

December 22, 2023

**GENERAL LETTER NO. 6-AP-163**

ISSUED BY: Bureau of Family, Financial, and Work Supports  
Division of Community Access

SUBJECT: Employees' Manual, Title 6 Appendix, **Income Maintenance Programs Appendix**, Contents 5 and 6, Contents 7-9, revised; Contents 10, removed; 216-270, 271-364, revised; 365, removed, and forms, revised..

**Summary**

This chapter is revised to update the following forms:

- 470-1668, *Notice of a Setoff of an Iowa Income Tax Refund for Debts Owed the DHS*, obsolete
- 470-2341, *SSI-Related (No Children) Medically Needy Spenddown Computation Worksheet*, revised to update values
- 470-2588, *Notice of Attribution of Resources*, revised to update values
- 470-2626, *SSI-Related (Children In Household) Medically Needy Spenddown Computation Worksheet*, revised to update values
- 470-3088, *FMAP-Related Medically Needy Spenddown Computation Worksheet*, revised to update values
- 470-3144, *Attribution of Resources Appeal Summary*, revised to update values
- 470-3624 and 470-3624(S), *Child Care Assistance Application*, revised to update content and style and formatting
- 470-3851 and 470-3851(S), *Important Information About Your FIP*, revised to update content and style and formatting
- 470-4139, *Notice of Income Offset Against State Warrants*, obsolete
- 470-5771, *Report of Stole SNAP Benefits*, added to 6-Appendix
- Comm. 121 and Comm 121(S), *Important Notice to Property Owners and Renters*, revised to update values and content
- Comm. 413, *Medicare Savings Programs*, revised to update values
- RC-0018, *Supplemental Security Income Payment Standards*, revised to update values
- RC-0130, *Medical Assistance Desk Aid*, revised to update values

**Effective Date**

Immediately.

**Material Superseded**

Remove the following pages from Employees' Manual, Title 6 Appendix, and destroy them:

<u>Page</u>	<u>Date</u>
Contents 5 and 6	February 24, 2023
Contents 7-10	June 23, 2023
216-270	February 24, 2023
271-365	June 23, 2023

**Additional Information**

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

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**Notice of Income (Payroll) Offset, Form 470-4140**

Purpose	Form 470-4140 is issued to inform a state employee that part of the employee's salary is being garnished to repay a debt owed as a result of a DHS overpayment.
Source	The Department of Inspections and Appeals issues form 470-4140.
Completion	<p>The Public Assistance Debt Recovery Unit sends the garnishment letter when the Department of Administrative Services matches overpayment recovery files and finds debtors who:</p> <ul style="list-style-type: none"><li>▪ Are state employees.</li><li>▪ Owe at least \$50.</li><li>▪ Have received at least one demand letter for:<ul style="list-style-type: none"><li>• A Child Care Assistance claim, or</li><li>• A FIP or RCA claim established after February 1986, or</li><li>• A SNAP claim, or</li><li>• A Hawki claim, or</li><li>• A Medicaid claim established after June 1987, or</li><li>• A PROMISE JOBS claim, or</li><li>• A State Supplementary Assistance claim established after June 1987.</li></ul></li><li>▪ Have failed to make an agreement on at least one claim per program or has failed to keep current with an agreement.</li></ul> <p>The debtor is allowed a 15-calendar-day appeal period and the opportunity to make a cash agreement. If no alternative arrangements are made, the employee's salary is garnished.</p>
Distribution	<p>One copy is sent to the debtor.</p> <p>One copy is sent to the central payroll unit in the Department of Administrative Services.</p> <p>One copy is kept in the Public Assistance Debt Recovery Unit file.</p>
Data	Public assistance debt recovery staff address the form and enter the dollar amounts.

**Notice of Lost Benefits, Form 470-0334**

Purpose	Form 470-0334 is used to notify the household of entitlement to lost SNAP benefits.
Source	Complete form 470-0334 using the template in: <ul style="list-style-type: none"><li>▪ SharePoint under Employee Manual/Forms.</li><li>▪ The Worker Information System Exchange (WISE).</li></ul>
Completion	Complete the original and one copy of the form when: <ul style="list-style-type: none"><li>▪ You determine that a household is entitled to restoration of lost benefits, or</li><li>▪ A restoration of lost benefits is ordered by a hearing decision.</li></ul>
Distribution	Send the original to the household. Keep the copy in the case record.
Data	The form explains: <ul style="list-style-type: none"><li>▪ The amount of lost benefits.</li><li>▪ Any amount applied against an uncollected claim against the household.</li><li>▪ The household's right to appeal any disputed benefits.</li></ul>



**Notice of Medical Assistance Debt Due to a Transfer of Asset(s), Form 470-4667**

Purpose	Form 470-4667, <i>Notice of Medical Assistance Debt Due to a Transfer of Asset(s)</i> , is an official notice of a medical assistance debt due to a transfer of assets. It is also a written agreement between a debtor and the Department for repayment when a medical assistance debt due to a transfer of assets exists.
Source	Form 470-4667 is generated by the Web-based Overpayment Recovery (WOPR) System.
Completion	WOPR generates and inserts specific DHS debt information into the form. The system prints this form on the last working day of each month.
Distribution	<p>One copy is mailed to the debtor from DHS central office with a return envelope enclosed.</p> <p>The debtor should return the completed form to the Iowa Department of Inspections and Appeals, Public Assistance Debt Recovery Unit, Lucas Building, Third Floor, 321 E 12th Street, Des Moines, IA 50319-0083 within 20 days.</p> <p>When a debtor fails to respond, other collection actions can be pursued. Other collection actions include:</p> <ul style="list-style-type: none"><li>▪ Take the debtor's Iowa income tax refund.</li><li>▪ Take money that is owed to the debtor by any state agency.</li><li>▪ Wage garnishment.</li></ul>
Data	The system completes the debtor's name, the Medicaid member's name, the case number, and the amount of the debt. The debtor completes the choice of repayment and signs and dates the form.

### **Notice of Medical Assistance Overpayment, Form 470-2891**

Purpose	<p>Form 470-2891:</p> <ul style="list-style-type: none"><li>▪ Informs the Medicaid or State Supplementary Assistance debtor of the amount and reason for the overpayment and requests repayment.</li><li>▪ Serves as the debtor's agreement for cash repayment.</li></ul>
Source	<p>Form 470-2891 is generated monthly by Web-based Overpayment Recovery (WOPR) System.</p>
Completion	<p>The form is printed on the last working day of the month for debtors who:</p> <ul style="list-style-type: none"><li>▪ Have a Medicaid or State Supplementary Assistance claim entered on WOPR, and</li><li>▪ Have not submitted an agreement to repay the debt.</li></ul> <p>The form is partly completed by WOPR. The debtor is responsible for completing the agreement to repay.</p> <p>One form must be sent before a debt setoff (state tax refunds) or any other income offset (state warrants) takes place.</p> <p>The form is no longer sent to the debtor when:</p> <ul style="list-style-type: none"><li>▪ The claim is suspended, or</li><li>▪ An agreement to repay is received, or</li><li>▪ Four forms have been sent.</li></ul>
Distribution	<p>One copy is mailed from Central Office.</p> <p>The debtor should return the completed bottom portion of the form to Department of Inspections and Appeals, Public Assistance Debt Recovery Unit, Third Floor, 321 E 12th Street, Des Moines, IA 50319-0083.</p>
Data	<p>The system completes the amount and type of error. The debtor completes the repayment terms.</p>

### **Notice of Pending Medicaid Application, Form 470-263 I**

Purpose	<p>Form 470-263 I is used to notify both Disability Determination Services (DDS) and the Social Security Administration (SSA) when a Medicaid application has been filed with the Department and the applicant states there is a decision pending on disability benefits administered by the SSA.</p> <p>DDS and SSA use this form to respond to the IM worker on the status of the identified case.</p>
Source	<p>Complete form 470-263 I using the template in:</p> <ul style="list-style-type: none"><li>▪ SharePoint under Employee Manual/Forms.</li><li>▪ The Worker Information System Exchange (WISE).</li></ul>
Completion	<p>The IM worker completes Sections I and III of the form each time Medicaid eligibility is being determined based on disability (other than for Medically Needy) when the applicant states that the applicant has applied for disability benefits administered by the SSA.</p> <p>Upon receipt of this notice, DDS reviews its files and responds as indicated on the form. DDS or SSA completes Section II.</p>
Distribution	<p>Send one copy to DDS and one copy to the local Social Security office. Attach a release signed by the client to send information to DDS and SSA. Keep one copy in the case record.</p>
Data	<p>Complete:</p> <ul style="list-style-type: none"><li>▪ The applicant information and IM worker information in Section I.</li><li>▪ The address for the Department office in Section III.</li></ul> <p>Then separate the form and enter the DDS address on one copy and the address for the local Social Security office on the second copy.</p> <p>DDS or SSA completes Section II and returns the form to the IM worker.</p> <p>If DDS is processing an SSA application, then DDS shall enter the claims examiner's name and telephone number under Section II.</p>

**Notice of SNAP Debt, Form 470-4179**

Purpose	Form 470-4179 informs the debtor of the amount of debt for trafficking or misuse of SNAP. The debtor completes part of the form to agree to make payments.
Source	Form 470-4179 is generated by the DHS Web-based Overpayment Recovery (WOPR) System.
Completion	<p>The form is printed in the month the debt is added to WOPR. EXCEPTION: The form is printed in the following month if system entry is made after debt notices have been issued for the month.</p> <p>WOPR partially completes the form. The debtor is responsible for completing the agreement to pay.</p>
Distribution	<p>One copy is mailed to the debtor from Central Office with a return envelope enclosed.</p> <p>The debtor should return the completed bottom portion of the form to Iowa Department of Inspections and Appeals, Public Assistance Debt Recovery Unit, 321 E. 12th St, 3rd Floor, Des Moines, IA 50319-0083.</p>
Data	The debtor has the choice of paying the full amount in one payment or making monthly payments.

**Notice of SNAP Overpayment, Form 470-4668**

Purpose	Form 470-4668 informs the debtor of the amount and reason for the overissuance in a SNAP claim and requests repayment.
Source	Form 470-4668 is generated by the Web-based Overpayment Recovery (WOPR) System.
Completion	<p>The form is printed and sent eight calendar days before the end of the month following the addition of the claim to WOPR. An additional form is sent if there is a change to:</p> <ul style="list-style-type: none"><li>▪ The claim amount.</li><li>▪ The months the claim covers.</li><li>▪ The appeal status in WOPR.</li><li>▪ Classify the claim as an intentional program violation.</li></ul> <p>WOPR partially completes the form. The debtor is responsible for completing the agreement to repay.</p>
Distribution	<p>One copy is mailed to the debtor from Central Office with a return envelope enclosed.</p> <p>The debtor should return the completed Agreement to Pay portion of the form to Iowa Department of Inspections and Appeals, Public Assistance Debt Recovery Unit, 3rd Floor, 321 E. 12th Street, Des Moines, IA 50319-0083.</p>
Data	The debtor has the choice of repaying through allotment reduction, in cash, or having DHS take benefits from an EBT account. NOTE: Agreement for allotment reduction is not acceptable if the debtor is not an active SNAP recipient.

**[Notice Regarding Acceptance of Other Benefits, Form 470-0383 or 470-0383\(S\)](#)**

Purpose	The purpose of form 470-0383 is to notify the client in writing of the requirement to apply for and accept any cash benefits or any other medical benefits to which the client may be entitled.
Source	Complete the English or Spanish version using the form in the Worker Information Exchange System (WISE).
Completion	The income maintenance worker completes Part A of this form whenever information suggests that other cash benefits or other medical benefits are available to the applicant or member.  The client completes Part B.
Distribution	Send two copies of the form to the client. The form is designed to fit into a window envelope. Include a preaddressed return envelope to ensure return to the scanning center.  You may upload the request to the electronic case file. When the original is returned, it will be scanned and uploaded.
Data	The name, address, social security number, social security claim number, and case number are self-explanatory. When any one of the numbers is not available, insert “NA” in the blank space.  Enter the date that is ten calendar days from the date the notice is given to the client or is mailed to the client’s current mailing address.  Enter the type of benefits for which the client may qualify.  Enter the name and address of the agency where application is to be made.

**Notification of SSI Approval, Form 470-5588**

Purpose	The <i>Notification of SSI Approval</i> is used to notify the IM worker when an individual who is not currently active on Medicaid has been approved for SSI benefits. Use this form to approve SSI Medicaid for the individual identified.
Source	This form is automatically routed in the IM worker queue when information received from the Social Security Administration (SSA) meets the rules to approve Medicaid.
Completion	<p>The IM worker is responsible for data entry into the ELIAS eligibility system to approve SSI Medicaid benefits for the individual identified on the form.</p> <p>The form contains all data elements necessary to make an SSI Medicaid eligibility determination. If the individual is requesting additional services, such as long-term care, send a <i>Request for Information</i> to gather necessary information (such as whether a transfer of assets has occurred) at that time. However, approve SSI Medicaid when the form is received.</p>
Distribution	Keep this form in the member's case file.
Data	This form verifies an individual's receipt of SSI benefits.

**Notification Regarding Annuity Benefits, Form 470-4382**

Purpose	Form 470-4382 notifies an annuity company that payment of the member's long-term care claims will entitle the state to the remainder benefits on the member's annuity.
Source	Complete 470-4382 using the form in the Worker Information System Exchange (WISE). The form may also be printed from: <ul style="list-style-type: none"><li>▪ The online manual.</li><li>▪ SharePoint under Employee Manual/Forms.</li></ul>
Completion	The IM worker is responsible for completing and sending this letter to the annuity company that issued the annuity to the member.
Distribution	Send the original to the annuity company. Send one copy of the letter to the member. Keep a copy of the letter in the member's file.
Data	This form is self-explanatory. Complete the name and address sections and sign the letter.



**Notification to the Bureau of Refugee Services, Form 470-0481**

Purpose	<p>The purpose of form 470-0481 is to notify the Bureau of Refugee Services of any refugees applying for assistance. The information is used to:</p> <ul style="list-style-type: none"><li>▪ Make the applicant aware of the services available,</li><li>▪ Help the applicant locate employment, and</li><li>▪ Maintain statistics regarding the location and number of refugees in Iowa, particularly those needing assistance.</li></ul>
Source	<p>Complete form 470-0481 using the template in:</p> <ul style="list-style-type: none"><li>▪ SharePoint under Employee Manual/Forms.</li><li>▪ The Worker Information System Exchange (WISE).</li></ul>
Completion	<p>The income maintenance worker prepares this when a refugee applies for cash or medical assistance. Attach a copy of the applicant's immigration document to this form before sending the form to the Bureau of Refugee Services.</p>
Distribution	<p>Email the form and a copy of the applicant's immigration document to <a href="mailto:BRSrefugee@dhs.state.ia.us">BRSrefugee@dhs.state.ia.us</a>. File a copy in the case record.</p>
Data	<p>The form contains identifying information about the applicant and the sponsor.</p>

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### ORR Certification Letters

Purpose	The purpose of an ORR certification letter is to provide proof that the person has been certified to be a victim of human trafficking, and thus is eligible for public assistance to the same extent as refugees.
Legal reference	The Trafficking Victims Protection Act of 2000, Public Law 106-386, Division A, 114 Stat. 1464 (2000).
Source	The Office of Refugee Resettlement (ORR) at U.S. Department of Health and Human Services issues the certification letters. There are separate formats for adults and for children.
Completion	ORR issues letters to each adult or child that ORR certifies as victims of human trafficking. The signature and make-up of the letters may change without ORR notifying the Department.
Distribution	The person who is issued the certification letter may present it to the Department as proof of eligibility as a victim of trafficking.
Data	The letters contain the following information: <ul style="list-style-type: none"><li>▪ HHS tracking number.</li><li>▪ Certification date: the date that ORR certifies the person as a victim of human trafficking.</li><li>▪ Expiration date: the date the person's status as a victim of human trafficking expires.</li><li>▪ The telephone number that workers can use to verify the letter's validity.</li></ul>

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### Other Insurance Request, Form 470-0403

Purpose	<p>Form 470-0403, <i>Other Insurance Request</i>, is used by the Iowa Medicaid Enterprise (IME) to collect information from Medicaid members or their representative when claims show they may have other health insurance.</p> <p>The information returned on the form is used to identify claims with third-party liability (TPL). This form allows the IME to recover and cost avoid some or all of the Medicaid expenditures made on the member's behalf.</p>
Source	<p>The form is computer-generated by the IME OnBase system.</p>
Completion	<p>The form is prepared automatically when a Medicaid claim code indicates an accident or injury.</p>
Distribution	<p>The form is sent to the member, who returns it to the IME on completion.</p> <p>Once completed by the member or the member's representative, the form may be returned in one of the following ways:</p> <p>Mail: Iowa Medicaid Enterprise PO Box 36446 Des Moines, IA 50315</p> <p>Phone: Member Services <b>1-800-338-8366</b> or locally in the Des Moines area at <b>515-256-4606</b> (Monday through Friday, 8:00 am to 5:00 pm)</p> <p>Email: <a href="mailto:RevColl_Lien@dhs.state.ia.us">RevColl_Lien@dhs.state.ia.us</a></p> <p>Fax: 515-725-1352</p>
Data	<p>The form requests information from the member concerning:</p> <ul style="list-style-type: none"><li>▪ The type of health insurance.</li><li>▪ Policy holder information.</li><li>▪ Insurance carrier information.</li></ul>

**Overpayment Recovery Supplemental Information, Form 470-0465**

Purpose	<p>Form 470-0465 informs the Public Assistance Debt Recovery Unit of additional information pertaining to an overpayment. From the information supplied, DIA can better determine whether to pursue voluntary repayment, investigation, civil prosecution, or criminal prosecution.</p> <p>If DIA refers the case for prosecution, this form is submitted to the county attorney to summarize the basis for the investigation.</p>
Source	<p>Department staff can complete form 470-0465 using the template in SharePoint under Employee Manual/Forms and the Worker Information System Exchange (WISE).</p> <p>Other users may print supplies from the online manual.</p>
Completion	<p>IM workers complete this form for overpayments in FIP, Refugee Cash Assistance, SNAP, Medicaid, Child Care Assistance, and State Supplementary Assistance.</p> <p>PROMISE JOBS workers complete this form for overpayments in Child Care Assistance and PROMISE JOBS programs.</p> <p>The Hawki program's third-party administrator completes this form for Hawki overpayments.</p> <p>Prepare an original and one copy of this form when:</p> <ul style="list-style-type: none"><li>▪ A claim is being revised, and<ul style="list-style-type: none"><li>• It is now a client error of over \$1,000, and</li><li>• The worker did not previously complete either form 470-0465 or a fraud referral screen in the direct claim entry screen.</li></ul></li><li>▪ The DIA Division of Investigations requests the information to pursue recovery action.</li><li>▪ The IM Unit wishes legal action pursued.</li><li>▪ Recovery will be attempted from the resources of an alien's sponsor.</li></ul>
Distribution	<p>Submit the original along with the Overpayment Recovery Information Input Summary (from the direct claim entry screen), form 470-0464, to:</p> <p style="padding-left: 40px;">DIA Investigations Division Public Assistance Debt Recovery Unit Lucas Building, Third Floor 321 E 12th St., Des Moines, Iowa 50319-0083</p> <p>(or send by local mail). Keep a copy in the case record.</p>

Data

Make the following entries:

- **State ID:** Enter the debtor's state identification number.
- **ABC case no.:** Depending on the type of claim, enter the debtor's ABC case number.
- **hawk-i case no.:** If this is a Hawki claim, enter the debtor's Hawki case number.
- **SRS case no.:** Depending on the type of claim, enter the debtor's SRS or KinderTrack case number.
- **Summary regarding overpayment:** Give a brief statement regarding the condition that caused the overpayment.
- **Possible witnesses and evidence:** List separately each person who can provide truthful and relevant testimony regarding the overpayment. Include the person's name, current address, and telephone number.

Under each witness's name, describe what that witness can testify to, including time and dates of contacts or statements. Be specific, but brief.

If the person is an employee of a state agency, name the county of location where the person is employed. List the office telephone number and the type of caseload carried.

List all related documents, giving the date of each document (examples: application, RRED, NOD). In addition, list all signed statements available from either the recipient or a collateral source.

