Iowa Department of Human Services

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July 3, 2015

GENERAL LETTER NO. 6-AP-115

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

Bureau of Adult and Children's Medical Programs,
Iowa Medicaid Enterprise

SUBJECT: Employees' Manual, Title 6, ***INCOME MAINTENANCE PROGRAMS APPENDIX***, Contents (pages 1 through 9 and 11), revised; pages 58, 59, 142 through 146, 160, 174, 175, 214, 287 through 308, 351 through 357, 359, 383, 384, 391, 416, and 437, revised; pages 2a, 2b, 64a, and 214a, new; and the following forms:

470-0398	*Accident Injury Request*, renamed and revised
470-5170	*Application for Health Coverage and Help Paying Costs*, revised
470-5170(S)	*Application for Health Coverage and Help Paying Costs* (Spanish), revised
470-3871	*Child Care Assistance Provider Agreement*, revised
470-3871(S)	*Child Care Assistance Provider Agreement* (Spanish), revised
470-5286	*Compliance with Third Party Liability (TPL)*, new
470-4473	*Free Lunch Notice*, revised
470-4473(S)	*Free Lunch Notice (Spanish)*, revised
470-5308	*HIPP Notice of Action*, new
470-5285	*Iowa Health and Wellness Plan Billing Statement*, revised
470-5285(S)	*Iowa Health and Wellness Plan Billing Statement* (Spanish), new
470-4392	*Level of Care Certification for HCBS Waiver Program*, revised
470-5287	*Noncompliance with Third Party Liability (TPL)*, new
470-0403	*Other Insurance Request*, renamed and revised
470-5322	*Resuming Overpayment Collection*, new
470-5323	*Suspension of Overpayment Collection*, new
470-4299	*Verification of Emergency Health Care Services*, revised
470-4299(S)	*Verification of Emergency Health Care Services* (Spanish), revised

Comm. 60 & 60(S),	*Medicaid for the Qualified Medicare Beneficiary* (English and Spanish), revised
Comm. 62	*Child Care Assistance*, revised
Comm. 62(S)	*Child Care Assistance* (Spanish), revised
Comm. 72	*Protection of Your Resources and Income*, revised
Comm. 238	*Cut Your Medical Costs if You Get Medicaid*, revised
Comm. 284	*Bringing Farmers Markets and Food Assistance Together*, revised
Comm. 337	*Medicaid for Kids with Special Needs*, revised

Summary

This chapter is revised to:

- Change and rename the following:
  - Form 470-0398 from *Priority Leads Letter* to *Accident Injury Request*.
  - Form 470-0403 from *TPL Leads Letter* to *Other Insurance Request*.

  Iowa Medicaid Enterprise (IME) uses these forms to collect information from Medicaid members or their representative to find out if the member was involved in an accident or suffered an injury. Depending on the response, a third party may be responsible for reimbursing the state for Medicaid expenses.

- Add pages for additional people to form 470-5170, *Application for Health Coverage and Help Paying Costs*, and its Spanish translation, form 470-5170(S). The application has room for information on up to five people.

- Add information and make form 470-3871, *Child Care Assistance Provider Agreement*, easier to understand for providers. This form is used by the KinderTrack system. The Spanish version, 470-3871(S), has also been updated to reflect these changes.

- Add instructions and form 470-5286, *Compliance with Third Party Liability (TPL)*. The Iowa Medicaid Enterprise (IME) uses this form to:
  - Notify the local office when a member has cooperated, and
  - Instruct the local office to lift a member's sanction.

- Update form 470-4473, *Free Lunch Notice*, and its Spanish translation, form 470-4473(S), to:
  - Add a statement to inform households they may add students living in their household that are not listed.
  - Simplify the nondiscrimination statement.
  - Clarify language regarding free or low cost health care coverage.

- Add form 470-5308, *HIPP Notice of Action*. This form is:
  - Updated to clarify the notice is from the HIPP unit, and
  - Formatted to fit in the new envelope.

- Update form 470-5285, *Iowa Health and Wellness Plan Billing Statement*, to:
  - Inform Iowa Health and Wellness Plan members about the Healthy Behaviors program. This program allows members to complete healthy behavior activities. Depending on the member's income level, completing these activities may waive the monthly contribution "premium" costs during the second year of eligibility.
  - Include a dental exam as a new healthy behavior activity.
  - Include information on using the member's dental coverage.
  - Include a resource to assist members in understanding their statement.
  - Include notice to members that more than 90 days non-payment of contribution amounts will be subject to recovery by the state.
  - Reflect policy changes.
  - Make grammatical changes
- Add the Spanish version of form 470-5285, *Iowa Health and Wellness Plan Billing Statement*.
- Revise form 470-4392, *Level of Care Certification for HCBS Waiver Program*, to:
  - Include clarifying language to allow completion of the form based on the assistance that the member needs.
  - Remove diagnosis and medication sections. Diagnoses and medications are required and should be submitted as an attachment.
  - Add questions regarding the member's need for nursing facility level of care.
  - Add additional frequency options necessary for supervision, cueing, and physical assistance for areas of bathing/grooming and dressing.
- Remove the instructions and the following forms as they are no longer being used:
  - 470-2527, *MAC Income Worksheet*
  - 470-2479, *PMIC Exchange of Information*
- Add instructions and form 470-5287, *Noncompliance with Third Party Liability (TPL)*. The Iowa Medicaid Enterprise (IME) uses this form to:
  - Notify the local office when a member has not cooperated, and
  - Instruct the local office to sanction a specific member.
- Add two new overpayment recovery forms. These forms are system-generated.
  - When the Department's decision has been affirmed on an appeal of overpayment, form 470-5322, *Resuming Overpayment Collection*, informs the debtor that collection actions on the overpayment will resume.
  - When a client appeals an overpayment, collections on the overpayment are suspended. Form 470-5323, *Suspension of Overpayment Collection*, is issued to inform the debtor that collection actions on the overpayment are suspended during the appeal process.
- Update form 470-4299, *Verification of Emergency Health Care Services*, and its Spanish translation, 470-4299(S), to comply with federal regulations.

- Update the following due to an increase in the resource limits effective January 1, 2015:
  - Comm. 60 and Comm. 60(S), *Medicaid for the Qualified Medicare Beneficiary*
  - Comm. 238, *Cut Your Medical Costs if You Get Medicaid*
- Update Comm. 62 and Comm. 62(S), *Child Care Assistance*, to revise the eligibility criteria for the Child Care Assistance Program to include combining part time school and part time work for a total of at least 28 hours per week.
- Update the dependent allowance for 2015 on Comm. 72, *Protection of Your Resources and Income*. Use the dependent allowance to determine the maintenance needs of the other dependents living with the community spouse.
- Update the following due to an increase in the income limits effective March 1, 2015:
  - Comm. 238, *Cut Your Medical Costs if You Get Medicaid*
  - Comm. 337, *Medicaid for Kids with Special Needs*
- Update the instructions to reflect the name change of Comm. 255-Comm. 255(S) from *Important Information About the HIPP Program* to *Benefits of the Health Insurance Premium Payment Program*.
- Update Comm. 284, *Bringing Farmers Markets and Food Assistance Together*, with current farmers and farmer's market information.

Effective Date

Upon receipt.

Material Superseded

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

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437	September 27, 2013

Additional Information

Use up existing supplies of 470-5170 and 470-5170(S), *Application for Health Coverage and Help Paying Costs*.

Destroy existing supplies of 470-3871, *Child Care Assistance Provider Agreement*. Order supplies of 470-3871, dated 3/15, from Anamosa in the usual manner.

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

- Comm. 60 and Comm. 60(S), *Medicaid for the Qualified Medicare Beneficiary*
- Comm. 72, *Protection of Your Resources and Income*
- Comm. 337, *Medicaid for Kids with Special Needs*

Use up existing supplies of Comm. 62, *Child Care Assistance*, before reordering supplies from Anamosa in the usual manner.

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

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Iowa Department of Human Services

Accident Injury Request

<<NAME>>
<<ADDRESS>>
<<ADDRESS>>
<<CITY>>, <<STATE>> <<ZIPCODE>>

<<Date>>

Reference Number: <<<<<>>>>>

Important Notice: If this form is not completed in writing or over the phone, Medicaid benefits *may* be canceled.

<<First Name Last Name>> received treatment for an accident or injury. The information on the back of this form must be completed to see if somebody else should have paid for the treatment.

A parent or legal guardian should complete and sign the form for a child under the age of 18, or call Iowa Medicaid Member Services at 1-800-338-8366 to complete the information over the phone. Iowa Medicaid Member Services will need the reference number. Please return the form using one of the following ways by <<DueDate>>.

Email: RevCoLLLien@dhs.state.ia.us

Fax: 515-725-1352

Mail: Iowa Medicaid Enterprise
Revenue Collections
P.O. Box 36446
Des Moines, IA 50315

Phone: Member Services
1-800-338-8366
or locally in the Des Moines area at **515-256-4606**
Monday through Friday, 8:00 am to 5:00 pm

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

Complete Accident Injury Request form and return it by <<DueDate>>:
If this form is not completed in writing or over the phone,
Medicaid benefits *may* be canceled.

<<First Name Last Name>>, <<Medicaid ID>>

Date of Treatment: <<date of service>> Reference Number: <<<<<>>>>>
Provider's Name: <<Provider's name>>

Was the treatment a result of an accident or injury? ☐ Yes ☐ No
If no, sign and date this form. See the front page on how to return the form.

If yes, did the accident or injury happen on <<Date of service>>? ☐ Yes ☐ No
If no, please tell us the correct date of the accident or injury. ____/____/_____
(mm/dd/yyyy)

Tell us what happened and what the injuries were. If more space is needed, attach a separate sheet of paper.

_____
_____
_____
_____
_____
_____

Has a lawyer been hired? ☐ Yes ☐ No If yes, complete this section.

Name of Lawyer		Phone Number
Address		
City	State	ZIP Code

Was a claim filed with an insurance company? ☐ Yes ☐ No If yes, complete this section.

Insurance Company Name		Contact Name
Address		
City	State	ZIP Code
Phone Number		Claim Number
Policy Holder Name		Policy Number

Sign, date, and return the completed form using the instructions on the front side.

Signature		Date
Print name		Relationship to member
Home Phone Number	Cell Phone Number	

Accident Injury Request, Form 470-0398

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

Data

The form requests information from the member concerning:

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

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 (If you leave blank because you don't have one, you must give us a mailing address below.)			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 five 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?

☐ Yes ☐ No If you are under age 19, do you want help with child support?

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?

☐ Yes ☐ No If *Person 2* is under age 19, do you want help with child support?

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).

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

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

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

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

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

Step 2. Person 3

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 3* live at the same address as you? **If no**, list address:

_____

Does *Person 3* 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 3* file jointly with a spouse? **If yes**, name of spouse: _____

☐ Yes ☐ No 2. Will *Person 3* claim any dependents on *Person 3's* tax return? **If yes**, list names of dependents: _____

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

How is *Person 3* related to the tax filer? _____

☐ Yes ☐ No Is *Person 3* pregnant? **If yes**, how many babies are expected during this pregnancy? _____

Does *Person 3* 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 7. Leave the rest of this page blank.

☐ Yes ☐ No Does *Person 3* 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 3* a U.S. citizen or U.S. national?

☐ Yes ☐ No If *Person 3* isn't a U.S. citizen or U.S. national, does *Person 3* have eligible immigration status? **If yes**, fill in their document type and ID number below.

Document type: _____ Document ID number: _____

☐ Yes ☐ No Has *Person 3* lived in the U.S. since 1996?

☐ Yes ☐ No Is *Person 3* or their spouse or parent a veteran or an active-duty member in the U.S. military?

☐ Yes ☐ No Is *Person 3* a resident of Iowa?

☐ Yes ☐ No Does *Person 3* want help paying for medical bills from the last three months?

☐ Yes ☐ No Does *Person 3* live with at least one child under the age of 19, and is *Person 3* the main person taking care of this child?

☐ Yes ☐ No Was *Person 3* in foster care at age 18 or older?

☐ Yes ☐ No If *Person 3* is under age 19, do you want help with child support?

Please answer the following questions if *Person 3* is 22 or younger:

☐ Yes ☐ No Did *Person 3* have insurance through a job and lose it within the past three months?

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

☐ Yes ☐ No Is *Person 3* 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 3*:

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

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

Type of work _____

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

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

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

Deductions: Check all that apply, and give the amount and how often you get it. If *Person 3* 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 3's* income changes from month to month. If you don't expect changes to *Person 3's* (pages 6 and 7) monthly income, don't complete.

Person 3's total income **this year**	*Person 3's* total income **next year** (if you think it will be different)
$	**$**

Step 2. Person 4

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 4* live at the same address as you? **If no**, list address:

_____

Does *Person 4* 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 4* file jointly with a spouse? **If yes**, name of spouse: _____

☐ Yes ☐ No 2. Will *Person 4* claim any dependents on *Person 4's* tax return? **If yes**, list names of dependents: _____

☐ Yes ☐ No 3. Will *Person 4* be claimed as a dependent on someone's tax return? **If yes**, list the name of the tax filer: _____

How is *Person 4* related to the tax filer? _____

☐ Yes ☐ No Is *Person 4* pregnant? **If yes**, how many babies are expected during this pregnancy? _____

Does *Person 4* 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 9. Leave the rest of this page blank.

☐ Yes ☐ No Does *Person 4* 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 4* a U.S. citizen or U.S. national?

☐ Yes ☐ No If *Person 4* isn't a U.S. citizen or U.S. national, does *Person 4* have eligible immigration status? **If yes**, fill in their document type and ID number below.

Document type: _____ Document ID number: _____

☐ Yes ☐ No Has *Person 4* lived in the U.S. since 1996?

☐ Yes ☐ No Is *Person 4* or their spouse or parent a veteran or an active-duty member in the U.S. military?

☐ Yes ☐ No Is *Person 4* a resident of Iowa?

☐ Yes ☐ No Does *Person 4* want help paying for medical bills from the last three months?

☐ Yes ☐ No Does *Person 4* live with at least one child under the age of 19, and is *Person 4* the main person taking care of this child?

☐ Yes ☐ No Was *Person 4* in foster care at age 18 or older?

☐ Yes ☐ No If *Person 4* is under age 19, do you want help with child support?

Please answer the following questions if *Person 4* is 22 or younger:

☐ Yes ☐ No Did *Person 4* have insurance through a job and lose it within the past three months?

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

☐ Yes ☐ No Is *Person 4* 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 4*:

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

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

Type of work _____

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

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

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

Deductions: Check all that apply, and give the amount and how often you get it. If *Person 4* 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 4's* income changes from month to month. If you don't expect changes to *Person 4's* (pages 8 and 9) monthly income, don't complete.

Person 4's total income **this year**	*Person 4's* total income **next year** (if you think it will be different)
$	**$**

Step 2. Person 5

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 5* live at the same address as you? **If no**, list address:

_____

Does *Person 5* 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 5* file jointly with a spouse? **If yes**, name of spouse: _____

☐ Yes ☐ No 2. Will *Person 5* claim any dependents on *Person 5's* tax return? **If yes**, list names of dependents: _____

☐ Yes ☐ No 3. Will *Person 5* be claimed as a dependent on someone's tax return? **If yes**, list the name of the tax filer: _____

How is *Person 5* related to the tax filer? _____

☐ Yes ☐ No Is *Person 5* pregnant? **If yes**, how many babies are expected during this pregnancy? _____

Does *Person 5* 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 11. Leave the rest of this page blank.

☐ Yes ☐ No Does *Person 5* 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 5* a U.S. citizen or U.S. national?

☐ Yes ☐ No If *Person 5* isn't a U.S. citizen or U.S. national, does *Person 5* have eligible immigration status? **If yes**, fill in their document type and ID number below.

Document type: _____ Document ID number: _____

☐ Yes ☐ No Has *Person 5* lived in the U.S. since 1996?

☐ Yes ☐ No Is *Person 5* or their spouse or parent a veteran or an active-duty member in the U.S. military?

☐ Yes ☐ No Is *Person 5* a resident of Iowa?

☐ Yes ☐ No Does *Person 5* want help paying for medical bills from the last three months?

☐ Yes ☐ No Does *Person 5* live with at least one child under the age of 19, and is *Person 5* the main person taking care of this child?

☐ Yes ☐ No Was *Person 5* in foster care at age 18 or older?

☐ Yes ☐ No If *Person 5* is under age 19, do you want help with child support?

Please answer the following questions if *Person 5* is 22 or younger:

☐ Yes ☐ No Did *Person 5* have insurance through a job and lose it within the past three months?

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

☐ Yes ☐ No Is *Person 5* 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 5*:

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

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

Type of work _____

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

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

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

Deductions: Check all that apply, and give the amount and how often you get it. If *Person 5* 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 5's* income changes from month to month. If you don't expect changes to *Person 5's* (pages 10 and 11) monthly income, don't complete.

Person 5's total income **this year**	*Person 5'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 Does the employer offer a health plan that meets the minimum value standard*****?

For the lowest-cost plan that meets the minimum value standard***** offered **only to the employee** (don't include family plans):

If the employer has wellness programs, provide the premium that the employee would pay if the employee received the maximum discount for any tobacco cessation programs, and did not receive any other discounts based on wellness programs.

How much would the employee have to pay in premiums for this plan? $ _____

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

***** 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 percent of such costs. (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)

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 my 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 deja el espacio en blanco porque no tiene, debe darnos un domicilio postal debajo.)			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 cinco 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?

☐ Sí ☐ No Si usted tiene menos de 19 años de edad, ¿desea ayuda para conseguir manutención de menores?

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).

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

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

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

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

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

Sección 2. Persona 2

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

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

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

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

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

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

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

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

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

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

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

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

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

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

☐ Sí ☐ No ¿Tiene ciudadanía o nacionalidad estadounidense?

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

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

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

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

☐ Sí ☐ No ¿Es residente de Iowa?

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

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

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

☐ Sí ☐ No Si la *Persona 2* tiene menos de 19 años de edad, ¿usted desea ayuda para conseguir manutención de menores?

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).

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

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

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

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

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

Sección 2. Persona 3

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 3* 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 3* con el contribuyente? _____

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

¿La *Persona 3* 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 7.

☐ 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 3,* 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?

☐ Sí ☐ No Si la *Persona 3* tiene menos de 19 años de edad, ¿usted desea ayuda para conseguir manutención de menores?

Responda las siguientes preguntas si la *Persona 3* 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 3*:

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

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

Tipo de trabajo _____

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

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

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

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

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

Ingreso anual: Complete estos datos sólo si los ingresos de esta persona cambian de un mes a otro. Si la *Persona 3* no espera cambios en sus ingresos mensuales (páginas 6 y 7), no complete estos datos.

Total de ingresos de la *Persona 3* **este año**	Total de ingresos del **próximo año** (si cree que serán diferentes)
$	**$**

Sección 2. Persona 4

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 4* 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 4* con el contribuyente? _____

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

¿La *Persona 4* 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 9.

☐ 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 4,* 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?

☐ Sí ☐ No Si la *Persona 4* tiene menos de 19 años de edad, ¿usted desea ayuda para conseguir manutención de menores?

Responda las siguientes preguntas si la *Persona 4* 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 4*:

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

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

Tipo de trabajo _____

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

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

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

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

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

Ingreso anual: Complete estos datos sólo si los ingresos de esta persona cambian de un mes a otro. Si la *Persona 4* no espera cambios en sus ingresos mensuales (páginas 8 y 9), no complete estos datos.

Total de ingresos de la *Persona 4* **este año**	Total de ingresos del **próximo año** (si cree que serán diferentes)
$	**$**

Sección 2. Persona 5

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 5* 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 5* con el contribuyente? _____

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

¿La *Persona 5* 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 11.

☐ 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 5,* 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?

☐ Sí ☐ No Si la *Persona 5* tiene menos de 19 años de edad, ¿usted desea ayuda para conseguir manutención de menores?

Responda las siguientes preguntas si la *Persona 5* 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 5*:

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

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

Tipo de trabajo _____

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

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

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

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

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

Ingreso anual: Complete estos datos sólo si los ingresos de esta persona cambian de un mes a otro. Si la *Persona 5* no espera cambios en sus ingresos mensuales (páginas 10 y 11), no complete estos datos.

Total de ingresos de la *Persona 5* **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 ¿El empleador ofrece un plan médico que cumple con la norma de valor mínimo*****?

En el caso del plan de menor costo que cumpla con la norma de valor mínimo***** ofrecido **al empleado solamente** (no incluir planes familiares):

Si el empleador tiene programas de bienestar, informe la prima que el empleado tendría que pagar en el caso de recibir el descuento máximo para programas para dejar de fumar y no recibiera otros descuentos basados en programas de bienestar.

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

¿Con qué frecuencia? ☐ Por semana ☐ Cada dos semanas ☐ Dos veces por mes ☐ Una vez por mes ☐ Por trimestre ☐ Por año

***** Un plan médico laboral cumple con "la norma de valor mínimo" si la proporción del costo total de las prestaciones cubiertas por el plan no es inferior al 60% de dicho costo (Sección 36B(c)(2)(C)(ii) del Código Tributario (*Internal Revenue Code*) de 1986)

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 anõs ☐ 4 anõs ☐ 3 anõs ☐ 2 anõs ☐ 1 anõ

☐ 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)	

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

Purpose

The *Child Care Assistance Provider Agreement* sets the terms for payment of a child care provider by the Department of Human Services.

Source

The English version of this form is generated from KinderTrack. The English version of the form is also printed in pads of 50 sets. Order supplies from Iowa Prison Industries at Anamosa.

Print or photocopy the Spanish version of the form from the sample in the manual.

Completion

A provider selected by a Child Care Assistance client initially completes pages 1 and 2 of the form and signs and dates it to indicate understanding and agreement to all of the terms and conditions stated on the form. The provider returns pages 1 through 4 of the form to the Centralized Child Care Assistance Unit and keeps the other pages for their records.

The Child Care Assistance worker:

- Reviews the agreement.
- Determines if the provider meets all of the requirements.
- Completes the third page with:
  - The provider type.
  - The provider number.
  - The provider's approved rates.
  - The effective date of the *Agreement*.
  - The termination date.

The *Agreement* must be renewed at least every two years, or when the provider reports changes.

Distribution

When the *Agreement* is approved and all signatures are secured, the Child Care Assistance Unit sends one copy of the *Agreement* back to the child care provider and keeps one copy.

