



Medicaid Enterprise
Department of Human Services

For Human Services use only:
General Letter No. 8-AP-299
Employees' Manual, Title 8
Medicaid Appendix

June 26, 2009

ALL PROVIDERS MANUAL TRANSMITTAL NO. 09-2

ISSUED BY: Bureau of Medical Supports,
Division of Financial, Health and Work Supports

SUBJECT: **ALL PROVIDERS MANUAL**, Chapter II, **Member Eligibility**, Table of Contents (page 1), revised, pages 1, 2, 8 through 16, 19, 28, 29, 31, 32 and 33, revised, and the following forms:

- 470-2580 *Presumptive Medicaid Eligibility Notice of Decision*, revised
- 470-2580(S) *Presumptive Medicaid Eligibility Notice of Decision* (Spanish), new
- 470-2927 *Health Services Application*, revised
- 470-2927(S) *Health Services Application* (Spanish), revised
- 470-4299(S) *Verification of Emergency Health Care Services* (Spanish), new
- 470-2629 *Presumptive Medicaid Income Calculation*, revised;

Appendix, Table of Contents (page 1), revised, and pages 1 through 17, revised.

Summary

This manual is revised to update the *Presumptive Medicaid Income Calculation* with income guidelines based on the federal poverty level for pregnant women increasing to 300% of the federal poverty level.

The *Presumptive Medicaid Eligibility Notice of Decision* is updated for the Department letterhead. The *Health Services Application* has been revised to:

- ◆ Add a column for reporting ethnicity, in response to federal requirements.
- ◆ Add a statement that the applicant agrees to cooperate in obtaining medical payments from third parties and to assign medical payments from a third party to the state of Iowa for people who become eligible for Medicaid.

Spanish translations of the *Presumptive Medicaid Eligibility Notice of Decision* and the *Verification of Emergency Health Care Services* are now available.

The Appendix is revised to update the addresses and phone numbers of Department offices, Social Security Administration offices, and EPSDT care coordination agencies.

Date Effective

July 1, 2009

Material Superseded

Remove the following form and pages from the **ALL PROVIDERS MANUAL** and destroy them:

<u>Page</u>	<u>Date</u>
Chapter II	
Contents (p. 1)	August 1, 2007
1, 2	August 1, 2007
470-2580 (after p. 2)	1/07
470-2927 (after p. 6)	5/06
470-2927(S)	1/08
8-12, 13, 14, 15, 16, 19	August 1, 2007
470-2629 (after p. 24)	4/09
28, 29, 31-33	June 30, 2005
Appendix	
Contents (p. 1)	February 1, 2006
1-10	April 1, 2008
12	February 1, 2006
13	April 1, 2008
14	February 1, 2006
15-18	April 1, 2008

Additional Information

Use up any remaining supplies of forms 470-2580, 470-2927, and 470-2927(S) before ordering supplies of the revised forms.

The updated provider manual containing the revised pages can be found at:
www.ime.state.ia.us/

If you do not have Internet access, you may request a paper copy of this manual transmittal by sending a written request to:

Iowa Medicaid Enterprise
Provider Services
PO Box 36450
Des Moines, IA 50315

Include your provider identifier, name, address, provider type, and the transmittal number that you are requesting.

If any portion of this manual is not clear, please direct your inquiries to Iowa Medicaid Enterprise.



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CHAPTER II. MEMBER ELIGIBILITY

A. DEMONSTRATION OF ELIGIBILITY

Most members will demonstrate Medicaid eligibility through a *Medical Assistance Eligibility Card*. EXCEPTIONS: It is possible that a person has or will have Medicaid coverage, but does not yet have a *Medical Assistance Eligibility Card*.

- ◆ People who have applied for Medicaid benefits may have form 470-2979, *Proof of Application for Medicaid*. This form verifies that as of the date the form is completed the person has applied for Medicaid benefits, but eligibility has not been determined. In some cases, the person may become eligible only after spending a certain amount on medical care (a "spenddown").
- ◆ Women may have a *Presumptive Medicaid Eligibility Notice of Decision*, form 470-2580 or 470-2589(S), to indicate time-limited Medicaid eligibility for:
 - Covered ambulatory medical services (for pregnant women) or
 - All Medicaid-covered services (for women with breast or cervical cancer).

These women are determined to be presumptively eligible for Medicaid pending a formal eligibility determination by the Department. Presumptive Medicaid eligibility is granted on a daily basis rather than a monthly basis.

Failure to present a *Medical Assistance Eligibility Card* for inspection does not mean a person is ineligible for Medicaid. You may verify eligibility through the Iowa Eligibility Verification System (ELVS) or the IME web portal.

Presentation of a *Medical Assistance Eligibility Card* does not guarantee that the person continues to be eligible for Medicaid or that the person is eligible for all Medicaid benefits. A person who is no longer eligible for Medicaid may present a card. See [Section 4](#) for more information on methods of verifying eligibility.

Persons who are eligible for IowaCare coverage do not receive a *Medical Assistance Eligibility Card*. IowaCare has a separate eligibility card.



1. Medical Assistance Eligibility Card, Form 470-1911

The *Medical Assistance Eligibility Card* is issued to new Medicaid members at the time of approval. Replacement cards are issued for current members in July of each year or upon the request of the member. To view a sample of the card, click [here](#).

Each member receives a wallet sized card plus two key chain cards. The cards display the member's name, state identification number, and birth date. The back of the card lists IME contact phone numbers for both members and providers.

Possession of the annual card does **not guarantee** Medicaid eligibility. Providers must call Eligibility Verification System (ELVS) or access the IME web portal to verify the member's specific eligibility information.

2. Presumptive Medicaid Eligibility Notice of Decision, Form 470-2580

Possession of form 470-2580 or 470-2580(S), *Presumptive Medicaid Eligibility Notice of Decision*, indicates that a qualified provider has determined that a woman is presumptively eligible for Medicaid. To view a sample of the English form on line, click [here](#); for the Spanish sample, click [here](#).

This determination entitles a woman to time-limited Medicaid coverage as follows:

- ◆ Coverage for presumptively eligible women who have or may have breast or cervical cancer extends to all Medicaid covered services.
- ◆ Coverage for presumptively eligible pregnant women extends **only** to Medicaid-covered ambulatory prenatal care.

"Ambulatory prenatal care" means all Medicaid-covered services except inpatient hospital care and charges associated with a miscarriage or with delivery of the baby. Medicaid will pay medical expenses for ambulatory prenatal care incurred during the presumptive eligibility period even if the woman does not attain Medicaid eligibility.

A woman who is determined to be presumptively eligible for Medicaid is eligible for Medicaid services as described beginning with the date of the presumptive eligibility determination. Eligibility continues up to the last day of the month following the month of the presumptive eligibility determination.



STATE OF IOWA

CHESTER J. CULVER, GOVERNOR
PATTY JUDGE, LT. GOVERNOR

DEPARTMENT OF HUMAN SERVICES
CHARLES J. KROGMEIER, DIRECTOR

Presumptive Medicaid Eligibility Notice of Decision

Notice Date

[Empty box for Notice Date]

- Presumptive eligibility options: ambulatory medical care for pregnant women, Medicaid services for women with breast or cervical cancer or precancerous condition. Includes fields for eligibility start/end dates and state ID number.

Denial reason field: Your application for presumptive Medicaid eligibility has been denied because: _____

This is not a formal Medicaid eligibility determination. You must ask that your application be sent to the Department of Human Services or file a separate application with the Department of Human Services for a formal Medicaid eligibility determination.

If you are approved for presumptive Medicaid but you want Medicaid beyond the end date above, you may either:
- Have your application sent to the Department of Human Services or
- File a new application for Medicaid with your county Department of Human Services.

If you file an application for Medicaid with the Department of Human Services before the end date shown above, your Medicaid may continue until a decision is made on your application.

Your Medicaid application has been handled as you have requested based on the box marked below:

- Options for application handling: sent to County Department of Human Services for an eligibility determination, or must file a Medicaid application to get Medicaid beyond the end date shown above.

This presumptive Medicaid eligibility determination was made by: (please print clearly)

Provider name: _____
Name of person completing: _____
Address: _____
Phone number with area code: _____

*** IMPORTANT - ALL PROVIDERS PLEASE READ ***

This Notice of Decision is not a guarantee of the woman's presumptive Medicaid eligibility. Before rendering services, please read the back of this notice.

INFORMATION FOR ALL PROVIDERS:

This Notice of Decision serves as an indicator of the possibility of Medicaid eligibility. A presumptively eligible woman will not be given a Medical Assistance Eligibility Card.

Presumptive Medicaid eligibility is granted on a daily basis, rather than a monthly basis and may end at any time. Therefore, if you want assurance of Medicaid eligibility after the presumptive eligibility period begins, you must verify that the woman is currently presumptively eligible.

Verify eligibility by calling the Eligibility Verification System (ELVS) at Iowa WATS: 1-800-338-7752 or in Des Moines: 515-323-9639.

If you do not have a touch-tone phone, verify eligibility by calling Quality Assurance at the Department of Human Services at Iowa WATS: 1-800-373-6306 or in Des Moines: 515-242-6306.

Services provided to a woman presenting this notice during the period she is presumptively eligible, as verified by ELVS, are payable by the Department of Human Services when a claim is presented according to program requirements for:

- ◆ Medicaid-covered ambulatory medical services for pregnant women, or
- ◆ Medicaid-covered services for women with breast or cervical cancer.

Note: “Ambulatory medical services for pregnant women” means all Medicaid-covered services except charges associated with inpatient care in a hospital or other medical institution and charges associated with delivery of the baby (including miscarriage).

If the woman files a Medicaid application with the Department of Human Services by the last day of the month when her presumptive period ends, presumptive eligibility may continue until the Department of Human Services makes an eligibility determination of the Medicaid application.

If the woman does not file a Medicaid application, her presumptive eligibility will not continue beyond the date shown on the front of this form.

A woman is allowed only one presumptive eligibility period per pregnancy.



Presumptive Medicaid Eligibility Notice of Decision
(Aviso de Decisión sobre Presunta Elegibilidad para Medicaid)

Fecha del Aviso

[Empty box for date]

- Usted es presuntamente elegible para recibir cobertura de Medicaid para pagar el costo de:
- Atención médica ambulatoria para mujeres embarazadas.
- Servicios de Medicaid para mujeres con cáncer de seno o cervical o en situación precancerosa.
Su elegibilidad empieza... de 20...
Su elegibilidad terminará el... de 20...
Su número de identificación del Estado es...
Su solicitud para una presunta elegibilidad de Medicaid ha sido negada porque:

Esta no es una determinación formal sobre elegibilidad de Medicaid. Usted debe pedir que se envíe su solicitud al Department of Human Services o presentar una solicitud aparte ante el Department of Human Services para una determinación formal de elegibilidad para Medicaid.

Si usted está aprobada para Medicaid presuntivo de su condado si desea Medicaid más allá de la fecha indicada anteriormente, usted puede pedir que se envíe su solicitud al Department of Human Services o presentar una nueva solicitud de Medicaid ante el Department of Human Services.

Si presenta una nueva solicitud de Medicaid ante el Department of Human Services antes de la fecha de terminación indicada arriba, su Medicaid podrá continuar más allá de dicha fecha hasta que se toma una decisión sobre su solicitud.

Su solicitud de Medicaid ha sido manejada según como usted lo solicitó, con base en la casilla marcada a continuación:

- Su solicitud de Medicaid ha sido enviada al Department of Human Services del Condado... para una determinación de elegibilidad.
Usted debe presentar una solicitud de Medicaid para recibir Medicaid después de la fecha indicada arriba.

Esta determinación de elegibilidad presuntiva para Medicaid fue hecha por: (por favor escriba claramente)

Nombre del proveedor:
Nombre de la persona que lo llena:
Dirección:
Número telefónico con código de área:

*** IMPORTANTE - TODOS LOS PROVEEDORES POR FAVOR LEER ***

Este Aviso de Decisión no es garantía de la elegibilidad presuntiva para Medicaid de la mujer. Antes de prestar servicios, por favor lea el reverso de este aviso.

INFORMACIÓN PARA TODOS LOS PROVEEDORES:

Este Aviso de Decisión sirve como indicador de la posibilidad de elegibilidad para Medicaid. Una mujer presuntamente elegible no recibirá una tarjeta médica.

La elegibilidad presuntiva para Medicaid se concede sobre una base diaria, y no mensual, y puede terminar en cualquier momento. Por lo tanto, si usted desea estar seguro sobre la elegibilidad para Medicaid después del inicio del período de elegibilidad presuntiva, debe verificar que la mujer sea presuntamente elegible en ese momento.

Verifique la elegibilidad llamando al Eligibility Verification System (ELVS) al Iowa WATS: 1-800-338-7752 o en Des Moines: 515-323-9639.

Si no tiene un teléfono de tonos, verifique la elegibilidad llamando a Quality Assurance al Department of Human Services de Iowa WATS: 1-800-373-6306 o en Des Moines: 515-242-6306.

