



Iowa Department of Human Services

Terry E. Branstad
Governor

Kim Reynolds
Lt. Governor

Charles M. Palmer
Director

For Human Services use only:

General Letter No. 8-AP-406
Employees' Manual, Title 8
Medicaid Appendix

August 1, 2014

ALL PROVIDERS MANUAL TRANSMITTAL NO. 14-4

ISSUED BY: Iowa Medicaid Enterprise

SUBJECT: **ALL PROVIDERS MANUAL**, Chapter II, **Member Eligibility**, Table of Contents (pages 1 and 2), revised; pages 1 through 39, revised; and the following forms:

470-5200	<i>Application for Certification to Become a Qualified Entity (QE), new</i>
470-2582	<i>Memorandum of Understanding with a Presumptive Provider for Presumptive Medicaid Eligibility Determinations, revised</i>
470-5201	<i>Qualified Entity (QE) Medicaid Presumptive Eligibility Portal (MPEP) Access Request Form, new</i>
470-5170	<i>Application for Health Coverage and Help Paying Costs, new</i>
470-5170(S)	<i>Application for Health Coverage and Help Paying Costs (Spanish), new</i>
470-5192	<i>Addendum to Application for Presumptive Eligibility, new</i>
470-5192(S)	<i>Addendum to Application for Presumptive Eligibility (Spanish), new</i>

Summary

ALL PROVIDERS MANUAL Chapter II is revised to:

- ◆ Align with current policies, procedures, and terminology.
- ◆ Ensure that current contact information is provided.
- ◆ Replace forms with links to ensure that the most recent version of the form is accessible.

Date Effective

Upon receipt.

Material Superseded

This material replaces the following pages in the **ALL PROVIDERS MANUAL**:

<u>Page</u>	<u>Date</u>
Chapter II	
Contents (pages 1 and 2)	August 1, 2011
1, 2	August 1, 2011
470-2580 (samples)	8/11
470-2580(S) (samples)	8/11
470-4164	3/11
3-13	August 1, 2011
14-17	April 1, 2013
18	August 1, 2011
19, 20	April 1, 2013
21-24	August 1, 2011
470-2927	6/11
470-2927(S)	6/11
25, 26	August 1, 2011
470-4990	10/10
470-2582	7/11
27	April 1, 2013
28	August 1, 2011
470-4855	6/11
470-4855(S)	6/11
29-34	August 1, 2011
470-2579	3/11
35	August 1, 2011
36	April 1, 2013
37-42	August 1, 2011
470-2629	5/13
43	August 1, 2011
44	April 2, 2013
45-52	August 1, 2011
470-3864	7/01
470-3865	7/01
53-63	August 1, 2011

Additional Information

The updated provider manual containing the revised pages can be found at:

<http://dhs.iowa.gov/sites/default/files/All-II.pdf>

If any portion of this manual is not clear, please contact the Iowa Medicaid Enterprise Provider Services Unit at 800-338-7909 or locally (in Des Moines) at 515-256-4609, or email at imeproviderservices@dhs.state.ia.us.

ALL PROVIDERS

II. MEMBER ELIGIBILITY



**Iowa Department
of Human Services**



TABLE OF CONTENTS

	<u>Page</u>
CHAPTER II. MEMBER ELIGIBILITY	1
A. DEMONSTRATION OF ELIGIBILITY	1
1. <i>Medical Assistance Eligibility Card, Form 470-1911</i>	2
2. <i>Presumptive Medicaid Eligibility Notice of Decision, Form 470-2580</i>	2
3. Eligibility Verification	3
B. GROUPS COVERED BY MEDICAID	6
1. Aliens Receiving Emergency Services	6
a. <i>Verification of Emergency Health Care Services, Form 470-4299</i>	6
b. Covered Services	7
2. Children in Foster Care or Subsidized Adoptions or Guardianship	7
3. Members Related to the Family Medical Assistance Programs	8
4. Members Related to the Supplemental Security Income Program.....	8
5. Members Receiving State Supplementary Assistance.....	9
6. Members Residing in Medical Institutions	9
7. Members Under the Iowa Family Planning Network	10
8. Members Under the Iowa Wellness Plan	10
9. Members Under the Medically Needy Program	12
a. Medically Needy Conditional Eligibility	13
b. Submitting Claims for a Person with a Spenddown.....	14
c. <i>Medically Needy Expense Deletion Request, Form 470-3931</i>	15
10. Members Under the Qualified Medicare Beneficiary Program.....	15
11. Services to Members Under Waiver and Grant Programs.....	16
a. Home- and Community-Based Services Waivers.....	16
b. Program for All-Inclusive Care for the Elderly (PACE)	17
c. Money Follows the Person (MFP) Grant Services	17
12. People Who Need Treatment for Breast or Cervical Cancer.....	18
C. PRESUMPTIVE ELIGIBILITY OVERVIEW.....	19
1. Presumptive Provider Categories	20
2. Application to Become a Presumptive Provider Organization.....	20
3. Application to Become an Individual Qualified Entity	21
4. Completing the Application for Health Coverage and Help Paying Costs.....	22
5. Calculating Household Size and Income	27
a. MAGI-Medicaid Household Composition and Size	27
b. Treatment of Income under MAGI	27



Iowa
Department
of Human
Services

Provider and Chapter

All Providers

Chapter II. Member Eligibility

Page

2

Date

August 1, 2014

Page

6.	Steps in Making a Presumptive Eligibility Decision.....	28
7.	Appeal Rights.....	29
8.	Covered Services.....	30
9.	Period of Eligibility.....	31
D.	ELIGIBILITY CATEGORIES AND REQUIREMENTS OVERVIEW.....	34
1.	Presumptive Eligibility for Children.....	36
2.	Presumptive Eligibility for Pregnant Women.....	36
3.	Presumptive Eligibility for Individuals Who Need Treatment for Breast or Cervical Cancer.....	37
4.	Presumptive Eligibility for Iowa Health and Wellness Plan.....	37
5.	Expanded Medicaid for Independent Young Adults.....	38
6.	Presumptive Eligibility for Parents and Caretakers.....	39



CHAPTER II. MEMBER ELIGIBILITY

A. DEMONSTRATION OF ELIGIBILITY

Most members will demonstrate Medicaid eligibility through form 470-1911, *Medical Assistance Eligibility Card*. See [Medical Assistance Eligibility Card, Form 470-1911](#), for more information.

EXCEPTIONS:

A *Medical Assistance Eligibility Card* will not be issued to women or children whose eligibility has been determined presumptively by a qualified medical assistance provider will instead have form 470-2580 or 470-2580(S), 470-5190 or 470-5190(S), or 470-5191 or 470-5191(S). It is possible that a person has or will have Medicaid coverage, but does not yet have a *Medical Assistance Eligibility Card*. For example:

- ◆ When the Department accepts financial responsibility for a child in foster care, form 470-2747 or 470-2747(S), *Foster Care Provider Medical Letter*, may be issued to the foster care provider for use in obtaining the child's medical care.

This form assures providers that the child will eventually be authorized for Medicaid coverage under the identification number given (usually within 60 days).

Click [here](#) to view an English sample of the form.

Click [here](#) to view a Spanish sample of the form.

- ◆ People who have applied for Medicaid benefits may have form 470-2979, *Proof of Application for Medicaid*. This form verifies that the person has applied for Medicaid benefits, but eligibility has not been determined.

This form is used most often by people who may become eligible for Medically Needy coverage only after spending a certain amount on medical care (a "spenddown"). The person may ask the provider to submit claims to count toward the spenddown. See [Members Under the Medically Needy Program](#) for more information on Medically Needy eligibility and procedures. Click [here](#) to view a sample of the form.



Failure to present a *Medical Assistance Eligibility Card* for inspection does not necessarily mean that a person is ineligible for Medicaid. The provider may verify eligibility through the Iowa Eligibility Verification System (ELVS) or the IME web portal. See [Eligibility Verification](#) for more information on how to verify eligibility.

1. *Medical Assistance Eligibility Card, Form 470-1911*

The *Medical Assistance Eligibility Card* is issued to new Medicaid members at the time of approval. Each member (not each household) receives a wallet-sized plastic card plus two keychain cards. Replacement cards are issued upon the request of the member.

The cards display the member's name, state identification number, and birth date. The back of the card lists IME contact phone numbers for both members and providers. Click [here](#) to view a sample of the card.

Note that possession of the *Medical Assistance Eligibility Card* does not guarantee Medicaid eligibility. Call the Eligibility Verification System (ELVS) or access the IME web portal to verify the member's specific eligibility information. See [Eligibility Verification](#) for more information on how to verify eligibility.

NOTE: Not all mental health services are covered under fee-for-service reimbursement. Preauthorization is necessary for people enrolled in the Iowa Plan. ELVS or the web portal will indicate if the member is enrolled in the Iowa Plan.

2. *Presumptive Medicaid Eligibility Notice of Decision, Form 470-2580*

Possession of a *Presumptive Medicaid Eligibility Notice of Action* (forms 470-2580 or 470-2580(S), 470-5190 or 470-5190(S), or 470-5191 or 470-5191(S)), indicates that a qualified entity has determined that a person is presumptively eligible for Medicaid. This notice explains the results of the eligibility determination.

This decision entitles a person to time-limited Medicaid coverage as described in [Covered Services](#).

 Iowa Department of Human Services	Provider and Chapter All Providers Chapter II. Member Eligibility	Page 3
		Date August 1, 2014

3. Eligibility Verification

All providers of service should request and inspect the member's eligibility card on each occasion of service. The Eligibility Verification System (ELVS) and the IME secure web portal offer providers a fast, convenient method of verifying a member's Medicaid eligibility.

Either call the ELVS line or access the IME secure web portal to verify the following information:

- ◆ If Medicaid, Marketplace Choice or Iowa Wellness Plan eligibility exists for date of service.
- ◆ If the member is eligible for limited benefits such as:
 - Aliens eligible for "emergency medical services." (See [Aliens Receiving Emergency Services](#) for more information.)
 - Members eligible under the Iowa Family Planning Network who are covered for specific family planning services. (See [Members Under the Iowa Family Planning Network](#) for more information.)
 - Members eligible under a presumptive Medicaid program.
 - Members eligible under the qualified Medicare beneficiary (QMB) coverage group and eligible only for the Medicare deductibles and coinsurance. (See [Members Under the Qualified Medicare Beneficiary Program](#) for more information.)
- ◆ If the member is enrolled in managed care, including a health maintenance organization, a prepaid health plan, or the Medicaid patient access to service system.
- ◆ If the member is locked in to specific providers.
- ◆ If the member has third party liability.

Only providers enrolled in Medicaid can obtain this information. Use the Medicaid provider number to access these systems. Click [here](#) to be redirected to the web portal. To get authorization to use the web portal, submit an *Additional Access Request Form for Iowa Medicaid Real-Time Transactions* to EDI Support Services. Click [here](#) to view this form online.



ELVS is an automated response system that uses a touch-tone telephone to report:

- ◆ A member's eligibility status as of specific dates of service.
- ◆ Whether other third-party resources exist.
- ◆ The name of the third-party payers, if known.
- ◆ Medicaid HMO, MediPASS, or Iowa Health and Wellness Plan coverage (and telephone number).
- ◆ Services not covered by the member's managed health care plan.
- ◆ Any lock-in restrictions for the member.
- ◆ The amount of the member's Medically Needy spenddown balance for the certification period (including the date of service), if any.
- ◆ Vision and dental eligibility.

The system can also give the date and amount of a provider's last payment. ELVS can process up to five inquires per call.

ELVS should be accessed:

- ◆ At the time service is provided or requested.
- ◆ When a person presents a *Presumptive Medicaid Eligibility Notice of Decision*, form 470-2580 or 470-2580(S).
- ◆ To obtain remaining spenddown amount to be met by a member on Medically Needy.

To use ELVS:

1. Call the ELVS line at (800) 338-7752, or locally in Des Moines at (515) 323-9639.
2. ELVS will greet the caller and ask for a choice of information.
 - ◆ Press **1** to hear the help message.
 - ◆ Press **2** for member eligibility.
 - ◆ Press **3** for provider payment.
 - ◆ If the caller does not have a touch-tone telephone, please hold for further instructions.

When entering data, it is not necessary to wait for message completion. Begin entering data after the first word is spoken for each prompt.



3. ELVS will ask for the national provider identification (NPI) number. Please enter the ten-digit NPI number. If the Medicaid provider number is miskeyed or inactive, re-enter the number or end the call.
4. ELVS will ask for a member identification number. Please enter the first seven digits of the member's Medicaid ID number, followed by the pound sign (#). (ELVS does not use the letter at the end.)

If there is no Medicaid identification number, enter the member's date of birth using eight digits (month, day, and year as MMDDYYYY, e.g., 04232003) followed by the member's social security number (nine digits).

5. Enter the date of service using the eight-digit format (month, day, and year as MMDDYYYY, e.g., 04232003), or press **9** for the current date. ELVS will repeat the date and confirm whether the member is eligible for basic Medicaid services on that date. If the member has other resources available, that information will be disclosed.
6. After the eligibility information is spoken:
 - ◆ Press **1** to repeat eligibility information for this member.
 - ◆ Press **2** to enter a new member's identification number.
 - ◆ Press **3** to enter a new date of service for this member.
 - ◆ Press **4** for provider payment information.
 - ◆ Press **9** to end the call.
 - ◆ Press **0** to be transferred to the IME Provider Services Unit (between the hours of 7:30 a.m. to 4:30 p.m., Monday through Friday).

Due to time lags in transferring information from the eligibility system to the claims system, updated eligibility information may not always appear on ELVS when accessing the system. It takes ELVS two to three days to update.

A member with a Medically Needy spenddown obligation who does not have a *Medical Assistance Eligibility Card*, and for whom ELVS indicates ineligibility for Medicaid, may later be determined to be retroactively eligible. ELVS indicates the remaining spenddown to be met.

When the person does not have a *Medical Assistance Eligibility Card*, but there is reason to believe that the person may be eligible on a particular date of service, even though ELVS does not indicate this, contact the Department of Human Services for final verification.



