

ALL PROVIDERS

II. MEMBER ELIGIBILITY



**Iowa Department
of Human Services**



TABLE OF CONTENTS

Page

CHAPTER II. MEMBER ELIGIBILITY..... 1

A. DEMONSTRATION OF ELIGIBILITY..... 1

 1. Medical Assistance Eligibility Card, Form 470-1911 2

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

 3. IowaCare Medical Card, Form 470-4164..... 3

 4. Eligibility Verification 3

B. GROUPS COVERED BY MEDICAID..... 7

 1. Members Related to the Family Medical Assistance Programs 7

 2. Members Related to the Supplemental Security Income Program..... 7

 3. Members Residing in Medical Institutions 8

 4. Members Receiving State Supplementary Assistance..... 8

 5. Children in Foster Care or Subsidized Adoptions or Guardianship 8

 6. Members Under the Medically Needy Program 9

 a. Medically Needy Conditional Eligibility10

 b. Submitting Claims for a Person with a Spenddown.....10

 c. Medically Needy Expense Deletion Request, Form 470-3931 11

 7. Aliens Receiving Emergency Services.....11

 a. Verification of Emergency Health Care Services, Form 470-4299 12

 b. Covered Services.....13

 8. Members Under the Qualified Medicare Beneficiary Program..... 13

 9. Women Who Need Treatment For Breast or Cervical Cancer..... 14

 10. Members Under the Iowa Family Planning Network.....14

 11. Members Under IowaCare18

 12. Services to Members Under Waiver and Grant Programs.....21

 a. Home- and Community-Based Service Waivers21

 b. Program for All-Inclusive Care for the Elderly (PACE) 21

 c. Money Follows the Person (MFP) Grant Services22

C. HOW MEDICAID ELIGIBILITY IS DETERMINED23

 1. What You Can Do for a Person Who Appears Eligible23

 2. Health Services Application, Form 470-2927 or 470-2927(S)24

 3. Retroactive Eligibility24

 4. Limited Eligibility for People Who Transfer Assets25



Page

D.	PRESUMPTIVE ELIGIBILITY FOR CHILDREN.....	25
1.	Qualified Entities.....	25
2.	Eligibility Determination for Children.....	27
a.	Application: Presumptive Health Care Coverage for Children, Form 470-4855 or 470-4855(S).....	28
b.	Determining Income and Household Size	29
c.	Steps in Making a Presumptive Eligibility Decision	31
d.	Appeal Rights.....	32
3.	Covered Services and Period of Eligibility for Children	32
E.	PRESUMPTIVE ELIGIBILITY FOR PREGNANT WOMEN	34
1.	Qualified Providers	34
2.	Eligibility Determination for Pregnant Women	36
a.	Completing the Health Services Application	37
b.	Calculating Income and Household Size	41
c.	Steps in Making a Presumptive Eligibility Decision	47
d.	Appeal Rights.....	48
3.	Covered Services and Period of Eligibility for Pregnant Women	49
F.	PRESUMPTIVE ELIGIBILITY FOR WOMEN WHO NEED TREATMENT FOR BREAST OR CERVICAL CANCER.....	52
1.	Qualified BCCT Providers.....	53
2.	BCCT Eligibility Determination	54
a.	Health Services Application	55
b.	Steps in Making a Presumptive Eligibility Decision	59
c.	Appeal Rights.....	60
3.	Covered BCCT Services and Period of Eligibility	60



CHAPTER II. MEMBER ELIGIBILITY

A. DEMONSTRATION OF ELIGIBILITY

Most members will demonstrate Medicaid eligibility through form 470-1911, *Medical Assistance Eligibility Card*. See [Section A.1](#) for more information.

EXCEPTIONS:

- ◆ The following persons will **not** be issued a *Medical Assistance Eligibility Card*:
 - Women or children whose eligibility has been determined presumptively by a qualified medical assistance provider will instead have form 470-2580 or 470-2580(S), *Presumptive Medicaid Eligibility Notice of Decision*, to indicate time-limited eligibility. See [Section A.2](#) for samples and coverage information.
 - Persons who are eligible for IowaCare coverage will have form 470-4164, *IowaCare Medical Card*. See [Section A.3](#) for samples and coverage information.
- ◆ It is possible that a person has or will have Medicaid coverage, but does not **yet** have a *Medical Assistance Eligibility Card*. For example:
 - When the Department accepts financial responsibility for a child in foster care, form 470-2747 or 470-2747(S), *Foster Care Provider Medical Letter*, may be issued to the foster care provider for use in obtaining the child's medical care.

This form assures providers that the child will eventually be authorized for Medicaid coverage under the identification number given (usually within 60 days). To view an English sample of the form, click [here](#); for a Spanish sample, click [here](#).

- People who have applied for Medicaid benefits may have form 470-2979, *Proof of Application for Medicaid*. This form verifies that the person has applied for Medicaid benefits, but eligibility has not been determined.

This form is used most often by persons who may become eligible for Medically Needy coverage only after spending a certain amount on medical care (a "spenddown"). The person may ask you to submit claims to count toward the spenddown. See [Section C.6](#) for more information on Medically Needy eligibility and procedures. To view a sample of the form, click [here](#).



Failure to present a *Medical Assistance Eligibility Card* for inspection does not necessarily mean that a person is ineligible for Medicaid. You may verify eligibility through the Iowa Eligibility Verification System (ELVS) or the IME web portal. See [Section A.4](#) for more information on how to verify eligibility.

1. **Medical Assistance Eligibility Card, Form 470-1911**

The *Medical Assistance Eligibility Card* is issued to new Medicaid members at the time of approval. Each member (not each household) receives a wallet-sized plastic card plus two keychain cards. Replacement cards are issued upon the request of the member.

The cards display the member's name, state identification number, and birth date. The back of the card lists IME contact phone numbers for both members and providers. To view a sample of the card, click [here](#).

Note that possession of the *Medical Assistance Eligibility Card* does **not guarantee** Medicaid eligibility. Call the Eligibility Verification System (ELVS) or access the IME web portal to verify the member's specific eligibility information. See [Section A.4](#) for more information on how to verify eligibility.

NOTE: Not all mental health services are covered under fee-for-service reimbursement. Preauthorization is necessary for people enrolled in the Iowa Plan. ELVS or the web portal will indicate if the member is enrolled in the Iowa Plan.

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

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

This decision entitles a woman or child to time-limited Medicaid coverage as follows, pending a formal eligibility determination by the Department:

- ◆ Coverage for presumptively eligible children and for presumptively eligible women who have or may have breast or cervical cancer extends to **all** Medicaid covered services.
- ◆ Coverage for presumptively eligible pregnant women extends **only** to Medicaid-covered ambulatory prenatal care. "Ambulatory prenatal care" means all Medicaid-covered services except:
 - Inpatient care in a hospital or other medical institution and
 - Charges associated with a miscarriage or with delivery of the baby.



Presumptive Medicaid eligibility is granted on a daily basis rather than a monthly basis. A person determined to be presumptively eligible is eligible for Medicaid services as described beginning with the date of the presumptive eligibility determination.

Eligibility may continue up to the last day of the month following the month of the presumptive eligibility determination. If the presumptively eligible woman or child files a Medicaid application within this period, Medicaid coverage continues until the date that a decision is made on the application.

The presumptive eligibility period ends when the Department approves or denies the Medicaid application. Medicaid will pay covered medical expenses incurred during the presumptive eligibility period even if the woman or child does not attain Medicaid eligibility.

3. IowaCare Medical Card, Form 470-4164

The *IowaCare Medical Card* is issued at the time of approval, and will be reissued annually after recertification is approved. To view a sample of this form on line, click [here](#).

The card contains the member's name and state ID number and a code that identifies the type of IowaCare the member is covered under. The card explains where a pregnant IowaCare member can receive prenatal or delivery care. The IME contact number for members is listed provided with the card.

Having an IowaCare card does not guarantee eligibility. Providers must call Eligibility Verification System (ELVS) or access the IME secure web portal to verify the member's specific eligibility information.

4. Eligibility Verification

All providers of service should request and inspect the member's eligibility card on each occasion of service. The Eligibility Verification System (ELVS) and the IME secure web portal offer providers a fast, convenient method of verifying a member's Medicaid eligibility.



Either call the ELVS line or access the IME secure web portal to verify the following information:

- ◆ If Medicaid or IowaCare eligibility exists for date of service.
- ◆ If the member is eligible for limited benefits such as:
 - Aliens eligible for “emergency medical services.” (See [Aliens Receiving Emergency Services](#) for more information.)
 - Members eligible under the Iowa Family Planning Network who are covered for specific family planning services. (See [Members Under the Iowa Family Planning Network](#) for more information.)
 - Members eligible under a presumptive Medicaid program.
 - Members eligible under the qualified Medicare beneficiary (QMB) coverage group and eligible only for the Medicare deductibles and coinsurance. (See [Members Under the Qualified Medicare Beneficiary Program](#) for more information.)
- ◆ If the member is enrolled in managed care, including a health maintenance organization, a prepaid health plan, or the Medicaid patient access to service system.
- ◆ If the member is locked in to specific providers.
- ◆ If the member has third party liability.

Only providers enrolled in Medicaid can obtain this information. You will need to use your Medicaid provider number to access these systems.

The address of the web portal is <http://ime-ediss.noridan.com/iowaxchange/>. To get authorization to use the web portal, you must submit an *Additional Access Request Form for Iowa Medicaid Real-Time Transactions* to EDI Support Services. This form is available on the IME provider web page, <http://www.ime.state.ia.us/Providers/>.

ELVS is an automated response system that uses a touch-tone telephone to report:

- ◆ A member’s eligibility status as of specific dates of service.
- ◆ Whether other third-party resources exist.
- ◆ The name of the third-party payors, if known.
- ◆ Medicaid HMO or MediPASS coverage (and telephone number).
- ◆ Services not covered by the member’s managed health care plan.
- ◆ Any lock-in restrictions for the member.
- ◆ The amount of the member’s Medically Needy spenddown balance for the certification period (including the date of service), if any.



The system can also give the date and amount of a provider's last payment. ELVS can process up to five inquires per call.

You should access ELVS:

- ◆ At the time service is provided or requested.
- ◆ When a person presents a *Presumptive Medicaid Eligibility Notice of Decision*, form 470-2580 or 470-2580(S).
- ◆ When you want to find out the remaining spenddown amount to be met by a member on Medically Needy.

To use ELVS:

1. Call one of these phone numbers:
Des Moines area or out-of-state: 515-323-9639
Iowa WATTS: 1-800-338-7752
2. ELVS will greet you and ask for your choice of information.
 - ◆ Press **1** to hear the help message.
 - ◆ Press **2** for member eligibility.
 - ◆ Press **3** for provider payment.
 - ◆ If you do not have a touch-tone telephone, please hold for further instructions.

When entering data, you do not need to wait for message completion. You may begin entering data after the first word is spoken for each prompt.

