INSTRUCTIONS FOR HEALTH SERVICES APPLICATION

Complete this form if you live in Iowa and want to get:

- Medical Assistance (Title 19 or Medicaid) – provides health care coverage
  Other programs within Medical Assistance Program are:
  - Facility Care – helps pay your nursing home cost
  - Medicaid for children in foster care or subsidized adoption
  - Waiver – helps keep people at home and not in a nursing home
  - Medicare Savings Program – pays all or part of your Medicare premium
  - State Supplementary Assistance (State Supp) – help for people who are at least 65 or disabled.
- WIC (Special Supplemental Nutrition Program for Women, Infants and Children) – helps with checks for special foods that can be used at Iowa grocery stores and pharmacies for pregnant and postpartum women, and children under the age of 5.
- Maternal and Child Health – provides health care services for children under the age of 21 and women of childbearing age.

This is not the right form if you want to get Food Assistance or cash assistance through the Family Investment Program (FIP).

Please do not let fear of the Immigration and Naturalization Service (INS) keep you from getting help for your family. Getting help will not keep you from gaining lawful, permanent residence, U.S. citizenship, or from sponsoring relatives.

To apply for help, follow these four easy steps:

1. **Complete the Application**
   Fill out and sign the application. Please be truthful. If you are applying for someone else, answer the questions as they relate to that person.
2. **File the Application**
   Mail or take it to the Department of Human Services (DHS) in your county. The date your help starts is based on the date the DHS office gets your application. Do not wait.
3. **Provide Any Needed Proof**
   See the table below for what is needed. Including copies of the proof will help speed up the processing of your application.
4. **An Interview May Be Needed**
   An interview may not be needed if you are applying only for a child. All adults applying for help must have an interview.

Needed Proof by Program

In addition to your application, please provide any proof needed for the program(s) you are applying for.

	Medical Assistance	Facility or Waiver	Medicare Savings Program	Foster Care-Sub Adoption	State Supp	WIC	Maternal and Child Services
Proof of who you are (ID): driver's license, birth certificate, etc.	✓	✓	✓	✓	✓	✓	✓
Proof you are a U.S. citizen or national (birth certificate with ID, U.S. passport, etc.)	✓	✓	✓	✓	✓		
Proof you have applied for a Social Security Number (if you don't already have one)	✓	✓	✓	✓	✓		
Proof of any health insurance premium paid: bill, pay stub showing deduction, etc.		✓		✓	✓		
Proof of income* or any other money coming into your household	✓	✓	✓	✓	✓	✓	✓
Proof of child care, dependent adult care costs, child support or alimony paid	✓		✓	✓	✓		
Most recent statements for any bank accounts: checking, credit union, savings, etc.**	✓	✓	✓	✓	✓		
Proof of current value of stocks/bonds, life insurance, certificates of deposit, trusts**	✓	✓	✓	✓	✓		
Proof of current living address						✓	✓

* Pay stubs from the last 30 days if you are employed or federal income tax records if you are self-employed. Award letters for Social Security Benefits, Veterans Benefits, etc.