Maintain all related documents in the case record until complete recovery has been made or the Division of Investigations requests the documents.

- **Worker:** Sign the form when it is completed.
- **Date:** Enter the date the form is completed.

**Paperless Enrollment Confirmation 470-5589 or 470-5589(S)**

Purpose	<i>Paperless Enrollment Confirmation, 470-5589 or 470-5589(S)</i> is a confirmation letter sent by ELIAS to a client has opted to go paperless on the SSP and whose email address has been validated.
Source	The ELIAS System generates form 470-5589 automatically. Form 470-5589(S) is generated when the Medicaid member has indicated that Spanish is their preferred language.
Completion	The ELIAS system completes form 470-5589 or 470-5589(S) when a client has opted to go paperless on the SSP and whose email address has been validated.
Distribution	This form is system generated by ELIAS A copy is filed in WISE.
Data	<p>The ELIAS system will populate the office address, current date, worker name, address, worker identification, customer name, customer address, and case number.</p> <p>A WISE narrative is created to indicate a Paperless Enrollment Confirmation letter was issued.</p>

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**PathTracker Case Activity Report, Form 470-5386**

Purpose	Form 470-5386, <i>PathTracker Case Activity Report</i> , provides a mechanism for nursing facilities (NFs), skilled nursing facilities (SNFs), and nursing facilities for people with mental illness (NFMIs) to report individual resident activities occurring at the facility level that may affect eligibility.
Source	The form is electronically generated using information entered by the facility provider into the PathTracker Plus system. The form is available on the Iowa Medicaid Enterprise (IME) website at <a href="http://dhs.iowa.gov/ime/providers/forms">http://dhs.iowa.gov/ime/providers/forms</a> .
Completion	Facility staff must complete entries in PathTracker Plus when a resident: <ul style="list-style-type: none"><li>▪ Enters the facility.</li><li>▪ Transfers out of the facility.</li><li>▪ Is discharged.</li><li>▪ Died.</li><li>▪ Has a change in level of care.</li><li>▪ Has a change in payment source. (I.e., Medicare coverage, newly approved for Medicaid, private pay, etc.)</li></ul>
Distribution	NFs, SNFs, and NFMIs must enter all resident information into PathTracker Plus. PathTracker Plus transmits this data electronically to the Department daily. When the transmitted data matches to a Medicaid member, the <i>PathTracker Case Activity Report (CAR)</i> form is created. The PathTracker CAR form is uploaded to Electronic Case File (ECF) nightly.  If a paper PathTracker CAR is requested, NFs, SNFs, and NFMIs shall mail, email or fax the form to the address below and keep a copy.

Centralized Facility Eligibility Unit  
Imaging Center I  
Iowa Department of Human Services  
417 E. Kaneshville Blvd.  
Council Bluffs, IA 51503-4470  
Fax: 515-564-4040  
Email: [facilities@dhs.state.ia.us](mailto:facilities@dhs.state.ia.us)

For NF, SNF, or NFMI residents enrolled in the Program for All-Inclusive Care for the Elderly (PACE) mail, email or fax the form to the address below and keep a copy.

Woodbury Adult Intake Team  
Imaging Center I  
Iowa Department of Human Services  
417 E. Kaneshville Blvd.  
Council Bluffs, IA 51503-4470  
Fax: 515-564-4014  
Email: [97cmz2@dhs.state](mailto:97cmz2@dhs.state)

Data

### Section 1. Member Data

This section contains resident specific information.

- **Name:** First and last name of the resident. Enter name as it appears on the *Medical Assistance Eligibility Card*.
- **Date Entered Facility:** The date the resident entered the facility for the first time or was readmitted to the facility following a discharge.
- **PASRR Date:** The date of the most recent PASRR approval.
- **State ID:** The member's Medicaid identification number. It contains seven numbers and one alphabetically character.

### Section 2. Facility Data

This section contains information on the facility involved and the person making the entries in PathTracker Plus.

- **Medicaid Provider or National Provider Identifier (NPI) Number:** The provider number of the facility where the member resides. This must correspond with the level of care indicated in Section 3.
- **Facility Type:** The type of facility where the member resides.
- **Facility Name:** The name of the facility where the member resides.
- **Street Address, City, State, ZIP:** The street address, city, state, and ZIP code of the facility where the member resides.
- **Person Completing Form:** The facility staff person who completed the entries into PathTracker Plus.
- **Date Completed:** The date the information was entered into PathTracker Plus.
- **Contact Phone Number and Contact Email:** The phone number and email of the facility staff person who completed the entries into PathTracker Plus.



### Section 3. Level of Care

This section identifies the member's level of care information.

- **Level of Care:** Select the level of care the member is receiving.
- **Level of Care Process:** Select who will be determining level of care. Select:
  - “IME Medical Services” if Medicaid eligibility is pending or if this is a new admission.
  - “Medicare” if this is a Medicare qualified stay.
  - “Managed Care” if this is a continued stay review.
  - “Non-Medicaid” if the member is private pay.
- **Effective Date:** Enter the effective date of level of care determination.

### Section 4. Medicare Information for Skilled Patients in Facilities

Complete this section when there is Medicare coverage that may apply to skilled care by entering the expected dates of Medicare coverage.

### Section 5. Discharge Data

Complete Section 5 when a resident leaves the facility or dies. Remember that Medicaid does not pay for the date of discharge.

- **Reason for Discharge:** Select from the list of reasons why the member was discharged from the facility.
- **Date of Discharge:** The date the member was discharged from the facility.
- **Per Diem at Discharge:** The computed rate for the facility.
- **Address Discharged to:** The facility name, street address, city, state, and ZIP where the member discharged to. This section should be completed if the reason for discharge was something other than “died.”

### Section 6. Hospice or PACE Provider Information

Complete Section 6 when a resident has elected hospice or is enrolled in the PACE program.

- **Elected/Enrolled Program Information:** Select the appropriate program that the member has elected or enrolled.
- **Medicaid Provider Number and NPI Number:** The provider number of the hospice or PACE provider.
- **Name of Hospice or PACE Provider:** The name of the hospice or PACE provider.
- **Date of Election/Enrollment:** The date the member elected the hospice benefit or signed the PACE enrollment form.

- **Date of Revocation/Disenrollment:** The date the member revoked their hospice benefit or disenrolled from the PACE program.
- **Contact Name for Hospice or PACE:** The staff person's name at the hospice or PACE who can assist with questions regarding the member's election or enrollment.
- **Contact Phone Number and Email:** The phone number and email of the hospice or PACE facility staff person.

**Payment Application for Nonregistered Providers, Form 470-2890 or 470-2890(S)**

Purpose	Nonregistered and in-home providers apply for Child Care Assistance payment by completing the <i>Payment Application for Nonregistered Providers</i> , form 470-2890 or 470-2890(S).
Source	<p>The English version of the form is printed with 100 forms on a pad. Order supplies from Iowa Prison Industries at Anamosa.</p> <p>Print the Spanish version of the form from:</p> <ul style="list-style-type: none"><li>▪ The online manual.</li><li>▪ SharePoint under Employee Manual/Forms.</li></ul>
Completion	<p>The provider completes the application when:</p> <ul style="list-style-type: none"><li>▪ Applying for payment for the first time; or</li><li>▪ Applying for a two-year renewal; or</li><li>▪ Applying after the expiration of a previous agreement; or</li><li>▪ There is a change of name, care, living or mailing address, or household composition.</li></ul> <p>The provider shall complete the form after reading all the instructions and the minimum requirements in Comm. 95, <i>Guidelines for Child Care Homes with a Child Care Assistance Provider Agreement</i>.</p>
Distribution	The provider returns the application to the Centralized Child Care Provider Registration Unit. The Unit files the application in the child care case record.
Data	<p>The applicant-provider shall:</p> <ul style="list-style-type: none"><li>▪ Indicate whether this is a new application or a renewal.</li><li>▪ Carefully print the name (and maiden name and other last names, if any) and addresses.</li><li>▪ Enter the birth date, last four digits of the social security number, and telephone numbers with area codes.</li><li>▪ Nonregistered providers add the names of other adults and children living in the home with birth dates and the last four digits of the social security number, if available.</li><li>▪ In-home providers list the names of the parents and children living in the home where care will be provided, if available.</li><li>▪ Sign the application and date it to certify compliance with the minimum requirements of the Department of Human Services and indicate agreement with the eight numbered statements.</li></ul>

**Pregnancy Verification Request, Form 470-3783**

Purpose	Form 470-3783, <i>Pregnancy Verification Request</i> , is used to collect information for certain Medicaid programs when the household reports a member of the household is pregnant.
Source	Complete 470-3783 using the form in the Worker Information System Exchange (WISE).
Completion	Complete this form when a household reports a member of the household is pregnant.
Distribution	Give one copy of the form to the client. You may upload the request to the electronic case file. When the client completes and returns the form, it will be scanned and uploaded.
Data	Certain areas of the form populate and a due date is calculated for return of the completed form.

### **Presumptive Medicaid Eligibility Notice of Action – Approval, Form 470-2580**

Purpose	<p>The <i>Presumptive Medicaid Eligibility Notice of Action – Approval</i> is used to:</p> <ul style="list-style-type: none"><li>▪ Notify applicants of the qualified entity’s presumptive eligibility decision.</li><li>▪ Verify presumptive Medicaid eligibility for Medicaid providers rendering:<ul style="list-style-type: none"><li>• Ambulatory prenatal care services to pregnant women or</li><li>• Medicaid services to other presumptively eligible individuals.</li></ul></li></ul>
Source	<p>The presumptive eligibility program generates form 470-2580 based on entries the qualified entity makes through the Medicaid Presumptive Eligibility Portal (MPEP).</p>
Completion	<p>The qualified entity makes entries into the MPEP to complete the form when an individual applies for presumptive eligibility for Medicaid.</p>
Distribution	<p>A copy of the notice will be saved in the electronic case file in the Worker Information System Exchange (WISE). The qualified entity shall:</p> <ul style="list-style-type: none"><li>▪ Print the notice,</li><li>▪ Give or mail a copy to the applicant, and</li><li>▪ Keep a copy in the presumptive Medicaid record.</li></ul>
Data	<p>The MPEP completes the information on the notice based on the entries the qualified entity made.</p> <ul style="list-style-type: none"><li>▪ The system enters:<ul style="list-style-type: none"><li>• Which type of presumptive eligibility is approved.</li><li>• The individual’s state identification number.</li><li>• The beginning date of presumptive eligibility.</li><li>• The ending date for presumptive eligibility.</li></ul></li><li>▪ The system enters the name, phone number, and email address of the entity making the determination.</li></ul>

**Presumptive Medicaid Eligibility Notice of Action – Approval/Denial,  
Form 470-5190**

Purpose	<p>The <i>Presumptive Medicaid Eligibility Notice of Action – Approval/Denial</i> is used to:</p> <ul style="list-style-type: none"><li>▪ Notify applicants of the qualified entity’s presumptive eligibility decision.</li><li>▪ Verify presumptive Medicaid eligibility for Medicaid providers rendering:<ul style="list-style-type: none"><li>• Ambulatory prenatal care services to pregnant women or</li><li>• Medicaid services to other presumptively eligible individuals.</li></ul></li></ul>
Source	<p>The presumptive eligibility program generates form 470-5190 based on entries the qualified entity makes through the Medicaid Presumptive Eligibility Portal (MPEP).</p>
Completion	<p>The qualified entity makes entries into the MPEP to complete the form when an individual applies for presumptive eligibility for Medicaid.</p>
Distribution	<p>A copy of the notice will be saved in the electronic case file in the Worker Information System Exchange (WISE). The qualified entity shall:</p> <ul style="list-style-type: none"><li>▪ Print the notice,</li><li>▪ Give or mail a copy to the applicant, and</li><li>▪ Keep a copy in the presumptive Medicaid record.</li></ul>
Data	<p>The MPEP completes the information on the notice based on the entries the qualified entity made.</p> <ul style="list-style-type: none"><li>▪ For approvals, the system enters:<ul style="list-style-type: none"><li>• Which type of presumptive eligibility is approved.</li><li>• The individual’s state identification number.</li><li>• The beginning date of presumptive eligibility.</li><li>• The ending date for presumptive eligibility.</li></ul></li><li>▪ For denials, the system provides an explanation of denial (e.g., you are over income, you have already received presumptive eligibility during this pregnancy, etc.).</li><li>▪ The system enters the name, phone number, and email address of the entity making the determination.</li></ul>

### Presumptive Medicaid Eligibility Notice of Action – Denial, Form 470-5191

Purpose	<p>The <i>Presumptive Medicaid Eligibility Notice of Action – Denial</i> is used to:</p> <ul style="list-style-type: none"><li>▪ Notify applicants of the qualified entity’s presumptive eligibility decision.</li><li>▪ Verify presumptive Medicaid eligibility for Medicaid providers rendering:<ul style="list-style-type: none"><li>• Ambulatory prenatal care services to pregnant women or</li><li>• Medicaid services to other presumptively eligible individuals.</li></ul></li></ul>
Source	<p>The presumptive eligibility program generates form 470-5191 based on entries the qualified entity makes through the Medicaid Presumptive Eligibility Portal (MPEP).</p>
Completion	<p>The qualified entity makes entries into the MPEP to complete the form when an individual applies for presumptive eligibility for Medicaid.</p>
Distribution	<p>A copy of the notice will be saved in the electronic case file in the Worker Information System Exchange (WISE). The qualified entity shall:</p> <ul style="list-style-type: none"><li>▪ Print the notice,</li><li>▪ Give or mail a copy to the applicant, and</li><li>▪ Keep a copy in the presumptive Medicaid record.</li></ul>
Data	<p>The MPEP completes the information on the notice based on the entries the qualified entity made.</p> <ul style="list-style-type: none"><li>▪ The system provides an explanation of denial (e.g., you are over income, you have already received presumptive eligibility during this pregnancy, etc.).</li><li>▪ The system enters the name, phone number, and email address of the entity making the determination.</li></ul>

### **Proof of Application for Medicaid, Form 470-2979**

Purpose	Form 470-2979, <i>Proof of Application for Medicaid</i> , provides the client a letter to verify that the client has applied for Medicaid. Clients may show this form to providers or others as proof of their application.
Source	Complete form 470-2979 using the template in: <ul style="list-style-type: none"><li>▪ SharePoint under Employee Manual/Forms.</li><li>▪ The Worker Information System Exchange (WISE).</li></ul>
Completion	IM workers complete the form when clients request proof that they have applied for Medicaid.
Distribution	Give or send the original copy to the client.
Data	Enter: <ul style="list-style-type: none"><li>▪ The name of the IM worker.</li><li>▪ The county number designation.</li><li>▪ The name and address of the applicant.</li><li>▪ The notice date (the date the form is completed).</li><li>▪ The date the household applied for Medicaid.</li><li>▪ The names of the individuals included in the application for Medicaid.</li></ul>



### **Provider Special Needs Decision, Form 470-532I**

Purpose	The <i>Provider Special Needs Decision</i> , form 470-532I, is used to tell a provider whether or not a family's children have been approved to receive special needs payment rates.
Source	Complete form 470-532I using the template in: <ul style="list-style-type: none"><li>▪ SharePoint under Employee Manual/Forms.</li><li>▪ The Worker Information System Exchange (WISE).</li></ul>
Completion	After the decision on whether or not to approve special needs rates has been made, the worker completes this letter with the: <ul style="list-style-type: none"><li>▪ Provider's mailing address.</li><li>▪ Child's name.</li><li>▪ Child's case number.</li></ul>
Distribution	Send this letter to the provider. File a copy of the letter in the DHS case record.
Data	This letter provides information to a child care provider regarding: <ul style="list-style-type: none"><li>▪ Whether or not special needs payment rates are approved for a child.</li><li>▪ Basic information regarding the definition of a special needs child.</li><li>▪ How a provider may qualify for special needs payment rates.</li></ul>

**Public Assistance Agency Information Request, Form SSA-1610-U2**

Purpose	The local DHS office is to use the <i>Public Assistance Agency Information Request</i> for exchange of information with the Social Security Administration that is not included on the TPQY response.
Source	Print supplies of form SSA-1610-U2 from the online manual as needed.
Completion	<p>The local DHS worker responsible for the case shall prepare form SSA-1610-U2 in the following situations:</p> <ul style="list-style-type: none"><li>▪ To resolve any discrepancies between other evidence and data in the TPQY files, such as an identification problem.</li><li>▪ To secure retroactive historical data not provided by the TPQY.</li><li>▪ To provide information to the Social Security office regarding mutual clients, e.g., a FIP case in which an SSI application is pending. See 4-C, <a href="#">SSI Recipient</a>.</li></ul> <p>Use of the SSA-1610-U2 shall be limited to these circumstances except for emergencies. Each Department office should arrange with its Social Security office for handling emergencies.</p>
Distribution	<p>Send the original to the local Social Security office. When information is being submitted to the Social Security office, you may upload the request to the electronic case file.</p> <p>When the Social Security returns the original, it will be scanned and uploaded to the case record.</p>
Data	Specific instructions for completing the form are printed on the back of the form.

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**Quality Assurance Transmittal, Form 470-0271**

Purpose	<p>The <i>Quality Assurance Transmittal</i> is used to request the Division of Information Technology (DoIT) to:</p> <ul style="list-style-type: none"><li>▪ Cancel a warrant,</li><li>▪ Issue a one-time payment, or</li><li>▪ Cross-reference a state identification number.</li></ul>
Source	<p>Complete form 470-0271 using the template in:</p> <ul style="list-style-type: none"><li>▪ SharePoint under Employee Manual/Forms, or</li><li>▪ The Worker Information System Exchange (WISE).</li></ul>
Completion	<p>The IM worker completes the “Date,” “From,” and “Case Identification” sections and completes the rest of the form depending on the action being requested:</p> <ul style="list-style-type: none"><li>▪ <b>Cancel Warrant:</b> When a client returns a warrant to a Department office, enter the warrant number, amount, and date in this section. Attach the warrant and the official receipt to the white copy of the 470-0271 and send them to Quality Assurance.</li></ul> <p>If Quality Assurance has the warrant, send the form alone to Quality Assurance. Leave the warrant number field blank for Quality Assurance to complete.</p> <p>In both cases, Quality Assurance takes the necessary actions to remove the warrant from the client’s automated records.</p> <ul style="list-style-type: none"><li>▪ <b>Issue One-Time Special Payment Over \$1800:</b> To request the payment, check this box and enter the amount of payment. Send 470-0271 to the designated person in the service area, with a memo attached to explain why the payment is needed.</li></ul> <p>The designated service area person will sign the form in the space provided, and forward it to Quality Assurance. Quality Assurance authorizes the amount for ABC system issuance.</p> <ul style="list-style-type: none"><li>▪ <b>State ID Cross Reference:</b> If two or more state identification numbers are on record for a client, use this section to indicate which state ID should be removed.</li></ul> <p>Also use this section to indicate any social security number that should be removed, in order to enter the number with another state identification record.</p> <p>In all cross-reference situations, use the “Comments” section to explain your request.</p>

If the name and state identification number of a child need to be changed due to adoption, but the child's social security number remains the same, use this section, but enter the new name under "Comments."

Distribution

Send the form in an envelope via local mail to DoIT, Hoover Building. Keep one copy for case file.

Quality Assurance contacts the worker who initiated the request if more information is needed before the requested actions are completed. Quality Assurance will return incomplete transmittals to the worker, so errors are prevented.

Quality Assurance may encounter error conditions when attempting to cross-reference state identification numbers. Edits prohibit deletion of state identification numbers that do exist and are used on current ABC individual income records or have active, disqualified, or sanctioned status codes on ABC.

Data

Self-explanatory.

