Iowa Department of Human Services

Application for Foster Care and Subsidized Adoption Medicaid

Complete this form if you want health care coverage (Medicaid or Title 19) for a child living in Iowa in a foster care or subsidized adoption placement.

If you want to get Food Assistance or cash assistance through the Family Investment Program (FIP), please complete the *Financial Support Application*, form 470-0462, or in Spanish 470-0462(S).

What you may need to apply

- Social Security Numbers (or document numbers for any legal immigrants who need health care coverage).
- Pay stubs from the last 30 days if you are employed or federal income tax records if you are self-employed. Award letters for all other types of money coming into the household such as Social Security Benefits, Veterans Benefits, etc.
- Receipts for child care, dependent adult care costs, child support or alimony paid.
- Most recent statements for any bank accounts: checking, credit union, savings, etc.

How do I get help?

Step 1. Fill out the application.
Fill out and sign the application. Use blue or black ink. If you are helping someone else, answer the questions for that person. Be truthful. Answer as many questions as you can. If you need help filling out an application, please ask for help at your local Department of Human Services (DHS) office or call our Help Center at 855-889-7985.

Step 2. Return the application to us.
You can take, fax or mail your application to a local DHS office. To find out where to mail the application, call 877-347-5678. The date your help starts is based on the date the DHS office gets your application.

Step 3. Give us proof later if asked.
Including copies of the proof now may speed up the processing of your application.

Information for children applying for Medical Assistance

- I give permission for DHS to share my medical and other health care records with federal and state officials.
- I give permission for my medical providers to share:
  - My 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 from third parties.
- 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 immigration 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 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 is not permitted on the basis of race, color, national origin, sex, age, sexual orientation, gender identity, 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 http://dhs.iowa.gov/sites/default/files/Comm233.pdf or I may request a copy by calling the DHS Contact Center at 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 sources like the Internal Revenue Service (IRS), Social Security Administration, the Department of Homeland Security, Asset Verification System (AVS), the state Income and Eligibility Verification System, or a consumer reporting agency. If the information doesn't match, we may ask you to send us proof.

The authorization to use the AVS database is in effect for as long as the Department is determining eligibility, the individual is a Medicaid recipient, or until the applicant or recipient revokes the authorization. If refusal or revocation of the authorization is submitted, the Department may, on that basis, determine the applicant or recipient ineligible for Medical Assistance.

If anyone on this application 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.
- If any child on this application has a parent living outside the home, I know I will be asked to cooperate with the agency that collects medical support from an absent parent. If I think that cooperating to collect medical support will harm me or my children, I can tell Medicaid and I may not have to cooperate.

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 http://dhs.iowa.gov/sites/default/files/Comm123.pdf (English) or http://dhs.iowa.gov/sites/default/files/Comm123S.pdf (Spanish).

My right to appeal

You, or the person helping you, may request an appeal hearing if you do not agree with any action taken on your case. You can appeal in writing, in person, or by telephone. To appeal in writing do one of the following:

- Fill out an appeal electronically at https://dhssecure.dhs.state.ia.us/forms/, **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 local DHS office.

Send or take your appeal to the Department of Human Services, Appeals Section, 5th Floor, 1305 E Walnut Street, Des Moines, IA 50319-0114. If you need help filing an appeal, ask your local DHS office.

You can represent yourself or you can have a friend, relative, lawyer, or someone else act on your behalf. You may contact your local DHS office about legal services. You may have to pay for these legal services. If you do, your payment will be based on your income. You may also call Iowa Legal Aid at (800) 532-1275. If you live in Polk County, call (515) 243-1193.

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Household Information

First Name	Middle Name	Last Name	
Home Address			
City	State	County	Zip Code
Mailing Address (if different from above) **OR** Payee or Representative's Name and Address			
Home Phone Number	Message Number	Name of Message Contact Person	

If you need more room to answer any of the following questions, attach extra pages.

Starting with yourself, list all the people who live in your home and mark the box **yes** or **no** if you are applying for that person. If you choose **no**, you only need to list their name, relationship to you, and their date of birth.

Note: We need your Social Security Number (SSN) if you want health coverage and have a SSN. Giving us your SSN can be helpful even if you don't want health coverage since it can speed up the application process. We use SSNs to check income and other information to see who's eligible for help with health coverage costs. If someone wants help getting an SSN, call 1-800-772-1213 or visit www.socialsecurity.gov/. TTY users should call 1-800-325-0778.

