Department of HUMAN SERVICES

Home- and Community-Based Services
Health and Disability Waiver
Information Packet

The Medicaid Home- and Community-Based Services (HCBS) Health and Disability Waiver (HD) provides service funding and individualized supports to maintain eligible persons in their own homes or communities who would otherwise require care in a medical institution. Provision of these services must be cost effective.

In addition to home and community-based waiver services, the Health and Disability Waiver enrolled members have access to Medicaid covered services and benefits. Medicaid covers a broad array of health services, in addition to the services provided by the waiver, limits out-of-pocket costs. These include, but not limited to, primary care, behavioral health services, skilled nursing care, dental, vision, and emergency care. Most of Iowa's Medicaid members are served by the managed care program called IA Health Link. Managed care organizations coordinate your care.

If you need assistance, please contact Iowa Medicaid Member Services at **1-800-338-8366** or locally in the Des Moines area at **515-256-4606**, Monday through Friday, from 8 a.m. until 5 p.m.

*For telephone accessibility assistance if you are deaf, hard-of-hearing, deaf-blind, or have difficulty speaking, call Relay Iowa TTY at **1-800-735-2942**.*

Comm. 529 (Rev. 05/22)

General Parameters

- Health and Disability waiver services are individualized to meet the needs of each member. The following services are available:
  - Homemaker
  - Home Health
  - Adult Day Care
  - Respite Care
  - Nursing
  - Counseling
  - Consumer-Directed Attendant Care,
  - Interim Medical Monitoring and Treatment,
  - Home And Vehicle Modification,
  - Personal Emergency Response System,
  - Home-Delivered Meals,
  - Nutritional Counseling,
  - Financial Management,
  - Independent Support Brokerage,
  - Self-Directed Personal Care,
  - Self-Directed Community Supports and Employment,
  - Individual-Directed Goods and Services
- All HCBS waiver services must be provided in integrated community-based settings.
- The services that are considered necessary and appropriate for the member will be determined through an interdisciplinary team (IDT) consisting of the member, Case Manager or Managed Care Organization (MCO) Community-based Case Manager (CBCM), service providers, Iowa Child Health Speciality Clinics regional nurse, and other persons the member chooses.
- The IDT meets to plan the interventions and supports a member needs to safely maintain the member's physical and mental health in the member's home.
- All members will have a comprehensive service plan developed by a case manager or DHS service worker in cooperation with the member. A case manager or DHS service worker prior to implementation of services must sign and date the comprehensive service plan. The member must receive case management services.
- This comprehensive service plan must be completed before the implementation of services.
- The service plan for members **aged 20 or under** must be developed or reviewed taking into consideration those services that may be provided through the individual education plan (IEP) and EPSDT (Care for Kids) plans.
- Members shall access all other services for which they are eligible, and which are appropriate to meet their needs as a precondition of eligibility for the HD waiver.
- The member must choose HCBS services as an alternative to institutional services.
- In order to receive HD waiver services, an approved HD waiver service provider must be available to provide those services.
- HD waiver services cannot be provided when a person is an inpatient of a medical institution.
- Members must need and use at least one unit of service from the HD waiver during each calendar quarter of the calendar year.

- Medicaid waiver services cannot be simultaneously reimbursed with another Medicaid wavier service or Medicaid service.
- The total costs of HD waiver services cannot exceed the following:

Nursing level of care	$993.56 per month
Skilled level of care	$2,891.79 per month
ICF/ID level of care	$3,875.80 per month

- The HD waiver has an advisory committee that meets regularly to make recommendations and takes action to ensure the waiver best meets the need of the person it serves.
- Following is the hierarchy for accessing waiver services:
  1. Private insurance
  2. Medicare
  3. Medicaid and/or EPSDT (Care for Kids)
  4. HD waiver services
  5. In-home health-related care
- In addition to services available through the HD waiver, assistance may be available through the In-Home Health-Related Care (IHHRC) program and the Rent Subsidy program through the Iowa Finance Authority.
- When a member of HD waiver reaches age 65, the member may continue to receive waiver services after applying for the elderly waiver.