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## **Race/Ethnic Report, Form 470-3716**

Purpose	<p>Form 470-3716 is used to gather information about race and ethnicity for a person associated with the SNAP household or FIP assistance unit.</p> <p>Clients are not required to provide this information. However, it is a federal requirement that Iowa report race or ethnicity for all who do provide the information.</p>
Source	<p>Complete form 470-3716 using the template in:</p> <ul style="list-style-type: none"><li>▪ SharePoint under Employee Manual/Forms.</li><li>▪ The Worker Information System Exchange (WISE).</li></ul>
Completion	<p>Issue this form whenever you realize that you do not have race or ethnicity information for all adults and children who are in the household or are associated with the FIP assistance unit, including people who are not included on the grant, such as stepparents, excluded parents, etc.</p> <p>Also issue the form when the household applies for benefits for a new household member.</p> <p>NOTE: Clients are not required to complete this form. If clients decline to do so, it does not affect their eligibility or their benefits.</p> <p>If clients decline to answer the questions or complete the form, use worker observation to collect the data. When observation is not possible, document that the form was offered but the client chose not to supply the information.</p>
Distribution	<p>Enter the race and ethnicity information collected for each person on the ABC system.</p>
Data	<p>Clients can choose one selection for ethnicity and choose as many selections as apply for race.</p>

**RCA Appointment Letter, Form 470-5682 or 470-5682(S)**

Purpose	Form 470-5682 is used to schedule an appointment for a Refugee Cash Assistance (RCA) applicants to meet with the Bureau of Refugee Services (BRS) to register for employment and complete an individual employment plan.
Source	Complete the English or Spanish version using the form in the Worker Information System Exchange (WISE). The form can also be printed from the online manual.
Completion	<p>The IM worker uses this form to notify an RCA applicants of their appointment to meet with the BRS to register for employment and complete an individual employment plan.</p> <p>The <i>RCA Appointment Letter</i> is issued by the IM worker during the initial RCA eligibility interview with the applicant. The form allows the IM worker to schedule an in-person or phone appointment.</p>
Distribution	<p>After the IM worker completes the form:</p> <ul style="list-style-type: none"><li>▪ Hand-issue, mail, or e-mail the form to the RCA applicant, and</li><li>▪ File a copy in the RCA case record.</li></ul>
Data	<p>On the page, the IM worker:</p> <ul style="list-style-type: none"><li>▪ Selects the type of appointment (in-person or phone)</li><li>▪ Enters the appointment date</li><li>▪ Time, and</li><li>▪ For phone interviews, the phone number for the client.</li></ul> <p>Complete all remaining fields in the Referral Information and Person Responsible for Registering for Work sections. The fields are self-explanatory.</p>

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**Reasonable Compatibility Tool, Form 470-5178**

Purpose	IM workers use the <i>Reasonable Compatibility Tool</i> to determine if an applicant's statement of income can be considered to be verified as it is reasonably compatible with income information from state data sources. Workers use this form for MAGI-Related Medicaid only.
Source	IM staff can complete form 470-5178 using the tool in: <ul style="list-style-type: none"><li>▪ SharePoint under Employee Manual/Forms.</li><li>▪ The Worker Information System Exchange (WISE).</li></ul>
Completion	The IM worker completes applicable fields of the tool when determining eligibility for MAGI-Related Medicaid for a member with countable income.
Distribution	File a copy of the completed tool in the case file.
Data	The IM worker enters data as follows: <ul style="list-style-type: none"><li>▪ <b>State Source Income</b> tab: Enter the amount of monthly income obtained from state data sources for each member.</li><li>▪ <b>Self-Attested Income</b> tab: Enter countable monthly income for each member in the field that identifies the type of income.</li><li>▪ <b>Reasonable Compatibility</b> tab: The tool determines if the difference between the member's self-attested income amount and state data source income amount is within 10% of the state data source income amount. The percentage of difference is displayed in the <i>Compatibility Percentage</i> field:<ul style="list-style-type: none"><li>• The <i>Reasonably Verified</i> field says "True" if the percentage is 10% or less. The worker may consider the income to be verified.</li><li>• The <i>Reasonably Verified</i> field says "False" if the percentage is more than 10%. The worker must obtain additional verification of the income.</li></ul></li></ul>

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**Record of Lost Benefits Restored, Form 470-0318**

Purpose	Form 470-0318 is used to document the amount of lost benefits owed and the amount of lost benefits restored to a household.
Source	Complete form 470-0318 using the template in: <ul style="list-style-type: none"><li>▪ SharePoint under Employee Manual/Forms.</li><li>▪ The Worker Information System Exchange (WISE).</li></ul>
Completion	<p>Complete form 470-0318 when you determine that a household is entitled to a restoration of lost benefits or when a restoration of lost benefits is ordered by a hearing decision. Notify the household of its entitlement to lost benefits by completing the <i>Notice of Lost Benefits Entitlement</i>, form 470-0334.</p> <p>Print an original and one copy of form 470-0318. Print one additional copy for each additional month for which benefits are restored.</p>
Distribution	File the original in the household's case record. Send one copy to the Bureau of Purchasing, Payments, Receipts and Payroll. If the household requests issuance in more than one month to restore lost benefits, forward an additional copy to the Bureau of Purchasing, Payments, Receipts and Payroll following each month's issuance.
Data	<p>Complete the form as follows:</p> <ul style="list-style-type: none"><li>▪ Complete Items 1 through 7 to establish the amount of and the reason for the restoration of lost benefits.</li><li>▪ If there is an unpaid claim against the household, enter the unpaid amount in Item 8. EXCEPTION: If the unpaid amount of the claim exceeds the amount in Item 7, enter the same amount as in Item 7.</li></ul> <p>To give the household credit on its claim, complete the form 470-0010, <i>Adjustment to Overpayment Balance</i>, showing the amount in Item 8 for the Bureau of Purchasing, Payments, Receipts and Payroll.</p> <ul style="list-style-type: none"><li>▪ If benefits are restored in a lump sum, complete Item 10.</li><li>▪ If benefits are restored in monthly installments per household request, complete Item 11, as needed.</li></ul>



### **Redetermination to Other Medical Programs, Form 470-4832**

Purpose	Form 470-4832, <i>Redetermination to Other Medical Programs</i> , is used when eligibility for Medicaid ends. It explains other medical programs that the member may be eligible for, and it requests the necessary information to determine eligibility for those alternatives.
Source	Complete 470-4832 using the form in the Worker Information System Exchange (WISE).
Completion	When eligibility for Medicaid ends, the worker may send this letter to the member. Any or all of the following program descriptions may be included: <ul style="list-style-type: none"><li>▪ Medically Needy</li><li>▪ Family Planning Services</li><li>▪ MEPD</li></ul>
Distribution	Send the letter to the member. You may upload the request to the electronic case file. When the member returns the requested information, it will be scanned and uploaded.

### Refugee Referral to IWD and to Refugee Services, Form 470-0480

Purpose	<p>Form 470-0480 is used in the Refugee Cash Assistance program to refer an employable refugee to the Iowa Workforce Development (IWD) and to the Bureau of Refugee Services (BRS).</p> <p>BRS uses the form to:</p> <ul style="list-style-type: none"><li>▪ Register the refugee for employment with IWD,</li><li>▪ register the refugee for employment or training, and</li><li>▪ to notify the local Department office when registration is complete.</li></ul>
Source	<p>Complete form 470-0480 using the template in:</p> <ul style="list-style-type: none"><li>▪ SharePoint under Employee Manual/Forms.</li><li>▪ The Worker Information System Exchange (WISE).</li></ul>
Completion	<p>The IM worker prepares the form, except for the Bureau of Refugee Services' signature and date.</p> <p>Prepare this form:</p> <ul style="list-style-type: none"><li>▪ At the time of application for those refugees determined to be employable.</li><li>▪ At any time a refugee who has been exempt from employment is no longer exempt and must register for employment.</li></ul>
Distribution	<p>Email the form to <a href="mailto:BRSrefugee@dhs.state.ia.us">BRSrefugee@dhs.state.ia.us</a>. After the refugee has been registered for work with IWD and employment and training services, BRS will email the form to the IM worker.</p> <p>Upload the form to the casefile.</p>
Data	<p>This form identifies the refugee and the IM worker.</p>

**Renewal Application Addendum, Form 470-5199 or 470-5199(S)**

Purpose	<p>MAGI-related Medicaid and Hawki applicants and recipients use the <i>Renewal Application Addendum</i> to provide tax information and consent to compare reported information with data sources on household members not included on the:</p> <ul style="list-style-type: none"><li>▪ <i>Application for Health Coverage and Help Paying Costs</i>, form 470-5170 or 470-5170(S), or</li><li>▪ <i>Medicaid/Hawki Review</i>, form 470-5168 or 470-5168(S).</li></ul>
Source	<p>Complete the English or Spanish version of this form using the template in:</p> <ul style="list-style-type: none"><li>▪ SharePoint under Employee Manual/Forms.</li><li>▪ The Worker Information System Exchange (WISE).</li></ul> <p>Supplies of the addendum may also be printed from the online manual.</p>
Completion	<p>The MAGI-related Medicaid or Hawki applicant or recipient completes the addendum.</p> <p>The applicant or recipient may obtain help in completing the addendum from friends, relatives, advocate groups, or Department staff, if needed.</p>
Distribution	<p>File the addendum and the <i>Application for Health Coverage and Help Paying Costs</i>, form 470-5170 or 470-5170(S), or the <i>Medicaid/Hawki Review</i>, form 470-5168 or 470-5168(S).</p>
Data	<p>The worker completes the <i>Case Number</i> field in the upper right corner of page I before the form is sent or issued to the applicant or recipient.</p> <p>The applicant or recipient must print their name, and sign and date page I of the addendum.</p> <p>The applicant or recipient must complete the Tax Information section for each household member not listed on the <i>Application for Health Coverage and Help Paying Costs</i>, form 470-5170 or 470-5170(S), or <i>Medicaid/Hawki Review</i>, form 470-5168 or 470-5168(S).</p>

**Report of Change in Circumstances – SSI-Related Programs, Form 470-0641**

Purpose	<p>Form 470-0641 is designed to be used for reporting to the Social Security Administration:</p> <ul style="list-style-type: none"><li>▪ Any change in circumstances that might alter the Supplemental Security Income (SSI) payment issued to a client of one of the assistance programs administered by the Department.</li><li>▪ A change of address for a person receiving Medicaid as an SSI beneficiary.</li></ul>
Source	<p>Complete 470-0641 using the form in the Worker Information System Exchange (WISE).</p>
Completion	<p>The IM worker responsible for the case initiates the form:</p> <ul style="list-style-type: none"><li>▪ Whenever there is a change in a client's circumstances which may change the person's SSI payment, or</li><li>▪ To inform the Social Security Administration of a change of address that has been reported to the Department.</li></ul>
Distribution	<p>Forward the original and one copy to the local Social Security Administration office. You may upload the request to the electronic case file.</p> <p>The Social Security Administration office indicates action on form, keeps a copy, and returns a copy to the Department as soon as action is taken. When the original is returned, it will be scanned and uploaded.</p>
Data	<p>The name of the Social Security Administration office involved and the name of the county populates based on information in the worker profile.</p> <ul style="list-style-type: none"><li>▪ For Section 1, entering the case number and state identification number populates the client's name, social security number, and address.</li><li>▪ For Section 2, obtain the name of the person to be contacted from the client at the time of the reported change, since there could have been a change since the last contact.</li><li>▪ In Section 3, check the applicable box to indicate the change in circumstances. (Whenever the change involves a new living arrangement, also complete Section 4.)</li></ul>

- Use Section 4 to report a change of address reported to the Department by a recipient of SSI, State Supplementary Assistance, or Medicaid.
- Use the “Comment” section to convey information not covered elsewhere on the form. (An employee of the Social Security Administration may also use this section to add information.)
- Sign and date the form.

The section “To Be Completed by SSA-DO” allows the Social Security Administration to indicate that action has been taken, the date of action, and the resulting change in SSI benefit.

**Report of Stolen SNAP Benefits, Form 470-5771 or 470-5771(S)**

Purpose	<p>Form 470-5771 allows for a household to provide a written request for replacement of SNAP benefits due to fraud and</p> <ul style="list-style-type: none"><li>▪ Verificaiton that the allotment was issued and the amount issued,</li><li>▪ The IM worker’s decision on the household’s request, and</li><li>▪ Documentation for reporting and auditing.</li></ul>
Source	<p>Complete 470-5771 using the form in the Worker Information System Exchange (WISE).</p>
Completion	<p>Issue the form each time a household requests replacement issuance for SNAP stolen due to fraud. The head of household, spouse, authorized representative, or responsible household member requesting replacement shall complete and sign the Household Statement section. Workers must obtain approval from their IMA prior to replacing any stolen benefits. The worker who makes the decision on the household’s request for replacement issuance shall complete and sign the HHS Use Only section.</p>
Distribution	<p>File the original in the household’s case record. Give a copy to the household.</p>
Data	<p>The form is self-explanatory.</p>

**Report on Incapacity, Form 470-0447 or 470-0447(S)**

Purpose	Use the <i>Report on Incapacity</i> to obtain information from a doctor, chiropractor, hospital, clinic, psychologist, psychiatrist or other medical professional.
Source	Complete the English or Spanish version of this form using the templates in: <ul style="list-style-type: none"><li>▪ SharePoint under Employee Manual/Forms.</li><li>▪ The Worker Information System Exchange (WISE).</li></ul> Supplies of the form may also be printed from the online manual as needed.
Completion	<p>The IM worker can issue this form when:</p> <ul style="list-style-type: none"><li>▪ A stepparent has applied to be included in the FIP or FMAP-related Medicaid eligible group due to incapacity.</li><li>▪ A Refugee Cash Assistance applicant or participant claims exemption from work or training requirements because the person is needed in the home to care for an incapacitated household member.</li><li>▪ A FIP applicant or participant requests a hardship exemption based on physical or mental health issues or disability.</li><li>▪ Incapacity must be determined for any other purpose.</li></ul> <p>The PROMISE JOBS worker can issue this form when:</p> <ul style="list-style-type: none"><li>▪ A FIP applicant or participant claims inability to participate in PROMISE JOBS activities either at all or in a reduced capacity due to a physical or mental health issue or a disability.</li><li>▪ Information obtained from the <i>Self-Assessment</i>, form 470-0806, other assessment information, observation, or key historical information indicates a possible barrier to full participation due to a physical or mental health issue or a disability.</li><li>▪ A participant fails to attend FIA activities and claims the absence was due to a temporary illness of the participant or another family member and documentation is needed to determine if the absence can be excused.</li></ul> <p>The IM or PROMISE JOBS worker fills in the identifying information and date due at the top of the form.</p> <p>The client completes and signs the Patient Permission section.</p> <p>The medical professional completes the remainder of the form.</p>
Distribution	<p>If an examination or additional information is required, mail the form to the examiner or to the client to deliver to the examiner.</p> <p>When an examination is required, advise Medicaid members to make an appointment with their managed health care provider or regular Medicaid provider, as applicable.</p>

If the person is not a Medicaid member, and no other medical resources are available, attach form 470-0502, *Authorization for Examination and Claim for Payment*, to the form.

Data

The form is self-explanatory.



### **Reporting SNAP Changes, Form 470-2960 or 470-2960(S)**

Purpose	<i>Reporting SNAP Changes</i> is the form used to inform SNAP households how to report changes. The form shows the maximum gross monthly income for the household's size.
Source	The ABC system generates form 470-2960 or 470-2960(S). Both the English and Spanish versions of this form are also available in the Worker Information System Exchange (WISE).
Completion	Issue this form: <ul style="list-style-type: none"><li>▪ At application.</li><li>▪ At recertification.</li></ul>
Distribution	If issuing a manual notice of decision, send or give the original form to the household and keep a copy of the form in the case file.
Data	Complete the client name, address, date, and case number on the form. For households with earnings at or below the gross income limit, fill in the gross monthly income applicable for household size.  Fill in the household's countable self-employment income if applicable.  Fill in the name of any Able-Bodied Adults Without Dependents (ABAWDs) who are eligible because they meet work requirements.

### Request for Child and Dependent Adult Abuse Information, Form 470-0643

Purpose	<p>Form 470-0643 is used to request information from the Central Abuse Registry:</p> <ul style="list-style-type: none"><li>▪ To determine whether there is record of a founded abuse report on a person in the child care provider's household.</li><li>▪ To assist in verifying a minor parent's claim of good cause for not living with an adult parent or legal guardian because of abuse.</li><li>▪ To record the dissemination of child abuse information.</li></ul>
Source	<p>IM staff can complete form 470-0643 using the template in:</p> <ul style="list-style-type: none"><li>▪ SharePoint under Employee Manual/Forms.</li><li>▪ The Worker Information System Exchange (WISE).</li></ul>
Completion	<p>The form is initiated by any person wishing to obtain child abuse information that is placed on the Central Abuse Registry. IM staff complete the form when:</p> <ul style="list-style-type: none"><li>▪ A nonregistered provider wishes to receive Child Care Assistance funds.</li><li>▪ A minor parent claims good cause for not living with an adult parent or legal guardian because of abuse.</li></ul> <p>Complete Section 1 with information about the person making the request (the worker).</p> <p>Complete Section 2 with information about the person whose records are being requested (the minor parent or child care provider).</p> <p>Section 4 is completed by the Central Abuse Registry staff or the local office staff person designated as approved to relay founded child abuse information to any authorized requester.</p> <p>All local offices are authorized to release information to the subjects of a child abuse investigation or assessment (or to a subject's legal representative) upon verification of identity and subject status.</p>
Distribution	<p>For internal DHS requests from licensing, registration or payment approval record checks, send one copy of the form to the person doing the registry checks in your area. Keep a copy of the form until the original is returned.</p> <p>For requests involving a minor parent, attach a copy of form 470-0461, <i>Authorization for Release of Information</i>, completed by the minor parent. The release shall:</p> <ul style="list-style-type: none"><li>▪ State that you are authorized to obtain information from the child abuse registry.</li><li>▪ Request that the status of the child abuse report and the worker number of the service worker be provided, for the purpose of FIP payment.</li></ul>

If the name is not found on the Registry, the person doing the check attaches a label saying this and returns the forms to you. File the original in the registration file or eligibility file, and discard the rest.

If the name is found on the registry as the person responsible for a founded incident, the person making the check:

- Labels it as such with the Iowa Code reference.
- Sends one copy to the Registry to record dissemination of the information.
- Keeps one copy of the completed form for the local office records.
- Sends one copy to the requester with the result of the check.

Data

Complete Section 1 as follows:

- Enter your name, telephone number, and office address.
- Enter “income maintenance worker” under relationship.
- Sign your name and enter the date.

In Section 2:

- Enter the complete name of the minor parent or the child care provider with birth date and social security number, if available.
- Enter the person’s address and the county of residence.
- Enter any other names previously used by this person.

Complete separate forms for:

- The provider’s spouse.
- Other adults living in the home.
- People with access to a child when the child is alone.
- The child care provider’s children.

The person authorized to access information in the child abuse registry for that area completes Section 4 of the form to verify the status of the child abuse report and, for minor parents, the worker number of the service worker.

**Request for FIP Beyond 60 Months, Form 470-3826 or 470-3826(S)**

Purpose	<p>Assistance from the Family Investment Program (FIP) is limited to a total of 60 months. The only way families may receive FIP beyond 60 months is if they request and are determined eligible for a “hardship exemption.”</p> <p>Form 470-3826 or 470-3826(S) is the form families must complete to request a hardship exemption. Receipt of the form in any DHS or PROMISE JOBS office protects the date of the request.</p> <p>The form is also an authorization for release of information that allows IM, PROMISE JOBS, Service, and FaDSS staff to share with each other substance abuse, mental health and AIDS/HIV-related information about the family that may be relevant to the hardship exemption determination.</p>
Source	<p>Obtain form 470-3826 from the Eligibility Tracking System (ETS), either from:</p> <ul style="list-style-type: none"><li>▪ The “Form History” page, or</li><li>▪ The “Active Cases That Have Used FIP For 36 or More Months” report.</li></ul> <p>Print the English or Spanish version of this form from:</p> <ul style="list-style-type: none"><li>▪ The online manual.</li><li>▪ SharePoint under Employee Manual/Forms.</li><li>▪ The Worker Information System Exchange (WISE).</li></ul>
Completion	<p>The hardship exemption applicant completes form 470-3826 or 470-3826(S). Issue the form to the family. Include a return envelope for the applicant to send the form to the scanning center. Document the date you issue the form in the case record.</p>
Distribution	<p>The applicant submits form 470-3826 or 470-3826(S) to any DHS or PROMISE JOBS office. If a PROMISE JOBS office receives the form, the office must forward the form to the IM worker within one working day.</p> <p>Return a copy of form 470-3826 or 470-3826(S) to the family as a record of the authorization to share information.</p> <p>Upon receipt of form 470-3826 or 470-3826(S) from the family, screen the family’s FIP case circumstances.</p> <ul style="list-style-type: none"><li>▪ If the request does not appear appropriate for the circumstances of the case, e.g., the family has received FIP for 57 or fewer months, deny the family’s request.</li><li>▪ If the family’s hardship exemption request appears appropriate for the FIP case circumstances, process the hardship exemption request.</li></ul>

EXCEPTION: When the family is no longer on FIP and needs to file a *Financial Support Application* to regain FIP eligibility, delay processing the hardship exemption request until you receive the application. If the family fails to return the application by the due date, deny the hardship exemption request for that reason.

