Iowa Department of Human Services

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GENERAL LETTER NO. 6-AP-112

ISSUED BY: Bureau of Financial, Health and Work Supports
Division of Adult, Children and Family Services

SUBJECT: Employees' Manual, Title 6, ***INCOME MAINTENANCE PROGRAMS APPENDIX***, Contents (pages 2, 4 through 8, 11, and 12), revised; pages 26, 44, 133, 134, 142, 146, 147, 162, 163, 164, 171 through 214, 219 through 228, 303 through 308, 308a, 315, 332, 340, 341, 351, 352, 353, 396, 405, 441, 443, and 446 through 463, revised; pages 68b, 135, 308b, 308c, 308d, 464, and 465, new; and the following forms:

470-3967	*ABAWD Letter*, revised
470-3967(S)	*ABAWD Letter* (Spanish), revised
470-5170	*Application for Health Coverage and Help Paying Costs*, revised
470-5170(S)	*Application for Health Coverage and Help Paying Costs* (Spanish), revised
470-5130	*DHS Investigative Referral to DIA*, new
470-4365	*Disposal of Assets Penalty Notice of Decision*, revised
470-2868	*HIPP Medical History Questionnaire*, revised
470-0374	*ICF/ID Resident Care Agreement*, revised
470-2527	*MAC Income Worksheet*, revised
470-4678	*MAIT Facility Worksheet*, revised
470-4679	*MAIT Waiver Worksheet*, revised
470-5168	*Medicaid/**hawk-i** Review*, revised
470-5168(S)	*Medicaid/**hawk-i** Review* (Spanish), revised
470-5168(M)	*Medicaid/**hawk-i** Review* (manual), new
470-5168(MS)	*Medicaid/**hawk-i** Review* (manual Spanish), new
470-4488	*Medical Assistance Income Trust*, revised
470-3630	*Medically Needy Transmittal*, revised
470-3902	*MEPD Billing Statement*, revised
470-0485(M)	*Notice of Action* (manual), new
470-0485(MS)	*Notice of Action* (manual Spanish), new
470-0485	*Notice of Decision*, revised
470-0485(S)	*Notice of Decision* (Spanish), revised
470-3491	*Proof of Medicaid Coverage*, revised
470-2169	*Provider Request for Member Disenrollment*, revised

470-5199	*Renewal Application Addendum*, revised
470-5199(S)	*Renewal Application Addendum* (Spanish), revised
470-2960	*Reporting Food Assistance Changes*, revised
470-2960(S)	*Reporting Food Assistance Changes* (Spanish), revised
470-2881	*Review/Recertification Eligibility Document*, revised
470-2881(S)	*Review/Recertification Eligibility Document* (Spanish), revised
470-2881(M)	*Review/Recertification Eligibility Document* (manual), revised
470-2881(MS)	*Review/Recertification Eligibility Document* (manual Spanish), revised
470-4833	*Waiver Slot Notice*, revised
Comm. 2	*Facts About the Food Assistance Program*, revised
Comm. 2(S)	*Facts About the Food Assistance Program* (Spanish), revised
Comm. 20	*Your Guide to Medicaid*, revised
Comm. 20(S)	*Your Guide to Medicaid* (Spanish), revised
Comm. 24	*One-Time Payments*, revised
Comm. 24(S)	*One-Time Payments* (Spanish), revised
Comm. 123	*Important Information for You and Your Family Members About the Estate Recovery Program*, revised
Comm. 123(S)	*Important Information for You and Your Family Members About the Estate Recovery Program* (Spanish), revised
Comm. 156A	***hawk-i*** *Brochure Income Guidelines for Health Care Coverage*, revised
Comm. 156B	***hawk-i*** *Brochure Income Guidelines for Dental Only Coverage*, revised
Comm. 180	*Medicaid for Employed People With Disabilities (MEPD)*, revised
Comm. 229	*Food Assistance Makes Iowa Stronger*, revised
Comm. 229(S)	*Food Assistance Makes Iowa Stronger* (Spanish), revised
Comm. 266	*Iowa's Estate Recovery Law*, revised
Comm. 284	*Bringing Farmers Markets and Food Assistance Together*, revised
Comm. 337	*Medicaid for Kids with Special Needs*, revised
Comm. 372	*Medicaid for Employed People with Disabilities (MEPD) Frequently Asked Questions*, revised
Comm. 374	*Iowa Family Planning Network (IFPN) Frequently Asked Questions*, new
RC-0033	*Desk Aid*, revised
RC-0130	*Desk Aid for MAGI, MIYA, IHAWP, and* ***hawk-i***, new

Summary

This chapter is revised to:

- Update all links to the Department's new website.
- Change the dates of the upcoming three-year period to December 1, 2014, through November 30, 2017, on form 470-3967, *ABAWD Letter*, and its Spanish translation form 470-3967(S).
- Expand the "renewal of coverage in future years" section on form 470-5170, *Application for Health Coverage and Help Paying Costs*, and its Spanish translation, form 470-5170(S), to allow the applicant to:
  - Choose "yes" or "no" to allow the Department to automatically renew eligibility in future years based on tax information, and
  - Allow the applicant to indicate the number of desired years if "yes" is chosen.
  - Move the section from page 10 to 11.
- Add form 470-5130, *DHS Investigative Referral to DIA.* This form provides complete information on referrals of fraudulent activity to the Department of Inspections and Appeals.
- Update the appeal rights and nondiscrimination policy on form 470-4365, *Disposal of Assets Penalty Notice of Decision*.
- Change form 470-2868, *HIPP Medical History Questionnaire*, and its instructions to reflect the systematic delivery of the form.

  The HIPP worker refers to this form when the computer system's cost-effective recommendation is to "not buy" the health insurance policy. The computer system's cost-effective recommendation is based on the average Medicaid utilization of a family with the same demographic data. If the form indicates that the family's Medicaid utilization may be higher than average, the policy may still be cost-effective.
- Revise the instructions and form 470-0374, *ICF/ID Resident Care Agreement*, to reflect the change in name of ICFs/MR to "intermediate care facilities for persons with an intellectual disability" (ICF/ID), as mandated by 2012 Iowa Acts, Senate File 2247.
- Remove obsolete form 470-0375, *ICF/ID Placement Statement*, and the instructions. The form is no longer being used.
- Remove IowaCare forms due to the end of the program effective December 31, 2013. The following forms are obsolete:
  - 470-4165, *IowaCare Billing Statement*
  - 470-4542, *IowaCare Insurance Information Request*
  - 470-4164, *IowaCare Medical Card*
  - 470-4310 and 470-4310(S), *IowaCare Refund Notice*
- Update the income limits due to the annual federal poverty level changes on form 470-2527, *MAC Income Worksheet*.

- Update form 470-4678, *MAIT Facility Worksheet*, and form 470-4679, *MAIT Waiver Worksheet*, to reflect a new legislative change on Medical Assistance Income Trusts (MAITs).

  Beginning on July 1, 2014, 125 percent of the statewide average charge for care is used to determine if a person with a MAIT qualifies for facility payment. Before July 1, 2014, the statewide average charge for care was used to determine if a MAIT would allow the person to be income-eligible for Medicaid.

  The instructions have been updated to reflect this change.

- Revise form 470-5168, *Medicaid/**hawk-i** Review*, and its Spanish translation, form 470-5168(S), to:
  - Change the name from "*MAGI Renewal*" to "*Medicaid/**hawk-i** Review,*" effective March 2014.
  - Renumber forms to reflect manually-issued forms 470-5168(M) and 470-5168(MS).
  - Include "***hawk-i***" in the statement that tells the member it is time for a review.
  - Add questions regarding physical, mental, or emotional health condition and foster care and incarceration.
  - Remove questions regarding school attendance and college or training programs.
  - Revise section regarding tax information.
  - Remove "income" section and replace with "work," "self-employment," and "other income" section. Add explanation in work section that if left blank, we will assume no income of this kind.
  - Add a section to allow the member to give DHS permission to use income information from tax returns in future years.
  - Add a "Your Rights and Responsibilities" section.
- Simplify the language on form 470-4488, *Medical Assistance Income Trust*, to make it easier for the trustee to know what payments need to be made from the member's Medical Assistance Income Trust (MAIT).
- Update the instructions and form 470-3630, *Medically Needy Transmittal*, to:
  - Revise the distribution instructions.
  - Change references from intermediate care facilities for the mentally retarded (ICF/MR) to intermediate care facilities for persons with an intellectual disability (ICF/ID).
  - Reflect the Department's branding.
- Change the zip code of the return mailing address on form 470-3902, *MEPD Billing Statement*.
- Add form 470-0485(M), *Notice of Action* (manual), and its Spanish translation, form 470-0485(MS), *Notice of Action* (manual Spanish). Both forms are available on line as templates on the DHS Intranet eForms web page.

- Update the appeal rights and policy on nondiscrimination on form 470-0485, *Notice of Decision*, and its Spanish translation 470-0485(S).
- Change form 470-3491, *Proof of Medicaid Coverage*, due to the elimination of the Zfold form sealer. The form is printed on plain paper and mailed in an envelope.
- Update the form and shorten the name of form 470-2169 from *Iowa Medicaid Managed Health Care Provider Request for Member Disenrollment* to *Provider Request for Member Disenrollment*.
- Revise 470-5199, *Renewal Application Addendum*, and its Spanish translation, form 470-5199(S), to:
  - Include a statement that the person signing is declaring under perjury that the information provided on the statement is true, correct, and complete.
  - Remove a reference to information from the Internal Revenue Service (IRS) and add general language regarding data sources.
  - Expand the consent statement to include all persons listed on the form.
  - Expand the tax information fields.
- Clarify when and how households must report Food Assistance changes on form 470-2960, *Reporting Food Assistance Changes*, and its Spanish translation, form 470-2960(S). Specific additions to the forms are:
  - The requirement for Able-Bodied Adults Without Dependents (ABAWDs) to report when they stop working 80 or more hours in a month,
  - The possibility of fines and criminal charges for purposely withholding information, and
  - The mailing address for the DHS Image Center 1 in Council Bluffs.
- Update the instructions for form 470-3924, *Request for ISIS Changes*.
- Remove the Medicaid language in the following forms:
  - 470-2881, *Review/Recertification Eligibility Document*
  - 470-2881(S), *Review/Recertification Eligibility Document* (Spanish)
  - 470-2881(M), *Review/Recertification Eligibility Document* (manual)
  - 470-2881(MS), *Review/Recertification Eligibility Document* (manual Spanish)

  The revised forms will be sent after the October 2014 IABC cut-off. Form 470-5168, *Medicaid/hawk-i Review*, and its Spanish translation, 470-5168(S), will be sent for the Medicaid program at that time.
- Update form 470-4833, *Waiver Slot Notice.* Form 470-5170, *Application for Health Coverage and Help Paying Costs*, is the application mailed with the letter.
- Update the current income limits and maximum allotment amounts on the following:
  - Comm. 2 and Comm. 2(S), *Facts About the Food Assistance Program*
  - Comm. 229 and Comm. 229(S), *Food Assistance Makes Iowa Stronger*
- Update Comm. 20, *Your Guide to Medicaid*, and its Spanish translation, Comm. 20(S), to reflect changes to Iowa Medicaid appeal and hearing rules.

- Update Comm. 24, *One-Time Payments*, and its Spanish translation, Comm. 24(S), to remove prorations of one-time lump sum payments for Medicaid eligibility based on the new MAGI rules effective January 1, 2014.
- Update Comm. 123, *Important Information for You and Your Family Members About the Estate Recovery Program*, and its Spanish translation, Comm. 123(S), to better clarify what estate recovery is and who is subject to estate recovery. IME Member Services contact information is added.
- Update the family income limits effective April 1, 2014, on the following fliers:
  - Comm. 156A, ***hawk-i*** *Brochure Income Guidelines for Health Care Coverage*
  - Comm. 156B, ***hawk-i*** *Brochure Income Guidelines for Dental Only Coverage*
- Update the MEPD premium chart with the new premiums effective August 1, 2014, on the following:
  - Comm. 180, *Medicaid for Employed People With Disabilities*
  - Comm. 372, *Medicaid for Employed People with Disabilities (MEPD) Frequently Asked Questions*
- Update Comm. 266, *Iowa's Estate Recovery Law*, to:
  - Clarify the language in the booklet.
  - Change a legal reference from "Iowa Code section 249A.5(2)" to "Iowa Code Section 249A.53(2)."
- Update the list of farmers and farmers' market information on Comm. 284, *Bringing Farmers Markets and Food Assistance Together*.

  The Department's website has been updated in the instructions. Print additional supplies of Comm. 284 from this website.
- Update the monthly income limits due to an increase in the federal poverty level on Comm. 337, *Medicaid for Kids with Special Needs*.
- Add Comm. 374, *Iowa Family Planning Network (IFPN) Frequently Asked Questions*. Comm. 374 gives basic information about the IFPN coverage group.
- Change RC-0033, *Desk Aid*, to:
  - Update the Food Assistance income and resource limits and the maximum allotment amounts.
  - Reflect the 2014 federal poverty levels.
  - Update the MEPD premium chart with the new premiums effective August 1, 2014.
- Add RC-0130, *Desk Aid for MAGI, MIYA, IHAWP, and* ***hawk-i***. RC-0130 provides poverty guidelines and income limits for these programs.

Effective Date

IowaCare changes are effective December 31, 2013.

The increase in monthly income limits for Medicaid for Kids with Special Needs are effective April 1, 2014.

The MAIT changes are effective July 1, 2014.

The updated MEPD premiums are effective August 1, 2014.

All other changes are effective upon receipt.

Material Superseded

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

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Additional Information

Use up existing supplies of form 470-3630, *Medically Needy Transmittal*. The form will no longer be printed at Anamosa.

Destroy existing supplies of the following before ordering supplies from Anamosa in the usual manner.

- Comm. 20, *Your Guide to Medicaid*
- Comm. 20(S), *Your Guide to Medicaid* (Spanish)
- Comm. 229, *Food Assistance Makes Iowa Stronger*
- Comm. 229(S), *Food Assistance Makes Iowa Stronger* (Spanish)

Destroy any existing supplies of Comm. 24 and Comm. 24(S), both dated 1/07. Order supplies of Comm. 24 and Comm. 24(S), both dated 1/14, from Anamosa in the usual manner.

Use up existing supplies of Comm. 123, *Important Information for You and Your Family Members About the Estate Recovery Program,* before ordering Comm. 123, dated 5/14, from Anamosa in the usual manner.

Destroy any existing supplies of Comm. 156A and Comm. 156B, dated earlier than 2/14. If needed, order supplies of Comm. 156A and Comm. 156B, both dated 2/14, from Anamosa in the usual manner.

Use up existing supplies of Comm. 180, *Medicaid for Employed People With Disabilities*, before ordering Comm. 180, dated 9/14, from Anamosa in the usual manner.

Destroy any remaining supplies of Comm. 266, dated 9/10. Order supplies of Comm. 266, dated 2/14, from Anamosa in the usual manner.

Destroy any remaining supplies of Comm. 284, dated before April 2014.

Use up existing supplies of Comm. 337, *Medicaid for Kids with Special Needs,* before ordering Comm. 337, dated 9/14, from Anamosa in the usual manner.

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

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Iowa Department of Human Services

Terry E. Branstad
Governor

Kim Reynolds
Lt. Governor

Charles M. Palmer
Director

Dear

Right now, you can get Food Assistance for only three months from December 1, 2014, through November 30, 2017.

To get Food Assistance for a longer time, you can do one or more of the following things for at least 80 hours a month:

- Work at a job that pays money
- Work at a job that pays you in other ways, like paying off your rent or other things you need
- Help at a non-profit agency (like a food bank)
- Do court-ordered community service

Or, you can also get Food Assistance longer if any of these things change:

- You turn 50 years old
- You have a physical or mental problem that keeps you from working
- You become pregnant
- You eat with someone under age 18 who lives with you, even if it's not all of the time

Remember that if you stop getting Food Assistance, you can always re-apply at any time.

Please call my office if you:

- Have questions, or
- Need this letter in another language.

I accept collect calls.

Thank you for your cooperation,

Income Maintenance Worker

Iowa Department of Human Services

Terry E. Branstad
Governor

Kim Reynolds
Lt. Governor

Charles M. Palmer
Director

Estimado (a)

Ahora mismo, usted puede recibir Food Assistance (Asistencia Alimenticia) únicamente por tres meses desde 1 de diciembre de 2014 hasta 30 de noviembre de 2017.

Para recibir Food Assistance por mas tiempo, puede hacer una o mas de las siguientes cosas por lo menos hasta 80 horas al mes:

- Tener un trabajo remunerado en dinero
- Tener un trabajo que pague de otras formas, como uno que pague su renta u otras cosas que usted necesite
- Ayudar a una agencia sin ánimo de lucro (como un banco de alimentos)
- Hacer trabajo comunitario por orden judicial

O, también puede recibir Food Assistance por más tiempo si alguna de estas cosas cambia:

- Usted ha cumplido 50 años
- Usted tiene un problema físico o mental que no le permite trabajar
- Usted queda embarazada
- Usted se alimenta con alguien menor de 18 años que viva con usted, aunque no sea todo el tiempo

Recuerde que si usted deja de recibir Food Assistance, usted siempre puede volver a solicitarla en cualquier momento.

Por favor llame a mi oficina si:

- Tiene preguntas, o
- Necesita esta carta en otro idioma.

Acepto llamadas por cobrar.

Gracias por su ayuda,

Trabajador de Mantenimiento de Ingreso

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

Purpose

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

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

Source

The English version of the form is printed with 15 forms on a pad. Print or photocopy supplies of the Spanish version from the sample in the manual.

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

Completion

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

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

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

An optional release of information is included on the last page of the application. The applicant may use this release to authorize the Department to contact other people or organizations for information needed to determine eligibility and benefits. The applicant is not required to sign this release.

Iowa Department of Human Services

Application for Health Coverage and Help Paying Costs

Use this application to see what coverage choices you qualify for

- Affordable private health insurance plans that offer comprehensive coverage to help you stay well
- A new tax credit that can immediately help pay your premiums for health coverage
- Free or low-cost insurance from Medicaid or the Children's Health Insurance Program (CHIP)

You may qualify for a free or low-cost program even if you earn as much as $94,000 a year (for a family of 4).

Who can use this application?

- Use this application to apply for anyone in your family.
- Apply even if you or your child already has health coverage. You could be eligible for lower-cost or free coverage.
- Families that include immigrants can apply. You can apply for your child even if you aren't eligible for coverage. Applying won't affect your immigration status or chances of becoming a permanent resident or citizen.
- If someone is helping you fill out this application, you may need to complete Step 6.

Apply faster online

Apply faster online at dhsservices.iowa.gov.

What you may need to apply

- Social Security Numbers (or document numbers for any legal immigrants who need insurance)
- Employer and income information for everyone in your family (for example, from paystubs, W-2 forms, or wage and tax statements)
- Policy numbers for any current health insurance
- Information about any job-related health insurance available to your family

Why do we ask for this information?

We ask about income and other information to let you know what coverage you qualify for and if you can get any help paying for it. **We'll keep all the information you provide private and secure, as required by law.**

What happens next?

Send your complete, signed application to the address on page 11. **If you don't have all the information we ask for, sign and submit your application anyway.** We'll follow-up with you within 30 days. You'll get instructions on the next steps to complete your health coverage. If you don't hear from us within 30 days, call the DHS Contact Center at **1-855-889-7985**. Filling out this application doesn't mean you have to buy health coverage.

Get help with this application

- **Online:** dhsservices.iowa.gov
- **Phone:** Call our Help Center at **1-855-889-7985**.
- **In person:** There may be counselors in your area who can help. Visit our website or call **1-855-889-7985** for more information.
- **En Español:** Llame a nuestro centro de ayuda gratis al **1-855-889-7985**.
- If you need help in a language other than English, call **1-855-889-7985** and tell the customer service representative the language you need. We'll get you help at no cost to you.
- TTY users should call **1-800-735-2942**.

Step 1. Tell us about yourself.

We need one adult in the family to be the contact person for your application.

First name, middle name, last name, and suffix			
Home address (Leave blank if you don't have one.)			Apartment or suite number
City	State	ZIP code	County
Mailing address (if different from home address)			Apartment or suite number
City	State	ZIP code	County
Phone number		Other phone number	
Do you want to get information about this application by email? ☐ Yes ☐ No Email address:			
Preferred spoken or written language (if not English)			

Step 2. Tell us about your family.

Who do you need to include on this application?

Tell us about all the family members who live with you. If you file taxes, we need to know about everyone on your tax return. (You don't need to file taxes to get health coverage.)

DO include:

- Yourself
- Your spouse
- Your children under 21 who live with you
- Your unmarried partner who needs health coverage
- Anyone you include on your tax return, even if they don't live with you
- Anyone else under 21 who you take care of and lives with you

You DON'T have to include:

- Your unmarried partner who doesn't need health coverage
- Your unmarried partner's children
- Your parents who live with you, but file their own tax return (if you're over 21)
- Other adult relatives who file their own tax return

The amount of assistance or type of program you qualify for depends on the number of people in your family and their incomes. This information helps us make sure everyone gets the best coverage they can.

Complete Step 2 for each person in your family. Start with yourself, then add other adults and children. If you have more than two people in your family, you'll need to make a copy of the pages and attach them. You don't need to provide immigration status or a Social Security Number (SSN) for family members who don't need health coverage. We'll keep all the information you provide private and secure as required by law. We'll use personal information only to check if you're eligible for health coverage.

Step 2. Person 1 (start with yourself)

Complete Step 2 for yourself, your spouse or partner and children who live with you and anyone on your same federal income tax return if you file one. See page 1 for more information about who to include. If you don't file a tax return, remember to still add family members who live with you.

First name, middle name, last name, and suffix		Relationship to you? **SELF**
Date of birth (mm/dd/yyyy)	Sex: ☐ Male ☐ Female	Social Security Number (SSN)

We need your SSN if you want health coverage and have a SSN. Providing your SSN can be helpful if you don't want health coverage too since it can speed up the application process. We use SSNs to check income and other information to see who's eligible for help with health coverage costs. If someone wants help getting an SSN, call 1-800-772-1213 or visit www.socialsecurity.gov/. TTY users should call 1-800-325-0778.

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

(You can still apply for health insurance even if you don't file a federal income tax return.)

☐ Yes. **If yes**, please answer questions 1-3. ☐ No. **If no**, skip to question 3.

☐ Yes ☐ No 1. Will you file jointly with a spouse?
If yes, name of spouse: _____

☐ Yes ☐ No 2. Will you claim any dependents on your tax return?
If yes, list names of dependents: _____

☐ Yes ☐ No 3. Will you be claimed as a dependent on someone's tax return? **If yes**, list the name of the tax filer: _____
How are you related to the tax filer? _____

☐ Yes ☐ No Are you pregnant? **If yes**, how many babies are expected during this pregnancy? What is the due date? _____

Do you need health coverage?

(Even if you have insurance, there might be a program with better coverage or lower costs.)

☐ Yes. **If yes**, answer all the questions below. ☐ No. **If no**, skip to the income questions on page 3. Leave the rest of this page blank.

☐ Yes ☐ No 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 Are you a U.S. citizen or U.S. national?

☐ Yes ☐ No If you aren't a U.S. citizen or U.S. national, do you have eligible immigration status?

If yes, fill in your document type and ID number below.

Document type: _____ Document ID number: _____

☐ Yes ☐ No Have you lived in the U.S. since 1996?

☐ Yes ☐ No Are you or your spouse or parent a veteran or an active-duty member of the U.S. military?

☐ Yes ☐ No Are you a resident of Iowa?

☐ Yes ☐ No Do you want help paying for medical bills from the last three months?

☐ Yes ☐ No Do you live with at least one child under the age of 19, and are you the main person taking care of this child?

☐ Yes ☐ No Are you a full-time student?

☐ Yes ☐ No Were you in foster care at age 18 or older?

The following ethnicity and race questions are optional. Check all that apply.

If Hispanic or Latino, ethnicity:

- ☐ Mexican
- ☐ Mexican American
- ☐ Chicano/a
- ☐ Puerto Rican
- ☐ Cuban
- ☐ Other: _____

Race:

- ☐ White
- ☐ Black or African American
- ☐ American Indian or Alaska Native
- ☐ Asian Indian
- ☐ Chinese
- ☐ Filipino
- ☐ Japanese
- ☐ Korean
- ☐ Vietnamese
- ☐ Other Asian
- ☐ Native Hawaiian
- ☐ Guamanian or Chamorro
- ☐ Samoan
- ☐ Other Pacific Islander
- ☐ Other: _____

Current Job and Income Information

☐ **Employed.** If you're currently employed, tell us about your income. Start with **Current Job 1**.

☐ **Not employed.** Skip to the **Other Income This Month** section.

☐ **Self-employed.** Skip to the **Self-Employment** section.

Current Job 1:

Employer name and address				Employer phone number
Wages and tips (before taxes) $	☐ Hourly ☐ Twice a month	☐ Weekly ☐ Monthly	☐ Every 2 weeks ☐ Yearly	Average hours worked each week:

Current Job 2: If you have more jobs and need more space, attach another sheet of paper.

Employer name and address				Employer phone number
Wages and tips (before taxes) $	☐ Hourly ☐ Twice a month	☐ Weekly ☐ Monthly	☐ Every 2 weeks ☐ Yearly	Average hours worked each week:

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

Self-Employment: If self-employed, answer the following questions.

Type of work _____

How much net income (profits once business expenses are paid) will you get from this self-employment this month? $ _____

Other Income This Month: Check all that apply, and give the amount and how often you get it. **NOTE:** You don't need to tell us about child support, veteran's payment, or Supplemental Security Income (SSI).

☐ None

		How often?			How often?
☐ Unemployment	$ _____	_____	☐ Alimony received	$ _____	_____
☐ Pensions	$ _____	_____	☐ Net farming/fishing	$ _____	_____
☐ Social Security	$ _____	_____	☐ Net rental/royalty	$ _____	_____
☐ Retirement accounts	$ _____	_____	☐ Other income	$ _____	_____
			Type _____		

Deductions: Check all that apply, and give the amount and how often you get it. If you pay for certain things that can be deducted on a federal income tax return, telling us about them could make the cost of health coverage a little lower. **NOTE:** You shouldn't include a cost that you already considered in your answer to net self-employment.

		How often?			How often?
☐ Alimony paid	$ _____	_____	☐ Other deductions	$ _____	_____
☐ Student loan interest	$ _____	_____	Type _____		

Yearly Income: Complete only if your income changes from month to month. If you don't expect changes to your monthly income, skip to the next person.

Your total income **this year** **$**	Your total income **next year** (if you think it will be different) **$**

Step 2. Person 2

Complete Step 2 for your spouse or partner and children who live with you and anyone on your same federal income tax return if you file one. See Page 1 for more information about who to include. If you don't file a tax return, remember to still add family members who live with you.

First name, middle name, last name, and suffix		Relationship to you?
Date of birth (mm/dd/yyyy)	Sex: ☐ Male ☐ Female	Social Security Number (SSN)

We need your SSN if you want health coverage and have a SSN. Providing your SSN can be helpful if you don't want health coverage too since it can speed up the application process.

☐ Yes ☐ No Does *Person 2* live at the same address as you? **If no**, list address: _____

Does *Person 2* plan to file a federal income tax return NEXT YEAR?

(You can still apply for health insurance even if you don't file a federal income tax return.)

☐ Yes. **If yes**, please answer questions 1-3. ☐ No. **If no**, skip to question 3.

☐ Yes ☐ No 1. Will *Person 2* file jointly with a spouse? **If yes**, name of spouse: _____

☐ Yes ☐ No 2. Will *Person 2* claim any dependents on *Person 2's* tax return? **If yes**, list names of dependents: _____

☐ Yes ☐ No 3. Will *Person 2* be claimed as a dependent on someone's tax return? **If yes**, list the name of the tax filer: _____

How is *Person 2* related to the tax filer? _____

☐ Yes ☐ No Is *Person 2* pregnant? **If yes**, how many babies are expected during this pregnancy? _____

Does *Person 2* need health coverage?

(Even if they have insurance, there might be a program with better coverage or lower costs.)

☐ Yes. **If yes**, answer all the questions below. ☐ No. **If no**, skip to the income questions on page 5. Leave the rest of this page blank.

☐ Yes ☐ No Does *Person 2* 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 *Person 2* a U.S. citizen or U.S. national?

☐ Yes ☐ No If *Person 2* isn't a U.S. citizen or U.S. national, does *Person 2* have eligible immigration status? **If yes**, fill in their document type and ID number below.

Document type: _____ Document ID number: _____

☐ Yes ☐ No Has *Person 2* lived in the U.S. since 1996?

☐ Yes ☐ No Is *Person 2* or their spouse or parent a veteran or an active-duty member in the U.S. military?

☐ Yes ☐ No Is *Person 2* a resident of Iowa?

☐ Yes ☐ No Does *Person 2* want help paying for medical bills from the last three months?

☐ Yes ☐ No Does *Person 2* live with at least one child under the age of 19, and is *Person 2* the main person taking care of this child?

☐ Yes ☐ No Was *Person 2* in foster care at age 18 or older?

Please answer the following questions if *Person 2* is 22 or younger:

☐ Yes ☐ No Did *Person 2* have insurance through a job and lose it within the past three months?

If yes, end date: _____ Reason insurance ended: _____

☐ Yes ☐ No Is *Person 2* a full-time student?

The following ethnicity and race questions are optional. Check all that apply.

If Hispanic or Latino, ethnicity:

- ☐ Mexican
- ☐ Mexican American
- ☐ Chicano/a
- ☐ Puerto Rican
- ☐ Cuban
- ☐ Other: _____

Race:

- ☐ White
- ☐ Black or African American
- ☐ American Indian or Alaska Native
- ☐ Asian Indian
- ☐ Chinese
- ☐ Filipino
- ☐ Japanese
- ☐ Korean
- ☐ Vietnamese
- ☐ Other Asian
- ☐ Native Hawaiian
- ☐ Guamanian or Chamorro
- ☐ Samoan
- ☐ Other Pacific Islander
- ☐ Other: _____

Current Job and Income Information

☐ **Employed.** If you're currently employed, tell us about your income. Start with **Current Job 1**.

☐ **Not employed.** Skip to the **Other Income This Month** section.

☐ **Self-employed.** Skip to the **Self-Employment** section.

Current Job 1:

Employer name and address				Employer phone number
Wages and tips (before taxes) $	☐ Hourly ☐ Twice a month	☐ Weekly ☐ Monthly	☐ Every 2 weeks ☐ Yearly	Average hours worked each week:

Current Job 2: If you have more jobs and need more space, attach another sheet of paper.

Employer name and address				Employer phone number
Wages and tips (before taxes) $	☐ Hourly ☐ Twice a month	☐ Weekly ☐ Monthly	☐ Every 2 weeks ☐ Yearly	Average hours worked each week:

In the past year, did *Person 2*:

☐ Change jobs ☐ Stop working ☐ Start working fewer hours ☐ None of these

Self-Employment: If self-employed, answer the following questions.

Type of work _____

How much net income (profits once business expenses are paid) will you get from this self-employment this month? $ _____

Other Income This Month: Check all that apply, and give the amount and how often you get it. NOTE: You don't need to tell us about child support, veteran's payment, or Supplemental Security Income (SSI).

		How often?			How often?
☐ None					
☐ Unemployment	$ _____	_____	☐ Alimony received	$ _____	_____
☐ Pensions	$ _____	_____	☐ Net farming/fishing	$ _____	_____
☐ Social Security	$ _____	_____	☐ Net rental/royalty	$ _____	_____
☐ Retirement accounts	$ _____	_____	☐ Other income Type _____	$ _____	_____

Deductions: Check all that apply, and give the amount and how often you get it. If *Person 2* pays for certain things that can be deducted on a federal income tax return, telling us about them could make the cost of health coverage a little lower. NOTE: You shouldn't include a cost that you already considered in your answer to net self-employment.

		How often?			How often?
☐ Alimony paid	$ _____	_____	☐ Other deductions	$ _____	_____
☐ Student loan interest	$ _____	_____	Type _____		

Yearly Income: Complete only if *Person 2's* income changes from month to month. If you don't expect changes to *Person 2's* (pages 4 and 5) monthly income, don't complete.

Person 2's total income **this year**	*Person 2's* total income **next year** (if you think it will be different)
$	**$**

Step 3. American Indian or Alaska Native (AI/AN) Family Members

American Indians and Alaska Natives can get services from the Indian Health Services, tribal health programs, or urban Indian health programs. They also may not have to pay cost sharing and may get special monthly enrollment periods. Answer the following questions to make sure your family gets the most help possible.

NOTE: If you have more people to include, make a copy of this page and attach.

☐ Yes ☐ No Are you or is anyone in your family an American Indian or Alaska Native?
If yes, fill in the information below. **If no**, skip to Step 4.

AI/AN Person 1:	**AI/AN Person 2:**
Name (first, middle, last)	Name (first, middle, last)

AI/AN Person 1:		**AI/AN Person 2:**
☐ Yes ☐ No	Member of a federally recognized tribe? **If yes**, tribe name:	☐ 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 the Children's Health Insurance Program (CHIP). 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.

Step 4. Your Family's Health Coverage

Answer these questions for anyone who needs health coverage.

☐ Yes ☐ No Is anyone enrolled in health coverage now from the following? **If yes**, check the type of coverage and write the persons' names next to the coverage they have.

- ☐ Medicaid _____
- ☐ CHIP _____
- ☐ Medicare _____
- ☐ TRICARE (Don't check if you have direct care or Line of Duty) _____
- ☐ VA health care programs _____
- ☐ Peace Corps _____
- ☐ Employer Insurance
  - Name of health insurance _____
  - Policy number _____
  - Is this COBRA coverage? ☐ Yes ☐ No
  - Is this a retiree health plan? ☐ Yes ☐ No
- ☐ Other
  - Name of health insurance _____
  - Policy number _____
  - Is this a limited-benefit plan (like a school accident policy?) ☐ Yes ☐ No

☐ Yes ☐ No Has anyone moved in or out of your home in the past three months? **If yes**, answer the following questions.

Name _____

Date of birth (mm/dd/yyyy) _____

Social Security Number (SSN) _____

Relationship to you? _____

Date moved in? _____

Date moved out? _____

☐ Yes ☐ No Is anyone listed on this application offered health coverage from a job? Check yes even if the coverage is from someone else's job, such as a parent or spouse.

If yes, answer the following question and the questions in Step 5.

If no, skip to Step 6.

☐ Yes ☐ No Is this a state employee benefit plan?

Step 5. Health Coverage from Jobs

You **don't** need to answer these questions unless someone in the household is eligible for health coverage from a job. Attach a copy of this page for each job that offers coverage. 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 Step 6.

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 health 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 health coverage to employees or change the premium for the lowest-cost plan available only 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: _____

Step 6. Assistance with Completing this Application

You can choose an authorized representative.

You can give a trusted person permission to talk about this application with us, see your information, and act for you on matters related to this application, including getting information about your application and signing your application on your behalf. This person is called an "authorized representative." If you ever need to change your authorized representative, contact the Marketplace. If you're a legally appointed representative for someone on this application, submit proof with the application.

Name of authorized representative (first name, middle name, last name)		
Address		Apartment or suite number
City	State	ZIP code
Phone number		
Organization name		ID number (if applicable)

By signing, you allow this person to sign your application, get official information about this application, and act for you on all future matters with this agency.

NOTE: Your signature here does not complete the application. You **must** sign and date on page 11 to complete this application.

Your signature	Date (mm/dd/yyyy)

For certified application counselors, navigators, agents, and brokers only.

Complete this section if you're a certified application counselor, navigator, agent, or broker filing out this application for somebody else.

Application start date (mm/dd/yyyy)	
First name, middle name, last name, and suffix	
Organization name	ID number (if applicable)

Step 7. Read and Sign this Application

- By signing this application, you give your permission for DHS to share your medical and other health care records with federal and state officials.
- By signing this application, you give your permission for your medical provider to share:
  - Your medical history with an HMO, PHP, or other managed care provider.
  - Information with IME Medical Services Unit to certify a medical need for certain Medical Assistance programs or services.

    I agree to assign medical payments from a third party to the Medicaid agency for myself and others who are eligible for Medicaid for whom I legally can assign benefits. I also agree to cooperate in obtaining medical payments for third parties.
- 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. I know I may be subject to penalties under federal law if I provide false or untrue information.
- I know that I must tell the Income Maintenance Call Center if anything changes (and is different than) what I wrote on this application. I can call **1-877-347-5678** to report any changes. I understand that a change in my information could affect the eligibility for members of my household.
- I know that under federal law, discrimination isn't permitted on the basis of race, color, national origin, sex, age, sexual orientation, gender identity, or disability. I can file a complaint of discrimination by visiting www.hhs.gov/ocr/office/file.
- I confirm that no one applying for health insurance on this application is incarcerated (detained or jailed). If not, the name of the person incarcerated is: _____

We need this information to check your eligibility for help paying for health coverage if you choose to apply. We'll check your answers using information in our electronic databases and databases from the Internal Revenue Service (IRS), Social Security Administration, the Department of Homeland Security, or a consumer reporting agency. If the information doesn't match, we may ask you to send us proof.

If anyone on this application is eligible for Medicaid

- I am giving to the Medicaid agency our rights to pursue and get any money from other health insurance, legal settlements, or other third parties. I am also giving to the Medicaid agency rights to pursue and get medical support from a spouse or parent.
- Does any child on this application have a parent living outside the home? ☐ Yes ☐ No
- If yes, I know I will be asked to cooperate with the agency that collects medical support from an absent parent. If I think that cooperating to collect medical support will harm me or my children, I can tell Medicaid and I may not have to cooperate.

My right to appeal

If I think the Health Insurance Marketplace or Medicaid/Children's Health Insurance Program (CHIP) has made a mistake, I can appeal its decision. To appeal means to tell someone at the Health Insurance Marketplace or Medicaid/CHIP that I think the action is wrong, and ask for a fair review of the action. I know that I can find out how to appeal by contacting the Marketplace at **1-800-318-2596**. 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.

Renewal of coverage in future years

To make it easier to determine eligibility for health coverage in future years, your income data, including information from tax returns, can be verified electronically. You can also change your mind and not allow the Department of Human Services to check this information.

Do you want this information to be verified in the future and used to automatically renew your eligibility?

☐ Yes, renew by eligibility automatically.

How long? ☐ 5 years ☐ 4 years ☐ 3 years ☐ 2 years ☐ 1 year

☐ No, don't use my information from tax returns to renew my coverage.

Sign this application

The person who filled out Step 1 should sign this application. If you're an authorized representative, you may sign here as long as you have provided the information required in Step 6.

I agree to allow my information to be used and retrieved from data sources for this application. I have consent for all people I will list on the application that allows their information to be retrieved and used from data sources for this application.

I declare under penalty of perjury under the laws of the United States of America that the information contained in this statement of facts is true, correct, and complete.

Signature	Date (mm/dd/yyyy)

Step 8. Mail the Completed Application

Mail your signed application to:

Imaging Center 4
PO Box 2027
Cedar Rapids, Iowa 52406

If you want to register to vote, you can complete a voter registration form at:
http://sos.iowa.gov/elections/pdf/voteapp.pdf

Addendum to Application and Review Forms for Release of Information

OPTIONAL Release of Information

Help Us Help You!

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

You should know that:

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

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

RELEASE OF INFORMATION

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

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

This release does not apply to protected health information.

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

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

Iowa Department of Human Services

Application for Health Coverage and Help Paying Costs

(Solicitud de cobertura médica y asistencia para abonar el costo)

Utilice este formulario para averiguar el tipo de cobertura para el que califica

- Planes de seguro médico privado y accesible que ofrecen cobertura médica integral
- Nuevo crédito fiscal que le ayudará a abonar las primas de la cobertura médica de inmediato
- Seguro gratuito o a bajo costo de Medicaid o del programa de seguro médico para niños (*Children's Health Insurance Program*, CHIP)

Puede calificar para el programa gratuito o a bajo costo aunque gane $94,000 por año (para una familia de 4 personas).

¿Quiénes pueden utilizar este formulario de solicitud?

- Utilice este formulario para solicitar cobertura médica para toda su familia.
- Presente la solicitud aunque usted y sus hijos ya tengan cobertura médica. Podría calificar para cobertura gratuita o más barata.
- Las familias que incluyan inmigrantes pueden presentar la solicitud. Puede solicitar cobertura para sus hijos aunque usted no califique para recibirla. La presentación de la solicitud no afectará su condición inmigratoria, ni su posibilidad de convertirse en residente permanente o de conseguir la ciudadanía.
- En el caso de que otra persona le ayude a completar este formulario, la misma tendrá que completar la Sección 6.

Presente la solicitud más rápido por Internet

Presente la solicitud más rápido ingresando a: dhsservices.iowa.gov.

Qué necesita para presentar la solicitud

- Números de Social Security (o los números de los documentos de los inmigrantes legales que necesiten seguro)
- Datos de los empleadores e ingresos de todos los integrantes de su grupo familiar (por ejemplo: recibos de sueldo, formularios W-2 o declaraciones salariales e impositivas)
- Números de las pólizas actuales de seguro médico
- Información sobre cualquier tipo de seguro médico laboral que su familia tenga a su disposición

¿Por qué le solicitamos estos datos?

Le preguntamos sobre sus ingresos y otros datos para poder informarle para qué cobertura califica y si puede recibir asistencia para pagarla. **Toda la información que nos entregue será confidencial y reservada, como exige la ley.**

¿Qué debe hacer después?

Envíe la solicitud completa y firmada al domicilio que figura en la página 11. **En el caso de no tener toda la información que le solicitamos, firme y presente su solicitud de todos modos.** Nos comunicaremos con usted dentro de los próximos 30 días para darle instrucciones sobre los pasos a seguir. Recibirá instrucciones sobre los pasos a seguir para completar su cobertura médica. Si no recibe noticias dentro de los próximos 30 diás, llame al Centro de Atención de DHS al teléfono **1-855-889-7985**. Completar esta solicitud no significa que tendrá obligación de contratar la cobertura de seguro médico.

Consiga ayuda para completar la solicitud

- **Internet:** dhsservices.iowa.gov
- **Por teléfono:** Llame a nuestro centro de ayuda al **1-855-889-7985**.
- **Personalmente:** Es posible que en su área de residencia haya asesores que pueden ayudarle. Visite nuestra página de Internet o llame al **1-855-889-7985** para obtener más información.
- **En Español:** Llame sin costo a nuestro centro de asistencia al **1-855-889-7985**.
- Si necesita ayuda en otro idioma, llame al **1-855-889-7985** y dígale al representante de atención al cliente qué idioma necesita. Le conseguiremos un intérprete sin costo.
- Los usuarios de TTY deben llamar al **1-800-735-2942**.

Sección 1. Infórmenos sobre usted.

Necesitamos que un adulto de la familia sea la persona de contacto para la solicitud.

Primer nombre, segundo nombre, apellido, sufijo			
Domicilio residencial (si no tiene, déjelo en blanco.)			Nº. de departamento o habitación
Ciudad	Estado	Código postal	Condado
Dirección postal (si es diferente al domicilio residencial)			Nº. de departamento o habitación
Ciudad	Estado	Código postal	Condado
Teléfono		Otro teléfono	
¿Desea recibir información por correo electrónico? ☐ Sí ☐ No Dirección de correo electrónico:			
Idioma oral o escrito preferido (que no sea inglés)			

Sección 2. Infórmenos sobre su familia.

¿A quién debe incluir en la solicitud?

Infórmenos sobre todos los familiares que viven con usted. Si presenta declaraciones impositivas, debemos saber qué personas figuran en su declaración de ingresos. (No es obligación presentar declaraciones impositivas para conseguir cobertura médica.)

DEBE incluir a:

- Usted
- Su cónyuge
- Sus hijos menores de 21 años que viven con Ud.
- Su concubino/a que necesita cobertura médica
- Todas las personas que figuran en su declaración de ingresos, aunque no vivan con usted
- Los menores de 21 años que estén a su cargo y vivan con usted

NO ES NECESARIO que incluya a:

- Su concubino/a que no necesita cobertura médica
- Los hijos de su concubino/a
- Sus padres que viven con usted pero presentan su propia declaración de ingresos (si usted es menor de 21 años)
- Otros familiares adultos que presentan su propia declaración de ingresos

El monto de la asistencia o el tipo de programa dependerá de la cantidad de personas en su familia y sus ingresos. Estos datos nos ayudan a garantizar que todas las personas reciban la mejor cobertura posible.

Complete la Sección 2 para cada persona de su familia. Comience con usted y después agregue a los adultos y a los niños. Si en su familia hay más de dos personas, tendrá que fotocopiar las páginas y adjuntarlas. No es necesario que informe la condición inmigratoria o los números de Social Security (SSN) de los familiares que no necesitan cobertura médica. Toda la información que nos entregue será confidencial y reservada como lo exige la ley. Utilizaremos sus datos personales solo para confirmar que califica para cobertura médica.

Sección 2. **Persona 1** (comience con usted)

Complete la Sección 2 con sus datos, los de su cónyuge o concubino/a y los hijos que vivan con usted, y todas las personas que figuren en su declaración impositiva de ingresos si corresponde. Vea a quién incluir en la página 1. Si no presenta declaraciones impositivas, recuerde que debe agregar a todos los familiares que viven con usted.

Primer nombre, segundo nombre, apellido, sufijo		¿Parentesco con usted? **YO**
Fecha de nacimiento (mm/dd/aaaa)	Sexo: ☐ Masc. ☐ Fem.	Nº. de Social Security (SSN)

Necesitamos su SSN si desea cobertura médica y tiene SSN. Sería útil que informe su SSN aunque no desee solicitar cobertura médica, ya que podría acelerar el procesamiento de la solicitud. Utilizamos los SSN para verificar los ingresos y otros datos con el fin de averiguar quién califica para recibir asistencia para abonar el costo de la cobertura médica. Si alguien necesita ayuda para conseguir el SSN, llame al 1-800-772-1213 o visite www.socialsecurity.gov/. Los usuarios de TTY deben llamar al 1-800-325-0778.

¿Va a presentar la declaración impositiva de ingresos EL PRÓXIMO AÑO?
(Puede solicitar seguro médico aunque no presente la declaración impositiva de ingresos.)

☐ Sí. **Si respondió sí**, responda las preguntas 1-3. ☐ No. **Si respondió no**, continúe con la pregunta 3.

☐ Sí ☐ No 1. ¿La presentará conjuntamente con su cónyuge? **Si respondió sí**, nombre del cónyuge: _____

☐ Sí ☐ No 2. ¿Declarará personas dependientes? **Si respondió sí**, indique sus nombres: _____

☐ Sí ☐ No 3. ¿Figurará como dependiente en la declaración impositiva de otra persona? **Si respondió sí**, indique el nombre del contribuyente: _____
¿Cuál es su relación con el contribuyente? _____

☐ Sí ☐ No ¿Está embarazada? **Si respondió sí**, ¿cuántos bebés espera? ¿Cuál es la fecha probable del parto? _____

¿Necesita cobertura médica?
(Aunque ya tenga seguro, podría haber un programa con mejor cobertura o más barato.)

☐ Sí. **Responda las siguientes preguntas**. ☐ No. **Si respondió que no**, deje en blanco el resto de esta página y continúe en la página 3.

☐ Sí ☐ No ¿Tiene problemas de salud (físicos, mentales o emocionales) que le causen limitaciones en sus actividades (como bañarse, vestirse, tareas del hogar, etc.) o vive en una institución médica o un geriátrico?

☐ Sí ☐ No ¿Tiene ciudadanía o nacionalidad estadounidense?

☐ Sí ☐ No Si respondió no a la pregunta anterior, ¿su condición inmigratoria es elegible?

Si respondió Sí, informe su tipo y número de documento de identidad.

Tipo de documento: _____ Nº. de Doc. de Identidad: _____

☐ Sí ☐ No ¿Ha vivido en los Estados Unidos desde 1996?

☐ Sí ☐ No ¿Usted, su cónyuge o sus padres son veteranos de guerra o están en servicio activo en las fuerzas armadas de los Estados Unidos?

☐ Sí ☐ No ¿Es residente de Iowa?

☐ Sí ☐ No ¿Desea asistencia para pagar facturas médicas de los últimos tres meses?

☐ Sí ☐ No ¿Vive con al menos un menor de 19 años que está a su cargo?

☐ Sí ☐ No ¿Es estudiante de tiempo completo?

☐ Sí ☐ No ¿Vivía en un hogar sustituto cuando tenía 18 años de edad o más?

Las siguientes preguntas sobre origen étnico y raza son optativas. Marque todas las que correspondan.

Si es hispano/a o latino/a etnia:

- ☐ Mexicano/a
- ☐ Mexicano/a estadounidense
- ☐ Chicano/a
- ☐ Puertorriqueño/a
- ☐ Cubano/a
- ☐ Otra: _____

Raza:

- ☐ Blanca
- ☐ Negra o afroamericana
- ☐ Indígena estadounidense o nativa de Alaska
- ☐ India asiática
- ☐ China
- ☐ Filipina
- ☐ Japonesa
- ☐ Coreana
- ☐ Vietnamita
- ☐ Otras razas asiáticas
- ☐ Nativa de Hawái
- ☐ Guameña o Chamorro
- ☐ Samoana
- ☐ Otras razas de islas del Pacífico
- ☐ Otra: _____

Información sobre empleo actual e ingresos

- ☐ **Empleado.** Si tiene empleo, infórmenos sobre sus ingresos. Comience con **Empleo actual 1**.
- ☐ **Desempleado.** Vaya a la sección **Otros ingresos de este mes**.
- ☐ **Empleo autónomo.** Vaya a la sección **Empleo autónomo**.

Empleo actual 1:

Nombre y domicilio del empleador				Teléfono del empleador
Salario y propinas (bruto) $	☐ Por hora ☐ 2 veces por mes	☐ Semanalmente ☐ Mensualmente	☐ Cada 2 semanas ☐ Anualmente	Promedio de horas trabajadas por semana:

Empleo actual 2: Si tiene más empleos y necesita más espacio, adjunte otra hoja.

Nombre y domicilio del empleador				Teléfono del empleador
Salario y propinas (bruto) $	☐ Por hora ☐ 2 veces por mes	☐ Semanalmente ☐ Mensualmente	☐ Cada 2 semanas ☐ Anualmente	Promedio de horas trabajadas por semana:

En el último año, usted:

☐ Cambió de empleo ☐ Dejó de trabajar ☐ Trabajó menos horas ☐ Ninguno

Empleo autónomo: Si trabaja por su cuenta, responda las siguientes preguntas.

Tipo de trabajo _____

¿Cuál será su ingreso neto (ganancia después de pagar gastos comerciales) este mes? $ _____

Otros ingresos recibidos este mes: Marque todos los que correspondan; informe el monto y la frecuencia.
NOTA: No necesita informar sobre manutención, pagos a veteranos, ni *Supplemental Security Income* (SSI).

		Frecuencia			Frecuencia
☐ Ninguno					
☐ Desempleo	$ _____	_____	☐ Pensión alimenticia	$ _____	_____
☐ Jubilaciones	$ _____	_____	☐ Neto cultivos/pesca	$ _____	_____
☐ Social Security	$ _____	_____	☐ Neto rentas/regalías	$ _____	_____
☐ Planes de retiro	$ _____	_____	☐ Otros ingresos	$ _____	_____
			Tipo _____		

Descuentos: Marque todos los que correspondan; informe el monto y la frecuencia. Infórmenos si paga ciertas cosas que pueden ser descontadas de la declaración impositiva de ingresos, ya que el costo de la cobertura podría ser inferior. **NOTA:** No debe incluir los gastos que ya descontó en el importe neto del empleo autónomo.

		Frecuencia			Frecuencia
☐ Pensión alimenticia	$ _____	_____	☐ Otros descuentos	$ _____	_____
☐ Intereses préstamos estudiantes	$ _____	_____	Tipo _____		

Ingreso anual: Complete estos datos sólo si sus ingresos cambian de un mes a otro. Si no espera cambios en sus ingresos, vaya a la sección siguiente.

Total de ingresos **este año**	Total de ingresos del **próximo año** (si cree que será diferente)
$	**$**

Sección 2. Persona 2

Complete la Sección 2 para su cónyuge o concubino/a y los hijos que vivan con usted, y todas las personas que figuren en su declaración impositiva de ingresos, si corresponde. Vea a quién incluir en la página 1. Si no presenta declaraciones impositivas, recuerde que debe agregar a todos los familiares que viven con usted.

Primer nombre, segundo nombre, apellido, sufijo		¿Parentesco con usted?
Fecha de nacimiento (mm/dd/aaaa)	Sexo: ☐ Masc. ☐ Fem.	Nº. de Social Security (SSN)

Necesitamos su SSN si desea cobertura médica y tiene SSN. Sería útil que informe su SSN aunque no desee solicitar cobertura médica, ya que podría acelerar el procesamiento de la solicitud.

☐ Sí ☐ No ¿Esta persona vive en el mismo domicilio que usted? **Si respondió no**, indique el domicilio: _____

¿La *Persona 2* va a presentar la declaración impositiva de ingresos EL PRÓXIMO AÑO?
(Puede solicitar seguro médico aunque no presente una declaración impositiva de ingresos.)

☐ Sí. **Si respondió sí**, responda las preguntas 1-3. ☐ No. **Si respondió que no**, continúe con la pregunta 3.

☐ Sí ☐ No 1. ¿La presentará conjuntamente con su cónyuge? **Si respondió que sí**, nombre del cónyuge: _____

☐ Sí ☐ No 2. ¿Declarará personas dependientes? **Si respondió sí**, indique sus nombres: _____

☐ Sí ☐ No 3. ¿Figurará como dependiente en la declaración impositiva de otra persona? **Si respondió sí**, nombre del contribuyente: _____

¿Cuál es la relación de la *Persona 2* con el contribuyente? _____

☐ Sí ☐ No ¿Está embarazada? **Si respondió sí**, ¿cuántos bebés espera? _____

¿La *Persona 2* necesita cobertura médica?
(Aunque ya tenga seguro, podría haber un programa con mejor cobertura o más barato.)

☐ Sí. Responda las siguientes preguntas. ☐ No. Si respondió que no, deje en blanco el resto de esta página y continúe con las preguntas de la página 5.

☐ Sí ☐ No ¿Tiene problemas de salud (físicos, mentales o emocionales) que le causen limitaciones (como bañarse, vestirse, tareas del hogar, etc.) o vive en una institución médica o un geriátrico?

☐ Sí ☐ No ¿Tiene ciudadanía o nacionalidad estadounidense?

☐ Sí ☐ No Si respondió no a la pregunta anterior, ¿su condición inmigratoria es elegible? **Si respondió sí**, informe su tipo y número de documento de identidad.

Tipo de documento: _____ Nº. de Doc. de Identidad: _____

☐ Sí ☐ No ¿Ha vivido en los Estados Unidos desde 1996?

☐ Sí ☐ No ¿La *Persona 2,* su cónyuge o sus padres son veteranos de guerra o están en servicio activo en las fuerzas armadas de los Estados Unidos?

☐ Sí ☐ No ¿Es residente de Iowa?

☐ Sí ☐ No ¿Desea asistencia para pagar facturas médicas de los últimos tres meses?

☐ Sí ☐ No ¿Vive con al menos un menor de 19 años que está a su cargo?

☐ Sí ☐ No ¿Vivió con una familia sustituta cuando tenía 18 años o más?

Responda las siguientes preguntas si la *Persona 2* tiene 22 años o menos:

☐ Sí ☐ No ¿Tenía seguro a través de su empleo y lo perdió durante los últimos tres meses?

Si respondió si, fecha: _____ Motivo: _____

☐ Sí ☐ No ¿Es estudiante de tiempo completo?

Las siguientes preguntas sobre origen étnico y raza son optativas. Marque todas las que correspondan.

Si es hispano/a o latino/a etnia:

- ☐ Mexicano/a
- ☐ Mexicano/a estadounidense
- ☐ Chicano/a
- ☐ Puertorriqueño/a
- ☐ Cubano/a
- ☐ Otra: _____

Raza:

- ☐ Blanca
- ☐ Negra o afroamericana
- ☐ Indígena estadounidense o nativa de Alaska
- ☐ India asiática
- ☐ China
- ☐ Filipina
- ☐ Japonesa
- ☐ Coreana
- ☐ Vietnamita
- ☐ Otras razas asiáticas
- ☐ Nativa de Hawái
- ☐ Guameña o Chamorro
- ☐ Samoana
- ☐ Otras razas de islas del Pacífico
- ☐ Otra: _____

Información sobre empleo actual e ingresos

- ☐ **Empleado.** Si tiene empleo, infórmenos sobre sus ingresos. Comience con **Empleo actual 1**.
- ☐ **Desempleado.** Vaya a la sección **Otros ingresos de este mes**.
- ☐ **Empleo autónomo.** Vaya a la sección **Empleo autónomo**.

Empleo actual 1:

Nombre y domicilio del empleador				Teléfono del empleador
Salario y propinas (bruto) $	☐ Por hora ☐ 2 veces por mes	☐ Semanalmente ☐ Mensualmente	☐ Cada 2 semanas ☐ Anualmente	Promedio de horas trabajadas por semana:

Empleo actual 2: Si tiene más empleos y necesita más espacio, adjunte otra hoja.

Nombre y domicilio del empleador				Teléfono del empleador
Salario y propinas (bruto) $	☐ Por hora ☐ 2 veces por mes	☐ Semanalmente ☐ Mensualmente	☐ Cada 2 semanas ☐ Anualmente	Promedio de horas trabajadas por semana:

Durante el último año, la *Persona 2*:

☐ Cambió de empleo ☐ Dejó de trabajar ☐ Trabajó menos horas ☐ Ninguno de los anteriores

Empleo autónomo: Si trabaja por su cuenta, responda las siguientes preguntas.

Tipo de trabajo _____

¿Cuál será su ingreso neto (ganancia después de pagar gastos comerciales) este mes? $ _____

Otros ingresos recibidos este mes: Marque todos los que correspondan; informe el monto y la frecuencia.
NOTA: No necesita informar sobre manutención, pagos a veteranos, ni *Supplemental Security Income* (SSI).

		Frecuencia			Frecuencia
☐ Ninguno					
☐ Desempleo	$ _____	_____	☐ Pensión alimenticia	$ _____	_____
☐ Jubilaciones	$ _____	_____	☐ Neto cultivos/pesca	$ _____	_____
☐ Social Security	$ _____	_____	☐ Neto rentas/regalías	$ _____	_____
☐ Planes de retiro	$ _____	_____	☐ Otros ingresos	$ _____	_____
			Tipo _____		

Descuentos: Marque todos los que correspondan; informe el monto y la frecuencia. Infórmenos si paga ciertas cosas que pueden ser descontadas de la declaración impositiva de ingresos, ya que el costo de la cobertura podría ser inferior. **NOTA:** No debe incluir los gastos que ya descontó en el importe neto del empleo autónomo.

		Frecuencia			Frecuencia
☐ Pensión alimenticia	$ _____	_____	☐ Otros descuentos	$ _____	_____
☐ Intereses préstamos estudiantes	$ _____	_____	Tipo _____		

Ingreso anual: Complete estos datos sólo si los ingresos de esta persona cambian de un mes a otro. Si la *Persona 2* no espera cambios en sus ingresos mensuales (páginas 4 y 5), no complete estos datos.

Total de ingresos de la *Persona 2* **este año**	Total de ingresos del **próximo año** (si cree que serán diferentes)
$	**$**

Sección 3. Miembros de la familia que son aborígenes estadounidenses o nativos de Alaska (AI/AN)

Los aborígenes estadounidenses y los nativos de Alaska pueden recibir atención médica de *Indian Health Services*, programas médicos tribales o de programas médicos urbanos para aborígenes. Además, es posible que no deban pagar costos compartidos y que puedan obtener períodos especiales de inscripción mensual. Responda las siguientes preguntas con el fin de que su familia reciba toda la asistencia posible.

NOTA: Si tiene que incluir a más personas, haga una copia de esta página y adjúntela.

☐ Sí ☐ No ¿Usted o alguien de su familia es aborigen estadounidense o nativo de Alaska?
Si respondió sí, complete los siguientes datos. **Si respondió no**, vaya a la Sección 4.

Persona 1 AI/AN:	**Persona 2 AI/AN:**
Nombre (primer nombre, segundo nombre, apellido)	Nombre (primer nombre, segundo nombre, apellido)

Persona 1 AI/AN:			**Persona 2 AI/AN:**	
☐ Sí	☐ No	¿Es miembro de una tribu con reconocimiento federal? **Si respondió que sí**, nombre de la tribu:	☐ Sí	☐ No
☐ Sí	☐ No	¿Alguna vez obtuvo servicios del *Indian Health Service*, de un programa médico tribal, o de un programa médico urbano para aborígenes, o a través de remisiones hechas por estos programas?	☐ Sí	☐ No
☐ Sí	☐ No	**Si respondió no**, ¿es elegible para alguno de dichos servicios?	☐ Sí	☐ No
$ Frecuencia		Determinados ingresos no son contabilizables para Medicaid o *Children's Health Insurance Program* (CHIP). Indique todos los ingresos (importe y frecuencia) informados en su solicitud que incluyan dinero de las siguientes fuentes:	$ Frecuencia	

- Pagos per cápita de una tribu, provenientes de recursos naturales, derecho de uso, alquileres o regalías.
- Pagos por recursos naturales, agricultura, ganadería, pesca, alquileres o regalías de tierras designadas como fideicomisos por el *Department of Interior* (incluso reservas y antiguas reservas).
- Dinero proveniente de la venta de artículos con valor cultural.