B. GROUPS COVERED BY MEDICAID

1. Aliens Receiving Emergency Services

Medicaid benefits are available to pay for the cost of emergency services for an alien who does not meet Medicaid citizenship or alienage or social security number requirements. To be eligible for Medicaid benefits, such aliens must:

- ◆ Meet financial, categorical, and state-residency requirements, and
- ◆ Have had or currently have an emergency medical condition.

“Emergency medical condition” means a medical condition of sudden onset (including labor and delivery) manifesting itself by acute symptoms of such severity (including severe pain) that the absence of immediate medical attention could reasonably result in:

- ◆ Placing the member’s health in serious jeopardy.
- ◆ Serious impairment of bodily function.
- ◆ Serious dysfunction of any bodily part or organ.

Any person who might be eligible for Medicaid emergency benefits should be referred to the Department of Human Services for the county in which the person claims residence. See the [Map of DHS Offices](#) for a list of the addresses of Human Services offices.

a. **Verification of Emergency Health Care Services, Form 470-4299**

Since the necessity of emergency medical treatment is a condition of eligibility under this provision, the Department of Human Services will seek verification of the emergency.

Department income maintenance workers use form 470-4299 or 470-4299(S), *Verification of Emergency Health Care Services*, to obtain the date of service and to verify that an emergency service was received from the medical provider. Click [here](#) to view a sample of the English form on line. Click [here](#) to view a sample of the Spanish version online.

Complete the section, “To be completed by the provider.” It is important to provide all the information requested so that the Department can determine whether an emergency service was provided. Return this form to the Department of Human Services. Contact the Department of Human Services with any questions regarding this form.



Following this determination and a determination that all other factors of eligibility are met, the Department will issue a *Medical Assistance Eligibility Card*, form 470-1911, to the member.

The member (or someone acting on the member's behalf) must present this card to the providers of emergency service. The providers may then submit a claim for Medicaid payment in the usual manner.

b. Covered Services

Payment for treatment of an emergency medical condition is limited to:

- ◆ Inpatient or outpatient hospital services.
- ◆ Physician services.
- ◆ Services of an independent diagnostic laboratory or x-ray facility.

To be payable, care must be provided during the three-day period beginning with the date the member presented for treatment of the emergency condition, regardless of the length of time the emergency condition exists.

If the member presents for treatment later during that month for some other emergency condition, three days of treatment for that condition are also payable in that month once the emergency condition has been verified.

If an emergency condition again takes place during a later month, DHS must again determine eligibility and verify the existence of an emergency condition.

2. Children in Foster Care or Subsidized Adoptions or Guardianship

Medicaid covers children in foster care, subsidized adoption, or subsidized guardianship if the Department of Human Services is wholly or partially financially responsible for their support.

Iowa Medicaid covers children who are from another state but residing in Iowa in foster care, subsidized adoption, or subsidized guardianship if:

- ◆ The child receives federal funding under Title IV-E of the Social Security Act, or
- ◆ The state providing an adoption subsidy has entered into a reciprocity agreement with Iowa.



3. Members Related to the Family Medical Assistance Programs

The Medicaid program covers:

- ◆ Low-income children and their parents or needy caretaker relatives who are recipients of the Family Medical Assistance Program (FMAP) for people who would be eligible for the Iowa Family Investment Program as in effect on July 16, 1996.
- ◆ People terminated from FMAP because of increased earnings or increased child support.
- ◆ People under 21 who are ineligible for FMAP because they do not qualify as dependent children.
- ◆ Pregnant women and infants whose income is not more than 300 percent of the federal poverty level.
- ◆ Children aged 1 through 18 whose income is not more than 133 percent of federal poverty level.

4. Members Related to the Supplemental Security Income Program

The Medicaid program covers all beneficiaries of cash assistance under the Supplemental Security Income (SSI) program for low-income people who are aged, blind, or disabled, which is administered by the Social Security Administration. The Medicaid program also covers:

- ◆ Aged, blind, or disabled people who:
 - Are ineligible for SSI because of rules that don't apply to Medicaid, or
 - Would be eligible for SSI if certain conditions were met (e.g., if changes in disability criteria or increases in social security benefits due to cost of living or actuarial changes were not considered).
- ◆ Medicaid for employed people with disabilities (MEPD) who:
 - Are under age 65.
 - Are considered disabled based on SSI medical criteria.
 - Have earned income from employment or self-employment.
 - Have resources under \$12,000 (individual) or \$13,000 (couple).
 - Have net family income of less than 250 percent of the federal poverty level.
 - Pay a premium assessed for each month of eligibility if gross income is over 150 percent of the federal poverty level.



- ◆ Children under age 19 (“kids with special needs” or MKSN) who:
 - Are considered disabled based on SSI disability criteria.
 - Have gross family income at 300 percent of the federal poverty level or less.
 - Are enrolled in a parent’s employer’s group health insurance when the employer pays at least half of the annual cost of premiums.

5. Members Receiving State Supplementary Assistance

People who receive State Supplementary Assistance are eligible for Medicaid. State Supplementary Assistance is a state program that makes a cash assistance payment to certain SSI beneficiaries and people that are not eligible for SSI due to income slightly exceeding the SSI standard.

The monthly State Supplementary Assistance payment supplements the person’s income to meet the cost of special needs, including residential care, in-home health-related care, family-life home care, a dependent person, or special needs due to blindness. Certain people eligible for both Medicare and Medicaid receive a small State Supplementary Assistance payment quarterly.

6. Members Residing in Medical Institutions

People who reside in a medical institution (a hospital, nursing facility, psychiatric institution, or intermediate care facility for the intellectually disabled) for a full calendar month may be eligible for Medicaid.

These people must meet all eligibility requirements for SSI, except that their monthly income may be such that they would be ineligible to receive cash assistance through the SSI program.

There is a special Medicaid income limit in effect for people in medical institutions. To be eligible in terms of income, the person’s monthly income may not exceed 300 percent of the basic SSI benefit. This limit generally increases on January 1 of each year, as increases occur in the basic SSI benefit.

 Iowa Department of Human Services	Provider and Chapter All Providers Chapter II. Member Eligibility	Page 10
		Date August 1, 2014

7. Members Under the Iowa Family Planning Network

The Iowa Family Planning Network provides limited Medicaid coverage. It is available to people who are capable of reproducing, who are not pregnant and who:

- ◆ Were Medicaid members at the time their pregnancy ended, or
- ◆ Are over age 12 and under age 55 and have countable income no greater than 300 percent of the federal poverty level.

Eligibility continues for 12 consecutive months beginning with:

- ◆ The month after the postpartum period ends for people who had a pregnancy end while a Medicaid member, or
- ◆ The first month in which eligibility is established for people who have income at or below 300 percent of the federal poverty level.

During the period of eligibility, a woman or man is entitled to limited Medicaid benefits. Covered services are limited to those that are either primary or secondary to family planning services. Payable services are found in Chapter III of the [Iowa Family Planning Network Waiver](#) manual.

8. Members Under the Iowa Wellness Plan

The Iowa Wellness Plan covers individuals aged 19-64:

- ◆ That are not eligible for other Medicaid coverage groups,
- ◆ That are not pregnant,
- ◆ That are not entitled to or enrolled in Medicare,
- ◆ Whose countable income does not exceed 100 percent of the Federal Poverty Level for their household size, and
- ◆ If there are dependent children, the children are covered by essential health benefits.

Individuals apply for coverage under the Iowa Wellness Plan by visiting the Federal website Healthcare.gov or by completing a DHS application.

- ◆ Click [here](#) to be re-directed to the Healthcare.gov website.
- ◆ Click [here](#) to access the DHS application online.



The Iowa Wellness Plan provides a comprehensive benefit package that ensures coverage for all of the Essential Health Benefits (EHB) as required by the Affordable Care Act (ACA). The EHB and other benefits covered include:

- ◆ Physician services, including primary care.
- ◆ Outpatient services.
- ◆ Emergency room services and emergency transportation (ambulance).
- ◆ Hospitalization.
- ◆ Mental health and substance use disorder services and treatments.
- ◆ Rehabilitative and habilitative services and devices (physical, occupational, and speech therapy, etc.).
- ◆ Lab services, x-rays, imaging (MRI, CT, etc.).
- ◆ Preventive and wellness services.
- ◆ Home- and community-based services for people with chronic mental illness.
- ◆ Prescription drugs.

After enrollment, Iowa Wellness Plan members will have 90 days to select a patient manager from the list of Iowa Wellness Plan-enrolled primary care providers. Until a patient manager has been selected the members are eligible as fee-for-service.

The patient manager provides the member a “medical home.” This provider has the responsibility of:

- ◆ Coordinating and monitoring necessary medical care,
- ◆ Acting as a monitor to assure appropriate utilization of services, and
- ◆ Serving as an advocate for the member who might not otherwise seek appropriate medical care.

The patient manager is also responsible for authorizing all referrals when necessary.



Medically Exempt Individuals

Individuals that likely have the need for coverage of some services beyond what is found in the Iowa Wellness Plan may be identified as “medically exempt.” Exempt individuals will have a choice between the Iowa Wellness Plan and the “regular” Medicaid state plan benefit, which offers more comprehensive coverage.

“Medically exempt” is defined in 42 CFR § 440.315(f) as including individuals with:

- ◆ Disabling mental disorders (including adults with serious mental illness),
- ◆ Chronic substance use disorders,
- ◆ Serious and complex medical conditions,
- ◆ A physical, intellectual or developmental disability that significantly impairs their ability to perform one or more activities of daily living, or
- ◆ A disability determination based on Social Security criteria.

9. Members Under the Medically Needy Program

The Medically Needy program provides medical coverage to people who are pregnant, under age 21, caretaker relatives, aged, blind, or disabled, and would qualify for Medicaid programs, other than the Iowa Wellness Plan, except that:

- ◆ They have slightly too much income or resources, or
- ◆ They have higher incomes but have unusually high medical expenses.

The Medically Needy income level is based on family size. Members whose income is equal to or less than the Medically Needy income level are eligible for Medicaid through the Medically Needy program.

Members who meet all eligibility factors for the Medically Needy program except for income are allowed to reduce their excess income through incurred medical expenses. This process is called spenddown.

Members who have a Medically Needy spenddown obligation are “conditionally eligible” for Medicaid until they have verified enough medical expenses to meet their spenddown for that certification period. Information about the status of these members is available through the Eligibility Verification System (ELVS). See [Eligibility Verification](#) for more information.



Eligibility for Medically Needy members is based on a certification period. For people with a spenddown obligation, the certification period is two months. A new application is required before eligibility can be re-established.

Medical Assistance Eligibility Cards are issued for Medically Needy members:

- ◆ Who do not have a spenddown amount, or
- ◆ Who have met their spenddown obligation.

NOTE: Not all mental health services are covered under fee-for-service reimbursement. Preauthorization is necessary for people enrolled in the Iowa Plan. ELVS or the web portal will indicate if the member is enrolled in the Iowa Plan.

Medically Needy members are entitled to receive all services covered by Medicaid except:

- ◆ Care in a nursing facility,
- ◆ Care in an institution for mental disease,
- ◆ Care in an intermediate care facility for the intellectually disabled.

Expenses used to meet spenddown are not payable by Medicaid. See [Medically Needy Conditional Eligibility](#) for information on how this affects billing and payment for services provided.

a. Medically Needy Conditional Eligibility

A member with a spenddown may not have a *Medical Assistance Eligibility Card* when service is requested, but may have met the spenddown, or may later be determined to be eligible retroactively.

Expenses used for spenddown are considered as a deductible and are not paid by Medicaid. Medicaid may cover a service provided before the member receives a *Medical Assistance Eligibility Card* if the service was not used to meet the spenddown obligation.

Expenses used to meet spenddown can include both services that would be covered by Medicaid if spenddown were met and services that would not be covered by Medicaid, such as a service provided before the Medically Needy certification period that remains unpaid at the beginning of the period.



Members who have successfully reduced their excess income through spenddown are notified what bills were used for spenddown and are, therefore, their personal obligation.

When a member has met spenddown, but eligibility has not yet been updated to reflect Medicaid coverage for the certification period, ELVS will report that the remaining spenddown is zero. The time lag between the spenddown reaching zero and the eligibility update showing the member as Medicaid-eligible should be no longer than two days.

b. Submitting Claims for a Person with a Spenddown

Once it is determined through ELVS that a conditionally eligible member has a spenddown balance to meet, submit claims for services for the member or responsible relative to the IME just as if the member were eligible for Medicaid, using claim forms or electronic billing.

If the member has not met spenddown, the IME will apply the claim to the spenddown balance. Claims that are used to meet spenddown will be denied for Medicaid payment. The amount used for spenddown will be listed on the *Remittance Statement*. Claims that are not used to meet spenddown or are only partially used to meet spenddown are automatically resubmitted for Medicaid payment.

In order for expenses to be accurately applied towards spenddown, the provider must bill a member's other insurance or Medicare before submitting the claim to the IME.

Claims will not be forwarded for spenddown processing and must be corrected and resubmitted if:

- ◆ They have missing or incorrect data (invalid procedure, national drug code, diagnosis, date of service, etc.).
- ◆ They post any edits for spenddown (EOB 480), insurance, or invalid data.
- ◆ The member's information is not on the Medically Needy system (EOB 270).



Conditionally eligible members who have “old bills” or other expenses that will not be Medicaid-payable need to have verification of these bills to apply the bills to their spenddown obligation and achieve Medicaid eligibility for current covered expenses. These claims cannot be filed electronically or submitted directly to the IME.

Submit claims for such services to the member’s income maintenance worker in the Department of Human Services. See the [Map of DHS Offices](#) for a list of the addresses of Human Services offices. The worker will attach the necessary documentation to the claim and forward it to the IME for spenddown processing.

c. *Medically Needy Expense Deletion Request, Form 470-3931*

When a prescription is filled and billed to Medicaid for a potentially eligible Medically Needy member, but the member does not pick up the prescription, the pharmacy must complete form 470-3931, *Medically Needy Expense Deletion Request*.

Click [here](#) to view a sample of this form on line. Fax the completed form to the IME as soon as possible to prevent claims for services not used to meet spenddown by the Medically Needy member.

10.Members Under the Qualified Medicare Beneficiary Program

The Medicare Catastrophic Coverage Act of 1988 mandated a coverage group for qualified Medicare beneficiaries (QMB). QMB coverage provides for limited Medicaid payment. Medicaid pays only for Medicare premiums (Part A or B), coinsurance, and deductibles.

