Iowa Department of Human Services

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January 30, 2015

GENERAL LETTER NO. 6-AP-113

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 1, 4, 5, 8, and 9), revised;pages 16, 135 through 142, 160 through 165, 336, 337, 338, 358, and 359, revised; and the following forms:

470-0261(S)	*Agreement for Automatic Deposit* (Spanish), new
470-5170	*Application for Health Coverage and Help Paying Costs*, revised
470-5170(S)	*Application for Health Coverage and Help Paying Costs* (Spanish), revised
470-3144	*Attribution of Resources Appeal Summary*, revised
470-2846	*Cancellation of Premium Payment*, revised
470-2847	*Denial of Health Insurance Premium Payment*, revised
470-3016	*Health Insurance Premium Payment (HIPP) Program Review*, new
470-3017	*HIPP Private Policy Review*, new
470-5285	*Iowa Health and Wellness Plan Billing Statement*, new
470-5168	*Medicaid/**hawk-i** Review*, revised
470-5168(S)	*Medicaid/**hawk-i** Review* (Spanish), revised
470-5168(M)	*Medicaid/**hawk-i** Review* (manual), revised
470-5168(MS)	*Medicaid/**hawk-i** Review* (manual Spanish), revised
470-2588	*Notice of Attribution of Resources*, revised
470-2845	*Notice of Health Insurance Premium Payment*, revised
470-0481	*Notification to the Bureau of Refugee Services*, revised
470-0480	*Refugee Referral to IWD and to Refugee Services*, revised
470-3826	*Request for FIP Beyond 60 Months*, revised
470-3826(S)	*Request for FIP Beyond 60 Months* (Spanish), new
470-0364	*SSI Medicaid Information*, revised
470-0364(S)	*SSI Medicaid Information* (Spanish), revised
470-0364(M)	*SSI Medicaid Information* (manual), revised
470-0364(MS)	*SSI Medicaid Information* (manual Spanish), revised

Comm. 52	*Medicaid for People in Nursing Homes and Other Care Facilities*, revised
Comm. 72	*Protection of Your Resources and Income*, revised
Comm. 121	*Important Notice to Property Owners and Renters*, revised
Comm. 121(S)	*Important Notice to Property Owners and Renters* (Spanish), revised
Comm. 255 and Comm. 255(S),	*Important Information About the HIPP Program*, revised
Comm. 413	*Medicare Savings Programs*, revised
Comm. 414	*Protecting Your Resources and Income*, revised
RC-0018	*Supplemental Security Income Payment Standards*, revised
RC-0033	*Desk Aid*, revised

Summary

This chapter is revised to:

- Add the Spanish versions of the following forms:
  - 470-0261, *Agreement for Automatic Deposit*
  - 470-3826, *Request for FIP Beyond 60 Months*
- Revise form 470-5170, *Application for Health Coverage and Help Paying Costs*, and its Spanish translation, form 470-5170(S), to include a statement in the "Current Job and Income Information" sections to:
  - Remind the applicant to report income from all jobs and,
  - Explain that if the applicant leaves a space blank, we will assume no income of that kind. This allows IM to consider the applicant's self-attested income to be zero when the applicant has left an income field blank.
- Increase the minimum monthly maintenance needs allowance (MMMNA) for 2015 on form 470-3144, *Attribution of Resources Appeal Summary.*
- Revise the Health Insurance Premium Payment (HIPP) forms to:
  - Increase the size of the name and address fields,
  - Reformat the form to fit in a new envelope, and
  - Update for clarity.

  These changes were made on the following forms:

  - 470-2846, *Cancellation of Premium Payment*
  - 470-2847, *Denial of Health Insurance Premium Payment*
  - 470-3016, *Health Insurance Premium Payment (HIPP) Program Review*
  - 470-3017, *HIPP Private Policy Review*
  - 470-2845, *Notice of Health Insurance Premium Payment*
- Add instructions and form 470-5285, *Iowa Health and Wellness Plan Billing Statement*. This system-generated form is issued to Iowa Health and Wellness Plan members that have been assessed a premium.

- Remove the language to send proof when returning the form on:
  - 470-5168, *Medicaid/**hawk-i** Review*
  - 470-5168(S), *Medicaid/**hawk-i** Review* (Spanish)
  - 470-5168(M), *Medicaid/**hawk-i** Review* (manual)
  - 470-5168(MS), *Medicaid/**hawk-i** Review* manual Spanish)
- Change form 470-2588, *Notice of Attribution of Resources*, to:
  - Increase the minimum monthly maintenance needs allowance (MMMNA) for 2015.
  - Increase the maximum community spouse resource allowance for 2015.
  - Add language to clarify that the attribution is not a determination of the fair market value when determining if there is a transfer of assets.
- Revise the address for the Bureau of Refugee Services on the following forms:
  - 470-0481, *Notification to the Bureau of Refugee Services*
  - 470-0480, *Refugee Referral to IWD and to Refugee Services*
- Update the name of the *Financial Support Application* on form 470-3826, *Request for FIP Beyond 60 Months*.
- Remove form 470-0506, *Service Report.* The form has been replaced by milestones in ISIS and communication by email.
- Update the appeal rights and nondiscrimination language on Comm. 52, *Medicaid for People in Nursing Homes and Other Care Facilities*.
- Update the:
  - Maximum community spouse resource allowance,
  - 300 percent of the SSI benefit level for one person, and
  - Minimum monthly maintenance needs allowance (MMMNA)

  These changes were made for 2015 on the following:
  - Comm. 72, *Protection of Your Resources and Income*
  - Comm. 414, *Protecting Your Resources and Income*
- Increase the maximum income amount for property tax credits and rent reimbursements from $21,697.99 to $22,011.00 per year for 2014 (filed after January 1, 2015). The increase was made on Comm. 121 and Comm. 121(S), *Important Notice for Property Owners and Renters*, and was added to the following forms:
  - 470-0364, *SSI Medicaid Information*
  - 470-0364(S), *SSI Medicaid Information* (Spanish)
  - 470-0364(M), *SSI Medicaid Information* (manual)
  - 470-0364(MS), *SSI Medicaid Information* (manual Spanish)
- Update Comm. 255 and Comm. 255(S), *Important Information About the HIPP Program*, to:
  - Exclude information on the IowaCare program.
  - Update program information.
  - Reflect the Department's branding.

Members and providers receive the this brochure when attending educational and outreach events. The Spanish version has been updated and is on the backside of the English brochure.

- Update Comm. 413, *Medicare Savings Programs*, due to an increase in the 2015 resource limits.
- Change RC-0018, *Supplemental Security Income Payment Standards*, to update the SSI-related Medicaid and State Supplementary Assistance income limits due to the Social Security and SSI cost-of-living increases effective January 1, 2015.
- Change RC-0033, *Desk Aid*, to:
  - Correct the monthly income limits for the expanded Food Assistance categorical eligibility coverage group effective October 1, 2014.
  - Increase the SSI-related income limits due to the Social Security and SSI cost-of-living increases effective January 1, 2015.
  - Increase the resource limits for an individual and couples on the QMB, SLMB, and E-SLMB programs for 2015.

Effective Date

The changes to the HIPP forms are effective January 20, 2015.

All other changes are effective January 1, 2015.

Material Superseded

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

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Comm. 121(S)	1/14
Comm. 255-Comm. 255(S)	3/10
Comm. 413	1/14
Comm. 414	1/14
RC-0018	1/14
RC-0033	11/14

Additional Information

Use up any existing supplies of Comm. 52, dated 4/13. Order supplies of Comm. 52, dated 1/15, from Anamosa in the usual manner.

Use up any existing supplies of Comm. 72, dated 1/14. Order supplies of Comm. 72, dated 1/15, from Anamosa in the usual manner.

Use up any existing supplies of Comm. 255 – Comm. 255(S), dated 3/10. Order supplies of Comm. 255 – Comm. 255(S), dated 12/14, from Anamosa in the usual manner.

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

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

Purpose	The *Agreement for Automatic Deposit* authorizes the Department to deposit payments automatically into a participant's financial institution account.
Source	Print form 470-0261 or 470-0261(S) from the on line manual or the DHS Intranet eForms web page or photocopy the samples in the manual.
Completion	Give this form to the following clients who want to start, change, or stop automated deposits: ♦ Family Investment Program (FIP) or Refugee Cash Assistance (RCA) clients receiving grants. (Any other cash assistance payments authorized on FIP or RCA cases will also be automatically deposited.) ♦ Facility residents who receive the state-funded payment for the difference between their countable income and the personal needs allowance. The participant completes the form and returns it with a voided check for the account. A deposit slip should be provided for savings accounts that do not provide checks.
Distribution	File the original in the case record after DIRD entries are made to start, change, or stop automated deposit. Give a copy to the client.
Data	The form indicates whether the client wants to start, stop, or change automated deposit, and gives information about the client's financial institution.

Iowa Department of Human Services

Agreement for Automatic Deposit
(Autorización para depósito automático)

Inicie, cambie o cancele su depósito automático

Marque la casilla correspondiente a lo que desea hacer.

☐ Quiero depositar mis beneficios en mi cuenta. Autorizo a mi banco o a mi cooperativa de ahorro y crédito a acreditar mis beneficios en la cuenta que se indica a continuación.

Los depósitos automáticos comenzarán cuando nuestro sistema se lo notifique a su banco o a su cooperativa de ahorro y crédito. Dicha notificación puede tardar hasta 10 días, así que podría recibir el cheque del próximo mes por correo.

☐ Quiero cambiar mi depósito automático a la cuenta que se indica a continuación. Autorizo a mi banco o a mi cooperativa de ahorro y crédito a acreditar mis beneficios en la cuenta que se indica a continuación.

☐ Quiero cancelar mi autorización para que mis beneficios sean depositados en mi cuenta.

Información sobre usted y su cuenta

Complete sus datos y los de su banco o cooperativa de ahorro y crédito. Tendrá que buscar los datos en uno de sus cheques.

Su **número de identificación bancaria** ("***route number***") es el número de 9 dígitos en la esquina inferior izquierda de su cheque. Se encuentra entre estos símbolos **I:** . **No** utilice el número de identificación bancaria del comprobante de depósito. Los números no son los mismos.

Si desea depositar sus beneficios en una cuenta de ahorro, comuníquese con su banco o con su cooperativa de ahorro y crédito para conseguir el número correcto.

Su **número de cuenta** es el número a la derecha del número de identificación bancara. La longitud del número puede variar, pero normalmente tiene 12 dígitos. Termina con el símbolo **II**⚑.

Su nombre (en letra de imprenta)		
Nombre de su banco o cooperativa de ahorro y crédito		
Ciudad	Estado	Código postal
Nº de identificación bancaria	Número de cuenta	
Tipo de cuenta: ☐ Cheques ☐ Ahorros		
Firma	Fecha	

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: You must tell us about the income of the people in your household. If someone has more than one job, tell us about all jobs. If you leave a space blank, we will assume that you have no income of this kind.

☐ **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).

		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 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: You must tell us about the income of the people in your household. If someone has more than one job, tell us about all jobs. If you leave a space blank, we will assume that you have no income of this kind.

- ☐ **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).

☐ 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 *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: Debe informarnos sobre los ingresos de su grupo familiar. Si alguien tiene más de un empleo, infórmenos sobre todos los empleos. Si deja espacios en blanco, asumiremos que no tienen ingresos de ese tipo.

- ☐ **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).

☐ Ninguno

		Frecuencia			Frecuencia
☐ 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: Debe informarnos sobre los ingresos de su grupo familiar. Si alguien tiene más de un empleo, infórmenos sobre todos los empleos. Si deja espacios en blanco, asumiremos que no tienen ingresos de ese tipo.

- ☐ **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).

☐ Ninguno

		Frecuencia			Frecuencia
☐ 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)	

Iowa Department of Human Services

Attribution of Resources Appeal Summary

Appeal Number		Worker No.	County No.
Name of Spouse in Facility or Waiver			Birthdate
Name of Spouse at Home		Age on Date of Appeal	Birthdate
Date of Application for Attribution	Date of Application for Assistance		Date Appeal was Filed

☐ Date institutionalized spouse entered medical institution (includes hospital, nursing facility care, etc.), or date IFMC approves waiver:

☐ Date the waiver applicant met level of care criteria in a medical institution as established by the peer review organization:

Total of current combined resources (if different from attribution amount): $ _____

A. Minimum monthly maintenance needs allowance as of the date of the appeal. **A** 2,980.50

B. Community spouse gross income not derived from countable resources:

Social Security (gross)	
Employment (gross wages)	
Private Pension	
IPERS	
Other Income (specify):	

B	
C	
D	
E	

C. Available income from institutionalized spouse to community spouse if entered a facility or waiver on or after February 8, 2006. Should be zero if entered before February 8, 2006.

D. **Total monthly income (B + C)**

E. **Shortfall of income (A – D)**

At least one quote must be obtained from an insurance company for single-premium immediate lifetime annuities that will provide the community spouse a monthly payment equal to the shortfall of income from the minimum monthly maintenance needs allowance as of the date of the appeal. The bids shall be for life annuities with no remainder or term-certain payments.

AN ANNUITY DOES NOT NEED TO BE PURCHASED BY THE APPLICANT OR THE COMMUNITY SPOUSE. The annuity estimate is used to determine the amount of resources needed to provide the community spouse with an adequate monthly income.

ATTACHMENTS:

1. Application for attribution and application for assistance (if applicable).
2. Copy of the annuity bid.
3. Information regarding any questionable resources (if applicable).
4. Other evidence the parties wish to submit (if applicable).

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

Date:

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

Cancellation of Premium Payment

The Iowa Department of Human Services, based upon a review or re-evaluation of your Health Insurance Premium Payment (HIPP) case, has made the following decision concerning your participation in the HIPP program:

Comments: Any questions or concerns regarding this action should be referred to the HIPP worker listed above.

SEE OTHER SIDE FOR YOUR APPEAL RIGHTS

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?