The hardship exemption eligibility determination is a two-step process:

1. Based on supporting evidence, determine whether the family has a hardship condition that affects its ability to be self-supporting.
2. If the family is determined to have a hardship condition, the family must then meet with PROMISE JOBS to develop and sign a six-month *Family Investment Agreement (FIA)* that addresses the family's documented hardship condition.

The family must meet the requirements of both steps and meet all FIP eligibility requirements before the hardship exemption request can be granted. See 4-C, [Hardship Exemption](#), for more information.

To process the exemption request:

- If the family has an active service case, forward a paper copy of form 470-3826 or 470-3826(S) and an electronic copy of form 470-3884, *Hardship Exemption: Service Information*, to the service worker. Request the worker's recommendations for steps to consider in the *Family Investment Agreement (FIA)*.
- Contact the family in writing to provide supporting evidence of its hardship condition. If the family does not meet the criteria, deny the family's hardship exemption request.
- After you have determined that the family has a hardship condition, forward to the local PROMISE JOBS office a copy of:
  - Form 470-3826 or 470-3826(S), *Request for FIP Beyond 60 Months*.
  - Form 470-3876, *Hardship Exemption Determination*.
  - The supporting hardship evidence.
  - Form 470-3884, *Hardship Exemption: Service Information*, received from the family's service worker (if applicable).

Upon receipt of these documents, PROMISE JOBS will initiate procedures for the adults in the family to attend the required interview and develop and sign the six-month FIA.

Retain the original form 470-3826 or 470-3826(S) in the permanent "Hardship Exemption" section of the case record.

Data

The family must complete designated items. To be considered valid, the form must contain a legible name and address, and must be signed by the “adult” in the family who is:

- The parent in the home, even if the parent is or will be excluded from the FIP grant. When both parents or a parent and stepparent are in the home, either parent or the stepparent can sign the form.
- The incapacitated stepparent when the stepparent is or requests to be on the FIP grant.
- The needy nonparental specified relative who is or requests to be on the FIP grant.

When the adult is incompetent or incapacitated, someone acting responsibly on the adult’s behalf may sign the form.

See 4-C, [Hardship Exemption: Valid Request](#), for additional information on signature requirements.

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**Request for ISIS Changes, Form 470-3924**

Purpose	The purpose of the <i>Request for ISIS Changes</i> , form 470-3924, is to transmit requests to add, change, or terminate program request information in ISIS when the information can't be submitted through ABC system entries.
Source	IM staff completes form 470-3924 using the template in: <ul style="list-style-type: none"><li>▪ SharePoint under Employee Manual/Forms.</li><li>▪ The Worker Information System Exchange (WISE).</li></ul>
Completion	An IM worker prepares the form when: <ul style="list-style-type: none"><li>▪ A program request needs to be added to ISIS and the information cannot be passed to ISIS by making entries in the ABC system.</li><li>▪ A change occurs to any information on a program request in ISIS and that information cannot be passed to ISIS by making entries in the ABC system.</li></ul> <p>The information must be submitted on the form before additions or corrections can be made to the ISIS program requests. Use the same form for additional requests for the same member. Use a different form for each new member.</p>
Distribution	Email the completed form to DHS, ISIS-Facilities.
Data	<p><b>Part 1: Member/Staff Information:</b> Enter the member's state identification number and name from the ABC system. Enter your name.</p> <p><b>Part 2: Eligibility Changes:</b></p> <p><b>Program request that needs changes:</b> Enter the dates and program currently shown in these fields on the ISIS program request that needs correction. If this is a request to add a program request rather than a request for corrections, leave this section blank.</p> <p><b>Correct Information:</b> Enter the correct information in each of the following fields:</p> <ul style="list-style-type: none"><li>▪ <b>Begin Date:</b> Enter the date the member becomes eligible or resumes eligibility for the waiver or facility program or the effective date of a change.</li><li>▪ <b>End Date:</b> Enter as the end date the last date eligibility exists or the day before a change is effective on the subsequent program request.</li><li>▪ <b>Aid Type:</b> Enter the aid type for the member's coverage group.</li><li>▪ <b>Program:</b> Enter the number or letter of the program type from the drop down box.</li><li>▪ <b>Co Res:</b> Enter the county where the case is assigned.</li><li>▪ <b>Co LS:</b> Enter the member's county of legal settlement.</li></ul>

- **CP 1st Month and CP Ongoing:** Enter the amount of first and ongoing client participation. Use the first five digits for dollars and the last two digits for cents.

Complete all boxes. Enter zeros when there is no client participation or when less than seven boxes are needed. (E.g., 0000000 shows client participation is zero; 0004220 shows client participation is \$42.20.)

- **Provider Number (Facility Only):** Enter the seven-digit provider number or the national provider indicator (NPI).
- **NF Provider #, if Hospice:** Enter the seven-digit provider number or NPI of the nursing facility where the member resides, if the member is receiving hospice services.
- **Application Date:** Enter the date of application for Medicaid.



**Request for Proof of Citizenship and Identity, Form 470-4909 or 470-4909(S)**

Purpose	Form 470-4909 or 470-4909(S) is used to tell a Medicaid or family planning applicant or member that U.S. citizenship and identity must be verified within 90 days or Medicaid or family planning will end and retroactive Medicaid (if requested) will be denied.
Source	This form is system-generated. This form is not to be generated by the worker.
Completion	<p>The system automatically generates this form for all persons active for Medicaid or family planning when:</p> <ul style="list-style-type: none"><li>▪ The code in the person's US or ID field indicates that citizenship or identity has not been verified <b>and</b></li><li>▪ An automated match cannot be requested through the IEVS system on the person.</li></ul> <p>EXCEPTION: The form will not be sent on a person who has already used one 90-day reasonable opportunity period.</p> <p>Form 470-4909(S) is system-generated when there is an "S" in the language indicator field.</p> <p>The system will track the 90-day reasonable opportunity period for the person to verify citizenship and identity based on the date the system-generated form is sent to the client.</p>
Distribution	One copy of the form is sent to the electronic case file. The second copy is sent to the client.

**Request for Replacement of Spoiled Food, Form 470-2920 or 470-2920(S)**

Purpose	<p>The purpose of form 470-2920 is to provide:</p> <ul style="list-style-type: none"><li>▪ The household's written request for replacement of food lost in a household misfortune,</li><li>▪ Verification that the allotment was issued and the amount issued,</li><li>▪ The IM worker's decision on the household's request, and</li><li>▪ Documentation for reporting and auditing.</li></ul>
Source	<p>Complete form 470-2920 using the template in:</p> <ul style="list-style-type: none"><li>▪ SharePoint under Employee Manual/Forms.</li><li>▪ The Worker Information System Exchange (WISE).</li></ul>
Completion	<p>Issue the form each time a household requests replacement issuance for food lost in a household disaster.</p> <p>The head of household, spouse, authorized representative, or responsible household member requesting replacement shall complete and sign the Household Statement section.</p> <p>The IM worker who makes the decision on the household's request for replacement issuance shall complete and sign the DHS Use Only section.</p>
Distribution	<p>File the original in the household's case record. Give a copy to the household.</p>
Data	<p>This form is self-explanatory.</p>

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**Request for School Verification, Form 470-1638**

Purpose	Form 470-1638 is designed to secure the client's permission for the Department to verify school enrollment. The school also uses the form to furnish the requested verification.
Source	Complete 470-1638 using the form in the Worker Information System Exchange (WISE).
Completion	The IM worker completes this form when it is necessary to verify school enrollment.
Distribution	<p>Make two photocopies after the client signs the form. Send the original to the school. Give a copy to the client.</p> <p>You may upload the request to the electronic case file. When the school returns the original, it will be scanned and uploaded.</p>
Data	<p>Enter the following information before obtaining the client's signature:</p> <ul style="list-style-type: none"><li>▪ The case number.</li><li>▪ The name and address of the school.</li><li>▪ The names of the students for whom the client needs verification.</li><li>▪ The dates for the time period to be verified.</li></ul> <p>The following information automatically populates:</p> <ul style="list-style-type: none"><li>▪ The worker number.</li><li>▪ The date the form is sent.</li><li>▪ The worker's name and address.</li><li>▪ The worker's phone number.</li><li>▪ The worker's email address.</li><li>▪ The date the authorization expires. (The expiration shall be 60 days from the date the form is signed, unless supervisory approval is given to extend the date.)</li></ul> <p>The client shall sign and date the form after the listed items have been completed.</p> <p>The school completes the remainder of the form.</p>

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**[Request for Special Update, Form 470-0397](#)**

Purpose	<p>The <i>Request for Special Update</i> is used to:</p> <ul style="list-style-type: none"><li>▪ Update the Medicaid eligibility file (the SSNI screen) to add months for which a client was eligible for Medicaid.</li><li>▪ Correct Medicaid data for current and past months (when the client becomes eligible for greater benefits).</li><li>▪ Change Medicare coverage codes for current and past months.</li></ul>
Source	<p>Workers can complete 470-0397 using the form in the Worker Information System Exchange (WISE).</p>
Completion	<p>The IM worker prepares three copies of this form:</p> <ul style="list-style-type: none"><li>▪ To authorize Medicaid coverage in the retroactive period when there is no current eligibility.</li><li>▪ To update the Medicaid eligibility file regarding Medicare supplemental insurance coverage.</li><li>▪ To add a newborn to the Medicaid eligibility file.</li><li>▪ To authorize past and current dates of benefits for some special Medicaid categories, such as when:<ul style="list-style-type: none"><li>• The person's aid type was Medically Needy with an unmet spenddown, but should have been in a non-Medically Needy coverage group.</li><li>• The person's aid type was Medically Needy on a coverage group requiring copayments, but the person should have been in a facility aid type or an aid type that does not require copayments.</li><li>• The person was in a QMB aid type but was actually eligible for full Medicaid coverage.</li></ul></li></ul>
Distribution	<p>Send two copies to the Division of Information Technology (DoIT). Keep a copy in the case record for reference.</p> <p>After the data are entered, Quality Assurance returns the original to the local office to indicate the date of completion.</p>
Data	<p>Complete the identifying information requested on the form. Use one form per case record. If there is more than one person to be updated per case record, use additional pages as needed.</p> <p>See I4-C, <a href="#">SSNI = Medicaid Eligibility File</a>, for a description of the SSNI fields. For coding instructions, see <a href="#">I4-B-Appendix</a> for items on the TD03 screen (<u>MEDICAL FUND</u>, <u>HEALTH</u>, <u>SRV</u>, <u>MN</u>, and <u>POV</u>).</p>

### **Request for Termination of Medical Assistance, Form 470-5763**

Purpose	<p>The <i>Request for Termination of Medical Assistance</i>, form 470-5763 provides:</p> <ul style="list-style-type: none"><li>▪ A simple means for the client to request that their Medical Assistance coverage be discontinued.</li><li>▪ A reminder to the client that requesting termination of Medical Assistance can also impact their eligibility for services they receive as well.</li></ul>
Source	<p>The form can be printed from the user manual.</p>
Completion	<p>Clients may complete the form and return it by mail, fax, or email to the HHS imaging center address listed on the form. Clients may also request that their Medical Assistance be discontinued by calling the IM Customer Service Center or in person at a HHS office.</p>
Distribution	<p>Issue the form when the client requests a form.</p> <p>When a member requests that their Medical Assistance be terminated, file the form (or narrate the request if no form is submitted) in the case record after the required action is completed. Document the resulting action in the case record.</p>

**Request for Verification of Citizenship and Identity, Form 470-4858 or 470-4858(S)**

Purpose	Form 470-4858 or 470-4858(S) is used to tell a Medicaid or family planning applicant or member that U.S. citizenship could not be verified using the identifying information provided. The form explains that citizenship and identity must be verified within 90 days or benefits will end and retroactive Medicaid (if requested) will be denied.
Source	This form is system-generated. This form is not to be generated by the worker.
Completion	<p>The system automatically generates this form for all persons active for Medicaid or family planning when:</p> <ul style="list-style-type: none"><li>▪ The IEVS system automated match returns a response that the person's citizenship was not substantiated <b>and</b></li><li>▪ The code in the person's US or ID field indicates that citizenship or identity has not been verified.</li></ul> <p>EXCEPTION: The form will not be sent on a person who has already used one 90-day reasonable opportunity period.</p> <p>Form 470-4858(S) is system-generated when there is an "S" in the language indicator field.</p> <p>The system will track the 90-day reasonable opportunity period for the person to verify citizenship and identity based on the date the system-generated form is sent to the client.</p>
Distribution	IABC sends one copy of the form to the electronic case file. The worker must upload this form to the electronic case file for family planning cases. The second copy is sent to the client.

### Requirements of Claiming Good Cause, Form 470-0170

Purpose	Form 470-0170 supplies the applicant or participant with specific information as to how to claim good cause.
Source	Print form 470-0170 from: <ul style="list-style-type: none"><li>▪ The online manual.</li><li>▪ SharePoint under Employee Manual/Forms.</li><li>▪ The Worker Information System Exchange (WISE).</li></ul>
Completion	The IM worker provides the form whenever the applicant or participant <ul style="list-style-type: none"><li>▪ Requests information as to the procedure involved in claiming good cause, or</li><li>▪ Indicates intent to claim good cause.</li></ul> The applicant or participant signs and dates the form to request good cause.
Distribution	Issue both copies of the form to the applicant or participant. Upon its return, file the signed and dated form in the case record. The applicant or participant keeps the other copy.
Data	Give instructions that if the applicant or participant wishes to claim good cause, the applicant or participant must sign and date the form and return the original to the Department before any consideration can be given to a claim of good cause.

**Requirements of Support Enforcement, Form 470-0169 or 470-0169(S)**

Purpose	<p>Form 470-0169 and 470-0169(S) are used to:</p> <ul style="list-style-type: none"><li>▪ Notify FIP applicants and participants of their right to claim good cause for refusal to cooperate in establishing paternity and securing support payments.</li><li>▪ Inform FMAP-related Medicaid applicants of the value of cooperating in obtaining medical support and notify parents and needy caretakers who are applicants or members of their right to claim good cause for refusal to cooperate in establishing paternity and securing support payments.</li></ul>
Source	<p>Order supplies of the English version of this form from Iowa Prison Industries at Anamosa.</p> <p>Print the English or Spanish version of this form from:</p> <ul style="list-style-type: none"><li>▪ The online manual.</li><li>▪ SharePoint under Employee Manual/Forms.</li><li>▪ The Worker Information System Exchange (WISE).</li></ul>
Completion	<p>At the time of the application, give this form to:</p> <ul style="list-style-type: none"><li>▪ Every person applying or reapplying for FIP who is required to cooperate with Child Support Recovery.</li><li>▪ Every person applying or reapplying for FMAP-related Medicaid.</li></ul> <p>Issue this form to participants upon request of the participant. Document in the case record when the form is provided.</p> <p>When a participant reports that a parent has left the home, and the case record shows that the participant previously was issued form 470-0169 at the time of the most recent application or more recently, you do not need to issue another form.</p>
Distribution	<p>The applicant or participant keeps the form.</p>



### [Resources Upon Entering a Medical Facility, Form 470-2577](#)

Purpose	<p>Form 470-2577 is used to collect information about a couple's resources for an attribution of resources between spouses. An attribution is required when a spouse:</p> <ul style="list-style-type: none"><li>▪ Goes into a medical institution expecting to remain for 30 consecutive days, or</li><li>▪ Applies for home- and community-based elderly waiver services.</li></ul>
Source	<p>Print form 470-2577 from:</p> <ul style="list-style-type: none"><li>▪ The online manual.</li><li>▪ SharePoint under Employee Manual/Forms.</li></ul>
Completion	<p>Either spouse (or an interested person on behalf of either spouse) may complete the form:</p> <ul style="list-style-type: none"><li>▪ When requested by a spouse (when one spouse enters a medical institution), or</li><li>▪ When a Medicaid application is submitted.</li></ul> <p>The form must be fully completed before an attribution of resources is determined.</p>
Distribution	<p>One copy shall be submitted. Provide a copy of the completed form when requested by either spouse.</p> <p>Establish a case record for the spouse in the institution and file this in the permanent section of the case file.</p>

**[Review/Recertification Eligibility Document, Form 470-2881, 470-2881\(S\), 470-2881\(M\), or 470-2881\(MS\)](#)**

Purpose	<p>The <i>Review/Recertification Eligibility Document</i>, forms 470-2881, 470-2881(S), 470-2881(M), and 470-2881(MS), is designed for use as:</p> <ul style="list-style-type: none"><li>▪ An application for subsequent certification for the SNAP program.</li><li>▪ The annual or semiannual review document for FIP and Refugee Cash Assistance.</li></ul> <p>This form contains instructions for completion and informs clients of their rights and responsibilities.</p>
Source	<p>Usually, the ABC system generates form 470-2881 automatically. Form 470-2881(S) is generated when there is an “S” in the language indicator field on the ABC TD01 screen.</p> <p>DHS staff may issue “manual” versions of the form, 470-2881(M) and 470-2881(MS), using the templates in:</p> <ul style="list-style-type: none"><li>▪ SharePoint under Employee Manual/Forms.</li><li>▪ The Worker Information System Exchange (WISE).</li></ul>
Completion	<p>The ABC system produces form 470-2881 or 470-2881(S) after the data processing cutoff for:</p> <ul style="list-style-type: none"><li>▪ SNAP when a case is due for recertification.</li><li>▪ FIP and Refugee Cash Assistance when a case is active or pending and the case coding indicates that the form should be sent.</li></ul> <p>Give or issue form 470-2881(M) or 470-2881(MS) to the participant upon request.</p> <p>The worker or the ABC system completes the top portion of page I before the form is sent or issued to the participant.</p> <p>The participant must complete the answers to all applicable questions. The participant may obtain help in completing the report from friends, relatives, advocate groups, or Department staff, if needed.</p> <p>For FIP and Refugee Cash Assistance, when both parents or a parent and a stepparent are in the home, either may sign the form. When a participant has a guardian or conservator, that person shall participate in completing the form. This person may sign for the client when necessary.</p> <p>For SNAP, only one signature is required to process this form as an application for recertification.</p>

Distribution	<p>Give or mail one copy of the report to the client for completion.</p> <p>File the completed original in the case record. Provide a copy of the completed form to the client upon request.</p>
Data	<p>Whenever the form is issued manually, provide a pre-addressed return envelope. Prepare the form as follows:</p> <ul style="list-style-type: none"><li>▪ Enter the Department office name and mailing address.</li><li>▪ Enter the case name and current mailing address.</li><li>▪ Enter the nine-digit case number and check digit.</li><li>▪ Enter the county number.</li><li>▪ Enter the worker’s telephone number in the “What if I have questions?” section.</li><li>▪ For FIP and Refugee Cash Assistance, insert the following message in the message section:<p style="margin-left: 40px;">“It’s time to review your case. Please fill out this form and send or bring it to the address above by &lt;due date&gt;. This information will be used to decide if you will continue to get Family Investment Program (FIP) or Refugee Cash Assistance benefits.”</p></li><li>▪ If an interview is needed for SNAP, enter:<p style="margin-left: 40px;">“Your Food Assistance will end &lt;last date of certification period&gt;. Return this signed form by &lt;15<sup>th</sup> of certification end month&gt;, to get Food Assistance at the regular time next month, if you are eligible. You must have an interview for Food Assistance. A worker will contact you by phone or appointment letter. If you miss the interview, your benefits may be delayed or canceled. You must ask your local office to reschedule and also provide verification.</p></li><li>▪ If an interview is <b>not</b> needed for SNAP, enter:<p style="margin-left: 40px;">“Your Food Assistance will end &lt;last date of certification period&gt;. Return this signed form by &lt;15<sup>th</sup> of certification end month&gt;, to get Food Assistance at the regular time next month, if you are eligible.</p></li><li>▪ Enter all data in the “Household Members” section (except <b>do not</b> enter the last grade completed and the “yes” or “no” responses). Enter only the last four digits of the social security number.</li></ul> <p><b>Screening:</b> Screen the form upon its receipt. All questions (for related programs) that have “yes or no” responses must have either “yes” or “no” marked.</p> <p>For FIP and Refugee Cash Assistance, if the answer is “yes,” all requested information must be completed and necessary verification provided for the form to be considered complete.</p>

If the participant fails to enter required information on the RRED but sends verification of that information with the RRED, the form is still considered complete.

