



# STATE OF IOWA

CHESTER J. CULVER, GOVERNOR  
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DEPARTMENT OF HUMAN SERVICES  
CHARLES J. KROGMEIER, DIRECTOR

February 19, 2010

## GENERAL LETTER NO. 1-C-AP-18

ISSUED BY: Bureau of Policy Coordination

SUBJECT: Employees' Manual, Title 1, Chapter C, **CONFIDENTIALITY AND RECORDS APPENDIX**, Title page, revised, Contents (page 1), revised; pages 1 through 21, revised; pages 22 through 26, new; and the following forms:

- 470-3946 *Acknowledgement of Notice of Privacy Rights and Practices*, unchanged
- 470-0461 *Authorization for Release of Information*, revised
- 470-0461(S) *Authorization for Release of Information (Spanish)*, revised
- 470-2115 *Authorization for the Department to Release Information*, updated
- 470-3951 *Authorization to Obtain or Release Health Care Information*, revised
- 470-3951(S) *Authorization to Obtain or Release Health Care Information (Spanish)*, revised
- 470-4375 *Child Records Query*, revised
- 470-0429 *Consent to Obtain and Release Information*, revised
- 470-3948 *Designation of Personal Representative*, unchanged
- 470-2078 *Electronic Security Information*, unchanged
- RC-0063 *Fees for Examining and Copying Records*, unchanged
- 470-3981 *HIPAA Complaint*, revised
- 470-4015 *Record of Disclosure of Health Information*, unchanged
- 470-3952 *Request for Access to Health Information*, revised
- 470-3985 *Request for List of Disclosures*, revised
- 470-3950 *Request to Amend Health Information*, revised
- 470-3947 *Request to Change How Health Information Is Provided*, revised
- 470-3949 *Request to End an Authorization*, unchanged
- 470-3953 *Request to Restrict Use or Disclosure of Health Information*, revised

## Summary

This chapter is revised to:

- ◆ Update the policy regarding discrimination, harassment, affirmative action and equal employment opportunity on the following forms to add sexual orientation and gender identity and remove references to the Diversity Programs Unit:
  - 470-0461, *Authorization for Release of Information*
  - 470-0461(S), *Authorization for Release of Information (Spanish)*
  - 470-3952, *Request for Access to Health Information*
  - 470-3985, *Request for List of Disclosures*
  - 470-3950, *Request to Amend Health Information*
  - 470-3947, *Request to Change How Health Information Is Provided*
  - 470-3953, *Request to Restrict Use or Disclosure of Health Information*
- ◆ Update forms 470-3951 and 470-3951(S), *Authorization to Obtain or Release Health Care Information*, to clarify that if the health care information is released to a person or organization that is not a health care plan or a health care organization, the released information may not continue to be protected under federal privacy regulations. Sexual orientation and gender identity are added to the discrimination policy statement.
- ◆ Change the letterhead on form 470-4375, *Child Records Query*, to reflect the current director's name.
- ◆ Remove references to health care information from form 470-0429, *Consent to Obtain and Release Information*, since it does not meet the requirements of the Health Insurance Portability and Accountability Act (HIPAA). Form 470-3951 or 470-3951(S), *Authorization to Obtain or Release Health Care Information*, must be used for an exchange of health care information. Sexual orientation and gender identity are added to the discrimination policy statement.
- ◆ Change the instructions for form 470-3948, *Designation of Personal Representative*, to reflect current version.
- ◆ Change the instructions and form 470-3981, *HIPAA Complaint*, to reflect that the unit to receive it is now the HIPAA Security and Privacy Office.
- ◆ Change the name of the appendix to match the name of Chapter 1-C, **CONFIDENTIALITY AND RECORDS**.

## Effective Date

Immediately

## Material Superseded

This material replaces the entire Chapter C, Appendix, in Title 1. This includes the following pages:

<u>Page</u>	<u>Date</u>
Title page	June 27, 2000
Contents (page 1)	October 5, 2007
470-0461	12/03
470-0461(S)	1/06
1	January 4, 2008
2	October 5, 2007
470-2115	11/86
3, 4	January 4, 2008
470-4375	11/08
4a, 4b	October 5, 2007
470-0429	4/04
5, 6	May 6, 2003
470-3948	8/03
6a	June 22, 2004
470-2078	7/05
7, 8	June 22, 2004
RC-0063	5/07
9	May 29, 2001
10	May 6, 2003
470-3946	4/03
470-3951	8/03
470-3951(S)	10/07
11	January 4, 2008
12, 13	October 5, 2007
14	June 22, 2004
470-3981	6/04
470-4015	6/04
14a, 14b	June 22, 2004
470-3952	10/07
15	June 22, 2004
16	May 6, 2003
470-3985	10/07
17, 18	June 22, 2004
470-3950	10/07
470-3947	6/04
19, 20	June 22, 2004
470-3953	10/07
470-3949	06/04
21	January 4, 2008

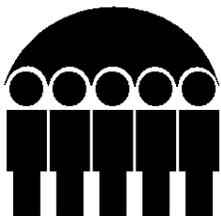
### **Additional Information**

Refer questions about this general letter to your area income maintenance administrator, area service administrator, regional collections administrator, your institution's privacy official, or the Department's Security and Privacy Office.

Revised February 19, 2010

Employees' Manual  
Title 1  
Chapter C Appendix

# **CONFIDENTIALITY AND RECORDS APPENDIX**



Iowa  
Department  
of  
Human Services

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	<u>Page</u>
Acknowledgement of Notice of Privacy Rights and Practices, Form 470-3946 .....	1
Authorization for Release of Information, Form 470-0461 or 470-0461(S).....	2
Authorization for the Department to Release Information, Form 470-2115 .....	4
Authorization to Obtain or Release Health Care Information, Form 470-3951 or 470-3951(S) .....	5
Child Records Query, Form 470-4375 .....	8
Consent to Obtain and Release Information, Form 470-0429.....	10
Designation of Personal Representative, Form 470-3948 .....	12
Electronic Security Information, Form 470-2078.....	13
Fees for Examining and Copying Records, Reference Card RC-0063.....	16
HIPAA Complaint, Form 470-3981 .....	17
Record of Disclosure of Health Information, Form 470-4015.....	18
Request for Access to Health Information, Form 470-3952.....	20
Request for List of Disclosures, Form 470-3985 .....	22
Request to Amend Health Information, Form 470-3950 .....	23
Request to Change How Health Information Is Provided, Form 470-3947 .....	24
Request to End an Authorization, Form 470-3949 .....	25
Request to Restrict Use or Disclosure of Health Information, Form 470-3953.....	26

**ACKNOWLEDGEMENT OF NOTICE OF PRIVACY RIGHTS AND PRACTICES**

Under federal law,\* the Department of Human Services must give you a copy of its Privacy Notice.

If you are receiving services directly from the Department, we must ask you for a written record that you have received the notice. Please complete the statement below indicating you have received a copy of the Privacy Notice. Return it to your worker.

<p>Client Name _____.</p> <p>I have received a copy of the Department of Human Services' Privacy Notice. I understand that if changes are made to this notice, the Department will post the changes and I can request a copy of the revised notice. I also understand that I have the right to receive an additional copy of the notice at any time.</p> <p>_____ Client or Personal Representative's Signature</p> <p>_____ Date</p>
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\* Public Law 104-191, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and 45 Code of Federal Regulations Parts 160 and 164.

**[Acknowledgement of Notice of Privacy Rights and Practices, Form 470-3946](#)**

Purpose	Form 470-3946 is used by Department health care facilities having a direct treatment relationship with a client to obtain written acknowledgement of the client's receipt of the notice of privacy rights and practices.
Source	Print or photocopy supplies of this form from the sample in the manual as needed.
Completion	<p>Add the client's name to the form and give it to the client or the client's representative to sign.</p> <p>If you are unable to get the client or the client's representative to sign the form, document your efforts to obtain the acknowledgement and the reason why the acknowledgement was not obtained in the case record.</p>
Distribution	File a copy in the case record and give a copy of the form to the client or the client's representative upon request.
Data	The form contains the client's name, authorized signature, and date of signature.

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

Purpose	Forms 470-0461 and 470-0461(S) are designed to secure the client's permission for the Department to investigate items of eligibility. 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 templates on the DHS Intranet eForms web page.
Completion	Income maintenance 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.  NOTE: This form should not be used to request any health care information, including mental health information, substance abuse information, or HIV information. See <a href="#">Authorization to Obtain or Release Health Care Information, Form 470-3951 or 470-3951(S)</a> .  The worker completes the identifying information and the description of the information requested. The client (or the person authorized to obtain the information) signs that section to give the authorization. The source of information completes Page 2 of the form. Additional pages may be used if necessary.
Distribution	Send one copy to the source of information with a self-addressed stamped envelope enclosed. Print an extra copy of Page 1 as a control copy.  When the source of information returns the original copy, destroy the control copy, and file the completed copy in the case record.

## Authorization for Release of Information

Date:

County:

**Information due date:**

Worker Number:

Worker Name:

Phone:

Email:

[Redacted area]

Dear [Redacted name]

This form gives you permission to share information with the Department of Human Services (DHS).

Please fill out this form and send it back to me by:

- Mailing it in the enclosed postage paid return envelope,
- Bringing it to my office at:
  
- Faxing it to:

If you have any questions, please call me at the phone number above.

### Information Requested

[Redacted area]

Please share this information with the Department of Human Services. I give my permission to the person or agency named above to share information about my family or me. I will not hold this person liable for giving information, even if it's confidential. This permission stops

\_\_\_\_\_.

Name (please print)	Signature	Date

Please use the next page to provide a response to this request.