Sección 4. La cobertura médica de su familia

Responda estas preguntas sobre todas las personas que necesiten cobertura médica.

☐ Sí ☐ No ¿Alguien está inscripto actualmente en cobertura médica de los siguientes programas? Si respondió si, marque el tipo de cobertura y escriba sus nombres al lado de la cobertura que tienen.

- ☐ Medicaid _____
- ☐ CHIP _____
- ☐ Medicare _____
- ☐ TRICARE (No marcar si tiene atención directa o en cumplimiento del deber) _____
- ☐ Programas para Veteranos _____
- ☐ Cuerpos de Paz _____
- ☐ Seguro del empleador
  - Nombre del seguro médico _____
  - Número de póliza _____
  - ¿Es cobertura COBRA? ☐ Sí ☐ No
  - ¿Es un plan médico para jubilados? ☐ Sí ☐ No
- ☐ Otra
  - Nombre del seguro médico _____
  - Número de póliza _____
  - ¿Es un plan de beneficios limitados (como una póliza por accidentes en una escuela)? ☐ Sí ☐ No

☐ Sí ☐ No ¿Alguien se mudó a su hogar o se fue de su hogar durante los últimos tres meses?
Si respondió que sí, responda las siguientes preguntas.

Nombre _____

Fecha de nacimiento (mm/dd/aaaa) _____

N°. de Social Security (SSN) _____

¿Parentesco con usted? _____

Fecha en que se mudó: _____

Fecha en que se fue: _____

☐ Sí ☐ No ¿A alguna de las personas mencionadas en esta solicitud le ofrecieron cobertura médica en su empleo? Marque Sí aunque la cobertura provenga del empleo de otra persona, como sus padres o su cónyuge.

Si respondió sí, responda la siguiente pregunta y las preguntas de la Sección 5.

Si respondió no, continúe en la Sección 6.

☐ Sí ☐ No ¿Es un plan de beneficios para empleados estatales?

Sección 5. Cobertura médica a través de empleos

No es necesario responder estas preguntas a menos que algún miembro de la familia califique para cobertura médica en su empleo. Adjunte una copia de esta página para cada empleo que ofrezca cobertura. Infórmenos sobre el **empleo** que ofrece cobertura.

Datos del empleado. El empleado debe completar esta sección.

Nombre del empleado (primer nombre, segundo nombre, apellido)	Nº. de Social Security

Datos del empleador. Pídale estos datos a su empleador.

Nombre del empleador	Nº. de identificación del empleador (EIN)	
Domicilio del empleador (Las notificaciones se enviarán a este domicilio)	Teléfono del empleador	
Ciudad	Estado	Código postal
¿Con quién podemos comunicarnos para averiguar sobre la cobertura médica laboral de este empleado?		
Teléfono (si es diferente al anterior)	Dirección de correo electrónico	

☐ Sí ☐ No ¿Califica actualmente para la cobertura que ofrece este empleador o será elegible en los próximos tres meses? **Si respondió sí**, complete los siguientes datos. **Si respondió no**, siga en la Sección 6.

Si está en el período de espera o de prueba, ¿cuándo podrá inscribirse en la cobertura?

_____

Indique los nombres de las personas que califican para cobertura a través de este empleo.

_____

Plan médico. Infórmenos sobre el **plan médico** que ofrece este empleador.

☐ Sí ☐ No ¿El plan médico cubre al cónyuge o a los dependientes del empleado?
Si respondió sí, ¿a quién cubre? ☐ Cónyuge ☐ Dependientes

☐ Sí ☐ No Un plan médico laboral cumple con "la norma de valor mínimo" si la proporción cubierta por el plan no es inferior al 60% del costo total de los beneficios permitidos. ¿El empleador ofrece un plan médico que cumple con la norma de valor mínimo?

☐ Sí ☐ No ¿El plan de menor costo que cumple con "la norma de valor mínimo" ofrece un programa de salud para **el empleado únicamente**? (No incluya planes familiares.)

Si respondió sí, ¿cuánto tendría que pagar en primas después de recibir el descuento máximo por programas para dejar de fumar? (No deduzca otros descuentos del programa.)

$ _____

¿Con qué frecuencia?
☐ Semanal ☐ Cada dos semanas ☐ Dos veces por mes ☐ Trimestral ☐ Anual

Cambios del empleador. ¿Qué cambios introducirá el empleador para el próximo plan anual (si sabe)?

☐ El empleador no ofrecerá cobertura médica

☐ El empleador comenzará a ofrecer cobertura médica a los empleados o modificará la prima para el plan de menor costo sólo para los empleados que cumplan con la norma de valor mínimo. (La prima debe reflejar el descuento por los programas de salud.)

¿Cuánto tendrá que pagar el empleado por las primas de ese plan? $ _____

Frecuencia ☐ Semanal ☐ Cada dos semanas ☐ Dos veces por mes ☐ Trimestral ☐ Anual

Fecha del cambio: _____

Sección 6. Ayuda para completar este formulario de solicitud

Puede elegir a un representante autorizado.

Puede darle permiso a una persona de su confianza para que hable con nosotros sobre esta solicitud, vea sus datos y actúe como su representante en los asuntos relacionados con esta solicitud, incluso para conseguir información sobre su solicitud y firmarla en su nombre. A dicha persona la llamamos "representante autorizado". En el caso de que quiera cambiar a su representante autorizado, comuníquese con Marketplace. Si usted representa legalmente a alguna de las personas que figuran en esta solicitud, presente el comprobante junto con la solicitud.

Nombre del representante autorizado (primer nombre, segundo nombre, apellido)		
Domicilio		Nº de departamento o habitación
Ciudad	Estado	Código postal
Teléfono		
Nombre de la organización		Nº. de ID (si corresponde)

Por medio de su firma, autoriza a esta persona a firmar su solicitud, a obtener información oficial sobre esta solicitud y a actuar en su nombre en todos los asuntos futuros con esta agencia.

NOTA: Su firma aquí no significa que ha terminado de completar la solicitud. **Debe** firmar y escribir la fecha en la página 11 para completar la solicitud.

Su firma	Fecha (mm/dd/aaaa)

Solo para asesores, navegadores, agentes y corredores acreditados.

Complete esta sección si usted es un asesor, navegador, agente o corredor acreditado para completar esta solicitud en representación de otra persona.

Fecha de inicio de la solicitud (mm/dd/aaaa)	
Primer nombre, segundo nombre, apellido, sufijo	
Nombre de la organización	Nº. de ID (si corresponde)

Sección 7. Lea y firme este formulario de solicitud

- Al firmar esta solicitud, usted autoriza a DHS a compartir sus registros médicos y otros documentos sobre atención médica con funcionarios federales y estatales.
- Al firmar esta solicitud, usted autoriza a su prestador de servicios médicos a compartir:
  - Su historia clínica con una HMO, PHP u otros prestadores de atención médica gestionada.
  - Información con la unidad de servicios médicos IME con el fin de certificar la necesidad de tratamiento médico para ciertos programas y servicios de asistencia médica.

    Acepto asignar pagos realizados por terceros a Medicaid en mi nombre y en el de otras personas que sean elegibles para Medicaid y para quienes estoy legalmente autorizado a asignar beneficios. Además, acepto cooperar para obtener pagos de terceros para servicios médicos.
- Al firmar esta solicitud, certifico bajo pena de cometer perjurio y dar falso testimonio que mis respuestas son correctas y completas a mi leal saber y entender, inclusive los datos provistos sobre la ciudadanía y la condición inmigratoria de cada uno de los integrantes de mi grupo familiar para los que solicito beneficios. Es de mi conocimiento que en el caso de presentar información falsa o ficticia estaré sujeto a sanciones bajo la ley federal.
- Es de mi conocimiento que debo informar al centro telefónico de *Income Maintenance* si algo cambia y es diferente a lo que escribí en esta solicitud. Debo llamar al **1-877-347-5678** para informar dichos cambios. Entiendo que dichos cambios podrían afectar la elegibilidad de los integrantes de mi grupo familiar.
- Es de mi conocimiento que, conforme a la ley federal, se prohíbe cualquier tipo de discriminación con respecto a raza, color, país de origen, sexo, edad, orientación sexual, identidad de género y discapacidad. Puedo presentar una queja por discriminación en www.hhs.gov/ocr/office/file.
- Confirmo que ninguna de las personas para las que se solicita seguro médico en este formulario se encuentra en prisión (detenido o preso).
  De lo contrario, la persona que se encuentra en prisión se llama: _____

Necesitamos estos datos para verificar su elegibilidad para recibir asistencia con el fin de abonar la cobertura médica si decide solicitarla. Verificaremos sus respuestas utilizando nuestras bases de datos informáticos y las bases de datos de *Internal Revenue Service* (IRS), *Social Security Administration*, *Department of Homeland Security*, y de otras agencias que suministran informes crediticios. En el caso de que los datos no coincidan, le pediremos que nos envíe comprobantes.

En el caso de que alguna de las personas mencionadas en esta solicitud califique para Medicaid

- Le cedo a la agencia Medicaid nuestro derecho a reclamar y recibir dinero de otros seguros médicos, acuerdos judiciales y terceros. Además, le cedo a la agencia Medicaid el derecho a reclamar y conseguir manutención de cónyuges o progenitores para atención médica.
- ¿Alguno de los padres de los niños mencionados no viven en el mismo hogar?
  ☐ Sí ☐ No
- Si la respuesta anterior es afirmativa, es de mi conocimiento que me pedirán que coopere con la agencia encargada de cobrarle manutención para atención médica al padre ausente. En el caso de creer que eso me perjudicaría a mí y a mis hijos, puedo informárselo a Medicaid y no tendría que cooperar.

Mi derecho a apelar

Puedo presentar una apelación en el caso de creer que el seguro médico Marketplace o Medicaid/Children's Health Insurance Program (CHIP) han cometido un error. Apelar significa contarle a alguien del seguro médico Marketplace o Medicaid/CHIP que creo que la resolución tomada es errónea y solicitar una revisión justa de la misma. Entiendo que para averiguar cómo apelar, me puedo comunicar con Marketplace al teléfono **1-800-318-2596**. También entiendo que otra persona puede actuar como mi representante durante el proceso. Entiendo que otra persona me puede representar durante el procedimiento y que me explicarán mi elegibilidad y otros datos importantes.

Renovación de la cobertura en los años sucesivos

Podemos verificar electrónicamente los datos sobre sus ingresos y sus declaraciones impositivas con el fin de facilitar la determinación de su elegibilidad para cobertura médica en el futuro. Además, puede cambiar de opinión y no dar su autorización para que Department of Human Services verifique dichos datos.

¿Desea que sus datos sean verificados y utilizados para renovar su elegibilidad automáticamente en el futuro?

☐ Sí, autorizo que mi elegibilidad sea renovada automáticamente.

¿Por cuánto tiempo? ☐ 5 años ☐ 4 años ☐ 3 años ☐ 2 años ☐ 1 año

☐ No, no autorizo que se utilice información de mis declaraciones impositivas para renovar mi cobertura.

Firme esta solicitud

La persona que completó la Sección 1 debe firmar esta solicitud. Si usted es un representante autorizado, puede firmar aquí siempre y cuando haya completado la Sección 6.

Acepto y autorizo que mis datos personales sean utilizados y recuperados de fuentes de datos con el fin de tramitar mi solicitud. Tengo el consentimiento de todas las personas que nombraré en la solicitud para que sus datos personales sean utilizados y recuperados de fuentes de datos con el fin de tramitar esta solicitud.

Certifico bajo pena de cometer perjurio conforme a las leyes de los Estados Unidos de Norteamérica que la información contenida en esta declaración de hechos es verdadera, correcta y completa.

Firma	Fecha (mm/dd/aaaa)

Sección 8. Envíe la solicitud por correo

Envíe la solicitud firmada por correo a:

Imaging Center 4
PO Box 2027
Cedar Rapids, Iowa 52406

Si desea registrarse para votar, puede completar el formulario de registro en:
http://sos.iowa.gov/elections/pdf/voteapp.pdf

Addendum to Application and Review Forms for Release of Information

(Adenda de los Formularios de Solicitud y Revisión para Divulgación de Información)

Divulgación de Información OPCIONAL

¡Ayúdenos a ayudarle!

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

Debe saber que:

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

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

DIVULGACIÓN DE INFORMACIÓN
(Release of Information)

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

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

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

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

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

Case Activity Report, Form 470-0042

Purpose

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

Source

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

Completion

Facility staff must complete the form when:

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

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

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

Distribution

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

Nursing facilities (NF), hospice, community ICFs/ID, skilled nursing facilities (SNF), and swingbeds shall mail, email or fax the form to the address below and keep a copy.

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

Fax: 515-564-4040 email: facilities@dhs.state.ia.us

DHS Investigative Referral to DIA, Form 470-5130

Purpose	Form 470-5130 is designed to make a referral to the Department of Inspections and Appeals (DIA).
Source	Workers can complete this form on line using the template on the DHS Intranet eForms web page.
Completion	Complete this form after receiving information that alleges fraudulent behavior.
Distribution	Forward an electronic copy of the form to DIA at welfare.fraud@dia.iowa.gov. Upload a copy of the form to the client's file in the electronic case file.
Data	Complete the following fields: ♦ Date of referral ♦ Your name ♦ Worker county and worker number ♦ Worker telephone number ♦ Worker email ♦ Client first and last name ♦ State identification number ♦ Client telephone number ♦ Client address ♦ County of client residence ♦ Case number ♦ Answer the yes and no questions ♦ Select all applicable programs ♦ Reporter name and number (if available) ♦ Anonymous (yes or no) ♦ Referral type ♦ Allegations and comments

Case Number

Current Date

Iowa Department of Human Services

DHS Investigative Referral to DIA

Date Referred	Worker Name	Worker County/Number

Worker Phone Number	Worker Email

Client First Name	Client Last Name	State ID	Client Phone Number

Client Address	County of Residence

Is client noncooperative with DIA at this time? ☐ Yes ☐ No

Is this referral generated from law enforcement? ☐ Yes ☐ No

Known safety concerns? ☐ Yes ☐ No

Programs questioned (select all that apply):

☐ Family Investment Program (FIP)
☐ Food Assistance (FA)
☐ Child Care Assistance Client (CCA-C)
☐ Child Care Assistance Provider (CCA-P)
☐ Medicaid (T-XIX)
☐ Transportation (TRANS)
☐ IowaCare (IC)
☐ ***hawk-i*** (HI)
☐ Other (OT) (explain): _____

Reporter Name (if available)	Anonymous? ☐ Yes ☐ No	Reporter Number (if available)

Referral Type

Allegation/Comments

Iowa Department of Human Services

Disposal of Assets Penalty Notice of Decision

Date:

Your application for Medicaid payment of long-term care services has been denied because you transferred assets for less than fair market value. You have been found to be ineligible from , through . This was determined by dividing the uncompensated value of the assets that were transferred by the amount of the average statewide cost to a private-pay resident in effect for the time of application, as shown below. If your application is approved for other Medicaid services, you will receive a separate notice.

Penalty Calculation

Step 1	Uncompensated transfer amount		**Step 3**	Uncompensated transfer amount	
	÷ Statewide average cost			– Penalty amount for whole months	
	Number of months penalty			Partial month penalty amount	
Step 2	Statewide average cost		**Step 4**	Partial month penalty amount	
	× Number of whole months penalty			÷ Daily rate	
	Penalty amount for whole months			Number of additional days penalty	

If you believe imposing this penalty will result in undue hardship, please inform your worker. You must provide evidence that all of the following conditions are met:

- Application of the transfer of asset penalty would deprive you of medical care such that your health or life would be endangered or you would be deprived of food, clothing, shelter, or other necessities of life.
- You or your spouse has exhausted all means to recover the resource, including legal remedies and consultation with an attorney.
- Your remaining available resources (after the attribution for any community spouse) are less than the monthly statewide average cost of nursing facility services to a private-pay resident, counting the value of all resources except for:
  - Your home, if occupied by a dependent relative or if a licensed physician verifies that you are expected to return home.
  - Household goods.
  - A vehicle you require for transportation.
  - Funds for burial of $4,000 or less.

441 IAC 75.23 Disposal of Assets for Less Than Fair Market Value

Worker's Name	Worker's Phone Number

You Have the Right to Appeal

What is an appeal?

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

How do I appeal?

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

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

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

How long do I have to appeal?

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

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

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

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

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

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

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

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

How will I know if I get a hearing?

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

Can I have someone else help me in the hearing?

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

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

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

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

Health Insurance Premium Payment Program Application, Form 470-2875 or 470-2875(S)

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

Data

The form is self-explanatory.

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

Pages 135 and 136 are reserved for future use.

HIPP Medical History Questionnaire, Form 470-2868

Purpose	Form 470-2868 is designed to secure additional information regarding specific health-related circumstances of a household for the Health Insurance Premium Payment (HIPP) Unit. The form is used to establish whether the family's Medicaid utilization may be higher than average.
Source	Form 470-2868 is system-generated or produced by the HIPP Unit.
Completion	The system or the HIPP Unit shall complete the top section of the form. Upon receipt of the form, the client ~~c~~hecks all conditions that apply. If yes is checked, list the name of the person with this condition and how often medical care is needed to treat the condition. The client is also instructed to sign, date, and provide their email address and phone numbers on the form. The HIPP worker refers to this form when the computer system's cost-effective recommendation is to "not buy" the health insurance policy. The computer system's cost-effective recommendation is based on the average Medicaid utilization of a family with the same demographic data. If the form indicates that the family's Medicaid utilization may be higher than average, the policy may still be cost-effective.
Distribution	Send a copy of the form to the policyholder to complete and return. Keep a control copy.
Data	The system or the HIPP worker enters the: ♦ Date. ♦ Policyholder's name. ♦ Due date for returning the form. ♦ The HIPP worker's name, phone extension, and email address. The policyholder answers the questions about: ♦ Medical conditions of household members. ♦ Institutional residence.

Iowa Department of Human Services

HIPP MEDICAL HISTORY QUESTIONNAIRE

Date:
Due Date:

To see if the HIPP program can pay for health insurance please answer the following questions regarding the health of the people who get Medicaid in your household. Check all conditions that apply. If yes is checked, list the name of the person with this condition and how often medical care is needed to treat the condition.

Condition			**If yes, list name of Medicaid-eligible member with this condition**	**How often is medical care required?**
ADHD	☐ Yes	☐ No		
Alcoholism/Drug Addiction	☐ Yes	☐ No		
Asthma or Breathing Problems	☐ Yes	☐ No		
Blood Disorder	☐ Yes	☐ No		
Cancer	☐ Yes	☐ No		
Diabetes	☐ Yes	☐ No		
Heart Condition	☐ Yes	☐ No		
HIV Positive/Acquired Immune Deficiency Syndrome (AIDS)	☐ Yes	☐ No		
Kidney or Liver Disorder	☐ Yes	☐ No		
Organ Transplant	☐ Yes	☐ No		
Other Disease/Condition	☐ Yes	☐ No		
Pregnancy List due date:	☐ Yes	☐ No		
Scoliosis or Back Injury	☐ Yes	☐ No		
Seizure Disorder	☐ Yes	☐ No		
Stroke or Head Injury	☐ Yes	☐ No		
Other Disease/Condition Requiring Treatment (list)	☐ Yes	☐ No		
Other comments:				

Are any of the persons covered by Medicaid periodically institutionalized or currently living in an institution (mental health institution, nursing home, hospital, etc.)? ☐ Yes ☐ No
If yes, list the name of the person and the reason they are institutionalized. _____

Your Signature	Date
Email Address	
Home Phone	Other Phone

Questions or need help? Toll Free 1-888-346-9562 Des Moines area (515) 974-3283
Fax (515) 725-0725
HIPP Unit, PO Box 36476, Des Moines, IA 50315-9907

Page 146 is reserved for future use.

Iowa Department of Human Services

ICF/ID Resident Care Agreement

This contract is between the Iowa Department of Human Services (DHS),

Resident _____,

and _____, an intermediate care facility for persons with intellectual disabilities, agree that:

- Effective: _____, the resident was admitted to the facility.
- The facility shall provide the resident with personal, medical, and habilitative services as specified in the *Medicaid Provider Manual for Intermediate Care Facilities for Persons with Intellectual Disabilities*.
- The resident (or the resident's legal representative) shall pay directly to the facility the amount *of client participation determined by DHS*. DHS shall pay the balance of the allowable payment for care directly to the facility.
- Any overpayments to the facility shall be treated in the manner specified in Item C. 2., Section II of the agreement for intermediate care facilities for persons with intellectual disabilities existing between the facility and DHS.
- Should the facility maintain the personal needs account for the resident, this function shall be performed in accordance with procedures outlined in the *Medicaid Provider Manual for Intermediate Care Facilities for Persons with Intellectual Disabilities*.
- Resident discharge or transfer shall be voluntary or otherwise justified, and may only be effected following appropriate notification and consultation with DHS, the resident (and legal representative or family), and the attending physician. The facility shall coordinate any alternate placement arrangements.
- If a resident is discharged from the facility on other than the last day of the month, a refund based on the daily payment rate must be made to the resident or the resident's legal representative of estate for any prepaid days of care not received.

By signing this contract the facility, the resident, and DHS accept all its provisions, none of which shall limit the responsibilities of the signing parties to abide by current or subsequently imposed laws, rules, and regulations.

Iowa Department of Human Services Signature	Date
Intermediate Care Facility Signature and Title	Date
Address	
Resident Signature (or Representative)	Date
Medicaid #	

ICF/ID Resident Care Agreement, Form 470-0374

Purpose

The *ICF/ID Resident Care Agreement* is a contract between the facility, the resident, and the Department spelling out the duties, rights, and obligations of all parties concerned.

Source

Complete form 470-0374 on line using the template on the DHS Intranet eForms web page.

Completion

The Department worker prepares three copies of the agreement for signatures when a resident:

- Is approved for Medicaid ICF/ID payment,
- Is reinstated after one month or more of ineligibility, or
- Transfers between intermediate care facilities for persons with intellectual disabilities.

Either the resident or the facility may sign first. A legal guardian may sign for the resident without the need for the signature of a witness.

If a resident is unable to sign the form, a letter "X" or the resident's thumbprint shall be affixed to the line reserved for the resident's name. In such cases, the signatures of two witnesses are necessary for an "X" signature and one witness for a thumbprint.

Review the document for completeness and revisions and sign last. Do not accept revisions in the language of the agreement. The Bureau of Long-Term Care shall sign the agreement on behalf of the Department for residents of Woodward and Glenwood State Resource Centers.

Distribution

After all signatures are obtained, return one copy of the form to the facility and to the resident. File one copy in the member's case record.

Data

Enter the date of the contract (date of Medicaid eligibility in the facility), and the member's and the facility's names.

IPV Referral Cover Sheet, Form 470-3035

Purpose	Form 470-3035 transmits a request for an administrative disqualification hearing to determine if a client has committed an intentional program violation (IPV) under the Food Assistance program.
Source	Complete the form on line using the template available on the DHS Intranet eForms web page.
Completion	The IM worker responsible for submitting the IPV referral completes the form. When requesting administrative disqualification on more than one member of the same household, complete a separate form and documentation for each referral. Attach: ♦ A summary of the alleged violation. ♦ Copies of documentary evidence supporting the allegation. ♦ A copy of form 470-0464, *Overpayment Recovery Information Input*, or the *Overpayment Recovery Information Input Summary* (from the direct claim entry screen), if applicable. Each referral shall contain a summary and supporting evidence. Do not send in multiple referrals with one set of evidence. You need to attach a summary and evidence for each referral.
Distribution	The worker forwards the referral packet to the worker's supervisor (or designee) for approval and signature. Submit the signed original with the rest of the referral information to the DHS Appeals Section, 5th Floor, 1305 E. Walnut Street, Des Moines, IA 50319-0114. Keep a copy of the entire referral packet in the case file.
Data	**Name:** Enter the first name, middle name (if known), and last name of the person being referred for fraud. If appellant has changed names, indicate previous names in this section also. **Date:** Enter the date of the referral. **Address:** Enter the complete address of the person being referred. If the person is no longer receiving benefits, list the last known address.

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

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

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

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

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

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

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

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

Pages 164 through 170 are reserved for future use.

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

Purpose

Form 470-4392, *Level of Care Certification for HCBS Waiver Program*, provides a mechanism for a medical professional to report a Medicaid member's admission, change in condition, or annual assessment for level of care.

Providers are encouraged to conduct the level of care process during a routine or preventative office visit.

Source

This form is available on the DHS website under provider forms. Department staff can issue the form on line using the template on the DHS Intranet eForms web page.

Completion

A medical professional (MD, DO, ARNP, or PA) must complete the form when:

- A Medicaid member is going to receive services provided in their home or community.
- A Medicaid member has a significant change in condition.
- A Medicaid member has an annual assessment.

The IME Medical Services Unit will make a level of care determination upon receipt of the form.

Distribution

The medical professional completing the form or others involved in assisting in arranging the services (i.e., facility staff, hospital discharge planner, case manager, or family member) shall:

- Fax the form to the IME Medical Services Unit at 515-725-1349 or
- Email the form to imeltc@dhs.state.ia.us and
- Provide a copy to the Medicaid member.

Data

Today's Date: The actual date the form is completed in MM/DD/YY format.

Iowa Medicaid Member Name: The Medicaid member's first, middle initial, and last name as it appears on the eligibility card.

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

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

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

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

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

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

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

Lost Form Request, Form 470-0272

Purpose

Form 470-0272 is used to request certain system-generated forms that are not received or are received and misplaced. A replacement document has the sequence number of the last document.

Source

Complete form 470-0272 on line using the template on the DHS Intranet eForms web page.

Completion

When you do not receive a form, determine if sufficient time for processing has elapsed before submitting a *Lost Form Request*.

Complete this form to request replacement of the following forms from the MMIS Medically Needy Subsystem:

- The *Eligibility Status Turnaround Document* (ESTD),
- The *Bill Status Turnaround Document* (BSTD), or
- The *Notice of Spenddown Status* (NOSS), for cases that have a spenddown.

If screens LF01 and IEV2 are not available, you can also use this form to request forms from:

- The Automated Benefit Calculation (ABC) system.
- The Income and Eligibility Verification System (IEVS).

Distribution

For forms from the Medically Needy subsystem, send the form to the IME Medically Needy Unit using the 'send' button on the template. Enter the e-mail address listed on the form.

For IEVS or ABC system forms, submit the form to the Quality Assurance Unit in the Division of Data Management, Hoover State Office Building.

Data

Mark the box indicating the form requested. For each request for replacement, complete the:

- Identifying numbers
- Worker number
- Date
- County
- Signature

MAC Income Worksheet, Form 470-2527

Purpose

The *MAC Income Worksheet* is used to calculate income when determining eligibility for the mothers and children coverage group for retroactive periods and recoupment purposes.

Source

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

Completion

The IM worker completes the form when determining eligibility for:

- Months in the retroactive period.
- Past months in computing an overpayment. NOTE: Page 2 of the form refers only to current poverty levels. For recoupments, the income calculated on page 1 must be compared to the poverty levels in effect at the time of the overpayment.

Distribution

Keep the original in the case record as part of the permanent record. Send a copy of the form to the client with the computation of the overpayment.

Data

Computation is explained section by section. (Click on the ¶ sign to see what boxes are calculated.)

Section I:

If there is a responsible person in the home (stepparent, self-supporting parents, etc.), use Section I to compute the portion of that person's income that is attributable to the eligible group. Enter the following:

- Gross income.
- Any applicable child-care expenses.
- Unearned income.
- Amounts paid to people who are not living in the home but are claimed for income tax purposes.
- Child support paid to people outside the home.
- Diversion for the responsible parent and dependents.

Iowa Department of Human Services

MAC Income Worksheet

Case Name:	Case Number:	Date:
Application Month:	Benefit Month:	

I. RESPONSIBLE PERSON INCOME (stepparent, self-supporting parents, etc.)

EARNED INCOME EMPLOYEE: EMPLOYER:

Date Paid	Gross	Tips	Total
	$	$	$
	$	$	$
	$	$	$
	$	$	$
	$	$	$
	$	$	$
	Total gross earnings		$

20% earned income deduction	-	
Child care expenses	-	
Unearned income	+	
Child support, alimony or other payments to people outside the home	-	
RP/dependent diversion	-	
A. Responsible Person Income	=	$

II. EARNED INCOME

EMPLOYEE: EMPLOYER:

Date Paid	Gross	Tips	Total
	$	$	$
	$	$	$
	$	$	$
	$	$	$
	$	$	$

Total gross earnings	=	$
20% earned income deduction	-	
Adult/child care expenses	-	
Court-ordered child support paid to people outside the home	-	
B. Countable Earned Income	=	$

EMPLOYEE: EMPLOYER:

Date Paid	Gross	Tips	Total
	$	$	$
	$	$	$
	$	$	$
	$	$	$
	$	$	$

Total gross earnings	=	$
20% earned income deduction	-	
Adult/child care expenses	-	
Court-ordered child support paid to people outside the home	-	
C. Countable Earned Income	=	$

III. UNEARNED INCOME

Unearned income of children	$	
Unearned income of parent	+	
Child support: $ minus exemption	+	
Court-ordered child support paid to persons outside the home (any remaining amount)	-	
D. Total Unearned Income	=	$

E. Total Countable Income Subtotal (Total of boxes A through D) = $

E. Total countable income from previous page: $ Household size:

Check the box for the applicable period:

☐ **Poverty Levels *After* April 1, 2014**

Maximum income limit at 133% of poverty (If income does not exceed this amount, children age 1 through age 18 are eligible.) $

Maximum income limit at 300% of poverty (If income does not exceed this amount, pregnant women and infants under age one are eligible.) $

Note: Consider an unborn child in determining the size of the household. Do not consider the stepparent in determining the size of the household if the stepparent is not included in the eligible group.

☐ **Poverty Levels *Before* April 1, 2014**

Maximum income limit at 133% of poverty (If income does not exceed this amount, children age 1 through age 18 are eligible.) $

Maximum income limit at 300% of poverty (If income does not exceed this amount, pregnant women and infants under age one are eligible.) $

Note: Consider an unborn child in determining the size of the household. Do not consider the stepparent in determining the size of the household if the stepparent is not included in the eligible group.

Notes:

The amount left over is the total income of the responsible parent that is considered toward the eligible group (Box A).

Section II: To arrive at the countable earned income (Box B and Box C), enter each person's:

- Earned income received in the month.
- Allowable child or adult care expenses.
- Court-ordered child support paid to a person outside the home.

Section III: To arrive at the total unearned income (Box D), enter:

- The unearned income of children.
- The unearned income of parents.
- The countable child support received.
- Court-ordered child support paid to people outside the home.

Boxes A, B, C, and D are added together to arrive at the total countable income (Box E on page 2). Enter the household size.

Check the box applicable to the period in question. (All boxes may be checked.) Double-click on the calculation box to have the template calculate the remaining figures.

Do not enter a poverty level on TD03. Enter the income and deductions on the BCWs. The system will calculate the poverty level and enter it in the POV field.

Do not enter income on the ABC system for a retroactive period or a recoupment. The ABC system is not automated to calculate the retroactive period or recoupments for MAC.

MAIT Facility Worksheet, Form 470-4678

Purpose

Form 470-4678 is used to calculate client participation for a member who resides in a medical institution and has a medical assistance income trust (MAIT or Miller trust).

Source

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

Completion

IM workers use this form when calculating client participation for members who reside in a medical institution and have a medical assistance income trust (MAIT or Miller trust). Complete a worksheet for each initial determination and annual review.

Distribution

File the original in the case file.

Data

Some modification in use may be needed to fit individual situations.

Enter the facility **case number**, including FBU. Entering the case number automatically populates the **case name**.

1. **Central office / local office approval date:** Enter the date the trust met the criteria for a medical assistance income trust (MAIT).

2. **Execution date:** Enter the date that the trust was signed and notarized.

3. **Date trust was established:** Enter the first day of the month that income is used to fund the trust. This will be the effective date of eligibility.

4. **Member's facility type:** Select ICF/ID, mental health institute, nursing facility, or PMIC from the dropdown box.

5. **Charge for care:** The worksheet defaults to the current state fiscal year and enters the amount based on the member's facility type. Select the other button to enter amounts based on the member's facility type for the previous state fiscal year.

Iowa Department of Human Services

MAIT Facility Worksheet

Case number: _____ Case name: _____

1. Central office/local office approval date _____
2. Execution date (date trust was signed and notarized) _____
3. Date trust was established (first day of the month in which income is used to fund the executed trust (effective date)) _____
4. Member's facility type _____
5. Charge for care (see 8-I, 125 Percent of the Statewide Average Charge for Care) _____
6. Gross income:

Income Source in the Trust	Gross Amount
Total gross income	

Gross income:
Do not list sources that are third party medical payments or that are not considered income, e.g., Veterans' A & A, nursing facility payments, and Veterans' UME.

VA reduced improved pension—Month of entry count pension as income in trust. Ongoing pension minus $90 as income in trust.

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

8. Months:_____
9. Division to community spouse? ☐ Yes ☐ No
10. Client participation:

Trust administration fee	
Personal needs allowance	
Adjusted gross income	
Spousal diversion	
Dependent diversion	
Unmet medical: medical insurance premium	
Unmet medical: Medicare Part D expenses	
Unmet medical: Medicare Part B	
Unmet medical: other	
Client participation	
Plus aid and attendance	
Plus nursing facility insurance payments	
Maximum client participation	

Dependent diversion:
See EM 8-I, Deduction for the Maintenance Needs of a Spouse and Dependents, for dependents that live with a CS.

See EM 8-I, Allowance for Other Dependents, for dependents that are children.

11. Vendor name:_____ Per diem:_____

28 days maximum Medicaid rate	
29 days maximum Medicaid rate	
30 days maximum Medicaid rate	
31 days maximum Medicaid rate	

CP cannot exceed per diem. See EM-I, If Client Participation Exceeds the Facility's Medicaid Rate.

Community Spouse Diversion

List Community Spouse's Income Below	Gross Amount
Total income for community spouse	
Maximum diversion amount	
Deficit	

System Entries: BCW2

"B" line:
Unearn1 SR 1 Unearn2 SR2
Soc Sec. B all other $ X

"E" line:
Unearn1 SR1
300% amt. S

Deduct 1 Deduct2 P Ded N P Ded P
Unmet Med 90 month after entry 10.00 Admin. Fee + Spousal div.

6. **Gross income:** Enter the source and gross amount of unearned and earned income used to fund the trust. The worksheet calculates the total gross income.

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

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

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

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

9. **Diversion to community spouse?** Check "Yes" if there is a community spouse. Check "No" if there is no community spouse.

10. **Client participation:** Enter the dependent diversion, unmet medical expenses, aid and attendance, and nursing facility insurance payments. The worksheet calculates the adjusted gross income, client participation, and maximum client participation.

11. **Vendor name:** Enter the name of the medical institution where the member resides.

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

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

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

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

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

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

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

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

Iowa Department of Human Services

MAIT Waiver Worksheet

Case number: _____ Case name: _____

1. Central office/local office approval date _____
2. Execution date (date trust was signed and notarized) _____
3. Date trust was established (first day of the month in which income is used to fund the executed trust (effective date)) _____
4. Member's level of care _____
5. Charge for care (see 8-I, 125 Percent of the Statewide Average Charge for Care) _____
6. Gross income:

Income Source in the Trust	Gross Amount
Total gross income	
Adjusted gross income	

Gross income:

Do not list sources that are third-party medical payments or that are not considered income, e.g., Veterans' A & A, nursing facility payments, and Veterans' UME.

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

8. Waiver type: _____
9. Months: _____
10. Client participation:

Maintenance allowance (300% of SSI benefit)	
Needs allowance for spouse or spouse & dependents	
Unmet medical: medical insurance premium	
Unmet medical: Medicare Part D expenses	
Unmet medical: Medicare Part B	
Unmet medical: other	
Client participation	
Plus aid and attendance	
Plus nursing facility insurance payments	
Total client participation	

Dependent diversion:

Needs allowance for spouse and dependents living with the waiver recipient to raise their income to the Medically Needy Income (MNIL).

System entries: Currently waiver cases require manual system entries.
TD05

1st CP Amount	Ongoing CP
Amount determined by worker	Amount determined by worker

MAIT Waiver Worksheet, Form 470-4679

Purpose	Form 470-4679 is used to calculate client participation for members who are eligible for a home- and community-based services (HCBS) waiver and have a medical assistance income trust (MAIT or Miller trust).
Source	Complete the form on line using the template on the DHS Intranet eForms web page.
Completion	The IM worker uses this form when calculating client participation for a member who has been approved for a HCBS waiver and has a medical assistance income trust (MAIT or Miller trust). Complete a worksheet for each initial determination and annual review.
Distribution	File the original in the case file.
Data	Some modification in use may be needed to fit individual situations.

Enter the facility **case number**, including FBU. Entering the case number automatically populates the **case name**.

1. **Central office / local office approval date:** Enter the date the trust met the criteria for a medical assistance income trust (MAIT).

2. **Execution date:** Enter the date that the trust was signed and notarized.

3. **Date trust was established:** Enter the first day of the month that income is used to fund the trust. This will be the effective date of eligibility.

4. **Member's level of care:** Select ICF/MD, mental health institute, or nursing facility from the dropdown box.

5. **Charge for care:** The worksheet defaults to the current state fiscal year and enters the amount based on the level of care selected in Item 4. Select the other button to enter amounts based on the level of care for the previous state fiscal year.

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

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

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

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

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

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

10. **Client participation:**

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

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

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

Medicaid Claim Denial Notice, Form 470-0385

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

Medicaid EPSDT Enrollees, Report Number X161C5A

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

Medicaid EPSDT Enrollees Due Screening by Periodicity, Report Number X1612C34

Purpose	The purpose of the *Medicaid EPSDT Enrollees Due Screening by Periodicity* report is to notify workers of children on their caseload due for "Care for Kids" screening.
Source	The Iowa Medicaid Enterprise generates this report monthly for each IM worker whose caseload includes children in foster care and persons who are eligible for Medically Needy with a spenddown, based on payment records for screening services.
Distribution	When you receive the new *Screening Due by Periodicity List*, you may discard the previous month's report.
Data	This list indicates the prior and next screening dates. The "PRIOR" screening date is the last screening paid by Medicaid in the last two years. The "NEXT" screening date is based upon the member's age and the Screening Periodicity schedule. A date will appear if: ♦ The member is due for a screening in the current or next two months. ♦ The member has not received a screening in the last year and the member is under seven years of age. The column labeled "OVER 1 YEAR" will contain a "YES" if it has been more than 12 months since this child has had a screening exam paid by Medicaid. A double asterisk (**) also identifies these same members. EXCEPTION: These indicators do not apply to anyone on the two-year screening schedule (i.e., 8-year, 10-year, etc.).

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

Purpose	Form 470-4376 is a reminder to members in the Medicaid for independent young adults (MIYA) coverage group that changes in addresses and health insurance must be reported to the income maintenance worker whenever they occur. It provides a simple means for the member to report a change.
Source	Complete form 470-4376 on line using the template on the DHS Intranet eForms web page.
Completion	When changes in addresses or health insurance occur, the member completes and submits the form to the assigned income maintenance worker.
Distribution	Issue the form: ♦ At the time of the automatic redetermination for Medicaid for independent young adults following the foster care exit. ♦ At the time of application. ♦ When Medicaid for independent young adults eligibility is established. ♦ At the annual review. ♦ When the member submits the form to report a change. ♦ When the member requests a form. File the submitted form in the case record after the required action is completed. Document the resulting action in the case record.

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

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

Items 8 through 11 are calculated by the template.

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

Items 13 through 15 are calculated by the template.

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

Items 17 and 18 are calculated by the template.

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

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

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

Answer the following questions:

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

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

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

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

Medicaid Notice of Sanction, Form 470-0409

Purpose	The *Medicaid Notice of Sanction* transmits information and instructions from the HIPP Unit to the IM worker.
Source	Form 470-0409 is generated by the HIPP Unit.
Completion	The HIPP Unit prepares the form when the HIPP worker determines that a Medicaid member (or someone acting on the member's behalf) has failed to cooperate in providing information or enrolling in a health insurance plan or by disenrolling in a plan that HIPP has determined cost effective.
Distribution	Send a copy to the IM worker responsible for the case via e-mail. File a copy in the HIPP Unit's files as permanent verification of the action taken. Upon receipt, the IM worker: ♦ Cancels the member's Medicaid benefits effective the first of the month following the expiration of the ten-day notice period. ♦ Issues a *Notice of Decision*, 470-0485 or 470-0486, informing the member of the action to be taken. ♦ Files form 470-0409 in the case record.
Data	The HIPP worker enters: ♦ The current date. ♦ The name of the office to which the form is being sent. ♦ The number of the IM worker responsible for the case. ♦ The name of the HIPP worker preparing the form. ♦ The name of the member whose benefits are to be canceled. ♦ The case number of the member's Medicaid case. ♦ A check in the box for the reason that Medicaid benefits are being canceled. ♦ The effective date of cancellation of the Medicaid benefits.

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

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

Data

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

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

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

Purpose	The *Medicaid/**hawk-i** Review* is designed for use as the annual review document for MAGI-related Medicaid. This form contains instructions for completion and informs clients of their rights and responsibilities.
Source	Usually, the ELIAS system generates form 470-5168 automatically. Form 470-5168(S) is generated when the Medicaid member has indicated that Spanish is their preferred language. DHS staff may issue a manual version of the form, 470-5168(M) or 470-5168(MS), using the templates available on the DHS Intranet eForms web page.
Completion	The ELIAS system produces form 470-5168 or 470-5168(S) at the end of the month for ***hawk-i*** and MAGI-related Medicaid when a case is active for Medicaid in the ELIAS system and due for an annual review. Give or issue the form to the member upon request. The worker or the ELIAS system completes the top portion of page 1 before the form is sent or issued to the participant. The member must complete the answers to all applicable questions. The participant may obtain help in completing the report from friends, relatives, advocate groups, or Department staff, if needed.
Distribution	Give or mail one copy of the form to the client for completion. The completed form is scanned and filed in the case record.

Medicaid/*hawk-i* Review

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 and your proof 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:		**AI/AN Person 2:**
☐ Yes ☐ No	Member of a federally recognized tribe? **If yes**, tribe name:	☐ 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 often are wages or tips paid? ☐ Hourly ☐ Every other week ☐ Monthly ☐ Weekly ☐ Twice a month ☐ Annually	How much does this person get paid (before taxes)? $		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 often are wages or tips paid? ☐ Hourly ☐ Every other week ☐ Monthly ☐ Weekly ☐ Twice a month ☐ Annually	How much does this person get paid (before taxes)? $		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 often are wages or tips paid? ☐ Hourly ☐ Every other week ☐ Monthly ☐ Weekly ☐ Twice a month ☐ Annually	How much does this person get paid (before taxes)? $		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 often are wages or tips paid? ☐ Hourly ☐ Every other week ☐ Monthly ☐ Weekly ☐ Twice a month ☐ Annually	How much does this person get paid (before taxes)? $	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?
	$	☐ Weekly ☐ Every other week ☐ Annually ☐ Monthly ☐ Twice a month ☐ Other_____
	$	☐ Weekly ☐ Every other week ☐ Annually ☐ Monthly ☐ Twice a month ☐ Other_____
	$	☐ Weekly ☐ Every other week ☐ Annually ☐ Monthly ☐ Twice a month ☐ Other_____
	$	☐ Weekly ☐ Every other week ☐ Annually ☐ Monthly ☐ Twice a month ☐ Other_____

Social Security

Name (first, middle, last & suffix)	How much?	How often?
	$	☐ Weekly ☐ Every other week ☐ Annually ☐ Monthly ☐ Twice a month ☐ Other_____
	$	☐ Weekly ☐ Every other week ☐ Annually ☐ Monthly ☐ Twice a month ☐ Other_____
	$	☐ Weekly ☐ Every other week ☐ Annually ☐ Monthly ☐ Twice a month ☐ Other_____
	$	☐ Weekly ☐ Every other week ☐ Annually ☐ Monthly ☐ Twice a month ☐ 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?
	$	☐ Weekly ☐ Every other week ☐ Annually ☐ Monthly ☐ Twice a month ☐ Other_____

Other Income Type_____

Name (first, middle, last & suffix)	How much?	How often?
	$	☐ Weekly ☐ Every other week ☐ Annually ☐ Monthly ☐ Twice a month ☐ 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?
	$	☐ Weekly ☐ Every other week ☐ Annually ☐ Monthly ☐ Twice a month ☐ Other_____

Student Loan Interest Paid

Name (first, middle, last & suffix)	How much?	How often?
	$	☐ Weekly ☐ Every other week ☐ Annually ☐ Monthly ☐ Twice a month ☐ Other_____

Other Deductions_____

Name (first, middle, last & suffix)	How much?	How often?
	$	☐ Weekly ☐ Every other week ☐ Annually ☐ Monthly ☐ Twice a month ☐ 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
- Tax status
- Employment
- Health insurance
- Divorce or marriage
- Address
- Pregnancy (list due date)
- Pregnancy ending
- 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	

Medicaid/*hawk-i* Review
(Revisión de Medicaid/*hawk-i*)

IOWA DEPT. OF HUMAN SERVICES

Fecha límite de entrega	Caso Nº.	Condado Nº.	Nombre del asistente
Dirección de correo electrónico	Teléfono	Modo de contacto preferido	

Ha llegado el momento de revisar su caso. Por favor, complete este formulario y envíelo al domicilio indicado arriba, antes de la fecha límite de entrega. Estos datos serán utilizados para decidir si continuará recibiendo servicios de Medicaid/***hawk-i***.

¿Qué hago con este formulario?

Debe:

- Completar este formulario.
- Firmarlo y escribir la fecha en la página 6.
- Enviarnos el formulario y los comprobantes al domicilio que figura arriba, antes del
- Use una hoja extra si necesita más espacio para sus respuestas.

¿Y si tengo dudas?

Llame a su asistente al . Aceptaremos llamadas por cobrar.

Integrantes del grupo familiar

Estas personas reciben beneficios con usted o son contabilizadas para calcular sus beneficios. Complete los datos faltantes en el siguiente cuadro. *Tache los datos que no sean correctos sobre los integrantes de su grupo familiar. Escriba los datos correctos.*

Nombre/Ident. Estatal o CIN	Fecha de Nac.	Nº. de Social Security	¿Parentesco con usted?	Género Masc./Fem	¿Reside en Iowa? Sí/No	¿Ciudadano de Estados Unidos? Sí/No	¿Condición inmigratoria elegible? Sí/No (Si respondió que sí, indique tipo y Nº. del documento de identidad)

¿Tiene problemas de salud (físicos, mentales o emocionales) que le causen limitaciones en sus actividades (como bañarse, vestirse, tareas del hogar, etc.) o vive en una institución médica o un geriátrico? ☐ Sí ☐ No

¿Alguna de las mujeres de su grupo familiar está embarazada? ☐ Sí ☐ No

Si respondió Sí, ¿quién?_____ Fecha de parto_____ Cantidad de bebés esperados_____

¿Hay personas viviendo en su hogar que no figuran en la página 1? ☐ Sí ☐ No
Si respondió que sí, complete los siguientes datos.

¿Alguien se mudó a su hogar o se fue de su hogar? ☐ Sí ☐ No
Si respondió que sí, complete los siguientes datos.

Nombre	Nº. de Social Security	Fecha de Nac.	Parentesco con usted	Fecha en que se mudó a su hogar	Fecha en que se fue de su hogar	¿Ciudadano de U.S.? Sí/No	¿Condición inmigratoria elegible? Sí/No (Si respondió que sí, indique tipo y Nº. del documento de identidad)	¿Solicita beneficios? Sí/No

Si usted se ha mudado, indique su nuevo domicilio.

Dirección residencial	Ciudad, Estado y Código Postal
Dirección postal (si es diferente)	Ciudad, Estado y Código Postal

Si alguien está en las fuerzas armadas, es veterano o cónyuge de un veterano de guerra, indique quién y qué son.

_____

¿Algún integrante del grupo familiar estuvo en un hogar sustituto cuando tenía 18 años o más?

Indique sus nombres aquí:_____

Confirmo que ninguna de las personas para las que se solicita asistencia médica en este formulario se encuentra en prisión (detenida o presa).

De lo contrario, la persona que se encuentra en prisión se llama:_____

Miembros de la familia que son aborígenes estadounidenses o nativos de Alaska (AI/AN)

¿Usted o alguien de su familia es aborigen estadounidense o nativo de Alaska? ☐ Sí ☐ No
Si respondió sí, complete los siguientes datos. Si respondió no, omita esta sección y continúe en la siguiente.

AI/AN Persona 1:	**AI/AN Persona 2:**
Nombre (primer nombre, segundo nombre, apellido)	Nombre (primer nombre, segundo nombre, apellido)

AI/AN Persona 1:		**AI/AN Persona 2:**
☐ Sí ☐ No	¿Es miembro de tribu reconocida a nivel federal? **Si respondió que sí,** nombre de la tribu: _____ _____	☐ Sí ☐ No
☐ Sí ☐ No	¿Alguna vez obtuvo servicios del Indian Health Service, de un programa médico tribal, o de un programa médico urbano para aborígenes, o a través de remisiones hechas por estos programas?	☐ Sí ☐ No
☐ Sí ☐ No	**Si respondió no,** ¿califica para obtener alguno de dichos servicios?	☐ Sí ☐ No
$ _____ ¿Con qué frecuencia? _____	Ciertos ingresos no pueden ser contabilizados para Medicaid o Healthy and Well Kids in Iowa (***hawk-i***). Indique todos los ingresos (monto y frecuencia) informados en su solicitud que incluyan dinero de las siguientes fuentes:	$ _____ ¿Con qué frecuencia? _____

- Pagos per cápita de una tribu, provenientes de recursos naturales, derecho de uso, alquileres o regalías.
- Pagos realizados por el Departamento del Interior y provenientes de recursos naturales, agricultura, ganadería, pesca, alquileres o regalías de tierras designadas como fideicomisos (incluso reservas y antiguas reservas).
- Dinero proveniente de la venta de artículos con valor cultural.

Información impositiva

Necesitamos información sobre las personas que presentan declaraciones impositivas. *Puede renovar su solicitud aunque no presente declaraciones impositivas.* Debe decirnos quienes presentan declaraciones impositivas de ingresos a nivel federal. Si deja esta sección en blanco, asumiremos que nadie lo hace. *Fotocopie esta página si necesita más espacio para incluir a otros contribuyentes.*

¿Va a presentar la declaración impositiva de ingresos EL PRÓXIMO AÑO?

☐ Sí Si respondió **sí**, conteste todas las siguientes preguntas. ☐ No Si respondió **no**, conteste las preguntas marcadas con una estrella ☆.

	Nombre (primero y segundo nombre, apellido y sufijo)	Si esta persona presentará una declaración conjunta, escriba el nombre del cónyuge:	Si declarará personas dependientes, escriba los nombres de los dependientes:
Persona 1			
Persona 2			
Persona 3			
Persona 4			

Si alguien será declarado como dependiente en la declaración impositiva de otra persona, escriba el nombre del contribuyente y de las personas dependientes. Responda sólo si la información es diferente a la indicada anteriormente o si no completó nada en las preguntas anteriores.

Nombre del contribuyente:_____

Nombre de las personas dependientes:_____

Infórmenos sobre el trabajo

Debe informarnos sobre todo el dinero que reciben las personas de su grupo familiar. Si alguien tiene más de un empleo, infórmenos sobre **todos los empleos**. Puede informar sobre **empleos autónomos o por cuenta propia** en la siguiente página. Si deja espacios en blanco, asumiremos que no reciben dinero de ese tipo. Use una hoja adicional si es necesario. Si tienen comprobantes de ingresos (recibos de sueldo, declaraciones del empleador, declaraciones impositivas, etc.), puede enviarlos con este formulario. Eso podría agilizar el procesamiento de la revisión. *Fotocopie esta página si necesita más espacio para incluir más empleos o más personas. Tache los datos que no sean correctos sobre los integrantes de su grupo familiar. Escriba los datos correctos o los datos que falten.*

Empleo 1

Nombre de la persona que está trabajando (primero y segundo nombre, apellido y sufijo)			
Nombre del empleador		Teléfono del empleador	
Domicilio del empleador	Ciudad	Estado	Código postal
¿Con qué frecuencia le pagan el sueldo o las propinas? ☐ Por hora ☐ Semana por medio ☐ Mensualmente ☐ Por semana ☐ Dos veces por mes ☐ Anualmente	¿Cuánto le pagan (antes de descontar impuestos)? $		Promedio de horas trabajadas por semana:

Empleo 2

Nombre de la persona que está trabajando (primero y segundo nombre, apellido y sufijo)			
Nombre del empleador		Teléfono del empleador	
Domicilio del empleador	Ciudad	Estado	Código postal
¿Con qué frecuencia le pagan el sueldo o las propinas? ☐ Por hora ☐ Semana por medio ☐ Mensualmente ☐ Por semana ☐ Dos veces por mes ☐ Anualmente	¿Cuánto le pagan (antes de descontar impuestos)? $		Promedio de horas trabajadas por semana:

Empleo 3

Nombre de la persona que está trabajando (primero y segundo nombre, apellido y sufijo)			
Nombre del empleador		Teléfono del empleador	
Domicilio del empleador	Ciudad	Estado	Código postal
¿Con qué frecuencia le pagan el sueldo o las propinas? ☐ Por hora ☐ Semana por medio ☐ Mensualmente ☐ Por semana ☐ Dos veces por mes ☐ Anualmente	¿Cuánto le pagan (antes de descontar impuestos)? $		Promedio de horas trabajadas por semana:

Empleo 4

Nombre de la persona que está trabajando (primero y segundo nombre, apellido y sufijo)			
Nombre del empleador		Teléfono del empleador	
Domicilio del empleador	Ciudad	Estado	Código postal
¿Con qué frecuencia le pagan el sueldo o las propinas? ☐ Por hora ☐ Semana por medio ☐ Mensualmente ☐ Por semana ☐ Dos veces por mes ☐ Anualmente	¿Cuánto le pagan (antes de descontar impuestos)? $		Promedio de horas trabajadas por semana:

¿El monto del dinero proveniente de sus empleos permanecerá más o menos igual? ☐ Sí ☐ No

Si respondió no, explique _____

¿Alguien ha sido contratado para un empleo pero aún no ha cobrado? ☐ Sí ☐ No

Si respondió sí, ¿quién? _____ Nombre del empleador _____

En los últimos tres meses, ☐ ¿cambió de empleo? ☐ ¿dejó de trabajar?
☐ ¿comenzó a trabajar menos horas? ☐ Ninguno de los anteriores

Empleo autónomo o por cuenta propia

Si alguno de los integrantes de su grupo familiar trabaja por cuenta propia, necesitamos saber sobre sus trabajos. *Lea las instrucciones con más información sobre las deducciones o retenciones.*

	Nombre (primero y segundo nombre, apellido y sufijo)	Tipo de trabajo:	¿Cuál es el ingreso neto que obtuvo este mes por empleo autónomo?
Persona 1			Importe $
Persona 2			Importe $

➢ Reste los gastos indicados debajo de su ingreso bruto para obtener el importe neto de ingresos por empleo autónomo.

- Gastos de autos o camionetas (por traslados durante la jornada laboral, que no sean para ir y regresar de su casa al trabajo)
- Depreciación
- Sueldo de empleados y beneficios adicionales
- Seguros de bienes, responsabilidad a terceros o pérdidas por interrupción comercial
- Intereses (incluye hipotecas pagadas a un banco, etc.)
- Servicios legales y profesionales
- Alquiler o arrendamiento del local o servicios públicos
- Comisiones, licencias, impuestos y honorarios
- Propaganda
- Trabajos contratados
- Reparaciones y mantenimiento
- Determinados viajes y comidas empresariales
- Impuestos deducibles para autónomos
- Costo del seguro médico para autónomos
- Contribuciones a SEP, SIMPLE, o planes de retiro calificado para empleados independientes

Infórmenos sobre otros ingresos

Tache los datos que **no sean correctos** sobre los integrantes de su grupo familiar. Escriba los datos correctos.
Fotocopie esta página si necesita más espacio para agregar otros tipos de ingresos.

Desempleo

Nombre (primero y segundo nombre, apellido y sufijo)	¿Cuánto?	¿Con qué frecuencia?
	$	☐ Semanalmente ☐ Semana por medio ☐ Anualmente ☐ Mensualmente ☐ Dos veces por mes ☐ Otra_____
	$	☐ Semanalmente ☐ Semana por medio ☐ Anualmente ☐ Mensualmente ☐ Dos veces por mes ☐ Otra_____
	$	☐ Semanalmente ☐ Semana por medio ☐ Anualmente ☐ Mensualmente ☐ Dos veces por mes ☐ Otra_____
	$	☐ Semanalmente ☐ Semana por medio ☐ Anualmente ☐ Mensualmente ☐ Dos veces por mes ☐ Otra_____

Social Security

Nombre (primero y segundo nombre, apellido y sufijo)	¿Cuánto?	¿Con qué frecuencia?
	$	☐ Semanalmente ☐ Semana por medio ☐ Anualmente ☐ Mensualmente ☐ Dos veces por mes ☐ Otra_____
	$	☐ Semanalmente ☐ Semana por medio ☐ Anualmente ☐ Mensualmente ☐ Dos veces por mes ☐ Otra_____
	$	☐ Semanalmente ☐ Semana por medio ☐ Anualmente ☐ Mensualmente ☐ Dos veces por mes ☐ Otra_____
	$	☐ Semanalmente ☐ Semana por medio ☐ Anualmente ☐ Mensualmente ☐ Dos veces por mes ☐ Otra_____

Informe sobre otros tipos de ingresos, como pensiones, jubilaciones, pensión alimenticia recibida, agricultura o pesca, ingresos por alquileres o regalías, etc.

Otro tipo de ingresos_____

Nombre (primero y segundo nombre, apellido y sufijo)	¿Cuánto?	¿Con qué frecuencia?
	$	☐ Semanalmente ☐ Semana por medio ☐ Anualmente ☐ Mensualmente ☐ Dos veces por mes ☐ Otra_____

Otro tipo de ingresos_____

Nombre (primero y segundo nombre, apellido y sufijo)	¿Cuánto?	¿Con qué frecuencia?
	$	☐ Semanalmente ☐ Semana por medio ☐ Anualmente ☐ Mensualmente ☐ Dos veces por mes ☐ Otra_____

Deducciones o retenciones

Si a alguna de las personas de su grupo familiar le realizan **deducciones o retenciones**, como pensión alimenticia, intereses por préstamos estudiantiles, etc., infórmenos de qué tipo. **No** debe incluir los costos que ya consideró en su respuesta para calcular el importe neto por empleo autónomo.

Pensión alimenticia pagada a otra persona

Nombre (primero y segundo nombre, apellido y sufijo)	¿Cuánto?	¿Con qué frecuencia?
	$	☐ Semanalmente ☐ Semana por medio ☐ Anualmente ☐ Mensualmente ☐ Dos veces por mes ☐ Otra_____

Intereses pagados por préstamos estudiantiles

Nombre (primero y segundo nombre, apellido y sufijo)	¿Cuánto?	¿Con qué frecuencia?
	$	☐ Semanalmente ☐ Semana por medio ☐ Anualmente ☐ Mensualmente ☐ Dos veces por mes ☐ Otra_____

Otras deducciones o retenciones_____

Nombre (primero y segundo nombre, apellido y sufijo)	¿Cuánto?	¿Con qué frecuencia?
	$	☐ Semanalmente ☐ Semana por medio ☐ Anualmente ☐ Mensualmente ☐ Dos veces por mes ☐ Otra_____

Seguro médico

Infórmenos sobre las **otras** coberturas de seguro médico que su grupo familiar tiene.

¿Alguien está inscripto en una cobertura médica actualmente? ☐ Sí ☐ No

Si respondió sí, marque la cobertura médica. ☐ Medicaid ☐ ***hawk-i*** ☐ Medicare ☐ Tricare
☐ Veteranos ☐ Cuerpos de Paz ☐ Plan médico para jubilados ☐ COBRA

☐ Seguro del empleador Nombre del seguro médico_____ Número de póliza_____

☐ Privado/otro_____

Coberturas médicas de empleos

Complete esta sección si alguna de las personas que figuran en este formulario califica para cobertura médica a través de su empleo, aunque no esté inscripta actualmente. Infórmenos sobre el empleo que ofrece cobertura.

Datos del empleado. El **empleado** debe completar esta sección.

Nombre del empleado (primer nombre, segundo nombre, apellido)	Nº. de Social Security

Datos del empleador. Pídale estos datos a su **empleador**.

Nombre del empleador	Nº. de identificación del empleador (EIN)	
Domicilio del empleador (Marketplace enviará notificaciones a este domicilio)	Teléfono del empleador	
Ciudad	Estado	Código postal
¿Con quién podemos comunicarnos para averiguar sobre la cobertura médica laboral de este empleado?		
Teléfono (si es diferente al anterior)	Dirección de correo electrónico	

☐ Sí ☐ No ¿Califica actualmente para la cobertura que ofrece este empleador o será elegible en los próximos tres meses?

Si respondió sí, complete los siguientes datos. **Si no**, continúe en la sección **Cambios esperados.**

Si está en el período de espera o de prueba, ¿cuándo podrá inscribirse en la cobertura?

