



# Iowa Department of Human Services

Terry E. Branstad  
Governor

Kim Reynolds  
Lt. Governor

Charles M. Palmer  
Director

September 4, 2015

## GENERAL LETTER NO. 6-AP-117

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

SUBJECT: Employees' Manual, Title 6, **INCOME MAINTENANCE PROGRAMS  
APPENDIX**, the following forms:

470-0130	<i>Billing Statement</i> , revised
470-1667	<i>Debt Setoff Credit</i> , revised
470-4846	<i>Medicare Savings Programs Additional Information Request</i> , revised
470-4846(S)	<i>Medicare Savings Programs Additional Information Request (Spanish)</i> , revised
470-4530	<i>Notice of Child Care Assistance Overpayment</i> , revised
470-4683	<i>Notice of FIP or RCA Overpayment</i> , revised
470-4179	<i>Notice of Food Assistance Debt</i> , revised
470-4668	<i>Notice of Food Assistance Overpayment</i> , revised
470-4667	<i>Notice of Medical Assistance Debt Due to a Transfer of Asset(s)</i> , revised
470-2891	<i>Notice of Medical Assistance Overpayment</i> , revised
470-1668	<i>Notice of Setoff of an Iowa Income Tax Refund for Debts Owed the Iowa Department of Human Services</i> , revised
470-3797	<i>Treasury Offset Program (TOP) Pre-Offset Notice</i> , revised
470-4299	<i>Verification of Health Care Services</i> , revised
470-4299(S)	<i>Verification of Health Care Services (Spanish)</i> , revised

## Summary

This chapter is revised to:

- ◆ Update the following forms to reflect the Department's branding:
  - 470-0130, *Billing Statement*
  - 470-4179, *Notice of Food Assistance Debt*
  - 470-4667, *Notice of Medical Assistance Debt Due to a Transfer of Asset(s)*
- ◆ Update the letterhead on the following forms to reflect the Department's branding:
  - 470-1667, *Debt Setoff Credit*
  - 470-3797, *Treasury Offset Program (TOP) Pre-Offset Notice*

- ◆ Update form 470-4846, *Medicare Savings Programs Additional Information Request*, and its Spanish translation, 470-4846(S).
- ◆ Change some overpayment recovery (OPR) forms to:
  - Update the appeals language.
  - Update the nondiscrimination policy.
  - Reflect the Department's branding.

These changes were made to the following forms:

- 470-4530, *Notice of Child Care Assistance Overpayment*
  - 470-4683, *Notice of FIP or RCA Overpayment*
  - 470-4668, *Notice of Food Assistance Overpayment*
  - 470-2891, *Notice of Medical Assistance Overpayment*
  - 470-1668, *Notice of Setoff of an Iowa Income Tax Refund for Debts Owed the Iowa Department of Human Services*
- ◆ Revise form 470-4299, *Verification of Health Care Services*, and its Spanish translation, 470-4299(S), to comply with federal regulations.

### **Effective Date**

Upon receipt.

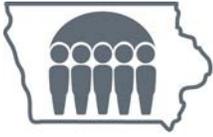
### **Material Superseded**

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

<u>Page</u>	<u>Date</u>
470-0130	6/08
470-1667	6/11
470-4846	1/10
470-4846(S)	1/10
470-4530	8/08
470-4683	6/09
470-4179	6/11
470-4668	6/11
470-4667	6/11
470-2891	5/11
470-1668	5/11
470-3797	1/11
470-4299	7/15
470-4299(S)	7/15

### **Additional Information**

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



Iowa Department of Human Services

# Billing Statement

**Account Number:**

*Write this number on your check or money order*

**Billing Date:**

Make check or money order payable to:  
**Iowa Department of Human Services**  
*(Do not send cash)*

Send payment to:  
Iowa Department of Human Services  
Cashiers Office  
1305 E Walnut St  
Des Moines, Iowa 50319-0114

Please make address corrections above

**Return top part with payment**

**Amount Enclosed:**

Cut here ✂ ✂ ✂ ✂ ✂ ✂ ✂ ✂

**Keep bottom part as your record**

**Account Number:**

**Billing Date:**

**Current Amount Due**

**Amount Past Due**

**Payment Due Date**

**Minimum Payment Due**

Account Activity (see back for detail)

Amount

Previous Balance

Payments Received

Adjustments

New Claims

New Account Balance

*Payments made after the 25<sup>th</sup> of the month may not show on this statement.*

**Important Messages about your Account (More information on the other side)**

### **Questions about this Billing Statement or how to make payments?**

Call the Department of Inspections and Appeals at **1-800-572-3945** or **515-281-5714** in the Des Moines area.

### **Questions on how your debt was figured?**

For most DHS Programs

**Call your DHS worker**

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.state.ia.us](http://www.dhs.state.ia.us)**

## Billing Statement

Account Number:

Billing Date:

*For more information about DHS programs:* [www.dhs.state.ia.us](http://www.dhs.state.ia.us)



# Iowa Department of Human Services

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Director

**This is your receipt for the amount of \$ \_\_\_\_\_**

This amount of money has been subtracted from what you owe the state. As an earlier letter told you, the money was withheld from your:

- Income tax refund,
- Federal retirement,
- Federal pay,
- Other federal benefits, or
- A state warrant.

This amount may not be subtracted from your balance on your next Account Statement. This will be shown on a future statement.

If you have questions, please call:

## Medicare Savings Programs Additional Information Request

Dear:

Date:

The Social Security Administration (SSA) sent information from your “Application for Extra Help with Medicare Prescription Drug Plan Costs” to the Iowa Department of Human Services (DHS). On that application you indicated that you wanted to apply for the Medicare Savings Programs (MSP). The Medicare Savings Program helps qualifying people pay for Medicare premiums, co-payments, and/or deductibles.

The information that you gave SSA has been entered on the enclosed form. Please answer the remaining questions on the form, provide the requested information, and send support documentation. Please send copies and NOT the original support documents.

Return the completed form back in the enclosed postage-paid envelope to the following address:

Please note, your MSP application will be denied if you don't return the form by

**Questions?? If you need help filling out this form, call your local DHS office.**

Another option to help to complete the Medicare Savings Programs Additional Information Request form is to call the Senior Health Insurance Information Program (SHIIP) at 800-351-4664. SHIIP, a service from the state of Iowa, provides help for Iowans with Medicare and health insurance questions or problems. SHIIP services are free and confidential.

Determination of your eligibility for the Medicare Savings Program will be made by the Department of Human Services.

**Keep the cover pages and Part E for your records.**

## How Do I Get Help?

Step 1. Complete this request for additional information.

Answer as many questions as you can. If you need help filling out the form, please ask.  
**Please finish and turn in the form by the date on the front of this letter.**

Please check to see that the information that SSA sent to the Department about you is correct. If the information is not correct, please change it.

Step 2. Return the form to us.

You can bring, mail, or fax it to a local DHS office. **The date we receive the form back starts the time DHS has to work on your application.**

Step 3. When you return the form, you may be asked to show us proof:

- Of the money you have gotten in the last 30 days. Proof can be things like check stubs, self-employment records or award letters.
- Of bank accounts, trust accounts, stocks or bonds, etc.

You may need to show other proof. If you are not able to get the proof right away, you will be given time to get the information. If you need help, ask DHS to help you get the information.

## What Do Our Terms Mean?

We use these terms in this form. This is what they mean.

<b>Eligible</b>	Meeting all program guidelines.
<b>Expanded-Specified Low-Income Medicare Beneficiary (E-SLMB)</b>	A Medicare Savings Program that helps pay your Medicare Part B premium.
<b>Household</b>	A group of people who live together.
<b>Medicaid</b>	A state-run program that provides hospital and medical coverage for people with low income and little or no resources.
<b>Medicare</b>	A national health insurance program for people ages 65 and over, or younger individuals with certain disabilities.
<b>Qualified Disabled and Working Persons (QDWP)</b>	A Medicare Savings Program that helps pay your Medicare Part A premium.
<b>Qualified Medicare Beneficiary (QMB)</b>	A Medicare Savings Program that helps pay your Medicare Part A and Part B premiums, co-payments and deductibles.
<b>Quality Control</b>	A DHS unit that might review your case to see if you are getting the correct assistance.
<b>Specified Low-Income Medicare Beneficiary (SLMB)</b>	A Medicare Savings Program that helps pay your Medicare Part B premium.

## Medicare Savings Programs Additional Information Request

### Tell Us About You

### Part A

**If any of the information that is already filled in is incorrect, please correct it and then answer questions that are not filled in.**

Name: \_\_\_\_\_ Case Number: \_\_\_\_\_

Birth Date: \_\_\_\_\_ Worker Number: \_\_\_\_\_

Telephone Number: \_\_\_\_\_ County: \_\_\_\_\_

Mailing Address: \_\_\_\_\_ DHS Telephone Number: \_\_\_\_\_

MSP Application Date: \_\_\_\_\_

DHS Received MSP Application On: \_\_\_\_\_

Address Where You Live (if different than your Mailing Address above)			Apt #
City	State	ZIP Code	
Telephone Number Where We Can Reach You (if different than your Telephone Number above)			

### Tell Us More About You

### Part A

**If any of the information that is already filled in is incorrect, please correct it and then answer questions that are not filled in.**

Applying For?	Last Name	First Name	Birth Date	Social Security Number
Yes				
Relationship to You	Ethnicity (Optional)	Race (Optional)	U.S. Citizen?	Receive benefits in another state?
<b>Self</b>	<input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino	<input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> Asian <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> Other	<input type="checkbox"/> Yes <input type="checkbox"/> No If No, what is your immigration status? _____	<input type="checkbox"/> Yes <input type="checkbox"/> No What state? _____

## Tell Us About the People in Your Home

## Part B

If any of the information that is already filled in is incorrect, please correct it and then answer questions that are not filled in.

