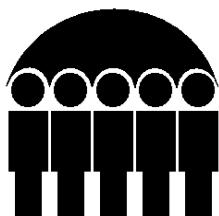


Revised October 9, 2009

Employees' Manual
Title 8
Chapter B

MEDICAID

APPLICATION PROCESSING



Iowa
Department
of
Human Services

	<u>Page</u>
Overview	1
Filing a Medicaid Application.....	1
Which Application Form to Use	2
Referrals From the <i>hawk-i</i> Program	4
Who Must Sign the Application	5
Where the Application Must Be Filed.....	6
Date of Application	8
Withdrawal of Application	9
Procedures for SSI Applicants or Potential SSI Eligibles	9
Collecting Eligibility Information From SSI Recipients.....	10
Concurrent Medicaid and Social Security Disability Determinations	12
Interviews	14
Information Provided	16
Voter Registration Procedures	18
Verification	19
Reporting Changes	20
Processing Standards	20
Guidelines for All Applications.....	20
Processing Applications With Children.....	21
Effective Date of Eligibility	24
Effective Date for SSI Recipients.....	25
Establishing Beginning Months of Eligibility for MEPD	27
Determining Eligibility for the Retroactive Period	29
Verification Requirements	31
Retroactive Eligibility for Medically Needy Recipients.....	31
Retroactive Eligibility for SSI Recipients	32
Referrals to CSRU	33
Pregnant Women.....	35
System Entries When the Custodial Parent is Pregnant	37
Referrals to the <i>hawk-i</i> Program.....	37
Representation	38
Responsible Person	38
Authorized Representative	39
Authorization to Represent.....	41

Overview

This chapter explains the procedures for processing Medicaid applications. The mechanics of filing and handling applications are covered first, followed by interview and verification procedures. Time lines for processing applications and effective date of eligibility are given in the next sections. The remaining pages of the chapter address eligibility for the retroactive period, referrals to the Child Support Recovery Unit (CSRU) and to the Healthy and Well Kids in Iowa (*hawk-i*) program, and representation.

Filing a Medicaid Application

Legal reference: 42 CFR 435.403, 435.906, and 435.908; 441 IAC 76.1(2) and (4), 86.3(2); Iowa Code Section 249A.3

All people have the right to apply for Medicaid for themselves or on behalf of another. Give an application to anyone who asks for one regardless of the person's county of residence. If the request is by mail or telephone, send the application in the next outgoing mail.

A separate application for Medicaid is not required when a person is also applying for:

- ◆ The Family Investment Program (FIP)
- ◆ Refugee Cash Assistance
- ◆ The Healthy and Well Kids in Iowa (*hawk-i*) program
- ◆ State Supplementary Assistance
- ◆ Supplemental Security Income (SSI) benefits

NOTE: People applying for FIP or Refugee Cash Assistance must also indicate on the application that they want to apply for Medicaid or notify the worker that they want Medicaid before a decision is made on the application. A person already **receiving** FIP or Refugee Cash Assistance must file a separate application for Medicaid.

An application for SSI benefits is automatically considered an application for Medicaid if SSI is approved. A denied SSI application is not considered a Medicaid application, and the filing date is not protected for Medicaid purposes. See [Collecting Eligibility Information From SSI Recipients](#).

When requested, assist the applicant with completing an application. Applicants can authorize other people to represent them during the application process. Other people can also help the applicant during the application process.

An application may be filed on behalf of a deceased person. Eligibility is based on whether the person would have been eligible had application been made on or before the date of death and whether there are unpaid medical bills. However, eligibility cannot be established any earlier than three months before the month of application.

An application may be filed on behalf of a person temporarily out of the state. This situation usually happens when someone is visiting outside the state and has an accident or sudden illness. Apply all of Iowa’s policies regarding application processing and eligibility. See 8-C, [RESIDENCY](#), for more information about determining when a client is a resident of Iowa.

Which Application Form to Use

Legal reference: 45 CFR 435.907, 435.909; 441 IAC 76.1(249A)

Determine which of the following application forms to use based on the assistance the applicant is requesting:

Application Form	Who Should Use the Form
<p><i>Health Services Application, forms 470-2927 and 470-2927(S)</i></p>	<p>People applying only for Medicaid under the following coverage groups:</p> <ul style="list-style-type: none"> ◆ FMAP-related coverage groups ◆ FMAP-related Medically Needy ◆ Refugee Medical Assistance ◆ Iowa Family Planning Network (IFPN) <p>An aged, blind, or disabled person applying for:</p> <ul style="list-style-type: none"> ◆ SSI-related Medicaid ◆ SSI-related Medically Needy <p>People applying for</p> <ul style="list-style-type: none"> ◆ Medical facility care ◆ A home- and community-based waiver ◆ State Supplementary Assistance <p>Women who need treatment for breast or cervical cancer.</p> <p>A child in foster care or subsidized adoption</p>

Application Form	Who Should Use the Form
<p><i>Health and Financial Support Application</i>, forms 470-0462 or 470-0466 (Spanish)</p> <p>hawk-i Application (located in Comm. 156 and Comm. 156(S)) or <i>Healthy and Well Kinds in Iowa (hawk-i) Electronic Application Summary</i>, form 470-4016</p>	<p>People applying for FIP or Food Assistance and the following Medicaid coverage groups:</p> <ul style="list-style-type: none"> ◆ FMAP-related coverage groups, ◆ FMAP-related Medically Needy ◆ Refugee Medical Assistance, ◆ Iowa Family Planning Network (IFPN) ◆ SSI-related coverage group ◆ SSI-related Medically Needy ◆ State Supplementary Assistance <p>People applying for the hawk-i program</p>

Include form 470-2826, *Insurance Questionnaire*, in the application packet for all new applications except for persons approved for SSI. Have the applicant complete the *Insurance Questionnaire* if insurance availability is indicated on the application or you are aware that the applicant has insurance available.

Exceptions:

- ◆ People who complete *SSI Medicaid Information*, form 470-2304, 470-2304(S), 470-0364, or 470-0364(S), do not have to complete the *Insurance Questionnaire*. A person approved for SSI must complete the insurance section of *SSI Medicaid Information* before Medicaid can be approved, unless you already have all the information needed.
- ◆ People who have received Medicaid within the last six calendar months do not have to complete the *Insurance Questionnaire* unless there has been a change in medical resources since the person last received assistance. Verify any changes and ask the person to complete the *Insurance Questionnaire*, if necessary.
- ◆ Applicants for the IFPN coverage group do not complete the *Insurance Questionnaire*.

See 6-Appendix for instructions about what to do with the *Insurance Questionnaire* and the information provided on the form. See 8-O, [Applications](#), for the applications that may be used for persons applying for IowaCare.

Referrals From the *hawk-i* Program

Legal reference: 441 IAC 86.3(514I)

When a ***hawk-i*** Application (located in Comm. 156 and Comm. 156(S)) or *Healthy and Well Kinds in Iowa (***hawk-i***) Electronic Application Summary* (form 470-4016) is filed with the ***hawk-i*** administrator, the application is screened to determine if the child may qualify for Medicaid.

If it appears that Medicaid eligibility exists, ***hawk-i*** staff will refer the application to income maintenance (IM) workers located at the ***hawk-i*** office for a Medicaid eligibility determination for the children. (A ***hawk-i*** application is considered a Medicaid application for the children only.) The ***hawk-i*** administrator also:

- ◆ Notifies the family of the referral.
- ◆ Returns any original verification documents.

NOTE: If the IM worker at the ***hawk-i*** office determines that the family has an active case at the local DHS office or a pending application for Medicaid or any other program, the ***hawk-i*** application is referred to that office for the Medicaid eligibility determination.

If the children's application is pending with the IM worker at the ***hawk-i*** office when the parents request Medicaid for themselves, the parents' application date is **initially** set the **same** as the children's application date.

The IM worker at the ***hawk-i*** office documents the contact date and sends the parents form 470-2927 or 470-2927(S), *Health Services Application*, to be completed and returned to the local office.

If the IM worker at the ***hawk-i*** office approves the children for Medicaid and the parents are eligible for Family Medical Assistance Program (FMAP), Child Medical Assistance Program (CMAP), or Mothers and Children (MAC), add the parents to the children's case without a Medicaid application. The effective date for the parents is the same as for the children.

If the IM worker at the ***hawk-i*** office approves the children for Medicaid and the parents are eligible only for Medically Needy, the parents must complete the *Health Services Application*. The Medically Needy application date is the date the local office receives the parents' application.

If the IM worker at the **hawk-i** office denies the children's application, the parents' *Health Services Application* is also a reapplication for the children. The date of application is the date the local office receives the *Health Services Application*.

If the parents contact the local office to request Medicaid for themselves while the children's Medicaid application is pending with the IM worker at the **hawk-i** office, the date the local office receives the paper application is the application date for adding the parents to the children's eligible group.

If the parents request Medicaid after the children are approved for Medicaid, the local office IM worker handles the request. All policies regarding application processing for Medicaid apply. These include, but are not limited to, time frames for processing the application and notice and verification requirements.

Who Must Sign the Application

Legal reference: 42 CFR 435.907 and 435.909; 441 IAC 76.1(249A), 76.1(2)

To be considered a valid application, an application must have the following:

- ◆ A legible name,
- ◆ An address, and
- ◆ A signature.

Before eligibility can be **approved**, one of the following must sign the application form:

- ◆ The applicant (including a child living independently or a minor applicant for the Iowa Family Planning Network), or
- ◆ A child's parent or stepparent in the home who is not prevented from acting on behalf of the child, or
- ◆ A spouse, or
- ◆ A guardian or conservator, or
- ◆ Someone acting on behalf of the applicant, or
- ◆ A responsible person acting on behalf of a minor or an incompetent, physically incapacitated, or deceased person. This includes a person or organization that has signed form 470-3356, *Inability to Find a Responsible Person*. See [Representation](#) in this chapter.

NOTE: If the applicant is under a guardianship or conservatorship that was established voluntarily, the applicant may sign the application. When a person voluntarily asks the court to appoint a guardian or conservator, the court may do so without making a determination that the person is incompetent.

Applications that are filed electronically, whether signed and faxed or scanned and e-mailed, do not have to be signed again.

Where the Application Must Be Filed

Legal reference: 441 IAC 76.1(1), 76.1(3), 86.3(3)

The application forms listed under [Which Application Form to Use](#) may be filed in one of the following locations:

- ◆ At a Department office (whether open full time or less than full time).
- ◆ At a disproportionate-share hospital, federally qualified health center, mental health institute, state resource center, or other facility where out-stationing activities are provided.
- ◆ With the third-party administrator for the *hawk-i* program.

Form 470-2927 or 470-2927(S), *Health Services Application*, can also be filed at:

- ◆ Offices of a qualified provider of presumptive Medicaid eligibility.
- ◆ WIC sites.
- ◆ Maternal or child health centers.

If you receive an application that should have been filed in another DHS office, send the application to the correct office for processing within two working days of receipt.

Responsibility for processing waiver service applications and applications from persons living in institutions lies with the county indicated on the following chart.

EXCEPTIONS:

- ◆ If the county where the client lives, the county of legal settlement, or the county where the facility is located has a less-than-full-time office, the application is processed at the full-time Department office associated with that county.
- ◆ If an income maintenance worker is out-stationed at a facility, that worker processes the application, regardless of the applicant's county of residence.

If the applicant is:	The application is processed in:
Requesting waiver services	The county where the applicant will live
In a hospital	The county where the applicant lives
In an intermediate care facility for persons with mental retardation (ICF/MR)	The county of legal settlement
In an ICF/MR and applying for waiver services	The county where the applicant will live
In a nursing facility (including skilled care)	The county where the facility is located
In a residential care facility (RCF)	The county where the facility is located
In an residential care facility for persons with mental retardation (RCF/MR)	The county where the facility is located
In a psychiatric medical institution for children (PMIC)	The county where the facility is located

Applications for Iowa Family Planning Network coverage can also be filed and processed at the following family planning agencies and their satellite clinics:

- ◆ Allen Memorial Hospital, Waterloo
- ◆ Broadlawn Family Planning Clinic, Des Moines
- ◆ Central Iowa Family Planning, Marshalltown
- ◆ Community Opportunities, Carroll
- ◆ Edgerton Women's Health Center, Davenport
- ◆ HCCMS Family Health Services, Denison
- ◆ Hillcrest Family Services, Dubuque
- ◆ Northeast Iowa Community Action, Decorah
- ◆ North Iowa Community Action, Marshalltown
- ◆ Planned Parenthood of East Central Iowa, Cedar Rapids
- ◆ Planned Parenthood of Greater Iowa, Des Moines
- ◆ Planned Parenthood of Nebraska and Council Bluffs
- ◆ Planned Parenthood of Southeast Iowa, Burlington
- ◆ Southern Iowa Family Planning Clinic, Ottumwa
- ◆ St. Luke's Hospital, Cedar Rapids
- ◆ Unity Healthcare, Muscatine
- ◆ Visiting Nurse Services, Des Moines
- ◆ Women's Health Services, Clinton

If a **hawk-i** Application (Comm. 156) is filed with the local office instead of the **hawk-i** administrator, date-stamp the application and send it to the **hawk-i** program administrator within two working days of receipt.

Date of Application

Legal reference: 441 IAC 76.1(2) and 86.3(4)

An application is considered filed on the date when a form that is listed under [Which Application Form to Use](#) and contains a legible name, address, and signature of the client or representative is received at a location defined under [Where the Application Must Be Filed](#).

Stamp or write the date received on the application form and enter the date on the *Application Register*, form 470-0554.

If the application was filed in the incorrect DHS office and sent to the appropriate office for processing, the date the application was filed in the first office is still the date of application.

An application left at a closed office will be considered received on the first day that is not a weekend or state holiday following the day that office was last open.

County A is a less-than-full-time office and open on Monday and Wednesday. The office was last open Wednesday, April 24. When the office re-opens on the following Monday, staff find several applications that have been left under the door. All applications are date-stamped as being received Thursday, April 25.

A faxed or electronic application shall be considered as an original application. A faxed or electronic application is considered filed on the date it is received when it comes in during normal business hours. If the application comes in after normal business hours (during the evening, weekend, or holiday), the application is considered received on the first day that is not a weekend or state holiday following the day that office was last open.

For SSI recipients, the date the SSI application was filed with the Social Security Administration as shown on the SDX, is the date of application for Medicaid. See [Effective Date for SSI Recipients](#) and 14-E, [SSI STATE DATA EXCHANGE](#), for SDX information.

When a person fills out an incorrect application form, the person must complete the correct form before eligibility can be established. Use the filing date on the incorrect application as the filing date when the correct application is received. Attach the incorrect application to the correct application and file it in the case record. On all applications, use the filing date as the application date.

Withdrawal of Application

Legal reference: 45 CFR 435.913(b)(1), 441 IAC 76.1(6)

Applicants may withdraw the application entirely or for any month covered by the application, if the request is made before the date the application is processed.