Member Eligibility Criteria

Members may be eligible for HCBS HD waiver services by meeting the following criteria:

- Be an Iowa resident and a United States citizen or a person of foreign birth with legal entry into the United States.
- Be under age 65.
- Be determined blind or disabled by Disability Determination Services or, in some exceptions, receive Social Security disability benefits.
- Persons shall meet the eligibility requirements of SSI except for the following:
  - The person is under 18 years of age, unmarried and not the head of household, and is ineligible for SSI because of the deeming of the parent’s or parents’ income.
  - The person is married and is ineligible for SSI because of the deeming of the spouse’s income or resources.
  - The person is ineligible for SSI due to excess income and the person’s income does not exceed 300 percent of the maximum monthly payment for one person under SSI.
  - The person is under 18 years of age and is ineligible for SSI because of excess resources.
- Be determined by the Iowa Medicaid Enterprise, Medical Services to need one of the following levels of care:
  - Nursing facility (NF)
  - Skilled nursing facility (SNF)
  - Intermediate care facility for the intellectually disabled (ICF/ID)

Service Descriptions

Please note:

HCBS HD waiver services are individualized to meet the needs of each member. However, decisions regarding what services are appropriate, the number of units or the dollar amounts of the appropriate services is based on the member's needs as determined by the member and an interdisciplinary team.

Adult Day Care

What: Adult day care services provide an organized program of supportive care in a group environment to persons who need a degree of supervision and assistance on a regular or intermittent basis in a day care center.

Where: Adult day program in the community that is certified to provide HD waiver services.

Unit: A unit of service is 15 minutes (up to four units per day), a half day (1.25 to 4 hours per day), a full day (4.25 to 8 hours per day), or an extended day (8.25 to 12 hours per day). Components of the service include health-related care, social services, and other related support services.

Consumer-Directed Attendant Care (CDAC)

What: Assistance to the member with self-care tasks that the member would typically do independently if the member was otherwise able. An individual or agency, depending on the member's needs may provide the service. The member, parent, guardian, or attorney-in-fact under a durable power of attorney for health care shall be responsible for selecting the individual or agency that will provide the components of the CDAC services to be provided.

The CDAC service may include assistance with non-skilled and skilled services. The skilled services must be done under the supervision of a professional registered nurse or licensed therapist working under the direction of a physician. The registered nurse or therapist shall retain accountability for actions that are delegated.

Skilled services may include, but are not limited to:

- Tube feedings,
- Intravenous therapy,
- Parenteral injections,
- Catheterizations,
- Respiratory care,
- Care of decubiti and other ulcerated areas,
- Rehabilitation services,
- Colostomy care,
- Care of medical conditions out of control,
- Postsurgical nursing care,
- Monitoring medications,
- Preparing and monitoring response to therapeutic diets, and
- Recording and reporting of changes in vital signs.

Non-skilled services may include, but are not limited to:

- Dressing,
- Hygiene,
- Grooming,
- Bathing supports,
- Wheelchair transfer,
- Ambulation and mobility,
- Toileting assistance,
- Meal preparation,
- Cooking,
- Eating and feeding,
- Housekeeping,
- Medications ordinarily self-administered,
- Minor wound care,
- Employment support,
- Cognitive assistance,
- Fostering communication, and
- Transportation.

This service is only appropriate if the member, parent, guardian, or attorney-in-fact under a durable power of attorney for health care has the ability to and is willing to manage all aspects of the service.

Where: In the member's home or community. Not in the provider's home.

Does not include: Daycare, respite, room and board, case management or supervision. CDAC cannot replace a less expensive service.

An individual CDAC provider cannot be the recipient of respite services provided on behalf of a member receiving HCBS services.

The cost of nurse supervision, if needed

Unit: A unit is 15 minutes.

Maximum The case manager or MCO CBCM working with the member and the IDT establishes a dollar amount that may be used for CDAC. The amount is then entered into the ISP along with information about other HCBS services the member may receive. This monetary information is also entered into the ISP along with the responsibilities of the member and the provider and the activities for which the provider will be reimbursed. The member and the provider come to agreement on the cost per unit. A completed copy of the CDAC Agreement is distributed to the member, the provider, and the case manager or MCO CBCM. The CDAC Agreement becomes part of the ISP. These steps must be completed **before** service provision.