Applying For?	Last Name	First Name	Birth Date	Social Security Number
<input type="checkbox"/> Yes <input type="checkbox"/> No				
Relationship to You	Ethnicity (Optional)	Race (Optional)	U.S. Citizen?	Receive benefits in another state?
<input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other	<input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino	<input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> Asian <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> Other	<input type="checkbox"/> Yes <input type="checkbox"/> No If No, what is your immigration status? _____	<input type="checkbox"/> Yes <input type="checkbox"/> No What state? _____

Applying For?	Last Name	First Name	Birth Date	Social Security Number
<input type="checkbox"/> Yes <input type="checkbox"/> No				
Relationship to You	Ethnicity (Optional)	Race (Optional)	U.S. Citizen?	Receive benefits in another state?
<input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other	<input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino	<input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> Asian <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> Other	<input type="checkbox"/> Yes <input type="checkbox"/> No If No, what is your immigration status? _____	<input type="checkbox"/> Yes <input type="checkbox"/> No What state? _____

Did you or anyone in your home receive medical care in the past three months?  Yes  No

If yes, who? \_\_\_\_\_ What months? \_\_\_\_\_

Does anyone have other health insurance besides Medicare?  Yes  No

If yes, who is covered? \_\_\_\_\_

Health Insurance Company? \_\_\_\_\_

**Tell Us About Your Household Income****Part C**

If any of the information that is already filled in is incorrect, please correct it and then answer questions that are not filled in.

Please tell us about all of the money the people in your household get. If you leave a space blank, we will take that to mean there is no money of this kind. Please use an additional sheet of paper, if needed.

<b>Unearned Income</b>	<b>Name of Person Who Gets This Income</b>	<b>Amount Per Month</b>
Social Security or SSI		
Railroad Benefits		
Veteran's Benefits		
Pensions or Retirement		
Interest or Dividends		
Unemployment or Worker's Compensation		
Child Support or Alimony		
Money from friends or relatives		
Other Unearned Income		

<b>Earned Income</b>	<b>Name of Person Who Gets This Income</b>	<b>Amount Per Month</b>
Money from work – You		
Money from work – Spouse		
Self-employment or Odd Jobs – You		
Self-employment or Odd Jobs – Spouse		
Tips, Bonuses, Commissions		
Other Earned Income		

**Tell Us About Your Resources (Assets)****Part D**

If any of the information that is already filled in is incorrect, please correct it and then answer questions that are not filled in.

Please tell us about all of the resources the people in your household have. If you leave a space blank, we will take that to mean there is no resource of this kind. Please use an additional sheet of paper, if needed.

List all cars, trucks, boats, campers, motorcycles or other licensed or unlicensed vehicles that anyone owns or is buying:

Year	Make	Model	Value or Worth	Amount Owed

Money Resources (Assets)	Name of Person Who Has This Resource	Amount
Bank or Credit Union Accounts		
Stocks or Bonds		
Cash		
Real Estate (other than the home you live in)		
Annuities		
Savings Certificates		
Keoghs or Other Assets		

Does anyone have a conservatorship or trust?  Yes  No  
 If yes, who? \_\_\_\_\_

Does anyone have a life or death benefit insurance?  Yes  No  
 If yes, who? \_\_\_\_\_

List the total money anyone has in:

Burial Contract \$ \_\_\_\_\_ Who? \_\_\_\_\_  
 Burial Spaces \$ \_\_\_\_\_ Who? \_\_\_\_\_

Does anyone expect to get a one-time payment, such as an inheritance or insurance settlement, or did anyone get one in the past 3 months?  Yes  No  
 If yes, who? \_\_\_\_\_

## 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



## Keep this page for your records.

### You Have the Right to Appeal

### Part E

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

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

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

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

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

### You Will Not Be Discriminated Against

### Part E

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

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

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

### You Need to Know

### Part E

#### We Check What You Tell Us

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

We check and use computer systems like the state Income and Eligibility Verification System. If something you told us is different from what the computer system tells us, we will check to find out what is correct. We might check your information by contacting your employer, your bank or other people. To do this kind of checking with your employer, bank, or other people, we will ask you first.

The Quality Control unit or Investigations unit may review your case. They may contact other people or organizations to get proof of your information. By signing this application, you give permission to release confidential information to the Quality Control unit or Investigations unit. You must cooperate with them to keep your benefits.

You will have to pay back any benefits you got or that was paid to a third party on your behalf for which you were not eligible.

Section 1128B of the Social Security Act provides federal penalties for fraudulent acts and false reporting in connection with these programs.

Anyone who gets; tries to get, or helps any other person get assistance to which they are not entitled, is guilty of violating the laws of the state of Iowa. This includes, but is not limited to, Iowa Code Chapters 239B, 243, 249, and 249A.

Comm. 233 will be mailed to you. It will tell you about any additional rights and responsibilities not covered with this application.

Within 5 working days of the date the change happens, you must tell DHS about changes, such as:

- Income, including lump sum payments, such as past due child support, inheritances, or settlements
- Resources or assets, which includes getting an inheritance
- Someone moving in or out of your home
- Your health insurance coverage
- You file an insurance claim or get an attorney to recover bills paid by Medicaid
- Mailing or living address

If approved for QMB, you give up your rights to medical support payments while you get benefits. The state of Iowa will keep and use those payments to help pay for your medical coverage.

If you are eligible for QMB, payments on future unpaid medical services will be paid directly to the doctors and medical suppliers under the Medicare Insurance Program (Medicare Part B).

Estate recovery will not include Medicaid payments made for Medicare cost sharing for MSP benefits.

**If you return this application, you give your permission for DHS to share:**

- Your medical and other health care records with federal and state officials.
- You agree to assign medical payments from a third party to the Medicaid agency for yourself and others who are eligible for Medicaid for whom you legally can assign benefits. You also agree to cooperate in obtaining medical payments from third parties.

**This permission ends when your Medicaid (Medicare Savings Programs) stops.**

Insert this sheet, along with other documents in the enclosed return envelope.

**DHS office address must be visible in envelope window.**



## **Medicare Savings Programs Additional Information Request** **(Solicitud de Información Adicional para los Programas de Ahorro de Medicare)**

Estimado/a:

Fecha:

La Administración de Seguridad Social (*Social Security Administration, SSA*) le envió información de su “*Application for Extra Help with Medicare Prescription Drug Plan Costs*” (Solicitud de ayuda extra para los costos del plan para medicamentos bajo receta de Medicare) al Iowa Department of Human Services (DHS). En dicha solicitud usted indicó que deseaba inscribirse para los Programas de Ahorro de Medicare (*Medicare Savings Programs, MSP*). El programa *Medicare Savings Program* brinda asistencia para pagar las primas, los copagos y los deducibles de las personas que califican.

La información que le facilitó a SSA ha sido registrada en el formulario adjunto. Por favor, responda el resto de las preguntas en el formulario, proporcione la información solicitada y envíe documentación como comprobante. Envíe fotocopias y NO los documentos originales como comprobantes.

Envíe el formulario completado en el sobre adjunto con franqueo pago al siguiente domicilio:

Tenga en cuenta que su solicitud de MSP será rechazada si no recibimos el formulario antes del

**¿¿Preguntas?? Si necesita ayuda para llenar este formulario, llame a su oficina local de DHS.**

Otra alternativa, si necesita ayuda para completar el formulario de solicitud de información adicional para *Medicare Savings Program*, es llamar al programa SHIIP (*Senior Health Insurance Information Program*) al 800-351-4664. SHIIP es un servicio del estado de Iowa que brinda ayuda para resolver problemas o dudas sobre Medicare y seguro médico. Los servicios de SHIIP son gratuitos y confidenciales.

*Department of Human Services* realizará la determinación de su elegibilidad para el programa Medicare Savings Program.

**Conserve las páginas de portada y la Parte E como referencia.**

## ¿Qué debo hacer para conseguir ayuda?

Paso 1. Complete esta solicitud de información adicional.

Responda todas las preguntas que pueda. Si necesita ayuda para llenar el formulario, por favor pregunte. **Complete el formulario y devuélvalo antes de la fecha que figura en la portada de esta carta.**

Verifique que su información personal enviada por SSA al Departamento sea correcta. Si la información es incorrecta, por favor corríjala.

Paso 2. Devuélvanos el formulario.

Puede traerlo o enviarlo por correo o por fax a la oficina local de DHS. **El tiempo que DHS tiene para gestionar su solicitud comienza en la fecha en que recibamos el formulario.**

Paso 3. Cuando devuelva el formulario, es posible que le pidamos comprobantes de:

- el dinero que recibió en los últimos 30 días. Los comprobantes pueden ser recibos de sueldo, registros de trabajo por cuenta propia o cartas aprobando asignaciones.
- de cuentas bancarias, cuentas de fideicomisos, acciones o bonos, etc.

