DHS office
Phone #
641-424-8641

Department of HUMAN SERVICES

Application for Health Coverage and Help Paying Costs

Use this application to see what coverage choices you qualify for

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

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

Who can use this application?

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

Apply faster online

Apply faster online at dhsservices.iowa.gov.

What you may need to apply

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

Why do we ask for this information?

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

What happens next?

Send your complete, signed application to the address on page 16. **If you don't have all the information we ask for, sign and submit your application anyway.** We'll follow-up with you within 30 days. You'll get instructions on the next steps to complete your health coverage. If you don't hear from us within 30 days, call the DHS Contact Center at **1-855-889-7985**. Filling out this application doesn't mean you have to buy health coverage.

Get help with this application

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

Step 1. Tell us about yourself.

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

First name, middle name, last name, and suffix			
Home address (If you leave blank because you don't have one, you must give us a mailing address below.)			Apartment or suite number
City	State	ZIP code	County
Mailing address (if different from home address)			Apartment or suite number
City	State	ZIP code	County
Phone number		Other phone number	
Do you want to get information about this application by email? ☐ Yes ☐ No Email address:			
Preferred spoken or written language (if not English)			

Step 2. Tell us about your family.

Who do you need to include on this application?

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

DO include:

- Yourself
- Your spouse
- Your children under 21 who live with you
- Your unmarried partner who needs health coverage
- Your unmarried partner who lives with you when you have a child or children together
- 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 lives with you and doesn't need health insurance unless you have a child or children together
- Your unmarried partner's children
- Your parents who live with you, but file their own tax return (if you're over 21)
- Other adult relatives who file their own tax return

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

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

Step 2. Person 1 (start with yourself)

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

First name, middle name, last name, and suffix		Relationship to you? **SELF**
Date of birth (mm/dd/yyyy)	Sex: ☐ Male ☐ Female	Social Security Number (SSN)

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

Do you plan to file a federal income tax return THIS 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? _____

☐ Yes ☐ No Are you currently incarcerated?

☐ Yes ☐ No Are you currently assigned to a work release program?
If yes, what is the start 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 before August 22, 1996?

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

☐ Yes ☐ No Are you a resident of Iowa?

☐ Yes ☐ No Do you need help paying for medical bills from the last three calendar months? If you answer yes and you fall into a category that allows for retroactive approval, we will determine if you are eligible for coverage during those months.

☐ Yes ☐ No Are you an adult who is a main person taking care of a child under the age of 19 living in the home?

☐ Yes ☐ No Are you a full-time student?

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

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

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

If Hispanic or Latino, ethnicity:
- ☐ Mexican
- ☐ Mexican American
- ☐ Chicano/a
- ☐ Puerto Rican
- ☐ Cuban
- ☐ Other: _____

Race:
- ☐ White
- ☐ Black or African American
- ☐ American Indian or Alaska Native
- ☐ Asian Indian
- ☐ Chinese
- ☐ Filipino
- ☐ Japanese
- ☐ Korean
- ☐ Vietnamese
- ☐ Other Asian
- ☐ Native Hawaiian
- ☐ Guamanian or Chamorro
- ☐ Samoan
- ☐ Other Pacific Islander
- ☐ Other: _____

Current Job and Income Information: You must tell us about the income of the people in your household. If someone has more than one job, tell us about all jobs. If you leave a space blank, we will assume that you have no income of this kind.

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

Current Job 1:

Employer name and address				Employer phone number
Wages and tips (before taxes) $	☐ Hourly ☐ Twice a month	☐ Weekly ☐ Monthly	☐ Every 2 weeks ☐ Yearly	Average hours worked each month:

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

Employer name and address				Employer phone number
Wages and tips (before taxes) $	☐ Hourly ☐ Twice a month	☐ Weekly ☐ Monthly	☐ Every 2 weeks ☐ Yearly	Average hours worked each month:

Will the amount of money from jobs stay about the same? ☐ Yes ☐ No
If no, explain: _____

In the past three months, 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? $ _____

Will the amount of monthly income from self-employment stay about the same? ☐ Yes ☐ No
If no, how much do you expect to average over a 12 month period? $ _____

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

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

Will the amount of money from other income stay about the same? ☐ Yes ☐ No
If no, explain: _____

Deductions: If you pay for certain things that can be deducted on a federal income tax return, check all that apply and give the amount and how often you pay. This information can be found on the Adjusted Gross Income section of your Federal 1040 form. **NOTE:** You shouldn't include a cost that you already considered in your answer to net self-employment.

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

Step 2. Person 2

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

First name, middle name, last name, and suffix		Relationship to you?
Date of birth (mm/dd/yyyy)	Sex: ☐ Male ☐ Female	Social Security Number (SSN)

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

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

Does *Person 2* plan to file a federal income tax return THIS 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? What is the due date? _____

☐ Yes ☐ No Is *Person 2* currently incarcerated?

☐ Yes ☐ No Is *Person 2* currently assigned to a work release program? **If yes**, what is the start date? _____

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 before August 22, 1996?

☐ Yes ☐ No Is *Person 2* or their spouse or parent an honorably discharged 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* need help paying for medical bills from the last three calendar months? If you answer yes and this person falls into a category that allows for retroactive approval, we will determine if this person is eligible for coverage during those months.

☐ Yes ☐ No Is *Person 2* an adult who is a main person taking care of a child under the age of 19 living in the home?