3. ELVS will ask for your provider identification number. Please enter your seven-digit ID number. If your Medicaid provider number is miskeyed or inactive, you may re-enter the number or end the call.
4. If you are an enrolled provider, ELVS will ask for a member identification number. Please enter the first seven digits of the member's Medicaid ID number, followed by the pound sign (#). (ELVS does not use the letter at the end.)

If you do not have the member's Medicaid identification number, you may enter the member's date of birth using eight digits (month, day, and year as MMDDYYYY, e.g. 04232003) followed by the member's social security number (nine digits).



5. Enter the date of service using the eight-digit format (month, day, and year as MMDDYYYY, e.g. 04232003), or press **9** for today's date. ELVS will repeat the date and inform you whether the member is eligible for basic Medicaid services on that date. If the member has other resources available, you will be told so at this time.
6. After the eligibility information is spoken:
 - ◆ Press **1** to repeat eligibility information for this member.
 - ◆ Press **2** to enter a new member identification number.
 - ◆ Press **3** to enter a new date of service for this member.
 - ◆ Press **4** for provider payment information.
 - ◆ Press **9** to end the call.
 - ◆ Press **0** to be transferred to the IME Provider Services Unit (between the hours of 7:30 a.m. to 4:30 p.m., Monday through Friday).

Due to time lags in transferring information from the eligibility system to the claims system, updated eligibility information may not always appear on ELVS when you access the system. It takes ELVS two to three days to update.

A member with a Medically Needy spenddown obligation who does not have a *Medical Assistance Eligibility Card*, and for whom ELVS indicates ineligibility for Medicaid, may later be determined to be retroactively eligible. ELVS indicates the remaining spenddown to be met.

When the person does not have a *Medical Assistance Eligibility Card*, but you have reason to believe that the person may be eligible on a particular date of service, even though ELVS does not indicate this, contact the Department of Human Services local office for final verification. (See the [Appendix](#) for a list the addresses and telephone numbers of local Human Services offices.)



B. GROUPS COVERED BY MEDICAID

1. Members Related to the Family Medical Assistance Programs

The Medicaid program covers:

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

2. Members Related to the Supplemental Security Income Program

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

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



- ◆ Children under age 19 (“kids with special needs” or MKSN) who:
 - Are considered disabled based on SSI disability criteria.
 - Have gross family income at 300% of the federal poverty level or less.
 - Are enrolled in a parent’s employer’s group health insurance when the employer pays at least half of the annual cost of premiums.

3. Members Residing in Medical Institutions

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

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

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

4. Members Receiving State Supplementary Assistance

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

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

5. Children in Foster Care or Subsidized Adoptions or Guardianship

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

Iowa Medicaid covers children who are from another state but residing in Iowa in foster care, subsidized adoption, or subsidized guardianship if:

- ◆ The child receives federal funding under Title IV-E of the Social Security Act, or



- ◆ The state providing an adoption subsidy has entered into a reciprocity agreement with Iowa.

6. Members Under the Medically Needy Program

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

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

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

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

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

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

Medical Assistance Eligibility Cards are issued for Medically Needy members:

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

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

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

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



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

a. Medically Needy Conditional Eligibility

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

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

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

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

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

b. Submitting Claims for a Person with a Spenddown

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

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



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

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

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

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

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

c. Medically Needy Expense Deletion Request, Form 470-3931

When a prescription is filled and billed to Medicaid for a potentially eligible Medically Needy member, but the member does not pick up the prescription, the pharmacy **must** complete form 470-3931, *Medically Needy Expense Deletion Request*.

To view a sample of this form on line, click [here](#). Fax the completed form to the IME as soon as possible to prevent claims for services not used to meet spenddown by the Medically Needy member.

7. Aliens Receiving Emergency Services

Medicaid benefits are available to pay for the cost of emergency services for an alien who does not meet Medicaid citizenship or alienage or social security number requirements. To be eligible for Medicaid benefits, such aliens must:

- ◆ Meet financial, categorical, and state-residency requirements, **and**
- ◆ Have had or currently have an emergency medical condition.



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

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

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

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

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

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

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

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

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



b. Covered Services

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

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

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

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

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

8. Members Under the Qualified Medicare Beneficiary Program

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

To qualify for QMB, a person must:

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

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

The QMB resource limits are the same as the resource limits for full premium subsidy under the Extra Help for Medicare Part D Drug Plan: \$6,680 for an individual and \$10,020 for a couple. SSI resource policies apply when determining countable resources.



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

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

9. Women Who Need Treatment For Breast or Cervical Cancer

Medicaid is available to women who:

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

Eligibility continues until the woman is:

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

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

10. Members Under the Iowa Family Planning Network

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

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



Eligibility continues for 12 consecutive months beginning with:

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

During the period of eligibility, a woman is entitled to limited Medicaid benefits. Covered services are limited to those that are either primary or secondary to family planning services. Payable services are:

<u>Code</u>	<u>Description</u>
00851	Anesthesia, tubal ligation or transection
11975	Insertion, implantable capsules
11976	Removal, implantable capsules with reinsertion
11977	Removal with reinsertion of implantable contraceptive capsule
36415	Venipuncture
36416	Drawing blood capillary
57170	Diaphragm or cervical cap fitting
57410	Pelvic exam under anesthesia
58300	Insertion of intrauterine device
58301	Removal of IUD
58600	Ligation or transection of fallopian tubes abdominal or vaginal approach, unilateral or bilateral
58611	Ligation or transection of fallopian tubes when done at the time of cesarean delivery or intra-abdominal surgery
58615	Occlusion of fallopian tubes by device (e.g., band, clip, Falope ring) vaginal or suprapubic approach
58670	Laparoscopy with fulguration of oviducts (with or without transection)
58671	Laparoscopy with occlusion of oviducts (e.g., band, clip, Falope ring)
58700	Salpingectomy, complete or partial, unilateral or bilateral (separate procedure)
81000	UA by regent strips
81001	UA, auto with scope
81002	UA, routine without microscopy
81003	UA, auto without scope
81025	Urine pregnancy test
82948	Glucose, blood, stick test
84703	Gonadotropin, qualitative (pregnancy test)
85004	Automated differential WBC count
85007	Differential WBC count
85013	Hematocrit



<u>Code</u>	<u>Description</u>
85014	Blood count, hematocrit
85018	Blood count, hemoglobin
85025	Automated hemogram
85027	Automated hemogram
86318	Immunoassay for infectious agent reagent strip
87102	Knickers test for yeast
87110	Culture, chlamydia
87205	Smear, gram stain
87205	Smear, primary source, with interpretation, routine
87210	Smear, primary source, with interpretation, wt mount
87211	Smear, primary source, with interpretation, wet/dry mount
87220	Koh test
87491	Chlamydia trachomatis, amplified probe technique
88164	Cytopathology, slides, cervical or vaginal (the Bethesda System); manual screening under physician supervision
90782	Therapeutic injection of medication (specify); subq
99000	Handling and conveyance of specimen for transfer from a physician's office to a lab
99001	Handling and conveyance of specimen for transfer from patient to other than physician's office to a lab (distance may be indicated)
99002	Handling, conveyance or other service in connection with the implementation of an order involving devices when devices are fabricated by an outside lab but which items have been designated, and are fitted and adjusted by the attending physician
99201	New patient office or other outpatient visit
99202	New patient office or other outpatient visit
99203	New patient office or other outpatient visit
99204	New patient office or other outpatient visit
99205	New patient office or other outpatient visit
99211	Established patient office or other outpatient visit
99212	Established patient office or other outpatient visit
99213	Established patient office or other outpatient visit
99214	Established patient office or other outpatient visit
99215	Established patient office or other outpatient visit
99241	New or established patient office or other outpatient consultations
99242	New or established patient office or other outpatient consultations
99243	New or established patient office or other outpatient consultations
99244	New or established patient office or other outpatient consultations
99245	New or established patient office or other outpatient consultations
99383	Preventive medicine service, new patient, initial, late childhood



<u>Code</u>	<u>Description</u>
99384	Preventive medicine service, new patient, evaluate, adolescent
99385	Preventive medicine service, new patient, 18-39 years of age
99386	Preventive medicine service, evaluate, 40-64 years
99393	Preventive medicine service, established patient, late childhood
99394	Preventive medicine service, established patient, adolescent
99395	Preventive medicine service, established patient, 18-39 years of age
99396	Preventive medicine service, 40-64 years of age
99420	Administration and inter health risk assessment instrument
99420	Completion of Risk Assessment form
A4261	Cervical cap
A4266	Diaphragm
A4267	Condom, nonspermicidal
A4267	Condom, spermicidal
A4268	Female condom
A4269	Spermicidal suppositories
A4269	Contraceptive foam
A4269	Contraceptive jelly
A4269	Contraceptive sponges
A4269	Vaginal contraceptive film
A4932	Basal thermometer
J1055	Depo Provera
J3490	Doxycycline
J3490	Flagyl
J3490	Vaginal cream, e.g., Terazol
J7300	Intrauterine device (IUD)
J7303	Contraceptive supply, hormone containing vaginal ring, each
S4989	Progestasert IUD
S4993	Oral contraceptive, 21-day supply
S4993	Oral contraceptive, 28-day supply
T1999	Supplies and materials provided by physician over/above normal service



11. Members Under IowaCare

The IowaCare program covers:

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

Applications for IowaCare may be obtained from the local Department of Human Services offices. Persons applying for IowaCare may use Comm. 239, *IowaCare Application*, or forms 470-2927 or 470-2927(S), *Health Services Application*. A copy of the *IowaCare Application* can be printed from <http://www.ime.state.ia.us/IowaCare/index.html>.

An *IowaCare Medical Card* is issued to persons determined to be eligible for IowaCare benefits. The card is issued at the beginning of the 12-month certification period. IowaCare benefits may be available for one retroactive month when certain conditions are met.

IowaCare members are assessed a premium based on their income when their family income is above 150% of the federal poverty level. Payment of the premium is a condition of eligibility unless a hardship exemption is requested.

A member who submits a written statement indicating that payment of the monthly premium will be a financial hardship is exempted from the premium payment for that month. The member may also use form 470-4165, *IowaCare Premium Billing Statement*, to request a hardship exemption. If the statement is not postmarked by the due date, the member is obligated to pay the premium.

IowaCare covers only services that are provided by a network provider. (This limitation does not apply to pregnant women.)



