Iowa Department of Health and Human Services

Express Lane Medicaid for Children

County number: Worker name and number:

Case number: Worker phone number:

NEW rules make it easy to get Medicaid for the children in your home who already get SNAP. You will not have to fill out an application.

If you want Medicaid for your children:

1. Check “Yes” for each child named below that needs help with paying medical bills.
2. Sign and mail this form to your HHS office or bring it to the HHS office by

Yes	No	Name of Child
☐	☐	
☐	☐	
☐	☐	
☐	☐	
☐	☐	
☐	☐	
☐	☐	
☐	☐	
☐	☐	

Health Insurance

Do the children have other health insurance? ☐ Yes ☐ No

If your children have health insurance, send back or bring to the HHS office form **470-2826, Insurance Questionnaire** (enclosed).

Medical Care

If any of your children were under age one in the last three calendar months, do you need help paying medical bills for them for those months? ☐ Yes ☐ No

If yes, please list: Child's name_____

Months in which medical care was received_____

Child Support Recovery

Do you want to get help from Child Support Recovery for the children named on this form?
☐ Yes ☐ No

Do any of the children named on this form get court-ordered medical support from an absent parent? ☐ Yes ☐ No

If "yes" to either question, give information for each parent who does not live in the home with the children.

Name and Address of Parent Not Living in the Home	Date of Birth of This Parent	Social Security Number of This Parent	Names of This Parent's Children	County Where Court Order is Filed, if Any

For each parent not in the home, please give the following information, if you know:

Name of Parent Not Living in the Home	Name of Employer	Employer's Address	If ever married to this parent, date and place of marriage

If you need more room to give this information, attach another sheet.

Renewal of Coverage in Future Years

To make it easier to determine eligibility for health coverage in future years, your income data, including information from tax returns, can be verified electronically. You can also change your mind and not allow the Department of Health and Human Services to check this information.

Do you want this information to be verified in the future and used to automatically renew your eligibility?

☐ Yes, renew my eligibility automatically.

How long? ☐ 5 years ☐ 4 years ☐ 3 years ☐ 2 years ☐ 1 year

☐ No, don't use my information from tax returns to renew my coverage.

Estate Recovery

Federal law requires Iowa to have an estate recovery program. If you get Medicaid, you may be subject to estate recovery. This means any Medicaid funds used to pay for your healthcare, including the monthly fee paid to a Managed Care Organization (MCO), will need to be paid back from your estate after your death. Estate recovery applies if you get Medicaid and are:

- Age 55 or older, or
- Are under age 55 and live in a medical facility and cannot reasonably be expected to return home.

For more information, call the Iowa Medicaid Estate Recovery Program at 1-877-463-7887 or go online to https://hhs.iowa.gov/media/6458 (English) or https://hhs.iowa.gov/media/6459 (Spanish).

Read and Sign this Form

- By signing this form, you give your permission for HHS to share your medical and other health care records with federal and state officials.
- By signing this form, you give your permission for your medical provider to share:
  - Your medical history with an MCO or other managed care provider.
  - Information with IME Medical Services Unit to certify a medical need for certain Medical Assistance programs or services.

  I agree to assign medical payments from a third party to the Medicaid agency for myself and others who are eligible for Medicaid for whom I legally can assign benefits. I also agree to cooperate in obtaining medical payments for third parties.
- By signing this form, I certify under penalty of perjury and false swearing that my answers are correct and complete to the best of my knowledge, including information provided about the citizenship or alien status for each household member applying for benefits. I know I may be subject to penalties under federal law if I provide false or untrue information.

- I know that I must tell the Income Maintenance Call Center if anything changes (and is different than) what I wrote on this application. I can call **1-877-347-5678** to report any changes. I understand that a change in my information could affect the eligibility for members of my household.
- I know that under federal law, discrimination isn't permitted on the basis of race, color, national origin, sex, age, or disability. I can file a complaint of discrimination by visiting www.hhs.gov/ocr/office/file.
- I know that I can access my Rights and Responsibilities online at https://hhs.iowa.gov/media/6509 or I may call the HHS Contact Center at **1-855-889-7985**.

We need this information to check your eligibility for help paying for health coverage if you choose to apply. We'll check your answers using information in our electronic databases and databases from the Internal Revenue Service (IRS), Social Security Administration, the Department of Homeland Security, or a consumer reporting agency. If the information doesn't match, we may ask you to send us proof.

If Anyone on This Form is Eligible for Medicaid

I am giving to the Medicaid agency our rights to pursue and get any money from other health insurance, legal settlements, or other third parties. I am also giving to the Medicaid agency rights to pursue and get medical support from a spouse or parent.

Your Signature	Date

Insurance Questionnaire

To ensure that your bills are paid as quickly as possible, please fill out this form and return to your local Department of Health and Human Services (HHS) office.

