

Medicaid/*hawk-i* Review

USE ONLY BLUE OR BLACK INK.

IOWA DEPT. OF HUMAN SERVICES

Due Date	Case Number	County Number	Worker Name
Email Address	Phone Number	Contact Preference	

It's time to review your case. Please fill out this form and send it to the address above by the due date. This information will be used to decide if you will continue to get Medicaid/*hawk-i*.

What do I do with this form?

- You must:
- Fill out this form.
 - Sign and date page 6.
 - Send the form to us at the address above by
 - Use extra paper, if needed for your answers.

What if I have questions?

Call your worker at . We will accept collect calls.

Household Members

These people get benefits with you or are counted to figure your benefits. Please fill in any missing information in the table below. *Cross out any information that is **not correct** about members of your household. Write in any new information.*

Name/State ID or CIN	Birth Date	Social Security Number	Relationship to You	Gender Male/Female	Resident of Iowa? Yes/No	U.S. Citizen? Yes/No	Eligible Immigration Status? Yes/No (If yes, list document type and ID number.)

Do you have a physical, mental, or emotional health condition that causes limitations in activities (like bathing, dressing, daily chores, etc.) or live in a medical facility or nursing home? Yes No

Is anyone in your household pregnant? Yes No

If yes, who? _____ Due date _____ Number of expected babies _____

Is there anyone else living in your home that is not listed on page 1? Yes No
If yes, fill out the information below.

Has anyone moved in or out of your home? Yes No
If yes, fill out the information below.

Name	Social Security Number	Birth Date	Relationship to You	Date Moved In	Date Moved Out	U.S. Citizen? Yes/No	Eligible Immigration Status? Yes/No (If yes, list document type and ID number.)	Applying for Benefits? Yes/No

If you have moved, give your new address.

Street Address	City, State and Zip Code
Mailing Address (if different)	City, State and Zip Code

If anyone is in the military, a veteran, or a spouse of a veteran, list who and which they are.

Was anyone in the household on foster care at age 18 or older?

List here: _____

I can confirm that no one applying for medical assistance on this application is incarcerated (detained or jailed).

If not, the name of the person incarcerated is? _____

American Indian or Alaskan Native Family Members (AI/AN)

Are you or anyone in your family an American Indian or Alaska Native? Yes No
If yes, fill out the information below. If no, skip to the next section.

AI/AN Person 1:

Name (first, middle, last) _____

AI/AN Person 2:

Name (first, middle, last) _____

AI/AN Person 1:

Yes No Member of a federally recognized tribe? **If yes**, tribe name: _____

AI/AN Person 2:

Yes No

Yes No Has this person ever gotten a service from the Indian Health Service, a tribal health program, or urban Indian health program or through a referral from one of these programs?

Yes No

Yes No **If no**, is this person eligible to get any of these services?

Yes No

\$ _____
How often? _____
Certain money received may not be counted for Medicaid or Healthy and Well Kids in Iowa (**hawk-i**). List any income (amount and how often) reported on your application that includes money from these sources:

\$ _____
How often? _____

- Per capita payments from a tribe that come from natural resources, usage rights, leases, or royalties.
- Payments from natural resources, farming, ranching, fishing, leases, or royalties from land designated as Indian trust land by the Department of Interior (including reservations and former reservations).
- Money from selling things that have cultural significance.

Tax Information

We need information about who files tax returns. *You can still renew if you do not file tax returns.* You must tell us about who files federal income tax returns. If you leave this blank, we will assume that you do not file federal income tax returns. *Make a copy of this page if you need space for more tax filers.*

Do you plan to file a federal income tax return NEXT YEAR?

Yes If **yes**, answer all of the questions below. No If **no**, answer the questions marked with a star ☆ below.

	Name (first, middle, last & suffix)	If this person is filing a joint return, write the name of the spouse:	If this person will claim dependents, write the names of the dependents:
Person 1			
Person 2			
Person 3			
Person 4			

☆ If anyone will be claimed as a dependent on someone else's tax return, write the name of the tax filer and the dependents. Answer only if different than what you reported above or if you did not fill in any information above.