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- 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:

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HIPP

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Date:

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

Denial of Health Insurance Premium Payment

THIS DECISION DOES NOT AFFECT YOUR MEDICAID (TITLE 19) COVERAGE.

The Iowa Department of Human Services has reviewed your participation in the Health Insurance Premium Payment (HIPP) program and has made the following decision that will not affect the Medicaid coverage of your household.

Comments:

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PO Box 36476
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HIPP Worker:
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E-mail: HIPP@dhs.state.ia.us

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HIPP Copy

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Health Insurance Premium Payment (HIPP) Program Outreach Letter, Form 470-5075

Purpose	Form 470-5075 is used for outreach to provide information regarding the Health Insurance Premium Payment (HIPP) program.
Source	IME Member Services Unit staff may order printed supplies of form 470-5075 from Iowa Prison Industries at Anamosa. HIPP unit staff use the copy stored on their computers.
Completion	The IME Member Services Unit encloses this form in the managed care packets sent to new Medicaid members. The HIPP Unit issues the form to pregnant women and members with high Medicaid bills. The HIPP Unit adds to member's name and address.
Distribution	The form is mailed to the Medicaid member.
Data	The form includes information about: ♦ What benefits the HIPP program provides ♦ How to contact the HIPP program

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

Purpose	Form 470-3016 is used for reviewing eligibility factors of employer-sponsored health insurance policies on active HIPP cases.
Source	Form 470-3016 is system-generated by the HIPP Unit.
Completion	The member completes the form.
Distribution	Separate copies are printed through Elixir and sent to the: ♦ Policyholder. ♦ HIPP file.
Data	The HIPP income maintenance worker shall process completed reviews to determine if it is cost-effective to continue premium payment reimbursement.

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

Date:

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

Health Insurance Premium Payment (HIPP) Program Review

Dear

It is time for the Iowa Department of Human Services to complete a review of your eligibility for the HIPP program. Complete and return items 1-3 listed below. Please fax, email, or mail the information listed below. We cannot return original documents.

What you must do:

1. Sign, date, and provide your phone number on the section labeled *Permission to Release Information on form* 470-3016, *Employer Verification for HIPP,* and then give the signed review form to your employer to complete.
2. Complete form 470-2868, *Medical History Questionnaire*, for everyone in your home who gets Medicaid and is also covered by your health insurance.
3. Send in a copy of:
   - Your most recent paystub that shows your health insurance deduction.
   - A copy of the front and back of your health insurance cards (not Medicaid cards).

IMPORTANT: To make sure your HIPP payments do not stop, all of the information listed above must be received in this office by .

Employer Verification for HIPP

IOWA DEPARTMENT OF HUMAN SERVICES Iowa Medicaid Enterprise-HIPP Unit PO Box 36476 Des Moines, IA 50315-9907	Date: HIPP Worker: Local Calls: 515-974- Toll Free: 1-888-346-9562 Fax: (515) 725-0725 E-mail: HIPP@dhs.state.ia.us

Permission to Release Information

My employer has my permission to give information about my health insurance benefits to the staff of the Iowa Department of Human Services. This information may be discussed either verbally or in writing. This permission will end thirteen months from the date of my signature. I understand that I have the right to notify my employer if I want the permission to end at an earlier date.

Name of Employee:	Phone Number:
Signature of Employee:	Date:

Give this form to your employer to complete.

Directions for completing this form.

Name of Employer:
Please return by:

The Health Insurance Premium Payment (HIPP) program is reviewing eligibility for

The amount/s the HIPP program reimburses for your employee or to your company is not necessarily the amount the employee has deducted from their paycheck. For example, the HIPP program may only reimburse for an employee + child(ren) plan even though the employee may pay for a family plan. If your employee is enrolled in a family plan and we are reimbursing at the employee + child(ren) rates, provide both rates so we can match the rates back to the paystub.

Please call if you have any questions or need help completing this review form. When you are done, give the completed review form back to your employee or let them know if you send it to us directly. Thank you!

1. The people covered under the employer sponsored health insurance are listed below. Mark yes if the person is covered by the health insurance or no if not covered by the health insurance. If someone is not listed that does have coverage, provide the individuals full name and the effective date of coverage on the back of this form in the comments section.

	☐ Yes ☐ No		☐ Yes ☐ No
	☐ Yes ☐ No		☐ Yes ☐ No
	☐ Yes ☐ No		☐ Yes ☐ No

	☐ Yes ☐ No		☐ Yes ☐ No
	☐ Yes ☐ No		☐ Yes ☐ No
	☐ Yes ☐ No		☐ Yes ☐ No
	☐ Yes ☐ No		☐ Yes ☐ No
	☐ Yes ☐ No		☐ Yes ☐ No
	☐ Yes ☐ No		☐ Yes ☐ No

Has any of this information listed below changed? Mark correct or not correct for each section. If you mark not correct, please explain below in the comments and provided verification.

2. Health Insurance Premium Amount: $	☐ Correct ☐ Not Correct
3. Frequency of payroll deduction for insurance:	☐ Correct ☐ Not Correct
4. Health Insurance Deductible: Single $ Family $	☐ Correct ☐ Not Correct
5. Plan:	☐ Correct ☐ Not Correct
6. Health Insurance Carrier:	☐ Correct ☐ Not Correct

7. Are there any wellness/health credits or special rates for smoker/non-smoker? If so, please include an explanation of how much they are worth and how they are used.

8. Circle the day of the week the employee gets paid: M T W Th F Sa Su

9. Are there any changes planned for the health insurance? For example, carrier change, increase in deductibles, etc. ☐ Yes ☐ No If yes, explain.

Comments:

Employer Representative Name (print)		Signature of Employer Representative	
Date	Phone number	Fax Number	E-mail address

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 the 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) 974-3282
Fax (515) 725-0725
HIPP Unit, PO Box 36476, Des Moines, IA 50315-9907

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

Purpose

The *Health Services Application* is designed to assist people applying for various health-related programs, including SSI-related, FMAP-related and refugee Medicaid and Medically Needy, and State Supplementary Assistance.

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

Source

Form 470-2927 is printed with 30 sets on a pad. The Spanish version, 470-2927(S), is printed with 10 sets on a pad. Order supplies of both from Iowa Prison Industries at Anamosa.

Completion

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

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

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

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

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

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

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

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

Distribution

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

When the application is filed at a **DHS office** and the applicant requests WIC or maternal and child health services in addition to Medicaid, fax or photocopy and mail the application to the local WIC or maternal and child health services office within two working days of receipt.

If necessary to determine the appropriate office, call the Department of Public Health at 1-800-383-3826 to obtain the name, address, and telephone number.

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

Data

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

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

For the WIC appointment date:

- If possible, contact the WIC office serving the applicant's county of residence and set up an appointment for the person while the person is in your office.
- If this is not possible, provide the applicant with the telephone number of the WIC office.
- If the application was filed by mail, indicate that no WIC appointment was made and no WIC telephone number was given.

Health Services Application Narrative, Form 470-3898

Purpose	Use form 470-3898 to document pertinent Medicaid eligibility factors when the *Health Services Application* is submitted as an application or review form.
Source	Complete form 470-3898 on line using the template on the DHS Intranet eForms web page.
Completion	The IM worker completes one copy of the form when processing a *Health Services Application* form as: ♦ An application, or ♦ A SSI-related program review.
Distribution	File the original of the form in the case record.
Data	Complete the applicable sections on the narrative to document the client's disability information, income, and resources. Provide additional pertinent information in the "comments" section of the form. Sign and date the narrative at the bottom of the form.

HIPP Medical History Questionnaire, Form 470-2868

Purpose	Form 470-2868 is designed to secure additional information regarding specific health-related circumstances of a household for the Health Insurance Premium Payment (HIPP) Unit. The form is used to establish whether the family's Medicaid utilization may be higher than average.
Source	Form 470-2868 is system-generated or produced by the HIPP Unit.
Completion	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.

HIPP Private Policy Review, Form 470-3017

Purpose	Form 470-3017 is used for reviewing eligibility factors of private health insurance policies on active HIPP cases.
Source	Form 470-3017 is system-generated by the HIPP Unit.
Completion	The member completes the form.
Distribution	Separate copies are printed through Elixir and sent to the: ♦ Policyholder. ♦ HIPP file.
Data	The HIPP income maintenance worker shall process completed reviews to determine if it is cost-effective to continue premium payment reimbursement.

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

Date:

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

HIPP Private Policy Review

Dear

The Iowa Department of Human Services is reviewing your eligibility for the Health Insurance Premium Payment (HIPP) program. This program pays for the cost of health insurance premiums for Medicaid eligibles when it is determined cost-effective to do so.

To make sure the HIPP program is paying correctly please answer questions 1-5 listed below:

1. What is your current insurance premium amount? $_____
2. Circle the frequency of your premiums: Monthly, Quarterly, Semi-Annually, Annually,

   Other _____
3. What are your deductible amounts: Single $_____ Family $_____
4. What is your policy number? _____
5. What is the name of your insurance company? _____

To make sure the HIPP program is paying correctly please turn in the items 6-9 listed below:

6. The HIPP Medical History Questionnaire on the back of this letter.
7. A copy of your private health insurance card.
8. Verification of premiums paid to your insurance company (bank or credit card statement).
9. From your insurance agent or carrier, an itemized breakdown on the total premium. Proof of what is the cost for each person for medical coverage.

IMPORTANT: To make sure your HIPP payments do not stop, all of the information listed above must be received in this office by .

Remember to report if there is a change in premiums cost, deductibles, or if the health insurance ends.

OVER⇒

Signature	**Date**
Phone Numbers	**Email address**

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 the 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) 974-3282
Fax (515) 725-0725
HIPP Unit, PO Box 36476, Des Moines, IA 50315-9907

Iowa Health and Wellness Plan Billing Statement, Form 470-5285

Purpose	The *Iowa Health and Wellness Plan Billing Statement* is sent to members in the Iowa Health and Wellness Plan (IHAWP) coverage group when a premium is assessed.
Source	The statement is computer-generated from the OnBase billing system at Iowa Medicaid Enterprise (IME). When a member reports non-receipt of a billing statement, advise the member to contact Member Services at IME.
Completion	The billing statement is issued directly from IME. A pre-addressed envelope is included for members to remit premium payments.
Distribution	One copy of the billing statement is mailed to the member. If a copy of the billing statement is needed for an appeal, contact Member Services at IME to request a copy.
Data	The billing statement: ♦ Contains the billing date, the case name and address, and the member's state identification number. ♦ Identifies the months, the amount owed per month, the payment due date, payment history, and Department contact information. ♦ Allows the member the opportunity to claim financial hardship for inability to pay the monthly premium. ♦ Instructs members to remit the bottom portion of the statement with payment, using the envelope provided.

Iowa Health and Wellness Plan Billing Statement

0000001
John Doe
123 Main Street
Anytown, Iowa 00000-0000

Billing Date: 05/25/15
Due Date: 06/15/14
Invoice: 000000000000000
Member ID: 0000000X

Hi John Doe,

As a member of the Iowa Health and Wellness Plan it is your responsibility to pay a member contribution. This statement tells you how much your contribution is and when it is due.

1. The total amount that you owe is $15.00. This amount is due 06/15/14.

2. Please return the amount owed with the payment coupon below. Make your check out to *Iowa Health and Wellness Plan Contributions*. Please do not send cash or any other documents with your payment.

3. If you are unable to pay your contribution, please check the hardship box below and return the payment coupon OR call Member Services at 1-800-338-8366. ***Important note: Checking the box below to claim financial hardship will apply to this month's amount due only. You will still be responsible for amounts due from past months.***

If you have any questions please call Member Services at **1-800-338-8366** Monday through Friday, from 8:00 a.m. to 5:00 p.m.

470-5285 (09/14)

TEAR HERE, KEEP ABOVE FOR YOUR RECORDS

RETURN BELOW WITH PAYMENT

Iowa Department of Human Services

☐ Hardship: By checking this box I am claiming financial hardship (see more information about hardship on back side).

Due Date: 06/15/14
Member ID: 0000000X 0
Amount Due: $15.00

John Doe
123 Main Street
Anytown, Iowa 00000-0000

Make check or money order out to:
Iowa Medicaid Enterprise
Iowa Health and Wellness Plan Contributions
PO Box 14485
Des Moines, IA 50306-3485

Amount Due: $15.00

Paid: $ ☐☐☐☐☐

DO NOT SEND CASH

00000006 0 0000000000 06152015 001500 1

Payment History

Premium Month	Contribution	Paid Date	Invoice Number	Amount Due	Hardship
January 2015	$5.00	01/17/15	0000000000000000	$5.00	
February 2015	$5.00	02/19/15	0000000000000000	$5.00	
March 2015	$0.00	03/12/15	0000000000000000	$5.00	$5.00
April 2015	$0.00		0000000000000000	$5.00	
May 2015	$0.00		0000000000000000	$5.00	
June 2015	$0.00		0000000000000000	$5.00	

Credit Amount: $0.00 **Total Amount Due: $15.00**

Call **1-800-338-8366** or **515-256-4606** in Des Moines, M-F 8am–5pm. Visit us on the web at www.dhs.iowa.gov

Para solicitar este documento en español, comuníquese con Servicios para Miembros al teléfono 1-800-388-8366 de 8:00 a.m. a 5:00 p.m., de lunes a viernes.

Iowa Department of Human Services

470-5285 (09/14)

TEAR HERE, KEEP ABOVE FOR YOUR RECORDS

RETURN BELOW WITH PAYMENT

Financial Hardship

If you are unable to pay the amount due, you must either call Member Services at 1-800-338-8366 OR check the hardship box on the front side of this coupon and mail it back to the IME. **By checking the hardship box you are stating that you have spent or will spend your monthly income on food, housing, utilities, transportation or other health care, and are unable to pay your Iowa Health and Wellness Plan member contribution for this month. Claiming financial hardship will count for this month only, not amounts due from past months.** This payment coupon must be received at the address shown and must be complete. If the claim for hardship is not received by the due date shown on the front you will still owe the member contribution for this month.