Your name:_____ Your State ID number, if any:_____

Do you, your children or others in your home have health insurance coverage? ☐ Yes ☐ No, then stop here.

If yes, who carries this health insurance?

☐ You ☐ A parent who does not live with you

☐ Someone else in your home ☐ Someone else not in your home

Please fill out the information below. The boxes with this mark * must be filled in. Use the next page if you have another policy to tell us about.

Information About First Policy

Choose **all** that apply to this policy:

☐ Major Medical ☐ Drug ☐ Medicare Supplement

☐ Dental ☐ Vision

*Policyholder (Last Name, First Name, Middle Initial)		Phone number ( )
Mailing address (House #, Street, Apt, *OR* PO Box, City, State, Zip)		
*Social Security number	*Date of birth	*State ID #
*Insurance company name		Phone number ( )
Insurance claims office mailing address (#, Street, *OR* PO Box, City, State, Zip)		
If the insurance is through an employer, employer's name		
*Policy number	Group number	Date policy is effective

People covered by the policy above:

Fill out the information below and tell us if each person is currently covered or if they are being added or dropped from the insurance.

Currently Covered	Choose One: Add	Drop	Effective Date	Last Name, First Name, Middle Initial	Date of Birth	State ID	Relationship to Policyholder
	☐	☐					
	☐	☐					
	☐	☐					
	☐	☐					
	☐	☐					

Information About Second Policy

Choose **all** that apply to this policy:

☐ Major Medical ☐ Drug ☐ Medicare Supplement
☐ Dental ☐ Vision

*Policyholder (Last Name, First Name, Middle Initial)		Phone number ( )
Mailing address (House #, Street, Apt, *OR* PO Box, City, State, Zip)		
*Social Security number	*Date of birth	*State ID #
*Insurance company name		Phone number ( )
Insurance claims office mailing address (#, Street, *OR* PO Box, City, State, Zip)		
If the insurance is through an employer, employer's name		
*Policy number	Group number	Date policy is effective

People covered by the policy above:

Fill out the information below and tell us if each person is currently covered or if they are being added or dropped from the insurance.

Currently Covered	Choose One: Add	Drop	Effective Date	Last Name, First Name, Middle Initial	Date of Birth	State ID	Relationship to Policyholder
	☐	☐					
	☐	☐					
	☐	☐					
	☐	☐					
	☐	☐					

Is there anything else about the insurance information you gave that you want to tell about? If yes, please use this space.

_____

_____

_____

_____

For office use only:
County # _____
Worker # _____
Date Rec'd _____

Are the children United States citizens?

Everyone who gets Medicaid must provide proof that they are a U.S. citizen. See **Comm. 258, Verifying Citizenship and Identity** on the back of this page for types of verification HHS can use. Please provide proof that the children named below are U.S. citizens by .

HHS may be able to help by doing an Iowa birth records check for any child born in Iowa. To find out more about this call your worker.

Are the children qualified aliens?

Qualified alien children may also get Medicaid. Please provide proof that the children named below are qualified aliens by .

To find out more about this call your worker.

IOWA HHS

Verifying Citizenship/Identity and/or Immigration Status

Examples of How to Prove U.S. Citizenship and Identity

Do not mail original documents. Bring them to the office. Photocopies may be mailed.

- Column A proves both citizenship and identity.

If you don't have a document from column A, you will need to provide documents from column B.

- Column B requires a document from both Part 1 and Part 2 to meet the requirement.

Column A	Column B	
Proves both Citizenship and Identity	**Part 1**	**Part 2**
	Proves only Citizenship	**Proves only Identity**
• U.S. passport • Certification of Naturalization • Documentation of membership or affiliation issued by a federally recognized Indian Tribe	• Official birth certificate issued by a U.S. county or state • Medical, school or insurance record showing U.S. place of birth • Other acceptable proof of citizenship	• Driver's license or ID card from the Department of Transportation • School photo ID • Clinic, doctor, hospital or school record (for children under 19) • Military ID or dependent card • Other acceptable proof of ID

Examples of How to Prove Immigration Status

- Arrival Departure Record in foreign passport (I-94)
- Arrival/Departure Record
- Certificate of Citizenship
- Certificate of Eligibility for Exchange Visitor
- Certificate of Eligibility for Nonimmigrant Student Status
- Employment Authorization Card
- Foreign passport
- Machine Readable Immigrant Visa (with temporary I-551 language)
- Permanent Resident Card
- Reentry permit
- Refugee travel document
- Temporary I-551 Stamp (on passport or I-94/I-94a)
- Other acceptable proof immigration status

Questions or Need Help?

- Call our toll-free number 1-877-937-3663.
- Contact your worker.