

Iowa Department of Human Services

MEDICAID QUESTIONNAIRE

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FROM:

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RE:

Review Month:

Dear _____ :

Federal regulations require the Iowa Department of Human Services to select a number of cases for a special eligibility review. The purpose of this review is to verify if the benefits received were correct. The review process will also independently verify all eligibility and payment requirements and determine any changes in circumstances such as income, resources or living arrangements.

This Medicaid-Title XIX case was selected for the month identified above from the master list in Des Moines of all Iowa residents receiving assistance for that month. Be assured that this case was selected at random and not because there is a specific question about it.

The signature page from a recent Public Assistance Application or Review Form indicates your willingness to cooperate fully in Quality Control's verification of eligibility and payment. Cooperation with Quality Control is an eligibility factor. Refusal to cooperate may result in cancellation of Medicaid assistance.

The information I have requested is due back to me within five working days of your receipt of this letter. A return envelope is enclosed for your convenience.

If you have any questions regarding the information that I have requested, please call me collect, if necessary, at the above listed number. Thank you for your cooperation.

Sincerely,

Quality Control Reviewer
Iowa Department of Human Services

Attachments

MEDICAID QUESTIONNAIRE

RE:

The following information is required regarding the above named client. Respond to each of the items marked (X) below. Include copies of any exact documentation you may have for any of the below listed items such as birth or death certificates, marriage licenses, contracts, or policies. I will return to you those items you identify for return as soon as I copy them for this review. **Please sign and date at the bottom of page five of this questionnaire.**

<input type="checkbox"/> Call me on _____, to discuss this review. Call me collect at the number listed in my letter to you (first page).				
<input type="checkbox"/> Date and place of birth. Please send a copy of the birth certificate. <table border="1"><tr><td>Date of Birth (month, day, year)</td><td>Place of Birth (city, county, state)</td></tr></table>	Date of Birth (month, day, year)	Place of Birth (city, county, state)		
Date of Birth (month, day, year)	Place of Birth (city, county, state)			
<input type="checkbox"/> Maiden name or name at birth: <table border="1"><tr><td> </td></tr></table>				
<input type="checkbox"/> Is the above named suffering from blindness or disability? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, explain:				
<input type="checkbox"/> Marital status (check): <input type="checkbox"/> Single <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Separated				
<input type="checkbox"/> Date and place of marriage for: <table border="1"><tr><td colspan="2" style="text-align: center;">and</td></tr><tr><td>Date of Marriage (month, day, year)</td><td>Place of Marriage (city, county, state)</td></tr></table>	and		Date of Marriage (month, day, year)	Place of Marriage (city, county, state)
and				
Date of Marriage (month, day, year)	Place of Marriage (city, county, state)			
<input type="checkbox"/> Date and place of death of: <table border="1"><tr><td>Date of Death (month, day, year)</td><td>Place of Death (city, county, state)</td></tr></table>	Date of Death (month, day, year)	Place of Death (city, county, state)		
Date of Death (month, day, year)	Place of Death (city, county, state)			
<input type="checkbox"/> Does the above named own any bank accounts, individual or joint? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, where are they located? If no, how are bills paid?				

- Name and telephone number of a person (non-relative) that I may contact to verify certain information regarding your living situation as of the review month.

Name	Telephone Number
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- Sign and return the enclosed *Authorization for Release of Information* to . You may retain a copy.

- Is there a safety deposit box? Yes No If yes, I will need a complete inventory of all items in the box signed by a bank official.

- Amount of cash on hand (not including any bank accounts) as of \$.

- Does the above named own any stocks or bonds? Yes No
If yes, identify all information:

Purchase Date	Issuer	Identification Number	Value

- Does the above named own any burial space? Yes No
If yes, complete:

Where are the spaces located?

- On the attached *Release of Information* list the name and phone number of the cemetery board or person I may contact to verify ownership of burial spaces. Sign the Release and return it to me. You may retain a copy.

- Please note the number of spaces and indicate by name and relationship to our client for whom use of the burial lot(s) is intended.

Number	Name	Relationship

- Does the above named have a prepaid burial agreement? Yes No If yes, enclose a copy.

Is there a trust fund? Yes No

If yes, give details:

Does the above named own any real estate property? Yes No

If yes, what is the address and legal description?

Address

Legal Description

State when and where the most recent real estate property owned was disposed of.

When

Where

State the city, county and state of residence prior to the current living arrangement.

City

County

State

Has there been any disposal of personal or real property in the past two years? Yes No

If yes, give details:

Is there any property being sold on contract? Yes No

If yes, give details:

Is there a life estate? Yes No

If yes, give details:

Does the above named own any personal property or motor vehicles? Yes No

If yes, give details:

Is there any coverage under any private life insurance carrier? Yes No

If yes, give details:

Name of Company

Policy Number	Face Value of Policy
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Send face sheet from _____ life insurance company so I may confirm face value, cash value, policy number, and issue date for the life policy.

State briefly the employment history for _____ and _____. I am looking for any possible source of private pension.

Is there any history of military service, government employment, or railroad employment for the client or spouse? Yes No If yes, give details:

Name	Dates	Branch or Employer

State the amount received in _____ for each of the below listed sources. State claim number, case or identification number. If no benefits are received, state none for those items.

	Amount	Number
Social Security		
SSI		
Veteran's benefits		
FIP		
Unemployment compensation		
Worker's compensation		
Railroad benefits		
Any other governmental benefit or pension		
Any private pension or benefit		
Support payments		
Income-in-kind		
Deemed income		
Interest income		
Any other source of income		
Foster care payment		
Wages or salary		

Send a statement from _____ showing the date and gross amount for each check received during _____ .

Is there coverage under any private health insurance carrier? Yes No

If yes, give details:

Name of Company	Policy Number
Names of Persons Covered	
Type of Benefits	Effective Date of Policy

Send receipts of canceled checks, or other verification of payment of private health insurance premiums paid since _____ .

Sign and return to me the attached *Authorization(s) for Release of Information* allowing me to confirm the information required. You may retain a copy of each.

Other information that is required:

I certify the above information is to the best of my knowledge true and complete.

Signature		Date	
Street	City	State	Zip
Telephone No. (Home)		Telephone No. (Work)	
Best time to telephone is:			