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

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

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

☐ Yes ☐ No Did *Person 2* have insurance through a job and lose it within the past three months?
If yes, end date: _____ Reason insurance ended: _____

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

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

If Hispanic or Latino, ethnicity:
- ☐ Mexican
- ☐ Mexican American
- ☐ Chicano/a
- ☐ Puerto Rican
- ☐ Cuban
- ☐ Other: _____

Race:
- ☐ White
- ☐ Black or African American
- ☐ American Indian or Alaska Native
- ☐ Asian Indian
- ☐ Chinese
- ☐ Filipino
- ☐ Japanese
- ☐ Korean
- ☐ Vietnamese
- ☐ Other Asian
- ☐ Native Hawaiian
- ☐ Guamanian or Chamorro
- ☐ Samoan
- ☐ Other Pacific Islander
- ☐ Other: _____

Current Job and Income Information: You must tell us about the income of the people in your household. If someone has more than one job, tell us about all jobs. If you leave a space blank, we will assume that you have no income of this kind.

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

Current Job 1:

Employer name and address				Employer phone number
Wages and tips (before taxes) $	☐ Hourly ☐ Twice a month	☐ Weekly ☐ Monthly	☐ Every 2 weeks ☐ Yearly	Average hours worked each month:

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

Employer name and address				Employer phone number
Wages and tips (before taxes) $	☐ Hourly ☐ Twice a month	☐ Weekly ☐ Monthly	☐ Every 2 weeks ☐ Yearly	Average hours worked each month:

Will the amount of money from jobs stay about the same? ☐ Yes ☐ No
If no, explain: _____

In the past three months, 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? $ _____
Will the amount of monthly income from self-employment stay about the same? ☐ Yes ☐ No
If no, how much do you expect to average over a 12 month period? $ _____

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

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

Will the amount of money from other income stay about the same? ☐ Yes ☐ No
If no, explain: _____

Deductions: If *Person 2* pays for certain things that can be deducted on a federal income tax return, check all that apply and give the amount and how often *Person 2* pays. This information can be found on the Adjusted Gross Income section of *Person 2's* Federal 1040 form. **NOTE:** You shouldn't include a cost that you already considered in your answer to net self-employment.

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

Step 2. Person 3

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

First name, middle name, last name, and suffix		Relationship to you?
Date of birth (mm/dd/yyyy)	Sex: ☐ Male ☐ Female	Social Security Number (SSN)

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

☐ Yes ☐ No Does *Person 3* live at the same address as you? **If no**, list address: _____

Does *Person 3* plan to file a federal income tax return THIS YEAR?

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

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

☐ Yes ☐ No 1. Will *Person 3* file jointly with a spouse? **If yes**, name of spouse: _____

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

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

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

☐ Yes ☐ No Is *Person 3* currently incarcerated?

☐ Yes ☐ No Is *Person 3* currently assigned to a work release program? **If yes**, what is the start date? _____

Does *Person 3* need health coverage?

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

☐ Yes. **If yes**, answer all the questions below. ☐ No. **If no**, skip to the income questions on page 7. Leave the rest of this page blank.

☐ Yes ☐ No Does *Person 3* have a physical, mental, or emotional health condition that causes limitations in activities (like bathing, dressing, daily chores, etc.) or live in a medical facility or nursing home?

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

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

☐ Yes ☐ No Has *Person 3* lived in the U.S. since before August 22, 1996?

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

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

☐ Yes ☐ No Does *Person 3* need help paying for medical bills from the last three calendar months? If you answer yes and this person falls into a category that allows for retroactive approval, we will determine if this person is eligible for coverage during those months.

☐ Yes ☐ No Is *Person 3* an adult who is a main person taking care of a child under the age of 19 living in the home?

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

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

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

☐ Yes ☐ No Did *Person 3* have insurance through a job and lose it within the past three months?
If yes, end date: _____ Reason insurance ended: _____

☐ Yes ☐ No Is *Person 3* a full-time student?

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

If Hispanic or Latino, ethnicity:
- ☐ Mexican
- ☐ Mexican American
- ☐ Chicano/a
- ☐ Puerto Rican
- ☐ Cuban
- ☐ Other: _____

Race:
- ☐ White
- ☐ Black or African American
- ☐ American Indian or Alaska Native
- ☐ Asian Indian
- ☐ Chinese
- ☐ Filipino
- ☐ Japanese
- ☐ Korean
- ☐ Vietnamese
- ☐ Other Asian
- ☐ Native Hawaiian
- ☐ Guamanian or Chamorro
- ☐ Samoan
- ☐ Other Pacific Islander
- ☐ Other: _____

Current Job and Income Information: You must tell us about the income of the people in your household. If someone has more than one job, tell us about all jobs. If you leave a space blank, we will assume that you have no income of this kind.

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

Current Job 1:

Employer name and address				Employer phone number
Wages and tips (before taxes) $	☐ Hourly ☐ Twice a month	☐ Weekly ☐ Monthly	☐ Every 2 weeks ☐ Yearly	Average hours worked each month:

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

Employer name and address				Employer phone number
Wages and tips (before taxes) $	☐ Hourly ☐ Twice a month	☐ Weekly ☐ Monthly	☐ Every 2 weeks ☐ Yearly	Average hours worked each month:

Will the amount of money from jobs stay about the same? ☐ Yes ☐ No
If no, explain: _____

In the past three months, did *Person 3*:
☐ Change jobs ☐ Stop working ☐ Start working fewer hours ☐ None of these

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

Type of work _____

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

Will the amount of monthly income from self-employment stay about the same? ☐ Yes ☐ No
If no, how much do you expect to average over a 12 month period? $ _____

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

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

Will the amount of money from other income stay about the same? ☐ Yes ☐ No
If no, explain: _____

Deductions: If *Person 3* pays for certain things that can be deducted on a federal income tax return, check all that apply and give the amount and how often *Person 3* pays. This information can be found on the Adjusted Gross Income section of *Person 3's* Federal 1040 form. **NOTE:** You shouldn't include a cost that you already considered in your answer to net self-employment.

