Iowa Department of Human Services

Medicaid Review

County Number: Worker Name:

Case Number: Phone No.:

Instructions

It is time for your eligibility for Medicaid or State Supplementary Assistance to be reviewed. You must answer the questions on this form and **sign Page 4**. Use only blue or black ink. Then, return it to the imaging center address by

Be sure to send proof of your expenses, income and assets. Send copies because we cannot return originals to you.

If you leave a space blank, we will take that to mean that you have no information to give us. You may be asked to prove what you tell us. Please use an additional sheet of paper, if needed. Most of the information that we ask for is required. You do not have to answer questions that are marked as optional. Your answers are used to decide if you can continue to get Medicaid. If you do not return the form by the due date or give us information, your Medicaid may stop. Call us if you have any questions.

Information About Your Family

List yourself and the people who live in your home.

Name (First, Last)	Relationship to You	Age	Social Security Number
	Self		

Tell us if your mailing or living address changed from the address shown above.

Mailing address			Living address		
City	State	Zip Code	City	State	Zip Code

Do you have a guardian, conservator, or representative? If yes, print their names here: ______________________

Expenses

To get the most help you can, tell us about your expenses. **Send proof of your expenses.**

Medical expenses

If you pay for health insurance, write in how much you pay: Amount $ ____________ per month

If you started or changed health insurance, write in the name of the new company: ______________________________

If your health insurance ended, write in the date it stopped: Date: ____________

List anyone in your home who has ongoing medical bills that Medicaid does not pay:

Who: ________________________ Relationship to you: ______________

Other expenses

List your share of any day care paid for a child or a disabled adult who lives with you:

Who gets care: ________________ Amount $ ____________ per month

If anyone currently pays child support, give the following information:

Who pays: ________________ Amount $ ____________ per month

Income

List income of the people in your home. This includes you, your spouse, and your unmarried children under the age of 18 who are living with you or who are living in a nursing home.

Where the Money Comes From	Who Gets the Money	Gross Amount Per Month
Social Security, Social Security Disability, or SSI		
Veterans, Pensions or Retirement Benefits		
Unemployment, Worker's Compensation or Disability		
Child Support or Alimony		
Cash Medical Support		
Money from Friends or Relatives		
Money from Interest or Dividends		
Money You Get from Contracts		
Money From Work Before Taxes (Gross)		
Self-Employment or Odd Jobs		
Tips, Bonuses and Commissions		
Other:		

List the name of all employers: ______________________________

Send proof of your money from work for the past 30 days.

Do you work for anyone who pays you in the form of food, clothing or shelter? ❑ Yes ❑ No

Does anyone give you food, clothing or shelter? ❑ Yes ❑ No

Assets

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

Make	Model	Year	Value or Worth	Amount Owed

List the total money everyone in your home has in:

Type	Who	Bank or Location	Amount
Cash			
Bank/Credit Union Accounts (Checking, savings, etc.)			
Stocks, bonds, savings certificates, IRAs, Keogh or other assets			
Nursing home account			
Other			

Send your most recent bank statement with this form.

List anyone in your home who has or owns any land, buildings or houses other than the house you live in: ______________________________

List anyone in your home who has or has sold a conservatorship, trust or life estates:

____

If you bought, changed, or disposed of life insurance, a burial contract, or a burial plot in the past year, tell us about the change: ______________________________

If you got an inheritance or turned down an inheritance, list the following:

When? ______________________ Amount $_____________________________

If anyone gave away anything of value, transferred anything for less than its value, or added someone else's name to a resource, tell us:

When? ______________________ What? ______________________________

Other Changes or Comments

____

____

____

____

Your Signature

I understand that if the children on this application are not eligible for Medicaid, this application may be referred to the ***hawk-i*** program to see if the children could get ***hawk-i*** health care coverage.

I certify, under penalty of perjury, that:

- My answers are correct and complete to the best of my knowledge.
- I kept the information on page 7 and 8.

Your Signature or Mark	Phone Number	Today's Date
Signature of Person, If Any, Who Helped Complete the Form	Relationship/Phone Number	Today's Date

Remember to send proof of your expenses, income and assets.

Addendum to Application and Review Forms for Release of Information

OPTIONAL Release of Information

Help Us Help You!

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

You should know that:

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

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

RELEASE OF INFORMATION

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

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

This release does not apply to protected health information.

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

______________________	______________________
Your Name (please print clearly)	Other Adult Name (please print clearly)
______________________	______________________
Signature or Mark	Signature or Mark
______________________	
Date	

Keep this page for your records.

You Have the Right to Appeal

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

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

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

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

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

You Will Not Be Discriminated Against

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

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

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

Changes You Need to Tell Us About

Within 10 days of the date the change happens, you must tell the DHS county office about changes, such as:

- Income, including any one-time payments you get
- Resources, which includes getting an inheritance or a one-time payment of past due child support
- Someone moving in or out of your home
- Your health insurance coverage
- You file an insurance claim or get an attorney to recover bills paid by Medicaid
- Someone is no longer disabled

Things You Need to Know

By signing this form, you give permission to release confidential information to the Quality Control unit or Investigations unit. You must cooperate with them to keep your benefits.

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

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

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

You must give the social security numbers for everyone who wants Medicaid. This is required by Section 1137(a)(1) of the Social Security Act and 42 CFR 435.910. We use social security numbers to:

- Identify people who apply for or get Medicaid
- Verify income and eligibility for Medicaid
- Match records with other agencies

By signing this application, you give your permission for DHS to share:

- The status of your Medically Needy case, the amount of your spenddown, and the bills used to meet your spenddown with the provider whose bills are being used.
- If the Medicaid for Employed People with Disabilities (MEPD) premium has been paid by the due date with your Medical provider.

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