Data

The first and second pages of the form gather provider information. The third through seventh pages set forth the terms and conditions to which both parties agree, as indicated by the signatures of the provider and Child Care Assistance worker.

Iowa Department of Human Services

Child Care Assistance Provider Agreement

Child Care Provider Information

In order for you to receive payment under the Child Care Assistance Program, you must provide the following information about your legal name and tax ID. Please fill out either Box A **OR** Box B.

Box A
Individual
If you answer **Yes** to Individual, please provide your Social Security Number **(SSN)** to use as your tax ID.

Are you: (Pick one)	**Yes**	**No**	**SSN**
Individual?	❑	❑	– –

If the answer to this question is No, complete Box B.

Provider Last Name			Provider First Name		
Address Where Care is Provided			Mailing Address (if different)		
City	State	Zip	City	State	Zip
Phone			Phone		

Box B
Corporation/Partnership/Government/Sole Proprietor

Is your business: (Pick one)	**Yes**	**No**	**Please provide your Employer Identification Number.**
Corporation or LLC	❑	❑	**EIN**
Partnership	❑	❑	-
Government	❑	❑	**NOTE:** Your legal business name and tax ID (EIN) must match IRS records.
Sole Proprietor	❑	❑	

Provider Legal Business Name					
Doing Business As (DBA) Name					
Address Where Care is Provided			Mailing Address (if different)		
City	State	Zip	City	State	Zip
Phone			Phone		

Eligible Provider

I must meet all federal, state, and local standards that pertain to the child care services being provided under this payment Agreement.

I must not assign, transfer, or subcontract any interest in this Agreement. This means that payment for services made under this Agreement can only go to the provider named in this Agreement for care provided at the location named in this Agreement.

Provider Rate Information

Please tell us the rates you charge for child care services (include all rates that you charge).

A ½ day rate is the rate you charge for up to 5 hours of care. A daily rate is the rate you charge for an entire day (up to 10 hours of care). A weekly rate is the rate you charge for an entire week of care.

	Infant/Toddler		**Preschool**		**School Age**	
Rate	Basic Rate	Special Needs	Basic Rate	Special Needs	Basic Rate	Special Needs
½ day						
Full day						
Hourly						
Weekly						

If you offer discount rates for second children or employees, or you have special rates for before and after school care, summer, etc., list these charges below:

_____

_____

_____

By signing this form, I agree to participate as a provider of child care services approved by the Iowa Department of Human Services (hereafter 'Department') and/or the PROMISE JOBS program and assure the Department that I will comply with the provisions of this Agreement.

Sign page 1 and return pages 1 through 4. Keep pages 5 through 7 for your records.

Name of Child Care Provider (please print)	
Signature of Child Care Provider	Date

This area to be completed by DHS worker only

Provider Type_____ **Provider Number**_____

Payments made by the Department will be in accordance with the "Approved ½ Day Rate" as listed below		
Age Group		**Approved ½ Day Rate ***
Infant/toddler	Basic Rate	
	Special Needs Rate	
Preschool	Basic Rate	
	Special Needs Rate	
School Age	Basic Rate	
	Special Needs Rate	
Other rates: (Second child, before and after school, summer, employee discount, etc.)		

Effective Date	Termination Date

* You will be paid the ½ day rate you normally charge or the maximum state reimbursement rate, whichever is less.

⇒ The Department of Human Services shall determine eligibility for services and shall authorize services if eligible. You may appeal through Department appeal procedures if you are dissatisfied with agency decisions.

Signature of Department Representative	Date

THIS PAGE INTENTIONALLY LEFT BLANK.

I understand the payment I will receive for providing child care for the Department of Human Services:

1. Will be based on a five-hour unit of service.
2. Will be effective only during the effective period of this Agreement. If I fail to renew this Agreement, any payments made after the termination date may be subject to recoupment.
3. May be re-negotiated before the termination date, with the agreement of all parties.

Client Fees

I understand:

1. I am responsible for collecting all fees assessed to the client, as determined by the Department, directly from the client. The Department can't collect these fees.
2. I will not bill any Child Care Assistance participant more than the required fee for the units of care provided, as stated on the participant's *Notice of Decision*.
3. I must maintain a record of all fees collected from clients and this record shall be available, upon request, for audit by the Department or its representatives.
4. I can't charge the participant any additional fees except for a late fee if the child is not picked up timely, an "activity fee" to cover the cost of field trips, or the cost of care used beyond the units approved on the participant's *Notice of Decision*.

Billing and Payment

I understand:

1. I must provide the service as authorized on the client *Notice of Decision* or *Certificate of Enrollment* before submitting the claim for payment.
2. At the end of each billing period, I will submit a *Child Care Assistance Billing/Attendance*, form 470-4534, to the Department only for the actual hours of child care services that were provided. This form must be signed by the provider and the parent and I must keep a copy of the signed form for my records.
3. I have the option to submit attendance online through the KinderTrack web portal. If I choose to do so, I must print a *Child Care Assistance Billing/Attendance Provider Record*, form 470-4535, which must be signed by the provider and the parent and kept for my records.
4. If I am not able to use form 470-4534 or 470-4535, I must keep adequate attendance records instead. To be considered adequate, attendance records must include the child's name, the dates and daily time in and time out entries for days the child was in care, and the signature of the parent or other adult designee certifying the attendance is accurate.
5. I will be paid only for the hours of care that were authorized by the Department on the *Notice of Decision* or *Certificate of Enrollment*.
6. I cannot bill the Department or PROMISE JOBS more than what I charge other families for the same service.
7. I cannot request or accept additional payment from families, except for the client fees mentioned above.
8. If I exceed the allowed child capacity for my facility based upon the number and ages of children, this Agreement may be terminated and any payments may be recouped.
9. Failure to comply with this Agreement or other Department child care rules may result in recoupment of payments made and termination of this Agreement for up to 36 months.

Payment for Child Absences

I understand:

1. I may bill for up to four days of absences per month (in accordance with the units approved for that day) **only** when a child is scheduled to be in attendance that day but is absent from care.
2. I may not bill for a day of absence if this policy is not applied to private pay families.
3. Holidays may be paid as an absent day **only** when the child care facility is closed for business, the child is normally scheduled to be in attendance on that day and these days are charged to private pay families. Holidays are included in the four days maximum per month.
4. I may not bill for days of absences when I am not available to provide care (vacation or sick).

Record Keeping and Auditing

I understand:

1. I am responsible for keeping accurate records that document times and dates of care provided to each individual child funded by the Department or PROMISE JOBS.
2. These records must be kept for five years.
3. If this case is selected for review or audit authorized by the Department, I will make these records immediately available, upon request, to substantiate the services I provided and received payment from Child Care Assistance funds.
4. Failure to keep accurate attendance records that have been signed by the parent, may result in termination of this Agreement and repayment of funds for time periods that I am unable to provide adequate attendance verification to support the payments I have received.

Protective Child Care

1. I understand that to provide protective child care, I must be a licensed or registered child care provider unless otherwise approved by the Department.
2. I will cooperate with all aspects of the child's/family's Departmental Case Permanency Plan.

Special Needs Child Care

1. Parents are responsible to provide the Department with written documentation that their children meet the definition of "special needs."
2. I understand that in order to receive "special needs" reimbursement rates, I must provide documentation to the Department that I am responding to a child's special needs with (but not limited to) adaptive equipment, more careful supervision, or special staff training.

Other Provider Requirements

Nondiscrimination:

I will not discriminate because of race, color, national origin, sex, sexual orientation, gender identity, religion, age, disability, or political belief against any person seeking services.

Change Reporting:

I am responsible for reporting changes in my household members, substitutes, assistants, address, phone number, criminal convictions, etc. within 10 days of any change. Failure to report these changes may result in recoupment of funds paid to me and termination of this Agreement.

Abuse Reporting:

I understand that as a registered or licensed provider, I am a mandatory reporter regarding suspected child abuse of children in my care and will report any suspected incidents of child abuse to the Department of Human Services immediately by phone and follow up with a written report. The number for reporting suspected child abuse is 800-362-2178.

I have a written policy stating how I will report suspected child abuse.

Confidentiality:

I will respect the privacy of the client and keep the client's relationship with the Department confidential. Personal information about the client may not be shared with anyone but the Department worker and the client. Failure to respect the client's privacy could result in cancellation of this Agreement and legal sanctions, if warranted.

Indemnity:

I understand that I have the status of an independent contractor only and shall in no sense be an agent, employee, or servant of the state of Iowa, the Iowa Department of Human Services, any of its employees, or its clients. I will not hold the state of Iowa, the Iowa Department of Human Services, its employees, or its clients liable, as I shall be responsible for all activity in the delivery of services.

Drug-Free Environment:

I will provide a drug-free child care environment in accordance with Executive Order Number 38.

Audits or Investigations:

I understand that when fraudulent practices are suspected, a referral may be made to an investigative unit, and that I must cooperate with the investigation. I agree to permit federal, state, and local officials to monitor and evaluate my child care facility with or without notice.

Repayment:

I understand that I may have to repay money received in error or as a result of failure to comply with Department rules, failure to report changes, or fraudulent billing.

Agreement Termination

Non-compliance with any of the provisions of this Agreement may result in termination of this Agreement upon ten days written notice from the Department. Termination of this Agreement may prevent you from making application for another Agreement. The Department may also refuse to enter into subsequent agreements with you for up to 36 months.

This Agreement may also be terminated upon mutual agreement of the parties.

Both parties agree that except in case of emergencies such as illnesses, death, or fire, ten days advance notice shall be given to allow for the arrangement of alternate service provision for clients.

Agreement Renewal

This Agreement must be renewed every two years from the effective date of this Agreement. Failure to enter into a new Agreement will result in termination.

Iowa Department of Human Services

Child Care Assistance Provider Agreement
(Acuerdo de Proveedor de asistencia de cuidado infantil)

Información sobre el proveedor de cuidado infantil

Para que usted reciba su pago conforme al Programa de Asistencia de cuidado infantil, debe suministrar la siguiente información acerca de su nombre legal y su número de identificación fiscal. Por favor, complete la casilla A **O** la casilla B.

Casilla A
Individual
Si responde **Sí** a Persona física, suministre su Número de Seguro Social **(SSN, por sus siglas en inglés)** para usarlo como su número de identificación fiscal.

Usted es: (Marque una)	**Sí**	**No**	**SSN**
una persona física	❑	❑	___ – __ – ____

Si la respuesta a esta pregunta es No, complete la Casilla B.

Apellido del proveedor			Nombre del proveedor		
Dirección donde se suministra el cuidado			Dirección postal (si es diferente)		
Ciudad	Estado	Código postal	Ciudad	Estado	Código postal
Teléfono			Teléfono		

Casilla B
Corporación/Sociedad/Gobierno/Propietario único

Su empresa es: (Marque una)	**Sí**	**No**	**Suministre su Número de identificación de empleador (EIN, por sus siglas en inglés).**
Corporación o SRL	❑	❑	**EIN**
Sociedad	❑	❑	__ - _____
Gobierno	❑	❑	**NOTA:** Su nombre comercial legal y su número de identificación fiscal (EIN) tienen que coincidir con los registros del IRS.
Propietario único	❑	❑	

Nombre comercial legal del proveedor					
Opera bajo el nombre comercial de (DBA, por sus siglas en inglés)					
Dirección donde se suministra el cuidado			Dirección postal (si es diferente)		
Ciudad	Estado	Código postal	Ciudad	Estado	Código postal
Teléfono			Teléfono		

Proveedor elegible

Tengo que cumplir con todos los estándares federales, estatales y locales que pertenezcan a los servicios de cuidado infantil que se suministran bajo este Contrato de pago.

No tengo que ceder, transferir o subcontratar ningún interés en este Contrato. Esto significa que el pago por los servicios realizado bajo este Contrato sólo puede ir al proveedor nombrado en este Contrato por los cuidados provistos en el sitio nombrado en este Contrato.

Información sobre las tarifas del proveedor

Por favor, díganos las tarifas que cobra por servicios de cuidado infantil (incluya todas las tarifas que cobra).

Una tarifa de ½ día es la tarifa que cobra por hasta 5 horas de cuidado. Una tarifa diaria es la tarifa que cobra por un día completo (hasta 10 horas de cuidado). Una tarifa semanal es la tarifa que cobra por una semana completa de cuidado.

	Bebé/niño pequeño		**Preescolar**		**Edad escolar**	
Tarifa	Tarifa básica	Necesidades especiales	Tarifa básica	Necesidades especiales	Tarifa básica	Necesidades especiales
½ día						
Día completo						
Por hora						
Por semana						

Si ofrece tarifas con descuento a segundos hijos o empleados, o si tiene tarifas especiales por cuidados antes y después de la escuela, verano, etc., indique estos cargos debajo:

_____

_____

_____

Al firmar este formulario, acepto participar como proveedor de servicios de cuidado infantil aprobados por el Iowa Department of Human Services (de aquí en adelante, el 'Departamento') y/o el programa PROMISE JOBS y le aseguro al Departamento que cumpliré con las cláusulas de este Contrato.

Firme la página 1 y devuelva las páginas 1 a 4. Conserve las páginas 5 a 7 para sus registros.

Nombre del proveedor de cuidado infantil (en letra de imprenta por favor)	
Firma del proveedor de cuidado infantil	Fecha

Esta área debe ser completada por la trabajadora del DHS exclusivamente

Tipo de proveedor_____ **Número de proveedor**_____

Los pagos efectuados por el departamento se realizarán de acuerdo con la "tarifa de ½ día aprobada" como se indica debajo		
Grupo etario		**Tarifa de ½ día aprobada ***
Bebé/niño pequeño	Tarifa básica	
	Tarifa por necesidades especiales	
Preescolar	Tarifa básica	
	Tarifa por necesidades especiales	
Edad escolar	Tarifa básica	
	Tarifa por necesidades especiales	
Otras tarifas: (segundo hijo, antes y después de la escuela, verano, descuento para empleados, etc.)		

Fecha efectiva	Fecha de finalización

* Se le pagará la tarifa de ½ día que cobra normalmente o la tarifa de reembolso máxima del estado, la que sea más baja.

⇒ El Department of Human Services determinará la elegibilidad para los servicios y autorizará los servicios si son elegibles. Puede apelar a través de los procedimientos de apelación del Departamento si no está satisfecho/a con las decisiones de la agencia.

Firma del representante del Departamento	Fecha

ESTA PÁGINA SE DEJA EN BLANCO INTENCIONALMENTE.

Comprendo que el pago que recibiré por proveer cuidado infantil para el Department of Human Services:

1. Se basará en una unidad de servicio de cinco horas.
2. Sólo se hará efectivo durante el período de vigencia de este Contrato. Si no renuevo este Contrato, todos los pagos realizados después de la fecha de finalización pueden estar sujetos a resarcimiento.
3. Puede ser renegociado antes de la fecha de finalización, con el acuerdo de todas las partes.

Tarifas del cliente

Entiendo que:

1. Soy responsable de cobrarle directamente al cliente todas las tarifas aplicadas al cliente, según lo determinado por el Departamento. El Departamento no puede cobrar estas tarifas.
2. No le facturaré a ningún participante en Asistencia para cuidado infantil más de la tarifa exigida por las unidades de cuidado provistas, según lo que se afirma en el *Notice of Decision* (*Aviso de Decisión*) del participante.
3. Tengo que llevar un registro de todas las tarifas cobradas a los clientes y este registro estará disponible, previa solicitud, para ser auditado por el departamento o sus representantes.
4. No puedo cobrarle al participante ninguna tarifa adicional, excepto un recargo por atraso si el niño no es retirado a la hora debida, una “tarifa por actividad” para cubrir el costo de excursiones, o el costo del cuidado usado más allá de las unidades aprobadas en el *Notice of Decision* del participante.

Facturación y pago

Entiendo que:

1. Tengo que proveer el servicio según lo autorizado en el *Notice of Decision* o *Certificate of Enrollment* (*Certificado de inscripción*) del cliente antes de presentar el reclamo del pago.
2. Al final de cada período de facturación, presentaré una *Child Care Assistance Billing/Attendance* (*Facturación/concurrencia de Asistencia de cuidado infantil*), formulario 470-4534 del Departamento, con las horas reales de servicios de cuidado infantil que fueron suministradas. Este formulario tiene que ser firmado por el proveedor y el/la padre/madre y yo tengo que conservar una copia para mis registros.
3. Tengo la opción de presentar la concurrencia en línea a través del portal web KinderTrack. Si escojo hacer esto, tengo que imprimir un *Child Care Assistance Billing/Attendance Provider Record* (*Registro de proveedor Facturación/concurrencia de Asistencia de cuidado infantil*), formulario 470-4535, el cual tiene que ser firmado por el proveedor y el/la padre/madre, y yo tengo que conservar una copia para mis registros.
4. Si no puedo usar el formulario 470-4534 o 470-4535, tengo que llevar un registro adecuado de la concurrencia. Para ser considerado adecuado, los registros de asistencia tienen que incluir el nombre del niño, las fechas y los horarios de entrada y de salida de los días en los que el niño recibió cuidados, y la firma del padre o la madre o de otro adulto designado como representante, certificando que la concurrencia es correcta.
5. Sólo se me pagará por las horas de cuidado que fueron autorizadas por el Departamento en el *Notice of Decision* o el *Certificate of Enrollment*.
6. No puedo facturar al Departamento o a PROMISE JOBS más de lo que les cobro a otras familias por el mismo servicio.
7. No puedo solicitar ni aceptar un pago adicional por parte de las familias, excepto por las tarifas del cliente que se mencionan arriba.
8. Si supero la capacidad de albergar niños que tiene mi establecimiento en lo que respecta a la cantidad y a las edades de los niños, este Contrato puede ser finalizado y todos los pagos pueden ser resarcidos.
9. Si no cumplo con este Contrato o con otras reglas de cuidado infantil del Departamento, esto puede resultar en el resarcimiento de los pagos efectuados y en la finalización de este Contrato por hasta 36 meses.

Pago por ausencias de los niños

Entiendo que:

1. Puedo facturar por hasta cuatro días de audiencia por mes (de acuerdo con las unidades aprobadas para ese día) **sólo** cuando un niño tenía programado asistir ese día pero se ha ausentado de sus servicios de cuidado.
2. No puedo facturar un día de ausencia si esta política no se aplica a las familias que pagan de manera privada.
3. Los días festivos se pueden pagar como un día de ausencia **sólo** cuando el establecimiento de cuidado infantil no abre al público, está programado que el niño asista ese día y estos días se cobran a las familias que pagan de manera privada. Los días festivos se incluyen en el máximo de cuatro días por mes.
4. No puedo facturar por días de ausencias cuando no estoy disponible para brindar cuidados (vacaciones o enfermedad).

Registros y auditorías

Entiendo que:

1. Soy responsable de llevar registros precisos que documenten las horas y fechas de cuidado provisto a cada niño financiado por el Departamento o por PROMISE JOBS.
2. Estos registros deben guardarse durante cinco años.
3. Si este caso es seleccionado para una revisión o auditoría del Departamento, pondré estos registros a disposición inmediatamente, a pedido, para confirmar los servicios que he brindado y el pago que he recibido de los fondos de Asistencia para el Cuidado Infantil.
4. Si no se llevan registros precisos de asistencia que han sido firmados por el padre o la madre, esto puede provocar la finalización de este Acuerdo y el pago de los fondos por los períodos de tiempo en los que no pueda suministrar una verificación de asistencia adecuada para respaldar los pagos que he recibido.

Cuidado infantil de protección

1. Entiendo que para proveer cuidado infantil de protección, tengo que ser un proveedor de cuidado infantil con licencia o registro, a menos que sea aprobado de otra manera por el Departamento.
2. Cooperaré con todos los aspectos del Plan Permanencia del Caso del Departamento del niño o la familia.

Cuidado infantil de necesidades especiales

1. Los padres son los responsables de suministrarle al Departamento documentación escrita que pruebe que sus hijos cumplen con la definición de “necesidades especiales”.
2. En tiendo que para recibir tarifas de reembolso por “cuidados especiales”, tengo que suministrar documentación al Departamento que demuestre que estoy respondiendo a las necesidades especiales de un niño con (pero no sólo con) equipos adaptados, una supervisión más cuidadosa o una capacitación especial del personal.

Otros requisitos para los proveedores

No discriminación:

No discriminaré por motivos de raza, color, nacionalidad, sexo, orientación sexual, identidad de género, religión, edad, discapacidad o creencia política a ninguna persona que solicite servicios.

Informes sobre cambios:

Soy responsable de informar cambios en los integrantes de mi hogar, reemplazantes, asistentes, dirección, número de teléfonos, condenas penales, etc. dentro de los 10 días posteriores a cualquier cambio. Si no se informan estos cambios, esto puede resultar en el resarcimiento de los fondos que se me hayan pagado y en la finalización de este Contrato.

Informe sobre abuso:

Entiendo que como proveedor registrado o con licencia, soy un informante obligado con respecto a la sospecha de abuso de niños bajo mi cuidado, y que informaré todos los incidentes sospechosos de abuso infantil al Department of Human Services por teléfono inmediatamente, y que luego elaboraré un informe escrito. El número para informar las sospechas de abuso infantil es el 800-362-2178.

Cuento con una política escrita que me indica cómo informaré una sospecha de abuso infantil.

Confidencialidad:

Respetaré la privacidad del cliente y mantendré en confidencialidad la relación del cliente con el Departamento. No se puede compartir información personal del cliente con nadie que no sea el/la trabajador/a del Departamento o el cliente. No respetar la privacidad del cliente podría provocar la cancelación de este Contrato y en sanciones legales, si se justifican.

Exención de responsabilidad:

Entiendo que tengo la condición de contratista independiente exclusivamente y que no seré en ningún sentido un agente, empleado o funcionario del estado de Iowa, el Iowa Department of Human Services, ni de ninguno de sus empleados o sus clientes. No haré responsable al estado de Iowa, el Iowa Department of Human Services, sus empleados o sus clientes, pues seré el responsable de todas las actividades durante la provisión de los servicios.

Ambiente libre de drogas:

Ofrecer un ambiente de cuidado infantil libre de drogas de acuerdo con la Orden Ejecutiva Número 38.

Auditorías o investigaciones:

Entiendo que se sospeche la existencia de actividades fraudulentas, se puede hacer una remisión a una unidad de investigaciones, y que tengo que cooperar con la investigación. Acepto permitir que funcionarios federales, estatales y local monitoreen y evalúen mi establecimiento de cuidado infantil con o sin previo aviso.