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

Step 2. Person 4

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

First name, middle name, last name, and suffix		Relationship to you?
Date of birth (mm/dd/yyyy)	Sex: ☐ Male ☐ Female	Social Security Number (SSN)

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

☐ Yes ☐ No Does *Person 4* live at the same address as you? **If no**, list address: _____

Does *Person 4* plan to file a federal income tax return THIS YEAR?

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

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

☐ Yes ☐ No 1. Will *Person 4* file jointly with a spouse? **If yes**, name of spouse: _____

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

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

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

☐ Yes ☐ No Is *Person 4* currently incarcerated?

☐ Yes ☐ No Is *Person 4* currently assigned to a work release program? **If yes**, what is the start date? _____

Does *Person 4* need health coverage?

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

☐ Yes. **If yes**, answer all the questions below. ☐ No. **If no**, skip to the income questions on page 9. Leave the rest of this page blank.

☐ Yes ☐ No Does *Person 4* have a physical, mental, or emotional health condition that causes limitations in activities (like bathing, dressing, daily chores, etc.) or live in a medical facility or nursing home?

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

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

☐ Yes ☐ No Has *Person 4* lived in the U.S. since before August 22, 1996?

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

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

☐ Yes ☐ No Does *Person 4* need help paying for medical bills from the last three calendar months? If you answer yes and this person falls into a category that allows for retroactive approval, we will determine if this person is eligible for coverage during those months.

☐ Yes ☐ No Is *Person 4* an adult who is a main person taking care of a child under the age of 19 living in the home?

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

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

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

☐ Yes ☐ No Did *Person 4* have insurance through a job and lose it within the past three months?
If yes, end date: _____ Reason insurance ended: _____

☐ Yes ☐ No Is *Person 4* a full-time student?

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

If Hispanic or Latino, ethnicity:
- ☐ Mexican
- ☐ Mexican American
- ☐ Chicano/a
- ☐ Puerto Rican
- ☐ Cuban
- ☐ Other: _____

Race:
- ☐ White
- ☐ Black or African American
- ☐ American Indian or Alaska Native
- ☐ Asian Indian
- ☐ Chinese
- ☐ Filipino
- ☐ Japanese
- ☐ Korean
- ☐ Vietnamese
- ☐ Other Asian
- ☐ Native Hawaiian
- ☐ Guamanian or Chamorro
- ☐ Samoan
- ☐ Other Pacific Islander
- ☐ Other: _____

Current Job and Income Information: You must tell us about the income of the people in your household. If someone has more than one job, tell us about all jobs. If you leave a space blank, we will assume that you have no income of this kind.

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

Current Job 1:

Employer name and address	Employer phone number
Wages and tips (before taxes) $ ☐ Hourly ☐ Twice a month ☐ Weekly ☐ Monthly ☐ Every 2 weeks ☐ Yearly	Average hours worked each month:

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

Employer name and address	Employer phone number
Wages and tips (before taxes) $ ☐ Hourly ☐ Twice a month ☐ Weekly ☐ Monthly ☐ Every 2 weeks ☐ Yearly	Average hours worked each month:

Will the amount of money from jobs stay about the same? ☐ Yes ☐ No
If no, explain: _____

In the past three months, did *Person 4*:
☐ Change jobs ☐ Stop working ☐ Start working fewer hours ☐ None of these

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

Type of work _____

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

Will the amount of monthly income from self-employment stay about the same? ☐ Yes ☐ No
If no, how much do you expect to average over a 12 month period? $

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

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

Will the amount of money from other income stay about the same? ☐ Yes ☐ No
If no, explain: _____

Deductions: If *Person 4* pays for certain things that can be deducted on a federal income tax return, check all that apply and give the amount and how often *Person 4* pays. This information can be found on the Adjusted Gross Income section of *Person 4's* Federal 1040 form. **NOTE:** You shouldn't include a cost that you already considered in your answer to net self-employment.

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

Step 2. Person 5

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

First name, middle name, last name, and suffix		Relationship to you?
Date of birth (mm/dd/yyyy)	Sex: ☐ Male ☐ Female	Social Security Number (SSN)

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

☐ Yes ☐ No Does *Person 5* live at the same address as you? **If no**, list address: _____

Does *Person 5* plan to file a federal income tax return THIS YEAR?

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

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

☐ Yes ☐ No 1. Will *Person 5* file jointly with a spouse? **If yes**, name of spouse: _____

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

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

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

☐ Yes ☐ No Is *Person 5* currently incarcerated?

☐ Yes ☐ No Is *Person 5* currently assigned to a work release program? **If yes**, what is the start date? _____

Does *Person 5* need health coverage?

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

☐ Yes. **If yes**, answer all the questions below. ☐ No. **If no**, skip to the income questions on page 11. Leave the rest of this page blank.

☐ Yes ☐ No Does *Person 5* have a physical, mental, or emotional health condition that causes limitations in activities (like bathing, dressing, daily chores, etc.) or live in a medical facility or nursing home?

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

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

☐ Yes ☐ No Has *Person 5* lived in the U.S. since before August 22, 1996?

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

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

☐ Yes ☐ No Does *Person 5* need help paying for medical bills from the last three calendar months? If you answer yes and this person falls into a category that allows for retroactive approval, we will determine if this person is eligible for coverage during those months.

☐ Yes ☐ No Is *Person 5* an adult who is a main person taking care of a child under the age of 19 living in the home?

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

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

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

☐ Yes ☐ No Did *Person 5* have insurance through a job and lose it within the past three months?
If yes, end date: _____ Reason insurance ended: _____

☐ Yes ☐ No Is *Person 5* a full-time student?

