Jefferson County Health Center

Iowa Medicaid Unwind Basics

What is the Medicaid Unwind?

Amid the COVID-19 Public Health Emergency, states were mandated to sustain Medicaid coverage for all enrollees, sidestepping the usual annual "redetermination" process to ensure continuous access to necessary services during the crisis. With the Public Health Emergency concluding on April 1, 2023, Iowa Medicaid initiated a reassessment of eligibility for all members, a process spanning several months.

Who does the Unwind impact?

The Unwind affects all individuals enrolled in Iowa's Medicaid program, encompassing thousands of Iowans and millions nationwide. It's important to note that this reassessment isn't punitive—it's a standard procedure necessitated by the end of the emergency. Responding to communications from the Iowa Department of Health and Human Services is crucial for maintaining Medicaid coverage. If uncertain about the last update or application, expect involvement in the Unwind.

When does the Unwind take place?

The Iowa Department of Health and Human Services chose a timeline to be carried out through May 2024. This long span of time is intended to keep the volume of cases more manageable, instead of cramming everything into a short timeframe.

What should I do if I'm still eligible and want to keep Medicaid coverage?

Proactiveness is key. Ensure your current address is on file by calling Iowa Medicaid Member Services at 1-800-338-8366, especially if you've relocated since 2019. Await correspondence from Medicaid outlining next steps, which may involve updating information or completing a new application. Complete the steps within the 60-day timeframe to maintain coverage.

For inquiries about the Medicaid Unwind, contact Iowa Medicaid Member Services at 1-800-338-8366 or visit hhs.iowa.gov/ime/unwind for additional information.

Jefferson County Health Center

If you have recently lost your Iowa Medicaid or Medicaid Managed Care coverage due to the states unwinding process and have not already turned in your application to get it reinstated; we would be happy to help.

Please return this form with the signature pages to The Financial Counselor at Jefferson County Health center, (located in the hospital near the lab) and we will assist you in the reinstatement process. If you have any questions, please feel free to contact our patient financial services department at 641-469-4311 or 641-469-4301.

Information needed to help Re-apply for Medicaid Coverage:

Applicants Name:_____

Applicants DOB:_____

Applicants SSN:_____

Applicants Mailing Address:_____

Additional Household members:

Name	Date of Birth	Relationship to applicant	Are they claimed on taxes

Applicants Household Income: _____

Is this income from Self-employment or an employer? If an employer what is your employers name:_____

When did you start working at this employer:_____

Will you file Taxes this year:_____

If yes, what will your status be: Single, Head of Household, Married file Joint, Married but file single.

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) Billie Harlan		
Address 2000 S Main Street		Apartment or suite number
City Fairfield	State Iowa	ZIP code 52556
Phone number 641-469-4311		
Organization name Jefferson County Health Center		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 Health and 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 **full** monthly fee paid to a Managed Care Organization (MCO), including medical and dental, even if the plan did not pay for any services, 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://hhs.iowa.gov/sites/default/files/Comm123.pdf (English) or http://hhs.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. Provide the Completed Application

- In-person – Bring to your local HHS office.
- Fax – Send to (515) 564-4017
- Email – Send to imagingcenter4@dhs.state.ia.us
- By mail – Send 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

Iowa Department of Health and Human Services

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 Health and 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	