FAMILIES FIRST
COUNSELING SERVICES

Partnering with Families today to help foster growth and success for tomorrow.

Dear Kinship Placement,

Welcome to Families First! Thank you for your commitment to your children and helping them to develop and grow! My name is Amber Busch and I supervise the Kinship Navigation program. Our goal at Families First is to ensure that your family receives exceptional services which are tailored for your families' specific needs. A Kinship Specialist has been assigned to provide service to your family. Your families Kinship Specialist is: (First Name Last Name) and can be reached at (Phone Number).

We'd like to thank you for opening your heart and home to your Kinship placement. Kinship Care allows us the opportunity to keep children better connected to their communities, school, and people whom them are close to. You are doing amazing things! Your Kinship Specialist can be a support to you in many ways including locating resources, making referrals, answering questions regarding DHS and the Juvenile Court process, as well as simply being a contact to help you navigate this new experience. No question or needs is too big or small so please let us know how we can help!

Please feel free to reach out to me if you have any questions or concerns that I can assist you with. You may hear from me periodically to see how services are going. I can be reached at (563)212-5266 or abusch@families-first.net.

Sincerely,

Amber Busch

Kinship Supervisor

Families First Counseling Services

111 Plaza Circle, Waterloo, IA 50701
Office: (319)433-0395 Fax: (319)433-3870 Toll Free: (888)316-3025
www.families-first.net

Department of
HUMAN SERVICES

Application for Health Coverage and Help Paying Costs

Use this application to see what coverage choices you qualify for

- Affordable private health insurance plans that offer comprehensive coverage to help you stay well
- A new tax credit that can immediately help pay your premiums for health coverage
- Free or low-cost insurance from Medicaid or the Children's Health Insurance Program (CHIP)

You may qualify for a free or low-cost program even if you earn as much as $94,000 a year (for a family of 4).

Who can use this application?

- Use this application to apply for anyone in your family.
- Apply even if you or your child already has health coverage. You could be eligible for lower-cost or free coverage.
- Families that include immigrants can apply. You can apply for your child even if you aren't eligible for coverage. Applying won't affect your immigration status or chances of becoming a permanent resident or citizen.
- If someone is helping you fill out this application, you may need to complete Step 6.

Apply faster online

Apply faster online at dhsservices.iowa.gov.

What you may need to apply

- Social Security Numbers (or document numbers for any legal immigrants who need insurance)
- Employer and income information for everyone in your family (for example, from paystubs, W-2 forms, or wage and tax statements)
- Policy numbers for any current health insurance
- Information about any job-related health insurance available to your family

Why do we ask for this information?

We ask about income and other information to let you know what coverage you qualify for and if you can get any help paying for it. **We'll keep all the information you provide private and secure, as required by law.**

What happens next?

Send your complete, signed application to the address on page 16. **If you don't have all the information we ask for, sign and submit your application anyway.** We'll follow-up with you within 30 days. You'll get instructions on the next steps to complete your health coverage. If you don't hear from us within 30 days, call the DHS Contact Center at **1-855-889-7985**. Filling out this application doesn't mean you have to buy health coverage.

Get help with this application

- **Online:** dhsservices.iowa.gov
- **Phone:** Call our Help Center at **1-855-889-7985**.
- **In person:** There may be counselors in your area who can help. Visit our website or call **1-855-889-7985** for more information.
- **En Español:** Llame a nuestro centro de ayuda gratis al **1-855-889-7985**.
- If you need help in a language other than English, call **1-855-889-7985** and tell the customer service representative the language you need. We'll get you help at no cost to you.
- TTY users should call **1-800-735-2942**.

Step 1. Tell us about yourself.

We need one adult in the family to be the contact person for your application.

First name, middle name, last name, and suffix			
Home address (If you leave blank because you don't have one, you must give us a mailing address below.)			Apartment or suite number
City	State	ZIP code	County
Mailing address (if different from home address)			Apartment or suite number
City	State	ZIP code	County
Phone number		Other phone number	
Do you want to get information about this application by email? ☐ Yes ☐ No Email address:			
Preferred spoken or written language (if not English)			

Step 2. Tell us about your family.

Who do you need to include on this application?

Tell us about all the family members who live with you. If you file taxes, we need to know about everyone on your tax return. (You don't need to file taxes to get health coverage.)

DO include:

- Yourself
- Your spouse
- Your children under 21 who live with you
- Your unmarried partner who needs health coverage
- Your unmarried partner who lives with you when you have a child or children together
- Anyone you include on your tax return, even if they don't live with you
- Anyone else under 21 who you take care of and lives with you

You DON'T have to include:

- Your unmarried partner who lives with you and doesn't need health insurance unless you have a child or children together
- Your unmarried partner's children
- Your parents who live with you, but file their own tax return (if you're over 21)
- Other adult relatives who file their own tax return

The amount of assistance or type of program you qualify for depends on the number of people in your family and their incomes. This information helps us make sure everyone gets the best coverage they can.

Complete Step 2 for each person in your family. Start with yourself, then add other adults and children. If you have more than five people in your family, you'll need to make a copy of the pages and attach them. You don't need to provide immigration status or a Social Security Number (SSN) for family members who don't need health coverage. We'll keep all the information you provide private and secure as required by law. We'll use personal information only to check if you're eligible for health coverage.

Step 2. Person 1 (start with yourself)

Complete Step 2 for yourself, your spouse or partner and children who live with you and anyone on your same federal income tax return if you file one. See page 1 for more information about who to include. If you don't file a tax return, remember to still add family members who live with you.

First name, middle name, last name, and suffix		Relationship to you? **SELF**
Date of birth (mm/dd/yyyy)	Sex: ☐ Male ☐ Female	Social Security Number (SSN)

We need your SSN if you want health coverage and have a SSN. Providing your SSN can be helpful if you don't want health coverage too since it can speed up the application process. We use SSNs to check income and other information to see who's eligible for help with health coverage costs. If someone wants help getting an SSN, call 1-800-772-1213 or visit www.socialsecurity.gov/. TTY users should call 1-800-325-0778.

Do you plan to file a federal income tax return THIS YEAR?

(You can still apply for health insurance even if you don't file a federal income tax return.)

☐ Yes. **If yes**, please answer questions 1-3. ☐ No. **If no**, skip to question 3.

☐ Yes ☐ No 1. Will you file jointly with a spouse?
If yes, name of spouse: _____

☐ Yes ☐ No 2. Will you claim any dependents on your tax return?
If yes, list names of dependents: _____

☐ Yes ☐ No 3. Will you be claimed as a dependent on someone's tax return? **If yes**, list the name of the tax filer: _____
How are you related to the tax filer? _____

☐ Yes ☐ No Are you pregnant? **If yes**, how many babies are expected during this pregnancy? What is the due date? _____

☐ Yes ☐ No Are you currently incarcerated?

☐ Yes ☐ No Are you currently assigned to a work release program?
If yes, what is the start date? _____

Do you need health coverage?

(Even if you have insurance, there might be a program with better coverage or lower costs.)

☐ Yes. **If yes**, answer all the questions below. ☐ No. **If no**, skip to the income questions on page 3. Leave the rest of this page blank.

☐ Yes ☐ No Do you have a physical, mental, or emotional health condition that causes limitations in activities (like bathing, dressing, daily chores, etc.) or live in a medical facility or nursing home?

☐ Yes ☐ No Are you a U.S. citizen or U.S. national?

☐ Yes ☐ No If you aren't a U.S. citizen or U.S. national, do you have eligible immigration status?
If yes, fill in your document type and ID number below.
Document type: _____ Document ID number: _____

☐ Yes ☐ No Have you lived in the U.S. since before August 22, 1996?

☐ Yes ☐ No Are you or your spouse or parent an honorably discharged veteran or an active-duty member of the U.S. military?

☐ Yes ☐ No Are you a resident of Iowa?

☐ Yes ☐ No Do you need help paying for medical bills from the last three calendar months? If you answer yes and you fall into a category that allows for retroactive approval, we will determine if you are eligible for coverage during those months.

☐ Yes ☐ No Are you an adult who is a main person taking care of a child under the age of 19 living in the home?

☐ Yes ☐ No Are you a full-time student?

☐ Yes ☐ No Were you in foster care at age 18 or older?

☐ Yes ☐ No If you are under age 19, do you want help with child support?

The following ethnicity and race questions are optional. Check all that apply.

If Hispanic or Latino, ethnicity:
- ☐ Mexican
- ☐ Mexican American
- ☐ Chicano/a
- ☐ Puerto Rican
- ☐ Cuban
- ☐ Other: _____

Race:
- ☐ White
- ☐ Black or African American
- ☐ American Indian or Alaska Native
- ☐ Asian Indian
- ☐ Chinese
- ☐ Filipino
- ☐ Japanese
- ☐ Korean
- ☐ Vietnamese
- ☐ Other Asian
- ☐ Native Hawaiian
- ☐ Guamanian or Chamorro
- ☐ Samoan
- ☐ Other Pacific Islander
- ☐ Other: _____

Current Job and Income Information: You must tell us about the income of the people in your household. If someone has more than one job, tell us about all jobs. If you leave a space blank, we will assume that you have no income of this kind.

- ☐ **Employed.** If you're currently employed, tell us about your income. Start with **Current Job 1.**
- ☐ **Not employed.** Skip to the **Other Income This Month** section.
- ☐ **Self-employed.** Skip to the **Self-Employment** section.

Current Job 1:

Employer name and address				Employer phone number
Wages and tips (before taxes) $	☐ Hourly ☐ Twice a month	☐ Weekly ☐ Monthly	☐ Every 2 weeks ☐ Yearly	Average hours worked each month:

Current Job 2: If you have more jobs and need more space, attach another sheet of paper.

Employer name and address				Employer phone number
Wages and tips (before taxes) $	☐ Hourly ☐ Twice a month	☐ Weekly ☐ Monthly	☐ Every 2 weeks ☐ Yearly	Average hours worked each month:

Will the amount of money from jobs stay about the same? ☐ Yes ☐ No
If no, explain: _____

In the past three months, did you:
☐ Change jobs ☐ Stop working ☐ Start working fewer hours ☐ None of these

Self-Employment: If self-employed, answer the following questions.

Type of work _____

How much net income (profits once business expenses are paid) will you get from this self-employment this month? $ _____

Will the amount of monthly income from self-employment stay about the same? ☐ Yes ☐ No
If no, how much do you expect to average over a 12 month period? $ _____

Other Income This Month: Check all that apply, and give the amount and how often you get it. **NOTE:** You don't need to tell us about child support, veteran's payment, or Supplemental Security Income (SSI).

		How often?			How often?
☐ None					
☐ Unemployment	$ _____	_____	☐ Alimony received	$ _____	_____
☐ Pensions	$ _____	_____	☐ Net farming/fishing	$ _____	_____
☐ Social Security	$ _____	_____	☐ Net rental/royalty	$ _____	_____
☐ Retirement accounts	$ _____	_____	☐ Other income Type _____	$ _____	_____

Will the amount of money from other income stay about the same? ☐ Yes ☐ No
If no, explain: _____

Deductions: If you pay for certain things that can be deducted on a federal income tax return, check all that apply and give the amount and how often you pay. This information can be found on the Adjusted Gross Income section of your Federal 1040 form. **NOTE:** You shouldn't include a cost that you already considered in your answer to net self-employment.

		How often?			How often?
☐ Alimony paid	$ _____	_____	☐ Other deductions	$ _____	_____
☐ Student loan interest	$ _____	_____	Type _____		

Step 2. Person 2

Complete Step 2 for your spouse or partner and children who live with you and anyone on your same federal income tax return if you file one. See Page 1 for more information about who to include. If you don't file a tax return, remember to still add family members who live with you.

First name, middle name, last name, and suffix		Relationship to you?
Date of birth (mm/dd/yyyy)	Sex: ☐ Male ☐ Female	Social Security Number (SSN)

We need your SSN if you want health coverage and have a SSN. Providing your SSN can be helpful if you don't want health coverage too since it can speed up the application process.

☐ Yes ☐ No Does *Person 2* live at the same address as you? **If no**, list address: _____

Does *Person 2* plan to file a federal income tax return THIS YEAR?

(You can still apply for health insurance even if you don't file a federal income tax return.)

☐ Yes. **If yes**, please answer questions 1-3. ☐ No. **If no**, skip to question 3.

☐ Yes ☐ No 1. Will *Person 2* file jointly with a spouse? **If yes**, name of spouse: _____

☐ Yes ☐ No 2. Will *Person 2* claim any dependents on *Person 2's* tax return? **If yes**, list names of dependents: _____

☐ Yes ☐ No 3. Will *Person 2* be claimed as a dependent on someone's tax return? **If yes**, list the name of the tax filer: _____
How is *Person 2* related to the tax filer? _____

☐ Yes ☐ No Is *Person 2* pregnant? **If yes**, how many babies are expected during this pregnancy? What is the due date? _____

☐ Yes ☐ No Is *Person 2* currently incarcerated?

☐ Yes ☐ No Is *Person 2* currently assigned to a work release program? **If yes**, what is the start date? _____

Does *Person 2* need health coverage?

(Even if they have insurance, there might be a program with better coverage or lower costs.)

☐ Yes. **If yes**, answer all the questions below. ☐ No. **If no**, skip to the income questions on page 5. Leave the rest of this page blank.

☐ Yes ☐ No Does *Person 2* have a physical, mental, or emotional health condition that causes limitations in activities (like bathing, dressing, daily chores, etc.) or live in a medical facility or nursing home?

☐ Yes ☐ No Is *Person 2* a U.S. citizen or U.S. national?

☐ Yes ☐ No If *Person 2* isn't a U.S. citizen or U.S. national, does *Person 2* have eligible immigration status? **If yes**, fill in their document type and ID number below.
Document type: _____ Document ID number: _____

☐ Yes ☐ No Has *Person 2* lived in the U.S. since before August 22, 1996?

☐ Yes ☐ No Is *Person 2* or their spouse or parent an honorably discharged veteran or an active-duty member in the U.S. military?

☐ Yes ☐ No Is *Person 2* a resident of Iowa?

☐ Yes ☐ No Does *Person 2* need help paying for medical bills from the last three calendar months? If you answer yes and this person falls into a category that allows for retroactive approval, we will determine if this person is eligible for coverage during those months.

☐ Yes ☐ No Is *Person 2* an adult who is a main person taking care of a child under the age of 19 living in the home?

☐ Yes ☐ No Was *Person 2* in foster care at age 18 or older?

☐ Yes ☐ No If *Person 2* is under age 19, do you want help with child support?

