

## Health and Financial Support Application

### What Kind of Help Would You Like?

Part A

The Department of Human Services (DHS) has many programs that may help you and your family. Please fill out this application so that we can help you find the programs that will meet your needs.

Look at the programs listed below. Choose the programs you want to apply for and fill out those sections of the application. **Everyone must fill out Part A (pink).**

### Food Assistance

Part B

The Food Assistance Program, formerly known as Food Stamps, helps you buy food for good health. You may be able to get Food Assistance by the 7<sup>th</sup> day after applying. This is called Emergency Service. If you want to apply for Food Assistance, fill out **Part A (pink)** and **Part B (orange)**.

### Medicaid or State Supplementary Assistance (SSA)

Part C

Medicaid is also known as Title 19. It helps pay for medical bills, prescription drugs, nursing home care, services that will keep people at home and out of a nursing home, and all or part of your Medicare premium. State Supplementary Assistance is a cash benefit for certain elderly or disabled persons. If you want to apply for Medicaid or State Supplementary Assistance, fill out **Part A (pink)** and **Part C (green)**.

### Well-Child and Prenatal Care

Part D

If you are pregnant, recently had a baby, or have children up to the age of 5, you may be eligible for the Women Infants and Children (WIC) program, which provides referrals for other health services, advice for staying healthy, and checks to spend at the grocery store for nutritious foods. If you are pregnant or have children up to age 21, there may be additional assistance in finding well child check-ups, immunizations or prenatal care. If you want these services, fill out **Part A (pink)** and **Part D (blue)**.

### Family Investment Program (FIP) or Refugee Cash Assistance

Part E

The Family Investment Program (FIP) is also known as Temporary Assistance for Needy Families (TANF). FIP provides temporary cash assistance to children and families. Refugees who do not get FIP may get Refugee Cash Assistance. If you want to apply for FIP or Refugee Cash Assistance, fill out **Part A (pink)** and **Part E (purple)**.

### Child Care Assistance

Part F

Child Care Assistance helps pay for the care of your child while a parent or caretaker works or attends school. It might also be used to care for children while a parent or caretaker is looking for work or is unable to care for children because of medical reasons. If you want to apply for Child Care Assistance, fill out **Part A (pink)** and **Part F (teal)**.

## How Do I Get Help?

You may apply for one or more programs listed on the previous page.

Step 1. Fill out an application.

Anyone may fill out an application. You may apply on a paper application or you can apply online at [www.oasis.iowa.gov](http://www.oasis.iowa.gov). If you decide to apply using this form, answer as many questions as you can. **If you can't fill out the whole application today, fill out and turn in Page 1. But, then please fill out and turn in the rest of the application as soon as you can.** If you need help filling out an application, please ask for help at your local Department of Human Services (DHS) office.

Step 2. Return the application to us.

You can bring or mail your application to a local DHS office. **The date we get Page 1 with your name, address and signature is your application date. This starts the time we have to work on your application. It is also the date your Food Assistance may start.**

Step 3. Give us proof and come to an interview if asked.

You **may** be asked to show us proof:

- Of who you are and who the people are for whom you apply. Examples are a driver's license, social security card, (not proof for Medicaid) or alien documentation card.
- That you and the people for whom you apply are U.S. citizens or nationals.
- Of the money you have gotten in the last 30 days, such as check stubs, self-employment records or award letters.
- Of things you have, such as bank accounts, trust accounts, stocks, or bonds.

You may need to show us other proof. If you are not able to show us proof right away, you will be given time to get the information. If you can't get proof, ask DHS to help you get the information.

An interview will be set up for you, if necessary. You should come to your interview even if you do not have all the proof we need. Interviews are not needed if you are applying only for Medicaid for a child or for Child Care Assistance.

## Information About Immigration Status

You can apply for part of your household even if some members do not have legal immigrant status. For example, parents who do not have legal immigrant status may apply for their children who are U.S. citizens or qualified legal immigrants. You may need to give proof of immigration status or U.S. citizenship for each person in your household for whom you apply.

