

CHAPTER 76
APPLICATION AND INVESTIGATION

[Ch 76, 1973 IDR, renumbered as Ch 911]
[Prior to 7/1/83, Social Services[770] Ch 76]
[Prior to 2/11/87, Human Services[498]]

441—76.1(249A) Application. An application for family medical assistance-related Medicaid programs shall be submitted on the Health and Financial Support Application, Form 470-0462 or Form 470-0466 (Spanish); the Health Services Application, Form 470-2927 or Form 470-2927(S); the HAWK-I Application, Comm. 156; or the HAWK-I Electronic Application Summary and Signature Page, Form 470-4016. The Health Services Application, Form 470-2927 or Form 470-2927(S), shall be used for persons applying for assistance under the medically needy program as provided at 441—subrule 75.1(35).

An application for SSI-related Medicaid shall be submitted on the Health Services Application, Form 470-2927 or Form 470-2927(S). The Health Services Application, Form 470-2927 or Form 470-2927(S), shall be used for persons applying for assistance under the medically needy program as provided at 441—subrule 75.1(35).

A person who is a recipient of supplemental security income (SSI) benefits shall not be required to complete a separate Medicaid application. If the county office does not have all information necessary to establish that an SSI recipient meets all Medicaid eligibility requirements, the SSI recipient may be required to complete Form 470-2304 or 470-0364, Medicaid Information Questionnaire for SSI Persons, and may be required to attend an interview to clarify information on this form.

An application for Medicaid for persons in foster care shall be submitted on Form 470-2927 or Form 470-2927(S), Health Services Application.

76.1(1) Place of filing. An application may be filed in any local office of the department or in any disproportionate share hospital, federally qualified health center or other facility in which outstationing activities are provided. The hospital, health center, or facility shall forward the application to the department office responsible for completing the eligibility determination.

a. The Health Services Application, Form 470-2927 or Form 470-2927(S), may also be filed at the office of a qualified provider of presumptive Medicaid eligibility, a WIC office, a maternal health clinic, or a well child clinic. The office or clinic shall forward the application within two working days to the department office responsible for completing the eligibility determination.

b. The HAWK-I Application, Comm. 156, and the HAWK-I Electronic Application Summary and Signature Page, Form 470-4016, shall be filed with the third-party administrator as provided at 441—subrule 86.3(3). If it appears that the family is Medicaid-eligible, the third-party administrator shall forward the application to the department office responsible for determining Medicaid eligibility.

c. Those persons eligible for supplemental security income and those who would be eligible if living outside a medical institution may make application at the social security district office.

d. Women applying for medical assistance for family planning services under 441—subrule 75.1(41) may also apply at any Iowa Title X family planning clinic or any delegate agency as defined in rule 441—173.1(234) that provided family planning services as of July 1, 2004, or later.

76.1(2) *Date and method of filing application.* An application is considered filed on the date an identifiable application, Form 470-0462, 470-0466 (Spanish), 470-2927, or 470-2927(S), is received and date-stamped in any place of filing specified in subrule 76.1(1).

a. When an application is delivered to a closed office, it will be considered received on the first day that is not a weekend or state holiday following the day that the office was last open.

b. An identifiable application, Form 470-2927 or 470-2927(S), which is filed to apply for FMAP or FMAP-related Medicaid at a WIC office, well child health clinic, maternal health clinic, or the office of a qualified provider for presumptive eligibility, shall be considered filed on the date received and date-stamped in one of these offices.

c. When a HAWK-I Application, Comm. 156, or HAWK-I Electronic Application Summary and Signature Page, Form 470-4016, is filed with the third-party administrator and subsequently referred to the department for a Medicaid eligibility determination, the date the application is received and date-stamped by the third-party administrator shall be the filing date.

d. A copy of an application received by fax at one of the places described above shall be given the same effect as the original application.

e. An identifiable application is an application containing a legible name, address, and signature.

f. If an authorized representative signed the application on behalf of an applicant, the signature of the applicant or the responsible person must be on the application before the application can be approved. For FMAP and FMAP-related Medicaid, the signature of each parent or stepparent in the home must be on the application before the application can be approved.