To qualify for QMB, a person must:

- ◆ Be entitled to hospital insurance benefits under Part A of Medicare.
- ◆ Be within the income and resource limits specific to QMB.
- ◆ Meet all other Medicaid eligibility requirements.

Income eligibility for QMB exists if the household’s income does not exceed 100 percent of the federal poverty level. Net countable income is determined using Supplemental Security Income (SSI) income policies.



The 2013 QMB resource limits are the same as the resource limits for full premium subsidy under the Extra Help for Medicare Part D Drug Plan: \$7,080 for an individual and \$10,620 for a couple. SSI resource policies apply when determining countable resources.

A member can be concurrently eligible for QMB and Medically Needy. Members who are conditionally eligible for Medically Needy and are eligible for QMB are entitled only to services covered under QMB until spenddown is met. Once spenddown is met, they are then entitled to Medicaid benefits payable under Medically Needy.

Eligibility for QMB becomes effective the first day of the month following the month of decision. Each person eligible for QMB is issued a *Medical Assistance Eligibility Card*, form 470-1911.

11. Services to Members Under Waiver and Grant Programs

a. Home- and Community-Based Services Waivers

Home- and community-based services (HCBS) waivers provide a variety of services in a member's home that are not available through regular Medicaid. Services provided under the waivers are not available to other Medicaid members.

The total costs of these services and regular Medicaid cannot exceed the total cost of care and services provided in a medical institution. There are currently seven HCBS waivers, targeting the following groups:

- ◆ *AIDS/HIV* provides services for people with acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV) infection who would otherwise require care in a medical institution.
- ◆ *Brain Injury (BI)* provides services for people with a specific brain injury diagnosis to allow them to live in the community.
- ◆ *Child Mental Health (CMH)* provides services for children with a serious mental, behavioral, or emotional disorder.
- ◆ *Elderly* provides services to elderly Iowa residents so they can stay in the home instead of entering a nursing facility.



- ◆ *Health and Disability (HD)* provides services to blind or disabled people who otherwise would need care in a nursing facility, skilled nursing facility, or an intermediate care facility for the intellectually disabled.
- ◆ *Intellectual Disabilities (ID)* provides services to people with a primary diagnosis of intellectual disability who would otherwise require care in a medical institution.
- ◆ *Physical Disabilities (PD)* provides services for people with a physical disability.

b. Program for All-Inclusive Care for the Elderly (PACE)

PACE allows enrolled Medicaid members to stay healthy and live in the community as long as possible. PACE is a seamless way of providing “managed” long-term care to Medicaid members.

PACE is similar to the Medicaid home- and community-based service (HCBS) waiver programs in that members must live in the community and must meet the nursing facility level of care in order to qualify.

PACE eligibility differs from HCBS waiver programs because Medicaid members who are enrolled in PACE continue to be eligible for PACE services if they become a resident of a medical institution.

The PACE provider receives a monthly capitation payment for each PACE enrollee, and in turn, is responsible for ensuring that enrollees receive any services determined necessary for their health and well-being.

c. Money Follows the Person (MFP) Grant Services

MFP grant services provide an opportunity for people to move out of intermediate care facilities for people with an intellectual disability (ICF/ID) and into their own homes in the community of their choice. As of 2014, MFP grant funds are also available to individuals with an intellectual disability and brain injury living in nursing facilities.



Grant funds provide funding for the transition services and enhanced supports needed for the first year after a person transitions into the community. MFP assistance is available to people who:

- ◆ Have a diagnosis of intellectual disability or brain injury,
- ◆ Have lived in an ICF/ID for at least 90 days,
- ◆ Have expressed an interest in moving from a nursing facility or ICF/ID into the community, and
- ◆ Need home- and community-based services (HCBS) in order to successfully reside in a community-based setting.

The MFP Program helps participants locate a place to live and arrange for medical, rehabilitative, home health, and other services in the community, as needed. MFP participants are covered by the program for 365 days, after which time, an HBCS waiver will provide ongoing services.

The MFP grant provides enhanced funding for services intended to support a successful transition and to help support participants in community living. The assistance of a transition specialist (TS) in coordinating transition planning, implementation, and follow-up in securing essential services is included.

12. People Who Need Treatment for Breast or Cervical Cancer

Medicaid is available to people who:

- ◆ Are under the age of 65, and
- ◆ Have been screened and diagnosed:
 - Through the Breast and Cervical Cancer Early Detection Program (BCCEDP), or
 - By any provider or entity and BCCEDP has elected to include screening activities by that provider or entity.
- ◆ This screening includes breast or cervical cancer screenings or related diagnostic services provided or funded by family planning or centers, community health centers, or nonprofit organizations, and the screenings or services are provided to individuals who meet the eligibility requirements established by the BCCEDP, and



- ◆ Have been found to need treatment for either breast or cervical cancer (including a pre-cancerous condition), and
- ◆ Do not otherwise have creditable coverage, as that term is defined by the Health Insurance Portability and Accountability Act, and
- ◆ Are not eligible under another mandatory Medicaid coverage group.

Eligibility continues until the person is:

- ◆ No longer receiving treatment for breast or cervical cancer,
- ◆ No longer under the age of 65, or
- ◆ Covered by creditable health coverage or Medicare.

During the period of eligibility, a person is entitled to full Medicaid coverage. Covered services are not limited to treatment of breast or cervical cancer.

C. PRESUMPTIVE ELIGIBILITY OVERVIEW

Legal reference: 42 USC § 1396a(a)(47)(b), 1396r-1, 1a, 1b;
42 CFR 435.1100-1103, 435.1110, 457.355;
Iowa Code 249A.3(1)(i), 249A.3(2)(a)(b)(2);
441 IAC 7.5(2)“a”(6); 75.1(30), (40), (44);
76.1(249A), 76.7(249A)

The goal of the presumptive eligibility process is to offer immediate health care coverage to individuals likely to be Medicaid eligible, before there has been an ongoing Medicaid determination.

Individuals can enroll in presumptive eligibility for a limited time before ongoing Medicaid applications are filed and processed, based on a determination of likely Medicaid eligibility from an approved provider. Based only on an individual's statements regarding household income and circumstances, a presumptive provider can “presume” that a patient will be eligible for Medicaid.

Presumptive providers can grant temporary Medicaid coverage to these individuals to pay for the cost of certain types of care during the presumptive period.



1. Presumptive Provider Categories

A presumptive provider is any organization that has been approved by the Department to conduct and authorize presumptive eligibility determinations.

The term “presumptive provider” applies to:

- ◆ A provider who has been designated a “qualified Medicaid provider” pursuant to 42 USC § 1396r-1 and 441 IAC 75.1(30)“a” related to presumptive eligibility for pregnant women;
- ◆ A provider who has been designated a “qualified Medicaid provider” pursuant to 42 USC § 1396r-1b and 441 IAC 75.1(40)“c”(1) for presumptive eligibility under the Breast and Cervical Cancer Treatment (BCCT) program;
- ◆ A provider who has been designated a “qualified entity” pursuant to 42 USC § 1396r-1a, 42 CFR § 435.1101 and 441 IAC 75.1(44)“a” related to presumptive eligibility for children; or
- ◆ A provider who has been designated a “qualified hospital” pursuant to 42 USC § 1396a(a)(47)(b), 42 CFR §435.1110, and 441 IAC 76.1(249A) related to presumptive eligibility determinations made by hospitals.

Presumptive providers are prohibited from performing presumptive eligibility determinations for Department programs for which they have not been designated by the Department as a presumptive provider for that program.

Pursuant to 42 CFR 435.1102(b)(2)(vi), only employees of the presumptive provider may be given the authority to make presumptive eligibility determinations. A presumptive provider may not delegate the authority to determine presumptive eligibility to another entity, subcontractor, or agent.

2. Application to Become a Presumptive Provider Organization

A “**presumptive provider (PP)**” is an organization, approved by the Department, to conduct and authorize PE determinations. The presumptive provider must meet the requirements outlined in the *Application for Certification to Become a Qualified Entity (QE)*. A presumptive provider organization that seeks to be authorized to make presumptive Medicaid eligibility determinations shall apply to DHS on form 470-5200, *Application for Certification to Become a Qualified Entity (QE)*. Click [here](#) to view the form online.



Iowa Department of Human Services
**Application for Certification to Become
a Qualified Entity (QE)**

This form is to be used by providers as an application to be certified by the Iowa Department of Human Services (DHS) as a Qualified Entity (QE) to make presumptive eligibility (PE) determinations.

Please check an eligibility category (check all that apply)

- Parents/Caretaker Relatives
Individuals 19-64 years old
Former Foster Care Children
Children
Pregnant Women
- Children
- Pregnant Women
- Breast & Cervical
Cancer Treatment
Patients

Provider / Organization Name		Date
Address		
City		State / Zip
Telephone	NPI Number	
Contact Name	Contact Email	
Admin Name	Admin Email	

- Please check here if you agree to receive future relevant provider information from the Iowa Medicaid Enterprise (IME) using this email address. This email address will not be given out and will not be used for any other purpose.

Are you currently enrolled as an Iowa Medicaid provider?

- YES NO

HOSPITAL GROUPS

If you are an Iowa Medicaid enrolled hospital, you will be able to complete PE determinations for the following eligibility categories if you are certified as a QE:

- Parents and Caretaker Relatives
- Individuals 19 to 64 years old
- Former Foster Care Children under the age of 26
- Children
- Pregnant Women

PREGNANT WOMEN

If you are an eligible provider and if you are certified as a QE, you will be able to complete PE determinations for the eligibility category Pregnant Women.

Please check all the appropriate boxes in order for Iowa Medicaid to determine if you can be certified as a QE for this eligibility category.

1. Do you provide the following services?

- | | | |
|---|-----|----|
| A. Rural health clinic services | Yes | No |
| B. Clinic services furnished by or under the direction of a physician | Yes | No |

2. Do you receive direct funds (not subcontract) under any of the following?

- | | | |
|--|-----|----|
| A. Migrant health centers (under Section 329 or 330 of the Public Health Services Act) | Yes | No |
| B. Community health centers (under Section 329 or 330 of the Public Health Services Act) | Yes | No |
| C. Maternal and child health centers (under Title V of the Social Security Act) | Yes | No |
| D. Health services for urban Indians (under Title V of the Indian Health Care Improvement Act) | Yes | No |

If yes, attach a copy of the award letter or other verification of funding.

3. Do you participate in any of the following programs?

- | | | |
|---|-----|----|
| A. Special Supplemental Food Programs for Women, Infants and Children (WIC) | Yes | No |
| B. Commodity Supplemental Food Program | Yes | No |
| C. A state perinatal program | Yes | No |

If yes, attach a copy of documentation showing your agency's participation in the program.

4. Are you an Indian Health Service or a health program or facility operated by a tribe or tribal organization under the Indian Self Determination Act?

- | | |
|-----|----|
| Yes | No |
|-----|----|

For provider eligibility reviews only:

If your answer to Question 1,2,3, or 4 above recently changed from Yes to No, list the service/funding/program participation that changed and the date of the change in the space provided below:

CHILDREN

If you are an eligible provider and if you are certified as a QE, you will be able to complete PE determinations for the eligibility category Children.

Please indicate your provider type:

Rural Health Clinics	Family Planning Centers
Local Education Agencies	Screening Centers
Maternal Health Centers	Area Education Agencies
Federally Qualified Health Centers (FQHC)	Nurse Practitioner - Advanced
Hospitals	Early Access Services Coordinators
Physicians	Indian Health Services

BREAST & CERVICAL CANCER TREATMENT PATIENTS (BCCT)

If you are an eligible provider and if you are certified as a QE, you will be able to complete PE determinations for the eligibility category BCCT.

1. Are you under contract with the Iowa Department of Public Health as lead agency for the Breast and Cervical Cancer Early Detection Program?

Yes No

If yes, please indicate which county(ies):

2. Do you have a cooperative agreement with the Iowa Department of Public Health under the Center for Disease Control and Prevention Breast and Cervical Cancer Early Detection Program to receive reimbursement for providing breast or cervical cancer screening or diagnostic services to participants in the Care for Yourself Breast and Cervical Cancer Early Detection Program?

Yes No

Signature and Date (print name and date then read and check the statement below)

By signing this document I understand that any false statement, omission or misrepresentation may result in prosecution under state and federal laws.

This form will be reviewed and a decision to approve or deny will be made. An email will be sent by IME Provider Enrollment when this process is complete to the email address listed on this form. This should take no more than 2 business days. Contact IME Provider Enrollment at 1-800-338-7909 for assistance in completing this form.

You may fill out, print, and mail or fax the completed form to:

Iowa Medicaid Enterprise
 Provider Services Unit
 PO Box 36450
 Des Moines, IA 50315
 Fax to (515) 725-1155
 Email: IMEMPEPsupport@dhs.state.ia.us



Memorandum of Understanding with a Presumptive Provider for Presumptive Medicaid Eligibility Determinations

Presumptive Medicaid Eligibility Provider General Terms

Goal of Presumptive Programs:

The goal of each presumptive program offered by Iowa Medicaid is to provide potentially eligible applicants with an easily accessible method of establishing Medicaid eligibility in order to:

- ◆ Allow the applicant to receive early and adequate pregnancy determinations and other ambulatory prenatal medical care;
- ◆ Improve early and adequate treatment for breast and cervical cancer to participants of the Iowa Care for Yourself Breast and Cervical Cancer Early Detection Program (BCCEDP);
- ◆ Provide children an opportunity to access Medicaid-covered services, including those under the EPSDT program; and
- ◆ Provide Medicaid during a presumptive eligibility period to individuals who are determined eligible by a qualified hospital.

To the extent that the Presumptive Provider is a current Iowa Medicaid provider, this Agreement is supplementary to the usual provider agreement entered into for participation in the Iowa Medical Assistance Program and all provisions of that agreement shall remain in full force and effect, except to the extent superseded by the specific terms of this Presumptive Provider agreement. This Agreement supersedes and replaces any former agreements the parties may have entered into addressing the Presumptive Provider providing presumptive eligibility services.