Your household's alien status may be checked with the Citizenship and Immigration Service. Any information we get from the Citizenship and Immigration Service may affect your household's benefits. We will not contact the Citizenship and Immigration Service about the people you don't apply for. However, we may use their income and assets to see if the rest of the household can get help.

## Addendum to Application and Review Forms for Release of Information

### OPTIONAL Release of Information

#### *Help Us Help You!*

You do not have to sign this, but it will help us get information we need to help you, without having to get your signature on specific requests.

**You should know that:**

- We may need more information to decide if you can get assistance.
- If more information is needed from you, you will get a letter telling you what we need and the date you must get it to us.
- You are responsible to get the information or to ask us for help to get it.
- If you do not give us the information or ask for help by the due date, your application may be denied or your assistance may stop.
- We may be able to use the release below to get the information we need. **But you still have to provide information we request or ask us for help.**
- We may attach a copy of this release to a form that asks other people or organizations (like your employer) for specific information needed about you or others in your household.

**Print and sign your name below to give us permission to get needed information.**

#### RELEASE OF INFORMATION

I hereby authorize any person or organization to give the Iowa Department of Human Services requested information about me or other members of my household.

A copy of this release is as valid as the original.

This release does not apply to protected health information.

This release is good for 12 months from the date signed.

\_\_\_\_\_  
Your Name (please print clearly)

\_\_\_\_\_  
Other Adult Name (please print clearly)

\_\_\_\_\_  
Signature or Mark

\_\_\_\_\_  
Signature or Mark

\_\_\_\_\_  
Date

## Health and Financial Support Application

**What Kind of Help Would You Like? Part A**

Check the box next to the programs you want to apply for. You do not need to apply for programs you already get.

- |                                                                                                                                                                              |                                                                                                                                     |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> <b>Food Assistance</b><br><input type="checkbox"/> <b>Family Investment Program</b><br><input type="checkbox"/> <b>Well Child and Prenatal Care</b> | <input type="checkbox"/> <b>Medicaid or State Supplementary Assistance</b><br><input type="checkbox"/> <b>Child Care Assistance</b> |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------|

**Tell Us About You Part A**

Name	Telephone Number (    )	<b>If needed, when is the best time to call?</b>	
Social Security Number	Birth Date		
Street Address	City	State	Zip Code
Mailing Address (if different)	City	State	Zip Code

**Your Signature Part A**

I certify, under penalty of perjury, that:

- The answers I am about to give are correct and complete to the best of my knowledge.
- My answer about citizenship or alien status of each person applying for assistance is correct.

Keep the cover page and Part G.

Your Signature or Mark	Today's Date
Signature of Person, If Any, Who Helped Complete the Form	Today's Date
Print Name of Person Who Helped Complete Form	Phone Number
Mailing Address of Person Who Helped Complete Form	City                      State                      Zip Code

**If you need help filling out this form, call your local DHS office.**

**Food Assistance in 7 days – Emergency Service**

This is who can get Food Assistance in 7 days:

- Households with gross monthly income less than \$150 and with assets, such as cash or bank accounts, of \$100 or less; or
- Households with rent, mortgage and utilities that are more than the household's gross monthly income and assets; or
- Households with a migrant or seasonal farm worker and with assets of \$100 or less whose income is stopping or starting.

**Food Assistance in 30 days**

If you don't get Emergency Service, you will get Food Assistance within 30 days if you are eligible, or a letter telling you why, if you are not eligible.

**All Other Programs**

We will send you a letter within 30 days of the date we get your application telling you if you will get help or not. If you are applying for Medicaid and are eligible for the Medically Needy program, we will send you a letter within 45 days.

We use these terms in the application. This is what they mean.

<b>Alien</b>	A person who is not a U.S. citizen.
<b>EAC card</b>	An electronic access card (Visa debit card) for getting your cash assistance.
<b>EBT card</b>	A plastic swipe card that you use at the grocery store to buy food.
<b>Eligible</b>	Meeting all of the program guidelines to get help from us.
<b>Household</b>	A group of people who live together.
<b>PROMISE JOBS</b>	A work and training program for the Family Investment Program (FIP).
<b>Quality Control</b>	A DHS unit that might review your case to see if you are getting the correct assistance. If your case is chosen, the Quality Control unit will contact you.
<b>Refugee</b>	A person who enters the U.S. with a refugee status.
<b>Special needs for child care</b>	A child with a condition diagnosed by a professional that limits major life activities.

