Department of HUMAN SERVICES

Health Insurance Information for Kids With Special Needs

Date:
Worker number:
Worker name:
Phone:

Fax number:
Worker E-mail:
Information due date:

Dear

You have applied for Medicaid for Kids With Special Needs for your child, _____. You are required to enroll this child in employer group health insurance that is available to you, and pay the premiums to keep the child enrolled. The only exception is when your employer pays less than half the annual cost of the health insurance premiums.

Check the box below that describes your child's health insurance status and send back this form and any other information.

☐ Parents living with the child **do not have health insurance available from their employers**.

☐ A parent, who does not live in the same home, has health insurance for this child. Please fill out and send back the enclosed *Insurance Questionnaire* form.

☐ This child is already enrolled in employer health insurance. If you checked this box, fill out the enclosed *Insurance Questionnaire* form.

☐ This child is not enrolled in employer group health insurance right now, but could be enrolled. Please ask your employer to fill out the enclosed *Health Insurance Information* form and send it back to me.

☐ This child is not enrolled in an employer health insurance plan. Please ask your employer to fill out the enclosed *Health Insurance Information* form and send it back to me.

Important: Due date to return information:

If you have any questions or problems in getting this information to me by the above due date, please contact me right away. If the requested information is not received by the due date, the application for your child will be denied.

Thank you for your help.

Income Maintenance Worker

Iowa Department of Human Services

Health Insurance Information

Please ask your employer to complete this form even if you cannot enroll your child right now.

Case Number	**Return this information by:**
Employer	
Employee's Name	Employee's Child's Name

I give permission to my employer to give this information to the Iowa Department of Human Services.

Employee's Signature	Date

Enrollment Information

Can the child listed above be enrolled in this health insurance plan at this time?

☐ No. If not, when can the child be enrolled? _____

☐ Yes. Effective date _____

Cost of Premiums

Does the employer pay at least half of the cost of premiums to cover the child? ☐ Yes ☐ No

Comments

_____

_____

_____

Employer Representative Name (Print)		Employer Representative Name (Sign)	
Date	Phone Number	Fax Number	E-mail

Questions or need help? Contact DHS:

Telephone Number	Fax Number	E-mail