## Authorization for Release of Information (Autorización Para Divulgación de Información)

Fecha:  
**Fecha de entrega  
de la información:**

Condado:  
Número del Asistente:  
Nombre del Asistente:  
Teléfono:

Email:

Estimado/a

Este formulario le autoriza a compartir información con Department of Human Services (DHS).

Por favor, llene este formulario y envíemelo:

- por correo en al sobre con franqueo pagado que se adjunta;
- o tráigalo a mi oficina sita en:
  
- por fax a:

Si desea hacer preguntas, por favor llámeme al teléfono indicado anteriormente.

### Información Solicitada

Le agradeceré que comparta esta información con Department of Human Services. Doy mi permiso para que la persona u organismo mencionado anteriormente comparta información sobre mi familia o mi persona. Exonero a dicha persona de toda responsabilidad por entregar información, aún si la misma es confidencial. Este permiso expirará el .

Nombre (en letra de imprenta)	Firma	Fecha
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Por favor, utilice la página siguiente para responder esta solicitud.



Data

To initiate the form, enter:

- ◆ The name and address of the source of information.
- ◆ The salutation
- ◆ The information requested. Be as specific as possible.  
Include the client's name and the client's address or social security number if they are needed to identify the requested information.

The template enters the worker information and the dates. The date the authorization expires is 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 for the Department to Release Information, Form 470-2115](#)

Purpose	Form 470-2115 is designed to secure the client's permission for the Department to release confidential information to persons or agencies outside the Department.
Source	Workers may complete this form on line using the template on the DHS Intranet eForms web page.
Completion	<p>The income maintenance worker prepares this form when the client requests the Department to release information to a person or agency outside the Department, and the client has not provided the Department with a release.</p> <p>The worker completes everything except the signature and date, which are completed by the client.</p>
Distribution	Keep the original of the form in the case record. Make a copy of the signed form for the client.
Data	<p>Enter:</p> <ul style="list-style-type: none"><li>◆ The name of person or agency that will receive the information.</li><li>◆ The nature of the confidential information that will be released. Be as specific as possible.</li><li>◆ The date the authorization expires. This should be no more than 60 days from the date the form is signed, unless supervisory approval is given to extend the date.</li></ul> <p>The client shall sign and date the form after the other items have been completed.</p>

**AUTHORIZATION FOR THE DEPARTMENT TO RELEASE INFORMATION**

I give the Department of Human Services permission to share with	
confidential information about me or my household. The information that can be shared is:	
This permission stops	
Signature	Date

**AUTHORIZATION TO OBTAIN OR RELEASE HEALTH CARE INFORMATION**

Client Name:	ID#:	SS#:
Date of Birth:	Parent/Guardian:	

**I authorize the following individual or agency to share written and oral information (two-way or reciprocal release) about my needs and the services I receive . . .**

Name or agency to release and receive information:	
Address:	
City/State/Zip:	
Phone:	Fax:

**With the following individual or agency:**

Name or agency to receive and release information:	
Address:	
City/State/Zip:	
Phone:	Fax:

- The information released or shared may include:**
- |  |   |   |   |  |
|--|---|---|---|--|
| <input type="checkbox"/> Discharge summary     | <input type="checkbox"/> Family data photos           | <input type="checkbox"/> Social history | <input type="checkbox"/> Lab results        | <input type="checkbox"/> Psychological reports         |
| <input type="checkbox"/> Diagnosis/allergies   | <input type="checkbox"/> X-ray/imaging reports        | <input type="checkbox"/> Team notes     | <input type="checkbox"/> Medication history | <input type="checkbox"/> Treatment and aftercare plans |
| <input type="checkbox"/> Initial assessment    | <input type="checkbox"/> Immunization record          | <input type="checkbox"/> School records | <input type="checkbox"/> Court documents    | <input type="checkbox"/> History & physical exam       |
| <input type="checkbox"/> Receiving phone calls | <input type="checkbox"/> Evaluation & recommendations |   |   |  |
- Consultation reports from (doctor/specialty name): \_\_\_\_\_
- Other (please specify): \_\_\_\_\_

<b>Other (note exceptions or limits to this release):</b>
<b>This information is being used ONLY for (state purpose):</b>

<b>SPECIFIC AUTHORIZATION FOR RELEASE</b>	<b>Type of Information</b>	<b>Authorizing Initials</b>
<b>I authorize the release of the information listed at the right, which requires specific consent under federal law:</b>	Mental health evaluation/treatment*	
	AIDS/HIV-related	
	Substance abuse**	

This authorization is valid for information already in existence and any information that may be generated while this authorization is effective. I understand that I have the right to see any information that is disclosed pursuant to this authorization for release. I may request to see this information during normal business hours. I understand that I can revoke my authorization at any time by completing form 470-3949, Request to Revoke an Authorization. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization shall expire on the date specified below. If I fail to specify an expiration date, this authorization will expire in six months after the date it is signed. I understand that authorizing the disclosure of this information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that if the persons or organization authorized to receive this information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations. However, there may be other federal or state laws that require the information to remain confidential. If I have questions about disclosure of my health information, I can contact (name) \_\_\_\_\_ at (phone) \_\_\_\_\_. I have read this form, or it has been read and explained to me, and I understand its content.

Authorizing signature:	Date:	Expiration date:
Relationship to client: <input type="checkbox"/> Self <input type="checkbox"/> Legal representative <input type="checkbox"/> Nearest living relative <input type="checkbox"/> Other (specify below)		
<input type="checkbox"/> Not Required	Witness signature:	
<input type="checkbox"/> Required	Witness signature:	

A photocopy of this signed authorization shall have the same force and effect as this original.

**RECORD OF DISCLOSURES**  
(Required for mental health information)

Date	Name of Recipient	Contents Disclosed	Sent By
1.			
2.			
3.			
4.			
5.			

\* Only a person 18 years of age or older or a person's legal representative can authorize release of mental health information.

\*\* Only the subject can authorize release of substance abuse information unless the subject is of such age and mental maturity that they are unable to authorize release.

**Notice to Recipients of Mental Health Information**

In accordance with "Disclosure of Mental Health and Psychological Information" (Iowa Code, Chapter 228), a recipient of mental health information may further disclose this information only with the written authorization of the subject or the subject's legal representative or as otherwise provided in Chapters 228 and 229. Unauthorized disclosure is unlawful and civil damages and criminal penalties may apply. Federal confidentiality rules (42 CFR Part 2) restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

**Notice to Recipients of Substance Abuse Information**

This information has been disclosed from records whose confidentiality is protected by federal law. Iowa Code, Chapter 125 and federal regulations (42 CFR, Part 2) prohibit any further disclosure without the specific written authorization of the person to whom the information pertains, or as otherwise permitted by such statute and regulations. A general authorization for the release of medical or other information is not sufficient for this purpose. Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

**Notice to Recipients of HIV-Related Testing Information**

This information has been disclosed to you from records whose confidentiality is protected by state law. State law prohibits you from making any further disclosure of the information without specific written consent of the person to whom it pertains, or as otherwise permitted by law. A general authorization for the release of medical or other information is not sufficient for this purpose. (Iowa Code Section 141A.9) Federal confidentiality rules (42 CFR, Part 2) restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

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

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

For assistance or consultation you may contact the IDHS Diversity Program Unit. Complaints should be filed promptly, but in most instances, no later than 180 days of the alleged discriminatory act. If you feel DHS has discriminated against or harassed you, you can send a letter of complaint to:

Iowa Department of Human Services, Administrator, Diversity Program Unit, 1305 E. Walnut, Des Moines IA 50319-0114; phone (800) 972-2017; fax (515) 281-4243.

**AUTHORIZATION TO OBTAIN OR RELEASE HEALTH CARE INFORMATION  
(AUTORIZACIÓN PARA OBTENER O PROPORCIONAR INFORMACIÓN SOBRE EL CUIDADO DE LA SALUD)**

Nombre del cliente:	Nº de documento:	Nº de Seguro social:
Fecha de nacimiento:	Padre/Tutor:	

**Autorizo a la siguiente persona o agencia a compartir información tanto escrita como oral (*información ida y vuelta o recíproca*) con respecto a mis necesidades y a los diferentes servicios que recibo. . .**

Nombre de la agencia que proporcionará y recibirá información:	Oficina del condado
Dirección:	
Ciudad/Estado/Código postal:	
Teléfono:	Fax:

**Para la siguiente persona o agencia:**

Nombre de la agencia que proporcionará y recibirá información:	
Dirección:	
Ciudad/Estado/Código postal:	
Teléfono:	Fax:

La información proporcionada o recibida puede incluir:

- |  |  |  |  |
|--|--|--|--|
| <input type="checkbox"/> Informes psicológicos   | <input type="checkbox"/> Resumen de descargo               | <input type="checkbox"/> Resumen del expediente clínico    | <input type="checkbox"/> Estado de admisión          |
| <input type="checkbox"/> Resultados del laboratorio  | <input type="checkbox"/> Tratamientos y planes pos-cuidado | <input type="checkbox"/> Fotografías de datos familiares   | <input type="checkbox"/> Antecedentes sociales       |
| <input type="checkbox"/> Comentarios del equipo  | <input type="checkbox"/> Historial de medicamentos         | <input type="checkbox"/> Diagnóstico/alergias              | <input type="checkbox"/> Rayos X/informes por imagen |
| <input type="checkbox"/> Certificado de vacunas  | <input type="checkbox"/> Informes escolares                | <input type="checkbox"/> Historial y chequeo físico        | <input type="checkbox"/> Evaluación inicial          |
| <input type="checkbox"/> Evaluación y recomendaciones  |  | <input type="checkbox"/> Documentos legales                |  |
| <input type="checkbox"/> Informes de consultas emitidos por parte de (nombre del médico/especialista): |  | <input type="checkbox"/> Recepción de llamadas telefónicas |  |
| <input type="checkbox"/> Otros (especifique):  |  |  |  |