Reembolso:

Entiendo que puedo tener que rembolsar dinero recibido por error o como resultado de incumplimiento de las reglas del Departamento, por no informar cambios o por una facturación fraudulenta.

Finalización del contrato

El incumplimiento de cualquiera de las cláusulas de este Contrato puede provocar la finalización de este Contrato diez días después de un aviso por escrito del Departamento. La finalización de este Contrato puede impedirle que presente una solicitud para otro Contrato. El Departamento también puede negarse a celebrar cualquier contrato posterior con usted por hasta 36 meses.

Este Contrato también puede ser finalizado por acuerdo mutuo de las partes.

Ambas partes aceptan que, excepto en caso de emergencias como enfermedades, la muerte, o un incendio, se dará un aviso con diez días de anticipación para permitir el arreglo de la provisión de un servicio alternativo para los clientes.

Renovación del contrato

Este Contrato tiene que ser renovado cada dos años desde la fecha efectiva de este Contrato. La falta de celebración de un nuevo Contrato resultará en la finalización.

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

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

On the second page, the provider:

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

On the third page, the Child Care Assistance worker:

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

Iowa Department of Human Services

Compliance with Third Party Liability (TPL)

FILE THIS NOTICE IN A PERMANENT PLACE IN THE CASE RECORD.

Subject:	MEDICAID NOTICE OF SANCTION
Date:	
To:	Imaging Center
From:	Iowa Medicaid Enterprise, Revenue Collections Unit

Please lift the Medicaid sanction for the member listed below as they have cooperated with TPL.

Member Name:	
Case Number:	
CIN or SID Number:	
Accident/Injury Number:	

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

Purpose	The Iowa Medicaid Enterprise (IME) uses the *Compliance with Third Party Liability (TPL)* to: ♦ Notify the local office when a member has cooperated and ♦ To instruct the local office to lift a member's sanction.
Source	The notice is computer-generated by the IME OnBase system.
Completion	The Revenue Collection Unit at the IME issues the notice when the member cooperates by completing form 470-5266, *Accident/Injury Letter Second Notice*.
Distribution	The IME OnBase system sends the notice of cooperation to the local office Imaging Center and stores a copy as a permanent record.
Data	The IME OnBase system completes the following: ♦ **Date**: The date the form is prepared. ♦ **To**: The local office Imaging Center associated with the county where the member lives. ♦ **Member Name**: The member's name. ♦ **Case Number**: The member's case number. ♦ **CIN or SID Number**: The member's state identification number. ♦ **Accident/Injury Number**: The member's assigned accident or injury number given by the Revenue Collections Unit.

Iowa Department of Human Services

Free Lunch Notice – Give this to the School

<u>Give this letter to the school</u> to get free lunches for the students listed below. They can also get free breakfast and after-school snacks if the school offers them. Do not call DHS about free lunches. If you have questions, call the school your child attends.

We try to give names of students who can get free meals to the schools they attend. The students listed in this letter were not matched with the school. To get free meals for the students listed in this letter, you must:

- Write the name of the school each student will be going to in the blank below. You may add any students living in your household that are not listed. Also write in the grade the student will be in.
- Sign and date this letter.
- **Give this letter to the school to start free meals for this school year. Giving the letter to the school at least 10 days before school starts guarantees free meals from the first day of class. Do not return this letter to DHS**.

Name	Birth Date	School	Grade

X _____ _____ _____

Your Signature | Date | Daytime Phone

FOR SCHOOL USE ONLY

These children qualify for free lunches, breakfasts, and snacks under the National School Lunch Program, Breakfast Program, and the After-School Snack Program.

_____ _____

Date Received | Signature of School Official

Nondiscrimination Statement. USDA is an equal opportunity provider and employer.

Information About Free or Low-Cost Health Care Coverage for Your Children

If your children do not have health insurance, you will be interested to know that many families getting free or reduced-price meals can also get free or low-cost health insurance for their children.

The law now requires schools to share your free and reduced price meal eligibility information with Medicaid and ***hawk-i***, the state's health care coverage program for uninsured children. Specifically, we will give them your child's name and your name and address. Medicaid and ***hawk-i*** can only use the information to identify children who may be eligible for free or low-cost health insurance and then to contact you. They are not allowed to use the information for any other purpose.

You do not have to allow us to share information from your children's Free Lunch Notice with Medicaid or the ***hawk-i*** program. It will not affect your children's eligibility for free or reduced-price meals. If you do **NOT** want your information shared with Medicaid or ***hawk-i***, you must tell us by filling out the information below and give it to the school with the Free Lunch Notice. If you want further information about ***hawk-i***, go to www.hawk-i.org.

If you are already receiving Medicaid or ***hawk-i***, please sign below. This will avoid another contact.

I DO NOT want to share information from my free and reduced-price meal application with Medicaid or ***hawk-i***.

_____ _____

Signature of Parent/Guardian Date

_____

Printed Name

Iowa Department of Human Services

Free Lunch Notice – Give this to the school

(Notificación sobre Almuerzo Gratuito para entregarla en la escuela)

<u>Entregue esta carta en la escuela</u> para que los estudiantes mencionados reciban almuerzos gratis. También pueden recibir desayuno gratis y refrigerios o colaciones gratis después del horario escolar si la escuela los ofrece. No llame a DHS para averiguar sobre almuerzos gratuitos. Si tiene dudas, llame a la escuela a la que asisten sus hijos.

Intentamos informarles a las escuelas sobre los nombres de los estudiantes que pueden recibir comidas gratuitas. Los estudiantes mencionados en esta carta no figuran en el registro escolar. Para que dichos estudiantes reciban comidas gratuitas, debe hacer lo siguiente:

- En la siguiente tabla, escriba el nombre de la escuela a la que asistirá cada estudiante. Puede agregar a todos los estudiantes que viven en su hogar y que no figuran en la lista. Además, escriba el grado que cursará cada uno de los estudiantes.
- Firme y escriba la fecha.
- **Entregue esta carta en la escuela para que reciban comidas gratis durante este año escolar. Si la entrega al menos 10 días antes de que comiencen las clases, los estudiantes recibirán comidas gratuitas desde el primer día de clases. No reenvíe esta carta a DHS.**

Nombre	Fecha de Nac.	Escuela	Grado

X _____ _____ _____

Su firma | Fecha | Teléfono diurno

PARA USO EXCLUSIVO DE LA ESCUELA

Estos estudiantes califican para almuerzo, desayuno y refrigerios gratis bajo los siguientes programas: *National School Lunch Program*, *Breakfast Program* y *After-School Snack Program*.

_____ _____

Fecha de recepción | Firma del funcionario escolar

Declaración contra discriminación. USDA es un empleador y prestador de servicios que brinda igualdad de oportunidades para todos.

470-4473(S) (Rev. 7/15) S4473A

Información sobre Cobertura Médica gratuita o a bajo costo para sus hijos

Si sus hijos no tienen seguro médico, le interesará saber que muchas de las familias que están recibiendo comidas gratis o a precios reducidos también pueden conseguir seguro médico gratis o a bajo costo para sus hijos.

Actualmente, la ley exige que las escuelas compartan información sobre elegibilidad para comidas gratis o a precios reducidos con Medicaid y ***hawk-i***, el programa estatal de cobertura médica para menores sin seguro. Específicamente, debemos informarles el nombre de su hijo o hija y su nombre y domicilio. Medicaid y ***hawk-i*** pueden utilizar dichos datos sólo para identificar a los menores que podrían ser elegibles para seguro médico gratis o a bajo costo y para comunicarse con usted. No se les permite utilizar dicha información con otros propósitos.

No es necesario que nos autorice a compartir la información contenida en la Notificación sobre Almuerzo Gratuito para sus hijos con Medicaid o el programa ***hawk-i***. No afectará la elegibilidad de sus hijos para comidas gratuitas o a precio reducido. Si **NO** desea que dicha información sea compartida con Medicaid o ***hawk-i***, debe informarnos del siguiente modo: complete los siguientes datos y entréguelos en la escuela junto con la Notificación sobre Almuerzo Gratuito. Si desea obtener más información sobre ***hawk-i***, visite www.hawk-i.org.

Si ya está recibiendo Medicaid o ***hawk-i***, firme a continuación. Eso evitará que se comuniquen con usted nuevamente.

NO deseo compartir información de mi solicitud para comidas gratis o a precio reducido con Medicaid o ***hawk-i***.

_____ _____

Firma del padre o tutor Fecha

_____

Nombre en letra de imprenta

HIPP Notice of Action, Form 470-5308

Purpose	The *HIPP Notice of Action* is issued by the HIPS system to notify clients of agency actions that affect the client's eligibility or benefit level. Each client has the right to be given information regarding eligibility and benefit determination.
Source	The HIPS system generates form 470-5308 based on worker entries or system processes.
Completion	The *HIPP Notice of Action* may be used for: ♦ Cancellation notices ♦ Reinstatement notices ♦ Change notices
Distribution	HIPS-generated notices are mailed to the client. A copy is filed in the electronic case file.
Data	The HIPP IM worker picks the appropriate field in HIPS to complete the *HIPP Notice of Action* in HIPS. The worker may also add comments.

Local address here

Date:

Worker name:
Case number:
Worker phone:

Address here

Please review the entire notice. If you have questions, call your worker. We take collect calls.

Iowa Department of Human Services

HIPP Notice of Action

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?

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

Additional Information: Health Insurance Portability and Accountability Act (HIPPA) information can be found online at www.dhs.iowa.gov.

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.

Household Member Questionnaire, Form 470-1630

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

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

The source of information completes the remainder of the form.

How Earnings May Change Your FIP, Form 470-2471, 470-2471(S), 470-2471(M), or 470-2471(MS)

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

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

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 Premium Payment System at Iowa Medicaid Enterprise (IME). When a member reports non-receipt of a billing statement, advise the member to contact Member Services at IME.
Completion	The billing statement is issued directly from IME. A preaddressed envelope is included for members to remit premium payments.
Distribution	One copy of the billing statement is mailed to the member. If a copy of the billing statement is needed for an appeal, contact Member Services at IME to request a copy.
Data	The billing statement: ♦ 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

000000
John Doe
123 Main Street
Anytown, Iowa 00000-0000

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

Dear 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 06/15/15.
2. Please return the amount owed with the payment coupon below. Make your check out to *Iowa Health and Wellness Plan*. 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 the Iowa Medicaid Enterprise (IME) Member Services at 1-800-338-8366. ***Important: 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. Any payment that is more than 90 days past due will be subject to recovery.***

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

470-5285 (Rev. 06/15)

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: 06/15/15
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

0000000X 0 0000000000 06152015 001500 1

Payment History

Premium Month	Original Due Date	Contribution	Paid Date	Hardship	Amount Due
January 2015	2/15/2015	$5.00	02/19/2015		$0.00
February 2015	2/15/2015	$5.00	02/19/2015		$0.00
March 2015	3/15/2015	$0.00	03/17/2015	$5.00	$0.00
April 2015	4/15/2015 (Past Due)	$0.00			$5.00
May 2015	5/15/2015 (Past Due)	$0.00			$5.00
June 2015	6/15/2015	$0.00			$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 1-800-338-8366 de 8:00 a.m. a 5:00 p.m., de lunes a viernes.

Iowa Department of Human Services

470-5285 (Rev. 06/15)

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 the IME 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 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. **Any payment that is more than 90 days past due will be subject to recovery.**

KEEP THIS PAGE FOR PROGRAM INFORMATION, DO NOT RETURN

Understanding Your Billing Statement

If you need help understanding each section of your Iowa Health and Wellness Plan Billing Statement, visit the Iowa Health Link webpage at: **https://dhs.iowa.gov/ime/members/medicaid-a-to-z/iahealthlink/your_benefits**

The Iowa Health Link webpage also shares program updates and other important information like the Iowa Wellness Plan member handbook.

Healthy Behaviors Program

Each year you are eligible for the Iowa Health and Wellness Plan you can participate in the Healthy Behaviors Program. To avoid paying a contribution next year by following these steps:

1. Get a wellness exam with your provider or an exam with your dental provider; and
2. Complete a Health Risk Assessment (HRA).

To complete your HRA for this year, you may call **1-800-338-8366** or visit www.AssessMyHealth.com and use code MBR11.

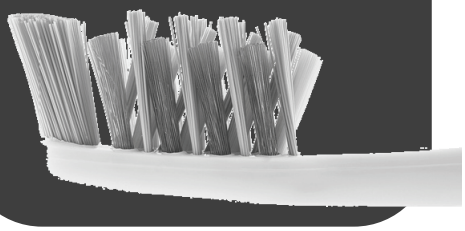
All members will have the first 30 days of each annual enrollment period to complete or self-report completion of healthy behaviors for the previous enrollment period. If you believe you are receiving this billing statement in error, please call the IME Member Services at 1-800-338-8366.

Keep Your Smile Bright!

Members who are enrolled in the Iowa Health and Wellness Plan have dental coverage through the Dental Wellness Plan.

The Dental Wellness Plan meets your basic dental needs, like x-rays and cleanings. When you make regular visits to your dental provider, you will get access to more services. These services include root canals and denture repair.

For more information about the Dental Wellness Plan or help finding a dental provider visit www.DWPIowa.com or call **1-888-472-2793**.



Iowa Department of Human Services

470-5285 (Rev. 06/15)

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.

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 – Bureau of Policy Coordination, 1305 E Walnut, Des Moines, IA 50319-0114 or via email contactdhs@dhs.state.ia.us

KEEP THIS PAGE

Iowa Health and Wellness Plan Billing Statement
(Facturación del Plan *Health and Wellness* de Iowa)

000000
Juan Pérez
123 Main Street
Ciudad, Iowa 00000-0000

Fecha de facturación: 25/05/15
Fecha de vencimiento: 15/06/14
Factura Nº: 000000000000000
ID del miembro: 0000000X

Hola, Juan Pérez

En calidad de miembro del Plan *Health and Wellness* de Iowa, tiene la obligación de pagar una contribución. En esta factura le informamos el importe y el vencimiento.

1. El importe total adeudado es de $15.00. Debe pagarlo antes del 15/06/14.

2. Envíe el dinero junto con el cupón de pago que se adjunta. Extienda su cheque a la orden de *Iowa Health and Wellness Plan*. No envíe dinero en efectivo, ni otros documentos con su pago.

3. Si no puede pagar la contribución, marque la casilla que dice "dificultades económicas" ("*hardship*") y envíe el cupón de pago; O llame a Servicios para Miembros al 1-800-338-8366. ***Importante*: Al marcar la casilla, está solicitando una exención por dificultades económicas para este mes solamente. Tendrá la obligación de abonar las contribuciones adeudadas en meses anteriores.**

Si tiene dudas, llame a Servicios para Miembros al **1-800-338-8366,** de lunes a viernes, de 8:00 a.m. a 5:00 p.m.

470-5285(S) (05/15)

CORTE AQUÍ. CONSERVE LA PARTE SUPERIOR Y ENVÍE LA INFERIOR CON SU PAGO.

Iowa Department of Human Services

☐ Dificultades económicas: Al marcar esta casilla está solicitando una exención (para mayor información, lea al dorso).

Vencimiento: 15/06/14
ID del Miembro: 0000000X 0
Monto a pagar: $15.00

NO ENVIE EFECTIVO

Juan Pérez
123 Main Street
Ciudad, Iowa 00000-0000

Expida el cheque o giro a la orden de:
Iowa Medicaid Enterprise
Iowa Health and Wellness Plan Contributions
PO Box 14485
Des Moines, IA 50306-3485

Monto a pagar: $15.00

Pagado: $ ☐☐☐☐☐

0000000X 0 0000000000 06152015 001500 1

Historial de pagos

Mes de prima	Contribución	Fecha de pago	Dificult. Econ.	Importe adeudado
Enero 2015	$5.00	17/01/15		$0.00
Febrero 2015	$5.00	19/02/15		$0.00
Marzo 2015	$0.00	12/03/15	$5.00	$0.00
Abril 2015	$0.00			$5.00
Mayo 2015	$0.00			$5.00
Junio 2015	$0.00			$5.00

Crédito: $0.00 **Total adeudado: $15.00**

Llame al **1-800-338-8366** o al **515-256-4606** en Des Moines, Lun-Vie 8am–5pm.
Visite nuestra página de Internet: www.dhs.iowa.gov

Para solicitar este documento en español, comuníquese con Servicios para Miembros al teléfono 1-800-338-8366 de 8:00 a.m. a 5:00 p.m., de lunes a viernes.

Iowa Department of Human Services

470-5285(S) (05/15)

CORTE AQUÍ. CONSERVE LA PARTE SUPERIOR

ENVÍE LA PARTE INFERIOR CON SU PAGO.

Dificultades económicas
(*Financial Hardship*)
Si no puede pagar el importe adeudado, debe llamar a Servicios para Miembros al 1-800-338-8366, O marque la casilla “dificultades económicas” en la parte delantera de este cupón y envíelo por correo a IME. **Al marcar la casilla “dificultades económicas”, usted declara que ha gastado o gastará su ingreso mensual en alimentos, vivienda, servicios públicos, transporte u otro tipo de atención médica, y que no puede pagar su contribución al Plan *Health and Wellness* de Iowa este mes. La exención por dificultades económicas será sólo para este mes y no se aplicará a deudas de meses anteriores.** Debe completar el cupón de pago y enviarlo al domicilio indicado. Tendrá que abonar la contribución de este mes si no recibimos la solicitud de exención por dificultades económicas antes de la fecha de vencimiento que figura en la parte delantera.

CONSERVE ESTA INFORMACIÓN SOBRE EL PROGRAMA: NO LA DEVUELVA

Ayuda para entender su factura

Tenemos un folleto donde se explica cada sección de su factura del Plan *Health and Wellness* de Iowa. Si necesita ayuda para entender su factura, visite la página de Internet de Iowa Health Link: **https://dhs.iowa.gov/ime/members/medicaid-a-to-z/iahealthlink/your_benefits**

En la página web de Iowa Health Link también encontrará las novedades del programa y otros datos importantes, como el manual para miembros del Plan *Iowa Wellness*.

Programa *Healthy Behaviors*

Durante cada año en que usted califica para el Plan *Health and Wellness* de Iowa, también puede participar en el Programa *Healthy Behaviors*. Para no tener que pagar una contribución el próximo año, siga los siguientes pasos:

1. Visite a su médico o a su dentista para un examen de control; y
2. Complete la evaluación de riesgos para la salud (*Health Risk Assessment*, HRA)

Para completar el formulario HRA de este año, puede llamar al **1-800-338-8366** o visitar www.AssessMyHealth.com y utilizar el código MBR11.

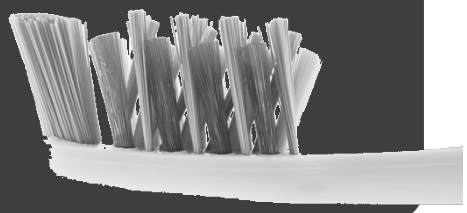
Todos los miembros tienen los primeros 30 días de cada período de inscripción anual para cumplimentar el Programa *Healthy Behaviors* o para informar que lo realizaron durante el previo período de inscripción. Si considera que ha recibido esta factura por error, por favor llame a Servicios para Miembros de IME al 1-800-338-8366.

¡Ayuda para conservar su sonrisa brillante!

Los miembros que están inscriptos en el Plan Health and Wellness de Iowa tienen cobertura dental a través del Plan Dental Wellness.

El Plan Dental Wellness cubre las prestaciones básicas, como radiografías y limpieza dental. Podrá acceder a más servicios si visita a su dentista regularmente. Dichos servicios incluyen tratamientos de conducto y reparación de dentaduras.

Para mayor información sobre el Plan Dental Wellness o si necesita ayuda para conseguir dentista, visite www.DWPIowa.com o llame al **1-888-472-2793**.



Iowa Department of Human Services

470-5285(S) (05/15)

¿Preguntas? Llame al **1-800-338-8366** o al **515-256-4606** en el área de Des Moines, Lun-Vie 8am – 5pm. Visite nuestra página de Internet: 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.

Tiene derecho a apelar

¿Qué es una apelación?

Una apelación es solicitar una audiencia porque no le gusta la decisión tomada por Department of Human Services (DHS). Tiene derecho a presentar una apelación si no está de acuerdo con una resolución. No tiene que pagar nada para presentar la apelación. [Código Administrativo de Iowa, Capítulo 7, artículo 441].

¿Cómo se apela?

Presentar una apelación es sencillo. Puede apelar personalmente, por teléfono o por escrito para Food Assistance o Medicaid. Debe apelar por escrito para todos los demás programas. Debe apelar por escrito de una de las siguientes maneras:

Complete el formulario electrónico de apelación 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 del condado.

¿Cuánto tiempo tengo para apelar?

Para presentar la apelación para Food Assistance o Medicaid, tiene 90 días corridos contados a partir de la fecha de la resolución. Para todos los demás programas, debe presentar la apelación:

En un plazo de 30 días corridos a partir de la fecha de una resolución, o

Antes de la fecha en que la resolución entrará en vigencia.

Si presenta la apelación después de transcurridos 30 días, pero antes de los 90 días corridos posteriores a la fecha de la resolución, deberá explicarnos por qué presentó la apelación tardíamente. Si existió una causa justificada por la cual presentó la apelación tardíamente, nosotros decidiremos si se le concederá una audiencia.

No podremos concederle una audiencia si presenta la apelación con posterioridad a los 90 días corridos contados a partir de la fecha de la resolución.

¿Puedo continuar recibiendo beneficios mientras mi apelación esté pendiente?

Puede conservar sus beneficios hasta que la apelación finalice o hasta el final de su período de certificación si presenta la apelación:

En un plazo de 10 días corridos a partir de la fecha en que recibió la notificación. Se considera que la notificación será recibida 5 días después de la fecha que figura en la notificación. O

Antes de la fecha en que la resolución entrará en vigencia.

Tendrá que reintegrar todos los beneficios que reciba mientras se resuelve la apelación si se determina que el Departamento actuó correctamente.

¿Cómo sabré si me concedieron una audiencia?

Recibirá una notificación de audiencia informándole la fecha y la hora programadas para la audiencia telefónica. En el caso de no concederle una audiencia, le enviaremos una carta informándole el motivo de dicha decisión. También se le explicará qué puede hacer si no está de acuerdo con la decisión de no concederle una audiencia.

¿Puedo tener ayuda de otra persona durante la audiencia?