76.1(3) *Applicant cooperation.* An applicant must cooperate with the department in the application process, which may include providing information or verification, attending a scheduled face-to-face interview, or signing documents. Failure to cooperate in the application process shall serve as a basis for rejection of an application.

76.1(4) *Who may apply.* Each person wishing to do so shall have the opportunity to apply for assistance without delay. The applicant shall immediately be given an application form to complete. When the applicant requests that the forms be mailed, the local office shall send the necessary forms in the next outgoing mail.

76.1(5) *Application not required.* For family medical assistance-related programs, a new application is not required when an eligible person is added to an existing Medicaid eligible group or when a responsible relative becomes a member of a Medicaid eligible household. This person is considered to be included in the application that established the existing eligible group. However, in these instances the date of application to add a person is the date the change is reported. When it is reported that a person is anticipated to enter the home, the date of application to add the person shall be no earlier than the date of entry or the date of report, whichever is later.

a. In those instances where a person previously ineligible for Medicaid for failure to cooperate in obtaining medical support or establishing paternity as described at 441—subrule 75.14(2) is to be granted Medicaid benefits, the person shall be granted Medicaid benefits effective the first of the month in which the person becomes eligible by cooperating in obtaining medical support or establishing paternity.

b. In those instances where a person previously ineligible for Medicaid for failure to provide a social security number or proof of application for a social security number as described at rule 441—75.7(249A) is to be granted Medicaid benefits, the person shall be granted Medicaid benefits effective the first of the month in which the person becomes eligible by providing a social security number or proof of application for a social security number.

c. In those instances where a person who has been voluntarily excluded from the eligible group in accordance with the provisions of rule 441—75.59(249A) is being added to the eligible group, the person shall be added effective the first of the month after the month in which the household requests that the person no longer be voluntarily excluded.

76.1(6) Right to withdraw the application. After an application has been filed, the applicant may withdraw the application at any time before the eligibility determination. The applicant may request that the application be withdrawn entirely or may, before the date the application is processed, request withdrawal for any month covered by the application process except as provided in the medically needy program in accordance with the provisions of 441—subrule 75.1(35). Requests for voluntary withdrawal of the application shall be documented in the case record and a Notice of Decision, Form 470-0485, 470-0486, 470-0486(S), or 470-0490, shall be sent to the applicant confirming the request.

76.1(7) Responsible persons and authorized representatives.

a. *Responsible person.* If the applicant or recipient is unable to act on the applicant's or recipient's behalf because the applicant or recipient is incompetent, physically incapacitated, or deceased, a responsible person may act responsibly for the applicant or recipient. The responsible person shall be a family member, friend or other person who has knowledge of the applicant's or recipient's financial affairs and circumstances and a personal interest in the applicant's or recipient's welfare or a legal representative such as a conservator, guardian, executor or someone with power of attorney. The responsible person shall assume the applicant's or recipient's position and responsibilities during the application process or for ongoing eligibility. The responsible person may designate an authorized representative as provided for in paragraph 76.1(7) "b" to represent the incompetent, physically incapacitated, or deceased applicant's or recipient's position and responsibilities during the application process or for ongoing eligibility. This authorization does not relieve the responsible person from assuming the incompetent, physically incapacitated, or deceased applicant's or recipient's position and responsibilities during the application process or for ongoing eligibility.

(1) When there is no person as described above to act on the incompetent, physically incapacitated, or deceased applicant's or recipient's behalf, any individual or organization shall be allowed to act as the responsible person if the individual or organization conducts a diligent search and completes Form 470-3356, Inability to Find a Responsible Person, attesting to the inability to find a responsible person to act on behalf of the incompetent, physically incapacitated, or deceased applicant or recipient.

(2) The department may require verification of incompetence or death and the person's relationship to the applicant or recipient or the legal representative status.

(3) Copies of all department correspondence that would normally be provided to the applicant or recipient shall be provided to the responsible person and the representative if one has been authorized by the responsible person.

b. *Authorized representative.* A competent applicant or recipient or a responsible person as described in paragraph 76.1(7) "a" may authorize any individual or organization to represent the applicant or recipient in the application process or for ongoing eligibility.