## Social Security Number Information

Part A

We can give help only to people who give us their Social Security Number or proof of application from the Social Security office. **You don't have to give us the Social Security Number for people in your household who you do not want help for, but you can choose to give us their Social Security Number.** However, we will use any Social Security Number given to us the same way we use the Social Security Number of people getting assistance.

We will deny assistance to the people for whom you do not give us a Social Security Number. There are some exceptions to this. Please ask your worker.

We will not give any Social Security Number to the Citizenship and Immigration Service.

## People in Your Home

Part A

List all the people who live in your home and mark the box **yes** or **no** if you are applying for that person. If you choose no, you only need to list their name, relationship to you and their date of birth.

We have to ask your ethnicity and race, but you don't have to answer. Your answer won't affect how much you get or how soon. If you choose to answer, use the following codes:

\* Ethnicity

H = Hispanic or Latino

N = Not Hispanic or Latino

\*\* Race (Choose all that apply)

W = White

B = Black or African American

A = Asian

I = American Indian or Alaskan Native

N = Native Hawaiian or other Pacific Islander

Apply for? Yes/No	Name (First, Last)	Relationship to You	Birth Date	Birth State	Last Grade in School	Social Security Number	Ethnicity *	Race **	Citizen Yes/No	If Alien, Status
		Self								

### Grandparents and others applying for children that are not your own:

If you are applying for FIP and Medicaid **only** for the children, answer the remaining questions only about the children. If you are applying for Food Assistance, Child Care Assistance, or want FIP or Medicaid for yourself, answer the questions about everyone in your home.

List anyone in your home who is disabled: \_\_\_\_\_

List anyone in your home who is pregnant: \_\_\_\_\_ Due Date: \_\_\_\_\_

List anyone age 18 or over who is in college or trade school: \_\_\_\_\_

List anyone getting benefits from another state: \_\_\_\_\_

What state? \_\_\_\_\_

**Expenses**

**Part A**

To get the most help you can, tell us about your expenses.

List your share of any day care for a child or a disabled adult who lives with you:

Who gets care: \_\_\_\_\_ \$ \_\_\_\_\_ per month

If anyone currently pays child support, give the following information:

Who pays: \_\_\_\_\_ \$ \_\_\_\_\_ per month

**Income**

**Part A**

You must tell us about all money the people in your household get. If you leave a space blank, we will take that to mean there is no money of this kind. Please use an additional sheet of paper, if needed.

List all jobs the people in your household have.

Who Works?	Employer Name?	How Much is this Person Paid Per Hour?	How Many Hours Does this Person Expect to Work Each Week?	How Often is this Person Paid?	Does this Person Get Tips?
		\$ _____	Regular Hours: _____  Overtime Hours: _____	<input type="checkbox"/> Weekly <input type="checkbox"/> Every 2 Weeks <input type="checkbox"/> Twice a Month <input type="checkbox"/> Monthly <input type="checkbox"/> Other (explain) _____	<input type="checkbox"/> Yes, Weekly Amount \$ _____ <input type="checkbox"/> No
		\$ _____	Regular Hours: _____  Overtime Hours: _____	<input type="checkbox"/> Weekly <input type="checkbox"/> Every 2 Weeks <input type="checkbox"/> Twice a Month <input type="checkbox"/> Monthly <input type="checkbox"/> Other (explain) _____	<input type="checkbox"/> Yes, Weekly Amount \$ _____ <input type="checkbox"/> No

Will the amount of money reported above from jobs stay about the same?  Yes  No

If no, explain \_\_\_\_\_

Has anyone been hired for a job but not received a paycheck yet?  Yes  No

If yes, Who? \_\_\_\_\_ Employer Name? \_\_\_\_\_

Has anyone's job ended in the last 30 days?  Yes  No

If yes, Who? \_\_\_\_\_ Employer Name? \_\_\_\_\_

What Other Money Do People in Your Household Get?	Who Gets the Money?	How Much Per Month?
Self-Employment or Odd Jobs		
Unemployment or Worker's Compensation		
Social Security or SSI		
Veterans Benefits, Pensions or Retirement		
Child Support or Alimony		
Money from Friends or Relatives		
Other: (Including irregular or one time payments) Explain:		

Will the amount of other money people in your household get stay about the same?  Yes  No

If no, explain \_\_\_\_\_

## Resources (Assets)

Part A

Does anyone have a car, truck, boat, camper, motorcycle or other vehicle?  Yes  No

If yes, list make, model, year below.