EXCEPTION: The Medically Needy coverage group requires that concurrent months be included in the certification period. A Medically Needy applicant may withdraw the application for the month in which the application is filed, if the applicant wants to have the certification period begin the following month.

The request to withdraw the application may be oral or in writing. Document the withdrawal in the case record. Issue an adequate notice of decision if the entire application is withdrawn. If only a month of the application is withdrawn, and a notice of decision will be issued when the remaining application is processed, a separate notice is not necessary.

Procedures for SSI Applicants or Potential SSI Eligibles

Legal reference: 441 IAC 76.1(249A), 76.2(249A)

Persons who would be eligible for Supplemental Security Income (SSI) may apply at the Social Security Administration district office for both SSI and Medicaid. Normally it is to a low-income person's advantage to apply for SSI because of the money payment. However, application for SSI is not a condition of eligibility for Medicaid.

If a person applying for Medicaid at a DHS office has income less than the SSI payment standard for the person's living arrangement, refer the person to the Social Security Administration district office to apply for SSI benefits:

- ◆ If the person chooses not to apply with the Social Security Administration, process the application as you would any SSI-related application. See 8-F, [SSI-RELATED COVERAGE GROUPS: People Eligible for SSI Benefits But Not Receiving Them](#).

- ◆ If the person has already applied for or intends to apply for SSI or Social Security disability benefits (SSDI) within ten working days of the Medicaid application, see [Concurrent Medicaid and Social Security Disability Determinations](#).

If the Social Security Administration has made an SSI eligibility determination, the information is sent to the Department via the SSI State Data Exchange (SDX) system. Information from the SDX is used to process SSI recipients for Medicaid. Chapter 14-E explains the SDX system and how to use and interpret the fields. See [Collecting Eligibility Information From SSI Recipients](#).

The Social Security Administration may presumptively determine an SSI applicant to be disabled. "Presumptive" disability is indicated by code "P" in the disability field on the SDX. If all other Medicaid eligibility criteria are met, the person is eligible for Medicaid for a maximum of six months. See 8-C, [Presumptive Disability](#).

When more than 60 days have passed since the person filed for SSI, you can send form 470-0363, *Certification of Eligibility of SSI Applicant*, to determine the status of the person's SSI eligibility determination. You may also use this procedure before 60 days have passed if the applicant has an urgent need. Form 470-0363 completed by the Social Security Administration indicating that a person is eligible for SSI may be accepted as verification in place of an SDX.

Collecting Eligibility Information from SSI Recipients

Legal reference: 441 IAC 75.2(249A), 76.1(249A), and 76.1(5)"d"

SSI recipients do not need to fill out a separate application for Medicaid. However, unless the SSI recipient was already receiving Medicaid, you will need additional information to determine Medicaid eligibility. Use *SSI Medicaid Information*, form 470-2304, 470-2304(S), 470-0364, or 470-0364(S), to:

- ◆ Gather information about Medicaid eligibility factors, such as qualifying trusts and other health insurance coverage.
- ◆ Gather information to determine retroactive Medicaid eligibility.
- ◆ Determine if an SSI recipient in a nursing facility has a community spouse.
- ◆ Obtain agreement to assign Medicare Part B claims to the medical provider.
- ◆ Inform the client that the Department can recover Medicaid payments from those responsible for the cost of the client's medical expenses, such as from third-party insurance or trusts that can be used to pay medical expenses.
- ◆ Issue Comm. 121 or Comm. 121(S), *Important Notice to Property Owners and Renters* (attached to the information form).

See 14-E, [SSI STATE DATA EXCHANGE](#), for instructions on how form 470-0364 is generated by the system. If the form is not automatically generated, issue the form within ten days of receipt of the SDX. If the client does not return the *SSI Medicaid Information* form in ten days, issue form 470-3193 or 470-3193(S), *SSI Medicaid Reminder*, if the system does not automatically issued it.

If more information is required after *SSI Medicaid Information* is returned, send a request with a due date and an explanation that Medicaid eligibility cannot be determined until the information is received. If the information is not returned, deny Medicaid eligibility.

If needed, conduct an interview to clarify information received. See [Interviews](#).

To gather information specifically for the month of SSI application (and the intervening months, when SSI was not approved back to the application date), manually issue form 470-2304 or 470-2304(S) and adjust the form as follows:

- ◆ On page 1, write the period for which the information is required.
- ◆ On page 2, cross out the heading "Retroactive Medical Coverage" and the first sentence under the "Income" heading. Write the months for which information is required in the spaces provided.
- ◆ On page 3, write the appropriate months in the spaces provided.

When one *SSI Medicaid Information* form will not cover the month of application and the intervening months, include additional pages for income and resources (pages 2 and 3 of the form) to cover these months.

When you need one *SSI Medicaid Information* form for the retroactive months and another form for the intervening months, issue both forms at the same time. This will make it less confusing for the applicant. Include a letter with the forms that explains why this information is needed. An example of language to use in this situation is as follows:

Dear [name],

You applied with the Social Security Administration for Supplemental Security Income (SSI) on [date]. Your application for SSI was approved effective [date].

An application for SSI is also used as an application for Medicaid. When you get SSI, the Department of Human Services (DHS) needs more information to decide if you can get Medicaid. DHS will decide if you can get Medicaid for the three months before you started getting SSI and for months that you did not get SSI.

We are sending you this form to fill out to get information to decide if you can get Medicaid for months that you did not get SSI. Please fill out the enclosed form(s) and send back to the DHS by _____.

If you have questions, please call [phone number].

Concurrent Medicaid and Social Security Disability Determinations

Legal reference: 42 CFR 435.909 and 435.541, 441 IAC 75.20 (2) "b" and "c"

Policy:

When a person has applied concurrently for both Social Security disability benefits and SSI-related Medicaid, the Department is required to await the outcome of the Social Security Administration disability determination.

If the applicant is eligible only for Medically Needy, see 8-J, [SSI-Related Medically Needy](#).

Procedure:

If an SSI-related applicant has not been determined to be disabled by the Social Security Administration, take the following actions:

1. Ask the applicant to apply for SSI and Social Security disability (SSDI) benefits from the Social Security Administration. The applicant will either:
 - ◆ State that an application has already been filed, or
 - ◆ Agree to apply for benefits within ten working days of the Medicaid application date.

2. When the applicant has already applied or agrees to apply for SSI and SSDI, complete form 470-2631, *Notice of Pending Medicaid Applications*, and send it to:
 - ◆ The Social Security Administration, and
 - ◆ Disability Determination Services (DDS).

DDS completes Section II of the form, giving the status of the disability determination and returns the form to the IM worker within 15 calendar days.

3. If DDS does not have a referral from the Social Security Administration, follow up on the DDS response by contacting the applicant to verify that the benefit application has been filed with the Social Security Administration.
4. If DDS has a pending disability determination for this person:
 - ◆ Make a note in the narrative, and
 - ◆ Make a tickler to check for the completed disability determination on the SDX screen or on the Income and Eligibility System (IEVS).
5. If DDS has already completed the disability determination for Social Security, check the SDX screen.
 - ◆ If the SDX shows SSI was approved, then approve Medicaid if all other eligibility requirements are met.
 - ◆ If the SDX shows SSI was denied due to disability, deny Medicaid as "not disabled."
4. If DDS has a pending disability determination for this person:
 - ◆ Make a note in the narrative, and
 - ◆ Make a tickler to check for the completed disability determination on the SDX screen or on the Income and Eligibility System (IEVS).
5. If DDS has already completed the disability determination for Social Security, check the SDX screen.
 - ◆ If the SDX shows SSI was approved, then approve Medicaid if all other eligibility requirements are met.
 - ◆ If the SDX shows SSI was denied due to disability, deny Medicaid as "not disabled."

6. If the SSI was denied due to other eligibility requirements, such as income or resources, contact the Social Security Administration to see if an eligibility decision for SSDI will be made within 30 days.
 - ◆ If so, wait for the Social Security Administration decision on SSDI.
 - ◆ If not, then get a copy of the disability determination from the Social Security Administration and get the income and resource verification from the applicant. Complete the application processing.

7. When a final Social Security disability determination has been made, contact the Social Security Administration to see if the full eligibility determination will be made within ten days.
 - ◆ If so, wait for the Social Security Administration decision.
 - ◆ If not, get a copy of the Social Security Administration disability decision and determine Medicaid eligibility.

Interviews

Legal reference: 42 CFR 435.905-435.914; 441 IAC 76.2(1), 76.1(3)

An interview is not required when determining Medicaid eligibility for an FMAP-related or SSI-related applicant or member unless you determine that an interview is necessary to:

- ◆ Clarify information on the application,
- ◆ Clarify questionable information, or
- ◆ Ensure there is a better understanding of programs.

It is important to treat applicants and members equitably and to use the “prudent person concept.” See 8-A, [Definitions](#), for “prudent person concept.”

An interview shall not be required for the following:

- ◆ Children as defined by the Medicaid program
- ◆ Applicants for Iowa Family Planning Network (IFPN)
- ◆ Applicants for IowaCare

Grant an interview if the applicant, member, or authorized representative requests one.

To require a face-to-face interview or a phone interview, you must issue written notice to the applicant or member. When an interview is needed or is requested by an applicant, a member, or an authorized representative, provide written notice of the date, time, place, and method of the interview (in the local office, home visit, or by phone, etc.).

Grant requests to reschedule when you determine that the applicant, member, or authorized representative is making every effort to cooperate with the interview process. Interviews rescheduled at the request of the applicant, member, or authorized representative may be agreed upon verbally and documented without written confirmation.

Failure to attend the interview you requested, including a scheduled phone interview, is cause to deny or cancel the adults on the application.

Contact the applicant or member whenever you need to clarify information in order to determine eligibility.

Ms. W applies for Medicaid for herself and her three-year-old son. The application date is May 4. The worker sends a request for additional information and verification with a due date of May 15 (ten calendar days). The worker determines an interview is necessary on this case to clarify questionable information. An interview is scheduled for May 10 at 10 A.M. in the local office.

Ms. W fails to attend the face-to-face interview. The worker can deny the application for Ms. W, but must leave the application pending for Ms. W's son. Or, the worker may wait to deny Ms. W until the application for her son is processed.

When you ask a client to come in to the local office for an interview, do not deny or cancel the children if the adult fails to attend the interview. However, if you request information at the same time as you set up an interview and the information is not provided within ten days, you may cancel or deny the entire household for failure to provide requested information.

Information Provided

Legal reference: 42 CFR 435.905

When conducting the interview or by other means, explain to the client:

- ◆ The programs for which the client may be eligible such as:
 - FMAP-related Medicaid
 - SSI-related Medicaid
 - Medically Needy
 - Home- and community-based service waivers
 - Iowa Care
 - State Supplementary Assistance
 - FIP
 - Food Assistance
- ◆ The policies and procedures for the client's coverage group.
- ◆ The factors of eligibility that must be verified, including what is needed as verification, and that documents that are the property of the client are returned to the client.
- ◆ The penalties for giving false information.
- ◆ The client's right to receive a ten-day advance notice of adverse actions and the right to appeal any decisions on Medicaid eligibility.
- ◆ The social service programs available. Make referrals when necessary.
- ◆ The client's responsibility to:
 - Report changes that occur during the application process within five days of the change. See [Processing Standards](#).
 - Report changes that occur after approval within ten days of the change and report any changes in medical resources. See 8-G, [Reporting Changes](#).
 - Cooperate with Quality Control and the Economic Assistance Fraud Bureau. See 8-C, [COOPERATION WITH INVESTIGATIONS AND QUALITY CONTROL](#).
 - Apply for and accept other benefits for which the client is eligible. See 8-C, [BENEFITS FROM OTHER SOURCES](#).
 - Cooperate with the HIPP Unit and the Third-Party Liability Unit and refund third-party payments for services paid by Medicaid. See 8-C, [Cooperation with the Health Insurance Premium Payment \(HIPP\) Unit](#) and [Cooperation with the Third-Party Liability Unit](#).

For Medically Needy applicants with a spenddown who have children, discuss the Healthy and Well Kids in Iowa (**hawk-i**) program. Explain that if it appears they meet the criteria for the **hawk-i** program, a referral will be made to the **hawk-i** program.

Give or mail to applicants or anyone inquiring about the Medicaid program the following pamphlets that explain coverage, conditions of eligibility, benefits of the program, related services available and client rights and responsibilities:

- ◆ Comm. 20, Your Guide to Medicaid
- ◆ Comm. 30, Medicaid for the Medically Needy
- ◆ Comm. 51, Information Practices
- ◆ Comm. 123 and Comm. 123(S), Important Information for You and Your Family Members About the Estate Recovery Program
- ◆ Comm. 209, Information About Your Privacy Rights
- ◆ Comm. 233 and Comm. 233(S), Rights and Responsibilities
- ◆ Comm. 255 and 255(S), Important Information about the HIPPA Program
- ◆ Comm. 258 and 258(S), Verifying Citizenship and Identity
- ◆ 470-0306 or 470-0307(Spanish), Application for Food Assistance. Exceptions: Do not give this application to people living in a medical institution or to children entering foster care unless supervised apartment living is the first foster care placement.

For all applicants under the age of 21, discuss the availability and benefits of the EPSDT "Care for Kids" program. Make sure the client understands the program and the advantages of screening. Give or mail to the applicant Comm. 4, *Care For Kids*. See 8-M, [CARE FOR KIDS \(EPSDT\)](#), for more information.

To FMAP-related applicants, also give:

- ◆ Comm. 27, Medicaid for Families and Children
- ◆ Iowa WIC Program income guidelines

The Department of Public Health revises the WIC flyer annually in March to incorporate updated WIC income guidelines. The revised flyer is effective April 1. Public Health sends a blanket supply of the revised flyer to local offices. Destroy previous versions of the flyer. Get additional supplies of the WIC flyer cost-free by calling 1-800-532-1579.

To applicants who are aged, blind, or disabled, also give:

- ◆ Comm. 28, Medicaid for SSI-Related Persons.
- ◆ Comm. 60, Medicaid for the Qualified Medicare Beneficiary.
- ◆ Comm. 121 and Comm. 121(S), Important Notice to Property Owners and Renters.
- ◆ Comm. 180, Medicaid for Employed People with Disabilities.

To applicants who are in a nursing facility, also give Comm. 52, *Medicaid for People in Nursing Homes and Other Care Facilities*. If the applicant has a spouse at home, also give Comm. 72, *Protection of Your Resources and Income*.

Voter Registration Procedures

Legal reference: 721 IAC Chapter 23

The Department is responsible for helping clients complete voter registration forms and for mailing the forms to the county election office. (The actual voter registration occurs at the election office.) Issue voter registration forms:

- ◆ With all applications,
- ◆ With the Review/Recertification Eligibility Document (RRED), and
- ◆ When the client moves within Iowa.

When an interview is held, ask if the client wants to register to vote. If the client wants to register and has not filled out the voter registration form, have the client complete it at the interview. Offer to help the client complete the form. Be careful when helping the client that you do not influence the client's voter registration options in any way.

