Healthy kids are Iowa's future.

hawk-i

(Healthy and Well Kids in Iowa)

Free or Low-Cost Health Care Coverage For Kids.

1-800-257-8563
(TDD 1-888-422-2319)
www.*hawk-i*.org

Español al otro lado

Comm. 156 (Rev. 6/03)

To qualify for *hawk-i,* a child must:

- Be under 19 years old
- Be uninsured
- Be ineligible for Medicaid
- Be a citizen or a lawfully admitted resident alien
- Meet the income limits

Questions & answers about *hawk-i:*

How will my doctor know my children are on *hawk-i*?
Your child will get a card from the health plan that covers *hawk-i* in your county.

What services are covered under *hawk-i*?

- Doctor Visits
- Hospital Care
- Prescriptions
- Well-child Visits
- Vaccines/Shots
- Emergencies
- Surgery
- Dental Care
- Vision Exams
- Hearing Services
- Mental Health & Substance Abuse Care
- Chiropractic Care
- Speech Therapy

What does *hawk-i* cost?
Look at the income charts to the right. If your family's yearly countable income is in the blue chart, then *hawk-i* is FREE! If your family's yearly countable income is in the yellow chart, the cost is $10 per month per child. But, no family will have to pay more than $20 per month … no matter how many children are in the family! NOTE: There is no cost for Native American or Alaskan Native children.

How long can my children get *hawk-i*?
There is no time limit as long as they are eligible. When your application is approved, your children will be enrolled for 12 months. If your child turns 19 or is no longer eligible for another reason, *hawk-i* will end before the 12 months are up. *REMEMBER: hawk-i coverage must be renewed every year. You will get a renewal form before the 12 months are up. Make sure to send the renewal form back to see if hawk-i can continue.*

Can my children get *hawk-i* if I am not a U.S. citizen?
Yes. The child must be a citizen or lawfully admitted resident alien to get *hawk-i,* but the citizenship status of the parent does not count. Information about families who apply for *hawk-i* is not given to the Immigration and Naturalization Service (INS).

Questions?
Call *hawk-i* customer service at
1-800-257-8563
(TDD 1-888-422-2319)

Income limits effective April 1, 2003

Use these charts to see how your children can get free or low-cost health care coverage.

20% of income from a job (before taxes) is not counted when comparing family income to the limits. The 20% deduction does not apply to unearned income such as child support, social security disability, or unemployment insurance benefits. After subtracting 20% of earned income, look up your family's yearly income in the charts to see if your children may qualify for free or low-cost health care coverage.

Family Size (parents, spouses, stepparents, & children under 19 living together)	Medicaid — If your family's yearly countable income is in this chart, your children may be able to get **FREE** coverage under Medicaid.
1	up to $11,944
2	up to $16,120
3	up to $20,296
4	up to $24,472
5	up to $28,649
6	up to $32,825
7	up to $37,001
8	up to $41,177

Family Size (parents, spouses, stepparents, & children under 19 living together)	*hawk-i* — If your family's yearly countable income is in this chart, your children may be able to get **FREE** coverage under *hawk-i*.
1	$11,945 to $13,470
2	$16,121 to $18,180
3	$20,297 to $22,890
4	$24,473 to $27,600
5	$28,650 to $32,310
6	$32,826 to $37,020
7	$37,002 to $41,730
8	$41,178 to $46,440

Family Size (parents, spouses, stepparents, & children under 19 living together)	*hawk-i* — If your family's yearly countable income is in this chart, your children may be able to get *hawk-i* for $10 per child per month. No family pays more than $20 per month.
1	$13,471 to $17,960
2	$18,181 to $24,240
3	$22,891 to $30,520
4	$27,601 to $36,800
5	$32,311 to $43,080
6	$37,021 to $49,360
7	$41,731 to $55,640
8	$46,441 to $61,920

Race, color, national origin, age, disability, or sex will not affect eligibility except where it is required by law.

hawk-i Application

This application is for medical coverage for children and teens under age 19. Please answer eve
If you have any questions or need help filling out this form, call *hawk-i* customer service at **1-8**

SECTION 1: APPLICANT INFORMATION. Please tell us who you are and how we can reach you. A parent or guardian, or someone acting for the parent or guardian, may apply for the children. Teens who do not live with a parent or guardian may apply for themselves. The person listed as the applicant is the person who will get any mail we send.

