Medicaid/Hawki Review

Para traducción al español: 1-877-347-5678

USE ONLY BLUE OR BLACK INK.

Due Date	Case Number	County Number	Worker Name

It's time to review your case. This information will be used to decide if you will continue to get Medicaid/Hawki.

You can provide the information in this form in any one of these ways

- **By mail:** Complete and return this form to, Imaging Center 4, PO Box 2027, Cedar Rapids, IA 52406
- **By phone:** Call the HHS Contact Center 1-855-889-7985
- **In-person:** Bring the completed form to your local HHS office.
- **Email:** Send to imagingcenter4@hhs.iowa.gov
- **Fax:** Send to 515-564-4017
- **Online:** Create or login to a HHS Services Portal Account at https://hhsservices.iowa.gov and complete your review online if a link is available in your portal account.

How to Complete this Form

1. Answer all of the questions on the form.
2. Read the information about you and each member of your household. Add any missing information. If any information has changed, write in the new information.
3. Sign the form on page 10.
4. **Return this form by .** If you do not return the form by this deadline, you may lose your Medicaid or Hawki coverage.

What We Need

We need information about each person living in your household and listed on your tax return, including:

- Those who get Medicaid or Hawki now,
- Those who do not get Medicaid or Hawki now but would like to apply, **and**
- Others who live in the household and do not get Medicaid or Hawki but do not want to apply.

We will check your answers using information from electronic data sources. If the information does not match, we may ask you to send more information.

If you do not qualify for Medicaid or Hawki

If you do not qualify for Medicaid or Hawki, we may refer you to the federal market place to see if you qualify for other kinds of health coverage.

What if I have questions?

Call your worker at or .

Your Contact Information

Review your contact information here.	Correct any wrong or missing information here.		
	Name *(first, middle, last & suffix)*		
Home Address	**Home** Address		
	City *(home)*	State	ZIP Code
	Mailing Address		
Mailing Address	City *(mailing)*	State	ZIP Code
	Best **phone number** to reach you: ☐ Home ☐ Cell		
	Email address, if you have one:		

Household Members

These people get benefits with you or are counted to figure your benefits. Please fill in any missing information in the table below. *Cross out any information that is **not correct** about members of your household. Write in any new information.*

Name/State ID or CIN	Age	Social Security Number	Relationship to You	Sex Male/Female	Resident of Iowa? Yes/No	Receiving Medicaid or Hawki on this case? Yes/No	If not a U.S. citizen or U.S. national and you have eligible immigration status, list document type and ID number.

Do you want to apply for Medicaid/Hawki for any household member listed above who is not receiving Medicaid or Hawki? ☐ Yes ☐ No

If yes, who? _____

Has any household member listed above moved out of your home? ☐ Yes ☐ No

If yes, who? _____

Do you expect this person to return to your home? ☐ Yes ☐ No

If yes, what date? _____

New Household Members

Is there anyone else living in your home that is not listed above? ☐ Yes ☐ No
If yes, fill out the information in the "New Household Members" section. If no, skip to the next section.

Note: If you have more people to include, make a copy of this section and attach.

New Person 1:

Name	
Birth Date	Social Security Number
Relationship to You	
Sex ☐ Male ☐ Female	Resident of Iowa ☐ Yes ☐ No

New Person 2:

Name	
Birth Date	Social Security Number
Relationship to You	
Sex ☐ Male ☐ Female	Resident of Iowa ☐ Yes ☐ No

New Person 1:			New Person 2:	
☐ Yes	☐ No	U.S. citizen or U.S. national?	☐ Yes	☐ No
		If not a U.S. citizen or U.S. national and you have eligible immigration status, list document type and ID number.		
☐ Yes	☐ No	Lived in the U.S. since before August 22, 1996?	☐ Yes	☐ No
☐ Yes	☐ No	Do you want to apply for Medicaid/Hawki for this person who has moved into your home?	☐ Yes	☐ No
		What date did this person move into your home?		
☐ Yes	☐ No	Was this person in foster care at age 18 or older?	☐ Yes	☐ No
☐ Yes	☐ No	Do you need help paying for medical bills from the last three calendar months? If you answer yes and you fall into a category that allows for retroactive approval, we will determine if you are eligible for coverage during those months.	☐ Yes	☐ No
☐ Yes	☐ No	Is this an adult who is a main person taking care of a child under the age of 19 living in the home?	☐ Yes	☐ No