The current “medical home” designations are as follows:

- ◆ Broadlawns Medical Center (BMC) in Des Moines is the medical home for IowaCare members who live in Appanoose, Boone, Clarke, Dallas, Decatur, Greene, Jasper, Lucas, Madison, Mahaska, Marion, Monroe, Polk, Ringgold, Story, Union, Warren, or Wayne County.
- ◆ Community Health Center in Fort Dodge is the medical home for IowaCare members who live in Calhoun, Cerro Gordo, Floyd, Franklin, Hamilton, Hancock, Humboldt, Kossuth, Mitchell, Pocahontas, Webster, Winnebago, Worth, or Wright County.
- ◆ The Council Bluffs Community Health Center is the medical home for IowaCare members who live in Adair, Adams, Audubon, Cass, Fremont, Guthrie, Harrison, Mills, Montgomery, Page, Pottawattamie, Shelby, or Taylor County.
- ◆ Crescent Community Health Center in Dubuque is the medical home for IowaCare members who live in Allamakee, Chickasaw, Clayton, Delaware, Dubuque, Fayette, Howard, or Winneshiek County.
- ◆ People’s Community Health Clinic in Waterloo is the medical home for IowaCare members who live in Black Hawk, Bremer, Buchanan, or Butler County.
- ◆ Primary Health Care in Marshalltown is the medical home for IowaCare members who live in Grundy, Hardin, Marshall, or Tama County.
- ◆ Siouxland Community Health Center in Sioux City is the medical home for IowaCare members who live in Buena Vista, Carroll, Cherokee, Clay, Crawford, Dickinson, Emmet, Ida, Lyon, Monona, O’Brien, Osceola, Palo Alto, Plymouth, Sac, Sioux, or Woodbury County.
- ◆ The University of Iowa Primary Care Clinics in Iowa City is the medical home for IowaCare members who live in Benton, Cedar, Clinton, Davis, Des Moines, Henry, Iowa, Jackson, Jefferson, Johnson, Jones, Keokuk, Lee, Linn, Louisa, Muscatine, Poweshiek, Scott, Van Buren, Wapello, or Washington County.

IowaCare members who have been assigned to a medical home must use that provider for their primary care and ongoing medical services. They may use the University of Iowa Hospitals and Clinics when referred there by their medical home for advanced and specialty care that is not available at the medical home.



IowaCare members who have not been assigned to a medical home must obtain care at the University of Iowa Hospitals and Clinics (UIHC). EXCEPTION: Qualifying pregnant women in the 300% group (aid type 60-P) who do not live in Cedar, Clinton, Iowa, Johnson, Keokuk, Louisa, Muscatine, Scott, or Washington County, may obtain pregnancy-related services from any provider or general hospital that participates in Iowa Medicaid.

IowaCare services are limited to the services covered by the Iowa Medicaid program, such as:

- ◆ Inpatient and outpatient hospital care
- ◆ Physician and advanced registered nurse practitioner services
- ◆ Certain dental services
- ◆ Certain pharmacy services
- ◆ Smoking cessation

IowaCare members may receive routine preventative medical examinations from a network provider or from any physician, advanced registered nurse practitioner, or physician assistant who participates in Medicaid.

Conditions for services include, but are not limited to, prior authorization requirements and exclusions for cosmetic procedures or those otherwise determined not to be required to meet the medical need of the patient.

Covered services for pregnant women who qualify for IowaCare are limited to:

- ◆ Inpatient hospital services when the diagnosis-related group (DRG) submitted for payment is between 370 and 384 and the primary or secondary diagnosis code is V22 through V24.9.
- ◆ Outpatient hospital services when the ambulatory patient group (APG) submitted for payment is 175, 304, 492, 493, or 494 and the primary or secondary diagnosis code is V22 through V24.9.
- ◆ Services from another provider participating in Medicaid if the claim form reflects that the primary or secondary diagnosis code is V22 through V24.9.
- ◆ Inpatient hospital services when the DRG submitted for payment is between 385 and 391.7.

Services provided by a health care provider other than a hospital shall be covered as provided for other IowaCare members.



12. Services to Members Under Waiver and Grant Programs

a. Home- and Community-Based Service Waivers

Home- and community-based service (HCBS) waivers provide a variety of services in a member's home that are not available through regular Medicaid. Services provided under the waivers are not available to other Medicaid members.

The total costs of these services and regular Medicaid cannot exceed the total cost of care and services provided in a medical institution. There are currently seven HCBS waivers, targeting the following groups:

- ◆ *AIDS/HIV* provides services for people with acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV) infection who would otherwise require care in a medical institution.
- ◆ *Brain Injury (BI)* provides services for people with a specific brain injury diagnosis to allow them to live in the community.
- ◆ *Child Mental Health (CMH)* provides services for children with a serious mental, behavioral, or emotional disorder.
- ◆ *Elderly* provides services to elderly Iowa residents so they can stay in the home instead of entering a nursing facility.
- ◆ *Ill and Handicapped (IH)* provides services to blind or disabled people who otherwise would need care in a nursing facility, skilled nursing facility, or an intermediate care facility for the mentally retarded.
- ◆ *Intellectual Disabilities (ID)* provides services to people with a primary diagnosis of mental retardation who would otherwise require care in a medical institution.
- ◆ *Physical Disabilities (PD)* provides services for people with a physical disability.

b. Program for All-Inclusive Care for the Elderly (PACE)

PACE allows enrolled Medicaid members to stay healthy and live in the community as long as possible. PACE is a seamless way of providing "managed" long-term care to Medicaid members.



PACE is similar to the Medicaid home- and community-based service (HCBS) waiver programs in that members must live in the community and must meet the nursing facility level of care in order to qualify.

PACE eligibility differs from HCBS waiver programs because Medicaid members who are enrolled in PACE continue to be eligible for PACE services if they become a resident of a medical institution.

The PACE provider receives a monthly capitation payment for each PACE enrollee, and in turn, is responsible for ensuring that enrollees receive any services determined necessary for their health and well-being.

c. Money Follows the Person (MFP) Grant Services

MFP grant services provide an opportunity for people to move out of intermediate care facilities for persons with mental retardation (ICF/MR) and into their own homes in the community of their choice.

Grant funds provide funding for the transition services and enhanced supports needed for the first year after a person transitions into the community. MFP assistance is available to people who:

- ◆ Have a diagnosis of mental retardation or brain injury,
- ◆ Have lived in an ICF/MR for at least six months,
- ◆ Have expressed an interest moving from the ICF/MR into the community, and
- ◆ Need home- and community based services (HCBS) in order to successfully reside in a community based settings.

The MFP Program helps participants locate a place to live and arrange for medical, rehabilitative, home health, and other services in the community, as needed. MFP participants are covered by the program for 365 days, after which time, an HBCS waiver will provide ongoing services.

The MFP grant provides enhanced funding for services intended to support a successful transition and to help support participants in community living. The assistance of a transition specialist (TS) in coordinating transition planning, implementation, and follow-up in securing essential services is included.



C. HOW MEDICAID ELIGIBILITY IS DETERMINED

Medicaid eligibility depends on such financial factors as income and property. In addition, people must meet certain other criteria, such as blindness, disability, age, or the need to support a family of dependent children.

Local Human Services office staff determine eligibility for Medicaid except in the following situations:

- ◆ The Social Security Administration determines eligibility for SSI cases.
- ◆ The Social Security Administration also determines eligibility for some State Supplementary Assistance cases and for Medicaid for people eligible for those types of State Supplementary Assistance.
- ◆ The Centralized Facility Eligibility Unit (CFEU) located in Council Bluffs determines eligibility for nursing facility, community ICF/MRs, and skilled nursing facility cases.
- ◆ The state resource centers and mental health institutions (MHIs) have out-stationed income maintenance workers located in the facility who determine eligibility for residents.
- ◆ Certain providers who are authorized by the Department make presumptive Medicaid eligibility determinations for women who are pregnant, for women who are in need of treatment for breast or cervical cancer, or for children. For procedures, see:
 - [PRESUMPTIVE ELIGIBILITY FOR CHILDREN](#),
 - [PRESUMPTIVE ELIGIBILITY FOR PREGNANT WOMEN](#), and
 - [PRESUMPTIVE ELIGIBILITY FOR WOMEN WHO NEED TREATMENT FOR BREAST OR CERVICAL CANCER](#).

1. What You Can Do for a Person Who Appears Eligible

If a patient has not applied for Medicaid, is unable to pay for services, and appears to meet the requirements of eligibility as outlined under [GROUPS COVERED BY MEDICAID](#), you may advise the patient or the patient's representative to contact the Department of Human Services local office.



Refer patients who are aged, blind, or disabled and not receiving monthly social security disability benefits or SSI to the district office of the Social Security Administration.

The [Appendix](#) lists the addresses and telephone numbers of local Human Services offices and Social Security offices.

2. Health Services Application, Form 470-2927 or 470-2927(S)

The basic application form for Medicaid is the Health Services Application form 470-2927 or 470-2927(S). People wishing to apply for Medicaid may obtain this form from local Department of Human Services offices, from maternal health services agencies, or from providers qualified to make presumptive eligibility determinations.

To view the English version of this form on line, click [here](#). To view the Spanish version of this form on line, click [here](#).

The completed form should be submitted to the local office of the Department of Human Services, unless the person only wants to apply for presumptive Medicaid. See the [Appendix](#) for a list of the addresses of local Human Services offices.

3. Retroactive Eligibility

The local Human Services office may determine that a person is eligible for retroactive Medicaid benefits in any of the three months preceding the month in which the person applies for Medicaid, when:

- ◆ The applicant has paid or unpaid medical expenses for covered medical services which were received during the retroactive period, and
- ◆ The applicant would have been eligible for Medicaid benefits in the month services were received if an application had been filed then (regardless of whether the applicant is alive when the application is actually filed).

The applicant need not be eligible in the month of application to be eligible in any month of the retroactive period.



4. Limited Eligibility for People Who Transfer Assets

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

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

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

D. PRESUMPTIVE ELIGIBILITY FOR CHILDREN

Legal reference: 42 USC 1396r-1a; 441 IAC 75.1(44); 42 CFR 435.1101-1102

The goal of the presumptive eligibility process is to offer immediate health care coverage to children likely to be Medicaid-eligible, before there has been a full Medicaid determination. Children can enroll in presumptive Medicaid for a limited time while a formal Medicaid eligibility determination is being made by the Department of Human Services.

A qualified entity can "presume" that a child will be eligible for Medicaid based on a family's statements regarding their circumstances and can grant temporary Medicaid eligibility during the presumptive period.

During the presumptive eligibility period, the child is entitled to receive full Medicaid coverage. Expenses incurred for Medicaid-covered services during the presumptive eligibility period will be paid even if the child does not attain ongoing Medicaid eligibility.

1. Qualified Entities

A "qualified entity" is defined as an enrolled Iowa Medicaid provider who is certified by DHS and is authorized to make presumptive eligibility determinations.



A potential qualified entity shall apply to DHS on form 470-4990, *Application for Authorization to Make Presumptive Medicaid Eligibility Determination for Children*. To view a sample of this form on line, click [here](#).

Send the completed application form to:

Iowa Medicaid Enterprise
Attn: Provider Enrollment
PO Box 36450
Des Moines, IA 50315
Or Fax: 515-725-1155 Attn: Provider Enrollment

For questions about applying to be a qualified entity, contact the IME Provider Enrollment Unit at 1-800-338-7909 (option 2), or locally (Des Moines) at 515-256-4609 (option 2) or by e-mail at imeproviderservices@dhs.state.ia.us.