Definition:

For purposes of these General Terms, the term “Presumptive Provider” means:

- ◆ A provider who has been designated a “qualified Medicaid provider” pursuant to Title XIX, Sec. 1920 of the Social Security Act and 441 Iowa Admin. Code §75.1(30)(a) related to presumptive eligibility for pregnant women;
- ◆ A provider who has been designated a “qualified Medicaid provider” pursuant to Title XIX, Sec. 1920B of the Social Security Act and 441 Iowa Admin. Code §75.1(40)(c)(1) for presumptive eligibility under the Breast and Cervical Cancer Treatment (BCCT) program;
- ◆ A provider who has been designated a “qualified entity” pursuant to Title XIX, Sec. 1920A of the Social Security Act, 42 CFR §435.1101 and 441 Iowa Admin. Code § 75.1(44)(a) related to presumptive eligibility for children; and
- ◆ A provider who has been designated a “qualified hospital” pursuant to Title XIX, Sec. 1902(a)(47)(B) of the Social Security Act, 42 CFR §435.1110, and 441 Iowa Admin. Code §76.1 related to presumptive eligibility determinations made by hospitals.

Presumptive Providers are prohibited from performing presumptive eligibility determinations for Department programs for which they have not been designated by the Department as a Presumptive Provider for that program.

The term “Presumptive Provider” applies equally to individual Presumptive Providers, Presumptive Provider organizations, and individual providers within those organizations to whom the organizations have delegated presumptive eligibility determination authority. Pursuant to 42 CFR 435.1102(b)(2)(vi), **only employees** of the qualified entity may be given the authority to make presumptive eligibility determinations. A qualified entity **may not** delegate the authority to determine presumptive eligibility to another entity, subcontractor, or agent.

The Presumptive Provider will:

- ◆ Participate in all trainings required by the Department.
- ◆ Become certified to make presumptive eligibility determinations as required by the Department.

- ◆ Notify the Department when an organization's Presumptive Provider who has access to the presumptive system should have that access terminated.
- ◆ Assist the applicant in understanding the presumptive eligibility program by answering any questions or, if unable to answer, directing the applicant to the appropriate source for the answer, such as the Department.
- ◆ **For BCCT presumptive program only:** Identify individuals as candidates for screening services as provided in its cooperative agreement with the Centers for Disease Control Prevention Breast Cervical Cancer Early Detection Program (BCCEDP), established under Title XV of the Public Health Service Act. Assist individuals screened and diagnosed with a pre-cancerous or cancerous breast or cervical condition under the BCCEDP program in establishing Medicaid eligibility.
- ◆ Encourage individuals who may potentially be eligible to apply for presumptive Medicaid. Assist in the completion of the presumptive Medicaid application as needed.
- ◆ **For pregnant women or BCCT presumptive programs only:** Explain that the applicant may choose to have the provider electronically forward the information provided on *Application for Health Coverage and Help Paying Costs*, form 470-5170 or 470-5170(S), and *Addendum to Application for Presumptive Eligibility*, form 470-5192 or 470-5192(S), to the Department for an ongoing Medicaid eligibility determination. The provider will reflect the individual's choice when using the Department's web-based eligibility determination system. Encourage and assist individuals who are potentially eligible for ongoing Medicaid to follow through with the process.
- ◆ **For presumptive for children and presumptive by hospitals only:** Explain to the applicant that the information provided on *Application for Health Coverage and Help Paying Costs*, form 470-5170 or 470-5170(S), and *Addendum to Application for Presumptive Eligibility*, form 470-5192 or 470-5192(S), will always be automatically forwarded to the Department electronically for an ongoing Medicaid eligibility determination. Encourage and assist applicants who are potentially eligible for ongoing Medicaid to follow through with the process.
- ◆ Use the Department's web-based system to make the presumptive eligibility determination, based on the information provided by the applicant.
- ◆ Establish presumptive Medicaid eligibility consistent with all applicable Department rules using forms furnished by the Department in a paper or electronic format. Explain to the applicant that presumptive eligibility may begin no earlier than the date a valid application is received by the presumptive provider.
- ◆ Explain to the applicant that, if eligible, presumptive Medicaid usually lasts from the date of approval until the end of the next month, but presumptive eligibility can end at any time without notice.
- ◆ If a paper application is filed, submit the application in the Department's web-based presumptive eligibility determination system within three working days of the date the paper application is received.
- ◆ If a paper application was not filed, print and have the applicant sign and date the electronic application summary before submitting the completed application in the Department's web-based system. Keep the original signed and dated electronic application summary in the provider's eligibility file. Give a copy to the applicant.

- ◆ Notify the applicant of the decision on the application by printing the *Presumptive Medicaid Eligibility Notice of Action* (form 470-2580 or 470-2580 (S), 470-5190 or 470-5190 (S), or 470-5191 or 470-5191 (S)), from the Department's web-based system and giving or mailing it to the applicant as soon as possible but no later than two working days after the date of determination. Keep a copy of this notice in the provider's eligibility file.
- ◆ Obtain from the Department and provide to the presumptively eligible applicant a state identification number.
- ◆ Participate in communications between both parties necessary to promote mutual understanding, expeditious eligibility determinations, and proper billing.
- ◆ Use any information provided by the Department under this Agreement solely for the purpose of determining eligibility of persons applying for presumptive Medicaid under the authority granted to it by the laws of the state of Iowa.
- ◆ Keep complete records for a period of five years on all applications and make them available upon a state or federal review and audit.

The Department will:

- ◆ Provide direction to the Presumptive Provider regarding the processing of the presumptive Medicaid eligibility.
- ◆ Provide supplies necessary for the Presumptive Provider to perform their responsibilities, i.e., applications, brochures, notices, and other materials.
- ◆ Honor the presumptive Medicaid eligibility determinations made by the Presumptive Provider when the determinations have been made in accordance with the policies and procedures established by the Department.
- ◆ Participate in communications between both parties necessary to promote mutual understanding, expeditious eligibility determinations, and proper billing.
- ◆ Provide education, training, and technical assistance to the Presumptive Provider.
- ◆ Adhere to all existing policies and procedures governing Iowa's Medicaid program related to billing, prior approval, reimbursement, etc.

Confidentiality:

Information of the Department, which identifies clients and services, is confidential in nature. The Presumptive Provider and its employees, agents, and subcontractors shall be allowed access to such information only as needed for providing services pursuant to this Agreement. The Presumptive Provider shall not use confidential information for any purpose other than carrying out the Presumptive Provider's obligations under this Agreement. The Presumptive Provider shall establish and enforce policies and procedures for safeguarding the confidentiality of such data. The Presumptive Provider may be held civilly or criminally liable for improper disclosure. The Presumptive Provider shall promptly notify the Department of any request for disclosure of confidential information received by the Presumptive Provider. The Presumptive Provider shall not disclose any information provided by the Department under this Agreement to any other person or entity without the prior written consent of the Department. Consent is not required for disclosure of such information to the applicant to whom the information pertains.

The Presumptive Provider, acting as the Department's Business Associate, performs certain services on behalf of or for the Department pursuant to this Agreement that require the exchange of information that is protected by the Health Insurance Portability and Accountability Act of 1996, as amended by Subtitle D of the Health Information Technology for Economic and Clinical Health Act, Title XIII of Division A and Title IV of Division B of the American Recovery and Reinvestment Act of 2009 (Pub. L. No. 111-5) and the federal regulations published at 45 CFR. parts 160 and 164. The Presumptive Provider agrees to comply with the Business Associate Agreement Addendum (BAA), and any amendments thereof, as posted to the Department's website: <http://www.dhs.state.ia.us/Consumers/Health/HIPAA/Home.html>.

The Presumptive Provider acknowledges that it may be receiving, storing, processing, or otherwise dealing with confidential patient records from programs covered by 42 CFR part 2, and the Presumptive Provider acknowledges that it is fully bound by those regulations. The Presumptive Provider will resist in judicial proceedings any efforts to obtain access to patient records except as permitted by 42 CFR part 2.

These confidentiality obligations survive termination or expiration of this Agreement.

Term and Termination:

- a. This Agreement is effective from the date of the Department's issuance of written (includes electronic) confirmation of acceptance of the Presumptive Provider. Absent early termination of the Agreement consistent with the terms of this Agreement, the Agreement shall expire six years from the date the Department issues confirmation of acceptance of the Presumptive Provider.
- b. The Presumptive Provider shall notify the Department within thirty days of any change in licensure, address, practice, or any other factor that may impact participation in the presumptive program.
- c. Termination of this agreement is governed by the following provisions:
 - i. Either party may terminate this Agreement on 30 days' notice to the other party.
 - ii. The Department may terminate this agreement with less than 30 days' advance notice if:
 1. The Department has imposed any sanction on the Presumptive Provider pursuant to 441 Iowa Admin. Code § 79.2;
 2. The Department determines that the Presumptive Provider has failed to carry out the substantive terms of this agreement; or
 3. The Department determines that the Presumptive Provider is no longer eligible to perform presumptive provider services.
 - iii. The agreement shall automatically terminate upon bankruptcy, dissolution or sale of the Presumptive Provider's practice. This Agreement is not transferrable.
 - iv. To the extent that the Presumptive Provider is required to be a current Iowa Medicaid provider, this agreement shall automatically terminate upon expiration or termination of Iowa Medicaid provider participation.

- d. In addition, this Agreement may be rendered null and void by changes in federal or state law or funding that prevents either or both parties from fulfillment of the conditions of the Agreement. In such case, each party agrees to notify the other as soon as possible.

Amendment:

The Department may amend this Agreement or the associated Business Associate Agreement by posting an updated version on the Agency's website and providing a notice to the Presumptive Provider through electronic means. The Presumptive Provider shall be deemed to have accepted the amendment unless the Presumptive Provider notifies the Agency of its non-acceptance in writing within 30 days of the Agency's notice. In the event that the Presumptive Provider does not accept such an Amendment, the Presumptive Provider's non-acceptance of the amendment shall constitute immediate termination of the Agreement.

Notice:

Other than notices related to amendment of the Agreement, which may be given electronically, any other notice required to be given pursuant to the terms and provisions of this Agreement shall be sent to (1) the Presumptive Provider at the address provided during the presumptive provider enrollment process or (2) the Department at the following address:

Iowa Department of Human Services
Presumptive Eligibility Programs
1305 E. Walnut, 5th Floor
Des Moines, IA 50319

All notices shall be in writing and sent by express delivery service or via the U.S. Postal Service. Notices submitted to the other party via the U.S Postal Services shall be deemed received by the other party five business days from the original postmark.

No Payment:

The Presumptive Provider agrees that it is not entitled to any payment or compensation for carrying out the responsibilities of this Agreement.

Non-Exclusivity:

This Agreement is not exclusive. The Department may enter into other agreements with other qualified entities to provide services identical to those contemplated herein.

Prohibited Affiliations with Individuals Debarred by Federal Agencies:

- a. *General requirement.* The Presumptive Provider may not knowingly have a relationship of the type described in paragraph (b) of this section with the following:
 - i. An individual who is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in nonprocurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549.
 - ii. An individual who is an affiliate, as defined in the Federal Acquisition Regulation, of a person described in paragraph (a)(i) of this section.
- b. *Specific requirements.* The relationships described in this paragraph are as follow:
 - i. A director, officer, or partner of the Presumptive Provider.
 - ii. A person with beneficial ownership of five percent or more of the Presumptive Provider's equity.
 - iii. A person with an employment, consulting or other arrangement with the Presumptive Provider for the provision of items and services that are significant and material to the Presumptive Provider's obligations under its Agreement with the Department.

- c. *Effect of Noncompliance.* If the Department finds that a Presumptive Provider is not in compliance with paragraphs (a) and (b) of this section, the Department:
 - i. Will notify the Secretary of the noncompliance.
 - ii. May continue an existing agreement with the Presumptive Provider unless the Secretary directs otherwise.
 - iii. May not renew or otherwise extend the duration of an existing agreement with the Presumptive Provider unless the Secretary provides to the Department and to Congress a written statement describing compelling reasons that exist for renewing or extending the agreement.
- d. *Consultation with the Inspector General.* Any action by the Secretary described in paragraphs (c)(ii) or (c)(iii) of this section is taken in consultation with the Inspector General.



Qualified Entity (QE) Medicaid Presumptive Eligibility Portal (MPEP) Access Request Form

This form is to be used by Qualified Entities (QE) that have completed their online training and are requesting access to the Medicaid Presumptive Eligibility Portal (MPEP).

NAME OF QUALIFIED ENTITY (QE):

FULL NAME OF USER:

PHONE NUMBER:

EMAIL OF USER:

Please check here if you agree to receive future relevant provider information from the Iowa Medicaid Enterprise (IME) using this email address. This email address will not be given out and will not be used for any other purpose.

Please check all that applies:

1. I am a qualified entity to make presumptive Medicaid Eligibility determinations for;

Pregnant Women

Children

BCCT (Breast & Cervical Cancer Treatment)

Hospitals (Former Foster Care Children, Individuals 19-64 years old, Parents & Care Takers, Children, Pregnant Women)

2. I am a qualified entity for more than one organization.

YES

NO

3. I have viewed the webinar training.

YES

NO

4. I have read and agree to the terms stated in the Memorandum of Understanding (MOU).

YES

NO

Signature and Date (print name and date then read and check the statement below)

I certify that I am an approved Qualified Entity enrolled with Iowa Medicaid certified by DHS with the authority to make presumptive eligibility determinations as a Qualified Entity. By signing this document I understand that any false statement, omission or misrepresentation may result in prosecution under state and federal laws.

This form will be reviewed and a decision to approve or deny will be made. An email will be sent when this process is complete to the email address listed on this form. This should take no more than 2 business days.

You may also fill out, print, and mail or fax the completed form to:

Iowa Medicaid Enterprise
Provider Services Unit
PO Box 36450
Des Moines, IA 50315
Fax to (515) 725-1155

 Iowa Department of Human Services	Provider and Chapter All Providers Chapter II. Member Eligibility	Page 21
		Date August 1, 2014

Send the completed application form and supporting documents (if applicable) to:

Iowa Medicaid Enterprise
 Attn: Provider Enrollment
 PO Box 36450
 Des Moines, IA 50315

Or Fax: (515) 725-1155 Attn: Provider Enrollment

For questions about applying to be a presumptive provider, contact the IME Provider Enrollment Unit at (800) 338-7909 (option 2), or locally (Des Moines) at (515) 256-4609 (option 2) or by e-mail at imeproviderservices@dhs.state.ia.us.