KEEP THIS PAGE FOR PROGRAM INFORMATION, DO NOT RETURN

Healthy Behaviors Program 2015

Your health coverage for 2016 could be free of cost by completing the Healthy Behaviors Program in 2015. To complete the Healthy Behaviors Program you need to complete a Health Risk Assessment AND get a wellness exam or physical with your provider. Finishing both steps means you will not pay a monthly contribution in 2016.

To complete your Health Risk Assessment (HRA) follow these steps:

1. Call you provider to get their special HRA code. Use MBR11 if your provider does not have a code.
2. Visit www.AssessMyHealth.com and enter the special code.
3. Answer all of the HRA questions the best that you can.
4. Enter your Medicaid member ID number when your finished and select 'yes' to share your results with your provider.
5. Talk about the results with your provider at your next office visit.

To complete your Wellness Exam follow these steps:

1. Call your primary care provider and schedule your check-up.
2. Talk to your provider about your health risk assessment results. Your provider might be able to help with any health goals you may have.
3. Keep your future appointments and work with your provider to stay healthy.

Important Family Changes

If there is a change in your family income or size in your family, let us know. A change in income could also mean a change in your member contribution. You can call 1-877-347-5678 Monday through Friday from 7:00 a.m. until 6:00 p.m.

New Year, Healthier You!

With the Iowa Health and Wellness Plan your annual physicals are covered at no cost to you. An annual physical can be a first step to kick starting health goals for the new year.

The physical will allow for you to find out where you stand and how you can make healthier decisions. If you have had any health concerns or new goals like eating healthier, write them down and take them with you to your check-up. Talk with your provider about them. Your provider may have helpful tips.

Iowa Department of Human Services

Questions? Call **1-800-338-8366** or **515-256-4606** locally in the Des Moines area, M-F 8am – 5pm. Visit us on the web at www.dhs.iowa.gov

Para solicitar este documento en español, comuníquese con Servicios para Miembros al teléfono 1-800-388-8366 de 8:00 a.m. a 5:00 p.m., de lunes a viernes.

470-5285 (09/14)

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

KEEP THIS PAGE

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

Purpose

Medicaid members in managed health care counties can use form 470-2168 or 470-2168(S) to register a choice of enrollment or a change in enrollment regarding their managed health care options.

This form does not function as a notice of enrollment to the managed health care provider. The IME Member Services Unit collects this information and generates an enrollment tape monthly. The Department then notifies the managed health care providers.

Source

This form is a one-page self-mailer addressed to the IME Member Services Unit. The IME Member Services Unit issues this form as part of the enrollment packet mailed to each new Medicaid case approved in a managed care county.

Make supplies of this form available to members at Department offices. (Obtain supplies from the IME Member Services Unit.) The form is also available through the Member Services call center toll-free at 1-800-338-8366 or (515) 725-1003 in the Des Moines area and at some participating managed health care providers.

Completion

The Medicaid member (or someone acting on the member's behalf) may complete this form to choose or change a managed health care option. (These choices can also be registered by phone to the numbers listed on the form.)

Distribution

A Department office or managed health care provider that receives a completed request form from a member should send the form to IME Member Services Unit.

Data

The member enters:

- The name or number of the county where the family resides.
- The date this request is signed.
- The last name, first name, and middle initial, birth date, and state ID number of every person in the family who is eligible to enroll in managed health care.

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

IPV Referral Cover Sheet, Form 470-3035

Purpose	Form 470-3035 transmits a request for an administrative disqualification hearing to determine if a client has committed an intentional program violation (IPV) under the Food Assistance program.
Source	Complete the form on line using the template available on the DHS Intranet eForms web page.
Completion	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 165 through 170 are reserved for future use.

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 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.
- Envíenos el formulario al domicilio indicado anteriormente, 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 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.
- Envíenos el formulario al domicilio indicado anteriormente, 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)	

☐ Original
☐ Revised

Iowa Department of Human Services

Notice of Attribution of Resources

Today's Date _____

Effective Date _____

Worker	County No.	Phone ( )
Name of Spouse in Facility or Waiver	Social Security Number	
Name of Spouse at Home	Social Security Number	

The amount of your resources as of the first of the month in which the spouse named above entered a medical facility are listed below. If you want to apply for Medicaid, you must also complete either the *Health and Financial Support Application* or the *Health Services Application*.

Countable Resources	Spouse in Facility	Spouse at Home	Total
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
The resources not counted are:		**Total**	

The amount of resources attributed to the spouse at home is:

☐ The minimum community spouse resource allowance of $_____.

☐ The maximum community spouse resource allowance of $_____. The maximum resource allowance will change each January. Contact the Department of Human Services to find out the revised amount.

☐ The amount established by court order $_____.

☐ The amount adequate to provide the minimum monthly maintenance needs allowance. The community spouse resource allowance per the appeal decision of $_____.

☐ One-half of the total countable spousal resources $_____.

All remaining resources are attributed to the spouse in the facility. The resource limit for the institutionalized spouse is $2,000. As of the date of entry, the institutionalized spouse is attributed $_____.

If you disagree with this attribution or believe that the income generated by the amount attributed to the spouse at home is not enough to meet the minimum monthly maintenance needs allowance of $2,980.50 for the spouse at home, you have the right to appeal. See the back of this form.

Retain this form for your Medicaid application when you need medical assistance.

The institutionalized spouse must transfer the resources attributed to the community spouse to the community spouse to remain eligible within 90 days of the date Medicaid eligibility is established. See your worker for further information.

This attribution is not a determination of fair market value. Any transfer of assets for less than fair market value may result in a period of ineligibility for Medicaid benefits. See 441 Iowa Admin. Code 75.23(249A).

441 IAC 75.5(249A); EM 8-D – Attribution of Resources

You Have the Right to Appeal

What is an appeal?

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

How do I appeal?

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

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

Send or take your appeal to the Department of Human Services, Appeals Section, 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 must file an appeal:

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

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

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

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

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

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

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

How will I know if I get a hearing?

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

Can I have someone else help me in the hearing?

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

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

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

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

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

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

Date:

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

Notice of Health Insurance Premium Payment

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

PAYMENT INFORMATION

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

Policyholder Name:

Employers Name:

Health Insurance Carrier:

Health Insurance Policy Number:

Health Insurance Premium Amount: $

Frequency of payroll deduction for insurance:

Health Insurance Deductible: Single $ Family $

Effective Date of Health Insurance Premium Payment:

Premiums will be paid in the following manner:

RECIPIENTS COVERED UNDER THIS POLICY

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

Name	Date of Birth	Name	Date of Birth

Comments:

PLEASE READ IMPORTANT NOTICE ON OTHER SIDE

IMPORTANT NOTICE

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

Medicaid (Title 19) Eligibility

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

Reporting Changes

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

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

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

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

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

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

You Have the Right to Appeal

What is an appeal?

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

How do I appeal?

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

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

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

How long do I have to appeal?

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

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

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

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

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

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

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

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

How will I know if I get a hearing?

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

Can I have someone else help me in the hearing?

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

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

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

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

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

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

Date:

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

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Policyholder Name:

Employers Name:

Health Insurance Carrier:

Health Insurance Policy Number:

Health Insurance Premium Amount: $

Frequency of payroll deduction for insurance:

Health Insurance Deductible: Single $ Family $

Effective Date of Health Insurance Premium Payment:

Premiums will be paid in the following manner:

MEDICAID RECIPIENTS COVERED UNDER THIS POLICY

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

Name	Date of Birth	Name	Date of Birth

Comments:

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HIPP File

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

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Iowa Department of Human Services

Notification to the Bureau of Refugee Services

Applicant's Name			Date of Entry	
Social Security No.	Alien No.		Phone Number ( )	
Street	City		State	Zip Code

Secondary Migrant ☐ Yes ☐ No

Total No. of People in Family

Date of Application

Type of Assistance Applied for

Voluntary Resettlement Agency

Sponsor's Name		Phone Number ( )	
Street	City	State	Zip Code

IM Worker Name

IM Phone Number ( )	County Name

Form 470-0480, *Refugee Referral to Iowa Workforce Development and to Bureau of Refugee Services*, was given to:

Client Name	Date
Client Name	Date

Additional comments of help to the Bureau of Refugee Services:

Please attach a copy of the refugee's immigration document to this form and send to:

Bureau of Refugee Services
1914 Carpenter
Des Moines IA 50314

Iowa Department of Human Services

Refugee Referral to IWD and to Refugee Services

APPLICANT: You are instructed to report in person and present this form to the Iowa Workforce Development Office at . You must register for employment. After Iowa Workforce Development has signed this form, you must register with the Bureau of Refugee Services by sending this form to the address shown below.

The Bureau of Refugee Services will sign and return this form to your income maintenance worker. Your worker cannot determine your eligibility for assistance without this form. If you have any questions, call the Bureau of Refugee Services at 1-800-362-2780 or 515-875-5600 if calling locally in Des Moines.

TO: Iowa Workforce Development

THIS WILL INTRODUCE:

Name	
Address	
Social Security Number	Case Number

IM Worker's Name	Date
Office Address	

Iowa Workforce Development Signature	Date

Bureau of Refugee Services Signature	Date

Original – IM file Copy 1 – Refugee Services Copy 2 – Control

470-0480 (Rev. 12/14)

Mail to:

Bureau of Refugee Services
1914 Carpenter
Des Moines IA 50314

Request for FIP Beyond 60 Months, Form 470-3826 or 470-3826(S)

Purpose

Assistance from the Family Investment Program (FIP) is limited to a total of 60 months. The only way families may receive FIP beyond 60 months is if they request and are determined eligible for a "hardship exemption."

Form 470-3826 or 470-3826(S) is the form families must complete to request a hardship exemption. Receipt of the form in any DHS or PROMISE JOBS office protects the date of the request.

The form is also an authorization for release of information that allows IM, PROMISE JOBS, Service, and FaDSS staff to share with each other substance abuse, mental health and AIDS/HIV-related information about the family that may be relevant to the hardship exemption determination.

Source

Obtain form 470-3826:

- From the Eligibility Tracking System (ETS), either from:
  - The "Form History" page, or
  - The "Active Cases That Have Used FIP For 36 or More Months" report
- By printing or photocopying the form from the sample in the manual.

Print or photocopy supplies of form 470-3826(S) from the sample in the manual.

Completion

The hardship exemption applicant completes form 470-3826 or 470-3826(S). Issue the form to the family. Include a return envelope for the applicant to send the form to the scanning center. Document the date you issue the form in the case record.

Distribution

The applicant submits form 470-3826 or 470-3826(S) to any DHS or PROMISE JOBS office. If a PROMISE JOBS office receives the form, the office must forward the form to the IM worker within one working day.

Return a copy of form 470-3826 or 470-3826(S) to the family as a record of the authorization to share information.

Iowa Department of Human Services

Request for FIP Beyond 60 Months

Introduction

Under federal law, families can get Family Investment Program (FIP) for up to 60 months in their lifetime. The only way families can get FIP for more than 60 months is if they have a hardship that keeps them from supporting themselves. This is called a hardship exemption.

Why do families get a hardship exemption?

Families may get a hardship exemption for the following reasons:

- Domestic violence
- Not enough skills to get or keep a job
- Quality child care not available
- Physical or mental health problems or disability
- Housing situation makes it difficult or impossible to work
- Substance abuse problems
- A parent needs to be at home to care for a child with special problems
- Other hardship reasons that keep the family from being self-supporting

How do I ask for a hardship exemption?

You can ask for a hardship exemption if you've been on FIP for at least 59 months. Your local Department of Human Services (DHS) office can tell you how many months you've been on FIP.

To get a hardship exemption, you must:

1. **Fill out this form and return it** to your local DHS or PROMISE JOBS office. If you are not on FIP now, you must also fill out a *Financial Support Application*. You can get the application from the local DHS office.

2. **Give proof of your hardship.** The DHS worker will tell you what's needed and when. The worker can help you get the proof or suggest ways you can get it. Proof can be things like:

   - Copies of medical, psychological, psychiatric, child protective, social services, court or police records.
   - Proof that you've applied for disability benefits or Supplemental Security Income (SSI).
   - Signed statements from doctors, psychologists, psychiatrists, domestic violence counselors, substance abuse counselors, job training or vocational rehabilitation counselors, or others who know about your family's hardship.
   - Written statements from friends and relatives along with other proof.

3. **Meet with PROMISE JOBS and sign a six-month Family Investment Agreement (FIA).** The FIA will list the steps you'll take to overcome your hardship. When both parents are in the home, both must sign the FIA. Other members of your family may also have to sign the FIA. You'll get a letter telling you where and when to meet with PROMISE JOBS, and who must come to the meeting.

If you don't follow the three steps above, your hardship exemption will be denied.

What will happen if I get a hardship exemption?

If you're approved for a hardship exemption, you must follow the steps in your FIA and meet all other FIP rules. If you don't follow the FIA, you will have chosen a Limited Benefit Plan and your FIP could stop before the six-month period is over.

If you follow the steps in your FIA and still have a hardship at the end of your six-month period, you can ask for anothersix-month hardship exemption. You'll have to set up a new FIA.

You'll get a written notice to approve or deny your hardship exemption request. You'll usually get this notice within 30 days of asking for a hardship exemption. Once you get the notice, you have the right to ask for a hearing if you disagree with the decision.

What do I need to fill out?

If you want to ask for a hardship exemption, fill out this information and read and **sign page 3**.

First name	Middle name	Last name
Social Security No.	Date of birth	Phone number
Name of other parent or stepparent in the home		
Street address		
Mailing address (if different)		
City	State	Zip code

Tell us about your hardship and how it keeps you from supporting yourself.

_____

_____

_____

_____

_____

_____

_____

Please read this page carefully. If you agree to the terms and want to ask for a hardship exemption, sign and date the form at the bottom of this page.

Return the form, along with any proof you have, to your local DHS or PROMISE JOBS office. Giving proof about your hardship right away may help us make a decision faster.

Agreement to Release Information

I agree that DHS, PROMISE JOBS, and FaDSS employees may:

- Talk with each other about me and my family members.
- Share with each other any written files that they have about me and my family members.