Last Name	First Name	Middle Name	Do the children you are applying for live with you? ❏ Yes ❏ No

Street Address			Apt. #	Home Phone ( )	How are you related to the children you are applying for? ❏ Parent ❏ Stepparent ❏ Guardian ❏ Self (if teen applying) ❏ Other	What language do you speak? ❏ English ❏ Español ❏ Other (list)
City	State	ZIP Code	County			

Mailing Address (if different):			Apt. #	Work Phone ( )		
City	State	ZIP Code	County			

SECTION 2: FAMILY MEMBERS. List all the people living in the home who are **PARENTS, STEPPARENTS OR GUARDIANS** of the children you are applying for. List the adults first and then the children below. You do not need to list children over the age of 19 or other friends or relatives who live in the home.

List the ADULTS here	Name (last, first, middle)	Birth Date (month/day/year)	Sex	Social Security Number (optional)	Race/Ethnicity (optional)
Adult 1	Start with yourself		❏ F ❏ M		❏ White ❏ Hispanic/Latino ❏ Other / ❏ Black ❏ American Indian/Alaska Native / ❏ Asian ❏ Native Hawaiian/Pacific Islander
Adult 2			❏ F ❏ M		❏ White ❏ Hispanic/Latino ❏ Other / ❏ Black ❏ American Indian/Alaska Native / ❏ Asian ❏ Native Hawaiian/Pacific Islander
Adult 3			❏ F ❏ M		❏ White ❏ Hispanic/Latino ❏ Other / ❏ Black ❏ American Indian/Alaska Native / ❏ Asian ❏ Native Hawaiian/Pacific Islander

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Three easy steps to apply!

1. **Fill out the application.** Answer every question completely. Each section is important. It will take longer to process your application if you don't answer all the questions or send in proof of your income.

2. **Sign the application.** The person who fills out the application and all parents or stepparents living in the home should sign the form.

3. **Mail the application** and proof of your income in the envelope that is provided. You do not need a stamp.

CHILDREN & TEENS Under age 19. List the children and teens who live in the home at least 50% of the time. Attach a separate piece of paper if you need more space.