If you are conducting a phone interview, ask the questions and send the form to the client for signature. No follow-up is necessary after the form has been mailed.

Review the client's rights as listed on the form. If the client chooses not to check "yes" or "no," leave the section blank and consider that the client has chosen not to register to vote. If the client chooses not to sign the form, print the client's name and the date where indicated, and initial the form.

If there isn't an interview, mail the form to the client and document your action.

If the client returns the form, follow your office procedures for handling it. Tear off the voter registration information section and give it to the client. Keep the declination part of the form. See [6-Appendix](#) for a copy of the *Voter Registration* form and for office procedures for handling the form after completion.

Verification

Legal reference: 441 IAC 76.1(3), 75.52(2), 75.57(2)

Applicants must provide requested verification. Notify the applicant in writing what additional information or verification is needed. Provide this notice to the applicant personally, by mail, or by facsimile. Give the applicant ten calendar days to supply the information.

Explain the following to the applicant in writing:

- ◆ An applicant who must obtain information from a third party should not leave the information with the expectation that the third party will return it timely.
- ◆ The applicant is responsible for following up with the third party to be sure the third party has the information ready to pick up or has mailed the information to the Department in time to be received by the due date.
- ◆ The applicant may ask the Department for more time to get the information if the third party does not have the information ready or it will not arrive by the due date.

When the applicant is making every effort to obtain the information from a third party but is unable to do so in ten days and notifies you about the problem, you can allow additional time. Help the applicant to get the needed information, as requested.

An applicant who provides a signed release to a specific individual or organization for specific information has met the requirement for supplying requested information or verification to give you permission to get it. The general release does not meet this requirement unless the applicant asks for help.

Deny the application if the applicant does not provide the requested information by the specified due date and does not authorize the Department to obtain the information within the requested time.

If the applicant is unable to get information from a spouse who is no longer in the household, do not deny the application. Contact the applicant to obtain the best information available. Ask the applicant about bank accounts, records showing deposits of the spouse's income, information from the divorce proceedings, and tax returns.

Ask the applicant to provide information that would help to verify what the applicant is telling you about a spouse who is no longer in the home. From the information provided, determine eligibility. If the applicant fails to provide the requested information, deny the application.

Reporting Changes

Legal reference: 441 IAC 76.2(249A); 76.10(249A)

The applicant shall report any change that occurs during the application process within five working days of the date of the change.

Processing Standards

Legal reference: 42 CFR 435.911, 441 IAC 76.3(249A)

The following sections explain:

- ◆ [Processing guidelines that apply to all Medicaid applications.](#)
- ◆ [Guidelines for processing applications for children.](#)

Guidelines for All Applications

Process applications on the earliest possible date. Determine eligibility and issue a written notice of decision for FMAP-related and SSI-related Medicaid by making system entries no later than the 30th day following the date of application. For the Medically Needy program, the applicant must receive a written notice approving or denying Medicaid no later than 45 days from the date of application.

If the 30th day or 45th day falls on a weekend or holiday, process the application by making system entries the next working day.

When the application is for SSI-related Medicaid, including SSI-related Medically Needy, and a blindness or disability determination is pending, the time limit is 90 days. See [Concurrent Medicaid and Social Security Disability Determinations](#).

If a person's eligibility is dependent upon a 30-day period of residency in a medical institution, delay the eligibility decision until the 30-day period has been met, unless the person is ineligible due to some other factor.

The time limit for approving or denying a Medicaid application can be waived in unusual circumstances. Examples of unusual circumstances include:

- ◆ When you and the applicant have made every reasonable effort to get necessary information and have not been able to do so within the time frames.
- ◆ Emergencies, such as fire or flood.
- ◆ Other conditions beyond the administrative control of the local office.

You cannot deny an application because of the time period alone. To deny the application, there must be either failure to act on the part of the applicant or a determination of ineligibility.

An applicant must cooperate with the application process. This may include providing information or verification, attending required interviews or signing documents. Failure to cooperate with the application process shall serve as a basis to deny an application.

Processing Applications with Children

Expedite the Medicaid eligibility determination for any child, regardless of any other programs for which the child is applying. Review the application and request any additional information or verification immediately. When adults and children apply together, do not delay the child's eligibility decision because of needed information or a necessary interview that affects only the adult's eligibility. See [Interviews](#).

Mrs. C and her two children apply for Medicaid on July 2. On July 3, the worker sends an appointment letter scheduling an interview for Mrs. C on July 19 because the worker determines information on the application is questionable. Also, on July 3, the worker sends a request for additional information and verification needed to make an eligibility determination with a due date of July 14.

All requested information and verification is supplied on July 9. The worker processes the application for the children, since their eligibility is not questionable. The household's countable income is within the FMAP income limits for a three-member household. However, since Mrs. C has not yet been approved, the children are approved for Medicaid under CMAP with Mrs. C coded as a considered person on the Automated Benefit Calculation (ABC) system case.

On July 19, Mrs. C attends the interview. The worker then processes the application for Mrs. C. Mrs. C is "added" to the ABC case by changing her entry reason and status code, entering a positive date, and changing her fund code. The worker also changes the ABC case aid type to the FMAP aid type and changes the children's fund codes.

A **hawk-i** application that is referred to Medicaid from **hawk-i** for a Medicaid eligibility determination is considered an application only for the children.

When it is not clear whether the application is for just the children or for both the adults and the children, contact the applicant for clarification. If attempts to contact the applicant are unsuccessful, presume that the applicant is applying for everyone listed on the application until the applicant can clarify otherwise.

When information is missing or questions on the application have not been answered, try to contact the applicant by phone before sending a written request, so the request can be as complete as possible. The applicant is still responsible to complete the application.

Regardless of whether attempts to contact the applicant by phone are successful, include in the written request the pages of the application that are incomplete and request that they be completed. Be sure to keep a copy of all application pages that you return to the applicant.

1. On July 7, a **hawk-i** application is referred to Medicaid because it appears the children will qualify for Medicaid. The IM worker located at **hawk-i** approves the children for CMAP, with the parents coded as considered person on the ABC sSystem. The IM worker then forwards the approved case record to the appropriate local local office.

In August, the parents call the local office to ask about getting Medicaid for themselves. They indicate they have medical bills in April, May, June, and July and request retroactive medical assistance. The inquiry is considered an application, and the date of the contact is documented in the case record as the date of application.

The worker explains that retroactive benefits go back only three months. The worker explores retroactive Medicaid eligibility for the parents for May, June, and July. Upon approval of the parents, the CMAP case is changed to an FMAP case.

2. Same as Example 1, except the parents contact the **hawk-i** office on July 20 requesting Medicaid while the application for the children is still pending. The IM worker documents the parents' request and the date of contact in the case file. The worker also sends the parents an application with instructions to return it to the local DHS office since there is no active case and only a **hawk-i** application has been completed.

The local office receives the application August 1. The IM worker at **hawk-i** approves the children's Medicaid under CMAP on August 4. When the worker in the local office, receives the case, the parents are added to the eligible group effective July 1, based on their verbal request of July 20. No interview is required, since adding the parents is handled in the same manner as adding a member to the eligible group.

3. On July 9, the local office receives a Medicaid Application in the mail listing Mr. and Mrs. F and their three children. The application is complete, but it is not clear for whom the F family is applying. The worker makes several unsuccessful attempts to contact the family by phone.

The worker proceeds as if everyone on the application is applying. On July 10, the worker sends a written request for additional information and verification with a due date of July 21 and another letter scheduling an interview for July 21.

4. On May 29, the local office receives an application in the mail requesting FIP, Medicaid, and Food Assistance and listing Ms. G and her child. The application contains a name, address, and signature, but most of the areas of the application are incomplete.

On May 29 and 30, the worker makes several unsuccessful attempts to reach Ms. G. On May 30, the worker sends Ms. G a written request for information, requesting Ms. G to complete the remainder of the application form. The due date is June 9 (ten calendar days). A face-to-face interview is scheduled for June 11 for FIP and Food Assistance.

On June 7, the requested information is returned. The completed application pages indicate the need for additional information and verification. The worker sends a written request with a due date of June 17 (ten calendar days).

During the interview with Ms. G on June 11, the worker determines that another piece of verification is needed. The worker gives a written request to Ms. G with a due date of June 21 (ten calendar days). On June 17, the verification is returned. The eligibility determinations for both Ms. G and her child can be processed together.

Effective Date of Eligibility

Legal reference: 42 CFR 435.914, 441 IAC 76.5(2)

The effective date of eligibility for Medicaid is the first day of the month an application was filed or the first day of the month all eligibility factors were met, whichever is later. EXCEPTION: Eligibility under the qualified Medicare beneficiary coverage group begins the first day of the month after the month of decision.

For **FMAP or FMAP-related** coverage groups, eligibility for Medicaid begins on the first day of the month when eligibility was established any time during the month.

FIP application filed	April 25
Date of decision	May 8
Eligible for FIP grant effective	May 2 (due to the seven-day waiting period)
Effective date of Medicaid eligibility	April 1 if eligibility requirements are met in April

For **SSI-related** coverage groups and State Supplementary Assistance, the applicant must meet all eligibility criteria and be resource-eligible as of the first moment of the first day of the month in order to be eligible for the month.

Effective Date for SSI Recipients

Legal reference: 441 IAC 76.5(249A)

An SSI recipient is eligible for Medicaid as of the first of the month before the month that the person attains SSI eligibility, unless either:

- ◆ The person's Iowa residency date is later, or
- ◆ There is a Medicaid policy that precludes eligibility, as listed in 8-F, [SSI Recipients](#).

1. Mr. M lives in Nebraska and files an application for SSI in January. In March, Mr. M moves to Iowa. Social Security processes Mr. M's application in March and establishes SSI eligibility effective January 1. Even though Mr. M was determined SSI-eligible in March, he is not eligible for Iowa Medicaid in January and February because he was not an Iowa resident. The earliest Mr. E's Iowa Medicaid eligibility can begin is March 1.
2. Ms. E is determined eligible for SSI beginning in May. After receiving an SDX about Ms. E's eligibility, the IM worker sends her form 470-2304 requesting more information. Ms. E returns the form but refuses to answer the questions about the paternity of her 13-year-old son, who is on Medicaid. The worker denies Medicaid for Ms. E due to refusal to cooperate in establishing paternity or support for a child under 18.

Beginning with determinations made on or after August 22, 1996, the effective date of approval under the SSI program is the later of:

- ◆ The month following the month of application for SSI, or
- ◆ The month following the month the client first meets all SSI eligibility factors.

1. Mr. A files for SSI on January 15. Mr. A meets all SSI eligibility criteria for January. SSI payment is approved effective February 1.
2. Mr. B files for SSI on January 15. Mr. B does not meet all SSI eligibility criteria until February (turns 65 in February). The earliest date that SSI payment will begin is March 1 (the month following the month that all SSI eligibility factors are first met).

For the month immediately before the effective date of approval, the Social Security Administration has already determined that the client meets all SSI eligibility factors. (The client does not receive an SSI payment due to SSI's effective date of approval policy.) Thus, for Medicaid purposes, it is not necessary to verify eligibility factors independently for that month.

Determine Medicaid eligibility for that month in the same manner as if the client was an SSI cash recipient. (It is still necessary to determine if the client has a trust or other item listed at 8-F, [SSI Recipients](#).)

1. Mr. A files for SSI on June 15. SSI cash payments are approved effective July 1. In order for SSI payments to begin effective July 1, the Social Security Administration must have determined that Mr. A met all SSI eligibility criteria for the month of June. Thus, it is not necessary to verify information independently for June.

The IM worker sends form 470-2304 to Mr. A using June 15 as the application date and March, April, and May as retroactive months. Mr. A returns the form indicating he does not have a trust or other item that precludes Medicaid eligibility (listed in 8-F, [SSI Recipients](#)). Mr. A is eligible for Medicaid in the month of June and ongoing (and potentially the retroactive months).

2. Mr. B files for SSI on January 15. SSI cash payments are approved effective March 1. In order for SSI payments to begin effective March 1, the Social Security Administration must have determined that Mr. B met all SSI eligibility criteria for the month of February.

Mr. B did not meet all eligibility criteria for the month of January (or SSI would have begun February 1). It is not necessary to verify information independently for the month of February. It is necessary to verify information and determine the reason that Mr. B was ineligible for January.

Use the SSI application date as the Medicaid application date. The effective date of eligibility can be no earlier than three months before the date of application for SSI. This date is on the SDX. When the date of the SSI application is in a different month from the month that SSI eligibility begins, determine if there is Medicaid eligibility for:

- ◆ The month of SSI application.
- ◆ All months between the date of application and the month of eligibility for SSI.
- ◆ The retroactive period.

See [Collecting Eligibility Information From SSI Recipients](#).

Establishing Beginning Months of Eligibility for MEPD

Legal reference: 441 IAC 75.1(39)"b""4", and 75.1(39)"b""6"

Policy:

Medicaid for Employed People with Disabilities (MEPD) applicants may choose to have either MEPD or Medically Needy coverage for months between the date of application and the date that the case is approved on the ABC system.

Comment:

Application processing may be delayed due to waiting for a disability determination decision. This may result in a delay of several months between the date of application and the date the approval is entered in ABC. "Back months" are the months between the date of application and the month when the case is actually approved on ABC.

"Conditional eligibility" for MEPD means the member must pay a premium before getting Medicaid eligibility for a month.

If the member wants to have Medically Needy for some back months, see the procedures in 8-F, [Relationship to Medically Needy](#).

Procedure:

The MEPD Billing System applies premium payments in a specified order. The person who enters the payments in the MEPD system cannot change the order of how the payment will be applied to pay for "back months."

Before entering conditional approval on ABC for back months, it is important to check with the applicant to see if the applicant wants Medicaid for each of the back months. Do **not** give the applicant conditional MEPD eligibility for a month when the applicant does not want MEPD benefits.

Corrections can be made on the MEPC screens after the initial and back months are assessed for MEPD premiums.

Changing Conditionally Approved Months for MEPD	
Situation:	Worker Action:
<p>After conditional eligibility has already been entered in ABC for "back months," the member tells the worker that there are some months for which the member does not want to pay premiums.</p> <ul style="list-style-type: none"> ◆ If the premiums for those months have not been paid... ◆ If the premiums for those months have been paid... 	<p>Ask the member to sign a statement that lists the "back months" for which the member does not want Medicaid. Do not block months until the signed statement is received.</p> <p>"Block" the months when the member does not MEPD coverage so that payments are not applied to premiums for those months. Enter "B" for the months that need to be blocked on the member's MEPC screen.</p> <p>Do not block the month, as Medicaid eligibility was already given.</p>
<p>The worker needs to "block" a paid month due to an error in giving conditional eligibility for that month.</p>	<p>"Block" the month by entering "B" for that month on the member's MEPC screen. The system will:</p> <ul style="list-style-type: none"> ◆ "Back out" the premium payment for the blocked month. ◆ Hold the premium payment as a credit or apply it to another unpaid month. ◆ Issue a WIFS requesting recoupment of the paid Medicaid claim for that month.
<p>A month is blocked in error.</p>	<p>"Unblock" the month on the MEPC by entering a "U" for unblock over the "B" on the month line. Remember, once a month is blocked, the member will not be given Medicaid eligibility for that month until it is unblocked.</p>

Comment:

See 14-B(9), [Change to MEPD Premium: Using MEPC](#).