Name of tax filer: _____

Name of dependents: _____

Tell Us About Work

You must tell us about all money the people in your household get. If someone has more than one job, tell us about **all jobs**. You can report **self-employment** on the next page. If you leave a space blank, we will assume that you have no money of this kind. Please use an additional sheet of paper, if needed. If you have proof of income (check stubs, employer's statement, tax returns, etc.), you may send it with this review. This may speed up the processing of your review. *Make a copy of this page if you need space for more jobs or people. Cross out any information that is **not correct** about members of your household. Write in any new or missing information.*

Job 1

Name of the Person Who is Working (first, middle, last & suffix)			
Employer Name		Employer Phone Number	
Employer Address	City	State	Zip Code
How much does this person get paid per pay period (before taxes)? \$	How often are wages or tips paid? <input type="checkbox"/> Hourly <input type="checkbox"/> Every other week <input type="checkbox"/> Monthly <input type="checkbox"/> Weekly <input type="checkbox"/> Twice a month <input type="checkbox"/> Annually		Average hours worked each week:

Job 2

Name of the Person Who is Working (first, middle, last & suffix)			
Employer Name		Employer Phone Number	
Employer Address	City	State	Zip Code
How much does this person get paid per pay period (before taxes)? \$	How often are wages or tips paid? <input type="checkbox"/> Hourly <input type="checkbox"/> Every other week <input type="checkbox"/> Monthly <input type="checkbox"/> Weekly <input type="checkbox"/> Twice a month <input type="checkbox"/> Annually		Average hours worked each week:

Job 3

Name of the Person Who is Working (first, middle, last & suffix)			
Employer Name		Employer Phone Number	
Employer Address	City	State	Zip Code
How much does this person get paid per pay period (before taxes)? \$	How often are wages or tips paid? <input type="checkbox"/> Hourly <input type="checkbox"/> Every other week <input type="checkbox"/> Monthly <input type="checkbox"/> Weekly <input type="checkbox"/> Twice a month <input type="checkbox"/> Annually		Average hours worked each week:

Job 4

Name of the Person Who is Working (first, middle, last & suffix)			
Employer Name		Employer Phone Number	
Employer Address	City	State	Zip Code
How much does this person get paid per pay period (before taxes)? \$	How often are wages or tips paid? <input type="checkbox"/> Hourly <input type="checkbox"/> Every other week <input type="checkbox"/> Monthly <input type="checkbox"/> Weekly <input type="checkbox"/> Twice a month <input type="checkbox"/> Annually		Average hours worked each week:

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

If no, explain _____

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

If yes, who? _____ Employer name? _____

In the past three months, did you: Change jobs Stop working Start working fewer hours None of these

Self-Employment

If anyone in your household is **self-employed**, we need to know about their work. *See the instructions for more information about deductions.*

	Name (first, middle, last & suffix)	Type of work:	How much net income will this person get from self-employment this month?
Person 1			Amount \$
Person 2			Amount \$

➤ Subtract the expenses below from your gross income to get your net self-employment income.

- Car and truck expenses (for travel during workday, not commuting)
- Depreciation
- Employee wage and fringe benefits
- Property, liability, or business interruption insurance
- Interest (including mortgage paid to bank, etc.)
- Legal and professional services
- Rent or lease of business property or utilities
- Commissions, licenses, taxes, and fees
- Advertising
- Contract labor
- Repairs and maintenance
- Certain business travel and meals
- Deductible self-employment taxes
- Cost of self-employed health insurance
- Contributions to self-employed SEP, SIMPLE, or qualified retirement plan

Tell Us About Other Income

Cross out any information that is **not correct** about members in your household. Write in any new information. *Make a copy of this page if you need space for more types of other income.*

