 470-4339, <i>Medical Assistance Debt Response</i> , when the deceased member's estate is subject to estate recovery according to 441 IAC 76.12(7)"b" and "c." Estate Recovery staff complete this form after the reported death of a Medicaid member who was either: <ul style="list-style-type: none"><li>◆ 55 years of age or older, or</li><li>◆ Under age 55, residing in a long-term care facility, and not able to return home.</li></ul>
Distribution	Estate Recovery staff sends the original to the designated interested party. A copy of the notice is retained in the Estate Recovery Unit case file.
Data	The form includes information about: <ul style="list-style-type: none"><li>◆ The deceased member's name and state identification number.</li><li>◆ The amount of medical debt.</li></ul>

**Medical Assistance Debt Response, Form 470-4339**

Purpose	The Estate Recovery Program of the IME Revenue Collection Unit uses form 470-4339 to obtain information about the assets of a deceased Medicaid member.
Source	Form 470-4339 is generated by the Estate Recovery Unit.
Completion	<p>The Estate Recovery Program staff issues form 470-4339 along with form 470-4342, <i>Medical Assistance Debt Notice</i>, when the deceased's estate is subject to estate recovery.</p> <p>The representative of the deceased member is to complete and sign the form and then returned to the Estate Recovery Program. The income maintenance worker is not responsible for assisting with this form. The Estate Recovery Program staff will assist representatives who need help with this form.</p>
Distribution	Estate Recovery Program staff sends the original to the designated interested party. A copy of form 470-4339 is retained in the Estate Recovery Program case file.
Data	<p>The form includes information about:</p> <ul style="list-style-type: none"><li>◆ Name and date of death of the recipient</li><li>◆ Representative's name, address, and telephone number</li><li>◆ Identification of assets</li><li>◆ Identification of other expenses that must be paid</li><li>◆ Identity of the spouse, if applicable</li><li>◆ Funeral home</li><li>◆ Name and address of nursing facility, if applicable</li></ul>

### Medical Assistance Eligibility Card, Form 470-1911

Purpose	The <i>Medical Assistance Eligibility Card</i> contains basic identifying information to enable a provider of medical care to confirm a Medicaid member's eligibility. The member is instructed to keep the permanent card and present it when receiving medical services.
Source	<p>The <i>Medical Assistance Eligibility Card</i> is computer-generated for new approvals during the daily processing.</p> <p>The IM worker or the IME Member Services Unit can generate replacement cards through the web-based system. Replacement cards for members enrolled in the Iowa Family Planning Network can also be replaced through the Family Planning Waiver system.</p>
Completion	<p>The <i>Medical Assistance Eligibility Card</i> is issued to the member directly. The first card is mailed at the time of initial approval.</p> <p>The Department will issue replacement cards:</p> <ul style="list-style-type: none"><li>◆ Upon a member's request,</li><li>◆ When foster care eligibility is established, or</li><li>◆ When card was last issued due to IFPN eligibility.</li></ul> <p>Circumstances under which a replacement card is necessary includes:</p> <ul style="list-style-type: none"><li>◆ The card has been lost, stolen, or damaged;</li><li>◆ The member did not receive the initial card;</li><li>◆ The member's name changes; or</li><li>◆ A duplicate card is needed for a member who is out of the home, for example, when a child is visiting relatives over the summer.</li></ul>

	<p>The member will not be issued a new card if the member changes Medicaid coverage groups.</p> <p>The new annual card does not guarantee Medicaid eligibility.</p>
Distribution	<p>Each member will receive one wallet-size card and two key tags at the time of initial approval. No more than three family members' cards will be mailed together. The cards will be mailed to the case name and mailing address. This includes those residing in a residential care facility.</p> <p>Cards for new members living in a medical facility will be mailed to the facility address.</p>
Data	<p>The member's name, date of birth, and state identification number are printed on the wallet card and key tags.</p> <p>Information on appeal rights, payment of medical bills, the Department's right to recover payments made or make a claim against another responsible for member's medical cost, and when a member should contact Iowa Medicaid Enterprise (IME) Member Services Unit is included on or with the card.</p> <p>The card and tags instruct providers to verify member eligibility by calling the Eligibility Verification System (ELVS) or via the verification website. Instructions on how to gain access to the website are included for the provider.</p> <p>At the time of service, providers must:</p> <ul style="list-style-type: none"><li>◆ Confirm eligibility,</li><li>◆ Identify any service restrictions (such as lock-in, HMO, MediPASS, or Iowa Plan), and</li><li>◆ Determine whether a member has other health insurance coverage.</li></ul>

### Replacing Medical Assistance Eligibility Cards

1. To replace an annual medical card, access the Online Card Replacement Application (OCRA) through the DHS field Intranet.
2. Click on the following headings:
  - ◆ IM
  - ◆ OCRA
3. Enter the member's state identification number, or the member's last name, and birth date. Click "Search."
4. Click on the state identification number.
5. Make sure all information is correct on PRSM. If not, contact Quality Assurance at 1-800-373-6306 or (515) 281-6401 to update PRSM.
6. Once information is correct, click on the "Send a Card" box for the person who needs a replacement. Then click on "continue" at the bottom of the screen.
7. At the next screen, choose a reason the medical card is being replaced. Make notes as appropriate. Click on "Submit Request."

Medical cards will be issued within 7 to 14 days.

In the meantime, providers may verify Medicaid eligibility using ELVS or the secure web portal.

**Medical Assistance Income Trust, Form 470-4488**

Purpose	Form 470-4488 is used to notify both a medical assistance income trust (MAIT) beneficiary who has applied for Medicaid facility or waiver service and the trustee that the application has been approved. The letter explains how the trust affects Medicaid eligibility and benefits and how the income of the trust should be distributed.
Source	Complete form 470-4488 on line using the template on the DHS Intranet eForms web page.
Completion	The income maintenance worker prepares the form when the Department approves a medical facility or waiver application involving MAIT income.
Distribution	Mail a copy to the Medicaid applicant or member (or the responsible person) and to the trustee. Keep a copy in the case record.
Data	Complete the preface page with the following information: <ul style="list-style-type: none"><li>◆ Case number</li><li>◆ Facility type</li><li>◆ Expenses the trustee may pay</li><li>◆ Any remaining trust income to be paid as client participation and the name of the provider this client participation would be paid to</li><li>◆ The name of anyone you would like to get a copy of this letter</li></ul>

**Medically Needy Recoupment Memo, Form 470-3739**

Purpose	The IME Medically Needy Unit uses form 470-3739 to notify the income maintenance worker that a recoupment needs to be completed because the client did not incur the expenses used to meet spenddown.
Source	The IME Medically Needy Unit supplies this form.
Completion	The IME Medically Needy Unit completes this form.
Distribution	The original is sent to the client's income maintenance worker.
Data	The Medically Needy Unit indicates the following information: <ul style="list-style-type: none"><li>◆ Client name</li><li>◆ Case number</li><li>◆ Reason for the recoupment</li><li>◆ Certification period</li><li>◆ Amount applied to spenddown or paid in error</li></ul>

**Medically Needy Transmittal, Form 470-3630**

Purpose	The purpose of the <i>Medically Needy Transmittal</i> is to allow the IM worker to submit old bills or non-Medicaid-payable charges to the IME Medically Needy Unit to apply toward spenddown.
Source	Complete form 470-3630 on line using the template available on the DHS Intranet eForms web page.
Completion	<p>The income maintenance worker completes the form and attaches it to a copy of the nontraditional or non-Medicaid-covered claim submitted for the person who is conditionally eligible or responsible relative, under the Medically Needy program. Some examples of non-Medicaid-payable expenses are:</p> <ul style="list-style-type: none"><li>◆ RCF personal care.</li><li>◆ Bills for services received before the start of a certification period.</li><li>◆ Non-Medicaid payable NF, SNF, ICF/ID, or MHI charges.</li><li>◆ Expenses from a provider not enrolled in Medicaid.</li><li>◆ Payment for rehabilitative services.</li><li>◆ Transportation expenses.</li><li>◆ Acupuncture.</li></ul>
Distribution	<p>Fax the form to the Medically Needy Unit at (515) 725-1350 or email the form to <a href="mailto:IMEMedicallyNeedy@dhs.state.ia.us">IMEMedicallyNeedy@dhs.state.ia.us</a>. Attach the medical claim or bill. EXCEPTION: No bill or claim needs to be attached for RCF personal care services, medical facility (SNF or ICF/ID) care, or transportation.</p> <p>Keep the second copy in the case record with a copy of the accompanying claim or bill.</p>
Data	<p><b>Case name:</b> Enter the complete case name, including last and first name, before sending to the Medically Needy Unit.</p> <p><b>Case number:</b> Enter the medically needy case number including the FBU.</p>

**Recipient ID:** This is the state identification number of the patient.

**Beginning Certification Date:** This is the first or beginning month of the certification period. Enter it in MM/YY order.

**Ending Certification Date:** This is the last or ending month of the certification period. Enter it in MM/YY order.

**Payment Date of the Claim:** When you know that a payment has been made on the claim or bill enter the date the payment was made in this box.

**Payment Amount:** When you know the amount of payment on a claim or bill was made enter the amount of payment made in this box.

**Payment Source:** Enter the source of the payment in:

- P Payment by patient
- I Insurance
- S State public programs other than Medicaid

Use the comments section of the form if further explanation is warranted.

**IM Worker County Number:** Use the numeric designation for your county, i.e.: Polk county is 77, Black Hawk 07.

**IM Worker Number:** Enter your complete worker number, using all four digits.

**IM Worker Name:** Use the first and last name of the worker having the case.

**IM Worker Phone Number:** Use complete phone number, including area code.

**Date Claim Received:** This is the date the claim was received in the local office.

**Date Claim Sent to Medically Needy Unit:** This date should be no later than five days from receipt in the local office.

**Comments:** Use this section:

- ◆ To clarify any issues regarding the claim or bill submitted, when you feel that further explanation will expedite the processing of the claim.
- ◆ To show computation of transportation charges or information regarding loans to pay medical charges.

Use the following instructions when submitting claims for RCF personal care, transportation, or medical facility (NF, SNF, ICF/ID) expenses to apply to spenddown.

RCF Personal Care, Transportation, or Medical Facility: Mark the applicable box.

**From Date:** For RCF personal care or medical facility services, this is the first day services were provided. For transportation charges, enter the first day transportation was used. Use MM/DD/YY format.

**To Date:** For RCF personal care or medical facility services, this is the last day services were provided. For transportation charges, enter the last day transportation was used. Use MM/DD/YY format.

**Procedure Code:** Enter the applicable code:

<b>Code</b>	<b>Service</b>
W1501	Transportation
W1500	RCF personal care services
W1504	SNF charges
W1506	NF or ICF/ID charges

**Charged Amount:** For RCF personal care services, medical facility, and transportation, put in the amount allowed according to policy.

**Provider Name:** For RCF personal care or medical facility services, this is the name of the facility where the client resides. For transportation, this is the name of the person providing the transportation. When that is the client, enter the client's name.

**Provider Address:** For RCF personal care or medical facility services, this is the street address of the facility where the client resides. For transportation, this is the address of the person providing the transportation. When that is the client, use the client's address.

**City:** This is the city where:

- ◆ The RCF or medical facility where the client resides is located, or
- ◆ The person providing the transportation lives.

**State:** This is the state where:

- ◆ The RCF or medical facility where the client resides is located, or
- ◆ The person providing the transportation lives.

**ZIP:** This is the ZIP code of:

- ◆ The RCF or medical facility where the client resides, or
- ◆ The person providing transportation.

**Phone Number:** This is the phone number, including the area code, for:

- ◆ The RCF or medical facility where the client resides, or
- ◆ The person providing the transportation.

**National Provider Identifier or Provider Number:** For RCF personal care or medical facility services, this is the provider number of the facility where the client resides.

For transportation charges, if the person providing the transportation does not have a provider number, write "NOT ENROLLED" in this field. The IME will then assign a provider number.

**Medicare Savings Programs Additional Information Request, Form 470-4846 or 470-4846(S)**

Purpose	Medicare beneficiaries who apply for Extra Help with Medicare Prescription Drug Costs may at the same time indicate that they want to apply for the Medicare Savings Programs (MSP). The Social Security Administration (SSA) will send the data from the application electronically to the Department.
Source	<p>The form will automatically be populated with the data from the <i>Application for Extra Help with Medicare Prescription Drug Plan Costs</i>. The system will generate the form and mail it to the applicant.</p> <p>Print supplies of the Spanish version from the sample in the manual.</p>
Completion	The applicant will review the printed data and make corrections as needed. The applicant will complete the additional questions needed to determine eligibility for the Medicare Savings Programs.
Distribution	SSA will provide only the mailing address. Applicants will return the form to a local office based on their mailing address. If the living address is in another county, the office receiving the form shall route the original form to the DHS office responsible for the applicant's county of residence within two days of receipt.
Data	<p>Date-stamp the original form before faxing or mailing it to the DHS office responsible for processing the application.</p> <p>The following information will be printed on form 470-4846, <i>Medicare Savings Programs Additional Information Request</i>:</p> <ul style="list-style-type: none"><li>◆ Applicant's name</li><li>◆ Birth date</li><li>◆ Spouse's name</li><li>◆ Telephone number</li><li>◆ Mailing address</li><li>◆ Case number and worker number</li></ul>

- ◆ County number that matches the mailing address
- ◆ DHS phone number
- ◆ MSP application date
- ◆ Date DHS received application
- ◆ Income information provided to SSA on applicant and spouse (gross earned income, net self-employment, Social Security, Veteran's Benefits, Railroad Retirement benefits, other pensions or annuities and other income)
- ◆ Resource information provided to SSA on applicant (bank account, stocks, bonds, other investments, cash, value of real estate other than the applicant's home)

**MEPD Billing Statement, Form 470-3902**

Purpose	The <i>MEPD Billing Statement</i> is sent to members in the Medicaid for Employed People with Disabilities (MEPD) coverage group when a premium is assessed.
Source	The statement is computer-generated from the MEPD billing system.
Completion	<p>The billing statement is issued directly from Central Office. When a member reports non-receipt of a billing statement, send a reprint of the billing statement by making entries on the MEPD STMT screen in the REPRINT CLIENT field.</p> <p>A postage-paid window envelope is included for members to remit premium payments.</p>
Distribution	One copy of the billing statement is mailed to the member. If a copy of a billing statement is needed for an appeal, make entries on the MEPD STMT screen in the REPRINT (WRKR) field.
Data	<p>The billing statement:</p> <ul style="list-style-type: none"><li>◆ Contains the billing date, the case name, and the member's state identification number.</li><li>◆ Identifies the amount owed per month, the payment due date, payments received, and date payments were applied.</li><li>◆ Notifies the MEPD member that the payment of premiums must be made before medical assistance is given.</li><li>◆ Instructs members to remit the coupon on the bottom portion of the statement in the enclosed envelope with their payment.</li></ul>

**MEPD Income Worksheet, Form 470-3686**

Purpose	Form 470-3686 is used to calculate income eligibility and the premium amount for the SSI-related coverage group "Medicaid for Employed People with Disabilities" (MEPD). It provides the client with information on the computation and assists the IM worker in making an accurate computation.
Source	Complete the form on line using the template on the DHS Intranet eForms web page.
Completion	The IM worker completes the form when calculating income eligibility for the retroactive or current premium period or as otherwise needed. When there are more than six family members, add the income of all other members and enter it in the last income column.
Distribution	Mail the form to the client. Attach a copy to the case record. Attach income verification to the form when required.
Data	<p>Fields requiring entries are:</p> <ol style="list-style-type: none"><li>1. <b>Case name:</b> Enter the name of the disabled person who is the eligible person on the case. This person is always "Person A." A message box will ask, "Is the MEPD person the only one with income?" "Yes" allows entries only for Person A. "No" allows entries for multiple people.</li><li>2. <b>Case number:</b> Enter the MEPD case number with FBU.</li><li>3. <b>Premium period:</b> Enter the 12-month premium period. The "From" entry is the first month of the period (the month and year in the TD05 LAST REVIEW field). The "Next" entry is the 12th month of the period (the month and year in the TD05 NEXT REVIEW field).  If the calculation is for individual months, such as months in the retroactive period that are determined on a month-by-month basis, enter month and year.</li><li>4. <b>Unearned income:</b><ul style="list-style-type: none"><li>◆ Enter the average monthly unearned income for the MEPD person from each source in column 4-A.</li></ul></li></ol>

- ◆ Enter in columns 4-B through 4-F the average monthly unearned income from each source for the persons included in the family size. Enter the full amount of child support received for children under the age of 18.
- 8. **Earned income:** First check the frequency the income is received. Checking "monthly" will total all the amounts entered. Checking "weekly," "twice a month," or "every 2 weeks" will average the amounts entered. All income from the MEPD person must be entered under Person A.
- 13. Enter impairment-related work expense. (If an entry is made in line 13, no entry is allowed in line 17.)
- 17. Enter work expenses for the blind. (If an entry is made in 17, no entry is allowed in 13.)
- 20. Enter the amount that is excluded under a plan for achieving self-support (PASS).

**Family size:** Enter the number of people considered in the family size.

**Calculations:** The template performs the calculations after you have made all required entries and double-click the red "calculate" button at the end of the form. The calculate button explains how to select the period for the calculation: "Calculate the MEPD income eligibility and premium amount when the 'TD05 Last Review Month' of the eligibility period is:"

The template:

- ◆ Subtotals unearned income in columns 4-A through 4-F.
- ◆ Deducts the \$20 general deduction from unearned income.
- ◆ Deducts one-third of support payments for minor children.
- ◆ Enters subtotal of unearned income.
- ◆ Deducts any amount remaining from the \$20 general deduction allowed in line 6, applying it to the earned income of "Person A" first.
- ◆ Subtotals the earned income of each family member.

- ◆ Subtracts one \$65 earning deduction from "Person A" first, then applies any remaining deduction to earned income in items 11-B through 11-F.
- ◆ Subtotals the earned income of each family member.
- ◆ Deducts impairment-related work expenses (IRWEs) for Person A.
- ◆ Applies the 1/2 earned income exclusion to each person's earned income. (Lines 14 and 15).
- ◆ Deducts work expenses for the blind for Person A. (Line 16 minus line 17.)
- ◆ Enters countable income. Adds lines 7 and 18A through 18F.
- ◆ Totals countable family income and inserts countable income for the family size. (Line 19 minus line 20.)
- ◆ Displays:
  - The total countable family income,
  - The 250% federal poverty level amount for the family size,
  - The calculated income eligibility poverty level, and
  - The calculated premium eligibility level.
- ◆ Compares the countable income to 250% of poverty for the family size and indicates if the poverty level test has been met by displaying an "X" in the applicable box.
- ◆ Calculates the monthly premium amount for "Person A."

When countable income for the family size is less than 250% of the federal poverty level, the disabled person is eligible and a premium is calculated for the person based on the person's gross income (item 4-A plus item 8-A).

When countable income is 250% of the federal poverty level or above, the disabled person is not eligible. No premium is calculated; the premium period is deleted from item 3 (page 1).

If you discover an entry error, correct the entry and double-click on the red calculating button. The system will recalculate based on your new entry.

**MEPD Information About Premium Payments, Form 470-3928**

Purpose	Form 470-3928, <i>MEPD Information About Premium Payments</i> , is a notice to advise MEPD members who need to pay a premium before they are eligible for Medicaid about the due date for premiums and to advise them they may want to pay the premium sooner than the due date.
Source	The form is system generated by the MEPD billing system.
Completion	The form is informational only.
Distribution	The form is sent to: <ul style="list-style-type: none"><li>◆ Members newly approved for MEPD who have a premium to pay.</li><li>◆ Current members who go from having zero premiums to having to pay a premium.</li></ul>
Data	The form advises the members about: <ul style="list-style-type: none"><li>◆ The due date for ongoing premiums.</li><li>◆ The fact that premiums must be paid before Medicaid will pay for medical expenses.</li><li>◆ The benefit of paying in advance of the due date.</li><li>◆ The address where premium payments are to be sent.</li></ul>

**[MEPD Intent to Return to Work, Form 470-4856](#)**

Purpose	Form 470-4856, <i>MEPD Intent to Return to Work</i> , is used only to collect information for the Medicaid for employed people with disabilities (MEPD) coverage group.
Source	Initiate the form on line using the template on the DHS Internet eForms web page.
Completion	<p>After a MEPD member reports a loss of employment, the income maintenance (IM) worker issues the form to obtain:</p> <ul style="list-style-type: none"><li>◆ The member's written statement of intent to return to work.</li><li>◆ The last day the member worked.</li><li>◆ Proof of final pay amount from employment.</li></ul> <p>The member completes and signs the form.</p>
Distribution	<p>Give one copy to the member.</p> <p>You may upload the request to the electronic case file. When the member returns the original, it will be scanned and uploaded.</p>
Data	<p>Entering the case number for the MEPD case will populate the name, address, and salutation of the MEPD member.</p> <p>The worker profile will populate the worker address and contact information.</p>

**MEPD Refund Notice, Form 470-3743**

Purpose	Form 470-3743, <i>MEPD Refund Notice</i> , explains why the member is receiving a refund. The form is used to issue a refund of excess premium payments for the Medicaid for employed people with disabilities coverage group.
Source	Form 470-3743 is issued by the Bureau of Purchasing, Payments, Receipts and Payroll in the Division of Data Management.
Completion	Staff in the Bureau of Purchasing, Payments, Receipts and Payroll who post premium payments for MEPD complete the form.
Distribution	Purchasing, Payments, Receipts and Payroll staff mail the original to the MEPD member and keep a copy.
Data	<p><b>Case number:</b> Case number for the MEPD case.</p> <p><b>State ID number:</b> State identification number of the member on the MEPD case.</p> <p><b>Dear:</b> Member's name.</p> <p>Purchasing, Payments, Receipts and Payroll staff complete the amount of the refund and check the applicable box for reason for refund.</p>

**[New Household Member, Form 470-3780](#)**

Purpose	Form 470-3780, <i>New Household Member</i> , is used to collect information for the Family Investment Program, Food Assistance program, and Medicaid program when the household reports a new household member.
Source	Complete the form on line using the template available on the DHS Intranet eForms web page.
Completion	Issue the form when a household reports a new household member.
Distribution	Print two copies of the form. Give one copy to the client and file one copy in the case record. The client completes the form and returns it to the requesting office.
Data	<p>The template populates address and worker information areas of the form and calculates a due date for the return of the requested information.</p> <p>The client completes identifying information and income and resource information about the new household member.</p>

**Newborn, Form 470-3781 or 470-3781(S)**

Purpose	Form 470-3781, <i>Newborn</i> , is used to collect information for Medicaid, Food Assistance, and the Family Investment Program when the household reports a newborn child in the home.
Source	Both English and Spanish versions of this form may be completed on line using the templates available on the DHS Intranet eForms web page.
Completion	Issue this form for the household to complete when a household reports that a newborn has entered the household.
Distribution	Print two copies of the form. Give one copy to the client and file one copy in the case record. The client completes the form and returns it to the requesting DHS office.
Data	<p>The templates will populate the address and worker information areas of the form and calculate a due date for the return of the requested information. The worker must indicate what additional information is requested.</p> <p>The client completes demographic information about the baby and indicates whether the baby is covered by health insurance.</p>

**Noncompliance with Third Party Liability (TPL), Form 470-5287**

Purpose	<p>The Iowa Medicaid Enterprise (IME) and the Managed Care Organizations (MCOs) use the <i>Noncompliance with Third Party Liability (TPL)</i> to:</p> <ul style="list-style-type: none"><li>◆ Alert the local office when a member has not cooperated and</li><li>◆ To instruct the local office to sanction a specific member.</li></ul>
Source	<p>The IM worker views the form from the link that displays within the alert message in WISE.</p>
Completion	<p>IME or one of the MCOs sends a record to the repository (IEVS), which generates a noncompliance alert record to the field.</p> <p>IME or one of the MCOs sends a record to the repository (IEVS), which generates an alert when the member fails to return TPL information.</p>
Distribution	<p>The repository (IEVS) sends the compliance alert to WISE. Only after the alert is worked by the IM worker is the alert indexed to the Electronic Case File (ECF).</p>
Data	<p>The repository (IEVS) populates the following:</p> <ul style="list-style-type: none"><li>◆ <b>Notice Date:</b> The date the alert is created.</li><li>◆ <b>Member Name:</b> The member's name.</li><li>◆ <b>Case Number:</b> The member's case number.</li><li>◆ <b>CIN or SID Number:</b> The member's Medicaid identification number.</li><li>◆ <b>Sanctioning Agency:</b> This will be the IME or one of the MCOs.</li><li>◆ <b>Agency Contact:</b> This will be the phone number of the IME or one of the MCOs.</li><li>◆ <b>Accident/Injury Number:</b> The member's assigned accident or injury number provided by the IME or one of the MCOs.</li></ul>

**Noncooperation Notice, Form 470-0479**

Purpose	The Bureau of Quality Control uses the <i>Noncooperation Notice</i> to notify the local office when a client has refused to cooperate and to instruct the local office on the action to take on a client's case.
Source	An electronic template for form 470-0479 is available on the QC share. Reviewers need to copy the form to their computer.
Completion	The Quality Control reviewer completes this form whenever Quality Control determines that a client has refused to cooperate.
Distribution	The Quality Control reviewer sends the original to the local office and files a copy as a permanent record with the completed review.
Data	<p>The Quality Control reviewer completes the following:</p> <ul style="list-style-type: none"><li>◆ <b>Date:</b> The date the form is prepared.</li><li>◆ <b>County:</b> The local office where the client currently receives benefits, last received benefits, or had an application rejected.</li><li>◆ <b>QC Reviewer:</b> The Quality Control reviewer's name.</li><li>◆ <b>Case Worker:</b> The IM worker who is currently handling the case record or last handled the case record.</li><li>◆ <b>Phone:</b> The Quality Control reviewer's telephone number.</li><li>◆ <b>Case Name:</b> The client's name.</li><li>◆ <b>Case No:</b> The client's case number.</li><li>◆ <b>Persons Not Cooperating:</b> The name of the person who was required to cooperate with Quality Control but failed to. List the client's name here if it is not the same person as the case name. All non-cooperating household members should be listed on this form.</li><li>◆ <b>QC Review No:</b> The client's Quality Control review number.</li><li>◆ <b>Reference:</b> The manual reference for failure to cooperate.</li></ul>

- ◆ **First Check Box:** An indication whether the non-cooperating client is in active status and the name of the program to be canceled.
- ◆ **Second Check Box:** Instruction for cases on which the client is not currently receiving assistance.
- ◆ **Third and Fourth Check Boxes:** If active, the name of the assistance program for which Quality Control determined the client refused to cooperate and the length of the sanction period.

**[Non-Law Enforcement Record Check Request Form A, 595-1489 or 595-1489\(S\)](#)**

**Purpose** *Non-Law Enforcement Record Check Request, Form A* is used to request a check for criminal convictions on a nonregistered child care provider and people who live in the provider's home or have access to a child when the child is alone.

**Source** The English version may be completed on line using the template on the DHS Intranet eForms web page. Pads of 50 two-part sets were printed by Iowa Prison Industries in Anamosa.

Supplies of the Spanish version of this form can be printed or photocopied from the sample in the manual.

**Completion** When the client's selected provider is a nonregistered child care home, the Centralized Child Care Provider Registration Unit issues this form for:

- ◆ The child care provider,
- ◆ Each person aged 14 or over residing in the provider's home,
- ◆ Anyone who works in the home, and for
- ◆ Anyone who has access to a child when the child is alone.

Complete the forms:

- ◆ At the time of initial application for payment.
- ◆ Whenever a new person moves into the home.
- ◆ Any time there is an indication that a person has a criminal record.
- ◆ At 24-month intervals following the initial check.

Obtain the signature of the person being checked under "waiver," so a complete record check may be performed.

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.

**Notarized Statement for Child Support Recovery Office, Form 470-2220**

Purpose	This notarized statement allows the Child Support Recovery Unit to use the <i>Financial Support Application</i> to establish paternity and secure support, should the natural father leave the home.
Source	Print form 470-2220 from the sample in the manual when needed.
Completion	When requested by the Child Support Recovery Unit, the income maintenance worker completes this form and signs it in the presence of a notary public.
Distribution	Send the completed form to the child support recovery office with a photocopy of <i>Financial Support Application</i> , form 470-0462 or form 470-0462(S). It is not necessary to retain a copy.
Data	Make the following entries: <ul style="list-style-type: none"><li>◆ The name or worker number of the child support recovery officer.</li><li>◆ The name of the income maintenance worker's office.</li><li>◆ The income maintenance worker's telephone number.</li><li>◆ The name and signature of the income maintenance worker.</li><li>◆ Certification by the notary public.</li></ul>

**Notice of Action, Form 470-0485(M) or 470-0485(MS)**

Purpose	The <i>Notice of Action</i> is issued by the ELIAS system to notify clients of agency actions that affect the client's eligibility or benefit level. Each client has the right to be given information regarding eligibility and benefit determination.
Source	<p>In most situations, the ELIAS system generates form 470-0485 based on worker entries or system processes. The Spanish version of the form is manually issued by the worker.</p> <p>Workers can complete the manual version, form 470-0485(M) or its Spanish translation <i>Notificación de Acción</i>, form 470-0486(MS), on line using the templates on the DHS Intranet eForms web page.</p>
Completion	<p>The <i>Notice of Action</i> may be used for:</p> <ul style="list-style-type: none"><li>◆ FIP, RCA, and Food Assistance actions</li><li>◆ FMAP-related Medicaid and RMA actions</li><li>◆ Medically Needy denials</li><li>◆ SSI-related Medicaid, State Supplementary Assistance, and HIPP actions, when appropriate</li></ul> <p>ELIAS system entries generate form 470-0485.</p>
Distribution	<p>ELIAS-generated notices are mailed to the client. A copy is filed in the electronic case file.</p> <p>For manually generated notices, send the original to the client. File the copy in the electronic case file.</p> <p>If there is a guardian, conservator or authorized representative, provide that person with a photocopy of the notice.</p>
Data	<p>The IM worker completes the fields for a manually prepared <i>Notice of Action</i> on eForms.</p> <p>Entering the case number on page 1 will populate the case number on pages 2 and 3.</p> <p>NOTE: When using the template, IM workers should copy the language of the system notice reasons from the file labeled "Master Library for NOA" found in Field Income Staff Resources, under ELIAS Resource links.</p>

**Notice of Attribution of Resources, Form 470-2588**

Purpose	Form 470-2588 is used to notify both spouses of what resources are protected for the community spouse.
Source	Complete form 470-2588 on line using the template on the DHS Intranet eForms web page.
Completion	The income maintenance worker prepares the form when the Department makes a decision on the attribution of resources.
Distribution	Mail a copy to each spouse and file a copy in the case record.
Data	<p>Enter the date and the income maintenance worker's name, county, and phone number.</p> <p>Enter the names and social security numbers of the spouse in the facility and the spouse at home.</p> <p>List all countable resources of both spouses and indicate the excluded resources. If there are jointly owned countable resources, list these under the column of each spouse by dividing the value in half.</p> <p>The template will calculate a total of the combined countable resources as they are entered and will automatically determine the amount of protected resources for the community spouse as directed in <a href="#">8-D, Calculating the Amount to Attribute to the Community Spouse</a>. The correct check box will automatically be marked based upon the calculation of the protected amount for the community spouse.</p> <p>The remainder of the resources will be assigned to the spouse in the medical institution.</p> <p>The template will automatically enter the minimum monthly maintenance needs allowance (MMMNA) that is in effect at the time of determination of attribution in the paragraph beginning "If you disagree." The worker has the ability to change this amount when needed.</p>

**Notice of Cancellation/Redetermination, Form 470-3152 or 470-3152(S)**

Purpose	The <i>Notice of Cancellation/Redetermination</i> combines the functions of the <i>Notice of Decision</i> and a request for additional information, to save time in automatic redetermination cases.
Source	Workers can complete the English version of this form on line using the template on the DHS Intranet eForms web page.  Print supplies of the Spanish version from the sample in the manual.
Completion	Complete the notice when you determine that a client is ineligible under the current coverage group, but you need additional information to determine eligibility under another coverage group.
Distribution	Send the original to the client. File the copy in the case record. Also provide a copy of the notice to the client's guardian or conservator, if there is one.
Data	The form is self-explanatory. Enter the following information: <ul style="list-style-type: none"><li>◆ County number, worker name, telephone number, and email address.</li><li>◆ Case name, number, and current mailing address.</li><li>◆ The date the notice is mailed.</li><li>◆ Date of cancellation and the reason the action is being taken.</li><li>◆ Manual and rule reference to support the reason for cancellation. The manual reference shall consist of the manual title, chapter number, and subheading (i.e., 8-C, Cooperation With Support Recovery). Use the legal references found under the subheading.</li><li>◆ Verification requested.</li><li>◆ Date requested verification is due in the requesting DHS office.</li><li>◆ The requesting office's return address. (This may be stamped on the form.)</li></ul>

**Notice of Child Care Assistance Overpayment, Form 470-4530**

Purpose	Form 470-4530 informs the debtor on a Child Care Assistance claim of the amount and reason for the overpayment and requests repayment.
Source	Form 470-4530 is generated monthly by the Overpayment Recovery System.
Completion	<p>The form is printed for debtors who:</p> <ul style="list-style-type: none"><li>◆ Have a Child Care Assistance claim entered on the Overpayment Recovery System, and</li><li>◆ Have not submitted an agreement to repay the debt.</li></ul> <p>This form is partly completed by the Overpayment Recovery System. The debtor is responsible for completing the agreement to repay.</p> <p>At least one form must be sent before a debt setoff takes place. State income tax refunds, rebates, or other state payments, including state employee wages may be offset to pay the debt.</p>
Distribution	One copy is mailed from Central Office.
Data	<p>The system completes:</p> <ul style="list-style-type: none"><li>◆ The amount of overpayment, and</li><li>◆ The type of error, and</li><li>◆ The reason for the overpayment.</li></ul> <p>The debtor completes the repayment terms.</p>

**[Notice of Child Care Assistance Provider Sanction, Form 470-4053](#)**

Purpose	The <i>Notice of Child Care Assistance Provider Sanction</i> is used to notify families that their child care provider has been sanctioned by the Child Care Assistance (CCA) program and that they may need to select another provider if they want CCA to continue paying for their child care services.
Source	This form is not available in printed form. CCA workers shall complete this form on line using the template on the DHS Intranet eForms web page. PROMISE JOBS workers shall complete this form on line using the template provided by DHS.
Completion	When a sanction is imposed, the DHS child care worker or PROMISE JOBS worker shall complete a <i>Notice of Child Care Assistance Provider Sanction</i> for every CCA family using the sanctioned provider.
Distribution	Mail one copy to the family and keep a copy in the family's DHS or PROMISE JOBS case file. Provide a copy of this letter to PROMISE JOBS if necessary.
Data	<p>The template automatically enters the notice date. Use the "tab" key to navigate between fields requiring data entry. Enter the following information:</p> <ul style="list-style-type: none"><li>◆ The family's name and mailing address</li><li>◆ The parent or guardian's first name</li><li>◆ The child care provider's name</li></ul> <p>Click or tab to the text box and:</p> <ul style="list-style-type: none"><li>◆ Choose "Yes" if the letter is going to a CCA family or "No" if the letter is going to a family who does not get CCA.</li><li>◆ Select the applicable sanction type.</li><li>◆ Click the "insert language" button.</li><li>◆ Enter the sanction effective date.</li></ul>

If the letter is going to a CCA family, enter:

- ◆ The child care worker's name
- ◆ The county name
- ◆ The worker's phone number

If the letter is **not** going to a CCA family, enter:

- ◆ The county name
- ◆ The DHS office phone number

Once all fields have been entered, print a copy of the letter for the family and another copy for the CCA case file, if any.