Please answer the following questions if *Person 2* is 22 or younger:

☐ Yes ☐ No Did *Person 2* have insurance through a job and lose it within the past three months?
If yes, end date: _____ Reason insurance ended: _____

☐ Yes ☐ No Is *Person 2* a full-time student?

The following ethnicity and race questions are optional. Check all that apply.

If Hispanic or Latino, ethnicity:
- ☐ Mexican
- ☐ Mexican American
- ☐ Chicano/a
- ☐ Puerto Rican
- ☐ Cuban
- ☐ Other: _____

Race:
- ☐ White
- ☐ Black or African American
- ☐ American Indian or Alaska Native
- ☐ Asian Indian
- ☐ Chinese
- ☐ Filipino
- ☐ Japanese
- ☐ Korean
- ☐ Vietnamese
- ☐ Other Asian
- ☐ Native Hawaiian
- ☐ Guamanian or Chamorro
- ☐ Samoan
- ☐ Other Pacific Islander
- ☐ Other: _____

Current Job and Income Information: You must tell us about the income of the people in your household. If someone has more than one job, tell us about all jobs. If you leave a space blank, we will assume that you have no income of this kind.

- ☐ **Employed.** If you're currently employed, tell us about your income. Start with **Current Job 1**.
- ☐ **Not employed.** Skip to the **Other Income This Month** section.
- ☐ **Self-employed.** Skip to the **Self-Employment** section.

Current Job 1:

Employer name and address				Employer phone number
Wages and tips (before taxes) $	☐ Hourly ☐ Twice a month	☐ Weekly ☐ Monthly	☐ Every 2 weeks ☐ Yearly	Average hours worked each month:

Current Job 2: If you have more jobs and need more space, attach another sheet of paper.

Employer name and address				Employer phone number
Wages and tips (before taxes) $	☐ Hourly ☐ Twice a month	☐ Weekly ☐ Monthly	☐ Every 2 weeks ☐ Yearly	Average hours worked each month:

Will the amount of money from jobs stay about the same? ☐ Yes ☐ No
If no, explain: _____

In the past three months, did *Person 2*:
☐ Change jobs ☐ Stop working ☐ Start working fewer hours ☐ None of these

Self-Employment: If self-employed, answer the following questions.

Type of work _____

How much net income (profits once business expenses are paid) will you get from this self-employment this month? $ _____

Will the amount of monthly income from self-employment stay about the same? ☐ Yes ☐ No
If no, how much do you expect to average over a 12 month period? $ _____

Other Income This Month: Check all that apply, and give the amount and how often you get it. **NOTE:** You don't need to tell us about child support, veteran's payment, or Supplemental Security Income (SSI).

		How often?			How often?
☐ None					
☐ Unemployment	$ _____	_____	☐ Alimony received	$ _____	_____
☐ Pensions	$ _____	_____	☐ Net farming/fishing	$ _____	_____
☐ Social Security	$ _____	_____	☐ Net rental/royalty	$ _____	_____
☐ Retirement accounts	$ _____	_____	☐ Other income Type _____	$ _____	_____

Will the amount of money from other income stay about the same? ☐ Yes ☐ No
If no, explain: _____

Deductions: If *Person 2* pays for certain things that can be deducted on a federal income tax return, check all that apply and give the amount and how often *Person 2* pays. This information can be found on the Adjusted Gross Income section of *Person 2's* Federal 1040 form. **NOTE:** You shouldn't include a cost that you already considered in your answer to net self-employment.

		How often?			How often?
☐ Alimony paid	$ _____	_____	☐ Other deductions	$ _____	_____
☐ Student loan interest	$ _____	_____	Type _____		

Step 2. Person 3

Complete Step 2 for your spouse or partner and children who live with you and anyone on your same federal income tax return if you file one. See Page 1 for more information about who to include. If you don't file a tax return, remember to still add family members who live with you.

First name, middle name, last name, and suffix		Relationship to you?
Date of birth (mm/dd/yyyy)	Sex: ☐ Male ☐ Female	Social Security Number (SSN)

We need your SSN if you want health coverage and have a SSN. Providing your SSN can be helpful if you don't want health coverage too since it can speed up the application process.

☐ Yes ☐ No Does *Person 3* live at the same address as you? **If no**, list address: _____

Does *Person 3* plan to file a federal income tax return THIS YEAR?

(You can still apply for health insurance even if you don't file a federal income tax return.)

☐ Yes. **If yes**, please answer questions 1-3. ☐ No. **If no**, skip to question 3.

☐ Yes ☐ No 1. Will *Person 3* file jointly with a spouse? **If yes**, name of spouse: _____

☐ Yes ☐ No 2. Will *Person 3* claim any dependents on *Person 3's* tax return? **If yes**, list names of dependents: _____

☐ Yes ☐ No 3. Will *Person 3* be claimed as a dependent on someone's tax return? **If yes**, list the name of the tax filer: _____
How is *Person 3* related to the tax filer? _____

☐ Yes ☐ No Is *Person 3* pregnant? **If yes**, how many babies are expected during this pregnancy? What is the due date? _____

☐ Yes ☐ No Is *Person 3* currently incarcerated?

☐ Yes ☐ No Is *Person 3* currently assigned to a work release program? **If yes**, what is the start date? _____

Does *Person 3* need health coverage?

(Even if they have insurance, there might be a program with better coverage or lower costs.)

☐ Yes. **If yes**, answer all the questions below. ☐ No. **If no**, skip to the income questions on page 7. Leave the rest of this page blank.

☐ Yes ☐ No Does *Person 3* have a physical, mental, or emotional health condition that causes limitations in activities (like bathing, dressing, daily chores, etc.) or live in a medical facility or nursing home?

☐ Yes ☐ No Is *Person 3* a U.S. citizen or U.S. national?

☐ Yes ☐ No If *Person 3* isn't a U.S. citizen or U.S. national, does *Person 3* have eligible immigration status? **If yes**, fill in their document type and ID number below.
Document type: _____ Document ID number: _____

☐ Yes ☐ No Has *Person 3* lived in the U.S. since before August 22, 1996?

☐ Yes ☐ No Is *Person 3* or their spouse or parent an honorably discharged veteran or an active-duty member in the U.S. military?

☐ Yes ☐ No Is *Person 3* a resident of Iowa?

☐ Yes ☐ No Does *Person 3* need help paying for medical bills from the last three calendar months? If you answer yes and this person falls into a category that allows for retroactive approval, we will determine if this person is eligible for coverage during those months.

☐ Yes ☐ No Is *Person 3* an adult who is a main person taking care of a child under the age of 19 living in the home?

☐ Yes ☐ No Was *Person 3* in foster care at age 18 or older?

☐ Yes ☐ No If *Person 3* is under age 19, do you want help with child support?

Please answer the following questions if *Person 3* is 22 or younger:

☐ Yes ☐ No Did *Person 3* have insurance through a job and lose it within the past three months?
If yes, end date: _____ Reason insurance ended: _____

☐ Yes ☐ No Is *Person 3* a full-time student?

The following ethnicity and race questions are optional. Check all that apply.

If Hispanic or Latino, ethnicity:
- ☐ Mexican
- ☐ Mexican American
- ☐ Chicano/a
- ☐ Puerto Rican
- ☐ Cuban
- ☐ Other: _____

Race:
- ☐ White
- ☐ Black or African American
- ☐ American Indian or Alaska Native
- ☐ Asian Indian
- ☐ Chinese
- ☐ Filipino
- ☐ Japanese
- ☐ Korean
- ☐ Vietnamese
- ☐ Other Asian
- ☐ Native Hawaiian
- ☐ Guamanian or Chamorro
- ☐ Samoan
- ☐ Other Pacific Islander
- ☐ Other: _____

Current Job and Income Information: You must tell us about the income of the people in your household. If someone has more than one job, tell us about all jobs. If you leave a space blank, we will assume that you have no income of this kind.

- ☐ **Employed.** If you're currently employed, tell us about your income. Start with **Current Job 1**.
- ☐ **Not employed.** Skip to the **Other Income This Month** section.
- ☐ **Self-employed.** Skip to the **Self-Employment** section.

Current Job 1:

Employer name and address				Employer phone number
Wages and tips (before taxes) $	☐ Hourly ☐ Twice a month	☐ Weekly ☐ Monthly	☐ Every 2 weeks ☐ Yearly	Average hours worked each month:

Current Job 2: If you have more jobs and need more space, attach another sheet of paper.

Employer name and address				Employer phone number
Wages and tips (before taxes) $	☐ Hourly ☐ Twice a month	☐ Weekly ☐ Monthly	☐ Every 2 weeks ☐ Yearly	Average hours worked each month:

Will the amount of money from jobs stay about the same? ☐ Yes ☐ No
If no, explain: _____

In the past three months, did *Person 3*:
☐ Change jobs ☐ Stop working ☐ Start working fewer hours ☐ None of these

Self-Employment: If self-employed, answer the following questions.

Type of work _____

How much net income (profits once business expenses are paid) will you get from this self-employment this month? $ _____

Will the amount of monthly income from self-employment stay about the same? ☐ Yes ☐ No
If no, how much do you expect to average over a 12 month period? $ _____

Other Income This Month: Check all that apply, and give the amount and how often you get it. **NOTE:** You don't need to tell us about child support, veteran's payment, or Supplemental Security Income (SSI).

		How often?			How often?
☐ None					
☐ Unemployment	$ _____	_____	☐ Alimony received	$ _____	_____
☐ Pensions	$ _____	_____	☐ Net farming/fishing	$ _____	_____
☐ Social Security	$ _____	_____	☐ Net rental/royalty	$ _____	_____
☐ Retirement accounts	$ _____	_____	☐ Other income	$ _____	_____
			Type	_____	

Will the amount of money from other income stay about the same? ☐ Yes ☐ No
If no, explain: _____

Deductions: If *Person 3* pays for certain things that can be deducted on a federal income tax return, check all that apply and give the amount and how often *Person 3* pays. This information can be found on the Adjusted Gross Income section of *Person 3's* Federal 1040 form. **NOTE:** You shouldn't include a cost that you already considered in your answer to net self-employment.

		How often?			How often?
☐ Alimony paid	$ _____	_____	☐ Other deductions	$ _____	_____
☐ Student loan interest	$ _____	_____	Type	_____	

Step 2. Person 4

Complete Step 2 for your spouse or partner and children who live with you and anyone on your same federal income tax return if you file one. See Page 1 for more information about who to include. If you don't file a tax return, remember to still add family members who live with you.

First name, middle name, last name, and suffix		Relationship to you?
Date of birth (mm/dd/yyyy)	Sex: ☐ Male ☐ Female	Social Security Number (SSN)

We need your SSN if you want health coverage and have a SSN. Providing your SSN can be helpful if you don't want health coverage too since it can speed up the application process.

☐ Yes ☐ No Does *Person 4* live at the same address as you? **If no**, list address: _____

Does *Person 4* plan to file a federal income tax return THIS YEAR?

(You can still apply for health insurance even if you don't file a federal income tax return.)

☐ Yes. **If yes**, please answer questions 1-3. ☐ No. **If no**, skip to question 3.

☐ Yes ☐ No 1. Will *Person 4* file jointly with a spouse? **If yes**, name of spouse: _____

☐ Yes ☐ No 2. Will *Person 4* claim any dependents on *Person 4's* tax return? **If yes**, list names of dependents: _____

☐ Yes ☐ No 3. Will *Person 4* be claimed as a dependent on someone's tax return? **If yes**, list the name of the tax filer: _____
How is *Person 4* related to the tax filer? _____

☐ Yes ☐ No Is *Person 4* pregnant? **If yes**, how many babies are expected during this pregnancy? What is the due date? _____

☐ Yes ☐ No Is *Person 4* currently incarcerated?

☐ Yes ☐ No Is *Person 4* currently assigned to a work release program? **If yes**, what is the start date? _____

Does *Person 4* need health coverage?

(Even if they have insurance, there might be a program with better coverage or lower costs.)

☐ Yes. **If yes**, answer all the questions below. ☐ No. **If no**, skip to the income questions on page 9. Leave the rest of this page blank.

☐ Yes ☐ No Does *Person 4* have a physical, mental, or emotional health condition that causes limitations in activities (like bathing, dressing, daily chores, etc.) or live in a medical facility or nursing home?

☐ Yes ☐ No Is *Person 4* a U.S. citizen or U.S. national?

☐ Yes ☐ No If *Person 4* isn't a U.S. citizen or U.S. national, does *Person 4* have eligible immigration status? **If yes**, fill in their document type and ID number below.
Document type: _____ Document ID number: _____

☐ Yes ☐ No Has *Person 4* lived in the U.S. since before August 22, 1996?

☐ Yes ☐ No Is *Person 4* or their spouse or parent an honorably discharged veteran or an active-duty member in the U.S. military?

☐ Yes ☐ No Is *Person 4* a resident of Iowa?

☐ Yes ☐ No Does *Person 4* need help paying for medical bills from the last three calendar months? If you answer yes and this person falls into a category that allows for retroactive approval, we will determine if this person is eligible for coverage during those months.

☐ Yes ☐ No Is *Person 4* an adult who is a main person taking care of a child under the age of 19 living in the home?

☐ Yes ☐ No Was *Person 4* in foster care at age 18 or older?

☐ Yes ☐ No If *Person 4* is under age 19, do you want help with child support?

Please answer the following questions if *Person 4* is 22 or younger:

☐ Yes ☐ No Did *Person 4* have insurance through a job and lose it within the past three months?
If yes, end date: _____ Reason insurance ended: _____

☐ Yes ☐ No Is *Person 4* a full-time student?

The following ethnicity and race questions are optional. Check all that apply.

If Hispanic or Latino, ethnicity:
- ☐ Mexican
- ☐ Mexican American
- ☐ Chicano/a
- ☐ Puerto Rican
- ☐ Cuban
- ☐ Other: _____

Race:
- ☐ White
- ☐ Black or African American
- ☐ American Indian or Alaska Native
- ☐ Asian Indian
- ☐ Chinese
- ☐ Filipino
- ☐ Japanese
- ☐ Korean
- ☐ Vietnamese
- ☐ Other Asian
- ☐ Native Hawaiian
- ☐ Guamanian or Chamorro
- ☐ Samoan
- ☐ Other Pacific Islander
- ☐ Other: _____

Current Job and Income Information: You must tell us about the income of the people in your household. If someone has more than one job, tell us about all jobs. If you leave a space blank, we will assume that you have no income of this kind.