_____

Indique los nombres de todas las personas que califiquen para cobertura a través de este empleo.

_____

Plan médico. Infórmenos sobre el **plan médico** que ofrece este empleador.

☐ Sí ☐ No ¿El plan médico ofrecido por el empleador cubre al cónyuge o a los dependientes del empleado?

Si respondió que sí, ¿a quién cubre? ☐ Cónyuge ☐ Dependientes

☐ Sí ☐ No Un plan médico laboral cumple con "la norma de valor mínimo" si la proporción cubierta por el plan no es inferior al 60% del costo total de los beneficios permitidos. ¿El empleador ofrece un plan médico que cumple con la norma de valor mínimo?

☐ Sí ☐ No ¿El plan de menor costo que cumple con "la norma de valor mínimo" ofrece un programa de salud **para el empleado únicamente**? (No incluya planes familiares.)

Si respondió sí, ¿cuánto tendría que pagar en primas después de recibir el descuento máximo por programas para dejar de fumar? (No reste los otros descuentos del programa.)

$_____

¿Con qué frecuencia? ☐ Semanalmente ☐ Cada dos semanas ☐ Dos veces por mes ☐ Trimestralmente ☐ Anualmente

Cambios del empleador. ¿Qué cambios introducirá el empleador para el próximo plan anual (si sabe)?

☐ El empleador no ofrecerá cobertura médica

☐ El empleador ofrecerá cobertura para los empleados o modificará la prima del plan de menor costo disponible para empleados que cumplan con la norma de valor mínimo. (La prima debe reflejar el descuento para programas de salud.)

¿Cuánto tendrá que pagar el empleado por las primas de ese plan? $_____

¿Con qué frecuencia? ☐ Semanalmente ☐ Cada dos semanas ☐ Dos veces por mes ☐ Trimestralmente ☐ Anualmente

Fecha del cambio:_____

Cambios esperados

Infórmenos si ha habido cambios o si podría haber cambios. Ejemplos:

- Personas en el grupo familiar
- Condición impositiva
- Empleo
- Seguro médico
- Divorcio o casamiento
- Domicilio
- Embarazo (indique la fecha de parto)
- Terminación de embarazo
- Otros

Explique qué y cuándo _____

Renovación de la cobertura en los años sucesivos

Lea la siguiente declaración y marque **una** casilla.

Con el fin de facilitar la verificación de mis ingresos para la revisión, autorizo a Department of Human Services a utilizar los datos que figuran en mis declaraciones impositivas por la cantidad de años que he marcado a continuación.

Entiendo que Department of Human Services me enviará una carta con los datos que tienen sobre mis ingresos. Podré modificarlos. Además, podré cambiar de opinión y no permitir que Department of Human Services verifique dichos datos.

Sí, doy mi autorización para verificar mis ingresos en las declaraciones impositivas por (marcar una casilla):

☐ 5 años (tiempo máximo) ☐ 4 años ☐ 3 años ☐ 2 años ☐ 1 año

☐ No, no doy mi autorización para utilizar mis declaraciones impositivas.

Lea y firme este formulario de solicitud

Su firma o marca	Teléfono	Fecha de hoy
Firma de la persona que ayudó a completar el formulario, si corresponde	Teléfono	Fecha de hoy

Conserve esta página para su información.

Sus derechos y obligaciones

- Al firmar esta solicitud, certifico bajo pena de cometer perjurio y dar falso testimonio que mis respuestas son correctas y completas a mi leal saber y entender, inclusive los datos provistos sobre la ciudadanía y la condición inmigratoria de cada uno de los integrantes de mi grupo familiar para los que solicito beneficios.
- Al firmar este formulario, autorizo a DHS a compartir sus registros médicos y otros documentos con funcionarios federales y estatales.
- Entiendo que una firma electrónica tiene el mismo efecto legal y puede ejecutarse de la misma manera que una firma escrita.
- Es de mi conocimiento que los datos que figuran en este formulario serán utilizados sólo para determinar mi elegibilidad para asistencia médica y que los mismos tendrán carácter confidencial como lo exige la ley.
- Entiendo que en el caso de recibir Medicaid, el Departamento iniciará el reclamo de ayuda económica sin fines médicos para mí y mis hijos si así lo solicito. Los servicios de ayuda económica para tratamiento médico incluyen el establecimiento de la paternidad y el establecimiento y la ejecución de ayuda económica para tratamiento médico.
- Entiendo las preguntas y los enunciados que figuran en este formulario.
- Entiendo que toda la información que he dado, inclusive los datos sobre beneficios e ingresos, serán cotejados con los datos de registros municipales, estatales y federales, como empleadores, el servicios de ciudadanía e inmigración de los Estados Unidos (USCIS), la Administración de Social Security, agencias impositivas, de bienestar social y desempleo, etc. y entiendo que la información recibida podría afectar mi elegibilidad para beneficios.
- Entiendo que los datos que he dado en este formulario, incluso los datos sobre beneficios e ingresos, están sujetos a investigación y revisión por personal federal, estatal y del condado, y que en el caso de haber provisto información incorrecta, mis beneficios serán denegados o suspendidos.
- Es de mi conocimiento que conforme a las leyes federales, se prohíbe cualquier tipo de discriminación con respecto a raza, color, país de origen, sexo y discapacidad. Puedo presentar una queja por discriminación en www.hhs.gov/ocr/office/file.
- Confirmo que ninguna de las personas para las que se solicita asistencia médica en este formulario se encuentra en prisión (detenido o preso).
- Es de mi conocimiento que otra persona puede actuar como mi representante durante el proceso. Entiendo que me explicarán sobre mi elegibilidad y otros datos importantes. Entiendo que un cambio en mi condición podría afectar la elegibilidad de los integrantes de mi grupo familiar.
- Puedo apelar la resolución de Health Insurance Marketplace o Medicaid/***hawk-i*** en el caso de considerar que se ha cometido un error. Apelar significa decirle a alguien del seguro médico Marketplace o de Medicaid/***hawk-i*** que creo que la resolución tomada es errónea y solicitar que la misma sea revisada de manera imparcial. Es de mi conocimiento que el procedimiento para apelar se encuentra en la página 8, en la sección Apelaciones.

¿Qué hago con este formulario ahora?

Después de completar el formulario, envíelo en el sobre que se adjunta. Envíelo por correo al domicilio impreso en la página 1. Dicho domicilio está debajo de su dirección postal. También puede traer el formulario personalmente a la oficina.

Información sobre los números de Social Security

Podemos ayudar sólo a aquellas personas que nos dan sus números de Social Security o el comprobante de solicitud expedido por la oficina de Social Security. **No tiene obligación de informarnos los números de Social Security de las personas de su grupo familiar que no solicitan asistencia, pero puede hacerlo si lo desea.** No obstante, tenga en cuenta que utilizaremos todos los números de Social Security del mismo modo que utilizamos los de aquellas personas que reciben asistencia.

Les denegaremos asistencia a aquellas personas de su grupo familiar que no nos informen sus números de Social Security. Existen algunas excepciones a esta regla. Por favor, pregúntele a su asistente.

No le entregaremos ningún número de Social Security al Servicio de Ciudadanía e Inmigración.

Conserve esta página para su información.

Medicaid

Verificamos lo que nos informa

La información provista será verificada por funcionarios federales, estatales y locales para constatar que es verdadera. Podríamos verificar: el número de Social Security, empleo y sueldo, saldo en cuentas bancarias, condición inmigratoria y dinero recibido de otras fuentes, como Social Security y seguro de desempleo, de cada una de las personas que figuren en la solicitud. Rechazaremos su solicitud si los datos presentados no son correctos.

Podemos revisar los registros de otros estados para ver si alguno de los integrantes de su grupo familiar puede recibir beneficios en Iowa. Esto podría ser debido a la inhabilitación de una persona en un programa de otro estado.

La verificación se realiza utilizando sistemas informáticos como el sistema estatal *Income and Eligibility Verification System* y el sistema federal *Federal Facilitated Exchange,* que incluye *Internal Revenue Service* (IRS), *Social Security Administration* (SSA) y *Department of Homeland Security* (DHS). En el caso de encontrar diferencias entre lo que nos informó y los registros del sistema informático, trataremos de averiguar cuáles son los datos correctos. Para verificar su información, podríamos comunicarnos con su empleador, su banco y otras personas. Le preguntaremos a usted primero, antes de verificar los datos con su empleador, su banco y otras personas.

Cosas que debe saber

- Deberá presentar la solicitud para otros beneficios a los que tenga derecho y deberá aceptarlos.
- Deberá entregarnos información y presentar comprobantes cuando los solicitemos.
- Deberá completar los formularios de revisión cuando sean solicitados.
- DHS podrá entregarle sus respuestas a los funcionarios encargados del orden público con el fin de capturar a aquellas personas que estén prófugas para evadir la ley.
- La unidad de Control de Calidad y la unidad de Investigaciones podrán revisar su caso. Podrían comunicarse con otras personas u organizaciones para conseguir la verificación de sus datos. Al firmar este formulario, nos da autorización para divulgar información confidencial a las unidades de Control de Calidad y de Investigaciones. Debe cooperar con ellos para conservar sus beneficios.
- Deberá reintegrar los beneficios que reciba o que sean pagados a terceros si no calificaba para recibirlos.
- La sección 1128B de la Ley de Social Security dispone sanciones a nivel federal por actos fraudulentos e informes falsos en relación a estos programas.
- Toda persona que obtenga, trate de obtener, o ayude a otra persona a obtener asistencia a la que no tiene derecho, será culpable de infringir las leyes del estado de Iowa. Esto incluye los capítulos 249 y 249A del Código de Iowa, entre otros.
- Puede presentar la solicitud para una parte de su grupo familiar aunque algunos de ellos no sean inmigrantes legales. Por ejemplo, los padres que no sean inmigrantes legales pueden presentar la solicitud para los hijos que sean ciudadanos de los Estados Unidos o extranjeros habilitados. El Departamento verificará la condición inmigratoria de su grupo familiar con el *Department of Homeland Security*. La información provista por dicho departamento podría afectar los beneficios de esas personas. No se le pedirá información a *Department of Homeland Security* sobre aquellas personas para las que no presente la solicitud. No obstante, es posible que se utilicen sus ingresos para ver si el resto del grupo familiar puede obtener Medicaid.
- ***La presentación deliberada de información incorrecta ocasionará que iniciemos un juicio civil o penal en su contra. Además, sus beneficios podrían sean reducidos o podría tener que devolver el dinero recibido.***

Esta autorización perderá validez cuando su Medicaid finalice.

Tiene derecho a apelar

Usted, o la persona que le ayuda, podrán solicitar una audiencia en caso de no estar de acuerdo con la acción tomada en su caso. Debe apelar por escrito. Para apelar por escrito, elija una de las siguientes maneras:

- Complete la apelación por Internet en https://dhssecure.dhs.state.ia.us/forms/, **o**
- Escriba una carta explicándonos por qué cree que la decisión es incorrecta, o
- Llene un formulario de Apelación y Solicitud de Audiencia (“Appeal and Request for Hearing”). Puede conseguirlo en la oficina DHS de su condado.

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

Puede representarse usted mismo o ser representado por un amigo, un familiar, un abogado o cualquier otra persona.

Si necesita servicios legales, comuníquese con la oficina DHS de su condado. Es posible que deba pagar por dichos servicios. En tal caso, el pago será proporcional a sus ingresos. Además, puede llamar a *Iowa Legal Aid* al teléfono (800) 532-1275. Si vive en el Condado de Polk, llame al (515) 243-1193.

No será discriminado

La política de Iowa Department of Human Services (DHS) es brindarles trato equitativo con respecto a empleo y prestación de servicios a los solicitantes, los empleados y los clientes, sin considerar su raza, color, país de origen, sexo, orientación sexual, identidad de género, religión, edad, discapacidad, ideología política o condición de veterano.

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

Divulgación de Información - Opcional

¡Ayúdenos a ayudarle!

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

Debe saber que:

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

Escriba su nombre en letra de imprenta y firme debajo para autorizarnos a obtener la información necesaria. Recuerde de firmar página 6.

DIVULGACIÓN DE INFORMACIÓN
(Release of Information)

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

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

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

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

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

Iowa Department of Human Services

Medicaid/*hawk-i* Review

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 and your proof 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:		**AI/AN Person 2:**
☐ Yes ☐ No	Member of a federally recognized tribe? **If yes**, tribe name:	☐ 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 often are wages or tips paid? ☐ Hourly ☐ Every other week ☐ Monthly ☐ Weekly ☐ Twice a month ☐ Annually	How much does this person get paid (before taxes)? $		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 often are wages or tips paid? ☐ Hourly ☐ Every other week ☐ Monthly ☐ Weekly ☐ Twice a month ☐ Annually	How much does this person get paid (before taxes)? $		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 often are wages or tips paid? ☐ Hourly ☐ Every other week ☐ Monthly ☐ Weekly ☐ Twice a month ☐ Annually	How much does this person get paid (before taxes)? $		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 often are wages or tips paid? ☐ Hourly ☐ Every other week ☐ Monthly ☐ Weekly ☐ Twice a month ☐ Annually	How much does this person get paid (before taxes)? $	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?
	$	☐ Weekly ☐ Every other week ☐ Annually ☐ Monthly ☐ Twice a month ☐ Other_____
	$	☐ Weekly ☐ Every other week ☐ Annually ☐ Monthly ☐ Twice a month ☐ Other_____
	$	☐ Weekly ☐ Every other week ☐ Annually ☐ Monthly ☐ Twice a month ☐ Other_____
	$	☐ Weekly ☐ Every other week ☐ Annually ☐ Monthly ☐ Twice a month ☐ Other_____

Social Security

Name (first, middle, last & suffix)	How much?	How often?
	$	☐ Weekly ☐ Every other week ☐ Annually ☐ Monthly ☐ Twice a month ☐ Other_____
	$	☐ Weekly ☐ Every other week ☐ Annually ☐ Monthly ☐ Twice a month ☐ Other_____
	$	☐ Weekly ☐ Every other week ☐ Annually ☐ Monthly ☐ Twice a month ☐ Other_____
	$	☐ Weekly ☐ Every other week ☐ Annually ☐ Monthly ☐ Twice a month ☐ 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?
	$	☐ Weekly ☐ Every other week ☐ Annually ☐ Monthly ☐ Twice a month ☐ Other_____

Other Income Type_____

Name (first, middle, last & suffix)	How much?	How often?
	$	☐ Weekly ☐ Every other week ☐ Annually ☐ Monthly ☐ Twice a month ☐ 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?
	$	☐ Weekly ☐ Every other week ☐ Annually ☐ Monthly ☐ Twice a month ☐ Other_____

Student Loan Interest Paid

Name (first, middle, last & suffix)	How much?	How often?
	$	☐ Weekly ☐ Every other week ☐ Annually ☐ Monthly ☐ Twice a month ☐ Other_____

Other Deductions_____

Name (first, middle, last & suffix)	How much?	How often?
	$	☐ Weekly ☐ Every other week ☐ Annually ☐ Monthly ☐ Twice a month ☐ 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
- Tax status
- Employment
- Health insurance
- Divorce or marriage
- Address
- Pregnancy (list due date)
- Pregnancy ending
- 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	

Iowa Department of Human Services

Medicaid/*hawk-i* Review
(Revisión de Medicaid/*hawk-i*)

IOWA DEPT. OF HUMAN SERVICES

Fecha límite de entrega de de	Caso Nº.	Condado Nº.	Nombre del asistente
Dirección de correo electrónico	Teléfono	Modo de contacto preferido	

Ha llegado el momento de revisar su caso. Por favor, complete este formulario y envíelo al domicilio indicado arriba, antes de la fecha límite de entrega. Estos datos serán utilizados para decidir si continuará recibiendo servicios de Medicaid/***hawk-i***.

¿Qué hago con este formulario?

Debe:

- Completar este formulario.
- Firmarlo y escribir la fecha en la página 6.
- Enviarnos el formulario y los comprobantes al domicilio que figura arriba, antes del de de
- Use una hoja extra si necesita más espacio para sus respuestas.

¿Y si tengo dudas?

Llame a su asistente al . Aceptaremos llamadas por cobrar.

Integrantes del grupo familiar

Estas personas reciben beneficios con usted o son contabilizadas para calcular sus beneficios. Complete los datos faltantes en el siguiente cuadro. *Tache los datos que no sean correctos sobre los integrantes de su grupo familiar. Escriba los datos correctos.*

Nombre/Ident. Estatal o CIN	Fecha de Nac.	Nº. de Social Security	¿Parentesco con usted?	Género Masc./Fem	¿Reside en Iowa? Sí/No	¿Ciudadano de Estados Unidos? Sí/No	¿Condición inmigratoria elegible? Sí/No (Si respondió que sí, indique tipo y Nº. del documento de identidad)

¿Tiene problemas de salud (físicos, mentales o emocionales) que le causen limitaciones en sus actividades (como bañarse, vestirse, tareas del hogar, etc.) o vive en una institución médica o un geriátrico? ☐ Sí ☐ No

¿Alguna de las mujeres de su grupo familiar está embarazada? ☐ Sí ☐ No

Si respondió Sí, ¿quién?_____ Fecha de parto_____ Cantidad de bebés esperados_____

¿Hay personas viviendo en su hogar que no figuran en la página 1? ☐ Sí ☐ No
Si respondió que sí, complete los siguientes datos.

¿Alguien se mudó a su hogar o se fue de su hogar? ☐ Sí ☐ No
Si respondió que sí, complete los siguientes datos.

Nombre	Nº. de Social Security	Fecha de Nac.	Parentesco con usted	Fecha en que se mudó a su hogar	Fecha en que se fue de su hogar	¿Ciudadano de U.S.? Sí/No	¿Condición inmigratoria elegible? Sí/No (Si respondió que sí, indique tipo y Nº. del documento de identidad)	¿Solicita beneficios? Sí/No

Si usted se ha mudado, indique su nuevo domicilio.

Dirección residencial	Ciudad, Estado y Código Postal
Dirección postal (si es diferente)	Ciudad, Estado y Código Postal

Si alguien está en las fuerzas armadas, es veterano o cónyuge de un veterano de guerra, indique quién y qué son.

_____

¿Algún integrante del grupo familiar estuvo en un hogar sustituto cuando tenía 18 años o más?

Indique sus nombres aquí:_____

Confirmo que ninguna de las personas para las que se solicita asistencia médica en este formulario se encuentra en prisión (detenida o presa).

De lo contrario, la persona que se encuentra en prisión se llama:_____

Miembros de la familia que son aborígenes estadounidenses o nativos de Alaska (AI/AN)

¿Usted o alguien de su familia es aborigen estadounidense o nativo de Alaska? ☐ Sí ☐ No
Si respondió sí, complete los siguientes datos. Si respondió no, omita esta sección y continúe en la siguiente.

AI/AN Persona 1:	**AI/AN Persona 2:**
Nombre (primer nombre, segundo nombre, apellido)	Nombre (primer nombre, segundo nombre, apellido)

AI/AN Persona 1:		**AI/AN Persona 2:**
☐ Sí ☐ No	¿Es miembro de tribu reconocida a nivel federal? **Si respondió que sí,** nombre de la tribu: _____ _____	☐ Sí ☐ No
☐ Sí ☐ No	¿Alguna vez obtuvo servicios del Indian Health Service, de un programa médico tribal, o de un programa médico urbano para aborígenes, o a través de remisiones hechas por estos programas?	☐ Sí ☐ No
☐ Sí ☐ No	**Si respondió no,** ¿califica para obtener alguno de dichos servicios?	☐ Sí ☐ No
$ _____ ¿Con qué frecuencia? _____	Ciertos ingresos no pueden ser contabilizados para Medicaid o Healthy and Well Kids in Iowa (***hawk-i***). Indique todos los ingresos (monto y frecuencia) informados en su solicitud que incluyan dinero de las siguientes fuentes:	$ _____ ¿Con qué frecuencia? _____

- Pagos per cápita de una tribu, provenientes de recursos naturales, derecho de uso, alquileres o regalías.
- Pagos realizados por el Departamento del Interior y provenientes de recursos naturales, agricultura, ganadería, pesca, alquileres o regalías de tierras designadas como fideicomisos (incluso reservas y antiguas reservas).
- Dinero proveniente de la venta de artículos con valor cultural.

Información impositiva

Necesitamos información sobre las personas que presentan declaraciones impositivas. *Puede renovar su solicitud aunque no presente declaraciones impositivas.* Debe decirnos quienes presentan declaraciones impositivas de ingresos a nivel federal. Si deja esta sección en blanco, asumiremos que nadie lo hace. *Fotocopie esta página si necesita más espacio para incluir a otros contribuyentes.*

¿Va a presentar la declaración impositiva de ingresos EL PRÓXIMO AÑO?

☐ Sí Si respondió **sí**, conteste todas las siguientes preguntas. ☐ No Si respondió **no**, conteste las preguntas marcadas con una estrella ☆.

	Nombre (primero y segundo nombre, apellido y sufijo)	Si esta persona presentará una declaración conjunta, escriba el nombre del cónyuge:	Si declarará personas dependientes, escriba los nombres de los dependientes:
Persona 1			
Persona 2			
Persona 3			
Persona 4			

Si alguien será declarado como dependiente en la declaración impositiva de otra persona, escriba el nombre del contribuyente y de las personas dependientes. Responda sólo si la información es diferente a la indicada anteriormente o si no completó nada en las preguntas anteriores.

Nombre del contribuyente:_____

Nombre de las personas dependientes:_____

Infórmenos sobre el trabajo

Debe informarnos sobre todo el dinero que reciben las personas de su grupo familiar. Si alguien tiene más de un empleo, infórmenos sobre **todos los empleos**. Puede informar sobre **empleos autónomos o por cuenta propia** en la siguiente página. Si deja espacios en blanco, asumiremos que no reciben dinero de ese tipo. Use una hoja adicional si es necesario. Si tienen comprobantes de ingresos (recibos de sueldo, declaraciones del empleador, declaraciones impositivas, etc.), puede enviarlos con este formulario. Eso podría agilizar el procesamiento de la revisión. *Fotocopie esta página si necesita más espacio para incluir más empleos o más personas. Tache los datos que no sean correctos sobre los integrantes de su grupo familiar. Escriba los datos correctos o los datos que falten.*

Empleo 1

Nombre de la persona que está trabajando (primero y segundo nombre, apellido y sufijo)			
Nombre del empleador		Teléfono del empleador	
Domicilio del empleador	Ciudad	Estado	Código postal
¿Con qué frecuencia le pagan el sueldo o las propinas? ☐ Por hora ☐ Semana por medio ☐ Mensualmente ☐ Por semana ☐ Dos veces por mes ☐ Anualmente	¿Cuánto le pagan (antes de descontar impuestos)? $		Promedio de horas trabajadas por semana:

Empleo 2

Nombre de la persona que está trabajando (primero y segundo nombre, apellido y sufijo)			
Nombre del empleador		Teléfono del empleador	
Domicilio del empleador	Ciudad	Estado	Código postal
¿Con qué frecuencia le pagan el sueldo o las propinas? ☐ Por hora ☐ Semana por medio ☐ Mensualmente ☐ Por semana ☐ Dos veces por mes ☐ Anualmente	¿Cuánto le pagan (antes de descontar impuestos)? $		Promedio de horas trabajadas por semana:

Empleo 3

Nombre de la persona que está trabajando (primero y segundo nombre, apellido y sufijo)			
Nombre del empleador		Teléfono del empleador	
Domicilio del empleador	Ciudad	Estado	Código postal
¿Con qué frecuencia le pagan el sueldo o las propinas? ☐ Por hora ☐ Semana por medio ☐ Mensualmente ☐ Por semana ☐ Dos veces por mes ☐ Anualmente	¿Cuánto le pagan (antes de descontar impuestos)? $		Promedio de horas trabajadas por semana:

Empleo 4

Nombre de la persona que está trabajando (primero y segundo nombre, apellido y sufijo)			
Nombre del empleador		Teléfono del empleador	
Domicilio del empleador	Ciudad	Estado	Código postal
¿Con qué frecuencia le pagan el sueldo o las propinas? ☐ Por hora ☐ Semana por medio ☐ Mensualmente ☐ Por semana ☐ Dos veces por mes ☐ Anualmente	¿Cuánto le pagan (antes de descontar impuestos)? $		Promedio de horas trabajadas por semana:

¿El monto del dinero proveniente de sus empleos permanecerá más o menos igual? ☐ Sí ☐ No

Si respondió no, explique _____

¿Alguien ha sido contratado para un empleo pero aún no ha cobrado? ☐ Sí ☐ No

Si respondió sí, ¿quién? _____ Nombre del empleador _____

En los últimos tres meses, ☐ ¿cambió de empleo? ☐ ¿dejó de trabajar?
☐ ¿comenzó a trabajar menos horas? ☐ Ninguno de los anteriores

Empleo autónomo o por cuenta propia

Si alguno de los integrantes de su grupo familiar trabaja por cuenta propia, necesitamos saber sobre sus trabajos. *Lea las instrucciones con más información sobre las deducciones o retenciones.*

	Nombre (primero y segundo nombre, apellido y sufijo)	Tipo de trabajo:	¿Cuál es el ingreso neto que obtuvo este mes por empleo autónomo?
Persona 1			Importe $
Persona 2			Importe $

➢ Reste los gastos indicados debajo de su ingreso bruto para obtener el importe neto de ingresos por empleo autónomo.

- Gastos de autos o camionetas (por traslados durante la jornada laboral, que no sean para ir y regresar de su casa al trabajo)
- Depreciación
- Sueldo de empleados y beneficios adicionales
- Seguros de bienes, responsabilidad a terceros o pérdidas por interrupción comercial
- Intereses (incluye hipotecas pagadas a un banco, etc.)
- Servicios legales y profesionales
- Alquiler o arrendamiento del local o servicios públicos
- Comisiones, licencias, impuestos y honorarios
- Propaganda
- Trabajos contratados
- Reparaciones y mantenimiento
- Determinados viajes y comidas empresariales
- Impuestos deducibles para autónomos
- Costo del seguro médico para autónomos
- Contribuciones a SEP, SIMPLE, o planes de retiro calificado para empleados independientes

Infórmenos sobre otros ingresos

Tache los datos que **no sean correctos** sobre los integrantes de su grupo familiar. Escriba los datos correctos.
Fotocopie esta página si necesita más espacio para agregar otros tipos de ingresos.

Desempleo

Nombre (primero y segundo nombre, apellido y sufijo)	¿Cuánto?	¿Con qué frecuencia?
	$	☐ Semanalmente ☐ Semana por medio ☐ Anualmente ☐ Mensualmente ☐ Dos veces por mes ☐ Otra_____
	$	☐ Semanalmente ☐ Semana por medio ☐ Anualmente ☐ Mensualmente ☐ Dos veces por mes ☐ Otra_____
	$	☐ Semanalmente ☐ Semana por medio ☐ Anualmente ☐ Mensualmente ☐ Dos veces por mes ☐ Otra_____
	$	☐ Semanalmente ☐ Semana por medio ☐ Anualmente ☐ Mensualmente ☐ Dos veces por mes ☐ Otra_____

Social Security

Nombre (primero y segundo nombre, apellido y sufijo)	¿Cuánto?	¿Con qué frecuencia?
	$	☐ Semanalmente ☐ Semana por medio ☐ Anualmente ☐ Mensualmente ☐ Dos veces por mes ☐ Otra_____
	$	☐ Semanalmente ☐ Semana por medio ☐ Anualmente ☐ Mensualmente ☐ Dos veces por mes ☐ Otra_____
	$	☐ Semanalmente ☐ Semana por medio ☐ Anualmente ☐ Mensualmente ☐ Dos veces por mes ☐ Otra_____
	$	☐ Semanalmente ☐ Semana por medio ☐ Anualmente ☐ Mensualmente ☐ Dos veces por mes ☐ Otra_____

Informe sobre otros tipos de ingresos, como pensiones, jubilaciones, pensión alimenticia recibida, agricultura o pesca, ingresos por alquileres o regalías, etc.

Otro tipo de ingresos_____

Nombre (primero y segundo nombre, apellido y sufijo)	¿Cuánto?	¿Con qué frecuencia?
	$	☐ Semanalmente ☐ Semana por medio ☐ Anualmente ☐ Mensualmente ☐ Dos veces por mes ☐ Otra_____

Otro tipo de ingresos_____

Nombre (primero y segundo nombre, apellido y sufijo)	¿Cuánto?	¿Con qué frecuencia?
	$	☐ Semanalmente ☐ Semana por medio ☐ Anualmente ☐ Mensualmente ☐ Dos veces por mes ☐ Otra_____

Deducciones o retenciones

Si a alguna de las personas de su grupo familiar le realizan **deducciones o retenciones**, como pensión alimenticia, intereses por préstamos estudiantiles, etc., infórmenos de qué tipo. **No** debe incluir los costos que ya consideró en su respuesta para calcular el importe neto por empleo autónomo.

Pensión alimenticia pagada a otra persona

Nombre (primero y segundo nombre, apellido y sufijo)	¿Cuánto?	¿Con qué frecuencia?
	$	☐ Semanalmente ☐ Semana por medio ☐ Anualmente ☐ Mensualmente ☐ Dos veces por mes ☐ Otra_____

Intereses pagados por préstamos estudiantiles

Nombre (primero y segundo nombre, apellido y sufijo)	¿Cuánto?	¿Con qué frecuencia?
	$	☐ Semanalmente ☐ Semana por medio ☐ Anualmente ☐ Mensualmente ☐ Dos veces por mes ☐ Otra_____

Otras deducciones o retenciones_____

Nombre (primero y segundo nombre, apellido y sufijo)	¿Cuánto?	¿Con qué frecuencia?
	$	☐ Semanalmente ☐ Semana por medio ☐ Anualmente ☐ Mensualmente ☐ Dos veces por mes ☐ Otra_____

Seguro médico

Infórmenos sobre las **otras** coberturas de seguro médico que su grupo familiar tiene.

¿Alguien está inscripto en una cobertura médica actualmente? ☐ Sí ☐ No

Si respondió sí, marque la cobertura médica. ☐ Medicaid ☐ ***hawk-i*** ☐ Medicare ☐ Tricare
☐ Veteranos ☐ Cuerpos de Paz ☐ Plan médico para jubilados ☐ COBRA

☐ Seguro del empleador Nombre del seguro médico_____ Número de póliza_____

☐ Privado/otro_____

Coberturas médicas de empleos

Complete esta sección si alguna de las personas que figuran en este formulario califica para cobertura médica a través de su empleo, aunque no esté inscripta actualmente. Infórmenos sobre el empleo que ofrece cobertura.

Datos del empleado. El **empleado** debe completar esta sección.

Nombre del empleado (primer nombre, segundo nombre, apellido)	Nº. de Social Security

Datos del empleador. Pídale estos datos a su **empleador**.

Nombre del empleador	Nº. de identificación del empleador (EIN)	
Domicilio del empleador (Marketplace enviará notificaciones a este domicilio)	Teléfono del empleador	
Ciudad	Estado	Código postal
¿Con quién podemos comunicarnos para averiguar sobre la cobertura médica laboral de este empleado?		
Teléfono (si es diferente al anterior)	Dirección de correo electrónico	

☐ Sí ☐ No ¿Califica actualmente para la cobertura que ofrece este empleador o será elegible en los próximos tres meses?

Si respondió sí, complete los siguientes datos. **Si no**, continúe en la sección **Cambios esperados.**

Si está en el período de espera o de prueba, ¿cuándo podrá inscribirse en la cobertura?

_____

Indique los nombres de todas las personas que califiquen para cobertura a través de este empleo.

_____

Plan médico. Infórmenos sobre el **plan médico** que ofrece este empleador.

☐ Sí ☐ No ¿El plan médico ofrecido por el empleador cubre al cónyuge o a los dependientes del empleado?

Si respondió que sí, ¿a quién cubre? ☐ Cónyuge ☐ Dependientes

☐ Sí ☐ No Un plan médico laboral cumple con "la norma de valor mínimo" si la proporción cubierta por el plan no es inferior al 60% del costo total de los beneficios permitidos. ¿El empleador ofrece un plan médico que cumple con la norma de valor mínimo?

☐ Sí ☐ No ¿El plan de menor costo que cumple con "la norma de valor mínimo" ofrece un programa de salud **para el empleado únicamente**? (No incluya planes familiares.)

Si respondió sí, ¿cuánto tendría que pagar en primas después de recibir el descuento máximo por programas para dejar de fumar? (No reste los otros descuentos del programa.)

$_____

¿Con qué frecuencia? ☐ Semanalmente ☐ Cada dos semanas ☐ Dos veces por mes ☐ Trimestralmente ☐ Anualmente

Cambios del empleador. ¿Qué cambios introducirá el empleador para el próximo plan anual (si sabe)?

☐ El empleador no ofrecerá cobertura médica

☐ El empleador ofrecerá cobertura para los empleados o modificará la prima del plan de menor costo disponible para empleados que cumplan con la norma de valor mínimo. (La prima debe reflejar el descuento para programas de salud.)

¿Cuánto tendrá que pagar el empleado por las primas de ese plan? $_____

¿Con qué frecuencia? ☐ Semanalmente ☐ Cada dos semanas ☐ Dos veces por mes ☐ Trimestralmente ☐ Anualmente

Fecha del cambio:_____

Cambios esperados

Infórmenos si ha habido cambios o si podría haber cambios. Ejemplos:

- Personas en el grupo familiar
- Condición impositiva
- Empleo
- Seguro médico
- Divorcio o casamiento
- Domicilio
- Embarazo (indique la fecha de parto)
- Terminación de embarazo
- Otros

Explique qué y cuándo _____

Renovación de la cobertura en los años sucesivos

Lea la siguiente declaración y marque **una** casilla.

Con el fin de facilitar la verificación de mis ingresos para la revisión, autorizo a Department of Human Services a utilizar los datos que figuran en mis declaraciones impositivas por la cantidad de años que he marcado a continuación.

Entiendo que Department of Human Services me enviará una carta con los datos que tienen sobre mis ingresos. Podré modificarlos. Además, podré cambiar de opinión y no permitir que Department of Human Services verifique dichos datos.

Sí, doy mi autorización para verificar mis ingresos en las declaraciones impositivas por (marcar una casilla):

☐ 5 años (tiempo máximo) ☐ 4 años ☐ 3 años ☐ 2 años ☐ 1 año

☐ No, no doy mi autorización para utilizar mis declaraciones impositivas.

Lea y firme este formulario de solicitud

Su firma o marca	Teléfono	Fecha de hoy
Firma de la persona que ayudó a completar el formulario, si corresponde	Teléfono	Fecha de hoy

Conserve esta página para su información.

Sus derechos y obligaciones

- Al firmar esta solicitud, certifico bajo pena de cometer perjurio y dar falso testimonio que mis respuestas son correctas y completas a mi leal saber y entender, inclusive los datos provistos sobre la ciudadanía y la condición inmigratoria de cada uno de los integrantes de mi grupo familiar para los que solicito beneficios.
- Al firmar este formulario, autorizo a DHS a compartir sus registros médicos y otros documentos con funcionarios federales y estatales.
- Entiendo que una firma electrónica tiene el mismo efecto legal y puede ejecutarse de la misma manera que una firma escrita.
- Es de mi conocimiento que los datos que figuran en este formulario serán utilizados sólo para determinar mi elegibilidad para asistencia médica y que los mismos tendrán carácter confidencial como lo exige la ley.
- Entiendo que en el caso de recibir Medicaid, el Departamento iniciará el reclamo de ayuda económica sin fines médicos para mí y mis hijos si así lo solicito. Los servicios de ayuda económica para tratamiento médico incluyen el establecimiento de la paternidad y el establecimiento y la ejecución de ayuda económica para tratamiento médico.
- Entiendo las preguntas y los enunciados que figuran en este formulario.
- Entiendo que toda la información que he dado, inclusive los datos sobre beneficios e ingresos, serán cotejados con los datos de registros municipales, estatales y federales, como empleadores, el servicios de ciudadanía e inmigración de los Estados Unidos (USCIS), la Administración de Social Security, agencias impositivas, de bienestar social y desempleo, etc. y entiendo que la información recibida podría afectar mi elegibilidad para beneficios.
- Entiendo que los datos que he dado en este formulario, incluso los datos sobre beneficios e ingresos, están sujetos a investigación y revisión por personal federal, estatal y del condado, y que en el caso de haber provisto información incorrecta, mis beneficios serán denegados o suspendidos.
- Es de mi conocimiento que conforme a las leyes federales, se prohíbe cualquier tipo de discriminación con respecto a raza, color, país de origen, sexo y discapacidad. Puedo presentar una queja por discriminación en www.hhs.gov/ocr/office/file.
- Confirmo que ninguna de las personas para las que se solicita asistencia médica en este formulario se encuentra en prisión (detenido o preso).
- Es de mi conocimiento que otra persona puede actuar como mi representante durante el proceso. Entiendo que me explicarán sobre mi elegibilidad y otros datos importantes. Entiendo que un cambio en mi condición podría afectar la elegibilidad de los integrantes de mi grupo familiar.
- Puedo apelar la resolución de Health Insurance Marketplace o Medicaid/***hawk-i*** en el caso de considerar que se ha cometido un error. Apelar significa decirle a alguien del seguro médico Marketplace o de Medicaid/***hawk-i*** que creo que la resolución tomada es errónea y solicitar que la misma sea revisada de manera imparcial. Es de mi conocimiento que el procedimiento para apelar se encuentra en la página 8, en la sección Apelaciones.

¿Qué hago con este formulario ahora?

Después de completar el formulario, envíelo en el sobre que se adjunta. Envíelo por correo al domicilio impreso en la página 1. Dicho domicilio está debajo de su dirección postal. También puede traer el formulario personalmente a la oficina.

Información sobre los números de Social Security

Podemos ayudar sólo a aquellas personas que nos dan sus números de Social Security o el comprobante de solicitud expedido por la oficina de Social Security. **No tiene obligación de informarnos los números de Social Security de las personas de su grupo familiar que no solicitan asistencia, pero puede hacerlo si lo desea.** No obstante, tenga en cuenta que utilizaremos todos los números de Social Security del mismo modo que utilizamos los de aquellas personas que reciben asistencia.

Les denegaremos asistencia a aquellas personas de su grupo familiar que no nos informen sus números de Social Security. Existen algunas excepciones a esta regla. Por favor, pregúntele a su asistente.

No le entregaremos ningún número de Social Security al Servicio de Ciudadanía e Inmigración.

Conserve esta página para su información.

Medicaid

Verificamos lo que nos informa

La información provista será verificada por funcionarios federales, estatales y locales para constatar que es verdadera. Podríamos verificar: el número de Social Security, empleo y sueldo, saldo en cuentas bancarias, condición inmigratoria y dinero recibido de otras fuentes, como Social Security y seguro de desempleo, de cada una de las personas que figuren en la solicitud. Rechazaremos su solicitud si los datos presentados no son correctos.

Podemos revisar los registros de otros estados para ver si alguno de los integrantes de su grupo familiar puede recibir beneficios en Iowa. Esto podría ser debido a la inhabilitación de una persona en un programa de otro estado.

La verificación se realiza utilizando sistemas informáticos como el sistema estatal *Income and Eligibility Verification System* y el sistema federal *Federal Facilitated Exchange,* que incluye *Internal Revenue Service* (IRS), *Social Security Administration* (SSA) y *Department of Homeland Security* (DHS). En el caso de encontrar diferencias entre lo que nos informó y los registros del sistema informático, trataremos de averiguar cuáles son los datos correctos. Para verificar su información, podríamos comunicarnos con su empleador, su banco y otras personas. Le preguntaremos a usted primero, antes de verificar los datos con su empleador, su banco y otras personas.

Cosas que debe saber

- Deberá presentar la solicitud para otros beneficios a los que tenga derecho y deberá aceptarlos.
- Deberá entregarnos información y presentar comprobantes cuando los solicitemos.
- Deberá completar los formularios de revisión cuando sean solicitados.
- DHS podrá entregarle sus respuestas a los funcionarios encargados del orden público con el fin de capturar a aquellas personas que estén prófugas para evadir la ley.
- La unidad de Control de Calidad y la unidad de Investigaciones podrán revisar su caso. Podrían comunicarse con otras personas u organizaciones para conseguir la verificación de sus datos. Al firmar este formulario, nos da autorización para divulgar información confidencial a las unidades de Control de Calidad y de Investigaciones. Debe cooperar con ellos para conservar sus beneficios.
- Deberá reintegrar los beneficios que reciba o que sean pagados a terceros si no calificaba para recibirlos.
- La sección 1128B de la Ley de Social Security dispone sanciones a nivel federal por actos fraudulentos e informes falsos en relación a estos programas.
- Toda persona que obtenga, trate de obtener, o ayude a otra persona a obtener asistencia a la que no tiene derecho, será culpable de infringir las leyes del estado de Iowa. Esto incluye los capítulos 249 y 249A del Código de Iowa, entre otros.
- Puede presentar la solicitud para una parte de su grupo familiar aunque algunos de ellos no sean inmigrantes legales. Por ejemplo, los padres que no sean inmigrantes legales pueden presentar la solicitud para los hijos que sean ciudadanos de los Estados Unidos o extranjeros habilitados. El Departamento verificará la condición inmigratoria de su grupo familiar con el *Department of Homeland Security*. La información provista por dicho departamento podría afectar los beneficios de esas personas. No se le pedirá información a *Department of Homeland Security* sobre aquellas personas para las que no presente la solicitud. No obstante, es posible que se utilicen sus ingresos para ver si el resto del grupo familiar puede obtener Medicaid.
- ***La presentación deliberada de información incorrecta ocasionará que iniciemos un juicio civil o penal en su contra. Además, sus beneficios podrían sean reducidos o podría tener que devolver el dinero recibido.***

Esta autorización perderá validez cuando su Medicaid finalice.

Tiene derecho a apelar

Usted, o la persona que le ayuda, podrán solicitar una audiencia en caso de no estar de acuerdo con la acción tomada en su caso. Debe apelar por escrito. Para apelar por escrito, elija una de las siguientes maneras:

- Complete la apelación por Internet en https://dhssecure.dhs.state.ia.us/forms/, **o**
- Escriba una carta explicándonos por qué cree que la decisión es incorrecta, o
- Llene un formulario de Apelación y Solicitud de Audiencia (“Appeal and Request for Hearing”). Puede conseguirlo en la oficina DHS de su condado.

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

Puede representarse usted mismo o ser representado por un amigo, un familiar, un abogado o cualquier otra persona.

Si necesita servicios legales, comuníquese con la oficina DHS de su condado. Es posible que deba pagar por dichos servicios. En tal caso, el pago será proporcional a sus ingresos. Además, puede llamar a *Iowa Legal Aid* al teléfono (800) 532-1275. Si vive en el Condado de Polk, llame al (515) 243-1193.

No será discriminado

La política de Iowa Department of Human Services (DHS) es brindarles trato equitativo con respecto a empleo y prestación de servicios a los solicitantes, los empleados y los clientes, sin considerar su raza, color, país de origen, sexo, orientación sexual, identidad de género, religión, edad, discapacidad, ideología política o condición de veterano.

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

Divulgación de Información - Opcional

¡Ayúdenos a ayudarle!

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

Debe saber que:

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

Escriba su nombre en letra de imprenta y firme debajo para autorizarnos a obtener la información necesaria. Recuerde de firmar página 6.

DIVULGACIÓN DE INFORMACIÓN
(Release of Information)

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

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

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

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

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

Data

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

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

Medical Assistance Debt Notice, Form 470-4342

Purpose	The Estate Recovery section of the IME Revenue Collection Unit uses form 470-4342 to notify interested parties, including family members, that a deceased Medicaid member incurred a debt to repay for paid Medicaid claims.
Source	Form 470-4342 is issued by the Iowa Medicaid Enterprise Estate Recovery Unit.
Completion	Form 470-4342 is issued in conjunction with form 470-4339, *Medical Assistance Debt Response*, when the deceased member's estate is subject to estate recovery according to 441 IAC 76.12(7)"b" and "c." Estate Recovery staff complete this form after the reported death of a Medicaid member who was either: ♦ 55 years of age or older, or ♦ Under age 55, residing in a long-term care facility, and not able to return home.
Distribution	Estate Recovery staff sends the original to the designated interested party. A copy of the notice is retained in the Estate Recovery Unit case file.
Data	The form includes information about: ♦ The deceased member's name and state identification number. ♦ The amount of medical debt.

Medical Assistance Debt Response, Form 470-4339

Purpose	The Estate Recovery Program of the IME Revenue Collection Unit uses form 470-4339 to obtain information about the assets of a deceased Medicaid member.
Source	Form 470-4339 is generated by the HIPP Unit.
Completion	The Estate Recovery Program staff issues form 470-4339 along with form 470-4342, *Medical Assistance Debt Notice*, when the deceased's estate is subject to estate recovery. The representative of the deceased member is to complete and sign the form and then returned to the Estate Recovery Program. The income maintenance worker is not responsible for assisting with this form. The Estate Recovery Program staff will assist representatives who need help with this form.
Distribution	Estate Recovery Program staff sends the original to the designated interested party. A copy of form 470-4339 is retained in the Estate Recovery Program case file.
Data	The form includes information about: ♦ Name and date of death of the recipient ♦ Representative's name, address, and telephone number ♦ Identification of assets ♦ Identification of other expenses that must be paid ♦ Identity of the spouse, if applicable ♦ Funeral home ♦ Name and address of nursing facility, if applicable

Medical Assistance Eligibility Card, Form 470-1911

Purpose

The *Medical Assistance Eligibility Card* contains basic identifying information to enable a provider of medical care to confirm a Medicaid member's eligibility. The member is instructed to keep the permanent card and present it when receiving medical services.

Source

The *Medical Assistance Eligibility Card* is computer-generated for new approvals during the daily processing.

The IM worker or the IME Member Services Unit can generate replacement cards through the web-based system. Replacement cards for members enrolled in the Iowa Family Planning Network can also be replaced through the Family Planning Waiver system.

Completion

The *Medical Assistance Eligibility Card* is issued to the member directly. The first card is mailed at the time of initial approval.

The Department will issue replacement cards:

- Upon a member's request,
- When foster care eligibility is established, or
- When card was last issued due to IFPN eligibility.

Circumstances under which a replacement card is necessary includes:

- The card has been lost, stolen, or damaged;
- The member did not receive the initial card;
- The member's name changes; or
- A duplicate card is needed for a member who is out of the home, for example, when a child is visiting relatives over the summer.

The member will not be issued a new card if the member changes Medicaid coverage groups.

The new annual card does not guarantee Medicaid eligibility.

Distribution

Each member will receive one wallet-size card and two key tags at the time of initial approval. No more than three family members' cards will be mailed together. The cards will be mailed to the case name and mailing address. This includes those residing in a residential care facility.

Cards for new members living in a medical facility will be mailed to the facility address.

Data

The member's name, date of birth, and state identification number are printed on the wallet card and key tags.

Information on appeal rights, payment of medical bills, the Department's right to recover payments made or make a claim against another responsible for member's medical cost, and when a member should contact Iowa Medicaid Enterprise (IME) Member Services Unit is included on or with the card.

The card and tags instruct providers to verify member eligibility by calling the Eligibility Verification System (ELVS) or via the verification website. Instructions on how to gain access to the website are included for the provider.

At the time of service, providers must:

- Confirm eligibility,
- Identify any service restrictions (such as lock-in, HMO, MediPASS, or Iowa Plan), and
- Determine whether a member has other health insurance coverage.

Replacing Medical Assistance Eligibility Cards

1. To replace an annual medical card, access the Online Card Replacement Application (OCRA) through the DHS field Intranet.

2. Click on the following headings:

   - IM
   - OCRA

3. Enter the member's state identification number, or the member's last name, and birth date. Click "Search."

4. Click on the state identification number.

5. Make sure all information is correct on PRSM. If not, contact Quality Assurance at 1-800-373-6306 or (515) 281-6401 to update PRSM.

6. Once information is correct, click on the "Send a Card" box for the person who needs a replacement. Then click on "continue" at the bottom of the screen.

7. At the next screen, choose a reason the medical card is being replaced. Make notes as appropriate. Click on "Submit Request."

Medical cards will be issued within 7 to 14 days.

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

Iowa Department of Human Services

Terry E. Branstad
Governor

Kim Reynolds
Lt. Governor

Charles M. Palmer
Director

You have been approved for Medicaid because you have set up a Medical Assistance Income Trust (MAIT). This letter explains how a MAIT is used when determining your eligibility and benefits for Medicaid.

A MAIT (also referred to as a Miller Trust) is a trust set up by a person who has income that exceeds the eligibility limit for Medicaid long-term care assistance. By establishing a MAIT, your countable income is reduced when you divert all or some of your income into the trust. Income assigned and paid to the trust is not countable income to you when determining your Medicaid eligibility. However, any money available to you from the trust for basic needs is countable as unearned income in the month it is available to you. This does not include money paid from the trust for your medical expenses or facility care.

Iowa Code section 633C.3(1) requires trustees of MAITs to make specific payments from any income received or held by the trust. As long as your total countable monthly income (including income paid to the trust) is less than 125 percent of the statewide average charge for _____ services for a private pay resident, currently $_____*, the trustee may make monthly payments from the trust in the following order:

1. A reasonable amount not to exceed $10.00 (without court order) for necessary expenses of the trust.
2. An amount for the personal needs allowance of the trust beneficiary.
3. An amount for the maintenance needs allowance of a spouse and/or dependents.
4. An amount for unmet medical needs.
5. Any remaining amount, up to the Medicaid rate, is paid directly to the provider of medical services.
6. At the trustee's option, any remainder may be paid directly to:
   a. Other medical providers that would otherwise be covered by medical assistance,
   b. The state as reimbursement for medical assistance paid on behalf of the beneficiary, or
   c. Kept in the trust.

Based on your countable income and the allowable payments from the MAIT, we have determined that your trustee is to pay:

$_____to the trustee for trust administration
$_____to you for your personal needs
$_____to your spouse and/or dependents for their maintenance needs
$_____for payments of your unmet medical needs
$_____to _____ for your medical services

Any income that remains in the MAIT each month must be retained in the trust. Upon your death, the state will receive all amounts remaining in the trust, up to the amount equal to the total medical assistance paid on your behalf.

If you have any questions regarding any of these instructions, please let me know. I may be reached by phone at _____ or by e-mail at _____.

Sincerely,

cc: Trustee

* 125 percent of the average statewide charge for services to a private pay resident is adjusted annually on July 1st.

Iowa Department of Human Services

Terry E. Branstad
Governor

Kim Reynolds
Lt. Governor

Charles M. Palmer
Director

You have set up a Medical Assistance Income Trust (MAIT) in order for the Department of Human Services to determine your eligibility for Medicaid. This letter explains how a MAIT is used when determining your eligibility and benefits for Medicaid.

A MAIT (also referred to as a Miller Trust) is a trust set up by a person who has income that exceeds the eligibility limit for Medicaid long-term care assistance. By establishing a MAIT, your countable income is reduced when you divert all or some of your income into the trust. Income assigned and paid to the trust is not countable income to you when determining your Medicaid eligibility. However, any money available to you from the trust for basic needs is countable as unearned income in the month it is available to you. This does not include money paid from the trust for your medical expenses or facility care.

Iowa Code section 633C.3(2) requires trustees of MAITs to make specific payments from any property received or held by the trust. Your total countable monthly income (including income paid to the trust) is equal to or greater than 125 percent of the statewide average charge for _____ services for a private pay resident, currently $_____*. Therefore, the trustee may make monthly payments from the trust in the following order:

1. A reasonable amount not to exceed $10.00 (without court order) for necessary expenses of the trust.

2. All remaining amounts paid into the trust or retained from prior months must be paid to the beneficiary. This payment is considered as income to the beneficiary when determining Medicaid eligibility.

Address goes here.

Based on your countable income and the allowable payment from the MAIT, we have determined that your trustee is to pay:

$_____to the trustee for trust administration
$_____to you

Based on these payments, the amount to be paid to you puts you over the income limit and ineligible for Medicaid.

If you have any questions regarding any of these instructions, please let me know. I may be reached by phone at _____ or by e-mail at _____.

Sincerely,

cc: Trustee

* 125 percent of the average statewide charge for services to a private pay resident is adjusted annually on July 1st.

Medical Assistance Income Trust, Form 470-4488

Purpose	Form 470-4488 is used to notify both a medical assistance income trust (MAIT) beneficiary who has applied for Medicaid facility or waiver service and the trustee that the application has been approved. The letter explains how the trust affects Medicaid eligibility and benefits and how the income of the trust should be distributed.
Source	Complete form 470-4488 on line using the template on the DHS Intranet eForms web page.
Completion	The income maintenance worker prepares the form when the Department approves a medical facility or waiver application involving MAIT income.
Distribution	Mail a copy to the Medicaid applicant or member (or the responsible person) and to the trustee. Keep a copy in the case record.
Data	Complete the preface page with the following information: ♦ Case number ♦ Facility type ♦ Expenses the trustee may pay ♦ Any remaining trust income to be paid as client participation and the name of the provider this client participation would be paid to ♦ The name of anyone you would like to get a copy of this letter

Medically Needy Recoupment Memo, Form 470-3739

Purpose	The IME Medically Needy Unit uses form 470-3739 to notify the income maintenance worker that a recoupment needs to be completed because the client did not incur the expenses used to meet spenddown.
Source	The IME Medically Needy Unit supplies this form.
Completion	The IME Medically Needy Unit completes this form.
Distribution	The original is sent to the client's income maintenance worker.
Data	The Medically Needy Unit indicates the following information: ♦ Client name ♦ Case number ♦ Reason for the recoupment ♦ Certification period ♦ Amount applied to spenddown or paid in error

Iowa Department of Human Services

Medically Needy Transmittal

Case Name		Case Number
Recipient ID	Beginning Certification Date	Ending Certification Date
Payment Date of the Claim	Payment Amount	Payment Source

IM Worker County Number	IM Worker Number
IM Worker Name	IM Worker Phone Number
Date Claim Received	Date Claim Sent to Medically Needy Unit

Medically Needy Transmittals and attached documents can be faxed to the Medically Needy Unit at (515) 725-1350, or sent to the IME Medically Needy Unit email at IMEMedicallyNeedy@dhs.state.ia.us.

Comments:

Complete this area if submitting a bill for RCF personal care, transportation or facility

☐ RCF Personal Care ☐ Transportation ☐ Medical Facility (NF, SNF, ICF-ID)

From Date	To Date	Procedure Code	Charged Amount

Provider Name			
Provider Address			
City	State	Zip Code	Phone Number ( )

National Provider _____ or Provider Number _____

Medically Needy Transmittal, Form 470-3630

Purpose	The purpose of the *Medically Needy Transmittal* is to allow the IM worker to submit old bills or non-Medicaid-payable charges to the IME Medically Needy Unit to apply toward spenddown.
Source	Complete form 470-3630 on line using the template available on the DHS Intranet eForms web page.
Completion	The income maintenance worker completes the form and attaches it to a copy of the nontraditional or non-Medicaid-covered claim submitted for the person who is conditionally eligible or responsible relative, under the Medically Needy program. Some examples of non-Medicaid-payable expenses are: ♦ RCF personal care. ♦ Bills for services received before the start of a certification period. ♦ Non-Medicaid payable NF, SNF, ICF/ID, or MHI charges. ♦ Expenses from a provider not enrolled in Medicaid. ♦ Payment for rehabilitative services. ♦ Transportation expenses. ♦ Acupuncture.
Distribution	Fax the form to the Medically Needy Unit at (515) 725-1350 or email the form to IMEMedicallyNeedy@dhs.state.ia.us. Attach the medical claim or bill. EXCEPTION: No bill or claim needs to be attached for RCF personal care services, medical facility (SNF or ICF/ID) care, or transportation. Keep the second copy in the case record with a copy of the accompanying claim or bill.
Data	**Case name:** Enter the complete case name, including last and first name, before sending to the Medically Needy Unit. **Case number:** Enter the medically needy case number including the FBU.

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

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

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

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

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

Payment Source: Enter the source of the payment in:

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

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

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

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

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

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

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

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

Comments: Use this section:

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

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

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

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

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

Procedure Code: Enter the applicable code:

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

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

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

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

City: This is the city where:

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

State: This is the state where:

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

ZIP: This is the ZIP code of:

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

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

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

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

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

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

Purpose	Medicare beneficiaries who apply for Extra Help with Medicare Prescription Drug Costs may at the same time indicate that they want to apply for the Medicare Savings Programs (MSP). The Social Security Administration (SSA) will send the data from the application electronically to the Department.
Source	The form will automatically be populated with the data from the *Application for Extra Help with Medicare Prescription Drug Plan Costs*. The system will generate the form and mail it to the applicant. Print supplies of the Spanish version from the sample in the manual.
Completion	The applicant will review the printed data and make corrections as needed. The applicant will complete the additional questions needed to determine eligibility for the Medicare Savings Programs.
Distribution	SSA will provide only the mailing address. Applicants will return the form to a local office based on their mailing address. If the living address is in another county, the office receiving the form shall route the original form to the DHS office responsible for the applicant's county of residence within two days of receipt.
Data	Date-stamp the original form before faxing or mailing it to the DHS office responsible for processing the application. The following information will be printed on form 470-4846, *Medicare Savings Programs Additional Information Request*: ♦ Applicant's name ♦ Birth date ♦ Spouse's name ♦ Telephone number ♦ Mailing address ♦ Case number and worker number

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

Iowa Department of Human Services

MEPD Billing Statement

Keep this part for your records
Name:
State ID Number:
Billing date:

ACCOUNT SUMMARY:
The DUE DATE on the coupon below is for the premium you need to pay this month. Each monthly line shows the due date for the premium each month that needs to be paid.

Month	Premium Amount	Due Date	Payment Received	Date Applied	Refund Amount	Amount to pay each month

Premium Owed:
Total you paid early:
Amount you need to pay:

470-3902 (Rev. 9/14) H3902A

Over

Tear along this line

MEPD Billing Coupon

Send this part with payment

You must send the **MEPD Billing Coupon** with your payment. If you do not send this coupon with your payment, it will delay being credited to your account. Write your name and State ID on your check or money order.

Name:
State ID number:

Due Date:
Amount you need to pay:
Amount paid:

Iowa Medicaid Enterprise
MEPD Premium
PO Box 10339
Des Moines, IA 50306-9948

Important Information About Your MEPD Bill

- ✓ You will not get Medicaid coverage for a month until you pay the premium owed for that month.
- ✓ If you do not pay the premium on time, you will be canceled from MEPD medical assistance.
- ✓ Be sure to include the MEPD billing coupon with your payment. If you do not include the MEPD billing coupon, your premium payment will take longer to be paid to your account.
- ✓ Send a payment for each MEPD member with the billing coupon for that member in one envelope.
- ✓ Payment may be made by **mail only.**
- ✓ If you lose the return envelope, mail payment to this address:

  Iowa Medicaid Enterprise
  MEPD Premium
  PO Box 10339
  Des Moines, IA 50306-9948
- ✓ Make your payment payable to the Iowa Department of Human Services, MEPD.
- ✓ Thank you for not sending cash.
- ✓ Thank you for not stapling, using paper clips, or including other papers in the same envelope with this payment.
- ✓ Payments can be sent in early. Some people like to pay a month before the due date.
- ✓ Use blue or black ink only.

Questions or changes? Call your DHS worker.

MEPD Billing Statement, Form 470-3902

Purpose	The *MEPD Billing Statement* is sent to members in the Medicaid for Employed People with Disabilities (MEPD) coverage group when a premium is assessed.
Source	The statement is computer-generated from the MEPD billing system.
Completion	The billing statement is issued directly from Central Office. When a member reports non-receipt of a billing statement, send a reprint of the billing statement by making entries on the MEPD STMT screen in the REPRINT CLIENT field. A postage-paid window envelope is included for members to remit premium payments.
Distribution	One copy of the billing statement is mailed to the member. If a copy of a billing statement is needed for an appeal, make entries on the MEPD STMT screen in the REPRINT (WRKR) field.
Data	The billing statement: ♦ Contains the billing date, the case name, and the member's state identification number. ♦ Identifies the amount owed per month, the payment due date, payments received, and date payments were applied. ♦ Notifies the MEPD member that the payment of premiums must be made before medical assistance is given. ♦ Instructs members to remit the coupon on the bottom portion of the statement in the enclosed envelope with their payment.

MEPD Income Worksheet, Form 470-3686

Purpose

Form 470-3686 is used to calculate income eligibility and the premium amount for the SSI-related coverage group "Medicaid for Employed People with Disabilities" (MEPD). It provides the client with information on the computation and assists the IM worker in making an accurate computation.

Source

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

Completion

The IM worker completes the form when calculating income eligibility for the retroactive or current premium period or as otherwise needed. When there are more than six family members, add the income of all other members and enter it in the last income column.

Distribution

Mail the form to the client. Attach a copy to the case record. Attach income verification to the form when required.

Data

Fields requiring entries are:

1. **Case name**: Enter the name of the disabled person who is the eligible person on the case. This person is always "Person A." A message box will ask, "Is the MEPD person the only one with income?" "Yes" allows entries only for Person A. "No" allows entries for multiple people.

2. **Case number**: Enter the MEPD case number with FBU.

3. **Premium period**: Enter the 12-month premium period. The "From" entry is the first month of the period (the month and year in the TD05 LAST REVIEW field). The "Next" entry is the 12th month of the period (the month and year in the TD05 NEXT REVIEW field).

   If the calculation is for individual months, such as months in the retroactive period that are determined on a month-by-month basis, enter month and year.