Podría tener que presentar otros comprobantes. Si no puede conseguir los comprobantes de inmediato, se le dará tiempo para que consiga la información. Si necesita ayuda, pídale a DHS que le ayude a conseguir la información.

## ¿Qué significan nuestros términos?

Utilizamos los siguientes términos en este formulario. Esto es lo que significan:

<b>Elegible</b>	Que cumple con todos los requisitos del programa.
<b>Expanded-Specified Low-Income Medicare Beneficiary (E-SLMB)</b>	(Beneficiario de Medicare con bajos ingresos específicos expandidos) Un Programa de Ahorro de Medicare que le ayuda a pagar su prima de Medicare Parte B.
<b>Grupo familiar</b>	Un grupo de personas que viven juntas.
<b>Medicaid</b>	Un programa administrado a nivel estatal que provee cobertura médica y hospitalización para personas con ingresos bajos y recursos escasos o nulos.
<b>Medicare</b>	Un programa nacional de seguro médico para personas mayores de 65 años o personas más jóvenes con determinadas discapacidades.
<b>Qualified Disabled and Working Persons (QDWP)</b>	(Discapacitados y trabajadores calificados) Un Programa de Ahorro de Medicare que le ayuda a pagar su prima de Medicare Parte A.
<b>Qualified Medicare Beneficiary (QMB)</b>	(Beneficiario calificado de Medicare) Un Programa de Ahorro de Medicare que le ayuda a pagar sus primas, copagos y deducibles de Medicare Parte A y Parte B.
<b>Control de calidad</b>	Una unidad de DHS que podría revisar su caso para ver si está recibiendo la asistencia correcta.
<b>Specified Low-Income Medicare Beneficiary (SLMB)</b>	(Beneficiario de Medicare con bajos ingresos específicos) Un Programa de Ahorro de Medicare que le ayuda a pagar su prima de Medicare Parte B.

## Medicare Savings Programs Additional Information Request

<b>Cuéntenos sobre usted</b>	<b>Parte A</b>
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**Si la información que está impresa no es correcta, por favor corríjala y después responda las preguntas que no están completadas.**

Nombre:	Nº del Caso:
Fecha de nacimiento:	Nº del Asistente:
Teléfono:	Condado:
Dirección postal:	Teléfono de DHS:

Fecha de la solicitud para MSP:

DHS recibió la solicitud para MSP el:

Domicilio donde usted vive ( <b>si no es el mismo que la dirección postal de arriba</b> )			Dpto. N°
Ciudad	Estado	Código postal	
Teléfono donde podemos comunicarnos con Ud. ( <b>si no es el mismo que indicó arriba</b> )			

<b>Cuéntenos más sobre usted</b>	<b>Parte A</b>
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**Si la información que está impresa no es correcta, por favor corríjala y después responda las preguntas que no están completadas.**

¿Solicitante?	Apellido	Primer nombre	Fecha de Nacimiento	Nº de Social Security
Sí				
Parentesco con usted	Origen étnico (Opcional)	Raza (Opcional)	¿Ciudadano de Estado Unidos?	¿Recibe beneficios en otro estado?
<b>Usted mismo</b>	<input type="checkbox"/> Hispano o Latino <input type="checkbox"/> Ni Hispano ni Latino	<input type="checkbox"/> Blanca <input type="checkbox"/> Negra <input type="checkbox"/> Asiática <input type="checkbox"/> Indio americano/Nativo de Alaska <input type="checkbox"/> Nativo de Hawái/Isla del Pacífico <input type="checkbox"/> Otra	<input type="checkbox"/> Sí <input type="checkbox"/> No  Si respondió No, ¿cuál es su situación migratoria? _____	<input type="checkbox"/> Sí <input type="checkbox"/> No  ¿En qué estado? _____

# Cuéntenos sobre las personas de su hogar

# Parte B

Si la información que está impresa no es correcta, por favor corríjala y después responda las preguntas que no están completadas.

¿Solicitante?	Apellido	Primer nombre	Fecha de Nacimiento	Nº de Social Security
<input type="checkbox"/> Sí <input type="checkbox"/> No				
Parentesco con usted	Origen étnico (Opcional)	Raza (Opcional)	¿Ciudadano de Estado Unidos?	¿Recibe beneficios en otro estado?
<input type="checkbox"/> Esposo/a <input type="checkbox"/> Hijo/a <input type="checkbox"/> Otro	<input type="checkbox"/> Hispano o Latino <input type="checkbox"/> Ni Hispano ni Latino	<input type="checkbox"/> Blanca <input type="checkbox"/> Negra <input type="checkbox"/> Asiática <input type="checkbox"/> Indio americano/Nativo de Alaska <input type="checkbox"/> Nativo de Hawái/Isla del Pacífico <input type="checkbox"/> Otra	<input type="checkbox"/> Sí <input type="checkbox"/> No  Si respondió No, ¿cuál es su situación inmigratoria? _____	<input type="checkbox"/> Sí <input type="checkbox"/> No  ¿En qué estado? _____

¿Solicitante?	Apellido	Primer nombre	Fecha de Nacimiento	Nº de Social Security
<input type="checkbox"/> Sí <input type="checkbox"/> No				
Parentesco con usted	Origen étnico (Opcional)	Raza (Opcional)	¿Ciudadano de Estado Unidos?	¿Recibe beneficios en otro estado?
<input type="checkbox"/> Esposo/a <input type="checkbox"/> Hijo/a <input type="checkbox"/> Otro	<input type="checkbox"/> Hispano o Latino <input type="checkbox"/> Ni Hispano ni Latino	<input type="checkbox"/> Blanca <input type="checkbox"/> Negra <input type="checkbox"/> Asiática <input type="checkbox"/> Indio americano/Nativo de Alaska <input type="checkbox"/> Nativo de Hawái/Isla del Pacífico <input type="checkbox"/> Otra	<input type="checkbox"/> Sí <input type="checkbox"/> No  Si respondió No, ¿cuál es su situación inmigratoria? _____	<input type="checkbox"/> Sí <input type="checkbox"/> No  ¿En qué estado? _____

¿Usted o alguien en su hogar recibió atención médica durante los últimos tres meses?  Sí  No

Si respondió "sí", ¿quién? \_\_\_\_\_

¿En qué meses? \_\_\_\_\_

¿Alguien tiene otro seguro médico aparte de Medicare?  Sí  No

Si respondió "sí", ¿quién tiene cobertura? \_\_\_\_\_

¿Compañía del seguro médico? \_\_\_\_\_

**Si la información que está impresa no es correcta, por favor corríjala y después responda las preguntas que no están completadas.**

Infórmenos sobre todo el dinero que reciben las personas de su grupo familiar. Si deja un espacio en blanco, entenderemos que no hay dinero de ese tipo. Escriba en otra hoja si es necesario.

<b>Ingresos no laborales</b>	<b>Nombre de la persona que recibe este ingreso</b>	<b>Monto por mes</b>
Social Security o SSI		
Beneficios Ferroviarios		
Beneficios para Veteranos		
Jubilaciones o Planes de Retiro		
Intereses o Dividendos		
Desempleo o Worker's Compensation		
Manutención o pensión alimentaria		
Dinero proveniente de amigos o parientes		
Otros ingresos no laborales		

<b>Ingresos laborales</b>	<b>Nombre de la persona que recibe este ingreso</b>	<b>Monto por mes</b>
Dinero recibido en el trabajo – Usted		
Dinero recibido en el trabajo – Su esposo/a		
Empleo por cuenta propia o trabajo esporádico – Usted		
Empleo por cuenta propia o trabajo esporádico – Su esposo/a		
Propinas, Bonos, Comisiones		
Otros ingresos laborales		

**Cuéntenos sobre sus recursos económicos (Activos)****Parte D**

Si la información que está impresa no es correcta, por favor corríjala y después responda las preguntas que no están completadas.

Infórmenos sobre todos los recursos que tienen las personas de su grupo familiar. Si deja un espacio en blanco, entenderemos que no hay recursos de ese tipo. Escriba en otra hoja si es necesario.

Indique todos los automóviles, camionetas, botes, casas rodantes, motocicletas y otros vehículos con o sin licencia que tengan o vayan a comprar:

Año	Marca	Modelo	Valor o Precio	Importe adeudado

Recursos económicos (Activos)	Nombre de la persona que posee este recurso	Importe
Cuentas bancarias o cooperativas de crédito		
Acciones o bonos		
Dinero en efectivo		
Bienes inmuebles (que no sea la propiedad donde vive)		
Anualidades		
Certificados de ahorro		
Keoghs u otros activos		

¿Alguien tiene un fideicomiso o una tutela testamentaria?  Sí  No

Si respondió "sí", ¿quién? \_\_\_\_\_

¿Alguien tiene un seguro de vida o beneficios por fallecimiento?  Sí  No

Si respondió "sí", ¿quién? \_\_\_\_\_

Indique la suma total de dinero que alguien tiene en:

Contrato funerario \$ \_\_\_\_\_ ¿Quién? \_\_\_\_\_

Tumbas \$ \_\_\_\_\_ ¿Quién? \_\_\_\_\_

¿Alguien espera recibir un pago por única vez, como por ejemplo, una herencia o la liquidación de un seguro, o alguien recibió uno en los últimos 3 meses?  Sí  No

Si respondió "sí", ¿quién? \_\_\_\_\_

## Anexo de los formularios de solicitud y revisión para divulgación de información

### Divulgación de información OPCIONAL

#### **¡Ayúdenos a ayudarle!**

No tiene obligación de firmar este formulario, pero el mismo nos ayudará a conseguir la información que necesitamos para ayudarle, sin tener que pedirle que firme cada una de las solicitudes.