Provider enroll: The provider must be enrolled with the Department and certified as a CDAC provider **before** the completion of the *HCBS Consumer-Directed Attendant Care Agreement*.

It may be important for the member to enlist more than one CDAC provider. Back up services may be necessary in case of an emergency.

Counseling Services

What: Counseling services are face-to-face mental health services provided to the member and caregiver by a mental health professional as defined in 441 Iowa Administrative Rule 24.1(225C) to facilitate home management of the member and prevent institutionalization. Counseling services are nonpsychiatric services necessary for:

- The management of depression,
- Assistance with the grief process,
- Alleviation of psychosocial isolation and support in coping with a disability or illness, including terminal illness.

Counseling services may be provided both for the purpose of training the member's family or other caregiver to provide care and for the purpose of helping the member and those caring for the member to adjust to the member's disability or terminal condition. Counseling services may be provided to the member's caregiver only when included in the case plan for the member.

Where: The community mental health center or other location used by a provider that meets accreditation under the Mental Health and Disabilities Commission.

Unit: A unit of individual counseling for the waiver member or the waiver member and the member's caregiver is 15 minutes. A unit of group counseling is 15 minutes. Payment for group counseling is based on the group rate divided by six, or, if the number of persons who comprise the group exceeds six, the actual number of persons who comprise the group.

Home and Vehicle Modification (HVM)

What: Physical modifications to the home and vehicle to assist with the health, safety, and welfare needs of the member and to increase or maintain independence. Competitive bids are essential to determine the cost effectiveness of the requested item. All modification requests are reviewed individually, and a determination is made regarding the appropriateness of the modification request.

Where: In or on the member's home or vehicle. **Please note that only the following modifications are included**:

- Kitchen counters, sink space, and cabinets
- Special adaptations to refrigerators, stoves, and ovens
- Bathtubs, bath chairs and toilets to accommodate transfer, special handles and hoses for showerheads, water faucet controls, and accessible showers and sink areas
- Grab bars and handrails
- Turnaround space adaptations
- Ramps, lifts, and door, hall, and window widening
- Fire safety alarm equipment specific for disability
- Voice activated, sound activated, light activated, motion activated, and electronic devices directly related to the member's disability

- Vehicle lifts, driver specific adaptations, remote start systems, including such modifications already installed in a vehicle
- Keyless entry systems
- Automatic opening device for home or vehicle door
- Special door and window locks
- Specialized doorknobs and handles
- Plexiglas replacement for glass windows
- Modification of existing stairs to widen, lower, raise or enclose open stairs
- Motion detectors
- Low pile carpeting or slip resistant flooring
- Telecommunications device for people who are deaf
- Exterior hard surface pathway
- New door opening
- Pocket doors
- Installation or relocation of controls, outlets, and switches
- Air conditioning and air filtering if medically necessary
- Heightening of existing garage door opening to accommodate modified van

Does not include: Modifications which increase the square footage of the home or items for replacement which are the responsibility of the homeowner or landlord; vehicle purchase, fences, furnaces, and any modifications or adaptations available through regular Medicaid.

Purchasing, leasing or repairs of a motorized vehicle are excluded.

Unit: A unit is the cost of the completed modification or adaptation.

Maximum: The member is eligible for up to $6592.66 year. This is not included in the monthly total.

Home Delivered Meals

What: Home-delivered meals are prepared outside of the member's home and delivered to the member.

Each meal must ensure that the member receives a minimum of one-third of the daily-recommended dietary allowance as established by the Food and Nutrition Research Council of the National Academy of Sciences. Each meal may also be a liquid supplement, which meets the minimum one-third standard.

When a restaurant provides home-delivered meals, a nutritional consultation must be completed. The nutritional consultation includes contact with the restaurant to explain the dietary needs of the client and explain what constitutes the minimum one-third daily dietary allowance.

Where: Delivered to the member's home

Unit: A unit is one meal.

Maximum units: Fourteen meals may be delivered during any week: a maximum of two meals per day. No morning, noon, evening or liquid replacement meals can be duplicated on any day.