4. **Unearned income**:

   - Enter the average monthly unearned income for the MEPD person from each source in column 4-A.

- Enter in columns 4-B through 4-F the average monthly unearned income from each source for the persons included in the family size. Enter the full amount of child support received for children under the age of 18.

8. **Earned income**: First check the frequency the income is received. Checking "monthly" will total all the amounts entered. Checking "weekly," "twice a month," or "every 2 weeks" will average the amounts entered. All income from the MEPD person must be entered under Person A.

13. Enter impairment-related work expense. (If an entry is made in line 13, no entry is allowed in line 17.)

17. Enter work expenses for the blind. (If an entry is made in 17, no entry is allowed in 13.)

20. Enter the amount that is excluded under a plan for achieving self-support (PASS).

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

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

The template:

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

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

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

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

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

MEPD Information About Premium Payments, Form 470-3928

Purpose	Form 470-3928, *MEPD Information About Premium Payments*, is a notice to advise MEPD members who need to pay a premium before they are eligible for Medicaid about the due date for premiums and to advise them they may want to pay the premium sooner than the due date.
Source	The form is system generated by the MEPD billing system.
Completion	The form is informational only.
Distribution	The form is sent to: ♦ Members newly approved for MEPD who have a premium to pay. ♦ Current members who go from having zero premiums to having to pay a premium.
Data	The form advises the members about: ♦ The due date for ongoing premiums. ♦ The fact that premiums must be paid before Medicaid will pay for medical expenses. ♦ The benefit of paying in advance of the due date. ♦ The address where premium payments are to be sent.

MEPD Intent to Return to Work, Form 470-4856

Purpose	Form 470-4856, *MEPD Intent to Return to Work*, is used only to collect information for the Medicaid for employed people with disabilities (MEPD) coverage group.
Source	Initiate the form on line using the template on the DHS Internet eForms web page.
Completion	After a MEPD member reports a loss of employment, the income maintenance (IM) worker issues the form to obtain: ♦ The member's written statement of intent to return to work. ♦ The last day the member worked. ♦ Proof of final pay amount from employment. The member completes and signs the form.
Distribution	Give one copy to the member. You may upload the request to the electronic case file. When the member returns the original, it will be scanned and uploaded.
Data	Entering the case number for the MEPD case will populate the name, address, and salutation of the MEPD member. The worker profile will populate the worker address and contact information.

MEPD Refund Notice, Form 470-3743

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

New Household Member, Form 470-3780

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

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

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

Noncooperation Notice, Form 470-0479

Purpose	The Bureau of Quality Control uses the *Noncooperation Notice* to notify the local office when a client has refused to cooperate and to instruct the local office on the action to take on a client's case.
Source	An electronic template for form 470-0479 is available on the QC share. Reviewers need to copy the form to their computer.
Completion	The Quality Control reviewer completes this form whenever Quality Control determines that a client has refused to cooperate.
Distribution	The Quality Control reviewer sends the original to the local office and files a copy as a permanent record with the completed review.
Data	The Quality Control reviewer completes the following:

- **Date:** The date the form is prepared.
- **County:** The local office where the client currently receives benefits, last received benefits, or had an application rejected.
- **QC Reviewer:** The Quality Control reviewer's name.
- **Case Worker:** The IM worker who is currently handling the case record or last handled the case record.
- **Phone:** The Quality Control reviewer's telephone number.
- **Case Name:** The client's name.
- **Case No:** The client's case number.
- **Persons Not Cooperating:** The name of the person who was required to cooperate with Quality Control but failed to. List the client's name here if it is not the same person as the case name. All non-cooperating household members should be listed on this form.
- **QC Review No:** The client's Quality Control review number.
- **Reference:** The manual reference for failure to cooperate.

NOTICE OF ACTION

Case Number: Date:

Worker ID:
Worker Name:
Worker Phone:

Please review the entire notice. If you have questions, call your worker. We take collect calls.

If you are in need of additional services (such as nursing facility, services to remain in your home, PMIC, help paying your Medicare premium, etc.), please contact your worker.

BENEFIT MONTH	
Unearned Income	
Unearned Income Deductions	
Net Unearned Income	
Combined Income Deductions	
Income Adjustments	
Allocation and Other Deductions	

BENEFIT YEAR 2014	
Earned Income	
Earned Income Deductions	
Net Earned Income	
Total Net Income	
Total Countable Income	
Household Size	
Household Income Limit	

These rules apply:

You have the right to ask for an appeal. For information on how to appeal, see the last page of this notice or go online to www.dhs.iowa.gov.

You Have the Right to Appeal

What is an appeal?

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

How do I appeal?

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

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

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

How long do I have to appeal?

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

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

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

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

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

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

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

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

How will I know if I get a hearing?

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

Can I have someone else help me in the hearing?

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

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

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

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

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

(Food Assistance only) USDA – Director, Office of Adjudication, 1400 Independence Ave SW, Washington, DC 20250-9410, or call 1-866-632-9992 voice. Individuals who are hearing impaired or have speech disabilities may contact USDA through the Federal Relay Service at 800-877-8339; or 800-845-6136 (Spanish).

Additional Information: Health Insurance Portability and Accountability Act (HIPPA) information can be found online at www.dhs.iowa.gov.

NOTICE OF ACTION
(NOTIFICACIÓN DE ACCIÓN)

Caso Nº: Fecha: de de

ID del asist.:
Nombre:
Teléfono:

Por favor, lea toda la notificación. Si tiene dudas, llame a su asistente. Aceptamos llamadas por cobrar.

Comuníquese con su asistente en el caso de necesitar servicios adicionales (como geriátrico, servicios para permanecer en su hogar, PMIC, asistencia para pagar la prima de Medicare, etc.).

BENEFICIO DEL MES	
Ingresos no laborales	
Descuentos sobre ingresos no laborales	
Total neto de Ingresos no laborales	
Descuentos combinados sobre ingresos	
Ajustes de ingresos	
Asignación y otros descuentos	

BENEFICIO DEL AÑO 2014	
Ingresos laborales	
Descuentos sobre ingresos laborales	
Total neto de ingresos laborales	
Total de ingresos netos	
Total de ingresos acreditables	
Tamaño del grupo familiar	
Límite de ingresos del grupo familiar	

Corresponde aplicar las siguientes normativas:

Tiene derecho a apelar. Para obtener información sobre cómo apelar, consulte la última página de esta notificación o por Internet en http://dhs.iowa.gov/.

Tiene derecho a apelar

¿Qué es una apelación?

Una **apelación** es solicitar una audiencia porque no está conforme con la decisión tomada por *Department of Human Services* (DHS). Tiene derecho a presentar una apelación si no está de acuerdo con una resolución. No tiene que pagar nada para presentar la apelación. [Código Administrativo de Iowa 441--Capítulo 7].

¿Cómo se apela?

Presentar una apelación es sencillo. Puede apelar personalmente, por teléfono o por escrito para Food Assistance o Medicaid. Debe apelar por escrito para todos los otros programas. Para apelar por escrito, haga **una** de las siguientes cosas:

- Complete el formulario de apelación por Internet en https://dhssecure.dhs.state.ia.us/forms/, **o**
- Escriba una carta explicando por qué cree que la decisión es incorrecta, **o**
- Complete el formulario de Apelación y Solicitud de Audiencia ("*Appeal and Request for Hearing*"). Puede conseguirlo en la oficina DHS de su condado.

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

¿Cuánto tiempo tengo para apelar?

Para presentar una apelación de Food Assistance o Medicaid, tiene 90 días corridos a partir de la fecha de la resolución. Para todos los otros programas, debe presentar la apelación:

- En un plazo de 30 días corridos a partir de la fecha de la resolución, o
- Antes de la fecha en que la resolución entre en vigencia.

Si presenta la apelación después de transcurridos 30 días, pero antes de los 90 días corridos posteriores a la fecha de la resolución, deberá explicarnos por qué presentó la apelación tardíamente. Si existió un motivo que justifique el retraso, nosotros decidiremos si se le concederá una audiencia.

No podremos concederle una audiencia si presenta la apelación con posterioridad a los 90 días corridos contados a partir de la fecha de la resolución.

¿Puedo continuar recibiendo beneficios mientras mi apelación esté pendiente?

Puede conservar sus beneficios hasta que se expida el fallo final de la apelación o hasta que termine su período de certificación, siempre y cuando presente la apelación:

- En un plazo de 10 días corridos a partir de la fecha en que reciba la notificación. Se considera que recibirá la notificación 5 días después de ser expedida, o
- Antes de la fecha en que la resolución entre en vigencia.

Si se determina que el Departamento actuó correctamente, tendrá que devolver todos los beneficios que reciba mientras se resuelve la apelación.

¿Cómo me informarán si me concedieron la audiencia?

Recibirá una notificación de audiencia informándole la fecha y la hora programadas para la audiencia telefónica. En el caso de no concederle una audiencia, le enviaremos una carta informándole el motivo de dicha decisión. También le explicaremos qué puede hacer si no está de acuerdo con la decisión de no concederle una audiencia.

¿Puedo tener ayuda de otra persona durante la audiencia?

Usted o alguien más, como un amigo o un pariente, podrán explicar por qué no está de acuerdo con la resolción del Departamento. También podrá tener ayuda de un abogado, pero el Departamento no pagará los honorarios. La oficina DHS de su condado le puede dar información sobre servicios legales. El costo de los servicios legales se calculará de acuerdo a sus ingresos. También puede llamar a *Iowa Legal Aid* al teléfono 1-800-532-1275. Si vive en el Condado de Polk, llame al 243-1193.

Política sobre discriminación, acoso, acción afirmativa e igualdad de oportunidades laborales

La política de Iowa Department of Human Services (DHS) es brindarles tratamiento equitativo con respecto a empleo y prestación de servicios a los solicitantes, los empleados y los clientes, sin considerar su raza, color, país de origen, sexo, orientación sexual, identidad de género, religión, edad, discapacidad, ideología política o condición de veterano.

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

(Food Assistance solamente) USDA – Director, Office of Adjudication, 1400 Independence Ave SW, Washington, DC 20250-9410, o llame al 1-866-632-9992 (voz). Aquellas personas que tengan deficiencias auditivas o problemas de habla pueden comunicarse con USDA a través del servicio *Federal Relay Service* al 800-877-8339, o al 800-845-6136 (español).

Información adicional: Consulte la Ley *Health Insurance Portability and Accountability* (HIPPA) por Internet en http://dhs.iowa.gov/.

Notice of Action, Form 470-0485(M) or 470-0485(MS)

Purpose

The *Notice of Action* is issued by the ELIAS system to notify clients of agency actions that affect the client's eligibility or benefit level. Each client has the right to be given information regarding eligibility and benefit determination.

Source

In most situations, the ELIAS system generates form 470-0485 based on worker entries or system processes. The Spanish version of the form is manually issued by the worker.

Workers can complete the manual version, form 470-0485(M) or its Spanish translation *Notificación de Acción*, form 470-0486(MS), on line using the templates on the DHS Intranet eForms web page.

Completion

The *Notice of Action* may be used for:

- FIP, RCA, and Food Assistance actions
- FMAP-related Medicaid and RMA actions
- Medically Needy denials
- SSI-related Medicaid, State Supplementary Assistance, and HIPP actions, when appropriate

ELIAS system entries generate form 470-0485.

Distribution

ELIAS-generated notices are mailed to the client. A copy is filed in the electronic case file.

For manually generated notices, send the original to the client. File the copy in the electronic case file.

If there is a guardian, conservator or authorized representative, provide that person with a photocopy of the notice.

Data

The IM worker completes the fields for a manually prepared *Notice of Action* on eForms.

Entering the case number on page 1 will populate the case number on pages 2 and 3.

NOTE: When using the template, IM workers should copy the language of the system notice reasons from the file labeled "Master Library for NOA" found in Field Income Staff Resources, under ELIAS Resource links.

Notice of Attribution of Resources, Form 470-2588

Purpose	Form 470-2588 is used to notify both spouses of what resources are protected for the community spouse.
Source	Complete form 470-2588 on line using the template on the DHS Intranet eForms web page.
Completion	The income maintenance worker prepares the form when the Department makes a decision on the attribution of resources.
Distribution	Mail a copy to each spouse and file a copy in the case record.
Data	Enter the date and the income maintenance worker's name, county, and phone number. Enter the names and social security numbers of the spouse in the facility and the spouse at home. List all countable resources of both spouses and indicate the excluded resources. If there are jointly owned countable resources, list these under the column of each spouse by dividing the value in half. The template will calculate a total of the combined countable resources as they are entered and will automatically determine the amount of protected resources for the community spouse as directed in 8-D, Calculating the Amount to Attribute to the Community Spouse. The correct check box will automatically be marked based upon the calculation of the protected amount for the community spouse. The remainder of the resources will be assigned to the spouse in the medical institution. The template will automatically enter the minimum monthly maintenance needs allowance (MMMNA) that is in effect at the time of determination of attribution in the paragraph beginning "If you disagree." The worker has the ability to change this amount when needed.

Notice of Cancellation/Redetermination, Form 470-3152 or 470-3152(S)

Purpose	The *Notice of Cancellation/Redetermination* combines the functions of the *Notice of Decision* and a request for additional information, to save time in automatic redetermination cases.
Source	Workers can complete the English version of this form on line using the template on the DHS Intranet eForms web page. Print supplies of the Spanish version from the sample in the manual.
Completion	Complete the notice when you determine that a client is ineligible under the current coverage group, but you need additional information to determine eligibility under another coverage group.
Distribution	Send the original to the client. File the copy in the case record. Also provide a copy of the notice to the client's guardian or conservator, if there is one.
Data	The form is self-explanatory. Enter the following information: ♦ County number, worker name, telephone number, and email address. ♦ Case name, number, and current mailing address. ♦ The date the notice is mailed. ♦ Date of cancellation and the reason the action is being taken. ♦ Manual and rule reference to support the reason for cancellation. The manual reference shall consist of the manual title, chapter number, and subheading (i.e., 8-C, Cooperation With Support Recovery). Use the legal references found under the subheading. ♦ Verification requested. ♦ Date requested verification is due in the requesting DHS office. ♦ The requesting office's return address. (This may be stamped on the form.)

Notice of Child Care Assistance Overpayment, Form 470-4530

Purpose	Form 470-4530 informs the debtor on a Child Care Assistance claim of the amount and reason for the overpayment and requests repayment.
Source	Form 470-4530 is generated monthly by the Overpayment Recovery System.
Completion	The form is printed for debtors who: ♦ Have a Child Care Assistance claim entered on the Overpayment Recovery System, and ♦ Have not submitted an agreement to repay the debt. This form is partly completed by the Overpayment Recovery System. The debtor is responsible for completing the agreement to repay. At least one form must be sent before a debt setoff takes place. State income tax refunds, rebates, or other state payments, including state employee wages may be offset to pay the debt.
Distribution	One copy is mailed from Central Office.
Data	The system completes: ♦ The amount of overpayment, and ♦ The type of error, and ♦ The reason for the overpayment. The debtor completes the repayment terms.

Notice of Child Care Assistance Provider Sanction, Form 470-4053

Purpose	The *Notice of Child Care Assistance Provider Sanction* is used to notify families that their child care provider has been sanctioned by the Child Care Assistance (CCA) program and that they may need to select another provider if they want CCA to continue paying for their child care services.
Source	This form is not available in printed form. CCA workers shall complete this form on line using the template on the DHS Intranet eForms web page. PROMISE JOBS workers shall complete this form on line using the template provided by DHS.
Completion	When a sanction is imposed, the DHS child care worker or PROMISE JOBS worker shall complete a *Notice of Child Care Assistance Provider Sanction* for every CCA family using the sanctioned provider.
Distribution	Mail one copy to the family and keep a copy in the family's DHS or PROMISE JOBS case file. Provide a copy of this letter to PROMISE JOBS if necessary.
Data	The template automatically enters the notice date. Use the "tab" key to navigate between fields requiring data entry. Enter the following information: ♦ The family's name and mailing address ♦ The parent or guardian's first name ♦ The child care provider's name Click or tab to the text box and: ♦ Choose "Yes" if the letter is going to a CCA family or "No" if the letter is going to a family who does not get CCA. ♦ Select the applicable sanction type. ♦ Click the "insert language" button. ♦ Enter the sanction effective date.

If the letter is going to a CCA family, enter:

- The child care worker's name
- The county name
- The worker's phone number

If the letter is **not** going to a CCA family, enter:

- The county name
- The DHS office phone number

Once all fields have been entered, print a copy of the letter for the family and another copy for the CCA case file, if any.

Notice of Decision

Worker Name

Case Number

Worker Phone

Please review the entire notice. If you have questions, call your worker. We take collect calls.

You may look at the Employees Manual (EM) at the department's county office. You have the right to ask for an appeal. If you want an appeal, read and follow the steps on the back of this page. If you need help in filing your appeal, you can ask for help from your county office or you may call Iowa Legal Aid at 1-800-532-1275. If you live in Polk County, call 243-1193 for Legal Aid.

See the other side of this notice for the action taken on your case.

You Have the Right to Appeal

What is an appeal?

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

How do I appeal?

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

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

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

How long do I have to appeal?

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

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

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

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

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

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

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

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

How will I know if I get a hearing?

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

Can I have someone else help me in the hearing?

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

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

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

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

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

(Food Assistance only) USDA – Director, Office of Adjudication, 1400 Independence Ave SW, Washington, DC 20250-9410, or call 1-866-632-9992 voice. Individuals who are hearing impaired or have speech disabilities may contact USDA through the Federal Relay Service at 800-877-8339; or 800-845-6136 (Spanish).

Notice of Decision

Worker Name

Case Number

Worker Phone

Please review the entire notice. If you have questions, call your worker. We take collect calls.

You may look at the Employees Manual (EM) at the department's county office. You have the right to ask for an appeal. If you want an appeal, read and follow the steps on the back of this page. If you need help in filing your appeal, you can ask for help from your county office or you may call Iowa Legal Aid at 1-800-532-1275. If you live in Polk County, call 243-1193 for Legal Aid.

Notice of Decision

Worker Name

Case Number

Worker Phone

Please review the entire notice. If you have questions, call your worker. We take collect calls

You may look at the Employees Manual (EM) at the department's county office. You have the right to ask for an appeal. If you want an appeal, read and follow the steps on the back of this page. If you need help in filing your appeal, you can ask for help from your county office or you may call Iowa Legal Aid at 1-800-532-1275. If you live in Polk County, call 243-1193 for Legal Aid.

Notice of Decision (Aviso de decisión)

Nombre del trabajador

Número del caso

Número del trabajador

Por favor lea detenidamente todo el contenido de la notificacion. Si tiene dudas, llame a su asistente. Aceptamos llamadas por cobrar.

Usted puede mirar el Manual del Empleado (EM) en la oficina del Condado. Tiene derecho a solicitar una apelación. Si desea una apelación, lea y siga los pasos que se indican al reverso de esta página. Si necesita ayuda para presentar su apelación, puede pedirla a su oficina de condado, o puede llamar a Iowa Legal Aid al 1-800-532-1275. Si vive en Polk County, llame al 243-1193.

Ver el reverso de este aviso para anotar la acción tomada en su caso.

Tiene derecho a apelar

¿Qué es una apelación?

Una **apelación** es solicitar una audiencia porque no está conforme con la decisión tomada por *Department of Human Services* (DHS). Tiene derecho a presentar una apelación si no está de acuerdo con una resolución. No tiene que pagar nada para presentar la apelación. [Código Administrativo de Iowa 441--Capítulo 7].

¿Cómo se apela?

Presentar una apelación es sencillo. Puede apelar personalmente, por teléfono o por escrito para Food Assistance o Medicaid. Debe apelar por escrito para todos los otros programas. Para apelar por escrito, haga **una** de las siguientes cosas:

- Complete el formulario de apelación por Internet en https://dhssecure.dhs.state.ia.us/forms/, **o**
- Escriba una carta explicando por qué cree que la decisión es incorrecta, **o**
- Complete el formulario de Apelación y Solicitud de Audiencia ("*Appeal and Request for Hearing*"). Puede conseguirlo en la oficina DHS de su condado.

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

¿Cuánto tiempo tengo para apelar?

Para presentar una apelación de Food Assistance o Medicaid, tiene 90 días corridos a partir de la fecha de la resolución. Para todos los otros programas, debe presentar la apelación:

- En un plazo de 30 días corridos a partir de la fecha de la resolución, o
- Antes de la fecha en que la resolución entre en vigencia.

Si presenta la apelación después de transcurridos 30 días, pero antes de los 90 días corridos posteriores a la fecha de la resolución, deberá explicarnos por qué presentó la apelación tardíamente. Si existió un motivo que justifique el retraso, nosotros decidiremos si se le concederá una audiencia.

No podremos concederle una audiencia si presenta la apelación con posterioridad a los 90 días corridos contados a partir de la fecha de la resolución.

¿Puedo continuar recibiendo beneficios mientras mi apelación esté pendiente?

Puede conservar sus beneficios hasta que se expida el fallo final de la apelación o hasta que termine su período de certificación, siempre y cuando presente la apelación:

- En un plazo de 10 días corridos a partir de la fecha en que reciba la notificación. Se considera que recibirá la notificación 5 días después de ser expedida, o
- Antes de la fecha en que la resolución entre en vigencia.

Si se determina que el Departamento actuó correctamente, tendrá que devolver todos los beneficios que reciba mientras se resuelve la apelación.

¿Cómo me informarán si me concedieron la audiencia?

Recibirá una notificación de audiencia informándole la fecha y la hora programadas para la audiencia telefónica. En el caso de no concederle una audiencia, le enviaremos una carta informándole el motivo de dicha decisión. También le explicaremos qué puede hacer si no está de acuerdo con la decisión de no concederle una audiencia.

¿Puedo tener ayuda de otra persona durante la audiencia?

Usted o alguien más, como un amigo o un pariente, podrán explicar por qué no está de acuerdo con la resolción del Departamento. También podrá tener ayuda de un abogado, pero el Departamento no pagará los honorarios. La oficina DHS de su condado le puede dar información sobre servicios legales. El costo de los servicios legales se calculará de acuerdo a sus ingresos. También puede llamar a *Iowa Legal Aid* al teléfono 1-800-532-1275. Si vive en el Condado de Polk, llame al 243-1193.

Política sobre discriminación, acoso, acción afirmativa e igualdad de oportunidades laborales

La política de Iowa Department of Human Services (DHS) es brindarles tratamiento equitativo con respecto a empleo y prestación de servicios a los solicitantes, los empleados y los clientes, sin considerar su raza, color, país de origen, sexo, orientación sexual, identidad de género, religión, edad, discapacidad, ideología política o condición de veterano.

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

(Food Assistance solamente) USDA – Director, Office of Adjudication, 1400 Independence Ave SW, Washington, DC 20250-9410, o llame al 1-866-632-9992 (voz). Aquellas personas que tengan deficiencias auditivas o problemas de habla pueden comunicarse con USDA a través del servicio *Federal Relay Service* al 800-877-8339, o al 800-845-6136 (español).

Notice of Decision (Aviso de decisión)

Nombre del trabajador

Número del caso

Número del trabajador

Por favor lea detenidamente todo el contenido de la notificacion. Si tiene dudas, llame a su asistente. Aceptamos llamadas por cobrar.

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Notice of Decision (Aviso de decisión)

Nombre del trabajador

Número del caso

Número del trabajador

Por favor lea detenidamente todo el contenido de la notificacion. Si tiene dudas, llame a su asistente. Aceptamos llamadas por cobrar.

Usted puede mirar el Manual del Empleado (EM) en la oficina del Condado. Tiene derecho a solicitar una apelación. Si desea una apelación, lea y siga los pasos que se indican al reverso de esta página. Si necesita ayuda para presentar su apelación, puede pedirla a su oficina de condado, o puede llamar a Iowa Legal Aid al 1-800-532-1275. Si vive en Polk County, llame al 243-1193.

Notice of Decision, Form 470-0485, 470-0485(S), 470-0486, or 470-0486(S)

Purpose

The *Notice of Decision* is used to notify clients of agency actions that affect the client's eligibility or benefit level. Each client has the right to be given information regarding eligibility and benefit determination.

Source

In most situations, the ABC system generates form 470-0485 and 470-0485(S), based on worker entries or system processes.

Workers can complete the manual version, form 470-0486 or its Spanish translation *Aviso de Decisión*, form 470-0486(S), on line using the templates on the DHS Intranet eForms web page.

Completion

The *Notice of Decision* is used for:

- FIP, RCA, and Food Assistance actions
- FMAP-related Medicaid and RMA actions
- Medically Needy denials
- SSI-related Medicaid, State Supplementary Assistance, and HIPP actions, when appropriate

System entries that produce the following actions will generate form 470-0485 (or form 470-0485(S) if the LI field on TD01 is coded "S"):

- An application is pended (for Food Assistance only).
- An application is approved (except for Medically Needy, SSI-related Medicaid, and State Supplementary Assistance cases).
- An application is denied or withdrawn (except for SSI-related Medicaid and State Supplementary Assistance cases).
- The benefit amount is calculated.
- Benefits are changed after a review or redetermination.
- Benefits are reinstated or a reinstatement request is denied.
- Benefits and eligibility are canceled for reasons other than failing to return a completed report form.
- Medical benefits change, including an extension after cancellation due to increased earnings of the payment of child support.

- A person is added to an ongoing case.
- A person is removed from an ongoing case.
- A person is added to a case for a preceding month and the income for that month is different from income for the current month.
- A payment adjustment or corrective payment is authorized (for FIP and RCA only).
- An allowance for a special need is authorized, denied, or canceled (for FIP and RCA only).
- Action is necessary by the household to receive or continue benefits (for Food Assistance only).

You may suppress the system-generated form and manually prepare form 470-0486 or 470-0486(S) when issues of timing, or overlapping case actions make the system-generated notice inappropriate. (See ABC system instructions in Title 14.)

NOTE: When issuing a manual notice for SSI-related Medicaid or State Supplementary Assistance actions, use form 470-0490, *Notice of Decision: Medical Assistance or State Supplementary Assistance*. When issuing a manual notice for Medically Needy actions, use form 470-2330, *Notice of Decision for Medically Needy*.

Distribution

System-generated notices are mailed to the client. A copy is filed in the electronic case file.

For manually generated notices, send the original to the client. File the copy in the case record.

If there is a guardian, conservator, or representative, provide that person with a photocopy of the notice.

Data

For a manually prepared *Notice of Decision*:

- Entering the case number will populate the case name and current mailing address.
- The worker profile will populate the worker's number, county number, name, phone number, and email address.

- The notice date will automatically populate.
- Select one of the following radio buttons on the Preface tab:
  - Blank
  - Multiple Programs
  - Emergency 3-Day Medical
  - Medicaid Approval > 12 months Prior

If **Blank** is selected, enter the explanation of the action being taken. This shall include:

- The action being taken (e.g., approval, denial, etc.).
- The reason for the action.
- The effect of the action on the household's eligibility and benefits.
- The effective date of the action.
- The legal references, including the Employees' Manual title, chapter number, and subheading; Iowa Administrative Code; and federal regulations.

NOTE: When using the template, you can copy the language of the system notice reasons from the file labeled "ABC Notice Codes" on the DHS Intranet eForms web page and insert it into the notice.

If **Multiple Programs** is selected, the explanation of the action and legal references populate based on the NOD reasons and programs selected on the "Multiple Programs" tab.

If **Emergency 3-Day Medical** or **Medicaid Approval > 12 months Prior** is selected, the explanation of the action and legal references will automatically populate.

For Medicaid Approval > 12 months Prior, select a radio button and enter the beginning and ending dates or the non-consecutive dates approved. Make sure to enter the state ID.

Food Assistance
Calculation: Complete this section when Food Assistance eligibility or benefits are affected by changes in income, deductions, or household size. Complete the "Gross Income Standard Test" only if applicable. Use information from the household's current form 470-0330, *Food Assistance Computation*, or Scratch Pad (SPAD) system screens.

Iowa Department of Human Services

Proof of Medicaid Coverage

Important Information, Please Save

This form is proof that the people listed below were covered by Medicaid. You may need to give proof of your Medicaid coverage if you enroll in a health insurance plan through work.

It is important to have this proof. Your new insurance plan may not pay for services to treat some medical conditions if you cannot show that you were covered under other insurances or Medicaid before joining the plan.

Questions?? You may call us at **1-800-338-8366** if you have questions. This is a free phone call. If you live in the Des Moines area, you may call **256-4606**. You can also write to us at: Iowa Medicaid Enterprise, Member Services, PO Box 36510, Des Moines, IA 50315 or e-mail us at IMEMemberServices@dhs.state.ia.us

Medicaid ID	Name	Dates of Medicaid Coverage

Cont'd

Medicaid ID	Name	Dates of Medicaid Coverage

Iowa Department of Human Services

Provider Request for Member Disenrollment

Provider: Please complete the following sections, including the program you are participating in as a Primary Care Case Manager (PCCM). After a request for disenrollment is submitted, the member is notified and allowed five days to respond. If the member does not make another selection and your request is approved, the disenrollment is processed. You must continue to provide care to the member or refer the member for care until the disenrollment is effective.

General Disenrollment Guidelines: Members may be disenrolled due to office policy; however, the office policy must apply to all patients in the provider's practice. Disenrollments must be based on behavioral and not monetary issues.

Send request to: IME Provider Services Unit
P.O. Box 36450
Des Moines, IA 50315

Or fax to 515-725-1155

Part A: Provider Information (Please complete the following information.)

Check type of managed care that applies: ☐ PCCM for MediPASS ☐ PCCM for Wellness

Provider Name	Provider ID/National Provider Identifier	
Street Address		
City	State	Zip Code
Provider Signature		Date

Part B: Disenrollment Request (Please complete the information below for each person for whom disenrollment is requested.)

Member Name	Medicaid Person ID (from Medicaid card)	Disenrollment Code (see right)	Disenrollment Reason Code (attach documentation)
			A. Continuously fails appointments B. Abusive behavior with office staff C. Seeks unauthorized care from others D. Drug seeking behavior E. Non-compliance with treatment regime F. Doesn't serve client's age/sex G. Other (please describe) _____

Part C: Managed Health Care Review Committee Decision (Central office use only.)

☐ Approved ☐ Denied ☐ Other _____ Member Contact Date:	
Comments	
Date Processed	Signature

NOTE: A copy of this request will be kept on file.

470-2169 (Rev. 9/13)

Provider Request for Member Disenrollment, Form 470-2169

Purpose

Managed health care providers can use form 470-2169 to request that a Medicaid member assigned to them be disenrolled or reassigned. Completion of this form does not cause immediate disenrollment.

Disenrollment is not effective until the managed health care review committee has reviewed the request and the IME Provider Services Unit has coded disenrollment with an effective date. Enrollment still exists until the provider's name no longer appears on the recipient's pink *Medical Assistance Eligibility Card*.

Source

This form is issued to managed health care providers in their managed care handbook. Additional copies are available to participating providers upon request to the IME Provider Services Unit.

Completion

The managed health care provider completes Parts A and B of this form when the provider wants to stop serving the member due to:

- The member's age or sex being outside the provider's normal scope of treatment.
- Issues such as failing to show up for appointments, noncompliance with treatment, and abusive or drug-seeking behavior.

An authorized member of the managed health care review committee is responsible for completing Part C of this form.

Distribution

The provider keeps a copy and mails the original to:

IME Provider Services Unit
PO Box 36450
Des Moines, Iowa 50315

Managed health care staff send a copy of the form to the member at the time of the provider's original request.

After the Review Committee decision has been recorded, the form shall be distributed as follows:

- The review committee retains the original.
- A copy is sent to the provider.

The IME Provider Services Unit does not enter any system action to disenroll the member until it has received instructions from the Division of Medical Services regarding the managed health care review committee's decision.

Data

Part A. Provider information: The managed health care provider completes Part A as follows:

- Check type of managed health care that applies.
- Enter name of managed health care provider.
- Enter Medicaid provider identification number or national provider identifier of the managed health care provider.
- Enter address of managed health care provider.
- Enter signature of authorized person making request for provider.
- Enter date the request is signed.

Part B. Disenrollment request: The managed health care provider completes Part B as follows:

- Enter name of each member for whom disenrollment is requested.
- Enter state Medicaid personal identification number for each member for whom disenrollment is requested.
- State reasons for each person for whom disenrollment is being requested by using disenrollment reason/code. Additional documentation shall be attached, if necessary.

Part C. Managed Health Care Review Committee Decision: The Managed Health Care Review Committee shall make a decision within 30 days of receipt of the request. When the form is completed, the MHC team member shall make the appropriate system entries within ten days.

Section C shall contain approval of the request, a denial of the request, or some specific instructions as to how the managed health care team or managed health care provider should proceed.

- Indicate the decision of the Managed Health Care Review Committee: "approve," "deny," or "other." If "other" is checked, an explanation should be included in the comments section.
- Include comments of the Managed Health Care Review Committee, if appropriate.
- Use this area to relay specific instructions to the income maintenance worker concerning implementation of the Review Committee's decision.
- An authorized member of the Managed Health Care Review Committee shall sign as the designee of the administrator of the Division of Medical Services. The date signed shall be included.

Public Assistance Agency Information Request, Form SSA-1610-U2

Purpose	The local DHS office is to use the *Public Assistance Agency Information Request* for exchange of information with the Social Security Administration that is not included on the TPQY response.
Source	Print or photocopy supplies of form SSA-1610-U2 from the sample in the manual as needed.
Completion	The local DHS worker responsible for the case shall prepare form SSA-1610-U2 in the following situations: ♦ To resolve any discrepancies between other evidence and data in the TPQY files, such as an identification problem. ♦ To secure retroactive historical data not provided by the TPQY. ♦ To provide information to the Social Security office regarding mutual clients, e.g., a FIP case in which an SSI application is pending. Refer to 4-C, SSI Recipient. Use of the SSA-1610-U2 shall be limited to these circumstances except for emergencies. Each Department office should arrange with its Social Security office for handling emergencies.
Distribution	Send the original to the local Social Security office. When information is being submitted to the Social Security office, you may upload the request to the electronic case file. When the Social Security returns the original, it will be scanned and uploaded to the case record.
Data	Specific instructions for completing the form are printed on the back of the form.

Quality Assurance Transmittal, Form 470-0271

Purpose

The *Quality Assurance Transmittal* is used to request the Quality Assurance Unit of the Division of Data Management to:

- Cancel a warrant,
- Issue a one-time payment, or
- Cross-reference a state identification number.

Source

Complete form 470-0271 on line using the template on the DHS Intranet eForms web page.

Completion

The IM worker completes the "Date," "From," and "Case Identification" sections and completes the rest of the form depending on the action being requested:

- **Cancel Warrant:** When a client returns a warrant to a Department office, enter the warrant number, amount, and date in this section. Attach the warrant and the official receipt to the white copy of the 470-0271 and send them to Quality Assurance.

  If Quality Assurance has the warrant, send the form alone to Quality Assurance. Leave the warrant number field blank for Quality Assurance to complete.

  In both cases, Quality Assurance takes the necessary actions to remove the warrant from the client's automated records.

- **Issue One-Time Special Payment Over $1800:** To request the payment, check this box and enter the amount of payment. Send 470-0271 to the designated person in the service area, with a memo attached to explain why the payment is needed.

  The designated service area person will sign the form in the space provided, and forward it to Quality Assurance. Quality Assurance authorizes the amount for ABC system issuance.

- **State ID Cross Reference:** If two or more state identification numbers are on record for a client, use this section to indicate which state ID should be removed.

Also use this section to indicate any social security number that should be removed, in order to enter the number with another state identification record.

In all cross-reference situations, use the "Comments" section to explain your request.

If the name and state identification number of a child need to be changed due to adoption, but the child's social security number remains the same, use this section, but enter the new name under "Comments."

Distribution

Send the form in an envelope via local mail to Quality Assurance, Division of Data Management, Hoover Building. Keep one copy for case file.

Quality Assurance contacts the worker who initiated the request if more information is needed before the requested actions are completed. Quality Assurance will return incomplete transmittals to the worker, so errors are prevented.

Quality Assurance may encounter error conditions when attempting to cross-reference state identification numbers. Edits prohibit deletion of state identification numbers that do exist and are used on current ABC individual income records or have active, disqualified, or sanctioned status codes on ABC.

Data

Self-explanatory.

Quarterly Report Follow-Up, Form 470-2721

Purpose	The *Quarterly Report Follow-Up* notifies the member of the additional information and verifications necessary to complete the *Transitional Medicaid Notice of Decision/Quarterly Income Report* and informs the member of the due date for submitting the information.
Source	Complete this form on line using the template on the DHS Intranet eForms web page.
Completion	The IM worker completes the form when the client returns a *Transitional Medicaid Notice of Decision/Quarterly Income Report* and either: ♦ Some of the questions were not answered, or ♦ Not all of the required proof was sent with the report.
Distribution	Mail or give the original to the member. File the copy in the case file.
Data	Enter the date, case name, and current mailing address where indicated. Check the first box if the member failed to answer all of the questions on the report. Check the second box if all required proof is not sent in with the report. List the missing proof in the spaces provided.

Race/Ethnic Report, Form 470-3716

Purpose	Form 470-3716 is used to gather information about race and ethnicity for a person associated with the Food Assistance household or FIP assistance unit. Clients are not required to provide this information. However, it is a federal requirement that Iowa report race or ethnicity for all who do provide the information.
Source	Initiate form 470-3716 on line using the template on the DHS Intranet eForms web page.
Completion	Issue this form whenever you realize that you do not have race or ethnicity information for all adults and children who are in the Food Assistance household or are associated with the FIP assistance unit, including people who are not included on the grant, such as stepparents, excluded parents, etc. Also issue the form when the household applies for benefits for a new household member. NOTE: Clients are not required to complete this form. If clients decline to do so, it does not affect their eligibility or their benefits. If clients decline to answer the questions or complete the form, use worker observation to collect the data. When observation is not possible, document that the form was offered but the client chose not to supply the information.
Distribution	Enter the race and ethnicity information collected for each person on the ABC system.
Data	Clients can choose one selection for ethnicity and choose as many selections as apply for race.

Reasonable Compatibility Tool, Form 470-5178

Purpose	IM workers use the *Reasonable Compatibility Tool* to determine if an applicant's statement of income can be considered to be verified as it is reasonably compatible with income information from state data sources. Workers use this form for MAGI-Related Medicaid only.
Source	IM staff can complete this form on line using the tool on the DHS Intranet eForms web page.
Completion	The IM worker completes applicable fields of the tool when determining eligibility for MAGI-Related Medicaid for a member with countable income.
Distribution	File a copy of the completed tool in the case file.
Data	The IM worker enters data as follows:

- **State Source Income** tab: Enter the amount of monthly income obtained from state data sources for each member.
- **Self-Attested Income** tab: Enter countable monthly income for each member in the field that identifies the type of income.
- **Reasonable Compatibility** tab: The tool determines if the difference between the member's self-attested income amount and state data source income amount is within 10% of the state data source income amount. The percentage of difference is displayed in the *Compatibility Percentage* field:
  - The *Reasonably Verified* field says "True" if the percentage is 10% or less. The worker may consider the income to be verified.
  - The *Reasonably Verified* field says "False" if the percentage is more than 10%. The worker must obtain additional verification of the income.

Record of Lost Benefits Restored, Form 470-0318

Purpose

Form 470-0318 is used to document the amount of lost benefits owed and the amount of lost benefits restored to a household.

Source

Complete form 470-0318 on line using the template on the DHS Intranet eForms web page.

Completion

Complete form 470-0318 when you determine that a household is entitled to a restoration of lost benefits or when a restoration of lost benefits is ordered by a hearing decision. Notify the household of its entitlement to lost benefits by completing the *Notice of Lost Benefits Entitlement*, form 470-0334.

Print an original and one copy of form 470-0318. Print one additional copy for each additional month for which benefits are restored.

Distribution

File the original in the household's case record. Send one copy to the Bureau of Purchasing, Payments, Receipts and Payroll. If the household requests issuance in more than one month to restore lost benefits, forward an additional copy to the Bureau of Purchasing, Payments, Receipts and Payroll following each month's issuance.

Data

Complete the form as follows:

- Complete Items 1 through 7 to establish the amount of and the reason for the restoration of lost benefits.
- If there is an unpaid claim against the household, enter the unpaid amount in Item 8. EXCEPTION: If the unpaid amount of the claim exceeds the amount in Item 7, enter the same amount as in Item 7.

  To give the household credit on its claim, complete the form 470-0010, *Adjustment to Overpayment Balance*, showing the amount in Item 8 for the Bureau of Purchasing, Payments, Receipts and Payroll.
- If benefits are restored in a lump sum, complete Item 10.
- If benefits are restored in monthly installments per household request, complete Item 11, as needed.

Case number:

Iowa Department of Human Services

Renewal Application Addendum

Due to the changes in the Affordable Care Act (ACA), more information is needed to process your Renewal Application/Reported Change. This form asks for this information. Next year you will get a form that has all the needed questions in one document.

The ACA also requires that electronic data sources be used as much as possible to process benefits. This will speed up benefit processing and cut down on proof you must give us. We need your permission (below).

To make it easier to determine my eligibility for help paying for health coverage in future years, I agree to allow the Iowa Department of Human Services (DHS) to use income data, including information from tax returns. The Iowa DHS will send me a notice and let me make any changes.

I declare under penalty of perjury under the laws of the United States of America that the information contained in this statement of facts is true, correct, and complete.

By signing below, I agree to allow my information to be used and retrieved from data sources for this renewal or reported change. I have consent for all people I will list on this form that allows their information to be retrieved and used from data sources for this renewal or reported change.

Print Name
Signature
Date

Tax Information

Next Year's Tax Return	***(Self)***	***(Partner or Spouse)***
Name		
Does this person plan to file a tax return **NEXT** year?	☐ Yes ☐ No	☐ Yes ☐ No
What filing status will be used on **NEXT** year's tax return?	☐ Head of household ☐ Married, filing jointly ☐ Married, filing separately ☐ Single ☐ Qualifying widow/widower with dependent child status ☐ Not filing	☐ Head of household ☐ Married, filing jointly ☐ Married, filing separately ☐ Single ☐ Qualifying widow/widower with dependent child status ☐ Not filing
Will this person be claimed as a dependent on someone else's tax return **NEXT** year?	☐ Yes ☐ No	☐ Yes ☐ No
Who will claim this person on their tax return **NEXT** year?		
Is this person the primary tax payer?	☐ Yes ☐ No	☐ Yes ☐ No
Current Year's Tax Return		
Did this person file taxes **LAST** year?	☐ Yes ☐ No	☐ Yes ☐ No
Was the filing status on this return different than this year?	☐ Yes ☐ No	☐ Yes ☐ No
What filing status was used on this tax return?	☐ Head of household ☐ Married, filing jointly ☐ Married, filing separately ☐ Single ☐ Qualifying widow/widower with dependent child status ☐ Not filing	☐ Head of household ☐ Married, filing jointly ☐ Married, filing separately ☐ Single ☐ Qualifying widow/widower with dependent child status ☐ Not filing
Was this person the primary tax payer?	☐ Yes ☐ No	☐ Yes ☐ No

Next Year's Tax Return	***(Dependent 1)***	***(Dependent 2)***
Name		
Does this person plan to file a tax return **NEXT** year?	☐ Yes ☐ No	☐ Yes ☐ No
What filing status will be used on **NEXT** year's tax return?	☐ Head of household ☐ Married, filing jointly ☐ Married, filing separately ☐ Single ☐ Qualifying widow/widower with dependent child status ☐ Not filing	☐ Head of household ☐ Married, filing jointly ☐ Married, filing separately ☐ Single ☐ Qualifying widow/widower with dependent child status ☐ Not filing
Will this person be claimed as a dependent on someone else's tax return **NEXT** year?	☐ Yes ☐ No	☐ Yes ☐ No
Who will claim this person on their tax return **NEXT** year?		
Is this person the primary tax payer?	☐ Yes ☐ No	☐ Yes ☐ No
Current Year's Tax Return		
Did this person file taxes **LAST** year?	☐ Yes ☐ No	☐ Yes ☐ No
Was the filing status on this return different than this year?	☐ Yes ☐ No	☐ Yes ☐ No
What filing status was used on this tax return?	☐ Head of household ☐ Married, filing jointly ☐ Married, filing separately ☐ Single ☐ Qualifying widow/widower with dependent child status ☐ Not filing	☐ Head of household ☐ Married, filing jointly ☐ Married, filing separately ☐ Single ☐ Qualifying widow/widower with dependent child status ☐ Not filing
Was this person the primary tax payer?	☐ Yes ☐ No	☐ Yes ☐ No
Other Dependents		
Can this person claim dependents **NOT** listed on this application?	☐ Yes ☐ No	☐ Yes ☐ No
How many dependents **NOT** listed on this application can be claimed?		
List the names of those dependents.		

Other Questions

☐ Yes ☐ No Do you have any other income that you didn't list on the renewal?

If Yes, please list:

Type of Income	Amount of Income	How Often Received

☐ Yes ☐ No Does anyone 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?

If Yes, please list the individuals who would fall under this category:

_____

_____

_____

_____

☐ Yes ☐ No Do you have any tax-deductible expenses such as student loan interest, alimony paid, or any other tax-deductible expenses?

If Yes, please indicate:

Person Responsible for Each Expense	Type of Expense	Amount of Each Expense	How Often Incurred
Example: John	Student loan	$1,200	Yearly

Número de caso:

Iowa Department of Human Services

Renewal Application Addendum

(Anexo a la solicitud de renovación)

Debido a los cambios en la Ley de Cuidado de Salud Asequible (ACA), se necesita más información para procesar su Solicitud de Renovación/Cambio informado. En este formulario se pide esta información. El año próximo usted recibirá un formulario que incluye todas las preguntas necesarias en un mismo documento.

La ACA también solicita que se utilicen las fuentes electrónicas de datos tanto como sea posible para procesar los beneficios. Esto acelerará el procesamiento de los beneficios y reducirá la cantidad de comprobantes que usted deba entregarnos. Para esto, necesitamos de su permiso (debajo).

Para facilitar el hecho de determinar mi elegibilidad para ayudar a pagar la cobertura de salud en los años próximos, acepto permitir que el Iowa Department of Human Services (DHS) utilice los datos de mis ingresos, incluyendo la información de la declaración de impuestos. El DHS de Iowa me enviará un aviso y me permitirá realizar cambios.

Certifico bajo pena de cometer perjurio conforme a las leyes de los Estados Unidos de Norteamérica que la información contenida en esta declaración de hechos es verdadera, correcta y completa.

Al firmar a continuación acepto que utilicen no sólo mi información sino también la de las personas a las que nombraré en este formulario. Así mismo acepto que recuperen información de diferentes recursos, tanto mía como de dichas personas, para esta renovación o para el cambio informado.

Nombre en letra de imprenta
Firma
Fecha

Información fiscal

Declaración de impuestos del año próximo	***(Propio)***	***(Pareja o cónyuge)***
Nombre		
Esta persona, ¿planea presentar una declaración de impuestos el año **PRÓXIMO**?	☐ Sí ☐ No	☐ Sí ☐ No
¿Qué estado civil se utilizará a los fines de la declaración de impuestos del año **PRÓXIMO**?	☐ Jefe de familia ☐ Casado, tributando juntos ☐ Casado, tributando separados ☐ Soltero ☐ Califica como viuda/viudo con hijos a cargo ☐ No tributa	☐ Jefe de familia ☐ Casado, tributando juntos ☐ Casado, tributando separados ☐ Soltero ☐ Califica como viuda/viudo con hijos a cargo ☐ No tributa
Esta persona, ¿será declarada como familiar a cargo en la declaración de impuestos de otra persona del año **PRÓXIMO**?	☐ Sí ☐ No	☐ Sí ☐ No
¿Quién declarará a esta persona en su declaración de impuestos del año **PRÓXIMO**?		
Esta persona, ¿es el contribuyente principal?	☐ Sí ☐ No	☐ Sí ☐ No
Declaración de impuestos del año actual		
¿Esta persona presentó una declaración de impuestos el año **PASADO**?	☐ Sí ☐ No	☐ Sí ☐ No
El estado civil manifestado en la declaración, ¿era diferente al declarado este año?	☐ Sí ☐ No	☐ Sí ☐ No
¿Qué estado civil se utilizó en esta declaración de impuestos?	☐ Jefe de familia ☐ Casado, tributando juntos ☐ Casado, tributando separados ☐ Soltero ☐ Califica como viuda/viudo con hijos a cargo ☐ No tributa	☐ Jefe de familia ☐ Casado, tributando juntos ☐ Casado, tributando separados ☐ Soltero ☐ Califica como viuda/viudo con hijos a cargo ☐ No tributa
¿Esta persona era el contribuyente principal?	☐ Sí ☐ No	☐ Sí ☐ No

Declaración de impuestos del año próximo	***(Familiar a cargo 1)***	***(Familiar a cargo 2)***
Nombre		
¿Esta persona planea presentar una declaración de impuestos el año **PRÓXIMO**?	☐ Sí ☐ No	☐ Sí ☐ No
¿Qué estado civil se utilizará a los fines de la declaración de impuestos del año **PRÓXIMO**?	☐ Jefe de familia ☐ Casado, tributando juntos ☐ Casado, tributando separados ☐ Soltero ☐ Califica como viuda/viudo con hijos a cargo ☐ No tributa	☐ Jefe de familia ☐ Casado, tributando juntos ☐ Casado, tributando separados ☐ Soltero ☐ Califica como viuda/viudo con hijos a cargo ☐ No tributa
Esta persona, ¿será declarada como familiar a cargo en la declaración de impuestos de otra persona del año **PRÓXIMO**?	☐ Sí ☐ No	☐ Sí ☐ No
¿Quién declarará a esta persona en su declaración de impuestos del año **PRÓXIMO**?		
Esta persona, ¿es el contribuyente principal?	☐ Sí ☐ No	☐ Sí ☐ No
Declaración de impuestos del año actual		
¿Esta persona presentó una declaración de impuestos el año **PASADO**?	☐ Sí ☐ No	☐ Sí ☐ No
El estado civil manifestado en la declaración, ¿era diferente al declarado este año?	☐ Sí ☐ No	☐ Sí ☐ No
¿Qué estado civil se utilizó en esta declaración de impuestos?	☐ Jefe de familia ☐ Casado, tributando juntos ☐ Casado, tributando separados ☐ Soltero ☐ Califica como viuda/viudo con hijos a cargo ☐ No tributa	☐ Jefe de familia ☐ Casado, tributando juntos ☐ Casado, tributando separados ☐ Soltero ☐ Califica como viuda/viudo con hijos a cargo ☐ No tributa
¿Esta persona era el contribuyente principal?	☐ Sí ☐ No	☐ Sí ☐ No
Otros familiares a cargo		
Esta persona, ¿puede declarar a familiares a cargo **NO** enlistados en esta solicitud?	☐ Sí ☐ No	☐ Sí ☐ No
¿Cuántos familiares a cargo **NO** enlistados en esta solicitud pueden ser declarados?		
Indique los nombres de dichos familiares a cargo.		

Otras preguntas

☐ Sí ☐ No ¿Tiene algún otro ingreso que no haya indicado en la renovación?

Si su respuesta es Sí, por favor indíquelo:

Tipo de ingreso	Monto del ingreso	Frecuencia con la cual recibe el ingreso

☐ Sí ☐ No ¿Alguna persona tiene un problema de salud física, mental o emocional que cause limitaciones en las actividades (como bañarse, vestirse, realizar las tareas de la casa, etc.) o vive en una residencia médica u hogar?

Si su respuesta es Sí, por favor indique quiénes son las personas que entrarían en esta categoría:

_____

_____

_____

_____

☐ Sí ☐ No ¿Tiene algún gasto deducible de impuestos como los intereses de un préstamo estudiantil, el pago de una pensión alimenticia o algún otro gasto deducible de impuestos?

Si su respuesta es Sí, por favor indíquelo:

Persona responsable de cada gasto	Tipo de gasto	Monto de cada gasto	Con qué frecuencia se incurre en dicho gasto
Ejemplo: John	Préstamo estudiantil	$1,200	Anual

Renewal Application Addendum, Form 470-5199 or 470-5199(S)

Purpose

MAGI-related Medicaid and ***hawk-i*** applicants and recipients use the *Renewal Application Addendum* to provide tax information and consent to compare reported information with data sources on household members not included on the:

- *Application for Health Coverage and Help Paying Costs*, form 470-5170 or 470-5170(S), or
- *Medicaid/**hawk-i** Review*, form 470-5168 or 470-5168(S).

Source

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

Supplies of the addendum may also be printed or photocopied from the sample in the manual.

Completion

The MAGI-related Medicaid or ***hawk-i*** applicant or recipient completes the addendum.

The applicant or recipient may obtain help in completing the addendum from friends, relatives, advocate groups, or Department staff, if needed.

Distribution

File the addendum and the *Application for Health Coverage and Help Paying Costs*, form 470-5170 or 470-5170(S), or the *Medicaid/**hawk-i** Review*, form 470-5168 or 470-5168(S).

Data

The worker completes the *Case Number* field in the upper right corner of page 1 before the form is sent or issued to the applicant or recipient.

The applicant or recipient must print their name, and sign and date page 1 of the addendum.

The applicant or recipient must complete the Tax Information section for each household member not listed on the *Application for Health Coverage and Help Paying Costs*, form 470-5170 or 470-5170(S), or *Medicaid/**hawk-i** Review*, form 470-5168 or 470-5168(S).

Reporting Food Assistance Changes, Form 470-2960 or 470-2960(S)

Purpose	*Reporting Food Assistance Changes* is the form used to inform Food Assistance households how to report changes. The form shows the maximum gross monthly income for the household's size.
Source	The ABC system generates form 470-2960 or 470-2960(S). Both English and Spanish versions of this form are also available on line as templates on the DHS Intranet eForms web page.
Completion	Issue this form: ♦ At application. ♦ At recertification.
Distribution	If issuing a manual notice of decision, send or give the original form to the household and keep a copy of the form in the case file.
Data	Complete the client name, address, date, and case number on the form. Fill in the gross monthly income applicable for household size. Fill in the household's countable self-employment income if applicable. The second paragraph under Step 1 prints only if the worker enters self-employment income. Fill in the name of any Able-Bodied Adults Without Dependents (ABAWDs) who are eligible because they meet work requirements.

Iowa Department of Human Services

Reporting Food Assistance Changes

Date:

Case #:

You received this letter because you were recently approved for Food Assistance (FA) benefits. This letter explains how and when to report changes that happen while you receive benefits. This form is for the FA program only. If you get Medicaid or Family Investment Program (FIP) benefits, you must report changes for those programs within 10 days of when the change happens.

Important! The changes listed below must be reported by the 10th of the next month after the change happens.

Your household's gross income limit is $_____. Gross income is the amount before taxes and other deductions are taken out. At the end of each month:

1. Add up the gross income everyone in your household got in the month. (This means income of all people who live and eat with you.) $ _____

   Add $_____, to your other kinds of income. This is the amount we count each month as self-employment earnings. + _____

2. Subtract child support anyone in your household paid in the month. – _____

3. Write down how much is left. = $ _____

4. If the amount in number 3 is more than $_____, **you must tell us by the 10th of the next month.**

If the following person(s) stop working 80 or more hours in a month, report by the 10th:

If you don't report on time, you will have to pay back benefits. If you purposely withhold information, you may be cut off Food Assistance for more than a year, pay fines or face criminal charges.

How to Report

- Call to 1-877-347-5678, or
- Email IMCustomerSC@dhs.state.ia.us, or
- Fax information to 515-564-4041
- Mail to: DHS Image Center 1, 417 E Kanesville Blvd, Council Bluffs, IA 51503-4470

Keep this form so that you know how and when to report changes.

Iowa Department of Human Services

Reporting Food Assistance Changes
(Cómo informar cambios a *Food Assistance*)

Fecha:

Caso Nº:

Le enviamos esta carta porque ha sido aprobado para beneficios de *Food Assistance* (FA). En esta carta le explicamos cómo y cuándo debe informar los cambios que surjan mientras esté recibiendo beneficios. Este formulario es para el programa FA únicamente. Si recibe prestaciones de Medicaid o del Programa FIP, debe informar los cambios en 10 días, a partir de la fecha en que se produzcan.

¡Importante! Los cambios que se indican a continuación deben ser informados antes del día 10 del mes siguiente.

El límite de ingresos brutos de su grupo familiar es $_____. El ingreso bruto es el importe total antes de descontar impuestos y otras retenciones. Al final de cada mes:

1. Sume los ingresos brutos recibidos por su grupo familiar durante el mes. (Es decir, los ingresos de todas las personas que viven y comen con Ud.) $

   Sume $_____, a sus otros tipos de ingresos. Éste es el importe que contabilizamos mensualmente en concepto de ganancias por trabajos por cuenta propia. + _____

2. Reste la manutención de menores que pagaron durante el mes. – _____

3. Escriba cuánto dinero quedó. = $ _____

4. Si el importe del ítem 3 es más de $_____, **debe informarnos antes del día 10 del mes siguiente.**

Si la(s) siguiente(s) persona(s) deja(n) de trabajar 80 o más horas por mes, infórmelo antes del día 10:

Si no lo informa puntualmente, tendrá que devolvernos los beneficios. Si oculta información adrede, no recibirá *Food Assistance* por más de un año, pagará multas o se iniciarán acciones penales.

Cómo informar cambios

- Llame al 1-877-347-5678, o
- Envíe un correo electrónico a IMCustomerSC@dhs.state.ia.us, o
- Envíe la información por fax a 515-564-4041
- o por correo a: DHS Image Center 1, 417 E Kanesville Blvd, Council Bluffs, IA 51503-4470

Conserve este formulario y consúltelo cuando deba informar cambios.

Request for ISIS Changes, Form 470-3924

Purpose	The purpose of the *Request for ISIS Changes*, form 470-3924, is to transmit requests to add, change, or terminate program request information in ISIS when the information can't be submitted through ABC system entries.
Source	IM staff completes this form on line using the template on the DHS Intranet eForms web page.
Completion	An IM worker prepares the form when: ♦ A program request needs to be added to ISIS and the information cannot be passed to ISIS by making entries in the ABC system. ♦ A change occurs to any information on a program request in ISIS and that information cannot be passed to ISIS by making entries in the ABC system. The information must be submitted on the form before additions or corrections can be made to the ISIS program requests. Use the same form for additional requests for the same member. Use a different form for each new member.
Distribution	E-mail the completed form to DHS, ISIS-Facilities.
Data	**Part 1: Member/Staff Information:** Enter the member's state identification number and name from the ABC system. Enter your name. **Part 2: Eligibility Changes:** **Program request that needs changes:** Enter the dates and program currently shown in these fields on the ISIS program request that needs correction. If this is a request to add a program request rather than a request for corrections, leave this section blank.

Correct Information: Enter the correct information in each of the following fields:

- **Begin Date:** Enter the date the member becomes eligible or resumes eligibility for the waiver or facility program or the effective date of a change.
- **End Date:** Enter as the end date the last date eligibility exists or the day before a change is effective on the subsequent program request.
- **Aid Type:** Enter the aid type for the member's coverage group.
- **Program:** Enter the number or letter of the program type from the drop down box.
- **Co Res:** Enter the county where the case is assigned.
- **Co LS:** Enter the member's county of legal settlement.
- **CP 1st Month and CP Ongoing:** Enter the amount of first and ongoing client participation. Use the first five digits for dollars and the last two digits for cents.

  Complete all boxes. Enter zeros when there is no client participation or when less than seven boxes are needed. (E.g., 0000000 shows client participation is zero; 0004220 shows client participation is $42.20.)
- **Provider Number (Facility Only):** Enter the seven-digit provider number or the national provider indicator (NPI).
- **NF Provider #, if Hospice:** Enter the seven-digit provider number or NPI of the nursing facility where the member resides, if the member is receiving hospice services.
- **Application Date:** Enter the date of application for Medicaid.

{IMAGING_CENTER_ADDRESS}

Iowa Department of Human Services

Review/Recertification Eligibility Document

{CUSTOMER_CONTACT_NAME_ADDRESS}

{IMAGING_CENTER_ADDRESS}

Due Date	Case Number	County Number	Worker Name
{DUE_DATE}	{CASE_NUMBER}	{COUNTY_NUMBER}	{WORKER_NAME}

Please follow the instructions of the checked boxes below.

☐ FIP/Refugee Cash Assistance: It's time to review your case. Please fill out this form and send or bring it to the address above by {DUE_DATE}. This information will be used to decide if you will continue to get Family Investment Program (FIP) or Refugee Cash Assistance benefits.

☐ Food Assistance: Your Food Assistance will end {CERT_END_DATE}. Return this signed form by {15th_OF_CERT_END_MONTH} to get Food Assistance at the regular time next month, if you are eligible.
☐ If this box is checked, you must have an interview for Food Assistance. If you miss your interview, you must ask your local office to reschedule.

Households consisting of only SSI applicants or recipients may apply for Food Assistance recertification at any SSA office.

What do I do with this form?

You must:

- Fill out this form.
- Send proof if the question has **Send proof** Examples of proof of the money you get can be check stubs, self-employment records or award letters.
- Sign and date page 4.
- Send the form and your proof to us at the address above by {DUE_DATE}.
- Use extra paper, if needed for your answers.

What if I have questions?

Call your worker at {WORKER_PHONE}. We will accept collect calls.

Household Members

These people get benefits with you or are counted to figure your benefits:

Name/State ID	Social Security Number	Age	Last Grade Completed in School	Citizen? Yes/No	If Alien, Status?