Other Information About All People in Your Household

Does anyone in your household have a physical, mental, or emotional health condition that causes limitations in activities (like bathing, dressing, daily chores, etc.) or live in a medical facility or nursing home? ☐ Yes ☐ No

If yes, who? _____

Is anyone in your household pregnant? ☐ Yes ☐ No

If yes, who? _____ Due date_____ Number of expected babies_____

Is anyone listed on this review form currently ☐ incarcerated or ☐ assigned to a work release program?

If yes, who? _____ Start date_____

Is anyone listed on this review form 18 years old and a full-time student? ☐ Yes ☐ No

If yes, who? _____

Do you want help with child support for anyone on this form who is under age 19? ☐ Yes ☐ No

If yes, who? _____

Is anyone in your household or their spouse or parent an honorably discharged veteran or active duty member of the U.S. military? ☐ Yes ☐ No

If yes, who? _____

Tax Information

You must tell us about all persons in your household who file federal income tax returns. *You can still renew if you do not file federal income tax returns.* If you leave this blank, we will assume that you do not file federal income tax returns. *Make a copy of this page if you need space for more tax filers.*

Do you plan to file a federal income tax return THIS YEAR?

☐ Yes If **yes**, answer all of the questions below. ☐ No If **no**, answer the questions marked with a * below.

	Name (first, middle, last & suffix)	If this person is filing a joint return, write the name of the spouse:	If this person will claim dependents, write the names of the dependents:
Person 1			
Person 2			
Person 3			
Person 4			

* If anyone will be claimed as a dependent on someone else's tax return, write the name of the tax filer and the dependents. Answer only if different than what you reported above or if you did not fill in any information above.

Name of tax filer:_____

Name of dependents:_____

Tell Us About Work

You must tell us about all money (including tips) the people in your household get. If someone has more than one job, tell us about **all jobs**. You can report **self-employment** on the next page. If you leave a space blank, we will assume that it does not apply to you. Please use an additional sheet of paper, if needed. If you have proof of income (check stubs, employer's statement, tax returns, etc.), you may send it with this review. This may speed up the processing of your review. **Make a copy of this page if you need space for more jobs or people. Cross out any information that is not correct about members of your household. Write in any new, different, or missing information.**

Job 1

Name of the Person Who is Working (first, middle, last & suffix)			
Employer Name		Employer Phone Number	
Employer Address	City	State	ZIP Code
Wages and tips (before taxes): $	How often paid (Examples: weekly, every other week, monthly):		

Job 2

Name of the Person Who is Working (first, middle, last & suffix)			
Employer Name		Employer Phone Number	
Employer Address	City	State	ZIP Code
Wages and tips (before taxes): $	How often paid (Examples: weekly, every other week, monthly):		

Job 3

Name of the Person Who is Working (first, middle, last & suffix)			
Employer Name		Employer Phone Number	
Employer Address	City	State	ZIP Code
Wages and tips (before taxes): $	How often paid (Examples: weekly, every other week, monthly):		

Job 4

Name of the Person Who is Working (first, middle, last & suffix)			
Employer Name		Employer Phone Number	
Employer Address	City	State	ZIP Code
Wages and tips (before taxes): $	How often paid (Examples: weekly, every other week, monthly):		

Will the amount of money from jobs stay about the same? ☐ Yes ☐ No

If no, explain _____

In the past three months, did you: ☐ Change jobs ☐ Stop working ☐ Start working fewer hours ☐ None of these

Self-Employment

If anyone in your household is **self-employed**, we need to know about their work.