Los servicios que se suministren a una mujer que presente este aviso durante el período en que es presuntamente elegible, según lo verifique el ELVS, los pagará el Department of Human Services cuando se presente una reclamación de acuerdo con los requisitos del programa para:

- ◆ Servicios médicos ambulatorios cubiertos por Medicaid para mujeres embarazadas, ó
- ◆ Servicios cubiertos por Medicaid para mujeres con cáncer de seno o cervical.

Nota: “Servicios médicos ambulatorios para mujeres embarazadas” significa todos los servicios cubiertos por Medicaid, excepto los cobros asociados con la atención de un paciente interno en un hospital o en otra institución médica y los costos asociados con el parto (incluyendo aborto espontáneo).

Si la mujer presenta una solicitud para Medicaid ante el Department of Human Services antes del último día del mes en que su período presuntivo termine, la elegibilidad presuntiva puede continuar hasta que el Department of Human Services tome una determinación de elegibilidad sobre la solicitud de Medicaid.

Si ella no presenta una solicitud de Medicaid, su elegibilidad presuntiva no continuará más allá de la fecha indicada al frente de este formulario.

A una mujer embarazada sólo se le permite un período de elegibilidad presuntiva por embarazo.



4. Limited Eligibility for People Who Transfer Assets

Transfers of assets for less than fair market value after August 10, 1993, disqualify a member for Medicaid payments as follows:

- ◆ For transfers by an institutionalized member or an institutionalized member's spouse, the penalty is ineligibility for Medicaid payment for:
 - Nursing facility services or an equivalent level of care in any facility.
 - Home- and community-based waiver services.
- ◆ For transfers by a noninstitutionalized member or a noninstitutionalized member's spouse, the penalty is ineligibility for Medicaid payment for:
 - Home health care services,
 - Home and community care for the functionally disabled elderly,
 - Personal care services, or
 - Other long-term care services.

Information concerning these members is on the Eligibility Verification System (ELVS) and the IME secure web portal. See [Eligibility Verification](#).

C. GROUPS COVERED BY MEDICAID

1. Members Related to the Family Medical Assistance Programs

The Medicaid program covers:

- ◆ Recipients of the Family Medical Assistance Program (FMAP) for persons who would be eligible for the Iowa Family Investment Program as in effect on July 16, 1996 (low-income children and their parents or needy caretaker relatives).
- ◆ People terminated from FMAP because of increased earnings or increased child support.
- ◆ People under 21 who are ineligible for FMAP because they do not qualify as dependent children.
- ◆ Pregnant women and infants whose income is not more than 300% of the federal poverty level.
- ◆ Children aged 1 through 18 whose income is not more than 133% of federal poverty level.



2. Members Related to the Supplemental Security Income Program

The Medicaid program covers all beneficiaries of cash assistance under the Supplemental Security Income (SSI) program for low-income persons who are aged, blind, or disabled, which is administered by the Social Security Administration. The Medicaid program also covers:

- ◆ Aged, blind, or disabled people who
 - Are ineligible for SSI because of rules that don't apply to Medicaid, or
 - Would be eligible for SSI if certain conditions were met (e.g., if changes in disability criteria or increases in social security benefits due to cost of living or actuarial changes were not considered).
- ◆ Employed people with disabilities (MEPD) who:
 - Are under age 65.
 - Are considered disabled based on SSI medical criteria.
 - Have earned income from employment or self-employment.
 - Have resources under \$12,000 (individual) or \$13,000 (couple).
 - Have net family income of less than 250% of the federal poverty level.
 - Pay a premium assessed for each month of eligibility if gross income is over 150% of the federal poverty level.
- ◆ Children under age 19 ("kids with special needs" or MKSN) who:
 - Are considered disabled based on SSI disability criteria.
 - Have gross family income at 300% of the federal poverty level or less.
 - Are enrolled in a parent's employer's group health insurance when the employer pays at least half of the annual cost of premiums.

3. Members Residing in Medical Institutions

People who reside in a medical institution (a hospital, nursing facility, psychiatric institution, or intermediate care facility for the mentally retarded) for a full calendar month may be eligible for Medicaid.

These people must meet all eligibility requirements for SSI, except that their monthly income may be such that they would be ineligible to receive cash assistance through the SSI program.

There is a special Medicaid income limit in effect for persons in medical institutions. To be eligible in terms of income, the person's monthly income may not exceed 300% of the basic SSI benefit. This limit generally increases on January 1 of each year, as increases occur in the basic SSI benefit.



4. Members Receiving State Supplementary Assistance

People who receive State Supplementary Assistance are eligible for Medicaid. State Supplementary Assistance is a state program that makes a cash assistance payment to certain SSI beneficiaries and persons that are not eligible for SSI due to income slightly exceeding the SSI standard.

The monthly State Supplementary Assistance payment supplements the person's income to meet the cost of special needs, including residential care, in-home health-related care, family-life home care, a dependent person, or special needs due to blindness. Certain people eligible for both Medicare and Medicaid receive a small State Supplementary Assistance payment quarterly.

5. Children in Foster Care or Subsidized Adoptions or Guardianship

Medicaid covers children in foster care, or subsidized adoptions or subsidized guardianship if the Department of Human Services is wholly or partially financially responsible for their support.

Iowa Medicaid covers children in foster care or subsidized adoptions who are placed in Iowa from another state if:

- ◆ The child receives federal funding under Title IV-E, Social Security Act, or
- ◆ The placing state has entered into a reciprocity agreement with Iowa.

6. Members Under the Medically Needy Program

The Medically Needy program provides medical coverage to people who are pregnant, under age 21, caretaker relatives, aged, blind, or disabled, and would qualify for Medicaid programs, other than IowaCare, except that:

- ◆ They have slightly too much income or resources, or
- ◆ They have higher incomes but have unusually high medical expenses.

The Medically Needy income level is based on family size. People whose income is equal to or less than the Medically Needy income level are eligible for Medicaid through the Medically Needy program.

People who meet all eligibility factors for the Medically Needy program except for income are allowed to reduce their excess income through incurred medical expenses. This process is called spenddown.

Eligibility for Medically Needy members is based on a certification period. For people with a spenddown obligation, the certification period is two months. A new application is required before eligibility can be re-established.



Medical Assistance Eligibility Cards are issued for Medically Needy members:

- ◆ Who do not have a spenddown amount, or
- ◆ Who have met their spenddown obligation.

When a member has a current *Medicaid Eligibility* at the time services are received, Medicaid will pay for covered services received on that date and any subsequent services received in that month.

Medically Needy members are entitled to receive all services covered by Medicaid except:

- ◆ Care in a nursing facility,
- ◆ Care in an institution for mental disease,
- ◆ Care in an intermediate care facility for the mentally retarded.

People who have a Medically Needy spenddown obligation are “conditionally eligible” for Medicaid until they have verified enough medical expenses to meet their spenddown for that certification period. Information about the status of these people is available through the Eligibility Verification System (ELVS). See [Eligibility Verification](#) for more information.

Expenses used to meet spenddown are not payable by Medicaid. See [Medically Needy Conditional Eligibility](#) for information on how this affects billing and payment for services provided.

a. Medically Needy Conditional Eligibility

People who have a Medically Needy spenddown obligation are “conditionally eligible” for Medicaid until they have verified enough medical expenses to meet their spenddown for that certification period.

A member with a spenddown may not have a *Medical Assistance Eligibility Card* when service is requested, but may have met the spenddown, or may later be determined to be eligible retroactively.

Expenses used for spenddown are considered as a deductible and are **not** paid by Medicaid. Medicaid may cover a service provided before the member receives a *Medical Assistance Eligibility Card* if the service was not used to meet the spenddown obligation.

Expenses used to meet spenddown can include both services that would be covered by Medicaid if spenddown were met and services that would not be covered by Medicaid, such as a service provided before the Medically Needy certification period that remains unpaid at the beginning of the period.



Members who have successfully reduced their excess income through spenddown are notified what bills were used for spenddown and are, therefore, their personal obligation.

When a member has met spenddown, but eligibility has not yet been updated to reflect Medicaid coverage for the certification period, ELVS will report that the remaining spenddown is zero. The time lag between the spenddown reaching zero and the eligibility update showing the member as Medicaid-eligible should be no longer than two days.

b. Submitting Claims for a Person with a Spenddown

When you have determined through ELVS that a conditionally eligible person has a spenddown balance to meet, submit claims for services for the person or responsible relative to the IME just as if the person were eligible for Medicaid, using claim forms or electronic billing.

If the person has not met spenddown, the IME will apply the claim to the spenddown balance. Claims that are used to meet spenddown will be denied for Medicaid payment. The amount used for spenddown will be listed on the *Remittance Statement*. Claims that are not used to meet spenddown or are only partially used to meet spenddown are automatically resubmitted for Medicaid payment.

In order for expenses to be accurately applied towards spenddown, you **must** bill a member's other insurance or Medicare before submitting the claim to the IME.

Claims will not be forwarded for spenddown processing and must be corrected and resubmitted if:

- ◆ They have missing or incorrect data (invalid procedure, national drug code, diagnosis, date of service, etc.).
- ◆ They post any edits for spenddown (EOB 480), insurance, or invalid data.
- ◆ The member's information is not on the Medically Needy system (EOB 270).

Conditionally eligible persons who have "old bills" or other expenses that will not be Medicaid-payable need to have verification of these bills to apply the bills to their spenddown obligation and achieve Medicaid eligibility for current covered expenses. These claims **cannot** be filed electronically or submitted directly to the IME.



Submit claims for such services **to the member's income maintenance worker** in the DHS local office. (See the [Appendix](#) for a list of the addresses of local Human Services offices.) The worker will attach the necessary documentation to the claim and forward it to the IME for spenddown processing.

c. Medical Expense Deletion Request, Form 470-3931

When a prescription is filled and billed to Medicaid for a potentially eligible Medically Needy member, but the member does not pick up the prescription, the pharmacy **must** complete form 470-3931, *Medically Needy Expense Deletion Request*. Fax the completed form to the IME as soon as possible to prevent claims for services not used to meet spenddown by the Medically Needy member.

To view a sample of this form on line, click [here](#).

7. Aliens Receiving Emergency Services

Federal immigration and naturalization laws provide limited Medicaid benefits for treatment of emergency medical conditions suffered by certain aliens.

Aliens who may be eligible for these benefits include otherwise eligible persons who do not allege status as a lawful resident of the United States or who were granted lawful status under the amnesty program. To be eligible for Medicaid benefits, such aliens must:

- ◆ Meet income and resource requirements, **and**
- ◆ Have had or currently have an emergency medical condition.

“Emergency medical condition” means a medical condition (including labor and delivery) manifesting itself by acute symptoms of such severity (including severe pain) such that the absence of immediate medical attention could reasonably result in:

- ◆ Placing the patient's health in serious jeopardy;
- ◆ Serious impairment of bodily function;
- ◆ Serious dysfunction of any bodily part.

Any person who, in your opinion, might be eligible for Medicaid emergency benefits should be referred to the Department of Human Services office in the county in which the person claims residence. See the [Appendix](#) for a list of the addresses of local Human Services offices.



a. Verification of Emergency Health Care Services, Form 470-4299

Since the necessity of emergency medical treatment is a condition of eligibility under this provision, the local office of the Department of Human Services will seek verification of the emergency.

Department income maintenance workers use form 470-4299 or 470-4299(S), *Verification of Emergency Health Care Services*, to obtain the date of service and to verify that an emergency service was received from the medical provider. To view a sample of the English form on line, click [here](#); for a sample of the Spanish version, click [here](#).

Complete the section, "**To be completed by the provider.**" It is important to provide all the information requested so that the Department can determine whether an emergency service was provided. Return this form to the local Department office. Contact your local office if you have any questions regarding this form.

Following this determination and a determination that all other factors of eligibility are met, the Department will issue a *Medical Assistance Eligibility Card*, form 470-1911, to the patient.

The patient (or someone acting on the patient's behalf) must present this card to the providers of emergency service. The providers may then submit a claim for Medicaid payment in the usual manner.

b. Covered Services

Payment for treatment of an emergency medical condition is **limited** to:

- ◆ Inpatient or outpatient hospital services.
- ◆ Physician services.
- ◆ Services of an independent diagnostic laboratory or x-ray facility.

To be payable, care must be provided during the **three-day** period beginning with the date the patient presented for treatment of the emergency condition, regardless of the length of time the emergency condition exists.

If the patient presents for treatment later during that month for some **other** emergency condition, three days of treatment for that condition are also payable in that month.

Verification of Emergency Health Care Services (Verificación de Servicios de Salud de Emergencia)

Nombre del cliente: (letra de imprenta o máquina)	SID #:	# de Condado y trabajador:
Padre/guardián:	SS #:	Fecha de nacimiento:

Otorgo permiso al proveedor medico o agencia para que comparta información escrita y oral acerca de los servicios de atención médica que recibí con el Department of Human Services.

Firma del paciente (o padre si es menor):	Fecha:	Esta autorización expira un año después de su firma.
Relación con el firmante: <input type="checkbox"/> Usted <input type="checkbox"/> Representante legal <input type="checkbox"/> Pariente vivo más cercano <input type="checkbox"/> Otros (especificar):		
Testigo de la firma si se requiere:		

Quien otorga la información

Nombre de la agencia o persona que brinda la información:	Teléfono:	Fax:
Dirección:	Ciudad/estado/cod. postal:	

Para ser llenado por el proveedor:

¿Tenía esta persona dolor o condición médica grave que se manifestara por síntomas agudos o de tal gravedad que la ausencia de atención médica inmediata podría esperarse que:

- Pusiera en serio peligro la salud del paciente, o
- Hubiera deterioro grave de funciones corporales, o
- Hubiera disfunción grave de cualquier órgano o parte del cuerpo?