#### **Debe saber que:**

- Podríamos necesitar más información para decidir si puede recibir asistencia.
- En caso de que necesitemos más información, recibirá una carta informándole lo que necesitamos y la fecha en que debe presentarla.
- Es su responsabilidad conseguir la información o pedirnos ayuda para conseguirla.
- Si no nos da la información o no pide ayuda antes de la fecha de entrega, su solicitud podrá ser denegada o su asistencia podrá ser cancelada.
- Podremos utilizar su autorización para divulgación para conseguir la información que necesitamos. **Pero aún así usted tendrá que presentar la información solicitada o pedirnos ayuda.**
- Podremos adjuntar una copia de esta autorización a cualquier formulario que les enviemos a otras personas u organizaciones (por ejemplo, su empleador) para conseguir información específica que necesitemos sobre usted o su grupo familiar.

**Imprima y firme debajo para darnos permiso para conseguir 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)



## Guarde esta página como referencia.

### Tiene derecho a apelar

Parte E

Usted, o la persona que le esté ayudando, puede solicitar una audiencia de apelación si usted no está de acuerdo con la acción tomada en su caso. En el caso de MSP debe apelar por escrito. Para apelar por escrito haga una de las siguientes cosas:

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

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

Puede auto representarse o puede pedirle a un amigo, un pariente, un abogado u otra persona que lo represente.

Puede comunicarse con la oficina DHS de su condado para averiguar sobre servicios jurídicos. Es posible que deba pagar por dichos servicios jurídicos. Si lo hace, el pago se hará de acuerdo a sus ingresos. También puede llamar a Iowa Legal Aid al teléfono (800) 532-1275. Si vive en el Condado de Polk County, llame al (515) 243-1193.

### No será discriminado

Parte E

La política de Iowa Department of Human Services (DHS) es brindarles trato igualitario con respecto a empleo y el ofrecimiento de servicios a todos los solicitantes, los empleados y los clientes sin tener en cuenta su raza, color, país de origen, sexo, orientación sexual, identidad sexual, religión, edad, discapacidad, ideología política o condición de veterano.

Si cree que ha sido discriminado o acosado por DHS, 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](mailto:contactdhs@dhs.state.ia.us)

### Cosas que debe saber

Parte E

#### Verificamos lo que nos informa

La información que nos entrega podrá ser verificada por funcionarios federales, estatales y locales para comprobar que la información es verdadera. Las cosas que podríamos verificar son: el número de Social Security, el empleo y el sueldo, el importe de las cuentas bancarias, el estado legal de extranjero y los montos recibidos de otras fuentes como Social Security o el seguro de desempleo, de las personas nombradas. Si encontráramos que la información presentada no es correcta, su solicitud podría ser denegada.

Para hacer las verificaciones, utilizamos sistemas informáticos como el *State Income and Eligibility Verification System* (Sistema estatal de verificación del ingreso y la elegibilidad). Si la información que nos dio es diferente a la del sistema informático, verificaremos para averiguar cuál es correcta. Podríamos verificar su información comunicándonos con su empleador, su banco u otras personas. Para hacer esta clase de verificación con su empleador, su banco u otras personas, le preguntaremos a usted primero.

La unidad de Control de Calidad o la unidad de Investigaciones pueden revisar su caso. Pueden comunicarse con otras personas u organizaciones para conseguir comprobantes de su información. Al firmar esta solicitud, usted autoriza la divulgación de información confidencial a la unidad de Control de Calidad o a la unidad de Investigaciones. Debe cooperar con ellos para conservar sus beneficios.

Deberá reintegrar todos los beneficios que reciba o que sean pagados por terceros a su nombre y para los cuales no era elegible.

La sección 1128B de la Ley de Social Security estipula sanciones a nivel federal por actos fraudulentos y la presentación de información falsa relacionada con estos programas.

Toda persona que obtenga, intente obtener o ayude a otra persona a obtener asistencia a la cual no tenga derecho, es culpable de violar las leyes del estado de Iowa. Esto incluye, entre otros, los Capítulos 239B, 243, 249 y 249A del Código de Iowa.

Recibirá por correo la Com. 233. En la misma, se le informará sobre otros derechos y obligaciones que no hayan sido mencionados en esta solicitud.

En un plazo de 5 días hábiles a partir de la fecha en que ocurra un cambio, deberá informarle a DHS sobre todos los cambios, como por ejemplo:

- Ingresos, inclusive pagos únicos, como por ejemplo manutención de menores adeudada, herencias o acuerdos por liquidación de deudas
- Recursos económicos o activos, entre los que se incluye recibir una herencia
- Alguien que se muda a su hogar o se va del mismo
- Su cobertura del seguro médico
- Usted presenta un reclamo al seguro o contrata a un abogado para que recupere el importe de las facturas pagadas por Medicaid
- Dirección postal o domicilio residencial

Si se aprueba su solicitud para QMB, usted renunciará a su derecho de recibir pagos de asistencia para servicios médicos mientras esté recibiendo los beneficios. El estado de Iowa conservará dichos pagos y los usará para ayudarle a pagar su cobertura médica.

Si resulta elegible para QMB, los pagos correspondientes a futuros servicios médicos impagos serán pagados directamente a los médicos y a los proveedores de servicios médicos bajo el Programa del Seguro Medicare (Medicare Parte B).

La recuperación de patrimonio no incluirá los pagos hechos por Medicaid debido al costo compartido de Medicare para los beneficios MSP.

**Al devolver esta solicitud, usted autoriza a DHS a compartir:**

- Su historia clínica y otros registros médicos con los funcionarios estatales y federales.
- Usted acepta ceder a la agencia Medicaid los pagos hechos por terceros para servicios médicos a su nombre y a nombre de otras personas que sean elegibles para Medicaid y para las cuales usted está legalmente autorizado a ceder beneficios. Además, usted acepta cooperar para conseguir pagos de terceros para servicios médicos.

**Esta autorización finalizará cuando su Medicaid (Medicare Savings Programs) termine.**

Introduzca esta hoja, junto con  
otros documentos, en el sobre  
que se adjunta.

**El domicilio de la oficina de DHS debe  
estar visible en la ventana del sobre.**





Iowa Department of Human Services  
**Notice of Child Care Assistance Overpayment**

Date:

Account Number:

**Keep this part**

If you have questions about repayment, call **1-800-572-3945** (toll free). If you have questions about the establishment of this claim, call your worker or local DHS office.

Our records show that you owe money to the Department of Human Services (DHS). The reason is checked below. The amount that you owe is \$ \_\_\_\_\_ for the months of :

- 1  A mistake by you that gave you child care assistance in error.
- 2  A mistake by DHS that gave you child care assistance in error.
- 3  A mistake by a provider that caused DHS to pay the provider incorrectly for child care services.
- 4  A mistake by DHS that incorrectly paid a provider for child care services.

**This overpayment happened because of** \_\_\_\_\_

**Step 1: Decide** \_\_\_\_\_ **What You Need to Do**

- If you **agree** that an overpayment has been made:
  1. Fill out the repayment agreement below.
  2. Make sure you sign and date the agreement.
  3. Using the enclosed envelope, return the agreement within 20 days.
- If you **do not agree** that you owe DHS money or if you do not agree with the amount, you may appeal within **30 calendar days** of the date on the first notice that was sent to you. Your appeal rights are explained on the back of this letter.

**Step 2: Choose a Payment Plan** \_\_\_\_\_

**Plan 1:** Pay the full amount in one payment.

**Plan 2:** Make monthly payments.

**Plan 3:** Pay part of what you owe now and pay the rest in monthly payments.

**Monthly Payments:** If you choose Payment Plan 2 or 3, your monthly payments cannot be less than \$50 or the amount you owe divided by 60 (one monthly payment for five years), whichever is greater. You can pay the entire balance at any time.

**Note:** If your household's income changes, you may ask to change this agreement.

**Step 3: Fill Out and Mail the Agreement to Pay – Remember to:** \_\_\_\_\_

- Fill in all the blanks.
- Choose a payment plan.
- Sign and date the form.

Mail the form to:  
Iowa Department of Inspections and Appeals  
Public Assistance Debt Recovery Unit  
321 E 12<sup>th</sup> St, 3<sup>rd</sup> Floor  
Des Moines, Iowa 50319-0083

After we get your signed agreement, you will get a bill with instructions on how to make payments.

## Actions to Collect the Debt

The debt has been referred to the Department of Inspections and Appeals (DIA) for collection. DIA will collect on this debt by doing one of the following:

- Bill you for the debt, or
- If you are not making payments and you are past due on your account:
  - Take your Iowa income tax refund, or
  - Take money that is owed to you by any state agency. For example, all or part of your income tax refund or state wages.
- If you gave wrong information on purpose or kept information from DHS to get more benefits than you were eligible for, your case can be referred for a criminal investigation.
- File a civil suit to collect the debt.