- ☐ **Employed.** If you're currently employed, tell us about your income. Start with **Current Job 1.**
- ☐ **Not employed.** Skip to the **Other Income This Month** section.
- ☐ **Self-employed.** Skip to the **Self-Employment** section.

Current Job 1:

Employer name and address				Employer phone number
Wages and tips (before taxes) $	☐ Hourly ☐ Twice a month	☐ Weekly ☐ Monthly	☐ Every 2 weeks ☐ Yearly	Average hours worked each month:

Current Job 2: If you have more jobs and need more space, attach another sheet of paper.

Employer name and address				Employer phone number
Wages and tips (before taxes) $	☐ Hourly ☐ Twice a month	☐ Weekly ☐ Monthly	☐ Every 2 weeks ☐ Yearly	Average hours worked each month:

Will the amount of money from jobs stay about the same? ☐ Yes ☐ No
If no, explain: _____

In the past three months, did *Person 4*:
☐ Change jobs ☐ Stop working ☐ Start working fewer hours ☐ None of these

Self-Employment: If self-employed, answer the following questions.

Type of work _____

How much net income (profits once business expenses are paid) will you get from this self-employment this month? $

Will the amount of monthly income from self-employment stay about the same? ☐ Yes ☐ No
If no, how much do you expect to average over a 12 month period? $

Other Income This Month: Check all that apply, and give the amount and how often you get it. **NOTE:** You don't need to tell us about child support, veteran's payment, or Supplemental Security Income (SSI).

		How often?			How often?
☐ None					
☐ Unemployment	$ _____	_____	☐ Alimony received	$ _____	_____
☐ Pensions	$ _____	_____	☐ Net farming/fishing	$ _____	_____
☐ Social Security	$ _____	_____	☐ Net rental/royalty	$ _____	_____
☐ Retirement accounts	$ _____	_____	☐ Other income Type _____	$ _____	_____

Will the amount of money from other income stay about the same? ☐ Yes ☐ No
If no, explain: _____

Deductions: If *Person 4* pays for certain things that can be deducted on a federal income tax return, check all that apply and give the amount and how often *Person 4* pays. This information can be found on the Adjusted Gross Income section of *Person 4's* Federal 1040 form. **NOTE:** You shouldn't include a cost that you already considered in your answer to net self-employment.

		How often?			How often?
☐ Alimony paid	$ _____	_____	☐ Other deductions Type _____	$ _____	_____
☐ Student loan interest	$ _____	_____			

Step 2. Person 5

Complete Step 2 for your spouse or partner and children who live with you and anyone on your same federal income tax return if you file one. See Page 1 for more information about who to include. If you don't file a tax return, remember to still add family members who live with you.

First name, middle name, last name, and suffix		Relationship to you?
Date of birth (mm/dd/yyyy)	Sex: ☐ Male ☐ Female	Social Security Number (SSN)

We need your SSN if you want health coverage and have a SSN. Providing your SSN can be helpful if you don't want health coverage too since it can speed up the application process.

☐ Yes ☐ No Does *Person 5* live at the same address as you? **If no**, list address: _____

Does *Person 5* plan to file a federal income tax return THIS YEAR?

(You can still apply for health insurance even if you don't file a federal income tax return.)

☐ Yes. **If yes**, please answer questions 1-3. ☐ No. **If no**, skip to question 3.

☐ Yes ☐ No 1. Will *Person 5* file jointly with a spouse? **If yes**, name of spouse: _____

☐ Yes ☐ No 2. Will *Person 5* claim any dependents on *Person 5's* tax return? **If yes**, list names of dependents: _____

☐ Yes ☐ No 3. Will *Person 5* be claimed as a dependent on someone's tax return? **If yes**, list the name of the tax filer: _____
How is *Person 5* related to the tax filer? _____

☐ Yes ☐ No Is *Person 5* pregnant? **If yes**, how many babies are expected during this pregnancy? What is the due date? _____

☐ Yes ☐ No Is *Person 5* currently incarcerated?

☐ Yes ☐ No Is *Person 5* currently assigned to a work release program? **If yes**, what is the start date? _____

Does *Person 5* need health coverage?

(Even if they have insurance, there might be a program with better coverage or lower costs.)

☐ Yes. **If yes**, answer all the questions below. ☐ No. **If no**, skip to the income questions on page 11. Leave the rest of this page blank.

☐ Yes ☐ No Does *Person 5* have a physical, mental, or emotional health condition that causes limitations in activities (like bathing, dressing, daily chores, etc.) or live in a medical facility or nursing home?

☐ Yes ☐ No Is *Person 5* a U.S. citizen or U.S. national?

☐ Yes ☐ No If *Person 5* isn't a U.S. citizen or U.S. national, does *Person 5* have eligible immigration status? **If yes**, fill in their document type and ID number below.
Document type: _____ Document ID number: _____

☐ Yes ☐ No Has *Person 5* lived in the U.S. since before August 22, 1996?

☐ Yes ☐ No Is *Person 5* or their spouse or parent an honorably discharged veteran or an active-duty member in the U.S. military?

☐ Yes ☐ No Is *Person 5* a resident of Iowa?

☐ Yes ☐ No Does *Person 5* need help paying for medical bills from the last three calendar months? If you answer yes and this person falls into a category that allows for retroactive approval, we will determine if this person is eligible for coverage during those months.

☐ Yes ☐ No Is *Person 5* an adult who is a main person taking care of a child under the age of 19 living in the home?

☐ Yes ☐ No Was *Person 5* in foster care at age 18 or older?

☐ Yes ☐ No If *Person 5* is under age 19, do you want help with child support?

Please answer the following questions if *Person 5* is 22 or younger:

☐ Yes ☐ No Did *Person 5* have insurance through a job and lose it within the past three months?
If yes, end date: _____ Reason insurance ended: _____

☐ Yes ☐ No Is *Person 5* a full-time student?

The following ethnicity and race questions are optional. Check all that apply.

If Hispanic or Latino, ethnicity:
- ☐ Mexican
- ☐ Mexican American
- ☐ Chicano/a
- ☐ Puerto Rican
- ☐ Cuban
- ☐ Other: _____

Race:
- ☐ White
- ☐ Black or African American
- ☐ American Indian or Alaska Native
- ☐ Asian Indian
- ☐ Chinese
- ☐ Filipino
- ☐ Japanese
- ☐ Korean
- ☐ Vietnamese
- ☐ Other Asian
- ☐ Native Hawaiian
- ☐ Guamanian or Chamorro
- ☐ Samoan
- ☐ Other Pacific Islander
- ☐ Other: _____

Current Job and Income Information: You must tell us about the income of the people in your household. If someone has more than one job, tell us about all jobs. If you leave a space blank, we will assume that you have no income of this kind.

- ☐ **Employed.** If you're currently employed, tell us about your income. Start with **Current Job 1**.
- ☐ **Not employed.** Skip to the **Other Income This Month** section.
- ☐ **Self-employed.** Skip to the **Self-Employment** section.

Current Job 1:

Employer name and address				Employer phone number
Wages and tips (before taxes) $	☐ Hourly ☐ Twice a month	☐ Weekly ☐ Monthly	☐ Every 2 weeks ☐ Yearly	Average hours worked each month:

Current Job 2: If you have more jobs and need more space, attach another sheet of paper.

Employer name and address				Employer phone number
Wages and tips (before taxes) $	☐ Hourly ☐ Twice a month	☐ Weekly ☐ Monthly	☐ Every 2 weeks ☐ Yearly	Average hours worked each month:

Will the amount of money from jobs stay about the same? ☐ Yes ☐ No
If no, explain: _____

In the past three months, did *Person 5*:
☐ Change jobs ☐ Stop working ☐ Start working fewer hours ☐ None of these

Self-Employment: If self-employed, answer the following questions.

Type of work _____

How much net income (profits once business expenses are paid) will you get from this self-employment this month? $

Will the amount of monthly income from self-employment stay about the same? ☐ Yes ☐ No
If no, how much do you expect to average over a 12 month period? $

Other Income This Month: Check all that apply, and give the amount and how often you get it. **NOTE:** You don't need to tell us about child support, veteran's payment, or Supplemental Security Income (SSI).

		How often?			How often?
☐ None					
☐ Unemployment	$		☐ Alimony received	$	
☐ Pensions	$		☐ Net farming/fishing	$	
☐ Social Security	$		☐ Net rental/royalty	$	
☐ Retirement accounts	$		☐ Other income	$	
			Type		

Will the amount of money from other income stay about the same? ☐ Yes ☐ No
If no, explain: _____

Deductions: If *Person 5* pays for certain things that can be deducted on a federal income tax return, check all that apply and give the amount and how often *Person 5* pays. This information can be found on the Adjusted Gross Income section of *Person 5's* Federal 1040 form. **NOTE:** You shouldn't include a cost that you already considered in your answer to net self-employment.

		How often?			How often?
☐ Alimony paid	$		☐ Other deductions	$	
☐ Student loan interest	$		Type		

Step 3. American Indian or Alaska Native (AI/AN) Family Members

American Indians and Alaska Natives can get services from the Indian Health Services, tribal health programs, or urban Indian health programs. They also may not have to pay cost sharing and may get special monthly enrollment periods. Answer the following questions to make sure your family gets the most help possible.

NOTE: If you have more people to include, make a copy of this page and attach.

☐ Yes ☐ No Are you or is anyone in your family an American Indian or Alaska Native? **If yes**, fill in the information below. **If no**, skip to Step 4.

AI/AN Person 1:

Name (first, middle, last)

AI/AN Person 2:

Name (first, middle, last)

AI/AN Person 1:		AI/AN Person 2:
☐ Yes ☐ No	Member of a federally recognized tribe? **If yes**, tribe name:	☐ Yes ☐ No
☐ Yes ☐ No	Has this person ever gotten a service from the Indian Health Service, a tribal health program, or urban Indian health program or through a referral from one of these programs?	☐ Yes ☐ No
☐ Yes ☐ No	**If no**, is this person eligible to get any of these services?	☐ Yes ☐ No
$ _____ How often? _____	Certain money received may not be counted for Medicaid or the Children's Health Insurance Program (CHIP). List any income (amount and how often) reported on your application that includes money from these sources: • Per capita payments from a tribe that come from natural resources, usage rights, leases, or royalties. • Payments from natural resources, farming, ranching, fishing, leases, or royalties from land designated as Indian trust land by the Department of Interior (including reservations and former reservations). • Money from selling things that have cultural significance.	$ _____ How often? _____

Step 4. Your Family's Health Coverage

Answer these questions for anyone who needs health coverage.

☐ Yes ☐ No Is anyone enrolled in health coverage now from the following? **If yes**, check the type of coverage and write the persons' names next to the coverage they have.

- ☐ Medicaid _____
- ☐ CHIP _____
- ☐ Medicare _____
- ☐ TRICARE (Don't check if you have direct care or Line of Duty) _____
- ☐ VA health care programs _____
- ☐ Peace Corps _____
- ☐ Employer Insurance
  - Name of health insurance _____
  - Policy number _____
  - Is this COBRA coverage? ☐ Yes ☐ No
  - Is this a retiree health plan? ☐ Yes ☐ No
- ☐ Other
  - Name of health insurance _____
  - Policy number _____
  - Is this a limited-benefit plan (like a school accident policy?) ☐ Yes ☐ No

☐ Yes ☐ No Has anyone moved in or out of your home in the past three months? **If yes**, answer the following questions.

- Name _____
- Date of birth (mm/dd/yyyy) _____
- Social Security Number (SSN) _____
- Relationship to you? _____
- Date moved in? _____
- Date moved out? _____

☐ Yes ☐ No Is anyone listed on this application offered health coverage from a job? Check yes even if the coverage is from someone else's job, such as a parent or spouse.

If yes, answer the following question and the questions in Step 5.

If no, skip to Step 6.

☐ Yes ☐ No Is this a state employee benefit plan?

Step 5. Health Coverage from Jobs

You **don't** need to answer these questions unless someone in the household is eligible for health coverage from a job. Attach a copy of this page for each job that offers coverage. Tell us about the **job** that offers coverage.

Employee Information. The **employee** needs to fill out this section.

Employee name (first, middle, last)	Social security number

Employer Information. Ask the **employer** for this information.

Employer name	Employer identification number (EIN)	
Employer address (the Marketplace will send notices to this address)	Employer phone number	
City	State	ZIP code
Who can we contact about employee health coverage at this job?		
Phone number (if difference from above)	Email address	

☐ Yes ☐ No Are you currently eligible for coverage offered by this employer, or will you become eligible in the next three months? **If yes**, fill out the information below. **If no**, skip to Step 6.

If you're in a waiting or probationary period, when can you enroll in coverage?

List the names of anyone else who is eligible for coverage from this job.

Health Plan. Tell us about the **health plan** offered by this employer.

☐ Yes ☐ No Does the employer offer a health plan that covers an employee's spouse or dependent?

If yes, which people? ☐ Spouse ☐ Dependents

☐ Yes ☐ No Does the employer offer a health plan that meets the minimum value standard*?

For the lowest-cost plan that meets the minimum value standard* offered **only to the employee** (don't include family plans):

If the employer has wellness programs, provide the premium that the employee would pay if the employee received the maximum discount for any tobacco cessation programs, and did not receive any other discounts based on wellness programs.

How much would the employee have to pay in premiums for this plan? $ _____

How often? ☐ Weekly ☐ Every two weeks ☐ Twice a month ☐ Once a month ☐ Quarterly ☐ Yearly

* An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs. (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)

Employer Changes. What change will the employer make for the new plan year (if known)?

☐ Employer won't offer health coverage

☐ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard. (Premium should reflect discount for wellness programs.)

How much will the employee have to pay in premiums for that plan? $ _____

How often? ☐ Weekly ☐ Every two weeks ☐ Twice a month ☐ Quarterly ☐ Yearly

Date of change: _____

Step 6. Assistance with Completing this Application

You can choose an authorized representative.

You can give a trusted person permission to talk about this application with us, see your information, and act for you on matters related to this application, including getting information about your application and signing your application on your behalf. This person is called an "authorized representative." If you ever need to change your authorized representative, let us know. If you're a legally appointed representative for someone on this application, submit proof with the application.

Name of authorized representative (first name, middle name, last name)		
Address		Apartment or suite number
City	State	ZIP code
Phone number		
Organization name		ID number (if applicable)

By signing, you allow this person to sign your application, get official information about this application, and act for you on all future matters with this agency.

NOTE: Your signature here does not complete the application. You **must** sign and date on page 16 to complete this application.

