June 13, 2025

GENERAL LETTER NO. 6-AP-172

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

SUBJECT: Employees' Manual, Title 6 Appendix, **Income Maintenance Programs Appendix**, Title Page, Contents 1-9, Contents 10-13, 1, 2 and 3, 4-9, 10-13, 14-312, 313, 314-348, 349, 350-383, revised; 384-401, removed; and forms, revised.

Summary

This chapter is revised to update the following forms for content, accessibility, style, and formatting throughout:

▪ 470-0462	Food and Financial Support Application
▪ 470-1632	Landlord Questionnaire
▪ 470-1632(S)	Landlord Questionnaire (Spanish Version)
▪ 470-2341	SSI-Related (No Children) Medically Needy Spenddown Computation Worksheet
▪ 470-2626	SSI-Related (Children in Household) Medically Needy Spenddown Computation Worksheet
▪ 470-3088	FMAP-Related Medically Needy Spenddown Computation Worksheet
▪ 470-3624	Child Care Assistance (CCA) Application
▪ 470-3871	Child Care Assistance (CCA) Provider Agreement
▪ 470-4473	Free Lunch Notice
▪ 470-4473(S)	Free Lunch Notice (Spanish Version)
▪ 470-4558	Notice of Decision: Child Care
▪ 470-4851	Express Lane Medicaid for Children
▪ 470-4851(S)	Express Lane Medicaid for Children (Spanish Version)

and to obsolete the following item:

- Comm. 091 The Health Insurance Premium Payment (HIPP) Program for Iowa Medicaid Recipients

Effective Date

Text changes effective immdiately; form revisions effective date present on form.

Material Superseded

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

Page	Date
Title Page	September 27, 2024
Contents 1-9	October 11, 2024
Contents 10-13	January 24, 2025
1	September 27, 2024
2 and 3	October 11, 2024
4-9	September 27, 2024
10-13	January 24, 2025
14-312	September 27, 2024
313	January 24, 2025
314-348	September 27, 2024
349	January 24, 2025
350-384	September 27, 2024
385-401	September 27, 2024
470-0462	05/24
470-1632	07/21
470-1632S	07/21
470-2341	12/24
470-2626	12/24
470-3088	12/24
470-3624	04/24
470-3871	06/22
470-4473	06/23
470-4473S	06/23
470-4558	08/14
470-4851	08/21
470-4851(S)	08/21
Comm. 091	10/12

Additional Information

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

Income Maintenance Programs Appendix

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Informational Materials

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Absent Parent Information, Form 470-3773 or 470-3773(S)

Purpose

Form 470-3773, *Absent Parent Information*, may be used to collect information for the Family Investment Program regarding the parent of a child for whom benefits are being sought when the parent is not living with that child.

Source

Complete the English version using the form in the Worker Information Exchange System (WISE).

Complete the Spanish version of the form using the template in:

- SharePoint under Employee Manual/Forms.
- The Worker Information System Exchange (WISE).

Completion

If the household has not provided information about the absent parent in another way, the household may be asked to complete the form when it reports that:

- A parent will leave home.
- A parent has left home.
- A child or newborn has entered the home and the child has an absent parent.

Certain areas of the form populate and a due date is calculated for return of the completed form.

Give the household assistance in completing this form if needed.

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.

Enter information regarding the absent parent on the ICAR system.

Data

The form requests identifying information and employment information about the absent parent and information about the parents' marriage and support obligations.

Accident or Injury Request for Information: First Request, Form 470-0398

Purpose

Form 470-0398, *Accident or Injury Request for Information: First Request* is used by Iowa Medicaid to collect information from Medicaid members or their representative when claims show they may have been involved in an accident or injury.

The information returned on the form is used to identify claims with potential third-party liability (TPL). This form allows Iowa Medicaid to recover some or all of the Medicaid expenditures made on the member's behalf in connection to an accident or injury.

Source

Form 470-0398 is computer-generated by the OnBase system.

Completion

The form is prepared automatically when a Medicaid claim code indicates an accident or injury. It is generated when field staff, a member, a provider, an insurance company, or an attorney reports that the member has been involved in an accident and the possibility of third-party liability exists.

Distribution

The form is sent to the member, who returns it to Medicaid on completion. Once completed by the member or the member's representative, the form may be returned in one of the following ways:

Mail: Iowa Medicaid Enterprise
PO Box 36446
Des Moines, IA 50315

Phone: Member Services
1-800-338-8366 or locally in the Des Moines area at **515-256-4606**
(Monday - Friday, 8:00 am to 5:00 pm)
Email: RevCoLLLien@dhs.state.ia.us
Fax: 515-725-1352

Data

The form requests information from the member concerning:

- When and how the injury occurred.
- Whether the recipient has filed an insurance claim or retained an attorney in connection with the injury.
- The name and address of any involved insurance companies or attorneys.

Accident or Injury Request for Information: Final Notice, Form 470-0399

Purpose	Form 470-0399, Accident or Injury Request for Information: Final Notice is used subsequent to 470-0398, Accident or Injury Request for Information: First Notice by Iowa Medicaid to collect information from Medicaid members or their representative when claims show they may have been involved in an accident or injury. The information returned is used to identify claims with potential third-party liability (TPL). This form allows Iowa Medicaid to recover some or all of the Medicaid expenditures made on the member's behalf in connection to an accident or injury.
Source	Form 470-0399 is computer-generated by the OnBase system.
Completion	The form is prepared automatically when a Medicaid claim code indicates an accident or injury. It is generated when field staff, a member, a provider, an insurance company, or an attorney reports that the member has been involved in an accident and the possibility of third-party liability exists.
Distribution	The form is sent to the member, who returns it to Medicaid on completion. Once completed by the member or the member's representative, the form may be returned in one of the following ways: **Mail**: Iowa Medicaid Enterprise PO Box 36446 Des Moines, IA 50315 **Phone**: Member Services **1-800-338-8366** or locally in the Des Moines area at **515-256-4606** (Monday - Friday, 8:00 am to 5:00 pm) **Email**: RevCoLLLien@dhs.state.ia.us **Fax**: 515-725-1352
Data	The form requests information from the member concerning: ▪ When and how the injury occurred. ▪ Whether the recipient has filed an insurance claim or retained an attorney in connection with the injury. ▪ The name and address of any involved insurance companies or attorneys.

Account Transfer Error, Form 470-5437

Purpose	Form 470-5437, *Account Transfer Error*, is a letter used to notify applicants who are ineligible for Medicaid or Hawki that the state was unable to successfully transfer their application for health care coverage to the Marketplace. The letter informs the applicant that they need to complete a Marketplace application to see if they qualify for coverage and help paying for it. The letter also provides instructions.
Source	The letter is created in Central Office from a batch file that identifies applications that were not successfully transferred to the Marketplace.
Completion	The date, primary applicant's name, and mailing address are auto-filled on the letter through a mail merge process in Central Office.
Distribution	The form is sent to the primary applicant.

Addendum to Application and Review Forms for Release of Information, Form 470-4670 or 470-4670(S)

Purpose

If signed, form 470-4670 or 470-4670(S) may be used to request information (other than protected health information) about any household member. The client is not required to sign this form.

Source

Print the English or Spanish version of the addendum from:

- The online manual.
- SharePoint under Employee Manual/Forms.
- The Worker Information System Exchange (WISE).

Completion

The client may use this form to authorize the Department to contact other people or organizations for information needed to determine eligibility and benefits without specific contacts with the client for each request. Instead of signing this form, the client may:

- Choose to provide necessary information, or
- Sign another form that is specific to the source and type of information, such as an *Employer's Statement of Earnings*.

If the client chooses to use this form to authorize release of information:

1. Make entries in the Online Narrative to document the date this form was signed.
2. Use this form to request from other people or organizations any information that is needed to determine eligibility and benefits.
3. If the source of the information will not respond based on the client having signed this form, request the needed information from the client in writing. Help the client get information if the client asks for help.

Distribution

If the client signs form 470-4670 or 470-4670(S):

- Send a copy to other caseworkers that have an active file for the client.
- File the original or copy in the case file.

This form is intended to collect information specified on a separate sheet. When using it to request information from other people or organizations in order to determine eligibility or benefits:

1. Fold form 470-4670 or 470-4670(S) in half and copy the “Release of Information” section of the form.
2. Fax or mail the copy to the source of information along with a form requesting specific information, such as form 470-2844, *Employer’s Statement of Earnings*, or form 470-0461, *Authorization for Release of Information*.

When a signed release is in the file, requests for information may also be made by telephone.

Data

If the client chooses to use the form to authorize release of information, the client shall:

- Print the client’s name, and
- Sign and date the form.

Addendum to Application for Help with Medicare Prescription Drug Plan Costs, Form 470-4167

Purpose	Form 470-4167, *Addendum to Application for Help with Medicare Prescription Drug Plan Costs*, is used in conjunction with the Social Security Administration application entitled, *Application for Help with Medicare Prescription Drug Plan Costs*, form SSA-1020B-OCR-SM.
Source	Print form 470-4167 from: ▪ The online manual. ▪ SharePoint under Employee Manual/Forms. ▪ The Worker Information System Exchange (WISE).
Completion	When an applicant demands that DHS process the application for extra help with Medicare prescription drug plan costs instead of the Social Security Administration, the applicant must sign and date this form.
Distribution	File the addendum and the *Application for Help with Medicare Prescription Drug Plan Costs* in the case file.
Data	The form advises the applicant of terms for DHS process.

Adding an EBT Cardholder, Form 470-3983 or 470-3983(S)

Purpose

Form 470-3983, *Adding an EBT Cardholder*, is used by households who want a second Iowa EBT card for another member or for an authorized representative to use for shopping for the household.

The form is also used as proof that the Department did not issue an additional Iowa EBT card on an account without permission of the household's primary cardholder.

This form is not to be used for drug and alcohol treatment center or group living arrangement authorized representatives.

Source

Complete the English version using the form in the Worker Information System Exchange (WISE).

Print the Spanish version of the form from:

- The online manual.
- SharePoint under Employee Manual/Forms.
- The Worker Information System Exchange (WISE).

Completion

The form is completed by the IM worker, the SNAP head of household (the primary cardholder), and the secondary cardholder or authorized representative.

The form must be fully completed and signed by all parties and returned to the DHS local office before a secondary cardholder or authorized representative can receive an Iowa EBT card on a SNAP household's EBT account.

Distribution

The SNAP household keeps the second copy when the form is given to the secondary cardholder or authorized representative. The secondary cardholder or the authorized representative keeps the third copy. File the completed original in the SNAP case record.

Data

Case Information: To be completed by the IM worker.

Case Name: Enter the name of the primary cardholder (the ABC case name).

Case Number: Enter the DHS SNAP case number.

Worker's Name: Enter name of the IM worker who is responsible for the SNAP case record.

Date: Enter the date the information is entered.

Adding an EBT Cardholder: These entries are completed by the primary cardholder (the ABC case name).

- **Name of Person You Want Added**: The primary cardholder enters the name of the person authorized as a secondary cardholder or authorized representative.
- **Your Signature**: The primary cardholder signs and dates the form.

New EBT Cardholder's Section: These entries are completed by the secondary cardholder or authorized representative.

- **Signature of New EBT Cardholder**: The person named by the primary cardholder signs to acknowledge agreement with the household.
- **Date**: The date of signature of the secondary cardholder or authorized representative.
- **Social Security Number**: The social security number of the secondary cardholder or authorized representative.
- **Birthday (mm/dd/yy)**: Enter the birth date of the secondary cardholder or authorized representative.
- **Phone**: The phone number of the secondary cardholder or authorized representative.

Adjustment to Overpayment Balance, Form 470-0010

Purpose	Form 470-0010 is used to record payments and adjustments to debtor accounts established on the Web-based Overpayment Recovery (WOPR) System.
Source	Complete form 470-0010 using the template in: ▪ SharePoint under Employee Manual/Forms. ▪ The Worker Information System Exchange (WISE).
Completion	The IM worker or PROMISE JOBS worker who receives payments from a debtor or who wants to communicate necessary adjustments to a debtor's overpayment account completes this form when: ▪ Payments (cash, returned warrants) are received in the local office, or ▪ A monetary adjustment to a debtor's account needs to be made (e.g., credits to date were applied incorrectly), or ▪ An offset needs to be credited. Complete one form for each transaction. Print two copies of the completed form. NOTE: The total amount of the claim is not adjusted with this form. Submit an *Overpayment Recovery Information Input Summary* (from the direct claim entry screen) to adjust the total owed.
Distribution	Send one copy with the official receipt and the payment (if applicable) to the Cashier's Office, Bureau of Purchasing, Payments, Receipts and Payroll, Hoover Building, First Floor, Room 14, 1305 E. Walnut Street, Des Moines, Iowa 50319-0114. Keep a copy in the client's case file. If the reduction is a result of cash payment, the check or money order must accompany this form.
Data	**Date**: Enter the date the form is being submitted. **Submitting Worker**: Enter the name of the worker preparing the form.

Agency/Office: Enter the department of the worker preparing the form (DHS, IWD).

Telephone: Enter the worker's telephone number.

Debtor Name: Enter the name of the debtor whose overpayment recovery account needs adjustment. Enter the name as listed on the *Overpayment Recovery Information Input Summary* (from the direct claim entry screen).

Identifying Number and Prefix: Enter the prefix and the main identifier. Use the state ID number when available.

Program: Enter the program for the claim to which the change is being made, the offset is being credited, or the payment is being applied. If this payment could be applied to more than one claim, list all that apply.

Date Established: Enter the date for the claim to which the change is being made, the offset is being credited, or the payment is being applied.

Action: Check whether the claim balance should be increased or decreased.

Reduce Balance: Enter the amount by which the debtor's account balance should be reduced.

Increase Balance: Enter the amount by which the debtor's account balance should be increased. This occurs in case of FIP grant reduction or SNAP benefit reduction adjustments.

Reason: Check the reason for the adjustment, and identify what the "other" reason is, if "other" is checked. If more than one reason is checked, indicate a separate amount for each reason. These amounts must total to the amount entered after the action.

Affidavit of Citizenship, Form 470-4373 or 470-4373(S)

Purpose	The *Affidavit of Citizenship* is a written declaration, made under penalty of perjury, by a third party to verify the U.S. citizenship of a Medicaid/Hawki or family planning applicant or member who does not have any other proof of U.S. citizenship. The form includes a cover letter to explain the affidavit.
Source	Workers can complete the English or Spanish version using the form in the Worker Information System Exchange (WISE).
Completion	The income maintenance worker provides this affidavit to applicants or members who need to verify their U.S. citizenship. The worker enters the person's state identification number and case number on the preface page.
Distribution	You may upload the request to the electronic case file. When the original is returned, it will be scanned and uploaded.
Data	Section 1 is the name of the person completing the form. Section 2 is the information about the applicant or member needing to verify U.S. citizenship. Section 3 is the signature of the person completing the form.

Affidavit of Identity, Form 470-4386 or 470-4386(S)

Purpose	The *Affidavit of Identity* is a written declaration, made under penalty of perjury, by a third party to verify the identity of a Medicaid/Hawki or family planning applicant or member who does not have any other proof of identity. The form includes a cover letter to explain the affidavit.
Source	Workers can complete the English or Spanish version using the form in the Worker Information System Exchange (WISE).
Completion	The income maintenance worker provides this affidavit to applicants or members who need to verify their identity. The worker enters the person's state identification number and case number on the preface page.
Distribution	You may upload the request to the electronic case file. When the original is returned, it will be scanned and uploaded.
Data	Section 1 is information regarding the applicant or member needing to verify identity. Section 2 is the name of the person completing the form. Section 3 is the signature of the person completing the form.

Agreement for Automatic Deposit, Form 470-0261 or 470-0261(S)

Purpose	The *Agreement for Automatic Deposit* authorizes the Department to deposit payments automatically into a participant's financial institution account.
Source	Print the English or Spanish version of the form from: ▪ The online manual. ▪ SharePoint under Employee Manual/Forms. ▪ The Worker Information System Exchange (WISE).
Completion	Give this form to the following clients who want to start, change, or stop automated deposits: ▪ Family Investment Program (FIP) or Refugee Cash Assistance (RCA) clients receiving grants. (Any other cash assistance payments authorized on FIP or RCA cases will also be automatically deposited.) ▪ Facility residents who receive the state-funded payment for the difference between their countable income and the personal needs allowance. The participant completes the form and returns it with a voided check for the account. A deposit slip should be provided for savings accounts that do not provide checks.
Distribution	File the original in the case record after DIRD entries are made to start, change, or stop automated deposit. Give a copy to the client.
Data	The form indicates whether the client wants to start, stop, or change automated deposit, and gives information about the client's financial institution.

Agreement for Telephone Hearing, Form 427-0415 or 427-0415(S)

Purpose	Form 427-0415 is an agreement signed by the client to consent to a telephone hearing for an intentional program violation for SNAP.
Source	The Department of Inspections and Appeals sends this form to the IM worker with the *Notice of Hearing*.
Completion	The IM worker and the respondent complete this form before the telephone hearing.
Distribution	Keep the original in the client's case file. Return a copy to the Department of Inspections and Appeals.
Data	Sign and date the form and complete the appeal number and case number. Have the respondent sign and date the form in your presence.

Agreement to Pay a Debt, Form 470-0495 or 470-0495(S)

Purpose	Form 470-0495 or 470-0495(S) is a written agreement between a debtor and the Department for repayment when a debt exists. This form is completed by the Department of Inspections and Appeals (DIA) and is included here for information only.
Source	This form is issued by DIA.
Completion	The DIA investigator sends this agreement to a debtor to seek repayment for a debt owed to the Department of Human Services. The investigator may also send this form when a notice of overpayment has been sent and there has been no response. The debtor should return this form within 10 days. When a debtor fails to respond, other collection actions are pursued.
Distribution	DIA places the original in the Web-based Overpayment Recovery (WOPR) file and gives the copy to the debtor.
Data	The form states the amount of the debt and the repayment terms the debtor agrees to.

Agreement to Sell Excess Property, Form 470-2909

Purpose

Form 470-2909, *Agreement to Sell Excess Property*, is a written commitment by a State Supplementary Assistance client to make good-faith efforts to sell resources that are in excess of program limits. With this agreement and an agreement to repay conditional benefits, form 470-2835, the client can be granted conditional eligibility.

Source

Print form 470-2909 from:

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

Completion

Complete the form before granting conditional benefits to an applicant.

For a recipient, complete the form within 10 days of learning that the person has excess property that would make the person ineligible. Do not cancel the case until the recipient has had 10 days to complete and return the form.

The IM worker shall complete the blanks on the form. The client or representative must sign the form.

Distribution

Two-part NCR.

File the yellow copy of the signed form in the case record and give the white copy to the client or representative.

Data

Complete Item 5 designating each program for which the client is eligible.

Complete Item 6 by checking the number of months that is appropriate or specifying the number of months of eligibility remaining under conditional policies when SSI has already granted conditional benefits. Also enter the effective date that the property is exempt and conditional benefits are granted.

If spouses' eligibility is considered together, both spouses must sign the agreement. When the client is a child, and the child or the parent has the excess resources, the parent must sign the form. If the client has a guardian, conservator, or payee, that person must sign the form.

When a sponsor's excess resources make the client ineligible, and the sponsor wishes to sell the resource, the sponsor shall also sign the form.

Annuity Release of Information, Form 470-4699

Purpose	Form 470-4699 is designed to secure the client's permission for the Department to obtain annuity information needed to determine eligibility. The source of information completes the form to provide the annuity information.
Source	Complete 470-4699 using the form in the Worker Information Exchange System (WISE).
Completion	Workers may complete this form when it is necessary to obtain annuity information from a source other than the client. Complete a separate form for each source of required information. The worker completes the identifying information. The client (or the person authorized to obtain information) signs the form to give the authorization. The source of information completes the remainder of the form.
Distribution	Send one copy to the source of information. You may upload the request to the electronic case file. When the original is returned, it will be scanned and uploaded.
Data	Complete the following: ▪ State ID ▪ Case number ▪ Check the boxes to determine eligibility for SNAP, medical, FIP, or child care assistance ▪ Name and address of the source information ▪ Policy number ▪ Annuity owner ▪ Payment date ▪ Client's social security number The client shall sign and date the form after these items have been completed. The expiration date shall be 90 days from the date the form is signed.

Appeal and Request for Hearing, Form 470-0487 or 470-0487(S)

Purpose

Form 470-0487 is used to initiate the appeal process and to supply information needed to proceed with an appeal.

Source

Department staff may complete the English version of the form using the template in:

- SharePoint under Employee Manual/Forms.
- The Worker Information System Exchange (WISE).

Appellants may also complete this form electronically at https://hhs.iowa.gov/programs/appeals. The request will be submitted directly to the Appeals Section to be processed.

Print the Spanish version of the form from:

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

Completion

The form is divided into two parts. The person wishing to appeal (the appellant) or someone acting for the appellant completes the top part to initiate the appeal. The worker should assist in completing this part of the form if the appellant wishes.

A worker who receives this form from the appellant completes the worker information section. (The worker information section is not required for appeal requests filed directly with the Appeals Section.)

An appeal may be requested without completing this form. Any written appeal is valid. A request for a SNAP appeal may be expressed verbally or in writing.

If the appellant requests an appeal verbally or in other written form, the worker shall complete the identifying information and attach the appeal request to the form.

Distribution

If the form is submitted to a Department office other than the Appeals section, make three copies of the completed form. Distribute them as follows:

- Give a copy to the appellant.
- Fax a copy to any other worker named in the "Worker Information" section, and follow up by email to confirm the worker was notified.
- Within 24 hours of receipt, send the original and the *Notice of Decision* to:

  DHS Appeals Section, 5th Fl
  1305 E Walnut Street
  Des Moines, Iowa 50319-0114

  Attach a copy of the *Notice of Decision* or other notice of an adverse action that is being appealed. If no copy of the notice is attached, note why. Attach the postmarked envelope if the appeal was mailed in.
- Keep a copy in the case file.

Data

Top Section

Complete all the information, including phone number, if applicable. Check the programs under appeal.

A person requesting an attribution appeal may also request an administrative hearing. An administrative hearing is a review of the record only and does not include an appearance by the worker or client.

Indicate whether the appellant:

- Wants benefits to continue while the appeal is pending.
- Requests an interpreter for the appeal hearing.
- Wishes to have a pre-hearing conference to discuss the appeal. (Explain the purpose of a pre-hearing conference.)

Explain why the appellant is appealing. The explanation may be as specific as the appellant wishes to make it.

List any other persons whom the appellant wishes to have notified of the time and place of the hearing, with their addresses. This may include an attorney or representative.

The form should be signed and dated, if possible.

Worker Information Complete the worker's name, number, telephone number, and office name, and the appellant's case number or state identification number.

Refer to the section of the manual that specifies when assistance continues in determining whether the appellant's assistance or services are continuing or being reinstated pending the outcome of the appeal. If assistance is not being continued or reinstated, check and note the reason why it is not.

Check the box and indicate if the appeal is based on a Disability Determination Services report, an IME level-of-care decision, a CSC worker action, a FIP limited benefit plan, a Quality Control report, or a DIA investigation. Include the worker office location if the appeal concerns a PROMISE JOBS, Quality Control, or DIA Investigations action.

If you have a special scheduling request in the next three months (such as a compressed work week, vacation plans, or being in training), list it on the line indicated.

Within ten days of the receipt of the appeal, forward a summary of all actions taken. The summary is a review of the facts about the situation and should include:

- Information on the household composition.
- The issue being appealed.
- A detailed explanation of actions taken that led to the appeal.
- Copies of all supporting documents, including applications, notices, any other applicable forms, and narratives.
- Manual references on the actions taken.

Provide the appellant and appellant's representatives, if any, with copies of all materials submitted to the Appeals Section. Also provide this information to any other worker involved in the appeal. Note on the materials sent to the Appeals Section that copies were sent and to whom.

Notify the Appeals Section if other agencies or staff are parties to the appeal.

Appendix A for Health Coverage, Form 470-5433 or 470-5433(S)

Purpose

Appendix A for Health Coverage is designed to assist people in the household who are aged 65 and older, blind, or disabled to apply for various health-related programs, including:

- Help paying facility costs
- Services to remain in the home
- Help paying Medicare premiums
- State Supplementary Assistance

Source

Appendix A is included as part of form 470-5170 and 470-5170(S), *Application for Health Coverage and Help Paying Costs*.

DHS staff may complete the English or Spanish version of the form using the template in:

- SharePoint under Employee Manual/Forms.
- The Worker Information System Exchange (WISE).

Completion

Give or mail the forms to anyone who asks for an application.

The applicant completes the form. A friend, relative or authorized representative may help.

Distribution

Scan and file the completed application in the case record. Give the applicant a copy at the applicant's request.

Enter information from the application into the Eligibility Integrated Application System (ELIAS) as appropriate.

Data

Date-stamp the application upon receipt.

Application for COVID-19 Testing Coverage, Form 470-5618 or 470-5618(S)

Purpose	The *Application for COVID-19 Testing Coverage* is designed to assist people applying for health coverage for COVID-19 testing.
Source	The *Application for COVID-19 Testing Coverage* is available electronically at the following locations: ▪ https://dhs.iowa.gov/how-to-apply ▪ https://dhs.iowa.gov/COVID19 The *Application for COVID-19 Testing Coverage* may be printed from the above locations.
Completion	Refer anyone who asks for an application for COVID-19 testing for the uninsured to one of indicated locations. Inform anyone who contacts the Department for an application of the option to submit an application by mail, by fax, electronically or by telephone. The applicant completes the form. A friend, relative or authorized representative may help. Phone numbers and a website that can be used to get help with the application are provided on the cover page of the form.
Distribution	The completed application will be automatically saved in the case record. Give the applicant a copy at the applicant's request. Information from a paper application will be entered into the electronic application, as appropriate, by the DHS Contact Center.
Data	Date-stamp the application upon receipt.

Application for Extra Help with Medicare Prescription Drug Plan Costs, Form SSA-1020B-OCR-SM

Purpose	The *Application for Extra Help with Medicare Prescription Drug Plan Costs*, form SSA-1020B-OCR-SM, is used to apply for help with Medicare prescription drug plan costs. A Medicare beneficiary can also apply with the state Medicaid agency for help with prescription drug plan costs and can require the state determine eligibility for this help.
Source	The *Application for Extra Help with Medicare Prescription Drug Plan Costs*, form SSA-1020B-OCR-SM, is issued by the Social Security Administration. Keep a supply in each local office. To order forms, contact the Social Security Administration office serving your area. NOTE: This form is not to be photocopied. A Medicare beneficiary who wants the Social Security Administration to determine eligibility must submit the application on an original form or apply via the Internet.
Completion	The applicant or the applicant's representative completes the application. To apply for state determination, the applicant or representative must also complete form 470-4167, *Addendum to Application for Help with Medicare Prescription Drug Plan Costs*.
Distribution	When the applicant wants the Social Security Administration to process the application, the form is to be mailed to the Social Security Administration in the pre-addressed envelope that is enclosed with the application. When the applicant wants the Department to process the application, the form is filed in the DHS case record with form 470-4167, *Addendum to Application for Help with Medicare Prescription Drug Plan Costs*.
Data	Record your action taken on this form as directed by the income maintenance supervisor 2 for your area.

Application for Foster Care and Subsidized Adoption Medicaid, Form 470-5535 or 470-5535(S)

Purpose	The *Application for Foster Care and Subsidized Adoption Medicaid* is designed to assist people applying for health care coverage for a child living in Iowa in a foster care or subsidized adoption placement.
Source	The English version of the form is printed with 25 sets on a pad. Order supplies from Iowa Prison Industries at Anamosa. Print the Spanish version of the form from: ▪ The online manual. ▪ SharePoint under Employee Manual/Forms.
Completion	Mail or give the *Application for Foster Care and Subsidized Adoption Medicaid* to a person applying for Medicaid for a child living in Iowa in a foster care or subsidized adoption placement. The applicant or an adult acting on a child's behalf completes the form. A friend, relative, authorized representative, or DHS/JCO staff may help, if needed. See 8-B, *Information Provided*, for a list of pamphlets to provide with the *Application for Foster Care and Subsidized Adoption Medicaid*. When the applicant is a child, the application must be signed by a parent, stepparent, or other adult in the home who has primary responsibility for the child's care, if applicable. If there is a guardian or other responsible person, the guardian or responsible person shall participate in completing the form and sign for the child.
Distribution	If the client wants a copy of the application, photocopy the form for the client. When a person does not file the application at a DHS office, and the person also requests Medicaid, the originating agency shall route the original to the DHS office responsible for the applicant's county of residence within two working days of receipt. The originating agency shall photocopy the application for their files.
Data	Date-stamp the original application before faxing or mailing the photocopy of the form to another agency.

Application for Health Coverage and Help Paying Costs, Form 470-5170 or 470-5170(S)

Purpose

The *Application for Health Coverage and Help Paying Costs* is designed to assist people applying for various health-related programs, including:

- Medicaid (MAGI and non-MAGI)
- Hawki (Children's Health Insurance Program or CHIP)
- Iowa Health and Wellness Plan (IHAWP)
- State Supplementary Assistance
- Help paying for health insurance costs

Source

Central Office has a contract to provide automatic shipments of form 470-5170 to local offices. The shipments are intended to cover a six-month supply. Additional supplies of form 470-5170 are also available through Central Office.

DHS staff may complete the English or Spanish version of the form using the template in:

- SharePoint under Employee Manual/Forms.
- The Worker Information System Exchange (WISE).

Completion

Give or mail the *Application for Health Coverage and Help Paying Costs* to anyone who asks for an application. Give or mail the *Voter Registration* form with the application.

Inform anyone who contacts the Department for an application of the option to submit an application in person, by mail, by fax, electronically or by telephone.

The applicant completes the form. A friend, relative or authorized representative may help. Phone numbers and a website that can be used to get help with the application are provided on the cover page of the form.

An optional release of information is included in the application. The applicant may use this release to authorize the Department to contact other people or organizations for information needed to determine eligibility and benefits. The applicant is not required to sign this release.

	Rights and Responsibilities, Comm. 233, is included at the end of the application. Applicants should retain Comm. 233 for reference.
Distribution	Scan and file the completed application in the case record. Give the applicant a copy at the applicant's request. Enter information from the application into the Eligibility Integrated Application System (ELIAS) as appropriate.
Data	Date-stamp the application upon receipt.

Asset Verification System (AVS) Payment Worksheet, Form 470-5498

Purpose	Form 470-5498 is used to calculate the payment that will be made to the asset verification system (AVS) contractor. It provides detailed case specific information used for accurate computation of payment.
Source	Complete 470-5498 using the form in the Worker Information Exchange System (WISE).
Completion	The IM worker completes the form when a non-MAGI case is denied for being over resources.
Distribution	Place a copy of the completed form into the case record for the person whom was denied for being over resources.
Data	Fields requiring entries are:

Did AVS report asset sources the Department was not aware of causing the result of a Transfer of Assets penalty period? The worker selects “Yes” or “No.” If “Yes” is selected, the worker will continue to complete Section B. If “No” is selected, the worker will continue to the next question.

Did AVS report asset sources the Department was not aware of causing member to be ineligible? The worker selects “Yes” or “No.” If “Yes” is selected, the worker will be finished with the form and should click on the “Submit to ECF” button.

Section A **Select coverage group**: The worker selects the coverage group from the drop down list that was denied due to the person being over resources.

Select individual or couple: The worker selects “Individual” or “Couple.”

Total amount of countable resources: The worker enters the person’s total amount of countable resources.

Section B **Select coverage group**: The worker selects the coverage group from the drop down list that the person has been assessed a penalty period for the transfer of assets.

Number of months ineligible: The worker selects from the drop down list the whole number of months, with a maximum of 12, that the person has been determined ineligible due to a transfer of assets for less than fair market value. This number should come from the person's completed form 470-4365, *Disposal of Assets Penalty Notice of Decision*.

Attribution of Resources Appeal Summary, Form 470-3144

Purpose	Form 470-3144 may be used as the Department's appeal summary when an appeal is filed to set aside additional resources for the community spouse.
Source	Complete form 470-3144 using the template in: ▪ SharePoint under Employee Manual/Forms. ▪ The Worker Information System Exchange (WISE).
Completion	The IM worker completes this form as an alternative to completing an appeal summary when an appeal is filed regarding the attribution of resources.
Distribution	Send one copy to the Department of Human Services, Appeals Section, 1305 E Walnut Street, 5th Floor, Des Moines, Iowa 50319-0114. Keep a copy in the case record. Send a copy to the appellant.
Data	Enter the appeal number, if you know it, and your worker number and county number on the form. List: ▪ The names and birth dates of the institutionalized spouse and the community spouse. ▪ The date of the application for attributions. ▪ The date of the application for assistance. ▪ The date of appeal. ▪ The beginning date of continuous institutionalization or the date the waiver applicant met medical institution level of care criteria. ▪ The total amount of the couple's current resources, if different from the attribution amount. ▪ Select from the drop down box the minimum monthly maintenance needs allowance (MMMNA) as of the date the appeal was filed.

Verify and list the community spouse's available gross income. Calculate the shortfall between the community spouse's available gross income and the MMMNA. Attach all documents listed under the attachments listing.

For people who became institutionalized on or after February 8, 2006, include the income made available to the community spouse in the client participation calculation as available to the community spouse.

Authorization for Examination and Claim for Payment, Form 470-0502

Purpose	Form 470-0502 is used to authorize an examination to determine if a person qualifies as an incapacitated stepparent for FIP or FMAP-related Medicaid. The form is also a billing form for the examiner to present a claim for payment.
Source	Complete form 470-0502 using the template in: ▪ SharePoint under Employee Manual/Forms. ▪ The Worker Information System Exchange (WISE).
Completion	The IM worker completes the top section of the form when the Department must determine if a person who does not receive Medicaid is incapacitated, disabled, or blind. The service area manager or designee signs as “county director.” The examiner completes and signs the claim section after the examination has been completed. Staff in Central Office complete the accounting section.
Distribution	Forward the form to the examiner, along with the form for the report of examination. The examiner shall return the form to the requesting DHS office. Make a copy to file in the client’s case record. Submit the original and a copy to the Bureau of Financial, Health and Work Supports, attached to the other forms that are required for determining eligibility. If the form is used to determine incapacity of a FIP stepparent, write “FIP” across the top. The Bureau reviews the claim, completes the accounting section to identify the funding source, and forwards the form to the Bureau of Purchasing, Payments, Receipts and Payroll for processing. One copy of the form is returned to the examiner with the payment.
Data	Indicate the DHS office name and address, the name and address of the person to be examined and the case number (when already assigned), the date of completion, the examiner’s name and address, and the type of determination involved.

Authorization for Release of Information, Form 470-0461 or 470-0461(S)

Purpose	Form 470-0461 is designed to secure the client's permission for the Department to investigate items of eligibility or to obtain information needed for providing services. The source of information may also use the form to furnish the requested information.
Source	Complete the English or Spanish version using the form in the Worker Information System Exchange (WISE).
Completion	Workers may complete this form when it is necessary to obtain information from a source other than the client. Complete a separate form for each source of required information. The worker completes the identifying information and the description of the information requested. The second page automatically populates with questions based on radio button selected on the preface page. The client (or the person authorized to obtain the information) signs that section to give the authorization. The source of information completes the remainder of the form. Additional pages may be used if necessary.
Distribution	Send one copy to the source of information. You may upload the request to the electronic case file. When the original is returned, it will be scanned and uploaded.
Data	Changes may be made to the following automatically-populated entries: ▪ Date ▪ Information due date ▪ The name and address of the source of information ▪ Your county ▪ Your worker number ▪ Your name ▪ Your phone number ▪ Your email address

In the “Information Requested” section, enter the information the source will need to respond to the request. Be as specific as possible. Include the client’s name, as well as the client’s address or social security number, if they are needed to identify the requested information.

The date the authorization expires automatically populates. The expiration date shall be 60 days from the date the form is signed, unless you have supervisory approval to extend the date.

The client shall sign and date the form after these items have been completed.

The source of information completes the remainder of the form.

Authorization to Disclose Information to the Iowa Department of Human Services, Form 470-4459 or 470-4459(S)

Purpose

Form 470-4459 or 470-4459(S) is a two-way release form used to get the permission of the Medicaid applicant or the applicant's legally authorized representative to share health information needed to determine disability with the Disability Determination Services Bureau (DDSB).