## 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.

### 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](mailto:contactdhs@dhs.state.ia.us)



Iowa Department of Human Services  
**Notice of Child Care Assistance Overpayment**

**Agreement to Pay**

**Mail this part**

Name:

Account Number:

I, \_\_\_\_\_, agree to pay the Department of Human Services by:  
(First Name, Middle Initial, and Last Name)

- Plan 1:** Pay the full amount in one payment
- Plan 2:** Make monthly payments of \$\_\_\_\_\_ per month  
Starting (date) \_\_\_\_\_
- Plan 3:** Pay \$\_\_\_\_\_ now and pay the rest in monthly payments of \$\_\_\_\_\_ per month

By signing this agreement, I understand that:

- If I choose Payment Plan 2 or 3, my monthly payments cannot be less than \$50 or the amount I owe divided by 60 (one monthly payment for five years), whichever is greater.
- I can pay the balance off at any time.
- If I sign this agreement and do not follow its terms, it will break the contract and action may be taken against me.

\_\_\_\_\_  
Signature Phone Date

For Office Use Only:		
Signed:	Date:	Title:





Iowa Department of Human Services  
**Notice of FIP or RCA Overpayment**

Date:

Account Number:

**Keep this part**

If you have questions about repayment, call **1-800-572-3945** (toll free). If you live in the Des Moines area call 281-3911. If you have questions about how this claim was determined, call your worker or local DHS office.

Our records show that you owe money to the Department of Human Services (DHS) for a Family Investment Program (FIP) or Refugee Cash Assistance (RCA) overpayment. The reason is checked below.  
The amount that you owe is \$ \_\_\_\_\_ for the months of: \_\_\_\_\_

1  A mistake by you that gave you FIP or RCA assistance in error.

2  A mistake by DHS that gave you FIP or RCA assistance in error.

**You owe this money because of:**

**What You Need to Do**

**Step 1: Decide**

- If you **agree** that an overpayment has been made, see Step 2 below.
- If you **do not agree** that you owe DHS money or if you do not agree with the amount, you may appeal within **30 calendar days** of the date on this letter. Your appeal rights are explained on the back of this letter.

**Step 2: Choose a Payment Plan**

**Plan 1:** Pay the full amount in one payment.

**Plan 2:** Make monthly payments.\*

**Plan 3:** Pay part of what you owe now and pay the rest in monthly payments.\*

**Plan 4:** Have the payments taken out of your FIP or RCA grant. We will keep 10% of your FIP or RCA benefit amount if the overpayment is because of your mistake or 1% if the overpayment is because of a DHS mistake. **Note:** If you are not getting FIP or RCA now, you will have to choose another plan.

**\* If you choose Plan 2 or 3:**

- If you get FIP or RCA, your monthly payments must be more than \_\_\_\_\_ % of your monthly FIP or RCA benefit.
- If you do not get FIP or RCA, your monthly payments cannot be less than \$50 or the amount you owe divided by 60 (one monthly payment for five years), whichever is more. **Note:** If you are not able to pay this amount each month, call the Department of Inspections and Appeals (DIA) at 1-800-572-3945 to discuss other payment options.
- You can pay the entire balance at any time.

**Step 3: Fill Out and Mail the Agreement to Pay – Remember to:**

- Fill in all the blanks.
- Choose a payment plan.
- Sign and date the form.
- Use the enclosed envelope and return the agreement within 20 days.

Mail the form to DIA at:  
Iowa Department of Inspections and Appeals  
Public Assistance Debt Recovery Unit  
321 E 12<sup>th</sup> St, 3<sup>rd</sup> Floor  
Des Moines, Iowa 50319-0083

After we get your signed agreement, you will get a bill with instructions on how to make payments.

## Actions to Collect the Debt

The debt has been referred to the Department of Inspections and Appeals (DIA) for collection. DIA will collect on this debt by doing one of the following:

- Take part of your FIP or RCA grant each month, or
- Bill you for the debt, or
- If you are not making payments and you are past due on your account:
  - Take your Iowa income tax refund, or
  - Take money that is owed to you by any state agency. For example, all or part of your state wages.
- If you gave wrong information on purpose or kept information from DHS to get more benefits than you were eligible for, your case can be referred for a criminal investigation.
- File a civil suit to collect the debt.

### 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.

#### 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](mailto:contactdhs@dhs.state.ia.us)

## Agreement to Pay

**Mail this part  
to DIA**

Case Name:

Account Number:

I, \_\_\_\_\_, agree to pay the Department of Human Services by:  
(First Name, Middle Initial, and Last Name)

- Plan 1:** Paying the full amount in one payment.
- Plan 2:** Making monthly payments of \$ \_\_\_\_\_ per month.  
Starting (date) \_\_\_\_\_
- Plan 3:** Paying \$ \_\_\_\_\_ now and pay the rest in monthly payments of \$ \_\_\_\_\_ per month.
- Plan 4:** Having DHS keep \_\_\_\_\_ % of my monthly FIP or RCA benefits.

By signing this agreement, I understand that:

- If I choose Payment Plan 2 or 3,
  - If I get FIP or RCA, my monthly payments must be more than \_\_\_\_\_ % of my monthly FIP or RCA benefit.
  - If I do not get FIP or RCA, my monthly payments cannot be less than \$50 or the amount I owe divided by 60 (one monthly payment for five years), whichever is more. If DIA and I agreed to a different amount, I understand I need to pay that amount.
- I can pay the balance off at any time.
- If I sign this agreement and do not follow its terms, it will break the contract and action may be taken against me.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Phone

\_\_\_\_\_  
Date

For Office Use Only:

Signed:

Date:

Title:





Date:

Iowa Department of Human Services  
**Notice of Food Assistance Debt**  
Account Number:

**Keep This Part**

If you have questions about this notice, call **1-800-572-3945** (toll free).

You were found guilty of trafficking or misuse of Food Assistance benefits and ordered to pay the Iowa Department of Human Services \$

**What You Need to Do**

Step 1: Choose a Payment Plan

If a payment was set by a court you must pay that amount.

If a court did not set your payments, you can choose one of the following:

- Plan 1. Pay the full amount in one payment.
- Plan 2. Make monthly payments.\*
- Plan 3. Pay part of what you owe now and pay the rest in monthly payments.\*
- Plan 4. Have DHS take benefits from your EBT account now. (If this does not pay all of the claim, choose an additional plan to pay the rest.) Note: Call DIA if you want to make monthly payments from your EBT account.
- Plan 5. Have DHS keep part of your monthly benefits if you get Food Assistance now.

\* If you choose Plan 2 or 3:

- If you get Food Assistance benefits, your monthly payments must be more than \$20 or 20% of your monthly Food Assistance benefit, whichever is higher.
- If you do not get Food Assistance benefits, your monthly payments cannot be less than \$50 or the amount you owe divided by 36 months, whichever is more. **Note:** If you are not able to pay this amount each month, call DIA at 1-800-572-3945 to discuss other payment options.

Step 2: Fill Out and Mail the Agreement to Pay – Remember to:

- Fill in all the blanks.
- Choose a payment plan.
- Sign and date the form.
- Return the Agreement to Pay within 20 days of the date of this letter.

Mail the form to:  
Iowa Department of Inspections and Appeals  
Public Assistance Debt Recovery Unit  
321 E 12<sup>th</sup> St 3<sup>rd</sup> Floor  
Des Moines, IA 50319-0083

If you choose Plan 1, 2, or 3, you will get a bill with instructions on how to make payments. If your household's income changes, you can ask us to change your agreement.

## **Action to Collect the Debt**

An Intentional Program Violation or court hearing found you guilty of trafficking or misuse of Food Assistance benefits. This debt has been passed on to the Department of Inspections and Appeals (DIA). DIA will collect on this debt by doing one of the following:

- Bill you for the debt, or
- If you do not return the signed agreement and make payments, we may:
  - Keep part of your monthly benefit if you get Food Assistance,
  - Take your Iowa income tax refund,
  - Take your federal tax refund, or
  - Take a part of your Social Security benefits or part of your salary if you work for the federal government.

If you don't provide the signed agreement, we will ask the Department of Treasury to collect the debt for us. If this happens, you will be charged for extra processing fees.

You can stop this action if you provide a signed agreement that says you will pay your debt before it is referred to the Department of Treasury.

## **Request to Reduce or Settle a Debt**

You have the right to ask the Department of Human Services not to collect some or all of your debt. We may reduce any part or all of the debt if we believe you are not able to repay the full amount.

If you want to ask us to lower part or all of your debt, write us a letter telling us:

- Your name and mailing address,
- A phone number where we can reach you or leave a message for you,
- Your social security number, and
- Why you cannot pay part or all of your debt.

Mail the letter to: Exceptions to Policy, DHS Appeals Section, 5th Fl, 1305 E Walnut, Des Moines, IA 50319-0114.

When you ask us to lower part or all of the amount you owe, we will look at things like:

- How much you owe,
- When (the date) the trafficking or misuse happened, and
- Things that make it hard for you to pay, like financial hardship or other unusual problems.