See 8-F, [Relationship to Medically Needy](#).

Determining Eligibility for the Retroactive Period

Legal reference: 42 CFR 435.914, 441 IAC 76.5(1)

Medicaid benefits are available for any or all of the three months before the month in which the application is filed. This time is called the “retroactive period.” **Exception:** The following coverage groups do not have retroactive eligibility:

- ◆ Iowa Family Planning Network (IFPN), and
- ◆ Qualified Medicare Beneficiary (QMB).

An IowaCare member may be eligible for only one retroactive month.

To be eligible for retroactive benefits, an applicant must meet both of these conditions:

- ◆ The applicant has paid or unpaid medical bills for Medicaid-covered services received during the retroactive period, **and**
- ◆ The applicant would have been eligible for Medicaid benefits in the months services were received, if a valid application had been filed.

An applicant does not need to be eligible in the month of application to be eligible for the retroactive period. If an application is submitted on behalf of a deceased person, determine the deceased person’s retroactive eligibility using the same requirements.

When retroactive coverage is requested, evaluate the three months preceding the month of the current application to see if eligibility exists even if some of those months were denied on a previous application.

1. Ms. A files an application for CMAP on July 8. She indicates on the application that she wants retroactive benefits. The worker requests in writing that Ms. A provide income verification for the months April through June. Ms. A fails to provide the income information and is denied Medicaid for the retroactive period. The application is approved for ongoing eligibility.
2. Same as Example 1, except that Ms. A is also denied for ongoing benefits due to failure to provide requested information. She reapplies on August 15, and this time cooperates in providing information needed to establish eligibility. She is eligible for the retroactive period of May through July, the three months before the month of the reapplication, and also for ongoing benefits.

Determine eligibility for the retroactive period on a month-by-month basis. This includes using a third or fifth paycheck when calculating monthly income. The coverage group under which the person is eligible in the retroactive period may be different for each month. EXCEPTION: See [Retroactive Eligibility for Medically Needy Recipients](#).

Issue a notice of decision when retroactive eligibility is denied.

When approving an application for retroactive Medicaid only, include the month when eligibility ended on either the *Notice of Decision* approving the retroactive months or on a separate notice. The notice does not need to be timely when assistance is simultaneously approved and ended for retroactive eligibility.

A member who did not know that there were bills in the retroactive period at the time of application can ask for a determination of eligibility for retroactive benefits at a later date. The retroactive period is the three months before the application month of the most recently **approved and active** Medicaid application. Retroactive eligibility cannot be determined at a later date on an application that was denied or canceled for ongoing benefits.

Also, a person may request retroactive coverage but may fail to provide the information needed to determine eligibility. Even though a notice of decision was issued, the member may request to have eligibility determined again for the same retroactive period if the application was approved for ongoing benefits **and** it remains the most recently approved Medicaid application.

Although a member can request retroactive benefits at any time, payment will not be authorized for covered medical services provided 23 months or more before the current month unless extenuating circumstances exist. See 8-M, [Submitting Claims](#), for more information.

Additionally, Medicaid benefits cannot be approved on the ABC system for any month before January 1 of the previous calendar year (e.g., in March 2000, benefits can be authorized only for January 1999 or later). Benefits can be approved for SSI approvals beyond the two years by submitting special updates when the SSI eligibility determination went beyond the two years.

Verification Requirements

When determining retroactive eligibility, accept a client's statement that the client has paid or unpaid medical bills (unless questionable). See 8-F, [Continuous Eligibility for Pregnant and Postpartum Women](#), for requirements when establishing continuous eligibility for pregnant women at the time of application.

Clearly document in the case record how eligibility or ineligibility for each month was established. Information to be documented includes:

- ◆ Verification of income and resources.
- ◆ Household composition for each month.
- ◆ Beginning date of disability, if applicable.

Retroactive Eligibility for Medically Needy Recipients

Legal reference: 441 IAC 75.25(249A)

A Medically Needy certification period is considered as one unit. Even though the period may include one or more months, determine eligibility for the entire certification period only. The retroactive period for Medically Needy is a one-month, two-month, or three-month period, depending on which month the client first incurred a medical expense. See [8-J](#).

1. Ms. S applies for Medically Needy on March 5. The certification period is March and April. Ms. S claims to have unpaid bills for December and January, which are within the three-month retroactive period.

The worker requests income and resource information for all three months of the retroactive period (December - February). If income or resource verification is not provided for December through February, eligibility for the retroactive period cannot be determined.

2. Ms. B applies for Medically Needy on April 15. The certification period will be April and May. She states that there are no unpaid medical bills for the retroactive period (January - March). In June, Ms. B reports that there is an unpaid medical bill for January.

The worker establishes eligibility for the three-month retroactive period. Income from all three months is used in computing spenddown. Spenddown for the retroactive period is \$100. The unpaid bill is \$500. The amount in excess of the spenddown (\$400) is Medicaid-payable in the retroactive period.

Retroactive Eligibility for SSI Recipients

Legal reference: 441 IAC 76.5(1)

For an SSI recipient to be eligible for retroactive benefits:

- ◆ The person must have been eligible for Medicaid benefits in the months services were received (if an application had been filed), and
- ◆ The person must have paid or unpaid medical bills for Medicaid-covered services received during the retroactive period. The SDX shows unpaid medical claims in the UNPAID RETRO field.

A person who is presumptively disabled (disability code P on the SDX) is not entitled to retroactive benefits until a final determination has been made that the person is eligible for disability.

Send form 470-2304, 470-2304(S), 470-0364, or 470-0364(S), *SSI Medicaid Information*, to collect information about the retroactive months. See [Collecting Eligibility Information From SSI Recipients](#). Examine retroactive eligibility for an SSI recipient as you would any other applicant. During the retroactive period, the person must have been either:

- ◆ At least 65 years of age, or
- ◆ Under 18 years of age, or
- ◆ Blind, or
- ◆ Disabled.

Accept the member's statement regarding the date of onset of blindness or disability, unless there is evidence to the contrary.

Referrals to CSRU

Legal reference: 441 IAC 75.14(5)

The Child Support Recovery Unit (CSRU) seeks medical support as well as financial support for people in the Medicaid eligible group.

Refer the absent parent (including an adoptive parent) to CSRU within two working days of the date assistance is approved, unless good cause exists. (See 8-C, [COOPERATION WITH SUPPORT RECOVERY](#).)

For foster care cases, link both parents. If the ICAR referrals have not been made, complete the referral.

If a mother claims more than one alleged father for a child, enter a referral on the **same** ICAR case for each alleged father. If the mother claims that her children have different but unknown fathers, establish a **separate** ICAR case for each child to reflect that child's alleged fathers.

The fathers of both child A and child B are unknown. The mother states that child A and child B have different fathers, but that child B's father could have been one of two people. One ICAR case must be set up for child A's father, and another ICAR case for child B's alleged fathers.

If the natural father is to be included in the eligible group and paternity has **not** been established, send to CSRU:

- ◆ A copy of the Medicaid application.
- ◆ A memo identifying the case as a two-parent case in which paternity has not been established.
- ◆ A completed form 470-2220, Notarized Statement for Child Support Recovery Office. (See [6-Appendix](#).)

When the putative father is deceased, send CSRU a copy of the application that lists the deceased father. Attach a memo stating that the information pertains to a deceased father.

If a mother claims that the father of the child is someone other than the man to whom she was married when the child was conceived or born (the legal father), make a referral on the legal father, but identify the biological father in the "Comment" section of REFER2.

When Medicaid is approved following a break in assistance, link the Medicaid case to the ICAR case established previously on the same absent parent. Update information in the comment section of REFER2 as needed.

EXCEPTIONS: Do not make a referral to CSRU:

- ◆ When both parents are in the home and paternity has been established.
- ◆ On a parent whose parental rights have been terminated by the court.
- ◆ On the parents of an underage parent who is a payee.
- ◆ When a child in subsidized adoption is placed in foster care and no child support order currently exists.
- ◆ When eligibility is established under the Iowa Family Planning Network coverage group.
- ◆ When the same absent parent was referred while a FIP-only case. However, link the existing ICAR case to the Medicaid case. Update information in the comment section on REFER2 as needed to reflect current case circumstances.
- ◆ When a parent's absence is solely because of the performance of active duty in the uniformed services of the United States. "Uniformed service" means the United States Army, Navy, Air Force, Marine Corps, Coast Guard, National Oceanographic and Atmospheric Administration, or Public Health Service.

NOTE: A parent whose absence is solely because of the performance of active duty in the uniformed services of the United States is considered to be absent for purposes of determining Medicaid eligibility. (See 8-C, [Absence](#).) However, a parent who is absent for this reason is not referred to CSRU.

If the parent later leaves the home, refer the absent parent via entries on REFER. If the children later receive Medicaid on a nonparental case, notify CSRU of the change in caretakers by making entries on the system. Refer both absent parents when establishing the nonparental case. CSRU determines whether a caretaker assignment is necessary or whether the existing assignment can continue with the new caretaker.

If an absent parent returns to the home and eligibility continues, continue to link the case. Enter in the "Comment" section of REFER2 that the absent parent has returned to the home and that Medicaid eligibility continues. Do not make a new referral, but change the code in the IABC deprivation field to reflect the change.

Make a new referral whenever a new absent parent is determined on a Medicaid case that was previously referred for a different absent parent.

Pregnant Women

Legal reference: 441 IAC 75.14(6) and (7)

As a condition of her eligibility, the woman must cooperate in establishing paternity and obtaining support for the children for whom she receives Medicaid (except for pregnant women under MAC).

Even though pregnant women applying for or receiving Medicaid under the MAC coverage group are automatically exempt from cooperation, request in the usual manner information about the absent parent of the born children for whom the woman is applying or receiving Medicaid.

Make a referral to CSRU when a pregnant woman is receiving Medicaid for other children who have an absent or deceased parent, if the information is provided.

Do not make a referral regarding the father of the unborn child until the 60-day postpartum period has ended. If the father of the unborn child is also the absent parent of other children for whom the pregnant woman receives Medicaid, make a referral for the other children.

(See also 8-C, [COOPERATION WITH SUPPORT RECOVERY](#), and 8-F, [Mothers and Children \(MAC\) Program](#).)

1. Ms. A is pregnant and lives alone. She applies for Medicaid. No referral is made and no information requested regarding the father of the unborn child until the 60-day postpartum period has ended.
2. Ms. B is pregnant and lives with her two children. She applies for Medicaid for herself and the children. Eligibility is examined under the FMAP coverage group.

A referral is made regarding the father of the two children, even if he is also the father of Ms. B's unborn child. As a condition of her Medicaid eligibility, Ms. B is required to cooperate in establishing paternity and obtaining support for these two children. When the 60-day postpartum period ends, a referral is also made for the unborn child.

3. Same as Example 2, except that Ms. B changes her mind and does not cooperate with CSRU after approval. Medicaid for Ms. B under the FMAP coverage group is canceled. She is placed in the MAC coverage group, because cooperation with CSRU is not an eligibility factor for pregnant women under MAC.

Ms. B's children are placed in the CMAP coverage group. Ms. B is coded as a considered person on the children's CMAP case, and the children are coded as considered people on Ms. B's MAC case.

4. Ms. C is pregnant and lives with a male friend. She applies for Medicaid. Eligibility is examined under the MAC coverage group. Ms. C is required to provide enough information about her male friend in order for the worker to determine if policy requires the male friend to be considered the legal father.

If he is not considered the legal father, no additional information is required regarding the father of the unborn child until the 60-day postpartum period has ended.

5. Ms. D is pregnant and receives Medicaid under the MAC coverage group for herself and her daughter. Ms. D wishes to have CSRU establish paternity and support for her daughter. The worker makes the referral to CSRU for the daughter.
6. Same as Example 5. The referral is made to CSRU. However, Ms. D changes her mind and does not cooperate with CSRU. Her Medicaid is not canceled, because she receives Medicaid under MAC as a pregnant woman, and is, therefore, exempt from the cooperation requirement.

System Entries When the Custodial Parent is Pregnant

If the custodial parent is pregnant and establishing eligibility under the MAC coverage group at the time the referral is made, enter in the "comments" field of the REFER2 screen "CP is pregnant/exempt from cooperating for child already born. Due date MM/YEE."

If the custodial parent is a pregnant woman establishing eligibility under a coverage group other than MAC at the time the referral is made, enter in the "comments" field of the REFER2 screen "CP is pregnant/not exempt. Due Date MM/YY."

If the custodial parent becomes pregnant after the referral is made, make the appropriate entry in the "comments" field of the REFER2 screen when Medicaid eligibility for the custodial parent is established or changed based on the pregnancy. If eligibility remains unchanged, make the comment on the REFER2 screen when an entry is made in the UNB field on TD03.

Referrals to the *hawk-i* Program

Legal reference: 441 IAC 86.4(514I)

Refer an applicant child to the ***hawk-i*** program when the child:

- ◆ Is only conditionally eligible for Medically Needy with a spenddown, or
- ◆ Has been voluntarily excluded from the Medicaid eligible group due the child's income or resources.

NOTE: Make referrals even if the child is insured. The ***hawk-i*** program staff will work with the family to coordinate the dropping of the child's health insurance and the ***hawk-i*** approval to provide seamless coverage.

Do not refer a child to the ***hawk-i*** program if the child:

- ◆ Is age 19 or older, or
- ◆ Does not meet Medicaid's alien requirements (they are the same for hawk-i), or
- ◆ Is ineligible for Medicaid due to noncooperation (failure to provide income verification, etc.).
- ◆ Has eligibility established under the Iowa Family Planning Network coverage group.

Make a referral by completing form 470-3565, *Referral to the **hawk-i** Program*, within one working day of the determination that the child is ineligible for Medicaid, must meet a spenddown, or has been voluntarily excluded. A copy of the notice of decision showing the income calculation establishing Medicaid ineligibility must accompany the referral form.

Fax the referral and notice of decision to 515-457-7701, or send them to:

Department of Human Services
Attn: MAXIMUS/**hawk-i** Program
Division of Financial, Health, and Work Supports
Hoover State Office Bldg. – 5th Floor
1305 E Walnut ST
Des Moines, IA 50319-0114

Representation

Legal reference: 441 IAC 76.1(7)

A Medicaid applicant or member may need or want to be represented by another person or organization. When a client is incompetent, physically incapacitated, or deceased, a “responsible person” is allowed to act on the client’s behalf. A competent person may name an “authorized representative” to participate in pursuing Medicaid eligibility. The policies and procedures for these two types of representation are discussed in this section.