After receiving form 470-5200, the Department determines if the applicant organization meets the criteria to become a presumptive provider. An email sent to the presumptive provider organization contains the required steps for each individual who will be making presumptive eligibility determinations. This email contains required self-directed training, form 470-2582, *Memorandum of Understanding with a Presumptive Provider for Presumptive Medicaid Eligibility Determinations*, and form 470-5201, *Qualified Entity (QE) Medicaid Presumptive Eligibility Portal (MPEP) Access Request Form*.

Click [here](#) to view the *Memorandum of Understanding (MOU) with a Provider for PE Determination*, form 470-2582.

Click [here](#) to view the *Qualified Entity (QE) Medicaid Presumptive Eligibility Portal (MPEP) Access Request Form*, form 470-5201.

3. Application to Become an Individual Qualified Entity

Once the presumptive provider organization has entered into the Memorandum of Understanding and the individual qualified entities (QEs) identified by the presumptive provider organization have completed the necessary requirements, the Department will authorize each individual QE's access to the presumptive eligibility system called Medicaid Presumptive Eligibility Portal (MPEP).



A qualified entity (QE) is an individual, under the supervision and authority of a presumptive provider (PP), who is authorized to determine presumptive eligibility (PE). Only employees of the presumptive provider may be given the authority to make presumptive eligibility determinations. Each individual QE must complete a web-based training module and be certified by the Department before they can begin to make eligibility determinations.

Each QE authorized to make presumptive eligibility determinations will have a unique identifier to access MPEP and cannot share that access authorization with others. Data entries made by the QE are used to determine presumptive eligibility electronically.

Individual QEs who make presumptive eligibility determinations are required to be recertified annually. Each QE within a presumptive provider organization will be notified by email 60 days in advance of the certification expiration date of the requirement to recertify. To be recertified, the QE must complete the self-directed training and re-attest to the *Memorandum of Understanding*.

4. Completing the Application for Health Coverage and Help Paying Costs

The choice of whether and when to apply for presumptive Medicaid belongs to the individual. Providers cannot refuse services based on an individual's decision whether to apply for PE.

Applications for presumptive Medicaid can be completed either by:

- ◆ The QE entering the applicant's information directly online into MPEP at the same time the information is being provided in-person by the applicant, or
- ◆ The QE collecting a paper application from the applicant and later entering the applicant's information into MPEP.

If using the paper application option, the applicant shall complete both the *Application for Health Coverage and Help Paying Costs*, form 470-5170 or 470-5170(S), and the *Addendum to Application for Presumptive Eligibility*, form 470-5192 or 470-5192(S).



Application for Health Coverage and Help Paying Costs

Use this application to see what coverage choices you qualify for

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

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

Who can use this application?

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

Apply faster online

Apply faster online at dhsservices.iowa.gov.

What you may need to apply

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

Why do we ask for this information?

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

What happens next?

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

Get help with this application

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

Step 1. Tell us about yourself.

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

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

Step 2. Tell us about your family.

Who do you need to include on this application?

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

DO include:

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

You DON'T have to include:

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

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

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

Step 2. Person 1 (start with yourself)

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

First name, middle name, last name, and suffix		Relationship to you? SELF
Date of birth (mm/dd/yyyy)	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Social Security Number (SSN)

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

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

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

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

Yes No 1. Will you file jointly with a spouse?

If yes, name of spouse: _____

Yes No 2. Will you claim any dependents on your tax return?

If yes, list names of dependents: _____

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

How are you related to the tax filer? _____

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

Do you need health coverage?

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

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

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

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

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

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

Document type: _____ Document ID number: _____

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

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

Yes No Are you a resident of Iowa?

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

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

Yes No Are you a full-time student?

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

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

If Hispanic or Latino, ethnicity:

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

Race:

- White
- Black or African American
- American Indian or Alaska Native
- Asian Indian
- Chinese
- Filipino
- Japanese

- Korean
- Vietnamese
- Other Asian
- Native Hawaiian
- Guamanian or Chamorro
- Samoan
- Other Pacific Islander
- Other: _____

Current Job and Income Information

- Employed.** If you're currently employed, tell us about your income. Start with **Current Job 1**.
- Not employed.** Skip to the **Other Income This Month** section.
- Self-employed.** Skip to the **Self-Employment** section.

Current Job 1:

Employer name and address				Employer phone number	
Wages and tips (before taxes) \$	<input type="checkbox"/> Hourly	<input type="checkbox"/> Weekly	<input type="checkbox"/> Every 2 weeks	Average hours worked each week:	
	<input type="checkbox"/> Twice a month	<input type="checkbox"/> Monthly	<input type="checkbox"/> Yearly		

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

Employer name and address				Employer phone number	
Wages and tips (before taxes) \$	<input type="checkbox"/> Hourly	<input type="checkbox"/> Weekly	<input type="checkbox"/> Every 2 weeks	Average hours worked each week:	
	<input type="checkbox"/> Twice a month	<input type="checkbox"/> Monthly	<input type="checkbox"/> Yearly		

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

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

Type of work _____

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

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

<input type="checkbox"/> None <input type="checkbox"/> Unemployment \$ _____ <input type="checkbox"/> Pensions \$ _____ <input type="checkbox"/> Social Security \$ _____ <input type="checkbox"/> Retirement \$ _____ accounts	How often?	<input type="checkbox"/> Alimony received \$ _____ <input type="checkbox"/> Net farming/fishing \$ _____ <input type="checkbox"/> Net rental/royalty \$ _____ <input type="checkbox"/> Other income \$ _____ Type _____	How often?
--	------------	---	------------

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

<input type="checkbox"/> Alimony paid \$ _____ <input type="checkbox"/> Student loan interest \$ _____	How often?	<input type="checkbox"/> Other deductions \$ _____ Type _____	How often?
---	------------	--	------------

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

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

Step 2. Person 2

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

First name, middle name, last name, and suffix		Relationship to you?
Date of birth (mm/dd/yyyy)	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Social Security Number (SSN)

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

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

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

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

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

Yes No 1. Will *Person 2* file jointly with a spouse?

If yes, name of spouse: _____

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

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

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

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

Does *Person 2* need health coverage?

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

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

Yes No Does *Person 2* have a physical, mental, or emotional health condition that causes limitations in activities (like bathing, dressing, daily chores, etc.) or live in a medical facility or nursing home?

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

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

Document type: _____ Document ID number: _____

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

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

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

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

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

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

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

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

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

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

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

If Hispanic or Latino, ethnicity:

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

Race:

- White
- Black or African American
- American Indian or Alaska Native
- Asian Indian
- Chinese
- Filipino
- Japanese

- Korean
- Vietnamese
- Other Asian
- Native Hawaiian
- Guamanian or Chamorro
- Samoan
- Other Pacific Islander
- Other: _____

Current Job and Income Information

- Employed.** If you're currently employed, tell us about your income. Start with **Current Job 1**.
- Not employed.** Skip to the **Other Income This Month** section.
- Self-employed.** Skip to the **Self-Employment** section.

Current Job 1:

Employer name and address	Employer phone number
Wages and tips (before taxes) \$ _____ <input type="checkbox"/> Hourly <input type="checkbox"/> Weekly <input type="checkbox"/> Every 2 weeks <input type="checkbox"/> Twice a month <input type="checkbox"/> Monthly <input type="checkbox"/> Yearly	Average hours worked each week: _____

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

Employer name and address	Employer phone number
Wages and tips (before taxes) \$ _____ <input type="checkbox"/> Hourly <input type="checkbox"/> Weekly <input type="checkbox"/> Every 2 weeks <input type="checkbox"/> Twice a month <input type="checkbox"/> Monthly <input type="checkbox"/> Yearly	Average hours worked each week: _____

In the past year, did *Person 2*:

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

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

Type of work _____

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

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

<input type="checkbox"/> None	How often? _____	How often? _____
<input type="checkbox"/> Unemployment \$ _____	_____	<input type="checkbox"/> Alimony received \$ _____
<input type="checkbox"/> Pensions \$ _____	_____	<input type="checkbox"/> Net farming/fishing \$ _____
<input type="checkbox"/> Social Security \$ _____	_____	<input type="checkbox"/> Net rental/royalty \$ _____
<input type="checkbox"/> Retirement accounts \$ _____	_____	<input type="checkbox"/> Other income \$ _____
	Type _____	_____

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

<input type="checkbox"/> Alimony paid \$ _____	How often? _____	<input type="checkbox"/> Other deductions \$ _____	How often? _____
<input type="checkbox"/> Student loan interest \$ _____	_____	Type _____	_____

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

<i>Person 2's</i> total income this year \$ _____	<i>Person 2's</i> total income next year (if you think it will be different) \$ _____
---	---

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

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

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

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

AI/AN Person 1:

Name (first, middle, last)

AI/AN Person 2:

Name (first, middle, last)

AI/AN Person 1:

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

AI/AN Person 2:

Yes No

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

Yes No

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

Yes No

\$ _____
How often? _____
Certain money received may not be counted for Medicaid or the Children's Health Insurance Program (CHIP). List any income (amount and how often) reported on your application that includes money from these sources:

\$ _____
How often? _____

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

Step 4. Your Family's Health Coverage

Answer these questions for anyone who needs health coverage.

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

Medicaid _____

CHIP _____

Medicare _____

TRICARE (Don't check if you have direct care or Line of Duty) _____

VA health care programs _____

Peace Corps _____

Employer Insurance

Name of health insurance _____

Policy number _____

Is this COBRA coverage?

Yes No

Is this a retiree health plan?

Yes No

Other

Name of health insurance _____

Policy number _____

Is this a limited-benefit plan (like a school accident policy?) Yes No

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

Name _____

Date of birth (mm/dd/yyyy) _____

Social Security Number (SSN) _____

Relationship to you? _____

Date moved in? _____

Date moved out? _____

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

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

If no, skip to Step 6.

Yes No Is this a state employee benefit plan?

Step 5. Health Coverage from Jobs

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

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

Employee name (first, middle, last)	Social security number
-------------------------------------	------------------------

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

Employer name	Employer identification number (EIN)	
Employer address (the Marketplace will send notices to this address)	Employer phone number	
City	State	ZIP code
Who can we contact about employee health coverage at this job?		
Phone number (if difference from above)	Email address	

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

If yes, fill out the information below. **If no**, skip to Step 6.

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

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

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

Yes No Does the employer offer a health plan that covers an employee's spouse or dependent?
If yes, which people? Spouse Dependents

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

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

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

How often?

Weekly Every two weeks Twice a month Quarterly Yearly

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

Employer won't offer health coverage

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

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

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

Date of change: _____

Step 6. Assistance with Completing this Application

You can choose an authorized representative.

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

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

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

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

Your signature	Date (mm/dd/yyyy)
----------------	-------------------

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

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

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

Step 7. Read and Sign this Application

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

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

- ◆ By signing this application, I certify under penalty of perjury and false swearing that my answers are correct and complete to the best of my knowledge, including information provided about the citizenship or alien status for each household member applying for benefits. I know I may be subject to penalties under federal law if I provide false or untrue information.
- ◆ I know that I must tell the Income Maintenance Call Center if anything changes (and is different than) what I wrote on this application. I can call **1-877-347-5678** to report any changes. I understand that a change in my information could affect the eligibility for members of my household.
- ◆ I know that under federal law, discrimination isn't permitted on the basis of race, color, national origin, sex, age, sexual orientation, gender identity, or disability. I can file a complaint of discrimination by visiting www.hhs.gov/ocr/office/file.
- ◆ I confirm that no one applying for health insurance on this application is incarcerated (detained or jailed). If not, the name of the person incarcerated is: _____

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

Renewal of coverage in future years

To make it easier to determine my eligibility for help paying for health coverage in future years, I agree to allow the Iowa Department of Human Services (DHS) to use income data, including information from tax returns. The Iowa DHS will send me a notice and let me make any changes.

I agree to allow the Iowa DHS to use income data, including information from tax returns.

If anyone on this application is eligible for Medicaid

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

My right to appeal

If I think the Health Insurance Marketplace or Medicaid/Children's Health Insurance Program (CHIP) has made a mistake, I can appeal its decision. To appeal means to tell someone at the Health Insurance Marketplace or Medicaid/CHIP that I think the action is wrong, and ask for a fair review of the action. I know that I can find out how to appeal by contacting the Marketplace at **1-800-318-2596**. I know that I can be represented in the process by someone other than myself. My eligibility and other important information will be explained to me.

Sign this application

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

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

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

Signature	Date (mm/dd/yyyy)
-----------	-------------------

Step 8. Mail the Completed Application

Mail your signed application to:

Imaging Center 4
PO Box 2027
Cedar Rapids, Iowa 52406

If you want to register to vote, you can complete a voter registration form at:

<http://sos.iowa.gov/elections/pdf/voteapp.pdf>

Addendum to Application and Review Forms for Release of Information

OPTIONAL Release of Information

Help Us Help You!

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

You should know that:

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

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

RELEASE OF INFORMATION

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

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

This release does not apply to protected health information.

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

Your Name (please print clearly)

Other Adult Name (please print clearly)

Signature or Mark

Signature or Mark

Date



Iowa Department of Human Services

Application for Health Coverage and Help Paying Costs **(Solicitud de cobertura médica y asistencia para abonar el costo)**

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

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

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

¿Quiénes pueden utilizar este formulario de solicitud?

- ◆ Utilice este formulario para solicitar cobertura médica para toda su familia.
- ◆ Presente la solicitud aunque usted y sus hijos tengan cobertura médica. Podría calificar para cobertura gratuita o más barata.
- ◆ Las familias con inmigrantes pueden presentar la solicitud. Puede solicitar cobertura para sus hijos aunque usted no califique para recibirla. La presentación de la solicitud no afectará su condición migratoria, ni su posibilidad de convertirse en residente permanente o de conseguir la ciudadanía.
- ◆ Si le ayudan a completar este formulario, dicha persona tendrá que completar la Sección 6.

Presente la solicitud más rápido por Internet

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

Qué necesita para presentar la solicitud

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

¿Por qué le solicitamos estos datos?

