

APPLICATION AND CONTRACT AGREEMENT FOR RESIDENTIAL CARE FACILITIES

I. This contract is between the Iowa Department of Human Services, referred to as the Department, and the _____, a provider of residential care and services, referred to as the facility.
Name of Facility

II. The facility accepts the terms of this contract, as evidenced by the following application:

Application Date _____ Provider Number _____

Name of Residential Care Facility _____

Address _____
(Street) (City) (ZIP)

License No. _____ Effective _____ Telephone No. _____

Type of Organization:

Check the Levels of Care Offered: No. of Beds:

_____ Governmental	_____ Partnership	_____ Skilled Nursing	_____
_____ Non-profit	_____ Corporation	_____ Nursing	_____
_____ Hospital-Based	_____ Pseudocorporation	_____ Residential	_____
_____ Individual Owner	_____ Other	_____ Hospital	_____
		_____ Other _____ Type	_____

Total Licensed Bed Capacity _____

(Complete only if facility is rented or leased)

Lessor _____

Address _____

Check One

The facility wishes to participate in the State Supplementary Assistance program under the cost-related system of payment for residential care.

The facility wishes to participate in the flat per diem rate of payment for residential care.

Fiscal Year _____

County Number _____

Vendor Code _____

(Not social security number. It is the number used on federal and state income tax forms.)

**Administrator:
Read and sign page 2.**

FOR DHS OFFICE USE ONLY IOWA DEPARTMENT OF HUMAN SERVICES	
Effective Date of Contract _____	
By: _____	Bureau Chief, Bureau of Long Term Care
Date _____	

III. The Facility Agrees:

To provide residential care including room, board, care and services to the State Supplementary Assistance residents according to all rules of the Department.

To have satisfactory policies and procedures for maintaining a medical record on each resident in the facility. This record must contain:

A written statement by a physician which says that the person being admitted requires residential care but does not require nursing services.

A contract between the resident and the facility. This contract shall not contain any provisions which are contrary to the rules of the Department about eligibility, the grant payment for residential care, or refunding of advance payments when the resident dies or leaves the facility. The contract shall not contain any provisions which risk loss of the resident's rights to continued eligibility for assistance.

To accept, as payment in full, the amount allowed through the cost-related reimbursement or flat rate reimbursement system administered by the Department. Reimbursement is limited by the maximum per diem rate established by the Department. The facility agrees to make no additional charge or accept any additional payment for the cost of care from the State Supplementary Assistance resident or any other source.

To submit a *Financial and Statistical Report*, form 470-0030, according to Department rules, when paid under the cost-related system.

To maintain an accounting system to permit the Department to make necessary audits, and to include complete records regarding the resident's personal funds which have been deposited with the facility.

To accept the Department's policy of suspension or cancellation of the facility's right to take part in the State Supplementary Assistance program when the facility fails to maintain proper accounting records.

To maintain a current license to operate as a residential care facility. The facility shall notify the Department immediately of any change in its license.

IV. The Department and the Facility Agree:

That the term of this contract shall be 12 months, subject to renewal, or until the state ceases to fund the program, or until either party gives 60 days notice of termination in writing to the other party.

That the per diem rate shall be set by the Department. The rate shall be in effect until adjustment is indicated by information submitted by the facility in the annual *Financial and Statistical Report* or until an adjustment in per diem rate is required for other reasons.

That this contract shall not be transferable or assignable.

Signature of Administrator of Facility

Date

INSTRUCTIONS

Fill out and return one copy to:

BUREAU OF LONG TERM CARE
IOWA MEDICAID ENTERPRISE
100 ARMY POST ROAD
DES MOINES IA 50315