Usted o alguien más, como un amigo o un pariente, podrán explicar por qué no está de acuerdo con la decisión del Departamento. También podrá tener ayuda de un abogado, pero el Departamento no pagará los honorarios del mismo. La oficina DHS de su condado le puede dar información sobre servicios legales. El costo de los servicios legales se calculará de acuerdo a sus ingresos. Además, puede llamar a Iowa Legal Aid al 1-800-532-1275. Si vive en Condado de Polk, llame al 243-1193.

Política sobre Discriminación, Acoso, Acción Afirmativa e Igualdad de Oportunidades Laborales

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

Si considera que ha sufrido discriminación o acoso, 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

CONSERVE ESTA PÁGINA

Iowa Department of Human Services

Level of Care Certification for HCBS Waiver Program

ATTENTION: Fax completed form to IME Medical Services (515) 725-1349.

When completing this form, respond according to what assistance the member needs rather than the availability or member's willingness to accept the assistance.
Medical professionals completing this form must provide a copy to the member.

Today's Date	Iowa Medicaid Member Name	State ID or Social Security #	Birthdate
Provider Name (please print)		Provider Telephone Number with Area Code	

HCBS Program: ☐ AIDS ☐ Elderly ☐ Health & Disability ☐ Physical Disability ☐ Admission ☐ SSR

☐ Attach diagnoses list ☐ Attach medication list

Level of Care Criteria: Mark all that apply. Review each category.

The HCBS waiver program is intended to serve persons who would otherwise require nursing facility placement. Using your medical judgment and knowledge of the person's condition, do you certify this person requires nursing facility level of care? ☐ Yes ☐ No If yes, provide additional information necessary to support this response.

How does the person complete activities of daily living (eating, personal hygiene, dressing, and toileting) when no assistance is available?

Form should be completed in office with member present.

Was the member seen in the office at the time the form was completed? ☐ Yes ☐ No

Cognitive
- ☐ No problem
- ☐ Language barrier
- ☐ Short/long term memory problem
- ☐ Problems with decision making
- ☐ Interferes with ability to do ADLs

Therapy
- ☐ Speech therapy
- ☐ Occupational therapy
- ☐ Physical therapy

Duration of therapy expected: _____

Ambulation
- ☐ Independent
- ☐ Cane
- ☐ Walker
- ☐ Wheelchair
- ☐ Motorized scooter
- ☐ Needs human assistance
- ☐ Age-appropriate child
- ☐ Restraint used
- ☐ Transfer assist

Behaviors
- ☐ Noncompliant
- ☐ Destructive or disruptive
- ☐ Repetitive movements
- ☐ Antisocial
- ☐ Aggressive or self-injurious
- ☐ Anxiety
- ☐ Depression
- ☐ Requires 24-hour supervision
- ☐ None

Medications
- ☐ Independent
- ☐ Requires set up
- ☐ Needs administered by others
- ☐ Daily IV
  Duration: _____
- ☐ Daily IM
  Duration: _____
- ☐ Insulin, set dosage
- ☐ Insulin, sliding scale
- ☐ Frequent lab values
- ☐ Age-appropriate

Tube Feedings
- ☐ Tube feeding

If requires tube feedings, order: _____

Bathing / Grooming	Dressing	Elimination
☐ Independent ☐ Has assist devices, independent ☐ Supervision or cueing needed How often: ☐ 1-2 x weekly ☐ 3-4 x weekly ☐ 5-6 x weekly ☐ Daily ☐ Physical assistance needed How often: ☐ 1-2 x weekly ☐ 3-4 x weekly ☐ 5-6 x weekly ☐ Daily ☐ Age-appropriate child	☐ Independent ☐ Has assist devices, independent ☐ Supervision or cueing needed How often: ☐ 1-2 x weekly ☐ 3-4 x weekly ☐ 5-6 x weekly ☐ Daily ☐ Physical assistance needed How often: ☐ 1-2 x weekly ☐ 3-4 x weekly ☐ 5-6 x weekly ☐ Daily ☐ Age-appropriate child	☐ Continent ☐ Bladder incontinence ☐ Bowel incontinence ☐ Urinary catheter ☐ Colostomy/ostomy ☐ Nephrostomy ☐ Age-appropriate child **Respiratory** ☐ No issue ☐ O2 use daily ☐ O2 PRN ☐ Tracheostomy ☐ Ventilator ☐ Suctioning Frequency:_____
Living Arrangement	**Skin**	**Eating**
☐ Lives alone ☐ Assisted living ☐ Lives with family/spouse ☐ Senior apartment ☐ Danger to live alone ☐ Nursing facility	☐ Intact ☐ Ulcer – stage = _____ ☐ Open wound ☐ Daily treatment ☐ Treatment PRN ☐ Home health for wound care	☐ Independent ☐ Assistive devices ☐ Requires human assistance excluding meal preparation

I attest the above information is correct.

Signature of Healthcare Professional (MD, DO, ARNP, PA)	Date

Additional comments:	Home services in place:

Page 174 is reserved for future use.

Page 175 is reserved for future use.

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

Purpose	The Iowa Medicaid Enterprise (IME) uses the *Noncompliance with Third Party Liability (TPL)* to: ♦ Notify the local office when a member has not cooperated and ♦ To instruct the local office to sanction a specific member.
Source	The notice is computer-generated by the IME OnBase system.
Completion	The Revenue Collection Unit at the IME issues the notice when the member fails to return form 470-5266, *Accident/Injury Letter Second Notice*.
Distribution	The IME OnBase system sends the notice of noncooperation to the local office Imaging Center and stores a copy as a permanent record.
Data	The IME OnBase system completes the following: ♦ **Date**: The date the form is prepared. ♦ **To**: The local office Imaging Center associated with the county where the member lives. ♦ **Member Name**: The member's name. ♦ **Case Number**: The member's case number. ♦ **CIN or SID Number**: The member's Medicaid identification number. ♦ **Accident/Injury Number**: The member's assigned accident or injury number given by the Revenue Collections Unit.

Iowa Department of Human Services

Noncompliance with Third Party Liability (TPL)

FILE THIS NOTICE IN A PERMANENT PLACE IN THE CASE RECORD.

Subject:	MEDICAID NOTICE OF SANCTION
Date:	
To:	Imaging Center
From:	Iowa Medicaid Enterprise, Revenue Collections Unit

Please sanction the Medicaid benefits for the member listed below for noncompliance with TPL, as it is an eligibility requirement per manual reference 8-C. The member did not return form, 470-5266, *Accident/Injury Second Notice*. The form is used by the Revenue Collections Unit at the Iowa Medicaid Enterprise (IME) to collect information from Medicaid members or their representative when medical claims show they may have been involved in an accident or injury.

Member Name:	
Case Number:	
CIN or SID Number:	
Accident/Injury Number:	

To fix the Medicaid sanction the member must contact IME Member Services and complete form 470-5266 over the phone.

Member Services:
1-800-338-8366 or locally in the Des Moines area at **515-256-4606**
Monday through Friday, 8:00 am to 5:00 pm

When the member cooperates with the Revenue Collections Unit a letter will be sent to your imaging center to lift the sanction.

Noncooperation Notice, Form 470-0479

Purpose	The Bureau of Quality Control uses the *Noncooperation Notice* to notify the local office when a client has refused to cooperate and to instruct the local office on the action to take on a client's case.
Source	An electronic template for form 470-0479 is available on the QC share. Reviewers need to copy the form to their computer.
Completion	The Quality Control reviewer completes this form whenever Quality Control determines that a client has refused to cooperate.
Distribution	The Quality Control reviewer sends the original to the local office and files a copy as a permanent record with the completed review.
Data	The Quality Control reviewer completes the following:

- **Date:** The date the form is prepared.
- **County:** The local office where the client currently receives benefits, last received benefits, or had an application rejected.
- **QC Reviewer:** The Quality Control reviewer's name.
- **Case Worker:** The IM worker who is currently handling the case record or last handled the case record.
- **Phone:** The Quality Control reviewer's telephone number.
- **Case Name:** The client's name.
- **Case No:** The client's case number.
- **Persons Not Cooperating:** The name of the person who was required to cooperate with Quality Control but failed to. List the client's name here if it is not the same person as the case name. All non-cooperating household members should be listed on this form.
- **QC Review No:** The client's Quality Control review number.
- **Reference:** The manual reference for failure to cooperate.

Iowa Department of Human Services

Other Insurance Request

<<NAME>>
<<ADDRESS>>
<<ADDRESS>>
<<CITY>>, <<STATE>> <<ZIPCODE>>

<<Date>>

Reference Number: <<<<<>>>>>

Iowa Medicaid has information that <<First Name Last Name>> has other insurance. The form on the back of this letter must be completed to see if other insurance should pay a claim before Medicaid. A parent or legal guardian should complete and sign the form for a child under the age of 18.

To complete the form over the phone, between 8:00 a.m. and 5:00 p.m., call the Iowa Medicaid Member Services Unit at 1-800-338-8366, or in the Des Moines area 515-256-4606. To better assist you, please have the above reference number ready when you call.

Please provide the insurance information by: <<DueDate>>.

If you prefer to return a written copy of the form, use one of the options below:

Email: Revcol@dhs.state.ia.us

Fax: 515-725-1352

Mail: Iowa Medicaid Enterprise
Revenue Collections
P.O. Box 36475
Des Moines, IA 50315-9930

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

Complete this form and return it by <<DueDate>>:

The information requested on this form is about: <<First Name Last Name>>

Medicaid #: <<Medicaid ID>> Reference Number: <<<<<>>>>>

Medical coverage ☐ Yes ☐ No If yes, complete this section.

Policy Holder's (PH) Name		Relationship to <<firstname>>
PH SSN	PH Date of Birth mm/dd/yyyy	PH Employer
Insurance Company Name	Insurance Policy Number	Insurance Company Phone Number

Prescription coverage ☐ Yes ☐ No If yes, complete this section.

Policy Holder's (PH) Name		Relationship to <<firstname>>
PH SSN	PH Date of Birth mm/dd/yyyy	PH Employer
Insurance Company Name	Insurance Policy Number	Insurance Company Phone Number

Dental coverage ☐ Yes ☐ No If yes, complete this section.

Policy Holder's (PH) Name		Relationship to <<firstname>>
PH SSN	PH Date of Birth mm/dd/yyyy	PH Employer
Insurance Company Name	Insurance Policy Number	Insurance Company Phone Number

Vison coverage ☐ Yes ☐ No If yes, complete this section.

Policy Holder's (PH) Name		Relationship to <<firstname>>
PH SSN	PH Date of Birth mm/dd/yyyy	PH Employer
Insurance Company Name	Insurance Policy Number	Insurance Company Phone Number

Is there anyone else in the family that is covered by the same policies? ☐ Yes ☐ No
If yes, provide their Medicaid #, name, and mark all the policies they have.

Medicaid #	First and Last Name	Medical	Rx	Dental	Vision

Sign, date, and return the completed form using the instructions on the front side.

Signature		Date
Print Name		Relationship to <<firstname>>
Home Phone Number	Cell Phone Number	

Other Insurance Request, Form 470-0403

Purpose

Form 470-0403, *Other Insurance Request*, is used by the Iowa Medicaid Enterprise (IME) to collect information from Medicaid members or their representative when claims show they may have other health insurance.

The information returned on the form is used to identify claims with third-party liability (TPL). This form allows the IME to recover and cost avoid some or all of the Medicaid expenditures made on the member's behalf.

Source

The form is computer-generated by the IME OnBase system.

Completion

The form is prepared automatically when a Medicaid claim code indicates an accident or injury.

Distribution

The form is sent to the member, who returns it to the IME on completion.

Once completed by the member or the member's representative, the form may be returned in one of the following ways:

Mail: Iowa Medicaid Enterprise
PO Box 36446
Des Moines, IA 50315

Phone: Member Services
1-800-338-8366 or locally in the Des Moines area at **515-256-4606** (Monday through Friday, 8:00 am to 5:00 pm)

Email: RevColl_Lien@dhs.state.ia.us

Fax: 515-725-1352

Data

The form requests information from the member concerning:

- The type of health insurance.
- Policy holder information.
- Insurance carrier information.

Overpayment Recovery Supplemental Information, Form 470-0465

Purpose

Form 470-0465 informs the Public Assistance Debt Recovery Unit of additional information pertaining to an overpayment. From the information supplied, DIA can better determine whether to pursue voluntary repayment, investigation, civil prosecution, or criminal prosecution.

If DIA refers the case for prosecution, this form is submitted to the county attorney to summarize the basis for the investigation.

Source

Department staff can complete this form on line using the template on the DHS Intranet eForms web page. Other users may print or photocopy supplies from the sample in the manual.

Completion

IM workers complete this form for overpayments in FIP, Refugee Cash Assistance, Food Assistance, Medicaid, Child Care Assistance, and State Supplementary Assistance.

PROMISE JOBS workers complete this form for overpayments in Child Care Assistance and PROMISE JOBS programs.

The ***hawk-i*** program's third-party administrator completes this form for ***hawk-i*** overpayments.

Prepare an original and one copy of this form when:

- A claim is being revised, and
  - It is now a client error of over $1,000, and
  - The worker did not previously complete either form 470-0465 or a fraud referral screen in the direct claim entry screen.
- The DIA Division of Investigations requests the information to pursue recovery action.
- The IM Unit wishes legal action pursued.
- Recovery will be attempted from the resources of an alien's sponsor.

Distribution

Submit the original along with the Overpayment Recovery Information Input Summary (from the direct claim entry screen), or the *Overpayment Recovery Information Input*, form 470-0464, to:

DIA Investigations Division
Public Assistance Debt Recovery Unit
Lucas Building, Third Floor
321 E 12th St., Des Moines, Iowa 50319-0083

(or send by local mail). Keep a copy in the case record.

Data

Make the following entries:

State ID: Enter the debtor's state identification number.

ABC case no.: Depending on the type of claim, enter the debtor's ABC case number.

hawk-i* case no.:** If this is a ***hawk-i claim, enter the debtor's ***hawk-i*** case number.

***SRS* case no.:** Depending on the type of claim, enter the debtor's SRS or KinderTrack case number.

Summary regarding overpayment: Give a brief statement regarding the condition that caused the overpayment.

Possible witnesses and evidence: List separately each person who can provide truthful and relevant testimony regarding the overpayment. Include the person's name, current address, and telephone number.

Under each witness's name, describe what that witness can testify to, including time and dates of contacts or statements. Be specific, but brief.

If the person is an employee of a state agency, name the county of location where the person is employed. List the office telephone number and the type of caseload carried.

List all related documents, giving the date of each document (examples: application, RRED, NOD). In addition, list all signed statements available from either the recipient or a collateral source.

Maintain all related documents in the case record until complete recovery has been made or the Division of Investigations requests the documents.

Worker: Sign the form when it is completed.

Date: Enter the date the form is completed.

Payment Application for Nonregistered Providers, Form 470-2890 or 470-2890(S)

Purpose	Nonregistered and in-home providers apply for Child Care Assistance payment by completing the *Payment Application for Nonregistered Providers*, form 470-2890 or 470-2890(S).
Source	The English version of form 470-2890 is printed with 100 forms on a pad. Order supplies from Iowa Prison Industries at Anamosa. The Spanish version can be printed or photocopied from the sample in the manual.
Completion	The provider completes the application when: ♦ Applying for payment for the first time; or ♦ Applying for a two-year renewal; or ♦ Applying after the expiration of a previous agreement; or ♦ There is a change of name, care, living or mailing address, or household composition. The provider shall complete the form after reading all the instructions and the minimum requirements in Comm. 95 or Comm. 95(S), "Minimum Health and Safety Requirements for Nonregistered Child Care Home Providers."
Distribution	The provider returns the application to the Centralized Child Care Provider Registration Unit. The Unit files the application in the child care case record.
Data	The applicant-provider shall: ♦ Indicate whether this is a new application or a renewal. ♦ Carefully print the name (and maiden name and other last names, if any) and addresses. ♦ Enter the birth date, last four digits of the social security number, and telephone numbers with area codes. ♦ Nonregistered providers add the names of other adults and children living in the home with birth dates and the last four digits of the social security number, if available.

- In-home providers list the names of the parents and children living in the home where care will be provided, if available.
- Sign the application and date it to certify compliance with the minimum requirements of the Department of Human Services and indicate agreement with the eight numbered statements.

Pregnancy Verification Request, Form 470-3783

Purpose	Form 470-3783, *Pregnancy Verification Request*, is used to collect information for certain Medicaid programs when the household reports a member of the household is pregnant.
Source	Complete the form on line using the template available on the DHS Intranet eForms web page.
Completion	Complete this form when a household reports a member of the household is pregnant.
Distribution	Give one copy of the form to the client. You may upload the request to the electronic case file. When the client completes and returns the form, it will be scanned and uploaded.
Data	Certain areas of the form populate and a due date is calculated for return of the completed form.

Page 294 is reserved for future use.

Presumptive Medicaid Eligibility Notice of Decision, Form 470-2580 or 470-2580(S)

Purpose

The *Presumptive Medicaid Eligibility Notice of Decision* is used to:

- Notify pregnant women, children, or women needing treatment for breast or cervical cancer of the qualified provider's presumptive eligibility decision.
- Verify presumptive Medicaid eligibility for Medicaid providers rendering:
  - Ambulatory prenatal care services to pregnant women, or
  - Full Medicaid services to children or to women with breast or cervical cancer.

Source

The presumptive eligibility program generates form 470-2580 or 470-2580(S) based on entries the qualified provider makes through the Iowa Medicaid Provider Access (IMPA) Portal.

Completion

The qualified provider makes entries into the presumptive eligibility program to complete the form when:

- A woman has filed form 470-2927 or 470-2927(S), *Health Services Application*, with the qualified provider; or
- A child or someone acting on a child's behalf has filed form 470-4855 or 470-4855(S), *Application: Presumptive Health Care Coverage for Children*, with the qualified provider.

Distribution

A copy of the notice will be saved in the presumptive eligibility system. The qualified provider shall:

- Print the notice,
- Give or mail a copy to the applicant, and
- Keep a copy in the presumptive Medicaid record.

Data

The presumptive eligibility program completes the information on the notice based on the entries the qualified provider made.

- For approvals, the system enters:
  - Which type of presumptive eligibility is approved.
  - The woman or child's state identification number.
  - The beginning date of presumptive eligibility.
  - The ending date for presumptive eligibility.
  - Whether the application has already been sent to the Department or the patient needs to submit a Medicaid application.
- For denials, the system provides an explanation of denial (e.g., you are over income, you have already received presumptive eligibility during this pregnancy, etc.).
- The system enters the name, address, telephone number, and email address of the provider making the determination.

Proof of Application for Medicaid, Form 470-2979

Purpose	Form 470-2979, *Proof of Application for Medicaid*, provides the client a letter to verify that the client has applied for Medicaid. Clients may show this form to providers or others as proof of their application.
Source	Complete this form on line using the template on the DHS Intranet eForms web page.
Completion	IM workers complete the form when clients request proof that they have applied for Medicaid.
Distribution	Give or send the original copy to the client.
Data	Enter: ♦ The name of the IM worker. ♦ The county number designation. ♦ The name and address of the applicant. ♦ The notice date (the date the form is completed). ♦ The date the household applied for Medicaid. ♦ The names of the individuals included in the application for Medicaid.

Proof of Medicaid Coverage, Form 470-3491

Purpose	Form 470-3491 provides evidence of prior health coverage under the Medicaid program. Clients may need to furnish this certificate if they become eligible under a group health plan that excludes coverage for medical conditions they had before enrollment (pre-existing conditions).
Source	This form is system-generated.
Completion	All entries are made by the system. The form is automatically sent ten days following the last day of the month in which the person lost Medicaid coverage.
Distribution	One copy is sent to Medicaid beneficiaries who have been terminated from Medicaid.

Provider Request for Member Disenrollment, Form 470-2169

Purpose

Managed health care providers can use form 470-2169 to request that a Medicaid member assigned to them be disenrolled or reassigned. Completion of this form does not cause immediate disenrollment.

Disenrollment is not effective until the managed health care review committee has reviewed the request and the IME Provider Services Unit has coded disenrollment with an effective date. Enrollment still exists until the provider's name no longer appears on the recipient's pink *Medical Assistance Eligibility Card*.

Source

This form is issued to managed health care providers in their managed care handbook. Additional copies are available to participating providers upon request to the IME Provider Services Unit.

Completion

The managed health care provider completes Parts A and B of this form when the provider wants to stop serving the member due to:

- The member's age or sex being outside the provider's normal scope of treatment.
- Issues such as failing to show up for appointments, noncompliance with treatment, and abusive or drug-seeking behavior.

An authorized member of the managed health care review committee is responsible for completing Part C of this form.

Distribution

The provider keeps a copy and mails the original to:

IME Provider Services Unit
PO Box 36450
Des Moines, Iowa 50315

Managed health care staff send a copy of the form to the member at the time of the provider's original request.

After the Review Committee decision has been recorded, the form shall be distributed as follows:

- The review committee retains the original.
- A copy is sent to the provider.

The IME Provider Services Unit does not enter any system action to disenroll the member until it has received instructions from the Division of Medical Services regarding the managed health care review committee's decision.

Data

Part A. Provider information: The managed health care provider completes Part A as follows:

- Check type of managed health care that applies.
- Enter name of managed health care provider.
- Enter Medicaid provider identification number or national provider identifier of the managed health care provider.
- Enter address of managed health care provider.
- Enter signature of authorized person making request for provider.
- Enter date the request is signed.

Part B. Disenrollment request: The managed health care provider completes Part B as follows:

- Enter name of each member for whom disenrollment is requested.
- Enter state Medicaid personal identification number for each member for whom disenrollment is requested.
- State reasons for each person for whom disenrollment is being requested by using disenrollment reason/code. Additional documentation shall be attached, if necessary.

Part C. Managed Health Care Review Committee Decision: The Managed Health Care Review Committee shall make a decision within 30 days of receipt of the request. When the form is completed, the MHC team member shall make the appropriate system entries within ten days.

Section C shall contain approval of the request, a denial of the request, or some specific instructions as to how the managed health care team or managed health care provider should proceed.

- Indicate the decision of the Managed Health Care Review Committee: "approve," "deny," or "other." If "other" is checked, an explanation should be included in the comments section.
- Include comments of the Managed Health Care Review Committee, if appropriate.
- Use this area to relay specific instructions to the income maintenance worker concerning implementation of the Review Committee's decision.
- An authorized member of the Managed Health Care Review Committee shall sign as the designee of the administrator of the Division of Medical Services. The date signed shall be included.