Responsible Person

Legal reference: 441 IAC 76.1(7)“a”

When a client is unable to act on the client’s own behalf because the client is incompetent, physically incapacitated, or deceased, another person may act responsibly for the client. The responsible person must be:

- ◆ A family member, friend, or other person who has knowledge of the client’s financial affairs and circumstances, and a personal interest in the client’s welfare, or
- ◆ A legal representative, such as a conservator, guardian, executor, or someone with power of attorney.

A responsible person assumes the client's position and responsibilities during the application process or for ongoing eligibility.

A responsible person may designate an authorized representative to represent the incompetent, physically incapacitated, or deceased client. (See [Authorized Representative](#).) However, this does not relieve the responsible person from assuming the client's position and responsibilities during the application process or for ongoing eligibility.

Provide copies of all correspondence and documents that you would normally provide to the applicant or member to the responsible person and to the representative, if the responsible person has authorized one.

When there is no person as described above to act as a responsible person, any individual or organization can act as the responsible person if the individual or organization:

- ◆ Conducts a diligent search for someone who meets the criteria for a responsible person but cannot locate such a person, and
- ◆ Completes form 470-3356, Inability to Find a Responsible Person.

Authorized Representative

Legal reference: 441 IAC 76.1(7) "b"

Policy:

A competent applicant or member or a responsible person (see [Responsible Person](#)) may authorize any individual or organization to represent the applicant or member in the application process or for ongoing eligibility. See [Authorization to Represent](#) for authorization requirements.

Authorized representatives may participate in the application process or in the ongoing eligibility process. Authorized representatives are allowed to:

- ◆ File applications.
- ◆ Check on the progress of an application or ongoing eligibility.
- ◆ Request reschedules of interviews or extensions for providing documentation or verification.

Appointment of an authorized representative does not relieve a competent applicant or member or a responsible person of the primary responsibility to cooperate with the application process or for establishing ongoing eligibility. The applicant, member, or responsible person is still required to:

- ◆ Attend interviews, when requested.
- ◆ Sign documents.
- ◆ Supply information or verifications.
- ◆ Meet all other requirements necessary to determine eligibility.

Procedure:

When an applicant, member, or responsible person has named an authorized representative, send the authorized representative copies of all correspondence sent to the applicant or member that will affect eligibility.

When a competent applicant names an authorized representative, send all correspondence to the applicant and copies of all correspondence that pertains to the eligibility determination to the authorized representative.

For incompetent, physically incapacitated, or deceased applicants, send correspondence to the responsible person and copies to the authorized representative.

For members under Medicaid for Employed People with Disabilities (MEPD), also provide a copy of each *MEPD Billing Statement*, form 470-3902, to the authorized representative.

Make entries on the member's MEPD STMT screen to generate a copy of the *MEPD Billing Statement*. See 14-C, [STMT=MEPD Billing Statement Screen](#), (REPRINT (WRKR) field) for entry instructions. After the entries are updated, the worker will receive the duplicate bill and send it to the authorized representative.

Authorization to Represent

Legal reference: 441 IAC 76.1(7)“b”

An authorization to represent is a written document or statement signed and dated by the competent applicant or member or by a responsible person that identifies the individual or organization that will act as the person’s authorized representative.

If the authorization identifies the period or the dates of medical services it is to cover, the authorization is valid for the initial application and any additional application filed by the representative or applicant for the stated period or dates of medical services, as well as appeals relating to the application.

If the authorization does not indicate the period or dates of medical services it is to cover, the authorization is valid for any applications filed within 120 days from the date the authorization was signed and all subsequent action pertaining to any applications filed within the 120-day period.

If an applicant, member, or responsible person notifies the Department in writing that the client or responsible person no longer wants an authorized representative to act on the person’s behalf, the Department will no longer recognize that individual or organization as the authorized representative.



TERRY E. BRANSTAD, GOVERNOR

DEPARTMENT OF HUMAN SERVICES

CHARLES M. PALMER, DIRECTOR

June 11, 1996

GENERAL LETTER NO. 8-B-36

ISSUED BY: Bureau of Eligibility/HIPP, Division of Medical Services

SUBJECT: Employees' Manual, Title 8, Chapter B, *Application Processing*, Title page, revised; Contents page 1, revised; and pages 1 through 24, new.

Summary

This general letter transmits the revised 8-B, *Application Processing*.

The existing chapter VIII-B, *General Eligibility Requirements*, has been reorganized and rewritten to incorporate the Department's updated manual format and writing style. Most of the information from the existing chapter has moved to other chapters. A comparison chart is provided as a reference.

Effective Date

August 1, 1996

Material Superseded

Remove all existing pages from the Employees' Manual, Title VIII, Chapter B, and destroy them.

Also obsolete interpretative memo MS-VIII-89-28, "Correct Aid Types For Pending and Approval of an Application for Medicaid When Income is Less than SSI Limits."

Additional Information

Refer questions about this general letter to your regional benefit payment administrator.

8-B Comparison Chart

<i>Current Section and Subsection Title</i>	<i>New Chapter</i>	<i>New Section</i>	<i>New Subsection</i>
Citizenship and Alienage	C/L	Citizenship (C), Determining Eligibility for Aliens (L)	Nonfinancial Eligibility (L)
Documentation	L	Determining Eligibility for Aliens	Nonfinancial Eligibility
Verification	L	Determining Eligibility for Aliens	Nonfinancial Eligibility
Residency	C	Residency	--
Client Over Age 21	C	Residency	Determining Residency for Persons Aged 21 or Over
Client Under Age 21	C	Residency	Determining Residency for Persons Under Age 21
Medicaid-Eligible Person Moves to Iowa	C	Residency	When a Medicaid-Eligible Person Moves to Iowa
Residing in a Public Institution	C	Residents of Institutions	Residents of Public Nonmedical Institutions
Institution Residents Eligible Due to Levings Ruling	C	Residents of Institutions	SSI-Related Eligibility Under Levings Rule
Furnishing a Social Security Number	C	Social Security Number	--
Verification of the Social Security Number	C	Social Security Number	Acting on an Error Report
Pursuing Other Case Benefits	C	Benefits From Other Sources	--
Verifying Intent to Apply	C	Benefits From Other Sources	--
Reports Indicating Possible Income or Resources	G	Changes in Household Circumstances	Acting on Changes Received Through IEVS
Verification of Benefits	E	Overview	Verification of Income
Trusts	D	Trusts	--
Use of Other Medical Resources	C	Cooperation	--
Third Party Defined	C	Cooperation	Cooperation With Third-Party Liability Unit
Reporting Medical Resources	G	Client Reporting Requirements	Reporting Changes

<i>Current Section and Subsection Title</i>	<i>New Chapter</i>	<i>New Section</i>	<i>New Subsection</i>
Establishing Availability of Group Health Insurance	C	Cooperation	Cooperation with the HIPP Unit
Accident-Related Injuries	C	Cooperation	Cooperation with Third-Party Liability Unit
Third Party Payments	C	Cooperation	Cooperation with Third-Party Liability Unit
Failure to Cooperate	C	Cooperation	Failure to Cooperate With HIPP or TPL
Good Cause for Failure to Cooperate	C	Cooperation	Failure to Cooperate With HIPP or TPL
Recipient's Responsibilities	--	--	--
Supplying Information	G	Client Reporting Requirements	Providing Information and Verification
Cooperating with Quality Control or the Food Stamp Investigation Section	C	Cooperation	Cooperation with Investigations and Quality Control
Reporting Changes	G	Client Reporting Requirements	Reporting Changes
Cooperation In Establishing Paternity and Obtaining Support	C	Cooperation With Support Recovery	--
(Subsections under this heading have been replaced with cross-references to 4-C.)			
Penalties for Failure to Cooperate	C	Cooperation With Support Recovery	Failure to Cooperate in Obtaining Support
Assignment of Support Payments	C	Assignment of Medical Support	--
Referrals to the Child Support Recovery Unit	B	Referrals to CSRU	--
Transfer of Assets	D	Transfer of Assets	--
Exempted Transfers	D	Transfer of Assets	Transfers That Do Not Cause Penalty
Compensation in Services or Support	D	Transfer of Assets	Rebuttal of Transfer of Assets
Period of Ineligibility	D	Transfer of Assets	Penalties for Transferring Assets
Continuing Eligibility	G	Automatic Redetermination	--

<i>Current Section and Subsection Title</i>	<i>New Chapter</i>	<i>New Section</i>	<i>New Subsection</i>
Death of Recipient	G	Changes in Household Circumstances	Death of a Recipient
Eligibility	G	Changes in Household Circumstances	Death of a Recipient
Estate Recovery	D	Estate Recovery	--
Long-Term Care Asset Preservation	D	SSI-Related Resource Policies	Long Term Care Asset Preservation



TERRY E. BRANSTAD, GOVERNOR

DEPARTMENT OF HUMAN SERVICES

CHARLES M. PALMER, DIRECTOR

January 7, 1997

GENERAL LETTER NO. 8-B-37

ISSUED BY: Bureau of Eligibility/HIPP, Division of Medical Services

SUBJECT: Employees' Manual, Title 8, Chapter B, *Application Processing*, Contents (page 1), revised; pages 13, 17 and 18, revised; and pages 18a and 18b, new.

Summary

This explains changes in the SSI program's effective date of approval policies and explains how those changes effect Medicaid eligibility.

Effective Date

Upon receipt.

Material Superseded

Remove Contents (page 1), and pages 13, 17 and 18, all dated June 11, 1996, from Employees' Manual, Title 8, Chapter B, and destroy them.

Additional Information

Contact your regional benefit payment administrator if you need additional information.



February 11, 1997

GENERAL LETTER NO. 8-B-38

ISSUED BY: Bureau of Eligibility/HIPP, Division of Medical Services

SUBJECT: Employees' Manual, Title 8, Chapter B, *Application Processing*, Contents (page 1), revised; pages 1, 3, 4, 5, 6, and 11 through 16, revised; and pages 16a, 25, 26, and 27, new.

Summary

This general letter transmits the following changes in 8-B due to changes in the rules in the Iowa Administrative Code.

- ◆ Adds a section on “representation” which identifies the two types of representation recognized by the Department for purposes of seeking Medicaid eligibility.
 - Responsible person.
 - Authorized representative.
- ◆ Defines and describes the scope of such representation.
- ◆ Clarifies the responsibilities of the applicant or recipient who has named an authorized representative.
- ◆ Adds a provision to allow an individual or organization that does not otherwise qualify as a responsible person to act as a responsible person for the incompetent, physically incapacitated, or deceased person if no one who fits the description of a responsible person can be found.
- ◆ Defines an authorization to represent and what is considered to determine the period of time the authorization covers.
- ◆ Clarifies who must sign an application before eligibility can be approved.
- ◆ Specifies that a written notice be issued when initially scheduling interviews and allows rescheduling requested by the applicant or the authorized representative to be agreed upon verbally without written confirmation.

- ◆ Specifies additional instances when a phone interview may be conducted rather than a face-to-face interview:
 - The applicant has moved out of state and can't be expected to commute to attend the interview.
 - An application is filed because rehabilitative treatment services are being provided.
- ◆ Specifies that failure to attend an interview is cause to deny an application.
- ◆ Provides that rescheduling of interviews is to be granted only when the applicant is making every effort to cooperate in attending.
- ◆ Specifies the Department's policy on faxed applications.

Effective Date

March 1, 1997

Material Superseded

Remove the following pages from Employees' Manual, Title 8, Chapter B, and destroy them:

<u>Page</u>	<u>Date</u>
Contents (page 1)	January 7, 1997
1, 3-6, 11, 12	June 11, 1996
13, 14	January 7, 1997
15, 16	June 11, 1996,

This release supersedes any previous instruction an authorized representative including Interpretive Memo MS-VIII-94-3, *Authorized Representative*, issued June 8, 1994.

Additional Information

Refer questions about this general letter to your regional benefit payment administrator.



TERRY E. BRANSTAD, GOVERNOR

DEPARTMENT OF HUMAN SERVICES

CHARLES M. PALMER, DIRECTOR

May 6, 1997

GENERAL LETTER NO. 8-B-39

ISSUED BY: Bureau of Eligibility/HIPP, Division of Medical Services

SUBJECT: Employees' Manual, Title 8, Chapter B, *Application Processing*, page 8, revised.

Summary

The MA-2124 has been revised and the name changed to more accurately reflect what happens with an SSI recipient who wants Medicaid. The new name is *Medicaid Questionnaire for SSI Persons*.

Also the questions on the form have been revised based on reformatting to go along with handling through X-Pert as well as for requests from the field. Information the clients attests to is revised to make the material more understandable for the client.

The *Important Notice to Property Owners and Renters* is part of the MA-2124-0 when issued on ABC. Workers will no longer have to send these out separately to SSI clients.

Effective Date

April 28, 1997

Material Superseded

Remove page 8, dated June 11, 1996, from Employees' Manual, Title 8, Chapter B, and destroy it.

Additional Information

Refer questions about this general letter to your regional benefit payment administrator.



December 2, 1997

GENERAL LETTER NO. 8-B-40

ISSUED BY: Bureau of Eligibility/HIPP, Division of Medical Services

SUBJECT: Employees' Manual, Title 8, Chapter B, *Application Processing*, Contents (page 1), revised; Contents (page 2), new; pages 1, 2, 3, 6, 11, 15, 16, 16a, 19, 20, 23, and 24, revised; and page 6a, new.

X-PERT Implementation

This general letter transmits changes for implementation of the X-PERT system, including:

- ◆ New application forms.
- ◆ Changes in the application process for households selected for the X-PERT system.
- ◆ Information on converting ongoing cases to X-PERT.

The X-PERT system will be implemented in phases until statewide conversion of FIP, food, and Medicaid cases is completed. The changes apply only to the counties where X-PERT is implemented.

Processing Applications

For cases selected for X-PERT, consider an application filed the day an applicant submits form 470-3112, *Application for Assistance Part 1* (or form 470-3122, Spanish), or form 470-2927, *Health Services Application* (or form 470-2927(S), Spanish) with a name, address and signature.

Consider the application complete when:

- ◆ The applicant has submitted a complete *Application for Assistance Part 1*, form 470-3112 (or form 470-3122, Spanish), or form 470-2927, *Health Services Application* (or form 470-2927(S), Spanish); and
- ◆ The interview has been held and the applicant has been provided with the system-generated *Summary of Facts*, form 470-3114, for review; and
- ◆ The applicant has signed the *Summary Signature Page*, form 470-3113 (or form 470-3123, Spanish).

If an applicant files an *Application for Assistance Part I*, form 470-3112 (or form 470-3122, Spanish), in error, give the applicant the appropriate application form to complete. Do not approve assistance unless the applicant completes the correct application form. However the date of application is the date the applicant filed the *Application for Assistance Part I*, with the applicant's name, address and signature.

Likewise, if an applicant selected for X-PERT submits an identifiable form PA-2207-0 (or form PA-2230-0, Spanish) or form 470-2927 (or form 470-2927(S), Spanish) or form PA-1107-0 in error, give the applicant an *Application for Assistance Part I*, to complete.