**[Notice of Decision, Form 470-0485, 470-0485\(S\), 470-0486, or 470-0486\(S\)](#)**

**Purpose** The *Notice of Decision* is used to notify clients of agency actions that affect the client's eligibility or benefit level. Each client has the right to be given information regarding eligibility and benefit determination.

**Source** In most situations, the ABC system generates form 470-0485 and 470-0485(S), based on worker entries or system processes.

Workers can complete the manual version, form 470-0486 or its Spanish translation *Aviso de Decisión*, form 470-0486(S), on line using the templates on the DHS Intranet eForms web page.

**Completion** The *Notice of Decision* is used for:

- ◆ FIP, RCA, and Food Assistance actions
- ◆ FMAP-related Medicaid and RMA actions
- ◆ Medically Needy denials
- ◆ SSI-related Medicaid, State Supplementary Assistance, and HIPP actions, when appropriate

System entries that produce the following actions will generate form 470-0485 (or form 470-0485(S) if the LI field on TD01 is coded "S"):

- ◆ An application is pended (for Food Assistance only).
- ◆ An application is approved (except for Medically Needy, SSI-related Medicaid, and State Supplementary Assistance cases).
- ◆ An application is denied or withdrawn (except for SSI-related Medicaid and State Supplementary Assistance cases).
- ◆ The benefit amount is calculated.
- ◆ Benefits are changed after a review or redetermination.
- ◆ Benefits are reinstated or a reinstatement request is denied.
- ◆ Benefits and eligibility are canceled for reasons other than failing to return a completed report form.
- ◆ Medical benefits change, including an extension after cancellation due to increased earnings of the payment of child support.

- ◆ A person is added to an ongoing case.
- ◆ A person is removed from an ongoing case.
- ◆ A person is added to a case for a preceding month and the income for that month is different from income for the current month.
- ◆ A payment adjustment or corrective payment is authorized (for FIP and RCA only).
- ◆ An allowance for a special need is authorized, denied, or canceled (for FIP and RCA only).
- ◆ Action is necessary by the household to receive or continue benefits (for Food Assistance only).

You may suppress the system-generated form and manually prepare form 470-0486 or 470-0486(S) when issues of timing, or overlapping case actions make the system-generated notice inappropriate. (See ABC system instructions in Title 14.)

NOTE: When issuing a manual notice for SSI-related Medicaid or State Supplementary Assistance actions, use form 470-0490, *Notice of Decision: Medical Assistance or State Supplementary Assistance*. When issuing a manual notice for Medically Needy actions, use form 470-2330, *Notice of Decision for Medically Needy*.

Distribution

System-generated notices are mailed to the client. A copy is filed in the electronic case file.

For manually generated notices, send the original to the client. File the copy in the case record.

If there is a guardian, conservator, or representative, provide that person with a photocopy of the notice.

Data

For a manually prepared *Notice of Decision*:

- ◆ Entering the case number will populate the case name and current mailing address.
- ◆ The worker profile will populate the worker's number, county number, name, phone number, and email address.

- ◆ The notice date will automatically populate.
- ◆ Select one of the following radio buttons on the Preface tab:
  - Blank
  - Multiple Programs
  - Emergency 3-Day Medical
  - Medicaid Approval > 12 months Prior

If **Blank** is selected, enter the explanation of the action being taken. This shall include:

- ◆ The action being taken (e.g., approval, denial, etc.).
- ◆ The reason for the action.
- ◆ The effect of the action on the household's eligibility and benefits.
- ◆ The effective date of the action.
- ◆ The legal references, including the Employees' Manual title, chapter number, and subheading; Iowa Administrative Code; and federal regulations.

NOTE: When using the template, you can copy the language of the system notice reasons from the file labeled "ABC Notice Codes" on the DHS Intranet eForms web page and insert it into the notice.

If **Multiple Programs** is selected, the explanation of the action and legal references populate based on the NOD reasons and programs selected on the "Multiple Programs" tab.

If **Emergency 3-Day Medical** or **Medicaid Approval > 12 months Prior** is selected, the explanation of the action and legal references will automatically populate.

For Medicaid Approval > 12 months Prior, select a radio button and enter the beginning and ending dates or the non-consecutive dates approved. Make sure to enter the state ID.

Food Assistance

Calculation: Complete this section when Food Assistance eligibility or benefits are affected by changes in income, deductions, or household size. Complete the "Gross Income Standard Test" only if applicable. Use information from the household's current form 470-0330, *Food Assistance Computation*, or Scratch Pad (SPAD) system screens.

**Notice of Decision: Child Care, Form 470-4558**

Purpose	The <i>Notice of Decision: Child Care</i> is used to notify clients of agency actions that affect the client's eligibility or benefit level. Each client has the right to be given information regarding eligibility and benefit determination.
Source	The KinderTrack system generates form 470-4558 based on worker entries.
Completion	The <i>Notice of Decision: Child Care</i> is used when: <ul style="list-style-type: none"><li>◆ An application is approved.</li><li>◆ An application is denied.</li><li>◆ A new or different provider is selected.</li><li>◆ Benefits are changed because of review or redetermination.</li><li>◆ Benefits are canceled.</li><li>◆ A provider is determined not eligible to provide child care.</li><li>◆ There is a change in family circumstances that results in a fee change (job or income, etc.).</li></ul>
Distribution	KinderTrack will mail a copy of the notice to the client and will also save a copy of the notice in the system.
Data	KinderTrack completes all information on the notice based on the worker entries into the system.

**Notice of Decision: Child Care Assistance, Form 470-3915 or 470-3915(S)**

Purpose	The <i>Notice of Decision: Child Care Assistance</i> is used to notify clients and providers of agency actions that affect the client's eligibility or benefit level. Each client or provider has the right to be given information regarding eligibility and benefit determination.
Source	This form is not available in printed form. Child Care Assistance workers complete this form on line using the English and Spanish templates on the DHS Intranet eForms web page. PROMISE JOBS workers complete form 470-3915 on-line using the template provided by DHS.
Completion	<p>The <i>Notice of Decision: Child Care Assistance</i> is used when:</p> <ul style="list-style-type: none"><li>◆ An application is approved.</li><li>◆ An application is denied.</li><li>◆ A new or different provider is selected.</li><li>◆ Benefits are changed because of a review or redetermination.</li><li>◆ Benefits are canceled.</li><li>◆ A provider is determined not eligible to provide child care.</li><li>◆ There is a change in family circumstances that results in a fee change (job or income change, etc.).</li></ul> <p>NOTE: If a family uses multiple providers, each provider must be issued a separate <i>Notice of Decision</i> when benefits are approved, changed, or canceled.</p>
Distribution	Send one copy to the client and file a copy in the case record. If there is a guardian, conservator, or representative, provide that person with a photocopy of the notice. Provide a copy to PROMISE JOBS if necessary. If a child care provider is affected by the <i>Notice of Decision</i> , mail a copy of the notice to the provider.

Data

The template automatically enters the notice date. Use the "tab" key to navigate between fields on the form. Enter dates as MM/DD/YY or Month/DD/YY. The template will reformat the date automatically to the Month/DD/YY format.

**Page 1** Enter the following identifying information:

- ◆ Worker county name and number.
- ◆ SRS case numbers (or ABC case number for PROMISE JOBS).
- ◆ Client name and current mailing address.
- ◆ A check in the boxes indicating the action taken (approval, denial, change, etc.).

Enter the explanation of the action being taken. This must include:

- ◆ What action you are taking (approval, denial, etc.).
- ◆ An explanation of the action. NOTE: The notice approving CCA needs both an effective date and an ending date. The end date can be more than six months from the effective date.
- ◆ The effect of the action on the client's eligibility and benefits.
- ◆ The effective date of the action.
- ◆ The legal references supporting the action, including the Employees' Manual title, chapter number, and subheading; Iowa Administrative Code; and federal regulations.

There are two "protected" fields within the "explanation of action" box. You will normally use only the first field. The second field is available if additional text is necessary to describe special situations or to provide information not present in the template language available.

The template provides "drop-down" boxes to fill in this section automatically. Tab to the first protected field in the "Explanation of Action" box to open the notice table box. Choose the applicable selection (approval, denial, cancellation, etc.).

Another drop-down box will open, allowing you to select the specific reason for the notice. (See the following section for the available choices.) The template will automatically enter the legal references for the selected notice reason.

If no reason fits the specific situation, choose the "other" category. This allows you to enter the appropriate language. NOTE: Make sure to complete the applicable legal reference, since the template will not fill in this section automatically when you choose "other."

You may change the information in a particular field at any time if you make an error. Exception: Once you make a choice in the "Explanation of Action" box, you must click the "Remove all inserted language" button to change the choices.

Selecting "will" or "will not" from the drop-down box to indicate the family is not responsible to pay fees. Enter the dollar amount of any fees. If there is no fee, enter \$0 as the amount.

Complete page 1 by entering:

- ◆ Your name.
- ◆ Your office address. Choose "DHS" or "PROMISE JOBS" from the drop-down box and complete the mailing address for the office.
- ◆ Your phone number.
- ◆ The name of the child care provider.

**Notice Language** The notice language choices for each action are listed below:

**Approval**

Used by:	Notice Language
DHS PJ	<p>You have been approved for Child Care Assistance for ____ effective ____, through _____. The units you have been authorized to use are shown on page 3.</p> <p>Se le ha aprobado Child Care Assistance (Asistencia de Cuidado Infantil) para ____ desde el ____, hasta el _____. Las unidades que se le han autorizado para usar se muestran en la página 3.</p>

Used by:	Notice Language
DHS PJ	<p>You have been approved for Child Care Assistance for ____ effective ____, through _____. The units you have been authorized to use are shown on page 3.</p> <p>You have also chosen a back-up provider who will provide child care services during the time that your regular provider is unable to provide care. The back-up provider is eligible to bill only for the actual time that children are in their care while the parent is going to school, working, or doing approved job search activities. The back-up provider is not eligible to bill for days of absence. The back-up provider must complete and submit an attendance record and invoice for each month in which child care services are provided. The attendance record will be compared with that of the regular provider to verify eligibility for payment.</p> <p>Se le ha aprobado Child Care Assistance (Asistencia de Cuidado Infantil) para ____ desde el ____, hasta el _____. Las unidades que se le han autorizado para usar se muestran en la página 3.</p> <p>Usted también ha elegido un proveedor de respaldo quien proveerá servicios de cuidado infantil durante el tiempo que su proveedor regular no pueda suministrar el cuidado. El proveedor de respaldo es elegible para facturar únicamente por el tiempo real en que los niños han estado a su cuidado mientras el padre asiste a la escuela, trabaja o realiza actividades de búsqueda de empleo. El proveedor de respaldo no es elegible para facturar días de ausencia. El proveedor de respaldo debe llenar y remitir un registro de asistencia y una factura para cada mes en que suministró servicios de cuidado infantil. El registro de atención se comparará con aquel del proveedor regular para verificar la elegibilidad del pago.</p>
DHS PJ	<p>You have been approved for Child Care Assistance for ____ effective ____, through _____. However, the provider you have chosen, _____, is not eligible to be paid with State funds. If you wish to receive Child Care Assistance, you must use a provider that is eligible for State payment. Contact your worker to choose another provider.</p> <p>Se le ha aprobado Child Care Assistance (Asistencia de Cuidado Infantil) para ____ desde el ____, hasta el _____. Sin embargo, el proveedor que ha elegido, _____, no es elegible para que se le pague con fondos del estado. Si desea recibir Child Care Assistance, debe usar un proveedor que sea elegible para pagos del estado. Contacte a su trabajador para elegir otro proveedor.</p>

Used by:	Notice Language
DHS PJ	<p>You have been approved for Child Care Assistance for ____ effective ____, through _____. However, the provider you have chosen, _____, has not yet been approved to be paid by State funds. If this provider is not approved, you will be responsible to pay for all child care bills from this provider. You may want to change to an approved provider. If you change your provider, you must notify your worker immediately so that the new provider can be approved for you.</p> <p>Se le ha aprobado Child Care Assistance (Asistencia de Cuidado Infantil) para ____ desde el ____, hasta el _____. Sin embargo, el proveedor que ha elegido, _____, no aún no ha sido aprobado para que se le pague con fondos del estado. Si este proveedor no es aprobado, usted deberá pagar todas las facturas de cuidado infantil de este proveedor. Usted deberá cambiar a un proveedor aprobado. Si cambia de proveedor, deberá notificar a su trabajador inmediatamente para que el nuevo proveedor le pueda ser aprobado.</p>
DHS PJ	Other (NOTE: You must type in the notice language.)

### Cancellation

Used by:	Notice Language
DHS PJ	<p>You have been canceled from the Child Care Assistance program effective ____, because your family does not meet the requirements of need for service from the program. In a household with two adults, <b>both</b> adults must meet the definition of need regarding hours of employment, hours of school or training, absence, or work search.</p> <p>Usted ha sido cancelado del programa de Child Care Assistance (Asistencia de Cuidado Infantil) a partir del ____, porque su familia no cumple con los requisitos de necesidad de servicio del programa. En un hogar con dos adultos, ambos adultos deben cumplir con la definición de necesidad en relación con las horas de empleo, horas de escuela o capacitación, ausencia o búsqueda de trabajo.</p>
DHS PJ	<p>You have been canceled from the Child Care Assistance program effective ____, because of your request.</p> <p>Se le ha cancelado del programa de Child Care Assistance (Asistencia de Cuidado Infantil) a partir del ____, por solicitud suya.</p>

Used by:	Notice Language
DHS PJ	<p>Your child, _____, is canceled from the Child Care Assistance program effective _____, because _____. Your other child(ren), _____, remain eligible through _____. The units you have been authorized to use are shown on page 3.</p> <p>Su hijo _____, ha sido cancelado del programa Child Care Assistance (Asistencia de Cuidado Infantil) a partir del _____, porque _____. Su(s) otro(s) hijo(s), _____, siguen siendo elegibles hasta _____. Las unidades que se le han autorizado para usar se muestran en la página 3.</p>
DHS PJ	<p>You have been canceled from the Child Care Assistance program effective _____, because your child(ren) do not meet age requirements.</p> <p>Se le ha cancelado del programa del Child Care Assistance (Asistencia de Cuidado Infantil) a partir del _____, porque sus hijos no cumplen con los requisitos de edad.</p>
DHS PJ	<p>You have been canceled from the Child Care Assistance program effective _____, because you are eligible for another funding source.</p> <p>Se le ha cancelado del programa del Child Care Assistance (Asistencia de Cuidado Infantil) a partir del _____, porque usted es elegible para otra fuente de financiación.</p>
DHS	<p>You have been canceled from the Child Care Assistance program effective _____, because your 30-day job search has expired.</p> <p>Se le ha cancelado del programa del Child Care Assistance (Asistencia de Cuidado Infantil) a partir del _____, porque búsqueda de trabajo de 30 días ha expirado.</p>
DHS	<p>You have been canceled from the Child Care Assistance program effective _____, because your medical incapacity period has expired.</p> <p>Se le ha cancelado del programa del Child Care Assistance (Asistencia de Cuidado Infantil) a partir del _____, porque período de incapacidad médica ha expirado.</p>
DHS	<p>You have been canceled from the Child Care Assistance program effective _____, because you have failed to pay the required fees to your child care provider.</p> <p>Se le ha cancelado del programa del Child Care Assistance (Asistencia de Cuidado Infantil) a partir del _____, porque usted no ha pagado las tarifas requeridas a su proveedor de atención infantil.</p>

Used by:	Notice Language
DHS PJ	<p>You have been canceled from the Child Care Assistance program effective ____, because you failed to provide requested information.</p> <p>Se le ha cancelado del programa del Child Care Assistance (Asistencia de Cuidado Infantil) a partir del ____, porque usted no suministró información requerida.</p>
DHS	<p>You have been canceled from the Child Care Assistance program effective ____, because funding is not available to provide the service.</p> <p>Se le ha cancelado del programa del Child Care Assistance (Asistencia de Cuidado Infantil) a partir del ____, porque no hay fondos disponibles para prestar el servicio.</p>
DHS	<p>You have been canceled from the Child Care Assistance program effective ____, because there are no funds available for child care assistance at this time. You have been placed on a waiting list for services.</p> <p>Se le ha cancelado del programa del (Asistencia de Cuidado Infantil) a partir del ____, porque no hay fondos disponibles para Child Care Assistance en el momento. Ha sido ubicado en una lista de espera.</p>
DHS PJ	<p>Your Child Care Assistance case is canceled effective ____, because your child does (children do) not meet citizen/alien requirements.</p> <p>Su caso de Child Care Assistance (Asistencia de cuidado infantil) se cancela a partir del ____, porque su hijo no cumple (sus hijos no cumplen) con los requisitos de ciudadano/ extranjero.</p>
DHS PJ	<p>Your child, ____, is canceled from the Child Care Assistance program effective ____, because your child does not meet citizen/alien requirements.</p> <p>Su hijo, ____, ha sido cancelado del programa de Child Care Assistance (Asistencia de cuidado infantil) a partir del ____, porque no cumple con los requisitos de ciudadano/extranjero.</p>
DHS	<p>You have been canceled from the Child Care Assistance program effective ____, because you are not employed at least 28 hours per week.</p> <p>Se le ha cancelado del programa del Child Care Assistance (Asistencia de Cuidado Infantil) a partir del ____, porque usted no está empleado por lo menos 28 horas a la semana.</p>

Used by:	Notice Language
DHS PJ	<p>You have been canceled from the Child Care Assistance program effective ____, because you are not enrolled in an approvable training program.</p> <p>Se le ha cancelado del programa del Child Care Assistance (Asistencia de Cuidado Infantil) a partir del ____, porque usted no está registrado en un programa de capacitación aprobado.</p>
DHS	<p>You have been canceled from the Child Care Assistance program effective ____, because you are not enrolled in training full time.</p> <p>Se le ha cancelado del programa del Child Care Assistance (Asistencia de Cuidado Infantil) a partir del ____, porque usted no está registrado en un programa de capacitación de tiempo completo.</p>
DHS	<p>You have been canceled from the Child Care Assistance program effective ____, because you do not meet at least one of the needs for service.</p> <p>Se le ha cancelado del programa del Child Care Assistance (Asistencia de Cuidado Infantil) a partir del ____, porque usted no cumple por lo menos con una de las necesidades del servicio.</p>
DHS	<p>You have been canceled from the Child Care Assistance program effective ____, because you do not meet the need for service because you are not absent due to hospitalization or outpatient treatment for physical or mental illness, or temporarily unable to care for your children as verified by a physician.</p> <p>Se le ha cancelado del programa del Child Care Assistance (Asistencia de Cuidado Infantil) a partir del ____, porque usted no cumple con la necesidad del servicio, porque usted no está ausente por hospitalización, ni tratamiento de paciente externo, ni enfermedad física y mental, ni es temporalmente incapaz de cuidar a sus hijos según lo verifica un médico.</p>
DHS PJ	<p>You have been canceled from the Child Care Assistance program effective ____, because you have exhausted your 24-month funding limit for postsecondary education.</p> <p>Se le ha cancelado del programa del Child Care Assistance (Asistencia de Cuidado Infantil) a partir del ____, porque usted ha terminado su límite de financiación de 24 meses para educación post-secundaria.</p>

Used by:	Notice Language
PJ	<p>You have been canceled from the Child Care Assistance program effective ____, because you are not participating in an approved PROMISE JOBS activity.</p> <p>Se le ha cancelado del programa del Child Care Assistance (Asistencia de Cuidado Infantil) a partir del ____, porque usted no está participando en una actividad de PROMISE JOBS aprobada.</p>
DHS	<p>You have been canceled from the Child Care Assistance program effective ____, because this is not a protective child care situation.</p> <p>Se le ha cancelado del programa del Child Care Assistance (Asistencia de Cuidado Infantil) a partir del ____, porque esta no es una situación de atención protectora de menores.</p>
DHS PJ	<p>You have been canceled from the Child Care Assistance program effective ____, because you are not seeking employment.</p> <p>Se le ha cancelado del programa del Child Care Assistance (Asistencia de Cuidado Infantil) a partir del ____, porque usted no está buscando empleo.</p>
DHS	<p>You have been canceled from the Child Care Assistance program effective ____, because you do not have eligible children living with you.</p> <p>Se le ha cancelado del programa del Child Care Assistance (Asistencia de Cuidado Infantil) a partir del ____, porque no hay menores elegibles viviendo con usted.</p>
DHS PJ	<p>Your Child Care Assistance is canceled effective ____, because you did not cooperate with the Investigation Section of the Department of Inspections and Appeals (DIA).</p> <p>Su Child Care Assistance (Asistencia de Cuidado Infantil) es cancelada con fecha de vigencia ____, porque usted no colaboró con la Sección de Investigaciones del Departamento de Inspecciones y Apelaciones (DIA).</p>
DHS	<p>You have been canceled from the Child Care Assistance program effective ____, because you are over the income guidelines.</p> <p>Se le ha cancelado del programa del Child Care Assistance (Asistencia de Cuidado Infantil) a partir del ____, porque usted sobrepasa las guías de ingresos.</p>

Used by:	Notice Language
DHS	<p>You have been canceled from the Child Care Assistance program effective ____, because the Department is unable to locate you and cannot establish that you are a resident of Iowa.</p> <p>Se le ha cancelado del programa del Child Care Assistance (Asistencia de Cuidado Infantil) a partir del ____, porque el departamento no puede ubicarle y no puede establecer que usted sea residente de Iowa.</p>
DHS PJ	<p>You have been canceled from the Child Care Assistance program effective ____, because _____. (NOTE: You must type in the notice language.)</p> <p>Se le ha cancelado del programa de Child Care Assistance (Asistencia de Cuidado Infantil) a partir del ____, porque _____. (NOTE: You must type in the notice language.)</p>

**Change, Reduction, or Reinstatement**

Used by:	Notice Language
DHS PJ	<p>Effective ____, the number of units that you have been authorized to use for child care assistance have been changed as shown on page 3. You are currently eligible until ____.</p> <p>A partir del ____, el número de unidades que se le autorizan para usar en Child Care Assistance han sido cambiadas como se muestra en la página 3. Actualmente usted es elegible hasta ____.</p>
DHS	<p>Effective ____, the fee you are required to pay per unit of child care services has changed. See the fee amount below. You are currently eligible until ____.</p> <p>A partir del ____, la cuota que debe pagar por unidad de servicios de atención de menores ha cambiado. Ver el monto a continuación. Actualmente usted es elegible hasta ____.</p>
DHS PJ	<p>Effective ____, the number of units that you have been authorized to use for child care assistance have been reduced as shown on page 3. You are currently eligible until ____.</p> <p>A partir del ____, el número de unidades que se le autorizan para usar en Child Care Assistance han sido reducidas como se muestra en la página 3. Actualmente usted es elegible hasta ____.</p>

Used by:	Notice Language
DHS	<p>Your Child Care Assistance benefits are reinstated for ____, effective ____, through ____. The units you have been authorized to use are shown on page 3.</p> <p>Sus beneficios de Child Care Assistance (Asistencia de Cuidado Infantil) se reestablecen para ____, a partir de ____ hasta ____. Las unidades que se le han autorizado para usar se muestran en la página 3.</p>
DHS	<p>You have requested a change in providers. Services provided by ____ for ____ are approved effective ____. Information about your fee is located below on this page. The units you have been authorized to use are shown on page 3. You are currently eligible until ____.</p> <p>Usted ha pedido un cambio de proveedores. Los servicios suministrados por ____ para ____ se aprueban a partir de _____. Más adelante en esta hoja se encuentra la información sobre su cuota. Las unidades autorizadas para este proveedor se muestran en la página 3. Actualmente usted es elegible hasta _____.</p>
PJ	<p>You have requested a change in providers. Services provided by ____ for ____ are approved effective ____. The units you have been authorized to use are shown on page 3. You are currently eligible until ____.</p> <p>Usted ha pedido un cambio de proveedores. Los servicios suministrados por ____ para ____ se aprueban a partir de _____. Las unidades autorizadas para este proveedor se muestran en la página 3. Actualmente usted es elegible hasta _____.</p>
DHS PJ	<p>You have requested a change in providers. Services provided by ____ for ____ are terminated effective ____, per your request. You are currently eligible until ____.</p> <p>Usted ha pedido un cambio de proveedores. Los servicios suministrados por ____ para ____ se terminan a partir de _____, según su solicitud. Actualmente usted es elegible hasta _____.</p>
DHS PJ	<p>Your Child Care Assistance benefit is reinstated because you filed a timely appeal.</p> <p>Su Child Care Assistance (Asistencia de Cuidado Infantil) se ha reinstaurado porque usted presentó una apelación a tiempo.</p>
DHS PJ	Other (NOTE: You must type in the notice language.)

**Denial**

<b>Used by:</b>	<b>Notice Language</b>
DHS	<p>Your application for the Child Care Assistance program is denied because your family does not meet the requirements of need for service from the program. In a household with two adults, <b>both</b> adults must meet the definition of need regarding hours of employment, hours of school or training, absence, or work search.</p> <p>Su solicitud para el programa de Child Care Assistance (Asistencia de Cuidado Infantil) ha sido negada porque su familia no cumple con los requisitos de necesidad de servicio del programa. En un hogar con dos adultos, <b>ambos</b> adultos deben cumplir con la definición de necesidad en relación con las horas de empleo, horas de escuela o capacitación, ausencia o búsqueda de trabajo.</p>
DHS	<p>Your application for the Child Care Assistance program is denied because your child(ren) do not meet age requirements.</p> <p>Su solicitud para el programa de Child Care Assistance (Asistencia de Cuidado Infantil) ha sido negada porque su(s) hijo(s) no cumplen con los requisitos de edad.</p>
DHS	<p>Your application for the Child Care Assistance program is denied because of your request.</p> <p>Su solicitud de Child Care Assistance (Asistencia de Cuidado Infantil) ha sido negada según su solicitud.</p>
DHS	<p>Your application for the Child Care Assistance program is denied because you are eligible for another funding source.</p> <p>Su solicitud para el programa de Child Care Assistance (Asistencia de Cuidado Infantil) ha sido negada porque usted es elegible para otra fuente de financiación.</p>
DHS	<p>Your application for the Child Care Assistance program is denied because you failed to provide requested information.</p> <p>Su solicitud de Child Care Assistance (Asistencia de Cuidado Infantil) ha sido negada porque usted no suministró la información solicitada.</p>
DHS	<p>Your application for the Child Care Assistance program is denied because funding is not available to provide the service.</p> <p>Su solicitud de Child Care Assistance (Asistencia de Cuidado Infantil) ha sido negada porque no hay fondos disponibles para prestar el servicio.</p>

Used by:	Notice Language
DHS	<p>Your application for the Child Care Assistance program is denied because there are no funds available for child care assistance at this time. You have been placed on a waiting list for services.</p> <p>Su solicitud de Child Care Assistance (Asistencia de Cuidado Infantil) ha sido negada porque no hay fondos disponibles para Child Care Assistance en el momento. Ha sido ubicado en una lista de espera.</p>
DHS	<p>Your application for the Child Care Assistance program is denied because your child does (children do) not meet citizen/alien requirements.</p> <p>Su solicitud para el programa de Child Care Assistance (Asistencia de Cuidado Infantil) ha sido negada porque su hijo no cumple (sus hijos no cumplen) con los requisitos de ciudadano/extranjero.</p>
PJ	<p>Your request for the Child Care Assistance program is denied because your child does (children do) not meet citizen/alien requirements.</p> <p>Su solicitud para el programa Child Care Assistance (Asistencia de Cuidado Infantil) es denegada porque su hijo/a no reúne (sus hijos no reúnen) los requisitos de ciudadanía/estado de extranjero.</p>
DHS	<p>Your application for the Child Care Assistance program is denied for ____ because your child does not meet citizen/alien requirements.</p> <p>Su solicitud para el programa de Child Care Assistance (Asistencia de Cuidado Infantil) ha sido negada para ____ porque su hijo no cumple con los requisitos de ciudadano/extranjero.</p>
PJ	<p>Your request for the Child Care Assistance program is denied for ____ because your child does not meet citizen/alien requirements.</p> <p>Su solicitud para el programa Child Care Assistance (Asistencia de Cuidado Infantil) de ____ es denegada porque su hijo/a no reúne los requisitos de ciudadanía/estado de extranjero.</p>
DHS	<p>Your application for the Child Care Assistance program is denied because you are not employed at least 28 hours per week.</p> <p>Su solicitud de Child Care Assistance (Asistencia de Cuidado Infantil) ha sido negada porque usted no está empleado por lo menos 28 horas a la semana.</p>

<b>Used by:</b>	<b>Notice Language</b>
DHS	<p>Your application for the Child Care Assistance program is denied because you are not enrolled in an approvable training program.</p> <p>Su solicitud de Child Care Assistance (Asistencia de Cuidado Infantil) ha sido negada porque usted no está registrado en un programa de capacitación aprobado.</p>
DHS	<p>Your application for the Child Care Assistance program is denied because you are not enrolled in training full time.</p> <p>Su solicitud de Child Care Assistance (Asistencia de Cuidado Infantil) ha sido negada porque usted no está registrado en un programa de capacitación de tiempo completo.</p>
DHS	<p>Your application for the Child Care Assistance program is denied because you do not meet at least one of the needs for service.</p> <p>Su solicitud de Child Care Assistance (Asistencia de Cuidado Infantil) ha sido negada porque usted no cumple por lo menos con una de las necesidades del servicio.</p>
DHS	<p>Your application for the Child Care Assistance program is denied because you do not meet the need for service because you are not absent due to hospitalization or outpatient treatment for physical or mental illness, or temporarily unable to care for your children as verified by a physician.</p> <p>Su solicitud de Child Care Assistance (Asistencia de Cuidado Infantil) ha sido negada porque usted no cumple con la necesidad del servicio, porque usted no está ausente por hospitalización, ni tratamiento de paciente externo, ni enfermedad física y mental, ni es temporalmente incapaz de cuidar a sus hijos según lo verifica un médico.</p>
DHS	<p>Your application for the Child Care Assistance program is denied because you have exhausted your 24-month funding limit for postsecondary education.</p> <p>Su solicitud de Child Care Assistance (Asistencia de Cuidado Infantil) ha sido negada porque usted ha terminado su límite de financiación de 24 meses para educación post-secundaria.</p>
DHS	<p>Your application for the Child Care Assistance program is denied because you do not meet the need for protective child care.</p> <p>Su solicitud de Child Care Assistance (Asistencia de Cuidado Infantil) ha sido negada porque esta no es una situación de atención protectora de menores.</p>

Used by:	Notice Language
DHS	<p>Your application for the Child Care Assistance program is denied because you are not seeking employment.</p> <p>Su solicitud de Child Care Assistance (Asistencia de Cuidado Infantil) ha sido negada porque no está buscando empleo.</p>
DHS	<p>Your application for the Child Care Assistance program is denied because you do not have eligible children living with you.</p> <p>Su solicitud de Child Care Assistance (Asistencia de Cuidado Infantil) ha sido negada porque no hay menores elegibles viviendo con usted.</p>
DHS	<p>Your application for Child Care Assistance is denied because you did not cooperate with the Investigation Section of the Department of Inspections and Appeals (DIA).</p> <p>Su solicitud para obtener Child Care Assistance (Asistencia de Cuidado Infantil) es denegada porque usted no colaboró con la Sección de Investigaciones del Departamento de Inspecciones y Apelaciones (DIA).</p>
PJ	<p>Your request for Child Care Assistance is denied because you did not cooperate with the Investigation Section of the Department of Inspections and Appeals (DIA).</p> <p>Su solicitud para el programa Child Care Assistance es denegada porque usted no colaboró con la Sección de Investigaciones del Department of Inspections and Appeals (DIA).</p>
DHS	<p>Your application for the Child Care Assistance program is denied because you are over the income guidelines.</p> <p>Su solicitud de Child Care Assistance (Asistencia de Cuidado Infantil) ha sido negada porque usted excede las guías de ingresos.</p>
DHS	<p>Your application for the Child Care Assistance program is denied because the Department is unable to locate you and cannot establish that you are a resident of Iowa.</p> <p>Su solicitud de Child Care Assistance (Asistencia de Cuidado Infantil) ha sido negada porque el departamento no puede ubicarle y no puede establecer que usted sea residente de Iowa.</p>
DHS	<p>Your application for the Child Care Assistance program is denied because _____. (NOTE: You must type in the notice language.)</p> <p>Su solicitud de Child Care Assistance (Asistencia de Cuidado Infantil) ha sido negada porque _____. (NOTE: You must type in the notice language.)</p>