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

¿Qué debe hacer después?

Envíe la solicitud completa y firmada al domicilio que figura en la página 11. **Firme y presente la solicitud aunque no tenga todos los datos que le solicitamos.** Nos comunicaremos con usted dentro de los próximos 30 días para darle instrucciones sobre los pasos a seguir. En el caso de no recibir noticias, llame al Centro de Contacto de DHS al **1-855-889-7985**. Completar la solicitud no significa que deba adquirir la cobertura.

Consiga ayuda para completar la solicitud

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

Sección 1. Infórmenos sobre usted.

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

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

Sección 2. Infórmenos sobre su familia.

¿A quién debe incluir en la solicitud?

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

DEBE incluir a:

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

NO ES NECESARIO que incluya a:

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

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

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

Sección 2. Persona 1 (comience con usted)

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

Primer nombre, segundo nombre, apellido, y sufijo		¿Parentesco con usted? YO
Fecha de nacimiento (mm/dd/aaaa)	Sexo: <input type="checkbox"/> Masc. <input type="checkbox"/> Fem.	Nº. de Social Security (SSN)

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

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

(Puede solicitar seguro médico aunque no presente una declaración impositiva de ingresos.)

Sí. **Si respondió Sí**, responda las preguntas 1-3. No. **Si respondió No**, vaya a la pregunta 3.

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

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

Sí No 3. ¿Se declarará como dependiente en la declaración impositiva de otra persona? **Si Sí**, indique su nombre: _____
¿Cuál es su relación con dicho contribuyente? _____

Sí No ¿Está embarazada? **Si Sí**, ¿cuántos bebés espera e en este embarazo? ¿Cuál es la fecha probable de parto? _____

¿Necesita cobertura médica?

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

Sí. Responda las siguientes preguntas. No. Vaya a las preguntas sobre ingresos en la página 3. Deje el resto de esta página en blanco.

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

Sí No ¿Tiene ciudadanía o nacionalidad estadounidense?

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

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

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

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

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

Sí No ¿Es residente de Iowa?

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

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

Sí No ¿Es estudiante de tiempo completo?

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

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

Si es hispano o latino, origen étnico:

- Mexicano
- Mexicano estadounidense
- Chicano/a
- Puertorriqueño
- Cubano
- Otro: _____

Raza:

- Blanca
- Negra o afroamericana
- Indígena estadounidense o nativa de Alaska
- India asiática
- China
- Filipina
- Japonesa

- Coreana
- Vietnamita
- Otras razas asiáticas
- Nativa de Hawái
- Guameña o Chamorro
- Samoana
- Otras razas de islas del Pacífico
- Otro: _____

Empleo y datos sobre ingresos

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

Empleo actual 1:

Nombre y domicilio del empleador	Teléfono del empleador
Salario y propinas (sin descuentos) \$ <input type="checkbox"/> Por hora <input type="checkbox"/> Semanal <input type="checkbox"/> Cada 2 semanas <input type="checkbox"/> 2 veces por mes <input type="checkbox"/> Mensual <input type="checkbox"/> Anual	Promedio de horas trabajadas por semana:

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

Nombre y domicilio del empleador	Teléfono del empleador
Salario y propinas (sin descuentos) \$ <input type="checkbox"/> Por hora <input type="checkbox"/> Semanal <input type="checkbox"/> Cada 2 semanas <input type="checkbox"/> 2 veces por mes <input type="checkbox"/> Mensual <input type="checkbox"/> Anual	Promedio de horas trabajadas por semana:

Durante el último año:

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

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

Tipo de trabajo _____

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

Otros ingresos de este mes: Marque todos los que correspondan, indique el monto y la frecuencia del mismo.

NOTA: No necesita informar sobre manutención, pagos a veteranos, ni *Supplemental Security Income* (SSI).

<input type="checkbox"/> Ninguno	¿Frecuencia?	<input type="checkbox"/> Pensión alimenticia	\$ _____	¿Frecuencia?
<input type="checkbox"/> Desempleo	\$ _____	<input type="checkbox"/> Neto cultivos/pesca	\$ _____	
<input type="checkbox"/> Jubilaciones	\$ _____	<input type="checkbox"/> Neto por rentas	\$ _____	
<input type="checkbox"/> Social Security	\$ _____	<input type="checkbox"/> Otros ingresos	\$ _____	
<input type="checkbox"/> Planes de retiro	\$ _____	Tipo	_____	

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

<input type="checkbox"/> Pensión alimenticia	\$ _____	¿Frecuencia?	<input type="checkbox"/> Otros descuentos	\$ _____	¿Frecuencia?
<input type="checkbox"/> Intereses de préstamos a estudiantes	\$ _____	Tipo	_____		

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

Total de ingresos este año \$ _____	Total de ingresos del próximo año (si cree que será diferente) \$ _____
---	---

Sección 2. Persona 2

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

Primer nombre, segundo nombre, apellido, sufijo		¿Parentesco con usted?
Fecha de nacimiento (mm/dd/aaaa)	Sexo: <input type="checkbox"/> Masc. <input type="checkbox"/> Fem.	Nº. de Social Security (SSN)

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

Sí No ¿La *Persona 2* vive en el mismo domicilio que usted? **Si respondió no**, indique el domicilio:

¿La *Persona 2* va a presentar la declaración impositiva de ingresos EL PRÓXIMO AÑO?

(Puede solicitar seguro médico aunque no presente una declaración impositiva de ingresos.)

Sí. **Si respondió Sí**, responda las preguntas 1-3. No. **Si respondió No**, pase a la pregunta 3.

Sí No 1. ¿La *Persona 2* la presentará conjuntamente con su cónyuge? **Si respondió Sí**, nombre del cónyuge: _____

Sí No 2. ¿La *Persona 2* declarará personas dependientes? **Si respondió Sí**, indique sus nombres: _____

Sí No 3. ¿La *Persona 2* se declarará como dependiente en la declaración impositiva de otra persona? **Si Sí**, indique su nombre: _____

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

Sí No ¿La *Persona 2* está embarazada? **Si Sí**, ¿cuántos bebés espera en este embarazo? _____

¿La *Persona 2* necesita cobertura médica?

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

Sí. Responda las siguientes preguntas. No. Vaya a las preguntas sobre ingresos en la página 5. Deje el resto de esta página en blanco.

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

Sí No ¿Tiene ciudadanía o nacionalidad estadounidense?

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

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

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

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

Sí No ¿Es residente de Iowa?

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

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

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

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

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

Fecha de terminación: _____ Motivo: _____

Sí No ¿Es estudiante de tiempo completo?

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

Si es hispano o latino, origen étnico:

- Mexicano
- Mexicano estadounidense
- Chicano/a
- Puertorriqueño
- Cubano
- Otro: _____

Raza:

- Blanca
- Negra o afroamericana
- Indígena estadounidense o nativa de Alaska
- India asiática
- China
- Filipina
- Japonesa

- Coreana
- Vietnamita
- Otras razas asiáticas
- Nativa de Hawái
- Guameña o Chamorro
- Samoana
- Otras razas de islas del Pacífico
- Otro: _____

Empleo y datos sobre ingresos

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

Empleo actual 1:

Nombre y domicilio del empleador	Teléfono del empleador
Salario y propinas (sin descuentos) \$ <input type="checkbox"/> Por hora <input type="checkbox"/> Semanal <input type="checkbox"/> Cada 2 semanas <input type="checkbox"/> 2 veces por mes <input type="checkbox"/> Mensual <input type="checkbox"/> Anual	Promedio de horas trabajadas por semana:

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

Nombre y domicilio del empleador	Teléfono del empleador
Salario y propinas (sin descuentos) \$ <input type="checkbox"/> Por hora <input type="checkbox"/> Semanal <input type="checkbox"/> Cada 2 semanas <input type="checkbox"/> 2 veces por mes <input type="checkbox"/> Mensual <input type="checkbox"/> Anual	Promedio de horas trabajadas por semana:

Durante el último año, la *Persona 2*:

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

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

Tipo de trabajo _____

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

Otros ingresos de este mes: Marque todos los que correspondan, indique el monto y la frecuencia del mismo.

NOTA: No necesita informar sobre manutención, pagos a veteranos, ni *Supplemental Security Income* (SSI).

<input type="checkbox"/> Ninguno	¿Frecuencia?	<input type="checkbox"/> Pensión alimenticia	\$ _____	¿Frecuencia?
<input type="checkbox"/> Desempleo	\$ _____	<input type="checkbox"/> Neto cultivos/pesca	\$ _____	
<input type="checkbox"/> Jubilaciones	\$ _____	<input type="checkbox"/> Neto por rentas	\$ _____	
<input type="checkbox"/> Social Security	\$ _____	<input type="checkbox"/> Otros ingresos	\$ _____	
<input type="checkbox"/> Planes de retiro	\$ _____	Tipo	_____	

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

<input type="checkbox"/> Pensión alimenticia	\$ _____	¿Frecuencia?	<input type="checkbox"/> Otros descuentos	\$ _____	¿Frecuencia?
<input type="checkbox"/> Intereses de préstamos a estudiantes	\$ _____	Tipo	_____		

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

Total de ingresos de la <i>Persona 2</i> este año \$ _____	Total de ingresos del próximo año (si cree que será diferente) \$ _____
--	--

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

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

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

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

AI/AN Persona 1:

Nombre (primer nombre, segundo nombre, apellido)

AI/AN Persona 2:

Nombre (primer nombre, segundo nombre, apellido)

AI/AN Persona 1:

Sí No ¿Miembro de tribu reconocida a nivel federal? **Si Sí**, nombre de la tribu:

AI/AN Persona 2:

Sí No

Sí No ¿Alguna vez obtuvo servicios del *Indian Health Service*, de un programa médico tribal, o de un programa médico urbano para aborígenes, o a través de remisiones hechas por estos programas?

Sí No

Sí No **Si respondió No**, ¿es elegible para alguno de dichos servicios?

Sí No

\$ _____
¿Frecuencia? _____
Ciertos ingresos no pueden ser contabilizados para Medicaid o *Children's Health Insurance Program* (CHIP). Indique todos los ingresos (importe y frecuencia) informados en su solicitud que incluyan dinero de las siguientes fuentes:

\$ _____
¿Frecuencia? _____

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

Sección 4. La cobertura médica de su familia

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

Sí No ¿Algún miembro de su familia está inscripto en alguna de las siguientes coberturas médicas?
Marque el tipo de cobertura y escriba sus nombres al lado de la cobertura que tienen.

Medicaid _____

CHIP _____

Medicare _____

TRICARE (No marque si tiene
atención directa o *Line of Duty*) _____

Programas para Veteranos _____

Cuerpos de Paz _____

Seguro del empleador _____

Nombre del seguro médico _____

Número de póliza _____

¿Es cobertura COBRA? Sí No

¿Es un plan médico jubilatorio? Sí No

Otro _____

Nombre del seguro médico _____

Número de póliza _____

¿Es un plan de beneficios limitados? (ej. accidentes escolares) Sí No

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

Nombre _____

Fecha de nacimiento (mm/dd/aaaa) _____

Número de Social Security (SSN) _____

¿Parentesco con usted? _____

¿Fecha en que se mudó? _____

¿Fecha en que se fue? _____

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

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

Si respondió no, vaya a la Sección 6.

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

Sección 5. Coberturas médicas de empleos

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

Datos del empleado. El empleado debe completar esta sección.

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

Datos del empleador. Pídale estos datos a su empleador.

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

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

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

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

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

Sí No ¿El plan médico ofrecido por el empleador cubre al cónyuge o a los dependientes del empleado? Si respondió Sí, ¿a quién cubre? Cónyuge Dependientes

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

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

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

\$ _____

¿Con qué frecuencia?

Semanal Cada dos semanas Dos veces al mes Trimestral Anual

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

El empleador no ofrecerá cobertura médica

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

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

\$ _____

¿Frecuencia? Semanal Cada dos semanas Dos veces al mes Trimestral Anual

Fecha del cambio: _____

Sección 6. Ayuda para completar este formulario de solicitud

Puede elegir a un representante autorizado.

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

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

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

NOTA: Además de firmar en esta sección, **debe** firmar y escribir la fecha en la página 11 para completar la solicitud.

Su firma	Fecha (mm/dd/aaaa)
----------	--------------------

Solo para asesores, navegadores, agentes y corredores acreditados.

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

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

Sección 7. Lea y firme este formulario de solicitud

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

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

Renovación de la cobertura en los años sucesivos

Con el fin de facilitar la determinación de mi elegibilidad para asistencia para abonar la cobertura médica en los años venideros, acepto autorizar a *Iowa Department of Human Services (DHS)* a utilizar los datos sobre ingresos, incluso la información de las declaraciones impositivas. DHS de Iowa me enviará una notificación y me permitirá realizar los cambios que correspondan.

Acepto autorizar a DHS de Iowa a utilizar los datos sobre ingresos, incluso la información de las declaraciones impositivas.

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

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

Mi derecho a apelar

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

Firme esta solicitud

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

Acepto autorizar que en esta solicitud se utilice información personal obtenida de fuentes de datos. Poseo el consentimiento de todas las personas que indicaré en esta solicitud para que se utilice información personal obtenida de fuentes de datos.

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

Firma	Fecha (mm/dd/aaaa)
-------	--------------------

Sección 8. Envíe la solicitud por correo

Envíe la solicitud firmada por correo a:

Imaging Center 4
PO Box 2027
Cedar Rapids, Iowa 52406

Si desea inscribirse para votar, puede completar el formulario de inscripción para votantes en:
<http://sos.iowa.gov/elections/pdf/voteapp.pdf>

Addendum to Application and Review Forms for Release of Information
(Adenda de los Formularios de Solicitud y Revisión para Divulgación de Información)

Divulgación de Información OPCIONAL

¡Ayúdenos a ayudarle!

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

Debe saber que:

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

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

DIVULGACIÓN DE INFORMACIÓN
(Release of Information)

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

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

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

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

Su nombre (en imprenta legible)
(Your Name – please print clearly)

Nombre de otro adulto (en imprenta legible)
(Other Adult Name – please print clearly)

Firma o marca
(Signature or Mark)

Firma o marca
(Signature or Mark)

Fecha
(Date)

ADDENDUM TO APPLICATION FOR PRESUMPTIVE ELIGIBILITY

Do you want to apply for ongoing Medicaid? Yes No

Have you received Presumptive Eligibility (PE) for Medicaid in the last 12 months? Yes No

Note: If you are pregnant, only **answer YES** to this question if you had Presumptive Eligibility during your current pregnancy. **Answer NO** if you had Presumptive Eligibility in the last 12 months but not during your current pregnancy.