- To get your self-employment income, subtract the expenses below from your gross income.
  - Car and truck expenses (for travel during workday, not commuting)
  - Depreciation
  - Employee wage and fringe benefits
  - Property, liability, or business interruption insurance
  - Interest (including mortgage paid to bank, etc.)
  - Legal and professional services
  - Rent or lease of business property or utilities
  - Commissions, licenses, taxes, and fees
  - Advertising
  - Contract labor
  - Repairs and maintenance
  - Certain business travel and meals
  - Deductible self-employment taxes
  - Cost of self-employed health insurance
  - Contributions to self-employed SEP, SIMPLE, or qualified retirement plan

Person 1:

Name (first, middle, last)
Type of Work

Person 2:

Name (first, middle, last)
Type of Work

Person 1:		**Person 2:**
$ _____	How much net income will this person get from self-employment this month?	$ _____
☐ Yes ☐ No	Will the amount of monthly income from self-employment stay about the same?	☐ Yes ☐ No
$ _____	If no, how much do you expect to average over a 12 month period?	$ _____

Tell Us About Other Income

Cross out any information that is **not correct** about members in your household. Write in any new information. *Make a copy of this page if you need space for more types of other income.*

Unemployment

Name (first, middle, last & suffix)	How much?	How often (Examples: weekly, every other week, monthly)?
	$	
	$	
	$	
	$	

Social Security (Disability, Retirement, and Survivors), SSI (Supplemental Security Income), and State Supplementary Assistance

Name (first, middle, last & suffix)	How much?	Type	How often?
	$	☐ Social Security ☐ SSI / State Supp.	☐ Monthly ☐ Other_____
	$	☐ Social Security ☐ SSI / State Supp.	☐ Monthly ☐ Other_____
	$	☐ Social Security ☐ SSI / State Supp.	☐ Monthly ☐ Other_____
	$	☐ Social Security ☐ SSI / State Supp.	☐ Monthly ☐ Other_____

Report other income **types**, such as pensions, retirement, alimony received, child support received, farming or fishing, rental income or royalties, etc.

Name (first, middle, last & suffix)	Other Income Type	How much?	How often?
		$	☐ Weekly ☐ Every other week ☐ Monthly ☐ Twice a month ☐ Annually ☐ Other_____
		$	☐ Weekly ☐ Every other week ☐ Monthly ☐ Twice a month ☐ Annually ☐ Other_____

Will the amount of money from other income stay about the same? ☐ Yes ☐ No

If no, explain _____

Income Deductions

If anyone in your household pays for certain things that can be deducted on a federal income tax return, such as alimony, student loan interest and other, tell us what kind. This information can be found on the Adjusted Gross Income section of your Federal 1040 Form. You should **not** include a cost that you already considered in your answer to net self-employment.

Alimony Paid to Someone Else

Name (first, middle, last & suffix)	How much?	How often?
	$	☐ Weekly ☐ Every other week ☐ Annually ☐ Monthly ☐ Twice a month ☐ Other_____

Student Loan Interest Paid

Name (first, middle, last & suffix)	How much?	How often?
	$	☐ Weekly ☐ Every other week ☐ Annually ☐ Monthly ☐ Twice a month ☐ Other_____

Other Deductions – Type:_____

Name (first, middle, last & suffix)	How much?	How often?
	$	☐ Weekly ☐ Every other week ☐ Annually ☐ Monthly ☐ Twice a month ☐ Other_____

American Indian or Alaskan Native Family Members (AI/AN)

Are you or anyone in your family an American Indian or Alaska Native? ☐ Yes ☐ No

If yes, fill out the information below. If no, skip to the next section.

AI/AN Person 1:	**AI/AN Person 2:**
Name (first, middle, last)	Name (first, middle, last)

AI/AN Person 1:			**AI/AN Person 2:**	
☐ Yes	☐ No	Member of a federally recognized tribe? **If yes**, tribe name:	☐ Yes	☐ No
☐ Yes	☐ No	Has this person ever gotten a service from the Indian Health Service, a tribal health program, or urban Indian health program or through a referral from one of these programs?	☐ Yes	☐ No
☐ Yes	☐ No	**If no**, is this person eligible to get any of these services?	☐ Yes	☐ No
$		Certain money received may not be counted for Medicaid or Healthy and Well Kids in Iowa (Hawki). List any income (amount and how often) reported on your application that includes money from these sources:	$	
How often?		• Per capita payments from a tribe that come from natural resources, usage rights, leases, or royalties.	How often?	
		• Payments from natural resources, farming, ranching, fishing, leases, or royalties from land designated as Indian trust land by the Department of Interior (including reservations and former reservations).		
		• Money from selling things that have cultural significance.		