		Sex	How is this child related to the adults listed above?			Are you applying for this child?	Does this child get SSI?	Is this child on Medicaid?	Race/Ethnicity (optional)	Full-time student?	Is this child in an institution?	Pregnant?	U.S. citizen?
Child 1	Name (last, first, middle) ___ Birth Date (month/day/year) ___ Social Security Number (optional)	❏ F ❏ M	Adult 1 ❏ Child ❏ Stepchild ❏ Other (list)	Adult 2 ❏ Child ❏ Stepchild ❏ Other (list)	Adult 3 ❏ Child ❏ Stepchild ❏ Other (list)	❏ Yes ❏ No if NO, Stop here	❏ Yes ❏ No	❏ Yes ❏ No	❏ White ❏ Black ❏ Asian ❏ Other ❏ Hispanic/Latino ❏ American Indian/Alaska Native ❏ Native Hawaiian/Pacific Islander	❏ Yes ❏ No	❏ Yes ❏ No If YES, when will they be released?	❏ Yes ❏ No	❏ Yes ❏ No If NO, send a copy of INS card or passport.
Child 2	Name (last, first, middle) ___ Birth Date (month/day/year) ___ Social Security Number (optional)	❏ F ❏ M	Adult 1 ❏ Child ❏ Stepchild ❏ Other (list)	Adult 2 ❏ Child ❏ Stepchild ❏ Other (list)	Adult 3 ❏ Child ❏ Stepchild ❏ Other (list)	❏ Yes ❏ No if NO, Stop here	❏ Yes ❏ No	❏ Yes ❏ No	❏ White ❏ Black ❏ Asian ❏ Other ❏ Hispanic/Latino ❏ American Indian/Alaska Native ❏ Native Hawaiian/Pacific Islander	❏ Yes ❏ No	❏ Yes ❏ No If YES, when will they be released?	❏ Yes ❏ No	❏ Yes ❏ No If NO, send a copy of INS card or passport.
Child 3	Name (last, first, middle) ___ Birth Date (month/day/year) ___ Social Security Number (optional)	❏ F ❏ M	Adult 1 ❏ Child ❏ Stepchild ❏ Other (list)	Adult 2 ❏ Child ❏ Stepchild ❏ Other (list)	Adult 3 ❏ Child ❏ Stepchild ❏ Other (list)	❏ Yes ❏ No if NO, Stop here	❏ Yes ❏ No	❏ Yes ❏ No	❏ White ❏ Black ❏ Asian ❏ Other ❏ Hispanic/Latino ❏ American Indian/Alaska Native ❏ Native Hawaiian/Pacific Islander	❏ Yes ❏ No	❏ Yes ❏ No If YES, when will they be released?	❏ Yes ❏ No	❏ Yes ❏ No If NO, send a copy of INS card or passport.
Child 4	Name (last, first, middle) ___ Birth Date (month/day/year) ___ Social Security Number (optional)	❏ F ❏ M	Adult 1 ❏ Child ❏ Stepchild ❏ Other (list)	Adult 2 ❏ Child ❏ Stepchild ❏ Other (list)	Adult 3 ❏ Child ❏ Stepchild ❏ Other (list)	❏ Yes ❏ No if NO, Stop here	❏ Yes ❏ No	❏ Yes ❏ No	❏ White ❏ Black ❏ Asian ❏ Other ❏ Hispanic/Latino ❏ American Indian/Alaska Native ❏ Native Hawaiian/Pacific Islander	❏ Yes ❏ No	❏ Yes ❏ No If YES, when will they be released?	❏ Yes ❏ No	❏ Yes ❏ No If NO, send a copy of INS card or passport.

Cut Here

SECTION 3: INCOME. Please tell us about your family income. List all income received by any parent, stepparent, and children under 19. Do not list the income of legal guardians or other adults who are not the parents or stepparents of the children listed in SECTION 2. Be sure to show the amount of income before taxes or other deductions (not the take-home pay). Include income from work, self-employment, social security benefits, child support payments, unemployment insurance, worker's compensation benefits, veteran's benefits, etc. BE SURE TO SEND PROOF OF YOUR INCOME. If there is no family income, write "NONE". For more information, see "How to Prove Your Income." ➡

Name of the person with income (first, middle, last)	Employer name or source of income	Amount of income before taxes or other deductions	How often is this amount received?		Is this income expected to continue for the next 12 months? If NO, explain in Section 8.	
		$	❏ Weekly ❏ Every other week ❏ Twice a month	❏ Monthly ❏ Yearly ❏ Other	❏ Yes	❏ No
		$	❏ Weekly ❏ Every other week ❏ Twice a month	❏ Monthly ❏ Yearly ❏ Other	❏ Yes	❏ No
		$	❏ Weekly ❏ Every other week ❏ Twice a month	❏ Monthly ❏ Yearly ❏ Other	❏ Yes	❏ No

SECTION 4: INSURANCE HISTORY.

Does any child you are applying for have insurance now or have they been covered by health insurance in the past 6 months? ❏ Yes ❏ No
(**if NO,** go to SECTION 5)

If YES, list their name(s):	If coverage **has ended:**	If coverage **has not ended:**
	How much were you paying for the insurance each month?	How much are you paying for the insurance each month?
Who is/was the policy holder?	When was the last date of coverage?	
Coverage is/was through? ❏ Employer ❏ Private policy ❏ COBRA	Why was it dropped?	