**Otros (tenga en cuenta las excepciones y limitaciones relacionadas con el suministro de información):**

**Esta información se utiliza ÚNICAMENTE para (indique fin):**

<b><u>AUTORIZACIÓN ESPECIAL PARA EL SUMINISTRO DE INFORMACIÓN</u></b>	<b>Tipo de información</b>	<b>Iniciales de Autorización</b>
Autorizo el suministro de la información proporcionada a la derecha, la cual necesita autorización específico, como lo estipula la ley federal:	Tratamiento/evaluación de salud mental*	
	Enfermedades relacionadas con VIH/SIDA	
	Abuso de sustancias**	

La presente autorización es válida para la información ya existente o para todo tipo de información que podría aparecer durante el período de efectividad de esta autorización. Entiendo que tengo el derecho de leer todo tipo de información proporcionada en relación con esta autorización para su posterior suministro. Es posible que pueda solicitar esta información durante el horario de trabajo normal. Entiendo de igual manera que podré modificar esta autorización en cualquier momento con sólo completar el formulario 470-3949, Request to Revoke an Authorization (Solicitud para Revocar una Autorización). Entiendo además que esta revocación no se aplicará a la información que ya ha sido proporcionada como respuesta a esta autorización. Entiendo que dicha modificación no se aplicará a mi compañía de seguros ya que la ley otorga a la aseguradora correspondiente el derecho de impugnar una demanda según lo estipulado en mi póliza. A menos que se determine lo contrario, esta autorización perderá toda la validez el día que se indica más abajo. Si no especifico una fecha de vencimiento determinada, esta autorización vencerá a los seis meses a partir de la fecha en la cual se firme. Entiendo que el suministro de esta información se autoriza por propia voluntad. Puedo negarme a firmar esta autorización. Entiendo que si las personas u organizaciones autorizadas a recibir esta información no fueran un plan médico o un profesional de la salud, la información divulgada ya no estaría protegida por las normas federales de privacidad. Sin embargo, podrían existir otras leyes federales o estatales que exijan que dicha información permanezca confidencial. Si tuviera alguna duda con respecto al suministro de información relacionada con mi salud, deberé comunicarme con (nombre) \_\_\_\_\_ llamando al (teléfono) \_\_\_\_\_. He leído este formulario, o el mismo se me ha leído o explicado, y afirmo entender su contenido.

Firma de autorización:	Fecha:	Fecha de vencimiento:
Relación con el cliente:	<input type="checkbox"/> Uno mismo	<input type="checkbox"/> Representante legal
	<input type="checkbox"/> Pariente más cercano	<input type="checkbox"/> Otro (especificar debajo)
<input type="checkbox"/> Opcional	Firma del testigo:	
<input type="checkbox"/> Obligatorio	Firma del testigo:	

La copia de esta autorización firmada tendrá la misma validez que el original.

## RECORD OF DISCLOSURES (INFORME DE DIVULGACIÓN)

(Para información de salud mental)

Fecha	Nombre del destinatario	Contenidos proporcionados	Enviado por
1.			
2.			
3.			
4.			
5.			

\* El suministro de información sobre salud mental sólo podrá ser autorizado por personas mayores de 18 años o por el representante legal de una persona.

\*\* El suministro de información sobre abuso de sustancias podrá ser autorizado únicamente por la persona en cuestión, a menos que la edad y nivel de madurez mental de la persona demuestren que la misma no está capacitada para autorizar el suministro de tal información.

### AVISO A LOS DESTINATARIOS DE INFORMACIÓN SOBRE SALUD MENTAL

De acuerdo con la sección "Suministro de información psicológica y de salud mental" (Código de Iowa, Capítulo 228), el destinatario de información sobre salud mental podrá continuar proporcionando información únicamente si obtiene una autorización de la persona afectada o del representante legal de dicha persona, o tal como lo estipulen los Capítulos 228 y 229. El suministro de información no autorizada se considera ilegal. Como consecuencia y ante este delito, podrían aplicarse ciertas penalizaciones criminales y civiles. Las reglas federales de confidencialidad (42 CFR Parte 2) limitan el uso de esta información con el fin de llevar a cabo una investigación penal o bien para procesar a cualquier paciente drogadicto o alcohólico.

### AVISO A LOS DESTINATARIOS DE INFORMACIÓN SOBRE ABUSO DE SUSTANCIAS

Esta información ha sido proporcionada a partir de los informes cuya confidencialidad se encuentra protegida por ley federal. El Código de Iowa, Capítulo 25, y las reglas federales (42 CFR, Parte 2) prohíben cualquier tipo de suministro de información adicional sin la previa autorización por escrito de la persona a quien pertenece esta información, o de otra forma permitido por dichos estatutos y reglamentos. Para este propósito, se requerirá mucho más que una autorización general para el suministro de información médica u otro tipo de información. Las reglas federales limitan el uso de esta información con el fin de llevar a cabo una investigación penal o bien para procesar a cualquier paciente drogadicto o alcohólico.

### AVISO A DESTINATARIOS DE INFORMACIÓN SOBRE PRUEBAS DE VIH

Esta información se le ha proporcionado a partir de los informes cuya confidencialidad se encuentra protegida por ley estatal. La ley estatal le prohíbe continuar suministrando información sin el previo consentimiento de la persona afectada, o de algún otro modo permitido por la ley. Para este propósito, se requerirá mucho más que una autorización general para el suministro de información médica u otro tipo de información. (Código Iowa, Sección 141<sup>a</sup>.9) Las reglas federales de confidencialidad (42 CFR Parte 2) limitan el uso de esta información con el fin de llevar a cabo una investigación penal o bien para procesar a cualquier paciente drogadicto o alcohólico.

### POLÍTICA RELATIVA A LA DISCRIMINACIÓN, EL ACOSO, LA ACCIÓN AFIRMATIVA, Y LA OPORTUNIDAD IGUALITARIA DE EMPLEO

Es política del Iowa Department of Human Services ofrecer trato igualitario en cuanto a empleo y ofrecimiento de servicios a los solicitantes, empleados y clientes, sin importar su raza, color, nacionalidad, sexo, orientación de sexual, identidad de género, religión, edad, incapacidad, creencia política o estatus de veterano.

Para recibir asistencia o hacer una consulta, puede comunicarse con IDHS Diversity Program Unit. Los reclamos deben ser presentados puntualmente, pero en la mayoría de los casos, antes de transcurridos 180 días de ocurrida la acción discriminatoria alegada. Si usted considera que el IDHS le ha discriminado o acosado, puede enviar una carta quejándose a:

Iowa Department of Human Services, Administrator, Diversity Program Unit, 1305 E. Walnut, Des Moines IA 50319-0114; teléfono (800) 972-2017; fax (515) 281-4243.

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

Purpose	<p>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:</p> <ul style="list-style-type: none"><li>◆ Release health information about the client to a third party.</li><li>◆ Obtain health information needed to provide service to the client.</li></ul>
Source	<p>Department staff may complete the English version of this form on line using the template:</p> <ul style="list-style-type: none"><li>◆ In the public state-approved Service forms folder on Outlook or</li><li>◆ On the DHS Intranet eForms web page.</li></ul> <p>The English version is also printed in pads of 25 three-part precarboned sets. Order supplies from Iowa Prison Industries at Anamosa.</p> <p>Supplies of the Spanish version of this form can be printed or photocopied from the sample in the manual.</p>
Completion	<p>Staff at Department medical facilities and service workers shall complete this form whenever it is necessary to obtain health information from or release health information to a source other than the client.</p> <p>Income maintenance workers and service workers may furnish this form to a client who requests that the Department share protected health care information for a purpose other than health care treatment or payment.</p> <p>Complete a separate form for each source from which information is being requested or to which information is being released.</p> <p>The worker may complete the identifying information and the description of the information being obtained or released. The client (or the client's personal representative) signs the section to give the authorization.</p>

Distribution

Send one copy to the source of information with a self-addressed stamped envelope enclosed. Keep one copy as a control copy. Give the third copy to the client.

When the source of information returns the original copy, destroy the control copy and file the completed copy in the case record.

Data

To initiate the form, enter:

- ◆ The client's name, state or patient ID number, social security number, date of birth, and parent's or guardian's name, if applicable.
- ◆ Your name, address, telephone number, and fax number in the first set of agency information.
- ◆ The name or agency to which the information is being released, or from which the information is being requested, and the agency's address, telephone number, and fax number.

In the section "The information released or shared may include," check the applicable boxes. If the "Other" box is checked, describe the information in a specific and meaningful fashion.

Describe any exceptions or limitations under **Other**. Sample entry: The Department may obtain information from, but not release information to, Heartland AEA.

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 evaluation/treatment, 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 evaluation/treatment and AIDS/HIV-related information. **Only the client** can give consent to release or obtain substance abuse information.

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

"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.

"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.

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

Ask the client to sign and date the form and enter a date when the authorization is to expire.

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

Obtain the signature of two witnesses for clients who are incapable of signing their name due to a physical or mental disability.

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.