Used by:	Notice Language
PJ	<p>Your request for the Child Care Assistance program is denied because _____. (NOTE: You must type in the notice language.)</p> <p>Su solicitud para el programa Child Care Assistance (Asistencia de Cuidado Infantil) es denegada porque _____. (NOTE: You must type in the notice language.)</p>

**Provider Eligibility**

Used by:	Notice Language
DHS	<p>Your <i>Child Care Assistance Provider Agreement</i> is terminated effective _____, because you have fraudulently received Child Care Assistance program payments.</p> <p>Effective _____, you will no longer be eligible to receive Child Care Assistance funding from the state of Iowa.</p> <p>As part of your sanction, you must submit the names and addresses of all families you provide care for to DHS within five business days. If you fail to do so, the Attorney General's office will ask the district court to issue an injunction preventing you from providing child care until the names are submitted.</p> <p>Su <i>Acuerdo de Proveedor de Child Care Assistance (Asistencia de Cuidado Infantil)</i> ha sido terminado a partir del _____ porque usted ha recibido fraudulentamente pagos del programa de Child Care Assistance.</p> <p>A partir del _____, usted ya no será elegible para recibir financiación de Child Care Assistance del estado de Iowa.</p> <p>Como parte de la sanción, deberá enviar los nombres y las familias para las que usted brinda atención al DHS dentro de los próximos cinco días hábiles. Si no lo hace, la fiscalía general pedirá al tribunal de distrito que emita una orden impidiéndole brindar el servicio hasta que envíe los nombres.</p>

Used by:	Notice Language
DHS PJ	<p>Your application to receive Child Care Assistance program payments is denied because you have fraudulently received Child Care Assistance payments.</p> <p>You will remain sanctioned. You are no longer eligible to receive Child Care Assistance funding from the state of Iowa.</p> <p>Su solicitud para recibir pagos del programa de Child Care Assistance (Asistencia de Cuidado Infantil) ha sido negada porque usted ha recibido pagos de Child Care Assistance en forma fraudulenta.</p> <p>Usted será sancionada. Usted ya no es elegible para recibir financiación de Child Care Assistance del estado de Iowa.</p>
DHS PJ	<p>Your application to receive Child Care Assistance program payments is denied because you have fraudulently received Child Care Assistance payments.</p> <p>You will remain sanctioned. You will not be able to receive Child Care Assistance program funding until _____. Once your suspension expires, you may reapply to receive Child Care Assistance funding.</p> <p>Su solicitud para recibir pagos del programa de Child Care Assistance (Asistencia de Cuidado Infantil) ha sido negada porque usted ha recibido pagos de Child Care Assistance en forma fraudulenta.</p> <p>Usted será sancionada. Usted no podrá recibir financiación del programa Child Care Assistance hasta el _____. Una vez expire su suspensión, puede volver a solicitar financiación de Child Care Assistance.</p>
DHS PJ	<p>Because you have fraudulently received Child Care Assistance program payments, you are subject to the following sanction:</p> <p>Effective _____, the invoices you submit for Child Care Assistance payment for the next six months will be subject to a detailed review before payment will be issued.</p> <p>Por cuanto usted ha recibido fraudulentamente pagos del programa Child Care Assistance (Asistencia de Cuidado Infantil), usted está sujeto(a) a la siguiente sanción:</p> <p>A partir del _____, las facturas que envíe para pago de Child Care Assistance durante los próximos seis meses estarán sujetas a una revisión detallada antes de realizar el pago.</p>

Used by:	Notice Language
DHS	<p>Your <i>Child Care Assistance Provider Agreement</i> is terminated effective ____, because you have fraudulently received Child Care Assistance program payments.</p> <p>Effective ____, you are suspended from receiving state Child Care Assistance program payments. You will not be able to receive Child Care Assistance program funding until ____.</p> <p>Once your suspension expires, you may reapply to receive Child Care Assistance funding.</p> <p>As part of your sanction, you must submit the names and addresses of all families you provide care for to DHS within five business days. If you fail to do so, the Attorney General's office will ask the district court to issue an injunction preventing you from providing child care until the names are submitted.</p> <p><i>Su Acuerdo de Proveedor de Child Care Assistance (Asistencia de Cuidado Infantil)</i> ha sido terminado a partir del ____ porque usted ha recibido fraudulentamente pagos del programa Child Care Assistance.</p> <p>A partir del ____, no recibirá pagos de Asistencia de Atención Infantil del estado. Usted no podrá recibir financiación del programa Child Care Assistance hasta el ____.</p> <p>Una vez expire su suspensión, puede volver a solicitar financiación de Child Care Assistance.</p> <p>Como parte de la sanción, deberá enviar los nombres y las familias para las que usted brinda atención al DHS dentro de los próximos cinco días hábiles. Si no lo hace, la fiscalía general pedirá al tribunal de distrito que emita una orden impidiéndole brindar el servicio hasta que envíe los nombres.</p>
DHS PJ	<p>Your <i>Child Care Assistance Provider Agreement</i> is terminated effective ____.</p> <p>You will no longer be eligible to receive funding from the Child Care Assistance program because you do not meet the minimum health and safety requirements established by the Department.</p> <p><i>Su Acuerdo de Proveedor de Child Care Assistance (Asistencia de Cuidado Infantil)</i> ha sido terminado a partir del ____.</p> <p>Usted ya no será elegible para recibir financiación del programa Care Assistance (Asistencia de Cuidado Infantil) porque usted no cumple con el mínimo de requisitos de salud y seguridad establecidos por el Departamento.</p>

Used by:	Notice Language
DHS	<p>You are not eligible to receive funding from the Child Care Assistance program because you do not meet the minimum health and safety requirements established by the Department.</p> <p>Usted no es elegible para recibir financiación del programa Care Assistance (Asistencia de Cuidado Infantil) porque usted no cumple con el mínimo de requisitos de salud y seguridad establecidos por el Departamento.</p>
DHS PJ	<p>You are not eligible to provide child care or to receive public funds for providing child care because you did not return a completed <i>Record Check Evaluation</i> form to the Department of Human Services.</p> <p>Usted no es elegible para ofrecer cuidado infantil ni para recibir fondos públicos por suministro de cuidado infantil porque no devolvió un formulario lleno de <i>Record Check Evaluation</i> al Department of Human Services.</p>
DHS	<p>Your <i>Child Care Assistance Provider Agreement</i> is terminated effective _____. You will no longer be eligible to receive funding from the Child Care Assistance program because you have failed to complete a new <i>Child Care Assistance Application, Child Care Assistance Provider Agreement, and record check forms</i>.</p> <p>Su <i>Acuerdo de Proveedor de Child Care Assistance (Asistencia de Cuidado Infantil)</i> ha sido terminado a partir del _____. Usted ya no será elegible para recibir financiación del programa Care Assistance (Asistencia de Cuidado Infantil) porque usted no ha llenado una nueva <i>solicitud de Proveedor de Child Care Assistance, Acuerdo de Proveedor de Child Care Assistance</i> y formularios de verificación de registros.</p>
DHS	<p>Your Child Care Assistance Provider Agreement is canceled effective ____, because you did not cooperate with the Investigation Section of the Department of Inspections and Appeals (DIA).</p> <p>Su Child Care Assistance Provider Agreement (Acuerdo con el Proveedor de Asistencia de Cuidado Infantil) es cancelado con fecha de vigencia ____, porque usted no colaboró con la Sección de Investigaciones del Departamento de Inspecciones y Apelaciones (DIA).</p>
DHS	<p>Your Child Care Assistance Provider Agreement is denied because you did not cooperate with the Investigation Section of the Department of Inspections and Appeals (DIA).</p> <p>Su Child Care Assistance Provider Agreement (Acuerdo con el Proveedor de Asistencia de Cuidado Infantil) es denegado porque usted no colaboró con la Sección de Investigaciones del Departamento de Inspecciones y Apelaciones (DIA).</p>

Used by:	Notice Language
DHS PJ	<p>You are not eligible to provide child care or to receive public funds for providing child care as a result of the Department of Human Services' evaluation of your child abuse or criminal record.</p> <p>Usted no es elegible para brindar cuidado infantil ni para recibir fondos públicos por brindar cuidado infantil como resultado de la evaluación del Department of Human Services sobre un abuso de menores o registro criminal.</p>
DHS	<p>Your Child Care Assistance Provider Agreement is canceled effective ____, because your child care home is not in a single family residence that you own, rent or lease.</p> <p>Su Acuerdo de Proveedor de Child Care Assistance (Asistencia para Cuidado Infantil) ha sido cancelado a partir del ____ porque su hogar de cuidado infantil no es una residencia familiar única que usted posee, alquila o renta.</p>
DHS	<p>Your application to be a nonregistered child care home provider is denied because your child care home is not in a single family residence that you own, rent or lease.</p> <p>Su solicitud para convertirse en un hogar proveedor de cuidado infantil no registrado ha sido denegada porque su hogar de cuidado infantil no es una residencia familiar única que usted posee, alquila o renta.</p>

**Page 3** Complete the "Hours of Eligibility" section as follows:

- ◆ Check the boxes indicating the reasons child care is being approved (e.g., work, training, job search, etc.).
- ◆ Complete a section for each child authorized for care, entering:
  - The child's name.
  - SRS (DHS) or ABC (PROMISE JOBS) case number.
  - The number on the Child Care Assistance Provider Agreement.
  - The provider's name.
  - The maximum units of child care authorized each day.
  - The total maximum units authorized each week for that child.

If the parent's schedule is such that a school-aged child needs more units on non-school days, complete two sections for each child. In the first section:

- ◆ After the child's name put "school days" in parentheses and
- ◆ Complete the section indicating the maximum units the child is approved for on school days.

In the second section:

- ◆ After the child's name put "non-school days" in parentheses and
- ◆ Complete the section indicating the maximum units the child is approved for on non-school days.

If there are more children in any family that need child care than can fit on the *Notice of Decision*, complete another *Notice of Decision* to show the hours of eligibility for the remaining children.

NOTE: The weekly maximum units do not always equal the sum of the daily maximum units. Daily units are based upon days a person may be eligible for child care. Weekly units are based upon average weekly hours of need.

EXAMPLE: If a person works 8-hour shifts, 40 hours per week, but may be scheduled on any day Monday through Saturday, then each of those six days would show 2 units, but the weekly total would be only 10 units (since the person would work only 5 days in any given week).

Use the tab key to navigate to the "cc: Child Care Provider" box and the template will automatically duplicate the entry from page 1.

To print the form, double-click on the box labeled "Double-click to Print," following page 4.

**[Notice of Decision for Extra Help with Medicare Prescription Drug Costs, Form 470-4199](#)**

**Purpose** "Extra Help with Medicare Prescription Drug Costs" is a program to offset the costs of the Medicare prescription drug benefit.

While Social Security Administration (SSA) administers the program, the eligibility decision for the benefit can be made either by the SSA or by the state Medicaid agency (the Department). Persons wishing to apply for extra help are encouraged to go to SSA. However, they may require the Department to process their application.

Form 470-4199 is used to notify applicants and recipients of extra help with Medicare prescription drug costs of actions taken on their case when the **Department** has made the decision.

**Source** Complete this form on line using the template on the DHS Intranet eForms web page.

**Completion** The IM worker completes an original and one copy of the notice of decision when the Department has made a decision about eligibility for extra help with Medicare prescription drug costs.

**Distribution** Send the original copy to the client and file a copy in the case record.

**Data** **Date:** Enter date the notice is completed.

**Worker Name:** Enter name of the IM worker processing the action.

**Client Names:** Enter the name of the client and of the spouse, if the client is married and living with the spouse.

**Telephone Number:** Enter the IM worker's phone number.

**SSN:** Enter the client's social security number and the spouse's social security number if the client is married and living with the spouse.

**Dear \_\_\_\_\_:** Enter client's name and the spouse's name if the client is married and living with the spouse.

**Notice Language:** Select language appropriate to the action you will be taking on the case (approve, cancel, change or deny), depending on action being taken on the case. Use entries from form 470-4193, *Extra Help for Medicare Prescription Drug Benefits Narrative/Worksheet*, to complete the blanks in the notice language.

Language for selected action is as follows:

**Approve** Based on the application you filed on \_\_\_\_, you are eligible for extra help with your Medicare prescription drug plan costs. This help is effective \_\_\_\_\_. You are eligible for:

- \_\_\_\_ subsidy to help pay your Medicare prescription drug plan **premium**.
- \_\_\_\_ prescription drug plan yearly **deductible**.
- Your **copayment** for each prescription is \_\_\_\_ for a generic or preferred drug, \_\_\_\_ for other drugs, or 15% of the total cost.

Your eligibility is based on 42 CFR § 423.773(a).

We based our decision on the following information:

- Your family size is \_\_\_\_ person/people.
- The income we considered is:

Source	Amount	Deductions

The total income is \_\_\_\_\_. The amount of deductions is \_\_\_\_\_. The amount allowed for \_\_\_\_ person/people is \_\_\_\_\_.

- The resources we considered are:

Source	Amount

The total amount of your resources is \_\_\_\_\_. The amount allowed for one person/a couple is \_\_\_\_\_.

### How to Enroll in a Medicare Prescription Drug Plan

To take advantage of this extra help, you must enroll in a Medicare prescription drug plan or Medicare health plan with prescription drug coverage, if you are not already in a plan. You can enroll beginning November 15, 2005. You will get more information about the prescription drug plans available in your area. You can also visit [www.medicare.gov](http://www.medicare.gov) or call toll-free 1--800-MEDICARE (1-800-633-4227) for more information. If you are deaf or hard of hearing, you may call the Medicare TTY number toll-free at 1-877-486-2048.

If you do not choose a Medicare prescription drug plan, Medicare will choose one for you to be sure you get this benefit. You will receive more information from Medicare.

You must notify this agency of any changes in your family's situation, such as employment, income, savings, property, stocks, bonds, and insurance; family members leaving or joining your household; marital status; address and telephone number. Any of these changes could affect your eligibility. You must report any changes in your situation within 10 working days of the change.

You will be required to reestablish your eligibility for this extra help at least once every 12 months. You will be notified of that requirement in advance of the due date. The necessary instructions and forms will be sent to you at that time.

If you do not agree with this decision, you have the right to request a hearing. The procedures for requesting a hearing are attached to this letter.

**Cancel** Based on the information received by this office on \_\_\_\_\_, you are no longer eligible for extra help with your Medicare prescription drugs costs. This decision is effective \_\_\_\_\_. You have been determined ineligible for the reasons checked below:

- You are no longer eligible for Medicare. [42 CFR §423.30(a)]
- You are no longer a resident of the state. [42 CFR §423.773(a)]
- You did not complete the redetermination process. [42 CFR §423.774(c)(1)]

- Your resources are more than the amount allowed.  
[42 CFR §423.773(a)]
- Your income is more than the amount allowed.  
[42 CFR §423.773(a)]

We based our decision on the following information:

- Your family size is \_\_\_\_ person/people.
- The income we considered is:

Source	Amount	Deductions

The total income is \_\_\_\_\_. The amount of deductions is \_\_\_\_\_. The amount allowed for a family size of \_\_\_\_\_ is \_\_\_\_\_. Therefore, you have \_\_\_\_\_ more income than is allowed.

- The resources we considered are:

Source	Amount

The total amount of your resources is \_\_\_\_\_. The amount allowed for one person/a couple is \_\_\_\_\_. Therefore, you have \_\_\_\_\_ more than is allowed.

#### Using Your Medicare Prescription Drug Plan

Even though you do not qualify for extra help, if you continue to be eligible for Medicare, you can still save on your prescription drug costs by remaining in a Medicare prescription drug plan or a Medicare health plan with prescription drug coverage. From November 15 to December 31 of each year, you can change the plan you are enrolled in. You can also visit [www.medicare.gov](http://www.medicare.gov) or call toll-free 1-800-MEDICARE (1-800-633-4227) for more information. If you are deaf or hard of hearing, you may call the Medicare TTY number toll-free at 1-877-486-2048.

If you do not agree with this decision, you have the right to request a hearing. The procedures for requesting a hearing are attached to this letter. You also have the right to reapply.

**Change** Based on information received by this office on \_\_\_\_\_, your eligibility for extra help with your Medicare prescription drug costs will change. You will receive increased/reduced extra help. Effective \_\_\_\_\_, you are eligible for:

- \_\_\_\_\_ subsidy to help pay your Medicare prescription drug plan premium.
- \_\_\_\_\_ prescription drug plan yearly deductible.
- Your copayment for each prescription is \_\_\_\_\_ for a generic or preferred drug, \_\_\_\_\_ for other drugs, or 15% of the total cost.

The change in your eligibility is based on 42 CFR § 423.773(a).

We based our decision on the following information:

- Your family size changed from \_\_\_\_\_ person/people to \_\_\_\_\_ person/people.
- Your countable income previously was \_\_\_\_\_. The income we are counting now is:

Source	Amount	Deductions

The total income is \_\_\_\_\_. The amount of deductions is \_\_\_\_\_. The amount allowed for \_\_\_\_\_ person/people is \_\_\_\_\_.

- Your countable resources previously were \_\_\_\_\_. The resources we are counting now are:

Source	Amount

The total amount of your resources is \_\_\_\_\_. The amount allowed for one person/a couple is \_\_\_\_\_.

### Using Your Medicare Prescription Drug Plan

You will pay more/less of the costs within your Medicare prescription drug plan than you did before. Even if you must pay more, you still save on your prescription drug costs by remaining in a Medicare prescription drug plan or Medicare health plan with prescription drug coverage. From November 15 to December 31 of each year, you can change the plan you are enrolled in. You can visit [www.medicare.gov](http://www.medicare.gov) or call toll-free 1-800-MEDICARE (1-800-633-4227) for more information. If you are deaf or hard of hearing, you may call the Medicare TTY number toll-free at 1-877-486-2048.

You must notify this agency of any changes in your family's situation, such as employment, income, savings, property, stocks, bonds, and insurance; family members leaving or joining your household; marital status; address and telephone number. Any of these changes could affect your eligibility. You must report any changes in your situation within 10 working days of the change.

You will be required to reestablish your eligibility for this extra help at least once every 12 months. You will be notified of that requirement in advance of the due date. The necessary instructions and forms will be sent to you at that time.

If you do not agree with this decision, you have the right to request a hearing. The procedures for requesting a hearing are attached to this letter.

**Deny** Based on the application you filed on \_\_\_\_\_, you are not eligible for extra help with your Medicare prescription drug costs. You have been determined ineligible for the reasons checked below:

- You are not eligible for Medicare. [42 CFR §423.30(a)]
- You are not a resident of the state. [42 CFR §423.773(a)]
- You did not complete the application process.  
[42 CFR §423.904(d)(2)]
- Your resources are more than the amount allowed.  
[42 CFR §423.773(a)]

- Your income is more than the amount allowed.  
[42 CFR §423.773(a)]
- Other:

We based our decision on the following information:

- Your family size is \_\_\_\_ person/people.
- The income we considered is:

Source	Amount	Deductions

The total income is \_\_\_\_\_. The amount of deductions is \_\_\_\_\_. The amount allowed for a family size of \_\_\_\_\_ is \_\_\_\_\_. Therefore, you have \_\_\_\_\_ more income than is allowed.

- The resources we considered are:

Source	Amount

The total amount of your resources is \_\_\_\_\_. The amount allowed for one person/a couple is \_\_\_\_\_. Therefore, you have \_\_\_\_\_ more than is allowed.

#### How to Enroll in a Medicare Prescription Drug Plan

Even though you do not qualify for extra help, if you are eligible for Medicare, you can still save on your prescription drug costs by enrolling in a Medicare prescription drug plan or a Medicare health plan with prescription drug coverage. You can enroll beginning November 15, 2005. You will get more information about the prescription drug plans available in your area. You can also visit [www.medicare.gov](http://www.medicare.gov) or call toll-free 1-800-MEDICARE (1-800-633-4227) for more information. If you are deaf or hard of hearing, you may call the Medicare TTY number toll-free at 1-877-486-2048.

If you do not agree with this decision, you have the right to request a hearing. The procedures for requesting a hearing are attached to this letter. You also have the right to reapply.

**Notice of Decision for Medically Needy, Form 470-2330**

Purpose	The <i>Notice of Decision for Medically Needy</i> provides the applicant with a notice of approval for Medically Needy coverage. Denials or cancellations for Medically Needy coverage are generated by the Automated Benefit Calculation system.
Source	Workers can complete this form on line using the template on the DHS Intranet eForms web page.
Completion	The IM worker issues the form when: <ul style="list-style-type: none"><li>◆ Approving certification or the retroactive period.</li><li>◆ Processing a change that results in the spenddown being recalculated.</li></ul>
Distribution	Send the original to the client with a copy of form 470-2341, <i>Medically Needy Spenddown Computation</i> , attached. Also send a copy of the notice the client's guardian or conservator, if there one. File a copy in the case record.
Data	Make the following entries: <ul style="list-style-type: none"><li>◆ Enter the DHS office name and address.</li><li>◆ Enter the case name and current mailing address.</li><li>◆ Enter the county number.</li><li>◆ Enter the date that the notice is mailed.</li><li>◆ Enter the worker number.</li><li>◆ Enter the worker's name.</li><li>◆ Enter the telephone number of the IM worker.</li><li>◆ Enter the Medically Needy case number and FBU.</li><li>◆ For shortening a certification period:<ul style="list-style-type: none"><li>• Check the first box.</li><li>• Check the second box. Circle the action being taken as a redetermination being approved or conditionally approved.</li></ul></li></ul>

- List the complete names of all persons who are eligible or conditionally eligible for the shortened certification period.
  - Enter the beginning and ending dates of the shortened certification period.
  - Enter the spenddown for the shortened certification period, if applicable.
  - List the complete name of all persons who are responsible relatives for the shortened certification period, if applicable.
- ◆ For a certification approval:
- Check the second box.
  - Circle the action being taken (application or redetermination).
  - Circle the action being taken as an approval or conditional approval for the current certification period.
  - List the complete names of all persons who are eligible or conditionally eligible for the current certification period.
  - Enter the beginning and ending dates of the current certification period.
  - Enter the amount of the spenddown for the current certification period, if applicable.
  - List the complete name of all persons who are responsible relatives for the current certification period, if applicable.
  - Enter the date after which the client needs to reapply for assistance.
- ◆ If eligibility is being approved for the retroactive period:
- Check the third box.
  - Circle the action being taken as an approval or conditional approval for the retroactive period.
  - List the complete names of all persons who are eligible or conditionally eligible for the retroactive period.

- Enter the beginning and ending dates of the retroactive period.
- Enter the amount of the spenddown for the retroactive period, if applicable.
- List the complete names of all persons who are responsible relatives for the retroactive period, if applicable.
- ◆ Enter in the fourth box the date that completed medical claim forms must be received in the local office or at the IME Core Services Unit.
- ◆ For Medically Needy clients who are eligible for the qualified Medicare beneficiary group:
  - Check the fifth box.
  - List the complete names of the qualified Medicare beneficiary (QMB) eligibles.
  - Enter the date of QMB eligibility.
- ◆ For Medically Needy clients who are eligible for the specified low income Medicare beneficiary group:
  - Check the sixth box.
  - List the complete names of the SLMB eligibles.
  - Enter the date that Medicaid begins paying the Medicare premium.

**[Notice of Decision: Medical Assistance or State Supplementary Assistance, Form 470-0490](#)**

Purpose	<p>Income maintenance workers use form 470-0490 to notify an applicant or recipient of SSI-related Medicaid or State Supplementary Assistance when the Department takes one of the following actions:</p> <ul style="list-style-type: none"><li>◆ Assistance is approved.</li><li>◆ An application is denied.</li><li>◆ A recipient transfers from one program or facility to another.</li><li>◆ Assistance continues after a review.</li><li>◆ Assistance is changed because of a redetermination.</li><li>◆ Assistance is canceled.</li></ul>
Source	<p>Complete this form on line using the template on the DHS Intranet eForms web page.</p>
Completion	<p>The IM worker responsible for the case completes this form when:</p> <ul style="list-style-type: none"><li>◆ A computer-generated notice cannot be issued, according to case action instructions in Chapter 14-B(9).</li><li>◆ The worker chooses to issue a manual notice instead of a computer-generated one.</li></ul>
Distribution	<p>Send the original to the client and file a copy in the case record. Make another copy and send to the guardian, conservator, or payee, when there is someone acting in this capacity on behalf of the client.</p>
Data	<p>Complete the form as follows:</p> <ul style="list-style-type: none"><li>◆ <b>Case number:</b> Enter the case number.</li><li>◆ <b>Facility name:</b> Enter the name of the facility involved.</li></ul>

Select Approved, Denied, Transfer, Review or Redetermination, or Canceled and enter the applicable information as follows:

◆ Approved:

Approvals for Medicaid institution care or State Supplementary Assistance:

- The effective date of approval shall be the date of application or the date of eligibility, whichever is later.
- Enter the amount of first-month client participation.
- Enter the beginning date of client participation.
- Enter the amount of ongoing client participation.

Approvals for Medical assistance: The effective date of medical assistance shall be the first day of the month in which eligibility is established.

◆ **Denied:** Select if an application is denied or withdrawn before approval.

◆ **Transfer:** Select if transferring from one facility to another:

- Enter the amount the client is required to pay to the previous facility.
- Enter the amount the client is required to pay for first month's participation in the new facility (if any).
- Enter the amount of ongoing client participation.
- Enter the names of the former and new facilities.

◆ Review or Redetermination:

- Select State Supplementary Assistance, Facility or Waiver.
- Enter the effective date of ongoing client participation.
- Enter the amount of client participation resulting from the recertification.

◆ Canceled:

State Supplementary Assistance cancellation: Enter the date that the State Supplementary Assistance is canceled.

Medicaid cancellation: Enter the effective date of cancellation of medical assistance. This date should be the first of the month unless the recipient died. Then enter the date of death.

◆ All actions:

- **Program:** Identify the program as follows:

<b>Entry</b>	<b>Used For</b>
ICF	Nursing facility care
RCF	Residential care
Skilled	Skilled nursing care
Hospital	Hospital care only
Family-life	Family-life home
In-home care	In-home health-related care
Medical	SSI Newborns Widows and widowers ineligible for SSI or SSA due to actuarial increase People who decline SSI or SSA cash People ineligible for SSI or SSA because of Social Security COLA (503)
HCBS	Home- and community-based services

- **Legal reference:** Enter the title and chapter number of the manual reference. Use the title of the paragraph in the manual that the decision was based on. Also enter the rule reference for this section.
- **Comments by worker:** Use this space to explain the specific reason for the action taken and any other comments which the worker feels are pertinent to the applicant or recipient. The worker may attach a separate sheet to explain the action.

The form will populate the following fields:

- ◆ The date field populates with the current date as the date the action is taken.
- ◆ The county number where the worker's office is located.
- ◆ The client's name and address.
- ◆ The worker's name and phone number.

The payment computation section serves as a record for determining client participation for a client residing in an ICF, SNF, or RCF, receiving in-home health-related care, or receiving home- and community-based service care. It may also be used to compute eligibility and state warrant in family life home cases.

- ◆ List and total all gross countable income.
- ◆ List all allowable deductions and diversions and add them to the personal allowance to determine total deductions.
- ◆ Click the checkbox to change the personal allowance to the RCF or veterans amount.
- ◆ The form will calculate the client's participation by subtracting the diversions, deductions, and personal allowance from the total income.

**[Notice of Decision on Denied Prior Authorization, Form 470-0390](#)**

Purpose	This notice is sent to the member or representative when a service requested by the prior authorization process is denied. This notice gives the clients their right to appeal.
Source	The Iowa Medicaid Enterprise issues this form.
Completion	IME Medical Prior Authorization staff prepare an original and one copy of this form when one or more services submitted by a medical provider on a request for prior authorization has been denied.
	This form is included in the manual for information only. No worker action is required unless the member appeals. Appeals are then handled in the usual manner.
Distribution	IME sends the original copy of the notice and a copy of the prior authorization form to the member or representative and retains a copy of the notice.
Data	The form includes the denial reason and denial code.

**Notice of Decision on Medicaid Claim, Form 470-0392**

Purpose	Form 470-0392 notifies the Medicaid member when a service has been determined to be approved or denied by Medicaid after the member's telephone inquiry to the Member Services call center regarding bills for medical services.
Source	The IME Member Services Unit issues this form.
Completion	IME Member Services Unit staff prepare an original and one copy of this notice after a telephone inquiry to the Member Services call center (1-800-338-8366 or (515) 725-1003 if in the Des Moines area).
	No worker action is required. The form is included in the manual for information only. If the member files an appeal, it shall be handled in the usual manner.
Distribution	The IME Member Services Unit sends the original to the member and keeps the yellow copy.
Data	<ul style="list-style-type: none"><li>◆ If the claim has been paid, the notice informs the member of that fact and that if the member continues to receive bills from the provider, the member may contact the local legal services agency.</li><li>◆ If the service is not covered by Medicaid, the notice notifies the member of the denial and the member's right to appeal that denial.</li></ul>

**Notice of Disqualification, Form 470-0288 or 470-0288(S)**

Purpose	<p>The <i>Notice of Disqualification</i> is used to:</p> <ul style="list-style-type: none"><li>◆ Notify a person who has been found to have committed an intentional program violation of the period of disqualification.</li><li>◆ Notify the remaining household members, if any, of the benefits they will receive during the period of disqualification, or that they must reapply for Food Assistance because the certification period has expired.</li></ul>
Source	<p>The form is an electronic template generated by the DHS Appeals Section and e-mailed to the IM worker.</p>
Completion	<p>The Appeals Section generates this form when an administrative law judge finds a client guilty of intentional program violation in the Food Assistance program.</p> <p>The local office may also request a form from the Appeals Section when the Department of Inspections and Appeals, Investigations Division, has notified the worker that a court has found that the household member committed an intentional program violation.</p> <p>The Appeals Section completes the address and identifying information. The IM worker completes the notice fields.</p>
Distribution	<p>The Appeals Section sends the form to the IM worker by electronic mail for completion and printing. The IM worker:</p> <ul style="list-style-type: none"><li>◆ Sends the original to the client.</li><li>◆ Places a copy in the client's file.</li><li>◆ Sends a copy to the Appeals Section once the disqualification is implemented.</li></ul>
Data	<p>The Appeals Section completes the names, addresses, appeal numbers, and salutations. The IM worker completes the length of sanction and the effect on household benefits, following the instructions given, and signs the form.</p>

**Notice of Employment, Form 470-0820**

Purpose	The PROMISE JOBS unit uses the <i>Notice of Employment</i> to notify the IM worker when a PROMISE JOBS participant begins employment.
Source	PROMISE JOBS staff complete this form using the template provided by DHS.
Completion	<p>The PROMISE JOBS worker completes Part A of the form when a participant begins or changes employment.</p> <p>IM staff complete Part B, unless:</p> <ul style="list-style-type: none"><li>◆ You have already sent the PROMISE worker form 470-2844, <i>Employer's Statement of Earnings</i>, from this employer, or</li><li>◆ You have the <i>Employer's Statement of Earnings</i> completed by the new employer and attach a copy of it to the <i>Notice of Employment</i>.</li></ul> <p>NOTE: When you become aware of a mandatory or volunteer PROMISE JOBS participant who has begun, ended, or changed employment, you should send a copy of the <i>Employer's Statement of Earnings</i> or equivalent verification to the PROMISE JOBS worker.</p> <p>If you don't know who the PROMISE JOBS worker is, send the verification to the PROMISE JOBS office designated under the coordination arrangement of the PROMISE JOBS local service plan.</p>
Distribution	<p>After completing Part A, PROMISE JOBS staff sends the form to the IM worker. PROMISE JOBS keeps a control copy.</p> <p>The IM worker:</p> <ul style="list-style-type: none"><li>◆ Completes Part B (or attached from 470-2844),</li><li>◆ Makes a copy to file in the participant's FIP case record, and</li><li>◆ Returns the form to the local PROMISE JOBS unit.</li></ul>

Data

When completing Part B, enter the following:

- ◆ The month before the month the earnings were applied to the FIP grant.
- ◆ The month that earnings were applied to the FIP grant.
- ◆ The current status of the FIP case.
- ◆ Date of last employment, if applicable.

### [Notice of Expiration, Form 470-0325](#)

#### Purpose

The purpose of the *Notice of Expiration* is to:

- ◆ Provide advance notice to households of the date their Food Assistance certification will expire,
- ◆ Notify households of the date by which they must file a timely application to be eligible to receive uninterrupted benefits, and
- ◆ Explain how and where to file the application.

Most households receive this notification through a message printed by the ABC system on the *Review/Recertification Eligibility Document* (RRED). Central Office mails the RRED to the household at the end of the month before the last month of certification.

The printed message is:

Your Food Assistance will end (COMPUTER-PRINTED LAST DATE OF CERTIFICATION). Return this signed form by (COMPUTER-PRINTED MONTH) 15th to get Food Assistance at the regular time next month, if you are eligible. You must have an interview. If you miss your interview, you must ask the local office to reschedule.

Use form 470-0325 to notify households that cannot be notified through this computer-generated message because of timing or the length of their certification.

#### Source

Complete this form on line using the template available on the DHS Intranet eForms web page.

#### Completion

Complete this form each time a household is certified for one month.

Complete this form each time a household is certified for two months when the ABC system entries are made after cutoff of the first month of certification.