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	Last Grade in School	Date Moved In	Date Moved Out	Citizen? Yes/No	If Alien, Status?

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 has dropped out or is no longer attending school full-time, list who and when.

_____

If anyone is in a college or training program, list who and what school or program they are enrolled in.

_____

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

_____

List the most recent address of each parent not in the home. **Do not complete if you only get Food Assistance.**

Name of Parent Not Living in the Home	Address of this Parent	Name of this Parent's Children

Tell Us About Criminal Actions and Disqualifications

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

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

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

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

Income

Send proof – Send all pay stubs or proof of income for the last 30 days.
For proof of tips, send pay stubs showing tips, employer's statement, or your tip records. For new jobs, send proof showing first pay date, hourly rate, and weekly number of hours. If job stopped, send proof of the date of the last pay.

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

List all jobs the people in your household have.

Who works?	Employer name?	Does this person get tips?
		☐ Yes ☐ No
		☐ Yes ☐ No

Will the amount of money from jobs stay about the same as shown on the proof you are sending? ☐ Yes ☐ No

If no, explain_____

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

If yes, who?_____ Employer name?_____

Has anyone's job ended in the last 30 days? ☐ Yes ☐ No

If yes, who?_____ Employer name?_____

What other money do people in your household get?	Who gets the money?	How much per month? Send Proof
Self-Employment or Odd Jobs (Send the most recent federal tax forms. If tax return was not filed, send records that show income and expenses.)		
Unemployment or Worker's Compensation		
Social Security or SSI		
Veterans Benefits, Pensions or Retirement		
Child Support or Alimony		
Money from Friends or Relatives		
Other: (Including irregular or one time payments) Explain:		

Will the amount of other money stay about the same as shown on the proof you are sending? ☐ Yes ☐ No

If no, explain_____

Resources (Assets)

Does anyone have a car, truck, boat, camper, motorcycle or other vehicle? ☐ Yes ☐ No
If yes, list make, model, year below.

_____

_____

List the money anyone has in:

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

Cash $_____ Who? _____

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

List anyone who has or owns any land, buildings, or houses, other than the house you live in: _____

List anyone who has a conservatorship or trust: _____

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

For FIP, list any tools, machinery, livestock, or collections that anyone has:

_____

Expenses

If you have **day care** expenses for a child or a disabled adult who lives with you, tell us.

Who gets care: _____ Amount $ _____ per month

If anyone pays court-ordered **child support**, tell us.

Who pays: _____ Amount $_____ per month **Send proof**

If you have **medical costs** not paid by insurance for anyone who is disabled or over age 59, tell us. These could be doctor or hospital bills, medicine, transportation, health insurance premiums, or other medical expenses.

Who pays: _____ Amount $ _____ per month **Send proof**

Shelter and Utilities (Answer these questions only if you get Food Assistance.)

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

Rent: $_____ per month

Lot rent: $_____ per month

Mortgage: $_____ per month

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

Property taxes: $_____ per _____

Homeowner's insurance: $_____ per _____

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

☐ Lights/electricity ☐ Telephone ☐ Garbage and trash

☐ Gas ☐ Water and sewage ☐ Extra charges from your landlord

☐ Other, explain_____

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

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

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

If you get help with your expenses, tell us:

Which Expense Was Paid	Who Paid	Amount Paid

Expected Changes

Tell us if anything has changed or is expected to change.

Sign and Date

I certify, under penalty of perjury, that:

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

I know what I reported may cause my benefits to be reduced, increased, or stopped and that the Department of Human Services may check my case.

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

If needed, when is the best time to call you?

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.

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 4.

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	

Please keep this page for your information.

All Programs

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, amounts received from other sources like Social Security or unemployment, and alien status. If any information you give us is not correct, we may deny your application.

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

We check and use computer systems like the State Income and Eligibility Verification System. If something you told us is different from what the computer system tells us, we will check to find out what is correct. We might check your information by contacting your employer, your bank or other people.

Things You Need to Know

We will use the information you give us on this form to determine what assistance you are eligible to receive.

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.

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

Food Assistance

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

By signing page 4, I agree that all members of my household will follow the Food Assistance work and training rules.

Rules of the Food Assistance Program

Follow these rules:

- **Don't** hide or give wrong information on purpose to get Food Assistance benefits.
- **Don't** use Food Assistance benefits to buy non-food items like alcohol or tobacco.
- **Don't** trade, sell or give away Food Assistance benefits.
- **Don't** use someone else's Food Assistance benefits for yourself.

Penalties of the Food Assistance Program

Anyone who breaks the above rules:

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

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

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

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

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

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

Please keep this page for your information.

FIP or Refugee Cash Assistance

Things You Need to Know

Using Your Electronic Access Card (EAC)

You cannot access your cash benefits with your EAC at a:

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

If the Department determines that you have accessed your cash benefits with your EAC card at one of the above places you:

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

Your Child Support Payments

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

Penalty for Getting FIP in More Than One State

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

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. For Food Assistance, you can appeal in writing or by telephone. For all other programs, you must appeal in writing. To appeal in writing do **one** of the following:

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

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

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

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

You Will Not Be Discriminated Against

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

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

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

(Food Assistance only) USDA – Director, Office of Adjudication, 1400 Independence Ave SW, Washington, DC 20250-9410, or call 1-866-632-9992 voice. Individuals who are hearing impaired or have speech disabilities may contact USDA through the Federal Relay Service at 800-877-8339; or 800-845-6136 (Spanish).

Iowa Department of Human Services

Review/Recertification Eligibility Document (Documento de Elegibilidad para Revisión/Recertificación)

{CUSTOMER_CONTACT_NAME_ADDRESS}

{IMAGING_CENTER_ADDRESS}

Fecha de Entrega	Número del Caso	Número del Condado	Nombre del Asistente
{DUE_DATE}	{CASE_NUMBER}	{COUNTY_NUMBER}	{WORKER_NAME}

Siga las instrucciones de las casillas marcadas a continuación.

☐ FIP/Refugee Cash Assistance (asistencia en efectivo para refugiados): Ha llegado el momento de revisar su caso. Complete este formulario y envíelo, o tráigalo, al domicilio que se indica arriba antes del {DUE_DATE}. Estos datos se usarán para decidir si continuará recibiendo beneficios de los programas Family Investment Program (FIP) o Refugee Cash Assistance.

☐ Food Assistance (asistencia para alimentos): Sus beneficios de Food Assistance finalizarán el {CERT_END_DATE}. Envíe este formulario firmado antes del {15th_OF_CERT_END_MONTH}, para recibir Food Assistance de manera regular el mes próximo, si es que califica. Si no se presenta para la entrevista, deberá pedirle a la oficina local que la reprograme.
☐ Si esta casilla está marcada, usted debe concurrir a una entrevista para Food Assistance. Si no concurre a su entrevista, debe pedir a su oficina local que reprograme la fecha.

Los grupos familiares cuyos integrantes solicitaron o son beneficiarios de SSI únicamente, pueden solicitar la recertificación de Food Assistance en cualquiera de las oficinas de SSA.

¿Qué debo hacer con este formulario?

Debe:
- Llenar este formulario.
- Enviar comprobantes si la pregunta indica **Enviar comprobantes** Por ejemplo, los comprobantes de sus ingresos pueden ser sus recibos de sueldo, sus registros de trabajo independiente o las cartas de asignaciones recibidas.
- Firmar y fechar la página 4.
- Enviar el formulario y sus comprobantes al domicilio mencionado antes del {DUE_DATE}
- Escriba sus respuestas en una hoja extra si no le alcanza el espacio.

¿Y si deseo hacer preguntas?

Llame a su asistente al teléfono {WORKER_PHONE}. Aceptamos llamadas por cobrar.

Miembros del Grupo Familiar

Estas personas reciben beneficios con usted o se contabilizan para calcular sus beneficios:

Nombre/Nº de ID Estatal	Número de Social Security	Edad	Último grado escolar terminado	¿Es ciudadano? Sí/No	Si es extranjero ¿estatus?

¿Vive alguien más en su casa que no figura en la lista de la página 1? ☐ Sí ☐ No En caso afirmativo, llene la siguiente información.

¿Alguien se ha mudado a su casa o se ha ido de su casa? ☐ Sí ☐ No En caso afirmativo, llene la siguiente información.

Nombre	Número de Social Security	Fecha de nacimiento	Relación con usted	Último grado escolar	Fecha en que se mudó	Fecha en que se fue	¿Ciudadano? Sí/No	Si es extranjero, ¿estatus?

Si se ha mudado, informe su nueva dirección.

Domicilio	Ciudad, estado y código postal
Dirección postal (si es diferente)	Ciudad, estado y código postal

Si alguien ha abandonado la escuela o ya no asiste tiempo completo, indique quién es y cuándo.

_____

Si alguien estudia en la universidad o en un programa de capacitación, indique quién, qué estudia y dónde.

_____

Si alguno está en militares, un veterano, o una esposa de un veterano, lista sus nombres y los relacionados.

_____

Indique el domicilio más reciente de cada padre/madre que no vive en el hogar. **No llene si solamente recibe Food Assistance (Asistencia para Alimentos).**

Nombre del padre/madre que no vive en el hogar	Domicilio de este padre/madre	Nombres de los hijos de este padre/madre

Por favor, díganos acerca de los procesos penales o descalificaciones

¿Alguien está escapando para evitar una acción judicial, custodia o encarcelamiento por un delito? ☐ Sí ☐ No

¿Alguien está violando una condición de libertad condicional o bajo palabra? ☐ Sí ☐ No

¿Alguien está encarcelado o se espera que vaya a la cárcel o prisión? ☐ Sí ☐ No

¿Alguien ha resultado descalificado de un programa de Food Assistance en cualquier estado debido a un caso de fraude o violación del programa? ☐ Sí ☐ No

Ingresos

Envíe comprobantes – Envíe todos los recibos de sueldo o comprobantes de ingresos de los últimos 30 días. Como comprobantes de propinas, envíe recibos de sueldos donde se indiquen las propinas, una declaración del empleador o sus registros de propinas. En el caso de empleos nuevos, envíe comprobantes donde figuren la primera fecha de pago, paga por hora y cantidad de horas semanales. Si dejó de trabajar, envíe un comprobante de la fecha en que cobró por última vez.

Debe informarnos sobre todo el dinero que gana cada una de las personas que vive en su casa. Si deja un espacio en blanco, consideraremos que no percibe este tipo de dinero. Por favor, utilice otra hoja de papel si la necesita.

Enumere todos los trabajos que tienen las personas que viven en su casa.

¿Quién trabaja?	¿Nombre del empleador?	¿Tiene esta persona recibe propinas?
		☐ Sí ☐ No
		☐ Sí ☐ No

¿La cantidad de dinero proveniente de los empleos es más o menos igual que la que se muestra en el comprobante que envía? ☐ Sí ☐ No

Si no, explique_____

¿Alguien ha sido contratado para un trabajo, pero no recibió un cheque de pago todavía ☐ Sí ☐ No

En caso afirmativo, ¿quién?_____ ¿Nombre del empleador?_____

¿El trabajo de alguna persona terminó en los últimos 30 días? ☐ Sí ☐ No

En caso afirmativo, ¿quién?_____ ¿Nombre del empleador?_____

¿Qué otro dinero ganan las personas que viven en su casa?	¿Quién recibe el dinero?	Cuanto por mes? **Envíe comprobante**
Por cuenta propia o trabajos esporádicos (Envíe los formularios federales de impuestos más recientes. Si no se completó la declaración de impuestos, envíe los registros que muestren sus ingresos y gastos.)		
Desempleo o Compensación a los Trabajadores		
Seguridad Social or SSI		
Beneficios para veteranos, pensiones o de jubilación		
Manutención de Menores o Pensión de Divorcio		
Dinero de amigos o parientes		
Otros: (Por ejemplo irregulares o una sola vez los pagos) Explique:		

¿La cantidad de dinero es más o menos igual que la que se muestra en el comprobante que envía?

☐ Sí ☐ No Si no, explique por favor_____

Recursos (Activos)

¿Alguien tiene un auto, camioneta, bote, casa rodante, motocicleta u otro vehículo con licencia?

☐ Sí ☐ No En caso afirmativo, la lista que el modelo y el año siguiente.

_____

_____

Indique el total de dinero que tienen en:

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

Efectivo $_____ ¿Quién? _____

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

Indique si alguien tiene o es propietario de terrenos, edificios, o viviendas, que no sea la casa en que usted vive: _____

Indique si alguien posee una tutela testamentaria o un fideicomiso: _____

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

Para FIP, indique todas las herramientas, maquinarias, ganado o colecciones que tengan:

_____

Gastos

Si tiene gastos de **cuidado diurno** de un niño o un adulto incapacitado que vive con usted, infórmenos.

Quién recibe cuidado: _____ Monto $ _____ por mes

Si alguien paga **manutención de menores** por orden judicial, infórmenos.

Quién paga: _____ Monto $_____ por mes **Envíe comprobante**

Si tiene **gastos médicos** de personas discapacitadas o mayores de 59 años que no están cubiertos por el seguro, infórmenos. Pueden ser facturas de médicos o del hospital, medicamentos, transporte, primas del seguro médico u otros gastos.

Quién paga: _____ Monto $ _____ por mes **Envíe comprobante**

Vivienda y Servicios Públicos (Conteste estas preguntas solamente si recibe Food Assistance.)

¿Cuánto paga por **su parte** de los siguientes gastos?

Alquiler: $_____ por mes

Alquiler de terreno: $_____ por mes

Hipoteca: $_____ por mes

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

Impuestos a la propiedad: $_____ por _____

Seguro de propietario: $_____ por _____

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

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

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

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

☐ Marque aquí si reside en una vivienda de renta reducida. Si la respuesta es sí, ¿cuál es su parte de la renta? $_____

Si recibe ayuda para pagar los gastos, infórmenos:

¿Qué gasto fue pagado?	¿Quién lo pagó?	Monto pagado

Cambios esperados

Infórmenos si algo ha cambiado o si espera que algo cambie.

Firma y Fecha

Certifico, bajo pena de cometer perjurio, que:

- Las respuestas que doy son correctas y completas según mi leal saber y entender.
- Mis respuestas con respecto a la ciudadanía o estado legal de extranjero de cada una de las personas que solicitan asistencia son correctas.

Sé que la información que proporcioné podría ocasionar que mis beneficios sean reducidos, aumentados o cancelados y que Department of Human Services podría revisar mi caso.

Su firma o marca	Teléfono	Fecha de hoy
Firma de la persona que ayudó a llenar este formulario, si corresponde	Teléfono	Fecha de hoy

Si es necesario, ¿cuando es el mejor momento para llamarte?

¿Qué debo hacer con el formulario?

Después de llenar el formulario, le agradeceremos que lo envíe en el sobre adjunto. Envíelo por correo a la dirección de la oficina que figura en la página 1. La dirección está debajo de su dirección postal. Si desea puede traerlo personalmente a la oficina.

Información sobre el Número de Social Security

Únicamente podemos brindar ayuda a aquellas personas que nos suministren su Número del Seguro Social o el comprobante de solicitud de la oficina de Social Security. **No es necesario que nos entregue los Números del Seguro Social de aquellos miembros de su grupo familiar para los cuales no solicitó ayuda, pero puede hacerlo si lo desea.** No obstante, usaremos los números de Seguro Social que nos proporcione del mismo modo que utilizamos los números de Seguro Social de las personas que reciben asistencia.

Si no nos proporciona los Números del Seguro Social de su grupo familiar, les denegaremos asistencia a dichas personas. Existen algunas excepciones. Por favor, pregúntele a su asistente.

No les daremos los Número de Social Security al Citizen and Immigration Service (Servicio de Ciudadanía e Inmigración).

Divulgación de Información - Opcional

¡Ayúdenos a ayudarle!

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

Debe saber que:

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

Escriba su nombre en letra de imprenta y firme debajo para autorizarnos a obtener la información necesaria. Recuerde de firmar página 4.

DIVULGACIÓN DE INFORMACIÓN
(Release of Information)

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

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

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

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

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

Por favor, guarde esta hoja para su información.

Todos los programas

Verificamos todo lo que nos informa

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

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

Verificamos y usamos sistemas informáticos como el State Income and Eligibility Verification System. Si algo que nos informó no coincide con la información del sistema, verificaremos para averiguar cuál es la correcta. Podríamos verificar su información contactando a su empleador, su banco o a otras personas.

Cosas que debe saber

Utilizaremos la información provista en este formulario para determinar qué asistencia puede recibir.

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

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

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

Food Assistance (Asistencia para alimentos)

Los hogares elegibles para la Food Assistance tal vez reciban un aviso de elegibilidad para el programa “Promoting Awareness of the Benefits of a Healthy Marriage” (“Concientización sobre los beneficios de un matrimonio saludable”) y un panfleto con dichos beneficios. Al brindar esta información, el DHS puede usar diferentes reglas que pueden ayudarle a obtener Food Assistance.

Al firmar la página 4, acepto que todos los miembros de mi grupo familiar deberán cumplir con las normas de trabajo y capacitación de Food Assistance.

Normas del Programa Food Assistance

Siga estas reglas:

- **No** oculte ni proporcione información falsa a propósito para obtener Food Assistance.
- **No** use los beneficios de Food Assistance para comprar artículos que no sean alimentos, como por ejemplo alcohol o tabaco.
- **No** canjee, venda ni regale los beneficios de Food Assistance.
- **No** utilice los beneficios de Food Assistance de otra persona para su uso personal.

Sanciones del Programa Food Assistance

Toda persona que quebrante las normas mencionadas:

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

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

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

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

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

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

Por favor, guarde esta página para su información.

FIP o Refugee Cash Assistance (FIP o Asistencia en efectivo para refugiados)

Cosas que debe saber

Cómo utilizar su Electronic Access Card (EAC) (Tarjeta de Acceso Electrónico)

No puede acceder a sus beneficios en efectivo con su tarjeta EAC en:

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

Si el departamento determina que usted ha accedido a sus beneficios de dinero en efectivo con su tarjeta EAC en uno de los lugares anteriormente mencionados, usted:

- Habrá cometido fraude
- Tendrá que volver a pagar el monto de dinero en efectivo al cual accedió en dicho lugar, y
- Su familia no obtendrá beneficios de dinero en efectivo durante 3 meses luego del primer uso incorrecto de la tarjeta, y 6 meses luego de cada uso incorrecto adicional

Sus pagos de manutención de menores

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

Multa por obtener FIP en más de un estado

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

Tiene Derecho a Apelar

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

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

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

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

Puede contactar a la oficina de DHS de su condado para informarse sobre servicios legales. Es posible que deba pagar dichos servicios. De ser así, su pago se basará en su ingreso. También puede llamar a Iowa Legal Aid al (800) 532-1275. Si vive en el condado de Polk, llame al (515) 243-1193.

No será Discriminado

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

Si cree que DHS le ha discriminado o acosado, le agradeceremos que envíe una carta explicando detalladamente su queja a:

Iowa Department of Human Services, Hoover Building, 5th Floor – Policy Bureau, 1305 E Walnut, Des Moines, IA 50319-0114 o a través de correo electrónico a contactdhs@dhs.state.ia.us

(*Únicamente para Food Assistance*) USDA – Director, Office of Adjudication, 1400 Independence Ave SW, Washington, DC 20250-9410, o llamar al 1-866-632-9992 voz. Las personas que tengan problemas de audición o de habla, pueden contactarse a la USDA a través de Federal Relay Services al 800-877-8339; o al 800-845-6136 (español).

Iowa Department of Human Services

Review/Recertification Eligibility Document

Due Date | Case Number | County Number | Worker Name

What do I do with this form?

You must:

- Fill out this form.
- Send proof if the question has **Send proof** Examples of proof of the money you get can be check stubs, self-employment records or award letters.
- Sign and date page 4.
- Send the form and your proof 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:

Name/State ID	Social Security Number	Age	Last Grade Completed in School	Citizen? Yes/No	If Alien, Status?

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	Last Grade in School	Date Moved In	Date Moved Out	Citizen? Yes/No	If Alien, Status?

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 has dropped out or is no longer attending school full-time, list who and when.

_____

If anyone is in a college or training program, list who and what school or program they are enrolled in.

_____

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

_____

List the most recent address of each parent not in the home. **Do not complete if you only get Food Assistance.**

Name of Parent Not Living in the Home	Address of this Parent	Name of this Parent's Children

Tell Us About Criminal Actions and Disqualifications

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

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

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

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

Income

Send proof – Send all pay stubs or proof of income for the last 30 days.
For proof of tips, send pay stubs showing tips, employer's statement, or your tip records. For new jobs, send proof showing first pay date, hourly rate, and weekly number of hours. If job stopped, send proof of the date of the last pay.

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

List all jobs the people in your household have.

Who works?	Employer name?	Does this person get tips?
		☐ Yes ☐ No
		☐ Yes ☐ No

Will the amount of money from jobs stay about the same as shown on the proof you are sending? ☐ Yes ☐ No

If no, explain_____

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

If yes, who?_____ Employer name?_____

Has anyone's job ended in the last 30 days? ☐ Yes ☐ No

If yes, who?_____ Employer name?_____

What other money do people in your household get?	Who gets the money?	How much per month? Send Proof
Self-Employment or Odd Jobs (Send the most recent federal tax forms. If tax return was not filed, send records that show income and expenses.)		
Unemployment or Worker's Compensation		
Social Security or SSI		
Veterans Benefits, Pensions or Retirement		
Child Support or Alimony		
Money from Friends or Relatives		
Other: (Including irregular or one time payments) Explain:		

Will the amount of other money stay about the same as shown on the proof you are sending? ☐ Yes ☐ No

If no, explain_____

Resources (Assets)

Does anyone have a car, truck, boat, camper, motorcycle or other vehicle? ☐ Yes ☐ No
If yes, list make, model, year below.

_____

_____

List the money anyone has in:

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

Cash $_____ Who? _____

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

List anyone who has or owns any land, buildings, or houses, other than the house you live in: _____

List anyone who has a conservatorship or trust: _____

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

For FIP, list any tools, machinery, livestock, or collections that anyone has:

_____

Expenses

If you have **day care** expenses for a child or a disabled adult who lives with you, tell us.

Who gets care: _____ Amount $ _____ per month

If anyone pays court-ordered **child support**, tell us.

Who pays: _____ Amount $_____ per month **Send proof**

If you have **medical costs** not paid by insurance for anyone who is disabled or over age 59, tell us. These could be doctor or hospital bills, medicine, transportation, health insurance premiums, or other medical expenses.

Who pays: _____ Amount $ _____ per month **Send proof**

Shelter and Utilities (Answer these questions only if you get Food Assistance.)

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

Rent: $_____ per month

Lot rent: $_____ per month

Mortgage: $_____ per month

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

Property taxes: $_____ per _____

Homeowner's insurance: $_____ per _____

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

☐ Lights/electricity ☐ Telephone ☐ Garbage and trash

☐ Gas ☐ Water and sewage ☐ Extra charges from your landlord

☐ Other, explain_____

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

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

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

If you get help with your expenses, tell us:

Which Expense Was Paid	Who Paid	Amount Paid

Expected Changes

Tell us if anything has changed or is expected to change.

Sign and Date

I certify, under penalty of perjury, that:

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

I know what I reported may cause my benefits to be reduced, increased, or stopped and that the Department of Human Services may check my case.

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

If needed, when is the best time to call you?

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.

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 4.

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	

Please keep this page for your information.

All Programs

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, amounts received from other sources like Social Security or unemployment, and alien status. If any information you give us is not correct, we may deny your application.

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

We check and use computer systems like the State Income and Eligibility Verification System. If something you told us is different from what the computer system tells us, we will check to find out what is correct. We might check your information by contacting your employer, your bank or other people.

Things You Need to Know

We will use the information you give us on this form to determine what assistance you are eligible to receive.

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.

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

Food Assistance

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

By signing page 4, I agree that all members of my household will follow the Food Assistance work and training rules.

Rules of the Food Assistance Program

Follow these rules:

- **Don't** hide or give wrong information on purpose to get Food Assistance benefits.
- **Don't** use Food Assistance benefits to buy non-food items like alcohol or tobacco.
- **Don't** trade, sell or give away Food Assistance benefits.
- **Don't** use someone else's Food Assistance benefits for yourself.

Penalties of the Food Assistance Program

Anyone who breaks the above rules:

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

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

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

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

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

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

Please keep this page for your information.

FIP or Refugee Cash Assistance

Things You Need to Know

Using Your Electronic Access Card (EAC)

You cannot access your cash benefits with your EAC at a:

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

If the Department determines that you have accessed your cash benefits with your EAC card at one of the above places you:

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

Your Child Support Payments

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

Penalty for Getting FIP in More Than One State

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

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. For Food Assistance, you can appeal in writing or by telephone. For all other programs, you must appeal in writing. To appeal in writing do **one** of the following:

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

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

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

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

You Will Not Be Discriminated Against

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

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

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

(Food Assistance only) USDA – Director, Office of Adjudication, 1400 Independence Ave SW, Washington, DC 20250-9410, or call 1-866-632-9992 voice. Individuals who are hearing impaired or have speech disabilities may contact USDA through the Federal Relay Service at 800-877-8339; or 800-845-6136 (Spanish).

Iowa Department of Human Services

Review/Recertification Eligibility Document (Documento de Elegibilidad para Revisión/Recertificación)

Fecha de Entrega	Número del Caso	Número del Condado	Nombre del Asistente
de de			

¿Qué debo hacer con este formulario?

Debe:

- Llenar este formulario.
- Enviar comprobantes si la pregunta indica **Enviar comprobantes** Por ejemplo, los comprobantes de sus ingresos pueden ser sus recibos de sueldo, sus registros de trabajo independiente o las cartas de asignaciones recibidas.
- Firmar y fechar la página 4.
- Enviar el formulario y sus comprobantes al domicilio mencionado antes del de de .
- Escriba sus respuestas en una hoja extra si no le alcanza el espacio.

¿Y si deseo hacer preguntas?

Llame a su asistente al teléfono . Aceptamos llamadas por cobrar.

Miembros del Grupo Familiar

Estas personas reciben beneficios con usted o se contabilizan para calcular sus beneficios:

Nombre/Nº de ID Estatal	Número de Social Security	Edad	Último grado escolar terminado	¿Es ciudadano? Sí/No	Si es extranjero ¿estatus?

¿Vive alguien más en su casa que no figura en la lista de la página 1? ☐ Sí ☐ No En caso afirmativo, llene la siguiente información.

¿Alguien se ha mudado a su casa o se ha ido de su casa? ☐ Sí ☐ No En caso afirmativo, llene la siguiente información.

Nombre	Número de Social Security	Fecha de nacimiento	Relación con usted	Último grado escolar	Fecha en que se mudó	Fecha en que se fue	¿Ciudadano? Sí/No	Si es extranjero, ¿estatus?

Si se ha mudado, informe su nueva dirección.

Domicilio	Ciudad, estado y código postal
Dirección postal (si es diferente)	Ciudad, estado y código postal

Si alguien ha abandonado la escuela o ya no asiste tiempo completo, indique quién es y cuándo.

_____

Si alguien estudia en la universidad o en un programa de capacitación, indique quién, qué estudia y dónde.

_____

Si alguno está en militares, un veterano, o una esposa de un veterano, lista sus nombres y los relacionados.

_____

Indique el domicilio más reciente de cada padre/madre que no vive en el hogar. **No llene si solamente recibe Food Assistance (Asistencia para Alimentos).**

Nombre del padre/madre que no vive en el hogar	Domicilio de este padre/madre	Nombres de los hijos de este padre/madre

Por favor, díganos acerca de los procesos penales o descalificaciones

¿Alguien está escapando para evitar una acción judicial, custodia o encarcelamiento por un delito? ☐ Sí ☐ No

¿Alguien está violando una condición de libertad condicional o bajo palabra? ☐ Sí ☐ No

¿Alguien está encarcelado o se espera que vaya a la cárcel o prisión? ☐ Sí ☐ No

¿Alguien ha resultado descalificado de un programa de Food Assistance en cualquier estado debido a un caso de fraude o violación del programa? ☐ Sí ☐ No

Ingresos

Envíe comprobantes – Envíe todos los recibos de sueldo o comprobantes de ingresos de los últimos 30 días. Como comprobantes de propinas, envíe recibos de sueldos donde se indiquen las propinas, una declaración del empleador o sus registros de propinas. En el caso de empleos nuevos, envíe comprobantes donde figuren la primera fecha de pago, paga por hora y cantidad de horas semanales. Si dejó de trabajar, envíe un comprobante de la fecha en que cobró por última vez.

Debe informarnos sobre todo el dinero que gana cada una de las personas que vive en su casa. Si deja un espacio en blanco, consideraremos que no percibe este tipo de dinero. Por favor, utilice otra hoja de papel si la necesita.

Enumere todos los trabajos que tienen las personas que viven en su casa.

¿Quién trabaja?	¿Nombre del empleador?	¿Tiene esta persona recibe propinas?
		☐ Sí ☐ No
		☐ Sí ☐ No

¿La cantidad de dinero proveniente de los empleos es más o menos igual que la que se muestra en el comprobante que envía? ☐ Sí ☐ No

Si no, explique_____

¿Alguien ha sido contratado para un trabajo, pero no recibió un cheque de pago todavía ☐ Sí ☐ No

En caso afirmativo, ¿quién?_____ ¿Nombre del empleador?_____

¿El trabajo de alguna persona terminó en los últimos 30 días? ☐ Sí ☐ No

En caso afirmativo, ¿quién?_____ ¿Nombre del empleador?_____

¿Qué otro dinero ganan las personas que viven en su casa?	¿Quién recibe el dinero?	Cuanto por mes? **Envíe comprobante**
Por cuenta propia o trabajos esporádicos (Envíe los formularios federales de impuestos más recientes. Si no se completó la declaración de impuestos, envíe los registros que muestren sus ingresos y gastos.)		
Desempleo o Compensación a los Trabajadores		
Seguridad Social or SSI		
Beneficios para veteranos, pensiones o de jubilación		
Manutención de Menores o Pensión de Divorcio		
Dinero de amigos o parientes		
Otros: (Por ejemplo irregulares o una sola vez los pagos) Explique:		

¿La cantidad de dinero es más o menos igual que la que se muestra en el comprobante que envía?

☐ Sí ☐ No Si no, explique por favor_____

Recursos (Activos)

¿Alguien tiene un auto, camioneta, bote, casa rodante, motocicleta u otro vehículo con licencia?

☐ Sí ☐ No En caso afirmativo, la lista que el modelo y el año siguiente.

_____

_____

Indique el total de dinero que tienen en:

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

Efectivo $_____ ¿Quién? _____

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

Indique si alguien tiene o es propietario de terrenos, edificios, o viviendas, que no sea la casa en que usted vive: _____

Indique si alguien posee una tutela testamentaria o un fideicomiso: _____

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

Para FIP o Medicaid, indique todas las herramientas, maquinarias, ganado o colecciones que tengan:

_____

Gastos

Si tiene gastos de **cuidado diurno** de un niño o un adulto incapacitado que vive con usted, infórmenos.

Quién recibe cuidado: _____ Monto $ _____ por mes

Si alguien paga **manutención de menores** por orden judicial, infórmenos.

Quién paga: _____ Monto $_____ por mes **Envíe comprobante**

Si tiene **gastos médicos** de personas discapacitadas o mayores de 59 años que no están cubiertos por el seguro, infórmenos. Pueden ser facturas de médicos o del hospital, medicamentos, transporte, primas del seguro médico u otros gastos.

Quién paga: _____ Monto $ _____ por mes **Envíe comprobante**

Vivienda y Servicios Públicos (Conteste estas preguntas solamente si recibe Food Assistance.)

¿Cuánto paga por **su parte** de los siguientes gastos?

Alquiler: $_____ por mes

Alquiler de terreno: $_____ por mes

Hipoteca: $_____ por mes

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

Impuestos a la propiedad: $_____ por _____

Seguro de propietario: $_____ por _____

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

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

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

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

☐ Marque aquí si reside en una vivienda de renta reducida. Si la respuesta es sí, ¿cuál es su parte de la renta? $_____

Si recibe ayuda para pagar los gastos, infórmenos:

¿Qué gasto fue pagado?	¿Quién lo pagó?	Monto pagado

Cambios esperados

Infórmenos si algo ha cambiado o si espera que algo cambie.

Firma y Fecha

Certifico, bajo pena de cometer perjurio, que:

- Las respuestas que doy son correctas y completas según mi leal saber y entender.
- Mis respuestas con respecto a la ciudadanía o estado legal de extranjero de cada una de las personas que solicitan asistencia son correctas.

Sé que la información que proporcioné podría ocasionar que mis beneficios sean reducidos, aumentados o cancelados y que Department of Human Services podría revisar mi caso.

Su firma o marca	Teléfono	Fecha de hoy
Firma de la persona que ayudó a llenar este formulario, si corresponde	Teléfono	Fecha de hoy

Si es necesario, ¿cuando es el mejor momento para llamarte?

¿Qué debo hacer con el formulario?

Después de llenar el formulario, le agradeceremos que lo envíe en el sobre adjunto. Envíelo por correo a la dirección de la oficina que figura en la página 1. La dirección está debajo de su dirección postal. Si desea puede traerlo personalmente a la oficina.

Información sobre el Número de Social Security

Únicamente podemos brindar ayuda a aquellas personas que nos suministren su Número del Seguro Social o el comprobante de solicitud de la oficina de Social Security. **No es necesario que nos entregue los Números del Seguro Social de aquellos miembros de su grupo familiar para los cuales no solicitó ayuda, pero puede hacerlo si lo desea.** No obstante, usaremos los números de Seguro Social que nos proporcione del mismo modo que utilizamos los números de Seguro Social de las personas que reciben asistencia.

Si no nos proporciona los Números del Seguro Social de su grupo familiar, les denegaremos asistencia a dichas personas. Existen algunas excepciones. Por favor, pregúntele a su asistente.

No les daremos los Número de Social Security al Citizen and Immigration Service (Servicio de Ciudadanía e Inmigración).

Divulgación de Información - Opcional

¡Ayúdenos a ayudarle!

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

Debe saber que:

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

Escriba su nombre en letra de imprenta y firme debajo para autorizarnos a obtener la información necesaria. Recuerde de firmar página 4.

DIVULGACIÓN DE INFORMACIÓN
(Release of Information)

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

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

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

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

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

Por favor, guarde esta hoja para su información.

Todos los programas

Verificamos todo lo que nos informa

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

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

Verificamos y usamos sistemas informáticos como el State Income and Eligibility Verification System. Si algo que nos informó no coincide con la información del sistema, verificaremos para averiguar cuál es la correcta. Podríamos verificar su información contactando a su empleador, su banco o a otras personas.

Cosas que debe saber

Utilizaremos la información provista en este formulario para determinar qué asistencia puede recibir.

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

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

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

Food Assistance (Asistencia para Alimentos)

Los hogares elegibles para la Food Assistance tal vez reciban un aviso de elegibilidad para el programa “Promoting Awareness of the Benefits of a Healthy Marriage” (“Concientización sobre los beneficios de un matrimonio saludable”) y un panfleto con dichos beneficios. Al brindar esta información, el DHS puede usar diferentes reglas que pueden ayudarle a obtener Food Assistance.

Al firmar la página 4, acepto que todos los miembros de mi grupo familiar deberán cumplir con las normas de trabajo y capacitación de Food Assistance.

Normas del Programa Food Assistance

Siga estas reglas:

- **No** oculte ni proporcione información falsa a propósito para obtener Food Assistance.
- **No** use los beneficios de Food Assistance para comprar artículos que no sean alimentos, como por ejemplo alcohol o tabaco.
- **No** canjee, venda ni regale los beneficios de Food Assistance.
- **No** utilice los beneficios de Food Assistance de otra persona para su uso personal.

Sanciones del Programa Food Assistance

Toda persona que quebrante las normas mencionadas:

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

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

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

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

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

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

Por favor, guarde esta página para su información.

FIP o Refugee Cash Assistance (FIP o Asistencia en efectivo para refugiados)

Cosas que debe saber

Cómo utilizar su Electronic Access Card (EAC) (Tarjeta de Acceso Electrónico)

No puede acceder a sus beneficios en efectivo con su tarjeta EAC en:

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

Si el departamento determina que usted ha accedido a sus beneficios de dinero en efectivo con su tarjeta EAC en uno de los lugares anteriormente mencionados, usted:

- Habrá cometido fraude
- Tendrá que volver a pagar el monto de dinero en efectivo al cual accedió en dicho lugar, y
- Su familia no obtendrá beneficios de dinero en efectivo durante 3 meses luego del primer uso incorrecto de la tarjeta, y 6 meses luego de cada uso incorrecto adicional

Sus pagos de manutención de menores

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

Multa por obtener FIP en más de un estado

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

Tiene Derecho a Apelar

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

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

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

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

Puede contactar a la oficina de DHS de su condado para informarse sobre servicios legales. Es posible que deba pagar dichos servicios. De ser así, su pago se basará en su ingreso. También puede llamar a Iowa Legal Aid al (800) 532-1275. Si vive en el condado de Polk, llame al (515) 243-1193.

No será Discriminado

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

Si cree que DHS le ha discriminado o acosado, le agradeceremos que envíe una carta explicando detalladamente su queja a:

Iowa Department of Human Services, Hoover Building, 5th Floor – Policy Bureau, 1305 E Walnut, Des Moines, IA 50319-0114 o a través de correo electrónico a contactdhs@dhs.state.ia.us

(*Únicamente para Food Assistance*) USDA – Director, Office of Adjudication, 1400 Independence Ave SW, Washington, DC 20250-9410, o llamar al 1-866-632-9992 voz. Las personas que tengan problemas de audición o de habla, pueden contactarse a la USDA a través de Federal Relay Services al 800-877-8339; o al 800-845-6136 (español).

Review/Recertification Eligibility Document, Form 470-2881, 470-2881(S), 470-2881(M), or 470-2881(MS)

Purpose

The *Review/Recertification Eligibility Document*, forms 470-2881, 470-2881(S), 470-2881(M), and 470-2881(MS), is designed for use as:

- An application for subsequent certification for the Food Assistance program.
- The annual or semiannual review document for FIP and Refugee Cash Assistance.

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

Source

Usually, the ABC system generates form 470-2881 automatically. Form 470-2881(S) is generated when there is an "S" in the language indicator field on the ABC TD01 screen.

DHS staff may issue "manual" versions of the form, 470-2881(M) and 470-2881(MS), using the Word templates available on the DHS Intranet eForms web page.

Completion

The ABC system produces form 470-2881 or 470-2881(S) after the data processing cutoff for:

- Food Assistance when a case is due for recertification.
- FIP and Refugee Cash Assistance when a case is active or pending and the case coding indicates that the form should be sent.

Give or issue form 470-2881(M) or 470-2881(MS) to the participant upon request.

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

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

For FIP and Refugee Cash Assistance, when both parents or a parent and a stepparent are in the home, either may sign the form. When a participant has a guardian or conservator, that person shall participate in completing the form. This person may sign for the client when necessary.

For Food Assistance, only one signature is required to process this form as an application for recertification.

Distribution

Give or mail one copy of the report to the client for completion.

File the completed original in the case record. Provide a copy of the completed form to the client upon request.

Data

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

- Enter the county number.
- Enter the nine-digit case number and check digit.
- Enter the case name and current mailing address.
- Enter the Department office name and mailing address.
- Enter the date the report is due back to the Department in the "Due Date" field and in the "What do I do with this form?" section.
- Enter the worker's telephone number in the "What if I have questions?" section.
- For FIP and Refugee Cash Assistance, insert the following message in the message section:

  "It's time to review your case. Please fill out this form and send or bring it to the address above by <due date>. This information will be used to decide if you will continue to get Family Investment Program (FIP) or Refugee Cash Assistance benefits."

- If an interview is needed for Food Assistance, enter:

  "Your Food Assistance will end <last date of certification period>. Return this signed form by <15th of certification end month> to get Food Assistance at the regular time next month, if you are eligible. You must have an interview. If you miss your interview, you must ask the local office to reschedule.

  "Households consisting of only SSI applicants or recipients may apply for Food Assistance recertification at any SSA office."

- If an interview is **not** needed for Food Assistance, enter:

  "Your Food Assistance will end <last date of certification period>. Return this signed form by <15th of certification end month> to get Food Assistance at the regular time next month, if you are eligible.

  "Households consisting of only SSI applicants or recipients may apply for Food Assistance recertification at any SSA office."

- Enter all data in the "Household Members" section (except **do not** enter the last grade completed and the "yes" or "no" responses). Enter only the last four digits of the social security number.

Screening: Screen the form upon its receipt. All questions (for related programs) that have "yes or no" responses must have either "yes" or "no" marked.

For FIP and Refugee Cash Assistance, if the answer is "yes," all requested information must be completed and necessary verification provided for the form to be considered complete.

If the participant fails to enter required information on the RRED but sends verification of that information with the RRED, the form is still considered complete.

NOTE: When the nonparental relative does not receive assistance for the relative's own needs, the information shall reflect the circumstances of each child.

To be complete, the form must be signed and dated by the necessary persons.

Voter Registration, Unnumbered

Purpose

The *Voter Registration* form:

- Gives clients information about registering to vote.
- Records a client's decision whether to register.
- Provides a detachable card that clients can use to register.

This process is required by the National Voter Registration Act of 1993 and Iowa Code Section 48A.19.

Source

Service areas periodically order a supply of these forms from the Field Operation Support Unit.

Spanish, Vietnamese, Laotian, and Bosnian versions of this form are available in on the Secretary of State's web site at: http://sos.iowa.gov/elections/voterinformation/voterregistration.html

Completion

Give this form to the client every time you give out an application, recertification, review, or address change form for FIP, Food Assistance, Medicaid, or Child Care Assistance.

At each application, recertification, or review interview, ask if the client wants to register to vote. If the client has not answered the voter registration question on the form, have the client complete the question at the interview.

Offer the client assistance in completing the voter registration form if the client wants to register to vote. Date-stamp each voter registration form. This verifies that the form is timely for voter registration purposes.

Distribution

Keep the declination section in the local office. Give the voter registration information section to the client.

Send or deliver all completed voter registration forms to the county election office every Friday. When Friday is a holiday, send the forms the last working day of that week. EXCEPTION: Deliver registration forms received on the tenth day before the general election to the election office on that day.

Iowa Department of Human Services

Terry E. Branstad
Governor

Kim Reynolds
Lt. Governor

Charles M. Palmer
Director

Dear

A payment slot is now available for the _____ Waiver. If you are still interested in receiving waiver services, please sign and return this letter by _____. If you don't, the slot will be awarded to the next person on the list. If you need waiver services later, you can reapply to be placed on the waiting list.

Please let me know if you are interested in this waiver or if you have any questions.

Sincerely,

I am interested in the _____ Waiver.

Signed: _____

Date: _____

Iowa Department of Human Services

Terry E. Branstad
Governor

Kim Reynolds
Lt. Governor

Charles M. Palmer
Director

Dear

A payment slot is now available for the _____ Waiver. If you are still interested in receiving waiver services, please complete and return the enclosed application by _____. If you don't, the slot will be awarded to the next person on the list. If you need waiver services later, you can reapply to be placed on the waiting list.

Please let me know if you are interested in this waiver or if you have any questions.

Sincerely,

Enclosure: Application for Health Coverage and Help Paying Costs, form 470-5170

Iowa Department of Human Services

Facts About the Food Assistance Program

INCOME GUIDELINES

Gross monthly income is the amount before taxes or other deductions are taken out. Net monthly income is what is left of gross income after certain allowable expenses are subtracted.

Income Guidelines

Household Size	1	2	3	4	5	6	7	8	Each Extra Person
Gross Monthly Limit	$1,265	$1,705	$2,144	$2,584	$3,024	$3,464	$3,904	$4,344	+$440
Net Monthly Limit	$973	$1,311	$1,650	$1,988	$2,326	$2,665	$3,003	$3,341	+$339

To be eligible, a household's monthly income must be within the above limits for its size. **Exceptions:**

- Households with an elderly (age 60 or over) or disabled person do not have to meet gross income limits.
- If everyone gets SSI or FIP, the household does not have to meet the gross or net monthly income limits.
- Some households that do not meet the above income guidelines might be eligible if monthly income is not more than the amount below (160% of the federal poverty level).

160% of Federal Poverty Level

Household Size	1	2	3	4	5	6	7	8	Each Extra Person
Monthly Limit	$1,557	$2,098	$2,640	$3,181	$3,722	$4,264	$4,805	$5,346	+$543

MAXIMUM FOOD ASSISTANCE BENEFIT AMOUNT

Households of the same size do not all get the same amount of Food Assistance. The benefit amount depends on both the household's size and income. Only households with very little or no income get the maximum benefit amount.

Household Size	1	2	3	4	5	6	7	8	Each Extra Person
Maximum Monthly Benefit	$194	$357	$511	$649	$771	$925	$1,022	$1,169	+$146

WHERE TO APPLY

You can apply online at https://secureapp.dhs.state.ia.us/oasis/. You can also apply at the Human Services office. The address and phone number is in the county government listing of your telephone book under "Human Services." (A few counties have the listing under "Social Services.")

Iowa Department of Human Services

Facts About the Food Assistance Program
(Datos sobre el Programa de Asistencia Alimentaria)

PAUTAS GENERALES SOBRE EL INGRESO

El ingreso mensual bruto es el monto que se recibe antes de impuestos u otras deducciones. El ingreso mensual neto es lo que queda del ingreso mensual bruto luego de que se restan ciertos gastos deducibles.

Pautas generales sobre el ingreso

Número de personas en el hogar	1	2	3	4	5	6	7	8	Cada persona adicional
Límite mensual bruto	$1.265	$1.705	$2.144	$2.584	$3.024	$3.464	$3.904	$4.344	+$440
Límite mensual neto	$973	$1.311	$1.650	$1.988	$2.326	$2.665	$3.003	$3.341	+$339

Para resultar elegible, el ingreso mensual de un hogar debe encontrarse dentro de los límites fijados más arriba según la cantidad de personas que viven en él. **Excepciones:**

- Los hogares en los que vive una persona anciana (de 60 años o más) o discapacitada no deben cumplir con ningún límite de ingresos brutos.
- Si todos reciben SSI o FIP, el hogar no debe cumplir con los límites de ingresos mensuales brutos o netos.
- Algunos hogares que no cumplen con las pautas sobre ingreso que se especifican arriba pueden ser elegibles si el ingreso mensual no supera el monto que se encuentra debajo (160% del nivel de pobreza federal).

160% del Nivel de pobreza federal

Número de personas en el hogar	1	2	3	4	5	6	7	8	Cada persona adicional
Límite mensual	$1.557	$2.098	$2.640	$3.181	$3.722	$4.264	$4.805	$5.346	+$543

MONTO MÁXIMO DEL BENEFICIO DE ASISTENCIA ALIMENTARIA

No todos los hogares con igual cantidad de personas reciben la misma cantidad de Asistencia Alimentaria. El monto del beneficio depende tanto de la cantidad de personas en el hogar como de sus ingresos. Sólo los hogares con muy pocos ingresos o sin ingresos reciben el monto máximo del beneficio.

Número de personas en el hogar	1	2	3	4	5	6	7	8	Cada persona adicional
Máximo beneficio mensual	$194	$357	$511	$649	$771	$925	$1.022	$1.169	+$146

DÓNDE PRESENTAR LA SOLICITUD

Usted puede presentar su solicitud en línea en https://secureapp.dhs.state.ia.us/oasis/. También puede hacerlo en la oficina del Department of Human Services. La dirección y el número de teléfono se encuentran en el listado de organismos gubernamentales del condado en su guía telefónica, debajo de “Human Services”. (Algunos condados poseen el listado debajo de “Social Services”)

Iowa Department of Human Services

Comm. 20 (Rev. 2/14)

Your Guide to Medicaid

Member Services:
Toll Free: 1-800-338-8366
Local: 515-256-4606

Website: www.ime.state.ia.us Email: IMEMemberServices@dhs.state.ia.us

Para solicitar este folleto en español, por favor póngase en contacto con Servicios para Miembros.

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Your Guide to Medicaid

Part I: Basic Medicaid Information

This guide tells you what Medicaid covers (pays for) and how to use the program.

- Keep this guide! Use it to learn more about your Medicaid benefits.
- **This booklet does not include benefits covered under the Iowa Health and Wellness Plan.**

Your Medical Assistance Eligibility Card

All members receive a new *Medical Assistance Eligibility Card*, form 470-1911.

- Keep your card until you receive a new one.
- Always carry your card with you and don't let anyone else use it.
- Show your card to the provider every time you get care.
- If you lose your card, call Member Services to ask for a new one.

Member Services: 1-800-338-8366
Member Services in the Des Moines area: 1-515-256-4606

Member Services Call Center is available Monday through Friday 8:00 a.m. until 5:00 p.m.

Retroactive Medicaid Eligibility

You may qualify for Medicaid for up to three months before the month you applied. These months are called the "retroactive period."

You can qualify for retroactive benefits only if **all** of these statements are true:

- You have medical bills for services that you received during the retroactive period. (The bills can be paid or unpaid.)
- The bills are for services covered by Medicaid.
- You would have qualified for Medicaid in the months you got services, if you had applied.

There is an exception:

- These groups do **not** allow retroactive benefits:
  - Iowa Family Planning Network (IFPN)
  - Home- and Community-Based Services Waiver (HCBS)
  - Program for all-inclusive care for the elderly (PACE)
  - Qualified Medicare Beneficiary (QMB)

- Call your local Department of Human Services (DHS) office if you think you or a family member qualifies for retroactive Medicaid.

Who Can Provide Services

Providers

With Medicaid, you will choose your own providers. Follow these steps:

1. To search for a provider, you can go to: https://secureapp.dhs.state.ia.us/providersearche/ or call Member Services at 1-800-338-8366 or in the Des Moines area at (515)-256-4606 Monday through Friday 8:00 a.m. until 5:00 p.m.

2. Choose a doctor, dentist, pharmacy, and other providers that take Medicaid.

3. Ask the providers if they take Iowa Medicaid before you make an appointment. Some providers limit their number of Medicaid patients or don't take Medicaid.

   a. **Remember:** Make sure the provider understands that you are in Iowa Medicaid. If you don't say you are an Iowa Medicaid member *before* you get services—and the provider doesn't take Iowa Medicaid—you may be billed for the entire cost!

4. Show your *Medical Assistance Eligibility Card* when you get to the appointment.

5. Ask if Medicaid covers the service you need or if you will have to pay for it.

Away from Home

If you are outside of Iowa and need medical care, check to see whether the provider is enrolled with Iowa Medicaid. A provider who participates in Medicaid in another state may not be participating in Iowa Medicaid.

A provider who is enrolled with Iowa Medicaid, must accept what Medicaid pays. Providers are not allowed to charge you for services that Medicaid covers.

If the provider does not participate in Iowa Medicaid, you will have to pay for the services.

Managed Care

Some Medicaid members get health care through MediPASS or a Health Maintenance Organization (HMO). Read more about MediPASS and HMOs on page 22.

Mental Health and Substance Abuse (Behavioral Health)

- Read about how to get these services through the Iowa Plan on page 22.

Program of All-Inclusive Care for the Elderly (PACE)

- Read about how to get these services through PACE on page 23.

Copayments

Some medical services have a copayment, which is your share of the cost. If there is a copayment, you will pay it to the provider. The provider will tell you the cost.

There is a copayment:

- If federal rules require one.
- If the service is not a service Medicaid requires but the state chooses to cover it. Examples are dental services and prescription drugs.
- For emergency room services if the visit is not an emergency.

  Examples of true emergencies are:

  - Heavy bleeding
  - Chest pain
  - Trouble breathing
  - Bad burns
  - Broken bone
  - Choking
  - Blacking out (fainting)
  - Suddenly unable to move or speak
  - Poisoning

There is **no** copayment:

- For care covered by Medicaid in a skilled nursing facility or nursing facility.
- If you are pregnant.
- If you are under age 21.
- For services provided by an HMO.

Limits to Medicaid-Covered Services

Some medical services may require certain approvals or may not be covered at all. Listed below are some limits to Medicaid service coverage; this is not a complete list. Please speak with your healthcare provider if you have questions about these service limitations.

- Limits to coverage for organ and tissue transplants. Only certain types of transplants are covered. For some transplants, you must get approval **before** the transplant. Your provider should know what types of transplants are covered and when approval is needed.
- **No** coverage for surgery for obesity without approval before the surgery. Only certain types of surgeries for obesity are covered, even with approval. Your medical provider should know what is covered. The provider will ask for the approval.
- **No** coverage for cosmetic, plastic or reconstructive surgery to improve appearance or for psychiatric purposes.
- **No** coverage for flatfoot treatment and routine foot care, such as cutting or removing corns or calluses and trimming nails.
- **No** coverage for acupuncture treatments.

Member Responsibilities

As a Medicaid member, it is your responsibility to:

- Keep all appointments you make with providers or call to cancel or reschedule. Some providers may stop seeing you if you miss one or more scheduled appointments.
- Ask **only** for medical services that are medically necessary. DHS may limit your services if you use Medicaid for services that are not necessary.
- Tell Iowa Medicaid Member Services about any changes to other health insurance coverage. Tell them if coverage ends, if you lose or get new coverage, or if you change insurance companies.
- Tell your medical providers about anyone else who may be legally responsible to pay your medical bills.
- Report to Iowa Medicaid Member Services if you are injured in an accident or if you claim medical negligence for something that required medical treatment.
- Report any settlements you get from lawsuits, insurance claims, or worker's compensation claims. Medicaid can be denied or canceled if you don't tell DHS about these settlements.
- Contact the Iowa Medicaid Enterprise (IME) if you were in a trauma-related incident. Some examples of trauma include any type of unexpected accident or injury that causes harm to the individual, including but not limited to, automobile or slip and fall. You or your representative must give consent before any documents will be released. Call the IME Revenue Collections/Lien Recovery Unit at **1-888-543-6742** or **1-515-256-4620** in the Des Moines area Monday through Friday from 8:00 a.m. until 5:00 p.m.

- Ensure your medical card or member identification number is not used by anyone else.
- Call the Iowa Department of Human Services if you suspect that someone is misusing their Medicaid benefits or someone who is not your provider requests your Medicaid information. Please call the Iowa Department of Human Services at 1-800-831-1394, Monday through Friday from 7:00 a.m. until 6:00 p.m.

Member Services Call Center

The Member Services Call Center toll-free telephone numbers are:

1-800-338-8366 and **1-515-256-4606** in the Des Moines area Monday through Friday from 8:00 a.m. until 5:00 p.m.

Your Member Services Call Center can answer questions and help with:

- Changing your address
- Asking for a new card
- Getting general Medicaid information
- Enrolling in Managed Health Care (MHC), including MediPASS and HMO
- Getting special approvals (special authorizations)
- Asking about third-party liability (TPL)
    - Medicaid is a "payer of last resort." This means that any other insurance you have must be billed first.
- Bills you've received for services you thought were covered

If you are calling about unpaid bills you think Medicaid should have covered, please have these things ready when you call:

- The medical bill.
- A brief description of the services provided.
- The member ID number on the *Medical Assistance Eligibility Card* of the person who received the bill for services provided.

You may also write or fax the Member Services Call Center at:

The Iowa Medicaid Enterprise
Attention: Billing
PO Box 36510
Des Moines, IA 50315
Fax number: 515-725-1351

Or go to http://www.ime.state.ia.us or email us at IMEMemberServices@dhs.state.ia.us.

Contact your county DHS office:

- If you move
- If you change your phone number
- If you have a change in income
- At the birth of a child
- At the death of a Medicaid member
- To ask about Medical Assistance, Food Assistance, Family Investment Program or Child Care Assistance

To find your county DHS office visit http://www.dhs.state.ia.us/Consumers/Find_Help/MapLocations.html or call IME Member Services at 1-800-338-8366.

Call the DHS Call Center at **1-877-347-5678** to:

- Correct the spelling of your name
- Change your name because of marriage or divorce
- Update the number of persons who live in your household
- Change a date of birth or Social Security number
- Report a gain or loss in financial resources

Appeals and Grievances

Appeals: An Appeal is a formal process involving the Department of Human Services and the Department of Inspections and Appeals regarding unpaid medical bills.

Grievances: A Grievance is a complaint involving access to care, quality of care, or communication issues with your primary care physician.

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

How long do I have to appeal?

You have 90 calendar days to file an appeal from the date of a decision.

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

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

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

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

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

How will I know if I get a hearing?

You will get a hearing notice that tells you the date and time a telephone hearing is scheduled. You will get a letter telling you if you do not get a hearing. The 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 515-243-1193.

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

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

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

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

Right to Submit a Grievance

If you want to file a complaint involving access to care, quality of care, communication issues with your primary care provider, or unpaid medical bills and you are enrolled in an HMO, please contact the HMO and work through their grievance process. If you feel that the HMO is not acting on your complaint, you may contact the Member Services Call Center at 1-800-338-8366 toll free or 515-256-4606 in the Des Moines area.

If you want to file a complaint involving access to care, quality of care, communication issues with your primary care provider, or unpaid medical bills and you are enrolled in the Iowa Wellness Plan, please contact the Member Services Call Center at 1-800-338-8366 toll free or 515-256-4606 in the Des Moines area.

Part II: Basic Medicaid Benefits

The following lists some Medicaid benefits and details about coverage. For all services you receive, be sure the provider is a Medicaid provider **before** you receive care. If the provider is not a Medicaid provider you will have to pay for the services you received.

Ambulance

In an emergency, call 911 for an ambulance. Tell the ambulance driver to take you to the nearest hospital.

But remember, Medicaid will pay for ambulance transportation to a hospital or skilled nursing facility **only** when it would be dangerous for your health for you to go on your own.

Medicaid may cover an air ambulance when a ground ambulance can't get you to care fast enough. If an ambulance is called to your home and you decline transport, Iowa Medicaid will not pay for the charges. You may be billed and be responsible for payment.

Ambulatory Surgical Centers

Medicaid covers surgical services that are medically necessary, with the same limits as for doctor services.

Birth Control and Family Planning Clinics

Medicaid family planning services include counseling, medical exams, laboratory tests, medications and supplies for family planning. You can get these supplies from any provider who takes Medicaid or your health plan.

Medicaid covers:

- Most birth control drugs and supplies for men and women. Brand-name birth control drugs or supplies may need your provider's approval.
- Oral contraceptives prescribed in 90-day supplies.

Case Management (Targeted)

Targeted case management makes it easier to get help with your medical care and social needs. Case management services are available to Medicaid members with:

- Intellectual disabilities
- Developmental disabilities
- Chronic mental illness

Targeted case management services include:

- Talking to the case manager to be sure all services and living-arrangement needs are identified
- Help to make sure there is an individual comprehensive plan (ICP) that addresses the total need for services and living arrangements
- Help getting the services and living arrangements in the ICP
- Help to make sure all providers follow the ICP
- Monitoring services and living arrangements to make sure they are still appropriate
- Help getting a referral to the appropriate provider in a crisis
- Discharge-planning activities for institutionalized persons:
  - For no more than 60 days before the estimated discharge date
  - For case manager discharge activities different from the institution's discharge-planning activities

Chiropractic Services

Except for members who are pregnant or under the age of 18, Medicaid covers only this chiropractic service:

- Chiropractic Manipulative Therapy (CMT) for subluxation or misalignment of the spine that is proven by an x-ray.

Clinics

Clinic services have the same coverage and limits as doctors and hospitals. Public Health Clinics are only able to provide immunizations and communicable disease testing under Medicaid.

Dental Services

Dental services may include teeth cleaning, fillings, extractions, disease control, and surgery.

Dental services have these limits:

- Routine exam: 1 time every 6 months
- Teeth cleaning: 1 time every 6 months
- Bitewing x-ray: 1 time every 12 months
- Complete x-ray: 1 time every 5 years, unless there is a need
- Sealant: only 1 time per tooth
- Dentures: 1 time every 5 years
- Complete exam: only once per dental provider

  This is a more thorough exam done if you have never been to that dentist or have not been to the dentist in 3 years.

- Contact your local I-Smile Coordinator if you need help finding a dentist who will see you or your child under 21 years of age. You can find your I-Smile Coordinator by calling **1-866-764-5315** toll-free or going to http://www.idph.state.ia.us/webmap/default.asp?map=ismile.

Doctor Visits

Medicaid covers these services performed in an office, clinic, hospital, your own home or other places:

- Medical and surgical services
- Diagnostic tests, including lab tests
- X-rays
- Treatment procedures
- Physical exams once a year with basic lab tests for members, including children and newly settled refugees, if they qualify

Limits to these services are listed on page 4.

Emergency Room Care

Go to an emergency room when you have a serious medical problem and it's not safe to wait. There is **no** co-pay when the member is:

- In need of emergency service, or
- Admitted to a hospital for inpatient stay, or
- Under age 21, or
- Pregnant, or
- Receiving family planning services

- Members may have a copayment when the visit is not for a true emergency. Also, members on MediPASS may be billed for emergency room visits that are not a true emergency if they do not have a referral from their assigned MediPASS primary care provider.

Eye Exams and Eyeglasses

Vision services may include eye exams, glasses, repairs to glasses and visual aids. Covered services include:

- Lens correction
- Protective lenses
- New frames
- Safety frames
- Contact lenses
- Replacement glasses
- Vision exams

- Contact Member Services for more information on eye care services.

Federally Qualified Health Centers

These services are covered, with the same limits as for doctors and dentists. Covered services provided by a federally qualified health center can include doctor, nurse practitioner, physician assistant, and other ambulatory services.