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**Child Records Query, Form 470-4375**

Purpose	Form 470-4375 is designed to inform a current or former client of a request from a parent who is not on the Department's case for information about a mutual child, including medical records, and to obtain the client's response.
Source	Complete this form on line using the template on the DHS Intranet eForms web page.
Completion	Both the Department income maintenance worker and the client (or the person authorized) complete this form.  A response must be provided to the requester no later than the 20 <sup>th</sup> day.
Distribution	Mail the original and the client's copy of the form to the current or former client's last known mailing address with a self-addressed stamped envelope.  Keep one copy of the form for the case file and track the form by the due date.
Data	To initiate the form, complete the following: <ul style="list-style-type: none"><li>◆ In the identifying information, enter<ul style="list-style-type: none"><li>• The client's name and address;</li><li>• The date;</li><li>• The county and worker numbers;</li><li>• The worker's name, phone number, and office address;</li><li>• The names of the parent requesting the information and the child that the information is requested about.</li></ul></li><li>◆ In the "Information requested" box, indicate what the parent of the child has requested.</li><li>◆ Enter the due date (<b>ten calendar days</b> from the date of the letter) in the blank space in the following sentence:  "If we do not get an answer from you by _____, we will decide what information can be shared based on Iowa law."</li></ul>



# STATE OF IOWA

CHESTER J. CULVER, GOVERNOR  
PATTY JUDGE, LT. GOVERNOR

DEPARTMENT OF HUMAN SERVICES  
CHARLES J. KROGMEIER, DIRECTOR

Date:

Respond to:

County Number:      Worker Number:

Worker Name:

Worker Phone:

Office Address:

Dear \_\_\_\_\_ :

We have received a request from \_\_\_\_\_ , as the parent of \_\_\_\_\_ , to share the following information about this child or children.

Information requested:

We need to know if you agree with us sharing this information. Please send your answer to the address listed above. If we do not get an answer from you by \_\_\_\_\_ , we will decide what information can be shared based on Iowa law.

Iowa law says that unless otherwise ordered by the court in a custody decree, both parents have legal access to information about their child, including medical records. Therefore, we may have to share information even if you don't agree. You can see a list of the kinds of information that may be shared on the back of this form. You will get a copy of whatever information we share.

### Response

- I agree that the Department may share this information.
- I do not agree that the Department may share this information because:

Please give your reason for not agreeing and provide any proof to support your reason. Please use an additional sheet of paper, if needed.

Signature:	Date:
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The Department may share the following information about a child with the child’s parent who is not on the Department case even if you don’t agree:

<b>Program</b>	<b>Information Shared</b>
Child Care Assistance	<ul style="list-style-type: none"> <li>• Whether the child received assistance</li> <li>• What months the child received assistance</li> </ul>
Family Investment Program	<ul style="list-style-type: none"> <li>• Whether the child received assistance</li> <li>• What months the child received assistance</li> </ul>
Food Assistance	<ul style="list-style-type: none"> <li>• Whether the child received assistance</li> <li>• What months the child received assistance</li> </ul>
<i>hawk-i</i>	<ul style="list-style-type: none"> <li>• Whether the child received assistance</li> <li>• What months the child received assistance</li> <li>• What services were paid</li> <li>• The amount of payments for services</li> </ul>
Medicaid	<ul style="list-style-type: none"> <li>• Whether the child received assistance</li> <li>• What months the child received assistance</li> <li>• What services were paid</li> <li>• To whom the services were paid</li> <li>• The amount of payments for services</li> </ul>

The client:

- ◆ Checks the response box of "agree" or "do not agree" that the Department may share this information.

If the "do not agree" box is selected, the client needs to give the reason for not agreeing and send copies of any proof to support the reason.

- ◆ Signs, dates, and returns the form with copies of any necessary proof to the designated address.

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### Consent to Obtain and Release Information, Form 470-0429

Purpose	<p>Form 470-0429 is designed to get the permission of the client or the client's legally authorized representative to:</p> <ul style="list-style-type: none"><li>◆ Release information about the client to a third party.</li><li>◆ Obtain information needed to provide service to the client.</li></ul> <p>The Department uses this form to secure or release non-health-related information for purposes of determining a client's eligibility or services. See <a href="#">Authorization to Obtain or Release Health Care Information, Form 470-3951 or 470-3951(S)</a>, for information used to authorize exchange of health care information.</p> <p>Staff from a county case management or central point of coordination office (a county worker) may also use this form.</p>
Source	<p>Department staff may complete this form on line using the template in the public state-approved forms under the Service folder on Outlook.</p> <p>The form is also printed in pads of 50 forms. Order supplies from Iowa Prison Industries at Anamosa.</p>
Completion	<p>The Department or county worker prepares the form and secures the signature of the client or the client's representative:</p> <ul style="list-style-type: none"><li>◆ At the initial request for services.</li><li>◆ When the current authorization expires.</li><li>◆ When new services are added to the client's plan.</li></ul>
Distribution	<p>File the original in the case record. Give the copy to the client or the client's representative. Provide a photocopy to each person or agency authorized to share information.</p>
Data	<p>Enter the requested identifying information at the top of the form. Check the applicable box to identify whether a Department worker or a county worker is preparing the form. For a county worker, also enter the name of the county.</p>

## Consent to Obtain and Release Information

Client Name	ID#
Address	Parent/Guardian
Date of Birth	Address

I authorize  DHS or  \_\_\_\_\_ County and the following individuals or agencies to share written and oral information about my needs and the services I receive:

Name/Agency

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DHS or County Worker

Name
Address
Phone

**The information released or shared may include:**

**Evaluation/Assessment**  
**Educational assessment**  
**Family and social data**

**Agency participation, plans, and progress reporting**  
**Physical status** (including vision, hearing, nutrition, communication skills, cognitive skills, and photographs)

**Other (note exception or limits to this release)**

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Authorizing signature	Date	Relationship to client	Expiration date
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A photocopy of this signed authorization shall have the same force and effect as this original.

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

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

If you feel DHS has discriminated against or harassed you, you can send a letter of complaint to:

Iowa Department of Human Services, Administrator, Diversity Program Unit, 1305 E. Walnut, Des Moines IA 50319-0114; phone (800) 972-2017; fax (515) 281-4243.

List each person or agency authorized to share information with or receive information from the Department or the identified county. In the box to the right of the list, enter the name, phone number, and address of the Department or county worker who is to receive the information.

Describe any exceptions or limitations under **Other**. Sample entry: DHS may obtain information from but not release information to Heartland AEA.

Enter the expiration date if it is other than *"upon termination of services."*

If the client **withdraws** authorization to share information with a listed person or agency, cross out the entry and secure the date and initials of the client or the client's legally authorized representative.

### 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 or photocopy this form from the sample in the manual.
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 caseworker,</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.

Iowa Department of Human Services

**DESIGNATION OF PERSONAL REPRESENTATIVE**

Name of Client	Date of Request	
Mailing Address – Street or P.O. Box	Social Security Number, Patient Number, or State ID	
City, State, and Zip Code	Phone Number	Birth Date
Check all of the programs that apply: <input type="checkbox"/> Medicaid <input type="checkbox"/> <i>hawk-i</i> <input type="checkbox"/> Facility		

**To be completed by client**

I designate \_\_\_\_\_ to act as my personal representative.  
(Name of Person)

Relationship of personal representative to client:

- Son or daughter
- Spouse
- Friend
- Attorney
- Other (Please specify) \_\_\_\_\_

Client's Signature	Date
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**MAINFRAME AUTHORIZATION REQUEST**State Employee: **Yes**

Date: 7/14/2005

CICS/NES User ID (If known)	User's Name
Service Area/Institution/Bureau	Work Location Address
Work Duties	

**Instructions:** Check each group of CICS transactions you need access to. If any transactions you need are not shown, enter their four character identifiers next to OTHER.

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> ISS3  | <input type="checkbox"/> ISS4   | <input type="checkbox"/> ISS5   |
| <input type="checkbox"/> CICST001 Public Assistance<br>ABCT DCAS EMAA EMAB EMAE<br>EMAH EMAS ICSC ISSV JOBS<br>OLRG PROV SPAD WKER<br>IABC View<br>XABC View | <input type="checkbox"/> CICST014 Time Study<br>STS   | <input type="checkbox"/> CICST020 Appeals<br>SSAI SSAN SSAP   |
| <input type="checkbox"/> CICST002 Public Purchase of Services<br>POSS View<br>SSRS View<br>KACT View   | <input type="checkbox"/> CICST022 Recoupment<br>OVCD OVCI OVDI OVLB OVNA OVNN<br>OVNS OVPI OVPR OVPT OVPY | <input type="checkbox"/> CICST041 ACAN View<br><input type="checkbox"/> CICST042 PADX<br><input type="checkbox"/> CICST045 DCPD<br><input type="checkbox"/> CICST046 FACS<br><input type="checkbox"/> CICST047 STAR - DOB<br><input type="checkbox"/> CICST048 VCAR<br><input type="checkbox"/> CICST049 HRIS |
| <input type="checkbox"/> CICST003 MMIS SDXD KACT HIMM  | <input type="checkbox"/> CICST060 PRIE (Payroll)  | <input type="checkbox"/> CICST061 PAYN-Bond (Payroll)   |
| <input type="checkbox"/> CICST005 Automated Deposit<br>EBTS  | <input type="checkbox"/> CICST063 PAYL (Payroll)  | <input type="checkbox"/> CICST070 BDGT (Agency # )  |
| <input type="checkbox"/> CICST006 IEVS   | <input type="checkbox"/> Other (specify):   |   |
| <input type="checkbox"/> CICST007 ICER   |   |   |
| <input type="checkbox"/> CICST008 FACS (IM Only)   |   |   |
| <input type="checkbox"/> CICST010 ICER (CSRU only)   |   |   |
| <input type="checkbox"/> CICST012 (IM & Service Worker)<br>ICAR  |   |   |
| <input type="checkbox"/> CICST013 (CSRU only)<br>PIEX ICAR   |   |   |

**Double click HERE to generate required Mainframe forms.**

**MEDICAID SYSTEMS AUTHORIZATION REQUEST**

Date: 7/14/2005

CICS/NES User ID (If known)	User's Name
Service Area/Institution/Bureau	Work Location Address
Work Duties	