I understand that these employees may have confidential information about me and my family members regarding mental health, alcohol or substance abuse, or AIDS/HIV-related information that they would not usually share with each other.

I understand that I may withdraw at any time my agreement allowing employees to share and discuss mental health, alcohol or substance abuse, or AIDS/HIV-related information about me and my family members. I also understand that if I withdraw my agreement, DHS may deny my hardship exemption request.

I understand that I have the right to see the information that the employees are sharing with each other.

I understand that my agreement to allow sharing of this information and files will end six months after the date that I sign the hardship exemption request.

I understand that a photocopy of this signed form is considered the same as this original form.

I have read this form, or it has been read and explained to me, and I understand it.

Your signature or mark	Date	Signature of person who helped complete the form, if any	Date

Iowa Department of Human Services

Request for FIP Beyond 60 Months
(Solicitud de FIP por más de 60 meses)

Introducción

La ley federal establece que una familia puede recibir beneficios del Programa FIP (*Family Investment Program*) por no más de 60 meses en toda su vida. Una familia puede conseguir beneficios FIP por más de 60 meses sólo si tienen problemas económicos ("*hardship*") que les impide mantenerse. Esto se llama exención por dificultades económicas.

¿Por qué una familia puede recibir una exención por dificultades económicas?

Una familia puede obtener una exención por dificultades económicas debido a:

- Violencia doméstica
- Insuficientes habilidades para conseguir o conservar un empleo
- No dispone de guardería o niñera calificada
- Problemas físicos o mentales o discapacidad
- La situación habitacional hace que trabajar sea difícil o imposible
- Problemas de drogadicción o alcoholismo
- El padre o la madre deben quedarse en su casa para cuidar a un niño con problemas especiales
- Otros motivos económicos que impiden que la familia pueda auto mantenerse

¿Qué debo hacer para solicitar una exención por dificultades económicas?

Puede solicitar una exención por dificultades económicas si ha estado en FIP por 59 meses como mínimo. La oficina local de *Department of Human Services* (DHS) le puede informar cuántos meses ha estado en FIP.

Para conseguir una exención por dificultades económicas debe hacer lo siguiente:

1. **Completar este formulario y presentarlo** en la oficina local de DHS o de PROMISE JOBS. Si actualmente no tiene FIP, también debe completar la solicitud de ayuda económica (Financial Support Application). Puede obtener el formulario de solicitud en la oficina local de DHS.

2. **Presentar pruebas de sus dificultades económicas.** Un asistente de DHS le informará qué necesita y cuándo. También puede ayudarle a conseguir comprobantes o hacerle sugerencias sobre cómo conseguirlos. Los comprobantes pueden ser:

   - Fotocopias de registros médicos, psicológicos, psiquiátricos, de protección a menores, de servicios sociales, del juzgado o de la policía.

   - Comprobantes de que ha solicita beneficios por discapacidad o *Supplemental Security Income* (SSI).

- Certificados firmados por médicos, psicólogos, psiquiatras, terapeutas en violencia doméstica, drogadicción, alcoholismo, capacitación laboral o rehabilitación vocacional, u otros profesionales con conocimiento de las dificultades de su familia.
- Declaraciones escritas por amigos o familiares conjuntamente con otros comprobantes.

3. **Reunirse con PROMISE JOBS y firmar un Acuerdo FIA (Family Investment Agreement) de 6 meses de duración.** En el acuerdo FIA se indicarán las acciones que realizará para resolver sus problemas. Si el padre y la madre viven juntos, ambos deben firmar el acuerdo FIA. Otros integrantes de su familia podrían tener que firmar el acuerdo FIA también. Le enviaremos una carta informándole dónde y cuándo se reunirá con PROMISE JOBS, y quiénes deben ir a la reunión.

Se rechazará su solicitud de exención por dificultades económicas si no cumple los tres pasos anteriores.

¿Qué sucederá si consigo la exención por dificultades económicas?

Si se aprueba su solicitud de exención, deberá seguir las instrucciones que figuran en el FIA y cumplir con todas las demás normativas de FIP. Si no cumple el acuerdo FIA, se considerará que ha elegido un Plan de Beneficios Limitados y los beneficios FIP serán suspendidos antes de que termine el período de 6 meses.

Si cumple con el FIA y aún tiene dificultades económicas al finalizar el período de 6 meses, podrá solicitar otros 6 meses de exención. Tendrá que firmar un nuevo acuerdo FIA.

Le enviaremos una notificación por escrito informándole si su solicitud de exención ha sido aprobada o rechazada. La recibirá dentro de los 30 días posteriores a la fecha de la solicitud. Cuando la reciba, tendrá derecho a solicitar una audiencia si no está de acuerdo con la resolución.

¿Qué debo completar?

Si desea solicitar una exención por dificultades económicas, complete los siguientes datos y lea y **firme la página 3**.

Primer nombre	Segundo nombre	Apellido
Nº de Social Security	Fecha de nacimiento	Teléfono
Nombre del otro progenitor o padrastro/madrastra que vive en el hogar		
Domicilio		
Dirección postal (si es diferente)		
Ciudad	Estado	Código postal

Infórmenos sobre sus dificultades económicas y cómo le impiden mantenerse.

_____

_____

_____

_____

_____

_____

_____

Por favor, lea esta página atentamente. Si acepta los términos y desea solicitar una exención por dificultades económicas, firme el formulario y escriba la fecha al pie de esta página.

Presente el formulario, junto con los comprobantes que tenga, en la oficina local de DHS o de PROMISE JOBS. Si entrega los comprobantes de inmediato, nos ayudará a tomar una decisión más rápido.

Autorización para divulgar información

Autorizo a los empleados de DHS, PROMISE JOBS, y FaDSS a:

- Hablar entre ellos sobre mí y mi familia.
- Compartir entre ellos los registros escritos que tienen sobre mí y mi familia.

Entiendo que dichos empleados pueden tener información confidencial sobre mí y mi familia con respecto a salud mental, alcoholismo o drogadicción, o datos relacionados con SIDA/VIH, que normalmente no compartirían entre ellos.

Entiendo que puedo revocar mi autorización en cualquier momento para que dichos empleados no puedan compartir, ni discutir la información que poseen sobre mí y mi familia con respecto a salud mental, alcoholismo o drogadicción, o datos relacionados con SIDA/VIH. Además, entiendo que en el caso de revocar mi autorización, DHS podrá rechazar mi solicitud de exención por dificultades económicas.

Entiendo que tengo derecho a ver la información que los empleados comparten entre ellos.

Entiendo que mi autorización para compartir información y registros finalizará seis meses después de la fecha en que firmé la solicitud de exención por dificultades económicas.

Entiendo que una fotocopia del formulario firmado tendrá la misma validez que el original.

He leído el presente formulario, o me lo han leído y explicado, y lo comprendo.

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

Upon receipt of form 470-3826 or 470-3826(S) from the family, screen the family's FIP case circumstances.

- If the request does not appear appropriate for the circumstances of the case, e.g., the family has received FIP for 57 or fewer months, deny the family's request.
- If the family's hardship exemption request appears appropriate for the FIP case circumstances, process the hardship exemption request.

EXCEPTION: When the family is no longer on FIP and needs to file a *Financial Support Application* to regain FIP eligibility, delay processing the hardship exemption request until you receive the application. If the family fails to return the application by the due date, deny the hardship exemption request for that reason.

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

1. Based on supporting evidence, determine whether the family has a hardship condition that affects its ability to be self-supporting.

2. If the family is determined to have a hardship condition, the family must then meet with PROMISE JOBS to develop and sign a six-month *Family Investment Agreement* (FIA) that addresses the family's documented hardship condition.

The family must meet the requirements of both steps and meet all FIP eligibility requirements before the hardship exemption request can be granted. See 4-C, Hardship Exemption, for more information.

To process the exemption request:

- If the family has an active service case, forward a paper copy of form 470-3826 or 470-3826(S) and an electronic copy of form 470-3884, *Hardship Exemption: Service Information*, to the service worker. Request the worker's recommendations for steps to consider in the *Family Investment Agreement* (FIA).

- Contact the family in writing to provide supporting evidence of its hardship condition. If the family does not meet the criteria, deny the family's hardship exemption request.
- After you have determined that the family has a hardship condition, forward to the local PROMISE JOBS office a copy of:
  - Form 470-3826 or 470-3826(S), *Request for FIP Beyond 60 Months*.
  - Form 470-3876, *Hardship Exemption Determination*.
  - The supporting hardship evidence.
  - Form 470-3884, *Hardship Exemption: Service Information*, received from the family's service worker (if applicable).

Upon receipt of these documents, PROMISE JOBS will initiate procedures for the adults in the family to attend the required interview and develop and sign the six-month FIA.

Retain the original form 470-3826 or 470-3826(S) in the permanent "Hardship Exemption" section of the case record.

Data

The family must complete designated items. To be considered valid, the form must contain a legible name and address, and must be signed by the "adult" in the family who is:

- The parent in the home, even if the parent is or will be excluded from the FIP grant. When both parents or a parent and stepparent are in the home, either parent or the stepparent can sign the form.
- The incapacitated stepparent when the stepparent is or requests to be on the FIP grant.
- The needy nonparental specified relative who is or requests to be on the FIP grant.

When the adult is incompetent or incapacitated, someone acting responsibly on the adult's behalf may sign the form.

See 4-C, Hardship Exemption: Valid Request, for additional information on signature requirements.

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Page 359 is reserved for future use.

Iowa Department of Human Services

SSI Medicaid Information

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

County Number

Case Number

State ID

Worker Number

Worker Name

Worker Phone

SSI Application Date

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

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

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

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

Retroactive Medicaid Coverage

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

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

Income

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

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

Resources or Assets

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

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

Health Insurance Information

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

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

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

Type of policy_____

Name policy holder_____ Relationship to you_____

Address_____

_____

Insurance company name_____

Claims office address_____

_____

Policy number_____ Group number_____

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

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

Things You Must Agree to If You Get Medicaid

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

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

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

Important Statements

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

I must not let someone else use my medical card.

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

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

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

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

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

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

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

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

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

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

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

What You Should Know

Reporting Changes

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

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

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

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

Your Rights

You have the right to:

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

Your Responsibilities

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

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

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

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

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

Important Notice to Property Owners and Renters

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

What is Tax Suspension?

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

Can My Property Taxes Be Suspended?

Your property taxes may be suspended if:

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

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

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

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

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

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

What is a Tax Credit?

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

Can I Get a Tax Credit?

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

The amount of the tax credit is based on your income. You may be able to get the extra tax credit if your household's income is less than $22,011.00 and you:

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

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

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

Can I Get Both?

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

What if I Am Renting My Home?

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

You may be eligible for the rent reimbursement if your household's income is less than $22,011.00 and you:

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

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

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

Iowa Department of Human Services

SSI Medicaid Information
(Recordatorio de Medicaid SSI)

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

Número del condado

Número de caso

Identificación del Estado

Número del trabajador

Nombre del trabajador

Teléfono del trabajador

Fecha de solicitud de SSI

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

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

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

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

Cobertura de Medicaid Retroactivo

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

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

Ingreso

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

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

Recursos o Activos

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

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

Información sobre Seguro Médico

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

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

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

Tipo de póliza _____

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

Domicilio _____

_____

Nombre de la compañía de seguros _____

Domicilio de la oficina de reclamos _____

_____

Número de póliza _____ Número de grupo _____

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

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

Si obtiene Medicaid, deberá aceptar lo siguiente

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

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

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

Declaraciones Importantes

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

No debo permitir que otra persona use mi tarjeta médica.

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

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

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

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

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

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

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

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

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

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

Examinamos su solicitud de Medicaid sin tener en cuenta su raza, credo, color, sexo, edad, incapacidad física o mental, religión, país de procedencia o creencias políticas. (Existen normas con respecto a su edad e incapacidad para la obtención de Medicaid).

Lo que debe saber

Cómo informar cambios

Cuando obtenga Medicaid, deberá informar algunos cambios a la oficina del condado del Department of Human Services y otras modificaciones a Social Security Administration. Informe sus ingresos, recursos y arreglos de alojamiento a Social Security Administration.

Informe los siguientes cambios a la oficina DHS del condado en un plazo de 10 días a partir de la fecha en que se entere de la modificación:

- La cobertura del seguro médico.
- El costo del seguro médico si vive en un centro de cuidados especializados.
- El ingreso a un centro de cuidados especializados.
- La donación de recursos o activos.
- La creación de un fideicomiso con sus recursos o activos.
- Su permanencia en un hospital por 15 días o más si obtiene servicios de exención (waiver services).
- Su mudanza a un nuevo domicilio.

Si obtiene otro tipo de asistencia de nuestro Departamento, como Food Assistance (Asistencia para Alimentos) o State Supplementary Assistance (Asistencia Estatal Suplementaria), también deberá informar estos datos. Pregúntele a su asistente social sobre este tema.

Sus derechos

Usted tiene derecho a:

- Tener Medicaid algunos meses antes de obtener los beneficios SSI, si usted tuviera facturas médicas que pagar. Su asistente social le dirá si DHS puede ayudarle a pagar dichas facturas.
- Solicitar la ayuda de otros programas que no sean Medicaid.
- Que le respondan sus preguntas.
- Que la información sea confidencial, a menos que sea necesaria para pagar sus facturas médicas correctamente.

Sus responsabilidades

Usted debe proporcionar pruebas de los datos sobre los que le preguntamos para recibir Medicaid. (*Ésta es solamente una guía*.)