We may then agree to settle, adjust, compromise or deny part or all of the debt. In other words we may agree that you don't have to pay back any of the debt or that you only have to pay back part of it.

**NOTE:** If your family's income changes, you can ask to change your repayment agreement to lower the amount you pay.

---

**Agreement to Pay**

Due Date:

**Mail This Part**

Case Name:

Account Number:

I, \_\_\_\_\_, agree to pay the Iowa Department of Human Services.  
(First Name, Middle Initial, and Last Name)

**If a court ordered payment, you must pay that amount.**

If you do not have a court ordered payment amount, check one of the plans below:

- Plan 1: Pay the full amount in one payment.
- Plan 2: Make monthly payments of \$\_\_\_\_\_ per month.  
Starting date: \_\_\_\_\_.
- Plan 3: Pay \$\_\_\_\_\_ now and pay the rest in monthly payments of \$\_\_\_\_\_ per month.
- Plan 4: Have DHS take benefits from my EBT account now. (If this does not pay all of the claim, choose an additional plan to pay the rest.) Note: Call DIA if you want to make monthly payments from your EBT account.
- Plan 5: Having DHS keep \$20 or 20% of my monthly Food Assistance benefits, whichever is more.

By signing this agreement, I understand that:

**\* If I choose Plan 2 or 3:**

- If I get Food Assistance benefits, my monthly payments must be more than \$20 or 20% of my monthly Food Assistance benefit, whichever is higher.
- If I do not get Food Assistance benefits, my monthly payments cannot be less than \$50 or the amount I owe divided by 36 months, whichever is more. If DIA agreed to a different amount, I understand I need to pay that amount.
- I can pay the balance off at any time.
- If I sign this agreement and do not follow its terms, it will break the contract and other action may be taken against me.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Phone

\_\_\_\_\_  
Date

For Office Use Only:

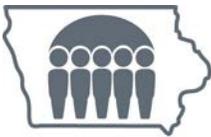
Signed:

Date:

Title:

In accordance with federal law and U.S. Department of Agriculture policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, sexual orientation, gender identity, religion, age, disability, political belief, or veteran status. To file a complaint of discrimination, write to: USDA – Director, Office of Adjudication, 1400 Independence Ave SW, Washington, DC 20250-9410, or call 1-866-632-9992 voice. Individuals who are hearing impaired or have speech disabilities may contact USDA through the Federal Relay Service at 800-877-8339; or 800-845-6136 (Spanish). USDA is an equal opportunity provider and employer.





### Notice of Food Assistance Overpayment

Date:

Account Number:

**Keep this part**

If you have questions about repayment, call **1-800-572-3945** (toll free). If you have questions about how your overpayment was figured, call your DHS worker at

Our records show that you owe money to the Department of Human Services (DHS). The reason is checked below. The amount you owe is \$ \_\_\_\_\_ for the months of: \_\_\_\_\_

- 1  An inadvertent mistake by you that gave you Food Assistance in error.
- 2  An Intentional Program Violation that gave you Food Assistance in error.
- 3  A mistake by DHS that gave you Food Assistance in error.

#### You owe this money because of

### What You Need to Do

#### Step 1: Decide

- If you **agree** that an overpayment has been made, see step 2 below.
- If you **do not agree** that you owe money or do not agree with the amount, you may appeal within 90 calendar days of the date on this notice. Your appeal rights are explained on the back of this notice.

#### Step 2: Choose a Payment Plan

- Plan 1:* Pay the full amount in one payment.
  - Plan 2:* Make monthly payments.\*
  - Plan 3:* Pay part of what you owe now and pay the rest in monthly payments.\*
  - Plan 4:* Have DHS take benefits from your EBT account now. (If this does not pay all of the claim, choose an additional plan to pay the rest.) Note: Call DIA if you want to make monthly payments from your EBT account.
- \* If you choose *Plan 2* or *3*:
- If you get Food Assistance benefits, your monthly payments must be more than \$ \_\_\_\_\_ or \_\_\_\_\_ % of your monthly Food Assistance benefit, whichever is higher.
  - If you do not get Food Assistance benefits, your monthly payments cannot be less than \$50 or the amount you owe divided by 36 months, whichever is more. Note: If you are not able to pay this amount each month, call DIA at 1-800-572-3945 to discuss other payment options.

**Note:** You have the right to ask DHS not to collect some or all of your overpayment. (See REQUEST TO REDUCE OR SETTLE A CLAIM on the back of this notice.)

#### Step 3: Fill Out and Mail the Enclosed Agreement to Pay - Remember to:

- Fill in all the blanks.
  - Choose a payment plan.
  - Sign and date the form.
  - Use the enclosed envelope and return the agreement within 20 days.
- Mail the form to:  
Iowa Department of Inspections and Appeals  
Public Assistance Debt Recovery Unit  
321 E 12<sup>th</sup> St, 3<sup>rd</sup> Floor  
Des Moines, Iowa 50319-0083

## Actions to Collect the Debt

FEDERAL RULES REQUIRE THAT DHS ESTABLISH ALL OVERPAYMENTS. Collection may be made from all adults who were members of your household at the time of the overpayment.

The debt has been referred to the Department of Inspections and Appeals (DIA) for collection. DIA will collect on this debt by doing one or more of the following:

- Keep part of your monthly benefit if you get Food Assistance, or
- Bill you for the debt.
- If you do not return an Agreement to pay or you are past due on your account:
  - Take your Iowa income tax refund, or
  - Take your federal tax refund, part of your Social Security benefit, or part of your pay if you work for the federal government\*, or
- File a civil suit to collect the overpayment, or
- Refer your case for prosecution (if we have reason to believe that you intentionally withheld or gave false information in order to get benefits you were not entitled to).

\* You can stop this action if you make a written agreement to repay your debt before the debt is referred to the Department of Treasury. If you fail to make a written agreement and your claim is referred to the Department of Treasury, you must pay additional processing charges when the collection is made.

Your DHS worker will let you look at the case record and give you a copy of the overpayment calculation if you request it.

## 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.

## Request to Reduce or Settle a Claim

You have the right to ask the Department of Human Services not to collect some or all of your overpayment. We may reduce any part or all of the claim if we believe you are not able to repay the claim.

If you want to ask us to lower part or all of your overpayment, write us a letter telling us:

- Your mailing address,
- A phone number where we can reach you or leave a message for you,
- Your social security number, and
- Why you cannot pay part or all of your overpayment.

Mail the letter to: Exceptions to Policy, DHS Appeals Section, 5th Fl, 1305 E Walnut, Des Moines, IA 50319-0114.

When you ask us to lower part or all of the amount you owe, we will look at things like:

- How much you owe,
- When (the date) the overpayment happened, and
- Things that make it hard for you to pay, like financial hardship or other unusual problems.

We may then agree to settle, adjust, compromise or deny part or all of the overpayment. In other words we may agree that you don't have to pay back any of the overpayment or that you only have to pay back part of it.

**NOTE:** If your family's income changes, you can ask to change your repayment agreement to lower the amount you pay.

## 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](mailto:contactdhs@dhs.state.ia.us)

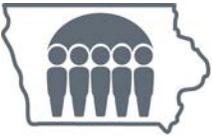
(Food Assistance only) USDA – Director, Office of Adjudication, 1400 Independence Ave SW, Washington, DC 20250-9410, or call 1-866-632-9992 voice. Individuals who are hearing impaired or have speech disabilities may contact USDA through the Federal Relay Service at 800-877-8339; or 800-845-6136 (Spanish).

470-4668 (Rev. 8/15) H4668B



Iowa Department of Human Services  
**Notice of Food Assistance Overpayment**

**Calculation of Overpayment**



Iowa Department of Human Services  
**Notice of Food Assistance Overpayment**

**Calculation of Overpayment**

# Agreement to Pay

**Mail this part**

Case Name:

Account Number:

I, \_\_\_\_\_, agree to pay the Department of Human Services by:  
(First Name, Middle Initial, and Last Name)

- Plan 1:** Paying the full amount in one payment.
- Plan 2:** Making monthly payments of \$\_\_\_\_\_ per month. Starting (date) \_\_\_\_\_
- Plan 3:** Paying \$\_\_\_\_\_ now and paying the rest in monthly payments of \$\_\_\_\_\_ per month.
- Plan 4:** Having DHS take \$\_\_\_\_\_ from my EBT account now. (If this does not pay all of the claim, choose an additional plan to pay the rest.) Note: Call DIA if you want to make monthly payments from your EBT account.

By signing this agreement, I understand that:

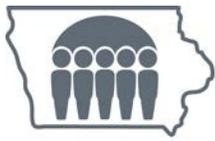
- If I choose Payment Plan 2 or 3:
  - If I get Food Assistance benefits, my monthly payments must be more than \$ \_\_\_\_\_ or \_\_\_\_\_ % of my monthly benefit amount, whichever is higher.
  - If I do not get Food Assistance benefits, my monthly payments cannot be less than \$50 or the amount I owe divided by 36 months, whichever is more. If DIA agreed to a different amount, I understand I need to pay that amount.
- I can pay the balance off at any time.
- If I sign this agreement and do not follow its terms, it will break the contract and other action may be taken against me.

If your household's income changes, you may ask to change this agreement.