<b>SYSTEM/FUNCTION</b>	<b>PRODUCTION</b>	<b>TEST Central Office Only</b>	<b>QA Central Office Only</b>
SSNI – Inquiry with PHI	<input type="checkbox"/> TXIXP101	<input type="checkbox"/> TXIXT101	<input type="checkbox"/> TXIXQ101
SSNI – Inquiry No PHI	<input type="checkbox"/> TXIXP102	<input type="checkbox"/> TXIXT102	<input type="checkbox"/> TXIXQ102
SSNI – QA staff – U	<input type="checkbox"/> TXIXP103	<input type="checkbox"/> TXIXT103	<input type="checkbox"/> TXIXQ103
SSNI – QA staff – A	<input type="checkbox"/> TXIXP104	<input type="checkbox"/> TXIXT104	<input type="checkbox"/> TXIXQ104
SSNI – Central Office IT staff	<input type="checkbox"/> TXIXP105	<input type="checkbox"/> TXIXT105	<input type="checkbox"/> TXIXQ105
SSNI – Central Office IT staff	<input type="checkbox"/> TXIXP106	<input type="checkbox"/> TXIXT106	<input type="checkbox"/> TXIXQ106
PRSM – Inquiry	<input type="checkbox"/> TXIXP151	<input type="checkbox"/> TXIXT151	<input type="checkbox"/> TXIXQ151
PRSM – QA staff	<input type="checkbox"/> TXIXP153	<input type="checkbox"/> TXIXT153	<input type="checkbox"/> TXIXQ153
MEPD – Inquiry	<input type="checkbox"/> TXIXP201	<input type="checkbox"/> TXIXT201	<input type="checkbox"/> TXIXQ201
MEPD – RETR update	<input type="checkbox"/> TXIXP204	<input type="checkbox"/> TXIXT204	<input type="checkbox"/> TXIXQ204
MEPD – Central Office IT staff	<input type="checkbox"/> TXIXP205	<input type="checkbox"/> TXIXT205	<input type="checkbox"/> TXIXQ205
MEPD – QA staff	<input type="checkbox"/> TXIXP206	<input type="checkbox"/> TXIXT206	<input type="checkbox"/> TXIXQ206
SSBI – Inquiry with PHI	<input type="checkbox"/> TXIXP301	<input type="checkbox"/> TXIXT301	<input type="checkbox"/> TXIXQ301
SSBI – Inquiry No PHI	<input type="checkbox"/> TXIXP302	<input type="checkbox"/> TXIXT302	<input type="checkbox"/> TXIXQ302
SSBI – Update	<input type="checkbox"/> TXIXP303	<input type="checkbox"/> TXIXT303	<input type="checkbox"/> TXIXQ303
DDM operations staff	<input type="checkbox"/> TXIXP999	<input type="checkbox"/> TXIXT999	<input type="checkbox"/> TXIXQ999





# NETWORK REMOTE ACCESS AUTHORIZATION REQUEST

State Employee: **Yes**

Date: 7/14/2005

Employee Name ,	Network Logon ID (If known)
Service Area/Institution/Bureau	Office/Work Phone Number ( )
Work Location Address	
Company Name (Non-DHS)	Company Phone (Non-DHS) Number: ( )

## TYPES OF ACCESS

- Access to servers                       Access to mainframe
- All
- Specific servers:
- 1.
  - 2.
  - 3.

## IMPORTANT INFORMATION – PLEASE READ CAREFULLY

Please be advised that you must work closely with DDM/Bureau of Institution and Network Support to set-up Remote Access Services (RAS). Several options are available. This includes dial back capabilities, full Wide Area Network functionality, and mainframe applications. Use of RAS is to be work-related **ONLY** as will be explained by your supervisor. At this time, **state equipment only**.

### UPON APPROVAL:

**Field** – Bring your laptop to your ITS so the hardware can be reviewed and software can be installed. The ITS will work with the Division of Data Management in getting the Remote Access set up on your computer.

**Central Office** – Bring your laptop to the Customer Service Support Center, Hoover Building, 1st Floor NW.

Iowa Department of Human Services  
**ICAR DATABASE REQUEST**

Date: 6/15/2004

<b>USER INFORMATION</b>			
CICS/NES User ID (If known)	Name (First)	(Middle)	(Last)
Date of Birth			
Department		Phone Number (   )	
Authorized By			
<input type="checkbox"/> <b>PRODUCTION</b>			
<input type="checkbox"/> 20 <input type="checkbox"/> 24	Application: <input type="checkbox"/> ICAR <input type="checkbox"/> ICER <input type="checkbox"/> Other:		OLQ YES
Indicate Action Add New ID		IDD (Display only) YES	
		Default Printer (Optional)	
Security Classes		Model User	
Subschemas		Default DBNAME	
Qfiles		Default Dictionary	
<input type="checkbox"/> <b>TEST</b>			
<input type="checkbox"/> 22 <input type="checkbox"/> 23	Application: <input type="checkbox"/> ICAR <input type="checkbox"/> ICER <input type="checkbox"/> Other:		OLQ YES
Indicate Action Add New ID		IDD (Display only) YES	
		Default Printer (Optional)	
Security Classes			
Subschemas			
Qfiles			
<input type="checkbox"/> <b>ASF</b>			
Indicate Action Add New ID		ASF Tables	Program Tools (IDD, OLM, etc) YES
		Row Level Security	Default Printer (Optional)
<input type="checkbox"/> <b>QUALITY ASSURANCE</b>			
<input type="checkbox"/> 29 Indicate Action Add New ID		Security Classes	

## FACS DATABASE REQUEST

Date: 6/15/2004

USER INFORMATION				
DB ID (worker ID for the FACS system)	CICS/NES User ID (If known)	Department		
Name (First)	(Middle)	(Last)	Phone Number (   )	
Contractor Company		Group/Task		
Authorized By		Information Change Only		
<b>Optional:</b>				
Model User		Default Printer		
Default Directory		Default DBNAME		
USE SEPARATE SECTION FOR EACH CV				
Production: <input type="checkbox"/> 20 <input type="checkbox"/> 24	<input type="checkbox"/> Add New ID	Programming Tools:	OLQ:	
Test: <input type="checkbox"/> 22 <input type="checkbox"/> 23	<input type="checkbox"/> Modify Existing ID	YES	YES	
QA: <input type="checkbox"/> 29	<input type="checkbox"/> Delete Existing ID	Update		
<b>Security Classes:</b> Add Remove				
<b>Subschemas:</b> Add Remove				
<b>Qfiles:</b> Add Remove				
Production: <input type="checkbox"/> 20 <input type="checkbox"/> 24	<input type="checkbox"/> Add New ID	Programming Tools:	OLQ:	
Test: <input type="checkbox"/> 22 <input type="checkbox"/> 23	<input type="checkbox"/> Modify Existing ID	YES	YES	
QA: <input type="checkbox"/> 29	<input type="checkbox"/> Delete Existing ID	Update		
<b>Security Classes:</b> Add Remove				
<b>Subschemas:</b> Add Remove				
<b>Qfiles:</b> Add Remove				
Production: <input type="checkbox"/> 20 <input type="checkbox"/> 24	<input type="checkbox"/> Add New ID	Programming Tools:	OLQ:	
Test: <input type="checkbox"/> 22 <input type="checkbox"/> 23	<input type="checkbox"/> Modify Existing ID	YES	YES	
QA: <input type="checkbox"/> 29	<input type="checkbox"/> Delete Existing ID	Update		
<b>Security Classes:</b> Add Remove				
<b>Subschemas:</b> Add Remove				
<b>Qfiles:</b> Add Remove				

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**Electronic Security Information, Form 470-2078**

**Purpose** Form 470-2078 is required to attain a security authorization for Department employees and contractors for the access to electronic systems and files needed for their work.

**Source** Department supervisors can access this form through the public state-approved forms folder on Outlook, under "LAN/WAN/MF Access." Choose the "Security Information Form." Be sure to check "Enable macros" when you open the form.

**Completion** Department supervisors complete this form to add, delete, or change computer access for their employees and contractors. This includes:

- ◆ Electronic mail access and mailbox.
- ◆ Mainframe authorization (requires both CICS and NES access).
- ◆ Medicaid systems access, including MMIS Medically Needy subsystem access.
- ◆ Network access, including remote access. (Form 470-4068, *Network Share Request*, is also available separately.)
- ◆ ICAR access. (Form 470-4069, *ICAR Database Request*, is also available separately.)
- ◆ FACS access. (Form 470-4070, *FACS Database Request*, is also available separately.)

NOTE: **Only** supervisors can complete the form. The information entered on the form is confidential. Nonsupervisory staff will not be able to access the form. (Nonsupervisory staff can access form 470-4068, *Network Share Request*, separately.)

The choices on the first page of the form cause other pages to generate. When all of the required information is completed, double-click on the box at the bottom of the page to generate the other pages needed.

If you chose mainframe access, there is a similar box to double-click at the bottom of the mainframe page to generate more forms.

When you exit the form, do not save changes. If you want a record of what you requested, print the form before closing it.

Each form contains information for only one person. To make a request for another employee, select the "Security Information Form" again from Outlook, and complete the process.

#### Distribution

Send the completed form to the Division of Data Management via E-mail. From the "File" menu, select "Send." This will create an E-mail message with the request attached.

Enter "DHS, Security" in the "To:" field. In the "Subject" field, enter the name of the person whose access is in question and the type of request (add, delete, or change).

