

Revised January 9, 2015

Employees' Manual  
Title 16  
Chapter J Appendix

# **IN-HOME HEALTH-RELATED CARE SERVICES**

## **APPENDIX**



---

	<u>Page</u>
Amendment to Provider Agreement, 470-1999.....	1
Authorization to Obtain or Release Health Care Information, 470-3951 and 470-3951(S) .....	2
Health Services Application, 470-2927 and 470-2927(S) .....	5
Individual Service Plan, 470-0583 .....	7
Notice of Decision: Services, 470-0602 and 470-0602(S) .....	9
Physician's Report, 470-0673 .....	11
Provider Agreement, 470-0636 .....	12
Provider Health Assessment, 470-0672 .....	15
Purchase of Service Provider Invoice, 470-0020 .....	16
Request for Taxpayer Identification Number and Certification, W-9 .....	18
Service Worker Comprehensive Assessment, 470-5044 .....	19
Statement of Services Rendered, 470-0648 .....	20

**[Amendment to Provider Agreement, 470-1999](#)**

Purpose	The <i>Amendment to Provider Agreement</i> records a required reduction in the state supplementation established in the <i>Provider Agreement</i> , form 470-0636.
Source	Print or photocopy the sample in the manual for use as needed. (Click on the blue form number to access the sample electronically.)
Completion	The DHS service worker assists providers and clients to complete an amendment for each provider agreement before delivery of service at the reduced rate.
Distribution	Place the original <i>Provider Agreement</i> in the client case file. Make a copy for the provider and for the client.
Data	Enter a change in the rate when client participation changes.

**Authorization to Obtain or Release Health Care Information, 470-3951 and 470-3951(S)**

Purpose	<p>Forms 470-3951 and 470-3951(S) are two-way release forms used to get the permission of a client or the client's legally authorized representative to:</p> <ul style="list-style-type: none"><li>◆ Obtain health information needed to provide service to a client; and</li><li>◆ Release health information about the client to a third party.</li></ul>
	<p>Use the form to obtain permission from the provider regarding the client's health status. Have the provider sign the form. Give a copy of the signed form to the provider to be submitted along with form 470-0672, <i>Provider Health Assessment</i>, to the provider's health care professional.</p>
Source	<p>The English version of this form is printed in pads of 25 three-part precarbonated sets. Order supplies from Iowa Prison Industries at Anamosa. Form 470-3951 may also be completed on line using the template on Outlook under "Public Folders/All Public Folders/State Approved Forms/Service."</p> <p>Print or photocopy supplies of the Spanish version, form 470-3951(S), from the sample in the manual. (Click on the blue form number to access the sample electronically.)</p>
Completion	<p>Complete this form when first meeting with a new client and the provider. Complete the identifying information and description of the information being requested or released. The client or the client's personal representative signs the section to give the authorization. The provider also signs the section to give authorization when completing the form. Update this form annually.</p> <p>Discuss the authorization and explain the use of the form. Make sure that the person understands the right to revoke the authorization at any time by completing form 470-3949, <i>Request to End an Authorization</i>.</p>

Distribution

Fax or scan a copy to the supervising registered nurse with a request for the physician's plan of care and supervising registered nurse's provider instructions.

Place a copy of the form in the client's DHS service case file. The person completing the form should also keep a copy.

Data

When initiating the form, enter:

- ◆ The person's name, state identification number (if any), social security number, date of birth, and parent's or guardian's name, if applicable.
- ◆ The name of the agency to release and receive information is the Iowa Department of Human Services. Enter the address, telephone number, and fax number.
- ◆ Enter the name of the agency to which the information is being released, or from which the information is being requested, and the agency's address, telephone number, and fax number.
- ◆ In the "information released may include" section, check the applicable boxes. If the "other" box is checked, describe the specific information being requested.
- ◆ Describe any exceptions or limitations under "other."  
Sample entry: "The Department may obtain information from, but not release information to, the client's daughter."
- ◆ State the purpose for which the information will be used.
- ◆ In the "Specific Authorization For Release" section, secure the person or the person's legal representative's initials if mental health, AIDS/HIV-related, or substance abuse information is to be obtained or released.