Sí No

¿Fueron servicios de parto?

Sí No

¿Se le trató por una condición relacionada con esta emergencia durante el mismo mes?

Sí No

Por favor anote las fechas de servicio y explique en detalle la(s) condición(es) médica(s) de emergencia para las que se ofreció tratamiento en la casilla inferior. **Nota:** Por favor especifique si el tratamiento fue relacionado con un transplante de órgano a partir del 10 de agosto de 1993.


Si esta persona tiene aprobados los Emergency Health Care Services, el pago cubrirá la fecha en que ocurrió la emergencia y los siguientes dos días.

Fechas del servicio	
Descripción de la condición médica de emergencia (adjunte páginas adicionales si es necesario):	
Nombre en letra de imprenta o a máquina:	Fecha:
Firma del proveedor médico:	Teléfono: ()

Una fotocopia de esta autorización firmada tendrá la misma fuerza y vigor que este original.

Una copia de esta autorización deberá guardarse en el expediente del caso y estará disponible si la Iowa Medicaid Enterprise solicita una copia.

Nombre del trabajador:	Número de teléfono:	Número de fax:
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 Medicaid Enterprise Department of Human Services	Provider and Chapter	Page
	All Providers Chapter II. Member Eligibility	15
		Date
		July 1, 2009

If an emergency condition again takes place during a **later** month, the local office must again determine eligibility and verify the existence of an emergency condition.

8. Members Under the Qualified Medicare Beneficiary Program

The Medicare Catastrophic Coverage Act of 1988 mandated a coverage group for qualified Medicare beneficiaries (QMB). QMB coverage provides for limited Medicaid payment. Medicaid pays only for Medicare premiums (Part A or B), coinsurance, and deductibles.

To qualify for QMB, a person must:

- ◆ Be entitled to hospital insurance benefits under Part A of Medicare.
- ◆ Be within the income and resource limits specific to QMB.
- ◆ Meet all other Medicaid eligibility requirements.

Income eligibility for QMB exists if the household's income does not exceed 100% of the federal poverty level. Net countable income is determined using Supplemental Security Income (SSI) income policies.

The resource limits are twice the current SSI resource limits. Resource limits for QMB are \$4,000 for an individual and \$6,000 for two or more. SSI resource policies apply when determining countable resources.

A person can be concurrently eligible for QMB and Medically Needy. People who are conditionally eligible for Medically Needy and are eligible for QMB are entitled only to services covered under QMB until spenddown is met. Once spenddown is met, they are then entitled to Medicaid benefits payable under Medically Needy.

Eligibility for QMB becomes effective the first day of the month following the month of decision. Each person eligible for QMB is issued a *Medical Assistance Eligibility Card*, form 470-1911.



9. Women Who Need Treatment For Breast or Cervical Cancer

Medicaid is available to women who:

- ◆ Are under the age of 65, and
- ◆ Have been screened for breast or cervical cancer under the Centers for Disease Control and Prevention's Breast and Cervical Cancer Early Detection Program, and
- ◆ Have been found to need treatment for either breast or cervical cancer (including a pre-cancerous condition), and
- ◆ Do not otherwise have creditable coverage, as that term is defined by the Health Insurance Portability and Accountability Act, and
- ◆ Are not eligible under another mandatory Medicaid coverage group.

Eligibility continues until the woman is:

- ◆ No longer receiving treatment for breast or cervical cancer;
- ◆ No longer under the age of 65; or
- ◆ Covered by creditable health coverage.

During the period of eligibility, a woman is entitled to full Medicaid coverage. Covered services are not limited to treatment of breast or cervical cancer.

10. Members Under the Iowa Family Planning Network

The Iowa Family Planning Network provides limited Medicaid coverage. It is available to women who are capable of bearing children, who are not pregnant and who:

- ◆ Were Medicaid members at the time their pregnancy ended or
- ◆ Are over age 12 and under age 45 and have countable income no greater than 200% of the federal poverty level.

Eligibility continues for 12 consecutive months beginning with:

- ◆ The month after the postpartum period ends for women who had a pregnancy end while a Medicaid member, or
- ◆ The first month in which eligibility is established for women who have income at or below 200% of the federal poverty level.

PRESUMPTIVE MEDICAID INCOME CALCULATION

If pregnant woman (1) is age 18 or older; or (2) is married, divorced, or widowed; or (3) does not reside with her parents, go directly to Section II. If the pregnant woman is under age 18, resides with her parents, and is unmarried (or her marriage has been annulled), consider parental income in the eligibility determination as follows in section I:

SECTION I. PARENTAL INCOME

	<u>Parent 1</u>	<u>Parent 2</u>																														
A. Enter total gross earned income	\$ _____	\$ _____																														
B. Enter 20% of Line A (work expense deduction)	- \$ _____	- \$ _____																														
C. Enter child care expenses: For employees, allow <u>up to</u> \$175/mo per child over age 2 \$200/mo per child under age 2 (allow for month child turns 2)																																
D. Subtotal (Subtract Lines B and C from Line A)	- \$ _____	- \$ _____																														
E. If more than one household member has earnings, add together their earned income from Line D.		= \$ _____																														
F. Using the table below, enter income to meet needs of parents and their dependents in the home. (DO NOT count the pregnant woman when determining the amount of income to subtract.)		- \$ _____																														
<table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 30%; text-align: left;"><u>Number of Persons</u></th> <th style="width: 30%; text-align: left;"><u>Amount of Income to Enter on Line F</u></th> <th style="width: 40%;"></th> </tr> </thead> <tbody> <tr> <td>1</td> <td>\$ 365</td> <td></td> </tr> <tr> <td>2</td> <td>\$ 719</td> <td></td> </tr> <tr> <td>3</td> <td>\$ 849</td> <td></td> </tr> <tr> <td>4</td> <td>\$ 986</td> <td></td> </tr> <tr> <td>5</td> <td>\$ 1,092</td> <td></td> </tr> <tr> <td>6</td> <td>\$ 1,216</td> <td></td> </tr> <tr> <td>7</td> <td>\$ 1,335</td> <td></td> </tr> <tr> <td>8</td> <td>\$ 1,457</td> <td></td> </tr> <tr> <td>For each additional person add \$173</td> <td>\$ 173</td> <td></td> </tr> </tbody> </table>			<u>Number of Persons</u>	<u>Amount of Income to Enter on Line F</u>		1	\$ 365		2	\$ 719		3	\$ 849		4	\$ 986		5	\$ 1,092		6	\$ 1,216		7	\$ 1,335		8	\$ 1,457		For each additional person add \$173	\$ 173	
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7	\$ 1,335																															
8	\$ 1,457																															
For each additional person add \$173	\$ 173																															
G. Subtotal (Line E minus Line F)		= \$ _____																														
H. Enter any unearned income of parents		+ \$ _____																														
I. COUNTABLE MONTHLY PARENTAL INCOME TO CONSIDER TOWARD THE PREGNANT WOMAN'S ELIGIBILITY (Line G plus Line H)		= \$ _____																														

SECTION II. INCOME OF THE PREGNANT WOMAN

Household Size* _____	<u>Pregnant Woman</u>	<u>Unborn's Father</u>
A. Enter total gross earned income**	\$ _____	\$ _____
B. Enter 20% of Line A (work expense deduction)	- \$ _____	- \$ _____
C. Enter child care expenses: For employees, allow <u>up to</u> \$175/mo per child over age 2 \$200/mo per child under age 2 (allow for month child turns 2)		
D. Subtotal (Line A minus Lines B and C)	- \$ _____	- \$ _____
E. Add the earnings of the pregnant woman, the unborn's father, and the unborn's siblings who are under age 19, if they are in the home.		= \$ _____
F. Enter any court-ordered child support payment made to persons outside the home by the pregnant woman or the father of the unborn child (if he is residing with the pregnant woman). (Allow the amount that is actually paid.)		- \$ _____
G. Subtotal (Line E minus Line F)		= \$ _____
H. Enter total monthly unearned income**		+ \$ _____
I. Enter countable parental income if applicable (See Line I in SECTION I.)		+ \$ _____
J. TOTAL COUNTABLE NET MONTHLY INCOME (Lines G plus H plus I)		= \$ _____

If the total countable income (Line J) does not exceed the income limit on the chart below for the household size, the pregnant woman is presumptively eligible.

Household Size	Income Limit
1	\$ 2,708
2	\$ 3,643
3	\$ 4,578
4	\$ 5,513
5	\$ 6,448
6	\$ 7,383
7	\$ 8,318
8	\$ 9,253
For each additional person, add	\$ 935

* To determine household size, count the pregnant woman, the unborn child(ren), the father of the unborn child and any siblings of the unborn child when in the home.

** Count the income of the pregnant woman, the father of the unborn child and siblings of the unborn child when in the home.



<u>Code</u>	<u>Description</u>
99396	Preventive medicine service, 40-64 years of age
99420	Administration and inter health risk assessment instrument
99420	Completion of Risk Assessment form
A4261	Cervical cap
A4266	Diaphragm
A4267	Condom, nonspermicidal
A4267	Condom, spermicidal
A4268	Female condom
A4269	Spermicidal suppositories
A4269	Contraceptive foam
A4269	Contraceptive jelly
A4269	Contraceptive sponges
A4269	Vaginal contraceptive film
A4932	Basal thermometer
J1055	Depo Provera
J3490	Doxycycline
J3490	Flagyl
J3490	Vaginal cream, e.g., Terazol
J7300	Intrauterine device (IUD)
J7303	Contraceptive supply, hormone containing vaginal ring, each
S4989	Progestasert IUD
S4993	Oral contraceptive, 21-day supply
S4993	Oral contraceptive, 28-day supply
T1999	Supplies and materials provided by physician over/above normal service

11. Members Under IowaCare

The IowaCare program covers:

- ◆ Person ages 19 through 64 who are not eligible for other Medicaid coverage groups and whose countable income is not more than 200% of the federal poverty level.
- ◆ Pregnant women who are over resources for Medicaid but whose countable income is less than 300% of the federal poverty level and who can reduce their income to 200% of the federal poverty level with obligated medical expenses.
- ◆ Newborn infants of women who were receiving IowaCare at time of newborn's birth and who are not eligible for Medicaid. NOTE: Infants must file an application to get Medicaid coverage.



c. Notice of Decision

The qualified provider shall:

- ◆ Make an eligibility decision based on the information the woman provided on the *Health Services Application*, form 470-2927 or 470-2927(S), and on the *Presumptive Medicaid Income Calculation*, form 470-2629.
- ◆ Complete the *Presumptive Medicaid Eligibility Notice of Decision*, form 470-2580 or 470-2580(S), to notify the woman of the presumptive eligibility decision.

See [Presumptive Medicaid Eligibility Notice of Decision, Form 470-2580](#), for samples of this form. (To use the Spanish version of the form, print or photocopy supplies from the sample in the manual.)

To complete the form, enter the name and address of the woman and the date of the notice in the spaces provided. If the application has been approved:

- ◆ Enter "X" for the appropriate coverage group.
- ◆ Enter the woman's state identification number.
- ◆ Enter the date the presumptive eligibility period begins. This date is usually the same date as the date on which the notice is being completed.
- ◆ Enter the date the presumptive eligibility period ends. This is the last day of the month following the month of the presumptive eligibility determination.
- ◆ Enter an "X" to indicate whether the *Health Services Application* has been submitted to the Department of Human Services. If so, indicate the local office it was sent to.

If presumptive eligibility is denied:

- ◆ Enter an "X" in the applicable box.
- ◆ Provide an explanation of the denial (such as, "You are over income"; "You have already received presumptive Medicaid eligibility during this pregnancy"; "You have creditable insurance coverage").



Enter the name, address, and telephone number of the qualified provider making the determination.

Give the original copy of the *Presumptive Eligibility Notice of Decision*, to the pregnant woman along with a copy of form 470-2629, *Presumptive Medicaid Income Calculation*. Keep a copy in the pregnant woman's file.

Within five days of your determination, send a copy of form 470-2580 or 470-2580(S) to the Department of Human Services office for the county where the woman lives.

E. PRESUMPTIVE ELIGIBILITY DETERMINATION FOR WOMEN WHO NEED TREATMENT FOR BREAST OR CERVICAL CANCER

Qualified providers can make an initial or "presumptive" determination of Medicaid eligibility for women who need treatment for breast and cervical cancer to facilitate the provision of care.

The goal of the presumptive eligibility process is to offer immediate health care coverage to women likely to be Medicaid eligible, before there has been a full Medicaid determination. Women can enroll in presumptive eligibility for a limited time before Medicaid applications are filed and processed, based on a determination of likely Medicaid eligibility from an approved provider.

A woman in this group who is determined to be presumptively eligible for Medicaid is eligible to receive all Medicaid-covered services during the presumptive eligibility period, not just services related to cancer treatment. Medicaid will pay medical expenses incurred during the presumptive eligibility period even if the woman does not attain Medicaid eligibility.