#### Data

The system enters the current date. On the first page, the supervisor must enter:

- ◆ The type of action requested.
- ◆ For a change request, the specific system access to be changed.
- ◆ The user's classification and duties.
- ◆ The counties where the user works.
- ◆ The worker numbers assigned to the user at those locations.
- ◆ The systems that the user needs access to.
- ◆ The user's CICS/NES user identification number, if already issued.
- ◆ The user's e-mail user identification number, if issued.
- ◆ The user's name and office phone number.
- ◆ The user's mother's maiden name.
- ◆ The user's social security number and birth date.
- ◆ The supervisor's name and worker number.
- ◆ The supervisor's e-mail user-identification number.

- ◆ The supervisor's telephone number, including the area code.
- ◆ The address of the user's work location, including the county.
- ◆ Whether the user is a state employee or a contractor.
- ◆ The end date of the contract, if the user is a contractor.
- ◆ What mainframe and LAN/WAN access is requested.
- ◆ The systems that the user needs access to. (For access to the MMIS Medically Needy subsystem, check "Other" on the "Mainframe Authorization" Request page and specify this subsystem.)

**Fees for Examining and Copying Records, Reference Card RC-0063**

Purpose	Reference Card RC-0063 is designed to meet requirement for Department offices to post the charges for the costs of examining and copying public records in the custody of the Department.
Source	Print or photocopy this poster from the sample in the manual.
Completion	Offices involved in programming in response to requests for records that are stored electronically may wish to be more specific about charges for programming costs.
Distribution	Each office where members of the public may request to examine or obtain a copy of a public record should post this form or something similar.
Data	Data on the form are based on Department policy at 1-C, <a href="#">Fees</a> .

## **FEES for EXAMINING and COPYING RECORDS**

Photocopies:	10¢ per page
Microfiche:	45¢ per fiche or actual cost, whichever is greater
Supervision (over ½ hour):	\$10.00 per hour
Systems programming:	\$11 to \$26 per hour
Postage:	Actual cost

Advance deposits may be required when the total fee is over \$25.

## HIPAA COMPLAINT

Federal law\* requires the Department of Human Services, both as an agency providing a health plan (Medicaid and **hawk-i**) and as a health care provider (Department facilities), to comply with standards to protect the security and privacy of protected health information. "Protected health information" is information that communicates a person's medical condition – past, present, or future.

The Department has rules at 441 Iowa Administrative Code Chapter 9 to set the policies and manual and forms at Employee's Manual, Chapter 1-C and 1-C-Appendix, to explain the procedures that the Department must follow to comply with the federal security and privacy law and regulations. You can view these rules and manuals on the Department's web site at <http://www.dhs.iowa.gov/policyanalysis>.

You may file a complaint with the Department if you believe that:

- The Department is not following its privacy policies and procedures, or
- The Department's privacy practices do not agree with the federal law and regulations.

To file a complaint, you may do one of the following:

- Complete this form and mail it to:

DHS HIPAA Security and Privacy Office  
Iowa Department of Human Services  
1305 East Walnut 1<sup>st</sup> Floor  
Des Moines, Iowa 50319-0114

- Write a letter stating your complaint and mail it to the DHS HIPAA Security and Privacy Office at the address above. (Use of this form is not required.)

Do not use this form to file an appeal. If you disagree with a Department decision on your specific case, you may file an appeal with the Department using the procedures given on the decision you received.

### How do we reach you?

Name:	Organization	Daytime Telephone Number
Mailing Address – Street or P.O. Box:	City, State, and Zip Code:	

### What is your complaint?

Please explain your complaint. Tell which of the Department's policies you disagree with and why. If you feel that a certain person, office, or facility of the Department is not following our procedures, please tell us. If you need more space, write on the back of this form or attach another page.

\* Public Law 104-191, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and 45 Code of Federal Regulations Parts 160 and 164)

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**[HIPAA Complaint, Form 470-3981](#)**

Purpose	<p>Form 470-3981 may be used to complain about the Department's policies or procedures implementing the Health Insurance Portability and Accountability Act (HIPAA) of 1996, Public Law 104-191, and federal regulations (45 CFR Parts 160 and 164).</p> <p>This form is not to be used to file an appeal of a decision made by the Department in regard to a HIPAA privacy request.</p>
Source	<p>Print or photocopy this form from sample in the manual.</p>
Completion	<p>A person wanting to complain may complete the form and mail it to the HIPAA Security and Privacy Office.</p> <p>Use of this form is not mandatory. A person may also complain by sending a letter or e-mail to the HIPAA Security and Privacy Office.</p> <p>If a person complains in person or through a telephone conversation and is unable to put the allegation in writing, you may complete the form on behalf of that person. Make a notation on the form that you have completed it on behalf of the complainant. Forward the complaint to the HIPAA Security and Privacy Office.</p>
Distribution	<p>Give a copy of the form to anyone requesting it. If you should receive a completed form, mail it to the HIPAA Security and Privacy Office by the end of the next working day.</p>
Data	<p>The complainant completes the identifying information and the statement of the complaint. You will not need to enter any information except as described above when completing the form on behalf of a person who is unable to complete the form.</p>

### Record of Disclosure of Health Information, Form 470-4015

Purpose	Form 470-4015 is designed to notify the HIPAA Security and Privacy Office or the facility privacy official when Department staff disclose protected health information.
Source	Complete this form on line using the template in the public state-approved forms folder on Outlook.
Completion	<p>Complete this form when you have made a disclosure of protected health information in one of the following categories:</p> <ul style="list-style-type: none"><li>◆ Accidental disclosures,</li><li>◆ Disclosures about suspected victims of abuse, neglect or domestic violence,</li><li>◆ Disclosures by whistle blowers,</li><li>◆ Disclosures for averting a threat to health or safety,</li><li>◆ Disclosures for cadaveric organ, eye, or tissue donation,</li><li>◆ Disclosures for health oversight activities,</li><li>◆ Disclosures for judicial and administrative proceedings,</li><li>◆ Disclosures for law enforcement purposes,</li><li>◆ Disclosures for public health activities,</li><li>◆ Disclosures for specialized government functions, except for national security or intelligence purposes,</li><li>◆ Disclosures to coroners, medical examiners, and funeral directors, or</li><li>◆ Disclosures to meet requirements of law.</li></ul> <p>Do <b>not</b> complete the form when you have made a disclosure of protected health information in one of the following categories:</p> <ul style="list-style-type: none"><li>◆ Disclosures as part of a limited data set in accordance with policies,</li><li>◆ Disclosures for national security or intelligence purposes,</li><li>◆ Disclosures incident to a use or disclosure otherwise permitted or required,</li><li>◆ Disclosures made before April 14, 2003,</li></ul>

Iowa Department of Human Services

**RECORD OF DISCLOSURE OF HEALTH INFORMATION**

Name of Client	State ID												
Social Security Number (Medicaid or <i>hawk-i</i> )	Client ID (facilities)												
Date of Birth	Parent/Guardian (if applicable)												
Name of Person or Entity Receiving Information	Date of Disclosure												
Address of Person or Entity – Street or P.O. Box	City, State, and Zip Code												
<p>Check purpose for the disclosure and provide a brief explanation of purpose checked or attach copy of written request for disclosure.</p> <table> <tr> <td><input type="checkbox"/> Health oversight activities</td> <td><input type="checkbox"/> Victims of abuse, neglect or domestic violence</td> </tr> <tr> <td><input type="checkbox"/> Judicial and administrative proceedings</td> <td><input type="checkbox"/> About decedents</td> </tr> <tr> <td><input type="checkbox"/> Law enforcement purposes</td> <td><input type="checkbox"/> For cadaveric organ, eye, or tissue donation</td> </tr> <tr> <td><input type="checkbox"/> To avert a threat to health or safety</td> <td><input type="checkbox"/> For specialized government functions</td> </tr> <tr> <td><input type="checkbox"/> Required by law</td> <td><input type="checkbox"/> By whistleblowers</td> </tr> <tr> <td><input type="checkbox"/> For public health activities</td> <td><input type="checkbox"/> Accidental disclosures</td> </tr> </table> <p>Explanation:</p>		<input type="checkbox"/> Health oversight activities	<input type="checkbox"/> Victims of abuse, neglect or domestic violence	<input type="checkbox"/> Judicial and administrative proceedings	<input type="checkbox"/> About decedents	<input type="checkbox"/> Law enforcement purposes	<input type="checkbox"/> For cadaveric organ, eye, or tissue donation	<input type="checkbox"/> To avert a threat to health or safety	<input type="checkbox"/> For specialized government functions	<input type="checkbox"/> Required by law	<input type="checkbox"/> By whistleblowers	<input type="checkbox"/> For public health activities	<input type="checkbox"/> Accidental disclosures
<input type="checkbox"/> Health oversight activities	<input type="checkbox"/> Victims of abuse, neglect or domestic violence												
<input type="checkbox"/> Judicial and administrative proceedings	<input type="checkbox"/> About decedents												
<input type="checkbox"/> Law enforcement purposes	<input type="checkbox"/> For cadaveric organ, eye, or tissue donation												
<input type="checkbox"/> To avert a threat to health or safety	<input type="checkbox"/> For specialized government functions												
<input type="checkbox"/> Required by law	<input type="checkbox"/> By whistleblowers												
<input type="checkbox"/> For public health activities	<input type="checkbox"/> Accidental disclosures												
<p>Brief description of the protected health information disclosed:</p>													
Signature of Person Making the Disclosure	Date												

- ◆ Disclosures made pursuant to an authorization,
- ◆ Disclosures to a person involved in the client's care or other notification,
- ◆ Disclosures to carry out treatment, payment and health care operations, or
- ◆ Disclosures to the client regarding protected health information about the client.

Distribution                      Send one copy to the Security and Privacy Office or the facility privacy official. Keep one copy for the client file.

Data                                      Complete the identifying information, check the category of the disclosure, and provide a brief explanation of the protected health information that was disclosed. The person who made the disclosure signs the form.