Home Health Aide Services (HHA)

What: Unskilled medical services that provide direct personal care. This service may include:

- Assistance with oral medications,
- Eating,
- Bathing,
- Dressing,
- Personal hygiene,
- Accompanying member to medical services,
- Transporting member to and from school or medical appointments, and
- Other necessary activities of daily living that is intended to prevent or postpone institutionalization.

Home health aide as a waiver service may be accessed ***after*** accessing services under the Medicaid state plan.

Transportation as a home health aide waiver service may be accessed ***after*** all transportation services available under the Medicaid non-emergent medical transportation program have been used.

Where: In the member's home except when transporting to or from school. Not in the provider's home.

Does not include: Homemaker services such as cooking and cleaning or services which meet the intermittent guidelines or those provided under the EPSDT authority.

May not duplicate any regular Medicaid or waiver services provided under the state plan.

Medicaid intermittent coverage: Regular Medicaid provides for intermittent coverage of skilled nursing and home-health aide services provided in the person's home for both children and adults. Services are usually provided two to three hours per day for two to three days per week. Intermittent skilled nursing coverage includes visits up to five days per week and daily or multiple daily visits for wound care or insulin injections. Intermittent home-health aide coverage includes visits twice per day up to seven days per week for persons attending school or working or when ordered by the physician and included in the plan of care, not to exceed 28 hours per week.

EPSDT (Care for Kids) program. EPSDT services for persons under age 21 only include private duty nursing and personal care services that meet the definition of medical necessity as provided by CMS for EPSDT. Services may be provided to a child outside of the child's residence when normal life activities take the child outside the residence.

Unit: A unit is a visit.

Homemaker Services

What: Homemaker services are those services provided when the member lives alone or when the person who usually performs these functions for the member needs assistance.

Homemaker service is limited to the following components:

- Essential shopping,
- Limited house cleaning, and
- Meal preparation.

Where: In the member's home and community. Not in the provider's home.

Does not include: Services shall not be simultaneously reimbursed with other waiver services.

Unit: A unit is 15 minutes.

Interim Medical Monitoring and Treatment (IMMT)

What: Monitoring and treatment of a medical nature requiring specially trained caregivers beyond what is normally available in a day care setting for persons who are 20 years of age and under. Interim medical monitoring and treatment (IMMT) services shall provide experiences for each member's social, emotional, intellectual, and physical development. The service will include developmental care and any special services for a member with special needs; and will include medical assessment, medical monitoring, and medical intervention as needed on a regular or emergency basis.

The service allows the member's usual caregivers to be employed. IMMT may also be used after the death of a usual caregiver. IMMT services may include supervision for the child during transportation to and from school when not available through school or other sources. IMMT services may also be provided for a limited period of time when the usual caregiver is involved in the following circumstances:

- Attendance at academic or vocational training
- Employment search
- Hospitalization
- Treatment for physical or mental illness

Note: The child must first be maximizing services under intermittent, EPSDT, home health or private duty nursing to be eligible to access this service.

Where: Services may be provided in:

- The member's home,
- A registered group child care home,
- A registered family child care home,
- A licensed child care center, or
- During transportation to and from school.

Providers of this service must:

- Be at least 18 years of age,
- Not be the spouse of the member or parent or stepparent of a member who is age 17 years of age or under,
- Not be the usual caregiver,
- Be qualified by training or experience as determined by the usual caregiver, and
- Be a licensed medical professional on the member's interdisciplinary team to provide medical intervention or intervention in a medical emergency.

Does not include: May not duplicate any regular Medicaid or waiver services provided under the state plan.

Daycare services to children who do not have a medical monitoring or treatment need.

Medicaid intermittent coverage: Regular Medicaid provides for intermittent coverage of skilled nursing and home health aide services provided in the person's home for both children and adults. Services are usually provided two to three hours per day for two to three days per week. Intermittent skilled nursing coverage includes visits up to five days per week and daily or multiple daily visits for wound care or insulin injections. Intermittent home health aide coverage includes visits twice per day up to seven days per week for persons attending school or working or when ordered by the physician and included in the plan of care, not to exceed 28 hours per week.

