Iowa Department of Human Services

Notice of Medical Assistance Debt Due to a Transfer of Asset(s)

Date: Account Number:

Keep This Part

If you have questions about this notice, call **1-800-572-3945** (toll free).

It has been determined that you owe a Medical Assistance debt up to $ _____.

There is a voluntary Agreement and/or Court Order.

What You Need to Do

Step 1: Payment Plan:

If a payment plan was previously established, you must pay according to that plan. You do **not** need to complete another Agreement to Pay.

If a payment plan has not been established you must choose one of the following to repay the debt:

Plan 1: Pay the full amount owed in one payment.

Plan 2: Make monthly payments until the debt is paid in full.

Plan 3: Pay part of what you owe now and pay the rest in monthly payments.

If you choose Plan 2 or 3, your monthly payments cannot be less than the amount you owe divided by 60 (one monthly payment for five years).

Under Plans 1, 2, or 3, you will get a bill with instructions on how to make payments. If your household's income changes, you can ask to change your agreement. Under any Plan, you can pay the entire amount at anytime.

Step 2: Fill Out and Mail the Agreement to Pay – Remember to:

- Fill in all the blanks.
- Choose a payment plan if one has not been previously established.
- Sign and date the form.
- Return the Agreement to Pay within 20 days of the date of this letter.

Mail 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

Action to Collect the Debt

The Department of Inspections and Appeals (DIA) can collect on this debt by doing one or more of the following:

- Bill you for the debt, or
- If you do not return an agreement or you are past due on your account, DIA may take the following actions:
    - Take money that is owed to you by any state agency. For example, all or part of your state income tax refund, lottery winnings or state wages, or
    - File a court action to collect the debt.

Agreement to Pay

Due Date:

Case Name:

Mail This Part

Account Number: DIA Case Number:

Complete and return this section only if you do not have a payment plan.

I, _____, agree to pay the Iowa Department of Human
(First Name, Middle Initial, and Last Name)
Services for a Medical Assistance debt up to the amount of $_____.

I do not have an agreed-to or court ordered payment plan and choose to repay the debt by (check one of the boxes below):

- ☐ Plan 1: Pay the full amount in one payment.
- ☐ Plan 2: Make monthly payments of $_____ beginning _____ and the same amount each month thereafter until the debt is paid in full.
- ☐ Plan 3: Pay part of what you owe now in the amount of $_____ and then make monthly payments of $_____ beginning _____ and the same amount each month thereafter until the debt is paid in full.

By signing this agreement, I understand that:

- If I choose Plan 2 or 3, my monthly payments cannot be less than the amount I owe divided by 60 (one monthly payment for five years).
- I can pay the balance off at any time.
- Not making the payments will break the agreement. The Department of Inspections and Appeals may take action to collect the debt.

_____ _____ _____
Signature Phone Date

Current address:

For Office Use Only:

Signed: Date: Title:

It is the policy of the Iowa Department of Human Services (DHS) to provide equal treatment in employment and provision of services to applicants, employees and clients without regard to race, color, national origin, sex, sexual orientation, religion, age, disability, political belief or veteran status.

If you feel DHS has discriminated against or harassed you, please send a letter detailing your complaint to: Iowa Department of Human Services, Hoover Building, 5th Floor – Policy Bureau, 1305 E Walnut, Des Moines, IA 50319-0114 or via email FDHS@hhs.iowa.gov

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