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**Request for Access to Health Information, Form 470-3952**

**Purpose** A client may use form 470-3952 to request access to or obtain a copy of the client's protected health information.

**Source** Print or photocopy this form from sample in the manual.

**Completion** If necessary, help the client or the client's personal representative to complete the form with the appropriate personal identifier for the client's circumstances.

The Department Security and Privacy Office or facility privacy official shall complete the form and act on the client's request:

- ◆ Within 30 days from the date on the request if the information is on site or
- ◆ Within 60 days from the date on the request if the information is not maintained or accessible to the Department on site.

The Security and Privacy Office or facility privacy official may extend the time for an additional 30 days if additional time is needed to act. If a 30-day extension is needed, the Security and Privacy Office or facility privacy official shall notify the client in writing of the reasons for the delay.

If the request is granted, the Security and Privacy Office or facility privacy official shall supply the requested information and charge the client any applicable fees.

**Distribution** Facility workers shall give one copy to the client and send one copy to the person acting as the facility privacy official. Field offices shall give one copy of the form to the client and send one copy to the Department's Security and Privacy Office.

## Request for Access to Health Information

Name of Client	Date of Request	
Mailing Address – Street or P.O. Box	Social Security Number, Patient Number, or State ID	
City, State, and Zip Code	Phone Number	Birth Date

Check all of the programs that apply:     Medicaid     **hawk-i**     Facility

**To be completed by the client or the client’s personal representative**

I ask the Department of Human Services give me access to the following health information about me or members of my family. I understand that I will get the information or a denial of my request in 30 days if the information is easily available. If the information is not easily available, I will get it in 60 days unless the Department writes to me giving me the reasons for needing more time (up to 30 more days).

I understand that there may be a charge for making a copy of this information and that I will be told of the charge before I receive the information.

I understand that there are certain types of health information that the Department cannot release by law, such as psychotherapy notes. I understand:

- If my request is denied because a medical professional believes the information may cause harm to me or to someone else, I can ask that another medical professional review the decision. If the second medical professional still denies my request, I can appeal that decision.
- If my request is denied for any other reason, I can appeal the decision.

I would like access to the following health information: *(Name the subject of the information.)*

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I want this information for the following dates:

From: \_\_\_\_\_ To: \_\_\_\_\_

Client or Personal Representative’s Signature	Date
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**To be completed by Security and Privacy Office**

- Request is granted.
- Request is denied. Reason for denial: \_\_\_\_\_  
\_\_\_\_\_

Manual and Rule Reference:

Security and Privacy Office Signature

Date

**You Have the Right to Appeal**

**What is an appeal?**

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

**How do I appeal?**

Filing an appeal is easy. You must appeal in writing by doing **one** of the following:

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

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

**How long do I have to appeal?**

You must file an appeal:

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

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

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

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

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

- Within 10 calendar days of the date of a decision or
- Before the date a decision goes into effect

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

**How will I know if I get a hearing?**

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

**Can I have someone else help me in the hearing?**

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

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

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

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

Iowa Department of Human Services, Office of Human Resources, Hoover Building – 1<sup>st</sup> Floor, 1305 E. Walnut, Des Moines IA 50319-0114; fax (515) 281-4243 or via e-mail [stopit@dhs.state.ia.us](mailto:stopit@dhs.state.ia.us)

Data

To initiate the form, enter:

- ◆ The client's name.
- ◆ The date of the request.
- ◆ The client's address.
- ◆ The client's state or patient ID number or social security number.
- ◆ The client's telephone number and date of birth.

Check the applicable program (Medicaid, ***hawk-i***, or facility).

The client or the client's personal representative shall enter the period for which access to the client's health information is wanted and the personal health information desired.

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**[Request for List of Disclosures, Form 470-3985](#)**

Purpose	Clients may use form 470-3985 to request a disclosure of the protected health information that the Department has released to another person or agency.
Source	Print or photocopy this form from sample in the manual.
Completion	<p>The client wanting to make the request or the client's personal representative will complete the form and mail it or give it to the Department's Privacy Office or to the facility privacy official.</p> <p>The privacy official in the facility or the Security and Privacy Office, acting for Medicaid and <b>hawk-i</b>, shall make the final decision on whether to make the disclosure in time to release the information to the client no later than 60 days after receiving a completed form 470-3985.</p> <p>The Security and Privacy Office or facility privacy official may extend the 60 days for one 30-day period if the Security and Privacy Office or facility privacy official notifies the client in writing of the reasons for the delay and the date by which a decision will be made.</p>
Distribution	Give a copy of the form to anyone requesting it. If you should receive a form, forward it to the Security and Privacy Office or give it to your facility privacy official by the end of the next working day.
Data	You may complete the identifying information and date on the form or the client or client's representative may complete it. The client will complete the sections identifying whose health information is requested and the period for which it is requested.

## Request for List of Disclosures

Name	Date of Request	
Mailing Address – Street or P.O. Box	Social Security Number, Patient Number, or State ID	
City, State, and Zip Code	Phone Number	Birth Date

Check all of the programs that apply:     Medicaid     *hawk-i*     Facility

**To be completed by client or client's personal representative**

I request a list of the disclosures the Department of Human Services has made of protected health information for the following family members.

I understand that there may be a charge for this list and that I will be informed of the charge before I receive the list. I will receive this information within 60 days unless I am notified in writing that an additional 30 days is needed to obtain the information.

I understand this list will include the date of the disclosure, the name and address (if known) of the person or agency who received the information, a brief description of the information disclosed, and a brief statement of the purpose of the disclosure.

Name of Individual	SSN, State ID, or Patient Number	Date of Birth

I want this information for the following time period (cannot be before April 14, 2003):

From: \_\_\_\_\_ To: \_\_\_\_\_

Client or Personal Representative's Signature	Date
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**To be completed by Security and Privacy Office**

- Request is granted.
- Request is denied. Reason for denial: \_\_\_\_\_  
\_\_\_\_\_

Manual and Rule Reference:

Security and Privacy Office Signature

Date

**You Have the Right to Appeal**

**What is an appeal?**

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

**How do I appeal?**

Filing an appeal is easy. You must appeal in writing by doing **one** of the following:

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

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

**How long do I have to appeal?**

You must file an appeal:

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

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

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

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

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

- Within 10 calendar days of the date of a decision or
- Before the date a decision goes into effect

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

**How will I know if I get a hearing?**

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

**Can I have someone else help me in the hearing?**

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

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

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

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

Iowa Department of Human Services, Office of Human Resources, Hoover Building – 1<sup>st</sup> Floor, 1305 E. Walnut, Des Moines IA 50319-0114; fax (515) 281-4243 or via e-mail [stopit@dhs.state.ia.us](mailto:stopit@dhs.state.ia.us).

## Request to Amend Health Information

Name of Client	Date of Request	
Mailing Address – Street or P.O. Box	Social Security Number, Patient Number, or State ID	
City, State, and Zip Code	Phone Number	Birth Date

Check all of the programs that apply:     Medicaid     **hawk-i**     Facility

**To be completed by the client or the client's personal representative**

I request that the Department of Human Services amend the following health information in my record. I understand that I can expect an answer in 60 days unless the Department writes to me, giving me the reasons more time is needed (up to 30 more days).

I understand that the Department is not required to agree to my request, but if it does agree, the Department will make the amendments as requested and will provide them to the persons I have identified and to other persons who may have relied on the information to my harm.

I also understand that if my request is not approved, I may appeal the denial of my request. If I lose my appeal, the Department will attach information regarding my request and the appeal to my record.

If I do not appeal, I may ask the Department to include my request and the Department's decision with any future releases of the information, and the Department will do so.

*(Be specific about the answers to these questions. Attach additional pages if necessary.)*

I would like the following health information amended: *(Name the subject of the information. Give the dates of the information. It cannot be before April 14, 2003.)*

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I want this information amended as follows: \_\_\_\_\_

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I want this information amended because: \_\_\_\_\_

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I want this amendment sent to: (Name of person or agency and address): \_\_\_\_\_

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Client or Personal Representative's Signature	Date
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## To be completed by Security and Privacy Office

- Request is granted.
- Request is denied. Reason for denial: \_\_\_\_\_

Manual and Rule Reference:

Security and Privacy Office Signature

Date

### You Have the Right to Appeal

#### What is an appeal?

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

#### How do I appeal?

Filing an appeal is easy. You must appeal in writing by doing **one** of the following:

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

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

#### How long do I have to appeal?

You must file an appeal:

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

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

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

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

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

- Within 10 calendar days of the date of a decision or
- Before the date a decision goes into effect

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

#### How will I know if I get a hearing?

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

#### Can I have someone else help me in the hearing?

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

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

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

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

Iowa Department of Human Services, Office of Human Resources, Hoover Building – 1<sup>st</sup> Floor, 1305 E. Walnut, Des Moines IA 50319-0114; fax (515) 281-4243 or via e-mail [stopit@dhs.state.ia.us](mailto:stopit@dhs.state.ia.us).

470-3950 (Rev. 2/10) Copy 1 – Client Copy 2 – Security and Privacy Office or Facility Privacy Official Copy 3 – File

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**Request to Amend Health Information, Form 470-3950**

Purpose	Clients may use form 470-3950 to request that protected health information in a client's designated record set be amended.
Source	Print or photocopy this form from sample in the manual.
Completion	<p>The client wanting to make the request or the client's personal representative will complete the form and mail it or give it to the Department's Security and Privacy Office or to the facility privacy official.</p> <p>The facility privacy official or the Security and Privacy Office, acting for Medicaid and <b>hawk-i</b>, shall make the final decision on whether to agree to the requested amendment no later than 60 days after receiving a completed form 470-3950.</p> <p>The Security and Privacy Office or facility privacy official may extend the 60 days for one 30-day period if the Security and Privacy Office or facility privacy official notifies the client in writing of the reasons for the delay and the date by which a decision will be made.</p>
Distribution	Give a copy of the form to anyone requesting it. If you should receive a form, forward it to the Security and Privacy Office or give it to your facility privacy official by the end of the next working day.
Data	You may complete the identifying information and date on the form or the client or client's representative may complete it. The client will complete the section identifying which health information should be amended and why. The client shall identify the amendments requested.