Su asistente social de Income Maintenance podría pedirle más información o más datos con respecto a la información que ya nos ha entregado. Si no puede conseguir la información, pídale a su asistente social que le preste ayuda. Su asistente social necesitará su autorización para comunicarse con otras personas y conseguir dicha información. Usted debe mostrarnos:

- Un fideicomiso creado con sus recursos o activos.
- El valor de los recursos o ingresos que usted donó, vendió o canjeó por menos del valor normal de mercado o de los que nunca tomó posesión.
- Los recursos de su cónyuge, si su cónyuge vive en su hogar y usted vive en un centro de cuidados especializados
- Los datos de sus ingresos y recursos o los de su cónyuge, si desea recibir Medicaid durante el período anterior a que comiencen los beneficios SSI.
- Podríamos necesitar más datos con respecto a su seguro médico.
- Podríamos necesitar más datos con respecto al padre ausente de un menor de 18 años.
- Los datos de sus ingresos y recursos, y los de sus padres si desea recibir Medicaid antes que comiencen los beneficios SSI, y si usted es menor de 18 años y vivía en su hogar antes del inicio de los beneficios SSI.

"Ingresos" significa: sueldo, ingresos por trabajo independiente, ingresos por rentas, beneficios de seguridad social, beneficios para veteranos, beneficios por retiro ferroviario, manutención de hijos, ingresos por intereses y dividendos, jubilaciones, y dinero en efectivo proveniente de propiedades vendidas por contrato, subsidios de desempleo, o beneficios de Workers´ Compensation.

"Recursos" o activos significa: dinero en efectivo, dinero en el banco, certificados de depósito, IRA (cuentas de jubilación particular), cuentas Keogh (plan de jubilación para profesionales autónomos o propietarios de microempresas), acciones y bonos, vehículos con o sin licencia, tierras o terrenos, propiedades vendidas por contrato, contratos funerarios, bienes inmuebles que no sean su vivienda familiar, lotes de sepultura, vehículos recreativos, propiedades, seguros de vida, o cuentas en el mercado de dinero.

Important Notice to Property Owners and Renters
(Aviso Importante para Propietarios y Arrendatarios)

Bajo las leyes de Iowa, sus impuestos sobre la propiedad pueden suspenderse o reducirse. Usted puede ser elegible si es anciano(a) o incapacitado(a).

¿Qué es la suspensión de impuestos?

La suspensión de impuestos significa que usted no tendrá que pagar sus impuestos sobre la propiedad hasta que ésta se venda o se transfiera a otra persona.

¿Pueden ser suspendidos mis impuestos sobre la propiedad?

Sus impuestos sobre la propiedad pueden suspenderse si:

- Usted recibe Supplemental Security Income (SSI) o State Supplementary Assistance (SSA), ó
- Si usted vive en un ancianato y el Department of Human Services paga la totalidad o parte del costo de la atención que usted recibe.

Usted no tendrá que pagar ninguna multa mientras sus impuestos estén suspendidos. Deberán pagarse los impuestos suspendidos cuando la propiedad se venda o transfiera. Si lo desea, puede aún pagar sus impuestos mientras están suspendidos.

La Junta de Supervisores del Condado dirige el programa de suspensión de impuestos. Usted debe brindarle pruebas a la Junta de Supervisores del Condado acerca de que usted califica para la suspensión de impuestos sobre la propiedad. Este trámite debe ser realizado en el condado donde está ubicada la propiedad.

Usted recibirá un Aviso de Decisión que le dirá si es elegible para la suspensión del impuesto. Este aviso será prueba de que usted califica. Este aviso dirá lo siguiente:

> "Usted recibe SSI, Asistencia Estatal Suplementaria, o vive en una vivienda cuyo costo es pagado parcial o totalmente por el Department of Human Service. Es posible que no deba pagar impuestos inmobiliarios en este momento. Lleve esta notificación al Consejo del Condado (Board of Supervisors) para plantear la posibilidad de que sus impuestos inmobiliarios sean demorados."

Lleve su aviso a la Junta de Supervisores del Condado del condado donde está ubicada su propiedad. Puede encontrar la dirección y número telefónico de la Junta de Supervisores del Condado en la sección de gobierno de su directorio telefónico.

¿Qué es el crédito de impuestos?

Un crédito de impuestos elimina o reduce el monto de impuestos que deberá pagar cuando venda o transfiera la propiedad.

¿Yo puedo obtener un crédito de impuestos?

Usted puede obtener un crédito de impuestos adicional hasta de $1.000. Usted debe ser dueño de su hogar y ser el responsable de pagar los impuestos sobre la propiedad.

El monto del crédito de impuestos se basa en su ingreso. Usted puede obtener crédito de impuestos adicional si el ingreso de su hogar es menor a $22.011,00, y usted:

- Tenía 65 años de edad o más al 31 de diciembre del año pasado, o
- Estaba totalmente incapacitado/a al 31 de diciembre del año pasado.

Nota: El cónyuge, el abogado, el tutor o el administrador de una persona elegible fallecida pueden radicar un reclamo de crédito fiscal a nombre de la persona fallecida.

Para obtener crédito de impuestos, debe solicitarlo ante el tesorero del condado.

¿Puedo obtener ambos?

Sí, es mejor si usted solicita tanto una suspensión de impuestos y un crédito de impuestos.

¿Qué pasa si estoy arrendando mi hogar?

Si usted arrienda su hogar y éste está sujeto a impuestos, usted puede recibir una devolución de hasta $1.000 del total de la renta que paga cada año. Si usted vive en un ancianato, usted se considera un arrendador para estos propósitos.

Usted puede ser elegible para un crédito de impuestos adicional si el ingreso de su hogar es menor a $22.011,00, y usted:

- Tenía 65 años de edad o más al 31 de diciembre del año pasado, o
- Estaba totalmente incapacitado/a al 31 de diciembre del año pasado.

Nota: El cónyuge, el abogado, el tutor o el administrador de una persona elegible fallecida pueden radicar un reclamo de reembolso de alquiler a nombre de la persona fallecida.

Los formularios de reembolso de renta están disponibles en la oficina del tesorero de su condado.

Iowa Department of Human Services

SSI Medicaid Information

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

Date:

County Number

Case Number

State ID

Worker Number

Worker Name

Worker Phone

SSI Application Date

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

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

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

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

Retroactive Medicaid Coverage

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

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

Income

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

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

Resources or Assets

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

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

Health Insurance Information

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

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

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

Type of policy_____

Name policy holder_____ Relationship to you_____

Address_____

_____

Insurance company name_____

Claims office address_____

_____

Policy number_____ Group number_____

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

_____

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

Things You Must Agree to If You Get Medicaid

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

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

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

Important Statements

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

I must not let someone else use my medical card.

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

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

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

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

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

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

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

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

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

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

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

What You Should Know

Reporting Changes

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

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

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

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

Your Rights

You have the right to:

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

Your Responsibilities

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

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

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

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

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

Important Notice to Property Owners and Renters

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

What is Tax Suspension?

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

Can My Property Taxes Be Suspended?

Your property taxes may be suspended if:

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

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

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

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

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

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

What is a Tax Credit?

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

Can I Get a Tax Credit?

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

The amount of the tax credit is based on your income. You may be able to get the extra tax credit if your household's income is less than $22,011.00 and you:

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

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

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

Can I Get Both?

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

What if I Am Renting My Home?

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

You may be eligible for the rent reimbursement if your household's income is less than $22,011.00 and you:

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

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

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

Iowa Department of Human Services

SSI Medicaid Information
(Recordatorio de Medicaid SSI)

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

Número del condado

Número de caso

Identificación del estado

Número del trabajador

Nombre del trabajador

Teléfono del trabajador

Fecha de solicitud de SSI

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

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

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

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

Cobertura de Medicaid Retroactivo

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

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

Ingreso

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

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

Recursos o Activos

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

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

Información sobre Seguro Médico

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

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

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

Tipo de póliza _____

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

Domicilio _____

_____

Nombre de la compañía de seguros _____

Domicilio de la oficina de reclamos _____

_____

Número de póliza _____ Número de grupo _____

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

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

Si obtiene Medicaid, deberá aceptar lo siguiente

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

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

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

Declaraciones Importantes

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

No debo permitir que otra persona use mi tarjeta médica.

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

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

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

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

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

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

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

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

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

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

Examinamos su solicitud de Medicaid sin tener en cuenta su raza, credo, color, sexo, edad, incapacidad física o mental, religión, país de procedencia o creencias políticas. (Existen normas con respecto a su edad e incapacidad para la obtención de Medicaid).

Lo que debe saber

Cómo informar cambios

Cuando obtenga Medicaid, deberá informar algunos cambios a la oficina del condado del Department of Human Services y otras modificaciones a Social Security Administration. Informe sus ingresos, recursos y arreglos de alojamiento a Social Security Administration.

Informe los siguientes cambios a la oficina DHS del condado en un plazo de 10 días a partir de la fecha en que se entere de la modificación:

- La cobertura del seguro médico.
- El costo del seguro médico si vive en un centro de cuidados especializados.
- El ingreso a un centro de cuidados especializados.
- La donación de recursos o activos.
- La creación de un fideicomiso con sus recursos o activos.
- Su permanencia en un hospital por 15 días o más si obtiene servicios de exención (waiver services).
- Su mudanza a un nuevo domicilio.

Si obtiene otro tipo de asistencia de nuestro Departamento, como Food Assistance (Asistencia para Alimentos) o State Supplementary Assistance (Asistencia Estatal Suplementaria), también deberá informar estos datos. Pregúntele a su asistente social sobre este tema.

Sus derechos

Usted tiene derecho a:

- Tener Medicaid algunos meses antes de obtener los beneficios SSI, si usted tuviera facturas médicas que pagar. Su asistente social le dirá si DHS puede ayudarle a pagar dichas facturas.
- Solicitar la ayuda de otros programas que no sean Medicaid.
- Que le respondan sus preguntas.
- Que la información sea confidencial, a menos que sea necesaria para pagar sus facturas médicas correctamente.

Sus responsabilidades

Usted debe proporcionar pruebas de los datos sobre los que le preguntamos para recibir Medicaid. (*Ésta es solamente una guía*.)

Su asistente social de Income Maintenance podría pedirle más información o más datos con respecto a la información que ya nos ha entregado. Si no puede conseguir la información, pídale a su asistente social que le preste ayuda. Su asistente social necesitará su autorización para comunicarse con otras personas y conseguir dicha información. Usted debe mostrarnos:

- Un fideicomiso creado con sus recursos o activos.
- El valor de los recursos o ingresos que usted donó, vendió o canjeó por menos del valor normal de mercado o de los que nunca tomó posesión.
- Los recursos de su cónyuge, si su cónyuge vive en su hogar y usted vive en un centro de cuidados especializados.
- Los datos de sus ingresos y recursos o los de su cónyuge, si desea recibir Medicaid durante el período anterior a que comiencen los beneficios SSI.
- Podríamos necesitar más datos con respecto a su seguro médico.
- Podríamos necesitar más datos con respecto al padre ausente de un menor de 18 años.
- Los datos de sus ingresos y recursos, y los de sus padres si desea recibir Medicaid antes que comiencen los beneficios SSI, y si usted es menor de 18 años y vivía en su hogar antes del inicio de los beneficios SSI.

"Ingresos" significa: sueldo, ingresos por trabajo independiente, ingresos por rentas, beneficios de seguridad social, beneficios para veteranos, beneficios por retiro ferroviario, manutención de hijos, ingresos por intereses y dividendos, jubilaciones, y dinero en efectivo proveniente de propiedades vendidas por contrato, subsidios de desempleo, o beneficios de Workers' Compensation.

"Recursos" o activos significa: dinero en efectivo, dinero en el banco, certificados de depósito, IRA (cuentas de jubilación particular), cuentas Keogh (plan de jubilación para profesionales autónomos o propietarios de microempresas), acciones y bonos, vehículos con o sin licencia, tierras o terrenos, propiedades vendidas por contrato, contratos funerarios, bienes inmuebles que no sean su vivienda familiar, lotes de sepultura, vehículos recreativos, propiedades, seguros de vida, o cuentas en el mercado de dinero.

Important Notice to Property Owners and Renters
(Aviso Importante para Propietarios y Arrendatarios)

Bajo las leyes de Iowa, sus impuestos sobre la propiedad pueden suspenderse o reducirse. Usted puede ser elegible si es anciano(a) o incapacitado(a).

¿Qué es la suspensión de impuestos?

La suspensión de impuestos significa que usted no tendrá que pagar sus impuestos sobre la propiedad hasta que ésta se venda o se transfiera a otra persona.

¿Pueden ser suspendidos mis impuestos sobre la propiedad?

Sus impuestos sobre la propiedad pueden suspenderse si:

- Usted recibe Supplemental Security Income (SSI) o State Supplementary Assistance (SSA), ó
- Si usted vive en un ancianato y el Department of Human Services paga la totalidad o parte del costo de la atención que usted recibe.

Usted no tendrá que pagar ninguna multa mientras sus impuestos estén suspendidos. Deberán pagarse los impuestos suspendidos cuando la propiedad se venda o transfiera. Si lo desea, puede aún pagar sus impuestos mientras están suspendidos.

La Junta de Supervisores del Condado dirige el programa de suspensión de impuestos. Usted debe brindarle pruebas a la Junta de Supervisores del Condado acerca de que usted califica para la suspensión de impuestos sobre la propiedad. Este trámite debe ser realizado en el condado donde está ubicada la propiedad.

Usted recibirá un Aviso de Decisión que le dirá si es elegible para la suspensión del impuesto. Este aviso será prueba de que usted califica. Este aviso dirá lo siguiente:

> "Usted recibe SSI, Asistencia Estatal Suplementaria, o vive en una vivienda cuyo costo es pagado parcial o totalmente por el Department of Human Service. Es posible que no deba pagar impuestos inmobiliarios en este momento. Lleve esta notificación al Consejo del Condado (Board of Supervisors) para plantear la posibilidad de que sus impuestos inmobiliarios sean demorados."

Lleve su aviso a la Junta de Supervisores del Condado del condado donde está ubicada su propiedad. Puede encontrar la dirección y número telefónico de la Junta de Supervisores del Condado en la sección de gobierno de su directorio telefónico.

¿Qué es el crédito de impuestos?

Un crédito de impuestos elimina o reduce el monto de impuestos que deberá pagar cuando venda o transfiera la propiedad.

¿Yo puedo obtener un crédito de impuestos?