NOTE: Only the person or the person's legally authorized representative can give consent to release or obtain mental health, AIDS/HIV-related, or substance abuse information.

"Mental health information" means oral, written, or recorded information that indicates the identity of an individual receiving professional services and which relates to the diagnosis, course, or treatment or the individual's mental or emotional condition.

"Substance abuse" means the use of chemical substances by persons suffering from chemical dependency, persons who are incapacitated by a chemical substance, substance abusers, or chronic substance abusers.

"AIDS" means a medical diagnosis of acquired immunodeficiency syndrome, based on the Center for Disease Control's "Revision of the CDC Surveillance Case Definition for Acquired Immunodeficiency Syndrome." "HIV" means a medical diagnosis of human immunodeficiency virus infection based on a positive HIV-related test.

- ◆ Ask the person to sign and date the form and enter a date when the authorization is to expire.
- ◆ Check the applicable box indicating the relationship of the person who signs the form to the person the information is concerning.
- ◆ Obtain the signature of two witnesses for people who are incapable of signing their name due to a physical or mental disability.

To use the form as the required documentation for the disclosure of mental health information, document on the back of the form which is kept in the DHS service case file:

- ◆ The date.
- ◆ The name of recipient of information.
- ◆ The information disclosed.
- ◆ The name of the person who disclosed the information.

**Health Services Application, 470-2927 and 470-2927(S)**

Purpose	Forms 470-2927 and 470-2927(S) are used to apply for State Supplementary Assistance programs and Medicaid. The information contained on the application is used to determine eligibility for assistance.
Source	Form 470-2927 is printed with 30 sets on a pad. The Spanish translation, form 470-2927(S), is printed with 10 sets on a pad. Order supplies from Iowa Prison Industries in Anamosa.  Copies may also be printed or photocopied from the samples in the manual. (Click on the blue form number to access the sample electronically.)
Completion	Provide or mail the form to the applicant when assistance is requested. A person wishing to receive assistance for in-home health-related care must complete this application annually.  The client completes the form or may enlist help in preparing the form.  If the client is mentally incompetent, the form may be completed by a relative, a person in whose home the client resides, or by the DHS service worker.  The client must sign the form unless mentally or physically unable to do so. If the client is mentally competent but unable to sign the application form, an "X" or a thumbprint may be used if witnessed by two persons who know the client.  If the application is not complete when it is filed, it must be fully completed upon the interview with the client or representative.

Distribution

The client submits one copy of the form to the local office. Date-stamp the completed application before sending it to the income maintenance worker. Provide a copy for the client upon request.

NOTE: The *Health Services Application* takes the place of the *Application for All Social Services*, form 470-0615 or 470-0615(S). The form is kept in the income maintenance case record. A copy of the form is not required to be kept in the DHS service case file.

Data

The form requests information necessary to determine State Supplementary Assistance and Medicaid eligibility.

[Individual Service Plan, 470-0583](#)

Purpose	The <i>Individual Service Plan</i> is used as a record of the plan of care for the individual client receiving in-home health-related care services.
Source	This form may be completed on line using the template in Outlook under "Public Folders/All Public Folders/State Approved Forms/Service."  (Click on the blue form number to access the sample electronically.)
Completion	The DHS service worker completes an <i>Individual Service Plan</i> when a new client is approved to receive in-home health-related care and annually thereafter. Update the plan if there are any changes in services and when the service is terminated.
Distribution	File in the DHS service case record. Send a copy to the client.
Data	<p><b>Member's Name:</b> Enter the client's name.</p> <p><b>Waiver Type:</b> Click on the dropdown box to select the waiver type or in-home health-related care (IHHRC).</p> <p><b>SID #:</b> Enter the client's state identification number.</p> <p><b>Original Service Plan Date:</b> Enter the date the original service began.</p> <p><b>Updated:</b> Enter the date the case plan is updated.</p> <p><b>Assessment – Date of Home Visit:</b> Enter the date of the home visit.</p> <p><b>Introduction:</b> Enter the demographic information about the client, including power of attorney and emergency contact.</p> <p><b>Medical Information:</b> Enter diagnosis, and physicians or other providers, and how often they are seen.</p> <p><b>Medications:</b> Enter current medications, hospitalizations, etc.</p>