Source

Complete the English version of the form using the template in:

- SharePoint under Employee Manual/Forms.
- The Worker Information System Exchange (WISE).

Print the Spanish version from:

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

Completion

This form should be used only in conjunction with a referral to the DDSB for a disability determination. You may either:

- Send one original form to the applicant for completion and signature, and then make a photocopy of the original for each source and complete the name and address of the source of information in the "Additional information" box before sending the forms to DDSB; or
- Send the applicants one original 470-4459 for each source of information. The name and address of the source of information must be completed in the "Additional information" box before the form is sent to the DDSB.

You may complete the identifying information. The applicant or the applicant's personal representative signs the section to give the authorization. Obtain the signature of two witnesses for an applicant who cannot sign the form due to a physical or mental disability.

Discuss the authorization and the explanation on page 3 regarding the use of this form and answer any questions raised by the applicant. Explain the consequences of failure to sign the form.

Explain that the applicant has the right to revoke the authorization at any time. (See 1-C-Appendix.)

Distribution

Give the applicant a copy. Give a photocopy to the legal representative, if any. Forward the forms to DDSB with the *Disability Transmittal*, form 470-2472, and form 470-2465, *Disability Report for Adults*.

Once a disability determination has been completed, DDSB returns the authorizations to the requesting office to be filed in the case record.

If there is any appeal filed with DHS due to the denial of disability, send copies of all disability forms, including the *Authorization to Disclose Information to the Department of Human Services*, to the DHS Appeals Section, the applicant, and the applicant's representative, if any.

Data

To initiate the forms complete the:

- Applicant's name,
- Social security number,
- Date of birth, and
- Parent's or guardian's name if applicable.

Ask the applicant or the applicant's representative to sign and date the forms. Check the box indicating the relationship to the applicant of the person who signs the form.

NOTE: Only the applicant or the applicant's legally authorized representative can give consent to release or obtain mental health and AIDS/HIV related information. Only the applicant can give consent to release or obtain substance abuse information.

"Mental health information" means oral, written, or recorded information that indicates the identity of an individual receiving professional services and which relates to the diagnosis, course, or treatment of the individual's mental or emotional condition.

"Substance abuse" means the use of chemical substance by persons suffering from chemical dependency, persons who are incapacitated by a chemical substance, substance abusers, or chronic substance abusers.

"AIDS" means a medical diagnosis of acquired immunodeficiency syndrome, based on the Center for Disease Control's "Revision of the CDC Surveillance Case Definition for Acquired Immunodeficiency Syndrome."

"HIV" means a medical diagnosis of human immunodeficiency virus infection based on a positive HIV-related test.

Authorization to Obtain or Release Health Care Information, Form 470-3951 or 470-3951(S)

Purpose	Form 470-3951 or 470-3951(S) is a two-way release form used to get the permission of the client or the client's legally authorized representative to share health information.
Source	The English version of the form is printed with 25 three-part precarboned sets on a pad. Order supplies from Iowa Prison Industries at Anamosa. DHS staff may complete the English version of the form using the template in: ▪ SharePoint under Employee Manual/Forms. ▪ The Worker Information System Exchange (WISE). Print the Spanish version of the form from: ▪ The online manual. ▪ SharePoint under Employee Manual/Forms. ▪ The Worker Information System Exchange (WISE).
Completion	Complete a separate form for each source. The worker may complete the identifying information and the description of the information being obtained. The client or the client's personal representative signs the section to give the authorization. Obtain the signature of two witnesses for clients who are incapable of signing their name due to a physical or mental disability.
Distribution	Give the client a copy upon signature of the form. Give a photocopy to the legal representative, if any.
Data	To initiate the form: ▪ Enter the client's name, state or patient identification number, social security number, date of birth, and parent's or guardian's name, if applicable. ▪ In the first set of agency information, enter the name and address of the provider from which information will be requested. Enter the telephone number and fax number if known.

- Enter information for DHS in the second set of agency information, as DDS will be sending the form to the provider. Use your office address and telephone number.

In the INFORMATION RELEASED OR SHARED MAY INCLUDE section, check the boxes as follows:

- For **hospitals**, mark: admission status, psychological reports, discharge summary, social history, lab results, treatment and aftercare plans, diagnosis/allergies, X-ray/imaging reports, medication history, history and physical exam, initial assessment, evaluation and recommendations, and receiving phone calls.
- For physical **doctors**, mark: lab results, treatment and aftercare plan, diagnosis/allergies, X-ray/imaging reports, medication history, history and physical exam, initial assessment, immunization record, evaluation and recommendations, receiving phone calls, and consultation reports.
- For **psychiatrists, psychologists, mental health centers,** etc., mark: admission status, psychological reports, discharge summary, social history, lab results, treatment and aftercare plans, diagnosis/allergies, team notes, medication history, initial assessment, evaluation and recommendations, receiving phone calls, and consultation reports.
- For **schools, AEAs, child care centers,** etc., mark: psychological reports, social history, treatment and aftercare plans, team notes, diagnosis/allergies, medication history, initial assessments, immunization record, school records, court documents, evaluation and recommendations, receiving phone calls, consultation reports, and other (note IEPs and teacher questionnaires).

NOTE: When in doubt, mark all boxes that you believe may apply. If the client indicates that a specific test or study was done, mark the “Other” box and list the specific study, test, or procedure performed.

State the purpose for which the information will be used.

In the SPECIFIC AUTHORIZATION FOR RELEASE section, secure the client’s or the client’s legal representative’s initials if mental health, AIDS/HIV-related, or substance abuse is to be obtained or released.

NOTE: Only the client or the client’s **legally authorized** representative can give consent to release or obtain mental health and AIDS/HIV-related information. **Only the client** can give consent to release or obtain substance abuse information.

"Mental health information" means oral, written, or recorded information that indicates the identity of an individual receiving professional services and which relates to the diagnosis, course, or treatment of the individual's mental or emotional condition.

"Substance abuse" means the use of chemical substances by persons suffering from chemical dependency, persons who are incapacitated by a chemical substance, substance abusers, or chronic substance abusers.

"AIDS" means a medical diagnosis of acquired immunodeficiency syndrome, based on the Center for Disease Control's "Revision of the CDC Surveillance Case Definition for Acquired Immunodeficiency Syndrome." "HIV" means a medical diagnosis of human immunodeficiency virus infection based on a positive HIV-related test.

Discuss the authorization and explanation paragraph regarding the use of this form and answer any questions raised. Explain the consequences of failure to sign the form. Ensure that the client understands the right to revoke the authorization at any time. (See 1-C-Appendix.)

Facility workers enter the name of the facility's privacy official and the privacy official's telephone number. IM workers enter "Privacy Officer" under NAME and "1-800-803-6591" under TELEPHONE NUMBER.

Ask the client or the client's representative to sign and date the form.

Enter an expiration date that is 12 months from the date the client signs the form.

Check the box indicating the relationship of the person who signs the form to the client.

To use this form as the required documentation for the disclosure of mental health information, enter on the back of the form kept in the case record:

- The date.
- The name of recipient of information.
- The information disclosed.
- The name of the person who disclosed the information.

Bank or Credit Union Information, Form 470-1631 or 470-1631(S)

Purpose	Form 470-1631 is designed to secure the client's permission for the Department to investigate information that can be provided by a bank or credit union. The bank or credit union also uses the form to furnish the requested information.
Source	Complete the English or Spanish version using the form in the Worker Information System Exchange (WISE).
Completion	Complete this form when it is necessary to verify interest income or resources. The client (or the person authorized to obtain the information) shall sign and date and enter their address on the form. The bank or credit union completes the remainder of the form.
Distribution	Send one copy to the bank or credit union with a cover letter and a return envelope. Give a copy to the client. You may upload the request to the electronic case file. When the original is returned, it will be scanned and uploaded.
Data	Complete the data items as follows: ▪ **Date**: Enter the date the form is sent. ▪ **Case #**: Enter client's ABC case number. ▪ **Worker #**: Enter your worker number. ▪ **Due date**: Enter the requested due date. ▪ **Signature**: The client signs and dates the form and enters the address. ▪ **Re**: Enter the names of the persons whose income or resources are being verified. ▪ **Checking and savings accounts for the time period of**: Enter the period of time for which the information is being requested. ▪ **Balance in account as of**: Enter the date for which information regarding the balance in the account is being requested.

- **Time certificates, for the time period of**: Enter the date for which information regarding time certificates and certificates of deposits is being requested.
- **Questions**: Enter the telephone number of the worker the bank or credit union representative should contact with questions.

The bank or credit union completes the remainder of the form.

Billing Statement, Form 470-0130

Purpose	The *Billing Statement* is sent to debtors who have received a demand letter requesting repayment of a debt. It notifies debtors of payments due and account balances. It also shows account activity including all payments or adjustments applied to an account.
Source	Form 470-0130 is generated by the Web-based Overpayment Recovery (WOPR) System.
Completion	This form is generated: ▪ Monthly to debtors with a cash agreement, reflecting all payments received during the month. ▪ Quarterly to debtors on grant or benefit reduction. ▪ Periodically to debtors who have not completed a repayment agreement. The statements are printed on the last working day of each month.
Distribution	The form is mailed to the debtor.
Data	Debtors making cash payments detach the top of the statement and return it with the payment to the Department of Human Services, Cashier's Office, 1305 E. Walnut Street, Des Moines, Iowa 50319-0114.

Cancellation of Premium Payment, Form 470-2846

Purpose	Form 470-2846 is used to provide adequate and timely notice to the HIPP recipient that the Department will no longer pay the recipient's health insurance premium.
Source	Form 470-2846 is system-generated by the HIPP Unit.
Completion	The HIPP worker generates this form through entries on the Cancellation Notice Request Screen whenever premium payments are being terminated. Send the form at least ten days before the date that premium payments will cease.
Distribution	Separate copies are printed for: ▪ The policyholder ▪ The HIPP file
Data	The form: ▪ Specifies the reason the request for payment is denied. ▪ Provides space for additional comments regarding the denial.

Case Activity Report, Form 470-0042

Purpose	Form 470-0042, *Case Activity Report*, provides a mechanism for nursing facilities, ICFs/ID, mental health institutes, PMICs, and residential care facilities to report individual resident activities occurring at the facility level that may affect eligibility.
Source	The form is available on the Iowa Medicaid Enterprise (IME) website at: http://dhs.iowa.gov/ime/providers/forms
Completion	Facility staff must complete the form when: ▪ A resident applies for Medicaid. ▪ A Medicaid member enters the facility. ▪ Medicare coverage for a Medicaid member residing in the facility starts or stops and the Medicaid rate is higher than the Medicare rate. ▪ A Medicaid member dies or is discharged. When a Medicaid applicant or member enters the facility, the facility completes Sections 1, 2, and 3 and, if applicable, Section 4. When a Medicaid applicant or member dies or is discharged, the facility completes Sections 1, 2, and 5.
Distribution	Facilities must submit the form to the appropriate Department office within two business days of the action. Nursing facilities (NF), hospice, community ICFs/ID, skilled nursing facilities (SNF), and swingbeds shall mail, email or fax the form to the address below and keep a copy. Centralized Facility Eligibility Unit Imaging Center 1 Iowa Department of Human Services 417 E. Kanesville Blvd. Council Bluffs, IA 51503-4470 Fax: 515-564-4040 Email: facilities@dhs.state.ia.us

Residential care facilities (RCFs), mental health institutes (MHIs), and state resource centers shall mail or fax a copy to the local DHS income maintenance worker and keep a copy.

Psychiatric medical institutions for children (PMICs) shall mail, email or fax the form to the address below and keep a copy.

Centralized Facility Eligibility Unit – PMIC
Imaging Center 1
Iowa Department of Human Services
417 E. Kanesville Blvd.
Council Bluffs, IA 51503-4470

Fax: 515-564-4040
Email: CSAPMIC@dhs.state.ia.us

Program for All-Inclusive Care for the Elderly (PACE) shall email or fax the form to the appropriate Imaging Center with an attention to your DHS IM worker. Keep a copy.

Western Service Area
Fax: 515-564-4014
Email: Imagingcenter1@dhs.state.ia.us

Northern Service Area
Fax: 515-564-4015
Email: Imagingcenter2@dhs.state.ia.us

Cedar Rapids Service Area
Fax: 515-564-4017
Email: Imagingcenter4@dhs.state.ia.us

Des Moines Service Area
Fax: 515-564-4018
Email: Imagingcenter5@dhs.state.ia.us

Data

Section 1. Member Data: Section 1 contains resident-specific information. The resident's name should be used as it appears on the *Medical Assistance Eligibility Card*. "Date Entered Facility" is the date the resident entered the facility for the first time or was readmitted to the facility following a discharge.

Section 2. Facility Data: Section 2 contains information on the facility involved and the person filling out the form. The provider number or national provider identifier must correspond with the level of care indicated in Section 3. The “DHS Per Diem” is the facility’s computed rate. The “Date Completed” is the date the form is completed and submitted.

Section 3. Level of Care: Section 3 lists the process used to determine level of care (IME Medical Services Unit, Medicare, managed care contractor, out-of-state skilled preapproval or utilization board) and the effective date of determination.

Section 4. Medicare Information for Skilled Patients in Facilities: Section 4 reflects Medicare coverage that may apply to skilled care or hospice. Complete this section when there is Medicare coverage but the Medicaid rate is higher than the Medicare rate.

Section 5. Discharge Data: Complete Section 5 when a resident leaves the facility or dies. The information under “Last Month in Facility” is used to recalculate client participation if the client transfers to another facility or living arrangement (not home). Remember that Medicaid does not pay for the date of discharge.

Certificate of Enrollment, Form 470-4444

Purpose	The *Certificate of Enrollment*, form 470-4444, is used to inform providers that a child has been approved for Child Care Assistance. This form informs the provider of the hours of care, units of service, and co-pay fee that each child in care is approved for.
Source	Form 470-4444 is generated by the KinderTrack system.
Completion	The KinderTrack system generates and completes this form for all Child Care Assistance approvals when the child has been assigned to a provider.
Distribution	This form is mailed to the provider that is assigned to the child. The form is also saved electronically in the KinderTrack system.
Data	The system completes all information on this form.

Certification of Eligibility of SSI Applicant, Form 470-0363

Purpose

Form 470-0363 is used to verify a person's SSI eligibility or SSI application status.

Source

DHS staff may complete 470-0363 using the form in the Worker Information System Exchange (WISE).

The form may also be printed from:

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

Department offices located in the same county as a Social Security Administration office shall supply copies of this form to the Social Security office upon request.

Completion

Either the Department or the Social Security Administration may initiate the form, depending on which agency receives a complaint.

The Department office prepares two copies of the form when the Department has not received an SDX indicating a client has been approved for SSI but the client claims:

- To have been approved for SSI for more than 60 days, or
- To have applied for SSI more than 60 days ago.

The Social Security office initiates the form when:

- It receives a complaint that a client who has been approved for SSI for more than 60 days has not been approved for Medicaid.
- A case is placed in forced pay, one-time pay, or limited period of eligibility status.

NOTE: In all situations involving forced pay, one-time pay, or a possible limited period of eligibility, the Department office should:

- Maintain a control on the case;
- Contact the Social Security office if no SDX information has been received on the case after six months;
- Cancel medical assistance if the Social Security office then indicates that the case has since been placed in a non-payment status.

Distribution	When the Department office initiates the form, forward the original to the Social Security office. You may upload the request to the electronic case file. When the original is returned, it will be scanned and uploaded If the form is initiated by the Social Security office, the original is forwarded to the Department office.
Data	When the form is initiated by a Department office, complete Section A (Identification) to the best of the information you have available. (When the form is initiated by the Social Security office, that agency completes all sections.)

Change in Health Insurance, Form 470-3792

Purpose	Form 470-3792, *Change in Health Insurance*, is a cover letter used to collect information for the SNAP and Medicaid programs.
Source	Complete 470-3792 using the form in the Worker Information System Exchange (WISE).
Completion	Complete this form when it is reported that someone in the household has gone to work. This form is used to request information and verification regarding the new income and forward the *Employer's Statement of Earnings* form.
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	The form populates address and worker information areas of the form and calculates a due date for the return of the requested information.

Change in Medical Deduction for SNAP, Form 470-4487 or 470-4487(S)

Purpose

Form 470-4487, *Change in Medical Deduction for SNAP*, is used in conjunction with a "warnings, informational, fatal, and summary" (WIFS) message when buy-in occurs for a SNAP household receiving the standard medical deduction.

Since the state is now paying the Medicare premium, the worker uses this form to determine if the person has other medical expenses that would qualify the household for the standard medical deduction.

Source

Complete the English or Spanish version of the form using the template in:

- SharePoint under Employee Manual/Forms.
- The Worker Information System Exchange (WISE).

Completion

An informational WIFS message will be sent to the worker associated with a SNAP case when:

- Buy-in of the Medicare premium occurs for any person active on the case, and
- The case is coded on BCW1 for the standard medical deduction for SNAP.

When you receive the WIFS message:

- Examine the case record to see if the household has any other verified medical expenses that qualify it for the SNAP standard medical deduction.
- If not, remove the coding for the standard deduction from the BCW1 screen and send this form.

Distribution

Send one copy to the household and document that the form was issued.

Data

The worker completes the date, address, case number, client name, and worker phone number and name. No due date is necessary, as this form is informational to the household and the household needs respond only if it has additional expenses to report.

Child Care Assistance Application, Form 470-3624 or 470-3624(S)

Purpose	The *Child Care Assistance Application*, form 470-3624 or 470-3624(S), collects information about people needing child care that is required to determine eligibility for Child Care Assistance.
Source	Central Office has a contract to provide automatic shipments of form 470-3624 to local offices. The shipments are intended to cover a six-month supply. Additional supplies of form 470-3624 are also available through Central Office. Print the Spanish version of the form from: ▪ The online manual. ▪ SharePoint under Employee Manual/Forms, Families may also fill out the application electronically through the Child Care Public Web Portal.
Completion	The applicant or someone representing the applicant prepares the form when the parent or guardian requests Child Care Assistance.
Distribution	The applicant mails the form to the Centralized Child Care Assistance Unit, Polk County River Place, 2309 Euclid Avenue, Des Moines, IA 50310. If an applicant submits this form to a local DHS office, it must be forwarded to the Centralized Child Care Assistance Unit.
Data	Questions on the first page gather information about the family, the children needing care, and the care provider the family has chosen. Questions on the second page ask about the family's need for service. The third page asks about monthly income. The fourth page asks about the provider the family is using for care. The back of the application states appeal rights. The applicant enters the following information: ▪ **Family Information**: (If two parents or guardians are in the home, the same information is needed for both.) • Name of the parent or guardian of the children needing care.

- The parent or guardian's date of birth.
- The parent or guardian's social security number. Leave blank if the person does not have a social security number.
- Phone number and address, including the street, city, and ZIP code.
- The name, relationship to the parent or guardian, date of birth, social security number, sex, name of school district, race, ethnicity, citizenship and alien status for all children needing care. Leave the social security number blank if the child does not have a number.
- A check to indicate whether a child has special needs. (If so, make sure that the parent or guardian submits a statement verifying a special needs diagnosis from a doctor or other medical professional.)
- The name and relationship to the parent or guardian of all other people in the home.

▪ **Need for Service**: (If two parents or guardians are in the home, the same information is needed for both.)

- A check indicating whether each parent or guardian is working.
- If so, the number of hours per day and per week the person works.
- Each person's work schedule, with starting and ending times for the shift of work.
- A check indicating whether the parent or guardian is a full-time student, and if so, the school name.
- A check indicating whether the parent or guardian is a graduate student. (If so, that person is not eligible to receive Child Care Assistance.)
- The school's name.
- Whether the person needs child care to look for work and when they will start searching.

The applicant must attach:

- The most recent pay stubs for each employed person, or
- A copy of the class schedule if the person is a student.

- **Monthly Family Income:**
  - The amount of gross wages, SSI, FIP benefits, social security, child support or alimony, and any other income. (If the children live with a guardian, only the child's income is needed.)
  - The name of the income maintenance worker if the client is receiving SNAP, FIP, or Medicaid.
- Provider Information:
  - The child care provider's name, phone number, street address, city, state, and ZIP code.
  - A check to indicate if the provider will watch the children in the parent or guardian's home.
  - Question asking whether the provider is a backup provider.

The parent or guardian must sign and date the application.

Child Care Assistance Billing/Attendance, Form 470-4534

Purpose	Form 470-4534 is used by a child care provider to bill the Department for child care services provided to a child eligible for Child Care Assistance (CCA).
Source	This form is generated by the KinderTrack system and mailed to the child care provider for each CCA-eligible child.
Completion	The KinderTrack system generates and completes the header information for each CCA-eligible child. This form prints and is mailed to the provider every four weeks. If the provider does not submit time and attendance on line through the Child Care Assistance Provider Portal, this form must be completed and returned to the Centralized Child Care Assistance Unit for processing. The provider is responsible for completing the remainder of the form, including having the parent sign it.
Distribution	This form is mailed to the child care provider from DHS central office. The provider must retain a signed copy of this form. This form also is saved electronically in KinderTrack.
Data	The KinderTrack system completes: ▪ **Provider**: The provider's name. ▪ **Child Name**: The name of the child the provider should bill for. ▪ **Case #**: The KinderTrack case number. ▪ **Billing Period**: The two-week billing period. ▪ **Parent Name**: The name of the child's parent. ▪ **Date**: Each day of the two-week billing period. The child care provider is responsible for: ▪ **In**: The time the child arrived at the provider's child care. ▪ **Out**: The time the child left the provider's care. ▪ **Absent**: Mark if a child was absent from the child care on a day that the child is normally scheduled to attend.

- **Parent Signature**: The parent of the child must sign the form to certify the hours of care being billed to the Department for this child are correct.
- **Provider Signature**: The provider of the child must sign the form to certify the hours of care being billed to the Department for this child are correct.

Child Care Assistance Billing/Attendance Provider Record, Form 470-4535

Purpose	Form 470-4535 serves as verification that an electronic bill has been submitted to the Department for child care services provided to a child eligible for Child Care Assistance (CCA).
Source	This form is generated by the KinderTrack system and is printed by the child care provider.
Completion	KinderTrack generates and completes all information for each CCA-eligible child. A provider that bills electronically is required to print this form after electronically submitting a bill for service and have the parent sign it.
Distribution	The provider must retain this form for ten years as verification that the electronic billing was correct and complete.
Data	The KinderTrack system completes all information on this form based on what the provider's electronic billing for: ▪ **Provider Name**: The provider's name. ▪ **Provider Address**: The provider's address. ▪ **Parent**: The name of the child's parent. ▪ **Child**: The name of the eligible child. ▪ **Case #**: The KT case number. ▪ **Billing Period**: The two-week billing period. ▪ **Date**: Each day of the two-week billing period. ▪ **Time In**: The time the child arrived at the provider's child care. ▪ **Time Out**: The time the child left the provider's care. ▪ **Absent**: Marked if the child was absent from the child care on a day that the child is normally scheduled to attend. ▪ **Parent's Signature**: The parent of the child must sign the form to certify the hours of care being billed to the Department for this child are correct. ▪ **Provider's Signature**: The provider of the child must sign the form to certify the hours of care being billed to the Department for this child care correct.

Child Care Assistance Change Form, Form 470-5004

Purpose	The *Child Care Assistance Change Form*, form 470-5004, provides a simple means for the client to report a change and submit explanatory information.
Source	This form is available to families on line from the DHS web page. It is also available from the county DHS offices as a paper form.
Completion	Clients may complete the form and mail or fax it to the Centralized Child Care Unit located in Des Moines at the River Place office address listed on the form.
Distribution	Issue the form: ▪ When a client contacts a county office other than the Polk County office at River Place to report a change. ▪ When the client requests a form. Document the resulting action in the case record.

Child Care Assistance Provider Agreement, Form 470-3871 or 470-3871(S)

Purpose

The *Child Care Assistance Provider Agreement* sets the terms for payment of a child care provider by the Department of Human Services.

Source

The English version of the form is generated from KinderTrack. It is also printed with 50 sets on a pad. Order supplies from Iowa Prison Industries at Anamosa.

Print the Spanish version of the form from:

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

Completion

A provider selected by a Child Care Assistance client initially completes pages 1 and 2 of the form and signs and dates it to indicate understanding and agreement to all of the terms and conditions stated on the form. The provider returns pages 1 through 4 of the form to the Centralized Child Care Assistance Unit and keeps the other pages for their records.

The Child Care Assistance worker:

- Reviews the agreement.
- Determines if the provider meets all of the requirements.
- Completes the third page with:
  - The provider type.
  - The provider number.
  - The provider's approved rates.
  - The effective date of the *Agreement*.
  - The termination date.

The *Agreement* must be renewed at least every two years, or when the provider reports changes.

Distribution

When the *Agreement* is approved and all signatures are secured, the Child Care Assistance Unit sends one copy of the *Agreement* back to the child care provider and keeps one copy.

Data

The first and second pages of the form gather provider information. The third through seventh pages set forth the terms and conditions to which both parties agree, as indicated by the signatures of the provider and Child Care Assistance worker.

On the first page, the provider chooses either Box A or Box B and:

- Enters the following identifying data:
  - Type of business
  - Social security number or employer identification number
  - Provider name
  - Address
  - Phone number

On the second page, the provider:

- Enters all of the rates the provider charges for basic and special needs care for each age group. Providers may enter half-day, full-day, hourly, or weekly rates. (If the provider does not enter half-day rates, the Child Care Assistance worker must calculate the half-day rate.)
- Signs the form to indicate the provider agrees to the terms and conditions set forth on pages 4 through 7.

On the third page, the Child Care Assistance worker:

- Enters the provider type and the provider number.
- Fills out the table with the approved half-day rates for the provider.
- Enters the effective date as follows:
  - Nonregistered: Based on the client's application or eligibility date.
  - Registered: The first date of the child care service or the registration effective date, whichever is later.
  - Licensed or exempt: The first date of the child care service or the license effective date, whichever is later.
- Enters the termination date, which can be no later than 24 months from the effective date.
- Signs the agreement.
- Sends a copy of the signed agreement to the provider.

Child Care Assistance Review, Form 470-4377(M) or 470-4377(S)

Purpose

The *Child Care Assistance Review*, form 470-4377(M) or 470-4377(S), collects information about people needing child care that is required to review eligibility for Child Care Assistance.

Source

A review form is generated from the KinderTrack system when a family is approved with a review date that is at least 40 days in the future.

If the system does not automatically generate the form:

- Print the form from the Family Summary page in the KinderTrack system.
- Complete the English or Spanish version of the form using the template in:
  - SharePoint under Employee Manual/Forms.
  - The Worker Information System Exchange (WISE).
- Print the English or Spanish version of the form from:
  - The online manual.
  - SharePoint under Employee Manual/Forms.
  - The Worker Information System Exchange (WISE).

Completion

The family or someone representing the family completes the form every six months when the eligibility review is due. The parent or guardian must sign and date the review form.

Distribution

The family mails the form, along with pay stubs and a school schedule if applicable, to the Centralized Child Care Assistance Unit, Polk County River Place, 2309 Euclid Avenue, Des Moines, IA 50310.

If a family submits this form to a local DHS office, it must be forwarded to the Centralized Child Care Assistance Unit.

Keep the completed form in the child care case file.

Data

The first two pages of the review form collect information about the family, the family's need for service, and family income. The third page collects information about the family's child care provider. The fourth page gives appeal rights.

The family enters the following information:

- **Family Information**: For each person who lives in the home:
  - A check to indicate whether the person needs care.
  - A check to indicate whether the person has special needs.
  - The person's name.
  - The person's relationship to the parent or guardian.
  - The person's sex.
  - The person's date of birth.
  - The person's social security number. (This field can be blank if the child does not have a number.)
  - "Yes" or "no" whether the person is a citizen.
  - Status, if the person is an alien.
  - Name of the school district the child attends.
- Child Care Needs:
  - For each person working, the person's name, the number of hours worked per week, the employer's name, and the work schedule, with starting and ending times for the shift of work.
  - For each person in school, checks indicating student status and a field to enter the school name.
  - For each person looking for work, questions about their job search plans.
- **Income**: The amount of gross wages, SSI, social security, child support, alimony, and any other income. (If the children live with a guardian, only the child's income is needed.)
- **Provider Information**: The child care provider's name, phone number, and address.

Child Care Claim Cover Letter, Form 470-4469 or 470-4469(S)

Purpose	The *Child Care Claim Cover Letter*, form 470-4469 and 470-4469(S), is used to tell a provider why a Child Care Assistance claim is being returned. The cover letter tells the provider whether the claim could be processed and if not, what needs to be done to correct the errors.
Source	Complete the English or Spanish version of the form using the template in: ▪ SharePoint under Employee Manual/Forms. ▪ The Worker Information System Exchange (WISE).
Completion	When the worker identifies that a claim is incorrect in an area that **can** be corrected: ▪ Make the corrections, copy the claim form, ▪ Highlight the corrected errors, and ▪ Send this cover letter and the corrected copy of the claim back to the provider for information. When the worker identifies that the claim is incorrect in an area that **cannot** be corrected: ▪ Specify on the cover letter the reasons the claim cannot be processed, and ▪ Send this cover letter along with a copy of the incorrect claim and a blank claim form back to the provider for corrections.
Distribution	Send one copy of this form along with a copy of the incorrect claim form to the provider along with a blank claim form, and file one copy of this form and the original claim in the DHS case record.
Data	The form includes instructions for the provider about the need to complete a new claim form (when necessary) and identifies any information that needs to be corrected.

Child Support Information Request, Form 470-3782

Purpose	Form 470-3782, *Child Support Information Request*, is a cover letter used to collect information for the Family Investment Program and the Medicaid program. This form is used with forms 470-3773, *Absent Parent Information*, and 470-0169, *Requirements of Support Enforcement*.
Source	Complete 470-3782 using the form in the Worker Information System Exchange (WISE).
Completion	Complete when a household reports that a parent is leaving or has left the home.
Distribution	Give one copy to the client and place a copy in the case record.
Data	Certain areas of the form populate and a due date is calculated for return of the completed form.

Claimant's Supplemental Statement, Form 470-0006

Purpose	Form 470-0006, *Claimant's Supplemental Statement*, is used to supply the Department of Inspections and Appeals (DIA), Investigations Division, with information to determine the appropriateness of request to replace a warrant stolen from a client's mailbox.
Source	Complete form 470-0006 using the template in: ▪ SharePoint under Employee Manual/Forms. ▪ The Worker Information System Exchange (WISE).
Completion	The payee completes this form at the same time as form 470-0004, *Affidavit as to Forged Endorsement*. The affidavit must be made and signed before an officer authorized to administer oaths generally, and the officer must certify that the officer administered the oath. If there is more than one payee, each person must complete a form.
Distribution	Keep the original *Supplemental Statement* in the client's case file. Forward one copy to DIA Investigations Division, 3rd Fl, 321 E 12th St., Des Moines, Iowa 50319-0083. EXCEPTION: If a viable, readable copy cannot be obtained, send the original to DIA. If DIA cannot read or discern the payee's signature well enough to make an informed decision as to whether or not to replace the warrant, there will be a delay while the original is requested.
Data	This form must be completed in front of a DHS employee, using the **exact wording and abbreviations as on the endorsement**. This includes the warrant address, not the client's current address (if different). If a question is not applicable, the payee completes the line with "N/A."

Compliance with Third Party Liability (TPL), Form 470-5286

Purpose	The Iowa Medicaid Enterprise (IME) and the Managed Care Organizations (MCOs) use the *Compliance with Third Party Liability (TPL)* to notify IM staff of the date a member cooperated with TPL.
Source	The IM worker views the form from the link that displays within the alert message in WISE.
Completion	IME or one of the MCOs sends a record to the repository (IEVS), which generates a compliance alert record to the field. The compliance alert record is sent to IM staff to lift the member's TPL sanction.
Distribution	The repository (IEVS) sends the compliance alert to WISE. Only after the alert is worked by the IM worker is the alert indexed to the Electronic Case File (ECF).
Data	The repository (IEVS) populates the following: ▪ **Cooperation Date**: The date the member cooperated. ▪ **Member Name**: The member's name. ▪ **Case Number**: The member's case number. ▪ **CIN or SID Number**: The member's state identification number.

Daily Tip Record, Form 470-3777

Purpose	Form 470-3777, *Daily Tip Record*, is used to collect information for the Family Investment Program, SNAP program, and Medicaid program when it is reported that someone in the household receives tip income.
Source	Complete 470-3777 using the form in the Worker Information System Exchange (WISE).
Completion	This form is for the household to use when it is reported that someone in the household has income from tips.
Distribution	Give one copy to the client and place a copy in the case record. The client completes the form and returns it to the assigned imaging center.
Data	The template populates case and worker information areas of the form. The client completes the employer information and the dates and amounts of tips received.

Debt Setoff Credit, Form 470-1667

Purpose	Form 470-1667 informs a debtor of the amount that has been credited to the debtor's overpayment account from the setoff of the debtor's state tax refund. The form also serves as a receipt.
Source	Form 470-1667 is system-generated monthly in the Division of Information Technology (DoIT).
Completion	Once each month, the Department of Administrative Services certifies to the Department of Human Services all money taken the previous month. This money is then credited to the debtor's account.
Distribution	One copy is mailed to the debtor. The DIA investigator keeps a copy in the Public Assistance Debt Recovery Unit file.
Data	The Department of Administrative Services assesses a $5 charge for record keeping. The charge is passed on to the debtor.

Denial of Health Insurance Premium Payment, Form 470-2847

Purpose	Form 470-2847 is used to provide the recipient adequate notice of the Department's decision to deny payment of the health insurance premium.
Source	Form 470-2847 is system-generated by the HIPP Unit.
Completion	The HIPP worker responsible for the eligibility determination generates the form through entries on the Denial Notice Request Screen after the decision to deny a request for premium payment is made.
Distribution	Separate copies are printed for: ▪ The policyholder ▪ The HIPP file
Data	The form: ▪ Specifies the reason the request for payment is denied. ▪ Provides space for additional comments regarding the denial.

Description of Efforts to Sell Property, Form 470-2908

Purpose

Form 470-2908, *Description of Efforts to Sell Property*, is used by conditionally eligible State Supplementary Assistance recipients to document their efforts to sell the property that they agreed to sell while being granted conditional benefits.

Source

Print form 470-2908 from:

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

Completion

Issue the form as follows:

- For personal property, issue the form every 30 days during the conditional period.
- For real property, issue the form 35 days after the agreement is signed and every 60 days after that during the conditional period.
- After the conditional period, issue the form every three months if the person continues to attempt to sell real property.

The client or designee completes all the pertinent sections and signs and dates the form. Other people that signed the agreement shall also sign the form, unless their relationship to the client has changed. If a different person now has that relationship, that person shall sign the form.

Distribution

Keep the yellow copy in the client's case record and mail the white copy to the client.

When the client returns the form:

- File the completed white copy of the form in the case record.
- Destroy the yellow copy.

Data

Before mailing the form, fill in the date, your name, the due date for the form's return (ten days from the issue date), and the client's name and address.

The form lists possible efforts the client has made to sell the property and gives space for explanations.

Designation of Personal Representative, Form 470-3948

Purpose	Clients may use form 470-3948 to designate a personal representative. A "personal representative" is someone designated by another as standing in the other's place or representing the other's interest for one or more purposes.
Source	Complete form 470-3948 using the template in: ▪ SharePoint under Employee Manual/Forms. ▪ The Worker Information System Exchange (WISE).
Completion	The client wanting to use this form to designate a personal representative completes the form and gives or sends it to: ▪ The income maintenance worker, ▪ The Department's Security and Privacy Office, or ▪ A facility privacy official. NOTE: Use of this form is not mandatory. A client may write a letter designating a personal representative. If you know the client, the client may also verbally inform you of the client's choice of personal representative and you can document the client's choice in the case file.
Distribution	Give a copy of the form to anyone requesting it. File the form in the case record.
Data	The client completes the needed information and signs the form. You will not need to enter any information.

DHS Investigative Referral Follow-Up to DIA, Form 470-5129

Purpose

Form 470-5129 is designed to inform the Department of Inspections and Appeals (DIA):

- Of the action taken by the IM worker on an applicant, participant or member's case as the result of the findings of an investigation, and
- To calculate any associated cost avoidance amounts.

Cost avoidance amounts determined following a referral to DIA are distinctly different than public assistance debt amounts. Recoupment will also need to be completed when a worker determines that previously issued benefits need to be recovered. See the Web-based Overpayment Recovery (WOPR) system user guide for more information.