Your signature	Date (mm/dd/yyyy)

For certified application counselors, navigators, agents, and brokers only.

Complete this section if you're a certified application counselor, navigator, agent, or broker filing out this application for somebody else.

Application start date (mm/dd/yyyy)	
First name, middle name, last name, and suffix	
Organization name	ID number (if applicable)

Step 7. Read and Sign this Application

Renewal of coverage in future years

To make it easier to determine eligibility for health coverage in future years, your income data, including information from tax returns, can be verified electronically. You can also change your mind and not allow the Department of Human Services to check this information.

Do you want this information to be verified in the future and used to automatically renew your eligibility?

☐ Yes, renew my eligibility automatically.

How long? ☐ 5 years ☐ 4 years ☐ 3 years ☐ 2 years ☐ 1 year

☐ No, don't use my information from tax returns to renew my coverage.

Estate Recovery

Federal law requires Iowa to have an estate recovery program. If you get Medicaid, you may be subject to estate recovery. This means any Medicaid funds used to pay for your healthcare, including the monthly fee paid to a Managed Care Organization (MCO), will need to be paid back from your estate after your death. Estate recovery applies if you get Medicaid and are:

- Age 55 or older, or
- Are under age 55 and live in a medical facility and cannot reasonably be expected to return home.

For more information, call the Iowa Medicaid Estate Recovery Program at 1-877-463-7887 or go online to http://dhs.iowa.gov/sites/default/files/Comm123.pdf (English) or http://dhs.iowa.gov/sites/default/files/Comm123S.pdf (Spanish).

Sign this application

The person who filled out Step 1 should sign this application. If you're an authorized representative, you may sign here as long as you have provided the information required in Step 6.

If I leave a question on this application blank, I am reporting that the question does not apply to me and all persons listed on this application.

I agree to allow my information to be used and retrieved from data sources, including an asset verification system database, for this application. I have consent for all people I will list on the application that allows their information to be retrieved and used from data sources for this application.

I acknowledge that I have read and agree to the contents of *Rights and Responsibilities*, Comm. 233. *Rights and Responsibilities*, Comm. 233 is pages 23 to 27 of this application.

By signing this application, I certify under penalty of perjury and false swearing that my answers are correct and complete to the best of my knowledge, including information provided about the citizenship or alien status for each household member applying for benefits. I know I may be subject to penalties under federal law if I provide false or untrue information.

I declare under penalty of perjury under the laws of the United States of America that the information contained in this statement of facts is true, correct, and complete.

Signature	Date (mm/dd/yyyy)

Step 8. Mail the Completed Application

Mail your signed application to:

Imaging Center 4
PO Box 2027
Cedar Rapids, Iowa 52406

If you want to register to vote, you can complete a voter registration form at:
http://sos.iowa.gov/elections/pdf/voteapp.pdf

Case Number:

Department of HUMAN SERVICES

Appendix A for Health Coverage

Complete this section if you or someone in the household is aged (65 and older), blind, or disabled.

Name of Person Requesting Services	Marital Status	Date of Birth	Social Security Number

Please indicate if you or someone in the household is in need of any of the following coverage:

- ☐ Help paying your facility costs (nursing facility, PMIC, skilled facility)
- ☐ Services to remain in your home (HCBS waivers, PACE)
- ☐ Assistance paying Medicare premiums
- ☐ State Supplementary Assistance (residential care facility, in-home health-related care, dependent person)
- ☐ Help paying for a hospital stay of 30 days or more.
- ☐ Other

PLEASE PROVIDE VERIFICATION OF ALL ITEMS YOU MARK BELOW (copies, not originals)

1. **Income** – Tell us about any additional sources of income for each individual in your household, such as child support, veteran's payments, Black Lung, Railroad, Supplemental Security Income (SSI), worker's compensation, interest, alimony, and dividends, etc.

Name of Person with Income	Income Type	Amount	How often received?

2. **Resources** – Tell us about all resources for each individual in your household, including cash on-hand, checking and savings accounts, social security debit card, stocks, bonds, mutual funds, annuities, safe deposit box, 401ks, IRAs, CDs, etc.

Name of Owner of Resource	Resource Type	Name/Location of Financial Institution	Account	Current Value

3. **Motor Vehicles** – Tell us about all the vehicles owned for each individual in your household, even if the vehicle is not in working condition.

Owner	Year/Make/Model	Fair Market Value	Amount Owed

4. **Unmet Medical Expenses** – Tell us about all medical expenses for each individual in your household not being reimbursed by a third party.

Name of Person with Unmet Medical Expenses	Type of Medical Expense	Amount	How often incurred?

5. **Burial/Funeral** – Tell us about all burial plots, burial or funeral funds, or burial contracts for each individual in your household.

Type	Location	How Many/ For Whom	Current Value

6. **Life Insurance** – Tell us about all life insurance policies owned by each individual in your household.

Policy Owner	Company Name and Address	Policy #

Do you intend to use your life insurance for burial expenses? ☐ Yes ☐ No

7. **Property** – Tell us about all property for each individual in your household including homestead (the home you live in) and non-homestead (other property such as vacation home, rental home, vacant lots, buildings, etc.).

Property Owner	Property Address	Property Value

8. Do you or anyone in your household have a life estate? ☐ Yes ☐ No

   If yes, who: _____

9. Do you or anyone in your household have a trust? ☐ Yes ☐ No

   If yes, who: _____

10. Have you or anyone in your household not accepted an inheritance in the past five years? ☐ Yes ☐ No

    If yes, who: _____

11. Have you or anyone in your household transferred, sold or given away resources for less than their value in the past five years? ☐ Yes ☐ No

    If yes, who/what: _____

    Date this occurred: _____

12. Does anyone applying for benefits live in a medical institution (nursing facility, hospital, PMIC, etc.)? ☐ Yes ☐ No

    If yes, who: _____ Date of entry: _____

    Name of facility: _____ Phone: _____

13. Do you or anyone in your household receive Long-Term Care insurance? ☐ Yes ☐ No

    Name of company: _____

14. If you are currently living in a medical institution and own your home, do you intend to return home? ☐ Yes ☐ No

15. Does anyone who is applying have a pending application for Social Security Disability? ☐ Yes ☐ No

    If yes, who: _____

To speed up the processing of your application, you may provide verification of the following with your application. If verification is not submitted with the application, you may receive a letter indicating what we need before we can process your application.

For anyone who is applying and is not a U.S. citizen:

- **Immigration status**
  Proof can be an alien identification card (green card, I-551, I-94), visa, passport, or documents from Immigration Services

Send verification for those individuals who are:

- **Working**
  Pay stubs from the last 30 days or a written statement of earnings from your employer if you do not have pay stubs.
- **Self-employed**
  Most recent income tax returns and all related schedules or business records if taxes are not filed.
- **Getting other income**
  (This includes child support, veteran's payments, Black Lung, Railroad, worker's compensation, interest and dividends, cash received from friends or relatives, pension, etc.) A statement from the person or company that issues the income, copy of checks (showing gross income amount), award letter, tax forms, court order, or other documents from the last 30 days or most current received.

Send verification for anyone who is 19 or older for the last 90 days from the date you are completing the application:

- **Bank accounts**
  Recent bank statements or written statement from bank showing current balance or value of accounts.
- **Property**
  Property tax statement. Include documents showing amount owed against the property.
- **Burial/funeral contracts**
  Burial contract and statement of goods and services from the company or funeral home that holds the contract.
- **Other resources**
  Includes stocks, bonds, mutual funds, annuities, safe deposit box, 401ks, IRAs, CDs, vehicles, etc.
- **Life insurance policies**
  Face and cash value, bonds, annuities, trusts, stock ownership statements, or other documents showing value of asset. Include documents showing current loan balance owed against the asset.
- **Unmet medical expenses**
  Billing statements, pharmacy statements, medical transportation.

Send copies of proofs. Do not send original documents.

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	

This page intentionally left blank

Department of HUMAN SERVICES

Please keep this page for your information.

Rights and Responsibilities

When you get Medicaid from the Department of Human Services (DHS), you have the following rights and responsibilities.

Note: "Medicaid" on this form means any DHS medical assistance program including Medicaid, Healthy and Well Kids in Iowa (Hawki), Iowa Health and Wellness Program (IHAWP), State Supplementary Assistance (SSA), and Refugee Medical Assistance (RMA).

What Are My Rights?

You have the right to:

- Apply for any program.
- File an application online, by phone, by mail, by fax, or in person at your county DHS office.
- Have someone help you apply.
- Have all of your questions answered.
- Get information about the programs you applied for and any other DHS program that you may be able to get.
- Be sent a notice within 45 days of the day we get your application telling you if your application was approved.
- Have information about you and your family kept private as required by law.
- Have your expenses used to figure your eligibility or the amount of assistance you get by reporting your expenses, and giving proof if we ask you to. If you do not report or give proof of your expenses when asked, you choose not to claim the expense. You can report and give proof later to have an expense used for future months.
- Be treated equally without regard to race, color, national origin, sex, sexual orientation, gender identity, religion, age, disability, political belief, or veteran status. If you feel we have discriminated against or harassed you, send a letter detailing your complaint to: DHS, Office of Human Resources, Hoover Building – 1st Floor, 1305 E. Walnut, Des Moines IA 50319-0114 or via email at contactdhs@dhs.state.ia.us.
- Appeal any decision you do not agree with by following the directions on the last page of this form.

What Are My Responsibilities?

- You must tell us the truth.
  - Section 1128B of the Social Security Act provides federal penalties for fraudulent acts and false reporting in connection with Medicaid programs.
  - Anyone who gets, tries to get, or helps any other person get assistance to which they are not entitled, is guilty of violating the laws of the State of Iowa. This includes, but is not limited to, Iowa Code Chapters 249, 249A, 249N, and 514I.
  - Giving wrong information on purpose may result in us taking criminal or civil legal action against you.
  - You will have to pay back any benefits paid in error for you or anyone you apply for. You may be liable for the full amount of any payments made, including payments made to the health and dental plan in which the person was enrolled.

Please keep this page for your information.

- You must tell us within 10 days about any changes that may affect your eligibility. This includes changes such as:
  - Mailing or living address.
  - Starting or stopping a job or any other income (including lump sum payments, past due child support, inheritances, settlements, or cash medical support).
  - Someone moving in or out of your home.
  - Resources or assets, including getting an inheritance.
  - Changes in any other health insurance coverage (including employer-sponsored insurance, Medicare, etc.).
  - Filing an insurance claim or getting an attorney to recover bills paid by Medicaid.

  To report a change:
  - Call 1-877-347-5678, or
  - Email IMCustomerSC@dhs.state.ia.us, or
  - Fax information to 1-877-238-0015.
- You must apply for and accept any other benefits and medical assistance coverage that you may be able to get.
- You must give us information and give us proof when we ask for it.
- You must fill out review forms when you are asked to.
- You must cooperate with Quality Control (QC) and the Department of Inspections and Appeals (DIA). They may contact other people or organizations to get proof of your information. By signing the application, you give permission to release confidential information to QC or DIA.
- If any child applying for or receiving Medicaid has a parent living outside the home, you must cooperate with the agency that collects medical support from an absent parent. If you think that cooperating to get medical support will harm you or your children, you can tell us and you may not have to cooperate.
- You must cooperate with the Health Insurance Premium Payment (HIPP) Program and enroll in a health plan through your employer, if we ask you to. Visit https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp for explanation.
- You must agree to assign medical payments from a third party to the Medicaid agency for yourself and others who are eligible for Medicaid for whom you can legally assign benefits, cooperate in getting medical payments from third parties, give the Medicaid agency rights to pursue and get medical support from a spouse, and give the Medicaid agency rights to pursue and get money from other health insurance, legal settlements, or other third parties.
- If you get money from another person or an insurance company to pay your medical bills, you must give that money to DHS if Medicaid paid the bill. This will be used to repay bills that Medicaid paid for you.

This permission ends when your Medicaid stops.

Please keep this page for your information.

Other Things You Need to Know

- DHS will provide documents or claim forms describing the services paid by Medicaid upon your request or the request of an attorney acting on your behalf. Such documents may also be provided to a third party, when necessary, to establish the extent of the DHS's claim for reimbursement.
- 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.
- If you become enrolled in a managed health care plan, you consent to disclosure of medical information, including any clinical mental health or substance abuse information, by your medical providers to the PCP, other managed care providers, or to the authorized administrative body contracted by the managed care provider to determine appropriateness, quality, or utilization of services you received while enrolled in managed health care. 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).

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 include any listed person's: social security number, job and pay, bank account amount, immigration or alien status, and amounts received from other sources like Social Security or unemployment. If any information you give us is not correct, we may ask you to send us proof or we may deny or cancel your benefits.

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.

As part of the eligibility determination process, we may need to retrieve your information from sources like the Internal Revenue Service (IRS), Social Security Administration (SSA), the Department of Homeland Security, Asset Verification System (AVS), and the state Income and Eligibility Verification System. If something you told us is different from what the computer systems 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. Such information may affect your household's eligibility and level of benefits.

The authorization to use AVS database is in effect for as long as the Department is determining eligibility, the individual is a Medicaid recipient, or the applicant or recipient revokes the authorization. If refusal or revocation of the authorization is submitted, the Department may, on that basis, determine the applicant or recipient ineligible for medical assistance.

Information About Requiring a Social Security Number

We can give help only to people who give us their social security number (SSN) or proof of application from the Social Security office, and we will deny assistance to the people for whom you do not give us a SSN. There are some exceptions to this. Please ask us if you have questions.

You don't have to give us the SSN for people in your household who you do not want help for, but you can choose to give us their SSN to speed up processing your case. We will use any SSN given to us in the same way we use the SSN of people getting assistance. As required by Section 1137(a)(1) of the Social Security Act and 42 CFR 435.910, we use SSNs to check income/eligibility/payments, determine a person's right to Medicaid, comply with federal law, and match records with other agencies.

Please keep this page for your information.

Information About Immigration Status

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

When you tell us a person applying has eligible immigration status, that person's immigration status is checked with the Department of Homeland Security, and this will require submission of certain information from your application or review form. Any information we get from the Department of Homeland Security may affect your household's eligibility and level of benefits. We will not contact the Department of Homeland Security about people you do not apply for. However, we may use their income and assets to see if the rest of the household can get help.

Information About Estate Recovery

Federal law requires Iowa to have an estate recovery program. If you get Medicaid, you may be subject to estate recovery. This means any Medicaid funds used to pay for your healthcare, including the monthly fee paid to a Managed Care Organization (MCO), will need to be paid back from your estate after your death. Estate recovery applies if you get Medicaid and are:

- Age 55 or older, or
- Are under age 55 and live in a medical facility and cannot reasonably be expected to return home.