After receiving form 470-4990, the Department will determine if the applicant meets the criteria to become a qualified entity. Form 470-2582, *Memorandum of Understanding with a Presumptive Provider for Presumptive Medicaid Eligibility Determinations*, will be provided electronically to qualifying applicants. To view a sample of this form on line, click [here](#).

Once the applicant has entered into the memorandum of understanding, the Department will authorize the applicant's access to the presumptive eligibility system. The qualified entity's certification must be renewed at least every six years.

An approved qualified entity may designate its employees, subcontractors, or other agents to determine presumptive eligibility. Each person must complete a web-based training module and be certified by the Department before they can begin to make eligibility determinations.

Each person authorized to make presumptive eligibility determinations will have a unique identifier to access the presumptive eligibility system and cannot share that access authorization with others. Data entries made by the qualified entity are used to calculate presumptive eligibility electronically.

Individuals who make presumptive eligibility determinations are required to be recertified annually. Each authorized person with the qualified entity will be notified via email 60 days in advance of the certification expiration date of the requirement to recertify. To be recertified, the person must complete training electronically.



2. Eligibility Determination for Children

Presumptive eligibility for children is based on the following criteria. The child must:

- ◆ Be under the age of 19. A child whose 19th birthday falls on the first of the month is no longer considered a child for the month of that birthday. A child whose 19th birthday falls on any other day of the month is considered a child for the month of the birthday.

A child who turns 19 on October 1 is considered a child through the month of September, but not in October.

A child who turns 19 anytime from October 2 through 31 is considered a child through the month of October.

- ◆ Be an Iowa resident.
- ◆ Be a citizen or qualified alien.
- ◆ Provide a social security number. EXCEPTIONS: Children who have applied for a social security number but have not yet received the number and children who do not have a social security number due to religious objection are not required to provide a social security number.
- ◆ Have gross family income less than 300% of the federal poverty level based on the size of the household. Proof of income is not required. Accept the family's statements regarding family income.

When income is changing (e.g., either starting, stopping, or fluctuating), discuss the details of the situation on a case-by-case basis to assist the applicant in providing a reasonable estimate of monthly income. See Section [D.2.b, Determining Income and Household Size](#), for more information.
- ◆ Not have received presumptive eligibility in the 12 months before the month of the eligibility decision. If the information provided indicates that a child will meet Medicaid eligibility requirements, the system will check for previous presumptive episodes in the last 12 months before assigning a state identification number to the child.

Additional information (e.g., citizen and alien status, resources, certain expenses, etc.) is requested on the application used to apply for presumptive Medicaid, but does not impact the presumptive Medicaid eligibility decision. This information will be verified before full Medicaid benefits can be approved.



NOTE: Select one of the following options when entering an alien status on the Department's web-based system:

- ◆ Qualified alien lawfully admitted to the United States with the privilege of residing permanently or indefinitely in the country,
- ◆ Nonqualified alien lawfully admitted to the United States for a specific temporary reason (e.g., visitors for work or vacation, exchange students, temporary workers, etc.), or
- ◆ Undocumented alien in the United States without papers or documentation of status.

a. Application: Presumptive Health Care Coverage for Children, Form 470-4855 or 470-4855(S)

A family requesting presumptive eligibility for a child shall complete an *Application: Presumptive Health Care Coverage for Children*, form 470-4855 or 470-4855(S). Any person can help the applicant complete the application.

The application is used to enter information into the presumptive system for a presumptive eligibility determination. This information also populates the OASIS application which is forwarded to the Department for a formal Medicaid eligibility determination.

A qualified entity will need to print a supply of forms 470-4855 and 470-4855(S). To view a sample of the English form on line, click [here](#). To view a sample of the Spanish form on line, click [here](#).

A child who is 18 years old or is an emancipated minor may sign the application unless mentally or physically unable to do so. Otherwise, the application should be signed by the child's parent or guardian. Only one signature is required when two parents are in the home.

If necessary, the application may also be signed by a conservator, a relative, an authorized representative, or a person in whose home the child resides. An "X" or a thumbprint may be accepted as a signature.

The qualified entity shall document the date the application was received. The date the qualified entity received the presumptive application is the date of application the Department uses for purposes of determining the effective date of ongoing Medicaid eligibility.



EXCEPTION: For the purposes of determining the date of application **for regular Medicaid**, an application received by a qualified entity on a weekend or state holiday will be deemed to be received on the next business day.

All presumptive applications are automatically forwarded to the Department for an ongoing Medicaid eligibility determination for the children.

b. Determining Income and Household Size

The determination of who is included in the household size and whose income is counted depends on whether or not the applicant child is an emancipated minor.

An “emancipated minor” is defined as a person who is or has been married and the marriage has not been annulled, or a person whom the courts have released from the control of parents.

If the applicant child is **not emancipated**, include the following people in the **household size** and count their **income** when determining presumptive eligibility for the applicant child:

- ◆ The applicant child,
- ◆ Siblings under age 19 (of whole or half blood, or adoptive) of the applicant child who are living with the applicant child,
- ◆ Parents or stepparent of the applicant child who are living with the applicant child,
- ◆ Any children of the applicant child who are living with the applicant child, and
- ◆ The parent of the applicant child’s children, if living with the applicant child.

1. **The applicant is a 2-year-old child** who is living with her 20-year-old mother and her mother’s two parents and brother. The parents and brother of the 20-year-old mother are not considered part of the 2-year-old applicant child’s household size. The household size is two (the 2-year-old applicant child plus that child’s mother).



2. **The applicant is 16-year-old child** who is living with her two parents, her 15-year-old brother, her 1-year-old child. The applicant child is not emancipated. The household size is five (the 16-year-old applicant, her parents, her brother, and her own child).

If the applicant child **is emancipated**, include the following people in the **household size** and count their **income** when determining presumptive eligibility for the emancipated minor applicant:

- ◆ The emancipated minor applicant.
- ◆ Any children of the emancipated minor applicant who are living with the emancipated minor.
- ◆ The parent or stepparent of the emancipated minor's children, if living with the emancipated minor.
- ◆ The spouse of the emancipated minor, if living with the emancipated minor.

1. **The applicant is 17-year-old child** who, along with his wife and their 1-year-old child, is living with his two parents and his 14-year-old sister.

Because the applicant is an emancipated minor, his parents and sister are not counted in the household size. The household size is three (the 17-year-old emancipated minor applicant, his spouse, and his 1-year-old child).

2. **The applicant is 16-year-old child** who, along with her husband, is living with her two parents. Because the applicant is an emancipated minor, her parents are not counted in the household size. The household size is two (the 16-year-old emancipated minor applicant and her spouse).

Count all income of everyone who is included in the household size with the applicant child.

Do **not** count income of any other relatives, legal guardians, or friends who live with the applicant child, regardless of the age of the child, unless they give or make money available to the child's household. Any money actually given or made available to the child's household is counted.



If the applicant child's household includes an alien who is sponsored, count any income the sponsor actually makes available to the household.

c. Steps in Making a Presumptive Eligibility Decision

Complete the following steps when determining presumptive eligibility for children:

1. Date-stamp the application when received.
2. Clarify information on the application, if necessary, before entering it into the presumptive eligibility system. All information on the application is self-declared by the family; therefore, it is not verified.
3. Inform the family that all applications are referred to the Department of Human Services for an ongoing Medicaid eligibility determination. During the formal Medicaid eligibility determination, the Department will verify income, citizenship, alien status, identity, and other information as necessary.
4. Enter information from the application into the presumptive system through the Iowa Medicaid Portal Access (IMPA). Make the system entries as soon as possible but always within three working days of the date the application was received. Presumptive eligibility cannot begin until the information is entered into the system.
5. Provide form *Presumptive Medicaid Eligibility Notice of Decision*, form 470-2580 or 470-2580(S), to the family that explains the results of the eligibility determination. Provide the notice as soon as possible but always within two working days after the determination is made.

(See [Presumptive Medicaid Eligibility Notice of Decision, Form 470-2580](#), for samples of this form.)

NOTE: If you discover after IMPA entries have been made and a notice of decision has been created that you made an error (e.g., wrong social security number, misspelled name), contact DHS for instructions on how to resolve the error. **Do not reenter** the application through IMPA unless instructed to do so by the DHS contact provided in the web-based training module.



6. Maintain documentation to support the presumptive eligibility decision for a period of five years for audit purposes. This may include, but is not limited to the application, clarification of any information provided by the family, and a copy of the *Notice of Decision*.

NOTE: Do not send photocopies of the application, notice of decision, or any other paperwork to DHS. Any information needed will be provided to DHS electronically based on the system entries made through IMPA.

d. **Appeal Rights**

There are no appeal rights for a presumptive eligibility decision because a presumptive period is temporary and is not considered a formal Medicaid eligibility determination. Appeal rights are given with formal or ongoing Medicaid eligibility determinations by the Department.

3. **Covered Services and Period of Eligibility for Children**

Presumptive eligibility begins on the date the qualified entity determines that the child is presumptively eligible, which is typically the same day as the qualified entity receives the application.

EXCEPTION: When a qualified entity does not have the necessary computer access to enter the applicant's data into IMPA on the day the application is received, the effective date of presumptive eligibility is the date when the qualified entity received the application.

A qualified entity working in a remote location without computer access receives an application for presumptive eligibility on September 30. The entity makes entries into IMPA on October 1. Presumptive eligibility begins on September 30.

A child who is determined presumptively eligible is eligible to receive full Medicaid benefits during the presumptive period. "Full Medicaid benefits" means that all Medicaid-covered services will be paid.

The child must go to medical providers who accept Iowa Medicaid. No medical charge will be billed to the family unless the charge is from a medical provider who does not accept Iowa Medicaid or the service is not covered by Iowa Medicaid.



A *Medical Assistance Eligibility Card* will not be issued to presumptively eligible children. The family should present the *Presumptive Medicaid Eligibility Notice of Decision* to show medical providers that a child is presumptively eligible for Medicaid covered services.

The provider should confirm eligibility through the Eligibility Verification System (ELVS) each time services are requested since presumptive eligibility is a day-to-day eligibility progression.

Unlike regular Medicaid eligibility, which is granted on a monthly basis, presumptive eligibility may end at any time during the month. A child may receive Medicaid coverage under presumptive eligibility until:

- ◆ The day ongoing Medicaid eligibility is established, or

An application for presumptive eligibility is received and approved on October 6. The application is automatically forwarded to the Department. The Department approves ongoing Medicaid November 3. Presumptive eligibility ends November 3.

- ◆ The last day of the month when ***hawk-i*** eligibility is established, or

An application for presumptive eligibility is received and approved on October 6. The application is automatically forwarded to the Department. The Department denies Medicaid eligibility on October 15 and refers the application to ***hawk-i***. ***Hawk-i*** eligibility is approved effective October 28. Presumptive ends October 31.

- ◆ The day Medicaid eligibility is denied if no referral to ***hawk-i*** is made, or

An application for presumptive eligibility is received and approved on October 6. The application is forwarded to the Department. The Department denies Medicaid eligibility on October 25 and does **not** refer the application to ***hawk-i***. Presumptive eligibility ends October 25.