Distribution	<p>Prepare an original and one copy.</p> <p>Give the original to the client. Retain the copy in the case record.</p>
Data	<p>In the middle of the first sentence, enter the date the Food Assistance certification period expires.</p> <p>The name and address of the local office shall be completed in the space provided. For example:</p> <p style="padding-left: 40px;">Polk County Department of Human Services Carpenter Office 1900 Carpenter Avenue Des Moines, Iowa 50314</p> <p>At the bottom of the first column, in the space provided, enter the date by which a new application must be filed to be considered timely. This date is 15 days from the date the notice is received or the fifteenth day of the last month of the certification period, whichever is later.</p>

**Notice of FIP or RCA Overpayment, Form 470-4683**

Purpose	Form 470-4683 informs the debtor on a FIP or RCA claim of the amount and reason for the overpayment and requests repayment.
Source	Form 470-4683 is generated by the Overpayment Recovery System.
Completion	The form is completed for debtors who have a FIP or RCA claim entered on the Overpayment Recovery System and have not submitted an agreement to repay.
Distribution	One copy is mailed from Central Office.
Data	<p>The system completes:</p> <ul style="list-style-type: none"><li>◆ The date,</li><li>◆ The debtor's name and address,</li><li>◆ The amount and months of the overpayment,</li><li>◆ The type of error,</li><li>◆ The reason for the overpayment.</li></ul> <p>The debtor completes the repayment terms.</p>

**Notice of Food Assistance Debt, Form 470-4179**

Purpose	Form 470-4179 informs the debtor of the amount of debt for trafficking or misuse of Food Assistance. The debtor completes part of the form to agree to make payments.
Source	Form 470-4179 is generated by the DHS Overpayment Recovery System.
Completion	<p>The form is printed in the month the debt is added to the Overpayment Recovery System. EXCEPTION: The form is printed in the following month if system entry is made after debt notices have been issued for the month.</p> <p>The Overpayment Recovery System partially completes the form. The debtor is responsible for completing the agreement to pay.</p>
Distribution	<p>One copy is mailed to the debtor from Central Office with a return envelope enclosed.</p> <p>The debtor should return the completed bottom portion of the form to Iowa Department of Inspections and Appeals, Public Assistance Debt Recovery Unit, 321 E. 12th St, 3rd Floor, Des Moines, IA 50319-0083.</p>
Data	The debtor has the choice of paying the full amount in one payment or making monthly payments.

**Notice of Food Assistance Overpayment, Form 470-4668**

Purpose	Form 470-4668 informs the debtor of the amount and reason for the overissuance in a Food Assistance claim and requests repayment.
Source	Form 470-4668 is generated by the Overpayment Recovery System, located in the Division of Data Management.
Completion	<p>The form is printed and sent eight calendar days before the end of the month following the addition of the claim to the Overpayment Recovery System. An additional form is sent if there is a change to:</p> <ul style="list-style-type: none"><li>◆ The claim amount.</li><li>◆ The months the claim covers.</li><li>◆ The appeal status in the Overpayment Recovery System.</li><li>◆ Classify the claim as an intentional program violation.</li></ul> <p>The Overpayment Recovery System partially completes the form. The debtor is responsible for completing the agreement to repay.</p>
Distribution	<p>One copy is mailed to the debtor from Central Office with a return envelope enclosed.</p> <p>The debtor should return the completed Agreement to Pay portion of the form to Iowa Department of Inspections and Appeals, Public Assistance Debt Recovery Unit, 3rd Floor, 321 E. 12th Street, Des Moines, IA 50319-0083.</p>
Data	The debtor has the choice of repaying through allotment reduction, in cash, or having DHS take benefits from an EBT account. NOTE: Agreement for allotment reduction is not acceptable if the debtor is not an active Food Assistance recipient.

**Notice of Health Insurance Premium Payment, Form 470-2845**

Purpose	Form 470-2845 is used to notify the policyholder that the Department has determined the health insurance plan is cost-effective.
Source	Form 470-2845 is system-generated in Central Office.
Completion	The HIPP worker generates the form through entries on the Approval Notice Request Screen when the Department determines that paying for the member's health insurance policy is cost-effective.
Distribution	Copies are printed for: <ul style="list-style-type: none"><li>◆ The policyholder</li><li>◆ The HIPP file</li></ul>
Data	The form: <ul style="list-style-type: none"><li>◆ Specifies the method and frequency of payment.</li><li>◆ Identifies the Medicaid members covered under the policy.</li><li>◆ Lists pertinent information regarding the insurance carrier and policy.</li></ul>

**Notice of Income Offset Against State Warrants, Form 470-4139**

Purpose	Form 470-4139 is issued to inform a debtor that part or all of a payment the debtor is due from the state (such as lottery winnings and payments to vendors or service providers, but not state employees' pay) is being withheld to repay a DHS overpayment.
Source	The Department of Inspections and Appeals issues form 470-4139.
Completion	<p>The DIA Public Assistance Debt Recovery Unit sends this notice when the Department of Administrative Services (DAS) notifies the Unit that a warrant is being held. DAS matches overpayment recovery files and withholds payments when the debtor meets all of the following criteria:</p> <ul style="list-style-type: none"><li>◆ The debtor owes at least \$50.</li><li>◆ The warrant is at least \$50.</li><li>◆ The debtor has received at least one demand letter for:<ul style="list-style-type: none"><li>• A Child Care Assistance claim, or</li><li>• A FIP or RCA claim established after February 1986, or</li><li>• A Food Assistance claim, or</li><li>• A <b>hawk-i</b> claim, or</li><li>• A Medicaid claim established after June 1987, or</li><li>• A PROMISE JOBS claim, or</li><li>• A State Supplementary Assistance claim established after June 1987.</li></ul></li><li>◆ The debtor has failed to make an agreement on at least one claim per program or has failed to keep current with an agreement.</li></ul> <p>The debtor is allowed 15 calendar days to file an appeal of the offset. After the appeal period, the Public Assistance Debt Recovery Unit informs DAS to release the warrant or the amount of the warrant that should be paid.</p>
Distribution	The original is sent to the debtor. One copy is sent to the Department of Administrative Services. One copy is kept in the Public Assistance Debt Recovery Unit file.
Data	Public Assistance Debt Recovery staff address the form and enter the dollar amounts.

**Notice of Income (Payroll) Offset, Form 470-4140**

Purpose	Form 470-4140 is issued to inform a state employee that part of the employee's salary is being garnished to repay a debt owed as a result of a DHS overpayment.
Source	The Department of Inspections and Appeals issues form 470-4140.
Completion	<p>The Public Assistance Debt Recovery Unit sends the garnishment letter when the Department of Administrative Services matches overpayment recovery files and finds debtors who:</p> <ul style="list-style-type: none"><li>◆ Are state employees.</li><li>◆ Owe at least \$50.</li><li>◆ Have received at least one demand letter for:<ul style="list-style-type: none"><li>• A Child Care Assistance claim, or</li><li>• A FIP or RCA claim established after February 1986, or</li><li>• A Food Assistance claim, or</li><li>• A <b>hawk-i</b> claim, or</li><li>• A Medicaid claim established after June 1987, or</li><li>• A PROMISE JOBS claim, or</li><li>• A State Supplementary Assistance claim established after June 1987.</li></ul></li><li>◆ Have failed to make an agreement on at least one claim per program or has failed to keep current with an agreement.</li></ul> <p>The debtor is allowed a 15-calendar-day appeal period and the opportunity to make a cash agreement. If no alternative arrangements are made, the employee's salary is garnished.</p>
Distribution	<p>One copy is sent to the debtor.</p> <p>One copy is sent to the central payroll unit in the Department of Administrative Services.</p> <p>One copy is kept in the Public Assistance Debt Recovery Unit file.</p>
Data	Public assistance debt recovery staff address the form and enter the dollar amounts.

**[Notice of Lost Benefits, Form 470-0334](#)**

Purpose	Form 470-0334 is used to notify the household of entitlement to lost Food Assistance benefits.
Source	Complete form 470-0334 on line using the template on the DHS Intranet eForms web page.
Completion	Complete the original and one copy of the form when: <ul style="list-style-type: none"><li>◆ You determine that a household is entitled to restoration of lost benefits, or</li><li>◆ A restoration of lost benefits is ordered by a hearing decision.</li></ul>
Distribution	Send the original to the household. Keep the copy in the case record.
Data	The form explains: <ul style="list-style-type: none"><li>◆ The amount of lost benefits.</li><li>◆ Any amount applied against an uncollected claim against the household.</li><li>◆ The household's right to appeal any disputed benefits.</li></ul>

**[Notice of Medical Assistance Debt Due to a Transfer of Asset\(s\), Form 470-4667](#)**

Purpose	Form 470-4667, <i>Notice of Medical Assistance Debt Due to a Transfer of Asset(s)</i> , is an official notice of a medical assistance debt due to a transfer of assets. It is also a written agreement between a debtor and the Department for repayment when a medical assistance debt due to a transfer of assets exists.
Source	Form 470-4667 is generated by the Overpayment Recovery System, operated by the Division of Data Management.
Completion	The Overpayment Recovery System generates and inserts specific DHS debt information into the form. The system prints this form on the last working day of each month.
Distribution	<p>One copy is mailed to the debtor from DHS central office with a return envelope enclosed.</p> <p>The debtor should return the completed form to the Iowa Department of Inspections and Appeals, Public Assistance Debt Recovery Unit, Lucas Building, Third Floor, 321 E 12th Street, Des Moines, IA 50319-0083 within 20 days.</p> <p>When a debtor fails to respond, other collection actions can be pursued. Other collection actions include:</p> <ul style="list-style-type: none"><li>◆ Take the debtor's Iowa income tax refund.</li><li>◆ Take money that is owed to the debtor by any state agency.</li><li>◆ Wage garnishment.</li></ul>
Data	The system completes the debtor's name, the Medicaid member's name, the case number, and the amount of the debt. The debtor completes the choice of repayment and signs and dates the form.

**Notice of Medical Assistance Overpayment, Form 470-2891**

Purpose	<p>Form 470-2891:</p> <ul style="list-style-type: none"><li>◆ Informs the Medicaid, IowaCare, or State Supplementary Assistance debtor of the amount and reason for the overpayment and requests repayment.</li><li>◆ Serves as the debtor's agreement for cash repayment.</li></ul>
Source	<p>Form 470-2891 is generated monthly by the Overpayment Recovery System.</p>
Completion	<p>The form is printed on the last working day of the month for debtors who:</p> <ul style="list-style-type: none"><li>◆ Have a Medicaid, IowaCare, or State Supplementary Assistance claim entered on the Overpayment Recovery system, and</li><li>◆ Have not submitted an agreement to repay the debt.</li></ul> <p>The form is partly completed by the Overpayment Recovery System. The debtor is responsible for completing the agreement to repay.</p> <p>One form must be sent before a debt setoff (state tax refunds) or any other income offset (state warrants) takes place.</p> <p>The form is no longer sent to the debtor when:</p> <ul style="list-style-type: none"><li>◆ The claim is suspended, or</li><li>◆ An agreement to repay is received, or</li><li>◆ Four forms have been sent.</li></ul>
Distribution	<p>One copy is mailed from Central Office.</p> <p>The debtor should return the completed bottom portion of the form to Department of Inspections and Appeals, Public Assistance Debt Recovery Unit, Third Floor, 321 E 12th Street, Des Moines, IA 50319-0083.</p>
Data	<p>The system completes the amount and type of error. The debtor completes the repayment terms.</p>

**[Notice of Pending Medicaid Application, Form 470-2631](#)**

Purpose	<p>Form 470-2631 is used to notify both Disability Determination Services (DDS) and the Social Security Administration (SSA) when a Medicaid application has been filed with the Department and the applicant states there is a decision pending on disability benefits administered by the SSA.</p> <p>DDS and SSA use this form to respond to the IM worker on the status of the identified case.</p>
Source	<p>Complete this form on line using the template on the DHS Intranet eForms web page.</p>
Completion	<p>The IM worker completes Sections I and III of the form each time Medicaid eligibility is being determined based on disability (other than for Medically Needy) when the applicant states that the applicant has applied for disability benefits administered by the SSA.</p> <p>Upon receipt of this notice, DDS reviews its files and responds as indicated on the form. DDS or SSA completes Section II.</p>
Distribution	<p>Send one copy to DDS and one copy to the local Social Security office. Attach a release signed by the client to send information to DDS and SSA. Keep one copy in the case record.</p>
Data	<p>Complete:</p> <ul style="list-style-type: none"><li>◆ The applicant information and IM worker information in Section I.</li><li>◆ The address for the Department office in Section III.</li></ul> <p>Then separate the form and enter the DDS address on one copy and the address for the local Social Security office on the second copy.</p> <p>DDS or SSA completes Section II and returns the form to the IM worker.</p> <p>If DDS is processing an SSA application, then DDS shall enter the claims examiner's name and telephone number under Section II.</p>

**[Notice of Setoff of an Iowa Income Tax Refund for Debts Owed the Department of Human Services, Form 470-1668](#)**

Purpose	Form 470-1668 is issued to inform debtors that part or all of their state tax refund is being withheld to repay a DHS overpayment.
Source	The Department of Inspections and Appeals issues form 470-1668.
Completion	<p>The DIA Public Assistance Debt Recovery Unit sends this notice on the fifth and the fifteenth working day of each month to debtors who meet the following criteria.</p> <ul style="list-style-type: none"><li>◆ The state tax refund is at least \$25, and</li><li>◆ The debtor owes a total of at least \$50, and</li><li>◆ The debtor has received at least one demand letter for:<ul style="list-style-type: none"><li>• A Food Assistance claim, or</li><li>• A FIP or RCA claim established after February 1986, or</li><li>• A PROMISE JOBS claim, or</li><li>• A Child Care Assistance claim, or</li><li>• A <b>hawk-i</b> claim, or</li><li>• A Medicaid or State Supplementary Assistance claim established after June 1987.</li></ul></li><li>◆ The debtor has failed to make an agreement on at least one claim per program, or has failed to keep current with an agreement.</li></ul>
Distribution	One copy is mailed to the debtor. The investigator keeps a copy in the Public Assistance Debt Recovery Unit file.
Data	After a 15-calendar-day appeal period has expired, the tax refund is taken or released via computer.

**Notice Regarding Acceptance of Other Benefits, Form 470-0383**

Purpose	The purpose of form 470-0383 is to notify the client in writing of the requirement to apply for and accept any cash benefits or any other medical benefits to which the client may be entitled.
Source	Complete the form on line using the template available on the DHS Intranet eForms web page.
Completion	<p>The income maintenance worker completes Part A of this form whenever information suggests that other cash benefits or other medical benefits are available to the applicant or member.</p> <p>The client completes Part B.</p>
Distribution	<p>Send two copies of the form to the client. The form is designed to fit into a window envelope. Include a preaddressed return envelope to ensure return to the scanning center.</p> <p>You may upload the request to the electronic case file. When the original is returned, it will be scanned and uploaded.</p>
Data	<p>The name, address, social security number, social security claim number, and case number are self-explanatory. When any one of the numbers is not available, insert "NA" in the blank space.</p> <p>Enter the date that is ten calendar days from the date the notice is given to the client or is mailed to the client's current mailing address.</p> <p>Enter the type of benefits for which the client may qualify.</p> <p>Enter the name and address of the agency where application is to be made.</p>

**Notification Regarding Annuity Benefits, Form 470-4382**

Purpose	Form 470-4382 notifies an annuity company that payment of the member's long-term care claims will entitle the state to the remainder benefits on the member's annuity.
Source	Complete this form on line using the template on the DHS Intranet eForms web page. The form may also be printed or photocopied from the sample in the manual.
Completion	The IM worker is responsible for completing and sending this letter to the annuity company that issued the annuity to the member.
Distribution	Send the original to the annuity company. Send one copy of the letter to the member. Keep a copy of the letter in the member's file.
Data	This form is self-explanatory. Complete the name and address sections and sign the letter.

**[Notification to the Bureau of Refugee Services, Form 470-0481](#)**

Purpose	<p>The purpose of form 470-0481 is to notify the Bureau of Refugee Services of any refugees applying for assistance. The information is used to:</p> <ul style="list-style-type: none"><li>◆ Make the applicant aware of the services available,</li><li>◆ Help the applicant locate employment, and</li><li>◆ Maintain statistics regarding the location and number of refugees in Iowa, particularly those needing assistance.</li></ul>
Source	<p>Complete this form on line using the template available on the DHS Intranet eForms web page.</p>
Completion	<p>The income maintenance worker prepares this when a refugee applies for cash or medical assistance. Attach a copy of the applicant's immigration document to this form before sending the form to the Bureau of Refugee Services.</p>
Distribution	<p>Send the original to Bureau of Refugee Services, 401 SW 7th Street, Ste. N, Des Moines, Iowa 50309. File a copy in the case record.</p>
Data	<p>The form contains identifying information about the applicant and the sponsor.</p>

### ORR Certification Letters

Purpose	The purpose of an ORR certification letter is to provide proof that the person has been certified to be a victim of human trafficking, and thus is eligible for public assistance to the same extent as refugees.
Legal reference	The Trafficking Victims Protection Act of 2000, Public Law 106-386, Division A, 114 Stat. 1464 (2000).
Source	The Office of Refugee Resettlement (ORR) at U.S. Department of Health and Human Services issues the certification letters. There are separate formats for adults and for children.
Completion	ORR issues letters to each adult or child that ORR certifies as victims of human trafficking. The signature and make-up of the letters may change without ORR notifying the Department.
Distribution	The person who is issued the certification letter may present it to the Department as proof of eligibility as a victim of trafficking.
Data	The letters contain the following information: <ul style="list-style-type: none"><li>◆ HHS tracking number.</li><li>◆ Certification date: the date that ORR certifies the person as a victim of human trafficking.</li><li>◆ Expiration date: the date the person's status as a victim of human trafficking expires.</li><li>◆ The telephone number that workers can use to verify the letter's validity.</li></ul>

**Other Insurance Request, Form 470-0403**

Purpose	<p>Form 470-0403, <i>Other Insurance Request</i>, is used by the Iowa Medicaid Enterprise (IME) to collect information from Medicaid members or their representative when claims show they may have other health insurance.</p> <p>The information returned on the form is used to identify claims with third-party liability (TPL). This form allows the IME to recover and cost avoid some or all of the Medicaid expenditures made on the member's behalf.</p>
Source	<p>The form is computer-generated by the IME OnBase system.</p>
Completion	<p>The form is prepared automatically when a Medicaid claim code indicates an accident or injury.</p>
Distribution	<p>The form is sent to the member, who returns it to the IME on completion.</p> <p>Once completed by the member or the member's representative, the form may be returned in one of the following ways:</p> <p><b>Mail:</b> Iowa Medicaid Enterprise PO Box 36446 Des Moines, IA 50315</p> <p><b>Phone:</b> Member Services <b>1-800-338-8366</b> or locally in the Des Moines area at <b>515-256-4606</b> (Monday through Friday, 8:00 am to 5:00 pm)</p> <p><b>Email:</b> <a href="mailto:RevColl_Lien@dhs.state.ia.us">RevColl_Lien@dhs.state.ia.us</a></p> <p><b>Fax:</b> 515-725-1352</p>
Data	<p>The form requests information from the member concerning:</p> <ul style="list-style-type: none"><li>◆ The type of health insurance.</li><li>◆ Policy holder information.</li><li>◆ Insurance carrier information.</li></ul>

**Overpayment Recovery Supplemental Information, Form 470-0465**

Purpose	<p>Form 470-0465 informs the Public Assistance Debt Recovery Unit of additional information pertaining to an overpayment. From the information supplied, DIA can better determine whether to pursue voluntary repayment, investigation, civil prosecution, or criminal prosecution.</p> <p>If DIA refers the case for prosecution, this form is submitted to the county attorney to summarize the basis for the investigation.</p>
Source	<p>Department staff can complete this form on line using the template on the DHS Intranet eForms web page. Other users may print or photocopy supplies from the sample in the manual.</p>
Completion	<p>IM workers complete this form for overpayments in FIP, Refugee Cash Assistance, Food Assistance, Medicaid, Child Care Assistance, and State Supplementary Assistance.</p> <p>PROMISE JOBS workers complete this form for overpayments in Child Care Assistance and PROMISE JOBS programs.</p> <p>The <b>hawk-i</b> program's third-party administrator completes this form for <b>hawk-i</b> overpayments.</p> <p>Prepare an original and one copy of this form when:</p> <ul style="list-style-type: none"><li>◆ A claim is being revised, and<ul style="list-style-type: none"><li>• It is now a client error of over \$1,000, and</li><li>• The worker did not previously complete either form 470-0465 or a fraud referral screen in the direct claim entry screen.</li></ul></li><li>◆ The DIA Division of Investigations requests the information to pursue recovery action.</li><li>◆ The IM Unit wishes legal action pursued.</li><li>◆ Recovery will be attempted from the resources of an alien's sponsor.</li></ul>

**Distribution** Submit the original along with the Overpayment Recovery Information Input Summary (from the direct claim entry screen), or the *Overpayment Recovery Information Input*, form 470-0464, to:

DIA Investigations Division  
Public Assistance Debt Recovery Unit  
Lucas Building, Third Floor  
321 E 12th St., Des Moines, Iowa 50319-0083

(or send by local mail). Keep a copy in the case record.

**Data** Make the following entries:

**State ID:** Enter the debtor's state identification number.

**ABC case no.:** Depending on the type of claim, enter the debtor's ABC case number.

**hawk-i case no.:** If this is a *hawk-i* claim, enter the debtor's *hawk-i* case number.

**SRS case no.:** Depending on the type of claim, enter the debtor's SRS or KinderTrack case number.

**Summary regarding overpayment:** Give a brief statement regarding the condition that caused the overpayment.

**Possible witnesses and evidence:** List separately each person who can provide truthful and relevant testimony regarding the overpayment. Include the person's name, current address, and telephone number.

Under each witness's name, describe what that witness can testify to, including time and dates of contacts or statements. Be specific, but brief.

If the person is an employee of a state agency, name the county of location where the person is employed. List the office telephone number and the type of caseload carried.

List all related documents, giving the date of each document (examples: application, RRED, NOD). In addition, list all signed statements available from either the recipient or a collateral source.

Maintain all related documents in the case record until complete recovery has been made or the Division of Investigations requests the documents.

**Worker:** Sign the form when it is completed.

**Date:** Enter the date the form is completed.

**PASRR Case Activity Report, Form 470-5386**

Purpose	Form 470-5386, <i>PASRR Case Activity Report</i> , 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 <a href="http://dhs.iowa.gov/ime/providers/forms">http://dhs.iowa.gov/ime/providers/forms</a> .
Completion	Facility staff must complete entries in PathTracker Plus when a resident: <ul style="list-style-type: none"><li>◆ Enters the facility.</li><li>◆ Transfers out of the facility.</li><li>◆ Is discharged.</li><li>◆ Died.</li><li>◆ Has a change in level of care.</li><li>◆ Has a change in payment source. (I.e., Medicare coverage, newly approved for Medicaid, private pay, etc.)</li></ul>
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 <i>PASRR Case Activity Report (CAR)</i> 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. Kaneshville Blvd. Council Bluffs, IA 51503-4470 Fax: 515-564-4040 Email: <a href="mailto:facilities@dhs.state.ia.us">facilities@dhs.state.ia.us</a>

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. Kaneshville Blvd.  
Council Bluffs, IA 51503-4470  
Fax: 515-564-4014  
Email: [97cmz2@dhs.state](mailto: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 <i>Payment Application for Nonregistered Providers</i> , 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	<p>The provider completes the application when:</p> <ul style="list-style-type: none"><li>◆ Applying for payment for the first time; or</li><li>◆ Applying for a two-year renewal; or</li><li>◆ Applying after the expiration of a previous agreement; or</li><li>◆ There is a change of name, care, living or mailing address, or household composition.</li></ul> <p>The provider shall complete the form after reading all the instructions and the minimum requirements in Comm. 95, <i>Guidelines for Child Care Homes with a Child Care Assistance Provider Agreement</i>.</p>
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	<p>The applicant-provider shall:</p> <ul style="list-style-type: none"><li>◆ Indicate whether this is a new application or a renewal.</li><li>◆ Carefully print the name (and maiden name and other last names, if any) and addresses.</li><li>◆ Enter the birth date, last four digits of the social security number, and telephone numbers with area codes.</li><li>◆ 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.</li></ul>

- ◆ In-home providers list the names of the parents and children living in the home where care will be provided, if available.
- ◆ Sign the application and date it to certify compliance with the minimum requirements of the Department of Human Services and indicate agreement with the eight numbered statements.

**Pregnancy Verification Request, Form 470-3783**

Purpose	Form 470-3783, <i>Pregnancy Verification Request</i> , is used to collect information for certain Medicaid programs when the household reports a member of the household is pregnant.
Source	Complete the form on line using the template available on the DHS Intranet eForms web page.
Completion	Complete this form when a household reports a member of the household is pregnant.
Distribution	Give one copy of the form to the client. You may upload the request to the electronic case file. When the client completes and returns the form, it will be scanned and uploaded.
Data	Certain areas of the form populate and a due date is calculated for return of the completed form.

**Presumptive Medicaid Eligibility Notice of Decision, Form 470-2580 or 470-2580(S)**

Purpose	<p>The <i>Presumptive Medicaid Eligibility Notice of Decision</i> is used to:</p> <ul style="list-style-type: none"><li>◆ Notify pregnant women, children, or women needing treatment for breast or cervical cancer of the qualified provider's presumptive eligibility decision.</li><li>◆ Verify presumptive Medicaid eligibility for Medicaid providers rendering:<ul style="list-style-type: none"><li>• Ambulatory prenatal care services to pregnant women, or</li><li>• Full Medicaid services to children or to women with breast or cervical cancer.</li></ul></li></ul>
Source	<p>The presumptive eligibility program generates form 470-2580 or 470-2580(S) based on entries the qualified provider makes through the Iowa Medicaid Provider Access (IMPA) Portal.</p>
Completion	<p>The qualified provider makes entries into the presumptive eligibility program to complete the form when:</p> <ul style="list-style-type: none"><li>◆ A woman has filed form 470-2927 or 470-2927(S), <i>Health Services Application</i>, with the qualified provider; or</li><li>◆ A child or someone acting on a child's behalf has filed form 470-4855 or 470-4855(S), <i>Application: Presumptive Health Care Coverage for Children</i>, with the qualified provider.</li></ul>
Distribution	<p>A copy of the notice will be saved in the presumptive eligibility system. The qualified provider shall:</p> <ul style="list-style-type: none"><li>◆ Print the notice,</li><li>◆ Give or mail a copy to the applicant, and</li><li>◆ Keep a copy in the presumptive Medicaid record.</li></ul>

Data

The presumptive eligibility program completes the information on the notice based on the entries the qualified provider made.

- ◆ For approvals, the system enters:
  - Which type of presumptive eligibility is approved.
  - The woman or child's state identification number.
  - The beginning date of presumptive eligibility.
  - The ending date for presumptive eligibility.
  - Whether the application has already been sent to the Department or the patient needs to submit a Medicaid application.
- ◆ For denials, the system provides an explanation of denial (e.g., you are over income, you have already received presumptive eligibility during this pregnancy, etc.).
- ◆ The system enters the name, address, telephone number, and email address of the provider making the determination.

**Proof of Application for Medicaid, Form 470-2979**

Purpose	Form 470-2979, <i>Proof of Application for Medicaid</i> , provides the client a letter to verify that the client has applied for Medicaid. Clients may show this form to providers or others as proof of their application.
Source	Complete this form on line using the template on the DHS Intranet eForms web page.
Completion	IM workers complete the form when clients request proof that they have applied for Medicaid.
Distribution	Give or send the original copy to the client.
Data	Enter: <ul style="list-style-type: none"><li>◆ The name of the IM worker.</li><li>◆ The county number designation.</li><li>◆ The name and address of the applicant.</li><li>◆ The notice date (the date the form is completed).</li><li>◆ The date the household applied for Medicaid.</li><li>◆ The names of the individuals included in the application for Medicaid.</li></ul>

**Proof of Medicaid Coverage, Form 470-3491**

Purpose	Form 470-3491 provides evidence of prior health coverage under the Medicaid program. Clients may need to furnish this certificate if they become eligible under a group health plan that excludes coverage for medical conditions they had before enrollment (pre-existing conditions).
Source	This form is system-generated.
Completion	All entries are made by the system. The form is automatically sent ten days following the last day of the month in which the person lost Medicaid coverage.
Distribution	One copy is sent to Medicaid beneficiaries who have been terminated from Medicaid.

**Provider Request for Member Disenrollment, Form 470-2169**

Purpose	<p>Managed health care providers can use form 470-2169 to request that a Medicaid member assigned to them be disenrolled or reassigned. Completion of this form does not cause immediate disenrollment.</p> <p>Disenrollment is not effective until the managed health care review committee has reviewed the request and the IME Provider Services Unit has coded disenrollment with an effective date. Enrollment still exists until the provider's name no longer appears on the recipient's pink <i>Medical Assistance Eligibility Card</i>.</p>
Source	<p>This form is issued to managed health care providers in their managed care handbook. Additional copies are available to participating providers upon request to the IME Provider Services Unit.</p>
Completion	<p>The managed health care provider completes Parts A and B of this form when the provider wants to stop serving the member due to:</p> <ul style="list-style-type: none"><li>◆ The member's age or sex being outside the provider's normal scope of treatment.</li><li>◆ Issues such as failing to show up for appointments, noncompliance with treatment, and abusive or drug-seeking behavior.</li></ul> <p>An authorized member of the managed health care review committee is responsible for completing Part C of this form.</p>
Distribution	<p>The provider keeps a copy and mails the original to:</p> <p style="text-align: center;">IME Provider Services Unit PO Box 36450 Des Moines, Iowa 50315</p> <p>Managed health care staff send a copy of the form to the member at the time of the provider's original request.</p>

After the Review Committee decision has been recorded, the form shall be distributed as follows:

- ◆ The review committee retains the original.
- ◆ A copy is sent to the provider.

The IME Provider Services Unit does not enter any system action to disenroll the member until it has received instructions from the Division of Medical Services regarding the managed health care review committee's decision.

Data

**Part A. Provider information:** The managed health care provider completes Part A as follows:

- ◆ Check type of managed health care that applies.
- ◆ Enter name of managed health care provider.
- ◆ Enter Medicaid provider identification number or national provider identifier of the managed health care provider.
- ◆ Enter address of managed health care provider.
- ◆ Enter signature of authorized person making request for provider.
- ◆ Enter date the request is signed.

**Part B. Disenrollment request:** The managed health care provider completes Part B as follows:

- ◆ Enter name of each member for whom disenrollment is requested.
- ◆ Enter state Medicaid personal identification number for each member for whom disenrollment is requested.
- ◆ State reasons for each person for whom disenrollment is being requested by using disenrollment reason/code.  
Additional documentation shall be attached, if necessary.

**Part C. Managed Health Care Review Committee**

**Decision:** The Managed Health Care Review Committee shall make a decision within 30 days of receipt of the request. When the form is completed, the MHC team member shall make the appropriate system entries within ten days.

Section C shall contain approval of the request, a denial of the request, or some specific instructions as to how the managed health care team or managed health care provider should proceed.

- ◆ Indicate the decision of the Managed Health Care Review Committee: "approve," "deny," or "other." If "other" is checked, an explanation should be included in the comments section.
- ◆ Include comments of the Managed Health Care Review Committee, if appropriate.
- ◆ Use this area to relay specific instructions to the income maintenance worker concerning implementation of the Review Committee's decision.
- ◆ An authorized member of the Managed Health Care Review Committee shall sign as the designee of the administrator of the Division of Medical Services. The date signed shall be included.

**Provider Special Needs Decision, Form 470-5321**

Purpose	The <i>Provider Special Needs Decision</i> , form 470-5321, is used to tell a provider whether or not a family's children have been approved to receive special needs payment rates.
Source	Complete this form on line using the template on the DHS Intranet eForms web page.
Completion	After the decision on whether or not to approve special needs rates has been made, the worker completes this letter with the: <ul style="list-style-type: none"><li>◆ Provider's mailing address.</li><li>◆ Child's name.</li><li>◆ Child's case number.</li></ul>
Distribution	Send this letter to the provider. File a copy of the letter in the DHS case record.
Data	This letter provides information to a child care provider regarding: <ul style="list-style-type: none"><li>◆ Whether or not special needs payment rates are approved for a child.</li><li>◆ Basic information regarding the definition of a special needs child.</li><li>◆ How a provider may qualify for special needs payment rates.</li></ul>

**Public Assistance Agency Information Request, Form SSA-1610-U2**

Purpose	The local DHS office is to use the <i>Public Assistance Agency Information Request</i> for exchange of information with the Social Security Administration that is not included on the TPQY response.
Source	Print or photocopy supplies of form SSA-1610-U2 from the sample in the manual as needed.
Completion	<p>The local DHS worker responsible for the case shall prepare form SSA-1610-U2 in the following situations:</p> <ul style="list-style-type: none"><li>◆ To resolve any discrepancies between other evidence and data in the TPQY files, such as an identification problem.</li><li>◆ To secure retroactive historical data not provided by the TPQY.</li><li>◆ To provide information to the Social Security office regarding mutual clients, e.g., a FIP case in which an SSI application is pending. Refer to <a href="#">4-C</a>, <u>SSI Recipient</u>.</li></ul> <p>Use of the SSA-1610-U2 shall be limited to these circumstances except for emergencies. Each Department office should arrange with its Social Security office for handling emergencies.</p>
Distribution	<p>Send the original to the local Social Security office. When information is being submitted to the Social Security office, you may upload the request to the electronic case file.</p> <p>When the Social Security returns the original, it will be scanned and uploaded to the case record.</p>
Data	Specific instructions for completing the form are printed on the back of the form.

**Quality Assurance Transmittal, Form 470-0271**

Purpose	<p>The <i>Quality Assurance Transmittal</i> is used to request the Quality Assurance Unit of the Division of Data Management to:</p> <ul style="list-style-type: none"><li>◆ Cancel a warrant,</li><li>◆ Issue a one-time payment, or</li><li>◆ Cross-reference a state identification number.</li></ul>
Source	<p>Complete form 470-0271 on line using the template on the DHS Intranet eForms web page.</p>
Completion	<p>The IM worker completes the "Date," "From," and "Case Identification" sections and completes the rest of the form depending on the action being requested:</p> <ul style="list-style-type: none"><li>◆ <b>Cancel Warrant:</b> When a client returns a warrant to a Department office, enter the warrant number, amount, and date in this section. Attach the warrant and the official receipt to the white copy of the 470-0271 and send them to Quality Assurance.</li></ul> <p>If Quality Assurance has the warrant, send the form alone to Quality Assurance. Leave the warrant number field blank for Quality Assurance to complete.</p> <p>In both cases, Quality Assurance takes the necessary actions to remove the warrant from the client's automated records.</p> <ul style="list-style-type: none"><li>◆ <b>Issue One-Time Special Payment Over \$1800:</b> To request the payment, check this box and enter the amount of payment. Send 470-0271 to the designated person in the service area, with a memo attached to explain why the payment is needed.</li></ul> <p>The designated service area person will sign the form in the space provided, and forward it to Quality Assurance. Quality Assurance authorizes the amount for ABC system issuance.</p> <ul style="list-style-type: none"><li>◆ <b>State ID Cross Reference:</b> If two or more state identification numbers are on record for a client, use this section to indicate which state ID should be removed.</li></ul>

Also use this section to indicate any social security number that should be removed, in order to enter the number with another state identification record.