Public Assistance Agency Information Request, Form SSA-1610-U2

Purpose	The local DHS office is to use the *Public Assistance Agency Information Request* for exchange of information with the Social Security Administration that is not included on the TPQY response.
Source	Print or photocopy supplies of form SSA-1610-U2 from the sample in the manual as needed.
Completion	The local DHS worker responsible for the case shall prepare form SSA-1610-U2 in the following situations: ♦ To resolve any discrepancies between other evidence and data in the TPQY files, such as an identification problem. ♦ To secure retroactive historical data not provided by the TPQY. ♦ To provide information to the Social Security office regarding mutual clients, e.g., a FIP case in which an SSI application is pending. Refer to 4-C, SSI Recipient. Use of the SSA-1610-U2 shall be limited to these circumstances except for emergencies. Each Department office should arrange with its Social Security office for handling emergencies.
Distribution	Send the original to the local Social Security office. When information is being submitted to the Social Security office, you may upload the request to the electronic case file. When the Social Security returns the original, it will be scanned and uploaded to the case record.
Data	Specific instructions for completing the form are printed on the back of the form.

Quality Assurance Transmittal, Form 470-0271

Purpose

The *Quality Assurance Transmittal* is used to request the Quality Assurance Unit of the Division of Data Management to:

- Cancel a warrant,
- Issue a one-time payment, or
- Cross-reference a state identification number.

Source

Complete form 470-0271 on line using the template on the DHS Intranet eForms web page.

Completion

The IM worker completes the "Date," "From," and "Case Identification" sections and completes the rest of the form depending on the action being requested:

- **Cancel Warrant:** When a client returns a warrant to a Department office, enter the warrant number, amount, and date in this section. Attach the warrant and the official receipt to the white copy of the 470-0271 and send them to Quality Assurance.

  If Quality Assurance has the warrant, send the form alone to Quality Assurance. Leave the warrant number field blank for Quality Assurance to complete.

  In both cases, Quality Assurance takes the necessary actions to remove the warrant from the client's automated records.

- **Issue One-Time Special Payment Over $1800:** To request the payment, check this box and enter the amount of payment. Send 470-0271 to the designated person in the service area, with a memo attached to explain why the payment is needed.

  The designated service area person will sign the form in the space provided, and forward it to Quality Assurance. Quality Assurance authorizes the amount for ABC system issuance.

- **State ID Cross Reference:** If two or more state identification numbers are on record for a client, use this section to indicate which state ID should be removed.

Also use this section to indicate any social security number that should be removed, in order to enter the number with another state identification record.

In all cross-reference situations, use the "Comments" section to explain your request.

If the name and state identification number of a child need to be changed due to adoption, but the child's social security number remains the same, use this section, but enter the new name under "Comments."

Distribution

Send the form in an envelope via local mail to Quality Assurance, Division of Data Management, Hoover Building. Keep one copy for case file.

Quality Assurance contacts the worker who initiated the request if more information is needed before the requested actions are completed. Quality Assurance will return incomplete transmittals to the worker, so errors are prevented.

Quality Assurance may encounter error conditions when attempting to cross-reference state identification numbers. Edits prohibit deletion of state identification numbers that do exist and are used on current ABC individual income records or have active, disqualified, or sanctioned status codes on ABC.

Data

Self-explanatory.

Quarterly Report Follow-Up, Form 470-2721

Purpose	The *Quarterly Report Follow-Up* notifies the member of the additional information and verifications necessary to complete the *Transitional Medicaid Notice of Decision/Quarterly Income Report* and informs the member of the due date for submitting the information.
Source	Complete this form on line using the template on the DHS Intranet eForms web page.
Completion	The IM worker completes the form when the client returns a *Transitional Medicaid Notice of Decision/Quarterly Income Report* and either: ♦ Some of the questions were not answered, or ♦ Not all of the required proof was sent with the report.
Distribution	Mail or give the original to the member. File the copy in the case file.
Data	Enter the date, case name, and current mailing address where indicated. Check the first box if the member failed to answer all of the questions on the report. Check the second box if all required proof is not sent in with the report. List the missing proof in the spaces provided.

Race/Ethnic Report, Form 470-3716

Purpose	Form 470-3716 is used to gather information about race and ethnicity for a person associated with the Food Assistance household or FIP assistance unit. Clients are not required to provide this information. However, it is a federal requirement that Iowa report race or ethnicity for all who do provide the information.
Source	Initiate form 470-3716 on line using the template on the DHS Intranet eForms web page.
Completion	Issue this form whenever you realize that you do not have race or ethnicity information for all adults and children who are in the Food Assistance household or are associated with the FIP assistance unit, including people who are not included on the grant, such as stepparents, excluded parents, etc. Also issue the form when the household applies for benefits for a new household member. NOTE: Clients are not required to complete this form. If clients decline to do so, it does not affect their eligibility or their benefits. If clients decline to answer the questions or complete the form, use worker observation to collect the data. When observation is not possible, document that the form was offered but the client chose not to supply the information.
Distribution	Enter the race and ethnicity information collected for each person on the ABC system.
Data	Clients can choose one selection for ethnicity and choose as many selections as apply for race.

Reasonable Compatibility Tool, Form 470-5178

Purpose	IM workers use the *Reasonable Compatibility Tool* to determine if an applicant's statement of income can be considered to be verified as it is reasonably compatible with income information from state data sources. Workers use this form for MAGI-Related Medicaid only.
Source	IM staff can complete this form on line using the tool on the DHS Intranet eForms web page.
Completion	The IM worker completes applicable fields of the tool when determining eligibility for MAGI-Related Medicaid for a member with countable income.
Distribution	File a copy of the completed tool in the case file.
Data	The IM worker enters data as follows:

- **State Source Income** tab: Enter the amount of monthly income obtained from state data sources for each member.
- **Self-Attested Income** tab: Enter countable monthly income for each member in the field that identifies the type of income.
- **Reasonable Compatibility** tab: The tool determines if the difference between the member's self-attested income amount and state data source income amount is within 10% of the state data source income amount. The percentage of difference is displayed in the *Compatibility Percentage* field:
  - The *Reasonably Verified* field says "True" if the percentage is 10% or less. The worker may consider the income to be verified.
  - The *Reasonably Verified* field says "False" if the percentage is more than 10%. The worker must obtain additional verification of the income.

Record of Lost Benefits Restored, Form 470-0318

Purpose	Form 470-0318 is used to document the amount of lost benefits owed and the amount of lost benefits restored to a household.
Source	Complete form 470-0318 on line using the template on the DHS Intranet eForms web page.
Completion	Complete form 470-0318 when you determine that a household is entitled to a restoration of lost benefits or when a restoration of lost benefits is ordered by a hearing decision. Notify the household of its entitlement to lost benefits by completing the *Notice of Lost Benefits Entitlement*, form 470-0334. Print an original and one copy of form 470-0318. Print one additional copy for each additional month for which benefits are restored.
Distribution	File the original in the household's case record. Send one copy to the Bureau of Purchasing, Payments, Receipts and Payroll. If the household requests issuance in more than one month to restore lost benefits, forward an additional copy to the Bureau of Purchasing, Payments, Receipts and Payroll following each month's issuance.
Data	Complete the form as follows: ♦ Complete Items 1 through 7 to establish the amount of and the reason for the restoration of lost benefits. ♦ If there is an unpaid claim against the household, enter the unpaid amount in Item 8. EXCEPTION: If the unpaid amount of the claim exceeds the amount in Item 7, enter the same amount as in Item 7. To give the household credit on its claim, complete the form 470-0010, *Adjustment to Overpayment Balance*, showing the amount in Item 8 for the Bureau of Purchasing, Payments, Receipts and Payroll. ♦ If benefits are restored in a lump sum, complete Item 10. ♦ If benefits are restored in monthly installments per household request, complete Item 11, as needed.

Iowa Department of Human Services

Resuming Overpayment Collection

Date: Account Number:

Name
Address
City State Zip

A timely appeal was filed on your:

(The line(s) appearing below should be dynamic, based on the program(s) being appealed.)

- $_____ FIP or RCA overpayment for period of _____
- $_____ Food Assistance overpayment for period of _____
- $_____ Child Care Assistance overpayment for period of _____
- $_____ Medical Assistance overpayment for period of _____
- $_____ ***hawk-i*** overpayment for period of _____
- $_____ PROMISE JOBS overpayment for period of _____
- $_____ State Supplementary Assistance for period of _____

The Department's decision has been affirmed and all collection actions will resume on the above overpayments. DIA will collect on this debt by doing one of the following:

- Bill you for the debt, or
- Reduce the amount of assistance you are currently receiving if you have a debt for and are currently receiving benefits for the following programs:
  - Family Investment Program
  - Food Assistance

If do not make payments or if you become past due on your account, we may also:

- Take money that is owed to you by any state agency. For example, all or part of your income tax refund or state wages.
- Take money that is owed to you by any federal agency. For example, all of part of your federal tax refund or Social Security benefits. Food Assistance debts only.
- Hold all or part of any casino or lottery winnings.
- File a suit to collect the debt.

If you have additional overpayments that are not listed on this form, you must also continue to make payments on those overpayments.

Questions about this letter?

Call the Department of Inspections and Appeals at **1-800-572-3945**.

Questions on your appeal or on how your debt was figured?

For most DHS Programs	**Call your DHS worker at**
For the **HIPP** Program	Call the HIPP Unit at **1-888-346-9562**
For the ***hawk-i*** Program	Call ***hawk-i*** Customer Service at **1-800-257-8563**

For more information about DHS programs: www.dhs.iowa.gov/

470-5322 (3/15)

Resuming Overpayment Collection, Form 470-5322

Purpose	When the Department's decision has been affirmed on an appeal of overpayment, form 470-5322 informs the debtor that collection actions on the overpayment will resume.
Source	Form 470-5322 is generated by the Overpayment Recovery System, located in the Division of Data Management.
Completion	The Overpayment Recovery System generates and inserts specific debt information into the form.
Distribution	One copy is mailed to the debtor from Central Office.
Data	The system completes the: ♦ Date, ♦ Account number, ♦ Debtor name, ♦ Debtor address, ♦ Program being appealed, and ♦ DHS worker phone number.

Review/Recertification Eligibility Document, Form 470-2881, 470-2881(S), 470-2881(M), or 470-2881(MS)

Purpose

The *Review/Recertification Eligibility Document*, forms 470-2881, 470-2881(S), 470-2881(M), and 470-2881(MS), is designed for use as:

- An application for subsequent certification for the Food Assistance program.
- The annual or semiannual review document for FIP and Refugee Cash Assistance.

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

Source

Usually, the ABC system generates form 470-2881 automatically. Form 470-2881(S) is generated when there is an "S" in the language indicator field on the ABC TD01 screen.

DHS staff may issue "manual" versions of the form, 470-2881(M) and 470-2881(MS), using the Word templates available on the DHS Intranet eForms web page.

Completion

The ABC system produces form 470-2881 or 470-2881(S) after the data processing cutoff for:

- Food Assistance when a case is due for recertification.
- FIP and Refugee Cash Assistance when a case is active or pending and the case coding indicates that the form should be sent.

Give or issue form 470-2881(M) or 470-2881(MS) to the participant upon request.

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

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

For FIP and Refugee Cash Assistance, when both parents or a parent and a stepparent are in the home, either may sign the form. When a participant has a guardian or conservator, that person shall participate in completing the form. This person may sign for the client when necessary.

For Food Assistance, only one signature is required to process this form as an application for recertification.

Distribution

Give or mail one copy of the report to the client for completion.

File the completed original in the case record. Provide a copy of the completed form to the client upon request.

Data

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

- Enter the county number.
- Enter the nine-digit case number and check digit.
- Enter the case name and current mailing address.
- Enter the Department office name and mailing address.
- Enter the date the report is due back to the Department in the "Due Date" field and in the "What do I do with this form?" section.
- Enter the worker's telephone number in the "What if I have questions?" section.
- For FIP and Refugee Cash Assistance, insert the following message in the message section:

  "It's time to review your case. Please fill out this form and send or bring it to the address above by <due date>. This information will be used to decide if you will continue to get Family Investment Program (FIP) or Refugee Cash Assistance benefits."

- If an interview is needed for Food Assistance, enter:

  "Your Food Assistance will end <last date of certification period>. Return this signed form by <15th of certification end month> to get Food Assistance at the regular time next month, if you are eligible. You must have an interview. If you miss your interview, you must ask the local office to reschedule.

  "Households consisting of only SSI applicants or recipients may apply for Food Assistance recertification at any SSA office."

- If an interview is **not** needed for Food Assistance, enter:

  "Your Food Assistance will end <last date of certification period>. Return this signed form by <15th of certification end month> to get Food Assistance at the regular time next month, if you are eligible.

  "Households consisting of only SSI applicants or recipients may apply for Food Assistance recertification at any SSA office."

- Enter all data in the "Household Members" section (except **do not** enter the last grade completed and the "yes" or "no" responses). Enter only the last four digits of the social security number.

Screening: Screen the form upon its receipt. All questions (for related programs) that have "yes or no" responses must have either "yes" or "no" marked.

For FIP and Refugee Cash Assistance, if the answer is "yes," all requested information must be completed and necessary verification provided for the form to be considered complete.

If the participant fails to enter required information on the RRED but sends verification of that information with the RRED, the form is still considered complete.

NOTE: When the nonparental relative does not receive assistance for the relative's own needs, the information shall reflect the circumstances of each child.

To be complete, the form must be signed and dated by the necessary persons.

Screening Related Services Rendered to Medicaid EPSDT Enrollees, Report X1612X5

Purpose	The *Screening Related Services* report provides the IM worker with a record of medical care received by a child when the worker is responsible for providing the EPSDT "Care for Kids" oversight. (See 8-M, Procedures for Notification and Tracking, for a description of IM responsibilities under this program.
Source	The Iowa Medicaid Enterprise generates the list quarterly from the fiscal agent's **paid** claims history file.
Completion	When there is a referral for diagnosis or treatment as a result of the most recent screening examination, and follow-up services are indicated, no further action is needed. When it is not clear whether the service has been received, contact the member to determine if assistance is needed.
Distribution	File the most recent report in the case record.
Data	The "LAST" screening date is the last screening paid by Medicaid in the last two years. The "NEXT" screening date is based upon the enrollee's age and the periodicity schedule. The report identifies the dental, hearing, medical, and vision services paid by Medicaid within the last six months. Enrollees are reported even if they did not have a service to report.

Section 503 Alert Notice, Report S470A110-A

Purpose	The *Section 503 Alert Notice* is a computer-generated notice that is issued to inform workers of a client's potential eligibility for Medicaid under the 503 coverage group (for people who have lost SSI eligibility due to a cost-of-living increase in their social security benefits).
Source	The ABC system generates this report as part of COLA processing.
Completion	When a new group of potential eligibles is identified (in processing a social security cost-of-living increase), one copy of the notice is generated in Central Office for each client affected.
Distribution	The notice is sent to the worker listed on the case. Carry out the instructions on the notice and file it in the case record with the permanent forms.
Data	The notice lists: ♦ The date of the cost-of-living increase ♦ The county and worker identification numbers ♦ The client's ABC case number ♦ The county name ♦ The client's name and social security number ♦ The payee address ♦ The client's residence address

Self-Assessment, Form 470-0806 or 470-0806(S)

Purpose	Form 470-0806, *Self-Assessment*, is used to obtain information about a PROMISE JOBS client as part of the assessment process, to identify potential barriers to participation in the PROMISE JOBS program or specific components.
Source	The English version of form 470-0806 is printed in pads of 25 sets. Order supplies from Iowa Prison Industries at Anamosa. The Spanish version can be printed or photocopied from the sample in the manual.
Completion	The IM worker issues a copy of the *Self-Assessment* along with form 470-3897, *FIA Appointment*, to clients referred to PROMISE JOBS. Instruct the client to complete all entries on the form.
Distribution	The completed form becomes part of the client's PROMISE JOBS case file.
Data	The form requests information about the client's: ♦ Family composition ♦ Work history ♦ Educational background ♦ Income ♦ Transportation ♦ Housing ♦ Legal status ♦ Health

Self-Employment Ledger, Form 470-3784

Purpose	Form 470-3784, *Self-Employment Ledger*, is used to collect information for the Family Investment Program, Food Assistance program, and Medicaid program, when the household reports new self-employment.
Source	Complete the form on line using the template available on the DHS Intranet eForms web page.
Completion	Complete this form when a household reports new self-employment.
Distribution	Print two copies of the form. Give one copy to the client and file one copy in the case record. The client completes the form and returns it to the assigned imaging center.
Data	Certain areas of the form populate and a due date is calculated for return of the completed form. The client records self-employment income and expenses.

Iowa Department of Human Services

Suspension of Overpayment Collection

Date: Account Number:

Name
Address
City State Zip

A timely appeal has been filed on your:

(The line(s) appearing below should be dynamic, based on the program(s) being appealed)

- $_____ FIP or RCA overpayment for period of _____
- $_____ Food Assistance overpayment for period of _____
- $_____ Child Care Assistance overpayment for period of _____
- $_____ Medical Assistance overpayment for period of _____
- $_____ ***hawk-i*** overpayment for period of _____
- $_____ PROMISE JOBS overpayment for period of _____
- $_____ State Supplementary Assistance for period of _____

Collection on the above overpayments is suspended during the appeal process. While your appeal is pending, any payments received after the date on this letter will be returned to you. If the Department is affirmed in the appeal, collection will resume on the above overpayments.

If you have additional overpayments that are not listed on this form, you must continue to make payments on those overpayments.

Questions about this letter?

Call the Department of Inspections and Appeals at **1-800-572-3945**.

Questions on your appeal or on how your debt was figured?

For most DHS Programs	**Call your DHS worker at**
For the **HIPP** Program	Call the HIPP Unit at **1-888-346-9562**
For the ***hawk-i*** Program	Call ***hawk-i*** Customer Service at **1-800-257-8563**

For more information about DHS programs: www.dhs.iowa.gov/

470-5323 (3/15)

Suspension of Overpayment Collection, Form 470-5323

Purpose	When a client appeals an overpayment, collections on the overpayment are suspended. Form 470-5323 is issued to inform the debtor that collection actions on the overpayment are suspended during the appeal process.
Source	Form 470-5323 is generated by the Overpayment Recovery System, located in the Division of Data Management.
Completion	The Overpayment Recovery System generates and inserts specific debt information into the form. The system prints this form.
Distribution	One copy is mailed to the debtor from Central Office.
Data	The system completes the: ♦ Date, ♦ Account number, ♦ Debtor name, ♦ Debtor address, ♦ Program being appealed, and ♦ DHS worker phone number.

Ten-Day Report of Change for FIP and Medicaid, Form 470-0499 or 470-0499(S)

Purpose

The *Ten-Day Report of Change for FIP and Medicaid*, form 470-0499, and its Spanish translation, form 470-0499(S), provide:

- A simple means for the client to report a change and submit explanatory information.
- A reminder to the client that changes in circumstances must be reported to DHS whenever they occur.
  - FIP or Medicaid clients must report changes to the IM Customer Service Center (and to the PROMISE JOBS worker as appropriate).
  - SSI-related clients must report changes by mail, fax or email to the DHS imaging center associated with the local office.

Source

Both English and Spanish versions of this form are available as templates on the DHS Intranet eForms web page for completion on line.

Completion

Select one of two options:

- "FMAP/FIP" which identifies the IM Customer Service Center for clients to report changes to, or
- "SSI-Related" which identifies the DHS imaging center for clients to report changes to.

Distribution

Issue the form:

- At the application interview.
- When the client turns the form to report a change.
- When the client requests a form.

File the form in the case record after the required action is completed. Document the resulting action in the case record. Issue a new form to the client.

Iowa Department of Human Services

Verification of Emergency Health Care Services

Client Name (print or type):	SID #:	County & Worker #:
Parent/Guardian:	SS #:	Date of Birth:

I give permission to the medical provider or agency to share written and oral information about the emergency health care services I received to the Department of Human Services.

Signature of Patient (or parent if patient is a minor):	Date:	This release expires one year from the date of signature
Relationship to person signing: ☐ Self ☐ Legal representative ☐ Nearest living relative ☐ Other (specify):		
Witness to signature if required:		

Provider Information

Name of the agency or person providing information:	Phone:	Fax:
Address:	City/State/Zip:	

To be completed by the provider:

Did this person have an emergency medical condition of sudden onset manifesting itself by acute symptoms of such severity (including severe pain) that the absence of immediate medical attention could reasonably be expected to result in:

- Placing the patient's health in serious jeopardy, or
- Serious impairment of bodily function, or
- Serious dysfunction of any bodily part or organ? ☐ Yes ☐ No

Were services for labor and delivery of a child? ☐ Yes ☐ No

Please give the dates of service and explain in detail the emergency medical condition(s) for which treatment was provided in the box below. **Note:** Please specify if treatment was related to an organ transplant procedure furnished on or after August 10, 1993.

If this person is approved for Emergency Health Care Services, the payment will cover services necessary to treat an emergency medical condition for the date span of the emergency.

Dates of Service (only include dates of treatment of emergency medical condition):	
Description of the emergency medical condition (attach additional pages if necessary):	
Print or Type Name:	Date:
Medical Provider's Signature:	Phone: ( )

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

A copy of this authorization shall be kept in the case file and available for Iowa Medicaid Enterprise review.

Worker Name:	Phone Number:	Fax Number:

Iowa Department of Human Services

Verification of Emergency Health Care Services
(Verificación de Servicios de Salud de Emergencia)

Nombre del cliente (letra de imprenta o máquina):	SID #:	# de Condado y trabajador:
Padre/guardián:	SS #:	Fecha de nacimiento:

Otorgo permiso al proveedor medico o agencia para que comparta información escrita y oral acerca de los servicios de atención médica que recibí con el Department of Human Services.

Firma del paciente (o padre si es menor):	Fecha:	Esta autorización expira un año después de su firma.
Relación con el firmante: ☐ Usted ☐ Representante legal ☐ Pariente vivo más cercano ☐ Otros (especificar):		
Testigo de la firma si se requiere:		

Quien otorga la información

Nombre de la agencia o persona que brinda la información:	Teléfono:	Fax:
Dirección:	Ciudad/estado/cod. postal:	

Para ser llenado por el proveedor:

¿Esta persona tuvo un problema de salud que se inició súbitamente y se manifestó con síntomas agudos de suficiente gravedad (incluso dolor severo) que la ausencia de atención médica inmediata podría haber derivado en una o más de las siguientes consecuencias?