- ◆ The day ***hawk-i*** eligibility is denied, or

An application for presumptive eligibility is received and approved on October 6. The application is forwarded to the Department. The Department denies eligibility on October 15 and refers the application to ***hawk-i***. ***Hawk-i*** eligibility is denied effective October 28. Presumptive eligibility ends October 28.



- ◆ The last day of the month following the month of the presumptive eligibility determination if the application for full Medicaid is either withdrawn before an eligibility determination or is not pended on the DHS' computer system.

An application for presumptive eligibility is received and approved on October 6. The full Medicaid application is automatically sent to DHS. Before an eligibility determination is made, the family contacts DHS and withdraws the full Medicaid application. Presumptive eligibility continues until November 30.

There is no retroactive coverage under the presumptive Medicaid program. No certificate of creditable coverage is issued for a presumptive eligibility period.

E. PRESUMPTIVE ELIGIBILITY FOR PREGNANT WOMEN

Legal reference: 42 USC 1396r-1; 441 IAC 75.1(30)

The goal of the presumptive eligibility process is to offer immediate health care coverage to pregnant women likely to be Medicaid eligible, before there has been a full Medicaid determination.

Pregnant women can enroll in presumptive eligibility for a limited time before full Medicaid applications are filed and processed, based on a determination of likely Medicaid eligibility from an approved provider. Based only on a woman's statements regarding her family income, a qualified provider can "presume" that the pregnant woman will be eligible for Medicaid.

Qualified providers can grant temporary Medicaid coverage to these women to pay for the cost of ambulatory prenatal care during the presumptive period. See [Section E.3, Covered Services and Period of Eligibility for Pregnant Women](#), for more information.

1. Qualified Providers

A "qualified provider" is defined as a provider who is eligible for payment under the Iowa Medicaid program and who meets the following criteria:

- ◆ Provides one or more of the following services:
 - Outpatient hospital services
 - Rural health clinic services
 - Clinic services furnished by or under the direction of a physician, without regard to whether a physician administers the clinic itself



AND EITHER

- ◆ Receives direct funds (not subcontract) under one or more of the following:

- Migrant Health Centers or Community Health Centers Programs
- Maternal and Child Health Services Programs
- Health Services for Urban Indians Program

OR

- ◆ Participates in any of the following programs:

- Special Supplemental Food Program for Women, Infants and Children (WIC)
- Commodity Supplemental Food Program
- The state perinatal program

OR

- ◆ Is an Indian health service office or health program or facility operated by a tribe or tribal organization under the Indian Self-Determination Act.

A provider that seeks to be authorized to make presumptive Medicaid eligibility determinations for pregnant women shall apply to DHS on form 470-2579, *Application for Authorization to Make Presumptive Medicaid Eligibility Determinations for Pregnant Women*. To view a sample of this form on line, click [here](#).

Send the completed application form and supporting documents (if applicable) to:

Iowa Medicaid Enterprise
Attn: Provider Enrollment
PO Box 36450
Des Moines, IA 50315
Or Fax: 515-725-1155 Attn: Provider Enrollment

For questions about applying to be a qualified provider, contact the IME Provider Enrollment Unit at 1-800-338-7909 (option 2), or locally (Des Moines) at 515-256-4609 (option 2) or by e-mail at imeproviderservices@dhs.state.ia.us.

After receiving form 470-2579, the Department will determine if the applicant meets the criteria to become a qualified provider. Form 470-2582, *Memorandum of Understanding with a Presumptive Provider for Presumptive Medicaid Eligibility Determinations*, will be provided electronically to qualifying applicants. To view a sample of this form on line, click [here](#).



Once the applicant has entered into the memorandum of understanding, the Department will authorize the applicant's access to the presumptive eligibility system. The qualified provider's certification must be renewed at least every six years.

An approved qualified provider may designate its employees, subcontractors, or other agents to determine presumptive eligibility. Each person must complete a web-based training module and be certified by the Department before they can begin to make eligibility determinations.

Each person authorized to make presumptive eligibility determinations will have a unique identifier to access the presumptive eligibility system and cannot share that access authorization with others. Data entries made by the qualified provider are used to calculate presumptive eligibility electronically.

Individuals who make presumptive eligibility determinations are required to be recertified annually. Each authorized person with the qualified provider will be notified by email 60 days in advance of the certification expiration date of the requirement to recertify. To be recertified, the person must complete training electronically.

2. Eligibility Determination for Pregnant Women

Only pregnant women who meet the criteria of this coverage group obtain Medicaid eligibility under presumptive eligibility provisions. The income and needs of other household members are considered in determining the pregnant woman's eligibility.

However, other household members are not entitled to receive Medicaid, unless an application has been filed with the Department of Human Services and the Department has made a determination approving eligibility.

Presumptive eligibility for a pregnant woman is based on the following criteria. The woman must:

- ◆ Be pregnant.
- ◆ Be an Iowa resident.
- ◆ Have net countable family income less than 300% of the federal poverty level for the household size. Proof of income is not required. Accept the woman's statements regarding her family income.



When income is changing (e.g., either starting, stopping, or fluctuating), discuss the details of the situation on a case-by-case basis to assist the applicant in providing a reasonable estimate of monthly income. See Section [E.2.b, Calculating Income and Household Size](#), for more information.

- ◆ Not have received presumptive Medicaid previously during the same pregnancy. The system will check for previous presumptive episodes during this pregnancy before assigning a state identification number to the pregnant woman.

Additional information (e.g., citizen and alien status, resources, certain expenses, etc.) is requested on the application used to apply for presumptive Medicaid, but does not impact the presumptive Medicaid eligibility decision. If the pregnant woman also chooses to apply for ongoing Medicaid with DHS, this information will be verified before full Medicaid benefits can be approved.

NOTE: Select one of the following options when entering an alien status on the Department's web-based presumptive eligibility system:

- ◆ Qualified alien lawfully admitted to the United States with the privilege of residing permanently or indefinitely in the country,
- ◆ Nonqualified alien lawfully admitted to the United States for a specific temporary reason (e.g., visitors for work or vacation, exchange students, temporary workers, etc.), or
- ◆ Undocumented alien in the United States without papers or documentation of status.

a. Completing the Health Services Application

A person requesting presumptive eligibility for a pregnant woman shall complete a *Health Services Application*, form 470-2927 or 470-2927(S). See [Health Services Application, Form 470-2927 or 470-2927\(S\)](#), for a sample of this form.

A qualified provider will need a supply of the *Health Services Application*, form 470-2927 and 470-2927(S). Instructions on how to obtain a supply of these forms are included in the web-based training module each provider completes through IMPA.



The choice to apply for presumptive Medicaid is indicated by checking the box for “Maternal and Children Health Services” on the form. Any person can help the applicant complete the application.

The application form must be signed by one of the following:

- ◆ The applicant,
- ◆ The parent of an applicant child,
- ◆ A guardian or conservator, or
- ◆ Someone acting responsibly for an incompetent or physically incapacitated person.

An “X” or a thumbprint may be accepted as a signature if necessary.

An application with a legible name, address, and signature is valid for purposes of protecting the filing date. The qualified provider shall document the date the application was received.

The rest of the application must be completed before a presumptive eligibility determination is made. The application is used to calculate income and enter information into the presumptive system for a presumptive eligibility determination.

Ensure that the pregnant woman understands that the presumptive Medicaid program for pregnant women does not provide full Medicaid coverage and that coverage under the presumptive program is temporary.

Explain to the pregnant woman that the presumptive eligibility determination is not a formal Medicaid eligibility decision by DHS. Also explain that she may apply for both presumptive Medicaid and full Medicaid at the same time. However, this is not required. Allow the pregnant woman to choose the programs for which she wants to apply. Also allow her to choose when she wants to apply.

Encourage the woman to also apply for full Medicaid during the presumptive period if she wants full, ongoing Medicaid. This will allow Medicaid benefits to begin in a timely manner **if** the applicant meets eligibility requirements.



The choice to apply for full Medicaid is indicated by checking the box for "Medical Assistance," "Facility," "Waiver," or "Medicare Savings Program," on the *Health Services Application*.

NOTE: The pregnant woman may choose to have her information sent via IMPA to DHS to initiate an application for full, ongoing Medicaid regardless of whether her application for presumptive is approved or denied.

If the woman chooses to also apply for full Medicaid, follow the instructions in the web-based training module to send the applicant's information to DHS via the Iowa Medicaid Portal Access (IMPA). Because IMPA will transmit the application electronically, do **not** send a paper copy of the application to DHS.

If the woman does choose to apply for full Medicaid with DHS at the same time she applies for presumptive eligibility, the date the qualified provider received the presumptive application is the date of application the Department uses for purposes of determining the effective date of ongoing Medicaid eligibility.

EXCEPTION: For the purposes of determining the date of application **for full Medicaid**, an application received by a qualified provider on a weekend or state holiday shall be deemed to be received on the next business day.

In some situations the pregnant woman may not want to apply for full Medicaid at all, or she may want to file a separate Medicaid application at a later date. Explain to the pregnant woman that:

- ◆ If she applies for full Medicaid and DHS denies that application for any reason, presumptive Medicaid will end on the day the full Medicaid application is denied. A pregnant woman cannot be determined presumptively eligible again during the same pregnancy.
- ◆ If she applies only for presumptive Medicaid initially, she can still file an application for full Medicaid or for limited Medicaid for emergency services at a later date. See [Section C.7](#) for more information on emergency services.

If the woman **does not** want to apply for full Medicaid, make entries on IMPA to process the application for presumptive Medicaid only. **Do not** select the option on IMPA to initiate an application for ongoing Medicaid in this situation.



Provide the pregnant woman with information that allows her to make a fully informed decision about when to apply and for which programs to apply, considering the details of her own situation and the limited nature of the presumptive Medicaid program.

A pregnant woman contacts a qualified provider to ask how to apply for Medicaid. The qualified provider explains to the woman that she must file a *Health Services Application*.

The qualified provider also tells the woman that she may choose to apply for **only** presumptive Medicaid, apply for **both** presumptive and full Medicaid at the same time, or apply for presumptive Medicaid now and apply for regular Medicaid at a later date. The qualified provider also explains the possible outcomes of each option.

1. The pregnant woman states that she wants to apply for full Medicaid at the same time as presumptive Medicaid. She understands that if she applies for full Medicaid and DHS denies that application for any reason, presumptive Medicaid will end on the day the full Medicaid application is denied.

The provider has the woman apply for both presumptive and full Medicaid on the *Health Services Application*. Then the provider completes entries on IMPA to process the presumptive application and initiate the full Medicaid application with DHS.

2. The pregnant woman wants to apply only for presumptive Medicaid at this time. She understands she may file an application for full Medicaid at a later date. The provider has the woman apply only for presumptive Medicaid on the *Health Services Application*. Then the provider completes entries on IMPA to process the presumptive application only.

In some situations, it may also be beneficial for a woman who has applied for presumptive to withdraw her application for the current month and begin her presumptive period on the first day of the next month. A new application is not necessary in this situation. If this occurs, document this in the case file.