Hearing Services

Medicaid covers hearing tests and will pay for hearing aids, batteries, supplies, and repairs if you need hearing aids.

Hearing services have these limits:

- Hearing aids: 1 time every 4 years, per ear
- Hearing exams: 1 time every 4 years, per ear

Home- and Community-Based Service (HCBS) Waiver Programs

You may qualify for an HCBS waiver program if you need care in a medical facility but would rather stay at home or would return home if the services you need could be arranged. HCBS waivers provide services in the home and community. HCBS waiver programs work to help people with disabilities or certain age groups.

Medical facilities include hospitals, nursing facilities, or intermediate care facilities for individuals with an intellectual disability.

Iowa has seven HCBS waiver programs:

- AIDS/HIV waiver
- Brain injury waiver
- Children's mental health waiver
- Elderly waiver
- Health and disability waiver
- Intellectual disability waiver
- Physical disability waiver

➢ Contact the local office of the Iowa Department of Human Services to see if you qualify for a waiver program.

For additional information on HCBS waivers go to "Are Home & Community Based Services Right for You?" at: www.ime.state.ia.us/docs/HCBSbrochure102606.pdf.

Home Health Care

Home health services can be given in the member's home by a Medicare-certified home health agency for an illness or injury.

Types of care in your home include:

- Skilled nursing care
- Physical, occupational or speech therapy
- Medical social services
- Home health aide

➢ To be covered by Medicaid, these services must be medically necessary to treat illness or injury and ordered by your physician.

Medicaid does **not** cover:

- Home care services to help people meet personal family and domestic needs
- Full-time nursing care at home
- Private-duty nursing services at home, except for persons up to age 21 when the care is medically necessary and pre-authorized.

Hospice Care

Hospice provides care to members who are terminally ill and wish to be comfortable and peaceful when they are dying. Hospice care can be given wherever the member is living.

Hospice services provided by a home health agency are covered if the agency has been certified to participate in Medicare and Medicaid.

Services can include nursing, hospice aide, social work, chaplain, volunteers, and durable medical equipment.

Hospital and Urgent Care

Medicaid covers both inpatient and outpatient hospital care, with some limits.

You may have a copayment when an emergency room visit is not for a true emergency. Go to your own doctor or to an urgent care clinic instead of an emergency room for:

- Sprained wrist or ankle
- Earache
- Cough
- Fever
- Vomiting
- Medical supplies and equipment

Lab and X-ray

Medicaid covers many lab and x-ray services. Be sure to ask whether the test is covered. If it is not covered, you will have to pay for it.

Maternity Care and Birth Center Services

Maternal health centers provide:

- Prenatal care (care during pregnancy)
- Health education
- Nutritional services
- Social services and case management

Birth center services provide:

- Prenatal care
- Delivery
- Postpartum care (after the birth)

Medical Equipment and Supplies

Medicaid may cover medical equipment and supplies that you need. Your doctor must write an order for equipment and supplies.

Examples of equipment and supplies Medicaid covers:

- Wheelchairs
- Prosthetic devices
- Bandages or wound-care supplies
- Oxygen and supplies

Medicaid does **not** cover:

- Air conditioners
- Dehumidifiers
- Blenders
- Massage devices
- Exercise equipment

Mental Health Services (Psychologists and Social Workers)

Mental health services are covered if the provider is practicing independently or employed by a hospital, a home health or rehabilitation agency, a community mental health center or a doctor.

Medicaid may pay for the services of a:

- Mental health counselor
- Marital and family counselor
- Certified drug counselor

Medicaid may also pay for covered services by a provider in private practice. See the Iowa Plan services on page 22.

Midwife Services

Covered services include prenatal, delivery, and postpartum care and other services allowed by state law.

Payment will be made only to certified nurse-midwives who are advanced registered nurse practitioners. Medicaid will not pay lay nurse-midwives who are not advanced registered nurse practitioners.

Nursing Home Services

Medicare-Certified Skilled Nursing Facilities

Medicaid helps with the cost of care in a nursing facility. A doctor must certify that you need nursing care, not a hospital, and that you qualify for medical assistance. The Iowa Medicaid Enterprise Medical Services Unit must confirm this. Medicaid may also cover the cost of care if you need the services of a certified skilled nursing facility.

You may keep part of your income for personal needs. The rest goes for the nursing home cost, unless the Family Investment Program (FIP) is your income source.

- Make sure you qualify both **medically** and **financially** for care in a nursing home. If you are admitted to a nursing home and later found not medically or financially eligible for medical assistance, Medicaid will not pay for any care you received.

Nurse Anesthetists and Nurse Practitioners

Certified Registered Nurse Anesthetists (CRNAs)

Medicaid will pay for services allowed by state law and given by certified registered nurse anesthetists. The limits are the same as for doctors.

If a CRNA is employed by a doctor, hospital or clinic, Medicaid pays the provider that employs the CRNA. Medicaid may also pay CRNAs who are in independent practice.

Advanced Registered Nurse Practitioners (ARNPs)

Medicaid will pay for services allowed by state law and given by nurse practitioners. The limits are the same as for doctors. Medicaid may directly pay nurse practitioners who practice in a specialty recognized by the Iowa Board of Nursing.

Podiatry and Orthopedic Shoes

Medicaid covers:

- Foot surgery
- Certain prosthetic appliances for the foot

Medicaid does **not** cover:

- Treatments for flatfoot
- Routine foot care, such as clipping nails or treatment of corns and calluses

Orthopedic shoes, shoes for persons with diabetes, inserts and modifications are covered only if prescribed in writing by a doctor, a physician's assistant or an advanced registered nurse practitioner.

If you don't have a written prescription, you must pay for the shoes.

Prescriptions and Over-the-Counter Drugs

Most prescription drugs and some over-the-counter drugs are covered. A doctor or qualified medical practitioner must write the order or prescription. For some drugs, you must get approval from Medicaid first.

Pharmacists must give you the lowest-cost item in stock that meets your provider's order. They must also give you (or your caregiver) information about how to use any drug you receive.

For most drugs, the first prescription must be for a 31-day supply. Some prescriptions cannot be for more than a 15-day supply at first. Refills can then be up to the normal 31-day supply.

Your pharmacist may refill a prescription only when you have used 85% of the supply:

- Refills for a 30-day supply are allowed after 26 days.
- Refills for a 90-day supply are allowed after 77 days.

➢ Ask your pharmacist for an exception if you need a longer supply or early refill of a drug or supply for reasons such as travel.

All birth control drugs and supplies are covered.

- If there is a generic drug, you will need approval for certain brand-name birth control drugs.
- Your pharmacist, doctor and other providers should know what is covered and what drugs need approval first.
- Oral contraceptives may be prescribed in 90-day supplies.

Prescription drugs that are **not** covered include:

- Most cough and cold medications
- Weight-loss drugs
- Drugs for cosmetic reasons such as hair growth
- Fertility drugs
- Erectile dysfunction drugs

Over-the-counter drugs are in regular packages, usually in 100-unit quantities. You may get up to a 31-day supply. You may get up to a 90-day supply of all covered medical supplies.

Covered over-the-counter drugs include:

- Aspirin
- Acetaminophen (Tylenol®)
- Multiple vitamins and minerals for pregnant and nursing women
- Multiple vitamins and minerals (with prior approval)

You must show your *Medical Assistance Eligibility Card* to your pharmacist to pay for prescription and over-the-counter drugs or supplies. If Medicaid will not pay for a drug or supply the doctor ordered, your pharmacist can explain why.

If you are not satisfied with the explanation, you may contact Iowa Medicaid Member Services. If you are still not satisfied, you can demand a formal, written notice of decision that explains your right to appeal. See page 6.

Rural Health Clinics

Covered services provided by a rural health clinic can include doctor services, nurse practitioner and physician's assistant services, visiting nurse services, and other ambulatory services.

Therapy Services (Occupational, Physical, and Speech)

Therapy services are covered when the therapist is employed by a hospital, home health or rehabilitation agency, nursing home or doctor.

Services provided by occupational, physical, and speech therapists in their own independent practice are covered if the therapist is certified and participates in Medicaid.

There are yearly limits on the amount that can be paid, unless you get the services at a hospital outpatient department.

Tobacco Cessation (Help to Quit Smoking)

You must first make an appointment with your provider. Together, you and your doctor will decide on the best plan for you.

Medicaid covers these drugs to help you quit smoking:

- Chantix
- Buproprion (generic for Zyban)
- Nicotine-replacement patches
- Nicotine gum

If your provider chooses Chantix, over-the-counter nicotine-replacement patches or gum, you must get Quitline Iowa counseling. Here is how to join Quitline Iowa:

1. Fill out an authorization form at your provider's office.
2. Your provider will fax the form to Quitline Iowa.
3. Quitline Iowa will contact you for information and enroll you.
4. Quitline Iowa will send a form to Iowa Medicaid for your medication.
5. Pick up your medication at your pharmacy once Iowa Medicaid approves it.

If you do not follow the steps above, you may have to pay for the services and drugs you receive.

Transportation Services

Non-Emergency Medical Transportation (NEMT)

Non-emergency medical transportation provides members with transportation or reimbursement (money paid back) for travel to medical, dental, pharmacy, and mental health appointments or services.

TMS is the agency that provides help with transportation.

Medicaid members who need a ride or want reimbursement for medical travel expenses through TMS must:

- Call TMS at **1-866-572-7662** at least three business days **before** the medical trip or appointment
- Give TMS your full name, state ID number, address, phone number, and trip dates
- Give TMS the name, address, phone number, and fax number of your medical provider

TMS will:

- Assess your transportation needs
- Make sure you qualify
- Make sure the medical provider is an Iowa Medicaid provider
- Make sure the service is an Iowa Medicaid covered service
- Ask for any additional information needed about the trip
- Make sure the medical trip meets the federal and state requirements for non-emergency medical transportation travel and reimbursement

TMS will give the member a confirmation number when the trip is booked.

Members who want reimbursement after the medical trip must send TMS:

- The confirmation number
- The claim form
- All receipts

- Learn more about non-emergency medical transportation at http://www.ime.state.ia.us/members/index.html.

- Medical transportation is **not** covered under Iowa Family Planning Network (IFPN).

Other Transportation Services

Local transportation is also available for children under age 21 and pregnant women for travel to medical, dental, or mental health care at local providers.

- Ask your local *Care for Kids* or maternal health care coordinators to arrange transportation for you.

- For contact information, call the Healthy Families Line at **1-800-369-2229**.

Part III: Other Program Benefits

Behavioral Health Intervention Services (BHIS)

BHIS services are provided through the Iowa Plan (see page 22). The services provide support, direction and teaching interventions in a community-based or residential group-care environment. Services are designed to improve the adult or child's level of functioning related to a mental illness. The main goal is to help the member and the member's family to learn age-appropriate skills to manage behavior and have self-control.

Children's Services

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) "Care for Kids"

EPSDT covers health exams for children under the age of 21 who get Medicaid. Medicaid will cover any follow-up services needed as a result of the screening.

A complete screening examination includes:

- Health and developmental history
- Well child physical examination and measurements
- Vision and hearing screening
- Oral (mouth) health assessment
  - At the age of 12 months, children should see a dentist.
- Mental health and nutritional assessments
- Lab tests
- Immunizations (shots)
- Health education

- For help finding a provider, making an appointment or getting transportation for medical care, call the Healthy Families Line at **1-800-369-2229**.

Infant and Toddler Services

Medical services are also provided through the Early Access program. These services are covered for children ages 0 through 3:

- Developmental assessments
- Audiology (hearing)
- Nursing
- Nutrition
- Occupational and physical therapy
- Speech/language therapy
- Vision

➢ For help, call 1-888-IA-KIDS1 (888-425-4371) or go to: http://www.earlyaccessiowa.org.

Local or Area Education Services

Medicaid may cover these services provided by local or area education agencies:

- Physical therapy
- Occupational therapy
- Speech therapy
- Mental health services
- Hearing services
- Nursing Services

Community Mental Health Centers

Medicaid may cover services by a psychiatrist, psychologist, social worker, or psychiatric nurse. The provider must be on the staff of a DHS-certified community mental health center.

Estate Recovery Program

Federal law calls for Iowa to have an estate recovery program when Medicaid dollars are used to pay for medical help if you are:

- 55 years old or older at the time you get Medicaid.
- Under age 55, live in a long-term care facility and are not likely to return home.

When a person who gets medical assistance dies, their assets must be used to repay the Iowa Department of Human Services (DHS) for the money that was spent on medical care. Assets can include money, material things, land, etc.

The collection can be delayed if there is a surviving spouse, dependent or disabled child. The collection can also be delayed if the collection would cause financial troubles to the surviving persons. If you have any questions about estate recoveries please go to http://www.ime.state.ia.us/Estate.html.

Habilitation Services—Home- and Community-Based Services (HCBS)

These services are designed to meet the needs of members with a history of chronic mental illness. A team led by a case manager will write a comprehensive service plan identifying needed services.

Covered services include:

- Home-based habilitation
- Day habilitation
- Pre-vocational services
- Supported employment

Health Home for Members with Chronic Conditions

In some areas a health home may be available for enrollment. Enrolling in a health home could mean that you must disenroll from any other managed care program. You will have the opportunity to discontinue your participation in a health home at any time.

Members with specific chronic conditions may qualify for additional services to help manage those conditions. A member can expect:

- A primary care practitioner that manages all your health care
- A nurse available to help you identify and achieve your health and wellness goals
- Access to support services to remove barriers to achieving better health
- Access to health education and promotion to address smoking, nutrition, and physical activity
- Assistance with transitional care and discharge planning after hospitalization or rehab
- Assistance in finding community resources and support services
- Assistance with managing your medication and medical treatments

The member must have one chronic condition and at risk of a second condition from the list below, or at least two chronic conditions from the list below:

- Hypertension
- Overweight
- Heart disease
- Diabetes
- Asthma
- Substance abuse
- Mental health condition

How to Apply for Health Home

It is your choice to become part of a health home. This is a voluntary program. If you are interested in being part of a health home, call the Member Services Call Center at 1-800-338-8366 or locally in the Des Moines area at 515-256-4606. Members with a serious persistent mental illness can also access health home services through trained providers. Ask your behavioral health provider for more information or call the Member Services Call Center.

Health Insurance Premium Payment (HIPP)

This program helps Medicaid members get or keep health insurance. HIPP helps by paying for the insurance premium. To qualify for HIPP:

- You or someone in your home must have Medicaid.
- You must have health insurance or be able to get it through your employer.
- The health insurance must be cost-effective.

AIDS/HIV Health Insurance Premium Payment (HIPP)

The AIDS/HIV HIPP program helps people living with AIDS/HIV-related illness. It pays their health insurance premiums when they become too ill to work. To qualify for services under the AIDS/HIV HIPP program, the person must:

- Not qualify for Medicaid
- Be a resident of Iowa
- Provide a doctor's certification that the person cannot work because of AIDS or HIV-related illness
- Be the health insurance plan policy holder or a dependent on the spouse's plan
- Have "liquid" assets (cash, stocks, bank accounts, etc.) of less than $10,000
- Meet the income limits

➢ To apply or contact HIPP, call **1-888-346-9562** toll-free, or email hipp@dhs.state.ia.us, or go to http://www.dhs.state.ia.us/hipp.

Intermediate Care Facilities for Persons with an Intellectual Disability and Related Conditions (ICF/ID)

An ICF/ID provides 24-hour care and services for persons with an intellectual disability or other related conditions.

- Services must be provided in a licensed facility setting.
- Persons must first be eligible for Medicaid and approved by the Iowa Medicaid Enterprise Medical Services.

➢ Contact the DHS local office to learn more about this program.

Iowa Plan for Behavioral Health

Most Medicaid members are enrolled in the Iowa Plan for Behavioral Health (Iowa Plan). The Iowa Plan is a statewide managed care program for mental health services and substance abuse treatment. Ask about the Iowa Plan toll-free at **1-800-317-3738**.

If you are enrolled in the Iowa Plan:

- You have the right to know how to get these Medicaid benefits.
- You will receive an information packet soon after you qualify for Medicaid.
- You can call the toll-free number if you have questions about mental health or substance abuse services.

To find a provider through the Iowa Plan, call the toll-free number for a list of providers. Or you may go directly to a provider to get care. Show your Medicaid card to the provider so the provider can check to see if you are in the Iowa Plan.

If your provider is not part of the Iowa Plan, the provider may want to join or refer you to another provider.

In a mental health or substance abuse emergency, go directly to a hospital emergency room to be evaluated for appropriate care and treatment.

Managed Health Care

If you are an Iowa Medicaid member and live in a county where there is Managed Health Care, you may be required to join a plan. This does not take away any Medicaid benefits. You may choose either a health maintenance organization (HMO) or a MediPASS doctor. IME will assign a provider if you do not choose.

With managed health care:

- You have a primary care doctor
- You build a doctor–patient relationship
- When you need medical services, you have a phone number to call and a doctor and staff who know you
- You get the medical care you need from your own doctor instead of from an impersonal emergency room or a doctor you don't know
- It's easier for you and your children to get preventive services to stay healthy—things like shots for children and a yearly PAP and pelvic exam for women

Managed Health Care changes the way you get some medical services, so be sure to read about your choices and how to get Medicaid services in Managed Health Care. You will get more written information once you choose (or are assigned if you don't choose).

- Call Member Services workdays (Monday through Friday) from 8:00 a.m. to 5:00 p.m. at **1-800-338-8366**, or **1-515-256-4606** in the Des Moines area.

You can also call if you have any problems after you are enrolled or if you want to change your enrollment. You may ask for a change if you're not happy with your choice or if your circumstances change (for example, if you move or your doctor retires).

Program for All-Inclusive Care for the Elderly (PACE)

PACE helps Medicaid members stay healthy and live in the community as long as possible. The PACE program will coordinate and provide all preventive, primary, in-home acute, and long-term care services for persons age 55 and older.

- Contact Member Services workdays (Monday through Friday) from 8:00 a.m. to 5:00 p.m. at **1-800-338-8366**, or **1-515-256-4606** in the Des Moines area to tell you if you live in a county that has a PACE program. The Member Services representative will give you contact information for the PACE program.

Important Contact Information

Use this page to keep track of important phone numbers for all your health care needs. Keep this near your phone for use in contacting the right people to help you with your health care.

Member Services Call Center

Toll Free: 1-800-338-8366

In the Des Moines area: 515-256-4606

Hours of operation: Monday through Friday 8:00 a.m. to 5:00 p.m.

Email: IMEMemberServices@dhs.state.ia.us

Website: www.ime.state.ia.us

Mental Health and Substance Abuse

Toll Free: 1-800-317-3738 (24 hours per day)

Primary Care Provider: _____

Hospital: _____

Emergency: 911

Iowa Department of Human Services

Comm. 20(S) (Rev. 2/14)

Your Guide to Medicaid

(Su Guía de Medicaid)

Servicios para Afiliados:
Llamada gratuita: 1-800-338-8366
Llamada local: 515-256-4606

Página web: www.ime.state.ia.us Correo electrónico: IMEMemberServices@dhs.state.ia.us

To request this brochure in English, contact Member Services.

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Su Guía de Medicaid

Parte I: Información básica sobre Medicaid

Esta guía contiene información sobre los servicios que cubre (paga) Medicaid y cómo usar el programa.

- ¡Consérvela! Úsela para saber más sobre las prestaciones de Medicaid.
- **Este folleto no incluye las prestaciones cubiertas por el Plan *Health and Wellness* de Iowa.**

Su tarjeta de elegibilidad para Asistencia Médica

Todos los afiliados recibirán una nueva *Tarjeta para Asistencia Médica*, formulario 470-1911.

- Conserve su tarjeta hasta que reciba la nueva.
- Llévela siempre con usted y no permita que otras personas la usen.
- Muéstrele su tarjeta a los prestadores de servicios cada vez que reciba atención médica.
- Si la pierde, llame a Servicios para Afiliados y solicite una tarjeta nueva.

Servicios para Afiliados: 1-800-338-8366
Servicios para Afiliados en el área de Des Moines: 1-515-256-4606

El Centro Telefónico de Servicios para Afiliados atiende al público de lunes a viernes desde las 8:00 a.m. hasta las 5:00 p.m.

Elegibilidad retroactiva para Medicaid

Es posible calificar para cobertura de Medicaid hasta tres meses antes de presentar la solicitud. Esos meses se llaman “período retroactivo”.

Para calificar para prestaciones retroactivas debe cumplir con **todas** las siguientes condiciones:

- Tiene facturas médicas por servicios que recibió durante el período retroactivo. (Las facturas pueden haber sido pagadas o estar impagas.)
- Las facturas son por servicios cubiertos por Medicaid.
- Habría calificado para Medicaid durante esos meses, si lo hubiera solicitado.

Existe una excepción:

- ♦ Los siguientes grupos **no** permiten prestaciones retroactivas:
  - *Iowa Family Planning Network* (IFPN) – Red de planificación familiar de Iowa
  - *Home- and Community-Based Services Waiver* (HCBS) – Servicios comunitarios y a domicilio
  - *Program for all-inclusive care for the elderly* (PACE) – Programa para adultos mayores con todos los servicios incluidos
  - *Qualified Medicare Beneficiary* (QMB) – Beneficiario calificado de Medicare

➢ Llame a la oficina local de *Department of Human Services* (DHS) si cree que usted o un integrante de su familia califica para prestaciones retroactivas de Medicaid.

Quiénes Pueden Prestar Servicios

Prestadores de servicios

Medicaid le permite elegir a sus prestadores de servicios. Siga estos pasos:

1. Para buscar prestadores, consulte: https://secureapp.dhs.state.ia.us/providersearche/ o llame a Servicios para Afiliados al 1-800-338-8366, o llame al (515)-256-4606 si vive en el área de Des Moines, de lunes a viernes desde las 8:00 a.m. hasta las 5:00 p.m.

2. Elija un médico, un dentista, una farmacia y otros prestadores que acepten Medicaid.

3. Pregúnteles si aceptan Medicaid antes de hacer una cita. Algunos prestadores atienden a una cantidad limitada de pacientes con Medicaid o no están adheridos.

   a. **Recuerde:** Debe cerciorarse de que el prestador comprenda que está afiliado a Medicaid de Iowa. Si no se lo dice *antes* de recibir servicios y el prestador no acepta Medicaid, ¡tendrá que pagar el costo total de los servicios!

4. Muestre su *Tarjeta de Elegibilidad para Asistencia Médica* cuando vaya a la cita.

5. Pregunte si Medicaid cubre el servicio que necesita o si tendrá que pagarlo.

En caso de viajar

Si viaja fuera de Iowa y necesita atención médica, verifique que el prestador esté inscripto en Medicaid de Iowa. Los prestadores adheridos a Medicaid de otros estados no pueden participar en Medicaid de Iowa.

Los prestadores inscriptos en Medicaid de Iowa deben aceptar lo que Medicaid les paga. No deben cobrarle por los servicios que cubre Medicaid.

Tendrá que pagar los servicios si el prestador no está adherido a Medicaid de Iowa.

Atención médica administrada ("*Managed Care*")

Algunos afiliados de Medicaid reciben atención médica a través de MediPASS o de una organización administradora de servicios médicos (HMO). Encontrará más información sobre MediPASS y las HMO en la página 23.

Salud mental y adicciones (Salud conductual)

- Lea sobre cómo conseguir estos servicios a través del Plan de Iowa en la página 24.

Programa para adultos mayores con todos los servicios incluidos (PACE)

- Lea sobre cómo conseguir estos servicios a través de PACE en la página 24.

Copagos

Algunos servicios médicos tienen copago, que es la parte del costo que le corresponde pagar a usted. En dicho caso, le abonará el copago al prestador, quien le informará cuál es el costo.

Debe abonar copago:

- Si las normativas federales lo exigen.
- Si el servicio no es un servicio exigido por Medicaid pero el estado ha decidido cubrirlo; por ejemplo: servicios odontológicos y medicamentos bajo receta.
- Por servicios en una sala de emergencias si no se tratara de una emergencia.

  Ejemplos de emergencias reales:

  - Hemorragia intensa
  - Dolor en el pecho
  - Problemas para respirar
  - Quemaduras graves
  - Fracturas
  - Asfixia
  - Desvanecimiento (desmayo)
  - Imposibilidad repentina de moverse o hablar
  - Intoxicación o envenenamiento

No debe abonar copago:

- Por atención médica cubierta por Medicaid en establecimientos médicos especializados o geriátricos.
- Si está embarazada.
- Si es menor de 21 años.
- Por los servicios provistos por una HMO.

Limitaciones de los servicios cubiertos por Medicaid

Algunos servicios médicos requieren autorización o, de lo contrario, no serán cubiertos. A continuación se detallan algunas limitaciones de la cobertura de Medicaid; éste es un listado parcial. Hable con su prestador de atención médica si desea averiguar sobre las limitaciones de estos servicios.

- Limitaciones de la cobertura en el caso de trasplantes de órganos o de tejidos. Cubre sólo ciertos tipos de trasplantes. Para algunos trasplantes, debe conseguir autorización **antes** del trasplante. Su prestador le informará qué tipos de trasplantes están cubiertos y si se necesita autorización.
- **No** cubre cirugía por obesidad sin autorización previa. Cubre sólo ciertos tipos de cirugías por obesidad, aún con autorización. El médico le informará qué cirugías están cubiertas y solicitará la autorización.
- **No** cubre cirugía cosmética, cirugía plástica, ni cirugía reconstructiva para mejorar la apariencia o con fines psiquiátricos
- **No** cubre tratamiento para pie plano, ni pedicuría de rutina, como cortar las uñas o extraer callosidades y durezas.
- **No** cubre tratamientos con acupuntura.

Obligaciones de los afiliados

En calidad de afiliado a Medicaid, tiene la obligación de:

- Cumplir con todas las citas con los prestadores o llamar para cancelarlas o reprogramarlas. Algunos profesionales podrían dejar de atenderlo si falta a una o más de las citas programadas.
- Solicitar **sólo** aquellos servicios médicos que son necesarios por razones de salud. DHS podrá limitar sus servicios si utiliza Medicaid para servicios que no son necesarios.
- Informarle al Servicio para Afiliados de Iowa Medicaid sobre cualquier tipo de cambios en otras coberturas de seguro médico. Infórmeles si la cobertura finaliza, si pierde la cobertura o si consigue una nueva, o si cambia de compañía de seguro.
- Informarles a sus prestadores médicos sobre otras personas que podrían tener la obligación legal de pagar sus facturas médicas.
- Informarle a Servicios para Afiliados de Iowa Medicaid si sufre lesiones en un accidente o si inicia una demanda por negligencia médica debido a que no recibió tratamiento médico que era necesario.
- Informar sobre la resolución de demandas judiciales, reclamaciones a seguros o al seguro de accidentes laborales. Medicaid será denegado o cancelado si no le informa a DHS sobre dichas resoluciones. Comunicarse con Iowa Medicaid Enterprise (IME) si sufre un traumatismo durante un incidente. Algunos ejemplos de traumatismos son: cualquier tipo de accidente o lesiones imprevistas que causen daños personales, como accidentes automovilísticos o resbalones y caídas. Usted o su representante deben dar su consentimiento antes de que se expida la documentación. Llame a la unidad de cobro de IME al teléfono **1-888-543-6742,** o al **1-515-256-4620** en el área de Des Moines, de lunes a viernes desde las 8:00 a.m. hasta las 5:00 p.m.

- Cerciorarse de que ninguna otra persona utilice su tarjeta médica o su número de afiliado.
- Llamar a *Iowa Department of Human Services* si sospecha que alguien está haciendo mal uso de sus prestaciones de Medicaid o si alguien que no es su prestador de servicios le solicita sus datos de Medicaid. Llame a *Iowa Department of Human Services* a 1-800-831-1394, de lunes a viernes desde las 7:00 a.m. hasta las 6:00 p.m.

Centro telefónico de Servicios para Afiliados

Los números telefónicos gratuitos del centro telefónico de Servicios para Afiliados son:

1-800-338-8366 y **1-515-256-4606** en el área de Des Moines, de lunes a viernes desde las 8:00 a.m. hasta las 5:00 p.m.

El centro telefónico de Servicios para Afiliados puede brindarle información y ayuda para:

- Cambiar su domicilio
- Solicitar una tarjeta nueva
- Conseguir información general sobre Medicaid
- Inscribirse en *Managed Health Care* (MHC), incluso MediPASS y HMO
- Conseguir aprobación de servicios especiales (autorizaciones especiales)
- Averiguar sobre responsabilidad de terceros (TPL)
  - Medicaid es “el último recurso” a la hora de pagar gastos médicos. Esto significa que los gastos médicos se deben facturar primero a cualquier otro seguro que usted tenga.
- Facturas recibidas por servicios que usted creía que estaban cubiertos.

Si llama para consultar sobre facturas impagas que cree que Medicaid debería haber cubierto, tenga a mano lo siguiente cuando llame:

- La factura médica.
- Una breve descripción de los servicios provistos.
- El número de identificación de la Tarjeta de Asistencia Médica de la persona a quien se facturaron los servicios provistos.

Además, puede escribir o enviar un fax al centro telefónico de Servicios para Afiliados a:

The Iowa Medicaid Enterprise
Attention: Billing
PO Box 36510
Des Moines, IA 50315
Fax: 515-725-1351

O visitar http://www.ime.state.ia.us o enviar un correo electrónico a IMEMemberServices@dhs.state.ia.us

Comuníquese con la oficina DHS de su condado de residencia:

- Si se muda
- Si cambia su número de teléfono
- Si hay cambios en sus ingresos
- Para informar el nacimiento de un hijo
- Para informar el fallecimiento de un afiliado a Medicaid
- Para averiguar sobre asistencia médica (*Medical Assistance*), asistencia para alimentos (*Food Assistance*), el programa FIP (*Family Investment Program*) y asistencia para cuidado infantil (*Child Care Assistance*)

Para averiguar sobre la oficina DHS de su condado de residencia, visite http://www.dhs.state.ia.us/Consumers/Find_Help/MapLocations.html o llame a servicios para afiliados de IME al 1-800-338-8366.

Llame al centro telefónico de DHS al **1-877-347-5678** para:

- Corregir un error de ortografía en su nombre
- Cambiar su nombre debido a casamiento o divorcio
- Actualizar la cantidad de personas que viven en su hogar
- Cambiar una fecha de nacimiento o un número de Social Security
- Informar sobre la pérdida o la obtención de recursos económicos

Apelaciones y quejas formales

Apelaciones: Una apelación es un proceso formal que involucra a *Department of Human Services* y a *Department of Inspections and Appeals* respecto a facturas médicas impagas.

Quejas formales: Una queja formal es un reclamo sobre acceso a atención médica, calidad del tratamiento o problemas de comunicación con su médico de cabecera.

Tiene derecho a apelar

¿Qué es una apelación?

Una **apelación** es solicitar una audiencia porque no está conforme con la decisión tomada por *Department of Human Services* (DHS). Tiene derecho a presentar una apelación si no está de acuerdo con una resolución. No tiene que pagar nada para presentar la apelación. [Código Administrativo de Iowa 441--Capítulo 7]

¿Cómo se apela?

Presentar una apelación es sencillo. Debe apelar por escrito de **una** de las siguientes maneras:

- Complete el formulario de apelación en https://dhssecure.dhs.state.ia.us/forms/, **o**
- Escriba una carta explicando por qué cree que una decisión es incorrecta, **o**
- Complete el formulario de Apelación y Solicitud de Audiencia ("*Appeal and Request for Hearing*"). Puede conseguirlo en la oficina DHS de su condado.

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

¿Cuánto tiempo tengo para apelar?

Tiene 90 días corridos a partir de la fecha de la resolución para presentar la apelación.

No podremos concederle una audiencia si presenta la apelación con posterioridad a 90 días corridos contados desde la fecha de la resolución.

¿Puedo continuar recibiendo beneficios mientras mi apelación esté pendiente?

Puede conservar sus beneficios hasta que la apelación finalice o hasta el final de su período de certificación, si presenta la apelación:

- En un plazo de 10 días corridos contados desde la fecha en que reciba la notificación. Se considera que recibirá la notificación 5 días después de la fecha de expedición, o
- Antes de la fecha en que la resolución entra en vigencia

Si se determina que el Departamento actuó correctamente, tendrá que reintegrar el costo de todas las prestaciones que reciba mientras se resuelve la apelación.

¿Cómo me informarán si me concedieron la audiencia?

Recibirá una notificación de audiencia informándole la fecha y la hora programadas para la audiencia telefónica. En el caso de no concederle una audiencia, le enviaremos una carta informándole el motivo de dicha decisión. También le explicaremos qué puede hacer si no está de acuerdo con la decisión de no concederle una audiencia.

¿Puedo tener ayuda de otra persona durante la audiencia?

Usted o alguien más, como un amigo o un pariente, podrán explicar por qué no está de acuerdo con la decisión del Departamento. También podrá tener ayuda de un abogado, pero el Departamento no pagará los honorarios. La oficina DHS de su condado le puede dar información sobre servicios legales. El costo de los servicios legales se calculará de acuerdo a sus ingresos. También puede llamar a Iowa Legal Aid al teléfono 1-800-532-1275. Si vive en el Condado de Polk, llame al 243-1193.

Política sobre Discriminación, Acoso, Acción Afirmativa e Igualdad de Oportunidades Laborales

La política de *Iowa Department of Human Services* (DHS) es brindarles tratamiento equitativo con respecto a empleo y prestación de servicios a los solicitantes, los empleados y los clientes, sin considerar su raza, color, país de origen, sexo, orientación sexual, identidad de género, religión, edad, discapacidad, ideología política o condición de veterano.

Si considera que ha sufrido discriminación o acoso por parte de DHS, le agradeceremos que envíe una carta detallando su queja a:

Iowa Department of Human Services, Hoover Building, 5th Floor – Policy Bureau, 1305 E Walnut, Des Moines, IA 50319-0114 o por correo electrónico a contactdhs@dhs.state.ia.us

Derecho a presentar una queja

Si está inscripto en una HMO y desea presentar un reclamo sobre acceso a atención médica, calidad del tratamiento, problemas de comunicación con su médico o facturas médicas impagas, debe comunicarse con la HMO y seguir los pasos del proceso para presentar quejas. Si considera que la HMO no ha hecho nada para resolver su reclamo, comuníquese con el centro telefónico de Atención al Afiliado al 800-338-8366 (llamada gratuita) o al 515-256-4606 en el área de Des Moines.

Si está inscripto en el *Iowa Wellness Plan* y desea presentar un reclamo con respecto a acceso a atención médica, calidad del tratamiento, problemas de comunicación con su médico de cabecera o facturas médicas impagas, le agradeceremos que se comunique con el centro telefónico de Atención al Afiliado al 800-338-8366 (llamada gratuita) o al 515-256-4606 en el área de Des Moines.

Parte II: Prestaciones básicas de Medicaid

A continuación se explica la cobertura de algunas prestaciones de Medicaid. En todos los casos, **antes** de recibir atención médica, cerciórese de que los prestadores estén adheridos a Medicaid. De lo contrario, tendrá que pagar los servicios que reciba.

Ambulancia

En el caso de una emergencia, llame al 911 para pedir una ambulancia. Dígale al conductor de la ambulancia que lo lleve al hospital más cercano.

Pero recuerde, Medicaid pagará el transporte en ambulancia a un hospital o un centro médico especializado **sólo** si trasladarse por sus propios medios fuera riesgoso para su salud.

Medicaid podría cubrir el costo de una ambulancia aérea en el caso de que una ambulancia terrestre no le pudiera llevar lo suficientemente rápido para recibir atención médica. Si pide una ambulancia y rehúsa el servicio cuando la ambulancia llega a su hogar, Iowa Medicaid no pagará los gastos y usted será responsable del pago de la factura.

Centros de cirugía ambulatoria

Medicaid cubre los servicios quirúrgicos que sean necesarios por razones de salud, con las mismas limitaciones que se aplican a los servicios brindados por médicos.

Clínicas de planificación familiar y control de la natalidad

Los servicios de planificación familiar de Medicaid incluyen orientación, exámenes médicos, análisis de laboratorio, medicamentos y suministros para planificación familiar. Puede obtener dichos suministros a través de su plan médico o de cualquier prestador de servicios adherido a Medicaid.

Medicaid cubre:

- La mayoría de los medicamentos y dispositivos para control de la natalidad para hombres y mujeres. Los medicamentos y dispositivos de marcas comerciales deben ser aprobados por su médico.
- Anticonceptivos orales recetados para 90 días.

Gestión de casos (con orientación específica)

La gestión de casos con orientación específica facilita que pueda recibir ayuda con su atención médica y sus necesidades sociales. Estos servicios se ofrecen a afiliados de Medicaid con:

- Discapacidad cognitiva
- Discapacidad del desarrollo
- Enfermedades mentales crónicas

Los servicios de gestión de casos con orientación específica incluyen:

- Conversar con el gestor de casos para que se identifiquen todos los servicios necesarios y el tipo de alojamiento que necesita
- Ayuda para cerciorarse de que exista un plan integral personalizado ("*individual comprehensive plan" o* ICP) que aborde todos los servicios necesarios y el tipo de alojamiento que necesita
- Ayuda para conseguir los servicios y el tipo de alojamiento que figuran en el ICP
- Ayuda para cerciorarse de que todos los prestadores cumplan con el ICP
- Monitoreo de los servicios y el alojamiento para asegurarse de que siguen siendo adecuados
- Ayuda para conseguir remisión a un prestador adecuado en caso de crisis
- Actividades orientadas al plan de alta en el caso de personas que se encuentren internadas:
  - Por no más de 60 días con anterioridad a la fecha estimada del alta
  - En el caso de que las actividades propuestas por el gestor de casos sean diferentes a las del plan de alta de la institución

Servicios quiroprácticos

Excepto en el caso de embarazadas y menores de 18 años, Medicaid cubre sólo este servicio:

- Fisioterapia manual debido a subluxación o desviación de la columna vertebral comprobada por medio de radiografía.

Clínicas

Los servicios clínicos tienen la misma cobertura y las mismas limitaciones que los médicos y los hospitales. Las clínicas de Salud Pública pueden brindar solamente vacunación y exámenes por enfermedades contagiosas a través de Medicaid.

Servicios odontológicos

Los servicios odontológicos pueden incluir limpieza dental, arreglo de caries, extracciones, control de enfermedades y cirugía.

Los servicios odontológicos tienen las siguientes limitaciones:

- Examen de rutina: 1 vez cada 6 meses
- Limpieza dental: 1 vez cada 6 meses
- Radiografía dental tipo "bitewing": 1 vez cada 12 meses
- Radiografía completa: 1 vez cada 5 años, a menos que sea necesario
- Sellador dental: sólo 1 vez por cada pieza dental
- Dentadura postiza: 1 vez cada 5 años
- Examen completo: solamente una vez por prestador de servicios odontológicos

  Éste es un examen más meticuloso que se realiza durante la primera visita a un dentista o si no ha ido al dentista por 3 años.

➢ Comuníquese con el coordinador local de I-Smile si necesita ayuda para encontrar a un dentista para usted o sus hijos menores de 21 años. Llame gratis al **1-866-764-5315** o visite http://www.idph.state.ia.us/webmap/default.asp?map=ismile

Visitas al médico

Medicaid cubre los siguientes servicios en consultorios, clínicas, hospitales, su propio hogar u otros lugares:

- Servicios médicos y quirúrgicos
- Exámenes de diagnóstico, inclusive análisis de laboratorio
- Radiografías
- Procedimientos para tratamiento
- Exámenes físicos una vez por año con análisis básicos de laboratorio para afiliados, inclusive niños y refugiados recién llegados, si califican

Las limitaciones de estos servicios figuran en la página 4.

Atención en salas de emergencia

Diríjase a una sala de emergencia cuando tenga un problema grave de salud y esperar podría ser peligroso. **No** debe abonar copago si:

- Necesita servicios de emergencia, o
- Ingresa a un hospital para internación, o
- Es menor de 21 años, o
- Está embarazada, o
- Está recibiendo servicios de planificación familiar

- Los afiliados podrían tener que abonar copago si la visita no se debe a una emergencia. Además, a los afiliados que tengan MediPASS se les podrá facturar las visitas a la sala de emergencias si los mismos no fueron derivados por el médico de atención primaria asignado por MediPASS y no se trata de una emergencia.

Exámenes de la vista y lentes

Los servicios oftalmológicos pueden incluir exámenes de la vista, lentes, reparación de lentes y dispositivos visuales. Los servicios cubiertos incluyen:

- Lentes correctoras
- Lentes protectoras
- Marcos o armazones nuevos
- Marcos de seguridad
- Lentes de contacto
- Lentes de reemplazo
- Exámenes de la vista

- Comuníquese con Servicios para Afiliados para obtener más información sobre los servicios oftalmológicos.

Centros médicos con acreditación federal

Estos servicios se cubren con las mismas limitaciones que los servicios de médicos y dentistas. Los servicios cubiertos por los centros médicos con acreditación federal incluyen atención de médicos, enfermeros profesionales, asistentes médicos y otros servicios ambulatorios.

Servicios de la audición

Medicaid cubre los exámenes auditivos y, en el caso de que necesite audífonos, se pagarán los audífonos, las baterías, los suministros y las reparaciones.

Los servicios auditivos tienen las siguientes limitaciones:

- Audífonos: 1 vez cada 4 años, para cada oído
- Exámenes auditivos: 1 vez cada 4 años, para cada oído

Programas HCBS – Servicios comunitarios y a domicilio

Puede calificar para el programa especial HCBS en el caso de necesitar atención médica en una institución médica pero usted preferiría quedarse en su casa si el tratamiento se pudiera brindar allí. HCBS ofrece servicios médicos en el hogar y en la comunidad. Los programas especiales de HCBS se ofrecen a personas con discapacidades y a ciertos grupos etarios.

Las instituciones médicas son hospitales, sanatorios, o instituciones de atención intermedia para personas con discapacidad cognitiva.

Iowa tiene 7 programas HCBS:

- SIDA y VIH
- Lesiones cerebrales
- Salud mental para niños y adolescentes
- Adultos mayores
- Salud y discapacidad
- Discapacidad cognitiva
- Discapacidad física

➢ Comuníquese con la oficina local de *Iowa Department of Human Services* para averiguar si califica para un programa especial.

Para obtener más información sobre los programas HCBS, consulte el folleto "*Are Home & Community Based Services Right for You?*" en: www.ime.state.ia.us/docs/HCBSbrochure102606.pdf.

Atención médica a domicilio

Los servicios médicos a domicilio se ofrecen debido a enfermedad o lesión a través de una agencia de servicios médicos a domicilio que posea la acreditación de Medicare.

Tipos de servicios médicos a domicilio:

- Enfermería especializada
- Fisioterapia, terapia ocupacional y terapia del habla
- Servicios médico-sociales
- Auxiliar de servicios médicos a domicilio

➢ Para que Medicaid cubra estos servicios, los mismos deben ser necesarios para tratar enfermedades y lesiones por razones de salud y haber sido ordenados por un médico.

Medicaid **no** cubre:

- Servicios médicos a domicilio con el fin de ayudar a la gente a cumplir con sus necesidades personales, familiares y domésticas
- Servicios de enfermería de tiempo completo en el hogar
- Servicios de enfermeros privados en el hogar, excepto en el caso de menores hasta la edad de 21 años cuando los servicios sean necesarios por razones de salud y hayan sido autorizados previamente

Cuidados paliativos

El servicio de cuidados paliativos ofrece atención para afiliados con enfermedades terminales que deseen sentirse cómodos y tranquilos hasta el momento de su muerte. Los servicios paliativos se ofrecen en el lugar donde el afiliado esté viviendo.

Se cubren servicios paliativos si los mismos son provistos por una agencia de servicios médicos a domicilio que esté acreditada para participar en Medicare y Medicaid.

Los servicios incluyen enfermería, auxiliar de cuidados paliativos, asistente social, capellán, voluntarios y equipo médico duradero.

Atención hospitalaria y de urgencia

Medicaid cubre la atención hospitalaria de pacientes internos y externos, con algunas limitaciones.

Tendrá que abonar copago si visita la sala de emergencias debido a una afección que no sea una emergencia real. Consulte a su propio médico o diríjase a una clínica de urgencias en el caso de:

- Esguince de muñeca o de tobillo
- Dolor de oído
- Tos
- Fiebre
- Vómitos
- Suministros y equipo médico

Análisis y radiografías

Medicaid cubre muchos tipos de análisis de laboratorio y radiografías. Pregunte si Medicaid cubre ese estudio. De no ser así, tendrá que pagarlo usted mismo.

Servicios en centros de atención maternal y maternidad

Los centros de atención maternal ofrecen los siguientes servicios:

- Atención prenatal (atención médica durante el embarazo)
- Educación para la salud
- Servicios nutricionales
- Servicios sociales y gestión de casos

Los centros de maternidad parto y nacimiento ofrecen:

- Atención prenatal
- Parto
- Atención posparto (después del nacimiento)

Equipo y suministros médicos

Medicaid cubre el equipo y los suministros médicos que necesite. Su médico debe escribir la orden para el equipo y los suministros.

Ejemplos de equipo y suministros que cubre Medicaid:

- Sillas de ruedas
- Prótesis
- Vendajes y suministros para el cuidado y tratamiento de heridas
- Oxígeno y suministros

Medicaid no cubre:

- Acondicionadores de aire
- Deshumidificadores
- Licuadoras
- Dispositivos para masajes
- Máquinas para hacer ejercicio

Servicios de salud mental (psicólogos y asistentes sociales)

Se cubren servicios de salud mental si son provistos por prestadores con prácticas privadas o contratados por hospitales, agencias de servicios médicos a domicilio, agencias de rehabilitación, centros comunitarios de salud mental o por médicos.

Medicaid paga los servicios de:

- Psicoterapeutas
- Consejeros matrimoniales y familiares
- Terapeutas acreditados en drogadicción

Medicaid también paga los servicios cubiertos si los mismos son provistos por prestadores con práctica privada. Vea los servicios del Plan de Iowa en la página 23.

Servicios de enfermería obstétrica (partera)

Los servicios cubiertos incluyen atención prenatal, parto, atención posparto y otros servicios permitidos por las leyes estatales.

El pago se hará únicamente a personal de enfermería acreditado y especializado en obstetricia que estén registrados y posean estudios avanzados. Medicaid no pagará los servicios de parteras sin acreditación, que no estén registradas, ni posean estudios avanzados.

Servicios en geriátricos

Centros geriátricos con acreditación de Medicare

Medicaid ayuda a pagar el costo de la atención en geriátricos. Un médico debe certificar que usted necesita atención en un geriátrico, no en un hospital, y que califica para asistencia médica. La unidad de servicios médicos de *Iowa Medicaid Enterprise* debe confirmarlo. Medicaid también cubre el costo de la atención si necesita los servicios de un centro acreditado de atención especializada.

Puede conservar parte de sus ingresos para necesidades personales. El resto se acredita al pago del geriátrico, a menos que su principal fuente de ingresos sea el programa FIP (*Family Investment Program*).

- Debe calificar tanto **médica** como **económicamente** para atención en un geriátrico. Medicaid no pagará la atención recibida si es internado en un geriátrico y más tarde se descubre que no califica para asistencia médica.

Personal de enfermería especializado en anestesia y medicina general

Enfermeros anestesistas acreditados y registrados (CRNA)

Medicaid pagará los servicios dispuestos por las leyes estatales y provistos por enfermeros anestesistas acreditados y registrados. Las limitaciones son las mismas que para los médicos.

Si un CRNA es empleado de un médico, hospital o clínica, Medicaid le paga al prestador que emplea al CRNA. Medicaid también les paga a los CRNA en prácticas privadas.

Profesionales registrados de enfermería avanzada (ARNP)

Medicaid pagará los servicios dispuestos por las leyes estatales y provistos por enfermeros profesionales especializados. Las limitaciones son las mismas que para los médicos. Medicaid les paga directamente a los enfermeros especializados en una especialidad reconocida por el *Iowa Board of Nursing*.

Podología y calzado ortopédico

Medicaid cubre:

- Cirugía de los pies
- Determinadas prótesis para los pies

Medicaid **no** cubre:

- Tratamientos para pie plano
- Cuidados de rutina, tales como recortar las uñas o el tratamiento de callosidades y durezas

Se cubre calzado ortopédico, calzado para diabéticos, plantillas y modificaciones sólo si fueron recetados por escrito por un médico, un asistente médico o un profesional registrado de enfermería avanzada.

Si no tiene la orden, deberá pagar el calzado usted mismo.

Medicamentos con receta médica y medicamentos de venta libre

La cobertura incluye la mayoría de los medicamentos con receta médica y algunos medicamentos de venta libre. Un médico o un profesional médico calificado deben escribir la orden o la receta. En el caso de algunos medicamentos, primero debe conseguir la autorización de Medicaid.

Los farmacéuticos deben entregarle el artículo de menor costo que tengan en stock y que cumpla con la orden de su prestador. Además, deben informarle a usted o a la persona responsable cómo se administra el medicamento que le entrega.

Para la mayoría de los medicamentos, la primera receta debe ser por una cantidad suficiente para 31 días. Algunas recetas no se pueden hacer por cantidades que superen los 15 días al principio. Las siguientes recetas podrán hacerse por la cantidad normal para 31 días.

Su farmacéutico podrá volver a surtir una receta sólo cuando se haya usado el 85% de la provisión:

- Una provisión para 30 días puede renovarse después de 26 días.
- Una provisión para 90 días puede renovarse después de 77 días.

➢ Pídale a su farmacéutico que haga una excepción si por alguna razón, como por ejemplo un viaje, necesita una provisión de medicamentos por más tiempo o que se los entregue antes del tiempo permitido.

La cobertura incluye todos los medicamentos y dispositivos para control de la natalidad.

- Necesitará autorización para determinados medicamentos de marcas comerciales, en el caso de que exista un medicamento genérico.
- Su farmacéutico, su médico u otros prestadores le informarán cuáles están cubiertos y qué fármacos necesitan autorización previa.
- Las recetas para anticonceptivos orales se pueden hacer por 90 días.

Los medicamentos con receta médica que **no** están cubiertos son:

- La mayoría de los medicamentos para la tos y el resfrío
- Medicamentos para adelgazar
- Medicamentos con propósitos cosméticos, como por ejemplo un fármaco para hacer crecer el cabello
- Medicamentos para incrementar la fertilidad
- Medicamentos para la disfunción eréctil

Los medicamentos de venta libre vienen en envases regulares que generalmente contienen 100 unidades. Le entregarán una provisión para 31 días como máximo. La provisión de todos los suministros médicos cubiertos es para 90 días como máximo.

Los medicamentos de venta libre que están cubiertos son:

- Aspirina
- Acetaminofén o paracetamol (Tylenol®)
- Múltiples vitaminas y minerales para embarazadas y mujeres que estén amamantando
- Múltiples vitaminas y minerales (con autorización previa)

Debe mostrarle su tarjeta de Asistencia Médica al farmacéutico para pagar los medicamentos y los suministros. En el caso de que Medicaid no pague alguno de los medicamentos y suministros ordenados por su médico, su farmacéutico le explicará el motivo.

Si no se siente conforme con la explicación dada, puede comunicarse con el Servicio para Afiliados de Iowa Medicaid. Si aún sigue disconforme, puede exigir que le envíen la notificación formal por escrito donde le expliquen su derecho a apelar. Vea la página 6.

Clínicas rurales

Los servicios provistos por clínicas rurales que se incluyen en la cobertura son: servicios de médicos, profesionales de enfermería especializada y asistentes médicos, servicios de enfermería a domicilio y otros servicios ambulatorios.

Servicios de terapia (ocupacional, física y del habla)

Los servicios terapéuticos están cubiertos cuando los terapeutas son empleados de un hospital, de una agencia de servicios médicos a domicilio, de una agencia de rehabilitación, de un geriátrico o de un médico.

Se cubren los servicios provistos por terapeutas ocupacionales, fisioterapeutas y terapeutas del habla en su propio consultorio, si los mismos están acreditados y adheridos a Medicaid.

El importe a pagar anualmente es limitado, a menos que reciba servicios en el departamento ambulatorio de un hospital.

Tratamiento antitabaco (Dejar de fumar)

Primero debe hacer una cita con su prestador médico. Juntos, usted y su médico decidirán cuál es el mejor tratamiento para su caso particular.

Medicaid cubre los siguientes medicamentos para dejar de fumar:

- Chantix
- Bupropión (genérico para Zyban)
- Parches sustitutos de nicotina
- Chicles con nicotina

En el caso de que su prestador le recete Chantix, parches o chicles de venta libre, deberá recibir terapia de apoyo de Quitline de Iowa. Debe hacer lo siguiente para inscribirse en Quitline de Iowa:

1. Llene el formulario de autorización en el consultorio de su prestador médico.
2. Su prestador enviará el formulario por fax a Quitline de Iowa.
3. Quitline de Iowa se comunicará con usted para pedirle sus datos y hacer la inscripción.
4. Quitline de Iowa le enviará un formulario a Iowa Medicaid para su medicación.
5. Pase a buscar sus medicamentos por la farmacia una vez que Iowa Medicaid los haya autorizado.

En el caso de no seguir los pasos detallados, tendrá que pagar los servicios y los medicamentos.

Servicios de transporte

Transporte de Rutina - Sin Emergencia (NEMT)

El servicio NEMT les brinda a los afiliados transporte o reembolso de gastos (se les devuelve el dinero) por traslado a las citas o los servicios con médicos, dentistas, farmacias y salud mental.

La agencia que ofrece asistencia con el transporte se llama TMS.

Los afiliados a Medicaid que necesiten transporte o deseen que se les reintegren los gastos de traslado a través de TMS deben:

- Llamar a TMS al **1-866-572-7662** por lo menos 3 días hábiles **antes** del traslado o de la cita médica
- Darle a TMS su nombre completo, número de identificación estatal, domicilio, número de teléfono y fechas del traslado
- Darle a TMS el nombre, domicilio, número de teléfono y número de fax de su prestador médico

TMS hará lo siguiente:

- Evaluará su necesidad de transporte
- Comprobará que usted califica para servicios de transporte
- Verificará que el prestador médico esté adherido a Iowa Medicaid
- Verificará que el servicio esté cubierto por Iowa Medicaid
- Solicitará cualquier tipo de información extra que sea necesaria
- Verificará que el traslado cumple con los requisitos federales y estatales para transporte médico de rutina y reintegro

TMS le dará un número de confirmación cuando haga la reserva para el traslado.

Los afiliados que deseen reintegro del traslado, le deben enviar a TMS:

- El número de confirmación
- El formulario de reclamo
- Todos los recibos

➢ Para averiguar sobre el transporte médico de rutina, consulte: http://www.ime.state.ia.us/members/index.html.

➢ El transporte médico **no** está cubierto por la Red de Planificación Familiar de Iowa (*Iowa Family Planning Network*, IFPN).

Otros servicios de transporte

El transporte local también está disponible para menores de 21 años y embarazadas que necesiten trasladarse para atención médica, odontológica y de salud mental con prestadores locales.

➢ Pídales a los coordinadores de Care for Kids o del programa de salud maternal que organicen su transporte.

➢ Para obtener la información de contacto, llame al servicio telefónico de Healthy Families al teléfono **1-800-369-2229**.

Parte III: Otras prestaciones del programa

Servicios de intervención para trastornos de la conducta (BHIS)

Los servicios BHIS se ofrecen a través del Plan de Iowa (ver página 23). Estos servicios brindan intervenciones de terapia psicológica, orientación e instrucción en entornos comunitarios y residenciales de atención grupal. Los servicios están diseñados para mejorar las funciones cognitivas de niños, adolescentes y adultos que padecen enfermedades mentales. El objetivo principal es ayudar a los afiliados y sus familias a aprender sobre las capacidades adecuadas de acuerdo a la edad con el fin de controlar las conductas y lograr autocontrol.

Servicios para niños y adolescentes

Exámenes periódicos, diagnóstico temprano y tratamiento (EPSDT) "Care for Kids"

EPSDT cubre los exámenes de control hasta la edad de 21 años. Medicaid cubrirá todos los servicios que se consideren necesarios como resultado del examen de control.

Un examen completo incluye:

- Historia médica y del desarrollo
- Examen físico de rutina y mediciones

- Examen de la vista y de la audición
- Examen bucal (dental)
  - La primera visita al dentista se debe realizar a los 12 meses de edad.
- Evaluaciones psicológicas y nutricionales
- Análisis de laboratorio
- Inmunizaciones (vacunas)
- Educación para la salud

- Para recibir ayuda para encontrar a un prestador, hacer una cita o conseguir transporte, llame al servicio telefónico de Healthy Families al **1-800-369-2229**.

Servicios para bebés y niños

También se brindan servicios médicos a través del programa Early Access. Los siguientes servicios se cubren desde el nacimiento hasta los 3 años:

- Evaluaciones del desarrollo
- Audiología (audición)
- Enfermería
- Nutrición
- Terapia ocupacional y fisioterapia
- Terapia del habla y el lenguaje
- Visión

- Si necesita asistencia, llame al 1-888-IA-KIDS1 (888-425-4371) o consulte: http://www.earlyaccessiowa.org.

Servicios educativos locales y regionales

Medicaid cubre los siguientes servicios provistos por agencias educativas locales y regionales:

- Fisioterapia
- Terapia ocupacional
- Terapia del habla
- Servicios de salud mental
- Servicios de la audición
- Servicios de enfermería

Centros comunitarios de salud mental

Medicaid cubre los servicios provistos por psiquiatras, psicólogos, asistentes sociales y enfermeros psiquiátricos. Los prestadores deben pertenecer al personal de un centro comunitario de salud mental que esté acreditado por DHS.

Programa de cobro a través del patrimonio sucesorio

La ley federal exige que Iowa tenga un programa de cobro a través del patrimonio sucesorio en el caso de que el dinero de Medicaid se utilice para pagar asistencia médica si usted:

- Tiene 55 años o más en el momento de obtener Medicaid.
- Es menor de 55 años, vive en una institución de atención médica a largo plazo y es probable que no pueda regresar a su hogar.

Cuando fallece una persona que recibe asistencia médica, su patrimonio debe ser utilizado para reintegrarle a Iowa Department of Human Services (DHS) el dinero que se gastó en atención médica. El patrimonio puede incluir dinero, cosas materiales, terrenos, etc.

El cobro se retrasará si a dicha persona la sobrevive su cónyuge, una persona dependiente o un hijo discapacitado. También se retrasará si el cobro les causara problemas económicos a sus sucesores. Si tiene dudas sobre el cobro a través del patrimonio sucesorio, consulte http://www.ime.state.ia.us/Estate.html.

Servicios de habilitación—Servicios Comunitarios y a Domicilio (HCBS)

Estos servicios están diseñados para satisfacer las necesidades de los afiliados con historial de enfermedad mental crónica. Un equipo dirigido por un gestor de casos redactará un plan integral de servicios, donde se identificarán los servicios necesarios.

Los servicios cubiertos son:

- Habilitación a domicilio
- Habilitación diaria
- Servicios pre-vocacionales
- Empleo asistido

Health Home para afiliados con enfermedades crónicas

Puede inscribirse en un *Health Home* en algunas áreas. Si se inscribe en un *Health Home* deberá cancelar su inscripción en otro programa de atención médica administrada. Tendrá la posibilidad de descontinuar su participación en un *Health Home* en cualquier momento.

Los afiliados con enfermedades crónicas específicas pueden calificar para servicios adicionales que les ayudarán a controlar dichas enfermedades. Las ventajas del programa son:

- Un médico de atención primaria que organiza toda su atención médica
- Personal de enfermería que le ayuda a identificar y a lograr sus objetivos de salud y bienestar
- Acceso a servicios de apoyo para eliminar los obstáculos que le impiden mejorar su salud
- Acceso a educación y promoción de la salud para solucionar problemas de nutrición, dejar de fumar y hacer actividad física

- Asistencia con atención transitoria y planificación del alta después de una hospitalización o de rehabilitación
- Asistencia para encontrar recursos comunitarios y servicios de apoyo
- Asistencia para administrar su medicación y tratamientos médicos

El afiliado debe tener una enfermedad crónica y estar en riesgo de padecer una de las enfermedades que se detallan a continuación, o tener al menos dos de las siguientes enfermedades crónicas:

- Hipertensión
- Sobrepeso
- Enfermedad cardíaca
- Diabetes
- Asma
- Adicción a sustancias
- Enfermedad mental

Cómo hacer la solicitud para *Health Home*

Debe decidir si desea inscribirse en un *Health Home*. Este programa es voluntario. En el caso de estar interesado, llame al centro telefónico de Servicios para Afiliados al 1-800-338-8366, o al teléfono local 515-256-4606 en el área de Des Moines. Los afiliados con enfermedades mentales severas y persistentes también pueden acceder a los servicios de *Health Home* a través de prestadores capacitados. Pídale más información a su prestador de la salud conductual o llame al centro telefónico de Servicios para Afiliados.

Pago de Primas del Seguro Médico (HIPP)

Este programa ayuda a los afiliados de Medicaid a conseguir seguro médico o a conservarlo. HIPP les ayuda pagando la prima del seguro. Para calificar para HIPP:

- Usted o alguien más de su grupo familiar debe tener Medicaid.
- Debe tener seguro médico o poder conseguirlo a través de su empleador.
- La relación costo-beneficio del seguro médico debe ser rentable.