- Pusiera en serio peligro la salud del paciente, o
- Hubiera deterioro grave de funciones corporales, o
- Hubiera disfunción grave de cualquier órgano o parte del cuerpo? ☐ Sí ☐ No

¿Fueron servicios de parto? ☐ Sí ☐ No

Por favor anote las fechas de servicio y explique en detalle la(s) condición(es) médica(s) de emergencia para las que se ofreció tratamiento en la casilla inferior. **Nota:** Por favor especifique si el tratamiento fue relacionado con un transplante de órgano a partir del 10 de agosto de 1993.

Si se autorizan Servicios de Emergencia Médica para esta persona, el pago cubrirá los servicios necesarios para tratamiento de emergencia durante el período de tiempo de la emergencia.

Fechas del servicio (incluya sólo las fechas de tratamiento de emergencia):	
Descripción de la condición médica de emergencia (adjunte páginas adicionales si es necesario):	
Nombre en letra de imprenta o a máquina:	Fecha:
Firma del proveedor médico:	Teléfono: ( )

Una fotocopia de esta autorización firmada tendrá la misma fuerza y vigor que este original.

Se conservará copia de esta autorización en el expediente del caso y estará disponible para revisión de Iowa Medicaid Enterprise.

Nombre del trabajador:	Número de teléfono:	Número de fax:

Verification of Emergency Health Care Services, Form 470-4299 or 470-4299(S)

Purpose	The Department uses form 470-4299 with emergency services Medicaid applications to get the client's permission to verify whether the services that the client received was an emergency. The health care provider or the provider's designee uses this form to furnish the requested information.
Source	Complete the English or Spanish version of the form on line using the template on the DHS Intranet eForms web page.
Completion	The worker completes the identifying information on the client. The client (or the person authorized to obtain the information) completes and signs in the section giving permission. The worker, the client, the provider, or the provider's designee completes the provider information. The health care provider or the provider's designee completes the information related to the health care that was given the client.
Distribution	Give this form to the client to obtain the information with a letter explaining when it is due back to the Department, or if the client has signed the form, send one copy to the source of information. Include a pre-addressed return envelope. You may upload the request to the electronic case file. When the source of information returns the original, it will be scanned and uploaded.
Data	To initiate the form, enter: ♦ The client's name ♦ The client's state identification number ♦ Your county and worker number ♦ The client's date of birth ♦ The client's social security number, if available ♦ The name of the client's parent or guardian, if applicable

Iowa Department of Human Services

Comm. 60 (Rev. 4/15)

Medicaid for the Qualified Medicare Beneficiary

A Medicare Savings Program

Iowa Department of Human Services

Comm. 60(S) (Rev. 4/15)

Medicaid for the Qualified Medicare Beneficiary

(Medicaid para el Beneficiario Calificado de Medicare)

Un Programa de Ahorro de Medicare

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Introduction

This pamphlet answers some questions on the “Qualified Medicare Beneficiary Program” (QMB). If you have more questions, please call your county Department of Human Services (DHS) worker.

What is Medicaid?

Medicaid is a program that helps pay medical bills of people who are eligible. Another name for Medicaid is Title 19. Don’t confuse Medicaid with Medicare. Medicare is an insurance program through the Federal Social Security Administration.

What is the QMB 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?

If you have Medicare Part A and your resources and income are within QMB limits, you could be eligible as a qualified Medicare beneficiary.

What does ‘have Medicare Part A’ mean? This means you are age 65 or older, blind or disabled and eligible to get Medicare Part A benefits.

If you do not know whether you are eligible for Medicare Part A, you can check with Medicare by calling **1-800-MEDICARE (1-800-633-4227)**.

Introducción

Este folleto contesta algunas de las preguntas sobre el programa “Beneficiario Calificado de Medicare” (QMB). Si usted desea realizar otras preguntas, por favor comuníquese con su asistente del Department of Human Services (DHS).

¿Qué es Medicaid?

Medicaid es un programa que ayuda a pagar las facturas médicas de las personas elegibles. Medicaid también es conocido como Title 19. No confunda Medicaid con Medicare. Medicare es un programa de seguros a través de Federal Social Security Administration.

¿Qué es el Programa QMB?

Bajo el programa QMB, Medicaid paga únicamente las primas, los deducibles y el coseguro de las personas que califican como beneficiarios de Medicare. Esto es un ahorro para usted.

¿Quién es un Beneficiario Calificado de Medicare?

Si usted tiene Medicare Parte A y sus recursos e ingresos están dentro de los límites establecidos para QMB, usted puede ser elegible como beneficiario calificado de Medicare.

¿Qué significa “tener un plan Medicare Parte A”? Esto significa que usted tiene 65 años o más, que está ciego o incapacitado y que es elegible para obtener los beneficios del plan Medicare Parte A.

Si usted no sabe si es elegible para Medicare Parte A, puede averiguarlo con Medicare llamando al **1-800-MEDICARE (1-800-633-4227)**.

What do you mean by resources? Resources are things you own, such as a house you are not living in, personal property, stocks and bonds, savings and checking accounts, or cash. The equity value of your car and the cash value of life insurance policies may also be considered in determining the amount of your resources. Not all resources are counted in the resource limit. For a single person, the resource limit is $7,280 and for a couple the resource limit is $10,930.

How does income affect eligibility? You must report all income to DHS, including interest, lump sums, earned and unearned income (such as Social Security, Veteran's Benefits or annuities), and the income of your spouse. You must also report the income of all family members who qualify for the QMB program. Your countable income must be equal to or be less than the QMB income level in order to get Medicaid under the QMB program.

The Social Security Cost of Living Increase (COLA) is not counted as income for the first three months of the calendar year for QMB eligibility.

The QMB monthly income limit is 100% of the federal poverty level. Please ask your DHS worker for the QMB monthly income limit.

> **Example:** Mr. and Mrs. Smith apply for the QMB program on May 7. Both are enrolled in Medicare Part A. Their countable income is less than the QMB income limit for a couple. They have countable resources which are less than the resource limits for a couple. Mr. and Mrs. Smith can get Medicaid under the QMB program to pay their Medicare premiums, coinsurance, and deductibles.

Note: To get QMB you must also apply for, or be getting all other benefits for which you are eligible. Other benefits include Social Security, Iowa Public Employees Retirement System (IPERS), Railroad Retirement, Veteran's Benefits, pensions from private employment, etc.

¿Qué significa "recursos"? Recursos son las cosas que usted posee, tal como una casa en la que no vive, propiedades personales, acciones y bonos, cuenta de ahorro y cuenta corriente bancaria, o efectivo. El valor líquido de su automóvil y el valor en efectivo de las pólizas de seguro de vida también pueden ser considerados al determinar el monto de sus recursos. No todos los recursos se toman en cuenta al determinar el límite de recursos. Para una persona soltera, el límite de recursos es de $7,280 y para una pareja el límite de recursos es de $10,930.

¿Cómo afectan los ingresos a la elegibilidad? Usted debe informar a DHS de todos sus ingresos, incluidos intereses, pagos recibidos por única vez, ingresos derivados de su trabajo o no (por ejemplo, Seguro Social, Beneficios de Veteranos Excombatientes o anualidades), y los ingresos de su cónyuge. Además, debe informar los ingresos de todos los miembros de la familia que califiquen para el programa QMB. Sus ingresos contables deben ser iguales o inferiores al nivel de ingresos establecido por QMB para obtener Medicaid bajo el programa QMB.

El aumento del costo de vida (COLA) para el Seguro Social no se toma en cuenta como un ingreso durante los primeros tres meses del año calendario al determinar la elegibilidad para QMB.

El límite de ingreso mensual de QMB es el 100% del nivel de pobreza federal. Por favor, consulte a su asistente DHS acerca del límite de ingreso mensual de QMB.

Ejemplo: El Sr. y la Sra. Smith solicitan el programa QMB el 7 de mayo. Ambos están inscriptos en Medicare Parte A. Su ingreso contable es inferior al límite de ingresos establecidos por QMB para una pareja. Los mismos poseen recursos contables inferiores al límite de recursos para una pareja. El Sr. y la Sra. Smith pueden obtener Medicaid bajo el programa QMB para pagar sus primas, coseguros y deducibles de Medicare.

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. The amount of medical expenses that exceed the spenddown may be payable by Medicaid. See the pamphlet *Medicaid for the Medically Needy* for more information (available from your DHS worker).
- **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. Ask your DHS worker about SLMB or E-SLMB.

Can I choose the medical provider?

You will need to show your Medicaid and Medicare cards to your health care providers before you get medical care. Not all health care providers take Medicaid and Medicare.

What medical services are covered by QMB?

When you have Medicaid 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.

If you do get help from DHS to pay your Medicare premiums, you may also get "extra help" for your prescriptions. Getting "extra help" means Medicare will help pay your Medicare drug plan's monthly premium, deductible, and copayments.

Nota: Para obtener QMB, usted debe también solicitar, o estar recibiendo todos los otros beneficios para los cuales es elegible. Los otros beneficios incluyen Seguro Social, IPERS (Sistema de Retiro para Empleados Públicos de Iowa), Railroad Retirement (Jubilación de Ferroviarios), Veteran's Benefits (Beneficios de Veteranos Excombatientes), jubilación de empleos privados, etc.

¿Qué pasa si mis ingresos o recursos son demasiado altos para QMB?

Si el total de sus ingresos o recursos contables es superior a los límites de QMB, existen otros programas para los que puede calificar:

- **Medically Needy** – Si tiene muchas facturas médicas y no le alcanza el dinero para pagarlas, pregunte en la oficina DHS acerca del programa *Medically Needy*. Si obtiene *Medically Needy*, deberá pagar sus facturas médicas hasta completar el importe calculado ("spend-down") o deducible. Los gastos médicos que excedan dicho importe podrán ser pagados por Medicaid. Vea el folleto *Medicaid for the Medically Needy* para mayor información. (Solicítelo a su asistente DHS).
- **SLMB** (Beneficiario Medicare de Bajos Ingresos Especificados) o **E-SLMB** (Beneficiario Medicare de Bajos Ingresos Expandidos) – SLMB y E-SLMB solo pagarán su prima de Medicare Parte B. El límite de ingresos es superior al 100% pero inferior al 135% del nivel de pobreza federal. Consulte a su asistente DHS con respecto a SLMB y E-SLMB.

¿Puedo elegir a mi proveedor médico?

Deberá mostrar sus tarjetas Medicaid y Medicare a sus proveedores médicos antes de obtener atención médica. No todos los proveedores médicos aceptan Medicaid y Medicare.

Do I need to pay anything for medical services?

All medical providers who accept Medicaid are required to accept payments made through the program as payment in full for services covered by Medicaid. You should not be charged an additional cost, unless you get medical services that are not covered by Medicare. If you get medical services that are not covered by Medicare, then Medicaid will not pay for them.

For a list of services covered by Medicare, you should get *The Medicare and You Handbook* from the Social Security Administration. For a copy of the handbook, you can call **1-800-633-4227.** If you have a specific question on Medicare's payment of medical services or the status of a medical claim, you can call the Medicare carrier for Iowa at **1-800-532-1285.**

How are payments made?

After you qualify for the QMB program you will get a Medical Assistance Eligibility Card. Keep this card until you get a new one even if your eligibility for services change. 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 **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.

¿Qué servicios médicos cubre QMB?

Cuando usted tiene Medicaid bajo el programa QMB, su cobertura Medicaid es limitada. Esto significa que Medicaid solo pagará las primas de Medicare, los deducibles y el coseguro de los servicios médicos cubiertos por Medicare.

Si usted recibe ayuda de DHS para pagar las primas de Medicare, también puede obtener "ayuda extra" para medicamentos. Obtener "ayuda extra" significa que Medicare le ayudará a pagar la prima, deducibles y copagos mensuales de su plan Medicare para medicamentos.

¿Debo pagar algo por los servicios médicos?

Todos los proveedores de atención médica que aceptan Medicaid deben aceptar pagos hechos a través del programa como pagos totales de los servicios cubiertos por Medicaid. No le deben cobrar costos adicionales, a menos que usted reciba servicios médicos que no estén cubiertos por Medicare. Si recibiera servicios médicos que no estén cubiertos por Medicare, entonces Medicaid no los pagará.

Para obtener una lista de los servicios cubiertos por Medicare, solicite el manual *The Medicare and You Handbook* en Social Security Administration. Para conseguir una copia del manual, puede llamar al **1-800-633-4227**. Si desea realizar una pregunta específica acerca del pago de servicios médicos de Medicare o con respecto a la condición de un reclamo médico, puede llamar a la empresa aseguradora Medicare para Iowa al teléfono **1-800-532-1285**.

How and where do I apply?

- You may pick up an application at your local Department of Human Services (DHS) office, **or**
- You can call and ask to have one mailed to you, **or**
- You can also get an application from the Internet at https://dhs.iowa.gov/sites/default/files/470-2927.pdf

Answer the questions on the application and take, mail or fax it back to the DHS office.

When will coverage begin?

QMB coverage begins the first day of the month following the date the local DHS office approves your application for the QMB program. The approval process may take up to 30 days. If you need help with medical bills prior to this time, discuss it with your DHS worker when you apply.

> **Example:** Mr. Kent applied for the QMB program on March 15. The county DHS office approved his application on April 10. The first day of coverage is May 1.

Can I get Medicaid if I have other insurance or Medicare?

Yes. If you have health or accident insurance, you and your health care provider are expected to collect payment from your insurance company and use it for your medical bills. Your health care provider will get paid by your insurance company and Medicare first and Medicaid second. Tell your doctor that you have Medicaid and Medicare or other insurance.

Tell your DHS worker if you have other health insurance coverage. Also, tell your worker within 10 days if your insurance company changes, or if there is a change in what your insurance covers so that your medical bills get paid correctly.

¿Cómo se realizan los pagos?

Después de calificar para el programa QMB, usted recibirá una "Medical Assistance Eligibility Card" (Tarjeta de Elegibilidad para Asistencia Médica). Conserve esta tarjeta hasta que reciba una nueva, aún si se modificara su elegibilidad para los servicios. Lleve su tarjeta y muéstresela a su proveedor médico cada vez que solicite servicios. Su tarjeta no puede ser usada por ninguna otra persona que no sea el individuo mencionado en la tarjeta. Si perdiera su tarjeta, comuníquese con la oficina DHS local o con Member Services al teléfono **1-800-338-8366**. Si vive en el área de Des Moines, llame al **256-4606**.

El proveedor médico le enviará la factura al programa Medicaid. El pago de deducibles y coseguro de Medicare será enviado directamente al proveedor. Medicaid pagará las primas de Medicare Parte A y Parte B.

¿Cómo y dónde realizo la solicitud?

- Puede retirar la solicitud en la oficina local del Department of Human Services (DHS), **o**
- Puede llamar y solicitar que se la envíen por correo, **o**
- Puede obtener el formulario en Internet en https://dhs.iowa.gov/sites/default/files/470-2927.pdf

Conteste las preguntas del formulario de solicitud y llévelo o envíelo por correo o por fax a la oficina DHS.

¿Cuándo comenzará la cobertura?

La cobertura QMB comenzará el primer día del mes siguiente a la fecha en que la oficina DHS apruebe su solicitud para el programa QMB. El proceso de aprobación puede tomar hasta 30 días. Si necesitara ayuda para abonar facturas médicas antes de esta fecha, consúltelo con su asistente DHS al realizar la solicitud.

What if I get money for my medical bills?

Tell your worker within 10 days when you get money from an insurance company or lawsuit for an accident or injury.

If you get money for medical expenses that were paid by Medicaid, you must refund this money to the Department.

We may get money back from any person or company that may be responsible for paying the costs of your medical expenses.

You must cooperate with us when another person or company is legally responsible for your medical bills.

Contact your DHS worker if you want copies of the medical bills that have been paid for you.

Can I appeal a decision from DHS?

Yes. You, or the person helping you, may request an appeal hearing if you do not agree with any action taken on your medical case. You must appeal in writing by doing ***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, Iowa 50319-0114. If you need help filing an appeal, ask your local DHS office.

You may contact your local 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**.

Ejemplo: El Sr. Kent solicitó el programa QMB el 15 de marzo. La oficina DHS del condado aprobó su solicitud el 10 de abril. El primer día de cobertura será el 1 de mayo.

¿Puedo obtener Medicaid si tengo otro seguro o Medicare?

Sí. Si tiene seguro de salud o de accidentes, usted y su proveedor médico deben recibir los pagos de su compañía de seguros y utilizarlos para abonar sus facturas médicas. Su proveedor médico recibirá pagos primero de su compañía de seguros y de Medicare, y después de Medicaid. Dígale a su médico que tiene Medicaid y Medicare u otro seguro.

Dígale a su asistente DHS si tiene otra cobertura de seguro médico. Además, infórme a su asistente en un plazo de 10 días si su compañía de seguros cambia o si hay una modificación en la cobertura de su seguro para que sus facturas médicas se paguen correctamente.

¿Y si recibo dinero para mis facturas médicas?

Comuníquele a su asistente en un plazo de 10 días cuando reciba dinero de una compañía de seguros o de una demanda judicial por un accidente o lesión.

Si recibiera dinero por gastos médicos que fueron pagados por Medicaid, deberá devolver ese dinero a DHS.

Podemos solicitar la devolución de dinero a cualquier persona o compañía que sea legalmente responsable de sus facturas médicas.

Usted deberá colaborar con nosotros cuando otra persona o compañía sea legalmente responsable de sus facturas médicas.

Comuníquese con su asistente DHS si desea obtener copias de las facturas médicas que hayamos pagado por usted.

What if I think I have been discriminated against?

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

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

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

¿Puedo apelar una resolución de DHS?

Sí. Usted, o la persona que lo asista, podrán solicitar una audiencia de apelación si no estuvieran de acuerdo con las acciones tomadas con respecto a su caso médico. Debe apelar por escrito utilizando ***una*** de las siguientes formas:

- Complete el formulario electrónico de apelación en https://dhssecure.dhs.state.ia.us/forms/ **o**
- Escriba una carta explicando por qué piensa que la decisión es errónea, **o**
- Complete el formulario Appeal and Request for Hearing (Apelación y Solicitud de Audiencia). Puede solicitar este formulario en la oficina DHS de su condado.

Envíe o lleve su apelación a: Department of Human Services, Appeals Section, 5th Floor, 1305 E Walnut Street, Des Moines, Iowa 50319-0114. Si necesita ayuda para completar la apelación, consulte a la oficina DHS local.

Puede comunicarse con la oficina DHS local para solicitar servicios legales. Podría tener que pagar por los servicios legales. Si debiera hacerlo, el pago será de acuerdo a sus ingresos. También puede llamar a Iowa Legal Aid (Asistencia Legal de Iowa) al teléfono **(800) 532-1275**. Si usted vive en Polk County, llame al **(515) 243-1193**.

¿Qué hago en caso de sentirme discriminado?

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

Si cree que DHS le ha discriminado o acosado, le agradeceremos que envíe una carta explicando detalladamente su queja a:

Iowa Department of Human Services, Hoover Building, 5th Floor — Bureau of Policy Coordination, 1305 E Walnut, Des Moines, IA 50319-0114 o a través de correo electrónico a contactdhs@dhs.state.ia.us

Southwest Iowa/South Central Iowa
West Central Community Action
701 10th St PO Box 709
Harlan, IA 51537
(800) 945-9778 or (712) 755-7381

Counties served: Adams, Audubon, Carroll, Cass, Fremont, Greene, Guthrie, Harrison, Mills, Monona, Montgomery, Page, Pottawattamie, Ringgold, Shelby, Taylor and Union

Southeast Iowa
Community Action of Eastern Iowa
500 E 59th St
Davenport, IA 52807
(866) 324-3236 or (855) 244-5301

Counties served: Benton, Cedar, Clinton, Des Moines, Henry, Iowa, Jackson, Jefferson, Johnson, Jones, Keokuk, Lee, Linn, Louisa, Muscatine, Poweshiek, Scott, Tama, Van Buren and Washington

Northeast Iowa
Exceptional Persons, Inc.
3675 University Ave PO Box 4090
Waterloo, IA 50704
(800) 475-0804 or (319) 233-0804

Counties served: Allamakee, Black Hawk, Bremer, Buchanan, Butler, Cerro Gordo, Chickasaw, Clayton, Delaware, Dubuque, Fayette, Floyd, Franklin, Grundy, Hancock, Howard, Mitchell, Winneshiek and Worth

Central Iowa
Orchard Place Child Guidance Center
808 5th Ave
Des Moines, IA 50309
(800) 722-7619 or (515) 246-3566

Counties served: Adair, Appanoose, Boone, Clarke, Dallas, Davis, Decatur, Hardin, Jasper, Lucas, Madison, Mahaska, Marion, Marshall, Monroe, Polk, Story, Wapello, Warren and Wayne

Your rights and responsibilities

You have the right to:

- Look at complaint files on providers in your local DHS office
- Ask for references from your provider
- Check references from your provider

You may have to pay a part of your child care costs. This is based on your family's income and the number of people in your family.

Your child care needs and child care provider will need to be approved before you get help with your child care costs.

You are responsible for reporting providers to DHS who do not meet health and safety standards.

You can report suspected abuse or neglect to the Abuse/Neglect Hotline at 1-800-362-2178. This is a free phone call.

Statement on Nondiscrimination

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

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

Iowa Department of Human Services, Office of Human Resources, 1st floor, 1305 E. Walnut, Des Moines, IA 50319-0114, fax (515) 281-4243 or via e-mail contactdhs@dhs.state.ia.us.

Iowa Department of Human Services

Comm. 62 (Rev. 7/15)

Child Care Assistance

What is Child Care Assistance?

Child Care Assistance helps pay for the care of your child while a parent or caretaker works or attends school.

It might also be used to care for children while a parent or caretaker is looking for work or is unable to care for children because of medical reasons.

Who can get Child Care Assistance?

You may be able to get Child Care Assistance if you:

- Have a child who needs care and is under the age of 13 (or under the age of 19 if your child has special needs), **and**
- Get help from the Family Investment Program (FIP).

You may still be able to get Child Care Assistance, even if you don't get FIP. You will need to meet the income guidelines and have a child who needs care and is under the age of 13 (or under the age of 19 if your child has special needs).