Unemployment

Name (first, middle, last & suffix)	How much?	How often?
	\$	<input type="checkbox"/> Weekly <input type="checkbox"/> Every other week <input type="checkbox"/> Annually <input type="checkbox"/> Monthly <input type="checkbox"/> Twice a month <input type="checkbox"/> Other _____
	\$	<input type="checkbox"/> Weekly <input type="checkbox"/> Every other week <input type="checkbox"/> Annually <input type="checkbox"/> Monthly <input type="checkbox"/> Twice a month <input type="checkbox"/> Other _____
	\$	<input type="checkbox"/> Weekly <input type="checkbox"/> Every other week <input type="checkbox"/> Annually <input type="checkbox"/> Monthly <input type="checkbox"/> Twice a month <input type="checkbox"/> Other _____
	\$	<input type="checkbox"/> Weekly <input type="checkbox"/> Every other week <input type="checkbox"/> Annually <input type="checkbox"/> Monthly <input type="checkbox"/> Twice a month <input type="checkbox"/> Other _____

Social Security

Name (first, middle, last & suffix)	How much?	How often?
	\$	<input type="checkbox"/> Weekly <input type="checkbox"/> Every other week <input type="checkbox"/> Annually <input type="checkbox"/> Monthly <input type="checkbox"/> Twice a month <input type="checkbox"/> Other _____
	\$	<input type="checkbox"/> Weekly <input type="checkbox"/> Every other week <input type="checkbox"/> Annually <input type="checkbox"/> Monthly <input type="checkbox"/> Twice a month <input type="checkbox"/> Other _____
	\$	<input type="checkbox"/> Weekly <input type="checkbox"/> Every other week <input type="checkbox"/> Annually <input type="checkbox"/> Monthly <input type="checkbox"/> Twice a month <input type="checkbox"/> Other _____
	\$	<input type="checkbox"/> Weekly <input type="checkbox"/> Every other week <input type="checkbox"/> Annually <input type="checkbox"/> Monthly <input type="checkbox"/> Twice a month <input type="checkbox"/> Other _____

Report other income types, such as pensions, retirement, alimony received, farming or fishing, rental income or royalties, etc.

Other Income Type _____

Name (first, middle, last & suffix)	How much?	How often?
	\$	<input type="checkbox"/> Weekly <input type="checkbox"/> Every other week <input type="checkbox"/> Annually <input type="checkbox"/> Monthly <input type="checkbox"/> Twice a month <input type="checkbox"/> Other _____

Other Income Type _____

Name (first, middle, last & suffix)	How much?	How often?
	\$	<input type="checkbox"/> Weekly <input type="checkbox"/> Every other week <input type="checkbox"/> Annually <input type="checkbox"/> Monthly <input type="checkbox"/> Twice a month <input type="checkbox"/> Other _____

Deductions

If anyone in your household has **deductions**, such as alimony, student loan interest and other, tell us what kind. You should **not** include a cost that you already considered in your answer to net self-employment.

Alimony Paid to Someone Else

Name (first, middle, last & suffix)	How much?	How often?
	\$	<input type="checkbox"/> Weekly <input type="checkbox"/> Every other week <input type="checkbox"/> Annually <input type="checkbox"/> Monthly <input type="checkbox"/> Twice a month <input type="checkbox"/> Other _____

Student Loan Interest Paid

Name (first, middle, last & suffix)	How much?	How often?
	\$	<input type="checkbox"/> Weekly <input type="checkbox"/> Every other week <input type="checkbox"/> Annually <input type="checkbox"/> Monthly <input type="checkbox"/> Twice a month <input type="checkbox"/> Other _____

Other Deductions

Name (first, middle, last & suffix)	How much?	How often?
	\$	<input type="checkbox"/> Weekly <input type="checkbox"/> Every other week <input type="checkbox"/> Annually <input type="checkbox"/> Monthly <input type="checkbox"/> Twice a month <input type="checkbox"/> Other _____

Health Insurance

Tell us about **other** health insurance coverage people have.

