Iowa Department of Human Services

HEALTH SERVICES APPLICATION NARRATIVE

Case name	Representative's name	Representative's phone number
Application/review date	Representative's address	
Interview date		

Marital status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated

DISABILITY INFORMATION

Denied/canceled from SSI/Social Security? ☐ No ☐ Yes If yes, date of denial/cancellation:

Social Security number

What was the disability?

Condition has: ☐ Remained the same ☐ Worsened ☐ Improved

New disability? ☐ No ☐ Yes, what?

New condition to last 12 continuous months or result in death? ☐ No ☐ Yes

INCOME

Employee	Employer	Frequency Paid			

Income Source				Income Source			
Alimony/child support				Rental property			
Black lung				RR retirement			
Civil service				Social Security			
Educational monies				SSI			
Gifts				UIB			
Inheritance				VA aid & attendance			
Insurance				Veteran's benefit			
Interest/dividends				Veteran's pension			
IPERS				Worker's comp			
Lump sum				Other unearned:			
Miller trust							
Pension							
Property sold on contract							

RESOURCES

Bank Account Type	Whose	Where	Balance	Interest	Verification

Annuities		Safe deposit box		
Burial lot		Stocks/bonds/time certificates		
Burial contract irrevocable? ☐ Yes ☐ No Interest added to contract? ☐ Yes ☐ No		Transfer of resources:		
Cash on hand		Vehicles – Make/Model	Value	Equity
Certificates of deposit				
Dividends/interest				
Homestead/nonhomestead				
Mortgages and contracts		Other resources:		
Mutual funds/money market				
Promissory notes				

LIFE INSURANCE

❶ Company

Face value	Cash value	Accumulative dividend amount

❷ Company

Face value	Cash value	Accumulative dividend amount

HEALTH INSURANCE

Insurance company		Premium
Medicare premium	Part A: ☐ Yes ☐ No Part B: ☐ Yes ☐ No	Social Security claim number

FACILITY INFORMATION

If entering a nursing facility:

Previous living arrangement

Name of nursing facility

Date entered facility	30th day

MISCELLANEOUS INFORMATION

Was a trust created within 60 months of application or within 60 months before entering a medical facility?
☐ No ☐ Yes If yes, get a copy of the trust.

Was an inheritance disclaimed or anything of value sold or given away? ☐ No ☐ Yes
What and when:

Anyone a veteran or previously worked for the federal, state or local government or the railroad?
☐ No ☐ Yes
If yes, who: Where:

Rights, responsibilities, and program explained/pamphlets given:

Forms completed:

☐ Tax Suspension
☐ Change Report Form
☐ Acceptance of Other Benefits
☐ Supplemental Insurance Questionnaire

Comments

Medical eligibility date	Facility eligibility date
Worker's name	Date