Health Insurance

Tell us about **other** health insurance coverage people have.

Is anyone enrolled in health coverage now? ☐ Yes ☐ No

If yes, who? _____

If yes, check the health coverage. ☐ Medicaid ☐ Hawki ☐ Medicare ☐ Tricare

☐ Veterans ☐ Peace Corps ☐ Retiree Health Plan ☐ COBRA

☐ Employer insurance Name of health insurance_____ Policy number_____

☐ Private/other_____

Health Coverage From Jobs

Complete this section if anyone on this form is eligible for health coverage from a job, even if not currently enrolled. Tell us about the **job** that offers coverage.

Employee Information. The **employee** needs to fill out this section.

Employee Name (first, middle, last)	Social Security Number

Employer Information. Ask the **employer** for this information.

Employer Name	Employer Identification number (EIN)	
Employer Address (the Marketplace will send notices to this address)	Employer Phone Number	
City	State	ZIP Code
Who can we contact about employee health coverage at this job?		
Phone Number (if difference from above)	Email Address	

☐ Yes ☐ No Are you currently eligible for coverage offered by this employer, or will you become eligible in the next three months?

If yes, fill out the information below. **If no**, skip to the **Expected Changes** section.

If you're in a waiting or probationary period, when can you enroll in coverage?

_____

List the names of anyone else who is eligible for coverage from this job.

_____

Health Plan. Tell us about the **health plan** offered by this employer.

☐ Yes ☐ No Does the employer offer a health plan that covers an employee's spouse or dependent?

If yes, which people? ☐ Spouse ☐ Dependents

☐ Yes ☐ No An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60% of such costs. Does the employer offer a plan that meets the minimum value standard?

☐ Yes ☐ No Does the employer's lowest-cost plan that meets the "minimum value standard" offer a wellness program to **only the employee**? (Do not include family plans.)

If yes, how much would the employee have to pay in premiums after receiving the maximum discount for any tobacco cessation programs? (Do not deduct any other discounts based on the wellness program.) $_____

How often? ☐ Weekly ☐ Every two weeks ☐ Twice a month ☐ Quarterly ☐ Yearly

Employer Changes. What change will the employer make for the new plan year (if known)?

☐ Employer won't offer health coverage.

☐ Employer will start offering coverage to employees or change the premium for the lowest-cost plan available to the employee that meets the minimum value standard. (Premium should reflect discount for wellness programs.)

How much will the employee have to pay in premiums for that plan? $

How often? ☐ Weekly ☐ Every two weeks ☐ Twice a month ☐ Quarterly ☐ Yearly

Date of change:_____

Expected Changes

Tell us if any changes happened or may happen. Examples:

- People in household
- Tax status
- Employment
- Health insurance
- Divorce or marriage
- Address
- Pregnancy (list due date)
- Pregnancy ending
- Other

Explain what and when:_____

Assistance with Completing this Review

You can choose an authorized representative. You can give a trusted person permission to talk about this review form with us, see your information, and act for you on matters related to your review, including getting information about your review and signing your review form on your behalf. This person is called an "authorized representative." If you ever need to change your authorized representative, let us know. If you're a legally appointed representative for someone listed on this form, submit proof with the review form.

Name of authorized representative (first name, middle name, last name)			
Address			Apartment or suite number
City	State	ZIP code	Phone number
Organization name			ID number (if applicable)

By signing, you allow this person to sign your review form, get official information about your review and eligibility, and act for you on all future matters with this agency.

Note: Your signature here **DOES NOT** complete the review form. **You must sign and date in the "Read and Sign This Form" section below.**

Your Signature	Date (mm/dd/yyyy)

Renewal of Coverage in Future Years

Read the statement below and check **one** box.