EPSDT (Care for Kids) program: EPSDT services for persons under age 21 only include private duty nursing and personal care services which meet the definition of medical necessity as provided by CMS for EPSDT. Services may be provided to a child outside of the child's residence when normal life activities take the child outside the residence.

Unit: A unit is 15 minutes.

Maximum units: Forty-eight 15 minute (12 hours) units of service per day.

Nursing Services

What: Nursing care services are services provided by a licensed nurse. The services are ordered by and included in the plan of treatment established by the physician. The services shall be reasonable and necessary to the treatment of an illness or injury and include:

- Observation;
- Evaluation;
- Teaching;
- Training;
- Supervision;
- Therapeutic exercise;
- Bowel and bladder care;
- Administration of medication;
- Intravenous, hypodermoclysis, and enteral feedings;
- Skin care;

- Preparation of clinical and progress notes;
- Coordination of services; and
- Informing the physician and other personnel of changes in the member's condition and needs.

Where: In the member's home. Not in the provider's home.

Does not include: Nursing services provided outside of the home or services that meet the intermittent guidelines or those provided under the EPSDT guidelines.

Medicaid intermittent coverage: Regular Medicaid provides for intermittent coverage of skilled nursing and home-health aide services provided in the person's home for both children and adults. Services are usually provided two to three hours per day for two to three days per week. Intermittent skilled nursing coverage includes visits up to five days per week and daily or multiple daily visits for wound care or insulin injections. Intermittent home-health aide coverage includes visits twice per day up to seven days per week for persons attending school or working or when ordered by the physician and included in the plan of care, not to exceed 28 hours per week.

EPSDT (Care for Kids) program: EPSDT services for persons under age 21 only include private duty nursing and personal care services that meet the definition of medical necessity as provided by CMS for EPSDT. Services may be provided to a child outside of the child's residence when normal life activities take the child outside the residence.

This nursing service shall not be simultaneously reimbursed with other Medicaid services.

Unit: A unit is a visit. A visit is zero (0) to two (2) hours.

Nutritional Counseling

What: Nutritional counseling for a severe nutritional problem or condition, which is beyond standard medical management.

Where: In the member's home. Not in the provider's home.

Unit: A unit is 15 minutes.

Personal Emergency Response System (PERS)

What: An electronic device connected to a 24-hour staffed system which allows the member to access assistance in the event of an emergency.

Where: The emergency response system is based in the member's home and includes an electronic device used by the member.

Unit: A unit is one time installation fee ***and/or*** one month of service.

Maximum Units: Twelve months of service per state fiscal year (July 1 – June 30).

Respite

What: Respite care services are services provided to the member that gives temporary relief to the usual caregiver and provides all the necessary care that the usual caregiver would provide during that time period. The purpose of respite care is to enable the member to remain in the member's current living situation.

- **Specialized respite** means respite provided on a staff-to-member ratio of one-to-one or higher for individuals with specialized medical needs requiring monitoring or supervision provided by a licensed registered nurse or licensed practical nurse.
- **Group respite** means respite provided on a staff-to-member ratio of less than one-to-one.
- **Basic individual respite** means respite provided on a staff-to-member ratio of one-to-one or higher for individuals without specialized medical needs that would require care by a licensed registered nurse or licensed practical nurse.

Where: Respite may be provided in:

- The member's home,
- Another family's home,
- Camps,
- Organized community programs (YMCA, recreation centers, senior citizens' centers, etc.),
- ICF/ID,
- RCF/ID,
- Hospital,
- Nursing facility,
- Skilled nursing facility,
- Assisted living program,
- Adult day care center,
- Foster group care,
- Foster family home, or
- DHS licensed daycare.

Respite provided outside the member's home or outside a facility in locations covered by the facility's licensure, certification, accreditation, or contract must be approved by the parent, guardian, or primary caregiver and interdisciplinary team, and must be consistent with the way the location is used by the general public. Respite in these locations may not exceed 72 continuous hours.

Does not include: Services shall not be reimbursable if the living unit is otherwise reserved for persons on a temporary leave of absence.

Respite ***cannot*** be provided to members residing in the family, guardian, or usual caregiver's home during the hours in which the usual caregiver is employed unless it is in a camp setting.