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List the total money anyone has in:

Checking/savings or other bank/credit union accounts \$ \_\_\_\_\_ Who? \_\_\_\_\_

Cash \$ \_\_\_\_\_ Who? \_\_\_\_\_

Stocks, bonds, savings certificates, annuities, IRAs, Keogh or other assets \$ \_\_\_\_\_ Who? \_\_\_\_\_

List anyone who has or owns any land, buildings or houses other than the house you live in:

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List anyone who has a conservatorship or trust:

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**Food Assistance****Part B**

If you do not get Food Assistance and want to apply, answer the questions in this section.

List the people in your household who are **not** applying for Food Assistance:

Tell us who does not eat with you: \_\_\_\_\_

List anyone who has an Iowa EBT card: \_\_\_\_\_

Is anyone a migrant or seasonal farm worker?  Yes  No

Has anyone quit a job in the last 30 days?  Yes  No

**Help With Your Food Assistance****Part B**

You can have someone fill out your application, answer questions for you, give information at your interview, and buy food with an EBT card. If you choose to have someone help you, we will be able to share information with this person. You don't have to do this.

We will be able to share information with this person. Tell us about the person you want to help you.

Name	Address	Telephone Number

**Food Assistance Expenses****Part B**

To get the most Food Assistance you can, please tell us about your bills.

**Shelter and Utilities**

How much is **your share** of the following expenses:

Rent: \$ \_\_\_\_\_ per month

Lot Rent: \$ \_\_\_\_\_ per month

Mortgage: \$ \_\_\_\_\_ per month

If you pay taxes or insurance separate from your mortgage, list amounts below:

Property Taxes: \$ \_\_\_\_\_ per \_\_\_\_\_

Homeowner's Insurance: \$ \_\_\_\_\_ per \_\_\_\_\_

Check the boxes next to the utility bills you have to pay:

- |                                               |                                                           |
|-----------------------------------------------|-----------------------------------------------------------|
| <input type="checkbox"/> Lights/Electricity   | <input type="checkbox"/> Water and Sewage                 |
| <input type="checkbox"/> Gas                  | <input type="checkbox"/> Garbage and Trash                |
| <input type="checkbox"/> Telephone            | <input type="checkbox"/> Extra charges from your landlord |
| <input type="checkbox"/> Other, explain _____ |                                                           |

- Check here if any of the utility bills you have to pay are for heating or air conditioning.
- Check here if you got energy assistance in the past year at your current address.
- Check here if you are on low rent housing. If yes, what is your part of the rent? \$ \_\_\_\_\_

### Medical Expenses

Tell us the medical costs that are not paid by insurance for everyone who is disabled or over age 59. These could be doctor and hospital bills, medicine, transportation, health insurance premiums or other medical services.

Who pays: \_\_\_\_\_ Amount per month: \$ \_\_\_\_\_

### Help Paying Expenses

If you get help with your expenses tell us:

Which Expense Was Paid	Who Paid	Amount Paid

## Medicaid or State Supplementary Assistance (SSA) Part C

If you do not get Medicaid or SSA and want to apply, answer the questions in this section.

List the people in your home who are **not** applying for Medicaid or SSA:

Did anyone receive medical care in the past three months?  Yes  No

Who? \_\_\_\_\_ What months? \_\_\_\_\_

Does anyone have life or death benefit insurance?  Yes  No

Did anyone give away anything of value or transfer anything for less than its value within the last 5 years?  Yes  No

Does anyone expect to get a one-time payment, such as an inheritance or insurance settlement, or did anyone get one in the past 3 months?  Yes  No

Does anyone have Medicare or other health insurance?  Yes  No

Check if you need additional help paying or information about:

- Medical costs for a person in a nursing home or other facility.  
Name of nursing home or facility: \_\_\_\_\_
- Your Medicare premium.
- Assistance for a dependent of an elderly or disabled person.
- Services to allow a person to stay at home.
- Medical costs for a child in foster care or subsidized adoption.
- Family planning services.

