Iowa Department of Human Services

PROOF OF APPLICATION FOR MEDICAID

Worker Name: _____

Co. No. _____

[ ] [ ]

Notice Date:

This letter verifies that you applied for Medicaid on , for the following persons:

This is not a determination that you are eligible for Medicaid. After this application is processed, you will receive a Notice of Decision. The Notice of Decision will indicate if you are eligible for Medicaid **or** if you are conditionally eligible for Medicaid and the amount of any spenddown that must be met to be eligible for Medicaid. If you are determined to have a spenddown, you are responsible for paying the spenddown amount to the provider(s).