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

If Hispanic or Latino, ethnicity:
- ☐ Mexican
- ☐ Mexican American
- ☐ Chicano/a
- ☐ Puerto Rican
- ☐ Cuban
- ☐ Other: _____

Race:
- ☐ White
- ☐ Black or African American
- ☐ American Indian or Alaska Native
- ☐ Asian Indian
- ☐ Chinese
- ☐ Filipino
- ☐ Japanese
- ☐ Korean
- ☐ Vietnamese
- ☐ Other Asian
- ☐ Native Hawaiian
- ☐ Guamanian or Chamorro
- ☐ Samoan
- ☐ Other Pacific Islander
- ☐ Other: _____

Current Job and Income Information: You must tell us about the income of the people in your household. If someone has more than one job, tell us about all jobs. If you leave a space blank, we will assume that you have no income of this kind.

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

Current Job 1:

Employer name and address		Employer phone number
Wages and tips (before taxes) $	☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly	Average hours worked each month:

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

Employer name and address		Employer phone number
Wages and tips (before taxes) $	☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly	Average hours worked each month:

Will the amount of money from jobs stay about the same? ☐ Yes ☐ No
If no, explain: _____

In the past three months, did *Person 5*:
☐ Change jobs ☐ Stop working ☐ Start working fewer hours ☐ None of these

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

Type of work _____
How much net income (profits once business expenses are paid) will you get from this self-employment this month? $
Will the amount of monthly income from self-employment stay about the same? ☐ Yes ☐ No
If no, how much do you expect to average over a 12 month period? $

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

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

Will the amount of money from other income stay about the same? ☐ Yes ☐ No
If no, explain: _____

Deductions: If *Person 5* pays for certain things that can be deducted on a federal income tax return, check all that apply and give the amount and how often *Person 5* pays. This information can be found on the Adjusted Gross Income section of *Person 5's* Federal 1040 form. **NOTE:** You shouldn't include a cost that you already considered in your answer to net self-employment.

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

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

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

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

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

AI/AN Person 1:	**AI/AN Person 2:**
Name (first, middle, last)	Name (first, middle, last)
☐ Yes ☐ No Member of a federally recognized tribe? **If yes**, tribe name:	☐ Yes ☐ No
☐ Yes ☐ No Has this person ever gotten a service from the Indian Health Service, a tribal health program, or urban Indian health program or through a referral from one of these programs?	☐ Yes ☐ No
☐ Yes ☐ No **If no**, is this person eligible to get any of these services?	☐ Yes ☐ No
$ _____ How often? _____	$ _____ 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:

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

Step 4. Your Family's Health Coverage

Answer these questions for anyone who needs health coverage.

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

- ☐ Medicaid _____
- ☐ CHIP _____
- ☐ Medicare _____
- ☐ TRICARE (Don't check if you have direct care or Line of Duty) _____
- ☐ VA health care programs _____
- ☐ Peace Corps _____
- ☐ Employer Insurance
  - Name of health insurance _____
  - Policy number _____
  - Is this COBRA coverage? ☐ Yes ☐ No
  - Is this a retiree health plan? ☐ Yes ☐ No
- ☐ Other
  - Name of health insurance _____
  - Policy number _____
  - Is this a limited-benefit plan (like a school accident policy?) ☐ Yes ☐ No

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

- Name _____
- Date of birth (mm/dd/yyyy) _____
- Social Security Number (SSN) _____
- Relationship to you? _____
- Date moved in? _____
- Date moved out? _____

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

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

If no, skip to Step 6.

☐ Yes ☐ No Is this a state employee benefit plan?

Step 5. Health Coverage from Jobs

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

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

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

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

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

☐ Yes ☐ No Are you currently eligible for coverage offered by this employer, or will you become eligible in the next three months? **If yes**, fill out the information below. **If no**, skip to Step 6.

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

_____

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

_____

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

☐ Yes ☐ No Does the employer offer a health plan that covers an employee's spouse or dependent?

If yes, which people? ☐ Spouse ☐ Dependents

☐ Yes ☐ No Does the employer offer a health plan that meets the minimum value standard*?

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

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

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

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

* An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs. (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)

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

☐ Employer won't offer health coverage

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

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

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

Date of change: _____

Step 6. Assistance with Completing this Application

You can choose an authorized representative.

You can give a trusted person permission to talk about this application with us, see your information, and act for you on matters related to this application, including getting information about your application and signing your application on your behalf. This person is called an "authorized representative." If you ever need to change your authorized representative, let us know. 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 16 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

Renewal of coverage in future years

To make it easier to determine eligibility for health coverage in future years, your income data, including information from tax returns, can be verified electronically. You can also change your mind and not allow the Department of Human Services to check this information.

Do you want this information to be verified in the future and used to automatically renew your eligibility?

☐ Yes, renew my eligibility automatically.
How long? ☐ 5 years ☐ 4 years ☐ 3 years ☐ 2 years ☐ 1 year

☐ No, don't use my information from tax returns to renew my coverage.

Estate Recovery

Federal law requires Iowa to have an estate recovery program. If you get Medicaid, you may be subject to estate recovery. This means any Medicaid funds used to pay for your healthcare, including the **full** monthly fee paid to a Managed Care Organization (MCO),including medical and dental, even if the plan did not pay for any services, will need to be paid back from your estate after your death. Estate recovery applies if you get Medicaid and are:

- Age 55 or older, or
- Are under age 55 and live in a medical facility and cannot reasonably be expected to return home.

For more information, call the Iowa Medicaid Estate Recovery Program at 1-877-463-7887 or go online to http://dhs.iowa.gov/sites/default/files/Comm123.pdf (English) or http://dhs.iowa.gov/sites/default/files/Comm123S.pdf (Spanish).

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.

If I leave a question on this application blank, I am reporting that the question does not apply to me and all persons listed on this application.

I agree to allow my information to be used and retrieved from data sources, including an asset verification system database, 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 acknowledge that I have read and agree to the contents of *Rights and Responsibilities*, Comm. 233. *Rights and Responsibilities*, Comm. 233 is pages 23 to 27 of this application.