In all cross-reference situations, use the "Comments" section to explain your request.

If the name and state identification number of a child need to be changed due to adoption, but the child's social security number remains the same, use this section, but enter the new name under "Comments."

Distribution

Send the form in an envelope via local mail to Quality Assurance, Division of Data Management, Hoover Building. Keep one copy for case file.

Quality Assurance contacts the worker who initiated the request if more information is needed before the requested actions are completed. Quality Assurance will return incomplete transmittals to the worker, so errors are prevented.

Quality Assurance may encounter error conditions when attempting to cross-reference state identification numbers. Edits prohibit deletion of state identification numbers that do exist and are used on current ABC individual income records or have active, disqualified, or sanctioned status codes on ABC.

Data

Self-explanatory.

**Quarterly Report Follow-Up, Form 470-2721**

Purpose	The <i>Quarterly Report Follow-Up</i> notifies the member of the additional information and verifications necessary to complete the <i>Transitional Medicaid Notice of Decision/Quarterly Income Report</i> and informs the member of the due date for submitting the information.
Source	Complete this form on line using the template on the DHS Intranet eForms web page.
Completion	The IM worker completes the form when the client returns a <i>Transitional Medicaid Notice of Decision/Quarterly Income Report</i> and either: <ul style="list-style-type: none"><li>◆ Some of the questions were not answered, or</li><li>◆ Not all of the required proof was sent with the report.</li></ul>
Distribution	Mail or give the original to the member. File the copy in the case file.
Data	Enter the date, case name, and current mailing address where indicated.  Check the first box if the member failed to answer all of the questions on the report.  Check the second box if all required proof is not sent in with the report.  List the missing proof in the spaces provided.

**Race/Ethnic Report, Form 470-3716**

Purpose	<p>Form 470-3716 is used to gather information about race and ethnicity for a person associated with the Food Assistance household or FIP assistance unit.</p> <p>Clients are not required to provide this information. However, it is a federal requirement that Iowa report race or ethnicity for all who do provide the information.</p>
Source	<p>Initiate form 470-3716 on line using the template on the DHS Intranet eForms web page.</p>
Completion	<p>Issue this form whenever you realize that you do not have race or ethnicity information for all adults and children who are in the Food Assistance household or are associated with the FIP assistance unit, including people who are not included on the grant, such as stepparents, excluded parents, etc.</p> <p>Also issue the form when the household applies for benefits for a new household member.</p> <p>NOTE: Clients are not required to complete this form. If clients decline to do so, it does not affect their eligibility or their benefits.</p> <p>If clients decline to answer the questions or complete the form, use worker observation to collect the data. When observation is not possible, document that the form was offered but the client chose not to supply the information.</p>
Distribution	<p>Enter the race and ethnicity information collected for each person on the ABC system.</p>
Data	<p>Clients can choose one selection for ethnicity and choose as many selections as apply for race.</p>

**Reasonable Compatibility Tool, Form 470-5178**

Purpose	IM workers use the <i>Reasonable Compatibility Tool</i> to determine if an applicant's statement of income can be considered to be verified as it is reasonably compatible with income information from state data sources. Workers use this form for MAGI-Related Medicaid only.
Source	IM staff can complete this form on line using the tool on the DHS Intranet eForms web page.
Completion	The IM worker completes applicable fields of the tool when determining eligibility for MAGI-Related Medicaid for a member with countable income.
Distribution	File a copy of the completed tool in the case file.
Data	<p>The IM worker enters data as follows:</p> <ul style="list-style-type: none"><li>◆ <b>State Source Income</b> tab: Enter the amount of monthly income obtained from state data sources for each member.</li><li>◆ <b>Self-Attested Income</b> tab: Enter countable monthly income for each member in the field that identifies the type of income.</li><li>◆ <b>Reasonable Compatibility</b> tab: The tool determines if the difference between the member's self-attested income amount and state data source income amount is within 10% of the state data source income amount. The percentage of difference is displayed in the <i>Compatibility Percentage</i> field:<ul style="list-style-type: none"><li>• The <i>Reasonably Verified</i> field says "True" if the percentage is 10% or less. The worker may consider the income to be verified.</li><li>• The <i>Reasonably Verified</i> field says "False" if the percentage is more than 10%. The worker must obtain additional verification of the income.</li></ul></li></ul>

**Record of Lost Benefits Restored, Form 470-0318**

Purpose	Form 470-0318 is used to document the amount of lost benefits owed and the amount of lost benefits restored to a household.
Source	Complete form 470-0318 on line using the template on the DHS Intranet eForms web page.
Completion	<p>Complete form 470-0318 when you determine that a household is entitled to a restoration of lost benefits or when a restoration of lost benefits is ordered by a hearing decision. Notify the household of its entitlement to lost benefits by completing the <i>Notice of Lost Benefits Entitlement</i>, form 470-0334.</p> <p>Print an original and one copy of form 470-0318. Print one additional copy for each additional month for which benefits are restored.</p>
Distribution	File the original in the household's case record. Send one copy to the Bureau of Purchasing, Payments, Receipts and Payroll. If the household requests issuance in more than one month to restore lost benefits, forward an additional copy to the Bureau of Purchasing, Payments, Receipts and Payroll following each month's issuance.
Data	<p>Complete the form as follows:</p> <ul style="list-style-type: none"><li>◆ Complete Items 1 through 7 to establish the amount of and the reason for the restoration of lost benefits.</li><li>◆ If there is an unpaid claim against the household, enter the unpaid amount in Item 8. EXCEPTION: If the unpaid amount of the claim exceeds the amount in Item 7, enter the same amount as in Item 7.</li></ul> <p>To give the household credit on its claim, complete the form 470-0010, <i>Adjustment to Overpayment Balance</i>, showing the amount in Item 8 for the Bureau of Purchasing, Payments, Receipts and Payroll.</p> <ul style="list-style-type: none"><li>◆ If benefits are restored in a lump sum, complete Item 10.</li><li>◆ If benefits are restored in monthly installments per household request, complete Item 11, as needed.</li></ul>

**Redetermination to Other Medical Programs, Form 470-4832**

Purpose	Form 470-4832, <i>Redetermination to Other Medical Programs</i> , is used when eligibility for Medicaid ends. It explains other medical programs that the member may be eligible for, and it requests the necessary information to determine eligibility for those alternatives.
Source	Form 470-4832 is available on line on the DHS Intranet eForms web page.
Completion	When eligibility for Medicaid ends, the worker may send this letter to the member. Any or all of the following program descriptions may be included: <ul style="list-style-type: none"><li>◆ Medically Needy</li><li>◆ Family Planning Services</li><li>◆ MEPD</li></ul>
Distribution	Send the letter to the member. You may upload the request to the electronic case file. When the member returns the requested information, it will be scanned and uploaded.

Page 310 is reserved for future use.

**Referral for Early and Periodic Screening, Diagnosis and Treatment, Form 470-0362**

Purpose	Form 470-0362 is completed to provide a record that screening was discussed with a child's parent or other responsible adult and to identify whether a child is referred to a physician or screening center. It is the resource document for input of the information concerning the results of the discussion on the ABC system.
Source	Form 470-0362 is printed with 25 forms on a pad. Order supplies from Iowa Prison Industries at Anamosa.
Completion	The IM worker responsible for the case completes the form when screening is discussed with the client, usually at the time of application.
Distribution	Keep the original in the "Health" section of the case file. Give the copy to the family (if requested).
Data	<p>Use one form per case, unless circumstances require additional forms. Note in the "Remarks" section all special procedures taken to inform the client, special actions or services requested, and local office response to the request.</p> <p>If there is no face-to-face interview, mail the form to the applicant with a request for the family to complete the form and return it to the local office. If the family does not return the form, complete another form to document the offer and the failure to respond.</p>

**Referral to the *hawk-i* Program, Form 470-3565**

Purpose	<p>Form 470-3565 is designed to notify MAXIMUS, the third-party administrator of the <b><i>hawk-i</i></b> program, that a child who was receiving Medicaid coverage has become ineligible for Medicaid or must meet a spenddown under the Medically Needy program.</p> <p>The form is also used to refer Medicaid applications to the <b><i>hawk-i</i></b> program when the child does not qualify for Medicaid but is potentially eligible for <b><i>hawk-i</i></b>. The referral is considered an application for the <b><i>hawk-i</i></b> program. Upon receipt, MAXIMUS will notify the family of the referral and begin the eligibility process.</p>
Source	<p>Complete form 470-3565 on line using the template on the DHS Intranet eForms web page.</p>
Completion	<p>The IM worker responsible for the case completes the form.</p>
Distribution	<p>Send the form to MAXIMUS via fax or mail it to:</p> <p>Iowa Medicaid Enterprise Attn: MAXIMUS/<b><i>hawk-i</i></b> Program 100 Army Post Road Des Moines, IA 50315 Fax: 877-457-7701</p> <p>Make a copy for the case file to document the referral.</p>
Data	<p>Enter:</p> <ul style="list-style-type: none"><li>◆ Whether referral is being made on a denied case or individual or a canceled case or individual. Provide the Medicaid application date for referrals on denied cases or individuals.</li><li>◆ Identifying information about the income maintenance worker and the case.</li><li>◆ The names, social security numbers, birth dates, and relationships for household members. Provide the Medicaid end date for referrals on canceled cases or individuals.</li><li>◆ The reason the case is being referred to <b><i>hawk-i</i></b>.</li></ul>

- ◆ The names of children who have been voluntarily excluded from Medicaid and thus are ineligible for *hawk-i*.
- ◆ Income source information for all family members, income information for voluntarily excluded children and information about non-recurring lump sum income being prorated, self-employment income, or unemployment benefits being received by a family member.

Note any attachments.

**[Refugee Referral to IWD and to Refugee Services, Form 470-0480](#)**

Purpose	<p>Form 470-0480 is used in the Refugee Cash Assistance program to refer an employable refugee to the Iowa Workforce Development (IWD) and to the Bureau of Refugee Services.</p> <p>IWD uses the form to register the refugee for employment. The Bureau of Refugee Services uses the form to register the refugee for employment or training and to notify the local Department office when registration is complete.</p>
Source	<p>Complete form 470-0480 on line using the template on the DHS Intranet eForms web page.</p>
Completion	<p>The IM worker prepares the form, except for the IWD signature and date and the Bureau of Refugee Services' signature and date.</p> <p>Prepare this form:</p> <ul style="list-style-type: none"><li>◆ At the time of application for those refugees determined to be employable.</li><li>◆ At any time a refugee who has been exempt from employment is no longer exempt and must register for employment.</li></ul>
Distribution	<p>Give two copies to the refugee to take to IWD when registering for work. You may upload the request to the electronic case file.</p> <p>IWD returns the form to the refugee, who mails the form to the Bureau of Refugee Services. The Bureau of Refugee Services keeps a copy and returns the original to the IM worker.</p> <p>When scanning center receives the completed copy, it will be scanned and uploaded.</p>
Data	<p>This form identifies the refugee and the IM worker.</p>

**Renewal Application Addendum, Form 470-5199 or 470-5199(S)**

Purpose	<p>MAGI-related Medicaid and <b>hawk-i</b> applicants and recipients use the <i>Renewal Application Addendum</i> to provide tax information and consent to compare reported information with data sources on household members not included on the:</p> <ul style="list-style-type: none"><li>◆ <i>Application for Health Coverage and Help Paying Costs</i>, form 470-5170 or 470-5170(S), or</li><li>◆ <i>Medicaid/hawk-i Review</i>, form 470-5168 or 470-5168(S).</li></ul>
Source	<p>Complete the English or Spanish version of the form on line using the template available on the DHS Intranet eForms web page.</p> <p>Supplies of the addendum may also be printed or photocopied from the sample in the manual.</p>
Completion	<p>The MAGI-related Medicaid or <b>hawk-i</b> applicant or recipient completes the addendum.</p> <p>The applicant or recipient may obtain help in completing the addendum from friends, relatives, advocate groups, or Department staff, if needed.</p>
Distribution	<p>File the addendum and the <i>Application for Health Coverage and Help Paying Costs</i>, form 470-5170 or 470-5170(S), or the <i>Medicaid/hawk-i Review</i>, form 470-5168 or 470-5168(S).</p>
Data	<p>The worker completes the <i>Case Number</i> field in the upper right corner of page 1 before the form is sent or issued to the applicant or recipient.</p> <p>The applicant or recipient must print their name, and sign and date page 1 of the addendum.</p> <p>The applicant or recipient must complete the Tax Information section for each household member not listed on the <i>Application for Health Coverage and Help Paying Costs</i>, form 470-5170 or 470-5170(S), or <i>Medicaid/hawk-i Review</i>, form 470-5168 or 470-5168(S).</p>

**Report of Change in Circumstances – SSI-Related Programs, Form 470-0641**

Purpose	<p>Form 470-0641 is designed to be used for reporting to the Social Security Administration:</p> <ul style="list-style-type: none"><li>◆ Any change in circumstances that might alter the Supplemental Security Income (SSI) payment issued to a client of one of the assistance programs administered by the Department.</li><li>◆ A change of address for a person receiving Medicaid as an SSI beneficiary.</li></ul>
Source	<p>Complete form 470-0641 on line using the template on the DHS Intranet eForms web page.</p>
Completion	<p>The IM worker responsible for the case initiates the form:</p> <ul style="list-style-type: none"><li>◆ Whenever there is a change in a client's circumstances which may change the person's SSI payment, or</li><li>◆ To inform the Social Security Administration of a change of address that has been reported to the Department.</li></ul>
Distribution	<p>Forward the original and one copy to the local Social Security Administration office. You may upload the request to the electronic case file.</p> <p>The Social Security Administration office indicates action on form, keeps a copy, and returns a copy to the Department as soon as action is taken. When the original is returned, it will be scanned and uploaded.</p>
Data	<p>The name of the Social Security Administration office involved and the name of the county populates based on information in the worker profile.</p> <ul style="list-style-type: none"><li>◆ For Section 1, entering the case number and state identification number populates the client's name, social security number, and address.</li><li>◆ For Section 2, obtain the name of the person to be contacted from the client at the time of the reported change, since there could have been a change since the last contact.</li></ul>

- ◆ In Section 3, check the applicable box to indicate the change in circumstances. (Whenever the change involves a new living arrangement, also complete Section 4.)
- ◆ Use Section 4 to report a change of address reported to the Department by a recipient of SSI, State Supplementary Assistance, or Medicaid.
- ◆ Use the "Comment" section to convey information not covered elsewhere on the form. (An employee of the Social Security Administration may also use this section to add information.)
- ◆ Sign and date the form.

The section "To Be Completed by SSA-DO" allows the Social Security Administration to indicate that action has been taken, the date of action, and the resulting change in SSI benefit.

**Report of Quality Control Review, Form 470-0451**

Purpose	Quality Control uses the <i>Report of Quality Control Review</i> to notify the IM worker when an error or new information is found in a case or a possible Food Assistance intentional program violation (IPV) is recommended for investigation.
Source	This form is located on each QC reviewer's share. The QC sections are completed on line.
Completion	<p>The quality control reviewer completes Sections A and B of this form when the review findings are one or more of the following:</p> <ul style="list-style-type: none"><li>◆ The case is found ineligible.</li><li>◆ There is no Medicaid coverage group eligibility.</li><li>◆ There is a Food Assistance overissuance or underissuance error or a potential IPV.</li><li>◆ There is an overstatement or understatement of Medicaid client participation.</li><li>◆ The reason for cancellation or rejection is in error.</li><li>◆ A timely notice of adverse action has not been sent to the applicant or recipient as required in the Food Assistance and Medicaid programs.</li><li>◆ There is new information to report that does not affect quality control findings.</li></ul> <p>If the report contains a reportable error or a Food Assistance potential IPV, the QC supervisor enters the challenge due date.</p> <p>The responsible office completes Section C of the final report to show what action is taken in response to a quality control finding of a reportable error or a potential Food Assistance IPV.</p>
Distribution	<p>When a potential reportable error has been identified, the QC reviewer:</p> <ul style="list-style-type: none"><li>◆ Makes three copies of the form.</li><li>◆ Labels them "Potential Error" in the top margin.</li><li>◆ Sends one copy to the IM worker.</li></ul>

- ◆ Sends one copy to the service area IM supervisor or designee.
- ◆ Attaches one to the review being submitted for monitoring.
- ◆ Incorporates the original within the review.

Upon supervisory determination that a reportable error has been made, the QC reviewer sends a copy of the form to the IM worker and to the service area IM supervisor or designee for challenge purposes before the distribution of the final report.

For the final report of error findings and for potential IPV recommendations and new information, the QC reviewer:

- ◆ Sends two copies to the office where the IM worker is housed.
- ◆ Sends one copy to the service area IM supervisor or designee for a control copy until the copy is received from the IM worker.
- ◆ Sends one copy to the Bureau of Financial, Health and Work Supports, depending on the program under review.
- ◆ Maintains one copy in the quality control case study file.

The IM worker and supervisor complete Section C if the report contains a reportable error or a potential Food Assistance IPV. Upon completion of Section C, clear the response and send a copy to the service area IM supervisor or designee. File the cleared copy in the case record.

When the case record has been transferred to an office other than the office from which the case was selected for review, forward the complete *Report of Quality Control Review* to the current office after copying it. Return the copy to Quality Control indicating to which office you forwarded the form.

The service area IM supervisor or designee:

- ◆ Reviews the response.
- ◆ Corrects it if necessary.
- ◆ Signs and dates it.
- ◆ Sends it to the Bureau of Financial, Health and Work Supports.

The program division:

- ◆ Maintains a control file and keeps the first copy of the form until the IM worker's copy is received.
- ◆ Reviews the IM worker response.
- ◆ Makes note of the action taken by the IM worker.
- ◆ Returns one copy to Quality Control within 30 calendar days.

Data

Complete the form as follows:

Section A.

Identification:

**Name:** The name of the case payee, guardian, or conservator.

**Case number:** Self-explanatory.

**Review number:** The five-digit identifying number for the quality control review. The first digit of the number is called "Lot" and identifies the type of case being studied, as follows:

LOT 4	Medicaid negative
LOT 5	Medicaid-only active
LOT 7	Food Assistance active
LOT 8	Food Assistance negative

**IM worker:** The name of the income maintenance worker who was responsible for the case as of the review date.

**County:** The name of the Department office that has responsibility for the review case on the review date. For Polk County and Lee County enter the branch office, e.g., Polk-Central, Lee-North.

**Area:** The number or name of the service area in which the Department office is located.

**Program:** The type of case being studied, i.e., Food Assistance or Medicaid.

**QC reviewer:** The name of the quality control reviewer who completed the study of the case.

**Review date:** The date for which the quality control reviewer determined the eligibility and payment status of this case.

- ◆ For Medicaid, it is the first day of the month studied.
- ◆ For Food Assistance, it is the first day of the month or the date of certification, whichever is later.

**Report date:** The date the quality control report is mailed to the IM worker.

**Challenge due date:** The date by which the IM Unit has to challenge a reported error (entered by the quality control supervisor).

Section B.  
Findings:

**Verbal report to county office (date):** The date any verbal report was made. Quality Control makes a verbal report to the service area manager or supervisor when Quality Control has information that affects current or future eligibility or payment status.

- ◆ On a negative study:
  - **Incorrect reason for cancellation/rejection:** A check in this box indicates an incorrect reason for cancellation or rejection. For Food Assistance, the box is checked only if the negative action is invalid.
  - **No timely notice sent:** A check in this box indicates a notice was not sent in a timely manner.
- ◆ On an active study:
  - **Case ineligible:** A check in this box indicates the entire case (all members covered by assistance) is ineligible. Enter the exact dollar amount of excess assistance received.
  - **Eligible with ineligible members:** A check in this box indicates a Medicaid-only case study has one or more ineligible members with remaining eligible members in the household. This box is never checked on a food stamp case study.

- **Overissuance/overpayment:** A check in this box indicates too many Food Assistance benefits have been issued, but the case remains eligible. The entry on the line is the exact amount of the overissuance.
- **Underissuance/underpayment:** A check in this box indicates an insufficient amount of Food Assistance benefits were issued. The entry on the line is the exact amount underissued.
- **Client participation overstated:** A check in this box indicates the recipient's client participation is overstated. The entry on the line is the exact amount of overstatement.
- **Client participation understated:** A check in this box indicates the recipient's client participation is understated. The entry on the line is the exact amount of understatement.
- **Agency error:** A check in this box indicates the findings are due to an agency error.
- **Client error:** A check in this box indicates the findings are due to a client error. If there is only one error and the findings are due to both an agency and a client error, only the "Agency Error" box is checked.  
  
If there is more than one error and part of the findings are due to client-caused error and part of the findings are due to agency-caused error, both the "Agency Error" box and the "Client Error" boxes are checked.
- **Food Stamp potential IPV:** A check in this box indicates that the QC reviewer found reason to believe there is a potential intentional program violation indicates on an active Food Assistance case. This box is used for Food Assistance cases only.
- **New information:** A check in this box indicates that the QC reviewer found information unknown to the IM worker. All new information is entered in the "Comments" section.

- **Comments:** For reviews with an error, the QC reviewer lists first the primary error or the error which contributed most to the overall case error, and lists additional errors in descending order.

Each error is explained and the information used to reach a final decision on the case is detailed. When known, the QC reviewer states why and how the error occurred and whether it was agency or client caused.

For reviews with a potential Food Assistance IPV, the reviewer explains the assessment of the potential IPV and attaches evidence of the potential IPV.

When the "New Information" box is checked, the reviewer explains the known details of the information all.

- ◆ **Employees' manual reference:** The comment section lists the manual references used in determining the error explained.

Section C. County  
Office Response:

Do not complete Section C of the copy of the report sent for challenge purposes. Complete Section C to indicate the action taken in response to reportable error findings on the review or in response to a potential Food Assistance IPV finding.

Reportable errors include the following:

- ◆ A client participation error of \$5.00 or more in Medicaid.
- ◆ An error of \$6.00 or more in Food Assistance.

Do not complete Section C for reports containing nonreportable errors, unless there is a potential IPV finding in the Food Assistance program.

When the case record has been transferred to a Department office other than the office from which the case was selected for review, forward the complete *Report of Quality Control Review* to the current office after copying it. Return the copy to Quality Control indicating to which office you forwarded the form.

**Corrected to QC Findings:** Check when the current (or ongoing) eligibility and payment status is changed to reflect the Quality Control findings as of the review date.

**Not Corrected to QC Findings:** Check this box when you believe Quality Control made an error in its findings as of the review date. The error may be the result of incorrect information, incorrect computations, or misapplication of policy.

Note a brief explanation of why there is a disagreement with the findings in the space provided after "Action Taken."

**Claim or Adjustment Completed (Date):** Check this box when the correction to QC finding's results in the need for a claim or an adjustment to be made. Enter on the line the date the action is completed.

**Potential IPV Referral (Date):** Check this box when the potential IPV has been referred for a hearing. Enter the date of the referral on the line.

**Potential IPV not Referred:** Check this box when you believe an IPV referral should not be made and enter an explanation in the next section.

**Action Taken:** Write in this space a short explanation of the action taken to correct the error. If the action taken corrects an error in payment or eligibility, include the consideration given to adding a corrective payment, collecting a reimbursement, or making a vendor adjustment for each month the error existed.

If the action taken is different than Quality Control's recommendation, explain why. A change in circumstances does not eliminate the necessity of correcting the error for the review date.

**Information about Error:** Answer these questions about suggestions for avoiding this type of error in the future.

**Signature of IM worker:** Enter the signature of the IM worker who responded to the report and corrected the errors.

**Date:** Enter the date when the report has been cleared, errors corrected, and response sent to the service area IM supervisor or designee or filed in the case record.

**Signature of service area IM supervisor or designee:**

Enter the signature of the service area IM supervisor or designee who evaluates the report submitted by the IM worker and resolves inadequate or confusing explanations before submittal to Quality Control.

**Date:** Enter the date when the report has been cleared by the service area IM supervisor or designee and submitted to Quality Control. Reports shall be returned within 30 calendar days.

**Report of Quality Control Review for CCA, Form 470-4674**

Purpose The Quality Control Unit (QC) uses the *Report of Quality Control Review for CCA* to notify the CCA worker of the findings of a Child Care Assistance case review.

Source This form is located on each QC reviewer's share. The QC sections are completed on line.

Completion The quality control reviewer completes page 1 after reviewing a CCA case.

The CCA worker and supervisor complete pages 2 and 3 of the final report to show what action is taken in response to a quality control finding.

Distribution Upon QC supervisory determination that a reportable error has been made and policy clearance of the error, the QC monitor emails a copy of the form to the CCA supervisor for the error resolution conference before the distribution of the final report.

For the final report of error findings and new information, the QC secretary:

- ◆ Sends two copies to the CCA eligibility unit.
- ◆ Maintains one copy in the quality control case study file.

The report is also sent if the case is correct.

The CCA worker and supervisor complete pages 2 and 3 if the report contains an over- or under-authorization. Upon completion of pages 2 and 3, the CCA worker and supervisor sign the form and send it back to QC. File a completed copy in the case record.

Quality Control:

- ◆ Maintains a control file and keeps the first copy of the form until the CCA Unit copy is received.
- ◆ Reviews the CCA Unit response.
- ◆ Sends a copy of the completed form to the Bureau of Financial, Health and Work Supports.

Data

Complete the form as follows:

**Case name:** The name of the case payee, guardian, or conservator.

**Case number:** Enter the SRS or KinderTrack case number.

**Review number:** The five-digit identifying number for the quality control review.

**Child's name:** The name of the child reviewed.

**Child's SID number:** Enter the reviewed child's state identification number.

**IM worker:** The name of the CCA worker who was responsible for the case as of the review month.

**County:** The name of the office that has responsibility for the review case on the review date.

**Service area:** The number or name of the service area in which the CCA office is located.

**QC reviewer:** The name of the quality control reviewer who completed the study of the case.

**Review date:** The month for which the quality control reviewer determined the authorization for payment status of this case.

**Date report sent to field:** The date the quality control report is mailed to the CCA office.

**Quality control findings:** The findings of the case review, which include:

- ◆ **Case correct:** A check in this box indicates a correct case.
- ◆ **Over authorization:** A check in this box indicates an incorrect case authorization that caused an over authorization of CCA.

- ◆ **Under authorization:** A check in this box indicates an incorrect case authorization that caused an under authorization of CCA.
- ◆ **Agency error:** A check in this box indicates the over- or under-authorization was the request of an agency error.
- ◆ **Client error:** A check in this box indicates the over or under authorization was the result of an agency error.
- ◆ **Point in time error was made:** The time in the assistance cycle when the over- or under-authorization occurred, such as at application, review, or time of a reported change.

**Reviewer's finding narrative:** The reviewer documents the findings of the case.

**Policy reference:** This section lists the manual references used in determining the error.

**New information for worker:** This section lists new information discovered during the review.

The CCA worker completes pages 2 and 3 in response to an over- or under-authorization case review finding. Please note that the worker needs to review the file to determine if the findings (over- or under-authorization) require action. A quality control finding of an over- or under-authorization does not automatically mean there is an overpayment or underpayment on the case.

**Corrected to QC findings:** Check yes or no that the current eligibility or benefit is changed to reflect the quality control findings. When the case is not updated to the quality control findings, briefly explain. For example, further information is obtained to show case was correct or no over or under payment occurred.

**Date claim or adjustment completed:** Indicate whether the correction to quality control finding's results in the need for a claim or an adjustment and attach documentation. Documentation of an adjustment may include a screen print or copy of a notice of decision. Enter the date the action is completed.

Please note that the worker needs to review the file to determine if the findings (over or under authorization) require action. A quality control finding of an over or under authorization does not automatically mean there is an overpayment or underpayment on the case.

**Describe what you did to correct this error:** Write in this space a short explanation of the action taken to correct the error. If the action taken corrects an error in payment or eligibility, include the consideration given to adding a corrective payment, collecting a reimbursement, or making a vendor adjustment for each month the error existed.

**Questions about the error:** Answer these questions about why the error occurred.

**Signature of IM worker:** The IM worker who responded to the report and corrected the errors signs here.

**Date:** Enter the date of the signature.

**Signature of the IM supervisor or designee:** Enter the signature of the IM supervisor or designee who evaluates and approves the report submitted by the CCA office.

**Date:** Enter the date of the signature.

Return the form to the Quality Control Unit within 30 days.

**Report on Incapacity, Form 470-0447 or 470-0447(S)**

Purpose	Use the <i>Report on Incapacity</i> to obtain information from a doctor, chiropractor, hospital, clinic, psychologist, psychiatrist or other medical professional.
Source	Complete this form on line using the template on the DHS Intranet eForms web page. Supplies of the form may also be printed or photocopied from the sample in the manual as needed.
Completion	<p>The IM worker can issue this form when:</p> <ul style="list-style-type: none"><li>◆ A stepparent has applied to be included in the FIP or FMAP-related Medicaid eligible group due to incapacity.</li><li>◆ A Refugee Cash Assistance applicant or participant claims exemption from work or training requirements because the person is needed in the home to care for an incapacitated household member.</li><li>◆ A FIP applicant or participant requests a hardship exemption based on physical or mental health issues or disability.</li><li>◆ Incapacity must be determined for any other purpose.</li></ul> <p>The PROMISE JOBS worker can issue this form when:</p> <ul style="list-style-type: none"><li>◆ A FIP applicant or participant claims inability to participate in PROMISE JOBS activities either at all or in a reduced capacity due to a physical or mental health issue or a disability.</li><li>◆ Information obtained from the <i>Self-Assessment</i>, form 470-0806, other assessment information, observation, or key historical information indicates a possible barrier to full participation due to a physical or mental health issue or a disability.</li><li>◆ A participant fails to attend FIA activities and claims the absence was due to a temporary illness of the participant or another family member and documentation is needed to determine if the absence can be excused.</li></ul>

	<p>The IM or PROMISE JOBS worker fills in the identifying information and date due at the top of the form.</p> <p>The client completes and signs the Patient Permission section.</p> <p>The medical professional completes the remainder of the form.</p>
Distribution	<p>If an examination or additional information is required, mail the form to the examiner or to the client to deliver to the examiner.</p> <p>When an examination is required, advise Medicaid members to make an appointment with their managed health care provider or regular Medicaid provider, as applicable.</p> <p>If the person is not a Medicaid member, and no other medical resources are available, attach form 470-0502, <i>Authorization for Examination and Claim for Payment</i>, to the form.</p>
Data	<p>The form is self-explanatory.</p>

**Reporting Food Assistance Changes, Form 470-2960 or 470-2960(S)**

Purpose *Reporting Food Assistance Changes* is the form used to inform Food Assistance households how to report changes. The form shows the maximum gross monthly income for the household's size.

Source The ABC system generates form 470-2960 or 470-2960(S). Both English and Spanish versions of this form are also available on line as templates on the DHS Intranet eForms web page.

Completion Issue this form:

- ◆ At application.
- ◆ At recertification.

| Distribution If issuing a manual notice of decision, send or give the original form to the household and keep a copy of the form in the case file.

Data Complete the client name, address, date, and case number on the form. Fill in the gross monthly income applicable for household size.

Fill in the household's countable self-employment income if applicable. The second paragraph under Step 1 prints only if the worker enters self-employment income.

| Fill in the name of any Able-Bodied Adults Without Dependents (ABAWDs) who are eligible because they meet work requirements.

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

Purpose	<p>Form 470-0643 is used to request information from the Central Abuse Registry:</p> <ul style="list-style-type: none"><li>◆ To determine whether there is record of a founded abuse report on a person in the child care provider's household.</li><li>◆ 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.</li><li>◆ To record the dissemination of child abuse information.</li></ul>
Source	<p>IM staff can complete this form on line using the template on the DHS Intranet eForms web page.</p>
Completion	<p>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:</p> <ul style="list-style-type: none"><li>◆ A nonregistered provider wishes to receive Child Care Assistance funds.</li><li>◆ A minor parent claims good cause for not living with an adult parent or legal guardian because of abuse.</li></ul> <p>Complete Section 1 with information about the person making the request (the worker).</p> <p>Complete Section 2 with information about the person whose records are being requested (the minor parent or child care provider).</p> <p>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.</p> <p>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.</p>

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.

**Request for FIP Beyond 60 Months, Form 470-3826 or 470-3826(S)**

**Purpose** Assistance from the Family Investment Program (FIP) is limited to a total of 60 months. The only way families may receive FIP beyond 60 months is if they request and are determined eligible for a “hardship exemption.”

Form 470-3826 or 470-3826(S) is the form families must complete to request a hardship exemption. Receipt of the form in any DHS or PROMISE JOBS office protects the date of the request.

The form is also an authorization for release of information that allows IM, PROMISE JOBS, Service, and FaDSS staff to share with each other substance abuse, mental health and AIDS/HIV-related information about the family that may be relevant to the hardship exemption determination.

**Source** Obtain form 470-3826:

- ◆ From the Eligibility Tracking System (ETS), either from:
  - The “Form History” page, or
  - The “Active Cases That Have Used FIP For 36 or More Months” report
- ◆ By printing or photocopying the form from the sample in the manual.

Print or photocopy supplies of form 470-3826(S) from the sample in the manual.

**Completion** The hardship exemption applicant completes form 470-3826 or 470-3826(S). Issue the form to the family. Include a return envelope for the applicant to send the form to the scanning center. Document the date you issue the form in the case record.

**Distribution** The applicant submits form 470-3826 or 470-3826(S) to any DHS or PROMISE JOBS office. If a PROMISE JOBS office receives the form, the office must forward the form to the IM worker within one working day.