1. Qualified Providers

A qualified provider is defined as a provider who is eligible for payment under the Medicaid program and either:

- ◆ Has been named lead agency for a county or regional local breast and cervical cancer early detection program under a contract with the Department of Public Health; or
- ◆ Has a cooperate agreement with the Department of Public Health to receive reimbursement for providing breast or cervical cancer screening or diagnostic services to participants in the Care for Yourself Breast and Cervical Cancer Early Detection Program (BCCEDP).



2. Eligibility Determination Process

Only women who met the criteria of this coverage group obtain Medicaid eligibility under the presumptive eligibility provisions. Other household members are not entitled to receive Medicaid, unless an application has been filed with the Department of Human Services and the Department has made a determination approving eligibility.

The woman must complete the *Health Services Application*, form 470-2927 or 470-2927(S) (Spanish). If the information provided indicates that the woman will meet Medicaid eligibility requirements, the qualified provider obtains a state identification number for her.

The qualified provider issues a *Presumptive Medicaid Eligibility Notice of Decision*, form 470-2580 or 470-2580(S) (Spanish), to inform the woman of the decision on her application.

A woman who is determined to be presumptively eligible for Medicaid under this coverage group is eligible for Medicaid services beginning with the date of the presumptive eligibility determination. Eligibility continues up to the last day of the month following the month of the presumptive eligibility determination.

If the woman files a Medicaid application within this period, Medicaid coverage continues until a decision is made on the application. The presumptive eligibility period ends when the Department approves or denies the Medicaid application.

A new period of presumptive eligibility shall begin each time a woman is screened, diagnosed, and found to need treatment for breast or cervical cancer and files a *Health Services Application* with a qualified provider.

a. Completing the Health Services Application

Qualified providers shall issue the *Health Services Application*, form 470-2927, or its Spanish translation, form 470-2927(S), to a woman who requests a determination of presumptive Medicaid eligibility based on the need for treatment for breast or cervical cancer.



See [Health Services Application, Forms 470-2927 and 470-2927\(S\)](#), for a sample of this form. The woman or someone acting on her behalf shall complete and sign the application. Use the information provided on the application to determine whether the woman meets the nonmedical requirements for presumptive eligibility.

Encourage the woman to apply for Medicaid by checking the "Medical Assistance" box on the application. This will allow Medicaid benefits to begin in a timely manner if the applicant meets eligibility requirements.

If the woman checked "Medical Assistance," "Facility or Waiver," or "Medicare savings program," photocopy the application. Keep the photocopy for your file. Within **two days** from the date of the presumptive determination, **send the original copy** of the application to the DHS office for the county in which the woman resides. (See the [Appendix](#) for a list of the addresses of local Human Services offices.)

If the woman requested WIC (Women, Infants, and Children nutrition program) or maternal and child health services, send a photocopy to the WIC program office that serves the woman's county of residence.

b. Issuing the Notice of Decision

The qualified provider shall:

- ◆ Base the eligibility decision on the information the woman provided on the *Health Services Application*, form 470-2927 or 470-2927(S).
- ◆ Complete the *Presumptive Medicaid Eligibility Notice of Decision*, form 470-2580 or 470-2580(S), to notify the woman of the presumptive eligibility decision.

(See [Presumptive Medicaid Eligibility Notice of Decision, Form 470-2580](#), for samples of this form. To use the Spanish version of the form, print or photocopy supplies from the sample in the manual.)

To complete the form, enter the name and address of the woman and the date of the notice in the spaces provided.

If the application has been approved:

- ◆ Enter "X" for the appropriate coverage group.
- ◆ Enter the woman's state identification number.

INSTRUCTIONS FOR HEALTH SERVICES APPLICATION

Complete this form if you live in Iowa and want to get:

- ◆ Medical Assistance (Title 19 or Medicaid) – provides health care coverage
Other programs within Medical Assistance Program are:
 - Facility Care – helps pay your nursing home cost
 - Medicaid for children in foster care or subsidized adoption
 - Waiver – helps keep people at home and not in a nursing home
 - Medicare Savings Program – pays all or part of your Medicare premium
 - State Supplementary Assistance (State Supp) – help for people who are at least 65 or disabled.
- ◆ WIC (Special Supplemental Nutrition Program for Women, Infants and Children) – helps with checks for special foods that can be used at Iowa grocery stores and pharmacies for pregnant and postpartum women, and children under the age of 5.
- ◆ Maternal and Child Health – provides health care services for children under the age of 21 and women of childbearing age.

This is not the right form if you want to get Food Assistance or cash assistance through the Family Investment Program (FIP).

Please do not let fear of the Immigration and Naturalization Service (INS) keep you from getting help for your family. Getting help will not keep you from gaining lawful, permanent residence, U.S. citizenship, or from sponsoring relatives.

To apply for help, follow these four easy steps:

- 1. Complete the Application**
Fill out and sign the application. Please be truthful. If you are applying for someone else, answer the questions as they relate to that person.
- 2. File the Application**
Mail or take it to the Department of Human Services (DHS) in your county. The date your help starts is based on the date the DHS office gets your application. Do not wait.
- 3. Provide Any Needed Proof**
See the table below for what is needed. Including copies of the proof will help speed up the processing of your application.
- 4. An Interview May Be Needed**
An interview may not be needed if you are applying only for a child. All adults applying for help must have an interview.

Needed Proof by Program

In addition to your application, please provide any proof needed for the program(s) you are applying for.

	Medical Assistance	Facility or Waiver	Medicare Savings Program	Foster Care-Sub Adoption	State Supp	WIC	Maternal and Child Services
Proof of who you are (ID): driver's license, birth certificate, etc.	✓	✓	✓	✓	✓	✓	✓
Proof you are a U.S. citizen or national (birth certificate with ID, U.S. passport, etc.)	✓	✓	✓	✓	✓		
Proof you have applied for a Social Security Number (if you don't already have one)	✓	✓	✓	✓	✓		
Proof of any health insurance premium paid: bill, pay stub showing deduction, etc.		✓		✓	✓		
Proof of income* or any other money coming into your household	✓	✓	✓	✓	✓	✓	✓
Proof of child care, dependent adult care costs, child support or alimony paid	✓		✓	✓	✓		
Most recent statements for any bank accounts: checking, credit union, savings, etc.**	✓	✓	✓	✓	✓		
Proof of current value of stocks/bonds, life insurance, certificates of deposit, trusts**	✓	✓	✓	✓	✓		
Proof of current living address						✓	✓

* Pay stubs from the last 30 days if you are employed or federal income tax records if you are self-employed. Award letters for Social Security Benefits, Veterans Benefits, etc.

** May not be needed if just applying for a child.

RIGHTS AND RESPONSIBILITIES – READ AND KEEP THIS SHEET

INFORMATION FOR ADULTS AND CHILDREN APPLYING FOR MEDICAL ASSISTANCE

- I understand I assume full responsibility for the accuracy of the statements on this form. I understand the Department of Human Services (DHS) will use this statement to determine my eligibility for Medical Assistance.
- I understand my eligibility will not be affected by my race, creed, color, national origin, age, disability, or sex, except where this is restricted by law.
- I understand that I have the right to a hearing if this application is denied or not acted upon promptly or if services granted are terminated, reduced, or suspended. I understand that I can get a hearing by making a request in writing to my local DHS office and that I may represent myself or use a lawyer, relative, friend, or other spokesperson.
- I am aware that my case may be picked by the Department for a complete Quality Control or other review of my eligibility for assistance. If my case is selected for verification, I will cooperate fully in the verification. I hereby authorize all persons to release confidential information concerning my eligibility to a DHS reviewer. I understand that failure to cooperate with such a review can result in denial or cancellation of benefits.
- I will notify my LOCAL DHS office within ten days of any changes in medical benefits or health insurance coverage. In addition, I understand that I am to notify my medical providers (doctors, pharmacist, etc.) if another party may be liable to pay my medical expenses. I will notify my LOCAL DHS office within ten days if I file an insurance claim or retain an attorney to seek payment for injuries and medical expenses resulting from those injuries that otherwise would be paid by Medicaid. Failure to comply with my responsibilities can give the Department cause to deny or terminate Medicaid eligibility.
- 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 understand that I am to reimburse the Department for any money paid to me or paid to a provider on my behalf to which I was not entitled.
- I further understand that the Department will provide documents or claim forms describing the services paid by Medicaid upon my request or the request of an attorney acting on my behalf. Such documents may also be provided to a third party when necessary to establish the extent of the Department's claim for reimbursement.
- I understand that federal and state law and rules permit access by authorized federal and state officials to Medicaid providers' records. I also fully understand that my acceptance of Medicaid is my consent for these authorized persons to have access to my medical and health care records during the time I am eligible for Medicaid, as necessary to verify appropriate Medicaid payment.
- I give my permission to tell my medical providers the status for my Medically Needy case, including the amount of my spenddown and their bills used to meet spenddown, or when a premium is due for Medicaid for Employed People with Disabilities.
- If I become enrolled in a managed health care plan, I consent to disclosure of medical information, including any clinical mental health or substance abuse information, by my medical providers to the HMO, PHP, other managed care providers or to the authorized administrative body contracted by the managed care provider to determine appropriateness, quality, or utilization of services I received while enrolled in managed health care.
- I understand that if Medical Assistance is approved, support payments intended for medical costs must be assigned and paid to the Department of Human Services to the extent of the benefits I receive. I understand that the Department may intervene, according but not limited to, Iowa Code Chapters 252A, 252B, 252C, 252D, 598, and 600B, to make claim and secure support from any person or party who may be responsible for my support or that of my children. I understand that if I receive Medicaid, the Department may pursue non-medical support for myself and my children unless I notify the Department that services unrelated to medical support are not wanted. Medical support services include the establishment of paternity and the establishment and enforcement of medical support.
- I am aware that Section 1128B of the Social Security Act provides federal penalties for fraudulent acts and false reporting. Anyone who obtains, or tries to obtain, or helps any other person to obtain public assistance to which the person is not entitled is guilty of violating the laws of the state of Iowa. These laws include, but are not limited to, Iowa Code Chapters 243, 239B, 249A, and 249A.
- I understand and agree that I will need to provide the Department with either documentation from the Immigration and Naturalization (INS) or other documents the Department considers to be proof of the immigration status of each person in my household who is not a United States citizen or national. I understand that alien status may be subject to verification with INS, which will require submission of certain information from this application form to INS. I further understand that information received from INS may affect my household's eligibility and level of benefits.
- If I filled out a separate application for food assistance and that application was referred to the Food Stamp Investigation Unit, I will cooperate with the investigation in order to receive Medicaid when the investigation involves income, resources and household composition that affect my Medicaid eligibility.
- I understand that the facts I give determine financial eligibility. A medical certification is also needed prior to approval for certain Medical Assistance programs. To determine medical certification, the Iowa Medicaid Enterprise (IME) Medical Services may need to contact my physician. I authorize my physician or health care provider to release information to IME Medical Services for this purpose. I agree to allow DHS to disclose the filing of this application to my nursing facility in order to obtain the level of care determination necessary for eligibility. A copy of this form received by fax will be given the same effect as the original.

MORE INFORMATION FOR ADULTS APPLYING FOR MEDICAL ASSISTANCE

- I will notify the LOCAL DHS office of any change in my information on this application, including but not limited to, anticipated income or property such as an inheritance, lump-sum payments on delinquent child support, or any change in income or living arrangements of myself or any other member of my family. If I have any doubt whether a particular change in circumstances is information that must be reported, I shall report this to my LOCAL office no later than ten days from the date the change occurs. I also understand that I am to pay back to the Department any money received by me or paid to a vendor on my behalf to which I was not entitled.
- I understand payments under the Medical Insurance Program (Part B of Medicare) will be made directly to the physicians and medical suppliers on any future unpaid bills for medical and other health services furnished me while eligible for Medicaid.
- I authorize the DHS to share information from this application, and information about my condition from the designated Assessment Tool with IME Medical Services for all home and community based service (HCBS) waivers and the Area Agency on Aging Case Management Team for my HCBS elderly waiver services.

INFORMATION FOR THOSE APPLYING FOR WIC OR MATERNAL AND CHILD HEALTH SERVICES

- I understand that a declaration of income and persons in my family and living in my household is necessary to ensure that federal and state funds are directed to those persons least able to secure services from other sources.
- I understand that the Maternal and Child Health Director of the Iowa Department of Public Health, the WIC Director, or their designees shall have access to all information available from records maintained by the agency providing maternal health, child health, or WIC services.

Iowa Department of Human Services
HEALTH SERVICES APPLICATION

HOUSEHOLD INFORMATION – Complete for all programs

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 & Address

Home Phone Number ()	Message Number ()	Name of Message Contact Person
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Check the program(s) you would like to receive:

<input type="checkbox"/> Medical Assistance (Title 19 or Medicaid)	<input type="checkbox"/> Maternal and Children Health Services
<input type="checkbox"/> Facility	<input type="checkbox"/> Medicare Savings Program
<input type="checkbox"/> Foster Care/Subsidized Adoption	<input type="checkbox"/> Waiver
<input type="checkbox"/> State Supplementary Assistance	<input type="checkbox"/> WIC
	<input type="checkbox"/> Iowa Family Planning Network

IF YOU NEED MORE ROOM TO ANSWER ANY OF THE FOLLOWING QUESTIONS, ATTACH EXTRA PAGES.