NOTE: When the nonparental relative does not receive assistance for the relative's own needs, the information shall reflect the circumstances of each child.

To be complete, the form must be signed and dated by the necessary persons.

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### Screening Related Services Rendered to Medicaid EPSDT Enrollees, Report X1612X5

Purpose	The <i>Screening Related Services</i> report provides the IM worker with a record of medical care received by a child when the worker is responsible for providing the EPSDT “Care for Kids” oversight. (See 8-M, <a href="#">Procedures for Notification and Tracking</a> , for a description of IM responsibilities under this program.)
Source	The Iowa Medicaid Enterprise generates the list quarterly from the fiscal agent’s <b>paid</b> claims history file.
Completion	<p>When there is a referral for diagnosis or treatment as a result of the most recent screening examination, and follow-up services are indicated, no further action is needed.</p> <p>When it is not clear whether the service has been received, contact the member to determine if assistance is needed.</p>
Distribution	File the most recent report in the case record.
Data	<p>The “LAST” screening date is the last screening paid by Medicaid in the last two years. The “NEXT” screening date is based upon the enrollee’s age and the periodicity schedule.</p> <p>The report identifies the dental, hearing, medical, and vision services paid by Medicaid within the last six months. Enrollees are reported even if they did not have a service to report.</p>

**Self-Assessment, Form 470-0806 or 470-0806(S)**

Purpose	Form 470-0806, <i>Self-Assessment</i> , is used to obtain information about a PROMISE JOBS client as part of the assessment process, to identify potential barriers to participation in the PROMISE JOBS program or specific components.
Source	Print the English or Spanish version of this form from: <ul style="list-style-type: none"><li>▪ The online manual.</li><li>▪ SharePoint under Employee Manual/Forms.</li></ul>
Completion	The IM worker issues a copy of the <i>Self-Assessment</i> along with form 470-3897, <i>FIA Appointment</i> , to clients referred to PROMISE JOBS. Instruct the client to complete all entries on the form.
Distribution	The completed form becomes part of the client's PROMISE JOBS case file.
Data	The form requests information about the client's: <ul style="list-style-type: none"><li>▪ Family composition</li><li>▪ Work history</li><li>▪ Educational background</li><li>▪ Income</li><li>▪ Transportation</li><li>▪ Housing</li><li>▪ Legal status</li><li>▪ Health</li></ul>

**Self-Employment Ledger, Form 470-3784**

Purpose	Form 470-3784, <i>Self-Employment Ledger</i> , is used to collect information for the Family Investment Program, SNAP program, and Medicaid program, when the household reports new self-employment.
Source	Complete 470-3784 using the form in the Worker Information System Exchange (WISE).
Completion	Complete this form when a household reports new self-employment.
Distribution	Print two copies of the form. Give one copy to the client and file one copy in the case record. The client completes the form and returns it to the assigned imaging center.
Data	Certain areas of the form populate and a due date is calculated for return of the completed form. The client records self-employment income and expenses.

**SNAP Complaint, Form 470-0323 or 470-0323(S)**

Purpose	Complainants or recipients of SNAP use forms 470-0323 or 470-0323(S) to file a written complaint.
Source	Print the English or Spanish version of the form from: <ul style="list-style-type: none"><li>▪ The online manual.</li><li>▪ SharePoint under Employee Manual/Forms.</li></ul>
Completion	A SNAP recipient or complainant completes this form at any time when filing a complaint. Make three copies of the submitted form. Inform the complainant that a written response will be issued within 45 days.
Distribution	The person making the complaint shall leave the form at the local office.  Provide the complainant with one copy and document that the form was issued. When the client returns the form, send the original and one copy to the Field Operations Support Unit in Central Office. Central Office will send a copy to the service area with a request for response to the complainant.
Data	Completion of the <i>SNAP Complaint</i> form is self-explanatory.



**SNAP Complaint Summary, Form 470-0328**

Purpose	Form 470-0328 enables the complaint coordinator in the Field Operations Support Unit to summarize the types of complaints received in a given month concerning the SNAP process.
Source	Print form 470-0328 from: <ul style="list-style-type: none"><li>▪ The online manual.</li><li>▪ SharePoint under Employee Manual/Forms.</li></ul>
Completion	The complaint coordinator in the Field Operations Support Unit prepares one copy at month's end.
Distribution	The original is attached to the <i>SNAP Complaint</i> forms received in that particular month.
Data	Completion of this form is self-explanatory.

### **SNAP Computation, Form 470-0330**

Purpose	The <i>SNAP Computation</i> , form 470-0330, is used for manual calculation of eligibility and benefits.
Source	Print form 470-0330 from: <ul style="list-style-type: none"><li>▪ The online manual.</li><li>▪ SharePoint under Employee Manual/Forms.</li></ul>
Completion	Complete the form at the time of certification or the processing of reported changes when manual calculation is necessary.
Distribution	File the original in the case record. Provide the household with a copy upon request.
Data	This form records income and expense information that affects benefit amounts.

**SNAP Farmer Self-Employment Worksheet, Form 470-5412**

Purpose	The <i>SNAP Farmer Self-Employment Worksheet</i> , form 470-5412, is used to manually calculate farm self-employment income and expenses used for eligibility and benefit determination.
Source	Access the form from WISE to make use of the built-in calculation formulas.
Completion	Complete the form at the time of certification or recertification or the processing of reported changes when the household has farm self-employment income.
Distribution	File the completed form in the Electronic Case File. Provide the household with a copy upon request.
Data	<p>This form records self-employment income and expense information that affects benefit amounts.</p> <p>Page 2 calculates the prorated shelter deduction when a portion of shelter costs are used as a business expense.</p> <p>Page 3 is a farm income interview checklist.</p>

**SNAP Self-Employment Worksheet, Form 470-5418**

Purpose	The <i>SNAP Self-Employment Worksheet</i> , form 470-5418, is used to manually calculate self-employment income and expenses used for eligibility and benefit determination.
Source	Access the form from WISE to make use of the built-in calculation formulas.
Completion	Complete the form at the time of certification or recertification or the processing of reported changes when the household has self-employment income.
Distribution	File the completed form in the Electronic Case File. Provide the household with a copy upon request.
Data	<p>This form records self-employment income and expense information that affects benefit amounts.</p> <p>Page 2 calculates the prorated shelter deduction when a portion of shelter costs are used as a business expense.</p>

**SNAP Work Rules, Form [470-5674](#) or [470-5674\(S\)](#)**

Purpose	The purpose of <i>SNAP Work Rules</i> is to notify the household of mandatory work registrant and ABAWD work requirements, rights, responsibilities, and the consequences of failure to comply with the requirements.
Source	The ABC System generates the form. Both English and Spanish versions are also available in the Worker Information System Exchange (WISE).
Completion	This form is issued to SNAP households when: <ul style="list-style-type: none"><li>▪ A member with a TD03 WR code of 3, L, or V is identified at application.</li><li>▪ A member with a WR code of 3, L, or V is identified at recertification.</li><li>▪ A member with a WR code of 9, 4, or E is updated to 3 during the certification period.</li><li>▪ A member with a WR code of 3, 9, 4, or E is updated to L or V during the certification period.</li></ul>
Distribution	If issuing a manual notice of decision at application or recertification approval, give or send the household representative a copy of this form and document in the case narrative.
Data	If hand issuing, enter the case name, case number, date the form was given or mailed to the household, and the names of the mandatory work registrants/ABAWDs.

**SSI-Related (Children in Household) Medically Needy Spenddown Computation Worksheet, Form 470-2626**

Purpose	Form 470-2626 is used when calculating earned and unearned income for a Medically Needy SSI-related deeming situation. The worksheet assists the worker in making an accurate computation and provides the client with information on the computation.
Source	Complete form 470-2626 using the template in: <ul style="list-style-type: none"><li>▪ SharePoint under Employee Manual/Forms.</li><li>▪ The Worker Information System Exchange (WISE).</li></ul>
Completion	The IM worker prepares the form when calculating income for the retroactive or current certification period, or as otherwise needed. Complete a worksheet for each certification or retroactive period.
Distribution	Print two copies. Mail one to the client and file one in the case record. Attach verification to the form, when required.
Data	Complete the form as follows: <b>Case name:</b> Enter the name of the case as it appears on agency records. <b>Case number:</b> Enter the Medically Needy case number, including FBU. <b>Retroactive period:</b> If income calculations are for the retroactive period, enter the months involved. <b>Certification period:</b> If income calculations are for the current certification period, enter the months involved. <b>Eligible spouse and ineligible spouse:</b> Enter the name of the person who is the eligible spouse and the name of the person who is the ineligible spouse. <b>Income source:</b> Enter the name of the employer. If the person is self-employed, indicate the nature of the self-employment business. If there is unearned income, enter the source. <b>Frequency:</b> Enter how often the person is paid (weekly, biweekly, monthly, etc.). <b>Month 1:</b> Enter the name of the first month of the certification period. <b>Month 2:</b> Enter the name of the second month of the certification period.

**Month 3:** Enter the name of the third month of the certification period. This is completed only for retroactive periods, when there is a third month.

1. Child A. List the name of child A.
2. Needs of child. For each month of the certification period or retroactive period, enter the needs of child A.
3. Income of child. For each month of the certification or retroactive period, enter the monthly income of child A.
4. Unmet needs of child A. For each month, subtract the income of child A from the needs of child A.
5. Child B. List the name of child B.
6. Needs of child. For each month of the certification or retroactive period, enter the monthly income of child B.
7. Income of child. For each month of the certification or retroactive period, enter the monthly income of child B.
8. Unmet needs of child B. For each month, subtract the income of child B from the needs of child B.
9. Child C. List the name of child C.
10. Needs of child. For each month of the certification period or retroactive period, enter the needs of child C.
11. Income of child. For each month of the certification or retroactive period, enter the monthly income of child C.
12. Unmet needs of child C. For each month, subtract the income of child C from the needs of child C.
13. Unearned income of ineligible spouse. Enter the dates the gross unearned income was received for each month in the eligibility period.
14. Subtotal unearned income of ineligible spouse. Total the unearned income for each month.
15. Total of monthly unmet needs of children. Total Lines 4, 8, and 12 for each month.
16. Net unearned income of ineligible spouse. Deduct Line 15 from Line 14.
17. Earned income of ineligible spouse. Enter the dates earned income was received during the month and the gross amount of earned income.
18. Subtotal earned income of ineligible spouse. Total the gross earned income for the ineligible spouse for each month.
19. Deduct remaining unmet needs of children from Line 18. Enter any remaining unmet needs of the children not previously used on Line 15.

20. Net earned income of ineligible spouse. Subtract Line 19 from Line 18 and enter the remainder.
21. Total net income of ineligible spouse (Line 16 + 20). Enter the total of Lines 16 and 20.
22. Compare Line 21 to needs of ineligible spouse. The needs of the ineligible spouse is the difference between SSI benefit rate for an eligible couple and the SSI benefit rate for an eligible individual.
23. Unearned income of eligible spouse. Enter the dates on which the eligible spouse received the gross unearned income for each month in the eligibility period.
24. Subtotal of eligible spouse's unearned income. Total the unearned income for each month.
25. Enter Line 16 if income is to be deemed to the eligible spouse. To determine if income is to be deemed to the eligible spouse, see Item 22.
26. Subtotal unearned income. Total Line 24 and 25.
27. \$20 general income exclusion. Enter a \$20 general income exclusion (but not more than the amount in Line 26).
28. Total countable unearned income. Deduct Line 27 from Line 26.
29. Earned income of eligible spouse. Enter the dates on which the eligible spouse received earned income during the month and the gross amount of earned income.
30. Subtotal of eligible spouse's earned income. Total the gross earned income for the eligible spouse for each month.
31. Enter Line 20 if income is to be deemed to eligible spouse. To determine if income is to be deemed to the eligible spouse, see Item 22.
32. Subtotal. Add Lines 30 and 31 and enter the total.
33. Deduct any remaining balance of the \$20 general income exclusion. Enter any remaining balance of the \$20 general income exclusion not previously used on Line 27.
34. Subtotal. Subtract Line 33 from Line 32 and enter the remainder.
35. Deduct \$65 work expense exclusion.
36. Subtotal. Subtract Line 35 from Line 34 and enter the remainder.
37. Deduct 1/2 of subtotal. Enter the amount that is one-half of the amount on Line 36.
38. Total countable earned income. Subtract Line 37 from Line 36 and enter the remainder.



39. Total countable unearned and earned income. Add together unearned income and earned income for each month (Lines 28 and 38) and enter the total.
40. Household size. Enter the household size for each month of the eligibility period.
41. MNIL. Enter the Medically Needy Income Level for each month based on the household size.
42. Insurance premiums. List the health insurance premium paid each month for the applicant and ineligible spouse.
43. Medicare premiums. List the Medicare premiums paid each month for the applicant and ineligible spouse.
44. Total insurance. Add Lines 42 and 43 and enter the total.
45. Total income for period. Add together the total income for each month of the eligibility period (Line 39 for months 1, 2, and 3).
46. Total MNIL for period. Add together the total Medically Needy Income Level for each month of the eligibility period (Line 41 for months 1, 2, and 3).
47. Spenddown. Subtract the MNIL (Line 46) from the total income for the period (Line 45) and enter the remainder.
48. Less total insurance. Add together the total insurance for each month of the eligibility period (Line 44 for months 1, 2, and 3).
49. Final spenddown. Subtract the total insurance (Line 48) from spenddown (Line 47). This is the final spenddown amount. Enter this amount on the *Notice of Decision for Medically Needy*, form 470-2330.
50. Poverty level percentage. For QMB, SLMB, or E-SLMB eligibles, determine the percentage of the federal poverty level for household size. Enter the percentage on this line as well, as in the poverty indicator field on IABC.

To determine poverty level for the months of January and February, deduct the Social Security COLA from Line 39 before dividing by the poverty level.

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**SSI-Related Income Worksheet, Form 470-2525**

Purpose	The <i>SSI-Related Income Worksheet</i> assists the worker in making an accurate computation when manually calculating earned and unearned income for many SSI-related programs.
Source	Complete form 470-2525 using the template in: <ul style="list-style-type: none"><li>▪ SharePoint under Employee Manual/Forms.</li><li>▪ The Worker Information System Exchange (WISE).</li></ul>
Completion	<p>The IM worker uses this form to calculate income for current eligibility for the following programs or as otherwise needed:</p> <ul style="list-style-type: none"><li>▪ Eligible for SSI or SSA but not receiving cash</li><li>▪ Expanded specified low-income Medicare beneficiary</li><li>▪ Qualified disabled working persons</li><li>▪ Qualified Medicare beneficiary</li><li>▪ Retroactive SSI eligibility</li><li>▪ Specified low-income Medicare beneficiary</li></ul> <p>Complete a worksheet at each initial determination and annual review. More than one worksheet may be needed when more than two household members have income.</p>
Distribution	File the original in the case record. Attach verification to the form, when required.
Data	<p>Go through the form to make the entries indicated. Then click on the “calculate” box on page 3 to complete the rest of the fields. In order to use the correct poverty levels, you must indicate the month and year you wish to have calculated.</p> <ol style="list-style-type: none"><li>1. Case name. Enter the name of the case as it appears on agency records.</li><li>2. Case number. Enter the case number, including FBU.</li></ol> <p>Complete lines 3 through 5 for each household member who has income that is considered to determine eligibility.</p> <ol style="list-style-type: none"><li>3. Household member. Enter the name of each person who is employed or has unearned income.</li><li>4. Source. Enter the name of the company or name of the employer. If person is self-employed, indicate the nature of the self-employment business. If the income is unearned, enter the source.</li><li>5. Frequency of pay. Enter the frequency the household member is paid; such as weekly, twice a month, or every two weeks.</li></ol>

6. Month of eligibility. Enter the month in which you are determining eligibility. Consider any prospective changes in income, resources, or other factors at the time of decision.
7. Unearned income. If the income of the people considered does not vary, use the first pair of columns to enter unearned income for the month listed in line 6.

If one or both of the people have variable incomes, use one or more columns for each person and enter the unearned income from the 30 days just before the month entered in line 6.

If the income fluctuates enough that 30 days does not provide an accurate indicator of future income, use income from prior months. Average the income by dividing the total for all months by the number of months. (Use the comment section for computation.) Enter the **average** as the monthly figure.

8. Diversion for ineligible children. Enter the amount to divert for ineligible children.

For each child, divert a maximum of the difference between the SSI payment standard for a couple and the SSI payment standard for one person. Reduce the allowable diversion per dependent by the amount of the dependent's income. (Use the comment section for computation.)

If the diversion is greater than the total of the household's unearned income amounts in line 7, enter only that amount and enter the rest of the diversion in line 12.

9. \$20 disregard. One \$20 disregard per household per month is allowed. The template will enter \$20 or the amount remaining after the deduction on line 8 if it is less than \$20.
10. Subtotal for unearned income. The template will enter the combined total in from line 7 less the amounts in line 8 and line 9.
11. Earned income. Follow the instructions on the form for entering income to be averaged to a monthly amount.
  - If a person's income is regular, enter the date and the gross amount of earned income received during the month of decision.
  - If a person's income varies, enter the amounts for one or more prior months.
12. Diversion for ineligible children. If the household has only earned income, calculate the diversion for ineligible children as instructed for line 8. Enter any portion of the diversion not already applied in line 8.

13. Subtotal earned income. The template will enter the difference between the total amount in line 11 and the entry in line 12.
14. \$20 disregard. The template will deduct any portion of the \$20 disregard not subtracted from unearned income. (See line 9.)
15. Deduct \$65 work expense. The template will enter \$65 or the remaining earned income if it is less than \$65.
16. Subtotal earned income. The template will enter the difference between line 13, 14, and line 15.
17. 1/2 earned income exclusion. The template will enter the amount that is one-half of the amount in line 16.
18. Subtotal earned income. The template will enter the difference between lines 16 and 17.
19. Countable income. The template will add earned and unearned income (lines 10 and 18) together and enter the result.
20. Household size. Enter the household size.
21. QMB income limit. The template enters the amount of income that is 100% of the poverty level for the number of people entered in line 20.
22. Poverty level. The template divides the net income (line 19) by 100% of the federal poverty level (line 21).
23. Enter on TD03. This is the rounded-off percentage of the poverty level to enter in the POV field on the TD03 screen.
24. Medicare Savings Program. This is the Medicare Savings Program the person or couple is eligible for. Enter the applicable code on the TD03 screen.

Income eligibility for QMB exists if the percentage on line 23 is equal to or less than 100.

Income eligibility for SLMB exists if the percentage on line 23 is over 100 but less than 120.

Income eligibility for expanded SLMB exists if the percentage on line 23 is at least 120 but less than 135.

**SSI-Related (No Children) Medically Needy Spenddown Computation Worksheet, Form 470-234I**

Purpose	Form 470-234I is used to calculate earned and unearned income for the SSI-related Medically Needy program when income is not deemed to children. The form provides the client with information on the manual computation and assists the worker in making an accurate computation.
Source	Complete form 470-234I using the template in: <ul style="list-style-type: none"><li>▪ SharePoint under Employee Manual/Forms.</li><li>▪ The Worker Information System Exchange (WISE).</li></ul>
Completion	The IM worker completes an original and one copy when calculating income for the retroactive or current certification period, or as otherwise needed. You may need more than one worksheet per period when more than two household members have income.
Distribution	Mail the original to the client and file the copy in the case record. Attach verification to the form, when required.
Data	Some modification in use may be needed to fit individual situations.