NOTE: Because the IMPA presumptive system will begin eligibility with the date of application, enter the application received date on IMPA as the first day of the next month.



1. A pregnant woman files an application with the qualified provider on March 23 but indicates she does not want presumptive eligibility to begin until April 1. Although the application is date-stamped as received on March 23, the provider documents that the woman withdrew her application for March.

On IMPA, the application "received date" is entered as April 1.
NOTE: If the woman chooses to apply for full Medicaid at the same time, the Medicaid application date transmitted to DHS via IMPA will also be April 1.

2. A pregnant woman files an application with the qualified provider on April 30. The provider explains that presumptive Medicaid may continue only up to May 31 in this situation, and asks Ms. Z if she would like to withdraw her application for April and make her application effective May 1.

Ms. Z indicates she wants to begin prenatal care right away and she does **not** want to withdraw her application for April. The qualified provider processes her presumptive eligibility beginning with April 30 by entering this as the application "received date" on IMPA.

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

b. Calculating Income and Household Size

Count the **income** of the pregnant woman and any of the following people living with the pregnant woman, when determining eligibility:

- ◆ Father of the unborn child,
- ◆ Siblings under age 19 (of whole or half blood, or adoptive) of the unborn child,
- ◆ Parents or stepparent of the pregnant woman, if the pregnant woman is a single minor, and
- ◆ Minor siblings (of whole or half blood, or adoptive) of the pregnant woman, if the pregnant woman is a single minor.



A “minor” is defined as a person who is under the age of 18 and is not legally married.

Count any income these people have, including money given or made available to these people. If a household includes an alien who is sponsored, count any income the sponsor makes available to the household.

Do **not** count income of any other relatives, legal guardians, or friends even when the pregnant woman lives with them, regardless of the age of the pregnant woman, unless they give or make money available to the pregnant woman’s household. Any income these people actually give or make available to the pregnant woman’s household is counted.

When determining **household size**, count only the following people, if living in the home with the pregnant woman:

- ◆ Pregnant woman,
- ◆ Unborn child or children,
- ◆ Father of the unborn child, and
- ◆ Siblings under age 19 (of whole or half blood, or adoptive) of the unborn child.

1. Ms. I, age 15, completes a *Health Services Application* for presumptive Medicaid. She lives with her parents and her two brothers, ages 9 and 12. Ms. I has never been married.

In determining eligibility for presumptive Medicaid, the income of Ms. I, her parents, and her siblings is counted and compared to the income limit for a two-member household (Ms. I and the unborn child).

2. Same as Example 1, except that Ms. I is married and separated from the father of her unborn child. Since he does not live with Ms. I, only the amount of income he makes available to her, if any, is counted along with her income and is compared to the income limit for a two-member household (Ms. I and the unborn child).



3. Ms. K, age 16, completes a *Health Services Application* for presumptive Medicaid. She is married and separated from her husband.

Ms. K lives with Mr. T, who is the biological father of the unborn child. However, Ms. K's husband is the legal father of the unborn child. Since her husband does not live with her, only the amount of income he makes available to her, if any, is counted.

The income of Mr. T is not counted and he is not counted in determining the household size of Ms. K, since there is a legal father. Only the income Mr. T makes available to Ms. K, if any, is counted,. This is true regardless of Ms. K's age.

4. Ms. N, age 18, completes a *Health Services Application* for presumptive Medicaid. Ms. N lives with her parents.

In determining Ms. N's eligibility for presumptive Medicaid, only the income of Ms. N is counted and compared to the limit for a two-member household (Ms. N and the unborn child). Ms. N's marital status does not have any bearing on whether to count the income of Ms. N's parents since she is 18 years old.

Using the income information provided by the pregnant woman on the application, the qualified provider shall complete the *Presumptive Medicaid Income Calculation*, form 470-2629, to determine the countable household income for the pregnant woman. To view a sample of this form on line, click [here](#).

This form is updated annually when new poverty guidelines are issued. The qualified provider is responsible for printing or photocopying a supply of the form from this sample.

Enter the result of the income calculation worksheet onto IMPA. The presumptive eligibility system will determine eligibility based on the total income and household members entered on IMPA.



Income limits are shown below. The federal poverty level usually increases each year effective April 1. These limits are effective for presumptive determinations made April 1, 2012, through March 31, 2013.

300% of poverty	HOUSEHOLD SIZE (Unborn children are counted in the household size.)						
	2	3	4	5	6	7	8
	\$3,783	\$4,773	\$5,763	\$6,753	\$7,743	\$8,733	\$9,723
For each additional person, add \$990							

If the countable household income exceeds the income limit for the applicable household size, the presumptive eligibility system will deny presumptive Medicaid eligibility.

Instructions for completing the form 470-2629, *Presumptive Medicaid Income Calculation*, are as follows:

Section I. Parental Income

Complete Section I when the pregnant woman lives with her parents or stepparent **and** she is under the age of 18 **and** is not married (or her marriage has been annulled).

If the pregnant woman is age 18 or older, is married (including divorced or widowed) regardless of age, or does not live with her parents or stepparent, do not complete this section. Go directly to Section II.

Line A. Enter the total **gross** monthly earned income (amount before any deductions for taxes, etc.) of the pregnant woman's parents or stepparent and any minor siblings of the pregnant woman. If any minor siblings (of whole or half blood, or adoptive) of the pregnant woman who are living in the home have income, create another column for their income.

Line B. Allow a 20% work expense deduction for each person with earned income.



Line C. Enter the amount of child care paid out for a child living in the home when the person incurs child care expenses due to employment. Allow only the actual amount of child care paid out, and permit only **up to** the maximum child care deduction allowed (\$175 per month per child age 2 and over or \$200 per month per child under age 2).

Line D. Subtract Lines B and C from Line A and enter the result here. If the amount is less than zero, enter \$0 on Line D.

Line E. If more than one person listed on this page of the worksheet has earned income, add their remaining earnings together from Line D and enter the total here.

Line F. Enter the total monthly unearned income (social security benefits, child support, alimony, unemployment benefits, etc.) of the pregnant woman's parents or stepparent and any minor siblings of the pregnant woman living in the home.

Line G. Add Line E and Line F and enter the result here.

Line H. Using the table, enter the amount of income to be diverted to meet the needs of the pregnant woman's parents or stepparent in the home and minor siblings of the pregnant woman in the home. Do not include the pregnant woman or her unborn child when determining the amount of income to divert.

Line I. Subtract Line H from Line G and enter the total here. If the amount is less than zero, enter \$0 on Line I. This is the amount of parental income to consider when determining the pregnant woman's eligibility.

Section II. Income of the Pregnant Woman

Household Size. Enter the size of the pregnant woman's household. Determine household size by considering the pregnant woman, the unborn child or children, the father of the unborn child (if he is in the home), and any siblings under age 19 (of whole or half blood, or adoptive) of the unborn child living with the pregnant woman.



Line A. Enter the total **gross** monthly earned income (amount before any deductions for taxes, etc.) of the pregnant woman, the father of the unborn child if he is in the home, and any siblings of the unborn child under age 19 who are living with the pregnant woman. If any siblings of the unborn child (of whole or half blood, or adoptive) under age 19 have earnings, create another column for their income.

Line B. Allow a 20% work expense deduction for each person with earned income.

Line C. Enter the amount of child care paid out for a child living in the home when the person incurs child care expenses due to employment. Allow only the actual amount of child care paid out, and permit only **up to** the maximum child care deduction allowed (\$175 per month per child age 2 and over or \$200 per month per child under age 2).

Line D. Subtract Lines B and C from Line A and enter the result here. If the amount is less than zero, enter \$0 on Line D.

Line E. Add the earnings from Line D of the pregnant woman, the unborn child's father if he is in the home, and the unborn child's siblings under age 19 living with the pregnant woman.

Line F. Enter the total of monthly unearned income (social security benefits, child support, alimony, unemployment benefits, etc.) of the pregnant woman, the unborn child's father if in the home, and the unborn child's siblings under age 19 if in the home.

Line G. Enter the total monthly court-ordered child support payments paid to people outside the home by the pregnant woman, the father of the unborn child if he is in the home, and the unborn child's siblings under age 19 living with the pregnant woman.

Line H. Add Line E to Line F, subtract Line G, and enter the result here.

Line I. Enter the countable parental income from Line I in Section I, if any.

Line J. Add Lines H and I together and enter the total countable net monthly income. Enter only the amount on Line J as income on the presumptive system.



If the total monthly income does not exceed the income limit for the applicable household size, the pregnant woman meets income requirements for eligibility for Medicaid.

Remember: When determining household size, consider only the pregnant woman, the unborn child, the father of the unborn child if he is in the home, and any siblings of the unborn child who are under age 19 and in the home.

c. Steps in Making a Presumptive Eligibility Decision

Complete the following steps when determining presumptive eligibility for pregnant women:

1. Date stamp the application when received.
2. Clarify information on the application, if necessary. All information on the application is self-declared by the pregnant woman; therefore, it is not verified.
3. Inform the pregnant woman that her application can be referred to the Department for a full, ongoing Medicaid eligibility determination if she chooses. During the formal Medicaid eligibility determination, the Department will verify income, citizenship, alien status, identity, and other information as necessary.
4. Complete form 470-2629, *Presumptive Medicaid Income Calculation*.
5. Enter information from the application and income calculation worksheet into the presumptive system through the Iowa Medicaid Portal Access (IMPA). Make the system entries as soon as possible but always within three working days of the date the application was received. Presumptive eligibility cannot begin until the information is entered into the system.
6. Provide *Presumptive Medicaid Eligibility Notice of Decision*, form 470-2580 or 470-2580(S), to the pregnant woman that explains the results of the eligibility determination. Provide the notice as soon as possible but always within two working days after the determination is made. (See [Presumptive Medicaid Eligibility Notice of Decision, Form 470-2580](#), for samples of this form.)



NOTE: If you discover after IMPA entries have been made and a notice of decision has been created that you have made an error (e.g., wrong social security number, misspelled name, woman is not pregnant), contact DHS for instructions on how to resolve the error. **Do not reenter** the application in IMPA unless instructed to do so by the DHS contact provided in the web-based training module.

7. Maintain documentation to support the presumptive eligibility decision for a period of five years for audit purposes. This may include, but is not limited to, the application, income calculation worksheet, clarification of any information provided by the woman, and a copy of the *Notice of Decision*.

NOTE: Do not send photocopies of the application, notice of decision, or any other paperwork to DHS. Any information needed will be provided to DHS electronically based on the system entries made on IMPA.

d. Appeal Rights

There are no appeal rights for a presumptive eligibility decision because a presumptive period is temporary and is not considered a formal Medicaid eligibility determination. Appeal rights are only given with formal or ongoing Medicaid eligibility determinations made by the Department.

Ms. L is pregnant and applies for presumptive eligibility at the office of a qualified provider on August 3. She also applies for Medicaid at the same time as she applied for presumptive eligibility.