** May not be needed if just applying for a child.

RIGHTS AND RESPONSIBILITIES – READ AND KEEP THIS SHEET

INFORMATION FOR ADULTS AND CHILDREN APPLYING FOR MEDICAL ASSISTANCE

- I understand I assume full responsibility for the accuracy of the statements on this form. I understand the Department of Human Services (DHS) will use this statement to determine my eligibility for Medical Assistance.
- I understand my eligibility will not be affected by my race, creed, color, national origin, age, disability, or sex, except where this is restricted by law.
- I understand that I have the right to a hearing if this application is denied or not acted upon promptly or if services granted are terminated, reduced, or suspended. I understand that I can get a hearing by making a request in writing to my local DHS office and that I may represent myself or use a lawyer, relative, friend, or other spokesperson.
- I am aware that my case may be picked by the Department for a complete Quality Control or other review of my eligibility for assistance. If my case is selected for verification, I will cooperate fully in the verification. I hereby authorize all persons to release confidential information concerning my eligibility to a DHS reviewer. I understand that failure to cooperate with such a review can result in denial or cancellation of benefits.
- I will notify my LOCAL DHS office within ten days of any changes in medical benefits or health insurance coverage. In addition, I understand that I am to notify my medical providers (doctors, pharmacist, etc.) if another party may be liable to pay my medical expenses. I will notify my LOCAL DHS office within ten days if I file an insurance claim or retain an attorney to seek payment for injuries and medical expenses resulting from those injuries that otherwise would be paid by Medicaid. Failure to comply with my responsibilities can give the Department cause to deny or terminate Medicaid eligibility.
- 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 from third parties.
- I understand that I am to reimburse the Department for any money paid to me or paid to a provider on my behalf to which I was not entitled.
- I further understand that the Department will provide documents or claim forms describing the services paid by Medicaid upon my request or the request of an attorney acting on my behalf. Such documents may also be provided to a third party when necessary to establish the extent of the Department's claim for reimbursement.
- I understand that federal and state law and rules permit access by authorized federal and state officials to Medicaid providers' records. I also fully understand that my acceptance of Medicaid is my consent for these authorized persons to have access to my medical and health care records during the time I am eligible for Medicaid, as necessary to verify appropriate Medicaid payment.
- I give my permission to tell my medical providers the status for my Medically Needy case, including the amount of my spenddown and their bills used to meet spenddown, or when a premium is due for Medicaid for Employed People with Disabilities.
- If I become enrolled in a managed health care plan, I consent to disclosure of medical information, including any clinical mental health or substance abuse information, by my medical providers to the HMO, PHP, other managed care providers or to the authorized administrative body contracted by the managed care provider to determine appropriateness, quality, or utilization of services I received while enrolled in managed health care.
- I understand that if Medical Assistance is approved, support payments intended for medical costs must be assigned and paid to the Department of Human Services to the extent of the benefits I receive. I understand that the Department may intervene, according but not limited to, Iowa Code Chapters 252A, 252B, 252C, 252D, 598, and 600B, to make claim and secure support from any person or party who may be responsible for my support or that of my children. I understand that if I receive Medicaid, the Department may pursue non-medical support for myself and my children unless I notify the Department that services unrelated to medical support are not wanted. Medical support services include the establishment of paternity and the establishment and enforcement of medical support.
- I am aware that Section 1128B of the Social Security Act provides federal penalties for fraudulent acts and false reporting. Anyone who obtains, or tries to obtain, or helps any other person to obtain public assistance to which the person is not entitled is guilty of violating the laws of the state of Iowa. These laws include, but are not limited to, Iowa Code Chapters 243, 239B, 249A, and 249A.
- I understand and agree that I will need to provide the Department with either documentation from the Immigration and Naturalization (INS) or other documents the Department considers to be proof of the immigration status of each person in my household who is not a United States citizen or national. I understand that alien status may be subject to verification with INS, which will require submission of certain information from this application form to INS. I further understand that information received from INS may affect my household's eligibility and level of benefits.
- If I filled out a separate application for food assistance and that application was referred to the Food Stamp Investigation Unit, I will cooperate with the investigation in order to receive Medicaid when the investigation involves income, resources and household composition that affect my Medicaid eligibility.
- I understand that the facts I give determine financial eligibility. A medical certification is also needed prior to approval for certain Medical Assistance programs. To determine medical certification, the Iowa Medicaid Enterprise (IME) Medical Services may need to contact my physician. I authorize my physician or health care provider to release information to IME Medical Services for this purpose. I agree to allow DHS to disclose the filing of this application to my nursing facility in order to obtain the level of care determination necessary for eligibility. A copy of this form received by fax will be given the same effect as the original.