**Level of Care:** Enter the date that the physician's information was received.

**Health Status/ADLS:** Enter information regarding which areas require assistance and what assistance is needed.

**Additional Comments:** Enter other pertinent information about the client in a narrative format.

**Team Communication:** Enter a goal for each service provided by the IHRC program.

**Safety and Crisis Plan:** Address all safety concerns that are present in the home environment.

NOTE: If there is a safety issue that was addressed with the client, but the client chooses to do nothing about that safety, issue document that in the case plan (under additional comments).

**Service:** List all services both formal and informal that the client receives.

**Responsibilities:** List the responsibilities of all members of the team.

EXAMPLE: A client's goal may be to communicate with DHS if there is a change in circumstances, i.e., the client moves, income changes, etc.

**Signatures:** Enter the DHS service worker's and the DHS supervisor's names. The DHS service worker and DHS supervisor must sign and date the form.

**Member's Signature:** The client must sign and check the appropriate box to indicate that the client agrees.

NOTE: Document in the client narrative if the client refuses to sign the case plan.

**Notice of Decision: Services, 470-0602 and 470-0602(S)**

Purpose	The <i>Notice of Decision: Services</i> notifies a service applicant or recipient of all actions taken that affect the person's case. Due process requirements are met when a <i>Notice of Decision: Services</i> is issued.
	For approvals, renewal, reviews or changes print the NOD from ISIS. For cancellations or denials hand write the NOD.
Source	The English and Spanish versions of the form may be completed on line using the template in Outlook under "Public Folders/All Public Folders/State Approved Forms/Service."  The forms may also be printed or photocopied from the samples in the manual and completed manually. (Click on the blue form number to access the sample electronically.)
Completion	The DHS service worker completes this form to notify clients of eligibility determination and service needs for in-home health-related care for the following case actions: <ul style="list-style-type: none"><li>◆ An application is approved, denied, or withdrawn.</li><li>◆ Services are renewed as a result of an annual or a special review.</li><li>◆ The service is changed.</li><li>◆ Services are terminated.</li><li>◆ Client participation is required, or the amount changes, or it is to be paid to a different provider.</li></ul>
Distribution	Give the original to the client. Send a copy to the provider. File a copy in the DHS service case record.

Data

**Identifying Information:** State identification number (SID #).

**Explanation of Action:** Include in this section:

- ◆ The action taken;
- ◆ The services, if new or changed; and
- ◆ The specific basis for the action in words the client can understand.

If services are being reduced, state the reason clearly. For a termination, include the basis for cancellation and the reason for termination.

**Manual or Rule References:** State the chapter and subsection of the *Employees' Manual* and the administrative rule reference that support the action taken.

**Fees:** For clients with client participation, specify:

- ◆ The service and the person to whom the client participation is paid.
- ◆ The amount of the client participation.
- ◆ The period covered by the client participation (e.g., \$20 per month).