The qualified provider determines that Ms. L's income exceeds 300% of the federal poverty limit for her household size and denies presumptive eligibility. If Ms. L requests an appeal on the presumptive eligibility determination, her appeal request will be denied, as there are no appeal rights under the presumptive Medicaid program.

However, if DHS also denies the full Medicaid application, Ms. L may appeal this decision.



3. Covered Services and Period of Eligibility for Pregnant Women

A pregnant woman who is determined presumptively eligible is eligible for Medicaid ambulatory prenatal care services during the presumptive period.

“Ambulatory prenatal care” means all Medicaid-covered services **except** inpatient hospital or institutional care and charges associated with delivery of the baby (including miscarriage or termination of a pregnancy). Medicaid will pay medical expenses for ambulatory prenatal care incurred during the presumptive eligibility period even if the woman does not attain full Medicaid eligibility.

If the pregnant woman also chooses to apply for full Medicaid and is approved by DHS, claims for inpatient services and services associated with a delivery or miscarriage will be paid, if they are Medicaid-covered services from an Iowa Medicaid provider.

1. Ms. A is determined presumptively eligible on June 29 and she applies for Medicaid with DHS at the same time. The full Medicaid application is processed on July 26.

Ms. A will be eligible for ambulatory prenatal services from June 29 through July 26. However, full Medicaid benefits will be granted back to June 1 (the first day of the month in which Ms. A is eligible for full Medicaid benefits) and will overlap the presumptive period.

2. Same as example 1, except that Ms. A is not eligible for full Medicaid for June. Full Medicaid benefits are approved effective July 1. All Medicaid-covered services incurred on or after July 1 will be payable. Only ambulatory prenatal services incurred on June 29 and June 30 will be payable.

Presumptive eligibility begins on the date the qualified provider determines on IMPA that the pregnant woman is presumptively eligible, which is typically be the same day the qualified provider receives the application.

EXCEPTION: When a qualified provider does not have the necessary computer access to enter the applicant’s data into IMPA on the same date the application is received, the effective date of presumptive eligibility is the date the qualified provider received the application. Eligibility cannot begin before the provider receives an application.



A qualified provider working in a remote location without computer access receives an application for presumptive eligibility on September 30. The provider makes entries into IMPA on October 1 using an application "received date" of September 30. Presumptive eligibility begins on September 30.

A *Medical Assistance Eligibility Card* will not be issued to presumptively eligible pregnant women. Instead, the qualified provider issues form 470-2580 or 470-2580(S), *Presumptive Medicaid Eligibility Notice of Decision*, to inform the woman of the decision on her application.

The woman should present the *Presumptive Medicaid Eligibility Notice of Decision* to show medical providers that she is presumptively eligible for "ambulatory prenatal care." The woman must go to medical providers who accept Iowa Medicaid.

The provider should confirm eligibility through the Eligibility Verification System (ELVS) each time services are requested since presumptive eligibility is a day-to-day eligibility progression.

Unlike regular Medicaid eligibility, which is granted on a monthly basis, presumptive eligibility may be terminated on any given day, without notice, once it is determined that the pregnant woman is not presumptively eligible. There is also no retroactive coverage under the presumptive Medicaid program.

NOTE: The Department will end the presumptive eligibility period immediately upon being notified a woman is not actually pregnant. This sometimes occurs when a woman is approved for presumptive Medicaid based on symptoms of pregnancy or a pregnancy test result that is later determined to be a false positive.

If the pregnant woman files a formal application for full Medicaid coverage either before or during the presumptive period, presumptive eligibility coverage continues until a decision is made on the full Medicaid application. The presumptive eligibility period ends on the day DHS enters a decision on the computer system to either approve or deny the Medicaid application.

If a Medicaid application has not been filed by the last day of the month following the month of the presumptive eligibility determination, presumptive eligibility ends on the last day of that month.



Presumptive eligibility will also end on the last day of the month following the month of the presumptive eligibility determination if an application for full Medicaid is withdrawn, or if the application for full Medicaid is not pended on the DHS' computer system by the last day of the month following the month of the presumptive eligibility determination.

NOTE: A pregnant woman may be determined presumptively eligible only once during her pregnancy. If a woman wants Medicaid after her presumptive eligibility ends, she must apply and be determined eligible for full Medicaid by DHS. She may not be determined presumptively eligible again within the same pregnancy.

No certificate of creditable coverage is issued for a presumptive eligibility period.

1. Ms. B is determined presumptively eligible on May 2. She does not apply for full Medicaid at the time she applies for presumptive Medicaid. Instead, she files a full Medicaid application on June 30, and DHS pends the application the same day. Ms. B's presumptive eligibility continues until DHS makes an eligibility determination on her Medicaid application.
2. Same as Example 1, except Ms. B's application for full Medicaid is either not filed with or not pended by DHS until July 1. Ms. B's presumptive eligibility ends on June 30.
3. Ms. C is determined presumptively eligible on June 6 and applies for full Medicaid at the same time she applied for presumptive Medicaid. On June 20, DHS determines that Ms. C is not eligible and her Medicaid application is denied. Ms. C's presumptive eligibility ends June 20.
4. Ms. D applies for full Medicaid at the same time she applies for presumptive eligibility. She is determined presumptively eligible on July 29. By August 31, DHS has not been able to make an eligibility determination on her Medicaid application. If her application was pended at DHS, Ms. D's presumptive eligibility extends beyond August 31 and continues until DHS makes an eligibility determination.
5. Provider A determines that Ms. E is presumptively eligible by on April 16. She does not apply for full Medicaid at the same time and does not file a Medicaid application with DHS by May 31. Ms. E's presumptive Medicaid coverage ends May 31.



In July, Ms. E moves and begins going to Provider B. Ms. E completes a new *Health Services Application* on July 3 on which she indicates she wants to apply for both presumptive Medicaid and full, ongoing Medicaid.

When Provider B enters her presumptive application on IMPA, the system determines if this pregnancy is the same pregnancy for which Provider A determined her eligible for presumptive Medicaid. If it is the same pregnancy, IMPA entries will result in a denial notice for presumptive Medicaid, which Provider B prints and gives to Ms. E.

Since Ms. E also indicated she wants to apply for full Medicaid, Provider B makes entries on IMPA to initiate an application with DHS for full Medicaid.

6. Ms. F is determined presumptively eligible on August 16. On August 10, she filed a Medicaid application with DHS, and the Medicaid application is still pending on August 16. Ms. F's presumptive eligibility continues until September 30 or until a decision is made on the Medicaid application, whichever is first.

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

Legal reference: Breast and Cervical Cancer Prevention and Treatment Act of 2000 (P.L. 106-354); 42 USC 1396r-1b; 441 IAC 75.1(40)"c"

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

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

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



1. Qualified BCCT Providers

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

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

A provider seeking to be authorized to make presumptive Medicaid eligibility determinations for women who need treatment for breast or cervical cancer shall apply to the BCCEDP coordinator at the Iowa Department of Public Health (IDPH) on form 470-3864, *Application for Authorization to Make Presumptive Medicaid Eligibility Determinations (BCCT)*. To view a sample of this form on line, click [here](#).

Send the completed application form to:

Care for Yourself/CFY Case Management Coordinator
Iowa Department of Public Health
Lucas State Office Building
321 East 12th Street
Des Moines, Iowa 50319-0175

After receiving form 470-3864, the BCCEDP coordinator will determine if the applicant meets the criteria to become a qualified provider. The Department will then electronically provide Form 470-2582, *Memorandum of Understanding with a Presumptive Provider for Presumptive Medicaid Eligibility Determinations*, to qualifying applicants. To view a sample of this form on line, click [here](#).

Once the applicant has entered into the memorandum of understanding, the Department will authorize the applicant's access to the presumptive eligibility system. Each person must complete a web-based training module and be certified by the Department before they can begin to make eligibility determinations.



Each person authorized to make presumptive eligibility determinations will have a unique identifier to access the presumptive eligibility system and cannot share that access authorization with others. Data entries made by the qualified provider are used to calculate presumptive eligibility electronically.

Individuals who make presumptive eligibility determinations are required to be recertified annually. Each authorized person with the qualified provider will be notified via email 60 days in advance of the certification expiration date of the requirement to recertify. To be recertified, the person must complete training electronically.

2. **BCCT Eligibility Determination**

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

Presumptive Medicaid eligibility is available under the breast and cervical cancer treatment (BCCT) coverage group to a woman who meets all the following eligibility requirements:

- ◆ Is under age 65.
- ◆ Is an Iowa resident.
- ◆ Was screened and diagnosed:
 - Through the Breast and Cervical Cancer Early Detection Program (BCCEDP), or
 - Using funds from the Susan G. Komen Foundation.
- ◆ Needs treatment for a cancerous or precancerous condition of the breast or cervix.
- ◆ Does not have creditable health insurance coverage.
- ◆ Has not received presumptive eligibility in the 12 months before the month of the eligibility decision. **EXCEPTION:** A woman who is diagnosed and completes treatment but then has a new cancer diagnosis may receive presumptive Medicaid again during the same 12 month period.



Additional information (e.g., citizen and alien status, income, resources, certain expenses, etc.) is requested on the application used to apply for presumptive Medicaid.

This information does not impact the presumptive Medicaid eligibility decision. If the woman also chooses to apply for ongoing Medicaid with DHS, this information may be verified before full Medicaid benefits can be approved.

a. Health Services Application

The woman or someone acting on her behalf shall complete and sign the *Health Services Application*, form 470-2927 and 470-2927(S) application. See [Health Services Application, Forms 470-2927 or 470-2927\(S\)](#), for a sample or to print this form.

A qualified provider may order a supply of the application by either contacting the local DHS office or by faxing a request to Iowa Prison Industries (IPI) at 1-800-741-0390.

The choice to apply for presumptive BCCT Medicaid is indicated by checking the box for "Medical Assistance" and writing in "BCCT" next to that box on the form. The woman must file the *Health Services Application*, form 470-2927 or 470-2927(S) (Spanish), with a BCCEDP screening provider.

An application with a legible name, address, and signature is valid for purposes of protecting the filing date. The qualified provider shall document the date the application was received.

The rest of the application must be completed before a presumptive eligibility determination is made. The application is used to enter information into the presumptive system for a presumptive eligibility determination.

Ensure that the woman understands that coverage under the presumptive program is temporary. Encourage the woman to file a Medicaid application during the presumptive period if cancer treatment will continue beyond the presumptive period.



Also explain to the woman that the presumptive eligibility determination is not a formal Medicaid eligibility decision by DHS. Explain that she may apply for both presumptive Medicaid and full Medicaid at the same time. However, this is not required. Allow the woman to choose the programs for which she wants to apply. Also allow her to choose when she wants to apply.

Use the information provided on the application to determine whether the woman meets the nonmedical requirements for presumptive BCCT eligibility. Enter the applicant's information on the presumptive eligibility system through Iowa Medicaid Portal Access (IMPA) to generate a state identification number and *Presumptive Medicaid Eligibility Notice of Decision* for the woman.