Respite shall not be simultaneously reimbursed or provided with duplicative services under the waiver.

Unit: A unit is 15 minutes.

Maximum Units: Fourteen consecutive days of 24-hour respite care may be reimbursed

AND

Respite services provided to 3 or more individuals for a period exceeding 24 consecutive hours for individuals who require nursing care because of a mental or physical condition must be provided by a licensed health care facility as described in the Iowa Code chapter 135C.

Consumer Choices Option

What: The **Consumer Choices Option (CCO)** is an option that is available under most HCBS waivers. This option will give you more control over a targeted amount of Medicaid dollars. You will use these dollars to develop an individual budget plan to meet your needs by directly hiring employees and purchasing other goods and services.

CCO offers more choice, control, and flexibility over your services, as well as more responsibility. Additional assistance is available if you choose this option. You will choose an Independent Support Broker who will help you develop your individual budget and help you recruit employees.

You will also work with a financial management service that will manage your budget for you and pay your workers on your behalf. Contact your service worker or case manager for more information. Additional information may also be found at the website: http://dhs.iowa.gov/ime/members/medicaid-a-to-z/consumer-choices-option.

Services that may be included in the individual budget under CCO are:

- Consumer-directed attendant care (unskilled)
- Home and vehicle modification
- Home-delivered meals
- Homemaker service
- Basic individual respite care

Where: In the member's home or community. Not in the provider's home.

Does not include: CCO cannot be used to pay for:

- Room and board,
- Workshop services,
- Other childcare, and
- Personal entertainment items.

Goods and services provided through CCO cannot otherwise be provided through Medicaid state plan services. Goods and services would:

- Decrease the need for other Medicaid services,
- Promote inclusion in the community, or
- Increase your safety in your home and community.

Unit: A monthly budget amount is set for each member

Application Process

The application process for the HD waiver requires a coordinated effort between DHS and non-department agencies on behalf of the prospective member. If you are currently working with DHS personnel, please contact that person regarding the application process.

Please respond immediately to correspondence from an income maintenance worker, a case manager or MCO CBCM. This will decrease the amount of time needed to complete the application process and assist in communication.

1. Application for Medicaid (Title XIX) and the HD waiver is made with an income maintenance worker (IM) at the local DHS office.

   Upon availability of a payment slot, the IM worker will process the application and refer the member to a Medicaid case manager or DHS service worker (MCM).

   For adults applying for the HD waiver, an appointment will be scheduled with the IM worker. For children applying for this waiver, telephone contact will be made to the family home. Documentation necessary for this application may include the following

   - Financial records
   - Title XIX card
   - Letter of Medicaid eligibility
   - Verification of Supplemental Security Income (SSI), Social Security Disability Insurance (SSDI) or State Supplemental Assistance (SSA) eligibility, if applicable. If assistance is not currently being received, a request may be made to apply at the local Social Security office.

2. The applicant will be contacted to schedule an assessment. The interRAI assessment must be completed as one of the eligibility requirements for the waiver. The assessor will send the completed assessment to the Iowa Medicaid Medical Services unit.

3. The IME Medical Services will review the interRAI assessment tool and documentation submitted to determine if the member's needs require intermediate or skilled level of care.

   If the member does not meet level of care, the IM will send a *Notice of Decision (NOD)* notifying the member of the denial. The member has the right to appeal the decision. The appeal process is explained on the *NOD*.

4. An assessment must be completed annually. If the member is enrolled with an MCO, then the MCO will make the annual level of care determination after the assessment is completed. If the member is FFS, then Iowa Medicaid will make the annual level of care determination after the assessment is completed. Iowa Medicaid retains the final determination authority for all level of care determinations.

5. An interdisciplinary team meeting is conducted to determine the services that are needed, the amount of service to be provided, and the providers of the services. The interdisciplinary team meeting will be attended by the member, the member's guardian or legal representative , the Case Manager or MCO CBCM, HD service providers, and other support persons the member may choose to attend. The end result of the interdisciplinary team decisions will be a comprehensive service plan developed, signed, and dated by the Case Manager or MCO CBCM.