Source

Workers can complete 470-5129 using the form in the Worker Information System Exchange (WISE).

Completion

Complete this form in 30 days or less of acting on information received in the findings of an investigation completed by DIA.

If the findings report indicates further investigation is needed on an application or review/recertification referral, the worker must complete the form. Select the appropriate referral type. Answer "Yes" to the question, "Application or Review/ Recertification changed to Ongoing Investigation" before submitting the response to DIA.

NOTE: WISE will open and prepopulate some fields with client case and worker information from the last case number accessed in WISE before opening the form. Change any of the prepopulated fields as needed to reflect the correct client and worker information and case number.

Distribution

Click the "Submit to DIA/ECF" button to forward an electronic copy of the form to DIA. WISE will upload a copy of the form to the electronic case file using the IABC or ELIAS case number.

Child care assistance staff click on "View Submitted Form" in the 'submission was successful' popup to view and print a copy for the paper case file.

Data

Review and change the following fields as needed:

- Worker number/county number
- State ID/CIN
- Case name
- IABC case number
- ELIAS case number
- KT case number

Make entries in the following fields:

- The DIA case number that is found on the DIA Investigative Report.
- Select the appropriate referral type.
- Answer the yes or no questions.
- Select the appropriate case action – benefits/eligibility.

  NOTE: The following fields will auto-populate based upon the information entered into the Calculation Sheet.

  - Were benefits or eligibility increased or decreased? (Answer Yes or No.)
  - Total Amount of Cost Avoidance Increase/Decrease for all programs entered.
  - Total Amount of Cost Avoidance Increase/Decrease by individual program as follows:
    - Medical
    - SNAP
    - Family Investment Program (FIP)
    - Child Care Assistance (CCA) – Provider or family
- Comments: Enter any additional information that applies to the cost avoidance calculations or investigation referral.
- View and complete the Calculation Sheet by entering the cost avoidance amounts, if applicable, based on the DIA Investigative Report findings.

  When DIA findings result in an application or review/ recertification denial, the worker must complete the:

  - Cost avoidance using client-provided information to determine “projected” eligibility, and
  - Number of months that would have been used for the review/recertification period had the application or review been approved.

For medical denials, use the aid code selections, as applicable:

001 App/Rev Denial – Adult

002 App/Rev denial – Child

NOTE: The system calculates the total cost avoidance amounts based on the date entered by the worker. Data is entered by program as follows:

- **Medical**: Calculate cost avoidance amounts for each individual, as applicable.
  - Select either the medical aid code or the rate type to auto-populate the capitation fee.
  - Enter the total number of months remaining in the medical review period. Tab out of the field to auto-populate the total change in medical capitation fees.
- **SNAP**: Enter the:
  - Current month's benefit amount received by the household.
  - Updated payment amount as determined by the worker (SPAD).
  - Total number of months remaining in the certification period. Tab out of the field to auto-populate the total change in SNAP benefits.
- **FIP**: Enter the:
  - Current payment amount.
  - Current household size.
  - Earned income monthly amount.
  - Unearned income monthly amount.
  - Additional adjustments, if any. Tab out of the field to auto-populate the updated monthly payment.
  - Total number of months remaining in the FIP review period. Tab out of the field to auto-populate the total change in FIP benefits.
- **CCA Provider**: Enter the:
  - Current monthly payment amount.
  - Updated monthly payment.

- Total number of months remaining in the family's certification period. Tab out of the field to auto-populate the total change provider and total CCA amounts.

- **CCA Family**: Enter the:
  - Current monthly payment amount.
  - Updated monthly payment.
  - Total number of months remaining in the family's certification period. Tab out of the field to auto-populate the total change family and total CCA amounts.

Return to the form tab to review the total cost avoidance amounts before clicking the "Submit to DIA/ECF" button.

Example 1: Application

Household composition: Ms. A, aged 34
Ms. A's child, aged 10
Mr. A, aged 35 (absent parent)

SNAP and medical applications are received for Ms. A and her child. Ms. A has a monthly income of $500.

The worker has reason to believe that Mr. A is in the household and submits a referral to DIA. The investigative findings determine that Mr. A is in the household. Mr. A has monthly income of $2,750.

The worker processes the applications based on DIA findings:

SNAP: Denied, over income
Medical: Ms. A denied, over income
Ms. A's child is approved for Hawki

Complete the *Calculation Sheet* on form 470-5129 using the results from the processed applications and the benefits that would have been received if DIA had not been involved.

Make entries in the following fields:

SNAP: If applicable, use Scratch Pad (SPAD) located in WISE to determine the correct issuance amount.

NOTE: For SNAP and FIP, the application month may not be a full month of benefits. To determine the amount to enter in the current monthly payment field, use the full amount of benefits that would have been issued for the month following the month of application. Use this amount for the entire certification or eligibility period.

Current payment: $357

Certification months remaining: 6

Medical:

Aid code: Select 001 – App/Rev denial, adult
(No entry for child as the child is eligible.)

Eligibility certification months counted: 12

Example 2: Application

Household composition: Same household composition as Example 1: Application

SNAP and medical applications are received for Ms. A and her child. Ms. A has a monthly income of $500.

The worker has reason to believe that Mr. A is in the household and submits a referral to DIA. The applications are processed timely as DIA needs more than 30 days to complete their investigation. The household is approved:

SNAP: Eligible – $357

Medical: Ms. A and her child are eligible for FMAP

The investigative findings received after the approvals determine that Mr. A is in the household. Mr. A has monthly income of $2,750.

The worker processes the applications based on DIA findings:

SNAP: Denied, over income

Medical: Ms. A denied, over income
Ms. A's child remains eligible; no calculation needed

Complete the *Calculation Sheet* on form 470-5129 using the results from the initial application processing and the results based on the DIA findings.

Make entries in the following fields:

SNAP: If applicable, use Scratch Pad (SPAD) located in WISE to determine the correct issuance amount.

NOTE: For SNAP and FIP, the application month may not be a full month of benefits. To determine the amount to enter in the current monthly payment field, use the full amount of benefits that would have been issued for the month following the month of application. Use this amount for the entire certification or eligibility period.

Current payment: $357

Certification months remaining: 4

Medical: When medical coverage was received previously, review SSNI to find the aid code to enter on the Calculation Sheet of form 470-5129.

Aid code: 308 – FMAP
(No entry for the child as the child is eligible.)

Eligibility certification months counted: 10

Example 3: Review

Household composition: Same household composition as Example 1: Application

SNAP and medical reviews are received for Ms. A and her child. Ms. A has a monthly income of $500.

The worker has reason to believe that Mr. A is in the household and submits a referral to DIA. The investigative finds determine that Mr. A is in the household. Mr. A has a monthly income of $2,750.

The worker processes the reviews based on DIA findings:

SNAP: Denied, over income

Medical: Ms. A denied, over income
Ms. A's child is approved for Hawki

Complete the *Calculation Sheet* on form 470-5129 using the results from the processed reviews and the benefits that would have been received if DIA had not been involved.

SNAP: Approved $357
Medical: Ms. A and her child are approved

Make entries in the following fields:

SNAP: If applicable, use Scratch Pad (SPAD) located in WISE to determine the correct issuance amount.

Current payment: $357

Certification months remaining: 6

Medical:

Aid code: Select 001 – App/Rev denial, adult
(No entry for the child as the child is eligible.)

Eligibility certification months counted: 12

Example 4: Review

Household composition: Same household composition as Example 1: Application

SNAP and medical reviews are received for Ms. A and her child. Ms. A has a monthly income of $500.

The worker has reason to believe that Mr. A is in the household and submits a referral to DIA. The reviews are processed timely as DIA needs more than 30 days to complete their investigation. The household is approved:

SNAP: Eligible – $357

Medical: Ms. A and her child are eligible for FMAP

The investigative findings received after the approvals determine that Mr. A is in the household. Mr. A has a monthly income of $2,750.

The worker processes the reviews based on DIA findings:

SNAP: Denied, over income

Medical: Ms. A denied, over income
Ms. A's child remains eligible

Complete the *Calculation Sheet* on form 470-5129 using the results from the initial review processing and the results based on the DIA findings.

SNAP: Approved $357

Medical: Ms. A and Ms. A's child are approved

Make entries in the following fields:

SNAP: If applicable, use Scratch Pad (SPAD) located in WISE to determine the correct issuance amount.

Current payment: $357
Certification months remaining: 4

Medical:

Aid code: Select 001 – App/Rev denial, adult
(No entry for child as the child is eligible.)

Eligibility certification months counted: 10

Example 5: Change – SNAP

Household composition: Same household composition as Example 1: Application

Ms. A and her child are currently receiving SNAP benefits of $357 per month.

An anonymous caller reports that Mr. A lives in the home. Mr. A earns $2,500 per month. The worker submits a referral to DIA. The investigative findings determine that Mr. A is in the household and has verified monthly income of $2,500.

The worker processes the change based on DIA findings:

SNAP: Denied, over income

Complete the *Calculation Sheet* on form 470-5129 using the results from the processed change and the benefits that would have been received if DIA had not been involved.

SNAP: Approved – $357

Make entries in the following fields:

SNAP: If applicable, use Scratch Pad (SPAD) located in WISE to determine the correct issuance amount.

Current payment: $357

Certification months remaining: 3

Example 6: Change – CCA

Household composition: Mr. B, Ms. B, and their child, aged 1

The household was approved for Child Care Assistance (CCA). The need for service is full-time employment which averages 28 hours per week or more. The household is approved for 10 units per week (2 units per day). The certification period is July 1, 2016, through June 30, 2017.

Later it was discovered that the household failed to report that the household's employment hours fell below the required minimum beyond the 90 day temporary change or lapse in need period making the household ineligible for CCA. A referral to DIA was completed.

The DIA findings determined the family did not regain CCA eligibility after the 90 day temporary change or lapse in need period. The worker makes the adjustment entries in KinderTrack to cancel the household allowing for timely notice.

The worker process the change in KinderTrack based on DIA findings:

CCA: Canceled

Complete the *Calculation Sheet* on form 470-5129 using the results from the processed change and the benefits that would have been received if DIA had not been involved.

CCA: Canceled

Make entries in the following fields:

CCA – Family:

$	8.19	Provider rate per unit
x	10	Number of weekly units
x	4	Number of weeks in the month
$	327.60	Current monthly payment
$	.00	Updated monthly payment (leave blank)
5		Eligible remaining months

Example 7: DIA Non-Coop

Household composition: Ms. C, aged 34
Mr. C, aged 35
Their child, aged 10

The household is currently receiving the following monthly benefits:

FIP: $426

SNAP: $511 per month

Medical: All household members are eligible

An anonymous caller reports that Ms. C is working and has income. The worker submits a referral to DIA. DIA reports that the household failed to cooperate with them.

The worker completes the appropriate system entries to sanction medical, if applicable, and FIP for noncooperation. A *Request for Information* (RFI) is issued requesting income verification for Ms. C. NOTE: SNAP cannot be sanctioned for DIA noncooperation.

The worker processes the change based on DIA findings:

SNAP: Discontinued
Medical: Ms. C is discontinued
The child remains eligible

Complete the *Calculation Sheet* on form 470-5129 using the results from the ongoing case benefit amounts and the DIA noncooperation sanction.

FIP: Canceled

Medical: Canceled

SNAP: Dependent on client's response to RFI

Make entries in the following fields:

FIP:

Current monthly payment: $426

Current household size: 3

Additional adjustment +/-: $426 (When closing a case, the current benefit amount must be entered as an adjustment in order to calculate the correct updated monthly payment amount.)

Eligible months remaining: 4

Medical: When medical coverage was previously received, review SSNI to find the aid code to enter on the *Calculation Sheet* on form 470-5129.

Aid code: Ms. C – 308, FMAP
Mr. C – 308, FMAP
(No entry for the child as the child is continuously eligible until the next review.)

Eligibility certification months counted: 4

SNAP: If applicable, use Scratch Pad (SPAD) located in WISE to determine the correct issuance amount.

Outcome 1: The client does not send the requested information. The SNAP case is canceled for failure to provide.

Current payment: $511

Certification months remaining: 4

Outcome 2: The client returns income verification showing Ms. C has a monthly income of $1,450. The worker makes the appropriate system entries to redetermine benefits with the verified income amount.

Current payment: $511
Updated payment: $210
Certification months remaining: 4

DHS Investigative Referral to DIA, Form 470-5130

Purpose	Form 470-5130 is designed to make a referral to the Department of Inspections and Appeals (DIA).
Source	Workers can complete 470-5130 using the form in the Worker Information System Exchange (WISE).
Completion	Complete this form after receiving information that alleges fraudulent behavior. NOTE: WISE will open and prepopulate some fields with client case and worker information for the case number last accessed in WISE before opening the form. Change any of the prepopulated fields as needed to reflect correct client and worker information and case number.
Distribution	Click the “Submit to DIA/ECF” button to forward an electronic copy of the form to DIA. WISE will upload a copy of the form to the electronic case file using the ELIAS or IABC case number. Child care assistance staff will click “View Submitted Form” in the ‘submission was successful’ popup to view and print a copy for the paper case file.
Data	Review and change the following fields as needed: ▪ Case number (populated initially with the last case number viewed in WISE before opening the referral form) ▪ Date referred ▪ Worker name ▪ Worker number ▪ Worker phone number and extension ▪ Worker email ▪ Client first name ▪ Client last name ▪ Date of birth ▪ State ID/CIN

- Client address line 1
- County of residence
- Client phone
- Client address line 2
- City
- State
- Zip

Complete the following fields:

- IABC, ELIAS, or KT case number
- Answer the yes and no questions
- Select all applicable programs
- Anonymous (yes or no)
- Complainant name and phone (if available)
- Select referral type
- Allegations and comments

Disability Report for Adults, Form 470-2465

Purpose

Form 470-2465 is used to gather information to establish disability. The Disability Determination Services Bureau (DDS), which is under contract to the Department, uses this report, along with vocational background material, contacts with medical personnel, and any information available from the Social Security Administration, to determine whether disability exists.

Source

Print form 470-2465 from:

- The online manual.
- SharePoint under Employee Manual/Forms.
- The Worker Information System Exchange (WISE).

Completion

When a client who is aged 18 or over is claiming disability and the Department must make the initial determination or the disability review, the client shall complete one copy the form. Provide assistance if requested. Complete Section 11 on your observations and perceptions of the client.

Distribution

Forward the form to DDS with the *Disability Transmittal*, form 470-2472. (The mailing address is on the *Disability Transmittal*.) If this is a subsequent application for Medicaid based on disability, also forward to DDS all disability forms from previous DHS determinations.

After making a determination, DDS returns the form to the requesting worker. Upon return from DDS, file the form in the permanent forms section of the case record. Provide a copy to the client if requested.

If the client appeals the denial of Medicaid based on the denial of disability determination, send copies of these forms to the DHS Appeals Section in Central Office, to the client, and to any representatives of the client.

Data

The client shall complete Sections 1 through 10. If the section does not apply, it shall be marked as “not applicable.” Information is requested on the client’s identification and characteristics; illnesses, injuries or conditions; work; medical records; medications; tests; education and training; vocational rehabilitation; additional remarks; and authorization for release of information.

Disability Report for Children, Form 470-3912

Purpose

Form 470-3912 is used to gather information to establish disability for a child. The Disability Determination Services Bureau (DDS), which is under contract with the Department, uses this report, along with educational, medical, and other pertinent information, to determine whether disability exists.

Source

Print form 470-3912 from:

- The online manual, or
- SharePoint under Employee Manual/Forms, or
- The Worker Information System Exchange (WISE).

Completion

When a client who is under age 18 is claiming disability and the Department must make the initial determination or the disability review, a person acting on behalf of the client shall complete one copy the form. Provide assistance if requested.

Distribution

Forward the form to DDS with the *Disability Transmittal*, form 470-2472. (The mailing address is on the *Disability Transmittal*.) If this is a subsequent application for Medicaid based on disability, also forward to DDS all disability forms from previous DHS determinations.

After making a determination, DDS returns the form to the requesting office. Upon return from DDS, file the form in the permanent forms section of the case record. Provide a copy to the client if requested.

If the client appeals the denial of Medicaid based on the denial of disability, send copies of these forms to the DHS Appeals Section in Central Office, to the client, and to any representatives of the client.

Data

The client shall complete Sections 1 through 10. If the section does not apply, it shall be marked as “not applicable.”

Information is requested on the child’s identification and characteristics, illnesses or injuries, medical assistance eligibility, medical treatment, medical sources, medications and tests; other sources of information, contact information, additional remarks; and authorization for release of information.

Disability Transmittal, Form 470-2472

Purpose

The *Disability Transmittal* serves as a communication form between the Department and Disability Determination Services Bureau (DDS). The form identifies the type of disability determination needed and informs the IM worker of the results.

Source

Complete form 470-2472 using the template in:

- SharePoint under Employee Manual/Forms.
- The Worker Information System Exchange (WISE).

Completion

The IM worker responsible for the case completes Part I of the form when:

- DDS is to complete a disability determination for the Department.
- The disability determination is to be terminated after the initial referral is made.
- The claimant's address changes while the disability determination is still pending.

The IM worker may attach comments on a separate sheet.

DDS completes Part II of the form and returns the form when a decision regarding the disability has been made.

Distribution

Forward two copies to DDS. (When this form is prepared to initiate a disability determination, attach this form to the *Disability Report*, form 470-2465.) Keep a copy as a control.

You may upload the request to the electronic case file. When DDS returns the original, it will be scanned and uploaded.

Data

Part I: IM Worker Name, E-mail Address, Worker Number, Office Phone, County Number, and Office Address: Print the IM worker's name, email address, worker number, worker's work telephone number, county number, and address.

Client Name, State ID Number, Social Security Number, Address, Birth Date: Enter the name, state ID number, social security number, complete mailing address, and birth date of the person for whom a disability determination is being requested. Any change in address while the disability determination is pending must be reported to DDS.

Disability Criteria - Check One: Check appropriate box.

Date of Application: Enter the date on which the person filed an application with the Department.

Status: Check the box that applies to the reason for submitting the form. Promptly notify DDS of any changes in status.

Use another sheet for any comments to notify DDS of unusual circumstances (such as a deceased client).

Part II:

1. **Client Disabled:**

   Disability began: DDS determines whether disability began within the three months before the date of application.

   Disability ceased: DDS enters the date that the disability ended. The IM worker shall take the appropriate action (partially approve, deny, or cancel). Give timely notice when applicable.

   Presumptive determination: The six months of presumptive eligibility begins with the effective date determined by DDS.

   Diary Date: DDS specifies when the next review of disability is due (MM YY) and the number of years (1-3, or 7) until next disability review (RSN).

2. **Client not disabled**: This section is completed when DDS determines disability does not exist. DDS also sends form 470-2463, *Explanation of Disability Determination*, to explain the reason for denial.
3. **Diagnosis**: DDS uses this field for a diagnosis entry to assist DDS at time of review or appeal.
4. **Disability Examiner**: The DDS representative signs and dates the form.

   Medical Consultant: The consultant who reviewed the disability determination signs and enters the date of review.
5. **Remarks**: DDS enters any additional information that may be helpful to the Department, such as when the next redetermination is due. On denials, a brief explanation is entered.

Disposal of Assets Penalty Notice of Decision, Form 470-4365

Purpose	Form 470-4365 is used to notify Medicaid applicants that a penalty has been imposed due to a transfer of assets for less than fair market value.
Source	Complete form 470-4365 using the template in: ▪ SharePoint under Employee Manual/Forms. ▪ The Worker Information System Exchange (WISE).
Completion	The income maintenance worker completes an original and one copy of this notice of decision when the Department has made a decision to impose a penalty because the applicant or the applicant's spouse has transferred assets for less than fair market value.
Distribution	Send one copy to the client and file another copy in the case record.
Data	Press tab to access data fields. Enter the uncompensated amount of the transfer in dollars and cents in the appropriate fields. Enter the date the penalty period will begin in MM DD YY format. Click complete entries. Enter the name and address of the client or representative to be used for mailing the form. Enter the date of the notice. **Worker's Name**: Enter the IM worker's name. **Worker's Phone Number**: Enter the IM worker's phone number.

Document Verification Request, Form G-845

Purpose	The purpose of federal form G-845S is to obtain additional verification of alien status from the U.S. Citizenship and Immigration Services (USCIS), the former Immigration and Naturalization Service (INS).
Source	Print form G-845S from the online manual or the USCIS website.
Completion	The worker responsible for the eligibility determination completes this form after submitting additional verification on the SAVE website when the worker: ▪ Is instructed to do so; or ▪ Still has questions about eligibility.
Distribution	Send the original form to USCIS. Attach a copy of the front and back of the original USCIS documents submitted by the client. Keep a copy for the case record.
Data	Complete only Section A of the form. Complete the address for the USCIS as follows: U.S. Citizenship and Immigration Services 10 Fountain Plaza, 3rd Floor Buffalo, NY 14202-2200 Complete the name and address of the submitting agency by entering the mailing address of the requesting office. Include your worker number. USCIS supplies the verification number on Line 6.

Documentation of Claim Determination, Form 470-0311

Purpose

Form 470-0311 is used to provide information on and documentation of:

- The reason for an overissuance.
- The amount of overissuance.
- The period when the overissuance occurred.

Source

Complete form 470-0311 using the template in:

- SharePoint under Employee Manual/Forms.
- The Worker Information System Exchange (WISE).

Completion

Prepare this form:

- When an overissuance has occurred.
- Each time a change occurs that affects the reason, amount, or time period covered by the overissuance.

Distribution

Attach the form to the corresponding copy of the *Overpayment Recovery Information Input Summary* (from the direct claim entry screen) and file it in the household's case file.

Data

Instructions correspond with the item number on the form.

Items 1 through 7: Self-explanatory.

Item 8: Documents the period of time and the application document used to determine the original basis of issuance. If the overissuance was on an adjustment allotment, do not complete this section.

- List all the certification periods covered by the claim.
- List the date each certification period was established.
- List the date of the application document used to establish eligibility for each individual certification period.

Item 9: Using worksheets completed for each month of the certification periods covered by this claim:

- For overissuances other than adjustment allotments:
  - List each month and year that an overissuance occurred.
  - For each month listed, enter the household size and net adjusted income that was used to determine the allotment, and the monthly allotment that the household originally received.

- For each month listed, enter the household size and net adjusted income that should have been used to determine the allotment and the monthly allotment that the household should have received for that month.

- For adjustment allotments:
  - List the month and year in which the incorrect adjustment allotment was issued.
  - Actual Issuance. The household size does not have to be completed. For “Net Income,” list the ABC code used on the TD06 on Section IX, field IMM/CAN, to issue the adjustment allotment. List the amount of the adjusted allotment issued.
  - Correct Issuance. For each month listed, leave household size blank. Enter the same ABC codes that were entered under “Actual Issuance.” List the amount the adjusted allotment should have been.
- For all uses:

  The amount of overissuance is the correct allotment minus the actual allotment for each month. Total:

  - The actual allotments issued in error,
  - The correct allotments that should have been issued, and
  - The amount of overissuance that occurred over the total period.

Item 10: Explain in detail the reason the overissuance occurred. List any contacts made pertaining to the overissuance. If the Department determines that the overissuance was due to client misrepresentation or possible fraud, explain how and why this determination was made.

The documentation in this section must be detailed enough that another person will know the circumstances of the overissuance by reviewing only this document.

Item 11: Sign and date the form. Obtain a supervisor’s signature.

Attach additional pages if necessary. Indicate the order of the pages and the total number of pages for this claim.

EBT Adjustment Request, Form 470-2574

Purpose

The *EBT Adjustment Request*, form 470-2574, is used to document and process a request for a return of SNAP from an EBT account. This form is used to request:

- A claims repayment.
- Voluntary SNAP termination.
- The return of all benefits in an EBT account when all SNAP household members are deceased.
- The return of benefits when all household members move to a nursing facility and are unlikely to return home.
- A return of a monthly allotment when a household wants to receive SNAP benefits for the month in another state.
- A return of SNAP benefits for other reasons.

Source

Complete form 470-2574 using the template in:

- SharePoint under Employee Manual/Forms.
- The Worker Information System Exchange (WISE).

Completion

For all debit adjustments to the EBT SNAP account, there must be corresponding ABC entries. See 14-B(5), *Recording Returned SNAP*.

To return an authorized SNAP issuance for reasons other than the death of all household members or all members moving permanently to a nursing facility, there must be a written request from the household. When the household has moved to another state, the written request to return the benefits may be made by fax or mail.

Attach the written request to the original and the copy. When a written request is attached, the client does not have to sign this form.

- For a claims repayment: When the request is to use EBT benefits to repay a claim, the written request must include the amount the client wants to apply to the claim. Attach the written request and form 470-0010, *Adjustment to Overpayment Balance*, to this form.
- For a voluntary SNAP termination: The written request must clearly state that the household wishes to terminate SNAP participation and return the balance of the EBT account. Check to see if the household has an outstanding SNAP claim to apply the returned benefits against.

- When all SNAP household members are deceased: The request to return the balance of the EBT account does not have to be in writing. Check to see if the household has an outstanding SNAP claim to apply the returned benefits against.
- When all household members move to a nursing facility and are unlikely to return home, the request does not need to be in writing. Check to see if the household has an outstanding SNAP claim to apply the returned benefits against.
- When a household requests to return a month's allotment in order to receive SNAP benefits in another state for the month, the full month's allotment must be available to be returned.

  If the household used any amount of the benefits issued for the month, the household has participated in Iowa for the month. The household can either use the Iowa EBT card in the new state, or if unable to use it, can ask for a coupon conversion.

  If the household has not used any of the benefits issued for the month, and the household has benefits remaining in the account after the month's benefits are returned, the household can spend down the remaining balance using the Iowa EBT card.

  If the household has moved to a location in which there is no place that will accept the Iowa EBT card, the remaining balance can be converted to coupons and mailed to the new address.
- When a household requests the return of benefits for a reason not listed above, the written request must state the reason and the amount of benefits returned, or that the entire balance of the EBT account be returned.

When the amount of the adjustment request exceeds the account balance, the adjustment amount is the balance amount. This needs to be documented in the case record.

Distribution

Forward one copy to the Bureau of Purchasing, Payments, Receipts and Payroll. For claims payment, attach a copy of form 470-0464, *Overpayment Recovery Information Input*, or the *Overpayment Recovery Information Input Summary* (from the direct claim entry screen).

You may upload the request to the electronic case file. When the Bureau of Purchasing, Payments, Receipts and Payroll returns the completed form after completing the requested action, it will be scanned and uploaded to the case file.

Data

Top Section: Completed by the IM worker:

Enter the ABC case name and case number, and the state identification number of the case name person.

Check the applicable box under 'Debit Reason' to show the reason the account is being debited. If you check "Claims payment," you must enter the date of the claim. If you check "Other," you must enter an explanation for the debit reason.

Client Signature and Date: If the primary cardholder is not available to sign this form, a written statement must be attached. The primary cardholder or another responsible household member must sign the written statement if the primary is not available to do so.

If all household members are deceased or have moved permanently to a nursing facility, this space can be used to document this. No signature is needed.

Central Office Section:

Bureau of Purchasing, Payments, Receipts and Payroll staff:

- Check the applicable box and enter the date the action was taken. If "Adjustment not completed because" is checked, a description of the reason must be entered.
- Sign and date when the adjustment action is taken.

Election of Iowa Family Planning Program, Form 470-4314

Purpose	The *Election of Iowa Family Planning Program*, form 470-4314, documents an applicant's decision to choose the limited benefit program Iowa Family Planning Program (FPP) when it appears that eligibility exists for a Medicaid coverage group.
Source	Staff may print form 470-4314 from: ▪ The online manual. ▪ SharePoint under Employee Manual/Forms.
Completion	Give this form to the applicant who chooses FPP when eligibility for a Medicaid coverage group appears to exist.
Distribution	Place the signed copy in the FPP case record. Give a copy to the client.

Employer Verification of COBRA Eligibility, Form 470-3037

Purpose	The *Employer Verification of COBRA Eligibility* is designed for employers to provide verification of health insurance enrollment for their employees.
Source	Form 470-3037 is system-generated by the HIPP Unit.
Completion	This form is completed by the member.
Distribution	The HIPP worker keeps one copy as a control copy. Send the original to the employee. When the form is returned: ▪ Discard the control copy. ▪ Keep the original in the case record.

Employer Verification of Insurance Coverage, Form 470-3036

Purpose	The *Employer Verification of Insurance Coverage* is designed for employers to provide verification of health insurance enrollment for their employees.
Source	Form 470-3036 is system-generated by the HIPP Unit.
Completion	The employee signs and dates the authorization section of the form and gives the form to their employer to complete.
Distribution	The HIPP worker keeps one copy as a control copy. Send the original to the employee with a self-addressed envelope. When the form is returned: ▪ Discard the control copy. ▪ Keep the original in the case record.

Employer's Statement of Earnings, Form 470-2844 or 470-2844(S)

Purpose

The *Employer's Statement of Earnings* is designed to:

- Secure the client's permission for the Department to obtain verification of earned income.
- Provide a means for the employer to furnish the requested verification.

Source

Workers can complete the English or Spanish version using the form in the Worker Information System Exchange (WISE).

Completion

Complete this form when it is necessary to determine earned income. Complete the identifying information on the form.

The client (or person authorized to obtain the information) shall sign and date the authorization section of the form.

The employer completes the sections of the form that the worker has checked by and the signature line.

Distribution

Forward one copy of the form to the employer. Employers who want a copy of the completed form for their records should photocopy it.

You may upload the request to the electronic case file. When the employer returns the original, it will be scanned and uploaded. Forward a copy to the local PROMISE JOBS office, if appropriate.

Data

The following entries automatically populate:

- The date sent
- Your name
- Your worker number
- Your telephone number
- Your fax number
- Your mailing address
- Your email address

Before sending the form:

- Enter:
  - The client's case number
  - The employee's name
  - The employer's name
  - The employee's social security number
  - Your toll free number, if applicable

- Check the box indicating each section the employer is to complete.
- Have the client sign and date the form or attach a signed generic release.

The person representing the employer shall:

- Complete the specific information requested in each section indicated.
- Sign the form.
- Indicate the name of the person completing the form, telephone number, and the date.

Employer's Verification of Earnings, Form 470-3741

Purpose	Use form 470-3741 to comply with Internal Revenue Service safeguard procedures when you seek verification of earnings reported on an IRS IEVS report. (See 14-G, *IRS Match Report, S470X615-A: Worker Action Required*, for safeguard procedures.) Use this form to get the client's permission to obtain verification of earned income and the availability of employment-related group health insurance. The employer also uses the form to furnish the requested verification.
Source	Print form 470-3741 as needed from the online manual. NOTE: The form is formatted for legal-size (8 ½" x 14") paper.
Completion	Complete this form when it is necessary to determine earned income and the availability of group health insurance that you identified through an IRS IEVS report. Complete one set of this form for each action. Complete the upper tear-off portion of the form. Check the boxes to identify the sections the employer is to complete. The client (or person authorized to obtain the information) shall complete the employee's name and social security number and sign and date the form. The employer completes the sections of the form that have been checked in the tear-off portion of the form and the signature line.
Distribution	Distribution of this form is indicated at the bottom of the form. Forward the release to the employer with a preaddressed return envelope. You may upload the request to the electronic case file. When the employer returns the original, it will be scanned and uploaded. Destroy the tear-off portion of the form in accordance with local IRS safeguard procedures. Employers who want a copy for their records may make a photocopy for themselves. Should the employer keep one of the copies, photocopy a copy for proper distribution.

Data

Complete the data items on the upper tear-off portion of the form as follows:

- TO: Enter the name and address of the employer.
- RE: Enter the name of the employee and the employee's social security number.
- Check the box or boxes for the verification you are seeking.
- Enter the date by which you must receive information.
- Enter the phone number the employer should use if there are questions.
- Enter your name.

The client shall enter the employee's name and social security number and sign and date the form after items on tear-off portion of the form have been completed.

Complete the data items on the form below the tear-off portion as follows:

- **Worker Name**: Enter your name.
- **Worker Phone No.**: Enter your office telephone number.
- **County**: Enter the county number.
- **Case #**: Enter the case number.

The employer or person representing the employer completes and signs the form and indicates job title, telephone number, and the date.

Enumeration Referral, Form 470-5745

Purpose	The *Enumeration Referral* is designed to refer a qualified alien that is not authorized to work in the U.S. to Social Security Administration (SSA) to apply for a nonwork social security number (SSN).
Source	Workers can complete the English or Spanish version using the form in the Worker Information System Exchange (WISE).
Completion	Complete this form for each qualified alien applying for FIP, RCA or SNAP that does not have work authorization and needs to be referred to SSA to apply for an SSN. The form must be signed by an IMA, IM supervisor or IM worker in blue ink and the original form with the ink signature must be sent to the client to take to SSA.
Distribution	Give the completed form with the IMA, IM supervisor, or IM worker's signature in blue ink to the client to take to SSA to apply for an SSN.
Data	Before sending the form, enter: ▪ The date ▪ Check the programs the individual is applying for ▪ Client name ▪ Client's date of birth ▪ Client's state ID ▪ Client's case number ▪ IM worker's phone number ▪ IM worker's email ▪ IMA, IM Supervisor, or IM worker must sign the form in blue ink ▪ Enter the date the IMA, IM Supervisor, or IM worker signed the form.

Estate Recovery Notice for New Approvals, Form 470-2980

Purpose	Form 470-2980 provides information to Medicaid members who are under the age of 55 and subject to the estate recovery program due to being in a medical institution. It explains that the member will have the opportunity to rebut the Department's presumption that the member cannot return home.
Source	Complete form 470-2980 using the template in: ▪ SharePoint under Employee Manual/Forms. ▪ The Worker Information System Exchange (WISE).
Completion	The IM worker is responsible for completing and sending this letter to all Medicaid members or to the person acting on the member's behalf when the member is under 55 years old at the time of initial approval for medical institution care.
Distribution	Send the original to the member or the person acting on the member's behalf. Keep a copy of the letter in the member's file.
Data	Complete all sections listed on the form.

Estate Recovery Program Referral, Form 470-4122

Purpose	Form 470-4122 is used to notify the Estate Recovery Program of the IME Revenue Collection Unit about the death of a Medicaid member when the deceased's estate is subject to estate recovery according to 8-D, *Estate Recovery*.
Source	Complete 470-4122 using the form in the Worker Information System Exchange (WISE).
Completion	Referrals should be made via the ABC referral screens for estate recovery. Use this form only when the estate recovery referral screens are unavailable. In that case, complete this form at the time of death for a Medicaid member who: ▪ Was 55 years of age or older, or ▪ Was under age 55, resided in a long-term care facility, and was not expected to return home.
Distribution	Send an electronic copy to the Estate Recovery Program at DHS, IME Estates@dhs.state.ia.us. Keep a copy of the referral form and retain it in the case file.
Data	The form includes information about: ▪ The deceased member. ▪ The person who is handling the member's affairs. ▪ The member's bank, funeral home, and attorney. ▪ The assets the member had at the time of death.

Estate Recovery Six-Month Follow-Up, Form 470-3209

Purpose	Form 470-3209 informs Medicaid members under age 55 years and receiving medical institution care how to rebut the Department's presumption that the member will not return home.
Source	Complete form 470-3209 using the template in: ▪ SharePoint under Employee Manual/Forms. ▪ The Worker Information System Exchange (WISE).
Completion	The IM worker shall complete this letter and send it to all Medicaid members or to the person acting on the member's behalf when the member: ▪ Is under 55 years old, and ▪ Is in a medical institution six months after approval of Medicaid or has died within the six months after Medicaid coverage for institution care began.
Distribution	Send the original to the member or to the person acting on the member's behalf. Keep a copy of the letter in the member's file.
Data	Complete the address and identifying information listed on the form.

Explanation of Disability Determination, Form 470-2463

Purpose	Form 470-2463 is used to explain to the client the Department's reasons for a finding of "not disabled" on a disability determination.
Source	Form 470-2463 is issued by Disability Determination Services (DDS).
Completion	DDS prepares this form after completing a disability determination on behalf of the Department when the result of the determination is a denial. DDS shall prepare a clear concise explanation of the denial to be forwarded to the client by the DHS worker.
Distribution	DDS forwards the original and one copy of the form to the local DHS office. Send the original to the client when you issue the *Notice of Decision*. File the copy of the *Explanation of Disability Determination* in the case record with the *Notice of Decision*.
Data	The form contains a narrative explanation of the DDS decision.