MORE INFORMATION FOR ADULTS APPLYING FOR MEDICAL ASSISTANCE

- I will notify the LOCAL DHS office of any change in my information on this application, including but not limited to, anticipated income or property such as an inheritance, lump-sum payments on delinquent child support, or any change in income or living arrangements of myself or any other member of my family. If I have any doubt whether a particular change in circumstances is information that must be reported, I shall report this to my LOCAL office no later than ten days from the date the change occurs. I also understand that I am to pay back to the Department any money received by me or paid to a vendor on my behalf to which I was not entitled.
- I understand payments under the Medical Insurance Program (Part B of Medicare) will be made directly to the physicians and medical suppliers on any future unpaid bills for medical and other health services furnished me while eligible for Medicaid.
- I authorize the DHS to share information from this application, and information about my condition from the designated Assessment Tool with IME Medical Services for all home and community based service (HCBS) waivers and the Area Agency on Aging Case Management Team for my HCBS elderly waiver services.

INFORMATION FOR THOSE APPLYING FOR WIC OR MATERNAL AND CHILD HEALTH SERVICES

- I understand that a declaration of income and persons in my family and living in my household is necessary to ensure that federal and state funds are directed to those persons least able to secure services from other sources.
- I understand that the Maternal and Child Health Director of the Iowa Department of Public Health, the WIC Director, or their designees shall have access to all information available from records maintained by the agency providing maternal health, child health, or WIC services.

HEALTH SERVICES APPLICATION

HOUSEHOLD INFORMATION – Complete for all programs				
First Name	Middle Name	Last Name		
Home Address	City	State	County	Zip Code
Mailing Address (if different from above) OR Payee or Representative's Name & Address				
Home Phone Number ( )	Message Number ( )	Name of Message Contact Person		

Check the program(s) you would like to receive:
- ❑ **Medical Assistance (Title 19 or Medicaid)**
  - ❑ **Facility** ❑ **Medicare Savings Program** ❑ **Waiver**
  - ❑ **Foster Care/Subsidized Adoption** ❑ **State Supplementary Assistance**
- ❑ **Maternal and Children Health Services**
- ❑ **WIC**
- ❑ **Iowa Family Planning Network**

IF YOU NEED MORE ROOM TO ANSWER ANY OF THE FOLLOWING QUESTIONS, ATTACH EXTRA PAGES.

Start with yourself, then list all the people who live in your home.

NAME (First, Middle, Last)	Are you applying for this person?	How is this person related?	Medical services received in past 3 months? What month(s)?	Social Security Number	Sex	Birth Date	Birth State	Last Grade Completed	Citizen	Ethnicity*	Race**	If a child, is a parent NOT living with them?	Other health insurance available?
	❑ Yes ❑ No	SELF	❑ Yes ❑ No Month(s):		❑ Male ❑ Female				❑ Yes ❑ No			❑ Yes ❑ No	❑ Yes ❑ No
	❑ Yes ❑ No		❑ Yes ❑ No Month(s):		❑ Male ❑ Female				❑ Yes ❑ No			❑ Yes ❑ No	❑ Yes ❑ No
	❑ Yes ❑ No		❑ Yes ❑ No Month(s):		❑ Male ❑ Female				❑ Yes ❑ No			❑ Yes ❑ No	❑ Yes ❑ No
	❑ Yes ❑ No		❑ Yes ❑ No Month(s):		❑ Male ❑ Female				❑ Yes ❑ No			❑ Yes ❑ No	❑ Yes ❑ No
	❑ Yes ❑ No		❑ Yes ❑ No Month(s):		❑ Male ❑ Female				❑ Yes ❑ No			❑ Yes ❑ No	❑ Yes ❑ No

We have to ask your ethnicity and race, but you don't have to answer. Your answer won't affect how much you get or how soon. If you answer, use the following coding:

* Ethnicity: H = Hispanic or Latino; N = Not Hispanic or Latino

** Race (Choose all that apply): W = White; B = Black or African American; A = Asian; I = American Indian or Alaskan Native; N = Native Hawaiian or other Pacific Islander.