**Identification**

**Section:**

**Case name:** Enter the name of the case as it appears on agency records.

**Case number:** Enter the Medically Needy case number, including FBU.

**Retroactive period:** If income calculations are for the retroactive period, enter the months involved.

**Certification period:** If income calculations are for the current certification period, enter the months involved.

**Eligible spouse and ineligible spouse:** Enter the name of the person who is the eligible spouse and the name of the person who is the ineligible spouse.

**Income source:** Enter the name of the company or the employer. If the person is self-employed, indicate the nature of the person's business. If there is unearned income, enter the source.

**Frequency:** Enter the frequency that the person is paid; i.e., weekly, biweekly, monthly, etc.

- Month 1. Enter the name of the first month of the certification period.
- Month 2. Enter the name of the second month of the certification period.
- Month 3. Complete this only for retroactive periods when there is a third month. Enter the name of the third month of the certification period.

1. Unearned income of ineligible spouse. Complete if applicable. Enter the dates the ineligible spouse received unearned income in each month in the eligibility period and the gross amount of income received.
2. Subtotal unearned income of ineligible spouse. Total the unearned income per month.
3. Earned income of ineligible spouse. Complete if applicable. Enter the dates when the ineligible spouse received earned income in each month in the eligibility period and the gross amount of income received.
4. Subtotal of earned income of ineligible spouse. Total the gross earned income per month.
5. Total net income of ineligible spouse. Total Line 2 (unearned income) and Line 4 (earned income) per month.
6. Compare Line 5 to needs of ineligible spouse. The needs of the ineligible spouse are the difference between the SSI benefit rate for an eligible couple and the SSI benefit rate for an eligible individual.
7. Unearned income of eligible spouse. Complete if applicable. Enter the dates the eligible spouse received unearned income in each month in the eligibility period and the gross amount of income received.
8. Subtotal of eligible spouse's unearned income. Total the unearned income per month.
9. Enter Line 2 if income is to be deemed to the eligible spouse. To determine if income is to be deemed to the eligible spouse, see Line 6.
10. Subtotal unearned income. Total Line 8 and Line 9.
11. \$20 general income exclusion. Enter a \$20 general income exclusion.
12. Total countable unearned income. Deduct Line 11 from Line 10.
13. Earned income of eligible spouse. Complete if applicable. Enter the dates when the eligible spouse received earned income in each month in the eligibility period and the gross amount of income received.
14. Subtotal of eligible spouses earned income. Total the gross earned income per month.
15. Enter Line 4 if income is to be deemed to eligible spouse. To determine if income is to be deemed to eligible spouse, see Line 6.
16. Subtotal. Total Lines 14 and 15.
17. Deduct any remaining balance of the \$20 general income exclusion. Enter any remaining balance of the \$20 disregard not previously used on Line 11.
18. Subtotal. Subtract Line 17 from Line 16 and enter the resulting amount on this line.

19. \$65 work expense exclusion.
20. Subtotal. Subtract Line 19 from the subtotal (Line 18) and enter the amount.
21. 1/2 of subtotal of Line 20. Enter one-half of the subtotal of Line 20.
22. Total countable earned income. Subtract Line 21 from Line 20 and enter the result.
23. Total countable unearned and earned income. Add Lines 12 and 22 and enter the total on this line.
24. Household size. Enter the household size for each month of the eligibility period.
25. MNIL. Enter the applicable Medically Needy Income Level for each month based on the household size.
26. Insurance premiums. List the insurance premium paid each month.
27. Medicare premiums. List the Medicare premiums paid each month.
28. Total insurance. Total Lines 26 and 27 and enter the amount on this line.
29. Total income for period. Add together the total income for each month of the eligibility period (Line 23 for months 1, 2, and 3).
30. Total MNIL for period. Add together the total Medically Needy Income Level for each month of the eligibility period (Line 25 for months 1, 2, and 3).
31. Spenddown. Subtract the total MNIL (Line 30) from the total income for the period (Line 29).
32. Less total insurance. Add together the total insurance for each month of the eligibility period (Line 28 for months 1, 2, and 3).
33. Final spenddown. Subtract the total insurance (Line 32) from spenddown (Line 31). This is the final spenddown amount. Enter this amount on the *Notice of Decision for Medically Needy*, form 470-2330.
34. Poverty level percentage. For QMB, SLMB, or E-SLMB eligibles, divide Line 23 by 100 percent of the federal poverty level for the QMB household size and enter the resulting percentage on this line, as well as in the poverty indicator field on IABC.

To determine poverty level for the months of January and February, deduct the Social Security COLA from Line 23 before dividing the poverty level amount.

**SSN Request for Information 470-5376 or 470-5376(S)**

Purpose	<p><i>SSN Request for Information, 470-5376 or 470-5376(S)</i> is to notify a client who has not provided an SSN for an active child who is about to turn 1 year old that an SSN is required.</p> <p>This form contains clear instructions for completion and informs clients on how to provide the information.</p>
Source	<p>The ELIAS System generates form 470-5376 automatically. Form 470-5376(S) is generated when the Medicaid member has indicated that Spanish is their preferred language.</p> <p>DHS staff may issue a manual Request for SSN by completing a <i>Request for Info, 470-5089</i> using the templates in SharePoint under Employee Manual/Forms and the Worker Information System Exchange (WISE).</p>
Completion	<p>The ELIAS system completes form 470-5376 or 470-5376(S) when client's newborn(s) are about to turn 1 year old.</p>
Distribution	<p>This form is system generated by ELIAS the second Thursday of the month, three months prior to the Newborn's first birthday and mailed to the client. A copy is filed in WISE.</p>
Data	<p>The ELIAS system will populate the name, address, worker identification, client name and due date.</p> <p>A WISE narrative is created to indicate SSN Request for Information was sent.</p>



**State Supplementary Assistance Agreement to Repay Conditional Benefits, Form 470-2835**

Purpose	Form 470-2835, <i>State Supplementary Assistance Agreement to Repay Conditional Benefits</i> , is the client's written commitment to repay benefits issued pending the sale of the client's excess resources.
Source	Print form 470-2835 from: <ul style="list-style-type: none"><li>▪ The online manual.</li><li>▪ SharePoint under Employee Manual/Forms.</li></ul>
Completion	The client or representative (guardian, spouse, parent, or sponsor, if any) shall complete and sign the form when the client is made eligible for State Supplementary Assistance under conditional benefits.
Distribution	File the original agreement in the case record and give the client a copy.
Data	The client or representative shall complete, sign, and date the form.

**State Supplementary Assistance Certification or Termination, Form 470-0640**

Purpose	<p>The Department uses form 470-0640 to notify the Social Security Administration district office that a person is approved for or canceled from State Supplementary Assistance dependent person or family-life home benefits. The Social Security Administration also uses the form to notify the IM worker of the action taken by that agency.</p>
Source	<p>Complete 470-0640 using the form in the Worker Information System Exchange (WISE).</p>
Completion	<p>Staff in the DHS office for the county where the client lives complete this form when the Department is referring a person to the Social Security Administration for a family-life home or a dependent person allowance.</p> <p>The IM worker and the service worker are both responsible for certifying a placement in a family-life home. Only the IM worker is involved in certifying a dependent person allowance. The Social Security Administration completes the second page of the form.</p>
Distribution	<p>Forward this form to the Social Security Administration office. Keep a copy in the IM file as a control.</p> <p>The Social Security Administration completes its portion of the form and returns it to the imaging center listed on the back of the form.</p> <p>Transfer the information supplied by the Social Security Administration and forward a copy to the service worker for a family-life home case. File a copy in the client's IM case record.</p>
Data	<p>The following should automatically populate:</p> <ul style="list-style-type: none"><li>▪ The name and address of the Department office.</li><li>▪ The name and address of the Social Security Administration office that serves your area.</li><li>▪ The address and fax number of the imaging center that serves the worker's county.</li></ul> <p>Under "Client Information," enter the client's name, case number (if one has been assigned), address, and social security number (not a claim number). Designate whether client is over 65, disabled or blind, and list a telephone number where client can be reached.</p> <p>If there is a representative payee, guardian, or conservator, indicate which and enter the person's name, address, and telephone number.</p> <p>Enter the name, relationship, address, and telephone number for a person other than a representative payee, guardian, or conservator who is designated by the client as one who could give pertinent information.</p>

To certify a client for a dependent person allowance, indicate the name, relationship, and age of the dependent person whose needs are to be included in the client's State Supplementary Assistance payment and the effective date as determined by the IM worker.

To certify a client for a family-life home payment, enter the name of the family with whom the client is residing and the effective date of client's entry into the certified family-life home.

To notify the Social Security Administration of a termination, enter the date that eligibility ended, and check whether the reason was death, removal of dependent person allowance, or that the client left the family-life home.

Use the comment section to enter additional information concerning the client, if needed.

The form requires the signature of both the service worker and the IM worker when placement is made in a family-life home. Only the IM worker need sign the form when a dependent person allowance is being approved.

### Statement of Citizenship Status, Form 470-2549

Purpose	Form 470-2549, <i>Statement of Citizenship Status</i> , is used to obtain a declaration in writing stating whether a person is a citizen or a national of the United States, or an alien.
Source	Complete form 470-2549 using the template in: <ul style="list-style-type: none"><li>▪ SharePoint under Employee Manual/Forms.</li><li>▪ The Worker Information System Exchange (WISE).</li></ul>
Completion	<p>The participant completes the form when FIP or Medicaid policy requires the person to make the citizenship or alien status declaration, but does not require the person to file an application (which includes the declaration).</p> <p>The form must be signed by an adult household member and returned before the person can be added to the eligible group.</p>
Distribution	Keep the signed form in the case record.
Data	The participant completes the form listing each member of the household, unless a declaration regarding the person's status was made on the application form. See 4-C, <a href="#">Citizenship</a> , and 8-C, <a href="#">Verifying Citizenship and Identity</a> , for policy regarding required signatures.

**Ten-Day Report of Change for FIP, Form 470-0499 or 470-0499(S)**

Purpose	<p>The <i>Ten-Day Report of Change for FIP</i>, form 470-0499, and its Spanish translation, form 470-0499(S), provide:</p> <ul style="list-style-type: none"><li>▪ A simple means for the client to report a change and submit explanatory information.</li><li>▪ A reminder to the client that changes in circumstances must be reported to DHS whenever they occur.</li></ul>
Source	<p>Workers can complete the English or Spanish version using the form in the Worker Information System Exchange (WISE).</p>
Completion	<p>Clients may complete the form and return it by mail, fax, or email to the DHS imaging center address listed on the form. Clients may also report changes by phone to the IM Customer Service Center or in person at a DHS office.</p>
Distribution	<p>Issue the form:</p> <ul style="list-style-type: none"><li>▪ At application.</li><li>▪ When the client turns in the form to report a change.</li><li>▪ When the client requests a form.</li></ul> <p>When a change is reported, file the form (or narrate the reported change if no form is submitted) in the case record after the required action is completed. Document the resulting action in the case record. Issue a new form to the client.</p>

**Ten-Day Report of Change for Medicaid/Hawki, Form 470-5590 or 470-5590(S)**

Purpose	<p>The <i>Ten-Day Report of Change for Medicaid/Hawki</i>, form 470-5590, and its Spanish translation, form 470-5590(S), provide:</p> <ul style="list-style-type: none"><li>▪ A simple means for the client to report a change and submit explanatory information.</li><li>▪ A reminder to the client that changes in circumstances must be reported to DHS whenever they occur.</li></ul>
Source	<p>Workers can complete the English or Spanish version using the form in the Worker Information System Exchange (WISE).</p>
Completion	<p>Clients may complete the form and return it by mail, fax, or email to the DHS imaging center address listed on the form. Clients may also report changes by phone to the IM Customer Service Center, in person at a DHS office, or through their online SSP account.</p>
Distribution	<p>Issue the form when the client requests a form.</p> <p>When a change is reported, file the form (or narrate the reported change if no form is submitted) in the case record after the required action is completed. Document the resulting action in the case record.</p>

**Treasury Offset Program (TOP) Pre-Offset Notice, Form 470-3797**

Purpose	<p>The <i>Treasury Offset Program (TOP) Pre-Offset Notice</i> is used to notify a debtor that the Department plans to refer the debtor's delinquent claim to the U. S. Treasury Department's offset program for further collection action.</p> <p>The debtor can avoid that referral by contacting the Department of Inspections and Appeals within 60 days and negotiating a repayment agreement.</p>
Source	<p>This form is computer-generated based on information recorded on the Web-based Overpayment Recovery (WOPR) System.</p>
Completion	<p>WOPR generates this form when:</p> <ul style="list-style-type: none"><li>▪ The debtor whose SNAP claim is delinquent meets the criteria for referral to the Treasury Offset Program (see 6-G, <a href="#">Federal Offset for Food Assistance</a>), and</li><li>▪ The Treasury Department has registered an address for the debtor.</li></ul>
Distribution	<p>One copy is sent to the household. One copy is filed in the DIA record.</p>
Data	<p>The debtor's name and social security number and the amount of the claim are entered as the form is generated.</p>

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### Verification of Educational Financial Aid, Form 470-1640

Purpose	Form 470-1640 is designed to secure the client's permission for the Department to obtain verification of student eligibility requirements and educational financial aid. The educational institution uses the form to furnish the requested verification.
Source	Complete 470-1640 using the form in the Worker Information System Exchange (WISE).
Completion	<p>Complete this form when it is necessary to verify student eligibility requirements and educational financial aid. Complete the identifying information on the form and check the boxes to identify the sections the educational institution is to complete.</p> <p>The client (or person authorized to obtain the information) shall sign and date the authorization section of the form.</p> <p>The educational institution completes the sections of the form that have been checked by the worker and the signature line.</p>
Distribution	Send the form to the educational institution. You may upload the request to the electronic case file. When the educational institution returns the original, it will be scanned and uploaded.
Data	<p>Before sending the form,</p> <ul style="list-style-type: none"><li>▪ Enter:<ul style="list-style-type: none"><li>• The worker number.</li><li>• The name and address of the educational institution.</li><li>• The date you send the form.</li><li>• The name of the worker.</li><li>• The phone number of the worker.</li><li>• The client's name. Enter the social security number also, if it is needed to obtain the requested information.</li><li>• The date of the academic term.</li><li>• The date the authorization expires. This date shall be 60 days from the date the form is signed, unless supervisory approval is given to extend the date.</li></ul></li><li>▪ Check the boxes indicating each section the educational institution is to complete.</li><li>▪ Have the client sign and date the authorization statement.</li></ul>



**Verification of Emergency Health Care Services, Form 470-4299 or 470-4299(S)**

Purpose	The Department uses form 470-4299 with emergency services Medicaid applications to get the client's permission to verify whether the services that the client received was an emergency. The health care provider or the provider's designee uses this form to furnish the requested information.
Source	Complete the English or Spanish version of this form using the template in: <ul style="list-style-type: none"><li>▪ SharePoint under Employee Manual/Forms.</li><li>▪ The Worker Information System Exchange (WISE).</li></ul>
Completion	<p>The worker completes the identifying information on the client.</p> <p>The client (or the person authorized to obtain the information) completes and signs in the section giving permission.</p> <p>The worker, the client, the provider, or the provider's designee completes the provider information.</p> <p>The health care provider or the provider's designee completes the information related to the health care that was given the client.</p>
Distribution	<p>Give this form to the client to obtain the information with a letter explaining when it is due back to the Department, or if the client has signed the form, send one copy to the source of information. Include a pre-addressed return envelope.</p> <p>You may upload the request to the electronic case file. When the source of information returns the original, it will be scanned and uploaded.</p>
Data	<p>To initiate the form, enter:</p> <ul style="list-style-type: none"><li>▪ The client's name</li><li>▪ The client's state identification number</li><li>▪ Your county and worker number</li><li>▪ The client's date of birth</li><li>▪ The client's social security number, if available</li><li>▪ The name of the client's parent or guardian, if applicable</li></ul>

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### Verification of Paid Medical Bills, Form 470-2224

Purpose	<p>Members and county agencies can receive direct reimbursement for certain paid medical bills. When an appeal decision by the Department or the Social Security Administration on an eligibility issue favors the member, members and county agencies may be entitled to reimbursements.</p> <p>A Medicaid member or a county agency may submit form 470-2224 to claim reimbursement of medical expenses paid on behalf of a Medicaid applicant during the appeal period, which is the time between the date of a <i>Notice of Decision</i> denying Medicaid and the date of a <i>Notice of Decision</i> approving Medicaid.</p> <p>See 8-A, <a href="#">Reimbursement After Appeal Decisions</a>.</p>
Source	<p>Print form 470-2224 from:</p> <ul style="list-style-type: none"><li>▪ The online manual.</li><li>▪ SharePoint under Employee Manual/Forms.</li></ul>
Completion	<p>The form is prepared when the member or a county agency requests reimbursement for paid medical bills.</p> <p>One copy of the form is required for each provider of service involved. If the number of entries exceeds the available space on the form, use additional forms.</p> <ul style="list-style-type: none"><li>▪ Section I, Member Information, is prepared by either the local DHS office or the county agency, giving identifying information.</li><li>▪ Section II, Eligibility Information, is completed by the Department. The information in this section certifies that the member attained Medicaid eligibility through the appeal process and identifies the period for when reimbursement can be received.</li><li>▪ Section III, Payment Information, is completed by either the member or the county agency, depending on who is to receive reimbursement.</li><li>▪ Section IV is completed by the provider of service. This section may also be completed by the county agency, if the county agency is claiming reimbursement or if it is furnishing information so the member may claim reimbursement.</li><li>▪ Section V is reviewed by the Interim Assistance Reimbursement coordinator in the Bureau of Financial, Health, and Work Supports for accuracy. The form is then sent to the Iowa Medicaid Enterprise (IME) to determine the correct amount to reimburse to the county agency or the member.</li></ul>

Distribution

Provide the member or the county agency with sufficient copies of the form to cover all of the involved providers and bills.

Following the provider's completion of Section IV, the member shall return the form to the local office, or the provider of service may mail it directly to the local office. The county agency, following preparation of the form from its records, submits it to the local office.

The worker submits the original form to the Interim Assistance Reimbursement coordinator in the Bureau of Financial, Health, and Work Supports. Following processing, a copy of the completed form will be returned to the county agency or the member by IME. The payment approved for each medical service is shown in Section IV, H.

Data

If the county agency is requesting reimbursement, the county must provide its vendor number, if previously assigned one by the state, or the county's federal identification number (the number used by the county for tax purposes).

If the member is requesting reimbursement, the member must sign and date the form, authorizing either the county agency or the medical service provider to release information.

The provider of service must enter a signature, title, business name, the type of provider, and the date. If the county agency provided the information from its records or is claiming reimbursement, the agency director or designee shall sign.

Instructions for completion of Section IV are given on the back of the form.

### **Voluntary Contribution Agreement, Form 470-0373**

Purpose	Form 470-0373 can be used to document a voluntary contribution made by a member or member's family towards the member's cost of care in a medical institution.
Source	Complete form 470-0373 using the template in: <ul style="list-style-type: none"><li>▪ SharePoint under Employee Manual/Forms.</li><li>▪ The Worker Information System Exchange (WISE).</li></ul>
Completion	Section 1 is completed by the contributor. Section 2 is completed by the medical institution. Section 3 is completed by the local DHS office.
Distribution	One copy should be retained by the contributor, the nursing facility, and the local DHS office.
Data	Complete the form fields to indicate: <ul style="list-style-type: none"><li>▪ Contributor's name</li><li>▪ Voluntary contribution amount</li><li>▪ Member's name</li><li>▪ Medical institution name and city</li><li>▪ Day of the month voluntary contribution is to be made</li></ul> The contributor, medical institution representative, and local DHS representative shall sign the form after these items have been completed.