The date of application is the date the applicant filed form PA-2207-0 (or form PA-2230-0, Spanish) or form 470-2927 (or form 470-2927(S), Spanish) or form PA-1107-0. However, do not approve assistance unless the applicant completes the three-part X-PERT application process.

A household may not check all programs for which it wants to apply on the application. If, during the interview, an applicant who filed an *Application for Assistance Part I*, asks to apply for additional programs, allow the household to check the appropriate boxes on *Part I*. The filing date for any additional program is the same date as the filing date for the programs the applicant checked when initially filing *Part I*.

However, the *Health Services Application* is a valid application form only for Medicaid. So, if, during the interview, the applicant who filed a *Health Services Application* asks to apply for additional programs, provide the household with an *Application for Assistance Part I*. The applicant must complete this and file it with the county office. This will establish a separate filing date for the *Application for Assistance Part I*.

Ongoing Cases

To review cases on X-PERT and those not on X-PERT, use form PA-2140-0, *Public Assistance Eligibility Report*, or form 470-2882, *Review/Recertification Eligibility Document*, or form 470-3118, *Medically Needy Recertification/State Supplementary and Medicaid Review*, as appropriate.

Conversion of ongoing cases to the X-PERT system at times other than review is considered a procedural change rather than a review. Correct errors you discover during the conversion process. Eligibility may be affected as a result of correcting the errors.

When converting cases outside review time, you may need additional information from the recipient to complete the conversion. To obtain the information, you may require the recipient to appear for an interview. Cancel assistance if the recipient fails to appear for the interview when so requested or fails to provide the requested information. Use notice reason 406 (failure to appear for an interview) or notice reason 206 (failure to provide information) in that instance.

Separated Spouses

In a recent case, the Polk County Court District Court issued a decision which reversed the Department's final appeal decision. The appellant had applied for Medicaid. At the time of his application, the appellant was no longer living with his wife and their child.

The Department's position was that since the appellant was applying for retroactive coverage during a month when he was a member of that household, the cooperation of the appellant's wife was necessary in determining eligibility and benefits. The court disagreed and determined that the appellant had cooperated and that it was unreasonable to require the cooperation of a spouse who was no longer in the household.

Do not deny an application when the client is unable to provide verification from a spouse who is no longer in the household. Interview the client to obtain the best information available. Ask the client to provide information that would help to verify what the client is telling you about the spouse. Determine eligibility from the information provided. If the client fails to provide the requested information, deny the application.

The reference to the work transition period (WTP) has been removed.

Effective Date

The X-PERT changes are effective upon implementation in the counties.

All other changes are effective upon receipt.

Material Superseded

Remove the following pages from the Employees' Manual, Title 8, Chapter B, and destroy them:

<u>Page</u>	<u>Date</u>
Contents (page 1)	February 11, 1997
1	February 11, 1997
2	June 11, 1996
3, 6, 11, 15, 16, 16a, 19, 20, 23, 24	February 11, 1997

Additional Information

Refer to 6-Appendix for copies of the new X-PERT forms and instructions for their use and completion.

Continue to use form PA-2207-0, *Public Assistance Application* (or form PA-2230-0, Spanish), form 470-2927, *Health Services Application* (or form 470-2927(S), Spanish), and form PA-1107-0, *Application for Medical Assistance or State Supplementary Assistance*, for Medicaid cases not selected for X-PERT.

Refer questions about this general letter to your regional benefit payment administrator.



January 6, 1998

GENERAL LETTER NO. 8-B-41

ISSUED BY: Bureau of Eligibility/HIPP, Division of Medical Services

SUBJECT: Employees' Manual, Title 8, Chapter B, *Application Processing*, Contents (page 1) revised; pages 2, 4, 8, 11, 12, 14, 16, 16a, 17 through 20, and 24, revised.

Family Medical Assistance Program (FMAP)

Before the passage of the Personal Responsibility and Work Opportunity Act of 1996 (PRWOA), people who received cash assistance under the Family Investment Program (FIP) were automatically eligible to receive Medicaid, unless they had a Medicaid qualifying trust or had transferred assets.

Due to the new five-year lifetime limit to receive cash assistance, the PRWOA removed the link between FIP and Medicaid, so that a person's eligibility for Medicaid was not dependent upon receipt of cash assistance.

The Family Medical Assistance Program (FMAP) replaces the coverage group for people who previously received Medicaid because they received FIP. Medicaid coverage groups for families and children will now be referred to as "FMAP-related" instead of "FIP-related."

Parents in a FMAP related household who worked over 100 hours no longer have to wait 30 days to become eligible. Eligibility is effective on the first day of the month when eligibility was established any time during the month.

Concurrent with the implementation of X-PERT the Department is implementing an automated process to send and track the receipt of the MA-2124 form, *Medicaid Information Questionnaire for SSI Persons*, for certain new SSI cases and to establish Medicaid eligibility when no further information is needed from the client. This process will occur whether or not you are using X-PERT for your eligibility work.

A new screen on XABC, called SDXT, has been developed for tracking the receipt of the MA-2124 form. Another new feature is that this screen will cause mainframe to send form 470-3193, *SSI Medicaid Reminder*, to the client when the receipt of the MA-2124 is not recorded on SDXT. To access SDXT after signing on to CICS, enter "XABC," then "SDXT" from the menu.

See 14-E, *SSI State Data Exchange*, for a description of the new process.

When your case is not selected for the automated process and you do not use the X-PERT process yet, IABC is available for you to record the Medicaid eligibility. Also, you can enter "V" in the retroactive Medicaid field on IABC, TD05 to send the reminder letter to your client when you have previously sent the MA-2124 and it has not been returned.

Effective Date

The automated process to send and track the MA 2124 and the use of the *SSI Reminder Notice*, will be effective when X-PERT is implemented.

Policies relating to the delinking of Medicaid from FIP cash assistance are effective retroactively to December 1, 1997.

Eliminating the 30 day wait for two-parent households is effective January 1, 1998.

Material Superseded

Remove the following pages from the Employees' Manual, Title 8, Chapter B, and destroy them:

<u>Page</u>	<u>Date</u>
Contents (page 1)	December 2, 1997
2	December 2, 1997
4	February 11, 1997
6	December 2, 1997
8	May 6, 1997
11	December 2, 1997
12, 14	February 11, 1997
16, 16a,	December 2, 1997
17, 18, 18a, 18b	January 7, 1997
20, 24	December 2, 1997

Additional Information

Refer questions about this general letter to your regional benefit payment administrator.



December 22, 1998

GENERAL LETTER NO. 8-B-42

ISSUED BY: Insurance Purchasing Unit, Bureau of Health Care Purchasing and Quality Management, Division of Medical Services

SUBJECT: Employees' Manual, Title 8, Chapter B, *Application Processing*, Contents (pages 1 and 2), revised; pages 1 through 5, 12, 13, 14, 23, and 24, revised; and pages 4a and 24a, new.

The Healthy And Well Kids in Iowa (HAWK-I) Program

The Balanced Budget Act of 1997 (Public Law 105-32) added a new Title XXI to the Social Security Act. Title XXI provides funding to states to create health care programs for targeted low-income, uninsured children. States can use Title XXI funding to:

- ◆ Expand existing Medicaid programs,
- ◆ Create a non-Medicaid program, or
- ◆ Take a combination approach.

In 1998, the Iowa Legislature passed House File 2517, which directs the Department to develop a combination approach for providing coverage to uninsured children. "Phase one" was a Medicaid expansion that was implemented on July 1, 1998. "Phase two" is the implementation of the Healthy And Well Kids in Iowa (HAWK-I) program, which is a non-Medicaid health insurance program for children.

The Department has contracted with Eligibility Services Incorporated (ESI) to administer the HAWK-I program. As the third-party administrator of the HAWK-I program, ESI will accept applications, screen applications for Medicaid eligibility, determine eligibility to participate in the HAWK-I program, determine if the family is required to pay a premium, and assist the family in enrolling in a health plan.

This General Letter transmits the policies and procedures to be followed when:

- ◆ A HAWK-I applicant is potentially eligible for Medicaid.
- ◆ A Medicaid applicant is potentially eligible for HAWK-I.

It was the intent of the General Assembly that families be allowed to move between the two programs as easily as possible. Additionally, families should not be required to fill out another application form in order to establish eligibility for the other program if they apply for one program and are not eligible. House File 2517 also mandated that a short application form be developed for the HAWK-I program. To meet this expectation, the Employees' Manual has been revised to specify that:

- ◆ The *Healthy and Well Kids in Iowa (HAWK-I) Application*, forms 470-3526 or 470-3591 (Spanish), is considered an application for Medicaid when the third party administrator determines that Medicaid eligibility may exist and refers the application to the county office.
- ◆ The third party administrator will send the *Medicaid Supplement to the HAWK-I Application*, forms 470-3564 or 470-3592 (Spanish), to the family at the same time the HAWK-I application is referred to the county office for a Medicaid eligibility determination. This form is a supplement to the HAWK-I application and asks additional questions needed for the Medicaid eligibility determination (i.e. resource information, absent parent information, etc.).
- ◆ Applications for both Medicaid and HAWK-I may be filed with Eligibility Services Inc. (ESI), the administrator of the HAWK-I program.
- ◆ If a HAWK-I application is filed with the county office, the application must be date-stamped and forwarded to ESI within two working days.

Effective Date

January 1, 1999

Material Superseded

Remove the following pages from the Employees' Manual, Title 8, Chapter B, and destroy them:

<u>Page</u>	<u>Date</u>
Contents (page 1)	January 6, 1998
Contents (page 2)	December 2, 1997
1	December 2, 1997
2	January 6, 1998
3	December 2, 1997
4	January 6, 1998
5	February 11, 1997
12	January 6, 1998
13	February 11, 1997
14	January 6, 1998
23	December 2, 1997
24	January 6, 1998

Additional Information

Refer questions about this general letter to your regional benefit payment administrator.



THOMAS J. VILSACK, GOVERNOR
SALLY J. PEDERSON, LT. GOVERNOR

DEPARTMENT OF HUMAN SERVICES
CHARLES M. PALMER, DIRECTOR

February 9, 1999

GENERAL LETTER NO. 8-B-43

ISSUED BY: Bureau of Eligibility Services, Division of Medical Services

SUBJECT: Employees' Manual, Title 8, Chapter B, *Application Processing*, pages 7 and 15, revised.

Summary

Policy has been changed in the length of time a client has to supply information or verification. Current policy requires a client to supply information or verification within five working days. With this change clients will be required to supply information or verification within ten calendar days.

All references that state that information or verification be provided within five calendar days have been changed to ten calendar days.

Correct reference to ten calendar days for length of time a person has to apply for SSI or SSDI to read ten working days.

Effective Date

Upon receipt of this manual material.

Material Superseded

Remove the following pages from Employees' Manual, Title 8, Chapter B, and destroy them:

<u>Page</u>	<u>Date</u>
7	June 11, 1996
15	December 2, 1997

Additional Information

Refer questions about this general letter to your regional benefit administrator.



THOMAS J. VILSACK, GOVERNOR
SALLY J. PEDERSON, LT. GOVERNOR

DEPARTMENT OF HUMAN SERVICES
JESSIE K. RASMUSSEN, DIRECTOR

June 22, 1999

GENERAL LETTER NO. 8-B-44

ISSUED BY: Bureau of Eligibility Services, Division of Medical Services

SUBJECT: Employees' Manual, Title 8, Chapter B, *Application Processing*, Contents (page 1), revised; pages 11 through 16 and 16a, revised; and pages 16b, 16c, and 16d, new.

Summary

The Seventy-Eighth Session of the Iowa General Assembly directed the Department to eliminate the face-to-face interview as a Medicaid eligibility requirement for children under age 21. In addition, it directed the Department to in no way delay the Medicaid eligibility determination of children while waiting for any adults in the eligible group to attend their required face-to-face interview.

This letter transmits changes to the section on interviews, specifying that a face-to-face interview can only be required of adults, and that failure to attend a face-to-face interview will serve as a basis for denial for only adults. Failure of adults to attend their face-to-face interview is not a basis of denial for children under age 21.

This letter also transmits changes to the processing standards section. This section is split into two subsections, one that discusses processing standards applicable to all Medicaid applications and another subsection that discusses processing standards specific to applications that include children.

Effective Date

July 1, 1999

For applications processed on or after July 1, 1999, failure to attend a face-to-face interview is not a reason to deny Medicaid to children under age 21, even if the interview was scheduled to occur before July 1, 1999.

Material Superseded

Remove the following pages from Employees' Manual, Title 8, Chapter B, and destroy them:

<u>Page</u>	<u>Date</u>
Contents (page 1)	December 22, 1998
11	January 6, 1998
12-14	December 22, 1998
15	February 9, 1999
16, 16a	January 6, 1998

Additional Information

Refer questions about this general letter to your regional benefit payment administrator.



THOMAS J. VILSACK, GOVERNOR
SALLY J. PEDERSON, LT. GOVERNOR

DEPARTMENT OF HUMAN SERVICES
JESSIE K. RASMUSSEN, DIRECTOR

August 10, 1999

GENERAL LETTER NO. 8-B-45

ISSUED BY: Bureau of Health Care Purchasing and Quality Management,
Division of Medical Services

SUBJECT: Employees' Manual, Title 8, Chapter B, *Application Processing*, Contents
(page 1), revised; and pages 2, 3, 4a, 5, 6, 24, and 24a, revised.

Summary

This chapter has been revised to incorporate the new procedures that ESI will follow when referring HAWK-I applications to the Medicaid program when the applicant appears to be eligible for Medicaid.

Previously, ESI referred applications to the DHS office in the county where the applicant resided. With the elimination of the face-to-face interview requirement for children, it is now possible to process these applications elsewhere. As a result, income maintenance staff will be colocated with ESI to process HAWK-I applications that are being referred to Medicaid.

These IM workers will make the eligibility determination and then forward the information to the appropriate county office. The IM worker will assign a separate FBU to the case to identify it as a referral from the HAWK-I program. If another case for the family exists (i.e. a food stamp case), the county IM worker will merge the two cases and close the referred case record so that two monthly reports are not generated.

Information about processing X-PERT applications is removed from the chapter.

Effective Date

August 1999

Material Superseded

Remove the following pages from Employees' Manual, Title 8, Chapter B, and destroy them:

<u>Page</u>	<u>Date</u>
Contents (page 1)	June 22, 1999
2, 3, 4a, 5	December 22, 1998
6, 6a	December 2, 1997
24, 24a	December 22, 1998

Additional Information

Refer questions about this general letter to your regional benefit payment administrator.



THOMAS J. VILSACK, GOVERNOR
SALLY J. PEDERSON, LT. GOVERNOR

DEPARTMENT OF HUMAN SERVICES
JESSIE K. RASMUSSEN, DIRECTOR

October 5, 1999

GENERAL LETTER NO. 8-B-46

ISSUED BY: Bureau of Eligibility Services,
Division of Medical Services

SUBJECT: Employees' Manual, Title 8, Chapter B, *Application Processing* page 16,
revised.