Also, you must be doing one of the following:

- Working an average of 28 hours per week,
- Attending an approved training or education program full-time,
- Working and attending training for a total of at least 28 hours per week, **or**
- Looking for work.

How do I apply?

You can apply for Child Care Assistance at your local Department of Human Services (DHS) office.

You may also apply online or print an application from our website at www.dhs.iowa.gov. Mail the completed application to:

Human Services River Place Office
2309 Euclid Avenue
Des Moines, IA 50310-5703

If you take part in activities approved by the PROMISE JOBS program, call your PROMISE JOBS worker.

Who can care for my child?

You can choose who you want to care for your child.

Child Care Assistance can be used to pay a variety of different types of providers. The provider you choose must be at least 18 years old and cannot be a parent or guardian of your child. You can choose a:

- Registered child development home
- Nonregistered child care home—the person must pass the child abuse and criminal record checks
- Licensed child care center
- Before and after school programs
- Relative, other than a parent or guardian
- Someone who cares for your children in your home, if you have 3 or more children who need care
- Child care program operated by or under contract to an accredited school

You will get forms from DHS to take to your child care provider. Your provider will need to fill out the forms and return to Child Care Assistance Unit, Hoover State Office Building, 1305 E Walnut St., Des Moines, IA 50319.

Your provider must meet certain requirements and meet health and safety standards. Your provider must also agree to allow you to visit your child when in care.

If you can't find good child care close to your home, ask your Child Care Assistance worker for help.

Who can help me find child care?

You want to be sure your child is properly cared for and safe. You want to make the best choice possible.

The Iowa Child Care Resource and Referral System (CCR&R) will give you information about the different types of care and how to choose excellent care.

They can help you find child care that fits your needs and is best for your family.

Information about the CCR&R is available at www.iowaccrr.org.

Northwest Iowa
Mid-Sioux Opportunity, Inc.
418 S Marion St
Remsen, IA 51050
(800) 859-2025 or (712) 786-2001

Counties served: Buena Vista, Calhoun, Cherokee, Clay, Crawford, Dickinson, Emmet, Hamilton, Humboldt, Ida, Kossuth, Lyon, O'Brien, Osceola, Palo Alto, Plymouth, Pocahontas, Sac, Sioux, Webster, Winnebago, Woodbury and Wright

Iowa Sur-occidental y del centro sur
West Central Development Corporation
701 10th St PO Box 709
Harlan, IA 51537
(800) 945-9778 or (712) 755-7381

Condados atendidos: Adams, Audubon, Carroll, Cass, Fremont, Greene, Guthrie, Harrison, Mills, Monona, Montgomery, Page, Pottawattamie, Ringgold, Shelby, Taylor y Union

Iowa sur-oriental
Community Action of Eastern Iowa
500 E 59th St
Davenport, IA 52807
(866) 324-3236 or (855) 244-5301

Condados atendidos: Benton, Cedar, Clinton, Des Moines, Henry, Iowa, Jackson, Jefferson, Johnson, Jones, Keokuk, Lee, Linn, Louisa, Muscatine, Poweshiek, Scott, Tama, Van Buren y Washington

Iowa nor-oriental
Exceptional Persons, Inc.
3675 University Ave PO Box 4090
Waterloo, IA 50704
(800) 475-0804 or (319) 233-0804

Condados atendidos: Allamakee, Black Hawk, Bremer, Buchanan, Butler, Cerro Gordo, Chickasaw, Clayton, Delaware, Dubuque, Fayette, Floyd, Franklin, Grundy, Hancock, Howard, Mitchell, Winneshiek y Worth

Central Iowa
Orchard Place Child Guidance Center
808 5th Ave
Des Moines, IA 50309
(800) 722-7619 or (515) 246-3560

Condados atendidos: Adair, Appanoose, Boone, Clarke, Dallas, Davis, Decatur, Hardin, Jasper, Lucas, Madison, Mahaska, Marion, Marshall, Monroe, Polk, Story, Wapello, Warren y Wayne

Sus derechos y responsabilidades

Usted tiene derecho a:

- Mirar los archivos de quejas sobre proveedores en su oficina local del DHS
- Pida referencias a su proveedor
- Verifique las referencias de su proveedor

Es posible que deba pagar parte de los costos del cuidado de su niño. Esto se basa en los ingresos y el número de personas de su familia.

Sus necesidades y proveedor de cuidado infantil deberán ser aprobados antes de recibir ayuda con esos costos.

Usted es responsable de reportar al DHS los proveedores que no cumplan con los estándares de salud y seguridad.

Usted puede reportar una sospecha de abuso o descuido a la línea de atención de Abuso/Descuido al 1-800-362-2178. Esta es una llamada gratuita.

Declaración de no discriminación

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

Si cree que DHS le ha discriminado o acosado, le agradeceremos que envíe una carta explicando detalladamente su queja a:

Iowa Department of Human Services, Office of Human Resources, 1st floor, 1305 E. Walnut, Des Moines, IA 50319-0114; fax (515) 281-4243 o a través de correo electrónico a contactdhs@dhs.state.ia.us.

Iowa Department of Human Services

Comm. 62(S) (Rev. 7/15)

Child Care Assistance (Asistencia para el cuidado de menores)

¿Qué es Child Care Assistance (Asistencia para el Cuidado de Menores)?

Child Care Assistance le ayuda a pagar el cuidado de su niño(a) mientras el padre o la madre, o su tutor están trabajando o asistiendo a la escuela.

También puede ser usado para el cuidado de los(as) niños(as) mientras su padre(madre) o tutor está buscando trabajo o no puede hacerse cargo por razones médicas.

¿Quién puede obtener Child Care Assistance?

Puede obtener Child Care Assistance si:

- Tiene un hijo que necesita cuidado y es menor de 13 años (o menor de 19 si tiene necesidades especiales), **y**
- Recibe ayuda del Family Investment Program—FIP (Programa de Inversión Familiar).

Usted aún puede obtener Child Care Assistance si no recibe FIP. Usted deberá cumplir con las guías de ingresos y tener un hijo que necesite cuidado y sea menor de 13 años (o menor de 19 si tiene necesidades especiales).

A demás, usted debe estar haciendo algo de lo que se indica a continuación:

- Trabajar un promedio de 28 horas a la semana,
- Asistir a un programa de capacitación o educación aprobado de tiempo completo,
- Trabajar y asistir a capacitación por un total de 28 horas semanales como mínimo, **o**
- Buscar un trabajo.

¿Cómo debo solicitarlo?

Puede hacer la solicitud de Child Care Assistance en su oficina local del Department of Human Services (DHS).

También puede completar su solicitud en línea o imprimir una solicitud desde nuestro sitio Web www.dhs.iowa.gov. Por correo la solicitud completa a:

Human Services River Place Office
2309 Euclid Avenue
Des Moines, IA 50309-5703

Si usted participa en actividades aprobadas por el programa PROMISE JOBS, llame a su trabajador de PROMISE JOBS.

¿Quién puede cuidar a mi hijo?

Puede elegir quién desea que cuide a su hijo.

Child Care Assistance puede usarse para pagar una variedad de diferentes tipos de proveedores. El proveedor que elija deberá tener por lo menos 18 años y no puede ser padre o guardián de su hijo. Usted puede elegir un:

- Hogar de desarrollo infantil registrado
- Hogar de cuidado infantil no registrado – la persona debe pasar las revisiones de abuso infantil y registro criminal
- Centro de cuidado infantil licenciado
- Programas para antes y después de la escuela
- Un pariente distinto de un padre o guardián
- Alguien que cuide a sus hijos en su hogar, si tiene 3 o más hijos que necesiten cuidado
- Un programa de cuidado infantil operado por o bajo un contrato con una escuela acreditada

Usted recibirá formularios del DHS para llevarlos a su proveedor de cuidado infantil.

Su proveedor deberá llenar los formularios y devolverlos a Child Care Assistance Unit, Hoover State Office Building, 1305 E Walnut St, Des Moines, IA 50319.

Su proveedor debe cumplir ciertos requisitos y cumplir con los estándares de salud y seguridad. Su proveedor también debe acceder a permitirle visitar a sus hijos mientras estén bajo su cuidado.

Si no puede encontrar un buen servicio de guardería cerca de su hogar, pida ayuda al trabajador de Child Care Assistance.

¿Quién puede ayudarme a encontrar servicio de cuidado de menores?

Usted quiere asegurarse que su niño esté bien cuidado y seguro. Usted quiere tomar la mejor opción posible.

El Iowa Child Care Resource and Referral System (CCR&R) le dará información acerca de los diferentes tipos de atención y cómo elegir un excelente servicio de atención.

Ellos pueden ayudarle a encontrar una atención infantil que se ajuste mejor a sus necesidades y que sea la mejor para su familia.

La información sobre el CCR&R está disponible en www.iowaccrr.org.

Iowa noroccidental
Mid-Sioux Opportunity, Inc.
418 S Marion St
Remsen, IA 51050
(800) 859-2025 or (712) 786-2001

Condados atendidos: Buena Vista, Calhoun, Cherokee, Clay, Crawford, Dickinson, Emmet, Hamilton, Humboldt, Ida, Kossuth, Lyon, O'Brien, Osceola, Palo Alto, Plymouth, Pocahontas, Sac, Sioux, Webster, Winnebago, Woodbury y Wright.

Iowa Department of Human Services

Comm. 72 (Rev. 3/15)

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 $1,992* 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

Comm. 91 or Comm. 91(S), The Health Insurance Premium Payment (HIPP) Program for Iowa Medicaid Recipients

Purpose	Brochures Comm. 91 and Comm. 91(S) explain the HIPP program and provides a tear-off application and return envelope.
Source	Printed supplies of both Comm. 91 and Comm. 91(S) may be ordered from Iowa Prison Industries at Anamosa.
Distribution	Provide this brochure to Medicaid applicants and members who are interested in applying for the HIPP program. Do not issue it with Medicaid applications. Use Comm. 255 or Comm. 255(S), "Benefits of the Health Insurance Premium Payment Program," for that purpose.
Data	The brochure explains the HIPP program, how HIPP determines if insurance is cost-effective, what kind of insurance the HIPP program will pay for, and how to report changes.

Iowa Department of Human Services

Cut Your Medical Costs if You Get Medicaid

How can I cut my Medicare prescription drug costs?

If you get Medicaid, your Medicare prescription drugs will cost $1 to $5. Medicaid can also lower or cut your Medicare prescription drug premium and co-insurance.

What is Medicaid?

Medicaid is a program run by the Iowa Department of Human Services (DHS). It is also known as Title 19.

Medicaid helps pay for medical bills, nursing home care, services that will help you live at home, and all or part of your Medicare premium.

What else can Medicaid help with?

There are different Medicaid benefits available to you. This is based on the Medicaid program that you qualify for.

There are programs that give full Medicaid benefits, and there are some programs that give limited benefits.

Full Medicaid

If you qualify for full Medicaid benefits, Medicaid will pay your medical costs for:

- Doctors
- Dentists
- Hospitals
- Chiropractors
- Rural health clinic services
- Vision services
- Ambulance service
- Ambulatory surgical centers
- Hearing aids
- Physical therapy
- Occupational therapy
- Speech therapy
- Home health agencies
- Orthopedic shoes
- Podiatrists
- Medical transportation
- Most of your other medical costs, which are not covered by Medicare. This includes your Medicare co-payments, deductibles, and premiums.

Medicaid pays for the services listed above after other medical insurance you have pays first.

Certain limits apply to the medical services listed above. For more information, call your local DHS office and ask for a copy of the brochure called *Your Guide to Medicaid.*

Limited Medicaid

If you get one of the limited Medicaid benefit programs, Medicaid will pay your Medicare Part B premium. Also, Medicaid may be able to pay your Medicare Part A premium, co-insurance, and deductibles.

Please read both sides

How to Determine if You Should Apply for Medicaid

Do I qualify for Medicaid?

DHS looks at two key factors to decide if you can get Medicaid; your monthly income and your total assets.

Assets are items such as:

- Cash
- Savings accounts
- Bonds
- Checking accounts
- Stocks
- Real estate (other than your home)

Compare your monthly income and assets to the chart below. If your monthly income and assets are at or below the amounts in the charts, you may be able to get help from one of the Medicaid programs.

If you are single, a widower, or you live apart from your spouse:

Countable income	Below $1,325 a month
Assets	Below $7,280

If you are married and living with a spouse:

Countable income	Below $1,793 a month
Assets	Below $10,930

If you think you meet the income and asset limits listed above, call your local DHS office and ask for an application.

Who can I call if I have questions?

If your assets are more than the limits above, you may still be able to get Medicaid. Call your local DHS office. If you need help finding the number for your local DHS office, call **1-877-347-1633 toll free**. If you live in Polk County, call 281-0504.

Help Buying Food

You may also be able to get Food Assistance. Food Assistance can help you stretch your food dollars to buy nutritious food for better health. For more information call 1-877-347-5678.

Please read both sides

Comm. 255 and Comm. 255(S), Benefits of the Health Insurance Premium Program

Purpose	Brochure Comm. 255 and Comm. 255(S) provides information about the Health Insurance Premium Payment (HIPP) program.
Source	Additional copies of Comm. 255 and Comm. 255(S), which are printed with English text on one side and Spanish text on the other, may be ordered from Iowa Prison Industries at Anamosa.
Distribution	Give Comm. Comm. 255 and Comm. 255(S) to: ♦ Applicants for HIPP benefits ♦ Other interested parties
Data	The brochure explains how a member can get HIPP, how HIPP decides if insurance is cost-effective, and what insurance plans the program will and will not pay for.

CEDAR RAPIDS (Linn County)

DOWNTOWN
Along SE 2nd St. & SE 2nd Ave.
June 6 & 20, July 4 & 18, August 1 & 15, September 5 & 19
Saturday 7:30 am – Noon
(Fruits, vegetables, meat, baked goods & more) Circle W Acres, Tatonka Farm, Musil Gardens, Meadowview Farms, Stillwater Greenhouse, Doty Angus Cattle Company, SNAX (June 20 & July 4), O'Brien's Own Gourmet Granola, Circle W Acres

NOELRIDGE
Corner of Collins Rd and Council St. NE
May 1 – October 1
Monday, Wednesday, Friday 4:00 – 6:00 pm
(Fruits, vegetables & more) Meadowview Farms, Musil Gardens

NEWBO CITY MARKET
1100 3rd Street SE
May 8 – October 16
Friday 4:00 – 8:00 pm
(Vegetables & more) Matthew 25

CHARLES CITY (Floyd County)

Central Park, 300 N. Main Street
May 9 – October 17, Wed. 3:30 – 6:00 pm, Sat. 9:00 am – Noon
(Fruits, vegetables, baked goods, honey & more) East View Orchard, Dana Martin, Apples on the Avenue Orchard (Aug. 15 – Oct. 17)

CLEAR LAKE (Cerro Gordo County)

2nd Avenue N, just South of Central Gardens
May 23 – October 17, Saturday 9:00 am – Noon
(Baked goods, meat, fruits, vegetables & more) North Iowa Berries, Iowa Supreme Meats

CORALVILLE (Johnson County)

Morrison Park, 1513 7th St.
May 4 – September 28, Monday 5:00 – 7:00 pm
(Fruits, vegetables, baked goods & more) Fertile Dirt Farms, SNAX

COUNCIL BLUFFS (Pottawattamie County)

Main Street Farmers Market
Historic 100 block of West Broadway
May 7 – October 1
Thursday 5:00 – 8:00 pm
(Honey, vegetables, apples & more) 3 Bee Farms

CRESTON (Union County)

McKinley Park, shelter house near playground
June 1 – October 12, Monday 4:00 – 6:30 pm
(*Honey, vegetables, fruits, baked goods & more*) Lappe's Farm Produces & Bakery, Lauri Long's Home Bakery, Burr Oak Farm

DAVENPORT (Scott County)

DAVENPORT FREIGHT HOUSE FARMERS MARKET
421 West River Dr.
YEAR AROUND MARKET
Tuesday 3:00 – 6:00 pm, Saturday 8:00 am – 1:00 pm
(*Meat, eggs, fruits, vegetables, jams, jellies, baked goods, honey, cheese & more*) Heilmann's Hawkeye Acres, Pride of the Wapsi, Allen's Grove Greenhouse, Sawyer Beef, Green Lane Farm, Hollow Maple Farm, Barnyard Produce, Grossman Meats, Oak Hill Acres, Palm Tree Pat/Garden Fresh Produce, Triple Creek Dairy (Sat. only), Farmer Ken's Produce (Sat. only)

NORTHPARK MALL – RIVER CITY
Northpark Mall, east entrance - Hwy 61 & Welcome Way
May 2 – October 31, Wednesday & Saturday 8:00 am – Noon
(Fruits, vegetables, & more) Weber Farm

DECORAH (Winneshiek County)

Winneshiek Farmers Market
Intersection of Clayborne Dr & Heirley St
May 2 – October 31, Wed. 3:00 – 6:00 pm, Sat. 8:00 – 11:00 am
(Vegetables, fruits, baked goods, herbs & more)
Zimmerman's Greenhouse

DENISON (Crawford County)

7th Ave. & Hwy 30 - parking lot
July 9 – October 29, Thursday 3:00 – 6:00 pm
(Vegetables, fruits, baked goods & more) Wacer Gardens

DES MOINES (Polk County)

DOWNTOWN:
Saturday Market - Court Ave. & 4th St.
May 2 – September 26, Saturday 7:00 am – Noon
October 3 – October 31, Saturday 8:00 am – Noon
(Meat, eggs, fruits, vegetables, salsa, granola, baked goods & more) Rinehart's Family Farm, Juan O'Sullivan's Gourmet Salsa (occ. vendor), Berry Patch Farm, Blue Gate Farm, Iowa Orchard, Westrum Produce, Scavo's Market, Story Book Orchard, Kat's Garden, Orale! Salsa, Shutt's Garden Center, Harvest Barn, Mast Family Farm LLC, Hickory Hills Organics, Coyote Run Farm (occ. vendor), O'Brien's Own Gourmet Granola, Tarre De Amore Farms (occ. vendor), Penick's Sweet Corn (July – Sept.), Stillwater Greenhouse, Connie's Creations (occ. vendor), Seven Pines Farm, Lucky George Farm, Patrick Cory, Mushroom Mills

BEAVERDALE
Beaverdale Park on Adams – 3422 Beaver Ave.
June 2 – September 15, Tuesday 4:30 – 7:30 pm
(Vegetables, fruit & more) Iowa Orchard, Central Iowa Organics, Seven Pines Farm

EASTSIDE FARMERS' MARKET (NEW)
3200 Delaware, Collectamania Parking Lot
May 5 – September 29, Tuesday 3:00 – 6:00 pm
(Vegetables & more)
Scavo's Market

SOUTHRIDGE FARMERS MARKET
1111 E Army Post Road
May 11 – October 19, Monday 3:30 – 6:30 pm
(Fruits, vegetables, baked goods and more) Scavo's Market, Shutt's Garden Center

VALLEY JUNCTION
100, 200, & 300 blocks on 5th St.
May 7 – October 1
Thursday 4:00 – 8:00 pm
(Fruits, vegetables & more) Iowa Orchard, Scavo's Market, Kat's Garden, Shutt's Garden Center, Fisher's Flowers & Produce, Story Book Orchard, Central Iowa Organics, Seven Pines Farm, Patrick Cory

Iowa Department of Human Services

Comm. 284 (Rev. 4/15)

IOWA'S EBT FARMERS MARKET PROJECT

Bringing Farmers Markets and Food Assistance Together

Look for the signs with the pictures of the EBT/Iowa card. You can spend your Food Assistance benefits at the farmers listed in this brochure.

SNAP EBT can be used to buy fruit, vegetables, meat, eggs, baked goods, honey, cheese, herbs, jelly and jam, etc. You may not use EBT for hot prepared foods or hot drinks.

For more information, visit www.dhs.iowa.gov and click on 'Food Assistance' to view information about the Farmers Market Project or call the Customer Call Center at (877) 937-3663.

EBT Farmers Market Project

2015

For the past ten years, Iowa Food Assistance households have been able to spend their benefits at farmers markets around the state.

This program was designed to provide fresh and nutritious foods from farmers markets to your family and to expand the awareness, use, and sales at farmers markets. **Certain farmers have special equipment that can accept the EBT card as payment.** The farmers can accept the EBT cards at the farmers markets, roadside stands, or even on the farm.

Just look for the farmers with the signs that show they accept EBT. In this brochure, you will learn where the markets are located and the names of the farmers who can accept EBT.