Explanation of Medicaid Benefits, Form 470-0387

Purpose	The purpose of form 470-0387 is to verify that Medicaid-paid benefits were received. This form indicates the services paid for by the Medicaid program for the named member.
Source	This form is prepared and sent by the Iowa Medicaid Enterprise.
Completion	The Iowa Medicaid Enterprise prepares the form on a random basis for Medicaid members.
Distribution	One copy is sent to the member. The Iowa Medicaid Enterprise retains a copy in OnBase. When a field office receives this form from a member and the member is alleging discrepancies with the services received, send the form to the Division of Medical Services for review and investigation.
Data	The form lists the provider of services, the description of the services, the date of service and the amount of Medicaid payment.

Express Lane Medicaid for Children, Form 470-4851 or 470-4851(S)

Purpose	Form 470-4851, *Express Lane Medicaid for Children*, is issued to parents and caretakers of children in the SNAP household who are eligible for Medicaid through the Mothers and Children group due to being eligible for SNAP.
Source	The ABC system issues the form to the SNAP households that include children under the age of 19 who are not already Medicaid members. When a client reports a lost form and asks for a new 470-4851, print a form from the on line manual.
Completion	The parent or caretaker will check off the children that the household wants to have on Medicaid and send the form to the designated Department office. The worker will use the completed form to approve eligibility for children who were requested to have Medicaid.
Distribution	One copy will be mailed to the household. The signed, returned copy will be attached to the case file.
Data	The first page of form 470-4851 includes information about Express Lane Medicaid for Children. It lists the names of the children who are eligible for Express Lane Medicaid. The fifth page is the Insurance Questionnaire. The seventh page is issued only if there are children who have already had their reasonable period of opportunity to verify citizenship and identity. The seventh page lists those children as well as other persons who need to prove a qualified legal alien status. It requests information to verify citizenship and identity or to verify qualified alien status.

Extra Help for Medicare Prescription Drug Benefits Narrative/Worksheet, Form 470-4193

Purpose	Form 470-4193, *Extra Help for Medicare Prescription Drug Benefits Narrative/Worksheet*, is used both to record information and to calculate eligibility for the extra help (subsidy) with Medicare for prescription drug costs.
Source	Complete form 470-4193 using the template in: ▪ SharePoint under Employee Manual/Forms. ▪ The Worker Information System Exchange (WISE).
Completion	Form 470-4193 is completed when an applicant for extra help (subsidy) with Medicare prescription drug costs refuses to apply with the Social Security Administration and requires the Department to determine eligibility for the program.
Distribution	File the form in the case record.
Data	**Application Date**: Enter the date form 470-4167, *Addendum to Application for Help with Medicare Prescription Drug Plan Costs*, and form SSA-1020B-OCR-SM, *Application for Help with Medicare Prescription Drug Plan Costs*, is received in the local office. **Interview Date**: Enter the date of the interview with client if an interview was conducted. Document whether the interview was conducted in person or by phone. **Consumer Information Section**: This section is self-explanatory. **Medical Benefit Questions**: Answer as appropriate to the individual. Deny or continue processing application based on entry. **Resources**: Enter countable resource information as indicated on the form. **Household Size**: Enter information as indicated. **Income**: Enter countable income information as indicated on the form.

Calculation – Income: Enter income as indicated and complete income calculation.

Calculation – Resources: Enter resource information as indicated and complete resource calculation.

Action on Application: Complete as indicated.

Calculation Table Desk Aid: Use to determine eligibility. If eligible, the level of eligibility.

Family Planning Program (FPP) Application, Form 470-5485 or 470-5485(S)

Purpose	The *Family Planning Program Application* is designed to assist people applying for various family planning and family planning-related services. The form is designed to be brief and easily understood.
Source	Form 470-5485 and 470-5485(S) are printed with ten sets on a pad. Order supplies of 470-5485 or 470-5485(S) from Iowa Prison Industries at Anamosa.
Completion	Mail or give the *Family Planning Program Application* to a person applying for family planning services. The applicant completes the form. A friend, relative, authorized representative, DHS staff or an authorized point-of-service Title X agency may help, if needed. The applicant must sign the form unless mentally or physically unable to do so. If the applicant is mentally competent but unable to sign the application, an “X” or a thumbprint may be used if witnessed by two people who know the applicant. If the applicant is mentally incompetent, the form may be completed by a legal guardian, a relative, a person in whose home the applicant resides, or by the IM worker if there is no other person able or willing to file the application.
Distribution	Photocopy the form if the client wants a copy of the application. When a person does not file the application at a DHS office and the person requests Medicaid, the originating agency shall inform the person how to apply for Medicaid.
Data	Date-stamp the original application. For the purpose of the Family Planning Program, the application date is the date the originating agency received the application.

Family Planning Program Review, Form 470-4071

Purpose	The *Family Planning Program Review*, form 470-4071, is designed for use as the annual recertification document for Family Planning Program (FPP) benefits. This form contains instructions for completion and informs members of their rights and responsibilities.
Source	Form 470-4071 is generated by the Family Planning (FP) system. DHS staff may also complete the form using the template in: ▪ SharePoint under Employee Manual/Forms. ▪ The Worker Information System Exchange (WISE).
Completion	*Family Planning Program Review*, form 470-4071, is generated 30 days before the end of the FPP certification period. Give or issue form 470-4071 to the FPP member upon request. The worker or the FP system completes the top portion of page 1 before the form is sent to the member. The FPP member must complete the form. A friend, relative, authorized representative, or DHS staff may help if needed. The FPP member must sign the form.
Distribution	File the signed and dated *Family Planning Program Review*, form 470-4071, in the case record. Give the member a copy at the member's request.
Data	The form requests information about the household's composition, income, and expenses.

FIA Appointment, Form 470-3897 or 470-3897(S)

Purpose

Form 470-3897 or 470-3897(S) is used to schedule an appointment for a Family Investment Agreement (FIA)-responsible person to meet with PROMISE JOBS for the nonfinancial eligibility criterion of completing and signing an FIA. For applicants, failure to complete and sign an FIA results in denial of the family's FIP application.

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

The IM worker uses this form to notify an FIA-responsible person of their appointment to meet with PROMISE JOBS to write and sign an FIA after scheduling the appointment in the PJCase Calendar.

The *FIA Appointment* form is issued by the IM worker:

- During the initial FIP eligibility interview with the applicant.
- When a participant has requested reconsideration of a first LBP and can be scheduled before the effective date.

For applicants, the IM worker completes the form only if the family appears eligible for FIP and includes a member of the assistance unit who is FIA-responsible. (When it appears that the family will not be eligible for FIP or there are no FIA-responsible members, 470-3897 will not be completed, as no involvement from PROMISE JOBS is needed.)

The form allows the IM worker to schedule an in-person or phone appointment.

Distribution

After the IM worker completes the form:

- Hand-issue, mail, or e-mail the form to the FIA-responsible person, and
- File a copy in the FIP case record.

Data

On the preface page, the IM worker selects the:

- Appropriate- PROMISE JOBS office from the displayed list of PROMISE JOBS office addresses displayed as choices.
- Type of appointment (in-person or phone) and enters the appointment date and time.

Page 1 of the form will be populated based on the IM worker's entries on the preface page.

Complete all remaining fields in the Referral Information and Person Responsible for Signing an FIA sections. The fields are self-explanatory.

FIA Referral for Mandatory Participants, Form 470-3105

Purpose	Form 470-3105 informs FIP clients that they have been referred to PROMISE JOBS as a mandatory participant and that they have ten days to contact PROMISE JOBS to schedule orientation and to write and sign a *Family Investment Agreement*.
Source	This form is generated from Central Office. Print a sample from the online manual to use in discussions with clients.
Completion	One of these forms is sent when the IM worker changes a referral code on the ABC system for a FIP recipient from exempt to mandatory for PROMISE JOBS participation.
Distribution	The form is mailed to the participant from Central Office.
Data	The forms list the address and phone number of the office the participant should contact and the deadline for the contact.

Financial Institution Verification, Form 470-3742

Purpose	Use form 470-3742 to comply with Internal Revenue Service safeguard procedure when seeking verification of information reported on an IRS IEVS report. (See 14-G, *IRS Match Report, S470X615-A: Worker Action Required* for safeguard procedures.) Use this form to get the client's permission to obtain information that can be provided by a financial institution. The financial institution also uses the form to furnish the requested information.
Source	Print form 470-3742 as needed from the on line manual. NOTE: The form is formatted for legal-size (8 ½" x 14") paper.
Completion	Complete this form when it is necessary to verify interest income or resources that you identified through an IRS IEVS report. Complete the upper tear-off portion of the form. Enter your worker number at the top of the form and the date the permission stops at the bottom. The client (or the person authorized to obtain the information) shall sign and date the form. The financial institution completes the remainder of the page.
Distribution	Send one copy to the financial institution with a return envelope. Keep a copy as a safeguarded control copy. (See 14-G for safeguard procedures.) When the financial institution returns the form, destroy the control copy and the tear-off portion of the form in accordance with the local IRS safeguard procedures. (See 14-G for instructions.)
Data	Complete the data items on the upper tear-off portion of the form as follows: ▪ To: Enter the name and address of the financial institution. ▪ RE: Enter the names of persons whose income/resources are being verified. ▪ Enter the date the information must be returned. ▪ Enter your phone number.

- Enter your name and number.
- Dates: Enter the period of time for which the information is being requested.

Below the tear-off portion, enter the date the authorization expires after "This permission stops on:" Except in unusual circumstances, this shall be 60 days from the date the form is signed.

The client and spouse shall sign this line after the items listed above have been completed.

The financial institution completes the remainder of the form.

FMAP-Related Medically Needy Spenddown Computation Worksheet, Form 470-3088

Purpose	The *FMAP-Related Medically Needy Spenddown Computation Worksheet* is used when calculating income for the FMAP-related Medically Needy program. It provides the client with information on the manual computation and assists the worker in making an accurate computation. The form is used for both earned and unearned income.
Source	Complete form 470-3088 using the template in: ▪ SharePoint under Employee Manual/Forms. ▪ The Worker Information System Exchange (WISE).
Completion	The IM worker completes the form when calculating income for the retroactive or current certification period, or as otherwise needed. Attach verification to the form when required.
Distribution	Mail the original to the client. Print a copy to file the in the case record.
Data	Complete a worksheet for each certification or retroactive period. You may need more than one worksheet for a period when more than two household members have income. Some modification in use may be needed to fit individual situations. **Case name**: Enter the name of the case as it appears on agency records. **Case number**: Enter the complete Medically Needy case number, including FBU and check digit. **Retroactive period**: If income calculations are for the retroactive period, enter the months involved. **Current certification period**: If income calculations are for the current certification period, enter the months involved. **Household member**: Enter the name of the person who is employed or has unearned income. Two boxes are available, household member A or household member B, when more than one member of the household has income. **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 the household member is paid (weekly, biweekly, monthly, etc.).

1. Earned income:

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

   3rd check: Check the box if the person is paid biweekly and received or is projected to receive three checks in this month. Do not check if the person is paid weekly; but started a job or ended a job; and has only received three checks this month.

   5th check: Check the box if the person is paid weekly and received or is projected to receive five checks in this month.

   The template completes the appropriate calculation based on whether there is an “x” at 3rd check or at 5th check, or if those boxes are left blank.

   NOTE: If a person receiving a 3rd or 5th check also has earnings from another source, do not check either box. Complete the calculations manually and enter the resulting monthly amount as one payment in the amount field.

   Enter the dates the gross earned income was received during the month for household member A and household member B, if applicable.

   For retroactive certification periods, use the actual gross income received each month including third and fifth checks. Total the gross earned income per household member per month.

   For the current certification period, use the income in the 30 days before the interview or before the date of application if this is a good indicator of future income for month one.

   Enter the actual gross income received during this time period when the person received four or fewer weekly checks or two or fewer biweekly checks. Use the same gross income to project for month two if it is indicative of future income.

Note for FMAP-related Medicaid only: When a third or fifth check is received in the 30-day period, total the gross income and divide by the number of checks received. Multiply the total by four if the income is received weekly, or by two if the income is received biweekly.

Use this amount as the gross earned **income used for both month one and month two.**

2. **20% earned income deduction**: Enter the 20% earned income deduction allowed under the FMAP program.
3. **Subtotal**: Subtract the work expense from Line 2 and enter the amount on this line.
4. **Child care**: Enter the verified monthly child or dependent care expenses allowed under the FMAP program.
5. **Paid court-ordered child support**: Enter the amount of monthly court-ordered child support or alimony paid for persons outside of the home, when applicable.

   NOTE: A stepparent's child support and alimony payments to persons outside of the home do not need to be court-ordered.
6. **Subtotal**: Subtract Lines 4 and 5 from Line 3 and enter the resulting amount on this line.
7. **Stepparent diversion**: Enter the appropriate stepparent diversion, if applicable.
8. **Total countable earned income**: Subtract Line 7 from Line 6 and enter the amount.
9. **Unearned income**: Enter the dates the countable unearned income was received for each month in the eligibility period. Use the countable unearned income received when paid monthly, biweekly or weekly. Complete for household member A and household member B if applicable.

   3rd check: Check the box if the person is paid biweekly and received or is projected to receive three checks in this month.

   Do not check the box if the payment started or ended during the month; and the person received only three checks this month.

   5th check: Check the box if the person is paid weekly and received or is projected to receive five checks in this month.

The template completes the appropriate calculation based on whether there is an "x" at 3rd check or at 5th check, or if those boxes are left blank.

NOTE: If a person receiving a 3rd or 5th check also has unearned income from another source, do **not** check either box. Complete the calculations manually and enter the resulting monthly amount as one payment in the amount field.

Total the unearned income per household member per month.

When a third or fifth check was received, total the countable unearned income and divide by the number of checks received. Multiply the total by four if the income is received weekly, or by two if the income is received biweekly. Use this amount as the countable unearned income.

10. **Any remaining balance of paid court-ordered child support**: Enter any remaining balance of paid court-ordered child support not previously used on Line 5.
11. **Total countable unearned income**: Deduct amounts found in Item 10 from the unearned income total.
12. **Total countable unearned and earned income**: Total Lines 8 and 11 and enter the amount on this line.
13. **Deduction**: Deduct any remaining balance of the stepparent diversion not previously used on Line 7.
14. **Subtotal**: Deduct Line 13 from Line 12 and enter the amount on this line.
15. **Household size**: Enter the household size for each month of the eligibility period.
16. **Medically needy income level (MNIL)**: Enter the appropriate Medically Needy Income Level for each month based on household size.
17. **Insurance premiums**: List the insurance premium paid each month.
18. **Medicare premiums**: List the Medicare premiums paid each month.
19. **Total insurance**: Total Lines 17 and 18 and enter the amount on this line.

20. **Total income for period**: Add together the total income for each month of the eligibility period (Line 14 from months 1, 2, and 3).
21. **Total MNIL**: Add together the total Medically Needy income level for each month of the eligibility period (Line 16 from months 1, 2, and 3).
22. **Spenddown**: Subtract the MNIL (Line 21) from the total income for the period (Line 20).
23. **Less total insurance**: Add together the total insurance for each month of the eligibility period (Line 19 from months 1, 2, and 3).
24. **Final spenddown**: Subtract the total insurance (Line 23) from spenddown (Line 22). This is the final spenddown amount. Enter this amount on the *Notice of Decision for Medically Needy*, form 470-2330.
25. **Poverty level percentage**: If anyone in the eligible group receives Medicare, determine if the person is QMB-eligible using SSI income calculations. For QMB, enter the percentage of poverty on this line and in the poverty indicator field on the ABC system.

    If the person is not QMB eligible, divide Line 12 by 100% of poverty for the household size and enter the percentage on this line as well as the poverty indicator field on ABC.

Food and Financial Support Application, Form 470-0462, 470-0462(S), or 470-0462(F)

Purpose

The *Food and Financial Support Application* is designed to help people present the information needed for IM workers to determine eligibility for:

- Family Investment Program (FIP)
- SNAP
- Refugee Cash Assistance (RCA)

Source

Central Office has a contract to provide automatic shipments of form 470-0462 and 470-0462(S) to local offices. The shipments are intended to cover a six-month supply. Additional supplies of form 470-0462 and 470-0462(S) are also available through Central Office.

Completion

Give or mail one copy of the *Food and Financial Support Application* to the applicant when assistance is requested. Mail or give the following pamphlets with the application form:

- Comm. 51, “Information Practices”
- Voter Registration form

A new application is not required when a new person is added to the FIP, SNAP, or RCA household.

The applicant shall complete the form. A friend, relative, or local office staff may help, if needed.

Only one signature is required. If there is a guardian or conservator, this person shall participate in completing the form and shall sign for the applicant, if necessary.

Unless verification is required, accept the applicant’s statements on the application, provided they are pertinent and consistent when related to other known facts and seem accurate. Help the applicant obtain verification when:

- Statements of the applicant are incomplete, unclear, or inconsistent, or
- Circumstances indicate that further inquiry should be made and the applicant cannot clarify the situation.

Staff who assist the applicant in completing the form (at the applicant’s request) shall sign on the line reserved for the person who helped complete the form.

An optional release of information is included on page 3. The applicant may use this release to authorize the Department to contact other people or organizations for information needed to determine eligibility and benefits.

The applicant is not required to sign this release. See *Addendum to Application and Review Forms for Release of Information*, Form 470-4670 or 470-4670(S), for instructions on using the release.

Distribution

Give one copy of the form to the applicant for completion.

File one copy of the completed application in the case record. Give the applicant a copy at the applicant's request.

Enter information from the form in the eligibility system as appropriate. In addition, enter information regarding the absent parent on the ICAR system.

Data

Before FIP, RCA, or SNAP can be approved, the applicant shall complete the sections of the application that correspond with the programs the applicant is applying for and provide them to the local office.

When a nonparental relative applies for FIP assistance for a child living in the home, but not for needy relative assistance, the information on "People in Your Home" section of the form shall relate to the relative. The remaining items shall reflect the circumstances of the child and the child's parents. The relative shall sign the form.

If additional information or documentation is obtained, note the particulars in the narrative in the case file. If information not supplied by the applicant on this form is used, record the information, the sources of the information, and the name of the worker making the decision.

Free Lunch Notice, Form 470-4473 or 470-4473(S)

Purpose	Forms 470-4473 and 470-4473(S) advise SNAP and FIP households that their school-age children are eligible for the free school lunch program. Forms are also sent to notify foster children of eligibility. The form also provides information about Hawki and Medicaid.
Source	The Department of Human Services (DHS) and the Department of Education (DE) electronically match names of foster children and children receiving SNAP and FIP with school records. This form is generated for children who are **not** identified by the DE match.
Completion	The form is mailed from Central Office by August 1 each year. Households are responsible to complete the form and provide it to the school. Families are also directed to sign the back of the form if they do not want their name released to the Hawki program or if they currently receive health insurance through Hawki or Medicaid.
Distribution	One copy is mailed to the household. Households should give the form to the school in order to get free lunches. If they do so at least ten days before school starts, the children listed on the form will be able to participate in the school lunch program on the first day of school. The schools will automatically send free lunch approval letters for children identified through the DE match. Students will receive free school lunches if: ▪ The student is identified by the electronic match between DHS and DE as being a foster child or as receiving SNAP or FIP, or ▪ The household receives form 470-4473 or 470-4473(S) for the student and provides the form to the school. Otherwise, the household must complete an application with the school to get free meals.
Data	The household completes the child's school and grade and signs the form.

General Accounting Expenditure, Form GAX

Purpose	IM staff use the *General Accounting Expenditure* to pay FIP benefits when the ABC system cannot issue the payment due to the age of the claim.
Source	Department staff can complete this form using the template in SharePoint under Employee Manual/Forms.
Completion	The worker or designated clerical staff prepare the form to issue FIP payment when an appeal decision requires the Department to issue payment for a month outside the ABC system capability (i.e., too old). The service area manager or designee signs the form. Make three more copies of the signed form.
Distribution	Submit the original and two copies of the form to the Division of Fiscal Management, Bureau of Purchasing, Payments, Receipts and Payroll. Keep a copy in the FIP case record.
Data	Note special instructions for direct payment for FIP claims. **Budget FY**: Enter the state fiscal year when the expense is to be paid. **Date**: Enter date the form is completed. **Vendor Code**: For FIP claims, enter 00000041300. **Agency Name**: Enter DHS. **Vendor Name and Address**: Enter the name and mailing address for the FIP client. **Order Approved By**: Enter the original signature of the authorized staff person and the date signed. If use of a stamp is authorized, the person approving the claim must initial the entry. Quantity Received: Enter 1. Unit of Measure: Leave blank. **Description of Item**: Enter “Appeal Decision” and attach a copy of the final decision. **Unit Price**: Enter the dollar amount of the claim. **Total Price**: The template does not allow entries in this field. The total price will be calculated automatically. **Contract Number:** Leave blank.

Document Total: The template does not allow entries in this field. The total will be calculated automatically.

Claimant's Signature: The client signs the form. In other cases, leave blank.

Fund: Enter 0001.

Agency: Enter 413.

Unit: Enter 0101.

Object: Enter 4210.

Amount: Enter the amount of each line.

Document Total: The template will not allow entries in this field. The total will be calculated automatically.

To complete the form, calculate the automatic fields by double-clicking the red "Calculate" button. Double-click the "Print" button as many times as necessary to print copies of the form for distribution.

Hardship Exemption Determination, Form 470-3876

Purpose

Assistance from the Family Investment Program (FIP) is limited to a total of 60 months. The only way families that have received FIP for 60 months may receive FIP beyond that limit is if they request and are determined eligible for a "hardship exemption."

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

1. Based on supporting evidence, the local IM worker determines whether the family has a hardship condition that affects its ability to be self-supporting. If the family does not meet the criteria, the IM worker denies the hardship exemption request at that point.
2. If the IM worker decides that the family meets hardship requirements, and there is an FIA-responsible person, 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.

A family:

- Without an FIA-responsible person has to meet step 1.
- With an FIA-responsible person has to meet both steps.

All families must also meet all other FIP eligibility requirements to be approved for a hardship exemption. Refer to 4-C, *Hardship Exemption*, for more information.

Form 470-3876 is used to document approval or denial of a family's hardship exemption request. The IM worker also uses the form to:

- Notify PROMISE JOBS of families with an FIA-responsible person that have met step one,
- Identify the FIA-responsible adults to PROMISE JOBS,
- Identify the family's service worker, if the family has an active service case.

Source

Complete form 470-3876 using the template in:

- SharePoint under Employee Manual/Forms.
- The Worker Information System Exchange (WISE).

You can also print the form from the online manual.

Completion

Complete this form when a family requests a hardship exemption from the FIP 60-month limit. The form consists of Parts A, B, and C.

- Complete only Part A if the family does **not** meet Step One.
- When the family **has** met Step One, complete Part A and later Part C. For a family with an FIA-responsible person the PROMISE JOBS worker completes Part B.

Distribution

Copies of form 470-3876 with Parts A, B, and C completed, as applicable, may be forwarded to appropriate parties using the most expedient method, such as in person (if co-located), or by email, fax, or local mail. Depending on the final hardship exemption disposition, copies of the form are distributed as described under "Data."

If difficulties are encountered when using email to exchange copies between IM and PROMISE JOBS, staff will need to use one of the other available methods for exchanging copies of the form.

Forward a copy of form 470-3876 that reflects the final hardship exemption determination to:

- The PROMISE JOBS worker (if applicable)
- The family's service worker identified in form 470-3884 (if any)

Maintain the completed original of form 470-3876 in the permanent "Hardship Exemption" section of the FIP case record.

Data

Part A: If you determine that the family **does not meet** hardship criteria:

- Complete the following sections of Part A:
  - The information about the client at the top,
  - The "Hardship Does Not Exist" section, and
  - The "Reason" section.
- No involvement from PROMISE JOBS is needed.
- Forward a copy of the form to the service worker identified on form 470-3884 (if any).
- Process the hardship exemption denial and make corresponding entries on ETS.

If you determine that the family **meets** hardship criteria:

- Complete the following sections of Part A:
  - The information about the client at the top,
  - The "Hardship Exist" section, and
  - The "Reason" section.

- For a family with an FIA-responsible person, forward copies of each of the following to the local PROMISE JOBS office within one working day:

  - Form 470-3876, Hardship Exemption Determination.
  - Form 470-3826, Request for FIP Beyond 60 Months.
  - The family's supporting hardship evidence.
  - Form 470-3884, *Hardship Exemption: Service Information*, if you received one from the family's service worker.

This notifies PROMISE JOBS that you have determined the family with an FIA-responsible person has a hardship condition and must now develop and sign a six-month FIA before the hardship exemption request can be granted.

Part B: Upon receipt of these documents, PROMISE JOBS initiates procedures for the FIA-responsible adults to attend an interview to develop and sign the six-month FIA. PROMISE JOBS then documents in Part B whether the family has met the FIA requirement and returns a copy of the form to you.

Part C: For families with an FIA-responsible person, upon receipt of a copy of form 470-3876 from PROMISE JOBS with Part B filled in, complete Part C of the form to reflect the final determination of the family's hardship exemption request.

- If Part B states that the family failed to attend the required interview or failed to sign the FIA, the family is not eligible for a hardship exemption. Check the "Denied – no FIA" box in Part C. Process the denial and make corresponding entries on ETS.
- If Part B states that the family has met the FIA requirement, but the family's circumstances have changed since you completed Part A and the family no longer meets nonfinancial FIP eligibility criteria, the family is not eligible for a hardship exemption.

  In that case, check the "Denied – no FIP eligibility" box in Part C. Process the denial and make corresponding entries on ETS.

- If Part B states that the family has met the FIA requirement, and the family continues to meet all nonfinancial FIP eligibility criteria, process the approval. However, do not complete Part C or make ETS entries until after the ABC system determines the family's financial eligibility for FIP.

  - If ABC determines the family is financially ineligible for FIP due to excess countable income or resources, the family is not eligible for a hardship exemption. Check the "Denied – no FIP eligibility" box in Part C.
  - If ABC determines the family is financially eligible for FIP, the family is eligible for a hardship exemption. Check the "Approved" box in Part C.

  Make corresponding entries on ETS.

For families without an FIA-responsible person, complete Part C of the form to reflect the final determination of the family's hardship exemption request.

- If the family's circumstances have changed since you completed Part A and the family no longer meets nonfinancial FIP eligibility criteria, the family is not eligible for a hardship exemption.

  In that case, check the "Denied – no FIP eligibility" box in Part C. Process the denial and make corresponding entries on ETS.

- If the family continues to meet all nonfinancial FIP eligibility criteria, process the approval. However, do not complete Part C or make ETS entries until after the ABC system determines the family's financial eligibility for FIP.

  - If ABC determines the family is financially ineligible for FIP due to excess countable income or resources, the family is not eligible for a hardship exemption. Check the "Denied – no FIP eligibility" box in Part C.
  - If ABC determines the family is financially eligible for FIP, the family is eligible for a hardship exemption. Check the "Approved" box in Part C.

Make corresponding entries on ETS.

Hardship Exemption: Service Information, Form 470-3884

Purpose

Assistance from the Family Investment Program (FIP) is limited to a total of 60 months. Families may receive FIP beyond 60 months if they have a hardship condition and they request and are determined eligible for a "hardship exemption." To request the exemption, a family must:

- Provide evidence that supports their hardship claim, and
- Complete form 470-3826, Request for FIP Beyond 60 Months.

The request contains an authorization for release of information that allows local income maintenance (IM), PROMISE JOBS, Service, and Family Development and Self-Sufficiency (FaDSS) program staff to share substance abuse, mental health, and AIDS/HIV-related information with each other.

The hardship exemption determination is a one- or two-step process:

1. Based on supporting evidence provided by the family, the IM worker determines whether the family has a hardship condition that keeps the family from self-sufficiency. If the family does not meet hardship criteria, the IM worker denies the hardship exemption request at this point.
2. If the IM worker determines the family meets hardship criteria, and there is an FIA-responsible person, 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.

A family:

- Without an FIA-responsible person has to meet step 1.
- With an FIA-responsible person has to meet both steps.

All families must also meet all other FIP eligibility requirements to be approved for a hardship exemption. Refer to 4-C, *Hardship Exemption*, for additional information.

Form 470-3884 is used to transmit relevant information from the service worker to:

- Assist PROMISE JOBS in developing an FIA with a family that has an FIA-responsible person.
- Provide the IM worker with the information on the form to use as an additional source to substantiate the family's hardship claim.

Source

Complete form 470-3884 using the template in:

- SharePoint under Employee Manual/Forms.
- The Worker Information System Exchange (WISE).

Completion

When a family requests a FIP hardship exemption, the IM worker determines whether the family's FIP case circumstances are appropriate for requesting a hardship exemption. If so, the IM worker then checks whether the family has an active service case.

If an open service case exists, the IM worker forwards to the service worker a paper copy of form 470-3826, *Request for FIP Beyond 60 Months*, and an electronic copy of form 470-3884 with Part A completed to request information about the family.

The service worker completes Part B and returns the form to IM.

Provided the family with an FIA-responsible person has met the requirements in Step 1, the IM worker forwards the completed form 470-3884, along with other pertinent documents, to PROMISE JOBS. PROMISE JOBS will then contact the family for completion of Step 2.

The IM worker notifies the service worker of the outcome of the family's request for a hardship exemption via a completed form 470-3876, *Hardship Exemption Determination*.

If the family's hardship exemption request is approved, and there is an FIA-responsible person, PROMISE JOBS will forward a copy of the *Family Investment Agreement* that the family completed to the service worker.

Distribution

The service worker returns the completed form 470-3884 to the IM worker within five working days.

For a family that has an FIA-responsible person, the IM worker forwards a copy of the completed form to the PROMISE JOBS office for use in developing the family's FIA. Completed copies of form 470-3884 are maintained:

- In the hardship exemption section of the IM case file.
- In the PROMISE JOBS case file (if appropriate).
- In the "Other Reports" section of the service case file.

Data

Completion of Part A is self-explanatory.

The service worker completes Part B as follows:

- In item 1, list the family's time commitments and responsibilities, to assist PROMISE JOBS in developing a family investment agreement for an FIA-responsible person that will not conflict with appointments or responsibilities the family has.

  For example, if a parent is court-ordered to attend therapy with the child every Monday, Wednesday, and Friday, the PROMISE JOBS worker needs to consider this when developing the FIA with the family.
- In item 2, write a brief assessment of the challenges, including safety issues, the family has that should be considered by the IM and addressed in the FIA for an FIA-responsible person.
- Fill in the service worker's name in the first box.
- Identify in the second box who filled out the form (this may be someone other than the assigned worker), that person's phone number, fax number, and complete email address.
- Date the form.

Health Insurance Information for Kids With Special Needs, Form 470-4633

Purpose	Form 470-4633 is used to determine if children applying under the Medicaid for Kids With Special Needs (MKSN) coverage group meet the health insurance enrollment requirement.
Source	Complete 470-4633 using the form in the Worker Information System Exchange (WISE).
Completion	The IM worker initiates an original and one copy of this form when the Department needs to gather information about: ▪ The availability of employer health insurance, ▪ The employer share of the premium cost, and ▪ Enrollment of the child in the health insurance plan. The parents: ▪ Check the correct box to describe their child's health insurance coverage, **and** ▪ Either: • Complete form 470-2826 or 470-2826(S), *Insurance Questionnaire*, **or** • Take the second page of form 470-4633 to their employer to be completed.
Distribution	Mail the original to the parents and file the copy in the case record. The parents must return the completed form to the assigned imaging center along with the information listed above.
Data	The template will populate the name, address, worker identification, and the due date.

Health Insurance Premium Payment Program Application, Form 470-2875 or 470-2875(S)

Purpose	Form 470-2875 is used to request the Department to pay for health insurance premiums on available health insurance policies.
Source	Form 470-2875 is attached to Comm. 91, "The Health Insurance Premium Payment (HIPP) Program for Iowa Medicaid Recipients." Order supplies of Comm. 91 from Iowa Prison Industries at Anamosa. Form 470-2875(S) is attached to Comm. 91(S), "Programa de Pago de Primas del Seguro Médico para Beneficiarios de Medicaid en el Estado de Iowa." Order supplies of Comm. 91(S) from Iowa Prison Industries at Anamosa. The application is also available from the HIPP website, http://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp. Both versions are considered a valid application for the HIPP Program.
Completion	The member or the member's representative completes the application when requesting the Department to pay for health insurance premiums.
Distribution	The form goes to the HIPP Unit at Iowa Medicaid Enterprise for processing. The form included with Comm. 91 should be sent in the postage-paid envelope to the HIPP Unit. Please send applications printed from the website or contact the HIPP Unit as follows: Phone: 1-888-346-9562 (toll-free); (515) 974-3282 (local) Fax: (515) 725-0725 U.S. mail: HIPP Unit PO Box 36476 Des Moines, IA 50315-9907 Interoffice/IME/HIPP email: HIPP@dhs.state.ia.us
Data	The form is self-explanatory. Please call the HIPP Unit at 1-888-346-9562 if there are additional questions regarding this form.

Health Insurance Premium Payment (HIPP) Program Review, Form 470-3016

Purpose	Form 470-3016 is used for reviewing eligibility factors of employer-sponsored health insurance policies on active HIPP cases.
Source	Form 470-3016 is system-generated by the HIPP Unit.
Completion	The member completes the form.
Distribution	Separate copies are printed through Elixir and sent to the: ▪ Policyholder. ▪ HIPP file.
Data	The HIPP income maintenance worker shall process completed reviews to determine if it is cost-effective to continue premium payment reimbursement.

HIPP Medical History Questionnaire, Form 470-2868

Purpose	Form 470-2868 is designed to secure additional information regarding specific health-related circumstances of a household for the Health Insurance Premium Payment (HIPP) Unit. The form is used to establish whether the family's Medicaid utilization may be higher than average.
Source	Form 470-2868 is system-generated or produced by the HIPP Unit.
Completion	The system or the HIPP Unit shall complete the top section of the form. Upon receipt of the form, the client ~~c~~hecks all conditions that apply. If yes is checked, list the name of the person with this condition and how often medical care is needed to treat the condition. The client is also instructed to sign, date, and provide their email address and phone numbers on the form. The HIPP worker refers to this form when the computer system's cost-effective recommendation is to "not buy" the health insurance policy. The computer system's cost-effective recommendation is based on the average Medicaid utilization of a family with the same demographic data. If the form indicates that the family's Medicaid utilization may be higher than average, the policy may still be cost-effective.
Distribution	Send a copy of the form to the policyholder to complete and return. Keep a control copy.
Data	The system or the HIPP worker enters the: ▪ Date. ▪ Policyholder's name. ▪ Due date for returning the form. ▪ The HIPP worker's name, phone extension, and email address. The policyholder answers the questions about: ▪ Medical conditions of household members. ▪ Institutional residence.

HIPP Notice of Action, Form 470-5308

Purpose	The *HIPP Notice of Action* is issued by the HIPS system to notify clients of agency actions that affect the client's eligibility or benefit level. Each client has the right to be given information regarding eligibility and benefit determination.
Source	The HIPS system generates form 470-5308 based on worker entries or system processes.
Completion	The *HIPP Notice of Action* may be used for: ▪ Cancellation notices ▪ Reinstatement notices ▪ Change notices
Distribution	HIPS-generated notices are mailed to the client. A copy is filed in the electronic case file.
Data	The HIPP IM worker picks the appropriate field in HIPS to complete the *HIPP Notice of Action* in HIPS. The worker may also add comments.

HIPP Private Policy Review, Form 470-3017

Purpose	Form 470-3017 is used for reviewing eligibility factors of private health insurance policies on active HIPP cases.
Source	Form 470-3017 is system-generated by the HIPP Unit.
Completion	The member completes the form.
Distribution	Separate copies are printed through Elixir and sent to the: ▪ Policyholder. ▪ HIPP file.
Data	The HIPP income maintenance worker shall process completed reviews to determine if it is cost-effective to continue premium payment reimbursement.