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 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

Department of HUMAN SERVICES

Case Number:

Appendix A for Health Coverage

Complete this section if you or someone in the household is aged (65 and older), blind, or disabled.

Name of Person Requesting Services	Marital Status	Date of Birth	Social Security Number

Please indicate if you or someone in the household is in need of any of the following coverage:

- ☐ Help paying your facility costs (nursing facility, PMIC, skilled facility)
- ☐ Services to remain in your home (HCBS waivers, PACE)
- ☐ Assistance paying Medicare premiums
- ☐ State Supplementary Assistance (residential care facility, in-home health-related care, dependent person)
- ☐ Help paying for a hospital stay of 30 days or more.
- ☐ Other

PLEASE PROVIDE VERIFICATION OF ALL ITEMS YOU MARK BELOW (copies, not originals)

1. **Income** – Tell us about any additional sources of income for each individual in your household, such as child support, veteran's payments, Black Lung, Railroad, Supplemental Security Income (SSI), worker's compensation, interest, alimony, and dividends, etc.

Name of Person with Income	Income Type	Amount	How often received?

2. **Resources** – Tell us about all resources for each individual in your household, including cash on-hand, checking and savings accounts, social security debit card, stocks, bonds, mutual funds, annuities, safe deposit box, 401ks, IRAs, CDs, etc.

Name of Owner of Resource	Resource Type	Name/Location of Financial Institution	Account	Current Value

3. **Motor Vehicles** – Tell us about all the vehicles owned for each individual in your household, even if the vehicle is not in working condition.

Owner	Year/Make/Model	Fair Market Value	Amount Owed

4. **Unmet Medical Expenses** – Tell us about all medical expenses for each individual in your household not being reimbursed by a third party.

Name of Person with Unmet Medical Expenses	Type of Medical Expense	Amount	How often incurred?

5. **Burial/Funeral** – Tell us about all burial plots, burial or funeral funds, or burial contracts for each individual in your household.

Type	Location	How Many/ For Whom	Current Value

6. **Life Insurance** – Tell us about all life insurance policies owned by each individual in your household.

Policy Owner	Company Name and Address	Policy #

Do you intend to use your life insurance for burial expenses? ☐ Yes ☐ No

7. **Property** – Tell us about all property for each individual in your household including homestead (the home you live in) and non-homestead (other property such as vacation home, rental home, vacant lots, buildings, etc.).

Property Owner	Property Address	Property Value

8. Do you or anyone in your household have a life estate? ☐ Yes ☐ No

   If yes, who: _____

9. Do you or anyone in your household have a trust? ☐ Yes ☐ No

   If yes, who: _____

10. Have you or anyone in your household not accepted an inheritance in the past five years? ☐ Yes ☐ No

    If yes, who: _____

11. Have you or anyone in your household transferred, sold or given away resources for less than their value in the past five years? ☐ Yes ☐ No

    If yes, who/what: _____

    Date this occurred: _____

12. Does anyone applying for benefits live in a medical institution (nursing facility, hospital, PMIC, etc.)? ☐ Yes ☐ No

    If yes, who: _____ Date of entry: _____

    Name of facility: _____ Phone: _____

13. Do you or anyone in your household receive Long-Term Care insurance? ☐ Yes ☐ No

    Name of company: _____

14. If you are currently living in a medical institution and own your home, do you intend to return home? ☐ Yes ☐ No

15. Does anyone who is applying have a pending application for Social Security Disability? ☐ Yes ☐ No

    If yes, who: _____

To speed up the processing of your application, you may provide verification of the following with your application. If verification is not submitted with the application, you may receive a letter indicating what we need before we can process your application.

For anyone who is applying and is not a U.S. citizen:

- **Immigration status**
  Proof can be an alien identification card (green card, I-551, I-94), visa, passport, or documents from Immigration Services

Send verification for those individuals who are:

- **Working**
  Pay stubs from the last 30 days or a written statement of earnings from your employer if you do not have pay stubs.
- **Self-employed**
  Most recent income tax returns and all related schedules or business records if taxes are not filed.
- **Getting other income**
  (This includes child support, veteran's payments, Black Lung, Railroad, worker's compensation, interest and dividends, cash received from friends or relatives, pension, etc.) A statement from the person or company that issues the income, copy of checks (showing gross income amount), award letter, tax forms, court order, or other documents from the last 30 days or most current received.

Send verification for anyone who is 19 or older for the last 90 days from the date you are completing the application:

- **Bank accounts**
  Recent bank statements or written statement from bank showing current balance or value of accounts.
- **Property**
  Property tax statement. Include documents showing amount owed against the property.
- **Burial/funeral contracts**
  Burial contract and statement of goods and services from the company or funeral home that holds the contract.
- **Other resources**
  Includes stocks, bonds, mutual funds, annuities, safe deposit box, 401ks, IRAs, CDs, vehicles, etc.
- **Life insurance policies**
  Face and cash value, bonds, annuities, trusts, stock ownership statements, or other documents showing value of asset. Include documents showing current loan balance owed against the asset.
- **Unmet medical expenses**
  Billing statements, pharmacy statements, medical transportation.

Send copies of proofs. Do not send original documents.

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

This page intentionally left blank

Department of HUMAN SERVICES

Please keep this page for your information.

Rights and Responsibilities

When you get Medicaid from the Department of Human Services (DHS), you have the following rights and responsibilities.

Note: "Medicaid" on this form means any DHS medical assistance program including Medicaid, Healthy and Well Kids in Iowa (Hawki), Iowa Health and Wellness Program (IHAWP), State Supplementary Assistance (SSA), and Refugee Medical Assistance (RMA).

What Are My Rights?