Do you have any dependents living with you? Yes No

Do they all have other medical coverage or are they all currently applying for other medical coverage? Yes No

Were you concurrently enrolled in foster care and Medicaid in Iowa when you were age 18 or older? Yes No

Addendum to Application for Presumptive Eligibility
(Anexo a la solicitud por presunta elegibilidad)

¿Quiere presentar la solicitud para extensión de Medicaid? Sí No

¿Ha recibido elegibilidad temporal (*Presumptive Eligibility, PE*) para Medicaid durante los últimos 12 meses? Sí No

Nota: Si está embarazada, **responda SÍ** a esta pregunta en el caso de haber tenido elegibilidad temporal durante el embarazo. **Responda NO** en el caso de haber tenido elegibilidad temporal durante los últimos 12 meses, pero no durante el embarazo.

¿Tiene personas dependientes o a su cargo que viven con usted? Sí No

¿Todas esas personas tienen otro seguro médico o actualmente están presentando la solicitud para otro seguro médico? Sí No

¿Estuvo inscripto o inscripta simultáneamente en crianza temporal (*foster care*) y en Medicaid en el estado de Iowa siendo mayor de 18 años? Sí No

 Iowa Department of Human Services	Provider and Chapter All Providers Chapter II. Member Eligibility	Page 23
		Date August 1, 2014

Click [here](#) to view the English version of form 470-5170.

Click [here](#) to view the Spanish version of form 470-5170(S).

Click [here](#) to view the English version of form 470-5192.

Click [here](#) to view the Spanish version of form 470-5192(S.)

Regardless of which method is used to apply, the completed application must be signed by one of the following:

- ◆ The applicant,
- ◆ An adult in the applicant's household or family,
- ◆ An authorized representative, or
- ◆ Someone acting responsibly for an incompetent or physically incapacitated person or for a minor child.

An "X" or a thumbprint may be accepted as a signature if necessary.

If the application is being entered directly online in MPEP, the QE must complete and submit the application in MPEP on that day.

When application entries cannot be completed in MPEP until a later date, a paper application must be completed in order to protect the application filing date. The QE is required to date-stamp a paper application with the date it is received from the applicant.

For purposes of protecting an application date, a paper application is valid and must be date-stamped on the date it is submitted to the QE with only the applicant's legible name, address, and signature. If necessary, the applicant may then answer the other necessary questions on the application after it has been submitted to and date-stamped by the QE.

All necessary information must be obtained from the applicant before the application can be completed and a presumptive eligibility determination is made in MPEP.

The QE must explain to applicants that coverage under the presumptive Medicaid coverage groups of Pregnant Women and the Iowa Health and Wellness Plan do not provide full Medicaid coverage.

The QE must explain to all applicants that coverage under the presumptive program is time limited.



The QE must also explain to applicants that the presumptive eligibility determination is not a formal Medicaid eligibility decision by DHS. With the exception of the presumptive Medicaid coverage groups of Pregnant Women and BCCT, application for ongoing Medicaid is required and occurs automatically when an individual applies for presumptive Medicaid. A presumptive applicant can also apply for presumptive or ongoing Medicaid for anyone else in the household as entered on the application.

The MPEP system automatically transfers the information from the presumptive application to DHS for processing for ongoing Medicaid. Because MPEP will transmit the application electronically, do not send a paper copy of the application to DHS.

Applicants for the presumptive Medicaid coverage groups of Pregnant Women and BCCT are not required to apply for an ongoing Medicaid determination. Applicants for the Pregnant Women or BCCT presumptive coverage groups may choose to apply only for presumptive Medicaid, or to also apply for ongoing Medicaid on the presumptive application. Encourage the pregnant woman or the BCCT applicant to also apply for ongoing Medicaid during the presumptive period if the applicant wants ongoing Medicaid. This will allow Medicaid benefits to begin in a timely manner if the applicant meets eligibility requirements.

The choice to apply for ongoing Medicaid is indicated by the pregnant woman or BCCT applicant answering "yes" to the question, "Do you want to apply for ongoing Medicaid?" on the *Addendum to Application for Presumptive Eligibility* or in MPEP. If the pregnant woman or BCCT applicant does not want to apply for ongoing Medicaid, answering "no" to the question, "Do you want to apply for ongoing Medicaid?" on MPEP ensures the application will be considered only for presumptive Medicaid.

NOTE: The pregnant woman or BCCT applicant may choose whether or not to apply for ongoing Medicaid regardless of whether the application for presumptive is approved or denied. If the pregnant woman or BCCT applicant does choose to apply for ongoing Medicaid with DHS at the same time the applicant applies for presumptive eligibility, the date the presumptive provider received the presumptive application is the date of application the Department uses for purposes of determining the effective date of ongoing Medicaid eligibility.



EXCEPTION: For the purposes of determining the date of application for ongoing Medicaid, an application received by a presumptive provider on a weekend or state holiday shall be deemed to be received on the next business day.

In some situations the pregnant woman or BCCT applicant may not want to apply for ongoing Medicaid at all, or may want to file a separate Medicaid application at a later date. Explain to the pregnant woman or BCCT applicant that:

- ◆ If the pregnant woman or BCCT applicant applies for ongoing Medicaid and DHS denies that application for any reason, presumptive Medicaid will end on the day the ongoing Medicaid application is denied. A pregnant woman cannot be determined presumptively eligible again during the same pregnancy. A BCCT applicant cannot be determined presumptively eligible again during the same 12 month period unless a new cancer diagnosis and treatment period occurs.
- ◆ If the pregnant woman or BCCT applicant applies only for presumptive Medicaid initially, the pregnant woman or BCCT applicant can still file an application for ongoing Medicaid or for limited Medicaid for emergency services at a later date. See [Aliens Receiving Emergency Services](#) for more information on emergency services.

Provide the pregnant woman or BCCT applicant with information that allows the individual to make a fully informed decision about when to apply and for which programs to apply, considering the details of pregnant woman or BCCT applicant's own situation and the limited nature of the presumptive Medicaid program.

A pregnant woman contacts a QE to apply for Medicaid.

During the presumptive application process, the QE tells the woman that she may choose to apply for only presumptive Medicaid, apply for both presumptive and ongoing Medicaid at the same time, or apply for presumptive Medicaid now and apply for regular Medicaid at a later date. The QE also explains the possible outcomes of each option.



1. The pregnant woman states that she wants to apply for ongoing Medicaid at the same time as presumptive Medicaid. She understands that if she applies for ongoing Medicaid and DHS denies that application for any reason, presumptive Medicaid will end on the day the ongoing Medicaid application is denied.

When the QE completes entries on MPEP to process the presumptive application, the question, "Do you want to apply for ongoing Medicaid?" is answered "yes."

2. The pregnant woman wants to apply only for presumptive Medicaid at this time. She understands she may file an application for ongoing Medicaid at a later date. When the QE completes entries on MPEP to process the presumptive application, the question, "Do you want to apply for ongoing Medicaid?" is answered "no."

In some situations, it may also be beneficial for an individual who has applied for presumptive to withdraw the application for the current month and begin her presumptive period on the first day of the next month. A new application is not necessary in this situation. If this occurs, document this in the case file.

NOTE: Because the MPEP system will begin eligibility with the date of application, enter the application received date on MPEP as the first day of the next month.

1. An individual files an application with the QE on March 29 but indicates not wanting presumptive eligibility to begin until April 1. Although the application is date-stamped as received on March 29, the provider documents that the person withdrew the application for March.

On MPEP, the "application date" is entered as April 1. **NOTE:** The Medicaid application date transmitted to DHS via MPEP, if applicable, will also be April 1.

2. A person files an application with the QE on April 30. The provider explains that presumptive Medicaid may continue only up to May 31 in this situation, and asks if the applicant would like to withdraw the application for April and make her application effective May 1.

The applicant does not want to withdraw the application for April. The QE processes the presumptive eligibility beginning with April 30 by entering this as the "application date" on MPEP.

 Iowa Department of Human Services	Provider and Chapter All Providers Chapter II. Member Eligibility	Page 27
		Date August 1, 2014

5. Calculating Household Size and Income

Legal reference: USC 42 1396a(a)(14); 42 CFR 435.603;
441 IAC 75.70 and 75.71

Because of the Affordable Care Act, eligibility for all income-based Medicaid programs uses tax-based rules for income and household composition. Modified Adjusted Gross Income (MAGI) is a tax-based methodology for how income is counted. MAGI generally includes all taxable earned and unearned income unless exempted by the Affordable Care Act.

a. MAGI-Medicaid Household Composition and Size

The household composition and size for each presumptive applicant is determined individually. Each applicant's household is constructed based on whether the applicant is a:

- ◆ Tax filer,
- ◆ Tax dependent, or
- ◆ Non-filer (neither a tax filer nor a tax dependent).

The applicant must provide information on the application about everyone living in the household, or in their tax household, if applicable. The family cannot exclude certain family members in order to attain eligibility for other members. (**NOTE:** The requirement to provide information about all household members does not mean that everyone in the household must apply for presumptive or ongoing Medicaid.)

The household size for an applicant or member whose MAGI-based Medicaid household includes a pregnant woman is determined by counting the pregnant woman plus the number of children she is expected to deliver.

b. Treatment of Income under MAGI

Eligibility for Medicaid is calculated using a household's Modified Adjusted Gross Income (MAGI).

The current month's expected income is used to determine presumptive Medicaid eligibility. When income is changing (e.g., either starting, stopping, or fluctuating), the QE should discuss the details of the situation on a case-by-case basis to assist the applicant in providing a reasonable estimate of monthly income.



The application and MPEP capture the information about income and certain allowable expenses that are needed for a calculation of the household's countable MAGI-based income.

The QE enters the taxable income and applicable expenses of each household member on MPEP. MPEP determines the countable amount for each applicant's MAGI-based household size and provides the eligibility decision.

6. Steps in Making a Presumptive Eligibility Decision

Qualified entities complete the following steps when determining presumptive eligibility:

1. Date-stamp the application with the date it is received by a presumptive provider organization or by an individual qualified entity. For purposes of protecting an application date, a paper application is valid and must be date-stamped on the date it is submitted with only the applicant's legible name, address, and signature.
2. Clarify information on the application, if necessary. However, PE Medicaid is based only on the applicant's self-attested situation. This means eligibility is based on the answers the person provides on the application and to the QE in the course of assisting during the application process. Verification cannot be requested or required for PE Medicaid.
3. Except in the case of an applicant for the presumptive coverage groups of Pregnant Women or BCCT, the QE informs the applicant that the application will automatically be sent on Medicaid Presumptive Eligibility Portal (MPEP) to the Department for an ongoing Medicaid eligibility determination.

An application for the presumptive coverage groups of Pregnant Women or BCCT can be sent on MPEP for an ongoing Medicaid determination if the applicant so chooses. During the formal Medicaid eligibility determination, the Department will verify income, citizenship, alien status, identity, and other information as necessary.



4. The QE enters information from the application into the presumptive eligibility system through the MPEP. The system entries should be made as soon as possible and within three working days of the date the application was received. Presumptive eligibility coverage cannot begin until the information is entered and the applicant is approved in MPEP.
5. The QE gives the *Presumptive Medicaid Eligibility Notice of Action* (form 470-2580 or 470-2580(S), 470-5190 or 470-5190(S), or 470-5191 or 470-5191(S)) to the applicant. This notice explains the results of the eligibility determination. The notice should be provided as soon as possible but always within two working days after the determination is made.

NOTE: If you discover after MPEP entries have been made and a *Notice of Action* has been created that you have made an error (e.g., wrong social security number, misspelled name, woman is not pregnant, etc.), ask the DHS Contact Center for instructions on how to resolve the error. Do not reenter the application in MPEP unless instructed to do so by DHS.

6. Maintain documentation to support the presumptive eligibility decision for a period of five years for audit purposes. This may include, but is not limited to:
 - ◆ The application and addendum,
 - ◆ Clarification of any information provided by the applicant,
 - ◆ Proof of screening under BCCEDP (BCCT only), and
 - ◆ A copy of the *Notice of Action*.

NOTE: Do not send photocopies of the application, *Notice of Action*, or any other paperwork to DHS unless instructed to do so by the DHS Contact Center. Any information needed will be provided to DHS electronically based on the system entries made on MPEP.

7. Appeal Rights

Legal reference: 441 IAC 7.5(2)"a"(6)

An applicant denied presumptive Medicaid is entitled to appeal that decision. However, an appeal hearing will not be granted for a presumptive Medicaid determination. Appeal hearings are granted only with formal or ongoing Medicaid eligibility determinations made by the Department.



An individual applies for presumptive eligibility at the office of a QE on August 3. The individual also applies for ongoing Medicaid at the same time the individual applied for presumptive eligibility.

The QE enters the applicant's taxable income in MPEP. MPEP determines that the applicant's income exceeds the applicable limit for the applicant's household size and denies presumptive eligibility. If the applicant requests an appeal on the presumptive eligibility determination, the appeal request will be denied.

However, if DHS also denies the ongoing Medicaid application, the applicant may be granted an appeal based on that decision.

8. Covered Services

Legal reference: 441 IAC 79.9(3)-(4)

Providers shall supply all the same services to Medicaid-eligible individuals served by the provider as are offered to other clients of the provider. Individuals must be informed before the service is provided that the individual will be responsible for the bill if a non-covered service is provided.

With the exceptions discussed below for the presumptive Medicaid coverage groups of Pregnant Women and the Iowa Health and Wellness Plan, presumptive Medicaid provides full Medicaid benefits during the presumptive period. "Full Medicaid benefits" means that all Medicaid-covered services received from an Iowa Medicaid provider can be submitted to Iowa Medicaid for processing.

NOTE: Individuals approved under the BCCT presumptive coverage group are eligible to receive all Medicaid-covered services during the presumptive eligibility period. Their coverage is not limited only to services related to cancer treatment.