\_\_\_\_\_  
Signature Phone Date

For Office Use Only:		
Signed:	Date:	Title:





Iowa Department of Human Services  
**Notice of Medical Assistance Debt  
Due to a Transfer of Asset(s)**

Date:

Account Number:

**Keep This Part**

If you have questions  
about this notice, call  
**1-800-572-3945** (toll free).

It has been determined that you owe a Medical Assistance debt up to \$ \_\_\_\_\_ for  
one of these reasons:

- There is a voluntary Agreement and/or Confession of Judgment or Court Order, OR
- You have received a notice pursuant to **Iowa Code** Chapter 249F and have not responded as required.

### What You Need to Do

#### Step 1: Payment Plan:

If a payment plan was previously established, you must pay according to that plan. You do **not** need to complete another Agreement to Pay.

If a payment plan has not been established you must choose one of the following to repay the debt:

Plan 1: Pay the full amount owed in one payment.

Plan 2: Pay part of what you owe now and pay the rest in monthly payments.

Plan 3: Make monthly payments until the debt is paid in full.

If you choose Plan 2 or 3, your monthly payments cannot be less than the amount you owe divided by 60 (one monthly payment for five years).

Under Plans 1, 2, or 3, you will get a bill with instructions on how to make payments. If your household's income changes, you can ask to change your agreement. Under any Plan, you can pay the entire amount at anytime.

#### Step 2: Fill Out and Mail the Agreement to Pay – Remember to:

- Fill in all the blanks.
- Choose a payment plan if one has not been previously established.
- Sign and date the form.
- Return the Agreement to Pay within 20 days of the date of this letter.

Mail the form to:  
Iowa Department of Inspections and Appeals  
Public Assistance Debt Recovery Unit  
321 E 12<sup>th</sup> St 3<sup>rd</sup> Floor  
Des Moines, IA 50319-0083

## **Action to Collect the Debt**

The Department of Inspections and Appeals (DIA) can collect on this debt by doing one of the following:

- Bill you for the debt, or
- If you do not have a signed agreement or have an agreement and become delinquent, DIA can take the following actions:
  - Take your Iowa income tax refund
  - Take money that is owed to you by any state agency
  - Wage garnishment

## Agreement to Pay

Due Date:

Case Name:

Mail This Part

Account Number:

DIA Case Number:

**Complete and return this section only if you do not have a payment plan.**

I, \_\_\_\_\_, agree to pay the Iowa Department of Human  
(First Name, Middle Initial, and Last Name)  
Services for a Medical Assistance debt up to the amount of \$\_\_\_\_\_.

I do not have an agreed-to or court ordered payment plan and choose to repay the debt by (check one of the boxes below):

- Plan 1: Pay the full amount in one payment.
- Plan 2: Pay part of what you owe now in the amount of \$\_\_\_\_\_ and then make monthly payments of \$\_\_\_\_\_ beginning \_\_\_\_\_ and the same amount each month thereafter until the debt is paid in full.
- Plan 3: Make monthly payments of \$\_\_\_\_\_ beginning \_\_\_\_\_ and the same amount each month thereafter until the debt is paid in full.

By signing this agreement, I understand that:

- If I choose Plan 2 or 3, my monthly payments cannot be less than the amount I owe divided by 60 (one monthly payment for five years).
- I can pay the balance off at any time.
- Not making the payments will break the agreement. The Department of Inspections and Appeals may take action to collect the debt.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Phone

\_\_\_\_\_  
Date

Current address:

For Office Use Only:

Signed:

Date:

Title:

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](mailto:contactdhs@dhs.state.ia.us)

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Iowa Department of Human Services  
**Notice of Medical Assistance Overpayment**

Date:

Account Number:

**Keep this part**

If you have questions about repayment, call **1-800-572-3945** (toll free). If you live in the Des Moines area call **281-5714**. If you have questions about the establishment of this claim, call your worker or local DHS office.

Our records show that you owe money to the Department of Human Services (DHS). The reason is checked below. The amount that you owe is \$ \_\_\_\_\_ for the months of :

- 1  A mistake by you that gave you assistance in error.
- 2  A mistake by DHS that gave you assistance in error.
- 3  You did not pay your premium.

**Step 1: Decide** \_\_\_\_\_ **What You Need to Do**

- If you **agree** that an overpayment has been made: 1. Fill out the repayment agreement below. 2. Make sure you sign and date the agreement. 3. Using the enclosed envelope return the agreement within 30 days.
- If you **do not agree** that you owe DHS money or if you do not agree with the amount, you may appeal within **30 calendar days** of the date on the first notice that was sent to you. Your appeal rights are explained on the back of this letter.

**Step 2: Choose a Payment Plan** \_\_\_\_\_

**Plan 1:** Pay the full amount in one payment.

**Plan 2:** Make monthly payments.

**Plan 3:** Pay part of what you owe now and pay the rest in monthly payments.

**Monthly Payments:** If you choose Payment Plan 2 or 3, your monthly payments cannot be less than the amount you owe divided by 60 (one monthly payment for five years). You can pay the entire amount at any time.

**Note:** If my household's income changes, I may ask to change this agreement.

**Step 3: Fill Out and Mail the Agreement to Pay – Remember to:** \_\_\_\_\_

- Fill in all the blanks.
- Choose a payment plan.
- Sign and date the form.

Mail the form to:  
Iowa Department of Inspections and Appeals  
Public Assistance Debt Recovery Unit  
321 E 12<sup>th</sup> St, 3<sup>rd</sup> Floor  
Des Moines, Iowa 50319-0083

After we get your signed agreement, you will get a bill with instructions on how to make payments.

**Agreement to Pay**

Case Name:

Account Number:

**Mail this part**

I, \_\_\_\_\_, agree to pay the Department of Human Services by:  
(First Name, Middle Initial, and Last Name)

- Plan 1:** Pay the full amount in one payment
- Plan 2:** Make monthly payments of \$ \_\_\_\_\_ per month  
Starting (date) \_\_\_\_\_
- Plan 3:** Pay \$ \_\_\_\_\_ now and pay the rest in monthly payments of \$ \_\_\_\_\_ per month

By signing this agreement, I understand that:

- If I choose Payment Plan 2 or 3, my monthly payments cannot be less than the amount I owe divided by 60 (one monthly payment for five years).
- I can pay the balance off at any time.
- If I sign this agreement and do not follow its terms, it will break the contract and action may be taken against me.

Signature \_\_\_\_\_

Phone \_\_\_\_\_

Date \_\_\_\_\_

For Office Use Only:

Signed: \_\_\_\_\_

Date: \_\_\_\_\_

Title: \_\_\_\_\_

## Actions to Collect the Debt

A debt was made because you or your household was not eligible or you did not pay your premium. The debt has been referred to the Department of Inspections and Appeals (DIA) for collection. DIA will collect on this debt by doing one of the following:

- Bill you for the debt, or
- If you are not making payments and you are past due on your account:
  - Take your Iowa income tax refund, or
  - Take money that is owed to you by any state agency. For example, all or part of your income tax refund or state wages.
- If you gave wrong information on purpose or kept information from DHS to get more benefits than you were eligible for, your case can be referred for a criminal investigation.
- File a civil suit to collect the debt.

### 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.

#### 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.

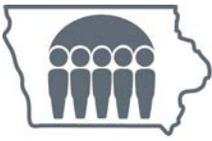
#### Can I have someone else help me in the hearing?

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](mailto:contactdhs@dhs.state.ia.us)



Iowa Department of Human Services  
**Notice of Setoff of an Iowa Income Tax Refund  
for Debts Owed the Iowa Department of Human Services**

Date Issued:

Account Number:

You owe money to the Department of Human Services (DHS). Either you have not made a satisfactory agreement to repay, or you have not kept your agreement to repay the money you owe.

As of the date on this notice the amount of past due debt on your account is \$ \_\_\_\_\_ The total you owe DHS may be more than this amount.

We are holding your Iowa income tax refund of \$ \_\_\_\_\_ to repay all or part of the past due amount you owe DHS.

**Frequently Asked Questions**

<b>What if my tax refund is more than my past due account?</b>
<ul style="list-style-type: none"> <li>Your tax refund may be used to pay other agencies you owe money to.</li> <li>The rest of your tax refund will be sent to you.</li> </ul>
<b>Will DHS keep my spouse's share of the tax refund?</b>
<p><b>You can ask DHS to split your tax refund if:</b></p> <ul style="list-style-type: none"> <li>You and your spouse filed a tax return together (joint return), and</li> <li>Your spouse was not living in the home during the time for which the money is owed.</li> </ul> <p><b>Follow these steps:</b></p> <ol style="list-style-type: none"> <li>You must <b>write us a letter within 15 calendar days of the date on this notice</b>. Your letter needs to include: <ul style="list-style-type: none"> <li>Your full name and your spouse's full name</li> <li>Both of your social security numbers</li> <li>The account number shown at the top of this notice</li> <li>The reason why you want the tax refund split</li> </ul> </li> <li><b>Mail the letter to:</b> Iowa Department of Inspections and Appeals, Division of Investigations, Public Assistance Debt Recovery Unit, 3rd Floor, 321 E. 12<sup>th</sup> Street, Des Moines, IA 50319-0083</li> </ol> <p>The Department of Revenue will split your tax refund by the percentage of your spouse's net income.  <b>Example: If your spouse's income equals one-half (50 percent) of your total income, one-half of the tax refund will go to your spouse and the other one-half will be applied to the amount you owe DHS.</b></p> <p><b>Questions????</b> If you have questions about splitting your tax refund, call the Department of Inspections and Appeals (DIA) at <b>1-800-572-3945</b> (toll free).</p>
<b>Can I appeal this tax setoff?</b>
<ul style="list-style-type: none"> <li>If you do not agree with having your state tax refund used to pay the money that you owe DHS, you may appeal. Your appeal rights are explained on the back of this notice.</li> <li>You do <u>not</u> need to file an appeal to ask for your tax refund to be split. Follow the instructions above under "Will DHS keep my spouse's share of the tax refund?" If your tax split is denied, you may appeal.</li> </ul>

If you need help understanding this notice or if you need help with an appeal, you may call Iowa Legal Aid at **1-800-532-1275**. If you live in Polk County, call **243-1193**.