You have the right to:

- Apply for any program.
- File an application online, by phone, by mail, by fax, or in person at your county DHS office.
- Have someone help you apply.
- Have all of your questions answered.
- Get information about the programs you applied for and any other DHS program that you may be able to get.
- Be sent a notice within 45 days of the day we get your application telling you if your application was approved.
- Have information about you and your family kept private as required by law.
- Have your expenses used to figure your eligibility or the amount of assistance you get by reporting your expenses, and giving proof if we ask you to. If you do not report or give proof of your expenses when asked, you choose not to claim the expense. You can report and give proof later to have an expense used for future months.
- Be treated equally without regard to race, color, national origin, sex, sexual orientation, gender identity, religion, age, disability, political belief, or veteran status. If you feel we have discriminated against or harassed you, send a letter detailing your complaint to: DHS, Office of Human Resources, Hoover Building – 1st Floor, 1305 E. Walnut, Des Moines IA 50319-0114 or via email at contactdhs@dhs.state.ia.us.
- Appeal any decision you do not agree with by following the directions on the last page of this form.

What Are My Responsibilities?

- You must tell us the truth.
  - Section 1128B of the Social Security Act provides federal penalties for fraudulent acts and false reporting in connection with Medicaid 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, 249N, and 514I.
  - Giving wrong information on purpose may result in us taking criminal or civil legal action against you.
  - You will have to pay back any benefits paid in error for you or anyone you apply for. You may be liable for the full amount of any payments made, including payments made to the health and dental plan in which the person was enrolled.

Please keep this page for your information.

- You must tell us within 10 days about any changes that may affect your eligibility. This includes changes such as:
  - Mailing or living address.
  - Starting or stopping a job or any other income (including lump sum payments, past due child support, inheritances, settlements, or cash medical support).
  - Someone moving in or out of your home.
  - Resources or assets, including getting an inheritance.
  - Changes in any other health insurance coverage (including employer-sponsored insurance, Medicare, etc.).
  - Filing an insurance claim or getting an attorney to recover bills paid by Medicaid.

  To report a change:
  - Call 1-877-347-5678, or
  - Email IMCustomerSC@dhs.state.ia.us, or
  - Fax information to 1-877-238-0015.
- You must apply for and accept any other benefits and medical assistance coverage that you may be able to get.
- You must give us information and give us proof when we ask for it.
- You must fill out review forms when you are asked to.
- You must cooperate with Quality Control (QC) and the Department of Inspections and Appeals (DIA). They may contact other people or organizations to get proof of your information. By signing the application, you give permission to release confidential information to QC or DIA.
- If any child applying for or receiving Medicaid has a parent living outside the home, you must cooperate with the agency that collects medical support from an absent parent. If you think that cooperating to get medical support will harm you or your children, you can tell us and you may not have to cooperate.
- You must cooperate with the Health Insurance Premium Payment (HIPP) Program and enroll in a health plan through your employer, if we ask you to. Visit https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp for explanation.
- You must agree to assign medical payments from a third party to the Medicaid agency for yourself and others who are eligible for Medicaid for whom you can legally assign benefits, cooperate in getting medical payments from third parties, give the Medicaid agency rights to pursue and get medical support from a spouse, and give the Medicaid agency rights to pursue and get money from other health insurance, legal settlements, or other third parties.
- If you get money from another person or an insurance company to pay your medical bills, you must give that money to DHS if Medicaid paid the bill. This will be used to repay bills that Medicaid paid for you.

This permission ends when your Medicaid stops.

Please keep this page for your information.

Other Things You Need to Know

- DHS will provide documents or claim forms describing the services paid by Medicaid upon your request or the request of an attorney acting on your behalf. Such documents may also be provided to a third party, when necessary, to establish the extent of the DHS's claim for reimbursement.
- If the State of Iowa was made the remainder beneficiary on an annuity in order for you 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 the Medicaid benefits paid.
- If you become enrolled in a managed health care plan, you consent to disclosure of medical information, including any clinical mental health or substance abuse information, by your medical providers to the PCP, other managed care providers, or to the authorized administrative body contracted by the managed care provider to determine appropriateness, quality, or utilization of services you received while enrolled in managed health care. A medical certification from the Iowa Medicaid Enterprise (IME) is needed for certain medical programs. Payments on any future unpaid medical services will be paid directly to the doctors and medical suppliers under the Medicare Insurance Program (Medicare Part B).

We Check What You Tell Us

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

We may check records from other states to see if any person in your household can get benefits in Iowa. This may be because a person was disqualified from a program in another state.

As part of the eligibility determination process, we may need to retrieve your information from sources like the Internal Revenue Service (IRS), Social Security Administration (SSA), the Department of Homeland Security, Asset Verification System (AVS), and the state Income and Eligibility Verification System. If something you told us is different from what the computer systems tells us, we will check to find out what is correct. We might check your information by contacting your employer, your bank, or other people. To do this kind of checking with your employer, bank, or other people, we will ask you first. Such information may affect your household's eligibility and level of benefits.

The authorization to use AVS database is in effect for as long as the Department is determining eligibility, the individual is a Medicaid recipient, or the applicant or recipient revokes the authorization. If refusal or revocation of the authorization is submitted, the Department may, on that basis, determine the applicant or recipient ineligible for medical assistance.

Information About Requiring a Social Security Number

We can give help only to people who give us their social security number (SSN) or proof of application from the Social Security office, and we will deny assistance to the people for whom you do not give us a SSN. There are some exceptions to this. Please ask us if you have questions.

You don't have to give us the SSN for people in your household who you do not want help for, but you can choose to give us their SSN to speed up processing your case. We will use any SSN given to us in the same way we use the SSN of people getting assistance. As required by Section 1137(a)(1) of the Social Security Act and 42 CFR 435.910, we use SSNs to check income/eligibility/payments, determine a person's right to Medicaid, comply with federal law, and match records with other agencies.