Summary

Revisions on page 16 change policy for the day that FMAP applicants must receive the written *Notice of Decision*. When you process applications, determine eligibility as soon as possible. Issue the *Notice of Decision* no later than the 30th day following the application date. When the 30th day falls on a weekend or holiday, make system entries no later than the next working day.

Effective Date

November 1, 1999

Material Superseded

Remove page 16, dated June 22, 1999, from Employees' Manual, Title 8, Chapter B, and destroy it.

Additional Information

Refer questions about this general letter to your regional benefit payment administrator.



THOMAS J. VILSACK, GOVERNOR
SALLY J. PEDERSON, LT. GOVERNOR

DEPARTMENT OF HUMAN SERVICES
JESSIE K. RASMUSSEN, DIRECTOR

November 2, 1999

GENERAL LETTER NO. 8-B-47

ISSUED BY: Insurance Purchasing Unit, Bureau of Health Care Purchasing and
Quality Management, Division of Medical Services

SUBJECT: Employees' Manual, Title 8, Chapter B, *Application Processing*, page 24a,
revised.

Summary

This General Letter transmits a change in how income is considered when determining eligibility for the HAWK-I program and removes a reference to the face-to-face interview. When considering family income to compare to the income limit, apply a 20% deduction to earned income.

Effective Date

Apply the new income guidelines to all HAWK-I applications filed on or after November 1, 1999, for coverage December 1, 1999, or later.

Material Superseded

Remove from the Employees' Manual, Title 8, Chapter G, page 24a, dated August 10, 1999, and destroy it.

Additional Information

Refer questions about this general letter to your regional benefit payment administrator.



THOMAS J. VILSACK, GOVERNOR
SALLY J. PEDERSON, LT. GOVERNOR

DEPARTMENT OF HUMAN SERVICES
JESSIE K. RASMUSSEN, DIRECTOR

February 1, 2000

GENERAL LETTER NO. 8-B-48

ISSUED BY: Bureau of Eligibility Services, Division of Medical Services

SUBJECT: Employees' Manual, Title 8, Chapter B, *Application Processing*, Table of contents (page 1), revised; pages 1, 2, 3, 4, 4a, 5, 6, 13 through 16, 16a, 16b, 16c, 19 through 24, and 24a, revised; and page 4b, new.

Summary

Page 1 is revised to clarify when a separate application for Medicaid is not required.

Page 2 is revised to allow children applying for subsidized adoption to use the *Health Services Application*.

Pages 3 and 4 are revised to clarify that the HAWK-I application along with the Medicaid supplement constitutes a Medicaid application for the entire family.

Page 14 is revised to:

- ◆ Add a reference to a pamphlet describing the new coverage group for people with disabilities who are employed.
- ◆ Clarify that a voter registration form should be sent when a family moves within Iowa.

Page 15 is revised to clarify the worker's and the applicant's responsibility when third-party information is needed for eligibility purposes.

Page 19 is revised to clarify that a client may request retroactive Medicaid on the most recently approved Medicaid application, even if Medicaid eligibility for the same retroactive period was previously denied for failure to supply requested information.

Page 20 is revised to reflect the ABC system limitations on the beginning date of eligibility correctly.

Example 3 on page 23 is revised to reflect the children are eligible under CMAP once FMAP is canceled.

Page 24 is revised to remove the paragraph stating that no REFER2 entry regarding pregnancy and due date regarding pregnancy and due date is necessary for FMAP if the client is also a FIP participant.

Page 24a is revised to clarify that depreciation of capital assets is an allowable deduction from self-employment income for HAWK-I but not an allowable deduction for Medicaid.

Other pages are revised for minor language changes.

Effective Date

Upon receipt.

Material Superseded

Remove the following pages from the Employees' Manual, Title 8, Chapter G, and destroy them.

<u>Page</u>	<u>Date</u>
Contents (page 1)	August 10, 1999
1	December 22, 1998
2, 3	August 10, 1999
4	December 22, 1998
4a, 5, 6	August 10, 1999
13-15	June 22, 1999
16	October 5, 1999
16a-16c	June 22, 1999
19	January 6, 1997
20	January 6, 1998
21, 22	June 11, 1996
23	December 22, 1998
24	August 10, 1999
24a	November 2, 1999

Additional Information

Refer questions about this general letter to your regional benefit payment administrator.



THOMAS J. VILSACK, GOVERNOR
SALLY J. PEDERSON, LT. GOVERNOR

DEPARTMENT OF HUMAN SERVICES
JESSIE K. RASMUSSEN, DIRECTOR

June 13, 2000

GENERAL LETTER NO. 8-B-49

ISSUED BY: Bureau of Eligibility Services, Division of Medical Services

SUBJECT: Employees' Manual, Title 8, Chapter B, *Application Processing*, Contents (page 1), revised; pages 2, 3, 4, 4a, 4b, 5, 6, 8, 9, 11, 12, 16b, 16c, 16d, 17, 21, and 24a, revised; and page 16e, new.

Summary

Pages 3 and 4 are revised to reflect that the copy of the *HAWK-I Application*, along with the *Medicaid Supplement to the HAWK-I Application*, is considered an application for the children.

Pages 11 and 12 are revised to clarify that interviews are not required for people under age 21.

Page 16b is revised that a *HAWK-I Application*, along with the *Medicaid Supplement to the HAWK-I Application*, will now be considered only an application for children.

Page 16c is revised to add an example reflecting a HAWK-I referral to Medicaid and clarify Example 2.

Page 24a is revised to change the third party administrator for HAWK-I to MAXIMUS effective June 1, 2000.

Page 24a is revised to increase the income limit for HAWK-I referrals to 200% of the federal poverty level.

Other pages are revised to correct references and form numbers.

Effective Date

June 1, 2000. MAXIMUS replaces ESI as the third party administrator of the HAWK-I program.

July 1, 2000. The income limit changes to 200% of the federal poverty level for pregnant women and infants under the MAC coverage group and for the HAWK-I program. This applies to benefits issued on or after July 1, 2000.

All other changes are effective upon receipt.

Material Superseded

Remove the following pages from Employees' Manual, Title 8, Chapter B, and destroy them:

<u>Page</u>	<u>Date</u>
Contents (p. 1)	February 1, 2000
2-4, 4a, 4b, 5, 6	February 1, 2000
8	January 6, 1998
9	June 11, 1996
11, 12	June 22, 1999
16b, 16c	February 1, 2000
16d	June 22, 1999
17	January 6, 1998
21, 24a	February 1, 2000

Additional Information

Refer questions about this general letter to your regional benefit payment administrator.



THOMAS J. VILSACK, GOVERNOR
SALLY J. PEDERSON, LT. GOVERNOR

DEPARTMENT OF HUMAN SERVICES
JESSIE K. RASMUSSEN, DIRECTOR

December 5, 2000

GENERAL LETTER NO. 8-B-50

ISSUED BY: Bureau of Eligibility Services, Division of Medical Services

SUBJECT: Employees' Manual, Title 8, Chapter B, *APPLICATION PROCESSING*, pages 2, 5, 7, 11, 14, 16, 17, 22, and 23, revised; and page 22a, new.

Summary

FMAP-related programs will no longer require that a child be deprived of parental care and support to be eligible for Medicaid.

Page 5 is revised to add where the application is processed when a person is in a PMIC.

Page 11 is revised to remove references to telephone interviews for children. Page 14 is revised to remove references to a semi-annual review and the PAER.

Page 22 is revised to match FIP's section on referral to CSRU. Page 22a is revised to add when to make a referral on foster care cases.

Page 2, 5, 7, 16, and 17 are revised to update form numbers. Page 23 is revised to delete a legal reference.

Effective Date

January 1, 2001

Material Superseded

Remove the following pages from Employees' Manual, Title 8, Chapter B, and destroy them.

<u>Page</u>	<u>Date</u>
2, 5	June 13, 2000
7	February 9, 1999
11	June 13, 2000
14, 16	February 1, 2000
17	June 13, 2000
22, 23	February 1, 2000

Additional Information

Refer questions about this general letter to your regional benefit payment administrator.



STATE OF IOWA

THOMAS J. VILSACK, GOVERNOR
SALLY J. PEDERSON, LT. GOVERNOR

DEPARTMENT OF HUMAN SERVICES
JESSIE K. RASMUSSEN, DIRECTOR

May 22, 2001

GENERAL LETTER NO. 8-B-51

ISSUED BY: Bureau of Eligibility Services, Division of Medical Services

SUBJECT: Employees' Manual, Title 8, Chapter B, *APPLICATION PROCESSING*, pages 22 and 22a, revised.

Summary

Page 22 is revised to state that IM workers will link both absent and custodial parents to the ICAR case for a child in foster care. If the ICAR referrals have not been made, the IM staff will make the necessary referral.

Page 22a is revised to remove the incorrect policy statement regarding referrals to CSRU on foster care cases, as well as clarify when a referral is made for a child in subsidized adoption who enters foster care.

Effective Date

Immediately.

Material Superseded

Remove from Employees' Manual, Title 8, Chapter B, pages 22 and 22a, both dated December 5, 2000, and destroy them.

Additional Information

Refer questions about this general letter to your regional benefit payment administrator.



STATE OF IOWA

THOMAS J. VILSACK, GOVERNOR
SALLY J. PEDERSON, LT. GOVERNOR

DEPARTMENT OF HUMAN SERVICES
JESSIE K. RASMUSSEN, DIRECTOR

June 26, 2001

GENERAL LETTER NO. 8-B-52

ISSUED BY: Bureau of Eligibility Services, Division of Medical Services

SUBJECT: Employees' Manual, Title 8, Chapter B, *APPLICATION PROCESSING*, pages 2 and 4b, revised.

Summary

Pages 2 and 4b are revised to indicate the application form to be used and where the application may be filed for a women who needs treatment for breast or cervical cancer.

Effective Date

July 1, 2001

Material Superseded

Remove the following pages from Employees' Manual, Title 8, Chapter B, and destroy them:

<u>Page</u>	<u>Date</u>
2	December 5, 2000
4b	June 13, 2000

Additional Information

Refer questions about this general letter to your regional benefit payment administrator.



December 18, 2001

GENERAL LETTER NO. 8-B-53

ISSUED BY: Bureau of Eligibility Services, Division of Medical Services

SUBJECT: Employees' Manual, Title 8, Chapter B, *APPLICATION PROCESSING*, Contents (page 1), revised; pages 2, 3, 4, 5, 16, 16a, and 24a, revised.

Summary

The *Health Services Application*, form 470-2927 or 470-2927(S), is revised and will be used for the following programs:

- ◆ FMAP-related Medicaid coverage groups
- ◆ Home- and community-based waiver services
- ◆ Medical facility care
- ◆ Medically Needy coverage
- ◆ SSI-related Medicaid coverage groups
- ◆ State Supplementary Assistance programs

The *Public Assistance Application*, form 470-0462 or 470-0466(S), shall be used when the person wants to apply for FIP or food stamps along with FMAP-related coverage groups or Refugee Medical Assistance.

The references to forms 470-0442, *Application for Medical Assistance or State Supplementary Assistance*; 470-3118, *Medically Needy Recertification/State Supplementary and Medicaid Review*, and 470-2779, *Foster Care Medicaid Application*, have been removed.

When reading the acronym HAWK-I, many people read the "I" as a Roman numeral one and refer to the program as "hawk-one." This has caused confusion for the public. Therefore, to facilitate name recognition and to "brand" the program, the acronym for the Healthy and Well Kids in Iowa program is being changed from HAWK-I to *hawk-i*.

Page 24a is revised to modify the referral process to *hawk-i* by allowing a referral when a family has insurance coverage.

Page 3 is revised to clarify what to do if applicants indicate they have insurance.

Page 16 is revised to amend the time when applicants must report changes from "working" days to "calendar" days. This is consistent with FIP policy.

Page 16a is revised to clarify that an eligibility decision for a child should not be held up when requesting information needed that only affects an adult's eligibility.

Effective Date

January 1, 2002

Material Superseded

Remove the following pages from Employees' Manual, Title 8, Chapter B, and destroy them:

<u>Page</u>	<u>Date</u>
Contents (page 1)	June 13, 2000
2	June 26, 2001
3, 4	June 13, 2000
5, 16	December 5, 2000
16a	February 1, 2000
24a	June 13, 2000

Additional Information

Refer questions about this general letter to your regional benefit payment administrator.



September 17, 2002

GENERAL LETTER NO. 8-B-54

ISSUED BY: Unit of Health Support, Division of Financial, Health, and Work Supports

SUBJECT: Employees' Manual, Title 8, Chapter B, APPLICATION PROCESSING, Contents (page 1), revised; pages 4b, 5, 6, 16e, 17, and 18, revised; and pages 4c and 16f, new.

Summary

This chapter has been revised to:

- Clarify that applications are processed at full-time offices.
Change the date of application for applications received or left at a closed office to the next day which is not a weekend or state holiday following the day that office was last open.
Clarify policy and procedures for using the redesigned Medicaid for Employed People with Disabilities (MEPD) billing system, implemented June 1, 2002. As the new billing system assigns payments of premium in a specified order, months of coverage from the positive date to the month that eligibility was approved that are not wanted by the client must be "blocked" on the billing system.

Effective Date

October 1, 2002

Material Superseded

Remove the following pages from Employees' Manual, Title 8, Chapter B, and destroy them:

Table with 2 columns: Page and Date. Rows include Contents (page 1), 4b, 5, 6, 16e, 17, and 18 with their respective dates.

Additional Information

Refer questions about this general letter to your area income maintenance supervisor 2.



STATE OF IOWA

THOMAS J. VILSACK, GOVERNOR
SALLY J. PEDERSON, LT. GOVERNOR

DEPARTMENT OF HUMAN SERVICES
JESSIE K. RASMUSSEN, DIRECTOR

January 21, 2003

GENERAL LETTER NO. 8-B-55

ISSUED BY: Unit of Health Support, Division of Financial, Health and Work Supports

SUBJECT: Employees' Manual, Title 8, Chapter B, *APPLICATION PROCESSING*, page 24a, revised.

Summary

This section dealing with referrals to the *hawk-i* program has been revised to more clearly indicate when a referral is to be made and how to make the referral.

Effective Date

Upon receipt.

Material Superseded

Remove the following page from Employees' Manual, Title 8, Chapter B, and destroy it:

<u>Page</u>	<u>Date</u>
24a	December 18, 2001

Additional Information

Refer questions about this general letter to your service area income maintenance supervisor 2.



STATE OF IOWA

THOMAS J. VILSACK, GOVERNOR
SALLY J. PEDERSON, LT. GOVERNOR

DEPARTMENT OF HUMAN SERVICES
KEVIN W. CONCANNON, DIRECTOR

August 19, 2003

GENERAL LETTER NO. 8-B-56

ISSUED BY: Unit of Health Support, Division of Financial, Health and Work Supports

SUBJECT: Employees' Manual, Title 8, Chapter B, *APPLICATION PROCESSING*, page 13, revised.