### Physician's Report, 470-0673

Purpose	<p>The <i>Physician's Report</i> is used to obtain medical information from a physician about an in-home health-related care client. (This form is also used in the family-life home program.) The physician's recommendations and orders regarding the client's level of care and the client's health needs are used for determining eligibility and for developing a plan of care and services.</p> <p>The <i>Physician's Report</i> may also be used as the <b>health care plan</b> if the supervising registered nurse or physician does not use a different form.</p>
Source	<p>Print or photocopy supplies of the form from the sample in the manual. (Click on the blue form number to access the sample electronically.)</p> <p>If this form is used as the plan of care, provide the supervising registered nurse with a supply of the forms.</p>
Completion	<p>Prepare this form:</p> <ul style="list-style-type: none"><li>◆ Upon receipt of referral.</li><li>◆ If the form is being used as a plan of care, the physician completes this form every 60 days thereafter.</li><li>◆ Annually at review.</li></ul> <p>Complete the items on the form that precede the consent box. The client and the client's legal guardian complete items in the "Consent for Physician's Release of Information" section, with assistance from the DHS service worker, if required. The physician completes the remaining portions of the form.</p>
Distribution	<p>The physician completes the form and sends it to the registered supervising nurse or agency responsible for planning and managing services to the client.</p> <p>The supervising registered nurse or agency maintains the form in the client's file and sends a copy to the DHS service worker for the client's service file.</p>

---

[Provider Agreement, 470-0636](#)

**Purpose** The *Provider Agreement* describes the responsibilities of a person providing in-home health-related care services to a client of the Department. The agreement specifies the payment to be made to each provider by the client. The Department assures the eligibility of the client.

**Source** This form may be completed on line using the template in Outlook under "Public Folders/All Public Folders/State Approved Forms/Service."

Supplies of the form may also be printed or photocopied from the sample in the manual. (Click on the blue form number to access the sample electronically.)

**Completion** The client and worker complete a *Provider Agreement* with each provider the client has. If a provider has more than one client, the provider must have a different agreement for each client.

A client may have more than one valid *Provider Agreement*, with each having a different number as providers will be assigned their own provider number.

Before the service is initiated and annually thereafter, the form shall be signed by:

- ◆ The client,
- ◆ The provider,
- ◆ The DHS service worker, and
- ◆ The service area manager or designee.

A new agreement must be completed when any of the following changes occur:

- ◆ Rate of payment
- ◆ Service to be provided
- ◆ Maximum cost
- ◆ Provider
- ◆ Who receives the client participation

Distribution

When the form is completed and signed by all parties the information is entered in ISIS. The original copy goes to the DHS service worker for the service case file. Mail a copy to the provider and to the client.

Data

**Provider number:** ISIS generates the provider number after the DHS service worker enters all information into ISIS. (Information is entered in ISIS under the provider tab.)

NOTE: The provider may already be a traditional Medicaid provider. Search the provider name before entering new information.

**State ID:** Enter the client's state identification number.

**Amendment:** Indicates this is an amendment to an agreement already in effect.

**Payee name:** Enter the name of the payee, if different from the client. Examples of payees are legal conservators, power of attorneys for financial affairs, and protective payees.

**Payee telephone number, street address, city, state, and zip code:** Entered if there is a payee.

**Client name, social security number, telephone number, street address, city, state, and zip code.** Enter on all agreements.

**Service provider's name, telephone number, street address, city, state, and zip code.** Enter on all agreements.

**Family member:** Indicates whether the provider is a family member, as defined on the agreement.

**Description of specific duties:** Enter the specific service codes that will be provided:

- R0001 Personal care number of 15 minute units  
Rate per unit total
- R0002 Homemaker number of 15 minute units rate
- R0003 Medication supervision number of 15 minute units  
rate
- R0004 Food preparation number of 15 minute units
- R0005 Transportation number of 15 minute units
- R0006 Other

**Provider signature and date:** Indicates approval of contract.

**Client signature and date:** Indicates approval of contract.

**Start date:** The date on which the agreement is to begin.

**End date:** The maximum term of the agreement, no longer than one year.

**Unit cost:** The dollar amount for the rate agreed upon.  
Example: \$2.00 per 15 minute increment.

**Per:** The basis for the rate. Use 15 minutes.

**Billable per month DHS:** The maximum amount the Department has agreed to provide to the client to purchase the service identified in this agreement.

**Client participation (CP):** The amount of client participation, if any.

**DHS service worker signature and date:** Approves payment for the service and certifies that the client is eligible.

**Area administrator or designee signature and date:** The service area manager or designee certifies the client for the program and gives final approval for the payment.