Return a copy of form 470-3826 or 470-3826(S) to the family as a record of the authorization to share information.

Upon receipt of form 470-3826 or 470-3826(S) from the family, screen the family's FIP case circumstances.

- ◆ If the request does not appear appropriate for the circumstances of the case, e.g., the family has received FIP for 57 or fewer months, deny the family's request.
- ◆ If the family's hardship exemption request appears appropriate for the FIP case circumstances, process the hardship exemption request.

EXCEPTION: When the family is no longer on FIP and needs to file a *Financial Support Application* to regain FIP eligibility, delay processing the hardship exemption request until you receive the application. If the family fails to return the application by the due date, deny the hardship exemption request for that reason.

The hardship exemption eligibility determination is a two-step process:

1. Based on supporting evidence, determine whether the family has a hardship condition that affects its ability to be self-supporting.
2. If the family is determined to have a hardship condition, the family must then meet with PROMISE JOBS to develop and sign a six-month *Family Investment Agreement (FIA)* that addresses the family's documented hardship condition.

The family must meet the requirements of both steps and meet all FIP eligibility requirements before the hardship exemption request can be granted. See [4-C, Hardship Exemption](#), for more information.

To process the exemption request:

- ◆ If the family has an active service case, forward a paper copy of form 470-3826 or 470-3826(S) and an electronic copy of form 470-3884, *Hardship Exemption: Service Information*, to the service worker. Request the worker's recommendations for steps to consider in the *Family Investment Agreement (FIA)*.

- ◆ Contact the family in writing to provide supporting evidence of its hardship condition. If the family does not meet the criteria, deny the family's hardship exemption request.
- ◆ After you have determined that the family has a hardship condition, forward to the local PROMISE JOBS office a copy of:
  - Form 470-3826 or 470-3826(S), *Request for FIP Beyond 60 Months*.
  - Form 470-3876, Hardship Exemption Determination.
  - The supporting hardship evidence.
  - Form 470-3884, *Hardship Exemption: Service Information*, received from the family's service worker (if applicable).

Upon receipt of these documents, PROMISE JOBS will initiate procedures for the adults in the family to attend the required interview and develop and sign the six-month FIA.

Retain the original form 470-3826 or 470-3826(S) in the permanent "Hardship Exemption" section of the case record.

Data

The family must complete designated items. To be considered valid, the form must contain a legible name and address, and must be signed by the "adult" in the family who is:

- ◆ The parent in the home, even if the parent is or will be excluded from the FIP grant. When both parents or a parent and stepparent are in the home, either parent or the stepparent can sign the form.
- ◆ The incapacitated stepparent when the stepparent is or requests to be on the FIP grant.
- ◆ The needy nonparental specified relative who is or requests to be on the FIP grant.

When the adult is incompetent or incapacitated, someone acting responsibly on the adult's behalf may sign the form.

See [4-C](#), Hardship Exemption: Valid Request, for additional information on signature requirements.

**Request for Iowa Birth Information, Form 470-4400 or 470-4400(S)**

Purpose	The <i>Request for Iowa Birth Information</i> is used to gather information from the Medicaid applicant or member in order to verify a birth in Iowa using the Birth Certificate Verification (BCV) system data match from Vital Records. A data match using the BCV system is considered a second-level document.
Source	Complete the English or Spanish version of the form on line using the template on the DHS Intranet eForms web page.  Print or photocopy supplies of the Spanish version of this form from the sample in the manual.
Completion	A household member who requests Medicaid and who was born in Iowa may complete this form to verify U.S. citizenship.
Distribution	Give this form to the applicant or member or mail it along with a cover letter. Keep the completed <i>Request for Iowa Birth Information</i> in the person's case file.
Data	Instructions for completion are stated on the form. The county of birth is a requirement, but if the county is unknown, then the town of birth may be completed. The father's name is not required, but should be completed if it is known.

**Request for ISIS Changes, Form 470-3924**

Purpose	The purpose of the <i>Request for ISIS Changes</i> , form 470-3924, is to transmit requests to add, change, or terminate program request information in ISIS when the information can't be submitted through ABC system entries.
Source	IM staff completes this form on line using the template on the DHS Intranet eForms web page.
Completion	<p>An IM worker prepares the form when:</p> <ul style="list-style-type: none"><li>◆ A program request needs to be added to ISIS and the information cannot be passed to ISIS by making entries in the ABC system.</li><li>◆ A change occurs to any information on a program request in ISIS and that information cannot be passed to ISIS by making entries in the ABC system.</li></ul> <p>The information must be submitted on the form before additions or corrections can be made to the ISIS program requests. Use the same form for additional requests for the same member. Use a different form for each new member.</p>
Distribution	E-mail the completed form to DHS, ISIS-Facilities.
Data	<p><b>Part 1: Member/Staff Information:</b> Enter the member's state identification number and name from the ABC system. Enter your name.</p> <p><b>Part 2: Eligibility Changes:</b></p> <p><b>Program request that needs changes:</b> Enter the dates and program currently shown in these fields on the ISIS program request that needs correction. If this is a request to add a program request rather than a request for corrections, leave this section blank.</p>

**Correct Information:** Enter the correct information in each of the following fields:

- ◆ **Begin Date:** Enter the date the member becomes eligible or resumes eligibility for the waiver or facility program or the effective date of a change.
- ◆ **End Date:** Enter as the end date the last date eligibility exists or the day before a change is effective on the subsequent program request.
- ◆ **Aid Type:** Enter the aid type for the member's coverage group.
- ◆ **Program:** Enter the number or letter of the program type from the drop down box.
- ◆ **Co Res:** Enter the county where the case is assigned.
- ◆ **Co LS:** Enter the member's county of legal settlement.
- ◆ **CP 1st Month and CP Ongoing:** Enter the amount of first and ongoing client participation. Use the first five digits for dollars and the last two digits for cents.

Complete all boxes. Enter zeros when there is no client participation or when less than seven boxes are needed. (E.g., 0000000 shows client participation is zero; 0004220 shows client participation is \$42.20.)

- ◆ **Provider Number (Facility Only):** Enter the seven-digit provider number or the national provider indicator (NPI).
- ◆ **NF Provider #, if Hospice:** Enter the seven-digit provider number or NPI of the nursing facility where the member resides, if the member is receiving hospice services.
- ◆ **Application Date:** Enter the date of application for Medicaid.

**Request for Proof of Citizenship and Identity, Form 470-4909 or 470-4909(S)**

Purpose	Form 470-4909 or 470-4909(S) is used to tell a Medicaid applicant or member that U.S. citizenship and identity must be verified within 90 days or Medicaid will end and retroactive Medicaid (if requested) will be denied.
Source	This form is system-generated. This form is not to be generated by the worker.
Completion	<p>The system automatically generates this form for all persons active for Medicaid when:</p> <ul style="list-style-type: none"><li>◆ The code in the person's us or ID field indicates that citizenship or identity has not been verified <b>and</b></li><li>◆ An automated match cannot be requested through the IEVS system on the person.</li></ul> <p>EXCEPTION: The form will not be sent on a person who has already used one 90-day reasonable opportunity period.</p> <p>Form 470-4909(S) is system-generated when there is an "S" in the language indicator field.</p> <p>The system will track the 90-day reasonable opportunity period for the person to verify citizenship and identity based on the date the system-generated form is sent to the client.</p>
Distribution	One copy of the form is sent to the electronic case file. The second copy is sent to the client.

**Request for Replacement of Spoiled Food, Form 470-2920**

Purpose	<p>The purpose of form 470-2920 is to provide:</p> <ul style="list-style-type: none"><li>◆ The household's written request for replacement of food lost in a household misfortune,</li><li>◆ Verification that the allotment was issued and the value issued,</li><li>◆ The IM worker's decision on the household's request, and</li><li>◆ Documentation for reporting and auditing.</li></ul>
Source	<p>Initiate this form on line using the template available on the DHS Intranet eForms web page.</p>
Completion	<p>Issue the form each time a household requests replacement issuance for food lost in a household disaster.</p> <p>The head of household, spouse, authorized representative, or responsible household member requesting replacement shall complete and sign the Statement of Loss section.</p> <p>The IM worker who makes the decision on the household's request for replacement issuance shall complete and sign the Verification and Decision on Request for Replacement sections.</p>
Distribution	<p>File the original in the household's case record. Give a copy to the household.</p> <p>Send a copy to the Food Assistance liaison in the Division of Fiscal Management.</p>
Data	<p>This form is self-explanatory.</p>

**Request for School Verification, Form 470-1638**

**Purpose** Form 470-1638 is designed to secure the client's permission for the Department to verify school enrollment. The school also uses the form to furnish the requested verification.

**Source** Complete this form on line using the template available on the DHS Intranet eForms web page.

**Completion** The IM worker completes this form when it is necessary to verify school enrollment.

**Distribution** Make two photocopies after the client signs the form. Send the original to the school. Give a copy to the client.

You may upload the request to the electronic case file. When the school returns the original, it will be scanned and uploaded.

**Data** Enter the following information before obtaining the client's signature:

- ◆ The case number.
- ◆ The name and address of the school.
- ◆ The names of the students for whom the client needs verification.
- ◆ The dates for the time period to be verified.

The following information automatically populates:

- ◆ The worker number.
- ◆ The date the form is sent.
- ◆ The worker's name and address.
- ◆ The worker's phone number.
- ◆ The worker's email address.
- ◆ The date the authorization expires. (The expiration shall be 60 days from the date the form is signed, unless supervisory approval is given to extend the date.)

The client shall sign and date the form after the listed items have been completed.

The school completes the remainder of the form.

**[Request for Special Update, Form 470-0397](#)**

Purpose	<p>The <i>Request for Special Update</i> is used to:</p> <ul style="list-style-type: none"><li>◆ Update the Medicaid eligibility file (the SSNI screen) to add months for which a client was eligible for Medicaid.</li><li>◆ Correct Medicaid data for current and past months (when the client becomes eligible for greater benefits).</li><li>◆ Change Medicare coverage codes for current and past months.</li></ul>
Source	<p>Workers can complete form 470-0397 on line using the template on the DHS Intranet eForms web page.</p>
Completion	<p>The IM worker prepares three copies of this form:</p> <ul style="list-style-type: none"><li>◆ To authorize Medicaid coverage in the retroactive period when there is no current eligibility.</li><li>◆ To update the Medicaid eligibility file regarding Medicare supplemental insurance coverage.</li><li>◆ To add a newborn to the Medicaid eligibility file.</li><li>◆ To authorize past and current dates of benefits for some special Medicaid categories, such as when:<ul style="list-style-type: none"><li>• The person's aid type was Medically Needy with an unmet spenddown, but should have been in a non-Medically Needy coverage group.</li><li>• The person's aid type was Medically Needy on a coverage group requiring copayments, but the person should have been in a facility aid type or an aid type that does not require copayments.</li><li>• The person was in a QMB aid type but was actually eligible for full Medicaid coverage.</li></ul></li></ul>

| Distribution

Send two copies to the Quality Assurance Section in the Division of Data Management. Keep a copy in the case record for reference.

After the data are entered, Quality Assurance returns the original to the local office to indicate the date of completion.

Data

Complete the identifying information requested on the form. Use one form per case record. If there is more than one person to be updated per case record, use additional pages as needed.

See [14-C, SSNI = Medicaid Eligibility File](#), for a description of the SSNI fields. For coding instructions, see [14-B-Appendix](#) for items on the TD03 screen ([MEDICAL FUND](#), [HEALTH](#), [SRV](#), [MN](#), and [POV](#)).

**Request for Verification of Citizenship and Identity, Form 470-4858 or 470-4858(S)**

Purpose	Form 470-4858 or 470-4858(S) is used to tell a Medicaid (including IFPN) applicant or member that U.S. citizenship could not be verified using the identifying information provided. The form explains that citizenship and identity must be verified within 90 days or benefits will end and retroactive Medicaid (if requested) will be denied.
Source	This form is system-generated. This form is not to be generated by the worker.
Completion	<p>The system automatically generates this form for all persons active for Medicaid (including IFPN) when:</p> <ul style="list-style-type: none"><li>◆ The IEVS system automated match returns a response that the person's citizenship was not substantiated <b>and</b></li><li>◆ The code in the person's US or ID field indicates that citizenship or identity has not been verified.</li></ul> <p>EXCEPTION: The form will not be sent on a person who has already used one 90-day reasonable opportunity period.</p> <p>Form 470-4858(S) is system-generated when there is an "S" in the language indicator field.</p> <p>The system will track the 90-day reasonable opportunity period for the person to verify citizenship and identity based on the date the system-generated form is sent to the client.</p>
Distribution	IABC sends one copy of the form to the electronic case file. The worker must upload this form to the electronic case file for IFPN cases. The second copy is sent to the client.

**Requirements of Claiming Good Cause, Form 470-0170**

Purpose	Form 470-0170 supplies the applicant or participant with specific information as to how to claim good cause.
Source	Print 470-0170 from the sample in the manual or from the DHS Intranet eForms web page.
Completion	<p>The IM worker provides the form whenever the applicant or participant</p> <ul style="list-style-type: none"><li>◆ Requests information as to the procedure involved in claiming good cause, or</li><li>◆ Indicates intent to claim good cause.</li></ul> <p>The applicant or participant signs and dates the form to request good cause.</p>
Distribution	Issue both copies of the form to the applicant or participant. Upon its return, file the signed and dated form in the case record. The applicant or participant keeps the other copy.
Data	Give instructions that if the applicant or participant wishes to claim good cause, the applicant or participant must sign and date the form and return the original to the Department before any consideration can be given to a claim of good cause.

**Requirements of Support Enforcement, Form 470-0169 or 470-0169(S)**

Purpose	<p>Form 470-0169 and 470-0169(S) are used to:</p> <ul style="list-style-type: none"><li>◆ Notify FIP applicants and participants of their right to claim good cause for refusal to cooperate in establishing paternity and securing support payments.</li><li>◆ Inform FMAP-related Medicaid applicants of the value of cooperating in obtaining medical support and notify parents and needy caretakers who are applicants or members of their right to claim good cause for refusal to cooperate in establishing paternity and securing support payments.</li></ul>
Source	<p>Order supplies of the English version of this form from Iowa Prison Industries at Anamosa or print supplies from the sample in the manual or from the DHS Intranet eForms web page.</p> <p>Print supplies of the Spanish version of the form from the sample in the manual or from the DHS Intranet eForms web page.</p>
Completion	<p>At the time of the application, give this form to:</p> <ul style="list-style-type: none"><li>◆ Every person applying or reapplying for FIP who is required to cooperate with Child Support Recovery.</li><li>◆ Every person applying or reapplying for FMAP-related Medicaid.</li></ul> <p>Issue this form to participants upon request of the participant. Document in the case record when the form is provided.</p> <p>When a participant reports that a parent has left the home, and the case record shows that the participant previously was issued form 470-0169 at the time of the most recent application or more recently, you do not need to issue another form.</p>
Distribution	<p>The applicant or participant keeps the form.</p>

**Resources Upon Entering a Medical Facility, Form 470-2577**

Purpose	<p>Form 470-2577 is used to collect information about a couple's resources for an attribution of resources between spouses. An attribution is required when a spouse:</p> <ul style="list-style-type: none"><li>◆ Goes into a medical institution expecting to remain for 30 consecutive days, or</li><li>◆ Applies for home- and community-based elderly waiver services.</li></ul>
Source	<p>Print supplies of this form from the sample in the manual.</p>
Completion	<p>Either spouse (or an interested person on behalf of either spouse) may complete the form:</p> <ul style="list-style-type: none"><li>◆ When requested by a spouse (when one spouse enters a medical institution), or</li><li>◆ When a Medicaid application is submitted.</li></ul> <p>The form must be fully completed before an attribution of resources is determined.</p>
Distribution	<p>One copy shall be submitted. Provide a copy of the completed form when requested by either spouse.</p> <p>Establish a case record for the spouse in the institution and file this in the permanent section of the case file.</p>

**Resuming Overpayment Collection, Form 470-5322**

Purpose	When the Department's decision has been affirmed on an appeal of overpayment, form 470-5322 informs the debtor that collection actions on the overpayment will resume.
Source	Form 470-5322 is generated by the Overpayment Recovery System, located in the Division of Data Management.
Completion	The Overpayment Recovery System generates and inserts specific debt information into the form.
Distribution	One copy is mailed to the debtor from Central Office.
Data	The system completes the: <ul style="list-style-type: none"><li>◆ Date,</li><li>◆ Account number,</li><li>◆ Debtor name,</li><li>◆ Debtor address,</li><li>◆ Program being appealed, and</li><li>◆ DHS worker phone number.</li></ul>

**[Review/Recertification Eligibility Document, Form 470-2881, 470-2881\(S\), 470-2881\(M\), or 470-2881\(MS\)](#)**

Purpose	<p>The <i>Review/Recertification Eligibility Document</i>, forms 470-2881, 470-2881(S), 470-2881(M), and 470-2881(MS), is designed for use as:</p> <ul style="list-style-type: none"><li>◆ An application for subsequent certification for the Food Assistance program.</li><li>◆ The annual or semiannual review document for FIP and Refugee Cash Assistance.</li></ul> <p>This form contains instructions for completion and informs clients of their rights and responsibilities.</p>
Source	<p>Usually, the ABC system generates form 470-2881 automatically. Form 470-2881(S) is generated when there is an "S" in the language indicator field on the ABC TD01 screen.</p> <p>DHS staff may issue "manual" versions of the form, 470-2881(M) and 470-2881(MS), using the Word templates available on the DHS Intranet eForms web page.</p>
Completion	<p>The ABC system produces form 470-2881 or 470-2881(S) after the data processing cutoff for:</p> <ul style="list-style-type: none"><li>◆ Food Assistance when a case is due for recertification.</li><li>◆ FIP and Refugee Cash Assistance when a case is active or pending and the case coding indicates that the form should be sent.</li></ul> <p>Give or issue form 470-2881(M) or 470-2881(MS) to the participant upon request.</p> <p>The worker or the ABC system completes the top portion of page 1 before the form is sent or issued to the participant.</p> <p>The participant must complete the answers to all applicable questions. The participant may obtain help in completing the report from friends, relatives, advocate groups, or Department staff, if needed.</p>

For FIP and Refugee Cash Assistance, when both parents or a parent and a stepparent are in the home, either may sign the form. When a participant has a guardian or conservator, that person shall participate in completing the form. This person may sign for the client when necessary.

For Food Assistance, only one signature is required to process this form as an application for recertification.

**Distribution**

Give or mail one copy of the report to the client for completion.

File the completed original in the case record. Provide a copy of the completed form to the client upon request.

**Data**

Whenever the form is issued manually, provide a pre-addressed return envelope. Prepare the form as follows:

- ◆ Enter the Department office name and mailing address.
- ◆ Enter the case name and current mailing address.
- ◆ Enter the nine-digit case number and check digit.
- ◆ Enter the county number.
- ◆ Enter the worker's telephone number in the "What if I have questions?" section.
- ◆ For FIP and Refugee Cash Assistance, insert the following message in the message section:

"It's time to review your case. Please fill out this form and send or bring it to the address above by <due date>. This information will be used to decide if you will continue to get Family Investment Program (FIP) or Refugee Cash Assistance benefits."

- ◆ If an interview is needed for Food Assistance, enter:

“Your Food Assistance will end <last date of certification period>. Return this signed form by <15<sup>th</sup> of certification end month>, to get Food Assistance at the regular time next month, if you are eligible. You must have an interview for Food Assistance. A worker will contact you by phone or appointment letter. If you miss the interview, your benefits may be delayed or canceled. You must ask your local office to reschedule and also provide verification.
- ◆ If an interview is **not** needed for Food Assistance, enter:

“Your Food Assistance will end <last date of certification period>. Return this signed form by <15<sup>th</sup> of certification end month>, to get Food Assistance at the regular time next month, if you are eligible.
- ◆ Enter all data in the “Household Members” section (except **do not** enter the last grade completed and the “yes” or “no” responses). Enter only the last four digits of the social security number.

**Screening:** Screen the form upon its receipt. All questions (for related programs) that have “yes or no” responses must have either “yes” or “no” marked.

For FIP and Refugee Cash Assistance, if the answer is “yes,” all requested information must be completed and necessary verification provided for the form to be considered complete.

If the participant fails to enter required information on the RRED but sends verification of that information with the RRED, the form is still considered complete.

NOTE: When the nonparental relative does not receive assistance for the relative’s own needs, the information shall reflect the circumstances of each child.

To be complete, the form must be signed and dated by the necessary persons.

**Screening Related Services Rendered to Medicaid EPSDT Enrollees, Report X1612X5**

Purpose	The <i>Screening Related Services</i> report provides the IM worker with a record of medical care received by a child when the worker is responsible for providing the EPSDT "Care for Kids" oversight. (See <a href="#">8-M, Procedures for Notification and Tracking</a> , for a description of IM responsibilities under this program.
Source	The Iowa Medicaid Enterprise generates the list quarterly from the fiscal agent's <b>paid</b> claims history file.
Completion	<p>When there is a referral for diagnosis or treatment as a result of the most recent screening examination, and follow-up services are indicated, no further action is needed.</p> <p>When it is not clear whether the service has been received, contact the member to determine if assistance is needed.</p>
Distribution	File the most recent report in the case record.
Data	<p>The "LAST" screening date is the last screening paid by Medicaid in the last two years. The "NEXT" screening date is based upon the enrollee's age and the periodicity schedule.</p> <p>The report identifies the dental, hearing, medical, and vision services paid by Medicaid within the last six months. Enrollees are reported even if they did not have a service to report.</p>

**Section 503 Alert Notice, Report S470A110-A**

Purpose	The <i>Section 503 Alert Notice</i> is a computer-generated notice that is issued to inform workers of a client's potential eligibility for Medicaid under the 503 coverage group (for people who have lost SSI eligibility due to a cost-of-living increase in their social security benefits).
Source	The ABC system generates this report as part of COLA processing.
Completion	When a new group of potential eligibles is identified (in processing a social security cost-of-living increase), one copy of the notice is generated in Central Office for each client affected.
Distribution	The notice is sent to the worker listed on the case. Carry out the instructions on the notice and file it in the case record with the permanent forms.
Data	The notice lists: <ul style="list-style-type: none"><li>◆ The date of the cost-of-living increase</li><li>◆ The county and worker identification numbers</li><li>◆ The client's ABC case number</li><li>◆ The county name</li><li>◆ The client's name and social security number</li><li>◆ The payee address</li><li>◆ The client's residence address</li></ul>

**Self-Assessment, Form 470-0806 or 470-0806(S)**

Purpose	Form 470-0806, <i>Self-Assessment</i> , is used to obtain information about a PROMISE JOBS client as part of the assessment process, to identify potential barriers to participation in the PROMISE JOBS program or specific components.
Source	<p>The English version of form 470-0806 is printed in pads of 25 sets. Order supplies from Iowa Prison Industries at Anamosa.</p> <p>The Spanish version can be printed or photocopied from the sample in the manual.</p>
Completion	The IM worker issues a copy of the <i>Self-Assessment</i> along with form 470-3897, <i>FIA Appointment</i> , to clients referred to PROMISE JOBS. Instruct the client to complete all entries on the form.
Distribution	The completed form becomes part of the client's PROMISE JOBS case file.
Data	<p>The form requests information about the client's:</p> <ul style="list-style-type: none"><li>◆ Family composition</li><li>◆ Work history</li><li>◆ Educational background</li><li>◆ Income</li><li>◆ Transportation</li><li>◆ Housing</li><li>◆ Legal status</li><li>◆ Health</li></ul>

Page 358 is reserved for future use.

**Self-Employment Ledger, Form 470-3784**

Purpose	Form 470-3784, <i>Self-Employment Ledger</i> , is used to collect information for the Family Investment Program, Food Assistance program, and Medicaid program, when the household reports new self-employment.
Source	Complete the form on line using the template available on the DHS Intranet eForms web page.
Completion	Complete this form when a household reports new self-employment.
Distribution	Print two copies of the form. Give one copy to the client and file one copy in the case record. The client completes the form and returns it to the assigned imaging center.
Data	Certain areas of the form populate and a due date is calculated for return of the completed form. The client records self-employment income and expenses.

**SSI Medicaid Information, Form 470-0364, 470-0364(S), 470-0364(M), or 470-0364(MS)**

Purpose	<p>The <i>SSI Medicaid Information</i> form is used to determine if SSI-eligible clients meet the additional Medicaid eligibility requirements. The form:</p> <ul style="list-style-type: none"> <li>◆ Provides the Department with information on the client's medical resources and absent parents.</li> <li>◆ Assigns Medicare Part B payments to the medical supplier.</li> <li>◆ Notifies the client that the Department may recover Medicaid payments from others who are responsible for the cost of medical expenses.</li> <li>◆ Includes Comm. 121, <i>Important Information for Property Owners and Renters</i>.</li> </ul>
Source	<p>The ABC system automatically generates form 470-0364 when there is an SDX referral for an SSI recipient. Form 470-0364(S) is generated when there is an "S" in the language indicator field on the ABC TD01 screen.</p> <p>The manually issued English version, form 470-0364(M), may be completed on line using template available on the DHS Intranet eForms web page.</p> <p>Supplies of the manually issued Spanish version, form 470-0364(MS) can be printed or photocopied from the sample in the manual.</p>
Completion	<p>Form 470-0364 may be system-generated and sent to the client when you enter an "X" in retroactive medical field on TD05. See <a href="#">14-B(9)</a>, <u>MEDICAID CASE ACTIONS: SSI Recipients</u>.</p>
	<p>A field office may provide form 470-0364(M) upon presentation of form 470-0363, <i>Certification of Eligibility of SSI Applicant</i>.</p>

	<p>When the client needs immediate medical care, the IM worker can certify the client for Medicaid for the SSI eligibility date, if the client does not have a Medicaid qualifying trust and meets other additional Medicaid eligibility criteria. The determination of retroactive eligibility can be delayed.</p>
	<p>The client shall complete the <i>SSI Medicaid Information</i> or enlist the help of someone in preparing the form. If there is a guardian, the guardian shall participate in completing the form and sign for the client.</p>
	<p>If the client is mentally incompetent, a legal guardian, a blood relative, or a person in whose home the client resides may complete the form. The IM worker may complete the form if there is no other person able or willing to complete the form on behalf of the client.</p>
Distribution	<p>The client shall return one copy of the completed form to the requesting office within ten days.</p>
	<p>File the original form in the case record. Furnish a copy of the form to the client upon the request of the client or the representative.</p>
	<p>When the insurance section on page 4 indicates insurance coverage other than Medicare, send a photocopy of page 4 to Iowa Medicaid Enterprise, Third Party Liability, PO Box 36475, Des Moines, IA 50315. Write the client's name and state identification number on the top of the photocopy.</p>
Data	<p>The client shall answer all questions on this form according to the instructions on the form.</p>
	<p>The client must sign the form unless mentally or physically unable to do so. If the client 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 client personally.</p>

**SSI Medicaid Reminder, Form 470-3193 or 470-3193(S)**

Purpose	The <i>SSI Medicaid Reminder</i> is sent to SSI recipients who do not return form 470-0364, 470-0364(S), 470-0364(M), or 470-0364(MS), <i>SSI Medicaid Information</i> , by the due date. It serves to inform an SSI recipient what needs to be done to get Medicaid.
Source	The system generates this form. The Spanish version, 470-3193(S), is generated when there is an "S" in the language indicator field on the ABC TD01 screen.
Completion	<p>This form is system-generated and sent to the client. It is either:</p> <ul style="list-style-type: none"><li>◆ Issued automatically when no tracking entries have been entered on the SDXT screen in the ten days after the <i>SSI Medicaid Information</i> was issued; or</li><li>◆ Issued when the worker enters a "V" in the retroactive medical field on TD05.</li></ul> <p>See 14-E, <a href="#"><u>SSI STATE DATA EXCHANGE</u></a>, for more information about the tracking process.</p>
Distribution	One copy is sent to the client.

**[SSI-Related \(Children in Household\) Medically Needy Spenddown Computation Worksheet, Form 470-2626](#)**

Purpose	Form 470-2626 is used when calculating earned and unearned income for a Medically Needy SSI-related deeming situation. The worksheet assists the worker in making an accurate computation and provides the client with information on the computation.
Source	Complete form 470-2626 on line using the template on the DHS Intranet eForms web page.
Completion	The IM worker prepares the form when calculating income for the retroactive or current certification period, or as otherwise needed. Complete a worksheet for each certification or retroactive period.
Distribution	Print two copies. Mail one to the client and file one in the case record. Attach verification to the form, when required.
Data	Complete the form as follows:  <b>Case name:</b> Enter the name of the case as it appears on agency records.  <b>Case number:</b> Enter the Medically Needy case number, including FBU.  <b>Retroactive period:</b> If income calculations are for the retroactive period, enter the months involved.  <b>Certification period:</b> If income calculations are for the current certification period, enter the months involved.  <b>Eligible spouse and ineligible spouse:</b> Enter the name of the person who is the eligible spouse and the name of the person who is the ineligible spouse.  <b>Income source:</b> Enter the name of the employer. If the person is self-employed, indicate the nature of the self-employment business. If there is unearned income, enter the source.

**Frequency:** Enter how often the person is paid (weekly, biweekly, monthly, etc.).

**Month 1:** Enter the name of the first month of the certification period.

**Month 2:** Enter the name of the second month of the certification period.

**Month 3:** Enter the name of the third month of the certification period. This is completed only for retroactive periods, when there is a third month.

1. Child A. List the name of child A.
2. Needs of child. For each month of the certification period or retroactive period, enter the needs of child A.
3. Income of child. For each month of the certification or retroactive period, enter the monthly income of child A.
4. Unmet needs of child A. For each month, subtract the income of child A from the needs of child A.
5. Child B. List the name of child B.
6. Needs of child. For each month of the certification or retroactive period, enter the monthly income of child B.
7. Income of child. For each month of the certification or retroactive period, enter the monthly income of child B.
8. Unmet needs of child B. For each month, subtract the income of child B from the needs of child B.
9. Child C. List the name of child C.
10. Needs of child. For each month of the certification period or retroactive period, enter the needs of child C.
11. Income of child. For each month of the certification or retroactive period, enter the monthly income of child C.

12. Unmet needs of child C. For each month, subtract the income of child C from the needs of child C.
13. Unearned income of ineligible spouse. Enter the dates the gross unearned income was received for each month in the eligibility period.
14. Subtotal unearned income of ineligible spouse. Total the unearned income for each month.
15. Total of monthly unmet needs of children. Total Lines 4, 8, and 12 for each month.
16. Net unearned income of ineligible spouse. Deduct Line 15 from Line 14.
17. Earned income of ineligible spouse. Enter the dates earned income was received during the month and the gross amount of earned income.
18. Subtotal earned income of ineligible spouse. Total the gross earned income for the ineligible spouse for each month.
19. Deduct remaining unmet needs of children from Line 18. Enter any remaining unmet needs of the children not previously used on Line 15.
20. Net earned income of ineligible spouse. Subtract Line 19 from Line 18 and enter the remainder.
21. Total net income of ineligible spouse (Line 16 + 20). Enter the total of Lines 16 and 20.
22. Compare Line 21 to needs of ineligible spouse. The needs of the ineligible spouse is the difference between SSI benefit rate for an eligible couple and the SSI benefit rate for an eligible individual.
23. Unearned income of eligible spouse. Enter the dates on which the eligible spouse received the gross unearned income for each month in the eligibility period.

24. Subtotal of eligible spouse's unearned income. Total the unearned income for each month.
25. Enter Line 16 if income is to be deemed to the eligible spouse. To determine if income is to be deemed to the eligible spouse, see Item 22.
26. Subtotal unearned income. Total Line 24 and 25.
27. \$20 general income exclusion. Enter a \$20 general income exclusion (but not more than the amount in Line 26).
28. Total countable unearned income. Deduct Line 27 from Line 26.
29. Earned income of eligible spouse. Enter the dates on which the eligible spouse received earned income during the month and the gross amount of earned income.
30. Subtotal of eligible spouse's earned income. Total the gross earned income for the eligible spouse for each month.
31. Enter Line 20 if income is to be deemed to eligible spouse. To determine if income is to be deemed to the eligible spouse, see Item 22.
32. Subtotal. Add Lines 30 and 31 and enter the total.
33. Deduct any remaining balance of the \$20 general income exclusion. Enter any remaining balance of the \$20 general income exclusion not previously used on Line 27.
34. Subtotal. Subtract Line 33 from Line 32 and enter the remainder.
35. Deduct \$65 work expense exclusion.
36. Subtotal. Subtract Line 35 from Line 34 and enter the remainder.
37. Deduct 1/2 of subtotal. Enter the amount that is one-half of the amount on Line 36.

38. Total countable earned income. Subtract Line 37 from Line 36 and enter the remainder.
39. Total countable unearned and earned income. Add together unearned income and earned income for each month (Lines 28 and 38) and enter the total.
40. Household size. Enter the household size for each month of the eligibility period.
41. MNIL. Enter the Medically Needy Income Level for each month based on the household size.
42. Insurance premiums. List the health insurance premium paid each month for the applicant and ineligible spouse.
43. Medicare premiums. List the Medicare premiums paid each month for the applicant and ineligible spouse.
44. Total insurance. Add Lines 42 and 43 and enter the total.
45. Total income for period. Add together the total income for each month of the eligibility period (Line 39 for months 1, 2, and 3).
46. Total MNIL for period. Add together the total Medically Needy Income Level for each month of the eligibility period (Line 41 for months 1, 2, and 3).
47. Spenddown. Subtract the MNIL (Line 46) from the total income for the period (Line 45) and enter the remainder.
48. Less total insurance. Add together the total insurance for each month of the eligibility period (Line 44 for months 1, 2, and 3).
49. Final spenddown. Subtract the total insurance (Line 48) from spenddown (Line 47). This is the final spenddown amount. Enter this amount on the *Notice of Decision for Medically Needy*, form 470-2330.

50. Poverty level percentage. For QMB, SLMB, or E-SLMB eligibles, determine the percentage of the federal poverty level for household size. Enter the percentage on this line as well, as in the poverty indicator field on IABC.