SECTION 5: REFERRALS TO MEDICAID. If your income is below *hawk-i* limits, this application will be reviewed to see if your children can get health care coverage through the Medicaid program. For more information, see "Helpful Hints." ➡

Does any child you are applying for have medical bills for care received during the last 3 months? ❏ Yes ❏ No	**If YES,** list the child's name and the month(s) care was received.	
	Child's name	Month(s) care was received
Does anyone pay child support for a person who does not live in the home? ❏ Yes ❏ No	**If YES,** list the name of the person who pays and the amount paid. Please send in proof of your payments. $	
Do you pay someone to take care of your children while you are at work or school? ❏ Yes ❏ No	**If YES,** list the names of the children and the amount you pay each month. Please send in proof of your payments.	

SECTION 6: RIGHTS AND RESPONSIBILITIES.

- **I understand that coverage under the *hawk-i* program needs to be renewed every year.**
- I agree to the release of personal and income information from this application form and any proof of this information to the agencies that run these programs so that they can decide if I am eligible. I understand that this information will be kept private according to the law.
- I understand that I must report any changes in the information on the form.
- I understand that I may be asked to give more information.
- I understand eligibility will not be affected by race, color, national origin, age, disability, or sex, except where it is required by law.
- I understand that this application may be sent to the Medicaid program if the children could get Medicaid instead of *hawk-i*.

- I understand that I can appeal any decisions made as a result of this application. I can find out how to appeal by calling the *hawk-i* program at 1-800-257-8563 or the Iowa Department of Human Services at 515-281-3094.
- I understand that anyone who lies on purpose or does not tell the truth or arranges for someone to lie on purpose or not tell the truth is committing a crime which can be punished under federal and state law. I understand that I may also have to pay back the value of the benefits received and I may be subject to fines or other civil penalties if the information I have given is not the truth.
- I swear under penalty of perjury that everything on the application form is the truth.

X
Signature or mark of applicant   Date

X
Signature or mark of other person or stepparent in the home   Date

X
Signature of person, if any, who helped fill out this form   Date

SECTION 7: HOW DID YOU HEAR ABOUT *hawk-i*?
Please check one.

❏ Television
❏ Radio
❏ Newspaper
❏ Billboard
❏ Friend or Relative
❏ WIC
❏ School
❏ Doctor or Pharmacist

❏ Department of Human Services
❏ Church
❏ Employer
❏ Health or Social Agency
❏ Daycare
❏ Other (list in Section 8)

How to Prove Your Income (SECTION 3)

Income from a job: Send copies of all pay stubs for the last 30 days. If you do not have pay stubs or if you have a new job, we can take a signed statement from your employer verifying your pay.

Income from self-employment: Send a copy of your most recent tax return (include Schedule C or F). If your self-employment business is new or your earnings are not the same as what is on your tax return, send a copy of the most recent business records; tell us what has changed.

Unearned income (such as child support, social security benefits, VA benefits, unemployment insurance, etc.): Send a copy of the award letter, divorce decree, or other proof that shows how much you get.

IMPORTANT: Make sure to tell us if the income is going to change. For example, tell us if your last 30 days' pay checks show that you worked more overtime than usual. If you work only part of the year, such as a construction worker or schoolteacher, tell us how much you earn for the entire year.

Helpful Hints About Medicaid (SECTION 5)

Your children will get more benefits under Medicaid than under *hawk-i*. Medicaid can also pay medical bills for the past 3 months for your children if they are eligible. To see if your children are eligible, send in proof of your income for any of the past 3 months in which your children have medical bills. Also, make sure to send in proof of your childcare payments so you can get a deduction to your income.

SECTION 8: Use this area if you need more room to answer any of the questions.