**[Provider Health Assessment, 470-0672](#)**

Purpose	Form 470-0672 is used to certify all providers for the in-home health-related care program. (It also is used in the family-life home program.)
Source	Print or photocopy supplies of the form from the sample in the manual. (Click on the blue form number to access the sample electronically.)
Completion	The provider's physician, advanced registered nurse practitioner, or a physician assistant working under the direction of a physician completes one <i>Assessment</i> before the initiation of service delivery and annually thereafter.
	The provider is responsible for delivering the completed form to the DHS service worker. The provider assumes full responsibility for any costs that may be incurred in the completion of this form.
Distribution	Keep the completed form in the client's DHS service case record. Make a copy for the provider upon request.

[Purchase of Service Provider Invoice, 470-0020](#)

Purpose	<p>This form is used to process:</p> <ul style="list-style-type: none"><li>◆ Payments for the previous fiscal year and</li><li>◆ The last payment for a client who has died.</li></ul>
Source	<p>This form is printed in pads of 25 three-part carbonized sets. Order supplies from Iowa State Industries at Anamosa.</p> <p>Supplies of the form may also be printed or photocopied from the sample in the manual. (Click on the blue form number to access the sample electronically.)</p>
Completion	<p>The DHS service worker completes this form when a bill is submitted after the end of the (carry over period for the previous) fiscal year, or when a client has died before the last payment is made to the provider.</p>
Distribution	<p>Submit a W-9 form for the provider, the original statement of services rendered signed by the provider, and the invoice to the address listed below. Keep a copy of the W-9, statement of services rendered, and the invoice in the DHS service file.</p> <p>Department of Human Services Bureau of Purchasing, Payments, Receipts and Payroll 1305 E. Walnut Street Des Moines, Iowa 50319</p> <p>Or scan this information and email it to: <a href="mailto:inhomehealthdemographic@dhs.state.ia.us">inhomehealthdemographic@dhs.state.ia.us</a></p>
Data	<p><b>Billing Period:</b> Enter the first and last date of the billing period, inclusively. Example: 10-1-99 - 10-31-99</p> <p><b>State/Local:</b> Enter code 'S' for state funds.</p> <p><b>County No. and Name:</b> Enter the county number and name. Example: 77 Polk</p> <p><b>Agreement No.:</b> Enter the provider number generated by ISIS.</p>

**Provider Name:** Enter the provider's name.

**Provider Addr:** Enter the provider's address.

**City/State/Zip:** Enter the city, state, and zip code.

**Case Number:** Enter the client's state identification number.

**Client's Name:** Enter the client or payee name exactly as entered on the ISIS system. (In most cases, this is the client.)

**Service Beginning:** For **new** clients, enter the service initiation date. Leave **blank** for ongoing clients.

**Service Ending:** Enter the termination date for clients who are **ending** service. Leave **blank** for ongoing clients.

**Service Code:** Enter the appropriate service code (i.e., R0001).

**Unit Cost:** Enter the cost for one unit of service as given in the *Provider Agreement*. (Example: 2.00 per 15 minutes)

**No. of Units:** Enter the number of units of service provided during the billing month.

EXAMPLE: 10 15-minute units per month

**Total Cost:** Enter the product of the unit cost and the number of units. (Example: The unit cost is \$2.00 and the number of units is 5. The total cost is \$10.00)

**Credits:** Enter any credits for overpayment or client participation.

**Net Cost:** Enter the total cost less credits. (Example: Total cost is \$100.00. Credits are \$20.00. Net cost to the Department is \$80.00.)