Start with yourself, then list all the people who live in your home.

NAME (First, Middle, Last)	Are you applying for this person?	How is this person related?	Medical services received in past 3 months? What month(s)?	Social Security Number	Sex	Birth Date	Birth State	Last Grade Completed	Citizen	Ethnicity*	Race**	If a child, is a parent NOT living with them?	Other health insurance available?
	<input type="checkbox"/> Yes <input type="checkbox"/> No	SELF	<input type="checkbox"/> Yes <input type="checkbox"/> No Month(s):		<input type="checkbox"/> Male <input type="checkbox"/> Female				<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		<input type="checkbox"/> Yes <input type="checkbox"/> No Month(s):		<input type="checkbox"/> Male <input type="checkbox"/> Female				<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		<input type="checkbox"/> Yes <input type="checkbox"/> No Month(s):		<input type="checkbox"/> Male <input type="checkbox"/> Female				<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		<input type="checkbox"/> Yes <input type="checkbox"/> No Month(s):		<input type="checkbox"/> Male <input type="checkbox"/> Female				<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		<input type="checkbox"/> Yes <input type="checkbox"/> No Month(s):		<input type="checkbox"/> Male <input type="checkbox"/> Female				<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

We have to ask your ethnicity and race, but you don't have to answer. Your answer won't affect how much you get or how soon. 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.

List pregnant persons who live in your home _____ Due Date (MMDDYY) _____

Are you interested in family planning services for females in your household who are at least 13 or under 45 years of age? Yes No

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, etc.

Person who received money	Employer or income source	Amount before taxes or deductions	How often is this amount paid?	Is this income expected to continue? If 'NO,' explain:
			<input type="checkbox"/> Weekly <input type="checkbox"/> Every other week <input type="checkbox"/> Monthly <input type="checkbox"/> Twice a month <input type="checkbox"/> Other _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Weekly <input type="checkbox"/> Every other week <input type="checkbox"/> Monthly <input type="checkbox"/> Twice a month <input type="checkbox"/> Other _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Weekly <input type="checkbox"/> Every other week <input type="checkbox"/> Monthly <input type="checkbox"/> Twice a month <input type="checkbox"/> Other _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Weekly <input type="checkbox"/> Every other week <input type="checkbox"/> Monthly <input type="checkbox"/> Twice a month <input type="checkbox"/> Other _____	<input type="checkbox"/> Yes <input type="checkbox"/> 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.

Person with resource	Type of resource	Amount or Value	Location (bank's name and address, home, etc.)

If you made the State of Iowa a remainder beneficiary on an annuity, in order to qualify for Medicaid payment of long-term care, the State of Iowa will get any benefits remaining in the annuity, up to the amount of Medicaid benefits paid.

Did anyone in your home sell or give away anything of value in the last 60 months? (This includes real and personal property; real estate; income; inheritance, etc.)

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? _____

Are you willing to cooperate to get medical support? Yes No (Answer if you are a parent or caretaker applying for self and a child.)

INFORMATION ABOUT THE PARENT(S) NOT LIVING IN THE HOME: List the name of any parent who is not living with you and the children you are applying for, who they are the parent of, their date of birth, and social security number. A child can still get medical assistance if you do not provide this information.

Name of parent not living in the home:	Name of children of this parent:	Date of birth of this parent:	Social security number of this parent:

SOCIAL SECURITY NUMBER (SSN)

You must fill in the SSN of all persons listed above on this application to get Medical Assistance. Section 1137(a)(1) of the Social Security Act and 42 CFR 435.910 requires this. If you do not want Medicaid, you do not have to give us your SSN. The SSN will be used:

- To check income, eligibility and amount of Medical Assistance payments to be made on your behalf.
- To determine another person's right to Medical Assistance.
- To comply with Federal law which requires release of information from Medicaid records.
- To match with records in other agencies such as: Social Security Administration, Internal Revenue Services, and Iowa Workforce Development. These matches may be done by computer or on an individual basis.

My rights and responsibilities were provided to me on the back of the instructions for this Health Services Application. I have read and removed the instruction sheet from this Health Services Application for my future use.

I CERTIFY THAT THESE STATEMENTS ARE CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF.

Signature or mark of applicant Date

Signature or mark of other Date
parent or stepparent in the home

Signature of person, if any, Date
who helped complete this form

INSTRUCCIONES PARA SOLICITUD DE SERVICIOS MÉDICOS

Completa esta forma si vive en Iowa y quiere obtener:

- ◆ Medical Assistance (Title 19 o Medicaid) – proporciona cobertura médica
Otros programas dentro del Medical Assistance Program son:
 - Facility Care – le ayuda a pagar los costos de casa para ancianos
 - Medicaid para niños bajo el cuidado de un hogar adoptivo o en adopción subvencionada
 - Waiver – ayuda a permanecer en sus hogares y no en casas para ancianos
 - Medicare Savings Program – paga todo o parte de su prima de Medicare
 - State Supplementary Assistance (State Supp) (Asistencia Estatal Complementaria) – ayuda para personas con 65 años o más o personas discapacitadas
- ◆ WIC (Programa Especial Suplemental de Nutrición para Mujeres, Infantes, y Niños) – ayuda con cheques para alimentos especiales que pueden ser utilizados en tiendas en Iowa y farmacias para mujeres embarazadas y post parto, y niños menores de 5 años.
- ◆ Maternal and Child Health – proporciona servicios de atención medica para niños menores de 21 años y mujeres en edad fértil.

Este no es el formulario adecuado si desea obtener Food Assistance (Asistencia Alimenticia) o ayuda en dinero a través del Family Investment Program (FIP).

Por favor no deje que el temor del Immigration and Naturalization Service (INS) no le permita obtener ayuda para su familia. Obtener ayuda no le quitara el poder obtener residencia permanente legalmente, ciudadanía de los E.U.A., o de poder patrocinar a sus parientes.

Para aplicar por ayuda, seguir los cuatro pasos fáciles:

- 1. Completar la Solicitud**
Llenar y firmar la solicitud. Por favor diga la verdad. Si está aplicando por alguien más, conteste las preguntas que tienen que ver con esa persona.
- 2. Llene la Solicitud**
Enviar por correo al Department of Human Services (DHS) en su condado. La fecha en que se inicia su ayuda está basada en la fecha en que la oficina de DHS reciba su solicitud. No espere.
- 3. Proporcione Cualquier Prueba Necesaria**
Ver la tabla a continuación para lo que se necesite. Incluyendo copias de las pruebas que ayudara a apresurar el proceso de su solicitud.
- 4. Se puede Necesitar Una Entrevista**
Una entrevista pueda no ser necesaria si está solicitando solo por un niño. Todos los adultos que solicitan ayuda deben tener una entrevista.

Prueba Necesaria para el Programa

Ademas de su solicitud, por favor proporcione cualquier prueba necesaria para el programa(s) que se estén solicitando.

	Medical Assistance	Facility or Waiver	Medicare Savings Program	Foster Care-Sub Adoption	State Supp	WIC	Maternal and Child Services
Prueba de quién es (I.D.) licencia de manejar, acta de nacimiento, etc.	✓	✓	✓	✓	✓	✓	✓
Prueba de que es ciudadano(a) o nacional de los EE.UU. (certificado de nacimiento, pasaporte de los EE.UU., etc.)	✓	✓	✓	✓	✓		
Prueba de solicitud para Número de Social Security (si aún no tiene uno)	✓	✓	✓	✓	✓		
Prueba de cualquier prima pagada de seguro médico: cuenta, talón de cheque demostrando la deducción, etc.		✓		✓	✓		
Prueba de ingreso * o cualquier dinero que entre en su hogar	✓	✓	✓	✓	✓	✓	✓
Prueba costos de cuidado para niños, adultos, manutención de niños/conyugue	✓		✓	✓	✓		
Reportes mensuales bancarios mas recientes; cheques, unión de crédito, ahorros, etc. **	✓	✓	✓	✓	✓		
Prueba del valor actual de valores/bonos, seguros de vida, certificados de deposito, fideicomisos **	✓	✓	✓	✓	✓		
Prueba de la presente dirección de domicilio						✓	✓

* Talón de cheque de los últimos 30 días si esta trabajando o récords de impuesto de ingreso federal si se tiene negocio propio. Cartas de Beneficios de Social Security, Beneficios de Veteranos, etc.

** Pueda que no sea necesario si solo esta solicitando por un niño.

DERECHOS Y RESPONSABILIDADES - LEA Y CONSERVE ESTA HOJA

INFORMACIÓN PARA ADULTOS Y NIÑOS SOLICITANDO PARA MEDICAL ASSISTANCE

- Yo tengo entendido que yo asumo total responsabilidad por la certeza de las declaraciones en esta forma. Yo entiendo que el Department of Human Services (DHS) usara esta declaración para determinar mi elegibilidad para Medical Assistance.
- Entiendo que mi elegibilidad no se verá afectada por mi raza, credo, color, origen nacional, edad, discapacidad o sexo, excepto cuando esto sea restringido por la ley.
- Yo tengo entendido que yo tengo el derecho de una audiencia si esta solicitud es negada o no es manejada rápidamente o si los servicios otorgados son cancelados, reducidos o suspendidos. Entiendo que puedo obtener una audiencia solicitándola por escrito a la oficina local del DHS y que puedo representarme a mí mismo, pedir la ayuda de un abogado, pariente, amigo u otro portavoz.
- Yo se que mi caso puede ser escogido por el Departamento para una completa revisión de Quality Control o cualquier otra de la elegibilidad para asistencia. Si mi caso es seleccionado para verificación, yo cooperare en total para la verificación. Yo en esta forma doy mi autorización a todas las personas para divulgar información confidencial relacionada con mi elegibilidad a una persona que revise para DHS. Yo entiendo que fallar en cooperar con dicha persona puede resultar en la negación o cancelación de los beneficios.
- Notificaré a la oficina del DHS LOCAL, en un plazo no mayor a diez días sobre cualquier cambio en los beneficios médicos o en el cubrimiento del seguro de salud. Además, yo entiendo que yo debo notificar a mi proveedor médico (doctores, farmacia, etc.) si alguna otra parte pueda ser responsable de pagar mis gastos médicos. Notificaré a la oficina del DHS LOCAL, en un plazo no mayor a diez días, si presento una reclamación o contrato a un abogado para solicitar la indemnización por heridas y gastos médicos que resulten de aquellas heridas, que de otra forma hubieran sido cubiertos por Medicaid. Fallar en cumplir con mis responsabilidades puede dar al Department causa de negar o terminar mi elegibilidad de Medicaid.
- Acepto entregar a la agencia Medicaid los pagos de gastos médicos realizados por terceros para mí y otras personas elegibles para Medicaid, para las cuales yo estoy legalmente autorizada a asignar beneficios. Además, acepto cooperar para obtener pagos de gastos médicos provenientes de terceros.
- Yo entiendo que yo debo reembolsar al Department por cualquier dinero pagado a mi o pagado a un proveedor a mi favor al cual yo no tenga derecho.
- Es mas yo entiendo que el Department puede proporcionar documentos o formas de demanda describiendo los servicios pagados por Medicaid cuando yo lo pida o a la petición de un abogado actuando a mi favor. Dichos documentos puedan también ser proporcionados a una tercera parte cuando sea necesario para establecer el punto en que la demanda del Department sea reembolsada.
- Yo entiendo que las leyes Federales y Estatales y las reglas permiten el acceso a oficiales Federales y Estatales autorizados para récords de Medicaid. Yo también entiendo en su totalidad que mi aceptación de Medicaid es mi consentimiento para que estas personas autorizadas tengan acceso a mis récords de atención medica durante el tiempo que yo sea elegible para Medicaid, como sea necesario para verificar los pagos apropiados de Medicaid.
- Concedo autorización para revelar a quienes me proporcionan asistencia médica el estado de mi caso de Medically Needy (Médicamente Necesitado), incluyendo el monto de mi Spenddown (la parte no cubierta por Medicaid), o en los casos que deba una prima a Medicaid for Employed People with Disabilities (Medicaid por Personas Discapacitadas Empleadas).
- Si yo quedo registrado en un plan de cuidado medico manejado, yo doy consentimiento de la divulgación de información medica, incluyendo cualquier salud mental clínica o información de abuso de substancia, por mis proveedores médicos al HMO, PHP, otros proveedores de cuidado medico manejado o al cuerpo administrativo autorizado contratado por el proveedor de cuidado medico manejado para determinar apropiacion, calidad, o utilización de servicios que yo he recibido cuando estuve registrado en el cuidado medico manejado.
- Yo entiendo que si el Medical Assistance es aprobado, pagos de apoyo intencionados para costos médicos deberán ser asignados y pagados por el Department of Human Services al punto de que los beneficios que yo reciba. Yo entiendo que el Department puede intervenir, conforme pero no limitandose, al Código de Iowa Capitulo 252^a, 252B, 252C, 252D, 598, y 600B, para hacer reclamo y asegurar el apoyo de cualquier persona o parte que pudiera ser responsable por mi manutención o de mis hijos. Yo entiendo que si yo recibo Medicaid, el Department puede pedir manutención no-medica para mi y mis hijos a menos que yo notifique al Department que los servicios relacionados al apoyo medico no son deseados. Servicios de apoyo medico incluyen el establecimiento de paternidad y el establecimiento y obligación de apoyo medico.
- Yo se que la Sección 1128B del Social Security Act dice que los castigos Federales por actos fraudulentos y por reportes falsos. Cualquiera que obtenga, o trate de obtener, o ayuda a otra persona a obtener asistencia publica a la cual la persona no tiene derecho es culpable de violación de las leyes del Estado de Iowa. Estas leyes incluyen, pero no están limitadas a, Código de Iowa Capitulo 243, 293B, 249 A, y 249A.
- Yo entiendo y estoy de acuerdo que yo necesitare proporcionar al Department con cualquier documentación de Immigration and Naturalization (INS) o cualquier otro documento que el Department considere ser prueba de mi situación de inmigración de cada persona en mi hogar que no sea un ciudadano de los Estados Unidos o nacional. Yo entiendo que la situación de extranjero puede ser sujeta a verificación con INS, lo cual puede requerir la entrega de cierta información de esta solicitud a INS. Yo además entiendo que la información recibida de INS puede afectar la elegibilidad de mi hogar y el nivel de beneficios.
- Si diligencio una solicitud separada para asistencia alimenticia, y dicha aplicación es remitida a la Food Stamp Investigation Unit (Unidad de Investigación de Estampillas de Alimentos), cooperaré con la investigación para recibir Medicaid cuando la investigación se refiera a ingresos recursos y composición del hogar que pueda afectar mi elegibilidad para Medicaid.
- Yo entiendo que los hechos que yo proporcione determinaran mi elegibilidad financiera. Una certificación medica es también necesaria antes de la aprobación para ciertos programas de Medical Assistance. Para determinar la certificación medica, el Iowa Medicaid Enterprise (IME) Medical Services puede necesitar contactar a mi medico. Yo autorizo a mi medico a mi proveedor de cuidado médico el divulgar información a IME Medical Services para este proposito. Yo estoy de acuerdo de permitir a DHS el divulgar el registro de esta solicitud a mi facilidad de cuidado a fin de obtener el nivel de determinación de cuidado necesario por elegibilidad. Una copia de este formulario recibido por fax tendrá el mismo efecto que el original.