Is anyone enrolled in health coverage now? Yes No

If yes, check the health coverage. Medicaid *hawk-i* Medicare Tricare
 Veterans Peace Corps Retiree Health Plan COBRA

Employer insurance Name of health insurance _____ Policy number _____
 Private/other _____

Health Coverage From Jobs

Complete this section if anyone on this form is eligible for health coverage from a job, even if not currently enrolled. Tell us about the **job** that offers coverage.

Employee Information. The **employee** needs to fill out this section.

Employee Name (first, middle, last)	Social Security Number
-------------------------------------	------------------------

Employer Information. Ask the **employer** for this information.

Employer Name	Employer Identification number (EIN)	
Employer Address (the Marketplace will send notices to this address)	Employer Phone Number	
City	State	Zip Code
Who can we contact about employee health coverage at this job?		
Phone Number (if difference from above)	Email Address	

Yes No Are you currently eligible for coverage offered by this employer, or will you become eligible in the next three months?

If **yes**, fill out the information below. If **no**, skip to the **Expected Changes** section.

If you're in a waiting or probationary period, when can you enroll in coverage?

List the names of anyone else who is eligible for coverage from this job.

Health Plan. Tell us about the **health plan** offered by this employer.

Yes No Does the employer offer a health plan that covers an employee's spouse or dependent?

If yes, which people? Spouse Dependents

Yes No An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60% of such costs. Does the employer offer a plan that meets the minimum value standard?

Yes No Does the employer's lowest-cost plan that meets the "minimum value standard" offer a wellness program to **only the employee**? (Do not include family plans.)

If **yes**, how much would the employee have to pay in premiums after receiving the maximum discount for any tobacco cessation programs? (Do not deduct any other discounts based on the wellness program.) \$ _____

How often? Weekly Every two weeks Twice a month Quarterly Yearly

Employer Changes. What change will the employer make for the new plan year (if known)?

Employer won't offer health coverage

Employer will start offering coverage to employees or change the premium for the lowest-cost plan available to the employee that meets the minimum value standard. (Premium should reflect discount for wellness programs.)

How much will the employee have to pay in premiums for that plan? \$ _____

How often? Weekly Every two weeks Twice a month Quarterly Yearly

Date of change: _____

Expected Changes

Tell us if any changes happened or may happen. Examples:

- People in household
- Health insurance
- Pregnancy (list due date)
- Tax status
- Divorce or marriage
- Pregnancy ending
- Employment
- Address
- Other

Explain what and when: _____

Renewal of Coverage in Future Years

Read the statement below and check **one** box.

To make it easier to check my income at review time, I give permission to the Department of Human Services to use income information from my tax returns for the number of years I checked below.

I understand that the Department of Human Services will send me a letter with the income information they have. I can make changes to it. I can also change my mind and not allow the Department of Human Services to check this information.

Yes, I give permission to check my income on tax returns for (check one box):

5 years (the longest time) 4 years 3 years 2 years 1 year

No, I do not give permission to use my tax returns.

Read and Sign This Application

Your Signature or Mark	Phone Number	Today's Date
Signature of Person, if Any, Who Helped Complete the Form	Phone Number	Today's Date

Please keep this page for your information.