**Totals:** Enter the total amount due the client.

**Approval:** Enter an authorized local office signature and date to approve the billing.

**Request for Taxpayer Identification Number and Certification, W-9**

Purpose	<p>The <i>Request for Taxpayer Identification Number and Certification</i>, form W-9, is used to obtain the client's social security number and legal name as registered with the Internal Revenue Service (IRS).</p> <p>NOTE: The W-9 form is also used to obtain the provider's social security number when the client passes away before the last payment is made to the provider.</p>
Source	<p>Click on the blue form number to access the form electronically.</p>
Completion	<p>The DHS service worker provides the form to the client before completion of the provider agreement.</p>
Distribution	<p>The DHS service worker sends the original form signed by the client to the address listed below. Keep a copy for the DHS service file.</p> <p>Department of Human Services Bureau of Purchasing, Payments, Receipts and Payroll 1305 E. Walnut Street Des Moines, Iowa 50319</p> <p>Or scan this information and email it to: <a href="mailto:inhomehealthdemographic@dhs.state.ia.us">inhomehealthdemographic@dhs.state.ia.us</a>.</p>
Data	<p>The client follows the instructions provided with the form.</p>

**[Service Worker Comprehensive Assessment, 470-5044](#)**

Purpose	The <i>Service Worker Comprehensive Assessment</i> makes an initial assessment of the client's medical and daily care needs.
Source	Print or photocopy the sample in the manual for use as needed. (Click on the blue form number to access the form electronically.)
Completion	Complete the assessment at the time of application and annually thereafter.
Distribution	Keep the original in the client's DHS service case file.
Data	<p>The DHS service worker completes the worker's name and DHS address in the first section of the form. The DHS service worker also completes page 10 if applicable.</p> <p>The client completes the other sections on the form where applicable including:</p> <ul style="list-style-type: none"><li>◆ Demographic information and living arrangements,</li><li>◆ Emergency contact information,</li><li>◆ Household care,</li><li>◆ Personal medical care,</li><li>◆ Services,</li><li>◆ Assistive devices,</li><li>◆ Medical conditions and equipment,</li><li>◆ Mobility,</li><li>◆ Wound care,</li><li>◆ Activities of daily living,</li><li>◆ Other services,</li><li>◆ Children (17 and under), and</li><li>◆ The narrative sections.</li></ul> <p>The client may request assistance from the provider or designate another party to assist in completing the form. The DHS service worker may also assist the client in completing the form.</p> <p>The client or designee assisting the client in completing the form for the client should certify it by signing and dating the form.</p>

**Statement of Services Rendered, 470-0648**

Purpose	The <i>Statement of Services Rendered</i> provides a means for an individual provider of service to keep a record of services provided to a client and to submit an invoice to the Department for payment.
Source	<p>This form is printed in pads of 25 three-part carbonized sets. Order supplies from Iowa State Industries at Anamosa.</p> <p>Supplies of the form may also be printed or photocopied from the sample in the manual. (Click on the blue form number to access the sample electronically.)</p>
Completion	<p>The DHS service worker supplies the forms to the client and provider when the <i>Provider Agreement</i> is approved.</p> <p>Providers should complete Section A at the beginning of each month. Complete the list of specific services, Section B, and each day that services are provided to the client. At the end of each month, the provider completes Section C and the client completes Section D. If there is more than one provider, complete a statement of services rendered for each provider.</p>
Distribution	The client sends the original to the DHS service worker for the client's service file. Clients should keep one copy for themselves and give one copy to the provider.
Data	<p><b>Section A.</b> Enter the provider's name, client's name and state identification number, and the dates (month and year) that service has been provided.</p> <p><b>Section B.</b> A log of time spent during which service was being provided.</p> <ul style="list-style-type: none"><li>◆ "Specific Services" lists the actual work done.</li><li>◆ "Rate" lists the rate of payment for the specific service.</li></ul>

- ◆ "Unit" lists the units of work for the specific service.  
(Example: 8:30 - 10:00 am should be broken down into six 15-minute units)
- ◆ "Monthly Units" lists the total dollar amount due to the provider for the specific service.
- ◆ Total row is the total number of units worked and the total payment due to the provider.
- ◆ "Signature." The provider signs and dates the first line. The client signs and dates the second line.

**Section C.** The total bill (amount due to the provider) equals client participation plus the DHS payment.

**Section D.** The client's name goes on line 1, the provider's name on line 2, and the month and year on line 3. The client signs the form and writes the date this section was completed.