This action is taken under the authority granted in Iowa Code Sections 8A.504, and the Iowa Administrative Code, 441--11.4(217) and 170.9(5).

## 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
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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.

### 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?

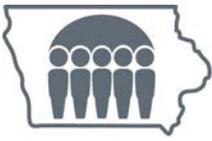
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### **Policy Regarding Discrimination, Harassment, Affirmative Action and Equal Employment Opportunity**

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](mailto:contactdhs@dhs.state.ia.us)

*(Food Assistance only)* USDA – Director, Office of Adjudication, 1400 Independence Ave SW, Washington, DC 20250-9410, or call 1-866-632-9992 voice. Individuals who are hearing impaired or have speech disabilities may contact USDA through the Federal Relay Service at 800-877-8339; or 800-845-6136 (Spanish).



Iowa Department of Human Services  
**Notice of Setoff of an Iowa Income Tax Refund  
 for Debts Owed the Iowa Department of Human Services**

Date Issued:

Account Number:

You owe money to the Department of Human Services (DHS). Either you have not made a satisfactory agreement to repay, or you have not kept your agreement to repay the money you owe.

As of the date on this notice the amount of past due debt on your account is \$ \_\_\_\_\_ The total you owe DHS may be more than this amount.

We are holding your Iowa income tax refund of \$ \_\_\_\_\_ to repay all or part of the past due amount you owe DHS.

**Frequently Asked Questions**

<b>What if my tax refund is more than my past due account?</b>
<ul style="list-style-type: none"> <li>Your tax refund may be used to pay other agencies you owe money to.</li> <li>The rest of your tax refund will be sent to you.</li> </ul>
<b>Will DHS keep my spouse's share of the tax refund?</b>
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# Iowa Department of Human Services

Terry E. Branstad  
Governor

Kim Reynolds  
Lt. Governor

Charles M. Palmer  
Director

Account/Case Number

Social Security Number

RE: Amount of past due debt owed to Agency: \$

Dear

You have not paid the amount you owe to the Department of Human Services (DHS). You owe this debt because

If you do not pay your debt or take other action described below before 60 days from the date of this letter, DHS will submit your debt to the U.S. Department of the Treasury (Treasury) for collection. Pursuant to the Debt Collection Act of 1982 (DCA), as amended by the Debt Collection Improvement Act 1996 (DCIA), and appropriate Supplemental Nutrition Assistance Program regulations, we are authorized to add penalties, fees, and other costs to your unpaid debt. Please note that the amount stated above is in addition to any other amount that may have been previously submitted by us to Treasury. DHS previously mailed or otherwise delivered a notice notifying you about the claim, including the right to a hearing on the claim, and has made any other required collection efforts. In addition to you having had an opportunity to request a hearing on the claim, the claim is:

- Equal to or exceeds the minimum amount established by Treasury;
- Not included under an automatic stay due to bankruptcy;
- Not currently under litigation; and
- Not currently being collected through allotment reduction or under a repayment plan that is currently approved by us.

Treasury collection: Once your debt is submitted, Treasury will reduce or withhold any of your eligible federal payments by the amount of your debt and may refer your debt to private collection contractors, the Department of Justice, or seek voluntary repayment. Collection of debts by Treasury is authorized by the DCA and DCIA. You may not receive another notice before your payment is offset. Federal payments eligible for offset include:

- Your income tax refunds, including any earned income tax credit payment you may be due (see attachment A for additional information);
- Up to 15% of federal salary pay, including military pay (See attachment A for additional information including how to request a waiver of this type of offset);
- Up to 25% of your federal retirement;
- Your military retirement pay;
- Your contractor/vendor payments;
- Other federal payments, including certain loans to you, that are not exempt from offset.

If you receive monthly federal payments, you should also know that the law allows Treasury to withhold a limited amount of certain monthly federal benefits, such as Social Security Retirement, Survivors and Disability benefits, Railroad Retirement (other than tier 2) benefits, and Black Lung Part B benefits, to pay back your debt. You would be entitled to keep at least \$750 per month or \$9,000 per year of your federal payments. Treasury policies finalized September 1998 limit withholding to an amount that is up to 15% of your benefit payment. If you receive Supplemental Security income disability benefits (SSI) from the Social Security Administration, those benefits will not be withheld to pay back your debt.

470-3797 (Rev. 8/15) H3797A

Before we submit your debt to Treasury, we are required to tell you that you may

In addition, the attachment to this letter provides important information if you and your spouse file a joint income tax return.

To avoid having your debt referred to Treasury you must do one of the following before 60 days from the date your notice has expired:

- **Repay your debt:** To repay your debt, send a check or money order, payable to the Department of Human Services for the full amount that you owe to: Iowa Department of Human Services, Cashiers Office, Rm 14, 1305 E Walnut Street, Des Moines, IA 50319-0114. Please include a statement with your payment that the payment is being made to avoid having your payment referred to the Department of Treasury for Food Assistance offset.
- **Agree to a repayment plan:** If you are unable to pay your debt in full, you must contact Overpayment Recovery, 1-888-462-2152, agree to a repayment plan acceptable to us, and make payments in the repayment plan.
- **Bankruptcy:** If you filed for bankruptcy and the automatic stay is in effect, you are not subject to offset or other collection actions while the stay is in effect. Please notify us of the stay by sending evidence concerning the bankruptcy to: Iowa Department of Inspections and Appeals, Division of Investigations, Lucas State Office Building, 321 E 12th Street, Des Moines, IA 50319-0083.

If you make or provide any knowingly false or frivolous statements, representations or evidence, you may be liable for penalties under the False Claims Act (31 U.S.C 3729-3731), or other applicable statutes, and or criminal penalties under 18 U.S.C 286,287,1001, and 1002, or other applicable statutes.

Unless prohibited by law or contract, we will promptly refund to you any amounts paid by you or deducted from your payment for your debt which are later waived or found not owed to the United States.

If you have any questions about this letter or your rights you should contact Public Assistance Debt Recovery Unit, 1-888-462-2152 immediately.

## ATTACHMENT A

### **If you file a joint income tax return:**

If you file a joint income tax return and your spouse was not a member of the Food Assistance household at the time the overpayment occurred, you should contact the Internal Revenue Service before filing your return regarding the steps to take to protect the share of the income tax refund which may be payable to your spouse, who is not the delinquent debtor to the U.S. Government.

### **If you are a federal employee:**

Your current net disposable pay is subject to offset if you do not pay your debt or take other action described above. Under the Treasury Offset Program (TOP), Treasury will deduct up to 15% of your disposable net pay beginning in the pay period that your debt is submitted for federal salary and wage offset and continuing every pay period until your debt plus fees, penalties, or other charges is paid in full.

When you are identified through TOP as receiving a federal salary or wage, you will be entitled to a hearing to dispute the existence or amount of the debt, or the amount of the payroll deduction. You will be provided information on where to file a written request for a hearing when you have been identified through TOP as receiving a federal salary or wage.

The timely filing of a petition for hearing will stay the commencement of offset proceedings for federal salary and wage offset; however, it will not stop offset of other types of federal payments. A final decision on the hearing (if one is requested) will be issued no later than 60 days after the filing of a petition requesting the hearing (unless extended by the hearing official).

As a federal employee, if you make or provide any knowingly false or frivolous statements, representations, or evidence, in addition to other penalties, you may be subject to disciplinary action.



### 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: <input type="checkbox"/> Self <input type="checkbox"/> Legal representative <input type="checkbox"/> Nearest living relative <input type="checkbox"/> 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 dates of service of the emergency. If you do not tell us the dates of service, when we receive this form (470-4299) we will assume the emergency began the first of the month of application and ends the last day of the following month.

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:
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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 médico 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: <input type="checkbox"/> Usted <input type="checkbox"/> Representante legal <input type="checkbox"/> Pariente vivo más cercano <input type="checkbox"/> 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 esta persona es aprobada para recibir Servicios de Atención Médica de Emergencia, el pago cubrirá los servicios necesarios para tratar una condición médica de emergencia durante las fechas en las que se preste el servicio para tratar la emergencia. Si usted no nos dice las fechas del servicio, cuando recibamos este formulario (470-4299) supondremos que la emergencia se inició el primer día del mes de la solicitud y que finaliza el último día del mes siguiente.

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:
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