Household Member Questionnaire, Form 470-1630

Purpose	Form 470-1630 is designed to secure the client's permission for the Department to investigate household composition. The source of information also uses the form to furnish the requested information.
Source	Complete form 470-1630 using the template in: ▪ SharePoint under Employee Manual/Forms. ▪ The Worker Information System Exchange (WISE).
Completion	The IM worker or QC reviewer completes this form when it is necessary to investigate household composition. The worker completes items identifying the information requested. The client completes the release section. The source of information completes the remainder of the page.
Distribution	Distribution of this form is indicated at the bottom of the form. Send one copy to the source of information with a pre-addressed return envelope enclosed. Give a copy to the client. You may upload the request to the electronic case file. When the source of information returns the original, it will be scanned and uploaded.
Data	Complete the form as follows: **Date**: Enter the date you are sending the form. **To**: Enter the name and address of the source of information. **From**: Enter your name, address, and phone number. **Address of**: Enter the client's name. **As of**: Enter the date for the period to be considered (in two places). **Was**: Enter the client's address. **List everyone living with**: Enter the client's name. **Signature and Date**: The client shall sign the form and complete the address and date after the items listed above have been completed. The source of information completes the remainder of the form.

How Earnings May Change Your FIP, Form 470-2471, 470-2471(S), 470-2471(M), or 470-2471(MS)

Purpose	*How Earnings May Change Your FIP*, form 470-2471, is for informational purposes only. It explains how earnings affect FIP eligibility and the amount of benefits.
Source	In most cases, the English version of form 470-2471 is issued automatically by the Automated Benefit Calculation (ABC) system. Form 470-2471(S) is also system-generated when there is an "S" in the language indicator field on the ABC TD01 screen. Workers may complete form 470-2471(M) using the template in: ▪ SharePoint under Employee Manual/Forms. ▪ The Worker Information System Exchange (WISE). The manually-issued English or Spanish version, 470-2471(M) or 470-2471(MS), may also be printed from: ▪ The online manual. ▪ SharePoint under Employee Manual/Forms.
Completion	The ABC system automatically issues form 470-2471 or 470-2471(S) to the participant the first time earnings are entered into the system for a member of the FIP eligible group. The worker can also issue the form manually as needed.
Distribution	Mail or give the form to the participant. The worker does not keep a copy.

ICF/ID Resident Care Agreement, Form 470-0374

Purpose

The *ICF/ID Resident Care Agreement* is a contract/agreement between the ICF/ID, the resident, and the Department spelling out the duties, rights, and obligations of all parties concerned. This form is completed after eligibility for Medicaid in the ICF/ID is approved by the income maintenance worker.

Source

Complete form 470-0374 using the template in SharePoint under Employee Manual/Forms or the Worker Information System Exchange (WISE).

Completion

The Department worker prepares three copies of the agreement for signatures by entering in the resident's name and Medicaid state ID, the ICF/ID facility, and the admission date. The Department worker signs the form before sending the form to the ICF/ID.

A form is completed when a resident:

- Is approved for Medicaid ICF/ID payment,
- Is reinstated after one month or more of ineligibility, or
- Transfers between ICF/IDs.

The ICF/ID is responsible for getting the resident's signature. A legal guardian may sign for the resident without the need for the signature of a witness.

If a resident is unable to sign the form, a letter "X" or the resident's thumbprint shall be affixed to the line reserved for the resident's name. In such cases, the signatures of two witnesses are necessary for an "X" signature and one witness for a thumbprint.

The ICF/ID reviews the document for completeness and signs last. Do not accept revisions in the language of the agreement. The Bureau of Medical and Long-Term Care shall sign the agreement on behalf of the Department for residents of Woodward and Glenwood State Resource Centers.

Distribution

After all signatures are obtained, the ICF/ID is responsible for distributing a copy to all parties.

- One copy is given to the resident,
- One copy is retained in the resident's file at the ICF/ID, and
- One copy is uploaded to the member's file in the Department's Iowa Medicaid Portal Access (IMPA) system.

Data	Enter the resident's name and Iowa Medicaid state ID, the facility's name, and the date the resident entered the ICF/ID. The date the resident entered the ICF/ID is the contract/agreement date.

Important Information About Your FIP, Form 470-3851

Purpose

Beginning on January 1, 1997, families can get FIP assistance for a total of only 60 months. The 60-month period need not be consecutive. See 4-C, *Limit on FIP Assistance*, for information about the 60-month FIP limit.

Form 470-3851 is issued to families whose FIP assistance is counted toward the 60-month limit. It informs families of the number of FIP months they have used and the number of FIP months they have left to use. The purpose is to alert them to prepare for becoming self-supporting by the end of their 60-month limit.

Source

Generate form 470-3851 from the following sources:

- For active FIP families that have received FIP for 36 or more months, generate form 470-3851 for the family by choosing the "Active Cases That Have Used FIP For 36 or More Months" report in ETS. Using this source will:
  - Simultaneously generate Comm. 137, *60-Month Limit on FIP*. Comm. 137 provides the family with basic information about the 60-month FIP limit.
  - Automatically record in ETS the date you generate the form and the number of FIP months used at that point.
  - Fill in all items except for your name and phone number. Complete these items before issuing the form to the client.
  - Automatically generate a copy of both documents for the case record.
- For families that are not active on FIP or have received FIP for fewer than 36 months, generate form 470-3851 from the "Form History" page in ETS. This will also generate Comm. 137.

  Form 470-3851 will be blank, requiring you to fill in all items before issuing the form to the client. Also, the date you generate the blank form will not be recorded in ETS.

  Using the "Form History" page, you can also:

  - Obtain Comm. 137 separately, without form 470-3851.
  - Obtain completely filled-in duplicates of form 470-3851 you previously sent to a family from the "Active Cases That Have Used FIP For 36 or More Months" report in ETS, if there is a need. For example, the family may request a duplicate copy.

- You can complete 470-3851 using the form in the Worker Information System Exchange (WISE). There is a button on Page 1 that links to Comm. 137. Click on the button to open and print Comm. 137.
- You can also print 470-3851 from:
  - The online manual.
  - SharePoint under Employee Manual/Forms.

Completion

Issue form 470-3851, along with Comm. 137, to parents or needy specified relatives whose FIP assistance is counted toward the 60-month limit. Obtain the number of months an applicant or a participant family has received FIP from the Eligibility Tracking System (ETS).

Issue the form:

- At months 36, 42, 48, 54, 56, and 58 to families active on FIP.
- At the annual review interview, regardless of how many months the family has received FIP. Discuss the family's FIP status and the impact of the 60-month limit.
- At the application interview for families that have not received FIP for 60 months and are reapplying for FIP. Discuss the family's FIP status and the impact of the 60-month limit.
- At the family's request.

NOTE: You may also issue form 470-3851 at any other time it appears appropriate or beneficial to the family. Examples:

- You may want to issue the form in month 59 or even month 60 to help families to better understand the connection between the number of months they have received FIP and the 60-month cancellation notice.
- You may want to include the form when issuing form 470-3826, *Request for FIP Beyond 60 Months*, to families that are close to the 60-month limit. (See 6-Appendix for information on issuing form 470-3826 to families that have received FIP for 58 or more months.)

Distribution

Issue the completed original of the form to the family along with Comm. 137.

If the form is generated through the "Active Cases That Have Used FIP for 36 or More Months" report, the issuance will automatically be recorded in the ETS Forms History.

If a blank form is completed from the ETS Forms History or from the on line manual or SharePoint, note the issuance in the On Line Narrative.

It is not necessary to keep a copy of the form in the case record.

Data

If you are generating a blank form 470-3851, fill in:

- The date.
- Your county office number.
- The FIP case number.
- The client's name and address.
- The number of FIP months the family has used.
- The number of FIP months the family has left to use.
- Your name, worker number, phone number, and email address.

If you are generating form 470-3851 from the "Active Cases That Have Used FIP For 36 or More Months" report in ETS, fill in your name and phone number.

NOTE: When generating a blank form 470-3851, be sure to state the most current number of FIP months the family has used. For example, if you are completing the form so late in month 56 that it will be month 57 before the family will get the form, state "57" as the number of FIP months used.

Important Information About Your Medicaid Benefits, Form 470-4537

Purpose	Form 470-4537 is used to notify the member that Medicaid will stop paying for most of their prescriptions.
Source	This form is system-generated.
Completion	Central office will mail form 470-4537 to a member: ▪ Two months before a member turns age 65, and ▪ When the Centers for Medicare and Medicaid Services notifies the Department that the member has Medicare benefits.
Distribution	One copy is mailed to the member.
Data	The form explains: ▪ That Medicaid stops paying for most prescriptions when Medicare coverage begins. ▪ What Part D costs Medicare will help pay for because the member receives help from Medicaid. ▪ What will happen if the member does not enroll in a Part D plan. ▪ What the member should do if the member has drug coverage through an employer or union. ▪ Who to call if the member has questions.

Inability to Find a Responsible Person, Form 470-3356

Purpose

The *Inability to Find a Responsible Person* is completed when an individual or an organization wants to be considered a "responsible person" for a client who is physically incapacitated, incompetent, or deceased and is in need of a "responsible person" to act on their behalf and there is otherwise no person to act in that capacity.

Source

Form 470-3356 is not printed. Print supplies as needed from:

- The online manual.
- SharePoint under Employee Manual/Forms.
- The Worker Information System Exchange (WISE).

Completion

The person or organization requesting to be considered as a responsible person completes the form.

Distribution

The party who completed the form submits one copy to the county DHS office and should keep one copy.

Data

The form contains:

- The name of the client.
- The reason that the client needs representations.
- The name of the person proposed to be the responsible person.
- The period of time for which responsibility is requested (during application, for ongoing eligibility, or both).
- The signature of the proposed responsible person.
- The date of the signature.
- The name of the business or organization the responsible person is from, if any.
- The signature of a person from that organization authorizing this designation.
- The position of the authorizing person.

Income Request for Information, Form 470-5533 or 470-5533(S)

Purpose	*Income Request for Information*, 470-5533 or 470-5533(S) is sent by ELIAS when a batch creates an EDBC with a status of “Deferred Verification”. This form contains clear instructions for completion and informs clients on how to provide the information.
Source	The ELIAS System generates form 470-5533 automatically. Form 470-5533(E) is generated when the Medicaid member has indicated that Spanish is their preferred language. DHS staff may issue a manual Income Request for Information by completing a *Request for Info,* 470-5089, using the templates in SharePoint under Employee Manual/Forms or in the Worker Information System Exchange (WISE).
Completion	The ELIAS system issues form 470-5533 or 470-5533(S), completed by the system.
Distribution	This form is system generated by ELIAS and mailed to the client. A copy is filed in WISE.
Data	The ELIAS system will populate the name, address, worker identification, client name, case number and due date. A WISE narrative is created to indicate the Income Request for Information was sent.

Institutional Spouse Intent to Transfer Resources, Form 470-4888

Purpose	Form 470-4888, *Institutional Spouse Intent to Transfer Resources*, is used to document the institutionalized spouse's intent to transfer ownership of their resources to the community spouse as a condition of ongoing Medicaid eligibility within 90 days of being approved for Medicaid facility assistance.
Source	Complete 470-4888 using the form in the Worker Information System Exchange (WISE).
Completion	After an institutionalized spouse is approved for Medicaid, the income maintenance (IM) worker issues the form to obtain: ▪ The member's written statement of intent to transfer resources to the community spouse within 90 days. ▪ Proof of the resources transferred.
Distribution	Give one copy to the member. Upload a copy to the electronic case file. The member signs the form and returns it. Upload the signed form into the case file.
Data	Entering the case number for the facility case will populate the name, address, and salutation of the member. The worker profile will populate the worker address and contact information.

Insurance Questionnaire, Form 470-2826 or 470-2826(S)

Purpose	The *Insurance Questionnaire* is used to identify members who have health insurance or other medical resources available to them. It is also used as an input document for transmitting information to the Third-Party Liability subsystem.
Source	Both the English and Spanish versions of the form are available as templates in: ▪ SharePoint under Employee Manual/Forms. ▪ The Worker Information System Exchange (WISE).
Completion	Give or mail this form to the members or their representatives to complete when a change in medical resources is reported. Case and worker number are entered into WISE by the IM worker.
Distribution	When a completed *Insurance Questionnaire* is returned, handle it as follows: ▪ If the form indicates no insurance coverage, no action is required. ▪ If the form indicates coverage from any source, send the completed form to the IME Revenue Collection Unit by: **Email**: Revcol@dhs.state.ia.us **Fax**: 515-725-1352 When you send the form to IME, you may keep a copy of the form in the case record. However, this is not mandatory because IME will scan all forms to the workflow processing system.

Insurance Report, Form 470-0444

Purpose	Form 470-0444 is used to obtain information regarding life insurance policies carried by an applicant or participant or a member of the family whose resources are considered in determining eligibility for FIP or Medicaid.
Source	Complete form 470-0444 using the template in: ▪ SharePoint under Employee Manual/Forms. ▪ The Worker Information System Exchange (WISE). This form is also printed with 20 two-part precarboned sets on a pad. Order supplies from Iowa Prison Industries at Anamosa.
Completion	The IM worker completes this form when authorized by the applicant or participant to secure information that is not otherwise available. Complete the cover letter. The client or authorized representative signs the authorization portion of the form. The insurance company representative completes the remainder of the form.
Distribution	Forward one copy to the insurance company. You may upload the request to the electronic case file. When the insurance company returns the original, it will be scanned and uploaded.
Data	Enter identifying information, sign the form as the person requesting information, and fill in the policy numbers if available. Enter the return address of the Department office at the bottom of the second page.

Iowa Medicaid Billing Statement, Form 470-5285 or 470-5285(S)

Purpose	The *Iowa Medicaid Billing Statement* is sent to members in the Iowa Health and Wellness Plan (IHAWP) coverage group when a premium is assessed.
Source	The statement is computer-generated from the Premium Payment System at Iowa Medicaid Enterprise (IME). When a member reports non-receipt of a billing statement, advise the member to contact Member Services at IME.
Completion	The billing statement is issued directly from IME. A preaddressed envelope is included for members to remit premium payments.
Distribution	One copy of the billing statement is mailed to the member. If a copy of the billing statement is needed for an appeal, contact Member Services at IME to request a copy.
Data	The billing statement: ▪ Contains the billing date, the case name and address, and the member's state identification number. ▪ Identifies the months, the amount owed per month, the payment due date, payment history, and Department contact information. ▪ Allows the member the opportunity to claim financial hardship for inability to pay the monthly premium. ▪ Instructs members to remit the bottom portion of the statement with payment, using the envelope provided.

IPV Referral Cover Sheet, Form 470-3035

Purpose	Form 470-3035 transmits a request for an administrative disqualification hearing to determine if a client has committed an intentional program violation (IPV) under SNAP.
Source	Complete 470-3055 using the form in the Worker Information System Exchange (WISE).
Completion	The IM worker responsible for submitting the IPV referral completes the form. When requesting administrative disqualification on more than one member of the same household, complete a separate form and documentation for each referral. Attach: ▪ A summary of the alleged violation. ▪ Copies of documentary evidence supporting the allegation. ▪ A copy of the *Overpayment Recovery Information Input Summary* (from the direct claim entry screen), if applicable. Each referral shall contain a summary and supporting evidence. Do not send in multiple referrals with one set of evidence. You need to attach a summary and evidence for each referral.
Distribution	The worker forwards the referral packet to the worker's supervisor (or designee) for approval and signature. Submit the signed original with the rest of the referral information to the DHS Appeals Section, 5th Floor, 1305 E. Walnut Street, Des Moines, IA 50319-0114. Keep a copy of the entire referral packet in the case file.
Data	**Name**: Enter the first name, middle name (if known), and last name of the person being referred for fraud. If appellant has changed names, indicate previous names in this section also. **Date**: Enter the date of the referral. **Address**: Enter the complete address of the person being referred. If the person is no longer receiving benefits, list the last known address. **Case number**: Enter the complete ABC case number of the person being referred. If the case is not active, list the closed case number. **SNAP Status**: Check the box to indicate whether the person is receiving benefits (active) or not (closed).

State Identification Number: List the state identification number of the person being referred.

Birthdate: List the birth date of the person being referred.

Social Security Number: List the social security number of the person being referred.

Previous Disqualifications: List any known previous IPV disqualifications of the person being referred. Include the appeal number or the date of the criminal order, if available.

IM Worker Name, Worker Number, and Telephone Number: List the name, number, and telephone number of the person completing the form.

IM Supervisor or Designee Signature: The worker's supervisor or the supervisor's designee shall review the information being submitted and sign the form to indicate approval.

Landlord Questionnaire, Form 470-1632 or 470-1632(S)

Purpose	Form 470-1632 or 470-1632(S), *Landlord Questionnaire*, is used to secure information from a landlord or roommate with the client's permission.
Source	Complete the English or Spanish version using the form in the Worker Information System Exchange (WISE).
Completion	The IM worker or QC reviewer completes this form when it is necessary to obtain information from a landlord or roommate. The client signs and dates the form. The landlord or roommate must complete the rest of the form.
Distribution	Send the form with the *Request for Information* any time rent or utilities need to be verified.
Data	Enter the following information before sending the form to the client: ▪ Due date ▪ Worker's phone number ▪ Tenant's name ▪ Property's address ▪ Months requiring household members verification ▪ Months requiring rent verification

Level of Care Certification for HCBS Waiver Program, Form 470-4392

Purpose

Form 470-4392, *Level of Care Certification for HCBS Waiver Program*, provides a mechanism for a medical professional to report a Medicaid member's admission, change in condition, or annual assessment for level of care.

Providers are encouraged to conduct the level of care process during a routine or preventative office visit.

Source

This form is available on the DHS website under provider forms.

Department staff can issue 470-4392 using the form on:

- SharePoint under Employee Manual/Forms.
- The Worker Information System Exchange (WISE).

Completion

A medical professional (MD, DO, ARNP, or PA) must complete the form when:

- A Medicaid member is going to receive services provided in their home or community.
- A Medicaid member has a significant change in condition.
- A Medicaid member has an annual assessment.

The IME Medical Services Unit will make a level of care determination upon receipt of the form.

Distribution

The medical professional completing the form or others involved in assisting in arranging the services (i.e., facility staff, hospital discharge planner, case manager, or family member) shall:

- Fax the form to the IME Medical Services Unit at 515-725-1349 or
- Email the form to imeltc@dhs.state.ia.us and
- Provide a copy to the Medicaid member.

Data

Today's Date: The actual date the form is completed in MM/DD/YY format.

Iowa Medicaid Member Name: The Medicaid member's first, middle initial, and last name as it appears on the eligibility card.

State ID or Social Security Number: The member's state identification number or social security number as it appears on the eligibility card.

Birth Date: The Medicaid member's birth date in MM/DD/YY format.

Provider Name and Telephone Number with Area Code: The specific information for the medical professional filling out the form.

HCBS Waiver: Contains the specific Medicaid home- and community-based (HCBS) waiver type.

Diagnoses and Medications: The member-specific health information related to diagnoses and medications. The healthcare practitioner may submit supporting documentation and a medication list along with the form in order to complete the review.

Level of Care Criteria: Mandatory criterion sections. Please review each category and check all applicable criteria. Please check all that apply, as well as additional comments the medical professional may want or need to add.

Signature with Title of Healthcare Professional (MD/DO/ ARNP/PA): The signature of the medical professional completing the form.

Lost Form Request, Form 470-0272

Purpose

Form 470-0272 is used to request certain system-generated forms that are not received or are received and misplaced. A replacement document has the sequence number of the last document.

Source

Complete form 470-0272 using the template in:

- SharePoint under Employee Manual/Forms.
- The Worker Information System Exchange (WISE).

Completion

When you do not receive a form, determine if sufficient time for processing has elapsed before submitting a *Lost Form Request*.

Complete this form to request replacement of the following forms from the MMIS Medically Needy Subsystem:

- The Eligibility Status Turnaround Document (ESTD),
- The Bill Status Turnaround Document (BSTD), or
- The *Notice of Spenddown Status* (NOSS), for cases that have a spenddown.

If screens LF01 and IEV2 are not available, you can also use this form to request forms from:

- The Automated Benefit Calculation (ABC) system.
- The Income and Eligibility Verification System (IEVS).

Distribution

For forms from the Medically Needy subsystem, send the form to the IME Medically Needy Unit using the 'send' button on the template. Enter the email address listed on the form.

For IEVS or ABC system forms, submit the form to the Division of Information Technology (DoIT), Hoover State Office Building.

Data

Mark the box indicating the form requested. For each request for replacement, complete the:

- Identifying numbers
- Worker number
- Date
- County
- Signature

MAIT Facility Worksheet, Form 470-4678

Purpose	Form 470-4678 is used to calculate client participation for a member who resides in a medical institution and has a medical assistance income trust (MAIT or Miller trust).
Source	Complete 470-4678 using the form in the Worker Information System Exchange (WISE).
Completion	IM workers use this form when calculating client participation for members who reside in a medical institution and have a medical assistance income trust (MAIT or Miller trust). Complete a worksheet for each initial determination and annual review.
Distribution	File the original in the case file.
Data	Some modification in use may be needed to fit individual situations. Enter the facility **case number**, including FBU. Entering the case number automatically populates the **case name**.

1. **Central office/local office approval date**: Enter the date the trust met the criteria for a medical assistance income trust (MAIT).
2. **Execution date**: Enter the date that the trust was signed and notarized.
3. **Date trust was established**: Enter the first day of the month that income is used to fund the trust. This will be the effective date of eligibility.
4. **Member's facility type**: Select ICF/ID, mental health institute, nursing facility, or PMIC from the dropdown box.
5. **Charge for care**: The worksheet defaults to the current state fiscal year and enters the amount based on the member's facility type. Select the other button to enter amounts based on the member's facility type for the previous state fiscal year.
6. **Gross income**: Enter the source and gross amount of unearned and earned income used to fund the trust. The worksheet calculates the total gross income.

7. Is member's adjusted gross income greater than 125 percent of the statewide average charge for care?

   If 125 percent of the statewide average charge for care is less than the total gross income, the worksheet enters "Yes, deny facility eligibility and approve Medicaid only under Medically Needy." Otherwise, if 125 percent of the statewide average charge for care is greater than the total gross income, the worksheet enters "No, calculate client participation."

8. **Months**: Enter the months that the client participation calculation is to cover.

9. **Diversion to community spouse?** Check "Yes" if there is a community spouse. Check "No" if there is no community spouse.

10. **Client participation**: Enter the dependent diversion, unmet medical expenses, aid and attendance, and nursing facility insurance payments. The worksheet calculates the adjusted gross income, client participation, and maximum client participation.

11. **Vendor name**: Enter the name of the medical institution where the member resides.

Per diem: Enter the per diem rate of the medical institution where the member resides. The maximum Medicaid rates automatically populate.

Entries for the second page (Sys Entries & Spouse tab) include:

Year: The worksheet defaults to the current year. Select the other button if you are calculating the client participation for the previous year.

Community spouse diversion: Enter the income source and the gross unearned and earned income of the community spouse.

Total income for community spouse: The worksheet calculates the total gross unearned and earned income of the community spouse.

Maximum diversion amount: The worksheet enters the amount based on the minimum monthly maintenance needs allowance (MMMNA) for the year selected.

Deficit: The worksheet calculates the community spouse's income shortfall and enters the amount in the "spousal diversion" field under Item 10.

System entries: Use these case actions to enter the Miller Trust information into the ABC system.

MAIT Waiver Worksheet, Form 470-4679

Purpose	Form 470-4679 is used to calculate client participation for members who are eligible for a home- and community-based services (HCBS) waiver and have a medical assistance income trust (MAIT or Miller trust).
Source	Complete 470-4679 using the form in the Worker Information System Exchange (WISE).
Completion	The IM worker uses this form when calculating client participation for a member who has been approved for a HCBS waiver and has a medical assistance income trust (MAIT or Miller trust). Complete a worksheet for each initial determination and annual review.
Distribution	File the original in the case file.
Data	Some modification in use may be needed to fit individual situations. Enter the facility **case number**, including FBU. Entering the case number automatically populates the **case name**. 1. **Central office/local office approval date**: Enter the date the trust met the criteria for a medical assistance income trust (MAIT). 2. **Execution date**: Enter the date that the trust was signed and notarized. 3. **Date trust was established**: Enter the first day of the month that income is used to fund the trust. This will be the effective date of eligibility. 4. **Member's level of care**: Select ICF/MD, mental health institute, or nursing facility from the dropdown box. 5. **Charge for care**: The worksheet defaults to the current state fiscal year and enters the amount based on the level of care selected in Item 4. Select the other button to enter amounts based on the level of care for the previous state fiscal year. 6. **Gross income**: Enter the source and gross amount of unearned and earned income used to fund the trust. The worksheet calculates the total gross income. The worksheet calculates the adjusted gross income after deducting the $10 trust administrative fee.

7. Is member's adjusted gross income greater than 125 percent of the statewide average charge for care?

   If 125 percent of the statewide average charge for care is less than the adjusted gross income, the worksheet enters "Yes, deny facility eligibility and approve Medicaid only under Medically Needy."

   If 125 percent of the statewide average charge for care is greater than the adjusted gross income, the worksheet enters "No, calculate client participation."

8. **Waiver type**: Enter the HCBS waiver type the member has been approved for.

9. **Months**: Enter the months that the client participation calculation is to cover.

10. **Client participation**: The worksheet enters the maintenance allowance based on the year selected. The worksheet defaults to the current year. Select the other button if you are calculating the client participation for the previous year.

    Enter the needs allowance for spouse or spouse and dependents, unmet medical expenses, aid and attendance, and nursing facility insurance payments. The worksheet calculates the client participation and total client participation.

System entries: Waiver cases require manual system entries. Use these case actions to manually enter the Miller trust information into the ABC system.

Medicaid Claim Denial Notice, Form 470-0385

Purpose	The purpose of form 470-0385 is to notify Medicaid members that the Iowa Medicaid Enterprise has denied a claim for service rendered to the member.
Source	This form is only issued by the IME Core Services Unit (the unit that processes and pays Medicaid claims).
Completion	The IME Core Services Unit prepares the form when a claim for ambulance service or rehabilitation agency services is denied because the criteria for payment are not met. The form is included in the manual for information only.
Distribution	The IME Core Services Unit sends the original to the member and keeps one copy for its files.
Data	Self-explanatory.

Medicaid EPSDT Enrollees, Report Number X161C5A

Purpose	The *Medicaid EPSDT Enrollees* report notifies workers that the local office is responsible for providing the EPSDT "Care for Kids" oversight. Responsibilities under this program are covered in 8-M.
Source	The Iowa Medicaid Enterprise generates this printout monthly.
Completion	This report is for information only. It identifies the children on the worker's caseload that are eligible for "Care for Kids" screenings.
Distribution	The report is issued to the IM workers for children in foster care and persons who are eligible for Medically Needy with a spenddown. Oversight for other cases is provided by local public health agencies under contract to the Department.
Data	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 screening periodicity schedule.

Medicaid EPSDT Enrollees Due Screening by Periodicity, Report Number X1612C34

Purpose	The purpose of the *Medicaid EPSDT Enrollees Due Screening by Periodicity* report is to notify workers of children on their caseload due for "Care for Kids" screening.
Source	The Iowa Medicaid Enterprise generates this report monthly for each IM worker whose caseload includes children in foster care and persons who are eligible for Medically Needy with a spenddown, based on payment records for screening services.
Distribution	When you receive the new *Screening Due by Periodicity List*, you may discard the previous month's report.
Data	This list indicates the prior and next screening dates. The "PRIOR" screening date is the last screening paid by Medicaid in the last two years. The "NEXT" screening date is based upon the member's age and the Screening Periodicity schedule. A date will appear if: ▪ The member is due for a screening in the current or next two months. ▪ The member has not received a screening in the last year and the member is under seven years of age. The column labeled "OVER 1 YEAR" will contain a "YES" if it has been more than 12 months since this child has had a screening exam paid by Medicaid. A double asterisk (**) also identifies these same members. EXCEPTION: These indicators do not apply to anyone on the two-year screening schedule (i.e., 8-year, 10-year, etc.).

Medicaid for Independent Young Adults Change Report, Form 470-4376

Purpose	Form 470-4376 is a reminder to members in the Medicaid for independent young adults (MIYA) coverage group that changes in addresses and health insurance must be reported to the income maintenance worker whenever they occur. It provides a simple means for the member to report a change.
Source	Complete form 470-4376 using the template in: ▪ SharePoint under Employee Manual/Forms. ▪ The Worker Information System Exchange (WISE).
Completion	When changes in addresses or health insurance occur, the member completes and submits the form to the assigned income maintenance worker.
Distribution	Issue the form: ▪ At the time of the automatic redetermination for Medicaid for independent young adults following the foster care exit. ▪ At the time of application. ▪ When Medicaid for independent young adults eligibility is established. ▪ At the annual review. ▪ When the member submits the form to report a change. ▪ When the member requests a form. File the submitted form in the case record after the required action is completed. Document the resulting action in the case record.

Medicaid for Kids With Special Needs Income Worksheet, Form 470-4632

Purpose	Form 470-4632 is used to calculate countable income for the SSI-related coverage group Medicaid for kids with special needs (MKSN). It can be used to provide the applicant or member with information on the computation and assists the worker in making an accurate income determination.
Source	Complete form 470-4632 using the template in: ▪ SharePoint under Employee Manual/Forms. ▪ The Worker Information System Exchange (WISE).
Completion	The IM worker completes an original and one copy when calculating income. Enter the number of children applying for MKSN. The health insurance information may be completed at the end of the form, but it is not required.
Distribution	Mail the original to the applicant or member and file the copy in the case record.
Data	**Item 1. Case name**: Enter the name of the child with disabilities who will be the eligible person on the case. NOTE: When there is more than one child per family who qualifies for MKSN, select one to enter here. **Item 2. Case number**: Enter the MKSN case number. **Item 3. Unearned income**: Enter the average monthly unearned income for each source for the disabled child. Enter the full amount of child support received for children under 18 years of age. Enter the average monthly unearned income for each source for the other family members who are included in the family size. When there are more than five family members, add the income of all other members and enter it in the last column. **Items 4 through 6** are calculated by the template. **Item 7. Earned income**: Enter the average monthly earned income from each source for the disabled child. Enter the average monthly earned income from each source for other members included in the family size. **Items 8 through 11** are calculated by the template. **Item 12**. Enter impairment-related work expense, if applicable.

Items 13 through 15 are calculated by the template.

Item 16. Enter work expenses for the blind, if applicable.

Items 17 and 18 are calculated by the template.

Items 19. Enter the monthly amount of the Plan for Achieving Self-Support (PASS).

Item 20. Family size: Enter the number in the household.

Item 21. Number of eligible children in the family: Enter the number of children with disabilities who are included in the MSKN case.

Answer the following questions:

- Does the employer pay at least half of the annual cost of the health insurance premiums?
- If yes, is the child enrolled in health insurance?

After you have made entries and double-clicked on the “Calculate” button at the end of the form, the template performs the income calculation. The calculation will populate the following fields:

- Total Countable Family Income,
- Income for Your Family Size Must Be No More Than (the dollar amount of 300% of the federal poverty level for the family size),
- Medicaid for Kids With Special Needs Poverty Level (the percentage of the federal poverty level represented by the family’s countable income), and
- Eligible or Not Eligible.

If you have made an error in entering data, correct the data and double click on the “Calculate” button again.

Medicaid/Hawki Review, Form 470-5168, 470-5168(S), 470-5168(M), or 470-5168(MS)

Purpose	The *Medicaid/Hawki Review* is designed for use as the annual review document for MAGI-related Medicaid. This form contains instructions for completion and informs clients of their rights and responsibilities.
Source	Usually, the ELIAS system generates form 470-5168 automatically. Form 470-5168(S) is generated when the Medicaid member has indicated that Spanish is their preferred language. DHS staff may issue a manual version of the form, 470-5168(M) or 470-5168(MS), using the templates in: ▪ SharePoint under Employee Manual/Forms. ▪ The Worker Information System Exchange (WISE).
Completion	The ELIAS system produces form 470-5168 or 470-5168(S) at the end of the month for Hawki and MAGI-related Medicaid when a case is active for Medicaid in the ELIAS system and due for an annual review. Give or issue the form to the member upon request. The worker or the ELIAS system completes the top portion of page 1 before the form is sent or issued to the participant. The member 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.
Distribution	Give or mail one copy of the form to the client for completion. The completed form is scanned and filed in the case record.
Data	Whenever the form is issued manually, provide a pre-addressed return envelope. Prepare the form as follows: ▪ Enter the Imaging Center name and address in the upper left hand corner of the form. ▪ Enter the case name and current mailing address. ▪ **Due Date**. Enter the date the renewal form is due back to the Department. ▪ **Case Number**. Enter the complete case number.

- **County Number**. Enter the county number.
- **Worker Name**. Enter the worker or team name.
- **What do I do with this form?** Enter the date the renewal form is due back to the Department.
- **What if I have questions?** Enter the telephone number of the worker or team.

Medicaid/State Supp Review, Form 470-5482, 470-5482(S), 470-5482(M), or 470-5482(MS)

Purpose	The *Medicaid/State Supp Review* is designed as the annual review document for Non-MAGI-related Medicaid. This form contains instructions for completion and informs clients of their rights and responsibilities.
Source	The ELIAS and ABC system generate form 470-5482 automatically. Form 470-5482(S) is generated when the Medicaid member has indicated that Spanish is their preferred language. DHS staff may issue a manual version of the form, 470-5482(M) or 470-5482(MS), using the templates in: ▪ SharePoint under Employee Manual/Forms. ▪ The Worker Information System Exchange (WISE).
Completion	The ELIAS and ABC system produce form 470-5482 at the end of the month for Non-MAGI Medicaid when a case is active for Medicaid and due for an annual review. Give or issue the form to the member upon request. The worker or the ELIAS or ABC system completes the top portion of page 1 before the form is sent or issued to the participant. The member must complete the answers to all applicable questions. The participant may obtain help in completing the form from friends, relatives, advocate groups, or Department staff, if needed.
Distribution	Give or mail one copy of the form to the client for completion. The completed form is scanned and filed in the case record.
Data	Whenever the form is issued manually, provide a pre-addressed return envelope. Prepare the form as follows: ▪ Enter the Imaging Center name and address in the upper left hand corner of the form. ▪ Enter the case name and current mailing address. ▪ **Due Date**. Enter the date the renewal form is due back to the Department. ▪ **Case Number**. Enter the complete case number.

- **County Number**. Enter the county number.
- **Worker Name**. Enter the worker or team name.
- **What do I do with this form?** Enter the date the renewal form is due back to the Department.
- **What if I have questions?** Enter the telephone number of the worker or team.

Medical Assistance Debt Notice, Form 470-4342

Purpose	The Estate Recovery section of the IME Revenue Collection Unit uses form 470-4342 to notify interested parties, including family members, that a deceased Medicaid member incurred a debt to repay for paid Medicaid claims.
Source	Form 470-4342 is issued by the Iowa Medicaid Enterprise Estate Recovery Unit.
Completion	Form 470-4342 is issued in conjunction with form 470-4339, *Medical Assistance Debt Response*, when the deceased member's estate is subject to estate recovery according to 441 IAC 76.12(7)"b" and "c." Estate Recovery staff complete this form after the reported death of a Medicaid member who was either: ▪ 55 years of age or older, or ▪ Under age 55, residing in a long-term care facility, and not able to return home.
Distribution	Estate Recovery staff sends the original to the designated interested party. A copy of the notice is retained in the Estate Recovery Unit case file.
Data	The form includes information about: ▪ The deceased member's name and state identification number. ▪ The amount of medical debt.

Medical Assistance Debt Response, Form 470-4339

Purpose	The Estate Recovery Program of the IME Revenue Collection Unit uses form 470-4339 to obtain information about the assets of a deceased Medicaid member.
Source	Form 470-4339 is generated by the Estate Recovery Unit.
Completion	The Estate Recovery Program staff issues form 470-4339 along with form 470-4342, *Medical Assistance Debt Notice*, when the deceased's estate is subject to estate recovery. The representative of the deceased member is to complete and sign the form and then returned to the Estate Recovery Program. The income maintenance worker is not responsible for assisting with this form. The Estate Recovery Program staff will assist representatives who need help with this form.
Distribution	Estate Recovery Program staff sends the original to the designated interested party. A copy of form 470-4339 is retained in the Estate Recovery Program case file.
Data	The form includes information about: ▪ Name and date of death of the recipient ▪ Representative's name, address, and telephone number ▪ Identification of assets ▪ Identification of other expenses that must be paid ▪ Identity of the spouse, if applicable ▪ Funeral home ▪ Name and address of nursing facility, if applicable

Medical Assistance Eligibility Card, Form 470-1911

Purpose

The *Medical Assistance Eligibility Card* contains basic identifying information to enable a provider of medical care to confirm a Medicaid member's eligibility. The member is instructed to keep the permanent card and present it when receiving medical services.