6. For MCO enrolled members, the MCO must approve the comprehensive service plan and authorize services.

7. For Fee for Service members (FFS) the Individualized Services Information System (IoWANS) process must be completed with the culmination of an approved comprehensive service plan before the implementation of services. An approved comprehensive service plan recorded in the IoWANS system authorizes payment for waiver services for FFS members.

8. The Medicaid case manager or MCO will issue a Notice of Decision if the member is approved to receive HD waiver services.

Estate Recovery

Estate recovery legal reference: 441 IAC 75.28(7)

Estate recovery applies to all persons who have received Medicaid on or after July 1, 1994, and are age 55 or older, or who live in a medical facility and cannot reasonably be expected to return home. This includes members on waiver programs such as the Elderly Waiver Program and Medically Needy Program.

When a Medicaid member dies, assets from their estate are used to reimburse the state for costs paid for medical assistance. This includes the full amount of capitation payments made to a Managed Care Organization (MCO) for medical and dental coverage, regardless of service use or how much the managed care entity paid for services.

Additional information may also be found at the website:
https://dhs.iowa.gov/ime/members/members-rights-and-responsibilities/estate-recovery

or contact:

Medicaid Member Services Toll Free: 800-338-8366
515-256-4606 (Des Moines area)
or
Iowa Estate Recovery Program Toll Free: 1-877-463-7887
8:00 a.m. – 5:00 p.m., Monday – Friday

Discrimination is Against the Law

The Iowa Department of Human Services (DHS) complies with applicable federal civil rights laws to provide equal treatment in employment and provision of services to applicants, employees, and clients and does not discriminate on the basis of race, color, national origin, age, disability or sex. DHS does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

DHS:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact Iowa Medicaid Member Services at 1-800-338-8366.

If you believe that DHS has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance with: DHS, Office of Human Resources, by emailing contactdhs@dhs.state.ia.us or in writing to:

DHS Office of Human Resources
Hoover State Office Building, 1st floor
1305 East Walnut Street
Des Moines, IA 50319-0114

You can file a grievance in person, by mail, or email. If you need help filing a grievance, the DHS Office of Human Resources is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue
SW Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al ***1-800-338-8366 (TTY: 1-800-735-2942).***

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 **1-800-338-8366 (TTY: 1-800-735-2942).**

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số **1-800-338-8366 (TTY: 1-800-735-2942).**

OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite **1-800-338-8366** (TTY- Telefon za osobe sa oštećenim govorom ili sluhom: **1-800-735-2942**).

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: **1-800-338-8366 (TTY: 1-800-735-2942).**

مصلا مكبلاو:***1-800-735-2942***). ةظوحلم: اذإ تنك ثدحتت ركذا ةغللا، نإف تامدخ ةدعاسملا ةيوغللا رفاوتت كل ناجملاب. لصتا مقرب ***1-800-338-8366*** (مقر فتاه

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ **1-800-338-8366 (TTY: 1-800-735-2942).**

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. **1-800-338-8366 (TTY: 1-800-735-2942)** 전화해 주십시오.

ध्यान द : य द आप हदी बोलते ह तो आपके िलए मुफ्त म भाषा सहायता सेवाएं उपलब्ध ह।

1-800-338-8366 (TTY: 1-800-735-2942) पर कॉल कर ।

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le **1-800-338-8366 (ATS: 1-800-735-2942).**

Wann du [Deitsch (Pennsylvania German / Dutch)] schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call **1-800-338-8366 (TTY: 1-800-735-2942).**

เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร **1-800-338-8366 (TTY: 1-800-735-2942).**

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa **1-800-338-8366 (TTY: 1-800-735-2942).**

ဟ်သူၣ်ဟ်သး– နမ့ၢ်ကတိၤ ကညီ ကျိာ်အဃိ, နမၤန့ၢ် ကျိာ်အတၢ်မၤစၢၤလၢ တလၢာ်ဘူၣ်လၢာ်စ့ၤ နီတမံၤဘၣ်သ့န့ၣ်လီၤ. ကိး **1-800-338-8366 (TTY: 1-800-735-2942).**

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните **1-800-338-8366** (телетайп: **1-800-735-2942**).