MAS INFORMACIÓN PARA ADULTOS SOLICITANDO PARA ASISTENCIA MEDICA

- Notificaré a la oficina del DHS LOCAL acerca de cualquier cambio en la información de esta aplicación, incluyendo, pero sin limitarse a ingresos anticipados o propiedad tales como una herencia, pagos integrales para el apoyo a niños delincuentes, o cualquier cambio en el ingreso o en mi vivienda o en la de cualquier otro miembro de mi familia. Si tengo alguna duda sobre si un cambio particular en las circunstancias, es información que debe ser informada, reportaré eso a mi oficina LOCAL dentro de los diez días siguientes a la fecha en que el cambio se presente. Yo también entiendo que yo debo reembolsar al Department cualquier dinero recibido por mi o pagado a un vendedor a mi nombre al cual yo no tenga derecho.
- Yo entiendo que los pagos bajo el Medical Insurance Program (Part B de Medicare) se haran directamente a los médicos y a los proveedores médicos de cualquier factura no pagada por servicios de atención medica que se me haya proporcionado cuando tenia elegibilidad de Medicaid.
- Yo autorizo a DHS a proporcionar información de esta solicitud, información sobre de mi condición del designado Assesment Tool con IME Medical Services para todos los servicios a mi hogar y comunidad (HCBS) renuncias de derecho y el Area Agency en Aging Case Management Team para mi HCBS renuncia de mis derechos de servicios para persona de edad avanzada.

INFORMACIÓN PARA AQUELLOS SOLICITANDO PARA WIC O SERVICIOS MATERNIDAD Y CUIDADO PARA NIÑOS

- Yo entiendo que una declaración de ingreso y personas en mi familia y viviendo en mi hogar es necesario para asegurar que fondos Federales y Estatales sean dirigidos a esas personas que tengan menos habilidad para asegurar servicios de otros recursos.
- Yo entiendo que el Maternal and Child Health Director of the Iowa Department of Public Health, el Director de WIC, o sus asignados deberán tener acceso a toda la información disponible de los récords que son mantenidos por la agencia proporcionando salud maternal, salud a niños, o servicios WIC.

HEALTH SERVICES APPLICATION (SOLICITUD DE SERVICIOS MÉDICOS)

INFORMACIÓN DEL HOGAR - Completar para todos los programas				
Primer Nombre	Segundo Nombre	Apellido Nombre		
Dirección del Hogar	Ciudad	Estado	Condado	Código
Dirección Postal (si es diferente a la anterior) O Nombre y Dirección del Pagador				
Numero Tel. Hogar ()	Número Mensajería ()	Nombre del Mensaje Persona Contacto		
Marcar los programas que usted quiere recibir: <input type="checkbox"/> Medical Assistance (Title 19 or Medicaid) <input type="checkbox"/> Maternal and Children Health Services <input type="checkbox"/> Facility <input type="checkbox"/> Medicare Savings Program <input type="checkbox"/> Waiver <input type="checkbox"/> WIC <input type="checkbox"/> Foster Care/Subsidized Adoption <input type="checkbox"/> State Supplementary Assistance (Renuncia) <input type="checkbox"/> Iowa Family Planning Network				
SI USTED NECESITA MAS ESPACIO PARA CONTESTAR CUALQUIERA DE LAS SIGUIENTES PREGUNTAS, ADJUNTAR HOJAS ADICIONALES				

Empezar con usted mismo, entonces enumera todas las personas que viven en su hogar.

NOMBRE (Primer, Segundo, Apellido)	¿Solicita por esta persona?	¿Cual relación con esta persona?	¿Servicios recibidos en 3 meses? ¿cuales meses?	Social Security Number	Genero	Fecha Nacimiento	Estado de nacimiento	Ultimo grado de escuela	Ciudadano	Raza *	¿Si es niño, los padres NO viven con el?	Otro Seguro Medico Disponible?
	<input type="checkbox"/> Si <input type="checkbox"/> No	MISMO	<input type="checkbox"/> Si <input type="checkbox"/> No Meses:		<input type="checkbox"/> Masc. <input type="checkbox"/> Fem.				<input type="checkbox"/> Si <input type="checkbox"/> No		<input type="checkbox"/> Si <input type="checkbox"/> No	<input type="checkbox"/> Si <input type="checkbox"/> No
	<input type="checkbox"/> Si <input type="checkbox"/> No		<input type="checkbox"/> Si <input type="checkbox"/> No Meses:		<input type="checkbox"/> Masc. <input type="checkbox"/> Fem.				<input type="checkbox"/> Si <input type="checkbox"/> No		<input type="checkbox"/> Si <input type="checkbox"/> No	<input type="checkbox"/> Si <input type="checkbox"/> No
	<input type="checkbox"/> Si <input type="checkbox"/> No		<input type="checkbox"/> Si <input type="checkbox"/> No Meses:		<input type="checkbox"/> Masc. <input type="checkbox"/> Fem.				<input type="checkbox"/> Si <input type="checkbox"/> No		<input type="checkbox"/> Si <input type="checkbox"/> No	<input type="checkbox"/> Si <input type="checkbox"/> No
	<input type="checkbox"/> Si <input type="checkbox"/> No		<input type="checkbox"/> Si <input type="checkbox"/> No Meses:		<input type="checkbox"/> Masc. <input type="checkbox"/> Fem.				<input type="checkbox"/> Si <input type="checkbox"/> No		<input type="checkbox"/> Si <input type="checkbox"/> No	<input type="checkbox"/> Si <input type="checkbox"/> No
	<input type="checkbox"/> Si <input type="checkbox"/> No		<input type="checkbox"/> Si <input type="checkbox"/> No Meses:		<input type="checkbox"/> Masc. <input type="checkbox"/> Fem.				<input type="checkbox"/> Si <input type="checkbox"/> No		<input type="checkbox"/> Si <input type="checkbox"/> No	<input type="checkbox"/> Si <input type="checkbox"/> No

Debemos preguntarle su origen étnico y raza, pero usted no está obligado/a a contestar. Su respuesta no afectará cuánto reciba o con qué rapidez. Si contesta, utilice la siguiente codificación:

* Origen étnico: H = Hispano o Latino; N = No Hispano ni Latino

** Raza (Seleccione todas las que correspondan): W = Blanca; B = Negra o Afroamericana; A = Asiática; I = Amerindia o Nativas de Alaska; N = Nativas de Hawai u otras islas del Pacífico.

Liste las personas embarazadas que viven en su hogar _____

Plazo (MMDDAA) _____

¿Está usted interesado en servicios de planificación familiar para las mujeres de su hogar que tengan entre 13 y 45 años de edad?

Si

No

INGRESO: Enumere todo el ingreso que las personas que viven en su hogar obtiene. Incluye ingresos laborales, como trabajador independiente, la Seguridad Social, Beneficios para Veteranos, Seguro de desempleo, sostenimiento de niños, indemnizaciones de trabajadores, Retiro de los Ferrocarriles, IPERS, servicio civil, dinero de amigos o parientes, etc.

Persona que recibe el dinero	Patrón o fuente de Ingreso	Cantidad antes de impuestos o deducciones	¿Que tan seguido se paga?	¿Se espera que este ingreso continúe? si NO explicar:
			<input type="checkbox"/> Semanal <input type="checkbox"/> Semana terciada <input type="checkbox"/> Mensual <input type="checkbox"/> Dos al mes <input type="checkbox"/> Otro _____	<input type="checkbox"/> Si <input type="checkbox"/> No
			<input type="checkbox"/> Semanal <input type="checkbox"/> Semana terciada <input type="checkbox"/> Mensual <input type="checkbox"/> Dos al mes <input type="checkbox"/> Otro _____	<input type="checkbox"/> Si <input type="checkbox"/> No
			<input type="checkbox"/> Semanal <input type="checkbox"/> Semana terciada <input type="checkbox"/> Mensual <input type="checkbox"/> Dos al mes <input type="checkbox"/> Otro _____	<input type="checkbox"/> Si <input type="checkbox"/> No
			<input type="checkbox"/> Semanal <input type="checkbox"/> Semana terciada <input type="checkbox"/> Mensual <input type="checkbox"/> Dos al mes <input type="checkbox"/> Otro _____	<input type="checkbox"/> Si <input type="checkbox"/> No

RECURSOS: Un recurso es dinero en efectivo o cualquier cosa que pueda canjearse por dinero. Enumerar todos los recursos y la cantidad o valor. Incluya dinero en efectivo disponible, cuentas corrientes, vehículos, seguros de vida, títulos valores, bonos, certificados de depósitos (CDs), fondos fiduciarios, cuentas de jubilación, contratos de entierro, espacios de entierro, anualidades, etc. Si solo se aplica la cobertura por un niño, los recursos no deberán contarse.

Persona con recurso	Tipo de recurso	Cantidad o Valor	Lugar (nombre del banco, y dirección, hogar, etc.)

Si usted designó al Estado de Iowa como beneficiario residual de una anualidad, a fin de calificar para un pago de Medicaid de un cuidado de largo plazo, el Estado de Iowa obtendrá cualquier beneficio restante de la anualidad, hasta el monto de los beneficios pagados por Medicaid.

¿Alguien en su hogar vendió o cedió algo de valor en los últimos 60 meses? (Esto incluye propiedades reales o personales, bienes inmobiliarios, ingresos, herencias, etc.) Si No

¿Alguien en el hogar paga manutención para niños o conyugue para una persona que no viva con ustedes? Si No

Si es si, ¿quién paga? _____ ¿Cantidad? _____

Alguien en el hogar paga a alguien para que cuide a un niño o aun adulto incapacitado? Si No

Si es si, ¿quién paga? _____ Que tan seguido? _____ ¿A quien? _____

¿Está dispuesto a cooperar para obtener apoyo medico? Si No (Contestar si usted es padre o quien está cuidando y está solicitando por si mismo y un niño.)

INFORMACIÓN SOBRE DE LOS PADRES QUE NO VIVEN EN EL HOGAR: Dar el nombre de cualquiera de los padres que no estén viviendo con usted y los niños por quién esta solicitando, quienes son estos padres, sus fechas de nacimiento, números de social security. Un niño puede obtener asistencia médica si usted no proporciona esta información.

Nombre del padre que no vive en casa:	Nombre del hijo de este padre:	El padre nació, fecha:	Número de Social Security de este padre:

NUMERO DE SOCIAL SECURITY (SSN)

Debe poner el SSN de todas las personas mencionadas en esta solicitud para obtener Medical Assistance. La Sección 1137(a)(1) del Social Security Act y el 42 CFR 435.910 requiere esto. Si usted no quiere Medicaid, usted no tiene que darnos su SSN. El SSN será utilizado:

- Para checar el ingreso, elegibilidad y la cantidad de pagos de Medical Assistance que se harán a su favor.
- Para determinar el derecho de otras personas a Medical Assistance.
- Para cumplir con las leyes Federales que requieren divulgación de información para récords de Medicaid.
- Para comparar con récords en otras agencias tales como: Social Security Administration, Internal Revenue Services, y Iowa Workforce Development. Estas comparaciones de pueden hacer por una computadora e un base individual.