Source

The *Medical Assistance Eligibility Card* is computer-generated for new approvals during the daily processing.

The IM worker or the IME Member Services Unit can generate replacement cards through the web-based system.

Completion

The *Medical Assistance Eligibility Card* is issued to the member directly. The first card is mailed at the time of initial approval.

The Department will issue replacement cards:

- Upon a member's request, or
- When foster care eligibility is established.

Circumstances under which a replacement card is necessary includes:

- The card has been lost, stolen, or damaged;
- The member did not receive the initial card;
- The member's name changes; or
- A duplicate card is needed for a member who is out of the home, for example, when a child is visiting relatives over the summer.

The member will not be issued a new card if the member changes Medicaid coverage groups.

The new annual card does not guarantee Medicaid eligibility.

Distribution

Each member will receive one wallet-size card and two key tags at the time of initial approval. No more than three family members' cards will be mailed together. The cards will be mailed to the case name and mailing address. This includes those residing in a residential care facility.

Cards for new members living in a medical facility will be mailed to the facility address.

Data

The member's name, date of birth, and state identification number are printed on the wallet card and key tags.

Information on appeal rights, payment of medical bills, the Department's right to recover payments made or make a claim against another responsible for member's medical cost, and when a member should contact Iowa Medicaid Enterprise (IME) Member Services Unit is included on or with the card.

The card and tags instruct providers to verify member eligibility by calling the Eligibility Verification System (ELVS) or via the verification website. Instructions on how to gain access to the website are included for the provider.

At the time of service, providers must:

- Confirm eligibility,
- Identify any service restrictions (such as lock-in, HMO, MediPASS, or Iowa Plan), and
- Determine whether a member has other health insurance coverage.

Replacing Medical Assistance Eligibility Cards

1. To replace an annual medical card, access the Online Card Replacement Application (OCRA) through the DHS field Intranet.
2. Click on the following headings:

   IM
   OCRA

3. Enter the member's state identification number, or the member's last name, and birth date. Click "Search."
4. Click on the state identification number.
5. Make sure all information is correct on PRSM. If not, contact Quality Assurance at 1-800-373-6306 or (515) 281-6401 to update PRSM.
6. Once information is correct, click on the "Send a Card" box for the person who needs a replacement. Then click on "continue" at the bottom of the screen.
7. At the next screen, choose a reason the medical card is being replaced. Make notes as appropriate. Click on "Submit Request."

Medical cards will be issued within 7 to 14 days.

In the meantime, providers may verify Medicaid eligibility using ELVS or the secure web portal.

Medical Assistance Income Trust, Form 470-4488

Purpose	Form 470-4488 is used to notify both a medical assistance income trust (MAIT) beneficiary who has applied for Medicaid facility or waiver service and the trustee that the application has been approved. The letter explains how the trust affects Medicaid eligibility and benefits and how the income of the trust should be distributed.
Source	Complete 470-4488 using the form in the Worker Information System Exchange (WISE).
Completion	The income maintenance worker prepares the form when the Department approves a medical facility or waiver application involving MAIT income.
Distribution	Mail a copy to the Medicaid applicant or member (or the responsible person) and to the trustee. Keep a copy in the case record.
Data	Complete the preface page with the following information: ▪ Case number ▪ Facility type ▪ Expenses the trustee may pay ▪ Any remaining trust income to be paid as client participation and the name of the provider this client participation would be paid to ▪ The name of anyone you would like to get a copy of this letter

Medically Needy Recoupment Memo, Form 470-3739

Purpose	The IME Medically Needy Unit uses form 470-3739 to notify the income maintenance worker that a recoupment needs to be completed because the client did not incur the expenses used to meet spenddown.
Source	The IME Medically Needy Unit supplies this form.
Completion	The IME Medically Needy Unit completes this form.
Distribution	The original is sent to the client's income maintenance worker.
Data	The Medically Needy Unit indicates the following information: ▪ Client name ▪ Case number ▪ Reason for the recoupment ▪ Certification period ▪ Amount applied to spenddown or paid in error

Medically Needy Transmittal, Form 470-3630

Purpose	The purpose of the *Medically Needy Transmittal* is to allow the IM worker to submit old bills or non-Medicaid-payable charges to the IME Medically Needy Unit to apply toward spenddown.
Source	Complete form 470-3630 using the template in: ▪ SharePoint under Employee Manual/Forms. ▪ The Worker Information System Exchange (WISE).
Completion	The income maintenance worker completes the form and attaches it to a copy of the nontraditional or non-Medicaid-covered claim submitted for the person who is conditionally eligible or responsible relative, under the Medically Needy program. Some examples of non-Medicaid-payable expenses are: ▪ RCF personal care. ▪ Bills for services received before the start of a certification period. ▪ Non-Medicaid payable NF, SNF, ICF/ID, or MHI charges. ▪ Expenses from a provider not enrolled in Medicaid. ▪ Payment for rehabilitative services. ▪ Transportation expenses. ▪ Acupuncture.
Distribution	Fax the form to the Medically Needy Unit at (515) 725-1350 or email the form to IMEMedicallyNeedy@dhs.state.ia.us. Attach the medical claim or bill. EXCEPTION: No bill or claim needs to be attached for RCF personal care services, medical facility (SNF or ICF/ID) care, or transportation. Keep the second copy in the case record with a copy of the accompanying claim or bill.
Data	**Case name**: Enter the complete case name, including last and first name, before sending to the Medically Needy Unit. **Case number**: Enter the medically needy case number including the FBU. **Recipient ID**: This is the state identification number of the patient.

Beginning Certification Date: This is the first or beginning month of the certification period. Enter it in MM/YY order.

Ending Certification Date: This is the last or ending month of the certification period. Enter it in MM/YY order.

Payment Date of the Claim: When you know that a payment has been made on the claim or bill enter the date the payment was made in this box.

Payment Amount: When you know the amount of payment on a claim or bill was made enter the amount of payment made in this box.

Payment Source: Enter the source of the payment in:

P Payment by patient
I Insurance
S State public programs other than Medicaid

Use the comments section of the form if further explanation is warranted.

IM Worker County Number: Use the numeric designation for your county, i.e.: Polk county is 77, Black Hawk 07.

IM Worker Number: Enter your complete worker number, using all four digits.

IM Worker Name: Use the first and last name of the worker having the case.

IM Worker Phone Number: Use complete phone number, including area code.

Date Claim Received: This is the date the claim was received in the local office.

Date Claim Sent to Medically Needy Unit: This date should be no later than five days from receipt in the local office.

Comments: Use this section:

- To clarify any issues regarding the claim or bill submitted, when you feel that further explanation will expedite the processing of the claim.
- To show computation of transportation charges or information regarding loans to pay medical charges.

Use the following instructions when submitting claims for RCF personal care, transportation, or medical facility (NF, SNF, ICF/ID) expenses to apply to spenddown.

RCF Personal Care, Transportation, or Medical Facility: Mark the applicable box.

From Date: For RCF personal care or medical facility services, this is the first day services were provided. For transportation charges, enter the first day transportation was used. Use MM/DD/YY format.

To Date: For RCF personal care or medical facility services, this is the last day services were provided. For transportation charges, enter the last day transportation was used. Use MM/DD/YY format.

Procedure Code: Enter the applicable code:

Code	Service
W1501	Transportation
W1500	RCF personal care services
W1504	SNF charges
W1506	NF or ICF/ID charges

Charged Amount: For RCF personal care services, medical facility, and transportation, put in the amount allowed according to policy.

Provider Name: For RCF personal care or medical facility services, this is the name of the facility where the client resides. For transportation, this is the name of the person providing the transportation. When that is the client, enter the client's name.

Provider Address: For RCF personal care or medical facility services, this is the street address of the facility where the client resides. For transportation, this is the address of the person providing the transportation. When that is the client, use the client's address.

City: This is the city where:

- The RCF or medical facility where the client resides is located, or
- The person providing the transportation lives.

State: This is the state where:

- The RCF or medical facility where the client resides is located, or
- The person providing the transportation lives.

ZIP: This is the ZIP code of:

- The RCF or medical facility where the client resides, or
- The person providing transportation.

Phone Number: This is the phone number, including the area code, for:

- The RCF or medical facility where the client resides, or
- The person providing the transportation.

National Provider Identifier or Provider Number: For RCF personal care or medical facility services, this is the provider number of the facility where the client resides.

For transportation charges, if the person providing the transportation does not have a provider number, write “NOT ENROLLED” in this field. The IME will then assign a provider number.

Medicare Savings Programs Additional Information Request, Form 470-4846 or 470-4846(S)

Purpose	Medicare beneficiaries who apply for Extra Help with Medicare Prescription Drug Costs may at the same time indicate that they want to apply for the Medicare Savings Programs (MSP). The Social Security Administration (SSA) will send the data from the application electronically to the Department.
Source	The form will automatically be populated with the data from the *Application for Extra Help with Medicare Prescription Drug Plan Costs*. The system will generate the form and mail it to the applicant. Print the Spanish version of the form from: ▪ The online manual. ▪ SharePoint under Employee Manual/Forms.
Completion	The applicant will review the printed data and make corrections as needed. The applicant will complete the additional questions needed to determine eligibility for the Medicare Savings Programs.
Distribution	SSA will provide only the mailing address. Applicants will return the form to a local office based on their mailing address. If the living address is in another county, the office receiving the form shall route the original form to the DHS office responsible for the applicant's county of residence within two days of receipt.
Data	Date-stamp the original form before faxing or mailing it to the DHS office responsible for processing the application. The following information will be printed on form 470-4846, *Medicare Savings Programs Additional Information Request*: ▪ Applicant's name ▪ Birth date ▪ Spouse's name ▪ Telephone number ▪ Mailing address ▪ Case number and worker number ▪ County number that matches the mailing address ▪ DHS phone number

- MSP application date
- Date DHS received application
- Income information provided to SSA on applicant and spouse (gross earned income, net self-employment, Social Security, Veteran's Benefits, Railroad Retirement benefits, other pensions or annuities and other income)
- Resource information provided to SSA on applicant (bank account, stocks, bonds, other investments, cash, value of real estate other than the applicant's home)

MEPD Billing Statement, Form 470-3902

Purpose	The *MEPD Billing Statement* is sent to members in the Medicaid for Employed People with Disabilities (MEPD) coverage group when a premium is assessed.
Source	The statement is computer-generated from the MEPD billing system.
Completion	The billing statement is issued directly from Central Office. When a member reports non-receipt of a billing statement, send a reprint of the billing statement by making entries on the MEPD STMT screen in the REPRINT CLIENT field. A postage-paid window envelope is included for members to remit premium payments.
Distribution	One copy of the billing statement is mailed to the member. If a copy of a billing statement is needed for an appeal, make entries on the MEPD STMT screen in the REPRINT (WRKR) field.
Data	The billing statement: ▪ Contains the billing date, the case name, and the member's state identification number. ▪ Identifies the amount owed per month, the payment due date, payments received, and date payments were applied. ▪ Notifies the MEPD member that the payment of premiums must be made before medical assistance is given. ▪ Instructs members to remit the coupon on the bottom portion of the statement in the enclosed envelope with their payment.

MEPD Income Worksheet, Form 470-3686

Purpose

Form 470-3686 is used to calculate income eligibility and the premium amount for the SSI-related coverage group “Medicaid for Employed People with Disabilities” (MEPD). It provides the client with information on the computation and assists the IM worker in making an accurate computation.

Source

Complete form 470-3686 using the template in:

- SharePoint under Employee Manual/Forms.
- The Worker Information System Exchange (WISE).

Completion

The IM worker completes the form when calculating income eligibility for the retroactive or current premium period or as otherwise needed. When there are more than six family members, add the income of all other members and enter it in the last income column.

Distribution

Mail the form to the client. Attach a copy to the case record. Attach income verification to the form when required.

Data

Fields requiring entries are:

1. **Case name**: Enter the name of the disabled person who is the eligible person on the case. This person is always “Person A.” A message box will ask, “Is the MEPD person the only one with income?” “Yes” allows entries only for Person A. “No” allows entries for multiple people.
2. **Case number**: Enter the MEPD case number with FBU.
3. **Premium period**: Enter the 12-month premium period. The “From” entry is the first month of the period (the month and year in the TD05 LAST REVIEW field). The “Next” entry is the 12th month of the period (the month and year in the TD05 NEXT REVIEW field).

   If the calculation is for individual months, such as months in the retroactive period that are determined on a month-by-month basis, enter month and year.
4. **Unearned income:**

   Enter the average monthly unearned income for the MEPD person from each source in column 4-A.

Enter in columns 4-B through 4-F the average monthly unearned income from each source for the persons included in the family size. Enter the full amount of child support received for children under the age of 18.

8. **Earned income**: First check the frequency the income is received. Checking “monthly” will total all the amounts entered. Checking “weekly,” “twice a month,” or “every 2 weeks” will average the amounts entered. All income from the MEPD person must be entered under Person A.

13. **Enter impairment-related work expense**. (If an entry is made in line 13, no entry is allowed in line 17.)

17. **Enter work expenses for the blind**. (If an entry is made in 17, no entry is allowed in 13.)

20. **Enter the amount that is excluded under a plan for achieving self-support (PASS).**

Family size: Enter the number of people considered in the family size.

Calculations: The template performs the calculations after you have made all required entries and double-click the red “calculate” button at the end of the form. The calculate button explains how to select the period for the calculation: “Calculate the MEPD income eligibility and premium amount when the ‘TD05 Last Review Month’ of the eligibility period is:”

The template:

- Subtotals unearned income in columns 4-A through 4-F.
- Deducts the $20 general deduction from unearned income.
- Deducts one-third of support payments for minor children.
- Enters subtotal of unearned income.
- Deducts any amount remaining from the $20 general deduction allowed in line 6, applying it to the earned income of “Person A” first.
- Subtotals the earned income of each family member.
- Subtracts one $65 earning deduction from “Person A” first, then applies any remaining deduction to earned income in items 11-B through 11-F.
- Subtotals the earned income of each family member.

- Deducts impairment-related work expenses (IRWEs) for Person A.
- Applies the 1/2 earned income exclusion to each person's earned income. (Lines 14 and 15).
- Deducts work expenses for the blind for Person A. (Line 16 minus line 17.)
- Enters countable income. Adds lines 7 and 18A through 18F.
- Totals countable family income and inserts countable income for the family size. (Line 19 minus line 20.)
- Displays:
  - The total countable family income,
  - The 250% federal poverty level amount for the family size,
  - The calculated income eligibility poverty level, and
  - The calculated premium eligibility level.
- Compares the countable income to 250% of poverty for the family size and indicates if the poverty level test has been met by displaying an "X" in the applicable box.
- Calculates the monthly premium amount for "Person A."

When countable income for the family size is less than 250% of the federal poverty level, the disabled person is eligible and a premium is calculated for the person based on the person's gross income (item 4-A plus item 8-A).

When countable income is 250% of the federal poverty level or above, the disabled person is not eligible. No premium is calculated; the premium period is deleted from item 3 (page 1).

If you discover an entry error, correct the entry and double-click on the red calculating button. The system will recalculate based on your new entry.

MEPD Information About Premium Payments, Form 470-3928

Purpose	Form 470-3928, *MEPD Information About Premium Payments*, is a notice to advise MEPD members who need to pay a premium before they are eligible for Medicaid about the due date for premiums and to advise them they may want to pay the premium sooner than the due date.
Source	The form is system generated by the MEPD billing system.
Completion	The form is informational only.
Distribution	The form is sent to: ▪ Members newly approved for MEPD who have a premium to pay. ▪ Current members who go from having zero premiums to having to pay a premium.
Data	The form advises the members about: ▪ The due date for ongoing premiums. ▪ The fact that premiums must be paid before Medicaid will pay for medical expenses. ▪ The benefit of paying in advance of the due date. ▪ The address where premium payments are to be sent.

MEPD Intent to Return to Work, Form 470-4856

Purpose	Form 470-4856, *MEPD Intent to Return to Work*, is used only to collect information for the Medicaid for employed people with disabilities (MEPD) coverage group.
Source	Complete 470-4856 using the form in the Worker Information System Exchange (WISE).
Completion	After a MEPD member reports a loss of employment, the income maintenance (IM) worker issues the form to obtain: ▪ The member's written statement of intent to return to work. ▪ The last day the member worked. ▪ Proof of final pay amount from employment. The member completes and signs the form.
Distribution	Give one copy to the member. You may upload the request to the electronic case file. When the member returns the original, it will be scanned and uploaded.
Data	Entering the case number for the MEPD case will populate the name, address, and salutation of the MEPD member. The worker profile will populate the worker address and contact information.

MEPD Refund Notice, Form 470-3743

Purpose	Form 470-3743, *MEPD Refund Notice*, explains why the member is receiving a refund. The form is used to issue a refund of excess premium payments for the Medicaid for employed people with disabilities coverage group.
Source	Form 470-3743 is issued by the Bureau of Purchasing, Payments, Receipts and Payroll in the Division of Fiscal Management.
Completion	Staff in the Bureau of Purchasing, Payments, Receipts and Payroll who post premium payments for MEPD complete the form.
Distribution	Purchasing, Payments, Receipts and Payroll staff mail the original to the MEPD member and keep a copy.
Data	**Case number**: Case number for the MEPD case. **State ID number**: State identification number of the member on the MEPD case. **Dear**: Member's name. Purchasing, Payments, Receipts and Payroll staff complete the amount of the refund and check the applicable box for reason for refund.

New Household Member, Form 470-3780

Purpose	Form 470-3780, *New Household Member*, is used to collect information for the Family Investment Program, SNAP, and Medicaid program when the household reports a new household member.
Source	Complete 470-3780 using the form in the Worker Information System Exchange (WISE).
Completion	Issue the form when a household reports a new household member.
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 requesting office.
Data	The template populates address and worker information areas of the form and calculates a due date for the return of the requested information. The client completes identifying information and income and resource information about the new household member.

Newborn, Form 470-3781 or 470-3781(S)

Purpose	Form 470-3781, *Newborn*, is used to collect information for Medicaid, SNAP, and the Family Investment Program when the household reports a newborn child in the home.
Source	Complete the English or Spanish version using the form in the Worker Information System Exchange (WISE).
Completion	Issue this form for the household to complete when a household reports that a newborn has entered the household.
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 requesting DHS office.
Data	The templates will populate the address and worker information areas of the form and calculate a due date for the return of the requested information. The worker must indicate what additional information is requested. The client completes demographic information about the baby and indicates whether the baby is covered by health insurance.

Noncompliance with Third Party Liability (TPL), Form 470-5287

Purpose	The Iowa Medicaid Enterprise (IME) and the Managed Care Organizations (MCOs) use the *Noncompliance with Third Party Liability (TPL)* to: ▪ Alert the local office when a member has not cooperated and ▪ To instruct the local office to sanction a specific member.
Source	The IM worker views the form from the link that displays within the alert message in WISE.
Completion	IME or one of the MCOs sends a record to the repository (IEVS), which generates a noncompliance alert record to the field. IME or one of the MCOs sends a record to the repository (IEVS), which generates an alert when the member fails to return TPL information.
Distribution	The repository (IEVS) sends the compliance alert to WISE. Only after the alert is worked by the IM worker is the alert indexed to the Electronic Case File (ECF).
Data	The repository (IEVS) populates the following: ▪ **Notice Date**: The date the alert is created. ▪ **Member Name**: The member's name. ▪ **Case Number**: The member's case number. ▪ **CIN or SID Number**: The member's Medicaid identification number. ▪ **Sanctioning Agency**: This will be the IME or one of the MCOs. ▪ **Agency Contact**: This will be the phone number of the IME or one of the MCOs. ▪ **Accident/Injury Number**: The member's assigned accident or injury number provided by the IME or one of the MCOs.

Non-Law Enforcement Record Check Request Form A, 595-1489 or 595-1489(S)

Purpose

Non-Law Enforcement Record Check Request, *Form A* is used to request a check for criminal convictions on a nonregistered child care provider and people who live in the provider's home or have access to a child when the child is alone.

Source

The English version of the form is printed with 50 two-part sets on a pad. Order supplies from Iowa Prison Industries in Anamosa.

Complete the English version of the form using the template in:

- SharePoint under Employee Manual/Forms.
- The Worker Information System Exchange (WISE).

Print the Spanish version of the form from:

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

Completion

When the client's selected provider is a nonregistered child care home, the Centralized Child Care Provider Registration Unit issues this form for:

- The child care provider,
- Each person aged 14 or over residing in the provider's home,
- Anyone who works in the home, and for
- Anyone who has access to a child when the child is alone.

Complete the forms:

- At the time of initial application for payment.
- Whenever a new person moves into the home.
- Any time there is an indication that a person has a criminal record.
- At 24-month intervals following the initial check.

Obtain the signature of the person being checked under "waiver," so a complete record check may be performed.

Distribution

The Centralized Child Care Provider Registration Unit sends this form to the unregistered home along with:

- Comm. 95, Guidelines for Child Care Homes with a Child Care Assistance Provider Agreement.
- Form 470-2890, Payment Application for Nonregistered Providers.
- Form 595-1489 or 595-1489(S), *Non-Law Enforcement Record Check Request Form A* (one form for each person over age 13 who lives in the household or has access to the children in care).
- Form 470-3871, Child Care Assistance Provider Agreement.
- A pre-addressed return envelope.

When the provider returns the form, the Unit checks each person's records using the Single Contact Repository (SING) system. If no criminal records are found, the form is filed in the provider's file.

When SING indicates criminal or abuse records, the Unit sends form 470-2310, *Record Check Evaluation*, to the subject of the record to get more information for the purpose of evaluating the conviction or abuse.

Data

Before mailing the form:

- Enter the requesting worker's name, work address, fax number and telephone number in the "From:" spaces.
- Enter the name, maiden name, sex, social security number, and birth date of the person whose records are requested.

The person being checked signs the "waiver" section.

Notice of Action, Form 470-0485(M) or 470-0485(MS)

Purpose

The *Notice of Action* is issued by the ELIAS system to notify clients of agency actions that affect the client's eligibility or benefit level. Each client has the right to be given information regarding eligibility and benefit determination.

Source

In most situations, the ELIAS system generates form 470-0485 based on worker entries or system processes. The Spanish version of the form is manually issued by the worker.

Workers can complete the manual version, form 470-0485(M) or 470-0485(MS), using the templates in:

- SharePoint under Employee Manual/Forms.
- The Worker Information System Exchange (WISE).

Completion

The *Notice of Action* may be used for:

- FIP, RCA, and SNAP actions
- FMAP-related Medicaid and RMA actions
- Medically Needy denials
- SSI-related Medicaid, State Supplementary Assistance, and HIPP actions, when appropriate

ELIAS system entries generate form 470-0485.

Distribution

ELIAS-generated notices are mailed to the client. A copy is filed in the electronic case file.

For manually generated notices, send the original to the client. File the copy in the electronic case file.

If there is a guardian, conservator or authorized representative, provide that person with a photocopy of the notice.

Data

The IM worker completes the fields for a manually prepared *Notice of Action* on SharePoint or WISE.

Entering the case number on page 1 will populate the case number on pages 2 and 3.

NOTE: When using the template, IM workers should copy the language of the system notice reasons from the file labeled "Master Library for NOA" found in Field Income Staff Resources, under ELIAS Resource links.

Notice of Attribution of Resources, Form 470-2588 or 470-2588(S)

Purpose	Form 470-2588 or 470-2588(S) is used to notify both spouses of what resources are protected for the community spouse.
Source	Complete the English or Spanish version of the form using the templates in: ▪ SharePoint under Employee Manual/Forms. ▪ The Worker Information System Exchange (WISE).
Completion	The income maintenance worker prepares the form when the Department makes a decision on the attribution of resources.
Distribution	Mail a copy to each spouse and file a copy in the case record.
Data	Enter the date and the income maintenance worker's name, county, and phone number. Enter the names and social security numbers of the spouse in the facility and the spouse at home. List all countable resources of both spouses and indicate the excluded resources. If there are jointly owned countable resources, list these under the column of each spouse by dividing the value in half. The template will calculate a total of the combined countable resources as they are entered and will automatically determine the amount of protected resources for the community spouse as directed in 8-D, *Calculating the Amount to Attribute to the Community Spouse*. The correct check box will automatically be marked based upon the calculation of the protected amount for the community spouse. The remainder of the resources will be assigned to the spouse in the medical institution. The template will automatically enter the minimum monthly maintenance needs allowance (MMMNA) that is in effect at the time of determination of attribution in the paragraph beginning "If you disagree." The worker has the ability to change this amount when needed.

Notice of Cancellation/Redetermination, Form 470-3152 or 470-3152(S)

Purpose

The *Notice of Cancellation/Redetermination* combines the functions of the *Notice of Decision* and a request for additional information, to save time in automatic redetermination cases.

Source

Complete the English version using the form in the Worker Information System Exchange (WISE).

Print the Spanish version of the form from:

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

Completion

Complete the notice when you determine that a client is ineligible under the current coverage group, but you need additional information to determine eligibility under another coverage group.

Distribution

Send the original to the client. File the copy in the case record. Also provide a copy of the notice to the client's guardian or conservator, if there is one.

Data

The form is self-explanatory. Enter the following information:

- County number, worker name, telephone number, and email address.
- Case name, number, and current mailing address.
- The date the notice is mailed.
- Date of cancellation and the reason the action is being taken.
- Manual and rule reference to support the reason for cancellation. The manual reference shall consist of the manual title, chapter number, and subheading (i.e., 8-C, Cooperation With Support Recovery). Use the legal references found under the subheading.
- Verification requested.
- Date requested verification is due in the requesting DHS office.
- The requesting office's return address. (This may be stamped on the form.)

Notice of Child Care Assistance Overpayment, Form 470-4530

Purpose	Form 470-4530 informs the debtor on a Child Care Assistance claim of the amount and reason for the overpayment and requests repayment.
Source	Form 470-4530 is generated monthly by the Web-Based Overpayment Recovery (WOPR) System.
Completion	The form is printed for debtors who: ▪ Have a Child Care Assistance claim entered on WOPR, and ▪ Have not submitted an agreement to repay the debt. This form is partly completed by WOPR. The debtor is responsible for completing the agreement to repay. At least one form must be sent before a debt setoff takes place. State income tax refunds, rebates, or other state payments, including state employee wages may be offset to pay the debt.
Distribution	One copy is mailed from Central Office.
Data	The system completes: ▪ The amount of overpayment, and ▪ The type of error, and ▪ The reason for the overpayment. The debtor completes the repayment terms.

Notice of Child Care Assistance Provider Sanction, Form 470-4053

Purpose

The *Notice of Child Care Assistance Provider Sanction* is used to notify families that their child care provider has been sanctioned by the Child Care Assistance (CCA) program and that they may need to select another provider if they want CCA to continue paying for their child care services.

Source

This form is not available in printed form. CCA workers can complete form 470-4053 using the template in SharePoint under Employee Manual/Forms or the Worker Information System Exchange (WISE).

PROMISE JOBS workers shall complete this form on line using the template provided by DHS.

Completion

When a sanction is imposed, the DHS child care worker or PROMISE JOBS worker shall complete a *Notice of Child Care Assistance Provider Sanction* for every CCA family using the sanctioned provider.

Distribution

Mail one copy to the family and keep a copy in the family's DHS or PROMISE JOBS case file. Provide a copy of this letter to PROMISE JOBS if necessary.

Data

The template automatically enters the notice date. Use the "tab" key to navigate between fields requiring data entry. Enter the following information:

- The family's name and mailing address
- The parent or guardian's first name
- The child care provider's name

Click or tab to the text box and:

- Choose "Yes" if the letter is going to a CCA family or "No" if the letter is going to a family who does not get CCA.
- Select the applicable sanction type.
- Click the "insert language" button.
- Enter the sanction effective date.

If the letter is going to a CCA family, enter:

- The child care worker's name
- The county name
- The worker's phone number

If the letter is **not** going to a CCA family, enter:

- The county name
- The DHS office phone number

Once all fields have been entered, print a copy of the letter for the family and another copy for the CCA case file, if any.

Notice of Decision, Form 470-0485, 470-0485(S), 470-0486, or 470-0486(S)

Purpose

The *Notice of Decision* is used to notify clients of agency actions that affect the client's eligibility or benefit level. Each client has the right to be given information regarding eligibility and benefit determination.

Source

In most situations, the ABC system generates form 470-0485 and 470-0485(S), based on worker entries or system processes.

Workers can complete the English or Spanish version using the forms in the Worker Information System Exchange (WISE).

Completion

The *Notice of Decision* is used for:

- FIP, RCA, and SNAP actions
- FMAP-related Medicaid and RMA actions
- Medically Needy denials
- SSI-related Medicaid, State Supplementary Assistance, and HIPP actions, when appropriate

System entries that produce the following actions will generate form 470-0485 (or form 470-0485(S) if the LI field on TD01 is coded "S"):

- An application is pended (for SNAP only).
- An application is approved (except for Medically Needy, SSI-related Medicaid, and State Supplementary Assistance cases).
- An application is denied or withdrawn (except for SSI-related Medicaid and State Supplementary Assistance cases).
- The benefit amount is calculated.
- Benefits are changed after a review or redetermination.
- Benefits are reinstated or a reinstatement request is denied.
- Benefits and eligibility are canceled for reasons other than failing to return a completed report form.
- Medical benefits change, including an extension after cancellation due to increased earnings of the payment of child support.
- A person is added to an ongoing case.
- A person is removed from an ongoing case.
- A person is added to a case for a preceding month and the income for that month is different from income for the current month.

- A payment adjustment or corrective payment is authorized (for FIP and RCA only).
- An allowance for a special need is authorized, denied, or canceled (for FIP and RCA only).
- Action is necessary by the household to receive or continue benefits (for SNAP only).

You may suppress the system-generated form and manually prepare form 470-0486 or 470-0486(S) when issues of timing or overlapping case actions make the system-generated notice inappropriate. (See ABC system instructions in Title 14.)

NOTE: When issuing a manual notice for SSI-related Medicaid or State Supplementary Assistance actions, use form 470-0490, *Notice of Decision: Medical Assistance or State Supplementary Assistance*. When issuing a manual notice for Medically Needy actions, use form 470-2330, *Notice of Decision for Medically Needy*.

Distribution

System-generated notices are mailed to the client. A copy is filed in the electronic case file.

For manually generated notices, send the original to the client. File the copy in the case record.

If there is a guardian, conservator, or representative, provide that person with a photocopy of the notice.

Data

For a manually prepared *Notice of Decision*:

- Entering the case number will populate the case name and current mailing address.
- The worker profile will populate the worker's number, county number, name, phone number, and email address.
- The notice date will automatically populate.
- Select one of the following radio buttons on the Preface tab:
  - Blank
  - Multiple Programs
  - Emergency 3-Day Medical
  - Medicaid Approval > 12 months Prior

If **Blank** is selected, enter the explanation of the action being taken. This shall include:

- The action being taken (e.g., approval, denial, etc.).

- The reason for the action.
- The effect of the action on the household's eligibility and benefits.
- The effective date of the action.
- The legal references, including the Employees' Manual title, chapter number, and subheading; Iowa Administrative Code; and federal regulations.

NOTE: When completing the manually issued form, you can copy the language of the system notice reasons from the file labeled "ABC Notice Codes" on WISE.

If **Multiple Programs** is selected, the explanation of the action and legal references populate based on the NOD reasons and programs selected on the "Multiple Programs" tab.

If **Emergency 3-Day Medical** or **Medicaid Approval > 12 months Prior** is selected, the explanation of the action and legal references will automatically populate.

For Medicaid Approval > 12 months Prior, select a radio button and enter the beginning and ending dates or the non-consecutive dates approved. Make sure to enter the state ID.

SNAP Calculation: Complete this section when SNAP eligibility or benefits are affected by changes in income, deductions, or household size. Complete the "Gross Income Standard Test" only if applicable. Use information from the household's current form 470-0330, *SNAP Computation*, or Scratch Pad (SPAD) system screens.

Notice of Decision: Child Care, Form 470-4558

Purpose	The *Notice of Decision: Child Care* is used to notify clients of agency actions that affect the client's eligibility or benefit level. Each client has the right to be given information regarding eligibility and benefit determination.
Source	The KinderTrack system generates form 470-4558 based on worker entries.
Completion	The *Notice of Decision: Child Care* is used when: ▪ An application is approved. ▪ An application is denied. ▪ A new or different provider is selected. ▪ Benefits are changed because of review or redetermination. ▪ Benefits are canceled. ▪ A provider is determined not eligible to provide child care. ▪ There is a change in family circumstances that results in a fee change (job or income, etc.).
Distribution	KinderTrack will mail a copy of the notice to the client and will also save a copy of the notice in the system.
Data	KinderTrack completes all information on the notice based on the worker entries into the system.

Notice of Decision for Extra Help with Medicare Prescription Drug Costs, Form 470-4199

Purpose	"Extra Help with Medicare Prescription Drug Costs" is a program to offset the costs of the Medicare prescription drug benefit. While Social Security Administration (SSA) administers the program, the eligibility decision for the benefit can be made either by the SSA or by the state Medicaid agency (the Department). Persons wishing to apply for extra help are encouraged to go to SSA. However, they may require the Department to process their application. Form 470-4199 is used to notify applicants and recipients of extra help with Medicare prescription drug costs of actions taken on their case when the **Department** has made the decision.
Source	Complete form 470-4199 using the template in: ▪ SharePoint under Employee Manual/Forms. ▪ The Worker Information System Exchange (WISE).
Completion	The IM worker completes an original and one copy of the notice of decision when the Department has made a decision about eligibility for extra help with Medicare prescription drug costs.
Distribution	Send the original copy to the client and file a copy in the case record.
Data	**Date**: Enter date the notice is completed. **Worker Name**: Enter name of the IM worker processing the action. **Client Names**: Enter the name of the client and of the spouse, if the client is married and living with the spouse. **Telephone Number**: Enter the IM worker's phone number. **SSN**: Enter the client's social security number and the spouse's social security number if the client is married and living with the spouse. **Dear ____**: Enter client's name and the spouse's name if the client is married and living with the spouse. **Notice Language**: Select language appropriate to the action you will be taking on the case (approve, cancel, change or deny), depending on action being taken on the case. Use entries from form 470-4193, *Extra Help for Medicare Prescription Drug Benefits Narrative/Worksheet*, to complete the blanks in the notice language.

Language for selected action is as follows:

Approve

Based on the application you filed on ____, you are eligible for extra help with your Medicare prescription drug plan costs. This help is effective ____. You are eligible for:

- ____ subsidy to help pay your Medicare prescription drug plan **premium**.
- ____ prescription drug plan yearly **deductible**.
- Your **copayment** for each prescription is ____ for a generic or preferred drug, ____ for other drugs, or 15% of the total cost.

Your eligibility is based on 42 CFR § 423.773(a).

We based our decision on the following information:

- Your family size is ____ person/people.
- The income we considered is:

Source	Amount	Deductions

  The total income is ____. The amount of deductions is ____. The amount allowed for ____ person/people is ____.

- The resources we considered are:

Source	Amount

  The total amount of your resources is ____. The amount allowed for one person/a couple is ____.

How to Enroll in a Medicare Prescription Drug Plan

To take advantage of this extra help, you must enroll in a Medicare prescription drug plan or Medicare health plan with prescription drug coverage, if you are not already in a plan. You can enroll beginning November 15, 2005. You will get more information about the prescription drug plans available in your area. You can also visit www.medicare.gov or call toll-free 1-800-MEDICARE (1-800-633-4227) for more information. If you are deaf or hard of hearing, you may call the Medicare TTY number toll-free at 1-877-486-2048.

If you do not choose a Medicare prescription drug plan, Medicare will choose one for you to be sure you get this benefit. You will receive more information from Medicare.

You must notify this agency of any changes in your family's situation, such as employment, income, savings, property, stocks, bonds, and insurance; family members leaving or joining your household; marital status; address and telephone number. Any of these changes could affect your eligibility. You must report any changes in your situation within 10 working days of the change.

You will be required to reestablish your eligibility for this extra help at least once every 12 months. You will be notified of that requirement in advance of the due date. The necessary instructions and forms will be sent to you at that time.

If you do not agree with this decision, you have the right to request a hearing. The procedures for requesting a hearing are attached to this letter.