To make it easier to check my income at review time, I give permission to the Department of Health and Human Services to use income information from my tax returns for the number of years I checked below.

I understand that the Department of Health and Human Services will send me a letter with the income information they have. I can make changes to it. I can also change my mind and not allow the Department of Health and Human Services to check this information.

Yes, I give permission to check my income on tax returns for (check one box):

☐ 5 years (the longest time) ☐ 4 years ☐ 3 years ☐ 2 years ☐ 1 year

☐ No, I do not give permission to use my tax returns.

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 **full** monthly fee paid to a Managed Care Organization (MCO),including medical and dental, even if the plan did not pay for any services, will need to be paid back from your estate after your death. Estate recovery applies if you get Medicaid are 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 application, 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 declare under penalty of perjury under the laws of the United States of America that the information contained in this statement of facts is true, correct, and complete.

Your Signature or Mark	Phone Number	Today's Date
Signature of Person, if Any, Who Helped Complete the Form	Phone Number	Today's Date

Please keep this page for your information.

Rights and Responsibilities

- By signing this application, 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.
- By signing this application, I give permission for HHS to share medical and other health care records with federal and state officials.
- I understand that an electronic signature has the same legal effect and can be enforced in the same way as a written signature.
- I know that my information on this form will only be used to determine eligibility for medical assistance and will be kept private as required by law.
- I understand that if I receive Medicaid, the Department will pursue non-medical support for myself and my children upon my request. Medical support services include the establishment of paternity and the establishment and enforcement of medical support.
- I understand the questions and statements on this application.
- I understand that any facts that I have given, including benefit and income facts, will be matched with local, state, and federal records, such as employers, U.S. Citizenship and Immigration Service (USCIS), the Social Security Administration, tax, welfare, and unemployment agencies, etc. and I understand that the information received may affect my eligibility for benefits.
- I understand information, including benefit and income facts, that I have given on this form is subject to investigation and review by county, state, and federal personnel and that if I give incorrect facts my benefits may be denied or stopped.
- I know that under federal law, discrimination isn't permitted on the basis of race, color, national origin, sex or disability. I can file a complaint of discrimination by visiting www.hhs.gov/ocr/office/file.
- I know that I can be represented in the process by someone other than myself. My eligibility and other important information will be explained to me. I understand that a change in my status could affect the eligibility for members of my household.
- If I think the Health Insurance Marketplace or Medicaid/Hawki has made a mistake, I can appeal its decision. To appeal means to tell someone at the Health Insurance Marketplace or Medicaid/Hawki that I think the action is wrong, and ask for a fair review of the action. I know that the process of how to appeal is found on page 10 in the Appeals section.
- If you want to register to vote, you can complete a voter registration form at https://hhs.iowa.gov/sites/default/files/Voter_Registration.pdf. Applying to register or declining to register to vote will not affect the amount of assistance that you will be provided by this agency.

Social Security Number Information

We can give help only to people who give us their Social Security Number or proof of application from the Social Security office. **You don't have to give us the Social Security Number for people in your household who you do not want help for, but you may choose to give us their Social Security Number.** However, we will use any Social Security Number given to us the same way we use the Social Security Number of people getting assistance.

If you do not give us a Social Security Number for people in your household, we will deny assistance to those people. There are some exceptions to this. Please ask your worker.

We will not give any Social Security Number to the Citizenship and Immigration Service.

Medicaid

We Check What You Tell Us

The information you give us may be checked by federal, state and local officials to make sure it is true. Things we might check are any listed person's: Social Security Number, job and pay, bank account amount, alien status, and amounts received from other sources like Social Security or unemployment. If any information you give us is not correct, we may deny your application.

We may check records from other states to see if any person in your household can get benefits in Iowa. This may be because a person was disqualified from a program in another state.

We check and use computer systems like the State Income and Eligibility Verification System, the Federal Facilitated Exchange including Internal Revenue Service (IRS), Social Security Administration (SSA), and Department of Homeland Security (DHS). If something you told us is different from what the computer system tells us, we will check to find out what is correct. We might check your information by contacting your employer, your bank or other people. To do this kind of checking with your employer, bank, or other people, we will ask you first.