### Voter Registration, Unnumbered

Purpose	<p>The <i>Voter Registration</i> form:</p> <ul style="list-style-type: none"><li>▪ Gives clients information about registering to vote.</li><li>▪ Records a client's decision whether to register.</li><li>▪ Provides a detachable card that clients can use to register.</li></ul> <p>This process is required by the National Voter Registration Act of 1993 and Iowa Code Section 48A.19.</p>
Source	<p>Central Office has a contract to provide automatic shipments of the <i>Voter Registration</i> form to local offices. The shipments are intended to cover a six-month supply. Additional supplies are also available through Central Office.</p>
Completion	<p>Give this form to the client every time you give out an application, recertification, review, or address change form for FIP, SNAP, Medicaid, or Child Care Assistance.</p> <p>At each application, recertification, or review interview, ask if the client wants to register to vote. If the client has not answered the voter registration question on the form, have the client complete the question at the interview.</p> <p>Offer the client assistance in completing the voter registration form if the client wants to register to vote. Date-stamp each voter registration form. This verifies that the form is timely for voter registration purposes.</p>
Distribution	<p>Keep the declination section in the local office. Give the voter registration information section to the client.</p> <p>Send or deliver all completed voter registration forms to the county election office every Friday. When Friday is a holiday, send the forms the last working day of that week. EXCEPTION: Deliver registration forms received on the tenth day before the general election to the election office on that day.</p> <p>Mail the voter registration forms to the county election office in a plain envelope without the Department's return address. Use the election office label for both the mailing address and the return address.</p>

File the declination portion of the form by date order in a secure, confidential location, separate from the individual case record. The forms must be available upon request. Keep the forms for 22 months after the next general election following the receipt of the form. Follow this retention schedule:

<b>Date Declination Signed</b>	<b>Election Date</b>	<b>Destroy After</b>
10/28/12 – 10/25/14	11/04/14	09/04/16
10/26/14 – 10/22/16	11/01/16	09/01/18
10/23/16 – 10/27/18	11/06/18	09/06/20
10/28/18 – 10/24/20	11/03/20	09/03/22

Data

If the client chooses not to check yes or no, leave this section blank and consider the client has chosen not to register to vote. If the client chooses not to sign the form, print the client name and date on the client name line and initial the form.

**Waiver Slot Notice, Form 470-4833**

Purpose	Form 470-4833, <i>Waiver Slot Notice</i> , is used to notify clients on the waiver waiting lists that a payment slot is available.
Source	Complete 470-4833 using the form in the Worker Information System Exchange (WISE).
Completion	<p>For ongoing, full Medicaid members, an application is not needed. To accept the open slot, the member should sign the bottom of the letter and return it by the due date.</p> <p>For other clients, an application must be returned by the due date to secure the open slot. Send form 470-5170, <i>Application for Health Coverage and Help Paying Costs</i> with the <i>Waiver Slot Notice</i>.</p> <p>Select the waiver type matching the waiver slot assignment.</p>
Distribution	Print a copy for the case file for documentation.
Data	The form provides a signature block for ongoing full Medicaid members to easily accept the open slot.

**Comm. 2 or Comm. 2(S), Facts About SNAP**

Purpose	The flier <i>Facts About SNAP</i> helps applicants to better understand income guidelines and allotment levels for SNAP. The flier allows clients to determine for themselves whether or not they may be eligible for SNAP.
Source	Print Comm. 2 or Comm. 2(S) from: <ul style="list-style-type: none"><li>▪ The online manual.</li><li>▪ SharePoint under Employee Manual/Forms.</li></ul>
Distribution	Local offices may give this form to SNAP applicants at the time they are given a <i>Food and Financial Support Application</i> , form 470-0462 or 470-0462(S).
Data	The flier lists the gross and net monthly income limits and maximum allotments by household size.



**Comm. 4, Care for Kids**

Purpose	The flier <i>Care for Kids</i> gives basic information about Medicaid early and periodic screening, diagnostic, and treatment services for members under the age of 21.
Source	Printed supplies of Comm. 4 with English text on one side and Spanish text on the other may be ordered from Iowa Prison Industries at Anamosa.
Distribution	Local offices may give this flier to Medicaid applicants at the time they are given an <i>Application for Health Coverage and Help Paying Costs</i> , form 470-5170 or 470-5170(S).
Data	The flier lists the services available to children, tells why regular checkups are important, and gives contact information.

**Comm. 18, State Supplementary Assistance**

Purpose	Brochure Comm. 18 gives basic information about the State Supplementary Assistance Program.
Source	Printed supplies of Comm. 18 may be ordered from Iowa Prison Industries at Anamosa.
Distribution	Local offices may give this brochure to applicants or other interested persons.
Data	The brochure describes SSI eligibility requirements and the various categories of living situations where SSI income may be supplemented.

**Comm. 20 or Comm. 20(S), Your Guide to Medicaid Fee-for-Service (FFS)**

Purpose	Booklet Comm. 20 or Comm. 20(S) gives basic information about the services covered under the Medicaid Program.
Source	Print Comm. 20 or Comm. 20(S) from: <ul style="list-style-type: none"><li>▪ The online manual.</li><li>▪ SharePoint under Employee Manual/Forms.</li></ul>
Distribution	Give this booklet to Medicaid applicants or other interested persons.
Data	The booklet describes the use of the <i>Medical Assistance Eligibility Card</i> , retroactive eligibility, copayment and other member responsibilities, who can provide covered services, the coverage limitations applicable to the various providers, managed care, and use of the Member Services Call Center.

**Comm. 24 or Comm. 24(S), One-Time Payments**

Purpose	Brochures Comm. 24 and Comm. 24(S) explain how receipt of a non-recurring lump sum may affect Medicaid or FIP eligibility.
Source	Printed supplies of Comm. 24 may be ordered from Iowa Prison Industries at Anamosa.  Print Comm. 24(S) from: <ul style="list-style-type: none"><li>▪ The online manual.</li><li>▪ SharePoint under Employee Manual/Forms.</li></ul>
Distribution	Provide this brochure to: <ul style="list-style-type: none"><li>▪ Each applicant for FIP or MAGI-related Medicaid, and</li><li>▪ Each FIP or MAGI-related Medicaid member:<ul style="list-style-type: none"><li>• Who reports receipt or possible receipt of a nonrecurring lump sum, or</li><li>• Whom you believe may receive a nonrecurring lump sum.</li></ul></li></ul>
Data	The brochure instructs clients what to do if they receive a lump sum, how one-time payments are counted, and how a period of ineligibility is determined.

**Comm. 28 or Comm. 28(S), Medicaid for Non-MAGI-Related Persons**

Purpose	The booklet <i>Medicaid for SSI-Related Persons</i> gives basic information about SSI-related coverage groups.
Source	Print Comm. 28 or Comm. 28(S) from: <ul style="list-style-type: none"><li>▪ The online manual.</li><li>▪ SharePoint under Employee Manual/Forms.</li></ul>
Distribution	Local offices may give this form to SSI-related Medicaid applicants at the time they are given an <i>Application for Health Coverage and Help Paying Costs</i> , form 470-5170 or 470-5170(S).
Data	The booklet explains the Medicaid program, SSI-related eligibility requirements, how a member gets medical care, the application process, the relationship between Medicaid and other insurance, and the member's rights and responsibilities.

**Comm. 30, Medicaid for the Medically Needy**

Purpose	The brochure Comm. 30 gives basic information about Medicaid Needy eligibility and coverage.
Source	Printed supplies of Comm. 30 with English text on one side and Spanish text on the other may be ordered from Iowa Prison Industries at Anamosa.
Distribution	Give this brochure to applicants who are determined eligible for Medically Needy coverage.
Data	The brochure lists the eligibility requirements and explains spenddown, when a <i>Medical Assistance Eligibility Card</i> is issued, and how to explain the program to the member's medical providers.

### **Comm. 51, Information Practices**

Purpose	Brochure Comm. 51 provides the notification to persons supplying information to the Department for income maintenance programs that is required by the Iowa Fair Information Practices Act, Iowa Code section 22.11.
Source	Printed supplies of Comm. 51 may be ordered from Iowa Prison Industries at Anamosa.
Distribution	Give this brochure to anyone who files an application for: <ul style="list-style-type: none"><li>▪ Child Care Assistance</li><li>▪ SNAP</li><li>▪ Medicaid</li><li>▪ State Supplementary Assistance</li><li>▪ The Family Investment Program</li></ul>
Data	The brochure explains in general way: <ul style="list-style-type: none"><li>▪ How the Department will use the information provided;</li><li>▪ Which persons outside the Department might routinely be provided this information;</li><li>▪ Which parts of the information requested are required and which are optional; and</li><li>▪ The consequences of failing to provide the information requested.</li></ul>

**Comm. 52, Medicaid for People in Nursing Homes and Other Care Facilities**

Purpose	Booklet Comm. 52 gives basic information about Medicaid eligibility and coverage in a medical facility.
Source	Printed supplies of Comm. 52 may be ordered from Iowa Prison Industries at Anamosa.
Distribution	<p>Give this booklet to anyone who files a Medicaid application for long-term facility care or other medical facility care.</p> <p>“Long-term facility care” includes care in a nursing facility (NF), an intermediate care facility for persons with mental retardation (ICF/MR), or a certified skilled facility (SNF).</p> <p>“Other medical facility care” includes care in a general hospital or a psychiatric institution.</p>
Data	<p>The booklet:</p> <ul style="list-style-type: none"><li>▪ Gives guidance on choosing a long-term care facility, and</li><li>▪ Explains admission procedures, the effect of Medicaid eligibility on facility payment and a spouse at home, client participation, reserve bed days, additional services available, the relationship between Medicare and Medicaid, and transfer and discharge from a facility.</li></ul>



**Comm. 60, Medicaid for the Qualified Medicare Beneficiary**

Purpose	Booklet Comm. 60 gives basic information about Medicaid coverage for qualified Medicare beneficiaries (QMB) in English and Spanish.
Source	Printed supplies of Comm. 60 with English text on one side and Spanish text on the other may be ordered from Iowa Prison Industries at Anamosa.
Distribution	Give this brochure to applicants who are determined eligible for QMB coverage.
Data	The booklet explains QMB eligibility requirements and covered services.

**Comm. 62 or Comm. 62(S), Child Care Assistance**

Purpose	Brochures Comm. 62 and 62(S) provides information about the Child Care Assistance program.
Source	Printed supplies of Comm. 62 may be ordered from Iowa Prison Industries at Anamosa.  Print Comm. 62(S) from: <ul style="list-style-type: none"><li>▪ The online manual.</li><li>▪ SharePoint under Employee Manual/Forms.</li></ul>
Distribution	Provide this brochure to: <ul style="list-style-type: none"><li>▪ Child Care Assistance applicants</li><li>▪ FIP applicants at the application interview</li><li>▪ FIP participants at the annual interview</li><li>▪ Other interested person upon request</li></ul>
Data	The brochure explains who can get Child Care Assistance, who can provide the care, where families can get help finding child care, and the rights and responsibilities of a parent who receives subsidized child care under this program

**Comm. 72, Protection of Your Resources and Income**

Purpose	The booklet Comm. 72 gives basic information about Medicaid policies affecting married people residing in long-term care facilities.
Source	Printed supplies of Comm. 72 may be ordered from Iowa Prison Industries at Anamosa.
Distribution	Give this booklet to married people who are applying for Medicaid coverage for long-term care or who may apply for such coverage in the future.
Data	The booklet explains the SSI regulations of the treatment of resources, the Long-Term Care Partnership Program for Medicaid asset protection, estate recovery, and Medicaid income policies for long-term care.

**Comm. 84 or Comm. 84(S), Information on Emergency Service**

Purpose	The <i>Information on Emergency Service</i> flier helps applicants to better understand SNAP emergency service and the criteria for receiving it. It allows applicants to determine for themselves whether or not they may be eligible for emergency service.
Source	Comm. 84 is printed with 25 forms on a pad. Order supplies from Iowa Prison Industries at Anamosa.  Print Comm. 84(S) from: <ul style="list-style-type: none"><li>▪ The online manual.</li><li>▪ SharePoint under Employee Manual/Forms.</li></ul>
Completion	Use of this flier is mandatory only for counties that choose not to issue an appointment letter that indicates the client's eligibility for an emergency SNAP appointment.  In counties that choose to distribute information on emergency service with applications, give this flier to all SNAP applicants at the time they are given a <i>Food and Financial Support Application</i> , form 470-0462 or 470-0462(S).
Distribution	In a county that chooses not to inform applicants on the appointment letter whether they have been screened as entitled to an emergency appointment, include one copy of Comm. 84 or Comm. 84(S) with the application form.
Data	The flier describes the criteria for emergency services and advises households what to do if they believe that they qualify for emergency services.

**Comm. 91 or Comm. 91(S), The Health Insurance Premium Payment (HIPP) Program for Iowa Medicaid Recipients**

Purpose	Brochures Comm. 91 and Comm. 91(S) explain the HIPP program and provides a tear-off application and return envelope.
Source	Printed supplies of Comm. 91 or Comm. 91(S) may be ordered from Iowa Prison Industries at Anamosa.
Distribution	Provide this brochure to Medicaid applicants and members who are interested in applying for the HIPP program. Do not issue it with Medicaid applications.
Data	The brochure explains the HIPP program, how HIPP determines if insurance is cost-effective, what kind of insurance the HIPP program will pay for, and how to report changes.

**Comm. 99, The Iowa AIDS/HIV Health Insurance Premium Payment Program**

Purpose	The booklet Comm. 99 gives basic information about the Iowa AIDS/HIV Health Insurance Premium Payment program. It also contains an application form and a return envelope.
Source	Printed supplies of Comm. 99 may be ordered from Iowa Prison Industries at Anamosa.
Distribution	Local offices may give this form to persons who express interest in applying for the Iowa AIDS/HIV Health Insurance Premium Payment program.
Data	The booklet explains the program and how people qualify for it, explains the program's relationship to the applicant's insurance coverage, and the process for determining eligibility and beginning benefits.

**Comm. 108, The Family Investment Program (FIP)**

Purpose	Brochure Comm. 108 gives basic information about the Family Investment Program (FIP), which offers cash assistance funded through the Temporary Assistance to Needy Families (TANF) federal block grant.
Source	Printed supplies of Comm. 108 may be ordered from Iowa Prison Industries at Anamosa.
Distribution	Local offices may give this form to persons who express interest in applying for FIP.
Data	The brochure explains FIP eligibility requirements, PROMISE JOBS activities, the limited benefit plan, application procedures, the effect of other income on the FP grant, and how FIP assistance is paid.

**Comm. 121 or Comm. 121(S), Important Notice to Property Owners and Renters**

Purpose	The <i>Important Notice to Property Owners and Renters</i> flier explains the income limits for both the property tax credit and rent reimbursement.
Source	Print Comm. 121 or Comm. 121(S) from: <ul style="list-style-type: none"><li>▪ The online manual.</li><li>▪ SharePoint under Employee Manual/Forms.</li><li>▪ The Worker Information System Exchange (WISE).</li></ul>
Distribution	Give or mail Comm. 121 or Comm. 121(S) to elderly and disabled applicants when they apply for benefits. Document this in the case record.



**Comm. 123 or Comm. 123(S), Important Information for You and Your Family Members About the Estate Recovery Program**

Purpose	The <i>Important Information for You and Your Family Members About the Estate Recovery Program</i> is a flier designed to give answers to questions about the Estate Recovery Program.
Source	Comm. 123 is printed with 50 fliers per pad. Order supplies from Iowa Prison Industries at Anamosa.  Print Comm. 123 or Comm. 123(S) from: <ul style="list-style-type: none"><li>▪ The online manual.</li><li>▪ SharePoint under Employee Manual/Forms.</li><li>▪ The Worker Information System Exchange (WISE).</li></ul>
Distribution	Issue a copy of this flier to all Medicaid applicants.

**Comm. 132 or Comm. 132(S), Family Planning Counseling**

Purpose	<p>The <i>Family Planning Counseling</i> brochure is designed to give basic information about family planning counseling services.</p> <p>FIP participants may choose family planning counseling as an option in their FIA but are not required to do so. Participants who choose family planning counseling as an FIA option and later decide against the service are not subject to the limited benefit plan.</p>
Source	<p>Print Comm. 132 or Comm. 132(S) from:</p> <ul style="list-style-type: none"><li>▪ The online manual.</li><li>▪ SharePoint under Employee Manual/Forms.</li></ul>
Distribution	<p>Give Comm. 132 at the FIP application interview and at review. PROMISE JOBS workers may issue at their discretion to PROMISE JOBS participants during the FIA process.</p>

**Comm. 133 or Comm. 133(S), FIP for Minor Parents**

Purpose	The <i>FIP for Minor Parents</i> brochure explains the FIP requirement for minor parents to live with their adult parent or legal guardian or show good cause for not doing so.
Source	Comm. 133 is printed with 100 copies per pad. Order supplies from Iowa Prison Industries at Anamosa. Print Comm. 133(S) from: <ul style="list-style-type: none"><li>▪ The online manual.</li><li>▪ SharePoint under Employee Manual/Forms.</li></ul>
Distribution	Issue Comm. 133: <ul style="list-style-type: none"><li>▪ When a minor parent applies for FIP.</li><li>▪ When FIP eligibility must be redetermined due to a change in a minor parent's living arrangement.</li></ul>

**Comm. 137 or Comm. 137(S), 60-Month Limit on FIP**

Purpose	Comm. 137, <i>60-Month Limit on FIP</i> , is designed to give answers to frequently asked questions about the 60-month limit on FIP benefits.
Source	DHS staff may print Comm. 137 from: <ul style="list-style-type: none"><li>▪ The online manual.</li><li>▪ SharePoint under Employee Manual/Forms.</li></ul> Comm. 137 is also available from the Eligibility Tracking System (ETS). PROMISE JOBS staff may photocopy Comm. 137 as needed.
Distribution	Issue Comm. 137 at the application interview and the annual review. Also include Comm. 137 whenever issuing form 470-3851, <i>Important Information About Your FIP</i> . PROMISE JOBS workers may issue Comm. 137 at their discretion to PROMISE JOBS participants.

**Comm. 170, Understanding the Limited Benefit Plan**

Purpose	Flier Comm. 170 provides information FIP limited benefit plan.
Source	Department staff may print Comm. 170 from: <ul style="list-style-type: none"><li>▪ The online manual.</li><li>▪ SharePoint under Employee Manual/Forms.</li><li>▪ The Worker Information System Exchange (WISE).</li></ul> PROMISE JOBS staff may print Comm. 170 from the sample in the PROMISE JOBS MS Library.
Distribution	Income maintenance staff and PROMISE JOBS workers should issue Comm. 170 any time it is necessary to inform participants about the consequences of the limited benefit plan.
Data	The flier tells how a limited benefit plan is chosen and the consequences and resolution conditions of a first limited benefit plan and of a subsequent limited benefit plan

**Comm. 180, Medicaid for Employed People With Disabilities (MEPD)**

Purpose	Brochure Comm. 180 gives basic information about Medicaid coverage for employed people who have disabilities (MEPD).
Source	Printed supplies of Comm. 180 may be ordered from Iowa Prison Industries at Anamosa.
Distribution	Give this brochure to persons who are applying for or interested in MEPD coverage.
Data	The brochure explains MEPD eligibility requirements and the requirements for premium payment.

**Comm. 209 or Comm. 209(S), Information About Your Privacy Rights**

Purpose	<p>Brochures Comm. 209 and Comm. 209(S) are notices required under the Health Insurance Portability and Accountability Act (HIPAA) to inform Medicaid members about the Department's uses and disclosures of protected health information.</p> <p>NOTE: State mental health institutes and resource centers each have their own brochures for this purpose.</p>
Source	<p>Printed supplies of Comm. 209 may be ordered from Iowa Prison Industries at Anamosa.</p> <p>Print Comm. 209(S) from:</p> <ul style="list-style-type: none"><li>▪ The online manual.</li><li>▪ SharePoint under Employee Manual/Forms.</li></ul>
Distribution	<p>Provide this brochure to Medicaid members and other interested persons.</p>
Data	<p>The brochure explains what:</p> <ul style="list-style-type: none"><li>▪ Disclosures the Department can make without the member's specific permission,</li><li>▪ Rights the member has under HIPAA and how to apply them, and</li><li>▪ Obligations the Department has to safeguard a member's privacy.</li></ul>

**Comm. 229 or Comm. 229(S), SNAP Makes Iowa Stronger**

Purpose	Brochures Comm. 229 and Comm. 229(S) give basic information about SNAP.
Source	Printed supplies of Comm. 229 may be ordered from Iowa Prison Industries at Anamosa.  Print Comm. 229(S) from: <ul style="list-style-type: none"><li>▪ The online manual.</li><li>▪ SharePoint under Employee Manual/Forms.</li></ul>
Distribution	Make this brochure available in public areas of Department offices. It may also be used in outreach and informational activities.
Data	The brochure explains how to get SNAP, the basic eligibility requirements, maximum allotments per household size, and steps to better health.