List of Participating Farmers by Market:

AMES FARMERS MARKET (Story County)

AMES MAIN STREET FARMERS MARKET
Tom Evans Plaza, 300 & 400 blocks of Main
May 2 – September 26, Saturday 8:00 a.m. – 12:30 p.m.
October 9:00 a.m. – 12:30 p.m.
(Fruits, vegetables, baked goods and more) Berry Patch Farm, Lacewing Acres, Crescentia Farms

NORTH GRAND MALL
North Grand Mall parking lot, 2801 Grand Ave.
May 2 – October 31
Wednesday 3:00 – 6:00 pm, Saturday 8:00 a.m. – 12:30 p.m.
(Baked goods, honey, fruits & vegetables, eggs & more) DeMoss Pumpkin Farm, Story Book Orchard (Wednesday), Fisher's Flowers & Produce, Red Granite Farms, Evans Produce

Winter Market
December weekends
Black Friday through Christmas eve
Open during mall hours
(Baked Goods, vegetables, honey, popcorn and more) DeMoss Pumpkin Farm

ANITA (Cass County)
Bandshell Park on Main Street
June 8 – August 31, Monday 3:30 – 6:00 pm
(*Honey, honey products, vegetables & more*) 3 Bee Farms

ANKENY (Polk County)
Corner of SW 3rd St. and SW Maple St.
May 16 – September 5, Saturday 8:00 am – Noon
(No market on July 4th)
Honey, vegetables, fruits & more) 3 Bee Farms, Central Iowa Organics

ATLANTIC (Cass County)
7th & Plum Street – Orscheln's parking lot
June 9 – September 8, Tuesday 5:00 – 7:00 pm
(*Honey, honey products, vegetables, & more*) 3 Bee Farms

AUDUBON (Audubon County) (NEW)
East side of City Square
Thursday 4:30 – 6:00 pm
(Meat, eggs, honey, jam & more) Audubon County Family Farms

AVOCA (Potawattamie County) (NEW)
Main Street by the Courthouse
June 3 – September 30, Wednesday 5:00 – 7:00 pm
(*Honey, honey products, vegetables, & more*) 3 Bee Farms

BETTENDORF (Scott County)

STATE STREET MARKET
2117 State St.
May 7 – October 29, Thursday 2:00 – 6:00 pm
(Fruits, vegetables, cheese, eggs & more) Weber Farm, Triple Creek Dairy

TRINITY MARKET
4500 Utica Ridge Rd
May 4 – October 26, Monday 3:00 – 6:00 pm
No market on Memorial Day or Labor Day.
(Fruits, vegetables, & more) Weber Farm

BLOOMFIELD (Davis County)
100 E. Jefferson, north side of Courthouse lawn
May 16 – October 17
Saturday 8:30 –11:30 am, Tues 3:00 – 6:00
(*Vegetables, fruits, baked goods, eggs & more*) Patsy Boas, Haines Family Farm

BOONE (Boone County)
Family Video parking lot, 6th & Story
June 4 – October 15, Thursday 3:00 – 6:00 pm
(Fruit, vegetables, & more) Wilber's Northside Market, Rinehart's Family Farm

BURLINGTON (Des Moines County)

RIVERFRONT MARKET
400 Front St. (Port of Burlington)
May 7 –October 1, Thursday 5:00 – 7:00 pm
(*Vegetables, fruit, baked goods, jam & jellies & more*) A Good-Natured Garden, Palm Tree Pat/Garden Fresh Produce

FARM FRESH MARKET
Dollar General parking lot, 3302 Agency
June 2 – October 27, Tuesday, 8:00 a.m. – 1:00 p.m.
May 9 – October 31, Saturday, 8:00 am – 1:00 pm
(Fr*uits, vegetables, baked goods & more*) A Good-Natured Garden

CARLISLE (Warren County)
Wyckoff's parking lot, 95 HWY 5
May 30 – October 31, Saturday 8:300 am – 11:30
(Vegetables & more) MmMm GOOD-hue Produce

CASEY'S CORPORATE FARMERS MARKET, ANKENY (Polk County) (NEW)
One SE Convenience Blvd., Ankeny
June 10 – September 9, Wednesday 11:00 am – 2:00 pm
(Vegetables, fruit, b*reads, cookies, fudge & more)*
Lauri Long's Home Bakery, Iowa Orchard

CEDAR FALLS (Black Hawk County)

COLLEGE HILL
2205 College St.
June 4 – October 29, Thursday 4:00 – 6:00 pm
(Fruits, vegetables, popcorn & more) Adolph's Produce & Bakery, Hershey Family Nursery, Fitkin Popcorn, Litteaur's Garden Produce

OVERMAN PARK
3rd & Clay along Overman Park
May 2 – October 31, Saturday 8:30 am – Noon
(Fresh fruits, vegetables, honey, eggs, popcorn, & more) Hershey Family Nursery, Hoffman Produce, Fitkin Popcorn, Kaiser Farm

DUBUQUE (Dubuque County)
MAIN STREET
Around City Hall & Iowa between 11th & 13th St.
May 2 – October 31, Saturday 7:00 am – Noon
(Vegetables, popcorn, granola & more) Klein Market, Stillmunkes Produce, Treasure Chest (occ. vendor)

EAGLE GROVE (Wright County)
208 S. Commercial
June 5 – October 2, Friday 3:00 – 5:30 pm
(Vegetables & more) Airport Gardens

ELDORA (Hardin County)
Corner of Edgington Ave. & 14th Street
May 14 – October 15, Thursday 4:00 – 6:00 pm
(Fruits, vegetables, jam/jellies & more) Prairie's Edge

EVERLY (Clay County) (NEW)
Everly City Park, Shelter House
June 5 – October 30
Friday 4:30 – 6:30 pm
(Meat & more) Troy Peterson

FAIRFIELD (Jefferson County)
Howard Park
Corner of Grimes & Court
May 2 – October 31
Wednesday 3:00 – 6:00 pm, Saturday 8:00 – 1:00 p.m.
(Fruits, vegetables, honey ,baked goods, eggs & more) Blooming Acres Farms, Newton's Own, Natures Way, Rolling Prairie Acres (Saturday)

Senior Center
209 South Court Street
November 7 – April 30
Saturday 9:00 am – 2:00 pm
(Vegetables, fruits & more) Natures Way

FORT DODGE (Webster County)
NW Corner of Crossroads Mall
1st Ave. S. & 25th St.
May 30 – Oct 31
Saturday 9:00 am – 1:00 pm
Wednesday, 1:30 – 5:30 p.m.
(*Vegetables & more*) Airport Gardens

FORT MADISON (Lee County)
Central Park Farmers Market, Ave. E & 9th St.
May 28 – October 1, Thursday 4:30 – 6:30 pm
(*Vegetables, fruits & more*) Jim's Greenhouse

GREENFIELD (Adair County)
400 Public Square – Courthouse Yard
June 4 – October 29, Thursday 3:00 – 6:00 pm
(Vegetables, fruit, honey, baked goods & more) Lappes Farm Products & Bakery

GRINNELL (Poweshiek County)
4th Avenue & Broad Street
May 14 – October 29, Thursday 3:00 – 6:00 pm
(Vegetables, fruit, meat & more) Hala's Honey, Doty Angus Cattle Company

HAMPTON (Franklin County)
Gazebo Park, corner of 1st St. NW & 1st Ave. NW
May 8 – October 16, Friday 5:00 – 7:00 pm
June 2 – October 13, Tuesday 5:00 – 7:00 pm
(Fruits, vegetables & more) Prairie's Edge, Hershey Family Nursery

HARLAN (Shelby County)
Shop-Ko parking lot, 2099 Chatburn Ave.
June 20 – October 31
Saturday 8:30 am – Noon, Wednesday 3:30 – 6:00 pm
(Fruits, vegetables, baked goods, eggs & more) Wacer Gardens, LNE Farm & Garden

HAWARDEN (Sioux County)
City Park, intersection of 13th St. and Ave. E
July 9 – October 1, Thursday 5:00 – 7:00 pm
(Vegetables, fruit, & more) Veggie Patch

HIAWATHA (Linn County)
Guthridge Park on 10th Ave.
April 26 – October 25, Sunday 11:00 am – 2:00 pm
(Vegetables, fruit, meat & more) Musil Gardens, Circle W Acres, Meadowview Farm, H & P Meats

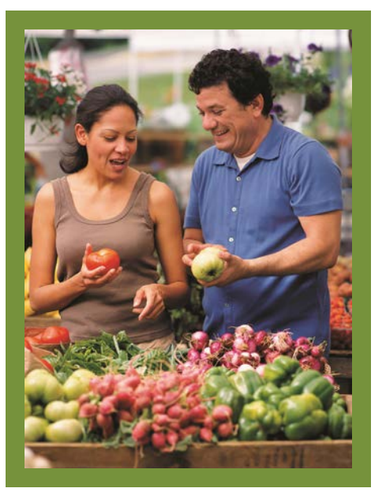
INDIANOLA (Warren County)
FAIRGROUNDS
Hwy 92 at Fairgrounds West Gate
June 6 – October 31, Saturday 8:00 am – Noon
July 1 – September 30 Wednesday 2:00 – 6:00 pm
(Baked goods, fruits, vegetables, honey & more)
Lappe's Farm Products & Bakery

IOWA CITY (Johnson County)
CHAUNCEY SWAN PARKING RAMP
Lower level between Washington and College St.
May 2 – October 31
Saturday 7:30 am – Noon, Wednesday 5:00 – 7:00 pm
(Fruits, vegetables, chocolates, meats & more) H&P Meats, Buffalo Ridge Orchard, Sat. only: Fertile Dirt Farms, Farmer Dave

MERCER PARK
1317 Dover Street
May 5 – October 27, Tuesday 3:00 – 6:00 pm
(Baked goods & more) SNAX

IOWA FALLS (Hardin County)
ESTES PARK
May 9 – October 17
Saturday 8:30 – 11:30 am
Wednesday 5:00 to 7:00 pm
(Fruits, vegetables, jam/jellies & more) Prairie's Edge

KEOTA (Keokuk County) (NEW)
Downtown
June 1 – September 14, Monday 5:00 – 7:00 pm
(Vegetables, fruits, baked goods & more) Rolling Prairie Acres



LYONS (Clinton County)
Lyons Farmers Market - Main Ave. & Roosevelt St.
May 23 – October 31
Saturday 8:00 – noon, Wednesday 4:00 – 6:00 pm
(Fruits, vegetables, meat & more) Shelly Farms, Mrs. Grossman's Meats

MARION (Linn County)
City Square Taube Park
May 2 – September 19
Saturday 8:00 – 11:30 am
(*Fruits, vegetables & more*) Meadowview Farms

MARSHALLTOWN (Marshall County)
CARTWRIGHT PAVILLION
108 N Second Avenue
May 13 – October 31
Wednesday 4:00 – 6:00 pm, Saturday 8:00 – 11:00 am
(Baked goods, fruits, vegetables, honey & more) Bev's Beehive, Hala's Honey

LINN STREET
103 E. Linn St.
May 15 – October 31
Friday 9:00 am – 5:00 pm, Saturday 9:00 am – 4:00 pm
(Fruits, vegetables, baked goods & more) Bev's Beehive

MASON CITY (Cerro Gordo County)
3200 4th St SW, Fleet Farm parking lot
May 15 – Oct. 30, Tuesday & Friday 3:00 – 6:00 pm
(Fruits, vegetables, meat & more) Stillwater Greenhouse (July – Oct.), North Iowa Berries & More, Sugar Creek Farm

MERCER MARSH INSURANCE FARMERS MARKET, (Polk County) (NEW)
12421 Meredith Drive, Urbandale
June 10 – September 9
Wednesday, 3:00 – 5:30 pm
(Breads, cookies, fudge & more)
Lauri Long's Home Bakery

MISSOURI VALLEY (Harrison County)
Harrison County Welcome Center, 2931 Monroe Ave.
May 21 – October 15
Thursday 3:30 – 6:30 pm
(*Vegetables, fruits, baked goods, fudge & more*) Hodge Greenhouse

MONTROSE (Lee County)
Montrose River Front Park, 201 N 1st St
May 7 – September 29, Tuesday 4:00 – 6:00 pm
(*Vegetables, fruits, & more*) Jim's Greenhouse

MOUNT VERNON (Linn County)
First Street Community Center lawn – 221 1st Street NE
May 7 – September 24
Thursday 4:00 – 6:00 pm
(*Fruits, vegetables, chocolates & more)* Farmer Dave

NEW HAMPTON (Chickasaw County)
City parking lot – north of Fareway
June 4 – September 24
Thursday 4:00 – 6:00 pm
(Baked goods, fruits, vegetables, honey & more)
Zimmerman's Greenhouse Produce, East View Orchard

NORTH LIBERTY (Johnson County) (NEW)
Community Center north parking lot
May 3 – October 25, Sunday 11:00 a.m. – 2:00 pm
(*Baked goods & more*) SNAX

OELWEIN (Fayette County)
110 E. Charles St, city parking lot
May 18 – October 19
Monday 3:00 – 5:30 p.m.
May 22 – October 23
Friday 8:00 am – 11:00 am
(Baked goods, vegetables, jams, jellies & more) Jason's Veggies

OSCEOLA (Clark County) (NEW)
SE corner of Courthouse Square
Tuesday June 2 – October 27
(Vegetables, fruit & more) Shutt's Garden Center

OSKALOOSA (Mahaska County)
100 Block of S 1st Street
May 26 – October 17
Tuesday 4:00 – 6:30 pm, Saturday 8:30 – 11:00 am
(Vegetables, fruit, baked goods, herbs & more!)
Grandma's Garden

OTTUMWA (Wapello County)
OTTUMWA FARMERS MARKET
1110 N Quincy Ave, Quincy Place Mall
May 27 – October 31
Wednesday 3:30 – 6:00 pm, Saturday 8:00 – 11:00 am
(Honey products & more) Newton's Own (Wed. only)

OTTUMWA WAPELLO COUNTY
Family Video parking lot – 819 Albia Rd.
May 21 -October 15
Monday & Thursday 2:30 – 5:30 p.m.
(Fruits, vegetables, noodles, baked goods, honey & more) Patsy Boas (Thursday), Gothic Gardens, Haines Family Farm, Newton's Own (occ. vendor), Sugar Fine Baked Goods, Fuel

PELLA (Marion County)
First Reformed Church parking lot
603 Broadway Street
April 23 – Oct. 17
Thursday 3:00 – 6:00 pm
Saturday 9:00 a.m. - noon
Closed during Tulip Time – May 7 - 9
(Vegetables, honey & more) Prairie Roots Farm, Grandma's Garden (Thursday)

PRESTON (Jackson County)
Twogood Park off Hwy 64
June 26 – September 18, Thursday 4:00 – 6:00 pm
(Vegetables & more) Shelly Farms

SHELDON (O'Brien County)
1200 S 2nd Avenue, Old Train Depot
June 1 – September 28
Monday 4:30 – 6:30 pm
(Vegetables, fruits & more) Veggie Patch

SIOUX CITY (Woodbury County)
Tyson Event Center parking lot
May 6 – October 31
Saturday & Wednesday 8:00 am – 1:00 pm
(Baked goods, fruits, vegetables, & more) Veggie Patch, Carol's Kitchen

SPENCER (Clay County)
Spencer Area Farmers Market
1019 S. Grand Avenue
June 6 – October 10
Saturday 8:00 – Noon, Wednesday 4:00 – 6:00 pm
(Vegetables, honey, & more) Janssen Honey Farms, Troy Peterson

SPIRIT LAKE (Dickinson County)
Dickinson County Fairgrounds, 1602 15th Street
June 6 – October 10
Saturday & Wednesday 7:30 am – Noon
(Meat & more) Iowa Supreme Meat

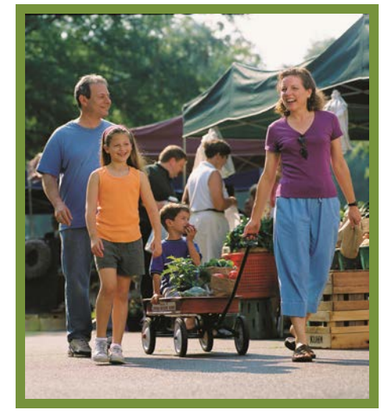
STRAWBERRY POINT (Clayton County)
Inger Park, 150 Park Street
May 27 – September 30, Wednesday 4:00 – 6:00 pm
(Vegetables, baked goods, jams, jellies & more) Jason's Veggies

TABOR FARMERS MARKET (Fremont County)
(NEW)
Main Street Green
June 11 – August 27
Thursday 5:00 to 7:00 pm
(Vegetables, honey & more) Lone Star Meadow

TIPTON (Cedar County)
North side of Court House, corner of Cedar & 5th
May 7 – October 29
Thursday 4:00 – 6:00 pm
(Fruits, vegetables, eggs & more) Hollow Maple Farm, Barnyard Produce

WATERLOO (Black Hawk County)
CEDAR VALLEY: KIMBALL RIDGE
Inside SE Corner of Kimball Ave. & Ridgeway Rd.
May 5 – October 27, Tuesday 3:30 – 6:00 pm
(Fruits, vegetables & more) Litteaur's Garden Produce

KIMBALL RIDGE FAMILY MARKET
NE corner of Kimball Ave. & Ridgeway Rd.
May 2 – October 31, Saturday 8:00 am – Noon
(Vegetables, fruit, baked goods, & more) Adolphs Produce & Bakery



WATERLOO (Black Hawk County) cont.
DOWNTOWN
Riverloop Expo Public Market, 327 W 3rd St.
May 7 – October 29, Thursday 3:30 – 6:00 p.m.
May 2 – October 24, Saturday 8:00 am – Noon
(Fruits, vegetables, baked goods, honey & more)
Kiefer's Produce, Litteaur's Garden Produce, Lloyd & Elaine Nolt, A Family Market Place (Sat.), Stillwater Greenhouse (Sat. only)

WAVERLY (Bremer County)
200 block of 1st Ave SE
June 2 – October 27, Tuesday 3:00 – 6:00 pm
(Vegetables, fruits, baked goods & more) Apples on the Avenue Orchard (Aug. 15 – Oct. 17)

WAUKEE (Dallas County)
Triangle Park – 6th St. and Ashworth Dr.
June 3 – September 30, Wednesday 4:00 – 7:00 pm
(Vegetables, fruits & more) KM Gardens, Shutt's Garden Center

WEBSTER CITY (Hamilton County)
400 Second Street, City Hall Plaza
June 6 – October 24, Saturday 8:00 – 11:00 am
(Vegetables, fruits & more) Evans Produce (Occ.vendor)

WEST BRANCH (Cedar County) (NEW)
Heritage Square Gazebo
June 2 – September 29 Tuesday 4:00 – 6:00 pm
(Baked goods & more) SNAX

WINTERSET (Madison County)
Town Square
May 9 – October 3, Saturday 8:00 – Noon
(Vegetables, baked goods, & more) Burr Oak Farm, Lauri Long's Home Bakery, KM Gardens

ROAD SIDE STANDS

APPLEBERRY FARM (Marshall County)
2402 West Main Street, Marshalltown
August 1 – October 31
Monday - Friday 9:00 am – 6:00 pm
Saturday 9:00 am – 5:00 pm
Sunday Noon – 5:00 pm

BERRY FRESH FARMS (Dallas County)
30339 K Avenue, Adel
June – July
Tuesday, Wednesday, Friday, Saturday 9:00 – 6:00 pm
Sunday 12:00 pm – 6:00 pm

COUNTRY MARKET (Woodbury County)
15th Street & Hamilton Blvd., Sioux City
July 3 – October 20
Monday - Saturday 9:00 am – 7:00 pm
Sunday 10:00 am – 5:00 pm

DAN-D FARMS (Marion County)
Hwy 14, Knoxville across from Walmart
July 1 – August 31, Monday - Sunday 9:00 am – 5:00 pm

GRUBBY'S KETTLE KORN (Mahaska County)
Radio Shack parking lot, Oskaloosa
June 25 – October 14, Daily 10:00 am – 6:00 pm

HEARTLAND FARMS (Black Hawk County)
5111 Osage Road, Waterloo
May 5 – October 31
Tuesday – Saturday 9:00 am – 7:00 pm
Open Sunday – September 18 – November 1

IOWA FOOD COOPERATIVE (Polk County)
4944 Franklin Avenue, Des Moines
Distribution occurs on every other Thursday from 4:00 – 7:00 p.m. and the following Saturday from 10:30 am – noon. Other remote drop off sites available.

JOKIR'S WILL BLACK ANGUS BEEF (Humbolt County)
1452 220th St., Gilmore City
Open year round
Tuesday – Friday 3:00 – 6:00 pm
Saturday 10:00 am – Noon
6th Annual Farm Fair – Saturday, August 1
10:00 am - 2:00 pm

LOG CABIN PRODUCE (Mitchell County) (NEW)
3011 Mitchell Line Street
June 15 – October 15
Monday – Friday 8:00 am – 8:00 pm
Saturday 8:00 am – 6:00 pm

MILLIGAN PRODUCE
Ida Grove – parking lot north of Skate Palace
Friday 2:00 – 6:00 pm
June 19 – October 30

Mapleton – inside Community Building
Monday 11:00 am – 1:30 pm
June 22 - October 26 (closed Labor Day)

WILLS FAMILY ORCHARD (Dallas County)
33130 Panther Creek Road, Adel
September 12 – October 31
Saturday 9:00 am – 5:00 pm, Sunday 1:00 – 5:00 pm

Iowa Department of Human Services

Comm. 337 (Rev. 4/15)

Medicaid for Kids with Special Needs

What is Medicaid for Kids with Special Needs?

It helps pay medical bills for children with special needs due to a disability.

Questions?

For information on how to get an application or for help completing an application, please call 1-877-937-3663.

Where is my local DHS office?

To find the location of the Department of Human Services office close to you call *2-1-1*.

www.dhs.state.ia.us

DHS Policy on Nondiscrimination

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

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

Iowa Department of Human Services
Bureau of Policy Coordination
Hoover Building – 5th Floor
1305 E Walnut
Des Moines IA 50319-0114

Via email contactdhs@dhs.state.ia.us

Is your child eligible?

Your child must be:

- ♥ Under the age of 19.
- ♥ Disabled. The disability must meet the standards of the Social Security Administration.
- ♥ Income eligible. Your family income must be no more than 300% of the federal poverty level for your family size. See the Income Amounts chart.
- ♥ A U.S. citizen.

Does your child have other health insurance?

- ♥ If yes, you must pay the premiums and keep your child covered for as long as your employer pays at least half of the premium cost.
- ♥ If no, but you can get health insurance from your employer **and** if your employer pays at least half of the premium cost, then you must enroll your child in the employer insurance plan.
- ♥ If your employer does not pay at least half of the insurance premium cost, then you are not required to enroll your child.

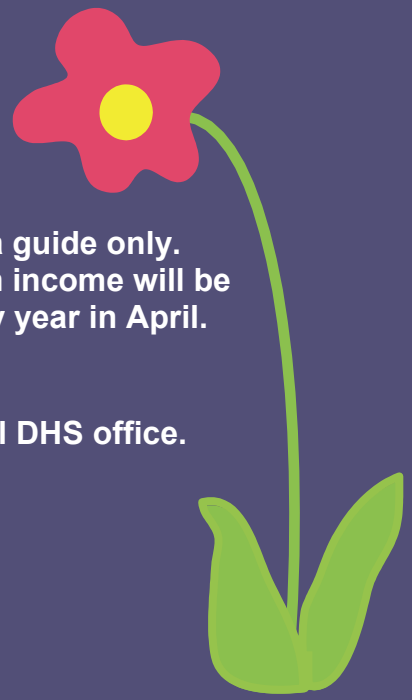
How do you apply for your child?

- ♥ Complete the Health Services Application and turn it in at your local Department of Human Services office (DHS).
- ♥ To help process your application, provide information requested by the worker. This includes your income, your child's disability, and health insurance.
- ♥ If your child had a disability determination by the Social Security Administration, then provide the decision to DHS.
- ♥ If your child has not had a disability determination by the Social Security Administration, then DHS will process the determination.

Income Amounts

Number in the Family	Monthly Income Limits
1	$2,943
2	$3,983
3	$5,023
4	$6,063
5	$7,103
6	$8,143
7	$9,183
8	$10,223

For each additional person add $1,040.



This chart is a guide only. The maximum income will be updated every year in April.

Questions?
Call your local DHS office.