For more information, call the Iowa Medicaid Estate Recovery Program at 1-877-463-7887 or go online to: http://dhs.iowa.gov/sites/default/files/Comm123.pdf (English) or http://dhs.iowa.gov/sites/default/files/Comm123S.pdf (Spanish).

By signing an application/review form, 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 spend down, and the bills used to meet your spend down with the provider whose bills are being used.
- The premium due date for Medicaid for Employed People with Disabilities (MEPD), IHAWP, DWP, and Hawki 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 an application/review form you:

- Give permission for your medical provider to share your medical history with a PCP, other managed care providers, or the authorized administrative body contracted by the managed care provider to determine appropriateness, quality, or utilization of services you received while enrolled in managed health care.
- Give permission for your medical provider to share information with IME Medical Services Unit to certify a medical need for certain medical assistance programs or services.

Please keep this page for your information.

Information for those Applying for WIC or Maternal and Child Health Services

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

Information for those Applying for Presumptive Medicaid Services

- Your answers to some questions will not impact the presumptive Medicaid eligibility decision. These answers are needed for DHS to make a decision for ongoing Medicaid only.
- If you are only applying for presumptive Medicaid, not all of your information will be checked against data in computer systems.
- If you choose to have your application forwarded to DHS for an ongoing Medicaid determination, DHS will verify income, citizenship, immigration status, identity, and other information as necessary.
- All presumptive Medicaid is granted on a daily basis and may be terminated on any given day, without notice, once it is determined that the individual is no longer presumptively eligible.
- Appeal hearings are not granted for presumptive Medicaid.

How to Appeal

You, or the person helping you, may request an appeal hearing if you do not agree with any action taken on your case. You can appeal in person, by phone, or in writing. To appeal in writing do one of the following:

- Fill out an appeal electronically at https://secureapp.dhs.state.ia.us/dhs_titan_public/appeals/appealrequest, 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 DHS, Appeals Section, 5th Floor, 1305 E Walnut Street, Des Moines, IA 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 **1-800-532-1275**. If you live in Polk County, call **(515) 243-1193**.

Iowa Department of Human Services

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. Pages 1 and 2 are for you to keep for your records. **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 7th day after applying. This is called Emergency Service. If you want to apply for Food Assistance, fill out Part A (pink) and Part B (green).

Family Investment Program (FIP) or Refugee Cash Assistance — Part C

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 C (purple).

Child Care Assistance — Part D

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 D (blue).

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. 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 with at least your name, address, and signature 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 take, fax 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, 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 Child Care Assistance.

Information About Immigration Status

You can apply for part of your household even if some members do not have lawful immigrant status. For example, parents who do not have lawful immigrant status may apply for their children who are U.S. citizens or qualified lawful immigrants. You 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	

Iowa Department of Human Services

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.

☐ Food Assistance ☐ Family Investment Program ☐ Child Care Assistance

Tell Us About You Part A

Name	Telephone Number ( )	Is morning or afternoon the best time to call you?
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 E.

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.

When Will I Get Help? — Part A

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.

What Do Our Terms Mean? — Part A

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

Alien	A person who is not a U.S. citizen.
EAC card	An electronic access card (Visa debit card) for getting your cash assistance.
EBT card	A plastic swipe card that you use at the grocery store to buy food.
Eligible	Meeting all of the program guidelines to get help from us.
Household	A group of people who live together.
PROMISE JOBS	A work and training program for the Family Investment Program (FIP).
Quality Control	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.
Refugee	A person who enters the U.S. with a refugee status.
Special needs for child care	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 (SSN) or proof of application from the Social Security office. **You don't have to give us the SSN for people in your household who you do not want help for, but you can choose to give us their SSN.** However, we will use any SSN given to us the same way we use the SSN of people getting assistance.

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

We will not give any SSN 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.

*Only required if applying for FIP.

We have to ask your ethnicity and race, but you don't have to answer. The reason for the information is to assure that program benefits are distributed without regard to race, color, or national origin. 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, MI, 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 **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 for yourself, answer the questions about everyone in your home.

List anyone in your home who is disabled: _____

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

List anyone getting benefits from another state: _____

Which state? _____

List anyone who is a boarder or striker: _____

Tell Us About Criminal Actions and Disqualifications — Part A

Is anyone fleeing to avoid prosecution, custody, or jail for a felony crime?	☐ Yes	☐ No
Is anyone violating a condition of probation or parole?	☐ Yes	☐ No
Is anyone in or expecting to go to jail or prison?	☐ Yes	☐ No
Has anyone been disqualified from a food assistance program in any state for fraud or a program violation?	☐ Yes	☐ No

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: _____	☐ Weekly ☐ Every 2 Weeks ☐ Twice a Month ☐ Monthly ☐ Other (explain) _____	☐ Yes, Weekly Amount $_____ ☐ No
		$_____	Regular Hours: _____ Overtime Hours: _____	☐ Weekly ☐ Every 2 Weeks ☐ Twice a Month ☐ Monthly ☐ Other (explain) _____	☐ Yes, Weekly Amount $_____ ☐ 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 reduced their work hours or ended a job 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 Benefits 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.

_____

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:

Owns land, buildings or houses other than the house you live in: _____

Owns resources with someone who does not live in your household: _____

Has a conservatorship or trust: _____

Has sold, traded or given away any resources in the past three months: _____

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

Have you or any member of your household been convicted, after September 22, 1996, of:

- Buying or selling Food Assistance benefits over $500? ☐ Yes ☐ No
- Fraudulently receiving duplicate Food Assistance benefits in any state? ☐ Yes ☐ No
- Trading Food Assistance benefits for drugs, guns, ammunition or explosives? ☐ 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:

- ☐ Lights/Electricity
- ☐ Water and Sewage
- ☐ Gas
- ☐ Garbage and Trash
- ☐ Telephone
- ☐ Extra charges from your landlord
- ☐ 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

Family Investment Program (FIP) or Refugee Cash Assistance — Part C

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 Electronic Access Card (EAC): _____

List anyone in your home who is pregnant: _____

List anyone who is in the military, a veteran, or a spouse of a veteran: _____

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

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: _____

Child Care Assistance — Part D

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

Please answer the following questions about yourself and the other parent or caretaker if they are in the home.

Are you, or the other parent in the home, on active duty in the military? ☐ Yes ☐ No

In a national guard or reserve unit? ☐ Yes ☐ No

If yes, who? _____

Do any of the following living arrangements apply to your family?

Do you live in a: Motel, car or campsite? ☐ Yes ☐ No
Shelter or other temporary housing?
House or apartment, with friends or family members (shared housing)?

Assets are things like homes, cars, campers, stocks and bonds, or cash.
Do you have less than one million dollars in assets? ☐ Yes ☐ No

You Have the Right to Appeal — Part E

You can appeal in person, by telephone or in writing for Food Assistance, Child Care Assistance, Family Investment Program or Medicaid. You must appeal in writing for all other programs by doing **one** of the following:

- Complete 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, 5th 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 E

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, sexual orientation, gender identity, religion, age, disability, political belief or veteran status.

If you feel DHS has discriminated against or harassed you, please send a letter detailing your complaint to: Iowa Department of Human Services, Hoover Building, 5th Floor – Policy Bureau, 1305 E Walnut, Des Moines, IA 50319-0114 or via email contactdhs@dhs.state.ia.us

Food Assistance

This institution is prohibited from discriminating on the basis of race, color, national origin, disability, age, sex, and in some cases, religion or political beliefs.

The U.S. Department of Agriculture (USDA) also prohibits discrimination based on race, color, national origin, sex, religious creed, disability, age, political beliefs or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

Persons with disabilities who require alternative means of communication for program information (e.g., Braille, large print, audiotape, American Sign Language, etc.), should contact the agency (state or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027), found online at: http://www.ascr.usda.gov/complaint_filing_cust.html, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by:

Mail: U.S. Department of Agriculture
Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue, SW
Washington, DC 20250-9410; or

Fax: (202) 690-7442; or

Email: program.intake@usda.gov

For any other information dealing with Supplemental Nutrition Assistance Program (SNAP) (Food Assistance in Iowa) issues, persons should either contact the USDA SNAP Hotline Number at (800) 221-5689, which is also in Spanish, or call the State Information/Hotline Numbers found online at: http://www.fns.usda.gov/snap/contact_info/hotlines.htm.

To file a complaint of discrimination regarding a program receiving Federal financial assistance through the U.S. Department of Health and Human Services (HHS), write: HHS Director, Office for Civil Rights, Room 515-F, 200 Independence Avenue, SW, Washington, DC 20201 or call (202) 619-0403 (voice) or (800) 537-7697 (TTY).

This institution is an equal opportunity provider.

All Programs — Part E

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. Such information may affect your household's eligibility and level of benefits.

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 E

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** purchase a product with Food Assistance benefits, with a returnable container that has a return deposit, with the intent of getting cash back when the empty container is returned to the store.
- **Don't** buy food on credit and attempt to pay for it with Food Assistance.
- **Don't** buy a product with Food Assistance benefits so you can get cash or something other than eligible food by reselling that product.
- **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 10th 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

Households eligible for Food Assistance may get a notice that they are eligible for the "Promoting Awareness of the Benefits of a Healthy Marriage" program and a pamphlet listing those benefits. By giving this information, DHS can use different rules that may help you get Food Assistance.

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 register for work and follow all of the work and training rules.

The application filing date is different if your household is in an institution and applying for Food Assistance and Supplemental Security Income at the same time. In this case, the filing date is the date of release from the institution.

You may not be denied Food Assistance benefits just because you were denied benefits from other programs. Food Assistance applications will not be delayed due to requirements of other programs you may apply for.

The collection of information on the application, including the social security number of each household member, is authorized under the Food and Nutrition Act of 2008 (formerly the Food Stamp Act of 1977), as amended, 7 U.S.C. 2011-2036. The information will be used to determine whether your household is eligible or continues to be eligible to participate in the Food Assistance program. We will verify this information through computer matching programs. This information will also be used to monitor compliance with program regulations and for program management.

Family Investment Program (FIP) or Refugee Cash Assistance — Part E

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 SSN
- 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 for the months you are on FIP. The state of Iowa will keep your child support to pay back the money you get from FIP.

Using Your FIP/RCA Electronic Access Card (EAC) or Your Debit Card to Access FIP/RCA Funds from Your Personal Bank Account

You cannot access your cash benefits with your EAC or personal debit card at a:

- Liquor store or any place that mainly sells liquor,
- Casino or other gambling or gaming establishment, or
- Business which provides adult-oriented entertainment in which performers disrobe or perform in an unclothed state (such as a strip club).

This includes these types of businesses located in Iowa, on tribal land, or in any other state.

If DHS determines that you have accessed your cash benefits with your EAC or personal debit card at one of the above places you:

- Will have committed fraud,
- Have to repay the amount of cash accessed at the location, as well as any access fees, and
- Your family will not get cash benefits for three months with the first misuse and six months for each additional misuse.

By having signed this application, you agree that no member of your household will use the EAC or your personal debit card to access FIP/RCA funds at prohibited locations.

Penalty for Getting FIP in More Than One State

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.

Child Care Assistance (CCA) Part E

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

Family Interaction Observation Checklist

Case Information	
Child(ren) Name(s):	
Parent/Caregiver Name:	Parent/Caregiver/Non-Custodial Name(s):
Date and Time of Interaction:	On time/Late to Interaction:
Place/Location of Interaction:	
Participants in Interaction:	

The elements to explore in assessing safety include three basic constructs: threats of maltreatment, child vulnerability, and caretaker's protective capacities.

- **Threats of Maltreatment** means the aggravating factors that combine to produce a potentially dangerous situation.
- **Child Vulnerability** means the degree that a child cannot on the child's own avoid, negate or minimize the impact of present or impending danger.
    - **Present Danger** means immediate, significant, and clearly observed maltreatment which is occurring to a child in the present or there is an immediate threat of maltreatment requiring immediate action to protect the child.
    - **Impending Danger** means a foreseeable state of danger in which family behaviors, attitudes, motives, emotions, or the child's physical environment poses a threat of maltreatment.
- **Protective Capacities** means family strengths or resources that reduce, control, and/or prevent threats of maltreatment.

Safety: (***refer to the safety concerns identified on the Family Interaction Plan and document here)***

Goals of Family Interaction

What are the identified goals outlined in the Family Interaction Plan?

1.

2.

3.

In responding to the questions below, attend to cultural and developmentally appropriate behaviors or responses.

Children's Behavior ***(things to consider when assessing progress relating to identified goals).*** When observing multiple children, address strengths and needs for the specific child under the "other" section.

How did the child(ren) respond when seeing parent? Check specific behaviors by checking appropriate box(es):

- ☐ Ran to greet parent
- ☐ Hugged parent
- ☐ Engaged with parent rather than toy or other object
- ☐ NA (i.e. infant)
- ☐ Able to make eye contact with parent
- ☐ Accepted physical contact with parent
- ☐ Other (explain):

Was the child(ren)'s affect during the interaction age appropriate? Check specific behaviors by marking appropriate box(es): Check yes or no by marking appropriate box(es):

Seemed at ease with the parent	☐ Yes	☐ No	☐ NA
Gave parent a lot of eye contact	☐ Yes	☐ No	☐ NA
Appeared to seek approval of parent	☐ Yes	☐ No	☐ NA
Easily startled by parents actions/language	☐ Yes	☐ No	☐ NA
Able to be comforted by parent when upset	☐ Yes	☐ No	☐ NA
Initiated & responded to physical contact	☐ Yes	☐ No	☐ NA
Initiated conversation with parents	☐ Yes	☐ No	☐ NA

☐ Other (explain):

The child demonstrated healthy connection with the parent(s) in the following ways. Check yes or no by marking appropriate box(es):

Looked to parent for nurturing	☐ Yes	☐ No	☐ NA
Looked to parent for comfort when upset	☐ Yes	☐ No	☐ NA
Calmed by parent when upset	☐ Yes	☐ No	☐ NA
Upset if parent left the room	☐ Yes	☐ No	☐ NA
Calmed down when parent returned	☐ Yes	☐ No	☐ NA
Smiling, cooing (infant)	☐ Yes	☐ No	☐ NA

☐ Other (explain):

Was the child(ren)'s affect after the interaction age appropriate? Check yes or no by marking appropriate box(es):

Sad interaction ended	☐ Yes	☐ No	☐ NA
Child was receptive to parents prompt in ending interaction	☐ Yes	☐ No	☐ NA

☐ Other (explain):

Parent's Behavior ***(things to consider when assessing progress relating to identified goals).*** When observing both parents, address strengths and needs for the specific parent under the "other" section.