	Person 1	Person 2	Person 3	Person 4	Person 5
Name (First, Middle, Last)					
Are you applying for this person?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
How is this person related?	SELF				
Date of birth					
Gender	☐ Male ☐ Female	☐ Male ☐ Female	☐ Male ☐ Female	☐ Male ☐ Female	☐ Male ☐ Female
Social Security Number					
Birth state					
U.S. citizen?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
If immigrant, status					
Disabled	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

	Person 1	Person 2	Person 3	Person 4	Person 5
Ethnicity *					
Race **					
Currently on Medicaid?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Other health insurance available?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

We have to ask your ethnicity and race, but you don't have to answer. Your answer won't affect if you get help. If you answer, use the following coding:

* **Ethnicity**:
H = Hispanic or Latino
N = Not Hispanic or Latino

** **Race** (Choose all that apply):
W = White
B = Black or African American
A = Asian
I = American Indian or Alaskan Native
N = Native Hawaiian or other Pacific Islander

Do you need help paying for medical bills from the last three calendar months? ☐ Yes ☐ No
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.

Who?_____ What months?_____

Is anyone fleeing to avoid prosecution, custody, or jail for a felony crime? ☐ Yes ☐ No

Is anyone violating a condition of probation or parole? ☐ Yes ☐ No

Is anyone in or expecting to go to jail or prison? ☐ Yes ☐ No

List pregnant persons who live in your home_____

_____ Due Date (MMDDYY)_____

List the name of your health insurance provider_____

Income

List all income the people living in your home get. Include income from work, self-employment, Social Security, Veteran's Benefits, unemployment insurance, child support, worker's compensation, railroad retirement, IPERS, pensions, civil service, cash from friends or relatives, and any other income you get.
If you leave this section blank, you are telling us that you have no income.

	Person 1	Person 2	Person 3	Person 4
Person who received money				
Employer or income source				
Amount before taxes or deductions				

	Person 1	Person 2	Person 3	Person 4
How often is this amount paid?	☐ Weekly ☐ Every other week ☐ Twice a month ☐ Monthly ☐ Other_____	☐ Weekly ☐ Every other week ☐ Twice a month ☐ Monthly ☐ Other_____	☐ Weekly ☐ Every other week ☐ Twice a month ☐ Monthly ☐ Other_____	☐ Weekly ☐ Every other week ☐ Twice a month ☐ Monthly ☐ Other_____
Is this income expected to continue? If **No**, explain:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Does anyone in your home pay child support or alimony for a person who does not live with you?
☐ Yes ☐ No If yes, who pays?_____ Amount?_____

Does anyone in your home pay for someone to care for a child or disabled adult?
☐ Yes ☐ No If yes, how much is paid?_____ How often?_____
To whom?_____

Is the Child Support Recovery Unit already helping you get or enforce a child support or a medical support?
☐ Yes ☐ No

The Child Support Recovery Unit can help you get child support or health insurance from an absent parent. They can also help locate absent parents and their employer, establish paternity, or establish paternity or modify support orders. **Do you want help from Child Support Recovery with any of these items?**
☐ Yes ☐ No

Are you willing to cooperate with us to get medical insurance or medical support from any parent not in the home? (You are not required to cooperate if you only want Medicaid for a child.)
☐ Yes ☐ No

	Person 1	Person 2	Person 3	Person 4
Name and address of parent not in the home				
Date of birth of this parent				
Social Security Number of this parent				
Name of the parent's children				
County where court order is filed, if any				
Is the parent court ordered to pay cash medical support?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Resources

A resource is cash or anything that can be changed to cash. List all resources and the amount or value. Include cash on hand, checking accounts, vehicles, life insurance, stocks, bonds, certificates of deposits (CDs), trust funds, retirement accounts, burial contracts, burial spaces, annuities, etc. If only applying for medical coverage for a child, resources may not be counted. **If you leave this section blank, you are telling us that you have no resources.**

	Person 1	Person 2	Person 3	Person 4
Person with resource				
Type of resource				
Amount or value				
Location (bank's name and address, home, etc.)				

I certify, under penalty of perjury, that these statements are correct to the best of my knowledge and belief.

Signature or mark of applicant	Date
Signature or mark of other parent or stepparent in the home	Date
Signature of person, if any, who helped complete this form	Date