Cancel

Based on the information received by this office on ____, you are no longer eligible for extra help with your Medicare prescription drugs costs. This decision is effective ____. You have been determined ineligible for the reasons checked below:

☐ You are no longer eligible for Medicare. [42 CFR §423.30(a)]

☐ You are no longer a resident of the state. [42 CFR §423.773(a)]

☐ You did not complete the redetermination process. [42 CFR §423.774(c)(1)]

☐ Your resources are more than the amount allowed. [42 CFR §423.773(a)]

☐ Your income is more than the amount allowed. [42 CFR §423.773(a)]

We based our decision on the following information:

- Your family size is ____ person/people.
- The income we considered is:

Source	Amount	Deductions

The total income is ____. The amount of deductions is ____. The amount allowed for a family size of ____ is ____. Therefore, you have ____ more income than is allowed.

- The resources we considered are:

Source	Amount

The total amount of your resources is _____. The amount allowed for one person/a couple is _____. Therefore, you have _____ more than is allowed.

Using Your Medicare Prescription Drug Plan

Even though you do not qualify for extra help, if you continue to be eligible for Medicare, you can still save on your prescription drug costs by remaining in a Medicare prescription drug plan or a Medicare health plan with prescription drug coverage. From November 15 to December 31 of each year, you can change the plan you are enrolled in. You can also visit www.medicare.gov or call toll-free 1-800-MEDICARE (1-800-633-4227) for more information. If you are deaf or hard of hearing, you may call the Medicare TTY number toll-free at 1-877-486-2048.

If you do not agree with this decision, you have the right to request a hearing. The procedures for requesting a hearing are attached to this letter. You also have the right to reapply.

Change

Based on information received by this office on _____, your eligibility for extra help with your Medicare prescription drug costs will change. You will receive increased/reduced extra help. Effective _____, you are eligible for:

- _____ subsidy to help pay your Medicare prescription drug plan premium.
- _____ prescription drug plan yearly deductible.
- Your copayment for each prescription is _____ for a generic or preferred drug, _____ for other drugs, or 15% of the total cost.

The change in your eligibility is based on 42 CFR § 423.773(a).

We based our decision on the following information:

- Your family size changed from ____ person/people to ____ person/people.

- Your countable income previously was ____. The income we are counting now is:

Source	Amount	Deductions

The total income is ____. The amount of deductions is ____. The amount allowed for ____ person/people is ____.

- Your countable resources previously were ____. The resources we are counting now are:

Source	Amount

The total amount of your resources is ____. The amount allowed for one person/a couple is ____.

Using Your Medicare Prescription Drug Plan

You will pay more/less of the costs within your Medicare prescription drug plan than you did before. Even if you must pay more, you still save on your prescription drug costs by remaining in a Medicare prescription drug plan or Medicare health plan with prescription drug coverage. From November 15 to December 31 of each year, you can change the plan you are enrolled in. You can visit www.medicare.gov or call toll-free 1-800-MEDICARE (1-800-633-4227) for more information.

If you are deaf or hard of hearing, you may call the Medicare TTY number toll-free at 1-877-486-2048.

You must notify this agency of any changes in your family's situation, such as employment, income, savings, property, stocks, bonds, and insurance; family members leaving or joining your household; marital status; address and telephone number. Any of these changes could affect your eligibility. You must report any changes in your situation within 10 working days of the change.

You will be required to reestablish your eligibility for this extra help at least once every 12 months. You will be notified of that requirement in advance of the due date. The necessary instructions and forms will be sent to you at that time.

If you do not agree with this decision, you have the right to request a hearing. The procedures for requesting a hearing are attached to this letter.

Deny

Based on the application you filed on ____, you are not eligible for extra help with your Medicare prescription drug costs. You have been determined ineligible for the reasons checked below:

☐ You are not eligible for Medicare. [42 CFR §423.30(a)]

☐ You are not a resident of the state. [42 CFR §423.773(a)]

☐ You did not complete the application process. [42 CFR §423.904(d)(2)]

☐ Your resources are more than the amount allowed. [42 CFR §423.773(a)]

☐ Your income is more than the amount allowed. [42 CFR §423.773(a)]

☐ Other:

We based our decision on the following information:

- Your family size is ____ person/people.
- The income we considered is:

Source	Amount	Deductions

The total income is ____. The amount of deductions is ____. The amount allowed for a family size of ____ is ____. Therefore, you have ____ more income than is allowed.

- The resources we considered are:

Source	Amount

The total amount of your resources is ____. The amount allowed for one person/a couple is ____. Therefore, you have ____ more than is allowed.

How to Enroll in a Medicare Prescription Drug Plan

Even though you do not qualify for extra help, if you are eligible for Medicare, you can still save on your prescription drug costs by enrolling in a Medicare prescription drug plan or a Medicare health plan with prescription drug coverage. You can enroll beginning November 15, 2005. You will get more information about the prescription drug plans available in your area. You can also visit www.medicare.gov or call toll-free 1-800-MEDICARE (1-800-633-4227) for more information.

If you are deaf or hard of hearing, you may call the Medicare TTY number toll-free at 1-877-486-2048.

If you do not agree with this decision, you have the right to request a hearing. The procedures for requesting a hearing are attached to this letter. You also have the right to reapply.

Notice of Decision for Medically Needy, Form 470-2330

Purpose

The *Notice of Decision for Medically Needy* provides the applicant with a notice of approval for Medically Needy coverage. Denials or cancellations for Medically Needy coverage are generated by the Automated Benefit Calculation system.

Source

Complete form 470-2330 using the template in:

- SharePoint under Employee Manual/Forms.
- The Worker Information System Exchange (WISE).

Completion

The IM worker issues the form when:

- Approving certification or the retroactive period.
- Processing a change that results in the spenddown being recalculated.

Distribution

Send the original to the client with a copy of form 470-2341, *Medically Needy Spenddown Computation*, attached. Also send a copy of the notice the client's guardian or conservator, if there one. File a copy in the case record.

Data

Make the following entries:

- Enter the DHS office name and address.
- Enter the case name and current mailing address.
- Enter the county number.
- Enter the date that the notice is mailed.
- Enter the worker number.
- Enter the worker's name.
- Enter the telephone number of the IM worker.
- Enter the Medically Needy case number and FBU.
- For shortening a certification period:
  - Check the first box.
  - Check the second box. Circle the action being taken as a redetermination being approved or conditionally approved.
  - List the complete names of all persons who are eligible or conditionally eligible for the shortened certification period.
  - Enter the beginning and ending dates of the shortened certification period.
  - Enter the spenddown for the shortened certification period, if applicable.

- List the complete name of all persons who are responsible relatives for the shortened certification period, if applicable.

- For a certification approval:
  - Check the second box.
  - Circle the action being taken (application or redetermination).
  - Circle the action being taken as an approval or conditional approval for the current certification period.
  - List the complete names of all persons who are eligible or conditionally eligible for the current certification period.
  - Enter the beginning and ending dates of the current certification period.
  - Enter the amount of the spenddown for the current certification period, if applicable.
  - List the complete name of all persons who are responsible relatives for the current certification period, if applicable.
  - Enter the date after which the client needs to reapply for assistance.
- If eligibility is being approved for the retroactive period:
  - Check the third box.
  - Circle the action being taken as an approval or conditional approval for the retroactive period.
  - List the complete names of all persons who are eligible or conditionally eligible for the retroactive period.
  - Enter the beginning and ending dates of the retroactive period.
  - Enter the amount of the spenddown for the retroactive period, if applicable.
  - List the complete names of all persons who are responsible relatives for the retroactive period, if applicable.
- Enter in the fourth box the date that completed medical claim forms must be received in the local office or at the IME Core Services Unit.
- For Medically Needy clients who are eligible for the qualified Medicare beneficiary group:
  - Check the fifth box.
  - List the complete names of the qualified Medicare beneficiary (QMB) eligibles.

- Enter the date of QMB eligibility.

▪ For Medically Needy clients who are eligible for the specified low income Medicare beneficiary group:

- Check the sixth box.
- List the complete names of the SLMB eligibles.
- Enter the date that Medicaid begins paying the Medicare premium.

Notice of Decision: Medical Assistance or State Supplementary Assistance, Form 470-0490

Purpose

Income maintenance workers use form 470-0490 to notify an applicant or recipient of SSI-related Medicaid or State Supplementary Assistance when the Department takes one of the following actions:

- Assistance is approved.
- An application is denied.
- A recipient transfers from one program or facility to another.
- Assistance continues after a review.
- Assistance is changed because of a redetermination.
- Assistance is canceled.

Source

Complete 470-0490 using the form in the Worker Information System Exchange (WISE).

Completion

The IM worker responsible for the case completes this form when:

- A computer-generated notice cannot be issued, according to case action instructions in 14-B(9).
- The worker chooses to issue a manual notice instead of a computer-generated one.

Distribution

Send the original to the client and file a copy in the case record. Make another copy and send to the guardian, conservator, or payee, when there is someone acting in this capacity on behalf of the client.

Data

Complete the form as follows:

- **Case number**: Enter the case number.
- **Facility name**: Enter the name of the facility involved.

Select Approved, Denied, Transfer, Review or Redetermination, or Canceled and enter the applicable information as follows:

- Approved:

  Approvals for Medicaid institution care or State Supplementary Assistance:

  - The effective date of approval shall be the date of application or the date of eligibility, whichever is later.
  - Enter the amount of first-month client participation.
  - Enter the beginning date of client participation.

- Enter the amount of ongoing client participation.

Approvals for Medical assistance: The effective date of medical assistance shall be the first day of the month in which eligibility is established.

- **Denied**: Select if an application is denied or withdrawn before approval.
- **Transfer**: Select if transferring from one facility to another:
  - Enter the amount the client is required to pay to the previous facility.
  - Enter the amount the client is required to pay for first month's participation in the new facility (if any).
  - Enter the amount of ongoing client participation.
  - Enter the names of the former and new facilities.
- Review or Redetermination:
  - Select State Supplementary Assistance, Facility or Waiver.
  - Enter the effective date of ongoing client participation.
  - Enter the amount of client participation resulting from the recertification.
- Canceled:

  State Supplementary Assistance cancellation: Enter the date that the State Supplementary Assistance is canceled.

  Medicaid cancellation: Enter the effective date of cancellation of medical assistance. This date should be the first of the month unless the recipient died. Then enter the date of death.

- All actions:
  - **Program**: Identify the program as follows:

Entry	Used For
ICF	Nursing facility care
RCF	Residential care
Skilled	Skilled nursing care
Hospital	Hospital care only
Family-life	Family-life home
In-home care	In-home health-related care
Medical	SSI Newborns Widows and widowers ineligible for SSI or SSA due to actuarial increase People who decline SSI or SSA cash People ineligible for SSI or SSA because of Social Security COLA (503)
HCBS	Home- and community-based services

  - **Legal reference**: Enter the title and chapter number of the manual reference. Use the title of the paragraph in the manual that the decision was based on. Also enter the rule reference for this section.
  - **Comments by worker**: Use this space to explain the specific reason for the action taken and any other comments which the worker feels are pertinent to the applicant or recipient. The worker may attach a separate sheet to explain the action.

The form will populate the following fields:

- The date field populates with the current date as the date the action is taken.
- The county number where the worker's office is located.
- The client's name and address.
- The worker's name and phone number.

The payment computation section serves as a record for determining client participation for a client residing in an ICF, SNF, or RCF, receiving in-home health-related care, or receiving home- and community-based service care. It may also be used to compute eligibility and state warrant in family life home cases.

- List and total all gross countable income.
- List all allowable deductions and diversions and add them to the personal allowance to determine total deductions.
- Click the checkbox to change the personal allowance to the RCF or veterans amount.
- The form will calculate the client's participation by subtracting the diversions, deductions, and personal allowance from the total income.

Notice of Decision on Denied Prior Authorization, Form 470-0390

Purpose	This notice is sent to the member or representative when a service requested by the prior authorization process is denied. This notice gives the clients their right to appeal.
Source	The Iowa Medicaid Enterprise issues this form.
Completion	IME Medical Prior Authorization staff prepare an original and one copy of this form when one or more services submitted by a medical provider on a request for prior authorization has been denied. This form is included in the manual for information only. No worker action is required unless the member appeals. Appeals are then handled in the usual manner.
Distribution	IME sends the original copy of the notice and a copy of the prior authorization form to the member or representative and retains a copy of the notice.
Data	The form includes the denial reason and denial code.

Notice of Decision on Medicaid Claim, Form 470-0392

Purpose	Form 470-0392 notifies the Medicaid member when a service has been determined to be approved or denied by Medicaid after the member's telephone inquiry to the Member Services call center regarding bills for medical services.
Source	The IME Member Services Unit issues this form.
Completion	IME Member Services Unit staff prepare an original and one copy of this notice after a telephone inquiry to the Member Services call center (1-800-338-8366 or 515-256-4606 if in the Des Moines area). No worker action is required. The form is included in the manual for information only. If the member files an appeal, it shall be handled in the usual manner.
Distribution	The IME Member Services Unit sends the original to the member and keeps the yellow copy.
Data	If the claim has been paid, the notice informs the member of that fact and that if the member continues to receive bills from the provider, the member may contact the local legal services agency. If the service is not covered by Medicaid, the notice notifies the member of the denial and the member's right to appeal that denial.

Notice of Disqualification, Form 470-0288 or 470-0288(S)

Purpose

The *Notice of Disqualification* is used to:

- Notify a person who has been found to have committed an intentional program violation of the period of disqualification.
- Notify the remaining household members, if any, of the benefits they will receive during the period of disqualification, or that they must reapply for SNAP because the certification period has expired.

Source

The form is an electronic template generated by the DHS Appeals Section and emailed to the IM worker.

Completion

The Appeals Section generates this form when an administrative law judge finds a client guilty of intentional program violation for SNAP.

The local office may also request a form from the Appeals Section when the Department of Inspections and Appeals, Investigations Division, has notified the worker that a court has found that the household member committed an intentional program violation.

The Appeals Section completes the address and identifying information. The IM worker completes the notice fields.

Distribution

The Appeals Section sends the form to the IM worker by electronic mail for completion and printing. The IM worker:

- Sends the original to the client.
- Places a copy in the client's file.
- Sends a copy to the Appeals Section once the disqualification is implemented.

Data

The Appeals Section completes the names, addresses, appeal numbers, and salutations. The IM worker completes the length of sanction and the effect on household benefits, following the instructions given, and signs the form.

Notice of Employment, Form 470-0820

Purpose

The PROMISE JOBS unit uses the *Notice of Employment* to notify the IM worker when a PROMISE JOBS participant begins employment.

Source

PROMISE JOBS staff complete this form using the template provided by DHS.

Completion

The PROMISE JOBS worker completes Part A of the form when a participant begins or changes employment.

IM staff complete Part B, unless:

- You have already sent the PROMISE worker form 470-2844, *Employer's Statement of Earnings*, from this employer, or
- You have the *Employer's Statement of Earnings* completed by the new employer and attach a copy of it to the *Notice of Employment*.

NOTE: When you become aware of a mandatory or volunteer PROMISE JOBS participant who has begun, ended, or changed employment, you should send a copy of the *Employer's Statement of Earnings* or equivalent verification to the PROMISE JOBS worker.

If you don't know who the PROMISE JOBS worker is, send the verification to the PROMISE JOBS office designated under the coordination arrangement of the service plan.

Distribution

After completing Part A, PROMISE JOBS staff sends the form to the IM worker. PROMISE JOBS keeps a control copy.

The IM worker:

- Completes Part B (or attached from 470-2844),
- Makes a copy to file in the participant's FIP case record, and
- Returns the form to the local PROMISE JOBS unit.

Data

When completing Part B, enter the following:

- The month before earnings were applied to the FIP grant.
- The month that earnings were applied to the FIP grant.
- The current status of the FIP case.
- Date of last employment, if applicable.

Notice of Family Planning Program Assistance Overpayment, Form 470-5483

Purpose

Form 470-5483:

- Informs the Family Planning Program debtor of the amount and reason for the overpayment and requests repayment.
- Serves as the debtor's agreement for cash repayment.

Source

Form 470-5483 is generated monthly by the Web-based Overpayment Recovery (WOPR) System.

Completion

The form is printed on the last working day of the month for debtors who:

- Have a Family Planning Program claim entered on WOPR, and
- Have not submitted an agreement to repay the debt.

The form is partly completed by WOPR. The debtor is responsible for completing the agreement to repay.

One form must be sent before a debt setoff (state tax refunds) or any other income offset (state warrants) takes place.

The form is no longer sent to the debtor when:

- The claim is suspended, or
- An agreement to repay is received, or
- Four forms have been sent.

Distribution

One copy is mailed from Central Office.

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.

Data

The system completes the amount and type of error. The debtor completes the repayment terms.

Notice of FIP or RCA Overpayment, Form 470-4683

Purpose	Form 470-4683 informs the debtor on a FIP or RCA claim of the amount and reason for the overpayment and requests repayment.
Source	Form 470-4683 is generated by the Web-based Overpayment Recovery (WOPR) System.
Completion	The form is completed for debtors who have a FIP or RCA claim entered on WOPR and have not submitted an agreement to repay.
Distribution	One copy is mailed from Central Office.
Data	The system completes: ▪ The date, ▪ The debtor's name and address, ▪ The amount and months of the overpayment, ▪ The type of error, ▪ The reason for the overpayment. The debtor completes the repayment terms.

Notice of Health Insurance Premium Payment, Form 470-2845

Purpose	Form 470-2845 is used to notify the policyholder that the Department has determined the health insurance plan is cost-effective.
Source	Form 470-2845 is system-generated in Central Office.
Completion	The HIPP worker generates the form through entries on the Approval Notice Request Screen when the Department determines that paying for the member's health insurance policy is cost-effective.
Distribution	Copies are printed for: ▪ The policyholder ▪ The HIPP file
Data	The form: ▪ Specifies the method and frequency of payment. ▪ Identifies the Medicaid members covered under the policy. ▪ Lists pertinent information regarding the insurance carrier and policy.

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

The Public Assistance Debt Recovery Unit sends the garnishment letter when the Department of Administrative Services matches overpayment recovery files and finds debtors who:

- Are state employees.
- Owe at least $50.
- Have received at least one demand letter for:
  - A Child Care Assistance claim, or
  - A FIP or RCA claim established after February 1986, or
  - A SNAP claim, or
  - A Hawki claim, or
  - A Medicaid claim established after June 1987, or
  - A PROMISE JOBS claim, or
  - A State Supplementary Assistance claim established after June 1987.
- Have failed to make an agreement on at least one claim per program or has failed to keep current with an agreement.

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.

Distribution

One copy is sent to the debtor.

One copy is sent to the central payroll unit in the Department of Administrative Services.

One copy is kept in the Public Assistance Debt Recovery Unit file.

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: ▪ SharePoint under Employee Manual/Forms. ▪ The Worker Information System Exchange (WISE).
Completion	Complete the original and one copy of the form when: ▪ You determine that a household is entitled to restoration of lost benefits, or ▪ A restoration of lost benefits is ordered by a hearing decision.
Distribution	Send the original to the household. Keep the copy in the case record.
Data	The form explains: ▪ The amount of lost benefits. ▪ Any amount applied against an uncollected claim against the household. ▪ The household's right to appeal any disputed benefits.

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

Purpose	Form 470-4667, *Notice of Medical Assistance Debt Due to a Transfer of Asset(s)*, 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	One copy is mailed to the debtor from DHS central office with a return envelope enclosed. 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. When a debtor fails to respond, other collection actions can be pursued. Other collection actions include: ▪ Take the debtor's Iowa income tax refund. ▪ Take money that is owed to the debtor by any state agency. ▪ Wage garnishment.
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	Form 470-2891: ▪ Informs the Medicaid or State Supplementary Assistance debtor of the amount and reason for the overpayment and requests repayment. ▪ Serves as the debtor's agreement for cash repayment.
Source	Form 470-2891 is generated monthly by Web-based Overpayment Recovery (WOPR) System.
Completion	The form is printed on the last working day of the month for debtors who: ▪ Have a Medicaid or State Supplementary Assistance claim entered on WOPR, and ▪ Have not submitted an agreement to repay the debt. The form is partly completed by WOPR. The debtor is responsible for completing the agreement to repay. One form must be sent before a debt setoff (state tax refunds) or any other income offset (state warrants) takes place. The form is no longer sent to the debtor when: ▪ The claim is suspended, or ▪ An agreement to repay is received, or ▪ Four forms have been sent.
Distribution	One copy is mailed from Central Office. 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.
Data	The system completes the amount and type of error. The debtor completes the repayment terms.

Notice of Pending Medicaid Application, Form 470-2631

Purpose

Form 470-2631 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.

DDS and SSA use this form to respond to the IM worker on the status of the identified case.

Source

Complete form 470-2631 using the template in:

- SharePoint under Employee Manual/Forms.
- The Worker Information System Exchange (WISE).

Completion

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.

Upon receipt of this notice, DDS reviews its files and responds as indicated on the form. DDS or SSA completes Section II.

Distribution

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.

Data

Complete:

- The applicant information and IM worker information in Section I.
- The address for the Department office in Section III.

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.

DDS or SSA completes Section II and returns the form to the IM worker.

If DDS is processing an SSA application, then DDS shall enter the claims examiner’s name and telephone number under Section II.

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	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. WOPR partially completes the form. The debtor is responsible for completing the agreement to pay.
Distribution	One copy is mailed to the debtor from Central Office with a return envelope enclosed. 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.
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	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: ▪ The claim amount. ▪ The months the claim covers. ▪ The appeal status in WOPR. ▪ Classify the claim as an intentional program violation. WOPR partially completes the form. The debtor is responsible for completing the agreement to repay.
Distribution	One copy is mailed to the debtor from Central Office with a return envelope enclosed. 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.
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 *Notification of SSI Approval* 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	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. 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 *Request for Information* 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.
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: ▪ The online manual. ▪ SharePoint under Employee Manual/Forms.
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	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: ▪ Make the applicant aware of the services available, ▪ Help the applicant locate employment, and ▪ Maintain statistics regarding the location and number of refugees in Iowa, particularly those needing assistance.
Source	Complete form 470-0481 using the template in: ▪ SharePoint under Employee Manual/Forms. ▪ The Worker Information System Exchange (WISE).
Completion	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.
Distribution	Email the form and a copy of the applicant's immigration document to BRSrefugee@dhs.state.ia.us. File a copy in the case record.
Data	The form contains identifying information about the applicant and the sponsor.

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: ▪ HHS tracking number. ▪ Certification date: the date that ORR certifies the person as a victim of human trafficking. ▪ Expiration date: the date the person's status as a victim of human trafficking expires. ▪ The telephone number that workers can use to verify the letter's validity.

Other Insurance Request, Form 470-0403

Purpose

Form 470-0403, *Other Insurance Request*, 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.

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.

Source

The form is computer-generated by the IME OnBase system.

Completion

The form is prepared automatically when a Medicaid claim code indicates an accident or injury.

Distribution

The form is sent to the member, who returns it to the IME on completion.

Once completed by the member or the member's representative, the form may be returned in one of the following ways:

Mail: Iowa Medicaid Enterprise
PO Box 36446
Des Moines, IA 50315

Phone: Member Services
1-800-338-8366 or locally in the Des Moines area at **515-256-4606**
(Monday through Friday, 8:00 am to 5:00 pm)

Email: RevColl_Lien@dhs.state.ia.us

Fax: 515-725-1352

Data

The form requests information from the member concerning:

- The type of health insurance.
- Policy holder information.
- Insurance carrier information.

Overpayment Recovery Supplemental Information, Form 470-0465

Purpose

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.

If DIA refers the case for prosecution, this form is submitted to the county attorney to summarize the basis for the investigation.

Source

Department staff can complete form 470-0465 using the template in SharePoint under Employee Manual/Forms and the Worker Information System Exchange (WISE).

Other users may print supplies from the online manual.

Completion

IM workers complete this form for overpayments in FIP, Refugee Cash Assistance, SNAP, Medicaid, Child Care Assistance, and State Supplementary Assistance.

PROMISE JOBS workers complete this form for overpayments in Child Care Assistance and PROMISE JOBS programs.

The Hawki program's third-party administrator completes this form for Hawki overpayments.

Prepare an original and one copy of this form when:

- A claim is being revised, and
  - It is now a client error of over $1,000, and
  - The worker did not previously complete either form 470-0465 or a fraud referral screen in the direct claim entry screen.
- The DIA Division of Investigations requests the information to pursue recovery action.
- The IM Unit wishes legal action pursued.
- Recovery will be attempted from the resources of an alien's sponsor.

Distribution

Submit the original along with the Overpayment Recovery Information Input Summary (from the direct claim entry screen), form 470-0464, to:

DIA Investigations Division
Public Assistance Debt Recovery Unit
Lucas Building, Third Floor
321 E 12th St., Des Moines, Iowa 50319-0083

(or send by local mail). Keep a copy in the case record.

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	*Paperless Enrollment Confirmation,* 470-5589 or 470-5589(S) 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	The ELIAS system will populate the office address, current date, worker name, address, worker identification, customer name, customer address, and case number. A WISE narrative is created to indicate a Paperless Enrollment Confirmation letter was issued.

PathTracker Case Activity Report, Form 470-5386

Purpose	Form 470-5386, *PathTracker Case Activity Report*, 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 http://dhs.iowa.gov/ime/providers/forms.
Completion	Facility staff must complete entries in PathTracker Plus when a resident: ▪ Enters the facility. ▪ Transfers out of the facility. ▪ Is discharged. ▪ Died. ▪ Has a change in level of care. ▪ Has a change in payment source. (I.e., Medicare coverage, newly approved for Medicaid, private pay, etc.)
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 *PathTracker Case Activity Report* (CAR) 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 1 Iowa Department of Human Services 417 E. Kanesville Blvd. Council Bluffs, IA 51503-4470 Fax: 515-564-4040 Email: 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 1
Iowa Department of Human Services
417 E. Kanesville Blvd.
Council Bluffs, IA 51503-4470
Fax: 515-564-4014
Email: 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 *Payment Application for Nonregistered Providers*, form 470-2890 or 470-2890(S).

Source

The English version of the form is printed with 100 forms on a pad. Order supplies from Iowa Prison Industries at Anamosa.

Print the Spanish version of the form from:

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

Completion

The provider completes the application when:

- Applying for payment for the first time; or
- Applying for a two-year renewal; or
- Applying after the expiration of a previous agreement; or
- There is a change of name, care, living or mailing address, or household composition.

The provider shall complete the form after reading all the instructions and the minimum requirements in Comm. 95, *Guidelines for Child Care Homes with a Child Care Assistance Provider Agreement*.

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

The applicant-provider shall:

- Indicate whether this is a new application or a renewal.
- Carefully print the name (and maiden name and other last names, if any) and addresses.
- Enter the birth date, last four digits of the social security number, and telephone numbers with area codes.
- 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.

- In-home providers list the names of the parents and children living in the home where care will be provided, if available.
- 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.

Pregnancy Verification Request, Form 470-3783

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

The *Presumptive Medicaid Eligibility Notice of Action – Approval* is used to:

- Notify applicants of the qualified entity's presumptive eligibility decision.
- Verify presumptive Medicaid eligibility for Medicaid providers rendering:
  - Ambulatory prenatal care services to pregnant women or
  - Medicaid services to other presumptively eligible individuals.

Source

The presumptive eligibility program generates form 470-2580 based on entries the qualified entity makes through the Medicaid Presumptive Eligibility Portal (MPEP).

Completion

The qualified entity makes entries into the MPEP to complete the form when an individual applies for presumptive eligibility for Medicaid.

Distribution

A copy of the notice will be saved in the electronic case file in the Worker Information System Exchange (WISE). The qualified entity shall:

- Print the notice,
- Give or mail a copy to the applicant, and
- Keep a copy in the presumptive Medicaid record.

Data

The MPEP completes the information on the notice based on the entries the qualified entity made.

- The system enters:
  - Which type of presumptive eligibility is approved.
  - The individual's state identification number.
  - The beginning date of presumptive eligibility.
  - The ending date for presumptive eligibility.
- The system enters the name, phone number, and email address of the entity making the determination.

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

Purpose

The *Presumptive Medicaid Eligibility Notice of Action – Approval/Denial* is used to:

- Notify applicants of the qualified entity's presumptive eligibility decision.
- Verify presumptive Medicaid eligibility for Medicaid providers rendering:
  - Ambulatory prenatal care services to pregnant women or
  - Medicaid services to other presumptively eligible individuals.

Source

The presumptive eligibility program generates form 470-5190 based on entries the qualified entity makes through the Medicaid Presumptive Eligibility Portal (MPEP).

Completion

The qualified entity makes entries into the MPEP to complete the form when an individual applies for presumptive eligibility for Medicaid.

Distribution

A copy of the notice will be saved in the electronic case file in the Worker Information System Exchange (WISE). The qualified entity shall:

- Print the notice,
- Give or mail a copy to the applicant, and
- Keep a copy in the presumptive Medicaid record.

Data

The MPEP completes the information on the notice based on the entries the qualified entity made.

- For approvals, the system enters:
  - Which type of presumptive eligibility is approved.
  - The individual's state identification number.
  - The beginning date of presumptive eligibility.
  - The ending date for presumptive eligibility.
- 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.).
- The system enters the name, phone number, and email address of the entity making the determination.

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

Purpose

The *Presumptive Medicaid Eligibility Notice of Action – Denial* is used to:

- Notify applicants of the qualified entity's presumptive eligibility decision.
- Verify presumptive Medicaid eligibility for Medicaid providers rendering:
  - Ambulatory prenatal care services to pregnant women or
  - Medicaid services to other presumptively eligible individuals.

Source

The presumptive eligibility program generates form 470-5191 based on entries the qualified entity makes through the Medicaid Presumptive Eligibility Portal (MPEP).

Completion

The qualified entity makes entries into the MPEP to complete the form when an individual applies for presumptive eligibility for Medicaid.

Distribution

A copy of the notice will be saved in the electronic case file in the Worker Information System Exchange (WISE). The qualified entity shall:

- Print the notice,
- Give or mail a copy to the applicant, and
- Keep a copy in the presumptive Medicaid record.

Data

The MPEP completes the information on the notice based on the entries the qualified entity made.

- The system provides an explanation of denial (e.g., you are over income, you have already received presumptive eligibility during this pregnancy, etc.).
- The system enters the name, phone number, and email address of the entity making the determination.

Proof of Application for Medicaid, Form 470-2979

Purpose	Form 470-2979, *Proof of Application for Medicaid*, 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: ▪ SharePoint under Employee Manual/Forms. ▪ The Worker Information System Exchange (WISE).
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: ▪ The name of the IM worker. ▪ The county number designation. ▪ The name and address of the applicant. ▪ The notice date (the date the form is completed). ▪ The date the household applied for Medicaid. ▪ The names of the individuals included in the application for Medicaid.

Provider Special Needs Decision, Form 470-5321

Purpose	The *Provider Special Needs Decision*, form 470-5321, 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 470-5321 using the template in: ▪ SharePoint under Employee Manual/Forms. ▪ The Worker Information System Exchange (WISE).
Completion	After the decision on whether or not to approve special needs rates has been made, the worker completes this letter with the: ▪ Provider's mailing address. ▪ Child's name. ▪ Child's case number.
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: ▪ Whether or not special needs payment rates are approved for a child. ▪ Basic information regarding the definition of a special needs child. ▪ How a provider may qualify for special needs payment rates.

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

Purpose	The local DHS office is to use the *Public Assistance Agency Information Request* 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	The local DHS worker responsible for the case shall prepare form SSA-1610-U2 in the following situations: ▪ To resolve any discrepancies between other evidence and data in the TPQY files, such as an identification problem. ▪ To secure retroactive historical data not provided by the TPQY. ▪ 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, *SSI Recipient*. 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.
Distribution	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. When the Social Security returns the original, it will be scanned and uploaded to the case record.
Data	Specific instructions for completing the form are printed on the back of the form.

Quality Assurance Transmittal, Form 470-0271

Purpose

The *Quality Assurance Transmittal* is used to request the Division of Information Technology (DoIT) to:

- Cancel a warrant,
- Issue a one-time payment, or
- Cross-reference a state identification number.

Source

Complete form 470-0271 using the template in:

- SharePoint under Employee Manual/Forms, or
- The Worker Information System Exchange (WISE).

Completion

The IM worker completes the "Date," "From," and "Case Identification" sections and completes the rest of the form depending on the action being requested:

- **Cancel Warrant**: 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.

  If Quality Assurance has the warrant, send the form alone to Quality Assurance. Leave the warrant number field blank for Quality Assurance to complete.

  In both cases, Quality Assurance takes the necessary actions to remove the warrant from the client's automated records.

- **Issue One-Time Special Payment Over $1800**: 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.

  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.

- **State ID Cross Reference**: If two or more state identification numbers are on record for a client, use this section to indicate which state ID should be removed.

  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.

In all cross-reference situations, use the “Comments” section to explain your request.

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.

Race/Ethnic Report, Form 470-3716

Purpose	Form 470-3716 is used to gather information about race and ethnicity for a person associated with the SNAP household or FIP assistance unit. 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.
Source	Complete form 470-3716 using the template in: ▪ SharePoint under Employee Manual/Forms. ▪ The Worker Information System Exchange (WISE).
Completion	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. Also issue the form when the household applies for benefits for a new household member. NOTE: Clients are not required to complete this form. If clients decline to do so, it does not affect their eligibility or their benefits. 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.
Distribution	Enter the race and ethnicity information collected for each person on the ABC system.
Data	Clients can choose one selection for ethnicity and choose as many selections as apply for race.

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	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. The *RCA Appointment Letter* 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.
Distribution	After the IM worker completes the form: ▪ Hand-issue, mail, or e-mail the form to the RCA applicant, and ▪ File a copy in the RCA case record.
Data	On the page, the IM worker: ▪ Selects the type of appointment (in-person or phone) ▪ Enters the appointment date ▪ Time, and ▪ For phone interviews, the phone number for the client. Complete all remaining fields in the Referral Information and Person Responsible for Registering for Work sections. The fields are self-explanatory.

Reasonable Compatibility Tool, Form 470-5178

Purpose

IM workers use the *Reasonable Compatibility Tool* 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:

- SharePoint under Employee Manual/Forms.
- The Worker Information System Exchange (WISE).

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:

- **State Source Income** tab: Enter the amount of monthly income obtained from state data sources for each member.
- **Self-Attested Income** tab: Enter countable monthly income for each member in the field that identifies the type of income.
- **Reasonable Compatibility** 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 *Compatibility Percentage* field:
  - The *Reasonably Verified* field says "True" if the percentage is 10% or less. The worker may consider the income to be verified.
  - The *Reasonably Verified* field says "False" if the percentage is more than 10%. The worker must obtain additional verification of the income.

Redetermination to Other Medical Programs, Form 470-4832

Purpose	Form 470-4832, *Redetermination to Other Medical Programs*, 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: ▪ Medically Needy ▪ Family Planning Services ▪ MEPD
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	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). BRS uses the form to: ▪ Register the refugee for employment with IWD, ▪ register the refugee for employment or training, and ▪ to notify the local Department office when registration is complete.
Source	Complete form 470-0480 using the template in: ▪ SharePoint under Employee Manual/Forms. ▪ The Worker Information System Exchange (WISE).
Completion	The IM worker prepares the form, except for the Bureau of Refugee Services' signature and date. Prepare this form: ▪ At the time of application for those refugees determined to be employable. ▪ At any time a refugee who has been exempt from employment is no longer exempt and must register for employment.
Distribution	Email the form to BRSrefugee@dhs.state.ia.us. After the refugee has been registered for work with IWD and employment and training services, BRS will email the form to the IM worker. Upload the form to the casefile.
Data	This form identifies the refugee and the IM worker.