Was the parent prepared to participate in the interaction? Check yes or no by marking appropriate box(es):

Parent was alert	☐ Yes	☐ No	☐ NA
Did not appear under the influence	☐ Yes	☐ No	☐ NA

Home is safe for interactions	☐ Yes	☐ No	☐ NA
Planned for interaction regarding meals/sacks/activities	☐ Yes	☐ No	☐ NA
Did not rely on others to bring supplies for interaction	☐ Yes	☐ No	☐ NA
Focused conversation with children rather than adults	☐ Yes	☐ No	☐ NA

☐ Other (explain):

What was the parent's initial reaction/interaction with the child(ren)? Check yes or no by marking appropriate box(es):

Acknowledged child(ren) verbally or physically	☐ Yes	☐ No	☐ NA
Asked how the child(ren) were and what been up to	☐ Yes	☐ No	☐ NA

☐ Other (explain):

Did the parent demonstrate accurate knowledge of child(ren)'s development? Check yes or no by marking appropriate box(es):

Set rules for the child(ren) during the interaction	☐ Yes	☐ No	☐ NA
Redirected child(ren)'s behaviors as necessary	☐ Yes	☐ No	☐ NA
Set limits based on age/ability of child(ren)	☐ Yes	☐ No	☐ NA
Child(ren) responded well to the activity	☐ Yes	☐ No	☐ NA

☐ Other (explain):

Was the parent actively engaged in the interaction? Check yes or no by marking appropriate box(es):

Focused on child and activity throughout interaction	☐ Yes	☐ No	☐ NA
Focused on engaging in age appropriate conversation	☐ Yes	☐ No	☐ NA
Initiated and engaged in play with the child(ren)	☐ Yes	☐ No	☐ NA

☐ Other (explain):

The parent demonstrated healthy connection with the child(ren) in the following ways. Check yes or no by marking appropriate box(es):

Responded to cues the child(ren) were hungry/tired/upset	☐ Yes	☐ No	☐ NA
Appropriately comforted child(ren) when upset	☐ Yes	☐ No	☐ NA
Smiled at child(ren) during interaction	☐ Yes	☐ No	☐ NA
Actively responded to child(ren)'s questions or requests/needs	☐ Yes	☐ No	☐ NA
Talked with the child(ren) during interaction	☐ Yes	☐ No	☐ NA
Praised or made positive comments to the child(ren)	☐ Yes	☐ No	☐ NA
Refrained from making negative comments to the child(ren)	☐ Yes	☐ No	☐ NA

☐ Other (explain):

How did the parent promote healthy separation at the end of the interaction? Check yes or no by marking appropriate box(es):

Sad interaction ended but was appropriate with child(ren)	☐ Yes	☐ No	☐ NA
Gave child(ren) prompts that interaction was ending	☐ Yes	☐ No	☐ NA
Gave child(ren) emotional support without prompting	☐ Yes	☐ No	☐ NA

☐ Other (explain):

Did the parent(s) stay for the entire interaction? ☐ Yes ☐ No

If no, explain why not?:

Summary: (*document any mitigating factors impacting interactions either positively or negatively)*

PROGRESS OBSERVED:

SAFETY CONCERNS:

ACTION STEPS:

Completed by:
Date:

Iowa Department of Human Services

Physical Record

Child's Name	Sex	Place of Birth	Date of Birth

FAMILY DISEASES (Check only those applicable)

- ❑ Heart problems
- ❑ Venereal
- ❑ Mental illness
- ❑ Mental retardation
- ❑ Epilepsy
- ❑ Alcoholic
- ❑ Diabetes
- ❑ Cancer

Other diseases _____

PREVIOUS DISEASES OF THIS CHILD (Check only those applicable and list approximate dates for previous disease.)
STATE SOURCE OF ABOVE INFORMATION – ATTACH RECORD OF IMMUNIZATIONS AND BOOSTERS.

- ❑ Chickenpox _____
- ❑ Influenza _____
- ❑ Measles _____
- ❑ Mumps _____
- ❑ Scarlet fever _____
- ❑ Arthritis _____
- ❑ Injuries _____
- ❑ Whooping cough _____
- ❑ Tonsillitis _____
- ❑ Operations _____
- ❑ Meningitis _____
- ❑ Rheumatic fever _____
- ❑ Pneumonia _____
- ❑ Tuberculosis _____
- ❑ Sexually transmitted disease _____
- ❑ Seizures _____
- ❑ Other _____

CHRONIC ILLNESS OF THIS CHILD (List of medications prescribed to treat chronic conditions)

Bedwetting (after 8 years old)
Chronic ear problem
Allergies
Malnutrition
Constipation
Other chronic illnesses

PHYSICAL EXAMINATION (Please write recommendation on other side)

Date	B/P	Pulse	Nasal passages
Height		Weight	Teeth
Normal height	A-C	Under W	Tonsils
General development			Glands
Posture defects			Heart
Orthopedic defects			Lungs
Hemoglobin or hematocrit			Skin and scalp
Eyes			Abdomen
Vision-Snellen test R-20		L-20	Genitalia
Ears – (drums)			Neurological
Hearing test – Rt		L	Remarks

Test	For Diagnosis	Date Taken	Result
Sickle cell			
Serology			
Lead poisoning			
Wasserman			
Vaginal smear			

Tuberculin test _____

Urinalysis _____ Specific gravity _____ Albumen _____ Sugar _____ Microscopic _____

Initial examination by doctor _____ Date completed _____

PRELIMINARY DIAGNOSIS AND RECOMMENDATIONS

Signed doctor _____ Date _____

CORRECTIVE WORK DONE

Date	Diagnosis	Treatment Given	By Whom

MENTAL HEALTH

Do you have concerns about the child's mental health needs related to emotions, behaviors, developmental, education, substance abuse, or family situation? ❑ No ❑ Yes

Do you recommend further assessment or evaluation? ❑ No ❑ Yes

What do you recommend to be further evaluated? _____

DENTAL HEALTH

Do you have concerns about the child's dental health? ❑ No ❑ Yes

Do you recommend further assessment or evaluation? ❑ No ❑ Yes

What do you recommend to be further evaluated? _____

Physician Name		Telephone ( )	
Street	City	State	Zip Code

Iowa Department of Human Services

Notice to Relatives Worksheet

Effective July 1, 2009, as a result of Section 471(a) of the federal Social Security Act, the Iowa Legislature enacted Senate File 152. This law mandates the Iowa Department of Human Services to notify the child's **grandparents, aunts and uncles, adult siblings, and adult relatives suggested by the parent** within 30 days of when a child is removed from the parents' custody. You are requested to provide the Department information about these relatives so they can be considered for placement of the child or can be used as an informal support for the child.

Child's name	
Mother	Father

Name	Relationship	Telephone	
Street/PO box	City	State	ZIP
I want this person to be considered for placement of my child	☐ Yes	☐ No	
I want this person to be involved in planning with my family	☐ Yes	☐ No	

Name	Relationship	Telephone	
Street/PO box	City	State	ZIP
I want this person to be considered for placement of my child	☐ Yes	☐ No	
I want this person to be involved in planning with my family	☐ Yes	☐ No	

Name	Relationship	Telephone	
Street/PO box	City	State	ZIP
I want this person to be considered for placement of my child	☐ Yes	☐ No	
I want this person to be involved in planning with my family	☐ Yes	☐ No	

Name	Relationship	Telephone	
Street/PO box	City	State	ZIP
I want this person to be considered for placement of my child	☐ Yes	☐ No	
I want this person to be involved in planning with my family	☐ Yes	☐ No	

Name	Relationship	Telephone	
Street/PO box	City	State	ZIP
I want this person to be considered for placement of my child	☐ Yes	☐ No	
I want this person to be involved in planning with my family	☐ Yes	☐ No	

Name	Relationship	Telephone	
Street/PO box	City	State	ZIP

I want this person to be considered for placement of my child ☐ Yes ☐ No
I want this person to be involved in planning with my family ☐ Yes ☐ No

Name	Relationship	Telephone	
Street/PO box	City	State	ZIP

I want this person to be considered for placement of my child ☐ Yes ☐ No
I want this person to be involved in planning with my family ☐ Yes ☐ No

Name	Relationship	Telephone	
Street/PO box	City	State	ZIP

I want this person to be considered for placement of my child ☐ Yes ☐ No
I want this person to be involved in planning with my family ☐ Yes ☐ No

Name	Relationship	Telephone	
Street/PO box	City	State	ZIP

I want this person to be considered for placement of my child ☐ Yes ☐ No
I want this person to be involved in planning with my family ☐ Yes ☐ No

Name	Relationship	Telephone	
Street/PO box	City	State	ZIP

I want this person to be considered for placement of my child ☐ Yes ☐ No
I want this person to be involved in planning with my family ☐ Yes ☐ No

Name	Relationship	Telephone	
Street/PO box	City	State	ZIP

I want this person to be considered for placement of my child ☐ Yes ☐ No
I want this person to be involved in planning with my family ☐ Yes ☐ No

Signature	Date

FAMILIES HELPING FAMILIES
— OF IOWA, INC. —

Programs

Families Helping Families of Iowa is proud to offer support programs to help families and children in foster care throughout the state of Iowa. Our support programs are utilized by thousands of families across the state each year, from preparing students for school through tutoring and activity scholarships to providing clothing options for foster families in need. You can help make a difference, too, by volunteering or making a donation to Families Helping Families.

Clothing Closet

With generous donations from sponsors and the community, Families Helping Families offers new and gently used clothing, infant supplies and hygiene items suitable for children aged newborn to 18 years old. Our Clothing Closet is located in the lower level of our Families Helping Families office and is staffed by volunteers.

Haircuts for Kids

We support the confidence every child and student needs while going to school, which is why we offer a Haircuts for Kids program. Eligible students in foster care can receive two complimentary vouchers for haircuts per year, as well as a one the Back to School Rally. These haircuts are provided by professional hairdressers at local salons.

School Supplies

To ensure children are prepared for school, Families Helping Families offers a School Supplies Closet, along with an annual Back to School Rally each August. Each year, backpacks are filled with new supplies and a voucher for a free haircut. We also fill extra backpacks to ensure children entering foster care during the school year have the materials they need. Local businesses and organizations graciously support our effort with their own school supplies drives. The school supplies closet is available at our office throughout the year.

Senior Pictures

Every high school senior wants to feel good about his or her legacy in the school yearbook. At Families Helping Families of Iowa, we support that goal with a complimentary one-hour photography session for professionally-taken senior pictures through our Senior Pictures program. Foster parents and guardians receive electronic copies of the final photos, so you can print them at your leisure.

Spread Your Wings Program

The Spread Your Wings Program helps children in foster care, relative, or other approved placement gain confidence by offering extracurricular activity scholarships of interest including art, music, sports and more. We have funded hundreds of children with these opportunities by providing financial assistance for program fees, equipment, uniforms and more.
Our Spread Your Wings Program also provides tutoring opportunities for students throughout the area, giving children at least a three-month-long tutoring program to help sustain confidence and abilities throughout the school year.

Shoe Voucher Program

Through a collaboration with the Kiwanis Club of Cedar Rapids, each child placed in foster care, relative, or other approved placement is eligible to receive one shoe voucher per year valued at $50. The vouchers are redeemable at any Kohl's Department Store, through our Shoe Voucher Program. Thanks to funds received from the Kiwanis Club, private donations, and grants, we can offer more than 1,000 pairs of shoes for children throughout Iowa.

3516 Center Point Rd NE
Cedar Rapids, IA 52402
Contact Us
319-294-9706

FOUR OAKS

Foster & Adoptive Family Connections

Kinship Care

Four Oaks Foster & Adoptive Family Connections is contracted by the Iowa Department of Human Services to recruit, train, license and support Iowa's foster and adoptive families, including those providing kinship care. We are here to help and support you along the way!

What is Kinship Care?

Grandparents, older siblings or other people close to a child can sometimes find themselves serving as a caregiver for a child whose parents are unable to care for them. This is called "kinship care." Sometimes, it is an informal, private arrangement between the relative caregivers and the parents. Other times, the Department of Human Services is involved.

Benefits

Whether you're licensed as a foster care parent or not, you are invited to take advantage of support groups and training opportunities at no charge. Additional benefits for licensed kinship providers include:

- Monthly reimbursement for care
- An ongoing support worker

Licensing Process

It usually takes about six to nine months to complete the licensing process. You'll need to fill out an inquiry form, attend an information session, complete fingerprint and background checks, attend a ten-week series of training classes and complete a home study before DHS makes a decision on your approval or licensure.

Want more information?

Contact the Cedar Rapids Service Area

844-380-2534 familyconnections-crsa@fouroaks.org

Visit iowafosterandadoption.org and the Four Oaks Family Connections Facebook page

FOUR OAKS

Foster & Adoptive Family Connections

Glossary of Terms

Adjudication: A court hearing at which the court determines whether the *Child in Need of Assistance* allegations are true. The judge will decide whether the case may be dismissed or remain involved with court, and whether the child will be removed from the home.
Adoption: The legal process through which the court gives exclusive rights to be the child's legal parent to an adult other than the child's biological parents.
Appeal: A request to the Supreme Court or Court of Appeals to review and change the decision of a lower court.
Assessment: An assessment is required when there has been a report of child abuse or neglect. The assessment includes the nature, extent, and cause of the child's injuries, and identifies who is responsible for the injuries. Goals of the assessment are 1) to protect the child, and 2) engage the family in services to increase their strengths and to address their needs so they can provide for the safety of their child.
Attorney/ Attorney at Law: Also called a lawyer, this person is licensed in the state of Iowa to practice law, including representing persons who become involved in the court system.
Case Manager: Also called a social worker, the case manager works for the Iowa Department of Human Services. The Case Manager works with the family to develop a case permanency plan.
Case Permanency Plan: The plan that is developed with the child's parents, which includes clear requirements and services for safe return of the child.
Central Registry: The Child Abuse Information Registry contains reports found to be true of abuse, neglect or child endangerment. The information is sealed after 10 years, and erased 8 years later.
Child Abuse: Any non-accidental injury to the child caused by the acts of a caretaker or failure to prevent harm by a caretaker.
Child Protective Worker: Child Protection Worker or Assessment Worker, this worker does an assessment of the family and the incident, when a child abuse report is filed.
CINA- The process for determining, through the courts, whether a child has been the victim of abuse or is in need of the court's help; and if so, how the state should protect the child.