List pregnant persons who live in your home ________________ Due Date (MMDDYY) ________________

Are you interested in family planning services for females in your household who are at least 13 or under 45 years of age? ❑ Yes ❑ No

INCOME: List all income the people living in your home get. Include income from work, self-employment, Social Security, Veteran's Benefits, unemployment insurance, child support, worker's compensation, railroad retirement, IPERS, pensions, civil service, cash from friends, or relatives, etc.

Person who received money	**Employer or income source**	**Amount before taxes or deductions**	**How often is this amount paid?**	**Is this income expected to continue? If 'NO,' explain:**
			❑ Weekly ❑ Every other week ❑ Monthly ❑ Twice a month ❑ Other _____	❑ Yes ❑ No
			❑ Weekly ❑ Every other week ❑ Monthly ❑ Twice a month ❑ Other _____	❑ Yes ❑ No
			❑ Weekly ❑ Every other week ❑ Monthly ❑ Twice a month ❑ Other _____	❑ Yes ❑ No
			❑ Weekly ❑ Every other week ❑ Monthly ❑ Twice a month ❑ Other _____	❑ Yes ❑ No

RESOURCES: A resource is cash or anything that can be changed to cash. List all resources and the amount or value. Include cash on hand, checking accounts, vehicles, life insurance, stocks, bonds, certificates of deposits (CDs), trust funds, retirement accounts, burial contracts, burial spaces, annuities, etc. If only applying for medical coverage for a child, resources may not be counted.

Person with resource	Type of resource	Amount or Value	Location (bank's name and address, home, etc.)

If you made the State of Iowa a remainder beneficiary on an annuity, in order to qualify for Medicaid payment of long-term care, the State of Iowa will get any benefits remaining in the annuity, up to the amount of Medicaid benefits paid.

Did anyone in your home sell or give away anything of value in the last 60 months? (This includes real and personal property; real estate; income; inheritance, etc.)
❑ Yes ❑ No

Does anyone in your home pay child support or alimony for a person who does not live with you? ❑ Yes ❑ No
If yes, who pays? _____ Amount? _____

Does anyone in your home pay for someone to care for a child or disabled adult? ❑ Yes ❑ No
If yes, how much is paid? _____ How often? _____ To whom? _____

Are you willing to cooperate to get medical support? ❑ Yes ❑ No (Answer if you are a parent or caretaker applying for self and a child.)

INFORMATION ABOUT THE PARENT(S) NOT LIVING IN THE HOME: List the name of any parent who is not living with you and the children you are applying for, who they are the parent of, their date of birth, and social security number. A child can still get medical assistance if you do not provide this information.

Name of parent not living in the home:	Name of children of this parent:	Date of birth of this parent:	Social security number of this parent:

SOCIAL SECURITY NUMBER (SSN)

You must fill in the SSN of all persons listed above on this application to get Medical Assistance. Section 1137(a)(1) of the Social Security Act and 42 CFR 435.910 requires this. If you do not want Medicaid, you do not have to give us your SSN. The SSN will be used:

- To check income, eligibility and amount of Medical Assistance payments to be made on your behalf.
- To determine another person's right to Medical Assistance.
- To comply with Federal law which requires release of information from Medicaid records.
- To match with records in other agencies such as: Social Security Administration, Internal Revenue Services, and Iowa Workforce Development. These matches may be done by computer or on an individual basis.

My rights and responsibilities were provided to me on the back of the instructions for this Health Services Application. I have read and removed the instruction sheet from this Health Services Application for my future use.

I CERTIFY THAT THESE STATEMENTS ARE CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF.

Signature or mark of applicant	Date	Signature or mark of other parent or stepparent in the home	Date	Signature of person, if any, who helped complete this form	Date