Pago de primas del seguro médico para SIDA/VIH (HIPP)

El programa HIPP para SIDA/VIH ayuda a las personas que sufren enfermedades relacionadas con SIDA/VIH y les paga las primas del seguro médico cuando están demasiado enfermas para trabajar. Para calificar para los servicios de este programa, es necesario que:

- No califique para Medicaid
- Sea residente de Iowa
- Presente la certificación de un médico indicando que no puede trabajar debido a una enfermedad relacionada con SIDA o VIH

- Sea titular de una póliza de seguro médico o figure como dependiente en el plan de su cónyuge
- Posea activos “líquidos” (efectivo, acciones, cuentas bancarias, etc.) por un importe inferior a $10,000
- Reúna los requisitos sobre límites de ingresos

➢ Para presentar la solicitud o comunicarse con HIPP, llame gratis al **1-888-346-9562** o envíe un correo electrónico a hipp@dhs.state.ia.us, o visite http://www.dhs.state.ia.us/hipp

Instituciones de cuidado intermedio para personas con discapacidad cognitiva y otras enfermedades relacionadas (ICF/ID)

Las ICF/ID brindan atención y servicios durante las 24 horas del día a personas con discapacidad cognitiva y otras enfermedades relacionadas.

- Los servicios deben brindarse en instituciones acreditadas.
- Las personas deben ser elegibles para Medicaid y estar autorizadas por Servicios Médicos de *Iowa Medicaid Enterprise*.

➢ Comuníquese con la oficina local de DHS para averiguar sobre este programa.

Plan de Iowa para trastornos de la conducta

La mayoría de los afiliados de Medicaid están inscriptos en el Plan de Iowa para trastornos de la conducta (Plan de Iowa). El Plan de Iowa es un programa estatal de atención médica administrada para servicios de salud mental y el tratamiento de la adicción a sustancias. Averigüe sobre el Plan de Iowa llamando gratis al **1-800-317-3738**.

Si está inscripto en el Plan de Iowa:

- Tiene derecho a saber cómo obtener estas prestaciones de Medicaid.
- Recibirá un paquete informativo poco después de calificar para Medicaid.
- Puede llamar al teléfono gratuito si desea hacer preguntas sobre los servicios de salud mental y adicciones a sustancias.

Para encontrar a un prestador a través del Plan de Iowa, llame al teléfono gratuito para obtener el listado de prestadores, o puede dirigirse directamente a un prestador para recibir atención médica. Muéstrele su tarjeta de Medicaid al prestador para que éste verifique que usted pertenece al Plan de Iowa.

Si su prestador no está adherido al Plan de Iowa, el mismo puede registrarse o hacer la remisión a otro prestador.

En el caso de una emergencia relacionada con problemas de salud mental o drogadicción, diríjase directamente a la sala de emergencias de un hospital para una evaluación y recibir la atención y el tratamiento adecuados.

Atención médica administrada (Managed Health Care)

Deberá inscribirse en un plan de *Managed Health Care* si usted es afiliado de Iowa Medicaid y vive en un condado donde hay servicios médicos administrados. No perderá las prestaciones de Medicaid. Podrá elegir entre una organización administradora de servicios médicos (HMO) o un médico de MediPASS. IME le asignará un prestador si no lo elige.

Las ventajas de la atención médica administrada son:

- Tiene un médico de atención primaria
- Se construye una buena relación médico-paciente
- Cuando necesita servicios médicos, tiene un número telefónico adonde llamar y un médico y personal que le conocen
- Recibe atención médica de su propio doctor y evita el trato impersonal de una sala de emergencias o de un médico desconocido
- Es más fácil para usted y sus hijos recibir servicios preventivos para conservar la salud (cosas como las vacunas de sus hijos y el PAP anual y el examen pélvico femenino)

La manera de conseguir algunos servicios es diferente con atención médica administrada, así que lea sobre sus opciones y sobre cómo obtener servicios de Medicaid a través de los servicios médicos administrados. Recibirá más información por escrito una vez que haya hecho su elección (o que sea asignado en el caso de no hacer la elección).

- Llame a Servicios para Afiliados en días hábiles (lunes a viernes) de 8:00 a.m. a 5:00 p.m. al teléfono **1-800-338-8366**, o al **1-515-256-4606** en el área de Des Moines.

Además, puede llamar si tiene algún problema después de inscribirse o si desea cambiar su inscripción. Puede solicitar un cambio si no le agrada la elección que hizo o si sus circunstancias cambian (por ejemplo, si se muda o si su médico se jubila).

Programa para adultos mayores con todos los servicios incluidos (PACE)

PACE les ayuda a los afiliados de Medicaid a mantenerse sanos y vivir en su comunidad por tanto tiempo como sea posible. El programa PACE coordinará y brindará todos los servicios a domicilio para cuidados preventivos, primarios, intensivos y a largo plazo para adultos a partir de los 55 años de edad.

- Comuníquese con Servicios para Afiliados en días hábiles (de lunes a viernes) de 8:00 a.m. a 5:00 p.m. al teléfono **1-800-338-8366**, o al **1-515-256-4606** en el área de Des Moines, para averiguar si vive en un condado que tiene el programa PACE. El representante de Servicios para Afiliados le dará la información de contacto para el programa PACE.

Datos importantes

Use esta página para anotar los teléfonos de todos sus prestadores de servicios médicos. Manténgala cerca de su teléfono y utilícela para comunicarse con las personas correctas para que le ayuden con su atención médica.

Centro telefónico de Servicios para Afiliados

Línea telefónica gratuita: 1-800-338-8366

En el área de Des Moines: 515-256-4606

Horario de atención al público: Lunes a viernes, de 8:00 a.m. a 5:00 p.m.

Correo electrónico: IMEMemberServices@dhs.state.ia.us

Internet: www.ime.state.ia.us

Salud mental y adicciones

Línea telefónica gratuita: 1-800-317-3738 (las 24 horas del día)

Prestador de atención primaria: _____

Hospital: _____

Emergencias: 911

Remember...

- Contact us as soon as you think that you may get a one-time payment.
- If you get a one-time payment while you are applying for or getting FIP, you must use the money to live on until your period of ineligibility has ended.

Statement on Nondiscrimination

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

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

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

(*Food Assistance only*)
USDA – Director, Office of Adjudication
1400 Independence Ave SW
Washington, DC 20250-9410
or call **1-866-632-9992** (voice)

Individuals who are hearing impaired or have speech disabilities may contact USDA through the Federal Relay Service at **800-877-8339**; or **800-845-6136** (Spanish).

Iowa Department of Human Services

Comm. 24 (Rev. 1/14)

One-Time Payments

What is a one-time payment?

A one-time payment is when you get money that you do not expect to get on a regular basis. We call this a nonrecurring lump-sum.

One-time payments can include:

- Insurance death benefits
- Lottery winnings
- Lawsuit settlements
- Inheritances
- Gifts

This can also include back payments that you get from:

- Social Security
- Worker's compensation
- Child support
- Unemployment benefits
- Veteran's benefits

What do I do if I get a one-time payment?

Tell us if you get or expect to get a one-time payment. We will tell you how the one-time payment will affect any benefits you get from us.

If you don't know in advance that you will be getting a one-time payment, tell us within ten days after you get the money. **It would be best for you and your family if you talk to us before you spend any of the money.**

How is a one-time payment counted?

We count one-time payments as income. This money is added to the other income that you get in a month. We use your income to decide if you can get Family Investment Program (FIP) or Medicaid.

FIP

If you are applying for the Family Investment Program (FIP) when you get a one-time payment, you might not be eligible to get FIP for a period of time.

If you are receiving FIP and the amount of your one-time payment plus your other income is too high, your FIP payments may stop for a period of time. We will tell you how long you will have to wait before you can get FIP again. This is called a period of ineligibility. If you want FIP after the period of ineligibility ends, you may reapply.

You cannot get FIP during your period of ineligibility even if you spend all of the money. This includes if you use the money to pay back bills or buy things you need, like a car or household items.

Medicaid

Effective January 1, 2014, if you are getting Medicaid when you get a one-time payment, we may count it as income in the month it is received. We will not prorate the lump sum for Medicaid.

Are there any payments that are not counted?

Some payments are not counted, like a property settlement from a divorce or gifts that are less than $30 in a three-month period. We will not count payments that you get and spend for:

- Medical expenses
- Funeral and burial expenses
- Repair or replacement of a house, car or other personal property
- Costs of getting the lump sum, such as attorney fees

We do not count the one-time payment if you get the money when you are not applying for or getting FIP.

For example, if you think you will get a one-time payment in October and you ask to stop your FIP before October 1, there will not be a period of ineligibility or period of proration.

- For FIP, if you get a FIP check in October, you must return the actual FIP check or we will have to figure a period of ineligibility.
- You can reapply for FIP in November. We will not count the one-time payment as income. Any part of the one-time payment you will have left will be counted as a resource.

How is my period of ineligibility for FIP figured?

To decide how long we will count the one-time payment for FIP, we divide your income in the month you get the one-time payment by the FIP standard of need. The standard of need chart is on the next panel.

Number of People in Your Group							
1	2	3	4	5	6	7	8
$365	$719	$849	$986	$1092	$1216	$1335	$1457
This chart increases if you have more than 8 people.							

Find the number of people in your FIP group in the chart. We will divide your one-time payment plus your other income by that amount.

Here is an example:

Ms. A and her two children get FIP. In October, the family gets $2,250 from a one-time insurance payment. Ms. A reports getting the money within ten days. The family has $300 in other income. The total income for October is $2,550 ($2,250 + $300 = $2,550). The period of ineligibility is figured by dividing the income by the standard of need for three people ($849). $2,550 ÷ $849 = 3. There is $3 left over. The period of ineligibility is October, November, and December. The extra $3 will be counted as income in January if Ms. A reapplies for FIP. Because Ms. A reported the one-time payment within ten days she will not have to repay the November FIP.

Can my period of ineligibility or period of proration be reduced?

Your period of ineligibility or period of proration can be reduced if you no longer have the money because of the following:

- The money is lost or stolen and you report this to the police.
- The person with the money no longer lives with your family and you cannot get the money.
- The money is spent on any of the following bills which are not covered by your insurance:
  - Medical services for members of your family
  - Home repairs over $25 if they are needed to keep your home livable and you own or are buying your home
  - Costs for replacing a home or household goods damaged in a natural disaster, such as a fire, flood or tornado
  - Funeral and burial expenses

When these things happen, the loss or expense may be deducted from the one-time payment. This would shorten the period of ineligibility or period of proration.

If you tell us the one-time payment is no longer available to you, you will have to show us proof. This proof can include a copy of a police report or a receipt that shows what you bought.

Here is an example:

Ms. A gives proof that she spent $500 of the one-time payment she received in October on medical expenses. She reported getting the lump sum within ten days. The $500 is deducted from her total income of $2,550. This leaves $2,050 as income. $2,050 divided by $849 equals a two-month period with $352 left over.

For FIP: Ms. A's family's period of ineligibility is October and November. The remaining $352 will be counted as income in December if she reapplies. Because she reported the one-time payment within ten days she will not have to repay the November FIP.

Can I continue to get other help?

You will not be able to get FIP during your period of ineligibility; however, you may be able to get other help. Some people can still get Medicaid and we will check to see if you can.

You may also be able to get more Food Assistance when your FIP stops.

Ask us about other types of help that may be available in your community.

What happens if I don't report a one-time payment?

If you don't report a one-time payment, you will risk:

- Having to pay back FIP benefits you should not have gotten.
- Having to pay some of your family's medical expenses.
- Losing a choice to have the one-time payment treated in a way that's better for you and your family.

What if I have questions?

If you have questions, contact your worker in your local Human Services office. You may also contact Iowa Legal Aid for assistance. The toll free number is: **1-800-532-1275**.

Recuerde…

- Contáctenos tan pronto como crea que puede recibir un pago único.
- Si recibe un pago único mientras esté solicitando u obteniendo FIP, deberá usar el dinero para vivir o hasta que su periodo de no-elegibilidad haya terminado.

Declaración de no discriminación

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

Si cree que DHS le ha discriminado o acosado, le agradeceremos que envíe una carta explicando detalladamente su queja a:

Iowa Department of Human Services
Hoover Building, 5th Floor
Policy Bureau
1305 E Walnut Street
Des Moines, IA 50319-0114
Correo electrónico: contactdhs@dhs.state.ia.us

(*Únicamente para Food Assistance*)
USDA – Director, Office of Adjudication
1400 Independence Ave SW
Washington, DC 20250-9410
o llamar al **1-866-632-9992** (voz)

Las personas que tengan problemas de audición o de habla, pueden contactarse a la USDA a través de Federal Relay Services al **800-877-8339**; o al **800-845-6136** (español).

Iowa Department of Human Services

Comm. 24(S) (Rev. 1/14)

One-Time Payments

(Pagos únicos o de una sola vez)

¿Qué es un pago único?

Un pago único es cuando usted recibe dinero que no espera recibir en forma regular. Nosotros le llamamos cantidad global no recurrente.

Los pagos únicos pueden incluir:

- Beneficios por seguro de muerte
- Ganancias de lotería
- Conciliaciones por demandas
- Herencias
- Regalos

Esto también puede incluir pagos atrasados que reciba de:

- Seguridad social
- Indemnización del trabajador
- Manutención infantil (child support)
- Beneficios de desempleo
- Beneficios de veteranos

¿Qué hago si recibo un pago único?

Infórmenos si recibe o espera recibir un pago único. Nosotros le informaremos cómo el pago único afectará los beneficios que recibe de nosotros.

Si no sabe con anticipación que recibirá un pago único, infórmenos dentro de los diez días siguientes a la recepción del dinero. **Sería mejor para usted y su familia si hablan con nosotros antes de gastar el dinero.**

¿Cómo se cuenta un pago único?

Nosotros contamos los pagos únicos como ingresos. Este dinero se suma a los otros ingresos que reciban durante el mes. Nosotros usamos su ingreso para decidir si puede recibir Family Investment Program (Programa de Inversión Familiar - FIP) or Medicaid.

FIP

Si está solicitando el Family Investment Program (FIP) cuando reciba un pago único, puede no ser elegible para recibir FIP durante un tiempo.

Si está recibiendo FIP y el monto de su pago único más sus otros ingresos es demasiado alto, sus pagos por FIP podrán suspenderse por un tiempo. Nosotros le informaremos qué tanto deberá esperar antes de recibir FIP nuevamente. Esto se llama un período de no-elegibilidad. Si desea el FIP después de la terminación del período de no-elegibilidad, puede volver a solicitarlo.

Usted no puede recibir FIP durante su período de no-elegibilidad, aún si gastó todo el dinero. Esto incluye si usted usó el dinero para pagar facturas vencidas, o para comprar cosas que necesitaba, como un auto o elementos para el hogar.

Medicaid

Si recibe prestaciones de Medicaid, a partir del 1 de enero de 2014 no prorratearemos los pagos que reciba por única vez, sino que los contabilizaremos como ingresos de dicho mes.

¿Hay algunos pagos que no se cuentan?

Algunos pagos no se cuentan, como una conciliación de propiedad de un divorcio o regalos que sumen menos de $30 en un periodo de tres meses. No contaremos pagos que usted recibe y los gasta en:

- Gastos médicos
- Gastos funerarios y de entierro
- Reparación o reemplazo de una casa, auto u otras propiedades personales
- Costos de recibir la suma global, como honorarios de abogado

No contamos el pago único si usted recibe el dinero cuando no está haciendo la solicitud u obteniendo FIP.

Por ejemplo, si usted cree que obtendrá un pago único en octubre, y pide que se suspenda su FIP antes del 1 de octubre, no habrá periodo de no-elegibilidad ni periodo de asignación o distribución.

- Para FIP, si usted recibe un cheque FIP en octubre, debe regresar el cheque FIP o tendremos que imponer un período de no-elegibilidad.
- Puede volver a solicitar FIP en noviembre. No contaremos el pago único como ingreso. Cualquier parte del pago único que le quede, será contada como un recurso.

¿Cómo se determina mi período de no-elegibilidad para FIP?

Para decidir por cuánto tiempo contaremos el pago único para FIP, dividimos su ingreso en el mes en que recibe el pago único por el estándar FIP de necesidad. La tabla con los importes estándar para cubrir las necesidades básicas se encuentra en el panel siguiente.

Número de personas en su grupo							
1	2	3	4	5	6	7	8
$365	$719	$849	$986	$1092	$1216	$1335	$1457
Este cuadro se aumenta si tiene más de 8 personas en su grupo.							

Encuentre el número de personas en su grupo FIP en el cuadro. Dividiremos su pago único más sus otros ingresos por esa cantidad.

Aquí hay un ejemplo:

La Sra. A y sus dos hijos reciben FIP. En octubre, la familia recibe $2.250 por un pago único de un seguro. La Sra. A reporta haber recibido el dinero dentro de los diez días siguientes. La familia tiene $300 en otros ingresos. El ingreso total para octubre es $2.550 ($2.250 + $300 = $2.550). El período de no-elegibilidad se obtiene dividiendo el ingreso por el estándar de necesidad para tres personas ($849). $2.550 ÷ $849 = 3. Hay un sobrante de $3. El período de no-elegibilidad es octubre, noviembre y diciembre. Los $3 adicionales se contarán como ingreso en enero si la Sra. A solicita nuevamente el FIP. Como la Sra. A reportó el pago único dentro de los diez días siguientes, ella no tendrá que hacer el repago del FIP de noviembre.

¿Pueden reducirse mis períodos de no-elegibilidad o de asignación?

Sus períodos de no-elegibilidad o de asignación pueden reducirse si ya no tiene el dinero por las siguientes causas:

- El dinero se perdió o fue robado y usted reportó el hecho a la policía.
- La persona que tiene el dinero ya no vive con su familia y usted no puede obtener el dinero.
- El dinero se gastó para pagar cualquiera de las siguientes facturas y no fueron cubiertas por su seguro:
  - Servicios médicos para miembros de su familia
  - Reparaciones domésticas por más de $25 si se requerían para mantener su hogar habitable y usted es el dueño o está comprando su hogar
  - Costos para remplazar un hogar o bienes del hogar dañados por un desastre natural, como un incendio, inundación o tornado
  - Gastos funerarios y de entierro

Cuando estas cosas ocurren, la pérdida o gasto pueden deducirse del pago único. Esto acortará el período de no-elegibilidad o el de asignación.

Si usted nos informa que el pago único ya no está disponible para usted, tendrá que mostrarnos una prueba. Esta prueba puede incluir una copia de un reporte policial o un recibo que muestre lo que compró.

Aquí hay un ejemplo:

La Sra. A ofrece una prueba de que ella gastó $500 del pago único recibido en octubre, en gastos médicos. Ella reportó haber recibido la suma global dentro de los diez días siguientes. Los $500 se deducen de su ingreso total de $2.550. Esto deja un ingreso de $2.050. $2.050 dividido por $849 igual a un período de dos meses con un sobrante de $352.

Para FIP: El período de no-elegibilidad de la familia de la Sra. A es octubre y noviembre. Los $352 restantes se contarán como ingreso en diciembre si ella vuelve a hacer la solicitud. Como ella reportó el pago único dentro de los diez días siguientes, no tendrá que repagar el FIP de noviembre

¿Puedo seguir recibiendo otras ayudas?

No podrá obtener FIP durante su período de no-elegibilidad; sin embargo, podrá recibir otras ayudas. Algunas personas aún pueden recibir Medicaid y nosotros verificaremos si usted puede.

Usted también puede obtener más Food Assistance (Asistencia Alimenticia) cuando su FIP esté suspendido.

Pregúntenos sobre otros tipos de ayuda que pueda haber en su comunidad.

¿Qué pasa si no reporto un pago único?

Si no reporta un pago único, arriesgará:

- Tener que repagar los beneficios FIP que no debió haber recibido.
- Tener que pagar algunos de los gastos médicos de su familia.
- Perder la opción de que el pago único sea tratado en la mejor forma para usted y su familia.

¿Qué pasa si tengo preguntas?

Si tiene preguntas, contacte a su trabajado en la oficina local de Human Services. También puede contactar a Iowa Legal Aid para asistencia. El número gratuito es: **1-800-532-1275**.

Comm. 24 or Comm. 24(S), One-Time Payments

Purpose	Brochures Comm. 24 and Comm. 24(S) explain how receipt of a non-recurring lump sum may affect Medicaid or FIP eligibility.
Source	Printed supplies of Comm. 24 and Comm. 24(S) may be ordered from Iowa Prison Industries at Anamosa.
Distribution	Provide this brochure to: ♦ Each applicant for FIP or MAGI-related Medicaid, and ♦ Each FIP or MAGI-related Medicaid member: • Who reports receipt or possible receipt of a nonrecurring lump sum, or • Whom you believe may receive a nonrecurring lump sum.
Data	The brochure instructs clients what to do if they receive a lump sum, how one-time payments are counted, and how a period of ineligibility is determined.

Iowa Department of Human Services

Important Information for You and Your Family Members About the Estate Recovery Program

What is the estate recovery program?

Medicaid is a government program that pays for health care for people with limited income. Medicaid covers many services, for example, primary care, hospital stays, prescriptions, and more. It also pays for people to live in a nursing home, if that is what they need.

To help pay for these services, every state must have a Medicaid Estate Recovery Program. If you received Medicaid benefits, the state of Iowa has the right to ask for money back from your estate after your death. The state will never ask for more money back than it paid for your Medicaid services. Estate recovery laws were passed by the U. S. Congress and all 50 states. In Iowa, the estate recovery program is run by the Iowa Department of Human Services (DHS).

Who does estate recovery impact?

Estate recovery only applies to Medicaid recipients who:

- Are age 55 or older, or
- Are under age 55 and live in a medical facility and will probably not return home.

What part of an "estate" can be recovered?

An "estate" includes all:

- Real property, such as your house, land, etc.
- Personal property, such as household goods, personal effects, cars, etc. or
- Any other asset that you own at the time of your death.

This includes items you own with someone else such as property, trusts, most annuities, and retained life estates.

Can repayment be delayed?

Medicaid repayment can be delayed if the repayment will create a hardship for your family. DHS decides, on a case-by-case basis, who gets a hardship. Your family will receive a letter about estate recovery and repayment. Your family will have 30 days from when the letter is received to apply for hardship. Hardship exists for a person applying for the waiver when:

- The total household income is less than 200% of the federal poverty level for the size of the household, and
- The total household resources are not more than $10,000, and
- Recovering the resources of the "estate" denies your family of food, clothing, shelter or medical care that might put a person's life or health in danger.

Medicaid repayment may be delayed if you have a spouse or a dependent child who is under age 21, blind, or disabled at your death.

For more information, please call IME Member Services:
800-338-8366 Toll Free
515-256-4606 (Des Moines area)
8:00 a.m. – 5:00 p.m., Monday – Friday

Iowa Department of Human Services

Important Information for You and Your Family Members About the Estate Recovery Program

(Información importante para usted y su familia sobre el programa de cobro a través del patrimonio sucesorio)

¿Qué es el programa *Estate Recovery Program*?

Medicaid es un programa gubernamental que paga el tratamiento médico de personas con ingresos limitados. Medicaid cubre muchos servicios, por ejemplo: atención médica primaria, hospitalización, medicamentos y otros más. También paga para que las personas vivan en una institución geriátrica, si es lo que necesitan.

Todos los estados deben tener un programa de cobro a través del patrimonio sucesorio (*Estate Recovery Program)* con el fin de conseguir ayuda para pagar los servicios de Medicaid. Si usted recibió beneficios de Medicaid, el estado de Iowa tiene derecho a solicitarle que reintegre el dinero con sus bienes después de su fallecimiento. El estado nunca solicitará que devuelva más dinero del que pagó por sus servicios de Medicaid. Las leyes sobre cobro a través del patrimonio sucesorio fueron aprobadas por el Congreso y los 50 estados de los Estados Unidos. En Iowa, dicho programa es administrado por Iowa Department of Human Services (DHS).

¿A quienes afecta este programa?

El cobro a través del patrimonio sucesorio es aplicable sólo a los beneficiarios de Medicaid que:

- Tienen 55 años o más, o
- Tienen menos de 55 años, viven en una institución médica y probablemente no regresarán a su hogar.

¿Qué parte del "patrimonio sucesorio" se puede reclamar?

El patrimonio sucesorio incluye:

- Inmuebles, como su casa, terreno, etc.
- Bienes personales, como artículos del hogar, efectos personales, automóviles, etc.
- Otros activos que posea en el momento de su fallecimiento.

También se incluyen los artículos que posea con otras personas, como propiedades, fideicomisos, la mayoría de las rentas vitalicias y los usufructos retenidos sobre bienes inmuebles.

¿Se puede retrasar la devolución del dinero?

El reembolso de Medicaid se puede retrasar si su familia sufriría problemas económicos al tener que devolver el dinero. DHS decide quién está exento por dificultades económicas, según cada caso en particular. Su familia recibirá una carta informándoles sobre el cobro a través del patrimonio sucesorio y el reintegro. Tendrán 30 días, a partir de la fecha en que reciban la carta, para solicitar una exención debido a dificultades económicas. Se otorgan exenciones por dificultades económicas cuando:

- El ingreso total del grupo familiar es inferior al 200% del índice de pobreza a nivel federal según el tamaño del grupo familiar, y
- Los recursos totales del grupo familiar no exceden de $10,000, y
- El cobro del dinero a través del patrimonio sucesorio priva a su familia de alimentos, vestimenta, vivienda o atención médica que podría poner en peligro la vida o la salud de una persona

El reintegro de Medicaid puede retrasarse si usted tiene un cónyuge o un hijo dependiente que es menor de 21 años, ciego o discapacitado en el momento de su fallecimiento.

Para mayor información, llame a Servicios para Miembros de IME:
800-338-8366 Llamada gratuita
515-256-4606 (área de Des Moines)
8:00 a.m. – 5:00 p.m., de lunes a viernes

Income limits effective April 1, 2014

Use these charts to see how your children can get free or low-cost health care coverage.

Family Size (parents, spouses, stepparents, & children under 19 living together)	**Medicaid** If your family's yearly income (before taxes) is in this chart, your children may be able to get **FREE** coverage under Medicaid.
1	Up to $15,521
2	Up to $20,921
3	Up to $26,321
4	Up to $31,720
5	Up to $37,120
6	Up to $42,520
7	Up to $47,920
8	Up to $53.320

Family Size (parents, spouses, stepparents, & children under 19 living together)	***hawk-i*** If your family's yearly income (before taxes) is in this chart, your children may be able to get **FREE** coverage under ***hawk-i*** .
1	$19,489 to $21,006
2	$26,269 to $28,314
3	$33,049 to $35,622
4	$39,830 to $42,930
5	$46,610 to $50,238
6	$53,390 to $57,546
7	$60,170 to $64,854
8	$66,950 to $72,162

Family Size (parents, spouses, stepparents, & children under 19 living together)	***hawk-i*** If your family's yearly income (before taxes) is in this chart, your children may be able to get ***hawk-i*** for $10 - $20 per child per month. No family pays more than $40 per month.
1	$21,007 to $ 35,243
2	$28,315 to $ 47,505
3	$35,623 to $ 59,766
4	$42,931 to $ 72,027
5	$50,239 to $ 84,288
6	$57,547 to $ 96,549
7	$64,855 to $108,811
8	$72,163 to $121,072

Race, color, national origin, sex, sexual orientation, gender identity, religion, age, disability, political belief, or veteran status will not affect eligibility except where it is required by law.

Comm. 156A (Rev. 2/14)

Límites de ingreso efectivo, 1 avril, 2014

Utilice estas gráficas para ver cómo sus hijos pueden obtener cobertura de cuidado médico gratis o a bajo costo.

Tamaño de la Familia (padres, cónyuges, padrastros, y niños menores de 19 viviendo juntos)	**Medicaid** Si el ingreso anual de su familia (antes de impuestos) está en esta gráfica, a sus hijos les puede ser posible obtener cobertura **GRATIS** bajo Medicaid.
1	hasta $15,521
2	hasta $20,921
3	hasta $26,321
4	hasta $31,720
5	hasta $37,120
6	hasta $42,520
7	hasta $47,920
8	hasta $53,320

Tamaño de la Familia (padres, cónyuges, padrastros, y niños menores de 19 viviendo juntos)	***hawk-i*** Si el ingreso anual de su familia (antes de impuestos) está en esta gráfica, a sus hijos les puede ser posible obtener cobertura **GRATIS** bajo ***hawk-i*** .
1	$19,489 a $21,006
2	$26,269 a $28,314
3	$33,049 a $35,622
4	$39,830 a $42,930
5	$46,610 a $50,238
6	$53,390 a $57,546
7	$60,170 a $64,854
8	$66,950 a $72,162

Tamaño de la Familia (padres, cónyuges, padrastros, y niños menores de 19 viviendo juntos)	***hawk-i*** Si el ingreso anual de su familia (antes de impuestos)está en esta gráfica, a sus hijos les puede ser posible obtener *hawk-i* por $10 - $20 ño por mes. Ninguna familia pagará mas de $40 or mes.
1	$21,007 a $ 35,243
2	$28,315 a $ 47,505
3	$35,623 a $ 59,766
4	$42,931 a $ 72,027
5	$50,239 a $ 84,288
6	$57,547 a $ 96,549
7	$64,855 a $108,811
8	$72,163 a $121,072

Raza, color, nacionalidad, sexo, orientación sexual, identidad de género, religión, incapacidad, creencias políticas o estátus de veterano no afectarán la elegibilidad con excepto cuando es requerido por ley.

Comm. 156A (Rev. 2/14)

hawk-i
Healthy and Well Kids in Iowa

Dental Only Coverage

Use these charts to see how your children can get free or low-cost dental care coverage.

Income limits effective April 1, 2014

Family Size (parents, spouses, stepparents, & children under 19 living together)	If your family's yearly countable income is in this chart, your children may be able to get **FREE** dental coverage.
1	Up to $17,738
2	Up to $23,910
3	Up to $30,081
4	Up to $36,252
5	Up to $42,423
6	Up to $48,594
7	Up to $54,766
8	Up to $60,397

Family Size (parents, spouses, stepparents, & children under 19 living together)	If your family's yearly countable income is in this chart, your children may be able to get dental coverage for **$5** per child per month. No family pays more than **$10** per month.
1	$17,739 to $23,690
2	$23,911 to $31,932
3	$30,082 to $40,174
4	$36,253 to $48,416
5	$42,424 to $56,657
6	$48,595 to $64,899
7	$54,767 to $73,141
8	$60,938 to $81,383

Family Size (parents, spouses, stepparents, & children under 19 living together)	If your family's yearly countable income is in this chart, your children may be able to get dental coverage for **$10** per child per month. No family pays more than **$15** per month.
1	$23,691 to $29,642
2	$31,933 to $39,954
3	$40,175 to $50,267
4	$48,417 to $60,579
5	$56,658 to $70,891
6	$64,900 to $81,204
7	$73,142 to $91,516
8	$81,384 to $101,829

Family Size (parents, spouses, stepparents, & children under 19 living together)	If your family's yearly countable income is in this chart, your children may be able to get dental coverage for **$15** per child per month. No family pays more than **$20** per month.
1	$29,643 to $35,243
2	$39,955 to $47,505
3	$50,268 to $59,766
4	$60,580 to $72,027
5	$70,892 to $84,288
6	$81,205 to $96,549
7	$91,517 to $108,811
8	$101,830 to $121,072

Race, color, national origin, age, disability, or sex will not affect eligibility except where it is required by law.

hawk-i
Healthy and Well Kids in Iowa

Cobertura Dental Solamente

Use estos cuadros para ver cómo obtener cobertura dental gratuita o económica para sus hijos.

Límites de ingresos al 1 de avril de 2014

Tamaño de la Familia (padres, cónyuges, padrastros, e hijos menores de 19 años que viven juntos)	Si los ingresos anuales contabilizables de su familia figuran en este cuadro, sus hijos podrían calificar para cobertura dental **GRATUITA**.
1	Hasta $17,738
2	Hasta $23,910
3	Hasta $30,081
4	Hasta $36,252
5	Hasta $42,423
6	Hasta $48,594
7	Hasta $54,766
8	Hasta $60,397

Tamaño de la Familia (padres, cónyuges, padrastros, e hijos menores de 19 años que viven juntos)	Si los ingresos anuales contabilizables de su familia figuran en este cuadro, sus hijos podrían calificar para cobertura dental por **$5** por niño por mes. Ninguna familia paga más de **$10** por mes.
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Tamaño de la Familia (padres, cónyuges, padrastros, e hijos menores de 19 años que viven juntos)	Si los ingresos anuales contabilizables de su familia figuran en este cuadro, sus hijos podrían calificar para cobertura dental por **$15** por niño por mes. Ninguna familia paga más de **$20** por mes.
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5	$70,892 a $84,288
6	$81,205 a $96,549
7	$91,517 a $108,811
8	$101,830 a $121,072

Su raza, color, país de origen, edad, incapacidad o sexo, no afectarán su elegibilidad, excepto cuando lo ordene la ley.

How much will I have to pay?

Look at the chart below to find the monthly premium that you may have to pay. Add your gross earned income and your gross unearned income together. Then find the total of your income on the chart and look for the premium on the same line.

PREMIUM SCHEDULE

If the monthly gross income of the disabled person is:	The monthly premium is:
$ 1,459 or Less	**$ 0**
More than: $ 1,459	$ 31
1,605	42
1,751	50
1,945	58
2,189	68
2,432	78
2,918	99
3,404	119
3,890	140
4,377	160
5,349	201
6,322	242
7,294	284
8,267	335
9,725	404
11,184	475
12,643	556
$ 14,393 and above	647

This chart is a guide only. Federal poverty levels may be updated each year. Changes in the poverty levels will change the income range for premiums.

When are premium payments due?

A billing statement will be sent to you that lists the months for which you have been approved and for which a premium is due. Generally, premiums should be paid by the last day of the month for the next month's coverage.

IMPORTANT: When you are first approved, the bill may be for more than one month and the premium amount or due dates may vary. **Please read the billing statement carefully.**

What happens when I do not pay the premiums?

If you do not pay the premium by the due date, your MEPD will be canceled. You may have to file a new application to get MEPD again.

If you make a late payment:

- MEPD can be reinstated if your ongoing month's payment is received by the last working day of the month it is due.
- MEPD coverage can be reopened if the payment is late but is received in the month after the month it is due.

Questions?

Call the DHS office in your county.

PRINTED ON RECYCLED PAPER

Iowa Department of Human Services

Comm. 180 (Rev. 9/14)

MEDICAID FOR EMPLOYED PEOPLE WITH DISABILITIES (MEPD)

MOVING ON UP WITH MEPD

Medicaid for Employed People with Disabilities

Medicaid for Employed People with Disabilities (MEPD) is a program for people with disabilities who work.

Are you eligible?

To qualify you must:

- Be under age 65.
- Be disabled. You are disabled if:
  - You are determined to be disabled by the Social Security Administration.
  - The Department of Human Services (DHS) has made a determination that you are disabled.
- Have income from work or be self-employed.
- Have monthly **net family income** less than 250% of the federal poverty level for your family size. Net income is your gross family income after deductions and disregards. The DHS office will tell you about the disregards and deductions you can get and if your family's net income is below 250% of the poverty level.
- Have countable assets that are less than:
  - $12,000 for one person
  - $13,000 for a couple

Some assets held by the MEPD applicant or member do not count for the MEPD program. They are:

- **Retirement accounts.** Examples are:
  - Simplified employee pension plans
  - Self-employment pension plans
  - Keogh plans
  - Individual retirement accounts
  - Roth individual retirement accounts
  - Savings incentive matched plans for employees and similar plans for retirement
- **Funds in assistive technology accounts.** This is money saved to get assistive technology to help you do your work. A physician, certified vocational rehabilitation counselor, licensed physical therapist, licensed speech therapist, or licensed occupational therapist must state that the assistive technology is needed to help you in your employment.
- **Funds in an exempt medical savings account.** This money is exempt from federal income taxation as stated in Section 220 of the United States Internal Revenue Code (26 U.S.C. § 220).

- Pay a monthly premium when **your** monthly **gross income** is above 150% of the federal poverty level. **Premiums are based only on the gross income of the disabled person (see MEPD Premium Chart).**
- Meet all other eligibility rules for the program.

How do I find out if I can get MEPD?

To find out if you can get MEPD:

- Complete an application from your local DHS office, or
- Use your computer to apply at this web site: https://dhsservices.iowa.gov/apspssp/ssp.portal

What happens when I have to pay a premium?

You will get a Notice of Decision telling you the amount of your monthly premium for the 12-month enrollment period.

- Your monthly premium will not go up during your 12-month enrollment period.
- The monthly premium may go down if you report that your income goes down.

How much income can we have?

Gross income means income before any deductions. *Net* income means gross income after deductions. For October 1, 2014, through September 30, 2015, the monthly income guidelines are:

People in Household	Gross Monthly Income	Net Monthly Income
1	$1,265	$ 973
2	1,705	1,311
3	2,144	1,650
4	2,584	1,988
5	3,024	2,326
6	3,464	2,665
7	3,904	3,003
8	4,344	3,341
More people	$ 440	$ 339

To be eligible, a household's monthly income must be within the above amounts for its size.
Exceptions:

- Households with an elderly (age 60 or over) or disabled person do not have to meet gross income guidelines.
- If everyone gets SSI or FIP, the household does not have to meet the gross or net monthly income guidelines.
- Some households that do not meet the above income guidelines might be eligible if monthly income is not more than the amount below (160% of the federal poverty level).

People in Household	Monthly Income 160% of Federal Poverty Level
1	$1,557
2	2,098
3	2,640
4	3,181
5	3,722
6	4,264
7	4,805
8	5,346
More people	$ 543

What are the allowable deductions?

To determine how much you can get, we use the following deductions:

- ▲ 20 percent of earned income;
- ▲ A standard deduction of $155 or more;
- ▲ Medical expenses over $35 a month for elderly (age 60 or over) or disabled persons;
- ▲ Certain dependent-care costs when needed for training, education, or work;
- ▲ Legally owed child support; and
- ▲ A percentage of shelter costs.

Choose foods to promote a healthy future at every stage of life.

- ▲ Food Assistance helps you to be able to buy and eat a variety of foods.
- ▲ Let the Plate guide your food choices.

- ▲ Aim for a healthy weight.
- ▲ Be physically active each day – at least 30 minutes for adults and 60 minutes for children.
- ▲ Choose a variety of grains (especially whole grains), fruits, and vegetables daily.

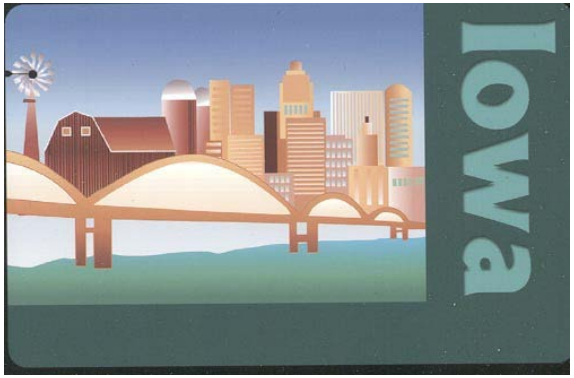
Food Assistance is a program under the United States Department of Agriculture's Food and Nutrition Service.

USDA is an equal opportunity provider and employer.

Iowa Department of Human Services

Comm. 229 (Rev. 9/14)

Food Assistance Makes Iowa Stronger



What is Food Assistance?

The program helps people with little or no income to buy food for a healthy diet.

There is enough Food Assistance for everyone who is eligible.

Food Assistance helps your local economy. The Food Assistance spent in local grocery stores helps to provide jobs for people.

How do I get Food Assistance?

You must fill out a Food Assistance application and turn it in to your Department of Human Services office. You can call toll free 1-877-DHS-5678 to find out where your Department of Human Services office is located. You may also apply online at https://secureapp.dhs.state.ia.us/oasis/.

You will be given an appointment for an interview. You will be asked to give us some things like ID, pay stubs for people in your household who work, and child-support orders.

Will I have to get a social security number?

You can choose to give us the Social Security Number of each person in your household. We can give Food Assistance only to the people who give us their Social Security Number.

You don't have to give us the Social Security Number for the people you do not want Food Assistance for.

Can legal noncitizens get Food Assistance?

Many can get Food Assistance. Even if you can't, your family members born in this country can.

Getting Food Assistance won't stop you if you want to become a citizen.

Can I get help if I'm not working?

If you can work, you must not quit a job unless you have a good reason. In some areas of the state, we have a program that can help you search for a job or get training.

If you can't work because of a mental or physical reason, tell your Food Assistance worker.

How many assets can we have?

Most households do not have to meet an asset test. If you do have to meet an asset test, your home and the value of at least one vehicle will not count.

If my household is eligible, how much will we get?

For November 1, 2014, through October 31, 2015, the table below shows the most you could get if you have no income. As your income goes up, the amount of Food Assistance you will get goes down.

People in Household	Maximum Monthly Allotment
1	$ 194
2	357
3	511
4	649
5	771
6	925
7	1,022
8	1,169
More people	$146 for each

Is Food Assistance cash?

Food Assistance comes through Electronic Benefit Transfer (EBT). You use a plastic EBT swipe card to buy food. Once your eligible food items have been totaled at the cash register, you will pass your EBT card through a point-of-sale (POS) terminal in the check out line. The cost of the food you purchase is subtracted from the amount in your Food Assistance EBT account.

What if I have more questions?

Please call your local Department of Human Services office. If you don't know where the office is, call the toll-free number, 1-877-DHS-5678 to find out.

You can also visit **"Food Assistance"** on Iowa's web site at http://dhs.iowa.gov/

¿Qué ingresos podemos tener?

Ingreso *Bruto* significa el ingreso antes de efectuar retenciones. Ingreso *Neto* significa el ingreso bruto después de efectuar retenciones. Desde el 1 de octubre de 2014, hasta el 30 de septiembre de 2015, el ingreso mensual establecido es:

Personas en el grupo familiar	Ingreso Mensual Bruto	Ingreso Mensual Neto
1	$1.265	$ 973
2	1.705	1.311
3	2.144	1.650
4	2.584	1.988
5	3.024	2.326
6	3.464	2.665
7	3.904	3.003
8	4.344	3.341
Más personas	$ 440	$ 339

Para calificar, el ingreso mensual del grupo familiar no debe superar el importe indicado de acuerdo al tamaño del mismo. **Excepciones:**

- Los grupos familiares con una persona anciana (60 años o más) o discapacitada no tienen obligación de cumplir las normas sobre ingresos.
- Si todos reciben SSI o FIP, el grupo familiar no tiene obligación de cumplir las normas sobre ingresos brutos o netos.
- Algunos grupos familiares que no reúnan los requisitos indicados arriba podrían calificar si el ingreso mensual no supera los siguientes importes (160% del índice de pobreza a nivel federal).

Personas en el grupo familiar	Ingreso Mensual 160% del índice de pobreza a nivel federal
1	$1.557
2	2.098
3	2.640
4	3.181
5	3.722
6	4.264
7	4.805
8	5.346
Más personas	$ 543

¿Cuáles son las retenciones deducibles?

Para determinar los beneficios que puede recibir, se utilizan las siguientes retenciones:

- ▲ 20% de ingresos laborales;
- ▲ Una retención estándar de $155 o más;
- ▲ Gastos médicos superiores a $35 por mes correspondientes a personas ancianas (60 años o más) o discapacitadas;
- ▲ Determinados costos por cuidado de dependientes cuando sean necesarios por razones de capacitación, educación o trabajo;
- ▲ Manutención de menores por orden judicial; y
- ▲ Un porcentaje de los costos de la vivienda.

Elija alimentos que promuevan un futuro saludable en cada etapa de la vida.

- ▲ Food Assistance le ayuda a comprar y comer una amplia variedad de alimentos.
- ▲ Secciones los alimento usando el plato como guia.

- ▲ Manténgase en un peso saludable.
- ▲ Haga ejercicio físico todos los días – al menos 30 minutos los adultos y 60 minutos los niños.
- ▲ Consuma cereales variados (especialmente cereales integrales), frutas y vegetales diariamente.

Food Assistance es un programa del Servicio de Alimentos y Nutrición del Departamento de Agricultura de EE.UU.

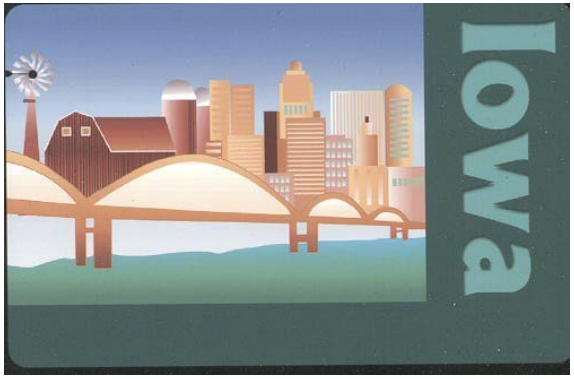
USDA es un empleador y proveedor de igualdad de oportunidades.

Iowa Department of Human Services

Comm. 229(S) (Rev. 9/14)

Food Assistance Makes Iowa Stronger

(Food Assistance Hace que Iowa Sea Más Fuerte)



¿Qué es Food Assistance?

El programa ayuda a las personas con ingresos bajos o sin ingresos a comprar alimentos sanos.

Tenemos suficiente Food Assistance para todas aquellas personas que sean elegibles.

Food Assistance ayuda a la economía local. Al comprar alimentos con Food Assistance en las tiendas locales, ayuda a crear empleos.

¿Cómo consigo Food Assistance?

Debe llenar un formulario de solicitud de Food Assistance y entregarlo en la oficina local de Department of Human Services. Puede llamar de forma gratuita al 1-877-DHS-5678 para averiguar dónde está ubicada la oficina local de Department of Human Services. Además, puede solicitar Food Assistance por Internet: https://secureapp.dhs.state.ia.us/oasis/.

Se programará una entrevista. Se le preguntará que nos dé algunas cosas como identificación, los recibos de sueldo de los integrantes de su grupo familiar que estén trabajando y las órdenes de manutención de menores.

¿Tendré que conseguir mi número de Social Security?

Tendrá que darnos el número de Social Security de cada una de las personas que soliciten Food Assistance. Podemos darles Food Assistance únicamente a aquellas personas que nos den su número de Social Security.

No tiene obligación de darnos los números de Social Security de las personas que no soliciten Food Assistance.

¿Pueden recibir Food Assistance las personas que no son ciudadanos legales?

Muchas personas pueden recibir Food Assistance. Aunque usted no pueda, los integrantes de su familia que hayan nacido en este país pueden recibirla.

Recibir Food Assistance no le impedirá convertirse en ciudadano.

¿Puedo recibir ayuda si no tengo trabajo?

Si puede trabajar, no debe renunciar a su empleo a menos que tenga una buena razón para hacerlo. En algunas zonas del estado, tenemos un programa que le puede ayudar a buscar empleo o recibir capacitación.

Si no puede trabajar por un problema mental o físico, dígaselo a su asistente de Food Assistance.

¿Qué bienes podemos tener?

La mayoría de los grupos familiares no tienen obligación de cumplir con los requisitos del análisis de bienes. Si usted no está obligado cumplir dichos requisitos, no se tendrá en cuenta el valor de su vivienda y de un vehículo por lo menos.

Si mi grupo familiar es elegible, ¿cuánto recibiremos?

Desde el 1 de noviembre de 2014, hasta el 31 de octubre de 2015, los beneficios que puede recibir si no tiene ingresos son los que se indican en la siguiente tabla. A medida que sus ingresos aumenten, el monto de Food Assistance se reducirá.

Personas en el grupo familiar	Máxima asignación mensual
1	$ 194
2	357
3	511
4	649
5	771
6	925
7	1.022
8	1.169
Más personas	$146 cada una

¿Food Assistance es en efectivo?

Food Assistance se recibe a través de transferencia electrónica (*Electronic Benefit Transfer*, EBT). Puede usar la tarjeta plástica EBT para comprar alimentos. Una vez que la cajera sume el importe total de los alimentos que compró, podrá pasar su tarjeta EBT por el lector de tarjetas que se encuentra en la caja. El costo de los alimentos que compró se debitará automáticamente de su cuenta EBT de Food Assistance.

¿Y si deseo hacer otras preguntas?

Por favor, llame a la oficina local de Department of Human Services. Si no sabe dónde está la oficina, llame de forma gratuita al 1-877-DHS-5678 para averiguar.

Además, puede consultar **"Food Assistance"** en la página electrónica de Iowa: http://dhs.iowa.gov/

What about annuities?

Annuities are used for repayment of Medicaid debt if the person who received Medicaid funding had an interest in the annuity at the time of their death. An annuity is an investment and is not treated like life insurance. Annuity payments that have not been paid are part of the Medicaid recipient's estate and so are subject to estate recovery repayment.

Can the debt be waived?

Yes.

Spouse or Disabled Child Waiver: If the person who dies leaves behind a husband or wife, or a disabled child, the debt is waived (permission is given to repay the debt later) until the husband, wife or disabled child who receives the waiver dies.

Minor Child Waiver: If the person who dies has a child who is under 21, the debt is waived and does not need to be repaid until that child turns 21.

Hardship Waiver: If repayment of the Medicaid debt would cause the heir or beneficiary to:

1. Not have enough money to pay for food, shelter, clothing, or medical care so that their life or health would be in danger, and
2. Have less than $10,000 in assets, and
3. Earn less than 200% of the federal poverty level, they can request a Hardship Waiver.

If the debt is waived because the person has an undue hardship, repayment will be delayed until that heir or beneficiary no longer meets the above requirements or until their death.

Definitions

Affidavit – is a written statement voluntarily made by a person where they swear under oath that what is in the written statement is the truth.

Annuity – payments that are paid out of an account a person has established, usually monthly over a certain period of time. It is **not** life insurance.

Assets – the money or property that belongs to a person.

Assistance – the money given to help a person in need.

Beneficiary – the person named in a written document who will receive money or property when another person dies.

Care facility – a place where patients live and receive medical care, also called a nursing home.

Debt – money that is owed.

Estate – the money, property, and objects of value that a person leaves, or in which the person had an interest, when they die.

Fair market value – the price of a property based on what other homes in the neighborhood are selling for.

Guaranteed – promised, pledge.

Heir – a family member who receives money or assets after a person dies when there is no will. Heirs are not named, but receive money because of their relationship to a deceased person**.**

Iowa Code – the books Iowa's laws are kept in.

Irrevocable – permanent, fixed, not able to be changed.

Joint bank account – a bank account two or more people own and can draw or deposit money in.

Lien – a legal document that is filed against the assets of a person who owes money to another.

Medicaid – Title 19 Medical Assistance used to help persons who do not have the funds to cover the cost of their long term health care and related expenses.

Medicare Savings Program – includes SLMB and QMB and, if provided after January 10, 2010, is not included in Estate Recovery.

Priority – most important, must be paid before other debts.

Probate – the legal process where a court settles the affairs of a person who has died by selling their assets, paying their debts, and then giving their money and property to who survive the person who died.

Survivor – people left behind when family member dies.

Title 19 – Also known as Title XIX and Medicaid, is a federal law that helps people pay for their medical care. It is funded by both federal and state tax dollars.

Trusts – a legal paper that tells someone else what do with money or property you own both before and after your death.

Waiver – permission to repay a debt at a later date.

Iowa Department of Human Services

Comm. 266 (Rev. 2/14)

Iowa's Estate Recovery Law

Estate Recovery Program
P.O. Box 36445
Des Moines, Iowa 50315

Phone: (515) 246-9841
Toll Free: (877) 463-7887
Fax: (515) 246-0155

E-Mail: estates@dhs.state.ia.us
www.ime.state.ia.us/estate.html

What is the estate recovery law?

Federal law requires Iowa to have an estate recovery program when Medicaid funds are used to pay for medical assistance for people who are:

- 55 years old or older at the time they get Medicaid.
- Under age 55, live in a long-term care facility and are not expected to return home.

When a person who gets medical assistance dies, their assets must be used to repay the Iowa Department of Human Services (DHS) for the money that was spent on medical care.

Medicaid is also called medical assistance or Title 19 and includes programs like the Elderly Waiver and Medically Needy. People can receive Medicaid while living in their own home or in a care facility. In Iowa the estate recovery law is found in Iowa Code section 249A.53(2).

What is an "estate" for estate recovery?

An estate includes all:

- Real property, such as your house, land, etc.,
- Personal property, such as household goods, bank accounts, annuities, personal effects, cars, etc., or
- Any other asset that you own or have an interest in at the time of your death.

This includes items that you own with someone else, such as joint property, trusts, and retained life estates.

What is a claim?

When the estate of a person who received Medicaid starts the probate process, the Estate Recovery Program must be contacted and a claim will be filed. Liens are not placed on property, but the fair market value of the property is an asset that can be used for repayment of the Medicaid debt. *The medical assistance debt is not subject to the four month limitation on filing claims. See Iowa Code section 633.410, for time limits that apply and Iowa Code 633.231 and 633.304A for the appropriate notices that must be sent electronically at* www.ime.state.ia.us/estate.html.

What expenses can be paid with the assets of the recipient?

Repayment of Medicaid can be made from the assets that are left after funeral and burial expenses, legal fees, medical expenses of last illness, and other costs used to settle the affairs of the person who has died. Donations to charities, travel expenses for relatives to the funeral, and caregiving by family members before death, cannot be paid before the Medicaid debt. *The order in which payment is to be made is listed in Iowa Code section 633.425. The medical assistance debt is a priority claim.*

How will I know how much money is owed to DHS?

At any time after death, the person managing the affairs of the deceased can get an updated listing of medical assistance payment by requesting a payment history. The Estate Recovery Program will send the amount of Medicaid paid expenses to the person managing the affairs of the deceased. The deceased person's name, birthdate, social security number, and date of death must be provided.

How is payment made if an estate is not probated?

Often, persons who receive Medicaid do not leave a large amount of money or property behind when they die. When this happens, the estate recovery repayment process is done without going through probate. For example, if the person who was on Medicaid left $1,000 in a joint bank account, the survivor can use the money to repay what is owed to Medicaid. If no one else's name is on the bank account, a Small Estate Affidavit (*Iowa Code 633.356*) can be signed by the heir or beneficiary that will direct the bank to use the money to repay what was given in medical assistance. Payment can be made by check or money order to Iowa Department of Human Services and mailed to:

Estate Recovery Program
P.O. Box 36445
Des Moines, IA 50315

What about life insurance policies?

Proceeds from life insurance policies are generally considered the assets of the person named as beneficiary. However, the Medicaid debt must still be repaid from the life insurance funds when:

- The estate of the person who was on Medicaid is the beneficiary of those life insurance funds or if the beneficiary dies before the person who was on Medicaid dies.
- A funeral home or DHS is named as the beneficiary of those life insurance funds or the policy is assigned to the funeral home.
- When the policy was not reported before the death and had a cash value that would have caused the person not to meet the rules that say who can and cannot receive Medicaid.

What about Medicaid trusts?

A Medicaid Trust names DHS as the beneficiary after the death of the person for whom the trust is established. These types of trusts include special needs trusts and income trusts. Income trusts are also known as Income Assignment Trusts, Qualified Income Trusts, and Miller Trusts. Money in Medicaid trusts is not part of the estate of the person who has received Medicaid, and cannot be used to pay estate expenses. The money left from these trusts must be used to repay the DHS Medicaid debt according to the terms of the trust and sent to the Iowa Estate Recovery Program.

What about burial trusts?

Funeral directors or bankers are required by law to contact the Estate Recovery Program when there are funds remaining in a Medicaid recipient's non-guaranteed irrevocable burial trust fund after the funeral expenses have been paid. The Estate Recovery Program then has sixty days in which to confirm if those funds are to be paid to DHS.

If the funds are in a guaranteed trust and the guaranteed services are provided, the funeral home may dispose of the funds as the funeral home deems appropriate.

If an insurance policy is assigned or made payable to the funeral home, any money that is left after funeral costs are paid on the Medicaid debt. *See Iowa Code Chapter 523A.*

CENTERVILLE (Appanoose) (NEW)
201 N. 12th Street – Courthouse lawn
June 4 – September 24, Wednesday 3:30 – 6:00 pm
(Vegetables, popcorn, honey, jam *& more*) V & K Marketing

CHARLES CITY (Floyd County)
Central Park, 300 N. Main Street
May 11 – October 19, Wed. 3:30 – 6:00 pm, Sat. 9:00 am – Noon
(Fresh fruits, vegetables, baked goods, honey & more) East View Orchard, Dana Martin

CLEAR LAKE (Cerro Gordo County)
City Hall parking lot
May 2 – October 31, Saturday 9:00 am – 11:00 am
(Baked goods, jams, fruits, vegetables & more) North Iowa Berries and More

CLINTON (Clinton County)
Lyons Farmers Market
Corner of Main Ave. & Roosevelt St.
May 28 – October 29, Wed. 4:00 – 6:00 pm, Sat. 8:00 – 11:00 am
(Meats, fruits, vegetables & more) Mrs. Grossman's Meats (Saturdays), Heilmann's Hawkeye Acres (Wed only)

CORALVILLE (Johnson County)
Morrison Park, 1517 7th St.
May 5 – October 2, Monday & Thursday 5:00 – 7:00 pm
(Fruits, vegetables, baked goods & more) Fertile Dirt Farms, Snax, Circle W Acres

COUNCIL BLUFFS (Pottawattamie County)
Main Street Farmers Market
Historic 100 block of West Broadway
May 1 – September 25
Thursday 5:00 – 8:00 pm
(Honey, vegetables, apples & more) 3 Bee Honey Farms

CRESTON (Union County)
McKinley Park, shelter house near playground
June 2 – October 13, Monday 4:00 – 6:30 pm
(*Honey, vegetables, fruits, baked goods & more*) Lappe's Farm Produces & Bakery, Lauri Long's Home Bakery

DAVENPORT (Scott County)

DAVENPORT FREIGHT HOUSE FARMERS MARKET
421 West River Dr.
YEAR AROUND MARKET
Tuesday 3:00 – 6:00 pm, Saturday 8:00 am – 1:00 pm
(*Meat, eggs, fruits, vegetables, jams, jellies, baked goods, honey, goat cheese & more*) Heilmann's Hawkeye Acres, Pride of the Wapsi, Sawyer Beef, Green Lane Farm, Hollow Maple Farm, Barb's Garden & Pantry, Barnyard Produce, Grossman Meats, Palm Tree Pat; Triple Creek Dairy, Allen's Grove Greenhouse (May 3 – Oct. 29), Tuftee's Garden (May 3 – Aug. 3), Farmer Ken's Produce

NORTHPARK MALL – RIVER CITY
Northpark Mall, east entrance - Hwy 61 & Welcome Way
May 3 – October 29, Wednesday & Saturday 8:00 am – Noon
(Fruits, vegetables, peanuts & more) Weber Farm, Bartenhagen Produce, Pride of the Wapsi, Nature's Pantry Foods, Inc.

DeWITT (Clinton County)
DeWitt Farmers Market – Lincoln Park
5th Ave & 10th Street
May 15 – October 16, Thursday 4:00 – 7:00 pm
(Vegetables, fruit & more) Pride of the Wapsi

DECORAH (Winneshiek County)
Winneshiek Farmers Market
Intersection of Clayborne Dr & Heirley St
May 3 – October 29, Wed. 3:00 – 6:00 pm, Sat. 8:00 – 11:00 am
(Vegetables, fruits, baked goods, herbs & more) Zimmerman's Greenhouse Produce, Patchwork Green Farm, Off the Land

DENISON (Crawford County)
7th Ave. & Hwy 30 - parking lot
July 10 – October 30, Thursday 3:00 – 6:00 pm
(Vegetables, fruits, baked goods & more) Wacer Gardens

DES MOINES (Polk County)

DOWNTOWN:
Saturday Market - Court Ave. & 4th St.
May 3 – September 27, Saturday 7:00 am – Noon
October 4 – October 25, Saturday 8:00 am – Noon
Winter Market
November 21 & December 12, Friday 11:00am – 2:00 pm
November 22 & December 13, 9:00 am – 1:00 pm
(Meat, eggs, fruits, vegetables, salsa, granola, baked goods & more) Rinehart's Family Farm, Juan O'Sullivan's Gourmet Salsa (occ. vendor), Berry Patch Farm, Blue Gate Farm, Iowa Orchard, Westrum Produce, Scavo's Market, Story Book Orchard, Cory's Country Lamb, Kat's Garden, Orale! Salsa, Shutt's Garden Center, Harvest Barn, LaVentosa Ranch, Harvey's Greenhouse, Mast Family Farm LLC, Hickory Hills Organics, Coyote Run Farm, Hensley's Farm, O'Brien's Own Gourmet Granola, Tarre De Amore Farms (Sept. 13 – Oct. 18), Penick's Sweet Corn (July – Sept.), Stillwater Greenhouse Connie's Creations (occ. vendor), Terraceberry Farm (occ.vendor)

BEAVERDALE
Beaverdale Park on Adams – 3422 Beaver Ave.
June 3 – September 16, Tuesday 4:30 – 7:30 pm
(Vegetables, fruit & more) Hensley's Farm, Iowa Orchard

FARM BUREAU (NEW)
5400 University Avenue – FB parking lot
June 11 – August 27, Wednesday 3:00 – 5:30
(Vegetables, baked goods, meat & more)
Doty Angus Cattle Co, Lauri Long's Home Bakery, Penick's Sweet Corn (occ. vendor), Shutt's Garden Center

GREENWOOD FARMERS MARKET (NEW)
Food Court inside Merle Hay Mall
May 28 – September 3, Wednesday 4:00 – 8:00 pm
(Fruits, vegetables, meat, eggs and more) Audubon County Family Farms, Hensley's Farm, Iowa Orchard

SOUTHRIDGE FARMERS MARKET
1111 E Army Post Road
May 12 – October 20, Monday 3:30 – 6:30 pm
(Fruits, vegetables, baked goods and more) Scavo's Market, Shutt's Garden Center, Iowa Orchard, Generations Good Home Cooking

VALLEY JUNCTION
100, 200, & 300 blocks on 5th St.
May 1 – October 2
Thursday 4:00 – 8:00 pm
(Fruits, vegetables, honey, jam, jellies & more) Iowa Orchard, Scavo's Market, Kat's Garden, Shutt's Garden Center, Fisher's Flowers & Produce, Story Book Orchard, Hensley's Farm, Connie's Creations

Iowa Department of Human Services

Comm. 284 (Rev. 4/14)

IOWA'S EBT FARMERS MARKET PROJECT

Bringing Farmers Markets and Food Assistance Together

Look for the signs with the pictures of the EBT/Iowa card. You can spend your Food Assistance benefits at the farmers listed in this brochure.