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

Purpose	MAGI-related Medicaid and Hawki applicants and recipients use the *Renewal Application Addendum* to provide tax information and consent to compare reported information with data sources on household members not included on the: ▪ Application for Health Coverage and Help Paying Costs, form 470-5170 or 470-5170(S), or ▪ *Medicaid/Hawki Review*, form 470-5168 or 470-5168(S).
Source	Complete the English or Spanish version of this form using the template in: ▪ SharePoint under Employee Manual/Forms. ▪ The Worker Information System Exchange (WISE). Supplies of the addendum may also be printed from the online manual.
Completion	The MAGI-related Medicaid or Hawki applicant or recipient completes the addendum. The applicant or recipient may obtain help in completing the addendum from friends, relatives, advocate groups, or Department staff, if needed.
Distribution	File the addendum and the *Application for Health Coverage and Help Paying Costs*, form 470-5170 or 470-5170(S), or the *Medicaid/Hawki Review*, form 470-5168 or 470-5168(S).
Data	The worker completes the *Case Number* field in the upper right corner of page 1 before the form is sent or issued to the applicant or recipient. The applicant or recipient must print their name, and sign and date page 1 of the addendum. The applicant or recipient must complete the Tax Information section for each household member not listed on the *Application for Health Coverage and Help Paying Costs*, form 470-5170 or 470-5170(S), or *Medicaid/Hawki Review*, form 470-5168 or 470-5168(S).

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

Purpose

Form 470-0641 is designed to be used for reporting to the Social Security Administration:

- 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.
- A change of address for a person receiving Medicaid as an SSI beneficiary.

Source

Complete 470-0641 using the form in the Worker Information System Exchange (WISE).

Completion

The IM worker responsible for the case initiates the form:

- Whenever there is a change in a client's circumstances which may change the person's SSI payment, or
- To inform the Social Security Administration of a change of address that has been reported to the Department.

Distribution

Forward the original and one copy to the local Social Security Administration office. You may upload the request to the electronic case file.

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.

Data

The name of the Social Security Administration office involved and the name of the county populates based on information in the worker profile.

- For Section 1, entering the case number and state identification number populates the client's name, social security number, and address.
- 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.

- 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.)
- 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	Form 470-5771 allows for a household to provide a written request for replacement of SNAP benefits due to fraud and ▪ Verification that the allotment was issued and the amount issued, ▪ The IM worker's decision on the household's request, and ▪ Documentation for reporting and auditing.
Source	Complete 470-5771 using the form in the Worker Information System Exchange (WISE).
Completion	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.
Distribution	File the original in the household's case record. Give a copy to the household.
Data	The form is self-explanatory.

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

Purpose

Use the *Report on Incapacity* 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:

- SharePoint under Employee Manual/Forms.
- The Worker Information System Exchange (WISE).

Supplies of the form may also be printed from the online manual as needed.

Completion

The IM worker can issue this form when:

- A stepparent has applied to be included in the FIP or FMAP-related Medicaid eligible group due to incapacity.
- 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.
- A FIP applicant or participant requests a hardship exemption based on physical or mental health issues or disability.
- Incapacity must be determined for any other purpose.

The PROMISE JOBS worker can issue this form when:

- 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.
- Information obtained from the *Self-Assessment*, 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.
- 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.

The IM or PROMISE JOBS worker fills in the identifying information and date due at the top of the form.

The client completes and signs the Patient Permission section.

The medical professional completes the remainder of the form.

Distribution

If an examination or additional information is required, mail the form to the examiner or to the client to deliver to the examiner.

When an examination is required, advise Medicaid members to make an appointment with their managed health care provider or regular Medicaid provider, as applicable.

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	*Reporting SNAP Changes* 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: ▪ At application. ▪ At recertification.
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

Form 470-0643 is used to request information from the Central Abuse Registry:

- To determine whether there is record of a founded abuse report on a person in the child care provider's household.
- 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.
- To record the dissemination of child abuse information.

Source

IM staff can complete form 470-0643 using the template in:

- SharePoint under Employee Manual/Forms.
- The Worker Information System Exchange (WISE).

Completion

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:

- A nonregistered provider wishes to receive Child Care Assistance funds.
- A minor parent claims good cause for not living with an adult parent or legal guardian because of abuse.

Complete Section 1 with information about the person making the request (the worker).

Complete Section 2 with information about the person whose records are being requested (the minor parent or child care provider).

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.

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.

Distribution

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.

For requests involving a minor parent, attach a copy of form 470-0461, *Authorization for Release of Information*, completed by the minor parent. The release shall:

- State that you are authorized to obtain information from the child abuse registry.
- 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.

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

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."

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.

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.

Source

Obtain form 470-3826 from the Eligibility Tracking System (ETS), either from:

- The "Form History" page, or
- The "Active Cases That Have Used FIP For 36 or More Months" report.

Print the English or Spanish version of this form from:

- The online manual.
- SharePoint under Employee Manual/Forms.
- The Worker Information System Exchange (WISE).

Completion

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.

Distribution

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.

Return a copy of form 470-3826 or 470-3826(S) to the family as a record of the authorization to share information.

Upon receipt of form 470-3826 or 470-3826(S) from the family, screen the family's FIP case circumstances.

- 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.
- If the family's hardship exemption request appears appropriate for the FIP case circumstances, process the hardship exemption request.

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.

Request for ISIS Changes, Form 470-3924

Purpose

The purpose of the *Request for ISIS Changes*, 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:

- SharePoint under Employee Manual/Forms.
- The Worker Information System Exchange (WISE).

Completion

An IM worker prepares the form when:

- A program request needs to be added to ISIS and the information cannot be passed to ISIS by making entries in the ABC system.
- 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.

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.

Distribution

Email the completed form to DHS, ISIS-Facilities.

Data

Part 1: Member/Staff Information: Enter the member's state identification number and name from the ABC system. Enter your name.

Part 2: Eligibility Changes:

Program request that needs changes: 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.

Correct Information: Enter the correct information in each of the following fields:

- **Begin Date**: Enter the date the member becomes eligible or resumes eligibility for the waiver or facility program or the effective date of a change.

- **End Date**: Enter as the end date the last date eligibility exists or the day before a change is effective on the subsequent program request.
- **Aid Type**: Enter the aid type for the member's coverage group.
- **Program**: Enter the number or letter of the program type from the drop down box.
- **Co Res**: Enter the county where the case is assigned.
- **Co LS**: Enter the member's county of legal settlement.
- **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	The system automatically generates this form for all persons active for Medicaid or family planning when: ▪ The code in the person's US or ID field indicates that citizenship or identity has not been verified **and** ▪ An automated match cannot be requested through the IEVS system on the person. EXCEPTION: The form will not be sent on a person who has already used one 90-day reasonable opportunity period. Form 470-4909(S) is system-generated when there is an "S" in the language indicator field. 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.
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	The purpose of form 470-2920 is to provide: ▪ The household's written request for replacement of food lost in a household misfortune, ▪ Verification that the allotment was issued and the amount issued, ▪ The IM worker's decision on the household's request, and ▪ Documentation for reporting and auditing.
Source	Complete form 470-2920 using the template in: ▪ SharePoint under Employee Manual/Forms. ▪ The Worker Information System Exchange (WISE).
Completion	Issue the form each time a household requests replacement issuance for food lost in a household disaster. The head of household, spouse, authorized representative, or responsible household member requesting replacement shall complete and sign the Household Statement section. The IM worker who makes the decision on the household's request for replacement issuance shall complete and sign the DHS Use Only section.
Distribution	File the original in the household's case record. Give a copy to the household.
Data	This form is self-explanatory.

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

Make two photocopies after the client signs the form. Send the original to the school. Give a copy to the client.

You may upload the request to the electronic case file. When the school returns the original, it will be scanned and uploaded.

Data

Enter the following information before obtaining the client's signature:

- The case number.
- The name and address of the school.
- The names of the students for whom the client needs verification.
- The dates for the time period to be verified.

The following information automatically populates:

- The worker number.
- The date the form is sent.
- The worker's name and address.
- The worker's phone number.
- The worker's email address.
- 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.)

The client shall sign and date the form after the listed items have been completed.

The school completes the remainder of the form.

Request for Special Update, Form 470-0397

Purpose

The *Request for Special Update* is used to:

- Update the Medicaid eligibility file (the SSNI screen) to add months for which a client was eligible for Medicaid.
- Correct Medicaid data for current and past months (when the client becomes eligible for greater benefits).
- Change Medicare coverage codes for current and past months.

Source

Workers can complete 470-0397 using the form in the Worker Information System Exchange (WISE).

Completion

The IM worker prepares three copies of this form:

- To authorize Medicaid coverage in the retroactive period when there is no current eligibility.
- To update the Medicaid eligibility file regarding Medicare supplemental insurance coverage.
- To add a newborn to the Medicaid eligibility file.
- To authorize past and current dates of benefits for some special Medicaid categories, such as when:
  - The person's aid type was Medically Needy with an unmet spenddown, but should have been in a non-Medically Needy coverage group.
  - 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.
  - The person was in a QMB aid type but was actually eligible for full Medicaid coverage.

Distribution

Send two copies to the Division of Information Technology (DoIT). Keep a copy in the case record for reference.

After the data are entered, Quality Assurance returns the original to the local office to indicate the date of completion.

Data

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.

See 14-C, *SSNI = Medicaid Eligibility File*, for a description of the SSNI fields. For coding instructions, see 14-B-Appendix for items on the TD03 screen (MEDICAL FUND, HEALTH, SRV, MN, and POV).

Request for Termination of Medical Assistance, Form 470-5763

Purpose	The *Request for Termination of Medical Assistance*, form 470-5763 provides: ▪ A simple means for the client to request that their Medical Assistance coverage be discontinued. ▪ A reminder to the client that requesting termination of Medical Assistance can also impact their eligibility for services they receive as well.
Source	The form can be printed from the user manual.
Completion	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.
Distribution	Issue the form when the client requests a form. 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.

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	The system automatically generates this form for all persons active for Medicaid or family planning when: ▪ The IEVS system automated match returns a response that the person's citizenship was not substantiated **and** ▪ The code in the person's US or ID field indicates that citizenship or identity has not been verified. EXCEPTION: The form will not be sent on a person who has already used one 90-day reasonable opportunity period. Form 470-4858(S) is system-generated when there is an "S" in the language indicator field. 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.
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: ▪ The online manual. ▪ SharePoint under Employee Manual/Forms. ▪ The Worker Information System Exchange (WISE).
Completion	The IM worker provides the form whenever the applicant or participant ▪ Requests information as to the procedure involved in claiming good cause, or ▪ Indicates intent to claim good cause. 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

Form 470-0169 and 470-0169(S) are used to:

- Notify FIP applicants and participants of their right to claim good cause for refusal to cooperate in establishing paternity and securing support payments.
- 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.

Source

Order supplies of the English version of this form from Iowa Prison Industries at Anamosa.

Print the English or Spanish version of this form from:

- The online manual.
- SharePoint under Employee Manual/Forms.
- The Worker Information System Exchange (WISE).

Completion

At the time of the application, give this form to:

- Every person applying or reapplying for FIP who is required to cooperate with Child Support Recovery.
- Every person applying or reapplying for FMAP-related Medicaid.

Issue this form to participants upon request of the participant. Document in the case record when the form is provided.

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.

Distribution

The applicant or participant keeps the form.

Resources Upon Entering a Medical Facility, Form 470-2577

Purpose

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:

- Goes into a medical institution expecting to remain for 30 consecutive days, or
- Applies for home- and community-based elderly waiver services.

Source

Print form 470-2577 from:

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

Completion

Either spouse (or an interested person on behalf of either spouse) may complete the form:

- When requested by a spouse (when one spouse enters a medical institution), or
- When a Medicaid application is submitted.

The form must be fully completed before an attribution of resources is determined.

Distribution

One copy shall be submitted. Provide a copy of the completed form when requested by either spouse.

Establish a case record for the spouse in the institution and file this in the permanent section of the case file.

Review/Recertification Eligibility Document, Form 470-2881, 470-2881(S), 470-2881(M), or 470-2881(MS)

Purpose

The *Review/Recertification Eligibility Document*, forms 470-2881, 470-2881(S), 470-2881(M), and 470-2881(MS), is designed for use as:

- An application for subsequent certification for the SNAP program.
- The annual or semiannual review document for FIP and Refugee Cash Assistance.

This form contains instructions for completion and informs clients of their rights and responsibilities.

Source

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.

DHS staff may issue "manual" versions of the form, 470-2881(M) and 470-2881(MS), using the templates in:

- SharePoint under Employee Manual/Forms.
- The Worker Information System Exchange (WISE).

Completion

The ABC system produces form 470-2881 or 470-2881(S) after the data processing cutoff for:

- SNAP when a case is due for recertification.
- FIP and Refugee Cash Assistance when a case is active or pending and the case coding indicates that the form should be sent.

Give or issue form 470-2881(M) or 470-2881(MS) to the participant upon request.

The worker or the ABC system completes the top portion of page 1 before the form is sent or issued to the participant.

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.

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.

For SNAP, only one signature is required to process this form as an application for recertification.

Distribution

Give or mail one copy of the report to the client for completion.

File the completed original in the case record. Provide a copy of the completed form to the client upon request.

Data

Whenever the form is issued manually, provide a pre-addressed return envelope. Prepare the form as follows:

- Enter the Department office name and mailing address.
- Enter the case name and current mailing address.
- Enter the nine-digit case number and check digit.
- Enter the county number.
- Enter the worker's telephone number in the "What if I have questions?" section.
- For FIP and Refugee Cash Assistance, insert the following message in the message section:

  "It's time to review your case. Please fill out this form and send or bring it to the address above by <due date>. This information will be used to decide if you will continue to get Family Investment Program (FIP) or Refugee Cash Assistance benefits."
- If an interview is needed for SNAP, enter:

  "Your Food Assistance will end <last date of certification period>. Return this signed form by <15th of certification end month>, 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.
- If an interview is **not** needed for SNAP, enter:

  "Your Food Assistance will end <last date of certification period>. Return this signed form by <15th of certification end month>, to get Food Assistance at the regular time next month, if you are eligible.
- Enter all data in the "Household Members" section (except **do not** enter the last grade completed and the "yes" or "no" responses). Enter only the last four digits of the social security number.

Screening: Screen the form upon its receipt. All questions (for related programs) that have “yes or no” responses must have either “yes” or “no” marked.

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.

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.

Screening Related Services Rendered to Medicaid EPSDT Enrollees, Report X1612X5

Purpose	The *Screening Related Services* 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, *Procedures for Notification and Tracking*, for a description of IM responsibilities under this program.
Source	The Iowa Medicaid Enterprise generates the list quarterly from the fiscal agent's **paid** claims history file.
Completion	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. When it is not clear whether the service has been received, contact the member to determine if assistance is needed.
Distribution	File the most recent report in the case record.
Data	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. 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.

PROMISE JOBS Stepping Stones to Family Success, Form 470-0806 or 470-0806(S)

Purpose	The *PROMISE JOBS Stepping Stones to Family Success,* form 470-0806 or 470-0806(S), is used to obtain information about a PROMISE JOBS client as part of the assessment process. This form helps identify and prioritize areas the client wants to change, which will then be listed as goals on their FIA. It also helps identify potential barriers that will be on their FIA.
Source	Print the English or Spanish version of this form from: ▪ WISE ▪ The online manual ▪ SharePoint under Employee Manual/Forms.
Completion	The PJ worker completes this form based on responses given by the client or gives it to the client to complete during the FIA appointment. This form may also be completed during the case management process, as deemed appropriate by the PJ worker. The IM worker may issue a copy of this form upon a client's request.
Distribution	The completed form becomes part of the client's PROMISE JOBS case file.
Data	The form requests information about the client's: ▪ Overall stress level ▪ Basic Needs: housing, transportation, and child care ▪ Health and Well-Being: general health, mental health, and substance use ▪ Legal Involvement ▪ Family Relationships: social support and relationships with partner ▪ Education and Learning: education, training, credential attainment and language ▪ Employment and Income: employment, job search skills, income, and expenses The form asks if the client has specific topics they would like to discuss with the PJ worker, and also inquires if any of their information, such as address, phone number, email, employment, household members, etc. needs to be updated.

Self-Employment Ledger, Form 470-3784

Purpose	Form 470-3784, *Self-Employment Ledger*, 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: ▪ The online manual. ▪ SharePoint under Employee Manual/Forms.
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 *SNAP Complaint* 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: ▪ The online manual. ▪ SharePoint under Employee Manual/Forms.
Completion	The complaint coordinator in the Field Operations Support Unit prepares one copy at month's end.
Distribution	The original is attached to the *SNAP Complaint* forms received in that particular month.
Data	Completion of this form is self-explanatory.

SNAP Computation, Form 470-0330

Purpose	The *SNAP Computation*, form 470-0330, is used for manual calculation of eligibility and benefits.
Source	Print form 470-0330 from: ▪ The online manual. ▪ SharePoint under Employee Manual/Forms.
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 *SNAP Farmer Self-Employment Worksheet*, 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	This form records self-employment income and expense information that affects benefit amounts. Page 2 calculates the prorated shelter deduction when a portion of shelter costs are used as a business expense. Page 3 is a farm income interview checklist.

SNAP Self-Employment Worksheet, Form 470-5418

Purpose	The *SNAP Self-Employment Worksheet*, 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	This form records self-employment income and expense information that affects benefit amounts. Page 2 calculates the prorated shelter deduction when a portion of shelter costs are used as a business expense.

SNAP Work Rules, Form 470-5674 or 470-5674(S)

Purpose	The purpose of *SNAP Work Rules* 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.
Completion	This form is issued to SNAP households when: ▪ A member with a TD03 WR code of 3, L, or V is identified at application. ▪ A member with a WR code of 3, L, or V is identified at recertification. ▪ A member with a WR code of 9, 4, or E is updated to 3 during the certification period. ▪ A member with a WR code of 3, 9, 4, or E is updated to L or V during the certification period.
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: ▪ SharePoint under Employee Manual/Forms. ▪ The Worker Information System Exchange (WISE).
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: **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 employer. If the person is self-employed, indicate the nature of the self-employment business. If there is unearned income, enter the source. **Frequency**: Enter how often the person is paid (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: 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.

SSI-Related Income Worksheet, Form 470-2525

Purpose

The *SSI-Related Income Worksheet* 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:

- SharePoint under Employee Manual/Forms.
- The Worker Information System Exchange (WISE).

Completion

The IM worker uses this form to calculate income for current eligibility for the following programs or as otherwise needed:

- Eligible for SSI or SSA but not receiving cash
- Expanded specified low-income Medicare beneficiary
- Qualified disabled working persons
- Qualified Medicare beneficiary
- Retroactive SSI eligibility
- Specified low-income Medicare beneficiary

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.

Distribution

File the original in the case record. Attach verification to the form, when required.

Data

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.

1. Case name. Enter the name of the case as it appears on agency records.
2. Case number. Enter the case number, including FBU.

   Complete lines 3 through 5 for each household member who has income that is considered to determine eligibility.
3. Household member. Enter the name of each person who is employed or has unearned income.
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.

5. Frequency of pay. Enter the frequency the household member is paid; such as weekly, twice a month, or every two weeks.
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 470-2341

Purpose	Form 470-2341 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 470-2341 using the template in: ▪ SharePoint under Employee Manual/Forms. ▪ The Worker Information System Exchange (WISE).
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	*SSN Request for Information*, 470-5376 or 470-5376(S) 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. This form contains clear instructions for completion and informs clients on how to provide the information.
Source	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. DHS staff may issue a manual Request for SSN by completing a *Request for Info,* 470-5089 using the templates in SharePoint under Employee Manual/Forms and the Worker Information System Exchange (WISE).
Completion	The ELIAS system completes form 470-5376 or 470-5376(S) when client's newborn(s) are about to turn 1 year old.
Distribution	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.
Data	The ELIAS system will populate the name, address, worker identification, client name and due date. A WISE narrative is created to indicate SSN Request for Information was sent.

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

Purpose	Form 470-2835, *State Supplementary Assistance Agreement to Repay Conditional Benefits*, 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: ▪ The online manual. ▪ SharePoint under Employee Manual/Forms.
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

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.

Source

Complete 470-0640 using the form in the Worker Information System Exchange (WISE).

Completion

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.

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.

Distribution

Forward this form to the Social Security Administration office. Keep a copy in the IM file as a control.

The Social Security Administration completes its portion of the form and returns it to the imaging center listed on the back of the form.

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.

Data

The following should automatically populate:

- The name and address of the Department office.
- The name and address of the Social Security Administration office that serves your area.
- The address and fax number of the imaging center that serves the worker's county.

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.

If there is a representative payee, guardian, or conservator, indicate which and enter the person's name, address, and telephone number.

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.

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, *Statement of Citizenship Status*, 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: ▪ SharePoint under Employee Manual/Forms. ▪ The Worker Information System Exchange (WISE).
Completion	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). The form must be signed by an adult household member and returned before the person can be added to the eligible group.
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, *Citizenship*, and 8-C, *Verifying Citizenship and Identity*, for policy regarding required signatures.

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

Purpose

The *Ten-Day Report of Change for FIP*, form 470-0499, and its Spanish translation, form 470-0499(S), provide:

- A simple means for the client to report a change and submit explanatory information.
- A reminder to the client that changes in circumstances must be reported to DHS whenever they occur.

Source

Workers can complete the English or Spanish version using the form in the Worker Information System Exchange (WISE).

Completion

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.

Distribution

Issue the form:

- At application.
- When the client turns in the form to report a change.
- When the client requests a form.

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.

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

Purpose

The *Ten-Day Report of Change for Medicaid/Hawki*, form 470-5590, and its Spanish translation, form 470-5590(S), provide:

- A simple means for the client to report a change and submit explanatory information.
- A reminder to the client that changes in circumstances must be reported to DHS whenever they occur.

Source

Workers can complete the English or Spanish version using the form in the Worker Information System Exchange (WISE).

Completion

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.

Distribution

Issue the form when the client requests a form.

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.

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

Purpose	The *Treasury Offset Program (TOP) Pre-Offset Notice* 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. The debtor can avoid that referral by contacting the Department of Inspections and Appeals within 60 days and negotiating a repayment agreement.
Source	This form is computer-generated based on information recorded on the Web-based Overpayment Recovery (WOPR) System.
Completion	WOPR generates this form when: ▪ The debtor whose SNAP claim is delinquent meets the criteria for referral to the Treasury Offset Program (see 6-G, *Federal Offset for Food Assistance*), and ▪ The Treasury Department has registered an address for the debtor.
Distribution	One copy is sent to the household. One copy is filed in the DIA record.
Data	The debtor's name and social security number and the amount of the claim are entered as the form is generated.

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

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.

The client (or person authorized to obtain the information) shall sign and date the authorization section of the form.

The educational institution completes the sections of the form that have been checked by the worker and the signature line.

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

Before sending the form,

- Enter:
  - The worker number.
  - The name and address of the educational institution.
  - The date you send the form.
  - The name of the worker.
  - The phone number of the worker.
  - The client's name. Enter the social security number also, if it is needed to obtain the requested information.
  - The date of the academic term.
  - 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.

- Check the boxes indicating each section the educational institution is to complete.
- Have the client sign and date the authorization statement.

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: ▪ SharePoint under Employee Manual/Forms. ▪ The Worker Information System Exchange (WISE).
Completion	The worker completes the identifying information on the client. The client (or the person authorized to obtain the information) completes and signs in the section giving permission. The worker, the client, the provider, or the provider's designee completes the provider information. The health care provider or the provider's designee completes the information related to the health care that was given the client.
Distribution	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. You may upload the request to the electronic case file. When the source of information returns the original, it will be scanned and uploaded.
Data	To initiate the form, enter: ▪ The client's name ▪ The client's state identification number ▪ Your county and worker number ▪ The client's date of birth ▪ The client's social security number, if available ▪ The name of the client's parent or guardian, if applicable

Verification of Paid Medical Bills, Form 470-2224

Purpose

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.

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 *Notice of Decision* denying Medicaid and the date of a *Notice of Decision* approving Medicaid.

See 8-A, *Reimbursement After Appeal Decisions*.

Source

Print form 470-2224 from:

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

Completion

The form is prepared when the member or a county agency requests reimbursement for paid medical bills.

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.

- Section I, Member Information, is prepared by either the local DHS office or the county agency, giving identifying information.
- 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.
- Section III, Payment Information, is completed by either the member or the county agency, depending on who is to receive reimbursement.
- 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.

- 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.

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: ▪ SharePoint under Employee Manual/Forms. ▪ The Worker Information System Exchange (WISE).
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: ▪ Contributor's name ▪ Voluntary contribution amount ▪ Member's name ▪ Medical institution name and city ▪ Day of the month voluntary contribution is to be made The contributor, medical institution representative, and local DHS representative shall sign the form after these items have been completed.

Voter Registration, Unnumbered

Purpose

The *Voter Registration* form:

- Gives clients information about registering to vote.
- Records a client's decision whether to register.
- Provides a detachable card that clients can use to register.

This process is required by the National Voter Registration Act of 1993 and Iowa Code Section 48A.19.

Source

Central Office has a contract to provide automatic shipments of the *Voter Registration* form to local offices. The shipments are intended to cover a six-month supply. Additional supplies are also available through Central Office.

Completion

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.

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.

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.

Distribution

Keep the declination section in the local office. Give the voter registration information section to the client.

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.

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.

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:

Date Declination Signed	Election Date	Destroy After
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
10/25/2020 – 10/22/2022	11/08/22	09/08/2024
10/23/2022 – 10/26/2024	11/05/2024	09/05/2026
10/27/2024 – 10/24/2026	11/03/2026	09/03/2028

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, *Waiver Slot Notice*, 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	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. For other clients, an application must be returned by the due date to secure the open slot. Send form 470-5170, *Application for Health Coverage and Help Paying Costs* with the *Waiver Slot Notice*. Select the waiver type matching the waiver slot assignment.
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 *Facts About SNAP* 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: ▪ The online manual. ▪ SharePoint under Employee Manual/Forms.
Distribution	Local offices may give this form to SNAP applicants at the time they are given a *Food and Financial Support Application*, 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 *Care for Kids* 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 *Application for Health Coverage and Help Paying Costs*, 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: ▪ The online manual. ▪ SharePoint under Employee Manual/Forms.
Distribution	Give this booklet to Medicaid applicants or other interested persons.
Data	The booklet describes the use of the *Medical Assistance Eligibility Card*, 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: ▪ The online manual. ▪ SharePoint under Employee Manual/Forms.
Distribution	Provide this brochure to: ▪ Each applicant for FIP or MAGI-related Medicaid, and ▪ Each FIP or MAGI-related Medicaid member: • Who reports receipt or possible receipt of a nonrecurring lump sum, or • Whom you believe may receive a nonrecurring lump sum.
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 *Medicaid for SSI-Related Persons* gives basic information about SSI-related coverage groups.
Source	Print Comm. 28 or Comm. 28(S) from: ▪ The online manual. ▪ SharePoint under Employee Manual/Forms.
Distribution	Local offices may give this form to SSI-related Medicaid applicants at the time they are given an *Application for Health Coverage and Help Paying Costs*, 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 *Medical Assistance Eligibility Card* 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: ▪ Child Care Assistance ▪ SNAP ▪ Medicaid ▪ State Supplementary Assistance ▪ The Family Investment Program
Data	The brochure explains in general way: ▪ How the Department will use the information provided; ▪ Which persons outside the Department might routinely be provided this information; ▪ Which parts of the information requested are required and which are optional; and ▪ The consequences of failing to provide the information requested.

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	Give this booklet to anyone who files a Medicaid application for long-term facility care or other medical facility care. "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). "Other medical facility care" includes care in a general hospital or a psychiatric institution.
Data	The booklet: ▪ Gives guidance on choosing a long-term care facility, and ▪ 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.

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: ▪ The online manual. ▪ SharePoint under Employee Manual/Forms.
Distribution	Provide this brochure to: ▪ Child Care Assistance applicants ▪ FIP applicants at the application interview ▪ FIP participants at the annual interview ▪ Other interested person upon request
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 *Information on Emergency Service* 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: ▪ The online manual. ▪ SharePoint under Employee Manual/Forms.
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 *Food and Financial Support Application*, 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. 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 and application form an 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 programs 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 *Important Notice to Property Owners and Renters* flier explains the income limits for both the property tax credit and rent reimbursement.
Source	Print Comm. 121 or Comm. 121(S) from: ▪ The online manual. ▪ SharePoint under Employee Manual/Forms. ▪ The Worker Information System Exchange (WISE).
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 *Important Information for You and Your Family Members About the Estate Recovery Program* 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: ▪ The online manual. ▪ SharePoint under Employee Manual/Forms. ▪ The Worker Information System Exchange (WISE).
Distribution	Issue a copy of this flier to all Medicaid applicants.

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

Purpose

The *Family Planning Counseling* brochure is designed to give basic information about family planning counseling services.

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.

Source

Print Comm. 132 or Comm. 132(S) from:

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

Distribution

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.

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

Purpose	The *FIP for Minor Parents* 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: ▪ The online manual. ▪ SharePoint under Employee Manual/Forms.
Distribution	Issue Comm. 133: ▪ When a minor parent applies for FIP. ▪ When FIP eligibility must be redetermined due to a change in a minor parent's living arrangement.

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

Purpose	Comm. 137, *60-Month Limit on FIP*, 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: ▪ The online manual. ▪ SharePoint under Employee Manual/Forms. 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, *Important Information About Your FIP*. 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: ▪ The online manual. ▪ SharePoint under Employee Manual/Forms. ▪ The Worker Information System Exchange (WISE). 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	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. NOTE: State mental health institutes and resource centers each have their own brochures for this purpose.
Source	Printed supplies of Comm. 209 may be ordered from Iowa Prison Industries at Anamosa. Print Comm. 209(S) from: ▪ The online manual. ▪ SharePoint under Employee Manual/Forms.
Distribution	Provide this brochure to Medicaid members and other interested persons.
Data	The brochure explains what: ▪ Disclosures the Department can make without the member's specific permission, ▪ Rights the member has under HIPAA and how to apply them, and ▪ Obligations the Department has to safeguard a member's privacy.

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: ▪ The online manual. ▪ SharePoint under Employee Manual/Forms.
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 *Rights and Responsibilities* 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 https://hhs.iowa.gov/media/6509 and https://hhs.iowa.gov/media/6510 or on SharePoint. Print supplies of the English or Spanish version of Comm. 233 from: ▪ The online manual. ▪ SharePoint under Employee Manual/Forms.
Distribution	Comm. 233 or Comm. 233(S) is provided to each applicant household as part of form 470-5170 or 470-5170(S), *Application for Health Coverage and Help Paying Costs*. 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: ▪ The online manual. ▪ SharePoint under Employee Manual/Forms.
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: ▪ The online manual. ▪ SharePoint under Employee Manual/Forms.
Distribution	Give Comm. 249 or Comm. 249(S) to: ▪ Men and women ages 12 through 54 who lose Medicaid eligibility, ▪ People who have eligibility established under the Iowa Family Planning Program. 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	*Verifying Citizenship/Identity and/or Immigration Status* is an informational notice about federal Medicaid requirements.
Source	Print Comm. 258 or Comm. 258(S) from: ▪ The online manual. ▪ SharePoint under Employee Manual/Forms. ▪ The Worker Information System Exchange (WISE).
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. 337, Medicaid for Kids with Special Needs

Purpose	Comm. 337 is a brochure that explains the Medicaid coverage group for children with special needs (MKSN).
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: ▪ Information on how to apply for MKSN ▪ An overview of MKSN eligibility requirements ▪ A chart of income limits ▪ Contact information for the Department.

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: ▪ The online manual. ▪ SharePoint under Employee Manual/Forms.
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: ▪ The online manual. ▪ SharePoint under Employee Manual/Forms. ▪ The Worker Information System Exchange (WISE).
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 *Benefits of a Healthy Marriage* 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	Print Comm. 390 and 390(S) from: ▪ The online manual ▪ SharePoint under Employee Manual/Forms
Distribution	Manually issue Comm. 390 and 390(S) to households upon request.
Data	The flier provides information on the benefits provided by a healthy marriage.

Comm. 411, Medicaid for People in Care Facilities

Purpose

The flier *Medicaid for People in Care Facilities* gives basic information about the services covered by Medicaid for long-term care.

Source

Print Comm. 411 from:

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

Distribution

Give Comm. 411 to:

- All long-term care applicants and
- Anyone who requests information about Medicaid coverage of facility care expenses.

When more detailed information is requested, send Comm. 52, *Medicaid for People in Nursing Homes and Other Care Facilities*, or give the internet link to Comm. 52 at:
http://dhs.iowa.gov/sites/default/files/Comm052.pdf

Data

Comm. 411 explains:

- Admission procedures,
- The effect of Medicaid eligibility on the facility payment,
- Consideration of a spouse at home,
- Client participation,
- Additional services available,
- The relationship between Medicare and Medicaid, and
- Transfer from one facility to another.

Comm. 413, Medicare Savings Programs

Purpose	The flier *Medicare Savings Programs* gives basic information about the qualified Medicare beneficiary (QMB) program.
Source	Print Comm. 413 from: ▪ The online manual. ▪ SharePoint under Employee Manual/Forms.
Distribution	Give Comm. 413 to: ▪ All members who qualify for QMB and ▪ Anyone who requests information about Medicare Savings Programs. When more detailed information is requested, send Comm. 60, *Medicaid for the Qualified Medicare Beneficiary*, or give the Internet link to Comm. 60 at: https://hhs.iowa.gov/media/6428
Data	Comm. 413 explains the eligibility requirements and services available under the QMB program.

Comm. 414, Protecting Your Resources and Income

Purpose	The flier *Protecting Your Resources and Income* gives basic information about how resources and assets are determined when a person applies for Medicaid for facility care.
Source	Print Comm. 414 from: ▪ The online manual. ▪ SharePoint under Employee Manual/Forms.
Distribution	Give Comm. 414 to: ▪ All applicants for facility care and ▪ Anyone who requests information about the treatment of resources for Medicaid eligibility for facility care. When more detailed information is requested, send Comm. 72, *Protection of Your Resources and Income*, or give the Internet link to Comm. 72 at: https://hhs.iowa.gov/media/6434
Data	Comm. 414 explains: ▪ The income limit for the spouse in the facility, ▪ How resources are divided between the spouse in the facility and the spouse at home, and ▪ What income can be protected.

Comm. 415, Medically Needy Medical Assistance

Purpose	The pamphlet *Medically Needy Medical Assistance* gives basic information about the Medically Needy program.
Source	Print Comm. 415 from: ▪ The online manual. ▪ SharePoint under Employee Manual/Forms.
Distribution	Give Comm. 415 to all applicants who are determined eligible for Medically Needy coverage. When more detailed information is requested, send Comm. 30, *Medicaid for the Medically Needy*, or give the internet link to Comm. 30 at: https://hhs.iowa.gov/media/6422
Data	Comm. 415: ▪ Lists the eligibility requirements. ▪ Explains spenddown. ▪ Tells when a Medical Assistance Eligibility Card is issued.

Comm. 479, Burial Contract Frequently Asked Questions

Purpose	The flier *Burial Contract Frequently Asked Questions* 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: ▪ The online manual. ▪ SharePoint under Employee Manual/Forms.
Distribution	Give Comm. 479 to Medicaid applicants and recipients.
Data	Medicaid applicants and recipients should read through the *Burial Contract Frequently Asked Questions* to determine: ▪ If this information pertains to them or ▪ If they need to contact DHS for further information relating to burial contracts.

Comm. 516, Iowa Medicaid Will Help Pay Your Out-of-Pocket Costs

Purpose	Comm. 516, *Iowa Medicaid Will Help Pay Your Out-of-Pocket Costs*, 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: ▪ The online manual. ▪ SharePoint under Employee Manual/Forms.
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 *User Guide* 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 x 2); the two-person allowance for utilities is $32.90 ($16.45 x 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: ▪ The online manual. ▪ SharePoint under Employee Manual/Forms. ▪ The Worker Information System Exchange (WISE).
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: ▪ The online manual. ▪ SharePoint under Employee Manual/Forms.
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: ▪ The online manual. ▪ SharePoint under Employee Manual/Forms. ▪ The Worker Information System Exchange (WISE).
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: ▪ The online manual. ▪ SharePoint under Employee Manual/Forms. ▪ The Worker Information System Exchange (WISE).
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: ▪ Continuing disability reviews (CDRs). ▪ Disability referrals based on worsened conditions or new conditions. ▪ The use of form 470-0363, Certification of Eligibility of SSI Applicant. ▪ Concurrent determinations for Medicaid and Social Security benefits.

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: ▪ Within the electronic application. ▪ The online manual

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:

- The online manual.
- SharePoint under Employee Manual/Forms.
- The Worker Information System Exchange (WISE).

Data

The chart lists income limits for:

- Modified adjusted gross income (MAGI)
- Medicaid for Independent Young Adults (MIYA)
- Iowa Health and Wellness Plan (IHAWP)
- Healthy and Well Children in Iowa (Hawki)