IOWA HHS

Application for COVID-19 Testing Coverage

The federal authority for the COVID-19 Testing Coverage group, which covers payment for COVID-19 testing, ends on May 11, 2023. Applications submitted after that date can be considered for eligibility only if an individual meets one of the following criteria:

- Pregnant (including within 60 days postpartum),
- Under the age of 19, or
- A resident of a nursing facility.

This application is only used for the determination of COVID-19 Testing medical coverage for the uninsured. Do not use this application for people who are not seeking coverage for COVID-19 tests.

The health coverage you will get if you are found eligible using this application will only pay for medical tests for COVID-19. It will not help you pay for other medical costs, including doctor visits, hospital care, or prescriptions.

To apply for full medical benefits, please visit dhsservices.iowa.gov or go to Healthcare.gov. You may also call the Help Center at 1-855-889-7985. Hours of operation are Monday through Friday 8:00 am to 5:00 pm.

Instructions:

- Complete the whole form. If you need more room to write, attach additional pages. If you are unable to complete the entire form now, you may print this application and send to the mailing address or fax number below with only a name, address, and signature provided. This will delay your eligibility determination.
- Complete this application for one person only. A separate application must be completed for each person needing COVID-19 testing coverage.
- Sign the application at the bottom of the last page. Your application is not complete until it is signed.

If you are unable to complete the entire form now, mail or fax your completed application to:

Member Services
P.O. Box 36510
Des Moines, IA 50315

Fax number: (515) 725-1351

CONTACT INFORMATION

One adult in the family should be the contact person. The contact person does not have to be applying for coverage.

First Name	**Last Name**		
Home Address ***(leave blank if you don't have one)***	**City**	**State**	**Zip**
Mailing Address ***(if different from home address)***	**City**	**State**	**Zip**
Phone Number	**Email address**		
Preferred written language	**Preferred spoken language**		

TELL US ABOUT THE PERSON APPLYING

Answer the following questions about the person applying for COVID-19 testing coverage. Do not apply for more than one person on this application.

470-5618 (5/23)

First Name	Last Name	Date of birth (mm/dd/yyyy)

Do you have a Social Security Number (SSN)?
…….…. ☐ YES ☐ NO
If YES, you must provide your SSN before we can determine eligibility: _____
If NO, tell us why you do not have an SSN. **☐ Religious beliefs ☐ Not eligible to receive an SSN ☐ Does not have an SSN and may only be issued a SSN for a valid nonwork reason ☐ Has applied for an SSN but not yet received one ☐ Does not have an SSN and none of the other options apply**

Are you a resident of Iowa?
…… ☐ YES ☐ NO

Are you a US Citizen or US National? (Select 'Yes' if you are a naturalized US citizen.)…… ☐ YES ☐ NO

If you are not a US Citizen or US National (including a naturalized US citizen), do you have eligible immigration status? ……..…. ☐ YES ☐ NO

Are you pregnant (including within 60 days postpartum), under the age of 19, or a resident of a nursing facility? ……..…. ☐ YES ☐ NO
***If NO, skip to* Your Current Health Coverage.**
If YES, do you need help paying for a COVID-19 test from the last three calendar months?
……..…. ☐ YES ☐ NO

Your Current Health Coverage

Answer the following question about other health coverage.

Are you enrolled in health coverage now? (Select 'No' if you are enrolled only in Family Planning Program or Medically Needy with a spenddown.) ……..…. ☐ YES ☐ NO

YOU CAN CHOOSE AN AUTHORIZED REPRESENTATIVE

You can give a trusted person permission to talk about this application with us, see your information, and act for you on matters related to this application, including getting information about your application and signing your application on your behalf. This person is called an "authorized representative."

Name of authorized representative (first name, middle name, last name)		
Address	**Apt. or Suite No**	
City	**State**	**Zip**
Phone Number		
Organization Name	**ID Number (if applicable)**	

By signing, you allow this person to sign your application, get official information about this application, and act for you on all future matters with this agency.
NOTE: Your signature here does not complete the application. You **must** check the box and electronically sign in the SIGNATURE section below to complete this application.

Your signature	Date (mm/dd/yyyy)

SIGN THIS APPLICATION

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 pay 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).

The person whose name is listed under the Contact Information section should sign this application. If you are an authorized representative, you may sign here as long as you have provided the information required or the applicant has provided limited verbal authorization for you to complete, sign, and submit an application on their behalf based on information that is being provided telephonically.

By signing this application, I acknowledge that I have read and agree to the contents of Rights and Responsibilities, Comm. 233.

I understand that an electronic signature has the same legal effect and can be enforced in the same way as a written signature.

I have agreed to submit this application by electronic means. 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 and 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.

SIGNATURE:

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.

☐ Check here to sign.

Signature	Date