**Comm. 233 or Comm. 233(S), Rights and Responsibilities**

Purpose	The <i>Rights and Responsibilities</i> brochure explains the client's rights and responsibilities when receiving Medicaid. For purposes of this form, Medicaid includes: Medicaid, Healthy and Well Kids in Iowa (Hawki), Iowa Health and Wellness Program (IHAWP), State Supplementary Assistance (SSA), and Refugee Medical Assistance (RMA).
Source	Comm. 233 and Comm. 233(S) are available online at <a href="http://dhs.iowa.gov/sites/default/files/Comm233.pdf">http://dhs.iowa.gov/sites/default/files/Comm233.pdf</a> and <a href="http://dhs.iowa.gov/sites/default/files/Comm233S.pdf">http://dhs.iowa.gov/sites/default/files/Comm233S.pdf</a> .  Print supplies of the English or Spanish version of Comm. 233 from: <ul style="list-style-type: none"><li>▪ The online manual.</li><li>▪ SharePoint under Employee Manual/Forms.</li></ul>
Distribution	Comm. 233 or Comm. 233(S) is provided to each applicant household as part of form 470-5170 or 470-5170(S), <i>Application for Health Coverage and Help Paying Costs</i> .  Also give or mail Comm. 233 or Comm. 233(S) to individuals upon request.

**Comm. 238, Cut Your Medical Costs if You Get Medicaid**

Purpose	Flier Comm. 238 explains the advantages of receiving SSI-related Medicaid benefits
Source	Print Comm. 238 from: <ul style="list-style-type: none"><li>▪ The online manual.</li><li>▪ SharePoint under Employee Manual/Forms.</li></ul>
Distribution	Provide this flier to people who may be eligible for SSI-Related Medicaid and other interested persons.
Data	The flier summarizes Medicaid benefits, explains SSI-related eligibility criteria, and gives contact information for SNAP and local offices.

**Comm. 249 or Comm. 249(S), Family Planning Program (FPP)**

Purpose	Brochures Comm. 249 and Comm. 249(S) provide information about services provided by the Iowa Family Planning Program.
Source	Printed supplies of Comm. 249 may be ordered from Iowa Prison Industries at Anamosa.  Print Comm. 249(S) from: <ul style="list-style-type: none"><li>▪ The online manual.</li><li>▪ SharePoint under Employee Manual/Forms.</li></ul>
Distribution	Give Comm. 249 or Comm. 249(S) to: <ul style="list-style-type: none"><li>▪ Men and women ages 12 through 54 who lose Medicaid eligibility,</li><li>▪ People who have eligibility established under the Iowa Family Planning Program.</li></ul> Display the brochures in the local office for public access.
Data	The brochures explain the availability of free birth control services for men and women under the Iowa Family Planning Program and give contact information for finding services.

**Comm. 258 or Comm. 258(S). Verifying Citizenship/Identity and/or Immigration Status**

Purpose	<i>Verifying Citizenship/Identity and/or Immigration Status</i> is an informational notice about federal Medicaid requirements.
Source	Print Comm. 258 or Comm. 258(S) from: <ul style="list-style-type: none"><li>▪ The online manual.</li><li>▪ SharePoint under Employee Manual/Forms.</li><li>▪ The Worker Information System Exchange (WISE).</li></ul>
Distribution	Give this notice to applicants and members when requested or needed.
Data	The notice includes examples of common documents that customers may provide to verify U.S. citizenship/identity and/or immigration status.

**Comm. 266, Iowa's Estate Recovery Law**

Purpose	Brochure Comm. 266 provides basic information on the provisions for recovery of Medicaid expenses from the estates of Medicaid members or their heirs.
Source	Printed supplies of Comm. 266 may be ordered from Iowa Prison Industries at Anamosa.
Distribution	Give to this brochure to Medicaid applicants who are over the age of 55 and to applicants under the age of 55 who are in long-term care.
Data	The brochure explains who is affected by the Estate Recovery Program, when a claim is made against an estate, how claims are paid, the relationship to life insurance, trusts, and annuities, and the provisions for waiving the debt.

**Comm. 284, Bringing Farmers Markets and SNAP Together**

Purpose	Comm. 284 is a brochure that promotes the use of SNAP benefits to purchase food at farmer's markets.
Source	Additional supplies of Comm. 284 may be printed on 8½" x 11" paper from the following Department website: <a href="http://dhs.iowa.gov/sites/default/files/Comm284.pdf">http://dhs.iowa.gov/sites/default/files/Comm284.pdf</a>
Distribution	Give Comm. 284 to: <ul style="list-style-type: none"><li>▪ New SNAP applicant households.</li><li>▪ Members of the public upon request.</li></ul>
Data	The brochure lists Iowa farmers markets that have vendors who accept the SNAP electronic benefit transfer (EBT) card as payment.

**Comm. 337, Medicaid for Kids with Special Needs**

Purpose	Comm. 337 is a brochure that explains the Medicaid coverage group for children with special needs (MKSNS).
Source	Printed supplies of Comm. 337 may be ordered from Iowa Prison Industries at Anamosa.
Distribution	Give Comm. 337 to applicants or potential applicants for MKSN coverage.
Data	The brochure contains: <ul style="list-style-type: none"><li>▪ Information on how to apply for MKSN</li><li>▪ An overview of MKSN eligibility requirements</li><li>▪ A chart of income limits</li><li>▪ Contact information for the Department.</li></ul>

**Comm. 372, Medicaid for Employed People with Disabilities (MEPD) Frequently Asked Questions**

Purpose	Comm. 372 gives the new MEPD member information about the coverage group.
Source	Print Comm. 372 from: <ul style="list-style-type: none"><li>▪ The online manual.</li><li>▪ SharePoint under Employee Manual/Forms.</li></ul>
Distribution	The Iowa Medicaid Enterprise will mail each new MEPD member a copy of Comm. 372. Local office staff may also give Comm. 372 to MEPD members.



**Comm. 377 or Comm. 377(S), FIP Electronic Access Card**

Purpose	Comm. 377 and Comm. 377(S) are fliers that provide information about the FIP electronic access card (EAC).
Source	Print Comm. 377 or Comm. 377(S) from: <ul style="list-style-type: none"><li>▪ The online manual.</li><li>▪ SharePoint under Employee Manual/Forms.</li><li>▪ The Worker Information System Exchange (WISE).</li></ul>
Distribution	Provide a copy of Comm. 377 or Comm. 377(S) to all FIP applicants.

**Comm. 390 and 390(S), Benefits of a Healthy Marriage**

Purpose	The flier <i>Benefits of a Healthy Marriage</i> constitutes the services provided under the categorical assistance program Promoting Awareness of the Benefits of a Healthy Marriage. (A household can be eligible for Promoting Awareness of the Benefits of a Healthy Marriage only when the household is otherwise eligible for SNAP.)
Source	The flier is generated by the Automated Benefit Calculation System when system entries are made to approve a household for Promoting the Awareness of the Benefits of a Healthy Marriage and, consequently, for SNAP. It is printed with English text on one side and Spanish text on the reverse.
Distribution	The flier is mailed to the household with the <i>Notice of Decision</i> approving the household for both programs.
Data	The flier provides information on the benefits provided by a healthy marriage.

### **Comm. 411, Medicaid for People in Care Facilities**

Purpose	The flier <i>Medicaid for People in Care Facilities</i> gives basic information about the services covered by Medicaid for long-term care.
Source	Print Comm. 411 from: <ul style="list-style-type: none"><li>▪ The online manual.</li><li>▪ SharePoint under Employee Manual/Forms.</li></ul>
Distribution	Give Comm. 411 to: <ul style="list-style-type: none"><li>▪ All long-term care applicants and</li><li>▪ Anyone who requests information about Medicaid coverage of facility care expenses.</li></ul> <p>When more detailed information is requested, send Comm. 52, <i>Medicaid for People in Nursing Homes and Other Care Facilities</i>, or give the internet link to Comm. 52 at: <a href="http://dhs.iowa.gov/sites/default/files/Comm052.pdf">http://dhs.iowa.gov/sites/default/files/Comm052.pdf</a></p>
Data	Comm. 411 explains: <ul style="list-style-type: none"><li>▪ Admission procedures,</li><li>▪ The effect of Medicaid eligibility on the facility payment,</li><li>▪ Consideration of a spouse at home,</li><li>▪ Client participation,</li><li>▪ Additional services available,</li><li>▪ The relationship between Medicare and Medicaid, and</li><li>▪ Transfer from one facility to another.</li></ul>

### **Comm. 413, Medicare Savings Programs**

Purpose	The flier <i>Medicare Savings Programs</i> gives basic information about the qualified Medicare beneficiary (QMB) program.
Source	Print Comm. 413 from: <ul style="list-style-type: none"><li>▪ The online manual.</li><li>▪ SharePoint under Employee Manual/Forms.</li></ul>
Distribution	Give Comm. 413 to: <ul style="list-style-type: none"><li>▪ All members who qualify for QMB and</li><li>▪ Anyone who requests information about Medicare Savings Programs.</li></ul> When more detailed information is requested, send Comm. 60, <i>Medicaid for the Qualified Medicare Beneficiary</i> , or give the Internet link to Comm. 60 at: <a href="http://dhs.iowa.gov/sites/default/files/Comm060.pdf">http://dhs.iowa.gov/sites/default/files/Comm060.pdf</a>
Data	Comm. 413 explains the eligibility requirements and services available under the QMB program.

### **Comm. 414, Protecting Your Resources and Income**

Purpose	The flier <i>Protecting Your Resources and Income</i> gives basic information about how resources and assets are determined when a person applies for Medicaid for facility care.
Source	Print Comm. 414 from: <ul style="list-style-type: none"><li>▪ The online manual.</li><li>▪ SharePoint under Employee Manual/Forms.</li></ul>
Distribution	Give Comm. 414 to: <ul style="list-style-type: none"><li>▪ All applicants for facility care and</li><li>▪ Anyone who requests information about the treatment of resources for Medicaid eligibility for facility care.</li></ul> <p>When more detailed information is requested, send Comm. 72, <i>Protection of Your Resources and Income</i>, or give the Internet link to Comm. 72 at: <a href="http://dhs.iowa.gov/sites/default/files/Comm072.pdf">http://dhs.iowa.gov/sites/default/files/Comm072.pdf</a></p>
Data	Comm. 414 explains: <ul style="list-style-type: none"><li>▪ The income limit for the spouse in the facility,</li><li>▪ How resources are divided between the spouse in the facility and the spouse at home, and</li><li>▪ What income can be protected.</li></ul>

### **Comm. 415, Medically Needy Medical Assistance**

Purpose	The pamphlet <i>Medically Needy Medical Assistance</i> gives basic information about the Medically Needy program.
Source	Print Comm. 415 from: <ul style="list-style-type: none"><li>▪ The online manual.</li><li>▪ SharePoint under Employee Manual/Forms.</li></ul>
Distribution	Give Comm. 415 to all applicants who are determined eligible for Medically Needy coverage.  When more detailed information is requested, send Comm. 30, <i>Medicaid for the Medically Needy</i> , or give the internet link to Comm. 30 at: <a href="http://dhs.iowa.gov/sites/default/files/Comm030.pdf">http://dhs.iowa.gov/sites/default/files/Comm030.pdf</a>
Data	Comm. 415: <ul style="list-style-type: none"><li>▪ Lists the eligibility requirements.</li><li>▪ Explains spenddown.</li><li>▪ Tells when a <i>Medical Assistance Eligibility Card</i> is issued.</li></ul>

**Comm. 479, Burial Contract Frequently Asked Questions**

Purpose	The flier <i>Burial Contract Frequently Asked Questions</i> gives information to Medicaid applicants and recipients of how a burial contract is counted when determining Medicaid eligibility. It also answers frequently asked questions regarding funding, amounts, verification, and where to contact for questions.
Source	Print Comm. 479 from: <ul style="list-style-type: none"><li>▪ The online manual.</li><li>▪ SharePoint under Employee Manual/Forms.</li></ul>
Distribution	Give Comm. 479 to Medicaid applicants and recipients.
Data	Medicaid applicants and recipients should read through the <i>Burial Contract Frequently Asked Questions</i> to determine: <ul style="list-style-type: none"><li>▪ If this information pertains to them or</li><li>▪ If they need to contact DHS for further information relating to burial contracts.</li></ul>

**[Comm. 516, Iowa Medicaid Will Help Pay Your Out-of-Pocket Costs](#)**

Purpose	Comm. 516, <i>Iowa Medicaid Will Help Pay Your Out-of-Pocket Costs</i> , helps Health Insurance Premium Payment (HIPP) members and their providers understand when and how Iowa Medicaid can help pay the member's out-of-pocket cost.
Source	Print Comm. 516 from: <ul style="list-style-type: none"><li>▪ The online manual.</li><li>▪ SharePoint under Employee Manual/Forms.</li></ul>
Distribution	HIPP staff may give Comm. 516 to applicants or other interested persons.
Data	The brochure instructs members and their providers when and how Iowa Medicaid can help pay their out-of-pocket cost.



**Comm. 674, HHS Services Portal User Guide**

Purpose	The <i>User Guide</i> is designed to provide information about the functions of the HHS Services Portal and instructions for applicants or members on how to utilize those functions.
Source	Print Comm. 674 from the online manual.
Distribution	Share this guide with persons needing assistance with navigating the HHS Services Portal.
Data	This guide details how someone can create an account, opt-in for paperless mailings, and link a portal account to a Medicaid case.

### **RC-0002, Schedule of Needs**

#### Purpose

Title IV-A of the Social Security Act requires states administering a cash assistance program (known as FIP in Iowa) to establish standards of assistance. These standards, expressed in money amounts, are for the purpose of determining financial need and the amount of assistance on an equitable basis.

The *Schedule of Living Costs* and the *Schedule of Basic Needs* are provided to comply with 1991 Iowa Acts, Chapter 267.

The instructions governing the use of the schedules are contained in [4-F, \*Applying Income Tests and Calculating the Amount of Assistance\*](#).

#### **Chart of Basic Needs Components:**

Below the *Schedule of Needs* is the *Chart of Basic Needs Components*. The total of the amounts of basic needs components does not exactly equal the amount shown on the corresponding *Schedule of Basic Needs*. This difference arises from many factors, but occurs primarily by reason of the “rounding off” procedures that are employed throughout the process culminating in the *Schedule of Basic Needs*.

This chart is used in determining applicant’s or participant’s net profit from renting out apartments in the applicant’s or participant’s own home. Note that the amounts set forth on the chart for each budgetary item are computed on a per-person basis.

For example, the two-person allowance for shelter is \$131.62 ( $\$65.81 \times 2$ ); the two-person allowance for utilities is \$32.90 ( $\$16.45 \times 2$ ).

#### **Allowances for Special Needs:**

A summary of the allowances for special needs is printed on the reverse for quick reference.

**RC-0008, Overpayment Recovery Codes**

Purpose RC-0008 explains the meaning of codes in the Overpayment Recovery System.

**RC-0018, Supplemental Security Income Payment Standards**

Purpose	The RC-0018 is a chart of SSI and State Supplementary Assistance payment standards. It may be used as a reference in determining eligibility and the amount of payment in SSI-related Medicaid and State Supplementary Assistance cases.
Source	Print RC-0018 from: <ul style="list-style-type: none"><li>▪ The online manual.</li><li>▪ SharePoint under Employee Manual/Forms.</li><li>▪ The Worker Information System Exchange (WISE).</li></ul>
Data	Payment standards for the various categories of State Supplementary Assistance are found under the headings listed on the chart.

**RC-0023 or RC-0023(S), Things You Need to Give Us for SNAP**

Purpose	RC-0023 and RC-0023(S) are fliers used to inform applicants of the verification requirements for the application process.
Source	RC-0023 is printed with 50 sheets on a pad. Order supplies from Iowa Prison Industries at Anamosa.  Print RC-0023(S) from: <ul style="list-style-type: none"><li>▪ The online manual.</li><li>▪ SharePoint under Employee Manual/Forms.</li></ul>
Distribution	Give one document to each household filing an initial application for SNAP.
Data	The flier explains which documents clients need to produce to verify their identity, alien status, social security number, residency, expenses, earnings and other income, and assets.

### **RC-0033, Desk Aid**

Purpose	The RC-0033 is a chart of SNAP and FIP income and resource limits. Workers can use it as a reference in determining eligibility and the amount of payment in these cases.
Source	Print RC-0033 from: <ul style="list-style-type: none"><li>▪ The online manual.</li><li>▪ SharePoint under Employee Manual/Forms.</li><li>▪ The Worker Information System Exchange (WISE).</li></ul>
Data	The chart lists income and resource limits for SNAP and FIP.

### **RC-0064, Unearned Income Desk Aid**

- Purpose
- The *Unearned Income Desk Aid* is designed as an immediate reference about unearned income for income maintenance staff. It:
- Gives information on the documents that verify child support, unemployment benefits, SSI benefits, and social security benefits.
  - Explains how to determine the receipt date for these income sources when determining initial and ongoing eligibility for the SNAP, FIP, and Medicaid programs.
  - Lists the child support account codes to distinguish between payments that are forwarded to the client and those that are kept by the state.
- Source
- Print RC-0064 from:
- The online manual.
  - SharePoint under Employee Manual/Forms.

### **RC-0103, Disability Determination Checklist**

Purpose	RC-0103 is used to assist income maintenance workers in submitting complete disability determination referrals to the Disability Determination Services Bureau (DDSB). It may be used as a checklist for each determination or as a general guide to ensure that all required information is included in the referral.
Source	Print RC-0103 from: <ul style="list-style-type: none"><li>▪ The online manual.</li><li>▪ SharePoint under Employee Manual/Forms.</li><li>▪ The Worker Information System Exchange (WISE).</li></ul>
Distribution	The worker may retain the form in the case file, but it is not required.
Data	The front of the form lists the required documentation to provide with disability referrals. The back of the form gives helpful tips for: <ul style="list-style-type: none"><li>▪ Continuing disability reviews (CDRs).</li><li>▪ Disability referrals based on worsened conditions or new conditions.</li><li>▪ The use of form 470-0363, <i>Certification of Eligibility of SSI Applicant</i>.</li><li>▪ Concurrent determinations for Medicaid and Social Security benefits.</li></ul>



**RC-0120 or RC-0120(S), Legal Information**

Purpose	RC-0120 and RC-0120(S) provide required legal information to FIP and SNAP applicants applying via electronic application.
Source	RC-0120 is available online: <ul style="list-style-type: none"><li>▪ Within the electronic application.</li><li>▪ The online manual</li></ul>

**RC-0128, Suspending Medicaid to Limited Benefits for Incarcerated Individuals Procedure Guide**

**Purpose** RC-0128 is used to assist income maintenance workers in determining the correct procedure for suspending Medicaid benefits to limited services for individuals who have been incarcerated for more than 30 consecutive days. It should be used as general guide to make sure all the required steps are completed.

**Source** Print RC-0128 from:

- The online manual.
- SharePoint under Employee Manual/Forms.

### **RC-0130, Medical Assistance Desk Aid**

Purpose	RC-0130 is a chart of monthly income limits. Workers can use it as a reference in determining eligibility in these cases.
Source	Print RC-0130 from: <ul style="list-style-type: none"><li>▪ The online manual.</li><li>▪ SharePoint under Employee Manual/Forms.</li><li>▪ The Worker Information System Exchange (WISE).</li></ul>
Data	The chart lists income limits for: <ul style="list-style-type: none"><li>▪ Modified adjusted gross income (MAGI)</li><li>▪ Medicaid for Independent Young Adults (MIYA)</li><li>▪ Iowa Health and Wellness Plan (IHAWP)</li><li>▪ Healthy and Well Children in Iowa (Hawki)</li></ul>