Covered services under the presumptive for Pregnant Women Medicaid coverage group are limited to ambulatory prenatal care services during the presumptive period. "Ambulatory prenatal care" means all Medicaid-covered services except inpatient hospital or institutional care and charges associated with delivery of the baby (including miscarriage or termination of a pregnancy).



If a woman approved under presumptive for Pregnant Women chooses to apply for ongoing Medicaid and is approved by DHS, claims for inpatient services and services associated with a delivery or miscarriage can be submitted to Iowa Medicaid for reimbursement consideration for Medicaid-covered services from an Iowa Medicaid provider.

Covered services under the Iowa Health and Wellness Plan presumptive Medicaid coverage group are limited to those benefits included under the Wellness Plan.

9. Period of Eligibility

The effective date of presumptive eligibility is the date a valid application for an eligible applicant was received by a presumptive provider organization or by an individual qualified entity (QE). Eligibility cannot be determined until a QE completes and submits the application into MPEP.

1. A QE working in a remote location without computer access receives an application for presumptive eligibility on September 30. The QE makes entries into MPEP on October 1 using the "application date" of September 30. The applicant is presumptively eligible. Presumptive eligibility begins on September 30.
2. An individual needing emergency surgery files a valid application with their name, address, and signature with a hospital QE before midnight on March 12. The QE obtains the rest of the applicant's necessary information and submits the application on MPEP on March 14 using the "application date" of March 12. The applicant is presumptively eligible. Presumptive eligibility begins on March 12.

A *Medical Assistance Eligibility Card* will not be issued to presumptively eligible applicants. Instead, the QE issues a *Presumptive Medicaid Eligibility Notice of Action* (form 470-2580 or 470-2580(S), 470-5190 or 470-5190(S), or 470-5191 or 470-5191(S)), to inform the applicant of the decision on the application.

The individual should present the *Presumptive Medicaid Eligibility Notice of Action* to show medical providers that the individual is presumptively eligible for benefits. Only Medicaid-covered services from medical providers who accept Iowa Medicaid may be covered.



Unlike regular Medicaid eligibility, which is granted on a monthly basis, presumptive eligibility may be terminated on any given day, without notice, once it is determined that the applicant is not presumptively eligible. Providers should confirm eligibility through the Eligibility Verification System (ELVS) each time services are requested. There is also no retroactive coverage under the presumptive Medicaid program.

If a presumptive applicant files an application for ongoing Medicaid coverage either before or during the presumptive period, presumptive eligibility coverage continues until a decision is made on the ongoing Medicaid application. The presumptive eligibility period ends on the day DHS enters a decision on the computer system to either approve or deny the Medicaid application.

An application for presumptive eligibility is received and approved on October 6. The application is automatically forwarded to DHS. DHS makes a decision on the ongoing Medicaid application on November 3. Presumptive eligibility ends November 3.

EXCEPTION: For children whose ongoing Medicaid is approved under the **hawk-i** coverage group, ongoing Medicaid coverage cannot begin until the first of the following month. The presumptive eligibility period ends the last day of the month before **hawk-i** coverage begins.

An application for presumptive eligibility for a child is received and approved on October 6. The application is automatically forwarded to DHS. DHS approves Medicaid under the **hawk-i** coverage group on October 18. Presumptive eligibility ends October 31.

If a Medicaid application has not been filed by the last day of the month following the month of the presumptive eligibility determination, presumptive eligibility ends on the last day of that month.

Presumptive eligibility will also end on the last day of the month following the month of the presumptive eligibility determination if an application for ongoing Medicaid is withdrawn, or if the application for ongoing Medicaid is not pended on the DHS' computer system by the last day of the month following the month of the presumptive eligibility determination.



An application for presumptive eligibility is received and approved on October 6. The ongoing Medicaid application is automatically sent to DHS. Before an eligibility determination is made, the applicant contacts DHS and withdraws the ongoing Medicaid application. Presumptive eligibility continues until November 30.

NOTE: A person may be determined presumptively eligible only once per pregnancy or once during a 12 month period (BCCT has an exception for a new cancer diagnosis). If a person wants Medicaid after presumptive eligibility ends, the person must apply and be determined eligible for ongoing Medicaid by DHS. The application may not be determined presumptively eligible again within a 12 month period (or during the same pregnancy for a pregnant woman).

No certificate of creditable coverage is issued for a presumptive eligibility period.

1. Ms. B is determined presumptively eligible as a pregnant woman on May 2. She does not apply for ongoing Medicaid at the time she applies for presumptive Medicaid. Instead, she files an ongoing Medicaid application on June 30, and DHS pends the application the same day. Ms. B's presumptive eligibility continues until DHS makes an eligibility determination on her Medicaid application.
2. Same as Example 1, except Ms. B's application for ongoing Medicaid is either not filed with or not pended by DHS until July 1. Ms. B's presumptive eligibility ends on June 30.
3. Child C is determined presumptively eligible on June 6 and applies for ongoing Medicaid at the same time the Child C applied for presumptive Medicaid. On June 20, DHS determines that Child C is not eligible and Child C's Medicaid application is denied. Child C's presumptive eligibility ends June 20.
4. Mr. D applies for ongoing Medicaid at the same time he applies for presumptive eligibility. He is determined presumptively eligible on July 29. By August 31, DHS has not been able to make an eligibility determination on his Medicaid application. If his application was pended at DHS, Mr. D's presumptive eligibility extends beyond August 31 and continues until DHS makes an eligibility determination.



D. ELIGIBILITY CATEGORIES AND REQUIREMENTS OVERVIEW

There are six types of Presumptive Eligibility (PE) programs:

- ◆ Children
- ◆ Pregnant women
- ◆ Breast and Cervical Cancer Treatment (BCCT)
- ◆ Iowa Health and Wellness Plan (IHAWP)
- ◆ Expanded Medicaid for Independent Young Adults (EMIYA)
- ◆ Parents and caretakers

NOTE: Hospitals are the only entities that may process all six types of PE programs.

Presumptive eligibility for all applicants is based on all the criteria discussed in this section. **NOTE:** Additional requirements specific to an eligibility category are covered later in the sections specific to each category.

All eligibility factors used in the presumptive eligibility determination are based on the applicant's self-attested circumstances. Proof of income or any other eligibility factor cannot be requested or required.

Presumptive Medicaid is available to individuals who are Iowa residents.

With exceptions for the presumptive categories of Pregnant Women and BCCT, an individual may only have presumptive eligibility once in a 12 month period. The Pregnant Women category limits presumptive eligibility to once per pregnancy. The BCCT category limits presumptive eligibility to once per 12 months but allows an exception for an individual who has a new cancer diagnosis and treatment period. MPEP data matches are used to determine if an individual had previous presumptive episodes in the applicable time period.

The PE application can be submitted without a social security number (SSN). Lack of a SSN has no impact on PE eligibility. However, QEs may encourage PE applicants to provide their SSNs to ensure proper identification. In addition, providing a SSN speeds up processing of the ongoing Medicaid application and allows DHS to verify more information through data matches, thus reducing information that must be requested from the applicant.



With the exceptions of the presumptive categories of Pregnant Women and BCCT, an individual must be either a U.S. citizen or have an eligible immigration status to be eligible for presumptive Medicaid.

These individuals never have eligible immigration status:

- ◆ Nonqualified aliens lawfully admitted to the U.S. only for a specific temporary reason (e.g., visitor for work or vacation, exchange student, temporary worker).
- ◆ Undocumented aliens in the U.S. without papers or status documentation.

These individuals always have eligible immigration status:

- ◆ Children under 21 lawfully present in the U.S.
- ◆ Asylees
- ◆ Refugees
- ◆ Cuban and Haitian entrants
- ◆ Conditional entrant granted before 1980
- ◆ Victims of trafficking and the victim's spouse, child, sibling, or parent or individuals with a pending application for a victim of trafficking visa
- ◆ People granted withholding of deportation
- ◆ Members of a federally recognized Indian tribe or American Indian born in Canada

Alien adults age 21 and over in these categories only have eligible immigration status once they have held a qualified status for five years:

- ◆ Lawful Permanent Residents (LPR/Green Card Holder)
- ◆ Battered non-citizens, spouses, children, or parents
- ◆ Paroled into the U.S. for at least one year



1. Presumptive Eligibility for Children

Legal reference: 42 USC 1396a(a)(A)(10)(i)(III), 1396a(e)(14), 1396r-1a, 1397bb;
42 CFR 435.118, 435.229, 435.603, 435.1101-1102, 457.310-320;
441 IAC 75.1(44), 75.70(240A), 75.71(249A), 86.2(2)

In addition to the general eligibility requirements, presumptive eligibility for children is based on the following criteria. The child must:

- ◆ Be under the age of 19. A child whose 19th birthday falls on the first of the month is no longer considered a child for the month of that birthday. A child whose 19th birthday falls on any other day of the month is considered a child for the month of the birthday.

A child who turns 19 on October 1 is considered a child through the month of September, but not in October. A child who turns 19 anytime from October 2 through 31 is considered a child through the month of October.

- ◆ Have countable household income that does not exceed 302 percent (children 1-18) or 375 percent (infants under age 1) of the federal poverty level based on the size of the household.

2. Presumptive Eligibility for Pregnant Women

Legal reference: 42 USC 1396a(a)(10)(i)(III), 1396a(e)(14), 1396r-1;
42 CFR 435.116, 435.603, 435.1103(a);
441 IAC 75.1(30), 75.70(249A) and 75.71(249A)

In addition to the general eligibility requirements, presumptive eligibility for a pregnant woman is based on the following criteria. The woman must:

- ◆ Have countable household income that does not exceed 375 percent of the federal poverty level for the household size.
- ◆ Be pregnant.

NOTE: The Department will end the presumptive eligibility period immediately upon being notified a woman is not actually pregnant. This sometimes occurs when a woman is approved for presumptive Medicaid based on symptoms of pregnancy or a pregnancy test result that is later determined to be a false positive.

There are no citizenship or immigration requirements for presumptive eligibility under the Pregnant Women coverage group.



3. Presumptive Eligibility for Individuals Who Need Treatment for Breast or Cervical Cancer

Legal reference: 42 USC 1396a(aa), 1396r-1b;
42 CFR 435.1103(c)(1);
441 IAC 75.1(40)“c”

In addition to the general eligibility requirements, presumptive eligibility under the breast and cervical cancer treatment (BCCT) coverage group is based on the following criteria. The individual must:

- ◆ Be under age 65.
- ◆ Have been screened and diagnosed:
 - Through the Breast and Cervical Cancer Early Detection Program (BCCEDP), or
 - By any provider or entity and BCCEDP has elected to include screening activities by that provider or entity.

This screening includes breast or cervical cancer screenings or related diagnostic services provided or funded by family planning or centers, community health centers, or nonprofit organizations, and the screenings or services are provided to individuals who meet the eligibility requirements established by the BCCEDP.

- ◆ Need treatment for a cancerous or pre-cancerous condition of the breast or cervix.
- ◆ Not have creditable health insurance coverage.

There are no income, resource, or citizenship or immigration requirements for presumptive eligibility under BCCT.

4. Presumptive Eligibility for Iowa Health and Wellness Plan

Legal reference: 42 USC 1396a(e)(14), 42 CFR 435.119, 435.1103, 435.1110, 440.315(f), Iowa Code 249A.4, 249N;
441 IAC Chapter 74; 441 IAC 75.70 (249A)

In addition to the general eligibility requirements, presumptive eligibility under the Iowa Health and Wellness Plan (IHAWP) coverage group is based on the following criteria. The individual must:

- ◆ Be at least age 19 and under age 65.
- ◆ Not be pregnant.



- ◆ Not be eligible for or enrolled in Medicare under Part A or Part B.
- ◆ Not be eligible for any other Medicaid coverage group, other than Medically Needy.
- ◆ Have or be applying for minimum essential coverage for any dependent children living in their household for whom the individual has parental control.
- ◆ Have income that does not exceed 133 percent of the federal poverty level based on the size of the household.

5. Expanded Medicaid for Independent Young Adults

Legal reference: USC 42 1396a(a)(10)(A)(i)(IX);
42 CFR 435.150, 1103, 435.1110;
Iowa Code 249A.3(1)(w);
441 IAC 75.1(45)

In addition to the general eligibility requirements, presumptive eligibility under the Expanded Medicaid for Independent Young Adults (EMIYA) coverage group is based on the following criteria. The individual must:

- ◆ Be at least age 18 and under age 26.
- ◆ Have been in a foster care placement under the responsibility of Iowa when the youth turned age 18 (or otherwise aged out of foster care).
- ◆ Have been receiving federally funded Medicaid through Iowa when the youth turned age 18 (or otherwise aged out of foster care).
- ◆ Not be eligible for Medicaid under another coverage group other than EMIYA, Iowa Health and Wellness Plan, or Medically Needy.

There are no income limits for presumptive eligibility under EMIYA.

Youth who were in foster care and receiving Medicaid from a state other than Iowa when reaching age 18 do not qualify for coverage under the presumptive EMIYA coverage group.

Youth who are under age 26 and who aged out of foster care before January 1, 2014, are eligible for presumptive EMIYA if the other eligibility requirements are met.



6. Presumptive Eligibility for Parents and Caretakers

Legal reference: 42 CFR 435.110, 435.1110;
441 IAC 75.70(249A) and 75.71(249A)

In addition to the general eligibility requirements, presumptive eligibility under the parents and caretakers coverage group is based on the following criteria. The individual must:

- ◆ Meet the applicable income limits for the household size.
- ◆ Have “parental control” of a dependent child under the age of 18 (or age 18 and still in high school) living in their household.

Parents automatically have parental control of their own dependent child.

Other adults are caretakers with “parental control” of a dependent child when they have assumed the role and responsibilities of a parent due to the absence or incapacity of a parent.

Spouses of parents and spouses of caretakers are also eligible to claim parental control.

MPEP will calculate eligibility under the parents and caretakers coverage group using the following income limits:

Household Size	Monthly Income Limit
1	\$447
2	\$716
3	\$872
4	\$1,033
5	\$1,177
6	\$1,330

Household Size	Monthly Income Limit
7	\$1,481
8	\$1,633
9	\$1,784
10	\$1,950
Over 10	Add \$178 for each additional person