Usted puede obtener un crédito de impuestos adicional hasta de $1.000. Usted debe ser dueño de su hogar y ser el responsable de pagar los impuestos sobre la propiedad.

El monto del crédito de impuestos se basa en su ingreso. Usted puede obtener crédito de impuestos adicional si el ingreso de su hogar es menor a $22.011,00, y usted:

- Tenía 65 años de edad o más al 31 de diciembre del año pasado, o
- Estaba totalmente incapacitado/a al 31 de diciembre del año pasado.

Nota: El cónyuge, el abogado, el tutor o el administrador de una persona elegible fallecida pueden radicar un reclamo de crédito fiscal a nombre de la persona fallecida.

Para obtener crédito de impuestos, debe solicitarlo ante el tesorero del condado.

¿Puedo obtener ambos?

Sí, es mejor si usted solicita tanto una suspensión de impuestos y un crédito de impuestos.

¿Qué pasa si estoy arrendando mi hogar?

Si usted arrienda su hogar y éste está sujeto a impuestos, usted puede recibir una devolución de hasta $1.000 del total de la renta que paga cada año. Si usted vive en un ancianato, usted se considera un arrendador para estos propósitos.

Usted puede ser elegible para un crédito de impuestos adicional si el ingreso de su hogar es menor a $22.011,00, y usted:

- Tenía 65 años de edad o más al 31 de diciembre del año pasado, o
- Estaba totalmente incapacitado/a al 31 de diciembre del año pasado.

Nota: El cónyuge, el abogado, el tutor o el administrador de una persona elegible fallecida pueden radicar un reclamo de reembolso de alquiler a nombre de la persona fallecida.

Los formularios de reembolso de renta están disponibles en la oficina del tesorero de su condado.

Iowa Department of Human Services

Comm. 52 (Rev. 1/15)

Medicaid

for

People in

Nursing Homes

and Other

Care Facilities

PRINTED ON RECYCLED PAPER

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Medicaid

for

People in

Nursing Homes

and Other

Care Facilities

This brochure answers some of the most commonly asked questions concerning Medicaid for people in Iowa nursing facilities and other medical facilities.

Long-term care facilities, or nursing homes, include nursing facilities (NF), intermediate care facilities for persons with an intellectual disability (ICF/ID), and certified skilled nursing facilities (SNF). Other medical facilities include general hospitals or psychiatric institutions.

The Medicaid program is sometimes referred to as the Title 19 program. This should not be confused with Medicare. The Social Security Office handles Medicare.

How do I choose a long-term care facility?

You are eligible for benefits in any Medicaid-certified facility that will accept Medicaid payment. Most Iowa facilities do participate in the Medicaid program. The fact that a long-term care facility is Medicaid certified does not guarantee entrance to the facility. Other factors, such as waiting lists, need for care, and the ability to meet your particular needs, may be considered by the facility before admitting you.

For Medicaid members, a facility must review the care needs of the member with the Iowa Medicaid Enterprise (IME) Medical Services Unit (a peer review organization) and receive approval for placement before Medicaid payments can be made.

Will Iowa Medicaid pay for care in an out-of-state nursing facility?

If you require a skilled nursing program not available in Iowa, your care in an out-of-state nursing facility or intermediate care facility for persons with an intellectual disability may be paid if it is approved in advance.

Out-of-state placement can be made only if the following conditions exist:

- The out-of-state facility participates in the Iowa nursing facility or intermediate care facility for persons with an intellectual disability program. Participating out-of-state facilities are generally found in states bordering Iowa. (Residential services are not payable out of state.)
- You are planning to return to Iowa when an appropriate placement becomes available.

Payment will be made by Iowa Medicaid for an out-of-state facility if:

- You are medically eligible; and
- Placement has been recommended by the Department.

Members who choose to move out of state should apply for Medicaid in their new state of residence.

What happens when I am admitted to a nursing facility?

A facility cannot request an advance payment or deposit from you or your family as a condition to accept you if you receive Medicaid. The deposit or advance payment made by private-pay residents, who later become Medicaid eligible, may be counted as an asset when determining your Medicaid eligibility. If you paid a deposit or advance payment when you entered the nursing facility, when you become eligible for Medicaid, these funds may be counted as an asset.

The nursing facility must make these funds available to you at your request. Upon admission, a nursing facility is required to provide you with a copy of *Residents' Rights in Nursing Facilities*.

When do I become Medicaid eligible?

You are considered a Medicaid member from the date on the *Notice of Decision*. However, the facility may charge private pay rates until your worker determines that you are Medicaid eligible. If you are currently a resident in a facility, you need to tell the facility when you apply for Medicaid.

A facility must accept Medicaid payment with your beginning date of Medicaid eligibility. Once you are Medicaid eligible, the facility must refund any payment received from you or your family member for the period of time for which you were determined to be eligible minus your client participation.

If you are not eligible for Medicaid because you have too much income or resources, you may be eligible for the "Medically Needy" program through Medicaid. However, "Medically Needy" members are not eligible for payment of services provided by nursing homes.

For factors related to eligibility, see the pamphlet "*Medicaid for SSI-Related Persons*," Comm. 28.

Will my spouse at home affect my eligibility for Medicaid?

Some eligibility factors are looked at differently when one spouse is in a medical facility and the other lives at home. A spouse living at home will not be required to contribute his or her income to the cost of your care. Also, if you are in a medical facility and are eligible for Medicaid, your income may be shared with your spouse living at home if they don't have enough to meet their needs. (See the pamphlet, *"Protection of Your Resources and Income*," Comm. 72.)

What is client participation?

"Client participation" is that amount of your income that you must pay to the long-term care facility at the beginning of each month for your care.

Medicaid pays any difference between the monthly client participation and the approved cost of the care in the facility. All of your monthly income is considered in order to compute the amount of client participation. The following deductions are given before the client participation is determined:

- Personal needs allowance of $50, to be used as you wish.
- If you have earned income, up to an additional $65 from earned income for your personal needs.
- Maintenance needs of your spouse or family at home.

- Living expenses for partial month of nursing home care, if you are eligible for Medicaid before entering the facility and don't have a spouse or family.
- Health insurance premiums, including the Medicare Part B and Part D premiums, deductibles, and coinsurance.
- Necessary medical care that is recognized by state law but not covered by Medicaid.
- Home maintenance needs for the month of discharge.

There is no client participation for hospital care.

If the facility will accept Medicaid eligibility from the date you enter the facility, pay the estimated client participation amount while you are waiting for a decision on your Medicaid application.

If your income is more than the cost of your care, you still should not pay a higher client participation than what Medicaid would pay the facility. Your DHS worker will notify you of that amount.

The Department will notify you and the facility of the amount of client participation you are to pay each month when your Medicaid application is approved.

It is your responsibility to pay the facility for your client participation. If the client participation is not paid, you may be discharged from the facility.

The amount you pay for client participation satisfies your financial obligation for nursing facility care under the Iowa Medicaid Program. A nursing facility should not charge you for any additional amount unless it is for additional goods or services that you specifically request.

What are my Medicaid benefits?

Medicaid covers the cost of care in a long-term care facility, plus other medically necessary services, such as physicians, dentists, hospitals, non-Part D covered prescribed drugs, ambulance services, and eyeglasses. *These services, plus important limits on them are covered in Comm. 20, "Your Guide to Medicaid," available at county Department offices*.

Other than client participation, no additional charges should be made to you or any family member unless it is for additional goods and services that you specifically request.

What additional services can I get?

Program of All-Inclusive Care for the Elderly (PACE) is a program designed to help you stay as healthy as possible. PACE will also provide for any other medical care that you may need such as hospitalizations, specialty care, nursing facility care, hospice, or emergency care. For more information ask for pamphlet Comm. 316, "*PACE (Program of All-Inclusive Care for the Elderly)*."

How does Medicaid work for people who get Medicare?

Once Medicaid is approved, the Department will pay your Part B Medicare premium if you are also eligible for Medicare.

It takes about three months to get this process started. In the meantime, the Part B premium may be withheld from your Social Security or Railroad Retirement check.

When the Department begins paying the premium, the Social Security Administration will refund the total amount of Part B premiums that were withheld from your check after you became eligible for Medicaid.

You must notify your DHS worker when the refund check has been received. You must pay the long-term care facility the Medicare premium amount for each month a deduction was given for the Medicare premium when calculating your client participation.

Is it possible to transfer from one facility to another?

You have a right to transfer at any time to any facility willing to admit you. If you are transferring to a facility offering the same level of care as your current facility, you must pay the cost of the transportation.

How are Medicaid members discharged from a facility?

You may be involuntarily discharged from a facility only if one of the following conditions exist:

- Discharge is necessary for medical reasons; e.g., a higher or lower level of care becomes necessary.
- Discharge is necessary for your own welfare or for the welfare of other residents.
- You do not pay the nursing home (client participation as determined by the Department) for care.

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 Medicaid. 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?

You have 90 calendar days to file an appeal from the date of the decision.

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.

Use of the Medicaid Toll-Free Hotline

A toll-free telephone number 1-800-338-8366 is available to help you resolve unpaid bills that you think Medicaid should have covered. The worker who answers this line will take down the information about your bill and submit it for review and reconsideration.

Before you call the Medicaid hotline, you should have the following information in front of you:

- The medical bill,
- A brief description of what services were provided, and
- The Personal Identification Number listed on your *Medical Assistance Eligibility Card*.

This hotline is not to be used to ask questions about Medicaid policy or if medical procedures or equipment are covered by Medicaid. These questions should be directed to your county DHS worker or to your medical provider.

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

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

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

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

Iowa Department of Human Services

Comm. 72 (Rev. 1/15)

Protection of Your Resources and Income

How Medicaid Can Help Married Couples Pay the Cost of a Spouse's Care in a Medical Facility

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This pamphlet answers questions on how Medicaid may be able to help a married couple pay the cost of a spouse's care in a medical facility. The main point is that the couple may not have to spend all of their money before the spouse in the medical facility qualifies for Medicaid.

The policies in this pamphlet apply only if you or your spouse plan to stay, or have stayed, in the medical facility 30 days or more and entered after September 30, 1989.

Some of this information may be hard to understand. If you have any questions, please contact your local Department of Human Services worker.

Here is an explanation of some of the terms:

Medical Facility means a hospital or nursing facility (nursing home).

Resource Protection means that a certain amount of the things owned and the money saved by a couple can be kept by the spouse at home. Resource protection is also referred to as the "resource allowance."

Income Allowance means the amount of income that can be protected for the spouse at home.

Community Spouse is also referred to as "the spouse at home." The community spouse could live in the couples' own home, a custodial home, an apartment, with relatives, or in other non-facility settings.

Medicaid (also known as Title 19) is a program that is funded with both federal and state money and can help pay medical bills. The amount of medical bills that Medicaid pays is based on certain resource and income guidelines that will be described later.

When can Medicaid help?

Medicaid can pay up to the full facility cost depending on your resources and income. If the spouse in the facility wants to find out if he or she can qualify for the Medicaid program, an application must be filled out and given to the Department of Human Services (DHS) office in the county where the facility is located. The form is called "*Health Services Application*" and is available at your local DHS office.

Different Medicaid policies apply for persons who stay in a medical facility less than 30 days or entered before September 30, 1989. For DHS to determine your eligibility for Medicaid in these situations, you will need to complete an application.

To get Medicaid, the spouse in the medical facility must be:

- Aged (65 or older), or
- Blind or disabled, or
- Part of a family with dependent children.

Please see the pamphlets "*Medicaid for Families and Children*" or "*Medicaid for SSI-Related Persons*" for more information on other eligibility factors that must be met by the spouse in the medical facility. Both of these pamphlets are available from your local DHS office.

The following pages have information on the resource and income guidelines DHS will follow to see if Medicaid can pay the cost of care in the medical facility.

What resources can be protected?

When a spouse enters a medical facility on or after September 30, 1989, there are four steps to determine the amount of resources that can be protected for the spouse at home and the date the spouse in the medical facility can qualify for Medicaid.

1. **Total Resources:** If the spouse entering a medical facility is going to need Medicaid now or in the future, the protection of resources for the spouse at home depends on the amount of the couple's combined resources as of the first day of the month in which the spouse entered the medical facility.

   Because of this, the amount of resources that can be protected should be determined as soon as possible. Your DHS worker can give you a form called "*Resources Upon Entering a Medical Facility.*" Fill out this form as soon as your spouse enters the medical facility. It is better to fill this form out as soon after entry as possible. It is easier to prove your resources for the month the spouse entered the facility than it will be to prove them at a later date.

   When you have completed the form, please turn it in to your local DHS office. DHS will request information and documents to confirm what you stated on the form. DHS will also need each spouse's social security number, which the Internal Revenue Services will match with its records. Through a "*Notice of Attribution of Resources*," DHS will inform each spouse of the decision on what resources can be protected. Otherwise this information is confidential.

2. **Countable Resources:** Resources that are owned as of the first day of the month of entry into the facility must be looked at by DHS but some resources are not counted.

However, all resources should be listed on the "*Resources Upon Entering a Medical Facility*" form.

Resources that are not counted include:

- The house that the spouse (or dependent relative) lives in,
- An automobile,
- Cash value of life insurance policies when the face value totals less than $1,500,
- An irrevocable funeral contract,
- Burial spaces, or
- Funds set aside for funeral expenses (up to $1,500).

Either spouse can use the resources that are not counted.

Examples of resources that are counted include:

- Cash,
- Savings and checking accounts,
- Certificates of deposit,
- Stocks and bonds,
- Contracts for the sale of real estate,
- Cash value of life insurance when the face value is more than $1,500.

3. **Resources for Each Spouse:** The amount of resources that can be protected for the spouse at home is the total amount of your countable resources as a couple divided by two. The spouse at home can protect half of the total resources or $24,000, whichever is greater. However, if half of the resources are more than $119,220*, the spouse at home can only protect $119,220*.

   * These amounts are indexed for inflation and change when the federal government releases the annual inflation rate.

   The amount of protected resources for the community spouse may be increased by a court order, or by an appeal decision, in order to increase income for the community spouse.