Your Rights and Responsibilities

- By signing this application, I certify under penalty of perjury and false swearing that my answers are correct and complete to the best of my knowledge, including information provided about the citizenship or alien status for each household member applying for benefits.
- By signing this application, I give permission for DHS to share medical and other health care records with federal and state officials.
- I understand that an electronic signature has the same legal effect and can be enforced in the same way as a written signature.
- I know that my information on this form will only be used to determine eligibility for medical assistance and will be kept private as required by law.
- I understand that if I receive Medicaid, the Department will pursue non-medical support for myself and my children upon my request. Medical support services include the establishment of paternity and the establishment and enforcement of medical support.
- I understand the questions and statements on this application.
- I understand that any facts that I have given, including benefit and income facts, will be matched with local, state, and federal records, such as employers, U.S. Citizenship and Immigration Service (USCIS), the Social Security Administration, tax, welfare, and unemployment agencies, etc. and I understand that the information received may affect my eligibility for benefits.
- I understand information, including benefit and income facts, that I have given on this form is subject to investigation and review by county, state, and federal personnel and that if I give incorrect facts my benefits may be denied or stopped.
- I know that under federal law, discrimination isn't permitted on the basis of race, color, national origin, sex or disability. I can file a complaint of discrimination by visiting www.hhs.gov/ocr/office/file.
- I can confirm that no one applying for medical assistance on this application is incarcerated (detained or jailed).
- I know that I can be represented in the process by someone other than myself. My eligibility and other important information will be explained to me. I understand that a change in my status could affect the eligibility for members of my household.
- If I think the Health Insurance Marketplace or Medicaid/*hawk-i* has made a mistake, I can appeal its decision. To appeal means to tell someone at the Health Insurance Marketplace or Medicaid/*hawk-i* that I think the action is wrong, and ask for a fair review of the action. I know that the process of how to appeal is found on page 8 in the Appeals section.

What do I do with the form now?

After you have filled out the form, please send the form back to us using the envelope that was included. Be sure to mail it to the office address printed on page 1. This address is under your mailing address. You may also bring this form to the office.

Social Security Number Information

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

If you do not give us a Social Security Number for people in your household, we will deny assistance to those people. There are some exceptions to this. Please ask your worker.

We will not give any Social Security Number to the Citizenship and Immigration Service.

Please keep this page for your information.

Medicaid

We Check What You Tell Us

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

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

We check and use computer systems like the State Income and Eligibility Verification System, the Federal Facilitated Exchange including Internal Revenue Service (IRS), Social Security Administration (SSA), and Department of Homeland Security (DHS). If something you told us is different from what the computer system tells us, we will check to find out what is correct. We might check your information by contacting your employer, your bank or other people. To do this kind of checking with your employer, bank, or other people, we will ask you first.

Things You Need to Know

- You must apply for and accept any other benefits which you may be entitled to receive.
- You must give us information and provide proof, when we ask for it.
- You must fill out review forms when you are asked to.
- DHS may give your answers to law enforcement officials to catch persons fleeing to avoid the law.
- The Quality Control unit or Investigations unit may review your case. They may contact other people or organizations to get proof of your information. By signing this application, you give permission to release confidential information to the Quality Control unit or Investigations unit. You must cooperate with them to keep your benefits.
- You will have to pay back any benefits you got or that were paid to a third party on your behalf for which you were not eligible.
- Section 1128B of the Social Security Act provides federal penalties for fraudulent acts and false reporting in connection with these programs.
- Anyone who gets, tries to get, or helps any other person get assistance to which they are not entitled, is guilty of violating the laws of the state of Iowa. This includes, but is not limited to, Iowa Code Chapters 249 and 249A.
- You can apply for part of your household even if some members do not have lawful immigrant status. For example, parents who do not have lawful immigrant status may apply for their children who are U.S. citizens or qualified aliens. The Department may check your household's alien status with the Department of Homeland Security. Any information from the Department of Homeland Security may affect that individual's benefits. The Department of Homeland Security will not be contacted about people you do not apply for. However, their income may be used to see if the rest of the household can get Medicaid.
- ***Giving wrong information on purpose may result in us taking criminal or civil legal action against you. It might also mean we reduce your benefits or take money back from you.***

This permission ends when your Medicaid stops.

You Have the Right to Appeal

You, or the person helping you, may request an appeal hearing if you do not agree with any action taken on your case. You must appeal in writing. To appeal in writing do **one** of the following:

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

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

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

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

You Will Not be Discriminated Against

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

Optional Release of Information

Help Us Help You!

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

You should know that:

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

Print and sign your name below to give us permission to get needed information. Remember to also sign page 6.

RELEASE OF INFORMATION

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

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

This release does not apply to protected health information.

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

Your Name (please print clearly)

Other Adult Name (please print clearly)

Signature or Mark

Signature or Mark

Date