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**[Request to Change How Health Information Is Provided, Form 470-3947](#)**

Purpose	Clients may use form 470-3947 to request that protected health information be shared with them by alternative means, such as by e-mail or fax or at a different location, either by mail or in person.
Source	Print or photocopy this form from sample in the manual.
Completion	<p>The client wanting to make the request or the client's personal representative will complete the form and mail it or give it to the Department's Security and Privacy Office or to the facility privacy official.</p> <p>The Security and Privacy Office (acting for Medicaid and <b>hawk-i</b>) may deny this request if a reasonable explanation of why the request is being made is not received. The facility privacy official may not deny the request for that reason.</p>
Distribution	Give a copy of the form to anyone requesting it. If you should receive a form, forward it to the Security and Privacy Office or your facility privacy official by the end of the next working day.
Data	You may complete the identifying information and date on the form or the client or client's representative may complete it. The client will complete the section identifying which health information should be shared differently and why and how.

## REQUEST TO CHANGE HOW HEALTH INFORMATION IS PROVIDED

Name of Client	Date of Request	
Mailing Address – Street or P.O. Box	Social Security Number, Patient Number, or State ID	
City, State, and Zip Code	Phone Number	Birth Date

Check all of the programs that apply:     Medicaid     *hawk-i*     Facility

**To be completed by the client or the client’s personal representative**

I request that the following health information currently being given to me by the Department of Human Services be given to me in a different way or in a different place.

I understand that the Department is not required to agree to my request if it is not reasonable.

I understand that if my request involves issues about payment for my health care, the Department will need to know how payment for services will be made before it will agree to my request.

I understand that if my request is approved, that means a different address for me must be entered into the Department computer system. All of the things that the Department mails to me through that system must go to that different address. This will include FIP or PROMISE JOBS cards, Medicaid cards, Food Assistance EBT cards, all Notices of Decision about eligibility and benefits, and other Department mailings.

I would like the following health information to be shared differently: \_\_\_\_\_

\_\_\_\_\_

I want this information shared differently because: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

*Check the box that tells how you want this information to be shared and complete the blank:*

Mail this information to the following address: \_\_\_\_\_

Give this information to the following person to share with me: \_\_\_\_\_

Other: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Client or Personal Representative’s Signature	Date
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**To be completed by Security and Privacy Office**

Request is granted. Should the Department need to stop honoring your request to change how information is provided, we will send you a written notice.

Request is denied. Reason for denial: \_\_\_\_\_

Manual and Rule Reference:

Security and Privacy Office Signature

Date

**RIGHT OF APPEAL**

If you disagree with any action or failure to act concerning this request, you have the right to appeal, as stated in 441 Iowa Administrative Code Chapter 7. To appeal means to ask the Department of Human Services to look one more time at the decision you think is wrong.

**How to Appeal.** You must appeal in writing. Mail your appeal to the Appeals Section of the Department of Human Services (DHS) at the address given below. There is no fee or charge for an appeal. Your appeal does not need to be on an appeal form, but if you would like to use a form, the appeal forms may be obtained at your local DHS county office, from **hawk-i** customer service, or from the privacy official in your facility. You can also submit your appeal electronically at [www.dhs.state.ia.us/appeals.asp](http://www.dhs.state.ia.us/appeals.asp).

Appeals Section, 5<sup>th</sup> Floor  
Iowa Department of Human Services  
1305 E Walnut Street  
Des Moines IA 50319-0114

**Time Limits.** To get a hearing, **you must mail your appeal within 30 days** of the date of decision on this form. The DHS Director can approve a late appeal if the Director finds that there is a good reason for the appeal being late. There will be no hearings for appeals filed more than 90 days after the date of the notice.

**Granting a Hearing.** DHS will determine whether a hearing will be held. If a hearing is held, you will get a letter telling you of the procedure for the hearing. If a hearing is not granted, you will get a letter telling the reason and what steps you can take at that point.

**Presenting Your Case.** If an appeal hearing is held, you may explain your disagreement or have someone else like a relative or friend explain your disagreement for you. You may be represented by an attorney, but DHS will not pay for the attorney. Your county DHS office has information about legal services available to you that are based on your ability to pay. You may also phone Iowa Legal Aid at 1-800-532-1275. If you live in Polk County, phone 243-1193.

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

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

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

Iowa Department of Human Services, Office of Human Resources, Hoover Building – 1<sup>st</sup> Floor, 1305 E. Walnut, Des Moines IA 50319-0114; fax (515) 281-4243 or via e-mail [stopit@dhs.state.ia.us](mailto:stopit@dhs.state.ia.us)

Iowa Department of Human Services

**REQUEST TO END AN AUTHORIZATION**

Name of Client		Date of Request	
Mailing Address – Street or P.O. Box		Social Security Number, Patient number, or State ID	
City, State, and Zip Code		Phone Number	Birth Date
Check all of the programs that apply: <input type="checkbox"/> Medicaid <input type="checkbox"/> <i>hawk-i</i> <input type="checkbox"/> Facility			
To be completed by the client or the client's personal representative			
<p>I request that the authorization I signed to release health care information to                  (name of person or organization) _____                  dated _____ be stopped.</p> <p>I understand that this request to end the authorization cannot apply to any action the                  Department has already taken on the authorization before this date.</p>			
Client or Personal Representative's Signature		Date	

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**Request to End an Authorization, Form 470-3949**

Purpose	Clients may use form 470-3949 to request that form 470-3951 or 470-3951(S), <i>Authorization to Obtain or Release Health Care Information</i> , or form 470-4459, <i>Authorization to Disclose Information to the Department of Human Services</i> , be revoked.
Source	Print or photocopy this form from sample in the manual.
Completion	The client wanting to make the request or the client's personal representative will complete the form and mail it or give it to the Department's Security and Privacy Office or to the facility privacy official.
Distribution	<p>Give a copy of the form to anyone requesting it.</p> <p>If this is a request to revoke an authorization in the case file for information you have requested, file the request with the authorization and mark the authorization void to make it clear the authorization is no longer valid.</p> <p>If this is a request to revoke an authorization that was sent to the Security and Privacy Office for information that is not available locally, forward the authorization to the Security and Privacy Office.</p>
Data	You may complete the identifying information and date on the form or the client or client's representative may complete it. The client will complete the section identifying which authorization should be revoked.

**[Request to Restrict Use or Disclosure of Health Information, Form 470-3953](#)**

Purpose	Clients may use form 470-3953 to request that the use or disclosure of protected health information be restricted.
Source	Print or photocopy this form from sample in the manual.
Completion	<p>The client wanting to make the request or the client's personal representative will complete the form and mail it or give it to the Department's Security and Privacy Office or to the facility privacy official.</p> <p>The facility privacy official or the Security and Privacy Office, acting for Medicaid and <i>hawk-i</i>, shall make the final decision on whether to agree to the requested restrictions.</p>
Distribution	Give a copy of the form to anyone requesting it. If you should receive a form, forward it to the Security and Privacy Office or your facility privacy official by the end of the next working day.
Data	You may complete the identifying information and date on the form or the client or client's representative may complete it. The client will complete the section identifying which health information should be restricted and why. The client shall identify the restrictions requested.

## Request to Restrict Use or Disclosure of Health Information

Name of Client	Date of Request	
Mailing Address – Street or P.O. Box	Social Security Number, Patient number, or State ID	
City, State, and Zip Code	Phone Number	Birth Date

Check all of the programs that apply:     Medicaid     **hawk-i**     Facility

**To be completed by the client or the client's personal representative**

I request that the Department of Human Services restrict the use or disclosure of the following health information.

I understand that the Department is not required to agree to my request, but if it does agree, the information will not be used or disclosed except as needed to get emergency treatment for me.

I understand that if my request involves issues about payment for my health care, the Department will need to know how payment for services will be made before it will agree to my request.

I would like use and disclosure of the following health information to be restricted: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

I want this information restricted because: \_\_\_\_\_

\_\_\_\_\_

*Check the box that tells how you want this information to be restricted and complete the blank:*

I do not want this information to be given to the following persons or agencies: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Other restrictions requested: \_\_\_\_\_

\_\_\_\_\_

Client or Personal Representative's Signature	Date
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**To be completed by Security and Privacy Office**

- Request is granted. Should the Department need to end these restrictions, you will be given written notice.
- Request is denied. Reason for denial: \_\_\_\_\_

Manual and Rule Reference:

Security and Privacy Office Signature

Date

**You Have the Right to Appeal**

**What is an appeal?**

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

**How do I appeal?**

Filing an appeal is easy. You must appeal in writing by doing **one** of the following:

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

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

**How long do I have to appeal?**

You must file an appeal:

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

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

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

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

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

- Within 10 calendar days of the date of a decision or
- Before the date a decision goes into effect

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

**How will I know if I get a hearing?**

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

**Can I have someone else help me in the hearing?**

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

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

Iowa Department of Human Services, Office of Human Resources, Hoover Building – 1<sup>st</sup> Floor, 1305 E. Walnut, Des Moines IA 50319-0114; fax (515) 281-4243 or via e-mail [stopit@dhs.state.ia.us](mailto:stopit@dhs.state.ia.us).