SNAP EBT can be used to buy fruit, vegetables, meat, eggs, baked goods, honey, cheese, herbs, jelly and jam, etc. You may not use EBT for hot prepared foods or hot drinks.

For more information, visit www.dhs.state.ia.us and click on 'Food Assistance' to view information about the Farmers Market Project or call the Customer Call Center at (877) 937-3663.

EBT Farmers Market Project

2014

For the past nine years, Iowa Food Assistance households have been able to spend their benefits at farmers markets around the state.

This program was designed to provide fresh and nutritious foods from farmers markets to your family and to expand the awareness, use, and sales at farmers markets. **Certain farmers have special equipment that can accept the EBT card as payment.** The farmers can accept the EBT cards at the farmers markets, roadside stands, or even on the farm.

Just look for the farmers with the signs that show they accept EBT. In this brochure, you will learn where the markets are located and the names of the farmers who can accept EBT.

List of Participating Farmers by Market:

ADEL FARMERS MARKET (Dallas County)

Harvey's Greenhouse & Garden Center
611 Nile Kinnick Center Drive S
June 10 – September 30, Tuesday 4:00 – 7:00 pm
(Vegetables, plants & more) Harvey's Greenhouse, Hensley's Farm

AMES FARMERS MARKET (Story County)

AMES MAIN STREET FARMERS MARKET
Tom Evans Plaza, Main between Bennett and Clark
May 3 – October 25, Saturday 8:00 – Noon
(Fruits, vegetables and more) Berry Patch Farm, Lacewing Acres, Hensley's Farm

NORTH GRAND MALL
North Grand Mall parking lot, 2801 Grand Ave.
May 3 – October 29
Wednesday 3:00 – 6:00 pm, Saturday 8:00 am –noon
(Baked goods, honey, fruits & vegetables, eggs & more) DeMoss Pumpkin Farm, Story Book Orchard (Wednesday), Fisher's Flowers & Produce, Red Granite Farms, Evans Produce (Wednesday)

Winter Market
December weekends
April 19 & 20 and April 26 & 27
Open during mall hours
(Baked Goods, vegetables, honey, popcorn and more) DeMoss Pumpkin Farm

ANAMOSA (Jones County)

Corner of Scott and Main
June 11 – October 18
Wednesday 3:00 – 6:00 pm, Saturday 8:00 – Noon
(Baked good, vegetables & more) Treasure Chest (Occ. Vendor)

ANITA (Cass County)

Bandshell Park on Main Street
June 2 – September 8, Monday 3:30 – 6:00 pm
(*Honey, honey products, vegetables, apples & more*) 3 Bee Honey Farms

ANKENY (Polk County)

Corner of SW 3rd St. and SW Maple St.
May 17 – September 6, Saturday 8:00 am – Noon
Honey, vegetables, fruits & more) 3 Bee Honey Farms, Shutt's Garden Center

ATLANTIC (Cass County) (NEW)

7th & Plum Street – Orscheln's parking lot
June 2 – September 8, Tuesday 5:00 – 7:00 pm
(*Honey, honey products, vegetables, apples & more*) 3 Bee Honey Farms

BETTENDORF (Scott County)

STATE STREET MARKET
2117 State St.
May 1 – October 30, Thursday 2:00 – 6:00 pm
(Fresh fruits, vegetables & more) Weber Farm, Pride of the Wapsi

TRINITY MARKET
4500 Utica Ridge Rd
May 5 – October 27, Monday 3:00 – 6:00 pm
(Fresh fruits, vegetables, goat cheese, eggs, & more) Weber Farm, Pride of the Wapsi, Triple Creek Dairy, Nature's Pantry Foods, Inc.

BLOOMFIELD (Davis County)

100 E. Jefferson, north side of Courthouse lawn
May 17 – October 18
Saturday 8:30 –11:30 am, Tues 3:00 – 6:00
(*Vegetables, fruits, baked goods & more*) Patsy Boas, Gothic Gardens

BOONE (Boone County)

Family Video parking lot, 6th & Story
June 5 – October 16, Thursday 3:00 – 6:00 pm
(Fruit, vegetables, eggs & more) Wilber's Northside Market, Rinehart's Family Farm, Tucker's Farm (occ. vendor)

BURLINGTON (Des Moines County)

RIVERFRONT MARKET
400 Front St. (Port of Burlington)
May 1 – September 11, Thursday 5:00 – 7:00 pm
(*Vegetables, fruit, baked goods, & more*) A Good-Natured Garden, Palm Tree Pat

FARM FRESH MARKET
Dollar General parking lot, 3302 Agency
May 3 – October 28, Tuesday & Saturday, 8:00 am – 1:00 pm
(*Fruits, vegetables, baked goods & more*) A Good-Natured Garden

CARLISLE (Warren County)

Wyckoff's parking lot, 95 HWY 5
June 7 – September 27, Saturday 8:300 am – 11:30
(Vegetables, pumpkins & more) MmMm GOOD-hue Produce

CEDAR FALLS (Black Hawk County)

COLLEGE HILL (NEW)
2205 College St.
June 5 – October 30, Thursday 4:00 – 6:00 pm
(Fruits, vegetables, popcorn, eggs & more) Adolph's Produce & Bakery, Hershey Family Nursery, Fitkin Popcorn, Kaiser Farm

OVERMAN PARK
3rd & Clay along Overman Park
May 3 – October 25, Saturday 8:30 am – Noon
(Fresh fruits, vegetables, popcorn, herbs & more) Hershey Family Nursery, Hoffman Produce, Fitkin Popcorn, Kaiser Farm

CEDAR RAPIDS (Linn County)

DOWNTOWN
Along SE 2nd St. & SE 2nd Ave.
June 7 & 21, July 5 & 19, August 2 & 16, September 6 & 20
Saturday 7:30 am – Noon
(Fruits, vegetables, meat, baked goods & more) Circle W Acres, Tatonka Farm, Musil Gardens, Hensley's Farm, Meadowview Farms, Stillwater Greenhouse, Doty Angus Cattle Company, Snax, O'Brien's Own Gourmet Granola, Vercande's Crafts, Nature's Pantry Foods, Inc.

NOELRIDGE
Corner of Collins Rd and Council St. NE
May 2 – October 17
Monday, Wednesday, Friday 4:00 – 6:00 pm
(Baked goods, fresh fruits, vegetables & more) Meadowview Farms, Circle W Acres, Musil Gardens

HAWKEYE DOWNS (NEW)
4400 6th ST SW
May 17 & 31, June 28, July 26, August 23, September 13 & 27, October 11 & 25
9:00 am to 5:00 pm
(Baked goods and more) Circle W Acres

DUBUQUE (Dubuque County)
MAIN STREET
Around City Hall & Iowa between 11th & 13th St.
May 3 – October 25, Saturday 7:00 am – Noon
(Baked goods, vegetables, popcorn & more) Klein Market, Stillmunkes Produce, Treasure Chest (occ. vendor)

DYERSVILLE (Dubuque County)
Commercial Club Park (Hwy 136)
May 15 – October 9, Thursday 2:30 – 6:00 pm
(Baked goods, vegetables & more) Treasure Chest

EAGLE GROVE (Wright County)
S. Hwy 17, 121 N. Iowa Avenue
June 6 – October 17, Friday 3:00 – 6:30 pm
(Vegetables & more) Airport Gardens

ELDORA (Hardin County)
Across from Post Office
May 15 – October 9, Thursday 4:00 – 6:00 pm
(Fruits, vegetables, eggs & more) Prairie's Edge

EMMETSBURG (Palo Alto County)
Gardener's Farmers Market
Courthouse Square – Northside
June 12 – Oct. 23
Thursday 12:00 – 5:00 pm
(Vegetables, honey & more) Thurs. only: Janssen Honey Farms (occ. vendor)

EVANSDALE (Blackhawk County)
3524 Lafayette
May 28 – October 15, Wednesday 2:30 – 5:30 pm
(Fruits, vegetables & more) A Family Market Place

FAIRFIELD (Jefferson County)
Howard Park
Corner of Grimes & Main
May 3 – October 29
Wednesday 3:00 – 6:00 pm, Saturday 8:00 – Noon
(Fruits, vegetables, honey ,baked goods & more)
Blooming Acres Farms, Yoder's Natural Farm, Newton's Own, Natures Way, Rolling Prairie Acres

Senior Center
209 South Court Street
November 1 – April 25
Saturday 9:00 am – 2:00 pm
(Baked goods, meats & more) Yoder's Natural Farm, Natures Way

FORT DODGE (Webster County)
Spin Market – NW Corner of Crossroads Mall
1st Ave. S. & 25th St.
June 14 & 28, July 12 & 26, August 9 & 23, September 13 & 27, Saturday 9:00 am – 1:00 pm
May 28 – October 29
Wednesday, 1:30 – 5:30 p.m.
(*Vegetables, jam, jellies & more*) Airport Gardens, Hensley's Farm (Sat. only), Connie's Creations (Sat. only)

FORT MADISON (Lee County)
Central Park Farmers Market, Ave. E & 9th St.
May 29 – October 2, Thursday 4:30 – 6:30 pm
(*Vegetables, fruits & more*) Jim's Greenhouse

GLENWOOD (Mills County) (NEW)
Glenwood Lake Park
June 4 – October 1, Wednesday 4:00 – 7:00 pm
(Vegetables, honey & more) Lone Star Meadow

GREENFIELD (Adair County) (NEW)
400 Public Square – Courthouse Yard
June 5 – September 25, Thursday 3:00 – 6:00 pm
(Vegetables, fruit, honey, eggs & more) Lappes Farm Products & Bakery

GRINNELL (Poweshiek County)
4th Avenue & Broad Street
May 15 – October 23, Thursday 3:00 – 6:00 pm
(Vegetables, beef , honey & more) Hala's Honey, Doty Angus Cattle Company

HAMPTON (Franklin County)
Gazebo Park, corner of 1st St. NW & 1st Ave. NW
May 9 – October 17, Friday 5:00 – 7:00 pm
June 3 – October 14, Tuesday 5:00 – 7:00 pm
(Fruits, vegetables, herbs & more) Prairie's Edge, Hershey Family Nursery (Friday only)

HARLAN (Shelby County)
Shop-Ko parking lot, 2099 Chatburn Ave.
June 21 – October 25
Saturday 8:30 am – Noon, Wednesday 3:30 – 6:00 pm
(Fruits, vegetables, baked goods & more) Wacer Gardens

HAWARDEN (Sioux County)
City Park, intersection of 13th St. and Ave. E
July 10 – October 2, Thursday 5:00 – 7:00 pm
(Vegetables, fruit, & more) Veggie Patch

HIAWATHA (Linn County)
Guthridge Park on 10th Ave.
April 27 – October 26, Sunday 11:00 am – 2:00 pm
(Vegetables, fruit, meat & more) Musil Gardens, Circle W Acres, Meadowview Farm, Fertile Dirt Farms, Snax, H & P Meats

HUMBOLDT (Humboldt County)
North side of Summer Ave
June 28 – October 4, Saturday 7:30 am - Noon
(*Vegetables, fruits, & more*) Boone Valley Produce (July 19 – October 4)

INDIANOLA (Warren County)
FAIRGROUNDS
Hwy 92 at Fairgrounds West Gate
June 7 – October 25, Saturday 8:00 am – Noon
Wednesday 2:00 – 6:00 pm
(Baked goods, fruits, vegetables, eggs, honey & more)
Lappe's Farm Products & Bakery

MARKET ON THE SQUARE
Indianola Town Square, courthouse lawn
June 5 – July 26, Thursday, 5:30-8:30 pm
(Salsa and more) Orale! Salsa

IOWA CITY (Johnson County)
CHAUNCEY SWAN PARKING RAMP
Lower level between Washington and College St.
May 3 – October 25
Saturday 7:30 am – Noon, Wednesday 5:00 – 7:00 pm
(Baked goods, meats, fruits, vegetables & more) H&P Meats, Buffalo Ridge Orchard, Sat. only: Snax, Fertile Dirt Farms, Farmer Dave

MERCER PARK
Bradferd St. east of 1st Ave.
May 6 – October 27, Tuesday 3:00 – 6:00 pm
(Baked goods & more) Snax

IOWA FALLS (Hardin County)
ESTES PARK
May 10 – October 11
Saturday 8:30 – 11:30 am
Wednesday 5:00 to 7:00 pm
(Fruits, vegetables, eggs & more) Prairie's Edge

JOHNSTON (Polk County)
City Hall – Merle Hay Road & NW 62nd Ave.
May 20 – October 7, Tuesday 3:30 – 6:30 pm
(Vegetables, fruits & more) Iowa Orchard, Hensley's Farm

KEOKUK (Lee County)
River City Mall parking lot, 300 Main St.
May 17 – October 11, Saturday 7:00 – 11:00 am
(Vegetables, fruits & more) Jim's Greenhouse

KEOTA (Keokuk County) (NEW)
Downtown
June 2 – September 15, Monday 5:00 – 7:00 pm
(Vegetables, fruits, baked goods & more) Rolling Prairie Acres

KNOXVILLE (Marion County) (NEW)
214 E. Main, west side of Courthouse
May 24 – October 11, Saturday 8:00 am – noon
(Vegetables, fruits, baked goods & more) Generations Good Home Cooking

LYONS (Clinton County)
Lyons Farmers Market - Main Ave. & Roosevelt St.
May 28 – October 29
Saturday 8:00 – 11:00 am, Wednesday 4:00 – 6:00 pm
(Fruits, vegetables & more) Shelly Farms

MARION (Linn County)
City Square Park
May 3 – September 27
Wednesday 3:00 – 6:00 pm, Saturday 8:00 – 11:30 am
(Baked goods, *Fruits, vegetables & more*) Circle W Acres, Meadowview Farms (Sat. only)

MARSHALLTOWN (Marshall County)
CARTWRIGHT PAVILLION
2nd Ave. & State St.
May 14 – October 29
Wednesday 4:00 – 6:00 pm, Saturday 8:00 – 11:00 am
(Baked goods, fruits, vegetables, honey & more) Bev's Beehive, Hala's Honey

LINN STREET
103 E. Linn St.
May 16 – October 31
Friday 9:00 am – 4:00 pm, Saturday 9:00 am – 4:00 pm
(Fruits, vegetables, baked goods & more) Bev's Beehive

MASON CITY (Cerro Gordo County)
NORTH IOWA FARMERS MARKET
K-Mart parking lot, Hwy 122
May 16 – Oct. 31, Tuesday & Friday 3:00 – 6:00 pm
(Closed 4th of July)
(Fruits, vegetables, meat & more) Stillwater Greenhouse, North Iowa Berries & More, Fri. only: Sugar Creek Farm, Log Cabin Produce (June 20 – July 10)

WINTER MARKET
Willowbrook Mall
November – April
Friday 3:00 – 6:00 pm
(Baked goods and more) North Iowa Berries & More

MISSOURI VALLEY (Harrison County)
Harrison County Welcome Center, 2931 Monroe Ave.
May 24 – October 18
Thursday 3:30 – 6:00 pm
(*Vegetables, fruits, honey, baked goods & more*) Hodge Greenhouse

MONTICELLO (Jones County)
Monticello Middle School, 217 S Maple St.
May 10 – October 29
Wednesday 3:00 – 5:30 pm, Saturday 8:00 – 11:00 am
(*Vegetables, baked goods & more*) Treasure Chest (occ.vendor)

MONTROSE (Lee County)
Montrose River Front Park, 201 N 1st St
May 6 – September 23, Tuesday 4:00 – 6:00 pm
(*Vegetables, fruits, & more*) Jim's Greenhouse

MOUNT VERNON (Linn County)
First Street Community Center lawn – 221 1st Street NE
May 1 – October 9
Thursday 4:00 – 6:00 pm
(Fruits, vegetables & more) Farmer Dave, Fertile Dirt Farms (occ. vendor), Nature's Pantry Foods, Inc.

NEW HAMPTON (Chickasaw County)
City parking lot – beside Fareway
May 22 – October 2
Thursday 4:00 – 6:00 pm
(Baked goods, fruits, vegetables, honey & more)
Zimmerman's Greenhouse Produce, East View Orchard

NEWTON (Jasper County) (NEW)
Centre for Arts & Artists, 501 W. 3rd St N
June 3 – September 30, Tuesday 4:00 – 6:00 pm
(*Vegetables, fruits, baked goods & more*) Generations Good Home Cooking

OELWEIN (Fayette County)
N.E. corner hwy 150 & Hwy 3, city parking lot
May 23 – September 24
Monday 2:30 – 5:30 pm, Friday 8:00 am – 11:00 am
(Baked goods, vegetables, jams, jellies & more) Keppler Kraft & Fabric

OSCEOLA (Clarke County)
SE corner of Courthouse Square
June 3 – October 18
Tuesday 3:00 – 6:00 pm, Saturday 8:00 am - Noon
(Fruits, vegetables, baked goods, honey & more!) Tues. only: Shutt's Garden Center, Lappe's Bakery and Farm Produce

OSKALOOSA (Mahaska County) (NEW)
South D Street & 1st Avenue W
May 27 – October 11
Tuesday 4:00 – 6:00 pm, Saturday 8:00 – 11:00 am
(Vegetables, eggs, & more!) Grandma's Garden

OTTUMWA (Wapello County)
OTTUMWA FARMERS MARKET
331 E Main St
May 28 – October 29
Wednesday 3:30 – 6:00 pm, Saturday 8:00 – 11:00 am
(Honey products, jelly & more) Newton's Own (Wed. only)

OTTUMWA WAPELLO COUNTY
Family Video parking lot – 819 Albia Rd.
May 15 – October 16, Thursday 2:30 – 5:30 pm
(Baked goods, fruits, vegetables & more) Patsy Boas, Gothic Gardens

PELLA (Marion County) (NEW)
First Reformed Church parking lot
605 Broadway Street
April 24 – Oct. 17
Thursday 3:00 – 6:00 pm, Saturday 9:00 – Noon
Closed during Tulip Time – May 3 & 5
(Vegetables, honey, eggs & more) Prairie Roots Farm, Grandma's Garden (Thursday only)

PERRY (Dallas County) (NEW)
Corner of 1st & Willis
June 5 – September 25, Thursday 4:00 – 6:00 pm
(Vegetables, eggs & more) Tucker's Farm

PLEASANT HILL (Polk County) (NEW)
Berean Assembly of God parking lot
May 8 – October 23, Thursday 4:00 – 7:00 pm
(Vegetables, fruits, baked goods & more) Generations Good Home Cooking

PRESTON (Jackson County)
Twogood Park off Hwy 64
June 26 – September 18, Thursday 4:00 – 6:00 pm
(Fruits, vegetables & more) Shelly Farms

SHELDON (O'Brien County)
416 9th St. Community Services, parking lot
June 2 – September 29
Monday 4:30 – 6:30 pm, Friday 11:00 am – 1:00 pm
(Fresh vegetable & more) Veggie Patch

SIOUX CENTER (Sioux County)
Central Mall
June 25 – September 24
Wednesday 8:00 – 1:00 pm
(Vegetables, meats & more) Van Donge Poultry

SIOUX CITY (Woodbury County)
Tyson Event Center parking lot
May 7 – October 25
Saturday & Wednesday 8:00 am – 1:00 pm
Monday 4:00 – 7:00 pm
(Baked goods, fruits, vegetables, meats & more) Veggie Patch, Carol's Kitchen, Van Donge Poultry (Sat)

SPENCER (Clay County)
Spencer Area Farmers Market
1019 S. Grand Avenue
June 4 – October 29
Saturday 7:30 – Noon, Wednesday 4:00 – 6:00 pm
(Vegetables, honey, & more) Janssen Honey Farms

SPIRIT LAKE (Dickinson County)
Dickinson County Fairgrounds, 15th & Peoria Ave.
June 7 – October 11
Saturday & Wednesday 7:30 am – Noon
(Meat & more) Iowa Supreme Meat

STRAWBERRY POINT (Clayton County)
Inger Park – Park St.
May 28 – October 24, Wednesday 4:00 – 6:00 pm
(Vegetables, baked goods, jams, jellies & more) Keppler Kraft & Fabric

STUART (Guthrie County) (NEW)
City Park on S Division between 3rd & 2nd Streets
May 2 – October 31, Wednesday 3:00 – 6:00 pm
(Vegetables & more) Hensley's Farm

TIPTON (Cedar County)
North side of Court House
May 1 – October 30
Thursday 4:00 – 6:00 pm
(Fruits, vegetables, meat, eggs & more) Hollow Maple Farm, Barnyard Produce

TOLEDO (Tama County)
East side of Courthouse Square
May 2 – October 31, Friday 5:00 – 7:00 pm
(Vegetables & more) Mattingly Farms Plants & Produce

WASHINGTON (Washington County)
Iowa Ave. & Washington St.
June 5 – October 23, Thursday 5:00 – 7:30 pm
(*Fruits & more)* Levi's Indigenous Fruit Enterprise

WATERLOO (Black Hawk County)
CEDAR VALLEY: KIMBALL RIDGE
Inside SE Corner of Kimball Ave. & Ridgeway Rd.
May 6 – October 28, Tuesday 3:30 – 6:00 pm
(Baked goods, fruits, vegetables & more) Kiefer's Produce, Litteaur's Garden Produce, Elaine & Lloyd Nolt, Stillwater Greenhouse

KIMBALL RIDGE FAMILY MARKET
NE corner of Kimball Ave. & Ridgeway Rd.
May 3 – October 25, Saturday 8:00 am – Noon
(Vegetables, fruit, baked goods, & more) Adolphs Produce & Bakery, Mattingly Farms Plants & Produce, Stillwater Greenhouse

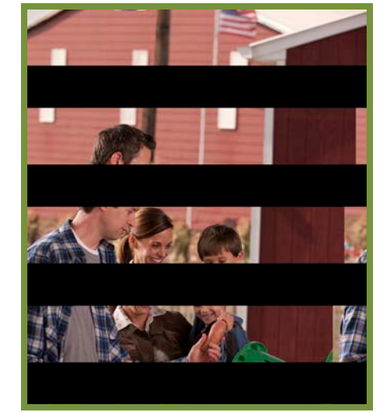
DOWNTOWN
Riverloop Expo Public Market, 327 W 3rd St.
May 8 – October 30, Thursday 3:30 – 6:00 p.m.
May 3 – October 25, Saturday 8:00 am – Noon
(Fruits, vegetables, baked goods, honey & more)
Kiefer's Produce, Litteaur's Garden Produce, Elaine & Lloyd Nolt, A Family Market Place, Stillwater Greenhouse, Nature's Pantry Foods, Inc.

WAVERLY (Bremer County) (NEW)
1st Avenue SE, by Post Office
June 3 – October 28, Tuesday 3:00 – 6:00 pm
(Vegetables, fruits, eggs, meat & more) Kaiser Farm

WAUKEE (Dallas County)
Triangle Park – 6th St. and Ashworth Dr.
June 4 – September 10, Wednesday 4:00 – 7:00 pm
(Vegetables & more) KM Gardens

WEBSTER CITY (Hamilton County) (NEW)
400 Second Street, City Hall Plaza
June 7 – October 25, Saturday 8:00 – 11:00 am
(Vegetables, fruits & more) Evans Produce

WINTERSET (Madison County)
Town Square
May 10 – October 4, Saturday 8:00 – Noon
(Vegetables, baked goods, & more) Burr Oak Farm, Lauri Long's Home Bakery



ROAD SIDE STANDS

APPLEBERRY FARM (Marshall County)
2402 West Main Street, Marshalltown
August 1 – November 1
Monday - Friday 9:00 am – 6:00 pm
Saturday 9:00 am – 5:00 pm
Sunday Noon – 5:00 pm

BERRY FRESH FARMS (Dallas County) (NEW)
30339 K Avenue
June – July
Tuesday, Wednesday & Friday 12:00 – 6:00 pm
Saturday & Sunday 9:00 am – 6:00 pm

COUNTRY MARKET (Woodbury County)
15th Street & Hamilton Blvd., Sioux City
July 5 – October 31
Monday - Saturday 9:00 am – 7:00 pm
Sunday 10:00 am – 5:00 pm

DAN-D FARMS (Marion County)
Hwy 14, Knoxville across from Walmart
July 1 – August 31, Monday - Sunday 9:00 am – 5:00 pm

GRUBBY'S KETTLE KORN (Mahaska County)
Radio Shack parking lot, Oskaloosa
June 25 – October 14, Daily 10:00 am – 6:00 pm

HEARTLAND FARMS (Black Hawk County) (NEW)
5111 Osage Road, Waterloo
May 10 – October 31
Tuesday – Saturday 9:00 am – 7:00 pm
Open Sunday – September 19 – October 31

JOKIR'S WILL BLACK ANGUS BEEF (Humbolt County)
1452 220th St., Gilmore City
Open year round
Tuesday – Friday 3:00 – 6:00 pm
Saturday 10:00 am - Noon

MILLIGAN PRODUCE

Holstien – St. Paul Lutheran Church parking lot
Wednesday 11:00 am – 1:30 pm
June 18 – September 17 (closed Sept. 3)

Ida Grove – parking lot north of Skate Palace
Friday 2:00 – 6:00 pm
June 20 – October 31 (closed 4th of July)

Mapleton – inside Community Building
Monday 11:00 am – 1:30 pm
June 23 October 27 (closed Labor Day)

WILLS FAMILY ORCHARD (Dallas County)
33130 Panther Creek Road, Adel
September 7 – October 27
Saturday 9:00 am – 5:00 pm, Sunday 1:00 – 5:00 pm

Comm. 284, Bringing Farmers Markets and Food Assistance Together

Purpose	Comm. 284 is a brochure that promotes the use of Food Assistance benefits to purchase food at farmer's markets.
Source	Additional supplies of Comm. 284 may be printed on 11" x 17" paper from the following Department website: http://dhs.iowa.gov/sites/default/files/Comm284.pdf (Click on the link for the latest list of farmers markets.)
Distribution	Give Comm. 284 to: ♦ New Food Assistance applicant households. ♦ Members of the public upon request.
Data	The brochure lists Iowa farmers markets that have vendors who accept the Food Assistance electronic benefit transfer (EBT) card as payment.

Comm. 316, PACE (Program of All-Inclusive Care for the Elderly)

Purpose	Comm. 316 provides information about PACE (Program of All-Inclusive Care for the Elderly), which provides "managed" long-term care to members who want to live in the community.
Source	Local offices may print the booklet from the sample in the manual. The booklet is also available on line at http://dhs.iowa.gov/sites/default/files/Comm316.pdf
Distribution	The local office issues the booklet to PACE members.
Data	The booklet explains how a member obtains services under PACE, the member's rights and responsibilities, and disenrolling from PACE.

Iowa Department of Human Services

Comm. 337 (Rev. 9/14)

Medicaid for Kids with Special Needs

What is Medicaid for Kids with Special Needs?

It helps pay medical bills for children with special needs due to a disability.

Questions?

For information on how to get an application or for help completing an application, please call 1-877-937-3663.

Where is my local DHS office?

To find the location of the Department of Human Services office close to you call *2-1-1*.

www.dhs.state.ia.us

DHS Policy on Nondiscrimination

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

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

Iowa Department of Human Services
Policy Bureau
Hoover Building – 5th Floor
1305 E Walnut
Des Moines IA 50319-0114

Via email contactdhs@dhs.state.ia.us

Is your child eligible?

Your child must be:

- ♥ Under the age of 19.
- ♥ Disabled. The disability must meet the standards of the Social Security Administration.
- ♥ Income eligible. Your family income must be no more than 300% of the federal poverty level for your family size. See the Income Amounts chart.
- ♥ A U.S. citizen.

Does your child have other health insurance?

- ♥ If yes, you must pay the premiums and keep your child covered for as long as your employer pays at least half of the premium cost.
- ♥ If no, but you can get health insurance from your employer **and** if your employer pays at least half of the premium cost, then you must enroll your child in the employer insurance plan.
- ♥ If your employer does not pay at least half of the insurance premium cost, then you are not required to enroll your child.

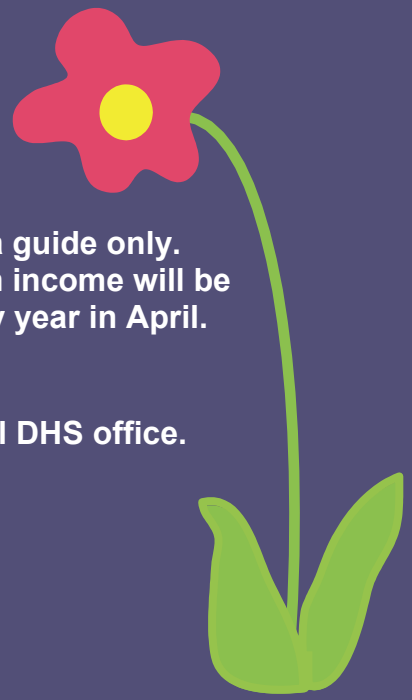
How do you apply for your child?

- ♥ Complete the Health Services Application and turn it in at your local Department of Human Services office (DHS).
- ♥ To help process your application, provide information requested by the worker. This includes your income, your child's disability, and health insurance.
- ♥ If your child had a disability determination by the Social Security Administration, then provide the decision to DHS.
- ♥ If your child has not had a disability determination by the Social Security Administration, then DHS will process the determination.

Income Amounts

Number in the Family	Monthly Income Limits
1	$2,918
2	$3,933
3	$4,948
4	$5,963
5	$6,978
6	$7,993
7	$9,008
8	$10,023

For each additional person add $1,015.



This chart is a guide only. The maximum income will be updated every year in April.

Questions?
Call your local DHS office.

Iowa Department of Human Services

Medicaid for Employed People with Disabilities (MEPD)
Frequently Asked Questions

Medicaid for Employed People with Disabilities (MEPD) is a program for people with disabilities who are employed.

What are the eligibility requirements for MEPD?

People who are disabled and have earned income can get Medicaid when the person:

- Is under age 65.
- Is still considered to be disabled based on SSI medical criteria for disability.
- Has earned income from employment or self-employment.
- Meets general SSI-related Medicaid eligibility requirements.
- Is not eligible for any other Medicaid coverage group other than QMB, SLMB, or Medically Needy.
- Have resources less than $12,000 for an individual and $13,000 for a couple.
- Has net family income less than 250% of the federal poverty level.
- Pays any premium due for the month of eligibility.

How do I find out if I can get MEPD?

To find out if you can get MEPD, you must fill out a Medicaid application and send it to your local Department of Human Services (DHS) office. The application may be mailed, faxed or delivered to the DHS office. **Or**, you may apply on-line at https://dhsservices.iowa.gov/apspssp/ssp.portal

Do I have to pay a premium for MEPD?

If your monthly gross income is over 150% of the federal poverty level, you will have to pay a premium. You will get a Notice of Decision telling you the amount of your monthly premium. See the premium chart on the next page.

Note: Your monthly premium will not go up during the 12-month enrollment period. The premium may go down if you report that your income has decreased.

How much will I have to pay each month?

You will get an MEPD Billing Statement telling you the amount of the premium. The chart on the next page can help you figure out the amount of your premium. This chart is a guide only, and the premium amount is updated annually in August.

To find your premium, add your gross earned income and your gross unearned income together. Then find the total of your monthly gross income on the chart. The premium you will have to pay will be on the same line.

If the monthly gross income of the disabled person is:	The monthly premium is:
$1,459 or less	**$0**
More than: $1,459	$31
$1,605	$42
$1,751	$50
$1,945	$58
$2,189	$68
$2,432	$78
$2,918	$99
$3,404	$119
$3,890	$140
$4,377	$160
$5,349	$201
$6,322	$242
$7,294	$284
$8,267	$335
$9,725	$404
$11,184	$475
$12,643	$556
$14,393 and above	**$647**

When are premiums due?

A billing statement will be sent to you that shows the month a premium is due. To get Medicaid on the first day of next month, premiums should be received by DHS by the last day of the month. Your MEPD will be canceled if you do not pay the premium by the 14th of the month.

Note: When you are first approved, the first billing statement may be for more than one month and the premium amount or due dates may vary. **Please read your billing statements carefully.**

What happens if I am late paying my premium?

If you do not pay the premium by the due date, your MEPD will be canceled. If you make a premium payment late:

- MEPD can be reinstated if your ongoing month's payment is received by the last day of the month it is due. For example, the payment for the July Medicaid was due July 14, but DHS received by July 31.
- MEPD coverage can be reopened if the payment is late but is received in the month after the month in which it was due. For example, the payment for July Medicaid was due July 14, but DHS received by August 31.

Note: If your payment is more than 3 months late, it will not be accepted and you will not be able to get Medicaid for that month. It is **very** important that you make your premium payment on time or early if possible.

How are my payments applied?

Payments are always applied to pay the current month premium, if unpaid. If the payment is received **after** the 14th of the month and the current month is already paid, it will be held to pay for the next month. See the last page for examples.

How do I pay my premium?

A postage-paid envelope is included with your bill. If you lose your MEPD Billing Statement, you can call your local DHS office to get a new one mailed to you. If you lose your envelope, you may mail your payment to the address below:

Iowa Medicaid Enterprise
MEPD Premium
PO Box 10339
Des Moines, IA 50306-9948

(**Note:** This address is different from the address on the preaddressed postage-paid envelope.)

Please write your name and your member ID number on the check or money order. If this information is not included, your payment may not be credited to the right account.

Where can I go to get services?

Members enrolled with MEPD may see any provider who agrees to be paid by Iowa Medicaid. You may contact Iowa Medicaid Member Services to find out who these providers are by:

- Phone: Monday through Friday 8:00 AM to 5:00 PM at 1-800-338-8366 or in Des Moines at 515-256-4606.
- E-mail at: IMEMemberServices@dhs.state.ia.us.

Or, search on Iowa Medicaid's website at: http://dhs.iowa.gov/ime/.

What services are covered?

MEPD members have all Iowa Medicaid benefits. This includes medical, dental, vision, and chiropractic services. Prescription services are included for members who do not have Medicare.

For those members enrolled with Medicare as well as MEPD, prescription coverage will go through a Medicare Part D plan. MEPD will pay for your Medicare premiums.

If you would like to know if a specific service is covered, you must work with your physician. Your physician will need to contact Provider Services to explain the service that you need to see if that service can be paid for by Medicaid.

Will I have to pay any co-payments?

Yes, the following is a breakdown of your co-payment amounts:

Co-payment Amount	Service
$1.00 per visit	Services from a podiatrist, chiropractor, and physical therapy.
$2.00 per visit	Ambulance services, audiology services, hearing aid dealer services, medical equipment, optical services, prosthetic devices, psychology services, and rehabilitation services.
$3.00 per visit	Dental services, hearing aides, physician office visits and lab services.

How can MEPD help me to stop smoking?

Counseling plus medication has proven to be the best way to help people stop smoking. If you follow these steps, Medicaid will pay the costs of these services:

- First, you will be asked to visit your physician and explain that you want to stop smoking. Your doctor will work with you to decide which program is best for you.
- You could also get:
  - A prescription for Chantix or Buproprion (but Medicaid will only pay for these prescriptions if you do not have Medicare).
  - Over-the-counter nicotine patches and gum.
- You will also have to participate in counseling through Quitline Iowa. This counseling is done over the phone while you are taking a drug to stop smoking. Together, the drug and counseling help you stop smoking.

Will I get an MEPD ID card?

Yes. It is the same card that all Medicaid members get. You will get a plastic card that says Iowa Department of Human Services Medical Assistance Eligibility Card. Keep this card. If your card becomes lost, damaged, or stolen, contact Iowa Medicaid Member Services to get a new card. Call **1-800-338-8366** or locally in the Des Moines area **515-256-4606.**

Is there anything else I need to know?

Yes. Be sure to report the following changes to your Income Maintenance Worker at your local DHS office if you:

- Stop working,
- Earn more money,
- Earn less money,
- Move to a new address, or
- Are no longer disabled according to the Social Security Administration.

Who can I call if I still have questions about MEPD?

Your local DHS office is a good source of information about the program. You can also call the Iowa Medicaid Enterprise Member Services at **1-800-338-8366** or in Des Moines area at **515-256-4606.**

How premium payments are applied?

This is the order that payments are applied to your account:

1. To the current month, if the current month is unpaid.
2. If the payment is received **before** the 14th, after paying the current month, any extra money will be applied to old unpaid months, in this order:
    a. To the month before the current calendar month, if unpaid.
    b. To the oldest unpaid month and forward until all old unpaid months have been paid.
3. If the payment is received **after** the 14th of the month, it will be held to pay to the next month.
4. When all unpaid months have been paid, any extra money will be held as a credit and used to pay future months.

Examples:

The member has a monthly premium of $58.00. The member has not made their first two premium payments and also owes for current month.

Example 1: The member mails in a payment for $116.00 and it is received on the 10th of the month.

- $58.00 will be applied towards the current month and,
- $58.00 will be applied towards the previous month, leaving a past due balance on the first month.

Example 2: The member mails in a payment for $116.00 and it is received on the 18th of the month.

- $58.00 will be applied towards current month and,
- $58.00 will be applied towards the following month.
- No payments will be applied towards the past due months.

Example 3: The member mails in a payment of $174.00 and it is received on the 10th of the month.

- $58.00 will be applied towards current month,
- $58.00 will be applied towards the previous month and,
- $58.00 will be applied towards the oldest unpaid month.

Example 4: The member mails in a payment of $174.00 and it is received on the 18th of the month.

- $58.00 will be applied towards current month,
- $58.00 will be applied towards the following month and
- $58.00 will be applied towards the previous month, leaving a past due amount for the oldest unpaid month.

Example 5: The member mails in a payment of $232.00 and it is received on the 10th of the month.

- $58.00 will be applied towards current month,
- $58.00 will be applied towards the previous month,
- $58.00 will be applied towards the oldest unpaid month and,
- $58.00 will be applied to the second oldest undpaid month.

Example 6: The member mails in a payment of $232.00 and it is received on the 18th of the month.

- $58.00 will be applied towards current month,
- $58.00 will be applied towards the following month,
- $58.00 will be applied towards the previous month and,
- $58.00 will be applied towards the oldest unpaid month.

Comm. 374, Iowa Family Planning Network (IFPN), Frequently Asked Questions

Purpose	Comm. 374 is a flier designed to give basic information about the Iowa Family Planning Network (IFPN) coverage group.
Source	Print supplies of Comm. 374 from the sample in the manual.
Distribution	Give Comm. 374 to applicants or potential applicants for Iowa Family Planning Network coverage.
Data	The flier explains: ♦ Who may be eligible for IFPN coverage. ♦ Where to receive IFPN services. ♦ What types of services may be covered. ♦ How to contact the Department of Human Services.

Iowa Department of Human Services

Comm. 374 (Rev. 9/14)

Iowa Family Planning Network (IFPN)
Frequently Asked Questions

What is covered?

Services are available for men and women ages 12 through 54.

- Birth control exams and advice
- Limited testing and treatment for sexually transmitted infections (STIs)
- Pap tests
- Birth control supplies for men and women
- Voluntary sterilization for men and women who are over the age of 21 and have signed a valid sterilization consent form

Where can I go for services?

Any participating family planning provider enrolled with Iowa Medicaid can provide IFPN services. Providers include:

- Family planning clinics
- Medical clinics
- Federally qualified health centers
- Rural health centers

I received a Medicaid card. Does this mean I am fully covered by Iowa Medicaid?

No, if you are only eligible for IFPN, you **do not** have coverage for services such as:

- Hospital visits (except during sterilization)
- Dental
- Vision
- Chiropractic care
- Medical or health care services not related to those covered by IFPN

You will continue to use the same Medicaid card but only family planning services are covered. To check your coverage call Member Services at 1-800-338-8366 or 515-256-4606.

I do not want any more children. Can IFPN help?

Yes, voluntary sterilization is covered. You must be over the age of 21 and sign a sterilization consent form at your health care provider's office 30 to 180 days before the procedure.

Are ultrasounds covered?

Only if they are medically necessary and related to birth control services.

What types of birth control are covered?

- Birth control implants
- IUDs
- Birth control pills
- Depo Provera shots
- Sterilizations
- Vasectomies
- Diaphragms, cervical caps, vaginal rings
- Condoms
- Spermicidal suppositories
- Birth control foam/jelly/sponges
- Basal thermometer

Is HPV vaccine such as Gardisil® covered?

No, it is not.

Are yeast infection treatments covered?

Yes. Please make an appointment with your health care provider.

Are pregnancy tests covered?

Yes. Please make an appointment with your health care provider for a pregnancy test.

Are abortions or a D & C covered?

No, not under IFPN.

If I become pregnant, how can I get Medicaid coverage?

Apply for full Iowa Medicaid coverage:

- Call the Call Center at 877-347-5678 to request a *Health Services Application*, or
- Apply online at https://dhsservices.iowa.gov/apspssp/ssp.portal

Why was I changed from full Medicaid to IFPN?

Eligibility questions should go to your local Department of Human Services (DHS) office. You can find the phone numbers on our website at http://dhs.iowa.gov/.

Who can I call if I still have questions about IFPN?

Call your local DHS office for information about the program. You can call Iowa Medicaid Enterprise Member Services at **1-800-338-8366** or locally in the Des Moines area at **515-256-4606,** or you can call The Healthy Family Hotline at **1-800-369-2229**.

Comm. 377 or Comm. 377(S), FIP Electronic Access Card

Purpose	Comm. 377 and Comm. 377(S) are fliers that provide information about the FIP electronic access card (EAC).
Source	Print or photocopy supplies of the fliers from the samples in the manual or from the DHS Intranet eForms web page.
Distribution	Provide a copy of Comm. 377 or Comm. 377(S) to all FIP applicants.

Comm. 390 and 390(S), Benefits of a Healthy Marriage

Purpose	The flier *Benefits of a Healthy Marriage* constitutes the services provided under the categorical assistance program Promoting Awareness of the Benefits of a Healthy Marriage. (A household can be eligible for Promoting Awareness of the Benefits of a Healthy Marriage only when the household is otherwise eligible for Food Assistance.)
Source	The flier is generated by the Automated Benefit Calculation System when system entries are made to approve a household for Promoting the Awareness of the Benefits of a Healthy Marriage and, consequently, for Food Assistance. It is printed with English text on one side and Spanish text on the reverse.
Distribution	The flier is mailed to the household with the *Notice of Decision* approving the household for both programs.
Data	The flier provides information on the benefits provided by a healthy marriage.

Comm. 411, Medicaid for People in Care Facilities

Purpose

The flier *Medicaid for People in Care Facilities* gives basic information about the services covered by Medicaid for long-term care.

Source

Print or photocopy supplies of Comm. 411 from the sample in the manual as needed.

Distribution

Give Comm. 411 to:

- All long-term care applicants and
- Anyone who requests information about Medicaid coverage of facility care expenses.

When more detailed information is requested, send Comm. 52, *Medicaid for People in Nursing Homes and Other Care Facilities*, or give the internet link to Comm. 52 at:

http://dhs.iowa.gov/sites/default/files/Comm052.pdf

Data

Comm. 411 explains:

- Admission procedures,
- The effect of Medicaid eligibility on the facility payment,
- Consideration of a spouse at home,
- Client participation,
- Additional services available,
- The relationship between Medicare and Medicaid, and
- Transfer from one facility to another.

Comm. 412, Medicaid Information

Purpose	The pamphlet *Medicaid Information* gives basic information about the medical services paid by Medicaid.
Source	Print or photocopy supplies of Comm. 412 from the sample in the manual as needed.
Distribution	Give Comm. 412 to: ♦ All Medicaid applicants and ♦ Anyone who requests information about Medicaid. When more detailed information is requested, send Comm. 20, *Your Guide to Medicaid*, or give the Internet link to Comm. 20 at: http://dhs.iowa.gov/sites/default/files/Comm020.pdf
Data	Comm. 412 explains: ♦ The Medical Assistance Eligibility Card, ♦ Retroactive eligibility, ♦ Copayment for services and other member responsibilities, ♦ Medicaid providers, ♦ Coverage limitations applicable to the various providers, ♦ Managed care, and ♦ Use of the Member Services Call Center.

Comm. 413, Medicare Savings Programs

Purpose	The flier *Medicare Savings Programs* gives basic information about the qualified Medicare beneficiary (QMB) program.
Source	Print or photocopy supplies of Comm. 413 from the sample in the manual as needed.
Distribution	Give Comm. 413 to: ♦ All members who qualify for QMB and ♦ Anyone who requests information about Medicare Savings Programs. When more detailed information is requested, send Comm. 60, *Medicaid for the Qualified Medicare Beneficiary*, or give the Internet link to Comm. 60 at: http://dhs.iowa.gov/sites/default/files/Comm060.pdf
Data	Comm. 413 explains the eligibility requirements and services available under the QMB program.

Comm. 414, Protecting Your Resources and Income

Purpose	The flier *Protecting Your Resources and Income* gives basic information about how resources and assets are determined when a person applies for Medicaid for facility care.
Source	Print or photocopy supplies of Comm. 414 from the sample in the manual as needed.
Distribution	Give Comm. 414 to: ♦ All applicants for facility care and ♦ Anyone who requests information about the treatment of resources for Medicaid eligibility for facility care. When more detailed information is requested, send Comm. 72, *Protection of Your Resources and Income*, or give the Internet link to Comm. 72 at: http://dhs.iowa.gov/sites/default/files/Comm072.pdf
Data	Comm. 414 explains: ♦ The income limit for the spouse in the facility, ♦ How resources are divided between the spouse in the facility and the spouse at home, and ♦ What income can be protected.

Comm. 415, Medically Needy Medical Assistance

Purpose	The pamphlet *Medically Needy Medical Assistance* gives basic information about the Medically Needy program.
Source	Print or photocopy supplies of Comm. 415 from the sample in the manual as needed.
Distribution	Give Comm. 415 to all applicants who are determined eligible for Medically Needy coverage. When more detailed information is requested, send Comm. 30, *Medicaid for the Medically Needy*, or give the internet link to Comm. 30 at: http://dhs.iowa.gov/sites/default/files/Comm030.pdf
Data	Comm. 415: ♦ Lists the eligibility requirements. ♦ Explains spenddown. ♦ Tells when a *Medical Assistance Eligibility Card* is issued.

Comm. 424, Medicaid Payback Trusts in Iowa

Purpose	Comm. 424 is an informational brochure available to income maintenance workers, as well as the general public, trustees, and attorneys to provide basic information about Medicaid Payback Trusts in Iowa.
Source	Print or photocopy supplies of Comm. 424 from the sample in the manual as needed.
Distribution	Give Comm. 424 to anyone who requests information about the Medicaid Payback Trusts in Iowa.

Comm. 438, Family Medicaid

Purpose	The flier *Family Medicaid* gives basic information about Medicaid for families with children.
Source	Print or photocopy supplies of Comm. 438 from the sample in the manual as needed.
Distribution	Give Comm. 438 to FMAP-related Medicaid applicants at the time they are given an *Application for Health Coverage and Help Paying Costs*, form 470-5170 or 470-5170(S). When more detailed information is requested, send Comm. 27, *Medicaid for Families and Children*, or give the internet link to Comm. 27 at: http://dhs.iowa.gov/sites/default/files/Comm027.pdf
Data	Comm. 438: ♦ Explains Medicaid eligibility requirements and application procedures, and ♦ How a member can access medical care.

RC-0002, Schedule of Needs

Purpose

Title IV-A of the Social Security Act requires states administering a cash assistance program (known as FIP in Iowa) to establish standards of assistance. These standards, expressed in money amounts, are for the purpose of determining financial need and the amount of assistance on an equitable basis.

The *Schedule of Living Costs* and the *Schedule of Basic Needs* are provided to comply with 1991 Iowa Acts, Chapter 267.

The instructions governing the use of the schedules are contained in 4-F, Applying Income Tests and Calculating the Amount of Assistance.

Chart of Basic Needs Components:

Below the *Schedule of Needs* is the *Chart of Basic Needs Components*. The total of the amounts of basic needs components does not exactly equal the amount shown on the corresponding *Schedule of Basic Needs*. This difference arises from many factors, but occurs primarily by reason of the "rounding off" procedures that are employed throughout the process culminating in the *Schedule of Basic Needs*.

This chart is used in determining applicant's or participant's net profit from renting out apartments in the applicant's or participant's own home. Note that the amounts set forth on the chart for each budgetary item are computed on a per-person basis.

For example, the two-person allowance for shelter is $131.62 ($65.81 x 2); the two-person allowance for utilities is $32.90 ($16.45 x 2).

Allowances for Special Needs:

A summary of the allowances for special needs is printed on the reverse for quick reference.

RC-0008, Overpayment Recovery Codes

Purpose

RC-0008 explains the meaning of codes in the Overpayment Recovery System.

RC-0018, Supplemental Security Income Payment Standards

Purpose	The RC-0018 is a chart of SSI and State Supplementary Assistance payment standards. It may be used as a reference in determining eligibility and the amount of payment in SSI-related Medicaid and State Supplementary Assistance cases.
Source	This chart is available on line on the DHS Intranet eForms web page. No supplies are printed.
Data	Payment standards for the various categories of State Supplementary Assistance are found under the headings listed on the chart.

RC-0023 or RC-0023(S), Things You Need to Give Us for Food Assistance

Purpose	RC-0023 and RC-0023(S) are fliers used to inform applicants of the verification requirements in the application and recertification processes.
Source	The English version of the flier is printed with 50 sheets on a pad. Order supplies from Iowa Prison Industries at Anamosa. The Spanish version can be printed or photocopied from the sample in the manual.
Distribution	Give one document to each household filing an initial application for Food Assistance or an application for recertification.
Data	The flier explains what documents clients need to produce to verify their identity, alien status, social security number, residency, expenses, earnings and other income, and assets.

RC-0033, Desk Aid

Purpose

The RC-0033 is a chart of Food Assistance, FIP, and Medicaid income and resource limits. Workers can use it as a reference in determining eligibility and the amount of payment in these cases.

Source

Print RC-0033 from the manual or the DHS Intranet eForms web page.

Data

The chart lists:

- Income and resource limits for:
  - Food Assistance
  - FIP
  - FMAP and FMAP-related Medicaid
  - Mothers and Children (MAC) Medicaid
  - Medically Needy Medicaid
  - Medicaid for Kids with Special Needs (MKSN) (no resource limit)
  - SSI-related Medicaid
  - QMB (Medicare savings)
  - SLMB (Medicare savings)
  - Expanded SLMB (Medicare savings)
  - QDWP (Medicare savings)
  - Medicaid for Employed People with Disabilities
- Income limits and premium levels for Medicaid for Employed People with Disabilities
- The Medicare Part B premium

Iowa Department of Human Services

Desk Aid

COVERAGE GROUP	RESOURCE LIMIT	MONTHLY INCOME LIMITS							
Food Assistance	$3,250 if one or more age 60 or older or disabled $2,250 all other households	Household Size							
			1	2	3	4	5	6	7
		Gross	$ 1,265	$ 1,705	$ 2,144	$ 2,584	$ 3,024	$ 3,464	$ 3,904
		Net	$ 973	$ 1,311	$ 1,650	$ 1,988	$ 2,326	$ 2,665	$ 3,003
		Max Allotment	$ 194	$ 357	$ 511	$ 649	$ 771	$ 925	$ 1,022
Expanded FA Cat Elig	None	Household Size							
		1	2	3	4	5	6	7	
		$ 1,533	$ 2,069	$ 2,605	$ 3,141	$ 3,677	$ 4,213	$ 4,749	
		For each additional household member add $536.							
FIP	$2,000 per applicant household $5,000 per recipient household	Household Size							
			1	2	3	4	5	6	7
		Test 1	$ 675.25	$1,330.15	$1,570.65	$1,824.10	$2,020.20	$2,249.60	$2,469.75
		Test 2	$ 365	$ 719	$ 849	$ 986	$ 1,092	$ 1,216	$ 1,335
		Test 3	$ 183	$ 361	$ 426	$ 495	$ 548	$ 610	$ 670
FMAP and FMAP-Related Medicaid	$2,000 per applicant household $5,000 per recipient household	Household Size							
			1	2	3	4	5	6	7
		Test 1	$ 675.25	$1,330.15	$1,570.65	$1,824.10	$2,020.20	$2,249.60	$2,469.75
		Test 2	$ 365	$ 719	$ 849	$ 986	$ 1,092	$ 1,216	$ 1,335
		Test 3	$ 183	$ 361	$ 426	$ 495	$ 548	$ 610	$ 670
Mothers and Children (MAC) Medicaid *	$10,000 per household	Household Size							
		Poverty Level	1	2	3	4	5	6	7
		300% Preg. women/infants	$ 2,918	$ 3,933	$ 4,948	$ 5,963	$ 6,978	$ 7,993	$ 9,008
		For each additional household member add $1,015							
		133% Children 1-18	$ 1,294	$ 1,744	$ 2,194	$ 2,644	$ 3,094	$ 3,544	$ 3,994
		For each additional household member add $450.							
Medically Needy Medicaid *	$10,000 per household	Medically Needy Income Level (MNIL) by Household Size							
		1	2	3	4	5	6	7	
		$ 483	$ 483	$ 566	$ 666	$ 733	$ 816	$ 891	

	1	2	3	4	5	6	7
100% Poverty Level	$ 973	$ 1,311	$ 1,650	$ 1,988	$ 2,326	$ 2,665	$ 3,003
	For each additional household member add $338.						

	1	2	3	4	5	6	7
300% Poverty Level Medicaid for Kids with Special Needs (MKSN)	$ 2,918	$ 3,933	$ 4,948	$ 5,963	$ 6,978	$ 7,993	$ 9,008
	For each additional household member add $1,015.						

SSI-Related Medicaid *

$2,000 for one person

$3,000 for a couple

Household Size (couple in own home)

1	2
$ 721	$ 1,082

QMB * (A Medicare Savings Program)

$7,160 for one person

$10,750 for a couple

	Poverty Level	Household Size: Individual	Household Size: Couple
Effective 4/1/14	100%	$ 973	$ 1,311

SLMB * (A Medicare Savings Program)

$7,160 for one person

$10,750 for a couple

Poverty Level	Household Size	Income Over	But Less Than
Effective 4/1/14 Over 100% but less than 120%	Individual	$ 973	$ 1,167
	Couple	$ 1,311	$ 1,573

Expanded SLMB * (QI-1) (A Medicare Savings Program)

$7,160 for one person

$10,750 for a couple

Poverty Level	Household Size	Income	But Less Than
Effective 4/1/14 120% but less than 135%	Individual	$ 1,167	$ 1,313
	Couple	$ 1,573	$ 1,770

QDWP Medicaid * (A Medicare Savings Program)

$4,000 for one person

$6,000 for a couple

	Poverty Level	Household Size: Individual	Household Size: Couple
Effective 4/1/14	200%	$ 1,945	$ 2,622

MEPD Medicaid for Employed People with Disabilities

$12,000 for one person

$13,000 for a couple

Net countable income is less than 250% FPL

MEPD Income Limit Household Size

1	2	3	4	5	6	7	8
$ 2,432	$ 3,278	$ 4,123	$ 4,969	$ 5,815	$ 6,661	$ 7,507	$ 8,353

* Note: Compare net countable income to the income limits.

Monthly Medicare Part B Premium
(Effective 1-1-2013)
$104.90

MEPD Premiums Effective August 1, 2014

If the gross monthly income of the person getting MEPD is:	FPL	Premium Amount
$ 1,459 or less	At or below 150%	**$ 0**
Above: $ 1,459	**Above:** 150%	$ 31
1,605	165%	42
1,751	180%	50
1,945	200%	58
2,189	225%	68
2,432	250%	78
2,918	300%	99
3,404	350%	119
3,890	400%	140
4,377	450%	160
5,349	550%	201
6,322	650%	242
7,294	750%	284
8,267	850%	335
9,725	1000%	404
11,184	1150%	475
12,643	1300%	556
$ 14,393 and above	1480%	647

RC-0064, Unearned Income Desk Aid

Purpose

The *Unearned Income Desk Aid* is designed as an immediate reference about unearned income for income maintenance staff. It:

- Gives information on the documents that verify child support, unemployment benefits, SSI benefits, and social security benefits.
- Explains how to determine the receipt date for these income sources when determining initial and ongoing eligibility for the Food Assistance, FIP, and Medicaid programs.
- Lists the child support account codes to distinguish between payments that are forwarded to the client and those that are kept by the state.

Source

Print or photocopy RC-0064 from the sample in the manual if needed.

RC-0085, Guide for Citizenship and Identification

Purpose	The *Guide for Citizenship and Identification* is a tool to help ensure that each Medicaid applicant and member provides documentation of identity and citizenship with the highest level of reliability that is readily available.
Source	Print the guide from the DHS Intranet eForms web page as needed.

RC-0103, Disability Determination Checklist

Purpose	RC-0103 is used to assist income maintenance workers in submitting complete disability determination referrals to the Disability Determination Services Bureau (DDSB). It may be used as a checklist for each determination or as a general guide to ensure that all required information is included in the referral.
Source	Print RC-0103 from the manual or the DHS Intranet eForms web page.
Distribution	The worker may retain the form in the case file, but it is not required.
Data	The front of the form lists the required documentation to provide with disability referrals. The back of the form gives helpful tips for: ♦ Continuing disability reviews (CDRs). ♦ Disability referrals based on worsened conditions or new conditions. ♦ The use of form 470-0363, *Certification of Eligibility of SSI Applicant*. ♦ Concurrent determinations for Medicaid and Social Security benefits.

RC-0128, Suspending Medicaid to Limited Benefits for Incarcerated Individuals Procedure Guide

Purpose	RC-0128 is used to assist income maintenance workers in determining the correct procedure for suspending Medicaid benefits to limited services for individuals who have been incarcerated for more than 30 consecutive days. It should be used as general guide to make sure all the required steps are completed.
Source	Print RC-0128 from the sample in the manual.

Iowa Department of Human Services

Desk Aid for MAGI, MIYA, IHAWP, and *hawk-i*

COVERAGE GROUP	RESOURCE LIMIT	MONTHLY INCOME LIMITS						
MAGI Children, Parents, and Caretakers FMAP	None	**Household Size**						
		1	2	3	4	5	6	7
		$ 447	$ 716	$ 872	$ 1,033	$ 1,177	$ 1,330	$ 1,481
		For each additional household member, see policy statement						
MAGI Children and Pregnant Women	None	**Household Size**						
		Poverty Level	1	2	3	4	5	6	7
		167% Children 1-18	$ 1,624.07	$ 2,189.09	$ 2,754.10	$ 3,319.12	$ 3,884.14	$ 4,449.15	$ 5,014.17
		For each additional household member add $565.01						
		375% Infants (under 1) and Preg. women	$ 3,646.87	$ 4,915.62	$ 6,184.37	$ 7,453.12	$ 8,721.87	$ 9,990.62	$ 11,259.37
		For each additional household member add $1,268.75						
MIYA	None	**Household Size**						
		Poverty Level	1	2	3	4	5	6	7
		254%	$ 2,470.15	$ 3,329.51	$ 4,188.88	$ 5,048.25	$ 5,907.61	$ 6,766.98	$ 7,626.35
		For each additional household member $859.36						

IOWA HEALTH AND WELLNESS PLAN (IHAWP) AGE 19-64	MONTHLY INCOME LIMITS						
	1	2	3	4	5	6	7
0-100% FPL WELLNESS PLAN	$ 972.50	$1,310.83	$1,649.17	$1,987.50	$2,325.83	$2,664.17	$3,002.50
	For each additional household member add $338.33						
101-133% FPL MARKETPLACE CHOICE	$1,293.42	$1,743.40	$2,193.39	$2,643.37	$3,093.35	$3,543.34	$3,993.32
	For each additional household member add $449.98						

hawk-i UNDER AGE 19	MONTHLY INCOME LIMITS						
	1	2	3	4	5	6	7
302% FPL	$2,936.95	$3,958.71	$4,980.48	$6,002.25	$7,024.01	$8,045.78	$10,089.31
	For each additional household member add $1,021.76						

RC-0130, Desk Aid for MAGI, MIYA, IHAWP, and *hawk-i*

Purpose	RC-0130 is a chart of monthly income limits. Workers can use it as a reference in determining eligibility in these cases.
Source	Print RC-0130 from the manual or the DHS Intranet eForms web page.
Data	The chart lists income limits for: ♦ Modified adjusted gross income (MAGI) ♦ Medicaid for Independent Young Adults (MIYA) ♦ Iowa Health and Wellness Plan (IHAWP) ♦ Healthy and Well Children in Iowa (***hawk-i***)