**Child Support**

If you are applying for Medicaid for children under 18, complete this section for each parent who does not live in the home with the children.

Are you willing to cooperate with us to get medical insurance or medical support from any parent not in the home?  Yes  No

Name and Address of Parent Not Living in the Home	Date of Birth of This Parent	Social Security Number of This Parent	Name of This Parent's Children	County Where Court Order is Filed, if Any

Name and address of employer of parent not in the home \_\_\_\_\_

If ever married to this parent, list the date and place of marriage: \_\_\_\_\_

**Well-Child and Prenatal Care** **Part D**

I give my permission for DHS to share the information in this application with the local child health, maternal health or WIC agency to help me with the following programs:

- Nutrition Assistance (WIC)
- Assistance for pregnant women
- Well Child Care Assistance

The local child health, maternal health or WIC agency will contact you.

If you do not get FIP or Refugee Cash Assistance and want to apply, answer the questions in this section.

List the people in your home who are **not** applying for FIP:

\_\_\_\_\_

List anyone who has an Iowa EAC Card \_\_\_\_\_

Does anyone expect to get a one-time payment such as an inheritance or insurance settlement or did anyone get one in the past 30 days?  Yes  No

Does anyone have life or death benefit insurance?  Yes  No

List anyone in your household who has received TANF or other cash assistance benefits outside of Iowa since January 1, 1997: \_\_\_\_\_

Where? \_\_\_\_\_

What months? \_\_\_\_\_

**Child Support**

If you filled this in on the previous page, you do not need to fill this out here. Complete this section for each parent who does not live in the home with the children.

Name and Address of Parent Not Living in the Home	Date of Birth of This Parent	Social Security Number of This Parent	Name of This Parent's Children	County Where Court Order is Filed, if Any

Name and address of employer of parent not in the home \_\_\_\_\_

If ever married to this parent, list the date and place of marriage: \_\_\_\_\_

If you do not get Child Care Assistance and want to apply, answer the questions in this section.

List the children in your home who need child care: \_\_\_\_\_

List any children who are identified as having special needs: \_\_\_\_\_

List the hours of work for the adults in your household.

Name of Person Working _____	Name of Person Working _____
Monday _____ to _____	Monday _____ to _____
Tuesday _____ to _____	Tuesday _____ to _____
Wednesday _____ to _____	Wednesday _____ to _____
Thursday _____ to _____	Thursday _____ to _____
Friday _____ to _____	Friday _____ to _____
Saturday _____ to _____	Saturday _____ to _____
Sunday _____ to _____	Sunday _____ to _____

Do you need child care while you attend school?  Yes  No  
 If yes, you will need to give us a copy of your class schedule.

Are you enrolled in graduate school?  Yes  No

Do you need child care for another reason, such as hospitalization or job search?  Yes  No

If yes, explain: \_\_\_\_\_

List the name of the person or agency that will be caring for your children:

Provider Name	Telephone Number	
Street Address		
City	State	Zip Code

## You Have the Right to Appeal

## Part G

You, or the person helping you, may request an appeal hearing if you do not agree with any action taken on your case. For Food Assistance, you can appeal in person or by telephone. For all other programs, you must appeal in writing. To appeal in writing do **one** of the following:

- Fill out an appeal electronically at <https://dhssecure.dhs.state.ia.us/forms/>, **or**
- Write a letter telling us why you think a decision is wrong, **or**
- Fill out an Appeal and Request for Hearing form. You can get this form at your county DHS office.

Send or take your appeal to the Department of Human Services, Appeals Section, 5<sup>th</sup> Floor, 1305 E Walnut Street, Des Moines, Iowa 50319-0114. If you need help filing an appeal, ask your county DHS office.

You can represent yourself. Or, you can have a friend, relative, lawyer or someone else act on your behalf.

