

Iowa Department of Human Services
Ten-Day Report of Change for Medicaid/Hawki

You must tell us when something changes. You will need to tell us within ten days of the change. If you don't tell us when changes happen, we may give you coverage you should not get. If so, you will have to pay back what you got in error. ***Complete this form only when you have a change.***

If you have proof of the change you reported, send it with this form. This may speed up processing of your reported change.

Tell Us About Yourself

Name (First Last):	Case Number or State ID:
Address Line 1:	Last 4 Digits of SSN:
Address Line 2:	Date of birth:
City and State:	Phone:
Zip Code:	Other phone:
Email:	
Is this a new address? <input type="checkbox"/> YES <input type="checkbox"/> NO	
Mailing Address (if different):	

Who You Live With

Pregnancy		
Is someone in your household pregnant?		<input type="checkbox"/> YES <input type="checkbox"/> NO
If yes, are you requesting Medicaid for this person?		<input type="checkbox"/> YES <input type="checkbox"/> NO
Do they need help paying for medical bills from the last three calendar months?		YES NO
Who	Due Date:	Number of expected babies:

Household Member Changes:

Did someone move in or move out (including a newborn baby)? Please provide details below.

Name				
Date Moved				
In or Out?	<input type="checkbox"/> In <input type="checkbox"/> Out	<input type="checkbox"/> In <input type="checkbox"/> Out	<input type="checkbox"/> In <input type="checkbox"/> Out	<input type="checkbox"/> In <input type="checkbox"/> Out
DOB				
SSN				
Relationship				
Tax Filer?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
If yes, what is the person's Tax Filing Status?				
	<input type="checkbox"/> Single <input type="checkbox"/> Head of Household <input type="checkbox"/> Married jointly <input type="checkbox"/> Married separately Qualifying widow(er)	<input type="checkbox"/> Single <input type="checkbox"/> Head of Household <input type="checkbox"/> Married jointly <input type="checkbox"/> Married separately Qualifying widow(er)	<input type="checkbox"/> Single <input type="checkbox"/> Head of Household <input type="checkbox"/> Married jointly <input type="checkbox"/> Married separately Qualifying widow(er)	<input type="checkbox"/> Single <input type="checkbox"/> Head of Household <input type="checkbox"/> Married jointly <input type="checkbox"/> Married separately Qualifying widow(er)
If you selected Married Filing Jointly or Married Filing Separately, list their spouse's name:				
Spouse's Name				
Is this person claiming anyone as a tax dependent?				
	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
If yes, list the people that they are claiming as a dependent.				
Dependents				
Is this person a tax dependent of someone else?				
	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
If yes, who claims the person as a tax dependent?				
For Those Who Moved In				
Are you requesting Medicaid for this person?				
	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
If yes, do they need help for Medical bills from the last three calendar months?				
	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
For Those Who Moved Out				
Did the person who moved out move to a nursing home?				
	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
Is the person who moved out expected to return?				
	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
If yes, when are they expected to return?				
Return Date				

Money Your Household Gets

Income and Job Changes

If someone in your household got a new job or if one of the new household members that moved in has a job list details below.

	Job 1	Job 2	Job 3	Job 4
Who				
Employer name				
Start Date				
Wages and tips (before taxes) per pay period:				
Date of First Paycheck				
Pay Frequency				
Is medical insurance available?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO

If anyone ended a job list details below

Who				
Employer name				
Date of Last Paycheck				
Last Date Worked				

If someone in your household had a change in work hours or pay list details below

Who				
Employer name				
Pay Frequency				
New wages and tips per pay period (before taxes)				
Date of first paycheck reflecting this change:				

Other Income Changes

(Self-Employment, Unemployment benefits, Social Security benefits, SSI, disability, child support, etc.)

If someone in your household had a change in other income explain below:

(If Self Employment, report the monthly net amount after expenses deducted)

Type of Income	Person who receives	Change	Monthly amount
		<input type="checkbox"/> Start <input type="checkbox"/> Stop <input type="checkbox"/> Increase <input type="checkbox"/> Decrease	
		<input type="checkbox"/> Start <input type="checkbox"/> Stop <input type="checkbox"/> Increase <input type="checkbox"/> Decrease	
		<input type="checkbox"/> Start <input type="checkbox"/> Stop <input type="checkbox"/> Increase <input type="checkbox"/> Decrease	
		<input type="checkbox"/> Start <input type="checkbox"/> Stop <input type="checkbox"/> Increase <input type="checkbox"/> Decrease	

Is anyone in your home expecting to get a one-time payment such as back child support, an inheritance, or an insurance settlement? If yes, explain:

Income Deductions

If someone in your household has a change in income deductions that they pay, explain below:

(This includes alimony, student loan interest, or other item(s) that can be deducted from a federal income tax return)

	Who pays?	How much?	How often?
Medical expenses not covered by insurance			
Alimony paid to someone else			
Student loan interest			
Other deductions Type: _____			

Assets and Resources

You must report any changes in resources (checking/savings accounts, bonds, home/land, vehicles/boat, life insurance, retirement account, etc.) Include specific information about the opening, closing, purchasing, selling of, or changes to resources.

Asset Type	Owned By	Value	Location/Company

Additional Information:

Medical Coverage

Did someone have a change in their health insurance premium, started or stopped paying premiums, including Medicare, or stopped or started getting other medical insurance?

Explain:

Other Changes

Someone in my household:

☐ Got a Social Security Number

Explain:

☐ Who is under 18, has enrolled in school or dropped out of school

Explain:

☐ Changed their federal income tax filing status, including change in claimed dependents

Explain:

☐ Changed immigration status

Explain:

☐ Any other change not already listed

Explain:

Signature

Date

To report your change by phone, call 1-877-347-5678 between the hours of 7 am and 6 pm Monday through Friday.

To report by mail, fax, or email, send the form to:

DHS, Income Maintenance Customer Service Center, Imaging Center 1
417 E Kanesville Blvd, Council Bluffs, IA, 51503
Fax: 877-238-0015
Email: IMCSC@dhs.state.ia.us