Please keep this page for your information.

Information About Immigration Status

You can apply for part of your household even if some members do not have lawful immigration status. For example, parents who do not have lawful immigration status may apply for their children who are U.S. citizens or qualified aliens. You may need to give proof of immigration status or U.S. citizenship for each person in your household for whom you apply.

When you tell us a person applying has eligible immigration status, that person's immigration status is checked with the Department of Homeland Security, and this will require submission of certain information from your application or review form. Any information we get from the Department of Homeland Security may affect your household's eligibility and level of benefits. We will not contact the Department of Homeland Security about people you do not apply for. However, we may use their income and assets to see if the rest of the household can get help.

Information About Estate Recovery

Federal law requires Iowa to have an estate recovery program. If you get Medicaid, you may be subject to estate recovery. This means any Medicaid funds used to pay for your healthcare, including the **full** monthly fee paid to a Managed Care Organization (MCO), including medical and dental, even if the plan did not pay for any services, will need to be paid back from your estate after your death. Estate recovery applies if you get Medicaid and are:

- Age 55 or older, or
- Are under age 55 and live in a medical facility and cannot reasonably be expected to return home.

For more information, call the Iowa Medicaid Estate Recovery Program at 1-877-463-7887 or go online to: http://dhs.iowa.gov/sites/default/files/Comm123.pdf (English) or http://dhs.iowa.gov/sites/default/files/Comm123S.pdf (Spanish).

By signing an application/review form, you give your permission for DHS to share:

- Your medical and other health care records with federal and state officials.
- The status of your Medically Needy case, the amount of your spend down, and the bills used to meet your spend down with the provider whose bills are being used.
- The premium due date for Medicaid for Employed People with Disabilities (MEPD), IHAWP, DWP, and Hawki with your medical provider.
- The information on your application for Home- and Community-Based Services (HCBS) waivers with the chosen case management agency or with the Iowa Department of Public Health (IDPH) Brain Injury Services Program manager (for HCBS brain injury waiver applications).
- The filing date of your application with your nursing facility.

By signing an application/review form you:

- Give permission for your medical provider to share your medical history with a PCP, other managed care providers, or the authorized administrative body contracted by the managed care provider to determine appropriateness, quality, or utilization of services you received while enrolled in managed health care.
- Give permission for your medical provider to share information with IME Medical Services Unit to certify a medical need for certain medical assistance programs or services.

Please keep this page for your information.

Information for those Applying for WIC or Maternal and Child Health Services

- A declaration of income and persons in your family and living in your household is necessary to ensure that federal and state funds are directed to those persons least able to secure services from other sources.
- 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.

Information for those Applying for Presumptive Medicaid Services

- Your answers to some questions will not impact the presumptive Medicaid eligibility decision. These answers are needed for DHS to make a decision for ongoing Medicaid only.
- If you are only applying for presumptive Medicaid, not all of your information will be checked against data in computer systems.
- If you choose to have your application forwarded to DHS for an ongoing Medicaid determination, DHS will verify income, citizenship, immigration status, identity, and other information as necessary.
- All presumptive Medicaid is granted on a daily basis and may be terminated on any given day, without notice, once it is determined that the individual is no longer presumptively eligible.
- Appeal hearings are not granted for presumptive Medicaid.

How 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. You can appeal in person, by phone, or in writing. To appeal in writing do one of the following:

- Fill out an appeal electronically at https://secureapp.dhs.state.ia.us/dhs_titan_public/appeals/appealrequest, 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 DHS, Appeals Section, 5th Floor, 1305 E Walnut Street, Des Moines, IA 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 **1-800-532-1275**. If you live in Polk County, call **(515) 243-1193**.

Department of HUMAN SERVICES

Comm. 209 (Rev. 6/20)

Information About Your Privacy Rights

This notice is given to you because your health plan is Medicaid or Healthy and Well Kids in Iowa (Hawki). The notice talks about your Personal Health Information (PHI), but it also includes the information for your dependent children under the health plan. This information does not affect eligibility for the health plan. PHI means records that can be used to identify you or your children who are covered by the health plan, medical care, or payment for medical care. Your PHI is protected by state and federal laws.

Your Rights to Privacy

Federal law gives you rights about PHI. You have the right to:

- Receive notice of Iowa Department of Human Services (DHS) policies and procedures used to protect your PHI.
- Ask that certain uses and disclosures of your PHI be restricted.
- Give a written request to inspect and copy your PHI.
- Give a written request that your PHI be changed.
- Ask for an accounting of disclosures by the health plan.
- Request communication of your PHI by alternative means or at an alternative address.
- Receive notice of unauthorized disclosure of your PHI.

Use and Disclosure of PHI

DHS is committed to keeping your PHI confidential and safe from being used by others without permission.

Only people who have both the need and legal right will be allowed to view your PHI. Your PHI will not be sold, used or shared for marketing or fundraising.

PLEASE READ CAREFULLY!

This notice tells you:

- ***How medical information about you may be used,***
- ***When it can be shared with others,***
- ***How you can get access to your information.***

Este aviso está disponible en español a petición.

Your health plan, Medicaid or Hawki, will ask for your written permission to release your PHI to others that are not given access to PHI under law. You may cancel your permission at any time by submitting your written instructions to the DHS Information Security and Privacy Officer.

As Required or Permitted By Law

To avoid a serious threat to health or safety: As required by law and standards of ethical conduct, we may release your PHI to the proper authorities if it is believed, in good faith, that it is necessary to prevent or minimize a serious and approaching threat to you or others' health or safety.

Treatment: Your PHI may be shared to coordinate health care. For example, your doctor may be notified about care you received in an emergency room.

