Iowa Department of Health and Human Services

Medicaid/State Supp Review

Para traducción al español: 1-877-347-5678
USE ONLY BLUE OR BLACK INK.

Due Date	Case Number	County Number	Worker Name
Already populated			

It is time for your eligibility for Medicaid or State Supplementary Assistance to be reviewed. This information will be used to decide if you will continue to get Medicaid.

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

- **By mail:** Complete and mail this form using the envelope that was included. Be sure to mail it to the address above.
- **In-person:** Bring the completed form to your local HHS office.

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. **If you have proof of your income, expenses, and resources/assets, you may send it with this review. This may speed up the processing of your review.**
   Send copies because we cannot return the originals to you.
3. Sign the form on page 5. Your signature is required for the form to be considered complete.
4. **Return this form by** . If you do not return the form by this deadline, you may lose your Medicaid or State Supplementary Assistance 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 → Name of faculty + their address
	City *(home)* / State / ZIP Code
	Mailing Address POA's address
Mailing Address C/O POA	City *(mailing)* / State / ZIP Code
	Best **phone number** to reach you: ☐ Home ☐ Cell POA's phone number
	Email address, if you have one: POA's email

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. Is there anyone else living in your home that is not listed below? If so, write in any new information.*

Name/State ID or CIN	Age	Social Security Number	Relationship to You	Gender Male/Female	Resident of Iowa? Yes/No	If not a U.S. citizen or U.S. national and you have eligible immigration status, list document type and ID number.
prepopulated If married, the Spouses name should be listed.						

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? N/A ☐ Yes ☐ No

If yes, what date? _____

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? Medicaid persons name

Name of facility _____

Date of entry _____

Is anyone in your household pregnant? ☐ Yes ☐ No

If yes, who? N/A 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? MA Start date _____

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? If yes, then fill in. If no, check 'no'

Tell Us About Income

List income of the people in your home. This includes you, your spouse, and your unmarried children under the age of 18 who are living with you or who are living in a nursing home. If you leave a space blank, we will assume that you have no money of this kind. Please use an additional sheet of paper, if needed. If you have proof of income (check stubs, employer's statement, pension, VA award letters, annuity benefit letters, tax returns, etc.), you may send it with this review. This may speed up the processing of your review.

Name (first, middle, last & suffix)	Income Type	How much?	How often?
Medicaid recipient		$	☐ Monthly ☐ Other
* Spouse if there is one		$	☐ Monthly ☐ Other
		$	☐ Monthly ☐ Other
		$	☐ Monthly ☐ Other
		$	☐ Monthly ☐ Other
		$	☐ Monthly ☐ Other

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

If no, explain

Self-Employment and/or Odd Jobs

If anyone in your household is **self-employed**, we need to know about their work. Send in the entire last year's tax return. If you did not file taxes, send in last year's income and expenses.
For example, a statement from the person you work for.
Send proof of your income from work for the past 30 days, this includes odd jobs.

Name (first, middle, last & suffix)	Type of Work	Amount Paid Each Month
	N/A	$
		$

Automobiles

List all cars, trucks, boats, campers, motorcycles, or other licensed or unlicensed vehicles that anyone in your home owns or is buying:

Who	Make/Model/Year	Value or Worth	Amount Owed?
Only if the automobile is in the name of the			$
Medicaid recipient!		$	$
		$	$

* DHS only needs the spouses income to determine if they should receive spousal allowance!

NO other information about the spouse is required!

Assets

List the total resources owned by everyone in your home:

Type	Who	Bank or Location	Amount?
Cash			$ —
Bank/credit union accounts (Checking, savings, etc.)	Medicaid recipient		$
Stocks, bonds, savings certificates, IRAs, Keogh, or other assets			$ —
Nursing home account	if they have one		$
Land, buildings, or houses			$ —
Burial contract, burial plot, or burial funds	if they have one		$
Trust			$ —
Life estate			$ —
Other Savings	if they have one		$

Life Insurance

Company Name	Policy Number	Face Value	Cash Value
Do not list if the life insurance has been changed to the funeral home!		$	$
		$	$

Send your most recent statements with this form.

If anyone gave away anything of value, transferred anything for less than its value, or added someone else's name to a resource, tell us:

When?_____ What? N/A

If anyone sold a resource, tell us:

When?_____ What? N/A

If you received an inheritance or turned down an inheritance, list the following:

When?_____ Amount $ N/A

only list if this actually happened. very rare!

Health Insurance

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

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

If yes, who? Medicaid recipient

Amount you pay: $_____ per month List policies separate (dollar amounts only)

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

☐ Tricare – rare ☐ Veterans ☐ Peace Corps

☐ Retiree Health Plan ☐ COBRA

☐ Employer insurance Name of health insurance_____ Policy number_____

☒ Private/other usually medicare supplement; medicare advantage; drug plans

List anyone in your home who has ongoing medical bills that Medicaid does not pay:

Who?_____ Relationship to you? N/A

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. DHS should already have the POA on file!

Do you have a guardian, conservator, or representative? If yes, please tell us about them. If you're a legally appointed representative, guardian, or conservator 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 located on page 6.**

Your Signature	Date (mm/dd/yyyy)
X	

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).

This Review is not considered complete unless it has been signed here.

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 POA	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 Medicaid/State Supp has made a mistake, I can appeal its decision. To appeal means to tell someone at Medicaid/State Supp 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 in the Appeals section of this form.
- 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, 5th Floor, 1305 E Walnut Street, Des Moines, IA 50319-0114. 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 800-532-1275. If you live in Polk County, call 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, gender identity, 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, Hoover Building, 5th Floor – Bureau of Policy Coordination, 1305 E Walnut,
Des Moines, IA 50319-0114 or via email contactdhs@dhs.state.ia.us

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 5.

Not necessary

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	