You may contact your county DHS office about legal services. You may have to pay for these legal services. If you do, your payment will be based on your income. You may also call Iowa Legal Aid at (800) 532-1275. If you live in Polk County, call (515) 243-1193.

## You Will Not Be Discriminated Against

## Part G

It is the policy of the Iowa Department of Human Services (DHS) to provide equal treatment in employment and provision of services to applicants, employees and clients without regard to race, color, national origin, sex, religion, age, disability, political belief or veteran status.

If you feel DHS has discriminated against or harassed you, you can send a letter of complaint to:

Iowa Department of Human Services, Administrator, Diversity Program Unit, 1305 E. Walnut, Des Moines IA 50319-0114; phone (800) 972-2017; fax (515) 281-4243.

*(Food Assistance only)* USDA - Director Office for Civil Rights, 1400 Independence Ave SW, Washington DC 20250-9410, or call 1-800-795-3272 voice or (202) 720-6382 (TTY).

## All Programs

## Part G

### We Check What You Tell Us

The information you give us may be checked by federal, state and local officials to make sure it is true. Things we might check are any listed person's: Social Security Number, job and pay, bank account amount, alien status, and amounts received from other sources like Social Security or unemployment. If any information you give us is not correct, we may deny your application.

We may check records from other states to see if any person in your household can get benefits in Iowa. This may be because a person was disqualified from a program in another state.

We check and use computer systems like the state Income and Eligibility Verification System. If something you told us is different from what the computer system tells us, we will check to find out what is correct. We might check your information by contacting your employer, your bank or other people. To do this kind of checking with your employer, bank, or other people, we will ask you first.

### **Things You Need to Know:**

DHS may give your answers to law enforcement officials to catch persons fleeing to avoid the law.

The Quality Control unit or Investigations unit may review your case. They may contact other people or organizations to get proof of your information. By signing this application, you give permission to release confidential information to the Quality Control unit or Investigations unit. You must cooperate with them to keep your benefits.

You will have to pay back any benefits you got or that was paid to a third party on your behalf for which you were not eligible.

Section 1128B of the Social Security Act provides federal penalties for fraudulent acts and false reporting in connection with these programs.

Anyone who gets, tries to get, or helps any other person get assistance to which they are not entitled, is guilty of violating the laws of the state of Iowa. This includes, but is not limited to, Iowa Code Chapters 239B, 243, 249, and 249A.

Your expenses may be used to figure the amount of assistance you get. You may have expenses included in your benefit calculation by reporting and giving proof of your expenses. If you do not report or give proof of your expenses, you choose not to claim the expense. You can report and give proof later, and the expense can be used for future months.

Comm. 233 will be given to you at your interview. It will tell you about any additional rights and responsibilities not covered with this application.

## **Food Assistance**

## **Part G**

### **Rules of the Food Assistance Program**

Follow these rules:

- **Don't** hide or give wrong information on purpose to get Food Assistance benefits.
- **Don't** use Food Assistance benefits to buy non-food items like alcohol or tobacco.
- **Don't** trade, sell or give away Food Assistance benefits.
- **Don't** use someone else's Food Assistance benefits for yourself.
- **Don't** fail to report if your household goes over its income limit.

If you get Food Assistance, your worker will tell you what your household's income limit is. If your household's income goes over your limit in any month you must tell us by the 10<sup>th</sup> day of the next month. If you don't tell us on time, you might have to pay back the benefits.

## Penalties of the Food Assistance Program

Anyone who breaks the above rules:

- May not get Food Assistance benefits for **1 year for the first time, 2 years for the second time, and forever for the third time;**
- May be fined up to \$250,000 or jailed up to 20 years or both; and
- May be kept off Food Assistance for an additional 18 months, if court ordered.

If a court finds you guilty of buying, selling, or trading more than \$500 in Food Assistance benefits, you will lose benefits forever.

If a court finds you guilty of trading Food Assistance benefits for firearms, ammunition or explosives, you will lose benefits forever.

If a court finds you guilty of trading Food Assistance benefits for controlled substances, you will lose benefits for two years the first time and forever the second time.