To determine poverty level for the months of January and February, deduct the Social Security COLA from Line 39 before dividing by the poverty level.

**SSI-Related Income Worksheet, Form 470-2525**

Purpose	The <i>SSI-Related Income Worksheet</i> assists the worker in making an accurate computation when manually calculating earned and unearned income for many SSI-related programs.
Source	Complete form 470-2525 on line using the template available on the DHS Intranet eForms web page.
Completion	<p>The IM worker uses this form to calculate income for current eligibility for the following programs or as otherwise needed:</p> <ul style="list-style-type: none"><li>◆ Eligible for SSI or SSA but not receiving cash</li><li>◆ Expanded specified low-income Medicare beneficiary</li><li>◆ Qualified disabled working persons</li><li>◆ Qualified Medicare beneficiary</li><li>◆ Retroactive SSI eligibility</li><li>◆ Specified low-income Medicare beneficiary</li></ul> <p>Complete a worksheet at each initial determination and annual review. More than one worksheet may be needed when more than two household members have income.</p>
Distribution	File the original in the case record. Attach verification to the form, when required.
Data	<p>Go through the form to make the entries indicated. Then click on the "calculate" box on page 3 to complete the rest of the fields. In order to use the correct poverty levels, you must indicate the month and year you wish to have calculated.</p> <ol style="list-style-type: none"><li>1. <b>Case name.</b> Enter the name of the case as it appears on agency records.</li><li>2. <b>Case number.</b> Enter the case number, including FBU.</li></ol> <p>Complete lines 3 through 5 for each household member who has income that is considered to determine eligibility.</p> <ol style="list-style-type: none"><li>3. <b>Household member.</b> Enter the name of each person who is employed or has unearned income.</li></ol>

4. **Source.** Enter the name of the company or name of the employer. If person is self-employed, indicate the nature of the self-employment business. If the income is unearned, enter the source.
5. **Frequency of pay.** Enter the frequency the household member is paid; such as weekly, twice a month, or every two weeks.
6. **Month of eligibility.** Enter the month in which you are determining eligibility. Consider any prospective changes in income, resources, or other factors at the time of decision.
7. **Unearned income.** If the income of the people considered does not vary, use the first pair of columns to enter unearned income for the month listed in line 6.

If one or both of the people have variable incomes, use one or more columns for each person and enter the unearned income from the 30 days just before the month entered in line 6.

If the income fluctuates enough that 30 days does not provide an accurate indicator of future income, use income from prior months. Average the income by dividing the total for all months by the number of months. (Use the comment section for computation.) Enter the **average** as the monthly figure.

8. **Diversion for ineligible children.** Enter the amount to divert for ineligible children.

For each child, divert a maximum of the difference between the SSI payment standard for a couple and the SSI payment standard for one person. Reduce the allowable diversion per dependent by the amount of the dependent's income. (Use the comment section for computation.)

If the diversion is greater than the total of the household's unearned income amounts in line 7, enter only that amount and enter the rest of the diversion in line 12.

9. **\$20 disregard.** One \$20 disregard per household per month is allowed. The template will enter \$20 or the amount remaining after the deduction on line 8 if it is less than \$20.
10. **Subtotal for unearned income.** The template will enter the combined total in from line 7 less the amounts in line 8 and line 9.
11. **Earned income.** Follow the instructions on the form for entering income to be averaged to a monthly amount.
  - ◆ If a person's income is regular, enter the date and the gross amount of earned income received during the month of decision.
  - ◆ If a person's income varies, enter the amounts for one or more prior months.
12. **Diversion for ineligible children.** If the household has only earned income, calculate the diversion for ineligible children as instructed for line 8. Enter any portion of the diversion not already applied in line 8.
13. **Subtotal earned income.** The template will enter the difference between the total amount in line 11 and the entry in line 12.
14. **\$20 disregard.** The template will deduct any portion of the \$20 disregard not subtracted from unearned income. (See line 9.)
15. **Deduct \$65 work expense.** The template will enter \$65 or the remaining earned income if it is less than \$65.
16. **Subtotal earned income.** The template will enter the difference between line 13, 14, and line 15.

17. **1/2 earned income exclusion.** The template will enter the amount that is one-half of the amount in line 16.
18. **Subtotal earned income.** The template will enter the difference between lines 16 and 17.
19. **Countable income.** The template will add earned and unearned income (lines 10 and 18) together and enter the result.
20. **Household size.** Enter the household size.
21. **QMB income limit.** The template enters the amount of income that is 100% of the poverty level for the number of people entered in line 20.
22. **Poverty level.** The template divides the net income (line 19) by 100% of the federal poverty level (line 21).
23. **Enter on TD03.** This is the rounded-off percentage of the poverty level to enter in the POV field on the TD03 screen.
24. **Medicare Savings Program.** This is the Medicare Savings Program the person or couple is eligible for. Enter the applicable code on the TD03 screen.
  - ◆ Income eligibility for QMB exists if the percentage on line 23 is equal to or less than 100.
  - ◆ Income eligibility for SLMB exists if the percentage on line 23 is over 100 but less than 120.
  - ◆ Income eligibility for expanded SLMB exists if the percentage on line 23 is at least 120 but less than 135.

**SSI-Related (No Children) Medically Needy Spenddown Computation Worksheet, Form 470-2341**

Purpose	Form 470-2341 is used to calculate earned and unearned income for the SSI-related Medically Needy program when income is not deemed to children. The form provides the client with information on the manual computation and assists the worker in making an accurate computation.
Source	Complete the form on line using the template available on the DHS Intranet eForms web page.
Completion	The IM worker completes an original and one copy when calculating income for the retroactive or current certification period, or as otherwise needed. You may need more than one worksheet per period when more than two household members have income.
Distribution	Mail the original to the client and file the copy in the case record. Attach verification to the form, when required.
Data	Some modification in use may be needed to fit individual situations.
Identification	
Section:	<b>Case name:</b> Enter the name of the case as it appears on agency records. <b>Case number:</b> Enter the Medically Needy case number, including FBU. <b>Retroactive period:</b> If income calculations are for the retroactive period, enter the months involved. <b>Certification period:</b> If income calculations are for the current certification period, enter the months involved. <b>Eligible spouse and ineligible spouse:</b> Enter the name of the person who is the eligible spouse and the name of the person who is the ineligible spouse.

**Income source:** Enter the name of the company or the employer. If the person is self-employed, indicate the nature of the person's business. If there is unearned income, enter the source.

**Frequency:** Enter the frequency that the person is paid; i.e., weekly, biweekly, monthly, etc.

- ◆ Month 1. Enter the name of the first month of the certification period.
  - ◆ Month 2. Enter the name of the second month of the certification period.
  - ◆ Month 3. Complete this only for retroactive periods when there is a third month. Enter the name of the third month of the certification period.
1. Unearned income of ineligible spouse. Complete if applicable. Enter the dates the ineligible spouse received unearned income in each month in the eligibility period and the gross amount of income received.
  2. Subtotal unearned income of ineligible spouse. Total the unearned income per month.
  3. Earned income of ineligible spouse. Complete if applicable. Enter the dates when the ineligible spouse received earned income in each month in the eligibility period and the gross amount of income received.
  4. Subtotal of earned income of ineligible spouse. Total the gross earned income per month.
  5. Total net income of ineligible spouse. Total Line 2 (unearned income) and Line 4 (earned income) per month.
  6. Compare Line 5 to needs of ineligible spouse. The needs of the ineligible spouse are the difference between the SSI benefit rate for an eligible couple and the SSI benefit rate for an eligible individual.

7. Unearned income of eligible spouse. Complete if applicable. Enter the dates the eligible spouse received unearned income in each month in the eligibility period and the gross amount of income received.
8. Subtotal of eligible spouse's unearned income. Total the unearned income per month.
9. Enter Line 2 if income is to be deemed to the eligible spouse. To determine if income is to be deemed to the eligible spouse, see Line 6.
10. Subtotal unearned income. Total Line 8 and Line 9.
11. \$20 general income exclusion. Enter a \$20 general income exclusion.
12. Total countable unearned income. Deduct Line 11 from Line 10.
13. Earned income of eligible spouse. Complete if applicable. Enter the dates when the eligible spouse received earned income in each month in the eligibility period and the gross amount of income received.
14. Subtotal of eligible spouses earned income. Total the gross earned income per month.
15. Enter Line 4 if income is to be deemed to eligible spouse. To determine if income is to be deemed to eligible spouse, see Line 6.
16. Subtotal. Total Lines 14 and 15.
17. Deduct any remaining balance of the \$20 general income exclusion. Enter any remaining balance of the \$20 disregard not previously used on Line 11.
18. Subtotal. Subtract Line 17 from Line 16 and enter the resulting amount on this line.
19. \$65 work expense exclusion.

20. Subtotal. Subtract Line 19 from the subtotal (Line 18) and enter the amount.
21. 1/2 of subtotal of Line 20. Enter one-half of the subtotal of Line 20.
22. Total countable earned income. Subtract Line 21 from Line 20 and enter the result.
23. Total countable unearned and earned income. Add Lines 12 and 22 and enter the total on this line.
24. Household size. Enter the household size for each month of the eligibility period.
25. MNIL. Enter the applicable Medically Needy Income Level for each month based on the household size.
26. Insurance premiums. List the insurance premium paid each month.
27. Medicare premiums. List the Medicare premiums paid each month.
28. Total insurance. Total Lines 26 and 27 and enter the amount on this line.
29. Total income for period. Add together the total income for each month of the eligibility period (Line 23 for months 1, 2, and 3).
30. Total MNIL for period. Add together the total Medically Needy Income Level for each month of the eligibility period (Line 25 for months 1, 2, and 3).
31. Spenddown. Subtract the total MNIL (Line 30) from the total income for the period (Line 29).
32. Less total insurance. Add together the total insurance for each month of the eligibility period (Line 28 for months 1, 2, and 3).

33. Final spenddown. Subtract the total insurance (Line 32) from spenddown (Line 31). This is the final spenddown amount. Enter this amount on the *Notice of Decision for Medically Needy*, form 470-2330.
34. Poverty level percentage. For QMB, SLMB, or E-SLMB eligibles, divide Line 23 by 100 percent of the federal poverty level for the QMB household size and enter the resulting percentage on this line, as well as in the poverty indicator field on IABC.

To determine poverty level for the months of January and February, deduct the Social Security COLA from Line 23 before dividing the poverty level amount.

**Standardized Income Maintenance Business Card, Form 470-3604**

Purpose	The <i>Standardized Income Maintenance Business Card</i> is used to inform clients how to contact their income maintenance worker to report changes. The card also provides information about what changes must be reported and the name, phone number and address of the contact person when reporting changes.
Source	Form 470-3604 is available on a template. Print the form using a network printer and Avery 5371 white business card stock.  Department offices may choose to have the card printed or to use other card stock, as long as the standard wording and logo are used.
Completion	Customize the face of the business card to reflect the name, address and phone numbers of each individual worker. Do not alter any other information on the card.
Distribution	Give the card to applicants and recipients at opportune times to remind them of the need to report changes.

**State Supplementary Assistance Agreement to Repay Conditional Benefits,  
Form 470-2835**

Purpose	Form 470-2835, <i>State Supplementary Assistance Agreement to Repay Conditional Benefits</i> , is the client's written commitment to repay benefits issued pending the sale of the client's excess resources.
Source	Print or photocopy form 470-2835 from sample in the manual when needed.
Completion	The client or representative (guardian, spouse, parent, or sponsor, if any) shall complete and sign the form when the client is made eligible for State Supplementary Assistance under conditional benefits.
Distribution	File the original agreement in the case record and give the client a copy.
Data	The client or representative shall complete, sign, and date the form.

**[State Supplementary Assistance Certification or Termination, Form 470-0640](#)**

Purpose	The Department uses form 470-0640 to notify the Social Security Administration district office that a person is approved for or canceled from State Supplementary Assistance dependent person or family-life home benefits. The Social Security Administration also uses the form to notify the IM worker of the action taken by that agency.
Source	Complete form 470-0640 on line using the template on the DHS Intranet eForms web page.
Completion	<p>Staff in the DHS office for the county where the client lives complete this form when the Department is referring a person to the Social Security Administration for a family-life home or a dependent person allowance.</p> <p>The IM worker and the service worker are both responsible for certifying a placement in a family-life home. Only the IM worker is involved in certifying a dependent person allowance. The Social Security Administration completes the second page of the form.</p>
Distribution	<p>Forward this form to the Social Security Administration office. Keep a copy in the IM file as a control.</p> <p>The Social Security Administration completes its portion of the form and returns it to the imaging center listed on the back of the form.</p> <p>Transfer the information supplied by the Social Security Administration and forward a copy to the service worker for a family-life home case. File a copy in the client's IM case record.</p>
Data	<p>The following should automatically populate:</p> <ul style="list-style-type: none"><li>◆ The name and address of the Department office.</li><li>◆ The name and address of the Social Security Administration office that serves your area.</li><li>◆ The address and fax number of the imaging center that serves the worker's county.</li></ul>

Under "Client Information," enter the client's name, case number (if one has been assigned), address, and social security number (not a claim number). Designate whether client is over 65, disabled or blind, and list a telephone number where client can be reached.

If there is a representative payee, guardian, or conservator, indicate which and enter the person's name, address, and telephone number.

Enter the name, relationship, address, and telephone number for a person other than a representative payee, guardian, or conservator who is designated by the client as one who could give pertinent information.

To certify a client for a dependent person allowance, indicate the name, relationship, and age of the dependent person whose needs are to be included in the client's State Supplementary Assistance payment and the effective date as determined by the IM worker.

To certify a client for a family-life home payment, enter the name of the family with whom the client is residing and the effective date of client's entry into the certified family-life home.

To notify the Social Security Administration of a termination, enter the date that eligibility ended, and check whether the reason was death, removal of dependent person allowance, or that the client left the family-life home.

Use the comment section to enter additional information concerning the client, if needed.

The form requires the signature of both the service worker and the IM worker when placement is made in a family-life home. Only the IM worker need sign the form when a dependent person allowance is being approved.

**Statement of Citizenship Status, Form 470-2549**

Purpose	Form 470-2549, <i>Statement of Citizenship Status</i> , is used to obtain a declaration in writing stating whether a person is a citizen or a national of the United States, or an alien.
Source	Complete form 470-2549 on line using the template on the DHS Intranet eForms web page.
Completion	<p>The participant completes the form when FIP or Medicaid policy requires the person to make the citizenship or alien status declaration, but does not require the person to file an application (which includes the declaration).</p> <p>The form must be signed by an adult household member and returned before the person can be added to the eligible group.</p>
Distribution	Keep the signed form in the case record.
Data	The participant completes the form listing each member of the household, unless a declaration regarding the person's status was made on the application form. See <a href="#">4-C, Citizenship</a> , and <a href="#">8-C, Verifying Citizenship and Identity</a> , for policy regarding required signatures.

**Suspension of Overpayment Collection, Form 470-5323**

Purpose	When a client appeals an overpayment, collections on the overpayment are suspended. Form 470-5323 is issued to inform the debtor that collection actions on the overpayment are suspended during the appeal process.
Source	Form 470-5323 is generated by the Overpayment Recovery System, located in the Division of Data Management.
Completion	The Overpayment Recovery System generates and inserts specific debt information into the form. The system prints this form.
Distribution	One copy is mailed to the debtor from Central Office.
Data	The system completes the: <ul style="list-style-type: none"><li>◆ Date,</li><li>◆ Account number,</li><li>◆ Debtor name,</li><li>◆ Debtor address,</li><li>◆ Program being appealed, and</li><li>◆ DHS worker phone number.</li></ul>

**Ten-Day Report of Change for FIP and Medicaid, Form 470-0499 or 470-0499(S)**

Purpose	<p>The <i>Ten-Day Report of Change for FIP and Medicaid</i>, form 470-0499, and its Spanish translation, form 470-0499(S), provide:</p> <ul style="list-style-type: none"><li>◆ A simple means for the client to report a change and submit explanatory information.</li><li>◆ A reminder to the client that changes in circumstances must be reported to DHS whenever they occur.<ul style="list-style-type: none"><li>• FIP or Medicaid clients must report changes to the IM Customer Service Center (and to the PROMISE JOBS worker as appropriate).</li><li>• SSI-related clients must report changes by mail, fax or email to the DHS imaging center associated with the local office.</li></ul></li></ul>
Source	<p>Both English and Spanish versions of this form are available as templates on the DHS Intranet eForms web page for completion on line.</p>
Completion	<p>Select one of two options:</p> <ul style="list-style-type: none"><li>◆ "FMAP/FIP" which identifies the IM Customer Service Center for clients to report changes to, or</li><li>◆ "SSI-Related" which identifies the DHS imaging center for clients to report changes to.</li></ul>
Distribution	<p>Issue the form:</p> <ul style="list-style-type: none"><li>◆ At the application interview.</li><li>◆ When the client turns the form to report a change.</li><li>◆ When the client requests a form.</li></ul> <p>File the form in the case record after the required action is completed. Document the resulting action in the case record. Issue a new form to the client.</p>

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Page 386 is reserved for future use.

Page 387 is reserved for future use.

**Treasury Offset Program (TOP) Pre-Offset Notice, Form 470-3797**

Purpose	<p>The <i>Treasury Offset Program (TOP) Pre-Offset Notice</i> is used to notify a debtor that the Department plans to refer the debtor's delinquent claim to the U. S. Treasury Department's offset program for further collection action.</p> <p>The debtor can avoid that referral by contacting the Department of Inspections and Appeals within 60 days and negotiating a repayment agreement.</p>
Source	<p>This form is computer-generated based on information recorded on the Overpayment Recovery System.</p>
Completion	<p>The Overpayment Recovery System generates this form when:</p> <ul style="list-style-type: none"><li>◆ The debtor whose Food Assistance claim is delinquent meets the criteria for referral to the Treasury Offset Program (see <a href="#">6-G, Federal Offset for Food Assistance</a>), and</li><li>◆ The Treasury Department has registered an address for the debtor.</li></ul>
Distribution	<p>One copy is sent to the household. One copy is filed in the DIA record.</p>
Data	<p>The debtor's name and social security number and the amount of the claim are entered as the form is generated.</p>

**Verification of Educational Financial Aid, Form 470-1640**

Purpose	Form 470-1640 is designed to secure the client's permission for the Department to obtain verification of student eligibility requirements and educational financial aid. The educational institution uses the form to furnish the requested verification.
Source	Complete this form on line using the template on the DHS Intranet eForms web page.
Completion	<p>Complete this form when it is necessary to verify student eligibility requirements and educational financial aid. Complete the identifying information on the form and check the boxes to identify the sections the educational institution is to complete.</p> <p>The client (or person authorized to obtain the information) shall sign and date the authorization section of the form.</p> <p>The educational institution completes the sections of the form that have been checked by the worker and the signature line.</p>
Distribution	Send the form to the educational institution. You may upload the request to the electronic case file. When the educational institution returns the original, it will be scanned and uploaded.
Data	<p>Before sending the form,</p> <ul style="list-style-type: none"><li>◆ Enter:<ul style="list-style-type: none"><li>• The worker number.</li><li>• The name and address of the educational institution.</li><li>• The date you send the form.</li><li>• The name of the worker.</li><li>• The phone number of the worker.</li></ul></li></ul>

- The client's name. Enter the social security number also, if it is needed to obtain the requested information.
- The date of the academic term.
- The date the authorization expires. This date shall be 60 days from the date the form is signed, unless supervisory approval is given to extend the date.
- ◆ Check the boxes indicating each section the educational institution is to complete.
- ◆ Have the client sign and date the authorization statement.

**Verification of Emergency Health Care Services, Form 470-4299 or 470-4299(S)**

Purpose	The Department uses form 470-4299 with emergency services Medicaid applications to get the client's permission to verify whether the services that the client received was an emergency. The health care provider or the provider's designee uses this form to furnish the requested information.
Source	Complete the English or Spanish version of the form on line using the template on the DHS Intranet eForms web page.
Completion	<p>The worker completes the identifying information on the client.</p> <p>The client (or the person authorized to obtain the information) completes and signs in the section giving permission.</p> <p>The worker, the client, the provider, or the provider's designee completes the provider information.</p> <p>The health care provider or the provider's designee completes the information related to the health care that was given the client.</p>
Distribution	<p>Give this form to the client to obtain the information with a letter explaining when it is due back to the Department, or if the client has signed the form, send one copy to the source of information. Include a pre-addressed return envelope.</p> <p>You may upload the request to the electronic case file. When the source of information returns the original, it will be scanned and uploaded.</p>
Data	<p>To initiate the form, enter:</p> <ul style="list-style-type: none"><li>◆ The client's name</li><li>◆ The client's state identification number</li><li>◆ Your county and worker number</li><li>◆ The client's date of birth</li><li>◆ The client's social security number, if available</li><li>◆ The name of the client's parent or guardian, if applicable</li></ul>

### Verification of Paid Medical Bills, Form 470-2224

Purpose	<p>Members and county agencies can receive direct reimbursement for certain paid medical bills. When an appeal decision by the Department or the Social Security Administration on an eligibility issue favors the member, members and county agencies may be entitled to reimbursements.</p> <p>A Medicaid member or a county agency may submit form 470-2224 to claim reimbursement of medical expenses paid on behalf of a Medicaid applicant during the appeal period, which is the time between the date of a <i>Notice of Decision</i> denying Medicaid and the date of a <i>Notice of Decision</i> approving Medicaid.</p> <p>See <a href="#">8-A, Reimbursement After Appeal Decisions</a>.</p>
Source	<p>Supplies of the form may be printed or photocopied as needed from the sample in the manual.</p>
Completion	<p>The form is prepared when the member or a county agency requests reimbursement for paid medical bills.</p> <p>One copy of the form is required for each provider of service involved. If the number of entries exceeds the available space on the form, use additional forms.</p> <ul style="list-style-type: none"><li>◆ Section I, Member Information, is prepared by either the local DHS office or the county agency, giving identifying information.</li><li>◆ Section II, Eligibility Information, is completed by the Department. The information in this section certifies that the member attained Medicaid eligibility through the appeal process and identifies the period for when reimbursement can be received.</li><li>◆ Section III, Payment Information, is completed by either the member or the county agency, depending on who is to receive reimbursement.</li><li>◆ Section IV is completed by the provider of service. This section may also be completed by the county agency, if the county agency is claiming reimbursement or if it is furnishing information so the member may claim reimbursement.</li></ul>

- ◆ Section V is reviewed by the Interim Assistance Reimbursement coordinator in the Bureau of Financial, Health, and Work Supports for accuracy. The form is then sent to the Iowa Medicaid Enterprise (IME) to determine the correct amount to reimburse to the county agency or the member.

Distribution

Provide the member or the county agency with sufficient copies of the form to cover all of the involved providers and bills.

Following the provider's completion of Section IV, the member shall return the form to the local office, or the provider of service may mail it directly to the local office. The county agency, following preparation of the form from its records, submits it to the local office.

The worker submits the original form to the Interim Assistance Reimbursement coordinator in the Bureau of Financial, Health, and Work Supports. Following processing, a copy of the completed form will be returned to the county agency or the member by IME. The payment approved for each medical service is shown in Section IV, H.

Data

If the county agency is requesting reimbursement, the county must provide its vendor number, if previously assigned one by the state, or the county's federal identification number (the number used by the county for tax purposes).

If the member is requesting reimbursement, the member must sign and date the form, authorizing either the county agency or the medical service provider to release information.

The provider of service must enter a signature, title, business name, the type of provider, and the date. If the county agency provided the information from its records or is claiming reimbursement, the agency director or designee shall sign.

Instructions for completion of Section IV are given on the back of the form.

**Vocational Report, Form 470-2466**

Purpose	Disability Determination Services (DDS), which is under contract to the Department, uses form 470-2466 to gather information regarding the applicant's work experience needed to complete the disability determination.
Source	Form 470-2466 is used only by Disability Determination Services.
Completion	<p>The Department is not responsible for completing this form. It is included in the manual for reference only. Once DDS receives the <i>Disability Transmittal</i>, form 470-2472, and the <i>Disability Report</i>, form 470-2465, DDS will determine whether additional documentation is required.</p> <p>DDS is responsible for the issuing the <i>Vocational Report</i> for persons who are referred to their office for disability determinations. DDS shall assist the applicant in completing the form.</p>
Distribution	<p>Once a determination is completed, the form shall be returned to the local DHS office to be filed in the case record.</p> <p>If the client files subsequent applications for Medicaid based on disability, and DHS is required to complete the disability determination, forward all disability forms from previous applications to DDS to be evaluated for the current determination.</p> <p>If the client files an appeal with DHS due to the denial of disability, forward copies of all disability forms from previous applications to the Appeals Section in Central Office and to the client and the client's representative.</p>
Data	The form requests information about the client's work history and job duties.

**Voluntary Contribution Agreement, Form 470-0373**

Purpose	Form 470-0373 can be used to document a voluntary contribution made by a member or member's family towards the member's cost of care in a medical institution.
Source	Complete the form on line using the template available on the DHS Intranet eForms web page.
Completion	Section 1 is completed by the contributor. Section 2 is completed by the medical institution. Section 3 is completed by the local DHS office.
Distribution	One copy should be retained by the contributor, the nursing facility, and the local DHS office.
Data	Complete the form fields to indicate: <ul style="list-style-type: none"><li>◆ Contributor's name</li><li>◆ Voluntary contribution amount</li><li>◆ Member's name</li><li>◆ Medical institution name and city</li><li>◆ Day of the month voluntary contribution is to be made</li></ul> <p>The contributor, medical institution representative, and local DHS representative shall sign the form after these items have been completed.</p>

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**Voter Registration, Unnumbered**

Purpose	<p>The <i>Voter Registration</i> form:</p> <ul style="list-style-type: none"><li>◆ Gives clients information about registering to vote.</li><li>◆ Records a client's decision whether to register.</li><li>◆ Provides a detachable card that clients can use to register.</li></ul> <p>This process is required by the National Voter Registration Act of 1993 and Iowa Code Section 48A.19.</p>
Source	<p>Central Office has a contract to provide automatic shipments of the <i>Voter Registration</i> form to local offices. The shipments are intended to cover a six-month supply. Additional supplies are also available through Central Office.</p>
Completion	<p>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.</p> <p>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.</p> <p>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.</p>
Distribution	<p>Keep the declination section in the local office. Give the voter registration information section to the client.</p> <p>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.</p>

Mail the voter registration forms to the county election office in a plain envelope without the Department's return address. Use the election office label for both the mailing address and the return address.

File the declination portion of the form by date order in a secure, confidential location, separate from the individual case record. The forms must be available upon request. Keep the forms for 22 months after the next general election following the receipt of the form. Follow this retention schedule:

<b>Date Declination Signed</b>	<b>Election Date</b>	<b>Destroy After</b>
10/24/04 - 10/28/06	11/07/06	09/07/08
10/29/06 - 10/26/08	11/04/08	09/04/10
10/27/08 - 10/23/10	11/02/10	09/02/12

Data

If the client chooses not to check yes or no, leave this section blank and consider the client has chosen not to register to vote. If the client chooses not to sign the form, print the client name and date on the client name line and initial the form.

**Waiver Slot Notice, Form 470-4833**

Purpose	Form 470-4833, <i>Waiver Slot Notice</i> , is used to notify clients on the waiver waiting lists that a payment slot is available.
Source	Complete form 470-4833 on line using the template on the DHS Intranet eForms web page.
Completion	<p>For ongoing, full Medicaid members, an application is not needed. To accept the open slot, the member should sign the bottom of the letter and return it by the due date.</p> <p>For other clients, an application must be returned by the due date to secure the open slot. Send form 470-5170, <i>Application for Health Coverage and Help Paying Costs</i> with the <i>Waiver Slot Notice</i>.</p> <p>Select the waiver type matching the waiver slot assignment.</p>
Distribution	Print a copy for the case file for documentation.
Data	The form provides a signature block for ongoing full Medicaid members to easily accept the open slot.

**Work Sheet Determining Income of Farm Operators, Form 470-0312**

**Purpose** This form is used to enable the worker to determine the net farm income when an applicant, recipient, or spouse is engaged in a farming enterprise.

**Source** Print or photocopy supplies of form 470-0312 as needed from the sample in the manual.

**Completion** The IM worker completes the form, with the assistance of the client.

Secure sufficient information to determine the client's net farm income. If it becomes necessary to contact an outside source to obtain verification of a specific item, obtain an *Authorization for Release of Information*, form 470-0461, from the applicant or recipient.

**Distribution** File the completed form into the client's case record.

**Data** The form is divided into three sections: Income, Resources, and Farm Expenses.

Farming is a form of self-employment, and income received from self-employment is usually received on other than a monthly basis. Prorate the annual income over the 12-month period.

Do not use any amount claimed for depreciation as an expense, since it is not an out-of-pocket expense. Depreciation is not considered income either, since no actual income is forthcoming.

**Work Sheet Determining Income of Self-Employed Business, Form 470-0313 (FP-2210-0)**

Purpose	This form was designed for use in the Food Assistance program; however, it has been adapted for use in the FIP and SSI-related Medicaid programs. This form is to be used when an applicant, recipient, or spouse is engaged in a self-employment business. The form enables the worker to determine countable income from self-employment (other than farming).
Source	Form 470-0313 is printed as individual sheets with no padding. Order supplies from Iowa Prison Industries at Anamosa.
Completion	<p>The IM worker completes this form with the assistance of the applicant or recipient whenever the income of an applicant, recipient, or spouse is based upon income from a self-employment business (other than farming).</p> <p>Secure sufficient information to determine the client's net income from self-employment. If it becomes necessary to contact an outside source, obtain an <i>Authorization for Release of Information</i>, form 470-0461, from the applicant or recipient.</p>
Distribution	Insert the completed form into the client's case record.
Data	<p>Income received from self-employment is rarely received on a monthly basis; therefore, the annual income is computed and prorated over the 12-month period.</p> <p>The form is divided into two sections, Business Expense and Gross Income, and a summary box.</p> <p>Any amount claimed as depreciation shall not be used as an expense since it is not an out-of-pocket expense. Depreciation is not considered as income either, since no actual income is forthcoming.</p>

**Comm. 2 or Comm. 2(S), Facts About the Food Assistance Program**

Purpose	The flier <i>Facts About the Food Assistance Program</i> helps applicants to better understand income guidelines and allotment levels for Food Assistance. The flier allows clients to determine for themselves whether or not they may be eligible for Food Assistance.
Source	Print copies of Comm. 2 and Comm. 2(S) from the samples in the manual.
Distribution	Local offices may give this form to Food Assistance applicants at the time they are given a <i>Financial Support Application</i> , form 470-0462 or 470-0462(S).
Data	The flier lists the gross and net monthly income limits and maximum allotments by household size.

**Comm. 4, Care for Kids**

Purpose	The flier <i>Care for Kids</i> gives basic information about Medicaid early and periodic screening, diagnostic, and treatment services for members under the age of 21.
Source	Printed supplies of Comm. 4 with English text on one side and Spanish text on the other may be ordered from Iowa Prison Industries at Anamosa.
Distribution	Local offices may give this flier to Medicaid applicants at the time they are given an <i>Application for Health Coverage and Help Paying Costs</i> , form 470-5170 or 470-5170(S).
Data	The flier lists the services available to children, tells why regular checkups are important, and gives contact information.

**Comm. 18, State Supplementary Assistance**

Purpose	Brochure Comm. 18 gives basic information about the State Supplementary Assistance Program.
Source	Printed supplies of Comm. 18 may be ordered from Iowa Prison Industries at Anamosa.
Distribution	Local offices may give this brochure to applicants or other interested persons.
Data	The brochure describes SSI eligibility requirements and the various categories of living situations where SSI income may be supplemented.

**Comm. 20 or Comm. 20(S), Your Guide to Medicaid Fee-for-Service (FFS)**

Purpose	Booklet Comm. 20 or Comm. 20(S) gives basic information about the services covered under the Medicaid Program.
Source	Printed supplies of Comm. 20 or Comm. 20(S) may be ordered from Iowa Prison Industries at Anamosa.
Distribution	Give this booklet to Medicaid applicants or other interested persons.
Data	The booklet describes the use of the <i>Medical Assistance Eligibility Card</i> , retroactive eligibility, copayment and other member responsibilities, who can provide covered services, the coverage limitations applicable to the various providers, managed care, and use of the Member Services Call Center.

**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: <ul style="list-style-type: none"><li>◆ Each applicant for FIP or MAGI-related Medicaid, and</li><li>◆ Each FIP or MAGI-related Medicaid member:<ul style="list-style-type: none"><li>• Who reports receipt or possible receipt of a nonrecurring lump sum, or</li><li>• Whom you believe may receive a nonrecurring lump sum.</li></ul></li></ul>
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.

**Comm. 27 and Comm. 27(S), Medicaid for Families and Children**

Purpose	The booklet <i>Medicaid for Families and Children</i> gives basic information about FMAP-related coverage groups.
Source	Printed supplies of Comm. 27 and Comm. 27(S), issued together in one booklet, may be ordered from Iowa Prison Industries at Anamosa.
Distribution	Give this booklet to FMAP-related Medicaid applicants at the time they are given an <i>Application for Health Coverage and Help Paying Costs</i> , form 470-5170 or 470-5170(S).
Data	The booklet explains Medicaid eligibility requirements and application procedures, how a member can access medical care, the relationship between Medicaid and other insurance, and the process for appeals or complaints.

**Comm. 28 or Comm. 127 (Spanish), Medicaid for SSI-Related Persons**

Purpose	The booklet <i>Medicaid for SS-Related Persons</i> gives basic information about SSI-related coverage groups.
Source	Printed supplies of Comm. 28 or Comm. 127 may be ordered from Iowa Prison Industries at Anamosa.
Distribution	Local offices may give this form to SSI-related Medicaid applicants at the time they are given an <i>Application for Health Coverage and Help Paying Costs</i> , form 470-5170 or 470-5170(S).
Data	The booklet explains the Medicaid program, SSI-related eligibility requirements, how a member gets medical care, the application process, the relationship between Medicaid and other insurance, and the member's rights and responsibilities.