Payment of medical bills: Medicaid or Hawki may release PHI to you, your insurance company, or other third party payer, so that treatment and services provided by a medical provider may be billed and collected. Bills requesting payment may include PHI, which identifies you, your diagnosis, and any procedures or supplies used. Your PHI may be shared with a health care provider, individual or entity covered by the HIPAA privacy regulations for payment activities, such as Medicaid, Medicare or your personal health insurance carrier.

Abuse reporting: Any PHI indicating child or dependent adult abuse must be reported to authorities.

Business operations: For medical review, legal services, and auditing, include provider fraud. For example: PHI may be used to evaluate the quality of care given by the managed care program.

Health care oversight: Your PHI may be shared with agencies that monitor, investigate, inspect, discipline or license those who work in the health care system.

Specialized government functions: Your PHI may be used or shared for limited government benefits, such as public assistance benefits or benefits from the Social Security Administration.

Judicial and administrative proceedings: If you are involved in a lawsuit or other administrative proceeding, your PHI may be shared because of a court order requesting the release.

Public health: Your PHI may be shared for research purposes. Such research might try to find out whether a certain treatment is effective in curing an illness. Information that identifies you will always be removed.

As required by law: When required by law, the health plan must share PHI.

Law Enforcement: The facility may release your PHI for law enforcement purposes as required by law or in response to a court order, subpoena or warrant or other lawful process.

Responsibilities of the Health Plan

Federal law also imposes certain obligations and duties upon the health plan to safeguard your PHI. The health plan is required to:

- Provide you with this notice of the health plan's legal duties and the policies regarding the use and disclosure of your PHI.
- Maintain the privacy of your PHI in accordance with state and federal law.
- Respond to your request to restrict certain uses and disclosures of your PHI.
- Allow you to inspect and obtain a copy of your PHI during the regular business hours and according to this policy.
- Act on your request to change your PHI within 60 days, and notify you of any delay that would require the deadline to be extended by 30 days.
- Accommodate reasonable requests to communicate PHI by alternative means or methods.
- Abide by the terms of the privacy notice currently in effect.

For More Information or to Report a Problem

This notice has been provided to you as a summary of how the health plan, Medicaid or Hawki, will use your PHI and your rights about your PHI. If you have any questions, or for more information regarding your PHI, please contact the Privacy Officer at the phone number below.

If you believe your privacy rights have been violated, you may file a complaint by contacting the Privacy Officer at the phone number listed below. You may also file a complaint with the Secretary of Health and Human Services. If you file a complaint, there will be no retaliation and you will continue to receive care and treatment.

Medicaid and Hawki reserve the right to revise practices about Protected Health Information and to revise this notice. You may ask for a revised Notice of Privacy Practices by calling the Privacy Officer at the number below.

For more information regarding your protected health information, contact:

DHS Information Security and Privacy Officer
Department of Human Services
1305 E. Walnut Street
Des Moines, IA 50319-0114

Telephone number: **1-800-803-6591**

Discrimination is Against the Law

The Iowa Department of Human Services (DHS) complies with applicable Federal civil rights laws to provide equal treatment in employment and provision of services to applicants, employees and clients and does not discriminate on the basis of race, color, national origin, age, disability or sex. DHS does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

DHS:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

  If you need these services, contact Iowa Medicaid Member Services at 1-800-338-8366.

If you believe that DHS has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance with: DHS, Office of Human Resources, by emailing contactdhs@dhs.state.ia.us or in writing to:

DHS Office of Human Resources
Hoover State Office Building, 1st floor
1305 E Walnut Street
Des Moines, IA 50319-0114

You can file a grievance in person or by mail, or email. If you need help filing a grievance, the DHS Office of Human Resources is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue
SW Room 509F, HHH Building
Washington, D.C. 20201

1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al ***1-800-338-8366 (TTY: 1-800-735-2942).***

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 **1-800-338-8366 (TTY: 1-800-735-2942).**

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số **1-800-338-8366 (TTY: 1-800-735-2942).**

OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite **1-800-338-8366** (TTY- Telefon za osobe sa oštećenim govorom ili sluhom: **1-800-735-2942**).

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: **1-800-338-8366 (TTY: 1-800-735-2942).**

مقر) ***1-800-338-8366*** مقربب لصتا .انجمابب كل رفاوتت ةيوغلل ةدعاسملا تامدخ نإف ،ةغللا رفاك اذك ثدحتت تنك اذإ :ةظوحلم). ***1-800-735-2942***:مكبلاو مصلا فتاه

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ **1-800-338-8366 (TTY: 1-800-735-2942).**

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. **1-800-338-8366 (TTY: 1-800-735-2942)** 전화해 주십시오.

ध्यान द : य द आप हदी बोलते ह तो आपके िलए मुफ्त म भाषा सहायता सेवाएं उपलब्ध ह।
1-800-338-8366 (TTY: 1-800-735-2942) पर कॉल कर ।

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le **1-800-338-8366 (ATS: 1-800-735-2942).**

Wann du [Deitsch (Pennsylvania German / Dutch)] schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call **1-800-338-8366 (TTY: 1-800-735-2942).**

เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร **1-800-338-8366 (TTY: 1-800-735-2942).**

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa **1-800-338-8366 (TTY: 1-800-735-2942).**

ဟ်သူဉ်ဟ်သး~ နမ့်ကတိၤ ကညီ ကျိာ်ဏယိ, နမၤန့ၣ် ကျိာ်ဏတၢ်မၤစၢၤလၢ တလၢာ်ဘူဉ်လၢာ်စုၤ နီတမံၤဘဉ်သ့နှဉ်လီၤ. ကိ: **1-800-338-8366 (TTY: 1-800-735-2942).**

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните **1-800-338-8366** (телетайп: **1-800-735-2942**).