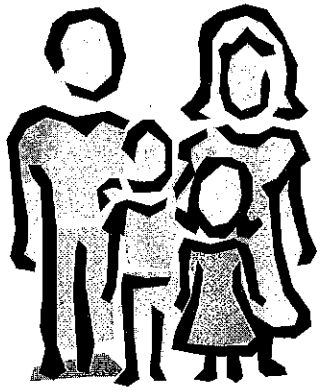
Child in Need of Assistance: The court can find that a child is in need of assistance (CINA), if a child:
A. has no caretaker or has been abandoned or deserted.
B. is or has been physically, sexually or emotionally abused.
C. is or has been neglected or denied medical, psychiatric or substance abuse treatment to drugs.
D. is or has been sexually exploited or encouraged to commit delinquent acts or exposed to drugs.
E. is unsupervised or has parents who are unable to care for the child.
F. wishes to be removed from their parents or has parents who no longer wish to care for them for good cause.

Court Appointed Special Advocate (CASA): a volunteer appointed by the Court to represent the best interest of the child and to report directly to the court.
Court order: Legal document reporting what happened at the hearing and tells the judge's findings.
Custody: With whom the court says a child must live.
Denial of Critical Care: When a child is denied adequate food, shelter, clothing or other care necessary to the child's health and welfare.
Disposition: A court hearing to determine what should be done for the child and family. The court may postpone a decision, allow the parents to keep custody, transfer custody to another adult, place the child somewhere other than their family home.
Findings: "Findings of fact" are what the court believes are the facts of the case based on the evidence presented. "Conclusions of law" are the court's findings on whether the factual findings meet the legal requirements of the case.
Guardian: Person who has the legal right to make the important decisions in a child's life.
Guardian ad Litem (GAL): The guardian ad Litem is usually a lawyer. The Guardian ad Litem and lawyer for the child can be the same person or two separate attorneys. Their duties are outlined in the law. The court appoints a Guardian ad Litem for a child in any case involving child abuse.
Hearing: Formal court meeting to determine facts of case and to finalize case plan.
Judge: Person who hears the case and makes final decision regarding the case.

Lack of supervision: Failing to supervise the child to the extent that there is a danger of the child suffering significant harm, injury, or death.
Lawyer: Also called an attorney, this person is licensed in the state of Iowa to practice law, including representing persons who become involved in the court system.
Modification: A hearing to decide if the court should change a court order for a good reason.
Permanency: When the child is returned home, adopted, or placed in the custody or guardianship of a caretaker other than DHS.
Petition: Formal written application to the court requesting judicial action.
Removal: When the court determines a child is at risk of harm if left in the home and orders that the child be placed in another home or institution.
Review hearings: The court must review the cases of all children in placement after six months and at least every 12 months after that.
Service Plan: A documents goals and the objectives with concrete strategies to address the needs and issues identified within the Child Protective Assessment summary (sent with the referral by DHS) or CPS, CINA Assessment Summary and assessment tools (sent with the referral by DHS).
Service Provider: Agencies, individuals and organizations who contract with DHS to provide treatment or supervision services for families involved with the DHS.
Social Worker: Sometimes called a Case Manager, the Social Worker is an employee of the Iowa Department of Human Services. The Case Manager works with the family to develop a case permanency plan. Others who may be called Social Worker provide treatment services to the child or their families. They may also be known as therapist, case aide, or private provider,
Termination: Now called *termination of the parent-child legal relationship,* the court takes away all of the parents' rights and the child is eligible for adoption.

Iowa Department of Human Services

Comm 108 (Rev 10/16)



The Family Investment Program (FIP)

What is the Family Investment Program?

The Family Investment Program (FIP) provides temporary cash assistance to families with children. The goal of FIP is to help you leave poverty and become self-supporting.

FIP is available to one-parent and two-parent families and to relatives caring for children whose parents are not in the home. FIP payments are based on the size of your family and your family's income.

Is there a time limit for FIP?

Federal law limits how long you can get FIP to a total of 60 months (five years). Months you get FIP or cash assistance in another state count toward the limit.

Months are not counted for:

- Persons on SSI
- Caretakers who don't get FIP for themselves. Caretakers are relatives who care for a child, but are not the child's parent.
- Children

If a parent gets FIP for 60 months, FIP stops for the whole family. If a caretaker gets FIP for 60 months, the caretaker is taken off the FIP grant but FIP can continue for the child.

The five years don't have to be in one block of time. For example, if you get FIP for 30 months, then go off FIP and come back on later, you can still get FIP for 30 more months.

The only way you can get FIP for more than 60 months is if you can prove that you have a reason why you cannot support your family. This is called a "hardship exemption". Examples of hardship are:

- Physical or mental health problems
- Substance abuse problems
- Domestic violence

A hardship exemption can last up to six months. To get an exemption you must:

- Fill out a form called "Request for FIP Beyond 60 Months" and turn it in at the local DHS or PROMISE JOBS office.
- Give us proof of why you cannot support your family.
- Sign a six-month Family Investment Agreement (FIA) that lists the steps you must take to overcome the hardship.

You may be able to get more than one hardship exemption if you work on overcoming your hardship and follow all of the FIP rules.

What is PROMISE JOBS?

To get a FIP check, you must work with PROMISE JOBS. PROMISE JOBS is a work and training program that will help you make a plan to support your family. This plan is called a **Family Investment Agreement (FIA)**.

You will meet with a PROMISE JOBS worker to plan and write your FIA. An FIA is a signed agreement between you and the state of Iowa. It will show:

- The steps you will take to be able to support your family, and
- How the state will help with those steps.

Your PROMISE JOBS worker will talk to you about help with child care and transportation while you do your FIA activities.

PROMISE JOBS activities that may be included in your FIA include:

Assessment

- Looking at your family's needs and goals so that you can choose activities for your FIA that will help you become self-supporting in the shortest amount of time.

Work-Related Activities

- **Individual Job Search:** Your PROMISE JOBS worker will help you develop a plan which includes the types of jobs you are looking for.
- **Monitored Employment:** Help for you to keep your job while you work. Your PROMISE JOBS worker also may be able to help you find a better job.
- **Self-Employment:** Classes may be available in your area to help you set up your own business or increase the income you get from your self-employment business.
- **Work Readiness Training:** Classes that prepare you for work and help you learn how to write a resumé, find job openings, complete job applications and letters of application, schedule a job interview, and how to dress and handle yourself in an interview and on the job.
- **Work Experience Placement:** Unpaid work experience in a real employment setting to get you ready for a job that pays a wage.
- **Unpaid Community Service:** A chance to learn basic skills while providing services to your community.

Training and Education

- **High School Completion Activities:** Including high school equivalency classes to help you earn a high school diploma.
- **Adult Basic Education:** Classes to help you improve your reading, writing, and math.
- **English as a Second Language:** Classes that help you speak, read, and understand English.
- **Post-Secondary Education:** Training courses that help you prepare for a specific area of employment. This includes:
  - Short-term training such as truck driving or nurses' aide.
  - Long-term training up to a four-year college degree.

Family Support Activities

- **Family Development and Self-Sufficiency (FaDSS):** A voluntary program that provides services and support in your home, to help you and your family become stable and deal with problems that keep you from becoming self-supporting.
- **Parenting Skills Training:** Training and support to be a good parent.

If you have problems or barriers that keep you from doing your FIA activities or from finding or keeping a job, tell your PROMISE JOBS worker. Activities related to removing these barriers, such as attending doctor's appointments, may be able to be included in your FIA.

Your PROMISE JOBS worker will answer your questions about PROMISE JOBS activities.

What is a Limited Benefit Plan (LBP)?

If you don't do what you said you would do in your FIA, you'll be choosing a Limited Benefit Plan (LBP). Your family cannot get FIP while you are in an LBP.

The first time you choose an LBP, your FIP benefits will stop right away. You must sign an FIA before you can get FIP again.

If you or the other parent in the home choose an LBP and either of you had one before, your family can't get FIP for at least six months. To get FIP after the six months end, you must:

- Sign an FIA
- Complete 20 hours of approved PROMISE JOBS activity
- Meet all other FIP rules

Are there other FIP rules?

Other FIP rules are:

- **Age** — Children must be under the age of 18. A child who is age 18 may get FIP only if they are going to high school and will complete high school before age 19.
- **Minor Parents** — If you are a parent under age 18 and never married (or the marriage was annulled), you must live with a parent or legal guardian or show proof of good reasons for not living with them. If you do live with your parents, we will count your parent's income to decide if you can get FIP.

  Minor parents must attend family development and parenting classes, and may have to take classes to finish high school.
- **Citizenship** — Family members must be U.S. citizens or eligible aliens.
- **Residency** — Your family must live in Iowa. Children must live with the parent or relative who applies for or gets FIP for them.
- **Social Security Number** — You must have a social security number for each family member to get FIP for them. If you don't have a number for a family member, you must apply for a number and give us the number when you get it.
- **Applying for Other Benefits** — You must apply for other benefits that are available to you, such as social security.
- **Child Support** — If a parent is absent from the home, you must give us information about that parent and help us collect child support from that parent. If you don't want to give us this information, you must prove that you have a good reason.

  When you get FIP, you give (assign) to the state of Iowa your rights to child support for the months you are on FIP. If the other parent gives you support, you must turn it in to DHS. The state will keep child support collected to pay back the state for the FIP you get. The state won't keep more than the total amount of FIP you get.

  You can ask DHS to stop your FIP at any time. Child support paid after your FIP stops will be sent to you. If more support is paid than is owed to you, the state will keep the additional money to pay back the state for the FIP you got.

Keep track of how much support the other parent pays to DHS, so you can decide if you would be better off staying on FIP or going off FIP and getting child support instead. You can find out how much child support the other parent pays by checking the report the DHS sends you every three months, or by calling the free number, 1-888-229-9223.

- **Resource (Asset) Limits** — Your family may have up to $2,000 worth of resources when you apply. After you are on FIP, you can have up to $5,000 in resources. Resources include cash, bank accounts, stocks and bonds, real estate, and motor vehicles.

  Some resources are not counted toward the limit, including the home you live in and one car for the family. If you have more than one car, part of the value of the other cars may count toward the limit.

- **Income** — Your family must meet the FIP income limits. Income includes pay from a job, social security income, unemployment benefits and any other money you get.

How do I apply for FIP?

You can get an application from any county DHS office. Fill out the application and take or mail it to the local DHS office in the county where you live. The earliest you can get FIP is seven days from the date we get your application.

You will be asked to come to an interview and show proof of some things, such as your income. If you have questions about your application, ask your DHS worker.

Your application should be handled within 30 days. You will get a written notice telling you if you can get FIP. If you are approved for FIP, you'll get your first check within seven days after you get the letter.

When do I have to fill out reports?

Everyone on FIP will be sent a report to fill out twice a year. Fill out the report and return it with proof of your income, by the due date on the form.

What changes do I need to report as soon as they happen?

You must report any changes in your family's situation, including changes in:

- Mailing or living address
- Employment or other income when it starts or stops
- Resources
- Someone moving in or out of your home
- Receipt of a social security number
- Change of school attendance of a child

Tell us about these changes within 10 days if you are on FIP or within five days if you are applying for FIP.

What if my family has income besides FIP?

Your family's income may be subtracted from your FIP grant. Income includes pay from work, social security payments, unemployment benefits or other money you get.

If you work, some of your earnings are used to figure your FIP grant. We subtract 20% and then 58% from your gross earnings. We use the remaining earnings after the deductions to figure your FIP grant.

You may also qualify for the federal and state Earned Income Tax Credit (EITC). EITC reduces taxes you must pay and may give you more take home pay on each paycheck or a refund when you file an income tax return. See your employer or call the IRS at 1-800-829-1040 for more information. EITC is not counted against your FIP.

A booklet called, *One-Time Payments*, gives important information about what to do if you get a one-time cash payment such as an inheritance, insurance or lawsuit settlement, gift or lottery winnings. If you think you will get one of these payments, ask your DHS worker for this information before you get or spend the money.

What happens if I quit my job?

You may be choosing a Limited Benefit Plan (LBP) and your FIP will stop if:

- You quit your job without a good reason, or
- You lose your job for a reason such as not showing up for work or not calling in.

If you're thinking about quitting your job, first talk to your PROMISE JOBS worker to find out what will happen to your FIP.

What happens if I get married or my children's other parent moves into the home?

Tell your DHS worker if you get married or your child's other parent moves into your home. You may still get FIP, depending on this person's income and resources.

If your child's other parent moves in, also contact your local child support recovery office. They can give you information on how this change affects child support the other parent may owe you, including information on how to stop an ongoing support order.

Can I get help if my child needs things for school?

You may be able to get help with your child's school expenses. We can help pay for things like gym shoes and some class fees. The item must be required for all students in the class and not available free of charge. We cannot pay tuition, or pay the cost of everyday school supplies like pens and notebooks.

How will I get my FIP payment?

Your FIP payments can be deposited to an electronic access card (also called a debit card) or your own checking or savings account.

- **Electronic Access Payment Card**

  If you get your payments on the electronic access card, you will be sent information about how to use the card. Be sure to keep the card and read the information when you get it. It will tell you how to use the card in ways that will help you get your money without cost.

  If you have questions about your card, call 1-866-899-5611 (toll free).

- **Direct Deposit**

  If you would like to have your payments deposited to your own checking or savings account, you must have an open checking or savings account at a bank, savings and loan or credit union.

  If you would like your payments deposited to your own account, ask your DHS worker how to sign up for direct deposit.

You cannot access your cash benefits with your electronic access card or personal debit card at a:

- Liquor store or any place that mainly sells liquor,
- Casino or other gambling or gaming establishment, or
- Business which provides adult-oriented entertainment in which performers disrobe or perform in an unclothed state (such as a strip club).

This includes these types of businesses located in Iowa, on tribal land, or in any other states.

If the Department determines that you have accessed your cash benefits with your electronic access card or personal debit card at one of the above places you:

- Will have committed fraud,
- Have to repay the amount of cash accessed at the location, as well as any access fees, and
- Your family will not get cash benefits for three months with the first misuse and six months for each additional misuse.

What if I don't agree with a decision made on my case?