Summary

Page 13 is revised to instruct when form 470-0306 or 470-0307(Spanish), *Application for Food Stamps*, is provided to a Medicaid recipient and to update a cross-reference.

Effective Date

Upon receipt.

Material Superseded

Remove the following page from Employees' Manual, Title 8, Chapter B, and destroy it:

<u>Page</u>	<u>Date</u>
13	February 1, 2000

Additional Information

Refer questions about this general letter to your service area income maintenance supervisor 2.



STATE OF IOWA

THOMAS J. VILSACK, GOVERNOR
SALLY J. PEDERSON, LT. GOVERNOR

DEPARTMENT OF HUMAN SERVICES
KEVIN W. CONCANNON, DIRECTOR

April 27, 2004

GENERAL LETTER NO. 8-B-57

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

SUBJECT: Employees' Manual, Title 8, Chapter B, *APPLICATION PROCESSING*, page 24a, revised.

Summary

The following clarifications have been made regarding the *hawk-i* referral process:

- ◆ The reference to the hardship criteria for dropping a child's health insurance has been removed. Families paying less than 5% of their gross income toward their health insurance are no longer assessed a six-month waiting period before *hawk-i* coverage can begin.
- ◆ The instructions not to refer a child to *hawk-i* if family income (gross earnings – 20% + unearned income) exceeds 200% or if the child is a dependent of a state of Iowa employee have been removed. All children who are only conditionally eligible for Medically Needy should be referred to the *hawk-i* program for an official determination of *hawk-i* eligibility, regardless of the amount of income or parental employment, to ensure that the family's appeal rights are protected.
- ◆ The name of the form used to make referrals to the *hawk-i* program has been changed to *Referral to the hawk-i Program*. The form number, 470-3565, remains unchanged.
- ◆ Instructions regarding the documents that must accompany the *Referral to the hawk-i Program*, form 470-3565, have been revised. The referral form needs to be accompanied only by the notice of decision that contains the income calculation establishing Medicaid ineligibility under coverage groups other than Medically Needy.

Effective Date

Upon receipt.

Material Superseded

Remove 24a, dated January 21, 2003, from Employees' Manual, Title 8, Chapter B, and destroy it.

Additional Information

Refer questions about this general letter to your service area income maintenance supervisor 2.



STATE OF IOWA

THOMAS J. VILSACK, GOVERNOR
SALLY J. PEDERSON, LT. GOVERNOR

DEPARTMENT OF HUMAN SERVICES
KEVIN W. CONCANNON, DIRECTOR

January 28, 2005

GENERAL LETTER NO. 8-B-58

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

SUBJECT: Employees' Manual, Title 8, Chapter B, *APPLICATION PROCESSING*,
pages 3, 4, 4a, 4b, 5, and 6, revised.

Summary

A faxed application shall be treated as an original application. An original signature is no longer required. A *hawk-i Electronic Application Summary and Signature Page*, form 470-4016, is also acceptable as a Medicaid application.

Effective Date

February 1, 2005

Material Superseded

Remove the following pages from Employees' Manual, Title 8, Chapter B, and destroy them:

<u>Page</u>	<u>Date</u>
3, 4	December 18, 2001
4a	June 13, 2000
4b, 5, 6	September 17, 2002

Additional Information

Refer questions about this general letter to your service area income maintenance supervisor 2.



January 20, 2006

GENERAL LETTER NO. 8-B-59

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

SUBJECT: Employees' Manual, Title 8, Chapter B, *APPLICATION PROCESSING*,
pages 3, 11 through 14, 16c, 16d, 20, and 24, revised.

Summary

This chapter is revised to:

- ◆ Change policy to accept a woman's statement that she is pregnant as verification of the pregnancy.
- ◆ Change all references from "Food Stamps" to "Food Assistance."
- ◆ Add Comm. 209, *Information About Your Privacy Rights*, to the list of information to be given to applicants or anyone inquiring about the Medicaid program.
- ◆ Update the names and the numbers of forms and pamphlets to reflect the current versions.
- ◆ Correct a cross-reference and update an organizational name.

Effective Date

February 1, 2006

Material Superseded

Remove the following pages from Employees' Manual, Title 8, Chapter B, and destroy them:

<u>Page</u>	<u>Date</u>
3	January 28, 2005
11	December 5, 2000
12	June 13, 2000
13	August 19, 2003
14	December 5, 2000
16c, 16d	June 13, 2000
20, 24	February 1, 2000

Additional Information

Refer questions about this general letter to your service area income maintenance administrator.



STATE OF IOWA

THOMAS J. VILSACK, GOVERNOR
SALLY J. PEDERSON, LT. GOVERNOR

DEPARTMENT OF HUMAN SERVICES
KEVIN W. CONCANNON, DIRECTOR

February 3, 2006

GENERAL LETTER NO. 8-B-60

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

SUBJECT: Employees' Manual, Title 8, Chapter B, APPLICATION PROCESSING,
pages 2, 3, 4b, 4c, 11, 12, 13, 17, 18, 22a, 24a, and 27, revised.

Summary

This chapter is revised to:

- ◆ Incorporate the procedures for a woman applying for the Iowa Family Planning Network (IFPN).
◆ Remove a reference to MEV forms.

Effective Date

February 1, 2006

Material Superseded

Remove the following pages from Employees' Manual, Title 8, Chapter B, and destroy them:

Table with 2 columns: Page and Date. Rows include page numbers 2, 3, 4b, 4c, 11-13, 17, 18, 22a, 24a, 27 and their corresponding dates from 1997 to 2006.

Additional Information

Refer questions about this general letter to your service area income maintenance administrator.



STATE OF IOWA

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

DEPARTMENT OF HUMAN SERVICES
KEVIN W. CONCANNON, DIRECTOR

January 19, 2007

GENERAL LETTER NO. 8-B-61

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

SUBJECT: Employees' Manual, Title 8, Chapter B, *APPLICATION PROCESSING*,
pages 10, 13, and 14, revised; and page 10a, new.

Summary

This chapter is revised to:

- ◆ Clarify the steps to follow when processing a Medicaid application when there is a current Social Security disability application.
- ◆ Change instructions for the income maintenance worker to now hand out the combined English and Spanish version of Comm. 255 and Comm. 255(S), "Important information about the HIPP Program," instead of Comm. 91, The Health Insurance Premium Payment (HIPP) Program for Iowa Medicaid Recipients."
- ◆ Change some form names to reflect current version.

Effective Date

Upon receipt.

Material Superseded

Remove the following pages from Employees' Manual, Title 8, Chapter B, and destroy them:

<u>Page</u>	<u>Date</u>
10	June 11, 1996
13	February 3, 2006
14	January 20, 2006

Additional Information

Refer questions about this general letter to your service area income maintenance administrator.



July 27, 2007

GENERAL LETTER NO. 8-B-62

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

SUBJECT: Employees' Manual, Title 8, Chapter B, **APPLICATION PROCESSING**,
Contents (page 1), revised; pages 1, 4, 10a, 11 through 16, 16a through 16d, and
27, revised.

Summary

This chapter is revised to:

- ◆ Eliminate the requirement for an interview for all coverage groups. Interviews may be requested when needed to clarify information needed to determine eligibility. Required pamphlets and information must still be given to clients.
- ◆ Add language to clarify some examples.
- ◆ Update form names and numbers.

Effective Date

August 1, 2007

Material Superseded

Remove the following pages from Employees' Manual, Title 8, Chapter B, and destroy them:

<u>Page</u>	<u>Date</u>
Contents (page 1)	September 17, 2002
1	February 1, 2000
4	January 28, 2005
10a	January 19, 2007
11, 12	February 3, 2006
13, 14	January 19, 2007
15	February 1, 2000
16, 16a	December 18, 2001
16b	June 13, 2000
16c, 16d	January 20, 2006
27	February 2, 2006

Additional Information

Refer questions about this general letter to your service area income maintenance administrator.



February 1, 2008

GENERAL LETTER NO. 8-B-63

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

SUBJECT: Employees' Manual, Title 8, Chapter B, **APPLICATION PROCESSING**,
Contents (pages 1 and 2), revised; pages 3, 7 through 10, 10a, 13, 21, 22, 25, 26,
and 27, revised; and page 28, new.

Summary

This chapter is revised to:

- ◆ Add Comm. 258 and Comm. 258(S), *Verifying Citizenship and Identity*, to the list given to all persons applying for Medicaid.
- ◆ Change names of the following forms:
 - 470-2304 and 470-0364 from *Medicaid Information Questionnaire for SSI Persons to SSI Medicaid Information*. Reference to the Spanish versions, 470-2304(S) and 470-0364(S), has also been added to the text. Since the forms have been revised, there are text changes on references to form page numbers and processing instructions for manually issuing the form.
 - 470-0363 from *Certification by SSA District Office to County Department of Social Services Re Eligibility of SSI Applicant to Certification of Eligibility of SSI Applicant*.
- ◆ Note under the use of form 470-2304 and 470-0364 that Comm. 121, *Important Notice to Property Owners and Renters*, is attached.
- ◆ Simplify the example letter for retroactive months and intervening months.
- ◆ Update references from "Medicaid recipient" to "Medicaid member."

Effective Date

January 1, 2008

Material Superseded

Remove the following pages from Employees' Manual, Title 8, Chapter B, and destroy them.

<u>Page</u>	<u>Date</u>
Contents (p.1)	July 27, 2007
Contents (p.2)	December 22, 1998

3	February 3, 2006
7	December 5, 2000
8, 9	July 13, 2000
10	January 19, 2007
10a, 13, 14	July 27, 2007
21	July 13, 2000
22	May 22, 2001
24a	February 3, 2006
25, 26	February 11, 1997
27	July 27, 2007

Additional Information

Refer questions about this general letter to your service area income maintenance administrator.



STATE OF IOWA

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

DEPARTMENT OF HUMAN SERVICES
EUGENE I. GESSOW, DIRECTOR

October 17, 2008

GENERAL LETTER NO. 8-B-64

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

SUBJECT: Employees' Manual, Title 8, Chapter B, *APPLICATION PROCESSING*,
pages 4a, 4b, 4c, 5 and 6, revised.

Summary

This chapter is revised to:

- ◆ Specify that when both parents or a parent and stepparent are in the home, either may sign the application.
- ◆ Specify that an application may be submitted electronically.

Effective Date

November 1, 2008

Material Superseded

Remove the following pages from Employees' Manual, Title 8, Chapter B, and destroy them.

<u>Page</u>	<u>Date</u>
4a	January 28, 2005
4b, 4c	February 3, 2006
5, 6	January 28, 2005

Additional Information

Refer questions about this general letter to your area income maintenance administrator.



February 13, 2009

GENERAL LETTER NO. 8-B-65

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

SUBJECT: Employees' Manual, Title 8, Chapter B, APPLICATION PROCESSING,
Contents (page 1), revised; pages 3, 4, 4a, 4b, 10, 10a, 17, and 18, revised.

Summary

This chapter is revised to:

- Clarify that the Health and Financial Support Application may be used for all Medicaid coverage groups, including State Supplementary Assistance.
Reference Chapter 8-O, IOWACARE, for applications that may be used for IowaCare.
Clarify "Restricting Months of Beginning Eligibility for MEPD" to state that an applicant may choose between MEPD and Medically Needy for "back months" before the date the MEPD approval was entered on the Automated Benefit Calculation system.
Delete the requirement to contact the Disability Determination Services claim examiner to track a disability referral.
Clarify that there is not any retroactive eligibility for qualified Medicare beneficiary coverage and that IowaCare has only one month of retroactive eligibility.

Effective Date

Upon receipt.

Material Superseded

Remove the following pages from Employees' Manual, Title 8, Chapter B, and destroy them.

Table with 2 columns: Page, Date. Rows include Contents (page 1), 3, 4, 4a, 4b, 10, 10a, 17, 18 with corresponding dates from 2006 to 2008.

Additional Information

Refer questions about this general letter to your area income maintenance administrator.



STATE OF IOWA

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

DEPARTMENT OF HUMAN SERVICES
EUGENE I. GESSOW, DIRECTOR

April 3, 2009

GENERAL LETTER NO. 8-B-66

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

SUBJECT: Employees' Manual, Title 8, Chapter B, *APPLICATION PROCESSING*,
pages 15 and 16, revised.

Summary

This chapter is revised to clarify that an applicant who provides a signed release to a specific individual or organization for specific information has met the requirements for supplying requested information or verification.

Effective Date

Upon receipt.

Material Superseded

Remove the following pages from Employees' Manual, Title 8, Chapter B, and destroy them:

<u>Page</u>	<u>Date</u>
15, 16	July 27, 2007

Additional Information

Refer questions about this general letter to your area income maintenance administrator.



STATE OF IOWA

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

DEPARTMENT OF HUMAN SERVICES
CHARLES J. KROGMEIER, DIRECTOR

October 9, 2009

GENERAL LETTER NO. 8-B-67

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

SUBJECT: Employees' Manual, Title 8, Chapter B, **APPLICATION PROCESSING**,
Title (page), revised; Contents (page 1), revised; pages 1 through 28,
revised; and pages 29 through 41, new.

Summary

This chapter is revised to:

- ◆ Clarify procedures for processing *hawk-i* applications when there may be eligibility for Medicaid.
- ◆ Update the list of clinics that process eligibility for the Iowa Family Planning Network coverage group.
- ◆ Update references to form 470-2826, *Supplemental Insurance Questionnaire*, to the new name of *Insurance Questionnaire*.
- ◆ Re-format the sections "Concurrent Medicaid and Social Security Disability Determination," "Establishing Beginning Months of Eligibility for MEPD," and "Authorized Representative," to use policy, procedure, and comment headings.
- ◆ Clarify that voter registration forms need to be mailed out when the applicant is not interviewed face to face.
- ◆ Clarify procedures for determining eligibility for the retroactive period.
- ◆ Add information under the section, "Authorized Representative," about sending *MEPD Billing Statements* to authorized representatives.

Effective Date

Upon receipt.

Material Superseded

Remove the entire Chapter B from Employees' Manual, Title 8. This includes the following pages:

<u>Page</u>	<u>Date</u>
Title (page)	June 11, 1996
Contents (page 1)	February 13, 2009
Contents (page 2)	February 1, 2008
1	July 27, 2007
2	February 3, 2006
3, 4, 4a-4c	February 13, 2009
5, 6	October 17, 2008
7, 8, 9	February 1, 2008
10, 10a	February 13, 2009
11, 12	July 27, 2007
13	2008
14	February 1, 2008
15, 16	April 3, 2009
16a-16d	July 27, 2007
16e, 16f	September 17, 2002
17, 18	February 13, 2009
19	February 1, 2000
20	January 20, 2008
21, 22	February 1, 2008
22a	February 3, 2006
23	December 5, 2000
24	January 20, 2006
24a	February 3, 2006
25-28	February 1, 2008

Additional Information

Refer questions about this general letter to your area income maintenance administrator.