Mis derechos y responsabilidades me serán proporcionados en la parte de atrás de las instrucciones de esta Health Services Application. Yo he leído y quitado la hoja de las instrucciones de esta Health Services Application para mi uso futuro.

YO CERTIFICO QUE ESTAS DECLARACIONES SON CORRECTAS A LO MEJOR DE MI CONOCIMIENTO Y CREENCIA.

Firma o marca del solicitante

Fecha

Firma o marca de otro padre o padrastro
en el hogar

Fecha

Firma de la persona, si hay que haya
ayudado a completar esta forma

Fecha

6/22/2009



Medicaid Enterprise

Provider and Chapter

All Providers

Chapter II. Member Eligibility

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Date

July 1, 2009

- ◆ Enter the date the presumptive eligibility period begins. This date is usually the same date as the date on which the notice is being completed.
- ◆ Enter the date the presumptive eligibility period ends. This is the last day of the month following the month of the presumptive eligibility determination.
- ◆ Enter an "X" to indicate whether the *Health Services Application* has been submitted to the Department of Human Services. If so, indicate the local office it was sent to.

If presumptive eligibility is denied:

- ◆ Enter an "X" in the applicable box.
- ◆ Provide an explanation of the denial (such as, "You are over income" or "You have creditable insurance coverage").

Enter the name, address, and telephone number of the qualified provider making the determination in the spaces indicated.

Give the original copy to the woman. Keep a copy in the woman's file. Within five days of your determination, send a copy to the Department of Human Services office for the county in which the woman resides.

 Medicaid Enterprise Department of Human Services	Provider	Page
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APPENDIX

A. ADDRESSES OF LOCAL HUMAN SERVICES OFFICES

County and Area Manager	Phone Numbers	Location	Mailing Address (if different)
Adair			
Wendy Rickman	641-743-2119 888-462-2931	400 Public Square Greenfield IA 50849	
Adams			
Wendy Rickman	641-322-4031	Courthouse Corning IA 50841	500 Ninth Street Corning IA 50841
Allamakee			
Gary Lippe	563-382-2928 800-611-7781	Courthouse Waukon IA 52172	
Appanoose			
Marc Baty	641-437-4450 888-820-0804	209 East Jackson Centerville IA 52544	PO Box 488 Centerville IA 52544
Audubon			
Thomas Bouska	866-202-5968	210 North Market Audubon IA 50025	
Benton			
Marc Baty	319-472-4746 888-480-0062	114 East Fourth St Vinton IA 52349	
Black Hawk			
Evan Klenk	319-291-2441	1407 Independence Ave Waterloo IA 50704	PO Box 7500 Waterloo IA 50704-7500
Boone			
Wendy Rickman	515-433-0593 800-753-2136	900 West Third Street Boone IA 50036	
Bremer			
Evan Klenk	319-352-4233 888-887-4296	209 20th Street NW Waverly IA 50677	PO Box 822 Waverly IA 50677
Buchanan			
Gary Lippe	319-334-6091 800-642-6609	1415 First Street West Independence IA 50644	PO Box 753 Independence IA 50644



County and Area Manager	Phone Numbers	Location	Mailing Address (if different)
Buena Vista Pat Penning	712-749-2536 800-205-8893	311 East Fifth Street Storm Lake IA 50588	
Butler Evan Klenk	319-267-2594 800-873-1340	713 Elm Street Allison IA 50602	PO Box 306 Allison IA 50602
Calhoun Kenneth Riedel	712-297-8524 877-529-6873	515 Court Street Rockwell City IA 50579	PO Box 71 Rockwell City IA 50579
Carroll Thomas Bouska	712-792-4391 866-202-5968	608 North Court Suite C Carroll IA 51401	
Cass Thomas Bouska	712-243-4401 877-455-3211	601 Walnut Street Atlantic IA 50022	
Cedar Denise Gonzales	563-263-9302 877-272-0614	120 East Third Street 4 th Floor Muscatine IA 52761	
Cerro Gordo Evan Klenk	641-424-8641 800-217-6903	Mohawk Square Suite 1 Mason City IA 50401	22 North Georgia Ave Mason City IA 50401
Cherokee Pat Penning	712-225-6723 866-640-7087	239 West Maple Cherokee IA 51012	
Chickasaw Evan Klenk	641-228-5713 888-417-9027	910 East Main New Hampton IA 50659	
Clarke Wendy Rickman	641-342-6516	109 South Main Osceola IA 50213	
Clay Pat Penning	712-262-3586 866-536-2749	217 West Fifth Street Spencer IA 51301	
Clayton Gary Lippe	563-422-5634 800-632-0014	Clayton Co. Office Bldg. Elkader IA 52043	100 Sandpit Road Elkader IA 52043
Clinton Gary Lippe	563-242-0573 800-798-4737	121 Sixth Avenue Clinton IA 52733	PO Box 1180 Clinton IA 52733



County and Area Manager	Phone Numbers	Location	Mailing Address (if different)
Crawford Thomas Bouska	712-263-5668 800-396-9027	1527 Fourth Avenue So Denison IA 51442	
Dallas Wendy Rickman	515-993-5817 800-397-3232	210 North 10 th Street Adel IA 50003	
Davis Marc Baty	641-664-2239 888-338-6067	203 South Madison Bloomfield IA 52537	PO Box 107 Bloomfield IA 52537
Decatur Wendy Rickman	641-446-4312	210 North Main Street Leon IA 50144	
Delaware Gary Lippe	563-927-4512 866-927-4512	721 South Fifth St Manchester IA 52057	PO Box 500 Manchester IA 52057
Des Moines Denise Gonzales	319-754-4622 800-423-4724	560 Division, Suite 200 Burlington IA 52601	
Dickinson Pat Penning	712-336-2555 866-336-2555	Dickinson County Courthouse Spirit Lake IA 51360	1802 Hill Avenue Spirit Lake IA 51360
Dubuque Gary Lippe	563-557-8251 800-650-6361	799 Main Street 410 Nesler Centre Dubuque IA 52004	PO Box 87 Dubuque IA 52004
Emmet Pat Penning	712-362-7237 800-449-6540	220 South First Street Estherville IA 51334	
Fayette Gary Lippe	563-422-5634 800-632-0014	129A North Vine West Union IA 52175	PO Box 476 West Union IA 52175
Floyd Evan Klenk	641-228-5713 888-417-9027	1206 South Main Charles City IA 50616	PO Box 158 Charles City IA 50616
Franklin Evan Klenk	800-873-1340	123 First Avenue SW Hampton IA 50441	



County and Area Manager	Phone Numbers	Location	Mailing Address (if different)
Fremont Thomas Bouska	800-486-1269	414 Clay Street Sidney IA 51652	
Greene Thomas Bouska	515-386-2143 866-202-5968	Courthouse Jefferson IA 50129	114 North Chestnut Jefferson IA 50129
Grundy Evan Klenk	319-267-2594 888-887-4296 800-873-1340	704 H Avenue Grundy Center IA 50638	
Guthrie Thomas Bouska	877-455-3211 866-202-5968	Courthouse Guthrie Center IA 50115	200 North Fifth Street Guthrie Center IA 50115
Hamilton Kenneth Riedel	515-832-9555 800-944-1764	2300 Superior Street Webster City IA 50595	
Hancock Evan Klenk	641-585-3271 866-707-3271	Courthouse Annex Garner IA 50438	120 East Eighth Street Garner IA 50438
Hardin Kenneth Riedel	641-939-8141 877-486-8141	1201 – 14th Avenue Eldora IA 50627	
Harrison Thomas Bouska	712-644-2460 800-326-7732	204 East Sixth Street Logan IA 51546	PO Box 189 Logan IA 51546
Henry Denise Gonzales	319-986-5157 800-824-4295	205 West Madison Mt Pleasant IA 52641	
Howard Gary Lippe	563-382-2928 800-611-7781	205 East Second Street Cresco IA 52136	
Humboldt Kenneth Riedel	515-332-3383 877-529-6873	Courthouse Dakota City IA 50529	PO Box 656 Humboldt IA 50548
Ida Pat Penning	712-225-6723 866-640-7087	401 Moorehead Ida Grove IA 51445	239 West Maple Cherokee IA 51012
Iowa Marc Baty	319-472-4746 888-480-0062	950 Franklyn Avenue Marengo IA 52301	



County and Area Manager	Phone Numbers	Location	Mailing Address (if different)
Jackson Gary Lippe	563-672-9501 800-237-0089	18720 – 250 th Avenue Bellevue IA 52031	
Jasper Kenneth Riedel	641-792-1955 800-342-0829	115 North Second Ave. E Suite H Newton IA 50208	
Jefferson Marc Baty	641-472-5011 800-642-6249	51 West Hempstead Fairfield IA 52556	PO Box 987 Fairfield IA 52556
Johnson Marc Baty	319-356-6050 866-886-9207	Service Unit	
	319-339-6127 866-405-6811	Income Maintenance Unit 855 South Dubuque St. Suite 102 Iowa City, IA 52240	
Jones Marc Baty	319-462-3557 800-765-3522	500 West Main Street Anamosa IA 52205	
Keokuk Marc Baty	641-622-2090 800-745-1481	1303 South 200th Ave. Sigourney IA 52591	PO Box 308 Sigourney IA 52591
Kossuth Pat Penning	515-295-7771 800-840-6525	109 West State Street Algona IA 50511	
Lee (North Office) Denise Gonzales	319-372-3651 888-381-6851	Workforce Center 610 Eighth Street Fort Madison IA 52627	PO Box 188 Fort Madison IA 52627
Lee (South Office) Denise Gonzales	319-524-1052 888-790-9757	307 Bank Street Keokuk IA 52632	PO Box 937 Keokuk IA 52632
Linn Marc Baty	319-892-6700 866-534-3112	411 Third Street SE Suite 300 & 400 Cedar Rapids IA 52401	411 Third Street SE Suite 160 Cedar Rapids IA 52401



County and Area Manager	Phone Numbers	Location	Mailing Address (if different)
Louisa			
Denise Gonzales	319-754-4622 800-423-4724	Service & Adult IM Units 409 North Fourth Burlington IA 52601	
Lucas			
Wendy Rickman	641-774-5071 888-818-1900	125 South Grand Chariton IA 50049	PO Box 377 Osceola IA 50213
Lyon			
Pat Penning	712-737-2943 800-337-2943	315 First Avenue Suite 210 Rock Rapids IA 51246	PO Box 375 Orange City IA 51041
Madison			
Wendy Rickman	515-462-2931 888-462-2931	209 East Madison Winterset IA 50273	
Mahaska			
Marc Baty	641-673-3496 800-407-6250	410 South 11th Street Oskaloosa IA 52577	PO Box 290 Oskaloosa IA 52577
Marion			
Wendy Rickman	641-842-5087 800-798-5524	3014 East Main Knoxville IA 50138	PO Box 191 Knoxville IA 50138
Marshall			
Kenneth Riedel	641-752-6741 800-714-4588	206 West State Street Marshalltown IA 50158	
Mills			
Thomas Bouska	712-527-4803 800-486-1269	101 Central Suite 124 Glenwood IA 51534	PO Box 469 Glenwood IA 51534
Mitchell			
Evan Klenk	888-417-9027	415 Pleasant Osage IA 50461	
Monona			
Thomas Bouska	800-326-7732	Courthouse Onawa IA 51040	610 Iowa Avenue Onawa IA 51040
Monroe			
Marc Baty	641-932-5187 888-818-2500	103 South Clinton Albia IA 52531	PO Box 176 Albia IA 52531
Montgomery			
Thomas Bouska	712-623-4838	1109 Highland Red Oak IA 51566	PO Box 525 Red Oak IA 51566



County and Area Manager	Phone Numbers	Location	Mailing Address (if different)
Muscatine			
Denise Gonzales	563-263-9302 877-272-0614	120 East Third Street 4th Floor Muscatine IA 52761	
O'Brien			
Pat Penning	712-957-5135 800-392-3895	160 Second Street SE Primghar IA 51245	PO Box 400 Primghar IA 51245
Osceola			
Pat Penning	712-957-5135 800-392-3895	300 Seventh Street Sibley IA 51249	PO Box 400 Primghar IA 51245
Page			
Thomas Bouska	712-542-5111 877-996-1199	121 South 15th Suite C Clarinda IA 51632	PO Box 178 Clarinda IA 51632
Palo Alto			
Pat Penning	800-449-6540 800-840-6525	2105 Main Emmetsburg IA 50536	220 South First St. Estherville IA 51334
Plymouth			
Pat Penning	712-546-8877 800-546-8870	19 Second Avenue NW LeMars IA 51031	
Pocahontas			
Kenneth Riedel	712-335-3565 877-529-6873	23 Third Avenue NE Pocahontas IA 50574	PO Box F Pocahontas IA 50574
Polk (Administrative)			
Wendy Rickman	515-725-2600	River Plaza 2309 Euclid Avenue Des Moines IA 50310	
Polk (Central)			
Wendy Rickman	515-286-3555	1900 Carpenter Des Moines IA 50314-1309	
Polk (East)			
Wendy Rickman	515-286-3270	1740 Garfield Des Moines IA 50316-2646	
Polk (Refugee Services)			
Wendy Rickman	515-283-7999	1200 University Avenue Des Moines IA 50314-2334	
Pottawattamie			
Thomas Bouska	712-328-5661 866-788-1805	417 E Kaneshville Blvd Council Bluffs IA 51503	