Resources given away by either spouse may affect the Medicaid eligibility.

4. **Medical Eligibility:** To determine if Medicaid can help pay the facility costs for the spouse in the facility, the resource allowance for the spouse at home is subtracted from the couple's total resources. If the result is $2,000 or less, the spouse in the medical facility meets the resource test for Medicaid.

   If the spouse in the medical facility has resources of more than $2,000, Medicaid cannot help pay the facility costs. But the spouse may still qualify for other Medicaid help.

An application must be made for Medicaid before DHS can determine eligibility. Your DHS worker will follow these guidelines to determine the amount of your protected resources and see if the requirements are met to qualify for Medicaid. Here are some examples that may help you better understand resource protection:

Example: Mr. Erickson entered a nursing home on March 27, 2015. He and his wife have total countable resources of $300,000. One half of their countable resources is $150,000. Mrs. Erickson, living at home, is able to keep $119,220* and the remaining $180,780 go to Mr. Erickson. Since Mr. Erickson's resources exceeded the $2,000 resource limit, he does not qualify for Medicaid at this time.

Example: Mr. Roth entered a nursing home on May 1, 2015. Mr. and Mrs. Roth have countable resources of $11,000. All of the resources are protected for Mrs. Roth since total resources are less than $24,000. Mr. Roth is eligible for Medicaid as his countable resources are less than $2,000.

Note: Medicaid can still be granted in certain cases of hardship. This can happen when there is estrangement and the spouse in the facility has used all legal means to access the resources of the estranged spouse.

Does it matter whose name the resources are in?

Yes. After DHS determines that the spouse in the medical facility is eligible for Medicaid, resources must be counted for the spouse who actually owns the resources. Any resources owned by the spouse in the medical facility that are more than the resource limits must be transferred to the spouse at home (please see the pamphlet "*Medicaid for SSI-Related Persons*" for information on resource limits for individuals). This must be done so the spouse in the facility can remain eligible for Medicaid.

Here is an example of resource protection and resource ownership:

> **Example: Mr. Johnson entered a nursing home June 2, 2015. He and his wife together have countable resources of $25,000. Mrs. Johnson is able to keep $24,000. The remaining $1,000 is counted as a resource to Mr. Johnson and he can qualify for Medicaid. However, Mr. Johnson owns a $5,000 Certificate of Deposit (CD). In order to remain eligible for Medicaid, he must transfer ownership of at least $4,000 of the CD to his wife so his resources will be within the $2,000 limit. He could transfer all the value of the CD to his wife. This transfer must be made within 90 days.**

What is the Long-Term Care Partnership Program?

The Iowa Long-Term Care Partnership program is a cooperative effort between private long-term care insurers and Medicaid to encourage individuals to plan ahead and provide for their long-term health needs.

People who purchase long-term care partnership policies may be able to qualify for Medicaid before spending all of their assets.

Partnership policies must meet state and federal requirements. They are only marketed by licensed insurance professionals who have completed eight hours of training required by the state of Iowa Insurance Division.

How does Medicaid asset protection work?

The Iowa partnership policy includes a feature known as Medicaid asset protection. This feature provides dollar-for-dollar asset protection. Each dollar that your partnership policy pays out in benefits entitles you to keep a dollar of your assets if you ever need to apply for Iowa Medicaid long-term care services. Protected assets are not considered in determining Medicaid eligibility.

> **Example: If you have a long-term care partnership policy that paid $200,000, you would be able to protect $200,000 in assets and still qualify for Medicaid. The amount of assets you are able to protect under the partnership policy is in addition to the $2,000 Medicaid allows an individual to keep.**

Are the protected assets under the Long-Term Care Partnership program subject to Medicaid estate recovery?

No. The asset adjustment is exempt from estate recovery for the member and the member's spouse.

What is the income limit?

The income of the spouse in the medical facility cannot be more than three times the SSI benefit (which currently is $2,199* per month) for Medicaid to help pay the cost of the facility. If the income of the spouse in the facility is more than three times the SSI benefit, Medicaid will not pay for the facility costs but may be able to pay for other medical services.

What income can be protected?

Once the spouse living in the medical facility qualifies for Medicaid, income can be protected for the spouse at home. These guidelines determine what income can be protected.

A. **Monthly Income:** The spouse in the medical facility can keep $50 of monthly income for personal needs, plus an additional $65 from earned income. The spouse in the facility can allow the spouse and certain dependent relatives at home to use the income that is above $50, or above $115 if there is earned income.

B. **Income Allowance:** The amount of income that can be allowed for the spouse at home, unless there is a court order or an appeal decision, is $2,980.50* per month. This is called “income allowance.” The income of the spouse at home is subtracted from the income allowance of $2,980.50 to determine the amount of income the spouse in the facility can give to the spouse at home.

An amount of income can also be allowed for certain dependent relatives living with the spouse at home. This amount is determined by subtracting the gross monthly income of each dependent from $1,967* and dividing that amount by three. Remember, the spouse in the medical facility must first provide income for the spouse at home before any income can be made available to the dependents.

C. **Remaining Income:** The remaining income of the spouse in the facility is used to pay for any unmet medical needs and toward payment of the cost of care in the facility. Payment to the facility is called client participation.

Your DHS worker will follow these guidelines to determine the protected income for the spouse at home and any dependents that qualify. Here are some examples that may help you better understand income protection:

Example: Mrs. Rogers lives in a skilled nursing facility with $900 gross monthly income and Mr. Rogers lives at home with $1,200 gross monthly income. The amount of income protected for Mr. Rogers is determined as follows:

Mrs. Rogers (in facility)

$	**900.00**	**monthly income**
-	**50.00**	**personal needs**
$	**850.00**	**is available for Mr. Rogers**

Mr. Rogers (at home)

$	**2,980.50**	**income allowance**
-	**1,200.00**	**monthly income**
$	**1,780.50**	**could be allowed from Mrs. Roger's income for Mr. Rogers, but she can only give the $850 from her income.**

Example: Mr. Smith lives in a nursing home and Mrs. Smith is living at home. Mr. Smith has gross monthly income of $1,800. Mrs. Smith has gross monthly income of $1,300. The amount of income from Mr. Smith to protect for Mrs. Smith is determined as follows:

Mr. Smith (in facility)

$	**1,800.00**	**monthly income**
-	**50.00**	**personal needs**
$	**1,750.00**	**is available for Mrs. Smith**

Mrs. Smith (at home)

$	**2,980.50**	**income allowance**
-	**1,300.00**	**monthly income**
$	**1,680.50**	**can be allowed from Mr. Smith's income for Mrs. Smith.**

Mr. Smith has remaining income of $69.50 after giving the $1,680.50 to Mrs. Smith ($1,750.00 minus $1,680.50 leaves $69.50). The remaining income goes to the facility as "client participation."

"Client participation" means a spouse in a medical facility shares in the cost of care by paying some of his or her own income to the medical facility. DHS determines the amount of client participation. The income of the spouse at home is NOT used to pay for the cost of care of the spouse in the facility.

If there is income remaining after the diversion to the spouse and dependents, some of the remaining income can be used to pay for private health insurance for the institutionalized spouse.

Does it matter whose name the income is in?

Usually when income is issued in the name of an individual, it is considered income to that individual. If the income is in the names of both spouses, the income is considered as one-half for each spouse. If there is trust property, the income shall be considered according to the trust document. Other examples of income include Social Security and Veteran's benefits, pensions from employment, etc. The income of each spouse must be established and any changes in income of either spouse must be reported to the local DHS office within 10 days of the change. If there is a dependent receiving protection of income, any changes in the dependent's income must also be reported within 10 days.

For a more complete explanation of Medicaid policies (including client participation) for people who live in a medical facility, please see pamphlet "*Medicaid Information for People in Nursing Homes and Other Facilities*."

What are my rights?

If you are dissatisfied with the actions or lack of action by DHS, you should discuss the matter with your DHS worker. If a satisfactory agreement cannot be reached, you have the right to file an appeal and ask for a hearing.

If you believe more resources should be protected for the community spouse to raise the community spouse's income to the monthly income allowance level, you have the right to file an appeal and ask for a hearing.

You can appeal in person, by telephone or in writing for Medicaid. 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.

You have 90 calendar days to file an appeal from the date on the *Notice of Decision* or *Notice of Attribution of Resources*. **Discussions with your worker or other DHS staff do not extend this time limit.**

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 or before the date the decision goes into effect. A notice is considered to be received five calendar days after the date on the notice.

If a hearing is allowed, it will be an informal meeting before an Administrative Law Judge from the Department of Inspections and Appeals, in which you can present your complaint. All the facts will be reviewed to see if the decision was correct or should be changed.

What are my responsibilities?

Present your Medical Assistance Eligibility Card each time you request services from a health care provider.

Inform your local DHS office of changes in your address, income, resources or household size (marriages, births, deaths) and any other changes that may affect your eligibility or amount of benefits (this includes the income and resources of a spouse, dependents or other persons who may affect your Medicaid eligibility). Please report any changes within 10 days for someone currently receiving benefits and within 5 days for an applicant.

Inform your health care providers of any medical resources that you have (Medicare, insurance, damage suits, etc.).

Notify your local DHS office within 10 days of any changes in your medical resources or health care coverage. You may be required to provide information and proof of any medical resources available to you.

File a claim or application for any income or medical resource that may be available to you. If required, you must also cooperate in the processing of any such claim or application.

Refund to DHS any money that you receive from a person or company to pay medical expenses which would otherwise be paid by Medicaid.

Failure to comply with your responsibilities can result in denial or cancellation of Medicaid. It may also result in the establishment of overpayments for which you will be responsible to pay back or possible prosecution for fraud.

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

PRINTED ON RECYCLED PAPER

Important Notice to Property Owners and Renters

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

What is Tax Suspension?

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

Can My Property Taxes Be Suspended?

Your property taxes may be suspended if:

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

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

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

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

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

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

What is a Tax Credit?

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

Can I Get a Tax Credit?

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

The amount of the tax credit is based on your income. You may be able to get the extra tax credit if your household's income is less than $22,011.00 and you:

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

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

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

Can I Get Both?

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

What if I Am Renting My Home?

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

You may be eligible for the rent reimbursement if your household's income is less than $22,011.00 and you:

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

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

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

Important Notice to Property Owners and Renters
(Aviso Importante para Propietarios y Arrendatarios)

Bajo las leyes de Iowa, sus impuestos sobre la propiedad pueden suspenderse o reducirse. Usted puede ser elegible si es anciano(a) o incapacitado(a).

¿Qué es la suspensión de impuestos?

La suspensión de impuestos significa que usted no tendrá que pagar sus impuestos sobre la propiedad hasta que ésta se venda o se transfiera a otra persona.

¿Pueden ser suspendidos mis impuestos sobre la propiedad?

Sus impuestos sobre la propiedad pueden suspenderse si:

- Usted recibe Supplemental Security Income (SSI) o State Supplementary Assistance (SSA), ó
- Si usted vive en un ancianato y el Department of Human Services paga la totalidad o parte del costo de la atención que usted recibe.

Usted no tendrá que pagar ninguna multa mientras sus impuestos estén suspendidos. Deberán pagarse los impuestos suspendidos cuando la propiedad se venda o transfiera. Si lo desea, puede aún pagar sus impuestos mientras están suspendidos.

La Junta de Supervisores del Condado dirige el programa de suspensión de impuestos. Usted debe brindarle pruebas a la Junta de Supervisores del Condado acerca de que usted califica para la suspensión de impuestos sobre la propiedad. Este trámite debe ser realizado en el condado donde está ubicada la propiedad.

Usted recibirá un Aviso de Decisión que le dirá si es elegible para la suspensión del impuesto. Este aviso será prueba de que usted califica. Este aviso dirá lo siguiente:

> "Usted recibe SSI, Asistencia Estatal Suplementaria, o vive en una vivienda cuyo costo es pagado parcial o totalmente por el Department of Human Service. Es posible que no deba pagar impuestos inmobiliarios en este momento. Lleve esta notificación al Consejo del Condado (Board of Supervisors) para plantear la posibilidad de que sus impuestos inmobiliarios sean demorados."

Lleve su aviso a la Junta de Supervisores del Condado del condado donde está ubicada su propiedad. Puede encontrar la dirección y número telefónico de la Junta de Supervisores del Condado en la sección de gobierno de su directorio telefónico.

¿Qué es el crédito de impuestos?

Un crédito de impuestos elimina o reduce el monto de impuestos que deberá pagar cuando venda o transfiera la propiedad.

¿Yo puedo obtener un crédito de impuestos?

Usted puede obtener un crédito de impuestos adicional hasta de $1.000. Usted debe ser dueño de su hogar y ser el responsable de pagar los impuestos sobre la propiedad.

El monto del crédito de impuestos se basa en su ingreso. Usted puede obtener crédito de impuestos adicional si el ingreso de su hogar es menor a $22.011,00, y usted:

- Tenía 65 años de edad o más al 31 de diciembre del año pasado, o
- Estaba totalmente incapacitado/a al 31 de diciembre del año pasado.

Nota: El cónyuge, el abogado, el tutor o el administrador de una persona elegible fallecida pueden radicar un reclamo de crédito fiscal a nombre de la persona fallecida.

Para obtener crédito de impuestos, debe solicitarlo ante el tesorero del condado.

¿Puedo obtener ambos?

Sí, es mejor si usted solicita tanto una suspensión de impuestos y un crédito de impuestos.

¿Qué pasa si estoy arrendando mi hogar?

Si usted arrienda su hogar y éste está sujeto a impuestos, usted puede recibir una devolución de hasta $1.000 del total de la renta que paga cada año. Si usted vive en un ancianato, usted se considera un arrendador para estos propósitos.

Usted puede ser elegible para un crédito de impuestos adicional si el ingreso de su hogar es menor a $22.011,00, y usted:

- Tenía 65 años de edad o más al 31 de diciembre del año pasado, o
- Estaba totalmente incapacitado/a al 31 de diciembre del año pasado.