Please keep this page for your information.

Things You Need to Know

- You must apply for and accept any other benefits which you may be entitled to receive.
- You must give us information and provide proof, when we ask for it.
- You must fill out review forms when you are asked to.
- HHS may give your answers to law enforcement officials to catch persons fleeing to avoid the law.
- The Quality Control unit or Investigations unit may review your case. They may contact other people or organizations to get proof of your information. By signing this application, you give permission to release confidential information to the Quality Control unit or Investigations unit. You must cooperate with them to keep your benefits.
- You will have to pay back any benefits you got or that were paid to a third party on your behalf for which you were not eligible.
- Section 1128B of the Social Security Act provides federal penalties for fraudulent acts and false reporting in connection with these programs.
- Anyone who gets, tries to get, or helps any other person get assistance to which they are not entitled, is guilty of violating the laws of the state of Iowa. This includes, but is not limited to, Iowa Code Chapters 249 and 249A.
- You can apply for part of your household even if some members do not have lawful immigrant status. For example, parents who do not have lawful immigrant status may apply for their children who are U.S. citizens or qualified aliens. The Department may check your household's alien status with the Department of Homeland Security. Any information from the Department of Homeland Security may affect that individual's benefits. The Department of Homeland Security will not be contacted about people you do not apply for. However, their income may be used to see if the rest of the household can get Medicaid.
- ***Giving wrong information on purpose may result in us taking criminal or civil legal action against you. It might also mean we reduce your benefits or take money back from you.***

This permission ends when your Medicaid stops.

You Have the Right to Appeal

You can appeal in person, by telephone or in writing for Medicaid. To appeal in writing do **one** of the following:

- Complete an appeal electronically at https://hhs.iowa.gov/programs/appeals **or**
- Write a letter telling us why you think a decision is wrong, **or**
- Fill out an Appeal and Request for Hearing form. You can get this form at your county HHS office.

Send or take your appeal to the Department of Health and Human Services, Appeals Section, 321 East 12th St. Des Moines, IA 50319. If you need help filing an appeal, ask your county HHS office.

You or someone else, such as a friend or relative, can tell why you disagree with the Department's decision. You may also have a lawyer help you, but the Department will not pay for one. Your county HHS office can give you information about legal services. The cost of legal services will be based on your income. You may also call Iowa Legal Aid at 1-800-532-1275. If you live in Polk County, call 515-243-1193.

You Will Not be Discriminated Against

It is the policy of the Iowa Department of Health and Human Services (HHS) 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 HHS has discriminated against or harassed you, please send a letter detailing your complaint to:
Iowa Department of Health and Human Services, Lucas Building, Bureau of Human Resources, 321 East 12th St. Des Moines, IA 50319 or via email inclusion@hhs.iowa.gov.

Optional Release of Information

Help Us Help You!

You do not have to sign this, but it will help us get information we need to help you, without having to get your signature on specific requests.

You should know that:

- We may need more information to decide if you can get assistance.
- If more information is needed from you, you will get a letter telling you what we need and the date you must get it to us.
- You are responsible to get the information or to ask us for help to get it.
- If you do not give us the information or ask for help by the due date, your application may be denied or your assistance may stop.
- We may be able to use the release below to get the information we need. **But you still have to provide information we request or ask us for help.**
- We may attach a copy of this release to a form that asks other people or organizations (like your employer) for specific information needed about you or others in your household.

Print and sign your name below to give us permission to get needed information. Remember to also sign page 10.

RELEASE OF INFORMATION

I hereby authorize any person or organization to give the Iowa Department of Health and Human Services requested information about me or other members of my household.

A copy of this release is as valid as the original.

This release does not apply to protected health information.

This release is good for 12 months from the date signed.

_____	_____
Your Name (please print clearly)	Other Adult Name (please print clearly)
_____	_____
Signature or Mark	Signature or Mark
_____	
Date	