County and Area Manager	Phone Numbers	Location	Mailing Address (if different)
Poweshiek Kenneth Riedel	641-236-3149	927 Broad Street Grinnell IA 50112	
Ringgold Wendy Rickman	641-464-2247	Courthouse Mount Ayr IA 50854	109 West Madison Mount Ayr IA 50854
Sac Thomas Bouska	866-202-5968	116 South State Street Suite B Sac City IA 50583-2350	
Scott Denise Gonzales	563-326-8794 563-326-8680	600 West Fourth Street 2 nd Floor – IM Unit 3 rd Floor – Service Unit Davenport IA 52801	
Shelby Thomas Bouska	800-396-9027	612 Court Street 1 st Floor Harlan IA 51537	
Sioux Pat Penning	712-737-2943 800-337-2943	215 Central Avenue SE Orange City IA 51041	PO Box 375 Orange City IA 51041
Story Kenneth Riedel	515-292-2035 800-232-7347	126 South Kellogg Suite 101 Ames IA 50010	
Tama Kenneth Riedel	641-484-3406	129 West High Street Toledo IA 52342	
Taylor Thomas Bouska	877-996-1199	309 Main Bedford IA 50833	
Union Wendy Rickman	641-782-1745	300 North Pine Street Suite 9 Creston IA 50801	
Van Buren Marc Baty	319-293-3791	Court House Keosauqua IA 52565	



County and Area Manager	Phone Numbers	Location	Mailing Address (if different)
Wapello Marc Baty	641-682-8793 888-338-6067	120 East Main Ottumwa IA 52501	PO Box 457 Ottumwa IA 52501
Warren Wendy Rickman	515-961-5353 800-286-6424	901 East Iowa Indianola IA 50125	PO Box 729 Indianola IA 50125
Washington Marc Baty	319-863-0049 866-863-0061	2175 Lexington Blvd Building 3 Washington IA 52353	PO Box 519 Washington IA 52353
Wayne Wendy Rickman	641-872-1820	117 West Jackson Corydon IA 50060	
Webster Kenneth Riedel	515-955-6353 877-529-6873	330 First Avenue N Fort Dodge IA 50501	
Winnebago Evan Klenk	641-585-3271 866-707-3271	126 South Clark Street Forest City IA 50436	
Winneshiek Gary Lippe	563-382-2928 800-611-7781	2307 US Hwy 52 S Decorah IA 52101	PO Box 286 Decorah IA 52101
Woodbury Pat Penning	712-255-0833 877-259-4992	Trosper-Hoyt County Services Bldg Sioux City IA	822 Douglas Street Sioux City IA 51101-1024
Worth Evan Klenk	800-217-6903	95 Ninth Street North Northwood IA 50459	
Wright Kenneth Riedel	515-532-6645 800-873-1759	114 First Street SW Clarion IA 50525	PO Box 346 Clarion IA 50525



B. ADDRESSES OF SOCIAL SECURITY ADMINISTRATION OFFICES

Patients may also use the toll-free number, 1-800-772-1213, to reach any office. Directions to the office and office hours are available on the Internet at: www.socialsecurity.gov.

Social Security Office	Phone Number	Counties Served
Ames 600 5th St Ste 100 Ames IA 50010	866-899-1928	Boone Dallas Story
Burlington 3012 Division St Burlington IA 52601	866-572-8381	Des Moines Henry Lee Louisa
Carroll 818 Bella Vista Drive Carroll IA 51401	866-572-8381	Audubon Carroll Crawford Greene Guthrie Shelby
Cedar Rapids 3165 Williams Blvd SW Cedar Rapids IA 52402	319-393-0045	Benton Iowa Jones Linn
Clinton 226 Fourth Ave S Clinton IA 52732	563-243-5002	Clinton
Council Bluffs 1026 Woodbury Avenue Council Bluffs IA 51503	712-328-0854	Fremont Harrison Mills Pottawattamie
Creston 906 East Taylor Street Creston IA 50801	866-613-2827	Adair Adams Cass Clarke Decatur Madison Montgomery Page Ringgold Taylor Union



Social Security Office	Phone Number	Counties Served
Davenport 131 W 3rd St Ste 100 Davenport IA 52801	563-326-1621	Cedar Muscatine Scott
Decorah 317 Washington St Ste 1 Decorah IA 52101	563-382-2924	Allamakee Chickasaw Howard Winneshiek
Des Moines Room 293 Federal Bldg 210 Walnut St Des Moines IA 50309	800-772-1213	Polk Warren
Dubuque 1635 Associates Dr Ste 101 Dubuque IA 52002	563-582-3626	Clayton Delaware Dubuque Jackson
Fort Dodge 2315 2nd Ave N Fort Dodge IA 50501	515-576-5185	Calhoun Hamilton Humboldt Kossuth Pocahontas Webster Wright
Iowa City 400 S Clinton Room 206 Iowa City IA 52240	319-338-9461	Johnson Washington
Marshalltown 2502 S 2nd St Marshalltown IA 50158	641-752-6376	Jasper Marshall Poweshiek Tama
Mason City 625 Village Green Drive SW Mason City IA 50401	641-423-4325	Cerro Gordo Floyd Franklin Hancock Mitchell Winnebago Worth



Social Security Office	Phone Number	Counties Served	
Ottumwa 1301 N Elm St 2nd Fl PO Box 458 Ottumwa IA 52501	641-682-8501	Appanoose Davis Jefferson Keokuk Lucas Mahaska	Marion Monroe Van Buren Wapello Wayne
Sioux City 3555 Southern Hills Dr Sioux City IA 51106	866-338-2859	Lyon Monona Plymouth	Sioux Woodbury
Spencer 1610 12 th Avenue SW Spencer IA 51301	712-262-5350	Clay Dickinson Emmet	O'Brien Osceola Palo Alto
Storm Lake Colonial Mall 800 Oneida St Storm Lake IA 50588	712-732-1095	Buena Vista Cherokee	Ida Sac
Waterloo 904 W 4th St Waterloo IA 50702	319-234-1554	Black Hawk Bremer Buchanan Butler	Fayette Franklin Grundy Hardin



C. ADDRESSES OF EPSDT CARE COORDINATION AGENCIES

County	EPSDT Contact and Contact Agency	Address	Phone Numbers
Adair	Mary Groves MATURA Action Corporation	203 W Adams St Creston IA 50801	641-782-8431
Adams	Joan Gallagher Taylor County Public Health	405 Jefferson Bedford IA 50833	712-523-3405 800-425-0051
Allamakee	Molly Lammers Visiting Nurse Association of Dubuque	1454 Iowa St PO Box 359 Dubuque IA 52004	563-556-6200 800-862-6133
Appanoose	Kate Roy Marion County Public Health	104 S Sixth St PO Box 152 Knoxville IA 50138	641-828-2238
Audubon	Beth Leichti Community Opportunities dba New Opportunities Inc.	23751 Hwy 30 PO Box 427 Carroll IA 51401	712-792-9266 800-642-6330
Benton	Kate Pergande Mid-Iowa Community Action, Inc.	1001 South 18 th St Marshalltown IA 50158	641-752-7162 Ext 163
Black Hawk	Crystal Schmitz Black Hawk County Health Department	1407 Independence Ave 4th Floor Waterloo IA 50703	319-291-2413
Boone	See Benton County.		
Bremer	See Black Hawk County.		
Buchanan	See Black Hawk County.		
Buena Vista	Tami Meendering Upper Des Moines Opportunity, Inc.	101 Robbins Ave PO Box 519 Graettinger IA 51342	712-580-3899 800-245-6151
Butler	Lisa Koppin North Iowa Community Action Organization	300 15th St NE PO Box 1627 Mason City IA 50401	641-423-5044 800-657-5856
Calhoun	See Audubon County.		
Carroll	See Audubon County.		



County	EPSDT Contact and Contact Agency	Address	Phone Numbers
Cass	Gayle Chapman Crawford Co. Home Health, Hospice, & Public Health	Courthouse Annex 105 N Main St Denison IA 51442	712-263-3303
Cedar	Jody Kirby Hillcrest Family Services	220 West 7 th Street Dubuque, IA 52001	563-557-4444
Cerro Gordo	See Butler County.		
Cherokee	Staci Morgan Mid-Sioux Opportunity	418 South Marion St Remsen IA 51050	712-786-3418 800-859-2025
Chickasaw	See Allamakee County.		
Clarke	See Appanoose County.		
Clay	See Buena Vista County.		
Clayton	See Allamakee County.		
Clinton	See Cedar County.		
Crawford	See Cass County.		
Dallas	See Audubon County.		
Davis	Peggy Moreland Lee County Health Department	2218 Avenue H Fort Madison IA 52627	319-372-5225 800-458-6672
Decatur	See Appanoose County.		
Delaware	See Allamakee County.		
Des Moines	See Davis County		
Dickinson	See Buena Vista County.		
Dubuque	See Allamakee County.		
Emmet	See Buena Vista County.		
Fayette	See Allamakee County.		
Floyd	See Butler County.		
Franklin	See Butler County.		
Fremont	Rae Miller Child Health Specialty Clinics	300 West Broadway Suite 106 Council Bluffs IA 51503	712-792-4500 866-652-0041



County	EPSDT Contact and Contact Agency	Address	Phone Numbers
Greene	See Audubon County.		
Grundy	See Black Hawk County.		
Guthrie	See Audubon County.		
Hamilton	June Weiss Webster County Health Department	330 1st Ave N Ste L-2 Fort Dodge IA 50501	515-574-3842 888-289-3318
Hancock	See Butler County.		
Hardin	See Benton County.		
Harrison	See Cass County.		
Henry	Jen Weidman Washington County Public Health & Home Care	110 N Iowa Avenue Suite 300 Washington IA 52353	319-653-7758 800-655-7758
Howard	See Allamakee County.		
Humboldt	See Hamilton County.		
Ida	See Cherokee County.		
Iowa	Judy Grecian Johnson County Public Health	855 South Dubuque Street Iowa City IA 52240	319-356-6040
Jackson	See Cedar County.		
Jasper	Vicki Nolton Grinnell Regional Medical Center	210 4th Ave Grinnell IA 50112	641-236-2566
Jefferson	See Davis County.		
Johnson	See Iowa County.		
Jones	See Cedar County.		
Keokuk	Delpha Hopkins Child Health Specialty Clinics/American Home Finding Association	201 S Market St Ottumwa IA 52501	641-682-8784 800-452-1098
Kossuth	See Butler County.		
Lee	See Davis County.		



County	EPSDT Contact and Contact Agency	Address	Phone Numbers
Linn	Gloria Witzberger Hawkeye Area Community Action Program, Inc.	1515 Hawkeye Dr Hiawatha IA 52233	319-393-7811 800-332-5289
Louisa	Rebecca Schultz Unity Health Care – Public Health	1609 Cedar St Muscatine IA 52761	563-263-0122
Lucas	See Appanoose County.		
Lyon	See Cherokee County.		
Madison	See Adair County.		
Mahaska	See Jasper County.		
Marion	See Appanoose County.		
Marshall	See Benton County		
Mills	See Fremont County		
Mitchell	See Butler County.		
Monona	See Cass County		
Monroe	See Appanoose County.		
Montgomery	See Adams County.		
Muscatine	See Louisa County.		
O'Brien	See Buena Vista County.		
Osceola	See Buena Vista County.		
Page	See Adams County.		
Palo Alto	See Buena Vista County.		
Plymouth	See Cherokee County		
Pocahontas	See Buena Vista County.		
Polk	Annie Wood Visiting Nurse Services	1111 9th St Ste 320 Des Moines IA 50314	515-558-9951
Pottawattamie	See Fremont County.		
Poweshiek	See Jasper County.		
Ringgold	See Adair County.		



County	EPSDT Contact and Contact Agency	Address	Phone Numbers
Sac	See Audubon County.		
Scott	JaNan Less Scott County Health Department	600 West 4 th Street Davenport IA 52801	563-328-4114
Shelby	See Cass County.		
Sioux	See Cherokee County.		
Story	See Benton County.		
Tama	See Benton County.		
Taylor	See Adams County.		
Union	See Adair County.		
Van Buren	See Davis County.		
Wapello	See Keokuk County.		
Warren	See Appanoose County.		
Washington	See Henry County.		
Wayne	See Appanoose County.		
Webster	See Hamilton County.		
Winnebago	See Butler County.		
Winneshiek	See Allamakee County.		
Woodbury	Ivy Guthridge Siouxland Community Health Center	1021 Nebraska St PO Box 5410 Sioux City IA 51102	712-202-1033 888-371-1965
Worth	See Butler County.		
Wright	See Hamilton County.		