**Comm. 30, Medicaid for the Medically Needy**

Purpose	The brochure Comm. 30 gives basic information about Medicaid Needy eligibility and coverage.
Source	Printed supplies of Comm. 30 with English text on one side and Spanish text on the other may be ordered from Iowa Prison Industries at Anamosa.
Distribution	Give this brochure to applicants who are determined eligible for Medically Needy coverage.
Data	The brochure lists the eligibility requirements and explains spenddown, when a <i>Medical Assistance Eligibility Card</i> is issued, and how to explain the program to the member's medical providers.

**Comm. 51, Information Practices**

Purpose	Brochure Comm. 51 provides the notification to persons supplying information to the Department for income maintenance programs that is required by the Iowa Fair Information Practices Act, Iowa Code section 22.11.
Source	Printed supplies of Comm. 51 may be ordered from Iowa Prison Industries at Anamosa.
Distribution	Give this brochure to anyone who files an application for: <ul style="list-style-type: none"><li>◆ Child Care Assistance</li><li>◆ Food Assistance</li><li>◆ Medicaid</li><li>◆ State Supplementary Assistance</li><li>◆ The Family Investment Program</li></ul>
Data	The brochure explains in general way: <ul style="list-style-type: none"><li>◆ How the Department will use the information provided;</li><li>◆ Which persons outside the Department might routinely be provided this information;</li><li>◆ Which parts of the information requested are required and which are optional; and</li><li>◆ The consequences of failing to provide the information requested.</li></ul>

**Comm. 52, Medicaid for People in Nursing Homes and Other Care Facilities**

Purpose	Booklet Comm. 52 gives basic information about Medicaid eligibility and coverage in a medical facility.
Source	Printed supplies of Comm. 52 may be ordered from Iowa Prison Industries at Anamosa.
Distribution	<p>Give this booklet to anyone who files a Medicaid application for long-term facility care or other medical facility care.</p> <p>“Long-term facility care” includes care in a nursing facility (NF), an intermediate care facility for persons with mental retardation (ICF/MR), or a certified skilled facility (SNF).</p> <p>“Other medical facility care” includes care in a general hospital or a psychiatric institution.</p>
Data	<p>The booklet:</p> <ul style="list-style-type: none"><li>◆ Gives guidance on choosing a long-term care facility, and</li><li>◆ Explains admission procedures, the effect of Medicaid eligibility on facility payment and a spouse at home, client participation, reserve bed days, additional services available, the relationship between Medicare and Medicaid, and transfer and discharge from a facility.</li></ul>

**Comm. 60, Medicaid for the Qualified Medicare Beneficiary**

Purpose	Booklet Comm. 60 gives basic information about Medicaid coverage for qualified Medicare beneficiaries (QMB) in English and Spanish.
Source	Printed supplies of Comm. 60 may be ordered from Iowa Prison Industries at Anamosa.
Distribution	Give this brochure to applicants who are determined eligible for QMB coverage.
Data	The booklet explains QMB eligibility requirements and covered services.

**Comm. 62 or Comm. 62(S), Child Care Assistance**

Purpose	Brochures Comm. 62 and 62(S) provides information about the Child Care Assistance program.
Source	Printed supplies of Comm. 62 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: <ul style="list-style-type: none"><li>◆ Child Care Assistance applicants</li><li>◆ FIP applicants at the application interview</li><li>◆ FIP participants at the annual interview</li><li>◆ Other interested person upon request</li></ul>
Data	The brochure explains who can get Child Care Assistance, who can provide the care, where families can get help finding child care, and the rights and responsibilities of a parent who receives subsidized child care under this program

**Comm. 69 or Comm. 69(S), Presumptive Eligibility for Pregnant Women**

Purpose	Brochures Comm. 69 and 69(S) explain the presumptive eligibility for pregnant women.
Source	Printed supplies of both Comm. 69 and Comm. 69(S) may be ordered from Iowa Prison Industries at Anamosa.
Distribution	Provide this brochure to pregnant women and other persons inquiring about the program.
Data	The brochure explains what services are covered, the application process, and the program's relationship to regular Medicaid benefits.

**Comm. 72, Protection of Your Resources and Income**

Purpose	The booklet Comm. 72 gives basic information about Medicaid policies affecting married people residing in long-term care facilities.
Source	Printed supplies of Comm. 72 may be ordered from Iowa Prison Industries at Anamosa.
Distribution	Give this booklet to married people who are applying for Medicaid coverage for long-term care or who may apply for such coverage in the future.
Data	The booklet explains the SSI regulations of the treatment of resources, the Long-Term Care Partnership Program for Medicaid asset protection, estate recovery, and Medicaid income policies for long-term care.

**Comm. 84 or Comm. 84(S), Information on Emergency Service**

Purpose	The <i>Information on Emergency Service</i> flier helps applicants to better understand Food Assistance emergency service and the criteria for receiving it. It allows applicants to determine for themselves whether or not they may be eligible for emergency service.
Source	Comm. 84 (English) is printed with 25 forms on a pad. Order supplies from Iowa Prison Industries at Anamosa.  Print copies of the Spanish translation, Comm. 84(S), from the sample in the manual.
Completion	Use of this flier is mandatory only for counties that choose not to issue an appointment letter that indicates the client's eligibility for an emergency Food Assistance appointment.  In counties that choose to distribute information on emergency service with applications, give this flier to all Food Assistance applicants at the time they are given a <i>Financial Support Application</i> , form 470-0462 or 470-0462(S).
Distribution	In a county that chooses not to inform applicants on the appointment letter whether they have been screened as entitled to an emergency appointment, include one copy of Comm. 84 or Comm. 84(S) with the application form.
Data	The flier describes the criteria for emergency services and advises households what to do if they believe that they qualify for emergency services.

**Comm. 91 or Comm. 91(S), The Health Insurance Premium Payment (HIPP) Program for Iowa Medicaid Recipients**

Purpose	Brochures Comm. 91 and Comm. 91(S) explain the HIPP program and provides a tear-off application and return envelope.
Source	Printed supplies of both Comm. 91 and Comm. 91(S) may be ordered from Iowa Prison Industries at Anamosa.
Distribution	Provide this brochure to Medicaid applicants and members who are interested in applying for the HIPP program. Do not issue it with Medicaid applications. Use Comm. 255 or Comm. 255(S), "Benefits of the Health Insurance Premium Payment Program," for that purpose.
Data	The brochure explains the HIPP program, how HIPP determines if insurance is cost-effective, what kind of insurance the HIPP program will pay for, and how to report changes.

Page 417 is reserved for future use.

**Comm. 99, The Iowa AIDS/HIV Health Insurance Premium Payment Program**

Purpose	The booklet Comm. 99 gives basic information about the Iowa AIDS/HIV Health Insurance Premium Payment program. It also contains and application form an a return envelope
Source	Printed supplies of Comm. 99 may be ordered from Iowa Prison Industries at Anamosa.
Distribution	Local offices may give this form to persons who express interest in applying for the Iowa AIDS/HIV Health Insurance Premium Payment program.
Data	The booklet explains the program and how people qualify for it, explains the programs relationship to the applicant's insurance coverage, and the process for determining eligibility and beginning benefits.

**Comm. 108, The Family Investment Program (FIP)**

Purpose	Brochure Comm. 108 gives basic information about the Family Investment Program (FIP), which offers cash assistance funded through the Temporary Assistance to Needy Families (TANF) federal block grant.
Source	Printed supplies of Comm. 108 may be ordered from Iowa Prison Industries at Anamosa.
Distribution	Local offices may give this form to persons who express interest in applying for FIP.
Data	The brochure explains FIP eligibility requirements, PROMISE JOBS activities, the limited benefit plan, application procedures, the effect of other income on the FP grant, and how FIP assistance is paid.

**[Comm. 121 or Comm. 121\(S\)](#), Important Notice to Property Owners and Renters**

Purpose	The <i>Important Notice to Property Owners and Renters</i> flier explains the income limits for both the property tax credit and rent reimbursement.
Source	Print supplies of the English and Spanish version from the sample in the manual or from the DHS Intranet eForms web page.
Distribution	Give or mail Comm. 121 or Comm. 121(S) to elderly and disabled applicants when they apply for benefits. Document this in the case record.

**Comm. 123 or Comm. 123(S), Important Information for You and Your Family Members About the Estate Recovery Program**

Purpose	The <i>Important Information for You and Your Family Members About the Estate Recovery Program</i> is a flier designed to give answers to questions about the Estate Recovery Program.
Source	<p>The English version of this flier is printed with 50 fliers per pad. Order supplies from Iowa Prison Industries at Anamosa.</p> <p>Print supplies of the English and Spanish versions from the samples in the manual or from the DHS Intranet eForms web page.</p>
Distribution	Issue a copy of this flier to all Medicaid applicants.

**Comm. 132 or Comm. 132(S), Family Planning Counseling**

Purpose	<p>The <i>Family Planning Counseling</i> brochure is designed to give basic information about family planning counseling services.</p> <p>FIP participants may choose family planning counseling as an option in their FIA but are not required to do so. Participants who choose family planning counseling as an FIA option and later decide against the service are not subject to the limited benefit plan.</p>
Source	<p>Comm. 132 is printed with 100 copies per pad. Order supplies from Iowa Prison Industries at Anamosa.</p> <p>Supplies of Comm. 132(S) can be printed or photocopied from the sample in the manual.</p>
Distribution	<p>Give Comm. 132 at the FIP application interview and at review. PROMISE JOBS workers may issue at their discretion to PROMISE JOBS participants during the FIA process.</p>

**Comm. 133 or Comm. 133(S), FIP for Minor Parents**

Purpose	The <i>FIP for Minor Parents</i> brochure explains the FIP requirement for minor parents to live with their adult parent or legal guardian or show good cause for not doing so.
Source	Comm. 133 is printed with 100 copies per pad. Order supplies from Iowa Prison Industries at Anamosa.  Comm. 133(S) can be printed or photocopied from the sample in the manual.
Distribution	Issue Comm. 133: <ul style="list-style-type: none"><li>◆ When a minor parent applies for FIP.</li><li>◆ When FIP eligibility must be redetermined due to a change in a minor parent's living arrangement.</li></ul>

**Comm. 137, 60-Month Limit on FIP**

Purpose	Comm. 137, <i>60-Month Limit on FIP</i> , is designed to give answers to frequently asked questions about the 60-month limit on FIP benefits.
Source	DHS staff may print Comm. 137 from the on line manual or from the DHS Intranet eForms web page.  Comm. 137 is also available from the Eligibility Tracking System (ETS).  PROMISE JOBS staff may photocopy Comm. 137 as needed.
Distribution	Issue Comm. 137 at the application interview and the annual review. Also include Comm. 137 whenever issuing form 470-3851, <i>Important Information About Your FIP</i> .  PROMISE JOBS workers may issue Comm. 137 at their discretion to PROMISE JOBS participants.

**Comm. 156A, *hawk-i* Brochure Income Guidelines for Health Care Coverage**

Purpose	Comm. 156A is a flier which gives the income guidelines for Medicaid and <b><i>hawk-i</i></b> .
Source	Printed supplies of Comm. 156A, which has English text on one side and Spanish text on the other, may be ordered from Iowa Prison Industries at Anamosa.
Distribution	Insert this flier: <ul style="list-style-type: none"><li>◆ Whenever form 470-5170 or 470-5170(S), <i>Application for Health Coverage and Help Paying Costs</i>, is issued and</li><li>◆ When a person asks about assistance with health coverage.</li></ul>
Data	The flier contains income limits and <b><i>hawk-i</i></b> income limits for families with and without premiums.

**Comm. 156B, hawk-i Brochure Income Guidelines for Dental Only Coverage**

Purpose	Comm. 156B is a flier which gives the <b>hawk-i</b> income guidelines for dental only coverage.
Source	Printed supplies of Comm. 156B, which has English text on one side and Spanish text on the other, may be ordered from Iowa Prison Industries at Anamosa.
Distribution	Insert this flier whenever form 470-5170 or 470-5170(S), <i>Application for Health Coverage and Help Paying Costs</i> is issued and when a person asks about assistance with dental coverage.
Data	The flier contains <b>hawk-i</b> income limits for families with and without premiums.

**Comm. 158 or Comm. 159, Myths and Truths About Medicaid**

Purpose	Brochures Comm. 158 and Comm. 159 (Spanish) explain the expanded medical assistance eligibility limits for children.
Source	Printed supplies of both Comm. 158 and Comm. 159 may be ordered from Iowa Prison Industries at Anamosa.
Distribution	Local offices and the <i>hawk-i</i> third-party administrator may give this brochure to persons who express interest in applying for medical assistance.
Data	The brochure lists common misconceptions people may have about the Medicaid program and provides current information.

**Comm. 160 or Comm. 161, *hawk-i* Poster and *hawk-i* Multilanguage Poster**

Purpose	Posters Comm. 160 and Comm. 161 provide information about the <b><i>hawk-i</i></b> program.
Source	Printed supplies of both Comm. 160 and Comm. 161 may be ordered from Iowa Prison Industries at Anamosa.
Distribution	An initial supply of each poster was sent to each local office to be posted in the reception area and other public areas.
Data	Comm. 161 contains the information from Comm. 160 in English, Spanish, Bosnian, Laotian, and Vietnamese.

**Comm. 170, Understanding the Limited Benefit Plan**

Purpose	Flier Comm. 170 provides information FIP limited benefit plan.
Source	Department staff may print supplies of Comm. 170 as needed from sample on the DHS Intranet eForms web page. PROMISE JOBS staff may print the flier from the sample in the PROMISE JOBS MS Library.
Distribution	Income maintenance staff and PROMISE JOBS workers should issue Comm. 170 any time it is necessary to inform participants about the consequences of the limited benefit plan.
Data	The flier tells how a limited benefit plan is chosen and the consequences and resolution conditions of a first limited benefit plan and of a subsequent limited benefit plan

**Comm. 180, Medicaid for Employed People With Disabilities (MEPD)**

Purpose	Brochure Comm. 180 gives basic information about Medicaid coverage for employed people who have disabilities (MEPD).
Source	Printed supplies of Comm. 180 may be ordered from Iowa Prison Industries at Anamosa.
Distribution	Give this brochure to persons who are applying for or interested in MEPD coverage.
Data	The brochure explains MEPD eligibility requirements and the requirements for premium payment.

**Comm. 209 or Comm. 209(S), Information About Your Privacy Rights**

Purpose	<p>Brochures Comm. 209 and Comm. 209(S) are notices required under the Health Insurance Portability and Accountability Act (HIPAA) to inform Medicaid members about the Department's uses and disclosures of protected health information.</p> <p>NOTE: State mental health institutes and resource centers each have their own brochures for this purpose.</p>
Source	<p>Order supplies of Comm. 209 from Iowa Prison Industries at Anamosa.</p> <p>Print or photocopy the Spanish version from the sample in the manual.</p>
Distribution	<p>Provide this brochure to Medicaid members and other interested persons.</p>
Data	<p>The brochure explains what:</p> <ul style="list-style-type: none"><li>◆ Disclosures the Department can make without the member's specific permission,</li><li>◆ Rights the member has under HIPAA and how to apply them, and</li><li>◆ Obligations the Department has to safeguard a member's privacy.</li></ul>

**Comm. 229 or Comm. 229(S), Food Assistance Makes Iowa Stronger**

Purpose	Brochures Comm. 229 and Comm. 229(S) give basic information about the Food Assistance program.
Source	Printed supplies of both Comm. 229 and Comm. 229(S) may be ordered from Iowa Prison Industries at Anamosa.
Distribution	Make this brochure available in public areas of Department offices. It may also be used in outreach and informational activities.
Data	The brochure explains how to get Food Assistance, the basic eligibility requirements, maximum allotments per household size, and steps to better health.

**Comm. 233 or Comm. 233(S), Rights and Responsibilities**

Purpose	The <i>Rights and Responsibilities</i> 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 <a href="http://dhs.iowa.gov/sites/default/files/Comm233/pdf">http://dhs.iowa.gov/sites/default/files/Comm233/pdf</a> .  Supplies of Comm. 233(S) can be printed or photocopied from the sample in the manual. Comm. 233(S) is available online at <a href="http://dhs.iowa.gov/sites/default/files/Comm233S/pdf">http://dhs.iowa.gov/sites/default/files/Comm233S/pdf</a> .
Distribution	Give or mail Comm. 233 to the applicant household when an applicant files form 470-0462 or 470-0462(S), <i>Financial Support Application</i> .  Also give or mail Comm. 233 or Comm. 233(S) to individuals upon request.

**Comm. 238, Cut Your Medical Costs if You Get Medicaid**

Purpose	Flier Comm. 238 explains the advantages of receiving SSI-related Medicaid benefits
Source	Print or photocopy supplies of Comm. 238 from the sample in the manual.
Distribution	Provide this flier to people who may be eligible for SSI-Related Medicaid and other interested persons.
Data	The flier summarizes Medicaid benefits, explains SSI-related eligibility criteria, and gives contact information for Food Assistance and local offices.

**Comm. 243 or Comm. 243(S), Primary Care Access**

Purpose	Pamphlets Comm. 243 and Comm. 243(S) explain where a woman can access primary care services in Iowa.
Source	Printed supplies of Comm. 243 may be ordered from Iowa Prison Industries at Anamosa.  Print supplies of the Spanish version from the sample in the manual.
Distribution	Provide this pamphlet to all women who are determined eligible under the Iowa Family Planning Network.
Data	The pamphlet lists rural health clinics and federally qualified health centers that generally can provide care on a sliding fee schedule.

**Comm. 249 or Comm. 249(S), It's Your Future**

Purpose	Brochures Comm. 249 and Comm. 249(S) provide information about services provided by the Iowa Family Planning Network.
Source	Additional copies of both Comm. 249 and Comm. 249(S) may be ordered from Iowa Prison Industries at Anamosa.
Distribution	<p>Give Comm. 249 or Comm. 249(S) to:</p> <ul style="list-style-type: none"><li>◆ Men and women ages 12 through 54 who lose Medicaid eligibility,</li><li>◆ People who have eligibility established under the Iowa Family Planning Network.</li></ul> <p>Display the brochures in the local office for public access.</p>
Data	The brochures explain the availability of free birth control services for men and women under the Iowa Family Planning Network and give contact information for finding services.

**Comm. 255 and Comm. 255(S), Benefits of the Health Insurance Premium Program**

Purpose	Brochure Comm. 255 and Comm. 255(S) provides information about the Health Insurance Premium Payment (HIPP) program.
Source	Additional copies of Comm. 255 and Comm. 255(S), which are printed with English text on one side and Spanish text on the other, may be ordered from Iowa Prison Industries at Anamosa.
Distribution	Give Comm. Comm. 255 and Comm. 255(S) to: <ul style="list-style-type: none"><li>◆ Applicants for HIPP benefits</li><li>◆ Other interested parties</li></ul>
Data	The brochure explains how a member can get HIPP, how HIPP decides if insurance is cost-effective, and what insurance plans the program will and will not pay for.

**Comm. 257, Verifying Citizenship and Identity Poster**

Purpose	Comm. 257 is a poster in English and Spanish about federal Medicaid requirements.
Source	Additional copies of Comm. 257 may be ordered from Iowa Prison Industries at Anamosa.
Distribution	Two posters were mailed to each local office and family planning clinic. These posters should be displayed in the reception area of the waiting room of all full-time and less-than-full-time local offices.
Data	The poster includes the basic documents for proof of citizenship and identity. It includes a web address that may be used to find phone and fax numbers for vital records offices in each state. These numbers will help applicants and members born outside of Iowa to apply for original birth certificates if they do not have verification of U.S. citizenship.

**[Comm. 258 or Comm. 258\(S\)](#), Verifying Citizenship/Identity and/or Immigration Status**

Purpose	<i>Verifying Citizenship/Identity and/or Immigration Status</i> 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.

**Comm. 266, Iowa's Estate Recovery Law**

Purpose	Brochure Comm. 266 provides basic information on the provisions for recovery of Medicaid expenses from the estates of Medicaid members or their heirs.
Source	Printed supplies of Comm. 266 may be ordered from Iowa Prison Industries at Anamosa.
Distribution	Give to this brochure to Medicaid applicants who are over the age of 55 and to applicants under the age of 55 who are in long-term care.
Data	The brochure explains who is affected by the Estate Recovery Program, when a claim is made against an estate, how claims are paid, the relationship to life insurance, trusts, and annuities, and the provisions for waiving the debt.

**Comm. 284, Bringing Farmers Markets and Food Assistance Together**

Purpose	Comm. 284 is a brochure that promotes the use of Food Assistance benefits to purchase food at farmer's markets.
Source	Additional supplies of Comm. 284 may be printed on 11" x 17" paper from the following Department website:  <a href="http://dhs.iowa.gov/sites/default/files/Comm284.pdf">http://dhs.iowa.gov/sites/default/files/Comm284.pdf</a>  (Click on the link for the latest list of farmers markets.)
Distribution	Give Comm. 284 to: <ul style="list-style-type: none"><li>◆ New Food Assistance applicant households.</li><li>◆ Members of the public upon request.</li></ul>
Data	The brochure lists Iowa farmers markets that have vendors who accept the Food Assistance electronic benefit transfer (EBT) card as payment.

**Comm. 295, It Pays to Work**

Purpose	Comm. 295 is a flier that explains the earned income tax credit (EITC).
Source	Printed supplies of Comm. 295 may be ordered from Iowa Prison Industries at Anamosa.
Distribution	<p>Give Comm. 295 to:</p> <ul style="list-style-type: none"><li>◆ All Family Investment Program (FIP applicants at the time of interview.</li><li>◆ FIP participants at other times as appropriate.</li></ul> <p>The pamphlet can also be posted in local offices to increase awareness of the advantages of working and of EITC.</p>
Data	The flier explains what EITC is and how to get it. It also shows how earned income can increase the money available to a family that is on FIP.

**Comm. 316, PACE (Program of All-Inclusive Care for the Elderly)**

Purpose	Comm. 316 provides information about PACE (Program of All-Inclusive Care for the Elderly), which provides “managed” long-term care to members who want to live in the community.
Source	Local offices may print the booklet from the sample in the manual. The booklet is also available on line at <a href="http://dhs.iowa.gov/sites/default/files/Comm316.pdf">http://dhs.iowa.gov/sites/default/files/Comm316.pdf</a>
Distribution	The local office issues the booklet to PACE members.
Data	The booklet explains how a member obtains services under PACE, the member’s rights and responsibilities, and disenrolling from PACE.

**Comm. 337, Medicaid for Kids with Special Needs**

Purpose	Comm. 337 is a brochure that explains the Medicaid coverage group for children with special needs (MKSN).
Source	Supplies of Comm. 337 may be ordered from Iowa Prison Industries at Anamosa.
Distribution	Give Comm. 337 to applicants or potential applicants for MKSN coverage.
Data	The brochure contains: <ul style="list-style-type: none"><li>◆ Information on how to apply for MKSN</li><li>◆ An overview of MKSN eligibility requirements</li><li>◆ A chart of income limits</li><li>◆ Contact information for the Department.</li></ul>

**[Comm. 372, Medicaid for Employed People with Disabilities \(MEPD\) Frequently Asked Questions](#)**

Purpose	Comm. 372 gives the new MEPD member information about the coverage group.
Source	Print supplies of Comm. 372 from the sample in the manual.
Distribution	The Iowa Medicaid Enterprise will mail each new MEPD member a copy of Comm. 372. Local office staff may also give Comm. 372 to MEPD members.

**Comm. 374, Iowa Family Planning Network (IFPN), Frequently Asked Questions**

Purpose	Comm. 374 is a flier designed to give basic information about the Iowa Family Planning Network (IFPN) coverage group.
Source	Print supplies of Comm. 374 from the sample in the manual.
Distribution	Give Comm. 374 to applicants or potential applicants for Iowa Family Planning Network coverage.
Data	The flier explains: <ul style="list-style-type: none"><li>◆ Who may be eligible for IFPN coverage.</li><li>◆ Where to receive IFPN services.</li><li>◆ What types of services may be covered.</li><li>◆ How to contact the Department of Human Services.</li></ul>

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

Purpose	Comm. 377 and Comm. 377(S) are fliers that provide information about the FIP electronic access card (EAC).
Source	Print or photocopy supplies of the fliers from the samples in the manual or from the DHS Intranet eForms web page.
Distribution	Provide a copy of Comm. 377 or Comm. 377(S) to all FIP applicants.

**Comm. 390 and 390(S), Benefits of a Healthy Marriage**

Purpose	The flier <i>Benefits of a Healthy Marriage</i> constitutes the services provided under the categorical assistance program Promoting Awareness of the Benefits of a Healthy Marriage. (A household can be eligible for Promoting Awareness of the Benefits of a Healthy Marriage only when the household is otherwise eligible for Food Assistance.)
Source	The flier is generated by the Automated Benefit Calculation System when system entries are made to approve a household for Promoting the Awareness of the Benefits of a Healthy Marriage and, consequently, for Food Assistance. It is printed with English text on one side and Spanish text on the reverse.
Distribution	The flier is mailed to the household with the <i>Notice of Decision</i> approving the household for both programs.
Data	The flier provides information on the benefits provided by a healthy marriage.

**Comm. 411, Medicaid for People in Care Facilities**

Purpose	The flier <i>Medicaid for People in Care Facilities</i> gives basic information about the services covered by Medicaid for long-term care.
Source	Print or photocopy supplies of Comm. 411 from the sample in the manual as needed.
Distribution	<p>Give Comm. 411 to:</p> <ul style="list-style-type: none"><li>◆ All long-term care applicants and</li><li>◆ Anyone who requests information about Medicaid coverage of facility care expenses.</li></ul> <p>When more detailed information is requested, send Comm. 52, <i>Medicaid for People in Nursing Homes and Other Care Facilities</i>, or give the internet link to Comm. 52 at:</p> <p><a href="http://dhs.iowa.gov/sites/default/files/Comm052.pdf">http://dhs.iowa.gov/sites/default/files/Comm052.pdf</a></p>
Data	<p>Comm. 411 explains:</p> <ul style="list-style-type: none"><li>◆ Admission procedures,</li><li>◆ The effect of Medicaid eligibility on the facility payment,</li><li>◆ Consideration of a spouse at home,</li><li>◆ Client participation,</li><li>◆ Additional services available,</li><li>◆ The relationship between Medicare and Medicaid, and</li><li>◆ Transfer from one facility to another.</li></ul>

**Comm. 412, Medicaid Information**

Purpose	The pamphlet <i>Medicaid Information</i> gives basic information about the medical services paid by Medicaid.
Source	Print or photocopy supplies of Comm. 412 from the sample in the manual as needed.
Distribution	Give Comm. 412 to: <ul style="list-style-type: none"><li>◆ All Medicaid applicants and</li><li>◆ Anyone who requests information about Medicaid.</li></ul> When more detailed information is requested, send Comm. 20, <i>Your Guide to Medicaid</i> , or give the Internet link to Comm. 20 at:  <a href="http://dhs.iowa.gov/sites/default/files/Comm020.pdf">http://dhs.iowa.gov/sites/default/files/Comm020.pdf</a>
Data	Comm. 412 explains: <ul style="list-style-type: none"><li>◆ The Medical Assistance Eligibility Card,</li><li>◆ Retroactive eligibility,</li><li>◆ Copayment for services and other member responsibilities,</li><li>◆ Medicaid providers,</li><li>◆ Coverage limitations applicable to the various providers,</li><li>◆ Managed care, and</li><li>◆ Use of the Member Services Call Center.</li></ul>

**Comm. 413, Medicare Savings Programs**

Purpose	The flier <i>Medicare Savings Programs</i> gives basic information about the qualified Medicare beneficiary (QMB) program.
Source	Print or photocopy supplies of Comm. 413 from the sample in the manual as needed.
Distribution	Give Comm. 413 to: <ul style="list-style-type: none"><li>◆ All members who qualify for QMB and</li><li>◆ Anyone who requests information about Medicare Savings Programs.</li></ul> <p>When more detailed information is requested, send Comm. 60, <i>Medicaid for the Qualified Medicare Beneficiary</i>, or give the Internet link to Comm. 60 at:</p> <p><a href="http://dhs.iowa.gov/sites/default/files/Comm060.pdf">http://dhs.iowa.gov/sites/default/files/Comm060.pdf</a></p>
Data	Comm. 413 explains the eligibility requirements and services available under the QMB program.

**Comm. 414, Protecting Your Resources and Income**

Purpose	The flier <i>Protecting Your Resources and Income</i> gives basic information about how resources and assets are determined when a person applies for Medicaid for facility care.
Source	Print or photocopy supplies of Comm. 414 from the sample in the manual as needed.
Distribution	<p>Give Comm. 414 to:</p> <ul style="list-style-type: none"><li>◆ All applicants for facility care and</li><li>◆ Anyone who requests information about the treatment of resources for Medicaid eligibility for facility care.</li></ul> <p>When more detailed information is requested, send Comm. 72, <i>Protection of Your Resources and Income</i>, or give the Internet link to Comm. 72 at:</p> <p><a href="http://dhs.iowa.gov/sites/default/files/Comm072.pdf">http://dhs.iowa.gov/sites/default/files/Comm072.pdf</a></p>
Data	<p>Comm. 414 explains:</p> <ul style="list-style-type: none"><li>◆ The income limit for the spouse in the facility,</li><li>◆ How resources are divided between the spouse in the facility and the spouse at home, and</li><li>◆ What income can be protected.</li></ul>

**Comm. 415, Medically Needy Medical Assistance**

Purpose	The pamphlet <i>Medically Needy Medical Assistance</i> gives basic information about the Medically Needy program.
Source	Print or photocopy supplies of Comm. 415 from the sample in the manual as needed.
Distribution	Give Comm. 415 to all applicants who are determined eligible for Medically Needy coverage.  When more detailed information is requested, send Comm. 30, <i>Medicaid for the Medically Needy</i> , or give the internet link to Comm. 30 at:  <a href="http://dhs.iowa.gov/sites/default/files/Comm030.pdf">http://dhs.iowa.gov/sites/default/files/Comm030.pdf</a>
Data	Comm. 415: <ul style="list-style-type: none"><li>◆ Lists the eligibility requirements.</li><li>◆ Explains spenddown.</li><li>◆ Tells when a <i>Medical Assistance Eligibility Card</i> is issued.</li></ul>

**[Comm. 424, Medicaid Payback Trusts in Iowa](#)**

Purpose	Comm. 424 is an informational brochure available to income maintenance workers, as well as the general public, trustees, and attorneys to provide basic information about Medicaid Payback Trusts in Iowa.
Source	Print or photocopy supplies of Comm. 424 from the sample in the manual as needed.
Distribution	Give Comm. 424 to anyone who requests information about the Medicaid Payback Trusts in Iowa.

**Comm. 438, Family Medicaid**

Purpose	The flier <i>Family Medicaid</i> gives basic information about Medicaid for families with children.
Source	Print or photocopy supplies of Comm. 438 from the sample in the manual as needed.
Distribution	<p>Give Comm. 438 to FMAP-related Medicaid applicants at the time they are given an <i>Application for Health Coverage and Help Paying Costs</i>, form 470-5170 or 470-5170(S).</p> <p>When more detailed information is requested, send Comm. 27, <i>Medicaid for Families and Children</i>, or give the internet link to Comm. 27 at:</p> <p><a href="http://dhs.iowa.gov/sites/default/files/Comm027.pdf">http://dhs.iowa.gov/sites/default/files/Comm027.pdf</a></p>
Data	<p>Comm. 438:</p> <ul style="list-style-type: none"><li>◆ Explains Medicaid eligibility requirements and application procedures, and</li><li>◆ How a member can access medical care.</li></ul>

**Comm. 479, Burial Contract Frequently Asked Questions**

Purpose	The flier <i>Burial Contract Frequently Asked Questions</i> 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 <i>Burial Contract Frequently Asked Questions</i> to determine: <ul style="list-style-type: none"><li>◆ If this information pertains to them or</li><li>◆ If they need to contact DHS for further information relating to burial contracts.</li></ul>

**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.

**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	<p>The chart lists:</p> <ul style="list-style-type: none"><li>◆ Income and resource limits for:<ul style="list-style-type: none"><li>• Food Assistance</li><li>• FIP</li><li>• Medically Needy Medicaid</li><li>• Medicaid for Kids with Special Needs (MKSN) (no resource limit)</li><li>• SSI-related Medicaid</li><li>• QMB (Medicare savings)</li><li>• SLMB (Medicare savings)</li><li>• Expanded SLMB (Medicare savings)</li><li>• QDWP (Medicare savings)</li><li>• Medicaid for Employed People with Disabilities</li></ul></li><li>◆ Income limits and premium levels for Medicaid for Employed People with Disabilities</li><li>◆ The Medicare Part B premium</li></ul>

**RC-0064, Unearned Income Desk Aid**

Purpose	<p>The <i>Unearned Income Desk Aid</i> is designed as an immediate reference about unearned income for income maintenance staff. It:</p> <ul style="list-style-type: none"><li>◆ Gives information on the documents that verify child support, unemployment benefits, SSI benefits, and social security benefits.</li><li>◆ 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.</li><li>◆ Lists the child support account codes to distinguish between payments that are forwarded to the client and those that are kept by the state.</li></ul>
Source	<p>Print or photocopy RC-0064 from the sample in the manual if needed.</p>

**[RC-0085](#), Guide for Citizenship and Identification**

Purpose	The <i>Guide for Citizenship and Identification</i> 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	<p>The front of the form lists the required documentation to provide with disability referrals. The back of the form gives helpful tips for:</p> <ul style="list-style-type: none"><li>◆ Continuing disability reviews (CDRs).</li><li>◆ Disability referrals based on worsened conditions or new conditions.</li><li>◆ The use of form 470-0363, <i>Certification of Eligibility of SSI Applicant</i>.</li><li>◆ Concurrent determinations for Medicaid and Social Security benefits.</li></ul>

**[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: <ul style="list-style-type: none"><li>◆ Modified adjusted gross income (MAGI)</li><li>◆ Medicaid for Independent Young Adults (MIYA)</li><li>◆ Iowa Health and Wellness Plan (IHAWP)</li><li>◆ Healthy and Well Children in Iowa (<i>hawk-i</i>)</li></ul>