You have the right to appeal if your application is denied, your FIP is reduced or canceled, or you disagree with your FIA or participation in PROMISE JOBS activities. Information about appeals is listed on each Notice of Decision you get from DHS. If you wish to appeal:

- File a written appeal in your county DHS office. You may ask for help in filing your appeal.
- Talk to your DHS or PROMISE JOBS worker or your worker's supervisor to see if you can work out the problem.
- Attend the appeal hearing when it is scheduled. An administrative law judge will hold the hearing, review the facts, and rule on whether the action was correct.

Are there other programs that can help my family?

- Medicaid can help pay for medical and dental services.
- The Food Assistance program can help buy food.
- Child Care Assistance (CCA) can help with childcare costs while you work or are in training with PROMISE JOBS.

You may be able to get help from these DHS programs and others in your area that are not run by DHS, like the Women, Infants and Children (WIC) program. You can ask us how to apply.

If your FIP stops because of a Limited Benefit Plan or because of the 60-month limit, you still may be able to get Food Assistance, Medicaid, and other kinds of assistance.

If you have questions, contact your worker in your local Human Services office. You may also call Iowa Legal Aid for help. The toll free number is: 1-800-532-1275

Iowa Department of Human Services

Policy Regarding Discrimination, Harassment, Affirmative Action and Equal Employment Opportunity

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, sexual orientation, gender identity, religion, age, disability, political belief or veteran status.

If you feel DHS has discriminated against or harassed you, please send a letter detailing your complaint to:

Iowa Department of Human Services, Hoover Building, 5th Floor—Bureau of Policy Coordination, 1305 E. Walnut, Des Moines IA 50319-0114 or via email contactdhs@dhs.state.ia.us

(Food Assistance only) USDA - Director, Office of the Assistant Secretary for Civil Rights, 1400 Independence Ave SW, Washington DC 20250-9410, or call 1-866-632-9992.

Iowa Department of Human Services

Terry E. Branstad
Governor

Kim Reynolds
Lt. Governor

Charles M. Palmer
Director

Child Care Assistance (CCA) subsidies are designed to promote equal access to quality child care services, regardless of income. CCA is available to the children of income-eligible parents who are absent for a portion of the day due to employment or participation in academic or vocational training or PROMISE JOBS activities. Assistance may also be available for a limited period of time to the children of a parent looking for employment.

Requirements vary by type of child care chosen. The following link provides an overview of the health and safety requirements and regulatory requirements for each type of child care eligible to accept CCA subsidies: http://dhs.iowa.gov/childcare/overview

Please be sure to check your child care provider's compliance and complaint history. This information may be accessed at: https://secureapp.dhs.state.ia.us/dhs_titan_public/ChildCare/ComplianceReport If you need further assistance with this, please contact us at FDHS@dhs.state.ia.us

Iowa's Quality Rating System (QRS)
To learn about Iowa's voluntary Quality Rating System (QRS) and to determine if your child care provider is a current participant in the QRS, please visit:
http://ccmis.dhs.state.ia.us/ClientPortal/ProviderSearch.aspx

Iowa Child Care Resource and Referral
Iowa Child Care Resource and Referral helps families make informed choices about child care and refers parents to child care that may meet the needs of you and your family. To talk to a parent specialist, contact 1-877-216-8481.

Child Care Complaint Hotline
If you have concerns regarding a child care provider, please contact the Child Care Complaint Hotline at 844-786-1296.

Developmental Screenings
While all children develop, learn, and grow at different paces, children do develop in predictable ways. Early Access is an early intervention service for children ages 0-3. Early Access works with families to identify needs and determines eligibility for services.

Iowa Family Support Network – www.iafamilysupportnetwork.org/early-access-iowa/what-is-ea

For more information on developmental screenings, please consider reviewing the material at the below links:

- Care for Kids: Early Periodic Screening, Diagnosis, and Treatment – www.dhs.iowa.gov/ime/members/Medicaid-a-to-z/care-for-kids-epsdt
- Early Access: Department of Education – www.educateiowa.gov/pk-12/early-childhood/early-access
- Individuals with Disabilities Education Act (IDEA) – www.idea.ed.gov/

Who can help me find child care?

The Iowa Child Care Resource and Referral System (CCR&R) will give you information about the different types of care and how to choose excellent care.

They can help you find child care that is the best fit for your family.

Information about the CCR&R is available at www.iowaccrr.org.

Northwest Iowa
Mid-Sioux Opportunity, Inc.
418 S Marion St
Remsen, IA 51050
(877) 216-8481 or (712) 786-3489

Southwest Iowa
West Central Community Action
1408A HWY 44
Harlan, IA 51537
(800) 945-9778 or (712) 755-7381

Southeast Iowa
Community Action of Eastern Iowa
500 E 59th St
Davenport, IA 52807
(866) 324-3236 or (855) 244-5301

Northeast Iowa
Exceptional Persons, Inc.
3675 University Ave PO Box 4090
Waterloo, IA 50704
(800) 475-0804 or (319) 233-0804

Central Iowa
Orchard Place Child Guidance Center
808 5th Ave
Des Moines, IA 50309
(800) 722-7619 or (515) 246-3566

Your rights and responsibilities

You have the right to:

- Look at complaint files on providers in your local DHS office
- Ask for references from your provider
- Check references from your provider

You may have to pay a part of your child care costs. This is based on your family's income and the number of people in your family.

Your child care needs and child care provider will need to be approved before you get help with your child care costs.

You are responsible for reporting providers to DHS who do not meet health and safety standards.

You can report suspected abuse or neglect to the Abuse/Neglect Hotline at 1-800-362-2178. This is a free phone call.

Statement on Nondiscrimination

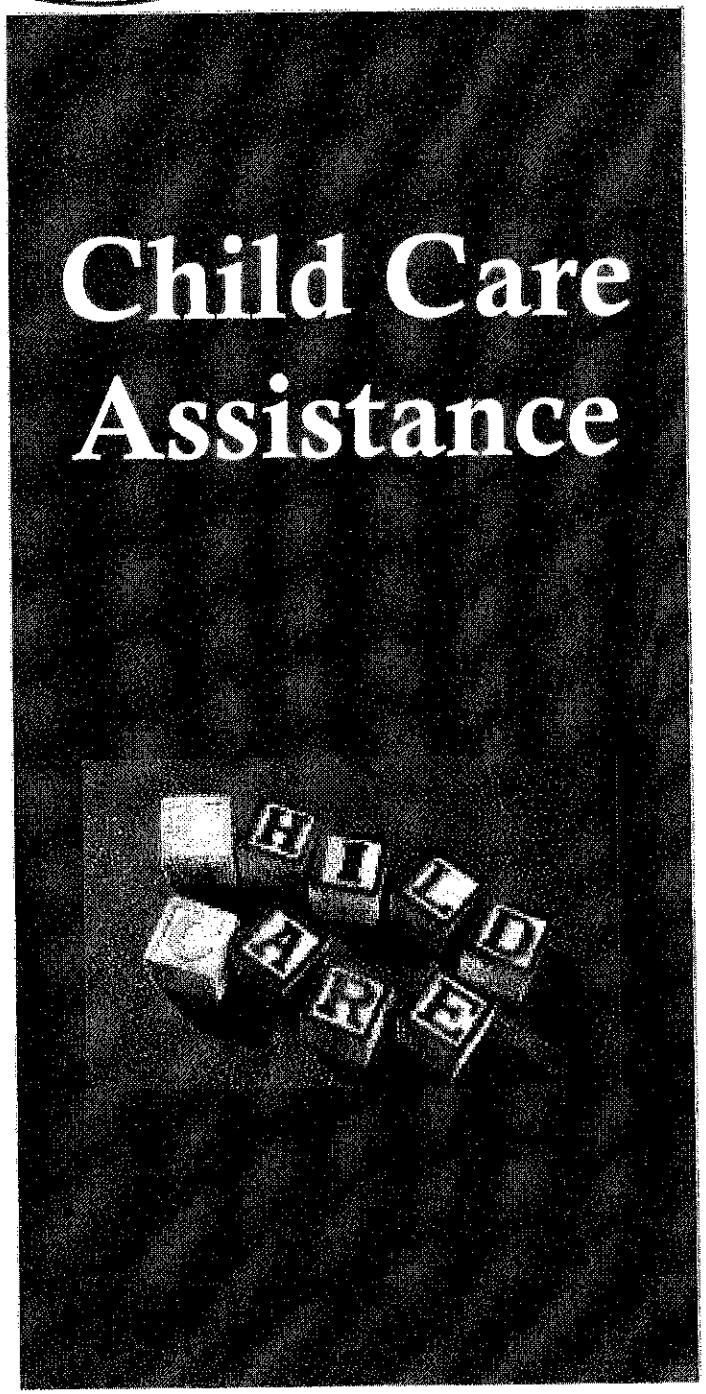
It is the policy of the Iowa Department of Human Services (DHS) to provide equal treatment in employment and provision of services to applicants, employees and clients without regard to race, color, national origin, sex, sexual orientation, gender identity, religion, age, disability, political belief 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, Office of Human Resources, 1st floor, 1305 E. Walnut, Des Moines, IA 50319-0114, fax (515) 281-4243 or via e-mail contactdhs@dhs.state.ia.us.

Iowa Department of Human Services
Comm. 62 (Rev. 7/16)

Child Care Assistance



What is Child Care Assistance?

Child Care Assistance (CCA) 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.

Who can get Child Care Assistance (CCA)?

You may be able to get Child Care Assistance if you:

- Have a child who needs care and is under the age of 13 (or under the age of 19 if your child has special needs), **and**
- Get help from the Family Investment Program (FIP), or
- Your family meets gross monthly income guidelines if you don't get FIP.

Also, you must be doing one of the following:

- Working an average of at least 28 hours per week,
- Attending an approved training or education program full-time,
- Working and attending training for a total of at least 28 hours per week, **or**
- Looking for work.

Note: Care provided while you attend postsecondary education/training has a 24-month lifetime limit.

Family eligibility will be established for a 12-month period.

Even if your family experiences a temporary loss of employment or education, you will continue to be eligible for child care for up to three months to allow you to find a new job or reenroll in school.

Exit Eligibility (CCA Plus)

If, at the end of your 12-month eligibility period, your income goes above the monthly eligibility threshold, you may be eligible for another 12-month period of child care under the new **CCA Plus** exit eligibility program.

Family income cannot exceed 85 percent of the State Median Income.

How do I apply?

You can apply for Child Care Assistance at your local Department of Human Services (DHS) office.

You may also apply online or print an application from our website at https://ccmis.dhs.state.ia.us/clientportal/.

Mail the completed application to:
Human Services River Place Office
2309 Euclid Avenue
Des Moines, IA 50310-5703

Questions? Call the centralized child care unit at (866) 448-4605.

If you take part in activities approved by the PROMISE JOBS program, call your PROMISE JOBS worker.

Who can care for my child?

You can choose who you want to care for your child.

Child Care Assistance can be used to pay a variety of different types of providers. The provider you choose must be at least 18 years old and cannot be a parent or guardian of your child. You can choose a:

- Licensed child care center
- Licensed before and after school program
- Registered child development home
- Nonregistered child care home — the person must pass the child abuse and criminal record checks
- Person who cares for your children in your own home, if you have three or more children who need care

You will get forms from DHS to take to your child care provider. Your provider will need to fill out the forms and return to Child Care Assistance Unit, Hoover State Office Building, 1305 E Walnut St., Des Moines, IA 50319.

Your provider must meet certain requirements, pass background checks, and meet health and safety standards.

For more information about how to identify quality child care, finding other assistance programs, and links to early intervention and child development resources, go to our website at: http://dhs.iowa.gov/childcare/tool-and-resources.

Department of HUMAN SERVICES

Kinship Caregiver Payment Program

For the purpose of this program, kinship caregiver is a person to whom a child is related by blood, marriage, or adoption, or a person who has a significant, committed, positive relationship with the child and who is caring for a child in foster care.

The Iowa Department of Human Services' (DHS) Kinship Caregiver Program is a Family First Initiative inspired program, which aims to keep children in the safe care of kin and fictive kin.

The Kinship Caregiver Payment Program is a time-limited payment specifically for kinship caregivers. This is an automatic payment so kinship caregivers are not required to complete an application to receive this payment. A kinship caregiver will receive a monthly payment of $300 for each child who is court ordered into their care. Payments are monthly and may start as soon as two months after the child is placed into the kinship caregiver's home and continue for up to six months.

During the first 60 days of kinship placement, kinship caregivers will receive assistance in applying for FIP (Family Investment Program) and Medicaid health care coverage for a child in their care. If a child is believed to have a disability, support and direction will be provided to connect with services or to apply for Social Security benefits. The FIP payment will end once the kinship caregiver payment begins.

After six months of receiving the kinship caregiver payment, this payment will end. In order for kinship caregivers to continue to receive financial support for the child who remains in care beyond the six months, DHS encourages kinship caregivers to consider becoming a licensed foster parent. The Recruitment, Retention, Training, and Support (RRTS) contractor will reach out to kinship caregivers to offer an informational session during the first 60 days of a child's placement in their home. An in-person or virtual meeting is available at the convenience of the kinship caregiver.

If the kinship caregiver becomes an approved licensed foster parent, the kinship caregiver will begin to receive a foster care payment. The foster care payment is more than twice the kinship caregiver payment monthly rate. In addition, once the kinship caregiver becomes a licensed foster parent, any child placed by court order in their home will automatically be enrolled in the Medicaid program. If the kinship caregiver does not become licensed, a FIP application is advised in order to resume receiving caretaker FIP payments.

Department of HUMAN SERVICES

Benefits of Becoming a Licensed Foster Parent

As a kinship caregiver, you are already making a positive difference for a child in need. Children who enter the child welfare system have experienced difficult family situations and traumatic events. Having a strong support system and loving home can make all the difference for the success of an individual child.

The Department of Human Services (DHS) encourages all kinship caregivers to consider becoming licensed foster parents. If a child placed in your care will be living with you for a length of time or if you are not sure how long they will be in your care, there are benefits to becoming a licensed foster parent.

These benefits include:

- A per-diem monthly stipend provided to you the entire length of time a child is placed in your home.
  - This stipend is twice the amount of the kinship caregiver payment
- Medicaid coverage for medical, mental health, and dental care of the child placed in your home
- Childcare subsidies for the child placed in your home.
  - Subsidies are not based on your family's income
- Financial assistance with clothing
- Foster children automatically qualify for free school lunches
- 24 days of paid respite care for the child placed in your home
- Free training opportunities
- Peer support groups

If you choose the path to become a licensed foster parent, a RRTS caseworker will be assigned to you who is available to answer questions, get you connected with services and supports, and will advocate for you and on your family's behalf. There is no cost associated with the licensing process or to any of the supportive services.