(1) The authorization must be in writing, and signed and dated by the applicant or recipient or a responsible person before the department shall recognize the authorized representative.

(2) If the authorization indicates the time period or dates of medical services it is to cover, this stated period or dates of medical services shall be honored and may include subsequent applications, if necessary, that relate to the time period or dates of medical services indicated on the authorization. If the authorization does not indicate the time period or dates of medical services it is to cover, the authorization shall be valid for any applications filed within 120 days from the date the authorization was signed and all subsequent actions pertaining to the applications filed within the 120-day period.

(3) Anytime an applicant or recipient or a responsible person notifies the department in writing that the applicant or recipient or a responsible person no longer wants an authorized representative to act on the applicant's or recipient's behalf, the department shall no longer recognize that person or organization as the applicant's or recipient's representative.

(4) Designation of an authorized representative does not relieve a competent applicant or recipient or a responsible person as defined in 76.1(7) "a" of the primary responsibility to cooperate with the department in the determination of initial and ongoing eligibility, which may include providing information or verification, attending a scheduled face-to-face interview, or signing documents on which the authorized representative's signature would be inadequate.

(5) Copies of all departmental correspondence shall be provided to the client and the representative if one has been authorized by the applicant or recipient.

441—76.2(249A) Information and verification procedure. The decision with respect to eligibility shall be based primarily on information furnished by the applicant or recipient. The county office shall notify the applicant or recipient in writing of additional information or verification that is required to establish eligibility. This notice shall be provided to the applicant or recipient personally, or by mail or facsimile. Applicants for whom eligibility is determined in whole or in part by the Social Security Administration (SSA) shall make application to the SSA within five working days of referral by the department. Failure of the applicant or recipient to supply the information or verification or refusal by the applicant or recipient to authorize the county office to secure the information or verification from other sources shall serve as a basis for rejection of an application or cancellation of assistance. Five working days shall be allowed for the applicant or recipient to supply the information or verification requested by the county office. The county office may extend the deadline for a reasonable period of time when the applicant or recipient is making every effort but is unable to secure the required information or verification from a third party.

76.2(1) Interviews.

a. In processing applications for Medicaid for adults, the department may require a face-to-face or telephone interview upon written notice to the applicant. An interview is not required as a condition of eligibility for children.

b. For SSI-related Medicaid for adults, the department may require a face-to-face or telephone interview at the time of review.

c. The department shall notify the applicant in writing of the date, time and method of an interview. This notice shall be provided to the applicant personally or by mail or facsimile. Interviews that are rescheduled at the request of the applicant or authorized representative may be agreed upon verbally; a written confirmation is not required.

d. Failure of the applicant or member to attend a scheduled interview shall serve as a basis for rejection of an application or cancellation of assistance for adults. Failure of the applicant or member to attend an interview shall not serve as a basis for rejection of an application or cancellation of assistance for children.

76.2(2) *Choice of coverage groups.* An applicant who meets the eligibility requirements of more than one coverage group shall be given the choice of coverage group under which eligibility shall be determined.

76.2(3) *Conditional benefits granted previous to October 1, 1993.* When the client is receiving Medicaid under the conditional benefit policy of the SSI program pursuant to subrule 75.13(2), the client shall be required to describe the efforts that are made to sell the property on Form 470-2908, Description of Efforts to Sell Property, as requested by the department. The department shall request that the form be completed no more often than specified. For personal property being sold Form 470-2908 shall be completed no more often than every 30 days during the conditional benefit period. For real property being sold Form 470-2908 shall be completed beginning 35 days after conditional benefits are granted and no more often than every 60 days thereafter for nine months. If eligibility continues and the real property is not sold, the form shall be completed no more often than every 90 days.

76.2(4) *Monthly reporting.* Rescinded IAB 10/4/00, effective 10/1/00.

76.2(5) *Reporting of changes.* The applicant shall report any change as defined at 441—paragraph 75.52(4) “c” which occurs during the application process within five working days of the change. Changes that occur after approval for benefits shall be reported in accordance with paragraph 75.52(4) “c.”