You will not get Food Assistance for 10 years if you are found guilty of getting or trying to get Food Assistance in more than one household at a time. This penalty happens if you give wrong information about who you are or where you live.

***Giving wrong information on purpose may result in us taking legal action against you, either criminal or civil. It might also mean we reduce your benefits or take money back from you.***

### Things You Need to Know:

If you have a Food Assistance overpayment, DHS will give your answers to federal and state agencies as well as private claims collection agencies, to collect the overpayment.

The Food Assistance office may contact other people or organizations to get proof of your information.

By having signed this application, you agree that all members of your household will follow the work and training rules.

## Medicaid or State Supplementary Assistance (SSA)

Part G

### Things You Need to Know:

Within 5 working days of the date the change happens, you must tell DHS about changes, such as:

- Income, including lump sum payments, such as past due child support, inheritances, or settlements
- Resources or assets, which includes getting an inheritance
- Someone moving in or out of your home
- Your health insurance coverage
- You file an insurance claim or get an attorney to recover bills paid by Medicaid
- Mailing or living address

You must give the social security numbers for everyone who wants Medicaid. This is required by Section 1137(a)(1) of the Social Security Act and 42 CFR 435.910. We use social security numbers to:

- Check income, eligibility, and Medicaid payments
- Determine a person's right to Medicaid
- Comply with federal law
- Match records with other agencies

If approved for Medicaid, you give up your rights to medical support payments while you get Medicaid. The state of Iowa will keep and use medical support payments to help pay for your medical coverage.

If you get Medicaid but not FIP, the Department will try to collect financial support for you and your children. If all you get is Medicaid, you can tell the Department that you only want medical support services.

A medical certification from the Iowa Medicaid Enterprise (IME) is needed for certain medical programs.

Payments on any future unpaid medical services will be paid directly to the doctors and medical suppliers under the Medicare Insurance Program (Medicare Part B).

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

**By signing this application, you give your permission for DHS to share:**

- Your medical and other health care records with federal and state officials
- The status of your Medically Needy case, the amount of your spenddown, and the bills used to meet your spenddown with the provider whose bills are being used
- The premium due date for Medicaid for Employed People with Disabilities (MEPD) with your medical provider
- The information on your application for Home- and Community-Based Services (HCBS) waivers with the chosen case management agency or with the Iowa Department of Public Health (IDPH) Brain Injury Services Program manager (for HCBS brain injury waiver applications)
- The filing date of your application with your nursing facility

**By signing this application, you give your permission for your medical provider to share:**

- Your medical history with an HMO, PHP, or other managed care provider
- Information with IME Medical Services Unit to certify a medical need for certain Medical Assistance programs or services

I agree to assign medical payments from a third party to the Medicaid agency for myself and others who are eligible for Medicaid for whom I legally can assign benefits. I also agree to cooperate in obtaining medical payments from third parties.

**This permission ends when your Medicaid stops.**

**Penalty of the FIP Program**

You will not get FIP for 10 years if you are found guilty of getting or trying to get FIP in more than one state at a time. This penalty happens if you give wrong information about where you live.

**Things You Need to Know:**

Within 10 days of the date the change happens, you must tell DHS about changes, such as:

- Income, when it starts or stops, including getting an inheritance or a one-time payment of past due child support
- Resources or assets
- Someone moving in or out of your home
- Mailing or living address
- Receipt of a Social Security Number
- Change of school attendance of a child

If your application for FIP or Refugee Cash Assistance is approved, your Food Assistance may go down or stop.

If you are approved for FIP, you will be registered with the PROMISE JOBS program. You agree that all members of your household who must cooperate with PROMISE JOBS will do so. Talk with your worker if you feel you have a reason not to cooperate.

If you choose not to take part in PROMISE JOBS, your FIP benefits will be limited.

While you get FIP, you give up your rights to child support. The state of Iowa will keep your child support to pay back the money you get from FIP.

**Child Care Assistance (CCA)****Part G****Things You Need to Know:**

Within 10 days of the date the change happens, you must tell DHS about changes, such as:

- Income, including a change in your hourly rate and when income starts or stops
- Work hours
- Mailing or living address
- Class schedule
- Someone moving in or out of the house
- Change in child care provider