Encourage the woman to also apply for ongoing Medicaid during the presumptive period. This will allow Medicaid benefits to begin in a timely manner **if** the applicant meets eligibility requirements.

The choice to apply for full Medicaid is indicated by checking box for the "Medical Assistance," "Facility," "Waiver," or "Medicare Savings Program," on the *Health Services Application*, form 470-2927 or 470-2927(S).

NOTE: The woman may choose to have her information sent to DHS to initiate a formal application for ongoing Medicaid regardless of whether her application for presumptive is approved or denied.

If the woman chooses to also apply for full Medicaid, select the "Applying for ongoing Medicaid" option on IMPA. Photocopy the application and keep the photocopy in your file.

Within **two working days** from the date of the presumptive determination, **send the original copy** of the application and proof of screening under the BCCEDP or using Susan G. Komen funds to the DHS office for the county in which the woman resides. (See the [Appendix](#) for a list of the addresses of local Human Services offices.)

If the woman does choose to apply for ongoing Medicaid with DHS at the same time she applies for presumptive, the date the qualified provider received the presumptive application is the date of application the Department uses for purposes of determining the effective date of ongoing Medicaid eligibility.



EXCEPTION: For the purposes of determining the date of application **for ongoing Medicaid**, an application received by a qualified provider on a weekend or state holiday will be deemed to be received on the next business day.

In some situations the woman may not want to apply for full Medicaid at all, or she may want to file a separate Medicaid application at a later date. Explain to the woman that:

- ◆ If she applies for full Medicaid and DHS denies that application for any reason, presumptive Medicaid will end on the day the full Medicaid application is denied. A woman can be determined presumptively eligible only once during a 12 month period.

EXCEPTION: A woman who is diagnosed and completes treatment but then has a new cancer diagnosis may receive presumptive Medicaid again during the same 12 month period.

- ◆ If she applies only for presumptive Medicaid initially, she can still file an application for ongoing Medicaid at a later date.

If the woman does not want to apply for full Medicaid, make entries on IMPA to process the application for presumptive Medicaid only. **Do not** select the "Applying for ongoing Medicaid" option on IMPA or forward the woman's application to DHS.

Provide the woman with information that allows her to make a fully informed decision about when to apply and for which programs to apply, considering the details of her own situation and the limited nature of the presumptive Medicaid program.

A woman in need of treatment for breast and cervical cancer contacts a qualified provider to ask how to apply for Medicaid. The qualified provider explains to the woman that she must file a *Health Services Application*.

The qualified provider also tells the woman that she may choose to apply for **only** presumptive Medicaid, apply for **both** presumptive and full Medicaid at the same time, or apply for presumptive initially and apply for regular Medicaid at a later date. The qualified provider also explains the possible outcomes of each option.



1. The woman states that she wants to apply for full Medicaid at the same time as presumptive Medicaid. She understands that if she applies for full Medicaid and DHS denies that application for any reason, presumptive Medicaid will end on the day the full Medicaid application is denied.

The provider has the woman apply for both presumptive and full Medicaid on the *Health Services Application*. Then the provider completes entries on IMPA to process the presumptive application and forwards the Medicaid application and BCCEDP screening to DHS.

2. The woman wants to apply only for presumptive Medicaid at this time. She understands she may file an application for full Medicaid at a later date.

The provider has the woman apply only for presumptive Medicaid on the *Health Services Application*. Then the provider completes entries on IMPA to process the presumptive application only. The provider does not forward the Medicaid application to DHS.

In some situations, it may also be beneficial for a woman who has applied for presumptive to withdraw her application for the current month and begin her presumptive period the first day of the next month. A new application is not necessary in this situation. If this occurs, document this in the case file.

NOTE: Because the IMPA presumptive system will begin eligibility with the date of application, enter the application received date on IMPA as the first day of the next month.

1. A woman files an application with the qualified provider on March 23 but indicates she does not want presumptive eligibility to begin until April 1. Although the application is date-stamped as received on March 23, the provider documents that the woman withdrew her application for March.

On IMPA, the application "received date" is entered as April 1.

NOTE: In this situation, if the woman chooses to apply for full Medicaid at the same time, the Medicaid application date transmitted to DHS via IMPA will also be April 1.



2. A woman files an application with the qualified provider on April 30. The provider explains that presumptive Medicaid may only continue up to May 31 in this situation, and asks if she would like to withdraw her application for April and make her application effective May 1.

The woman indicates she wants coverage to begin right away and she does **not** want to withdraw her application for April. The qualified provider processes her presumptive eligibility beginning with April 30 by entering this as the application "received date" on IMPA.

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

b. Steps in Making a Presumptive Eligibility Decision

Complete the following steps when determining presumptive eligibility for women under the BCCT coverage group:

1. Date stamp the application when received.
2. Clarify information on the application, if necessary.
3. Inform the woman that her application can be referred to the Department for an ongoing Medicaid eligibility determination if she chooses. During the formal Medicaid eligibility determination, the Department will verify income, citizenship, alien status, identity, and other information as necessary.
4. Enter information from the application into the presumptive system through the Iowa Medicaid Portal Access (IMPA). Make the system entries as soon as possible but always within three working days of the date the application was received. Presumptive eligibility cannot begin until the information is entered into the system.
5. Provide *Presumptive Medicaid Eligibility Notice of Decision*, form 470-2580 or 470-2580(S), to the woman that explains the results of the eligibility determination. Provide the notice as soon as possible but always within two working days after the determination is made. (See [Presumptive Medicaid Eligibility Notice of Decision, Form 470-2580](#), for samples of this form.)



NOTE: If you discover after IMPA entries have already been made and a notice of decision has been created that an error was made (e.g., wrong SSN, misspelled name), contact DHS for instructions on how to resolve the error. **Do not reenter** the application in IMPA unless instructed to do so by the DHS contact provided in the web-based training module.

6. If the woman chose to also apply for ongoing Medicaid, forward the application and proof of screening under the BCCEDP or using Susan G. Komen funds to the local DHS office within two working days from the date of the presumptive eligibility determination.
7. Maintain documentation to support the presumptive eligibility decision for a period of five years for audit purposes. This may include, but is not limited to the application, proof of screening under the BCCEDP or using Susan G. Komen funds, clarification of any information provided by the woman, and a copy of the Notice of Decision.

c. Appeal Rights

There are no appeal rights for a presumptive eligibility decision because a presumptive period is temporary and is not considered a formal Medicaid eligibility determination. Appeal rights are only given with formal or ongoing Medicaid eligibility determinations made by the Department.

3. Covered BCCT Services and Period of Eligibility

A woman who is determined to be presumptively eligible for Medicaid under this coverage group is eligible for Medicaid services during the presumptive period. Medicaid will pay covered medical expenses incurred during the presumptive eligibility period even if the woman does not attain full Medicaid eligibility.

Presumptive eligibility begins on the date the qualified provider determines on IMPA that the woman is presumptively eligible. The date of the presumptive eligibility determination will typically be the same day the application is received by the qualified provider. Eligibility cannot begin before the provider receives an application.



EXCEPTION: When a qualified provider does not have the necessary computer access to make the entries of the applicant's data into the IMPA system on the same date the application is received, the effective date of presumptive eligibility is the date the application was received by the qualified provider.

A qualified provider working in a remote location without computer access receives an application for presumptive eligibility on September 30. The provider makes entries into IMPA on October 1 using an application "received date" of September 30. Presumptive eligibility begins on September 30.

A *Medical Assistance Eligibility Card* will not be issued to presumptively eligible women. Instead, the qualified provider issues form 470-2580 or 470-2580(S), *Presumptive Medicaid Eligibility Notice of Decision*, to inform the woman of the decision on her application.

The woman should present the *Presumptive Medicaid Eligibility Notice of Decision* to show medical providers that she is presumptively eligible for Medicaid. The woman must go to medical providers who accept Iowa Medicaid.

The provider should confirm eligibility through the Eligibility Verification System (ELVS) each time services are requested since presumptive eligibility is a day-to-day eligibility progression.

Unlike regular Medicaid eligibility, which is granted on a monthly basis, presumptive eligibility may be terminated on any given day, without notice, once it is determined that the woman is not presumptively eligible. There is also no retroactive coverage under the presumptive Medicaid program.

If the woman files a formal application for full Medicaid coverage either before or during the presumptive period, presumptive eligibility coverage continues until a decision is made on the full Medicaid application. The presumptive eligibility period ends on the day DHS enters a decision on the computer system to either approve or deny the Medicaid application.

If a Medicaid application has not been filed by the end of the last day of the month following the month of the presumptive eligibility determination, presumptive eligibility ends on the last day of that month.



Presumptive eligibility will also end on the last day of the month following the month of the presumptive eligibility determination if an application for full Medicaid is withdrawn, or if the application for full Medicaid is not pended on the DHS' computer system by the last day of the month following the month of the presumptive eligibility determination.

NOTE: A women may be determined eligible for presumptive Medicaid only once during a 12 month period. EXCEPTION: A woman who is diagnosed and completes treatment but then has a new cancer diagnosis may receive presumptive Medicaid again during the same 12 month period. The woman must file a *Health Services Application* with a qualified provider to initiate each presumptive eligibility determination.

No certificate of creditable coverage is issued for a presumptive eligibility period.

1. A woman is determined presumptively eligible for Medicaid on July 31. She does not apply for full Medicaid at the same time she applies for presumptive Medicaid.

Instead, she files an application for full Medicaid on August 31 (the last day of the month following the month of the presumptive eligibility determination). DHS pends the application the same day. Presumptive eligibility continues until DHS makes a decision on her Medicaid application.
2. Same as Example 1, except the woman's application for full Medicaid is either not filed with or not pended by DHS until September 1. The woman's presumptive eligibility ends on August 31.
3. A woman is determined presumptively eligible for Medicaid on July 1. She does not apply for full Medicaid at the same time she applies for presumptive Medicaid. Instead, she files an application for full Medicaid on July 31. On August 5, the IM worker denies the application because the woman turned 65 years of age on August 1. Presumptive eligibility ends on August 5.
4. A woman is determined presumptively eligible on June 6 and applies for full Medicaid at the same time. On June 20, DHS determines that she is not eligible and her Medicaid application is denied. Her presumptive eligibility period also ends on June 20.



Iowa
Department
of Human
Services

Provider and Chapter

All Providers

Chapter II. Member Eligibility

Page

63

Date

August 1, 2011

5. A woman is determined presumptively eligible on July 29 and applies for full Medicaid at the same time. By August 31, DHS has not been able to make an eligibility determination on her Medicaid application. If the woman's application was pended at DHS, the woman's presumptive eligibility extends beyond August 31 and continues until DHS makes an eligibility determination.
6. A woman is determined presumptively eligible on August 16. On August 10, she had filed a full Medicaid application directly with DHS, and the Medicaid application is still pending on August 16. The woman's presumptive eligibility continues until September 30 or until a decision is made on the full Medicaid application, whichever is first.