Nota: El cónyuge, el abogado, el tutor o el administrador de una persona elegible fallecida pueden radicar un reclamo de reembolso de alquiler a nombre de la persona fallecida.

Los formularios de reembolso de renta están disponibles en la oficina del tesorero de su condado.

Iowa Department of Human Services

Comm. 255 (Rev. 12/14)

Benefits of the Health Insurance Premium Payment Program

What is the HIPP Program?

The Health Insurance Premium Payment (HIPP) program is a service available to people who get Medicaid. The HIPP program helps people get or keep health insurance through their employer by reimbursing the cost of the health insurance premium. The HIPP program is a way for the State of Iowa to save money.

Why do I want other health insurance?

- The other insurance may cover services that are not covered by Medicaid.
- Other people in your family who are not covered by Medicaid may be covered by your health insurance.
- HIPP helps you get and keep insurance you might not be able to afford.

How can I get HIPP?

- You or someone in your home has to have Medicaid.
- You must have medical insurance or be able to get it through your employer.
- The health plan must be cost-effective.

What is "Cost-Effective"?

"Cost-effective" means that it costs the State less to reimburse all or a portion of your health insurance premium to help pay your medical bills than for Medicaid to pay the full cost of the medical bills.

Does HIPP cost me anything?

No. When you get medical care for your Medicaid-eligible family members, give the provider your health insurance card and your Medicaid card. Your health insurance is billed first. Then as long as you go to a Medicaid provider, Medicaid is billed for the co-insurance, deductibles and any other services not covered by your health insurance.

How do you decide if my insurance is cost-effective?

- The HIPP program looks at the services covered under your health insurance plan.
- The program compares the average cost of your Medicaid-eligible family members to the cost of your health insurance premium.

Important: To make an eligibility decision, please return any information we may ask for in order to evaluate the health insurance.

The HIPP program does not provide premium assistance for:

- Insurance for someone who does not live in your home.
- School plans based on enrollment or attendance as a student.
- An insurance plan that pays income to the policyholder or pays only limited amounts for services.
- Plans that are limited to a temporary period of time.
- Plans that have an absent parent as the policyholder, or when the policyholder is not part of your Medicaid household.
- An insurance premium that is used to reduce the Medically Needy spenddown amount for Medicaid or used as a deduction in computing the client participation.
- Anyone covered under Medicare, Medicaid Kids with Special Needs, Iowa Family Planning Network.

For questions to apply for HIPP

To complete an application over the phone or for questions call:

Toll-Free Number: 1-888-346-9562

For a paper application go to:

Internet address: www.dhs.state.ia.us/hipp

Fax: 1-515-725-0725

Email address: hipp@dhs.state.ia.us

Iowa Department of Human Services

Comm. 255(S) (Rev. 12/14)

Benefits of the Health Insurance Premium Payment Program (Información importante sobre el Programma HIPP)

¿Qué es el Programa HIPP?

El programa pago de la prima del seguro de salud (HIPP, por su sigla en ingles) es us servicio disponible para personas que reciben Medicaid. El programa HIPP ayuda a la gente a obtener o mantener su seguro de salud a travs de su empleador, mediante el reembolsodel costo de la prima del seguro de salud. El Programa HIPP le permite ahorrar dinero al Estado de Iowa.

¿Para qué quiero otro seguro de salud?

- El otro seguro de salud puede cubrir servicios que Medicaid no cubre.
- Su seguro de salud puede cubrir a otros miembros de su familia, a quienes Meidcaid no cubre.
- HIPP le ayuda a obtener y mantener un seguro de salud que quizás no podria pagar de otra manera.

¿Cómo puedo obtener el HIPP?

- Usted o un miembro de su hogar debe tener Medicaid.
- Debe tener un seguro de salud o ser capaz de conseguirlo a trevés de su empleador
- El seguro de salud debe ser economic.

¿Qué significa “económico”?

“Económico” significa que al Estado le cuesta menos reembolsar la totalidad o una parte de la prima de su seguro de salud para atudarle a pagar sus factures médicas que lo que le cuesta a médicas.

¿El HIPP tiene algún costo para mí?

No. Cuando recibe atención médica para los miembros de su familia elegibles para Medicaid, entréguele al proveeaor su tarjeta del seguro médico y su tarjeta de Medicaid. SU seguro de salud es facturado en primer lugar. Luego, siempre que vaya a un proveedor de Medicaid. Medicaid es facturado por el co seguro, los deducibles y todos los demaás servicios que su seguro de salud no cubre.

¿Comó determinan si mi seguro es económico?

- El Programa HIPP revisa los servicios cubiertos por su plan seguro de salud.
- El programa compara el costo promedio de los miembros de su familia elegibles para Medicaid con el costo de la prima de su seguro médico.

Importante: Para que tomemos una decision sobre su elegibilidad, usted debe suministarnos toda la información que le solicitemos y que necesitamos para evaluar e seguro de salud.

El Programa HIPP no brinda ayuda con la prima en los siguientes casos:

- Seguro para una persona que no vive en su hogar.
- Planes escolares basados en la inscripción o la asistencia como estudiante.
- Un plan de seguro que le paga una renta al titular de la póliza o solo pago monto limitados por los servicios.
- Planes que se limitan a un periodo de tiempo provisional.
- Planes que tienen como titular de la póliza a un/a padre/madre ausente, o cuando el titular de la póliza no es miembro de su hogar con Medicaid.
- Una prima de seguro que se usa para reducer el monto del programa Medically Needy Spendown (programa de costos comapartidos para personas con necesidades médicas) para Mediciad o como deducción a la hora de calcualr la participación del cliente.
- Cualquier persona con cobertura de Medicare, Medicaid para niños con necisidades especiales, la red de planificación familiar de Iowa.

Tiene alguna pregunta o desea solicitor el HIPP:

Para completer una solicitud por teléfono, o si tiene alguna pregunta, llame al:

Line gratuita: 1-888-346-9562

Para completer una solicitud impresa, visite:

Dirección de Internet: www.dhs.state.ia.us/hipp

Fax: 1-515-725-0725

Dirreción de correo electrónico: hipp@dhs.state.ia.us

Iowa Department of Human Services

Comm. 413 (Rev. 1/15)

Medicare Savings Programs

What is the Qualified Medicare Beneficiary (QMB) Program?

Medicare refers to the Qualified Medicare Beneficiary (QMB) group as a "Medicare Savings Program." Under the QMB program, Medicaid only pays Medicare premiums, deductibles, and coinsurance for persons who are qualified Medicare beneficiaries. This saves you money.

Who is a Qualified Medicare Beneficiary?

You could be eligible as a qualified Medicare beneficiary if you:

- Are 65 or older, blind or disabled and eligible to get Medicare Part A benefits.
- Have resources less than $7,280 for a single person or $10,930 for a couple.
- Have income at or below 100% of the federal poverty level.

What if my income or resources are too high for QMB?

If your total countable income or resources are higher than the QMB limits, there are other programs you may qualify for:

- **Medically Needy:** Ask the DHS office about Medically Needy if you have lots of medical bills and not enough money to pay the bills. If you get Medically Needy, you will need to pay your medical bills up to the spenddown or deductible.
- **SLMB (Specified Low Income Medicare Beneficiary) or E-SLMB (Expanded Specified Low Income Medicare Beneficiary):** SLMB and E-SLMB will only pay your Medicare Part B premium. The income limit is over 100% but less than 135% of the federal poverty level.

What medical services are covered?

Under the QMB program, you get limited Medicaid coverage. This means Medicaid will pay only for the Medicare premiums, deductibles, and co-insurance for medical services covered by Medicare.

Do I need to pay anything for medical services?

Medicaid covers the cost of medically necessary services, such as physicians, dentists, hospitals, prescribed drugs that are not paid by Medicare drug plans, ambulance services, and eyeglasses. These services plus limits on them are explained in *"Your Guide to Medicaid,"* which is on the internet at: http://www.dhs.state.ia.us/policyanalysis/PolicyManualPages/Manual_Documents/Forms/Comm20.pdf

or you can call your DHS worker to get a copy of the brochure.

How are payments made?

After you qualify for the QMB program you will get a Medical Assistance Eligibility Card. Carry your card with you and show it to the medical provider every time you request service. Your card may not be used by people other than the individual listed on the card. If you lose your card, contact your local DHS office or Member Services at **1-800-338-8366** (If you live in the Des Moines area, call **515-256-4606**).

The medical provider will bill the Medicaid program. Payment for Medicare deductibles and co-insurance will be sent directly to the provider. Medicaid will pay for Medicare Part A and Part B premiums.

Iowa Department of Human Services

Comm. 414 (Rev. 1/15)

Protecting Your Resources and Income

Medicaid help married couples pay the cost of a spouse's care in a medical facility.

These policies apply only if you or your spouse plan to stay, or have stayed, in the medical facility 30 consecutive days or more and entered after September 30, 1989.

When can Medicaid help?

Medicaid may pay up to the full facility cost depending on your resources and income. To find out if you or your spouse qualifies for Medicaid, you will need to complete an application.

To get Medicaid, the spouse in the medical facility must be aged 65 or older, blind, disabled or part of a family with dependent children.

What resources can be protected?

The protection of resources for the spouse at home depends on the couples' total combined resources as of the first day of the month the spouse entered the medical facility. All resources must be listed on the Medicaid application. The Department of Human Services (DHS) will determine which resources are countable to determine eligibility, and then split the amount between the spouse in the facility and the spouse at home.

The spouse at home can keep:

- Half of the total resources, or $24,000 whichever is greater,
- But no more than $119,220*.

The amount of resources kept by the spouse at home may be increased by a court order or by an appeal decision.

To be eligible for Medicaid long-term care coverage, the applicant cannot have more than $2,000 after resources are split between the spouses.

What is the income limit?

The income of the spouse in the medical facility cannot exceed three times the monthly SSI cash benefit for Medicaid to help pay the cost of care. (This is $2,163* per month in 2014. In 2015, it is $2,199 per month.)

What income can be protected?

The spouse in the medical facility can keep $50 of monthly income for personal needs. If the spouse in the facility has earnings, they can also keep an additional $65 per month. The DHS worker will determine if income from the spouse in the facility can be given to the spouse at home and dependent relatives living with the spouse to help them pay their living expenses.

Does it matter whose name the income is in?

In most cases, when income is in the name of one individual, DHS considers the income belongs to that individual. If the income is in the names of both spouses, DHS considers one half belongs to each spouse. If there is trust property, the income shall be considered according to the trust document.

* These amounts are indexed for inflation and change when the federal government releases the annual inflation amount.

Iowa Department of Human Services

SUPPLEMENTAL SECURITY INCOME PAYMENT STANDARDS

Individual in own home	$ 733.00
Couple in own home	1,100.00
Individual in medical institution	30.00
Individual in household of another	488.67
Couple in household of another	733.34
Essential person increment	367.00

MEDICAL INSTITUTION LIMITS

Medicaid income cap for nursing care, hospital, MHI, ICF/MR, PMIC	$ 2,199.00
Minimum monthly maintenance needs allowance (MMMNA)	2,980.50
Maximum community spouse resource allowance	119,220.00

STATE SUPPLEMENTARY ASSISTANCE STANDARDS

Family-Life Home

Payment to family	$	794.00
Personal needs allowance	+	101.00
Payment standard	$	895.00

Blind Allowance *(Maximum payment $22.00)*

Individual	$ 755.00
Couple, one is blind	1,122.00
Couple, both are blind	1,144.00

Dependent Person *(Maximum payment $377.00)*

Aged or disabled client and dependent relative	$ 1,110.00
Aged or disabled client, eligible spouse, and dependent relative	1,477.00
Blind client and dependent relative	1,132.00
Blind client, aged or disabled spouse, and dependent relative	1,499.00
Blind client, blind spouse, and dependent relative	1,521.00

In-Home Health-Related Care *(Maximum payment $480.55)*

Income limits after $65 + 1/2, unmet medical needs, and diversion for dependents:

Individual in own home	($480.55 + 733 home maintenance)	$ 1,213.55
Couple, one member needs care	($480.55 + 1,100 home maintenance)	1,580.55
Couple, both need care	($480.55 + 480.55 + 1,100 home maintenance)	2,061.10

Home maintenance allowance:

Individual in own home	$ 733.00
Couple in own home	1,100.00
Each additional family member	367.00

Residential Care

Flat per diem rate = $17.86. Client's maximum income after $65 + 1/2, unmet medical needs and diversions for spouse and dependents is $654.66 ($17.86 x 31 days + $101 personal needs allowance).

Maximum cost-related per diem rate = $30.05. Client's maximum income after $65 + 1/2, unmet medical needs and diversions for spouse and dependents is $1,032.55 ($30.05 x 31 days + $101 personal needs allowance).

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	
		$ 1,557	$ 2,098	$ 2,640	$ 3,181	$ 3,722	$ 4,264	$ 4,805	
		For each additional household member add $543.							
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	

100% Poverty Level	1	2	3	4	5	6	7
	$ 973	$ 1,311	$ 1,650	$ 1,988	$ 2,326	$ 2,665	$ 3,003
	For each additional household member add $338.						

300% Poverty Level Medicaid for Kids with Special Needs (MKSN)	1	2	3	4	5	6	7
	$ 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
$ 733	$ 1,100

QMB * (A Medicare Savings Program)

$7,280 for one person

$10,930 for a couple

	Poverty Level	Household Size: Individual	Household Size: Couple
Effective 4/1/14	100%	$ 973	$ 1,311

SLMB * (A Medicare Savings Program)

$7,280 for one person

$10,930 for a couple

Poverty Level	Household Size	Income Over	But Less Than
Effective 4/1/14	Individual	$ 973	$ 1,167
Over 100% but less than 120%	Couple	$ 1,311	$ 1,573

Expanded SLMB * (QI-1) (A Medicare Savings Program)

$7,280 for one person

$10,930 for a couple

Poverty Level	Household Size	Income	But Less Than
Effective 4/1/14	Individual	$ 1,167	$ 1,313
120% but less than 135%	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