

Iowa Department of Human Services
Level of Care Certification for HCBS Waiver Program

ATTENTION: Fax Form to: Iowa Medicaid Enterprise - Medical Services (515) 725-1349

Form should be completed in office with member present.

Medical professional completing this form must provide a copy to the member.

Today's Date	Iowa Medicaid Member Name	State ID or Social Security Number	Birth Date
Provider Name (please print)		Provider Telephone Number with Area Code	

HCBS Program: AIDS Elderly Ill and Handicap Physical Disability Admission Annual Review

Diagnoses (please list or attach DX list):	Medications (include dose and frequency) or attach full medication list:
1.	1.
2.	2.
3.	3.
4.	4.
5.	5.
6.	6.
7.	7.
8.	8.
9.	9.

Level of Care Criteria: Mark all that apply, review each category	Was the member seen in the office at the time the form was completed? _____
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<p style="text-align: center;">Cognitive</p> <input type="checkbox"/> No problem <input type="checkbox"/> Language Barrier <input type="checkbox"/> Short/Long term memory problem <input type="checkbox"/> Problems with decision making <input type="checkbox"/> Interferes with ability to do ADLs	<p style="text-align: center;">Dressing</p> <input type="checkbox"/> Independent <input type="checkbox"/> Supervision or cueing needed <input type="checkbox"/> Physical assistance needed How often is assistance needed? <input type="checkbox"/> 1 - 2 X weekly <input type="checkbox"/> 3 - 4 X weekly <input type="checkbox"/> > 4 X weekly <input type="checkbox"/> Age-appropriate child	<p style="text-align: center;">Elimination</p> <input type="checkbox"/> Continent <input type="checkbox"/> Bladder incontinence <input type="checkbox"/> Bowel incontinence <input type="checkbox"/> Urinary Catheter <input type="checkbox"/> Colostomy / ostomy <input type="checkbox"/> Nephrostomy <input type="checkbox"/> Age-appropriate child	<p style="text-align: center;">Medications</p> <input type="checkbox"/> Independent <input type="checkbox"/> Requires set up <input type="checkbox"/> Needs administered by others <input type="checkbox"/> Daily IV Duration: <input type="checkbox"/> Daily IM Duration: <input type="checkbox"/> Insulin, set dosage <input type="checkbox"/> Insulin, sliding scale <input type="checkbox"/> Frequent lab values <input type="checkbox"/> Age appropriate
<p style="text-align: center;">Ambulation</p> <input type="checkbox"/> Independent <input type="checkbox"/> Cane <input type="checkbox"/> Walker <input type="checkbox"/> Wheelchair <input type="checkbox"/> Motorized scooter <input type="checkbox"/> Needs human assistance <input type="checkbox"/> Age-appropriate child <input type="checkbox"/> Restraint used <input type="checkbox"/> Transfer Assist	<p style="text-align: center;">Therapy</p> Check all applicable: <input type="checkbox"/> Speech therapy <input type="checkbox"/> Occupational therapy <input type="checkbox"/> Physical Therapy Duration of therapy expected:	<p style="text-align: center;">Living Arrangement</p> <input type="checkbox"/> Lives alone <input type="checkbox"/> Assisted Living <input type="checkbox"/> Lives with family/spouse <input type="checkbox"/> Senior apartment <input type="checkbox"/> Danger to live alone <input type="checkbox"/> Nursing facility	<p style="text-align: center;">Eating</p> <input type="checkbox"/> Independent <input type="checkbox"/> Assistive Devices <input type="checkbox"/> Requires Human Assistant
<p style="text-align: center;">Bathing/Grooming</p> <input type="checkbox"/> Independent <input type="checkbox"/> Has assistive devices, independent <input type="checkbox"/> Supervision or cueing needed <input type="checkbox"/> Physical assistance needed How often is assistance needed: <input type="checkbox"/> 1 - 2 X weekly <input type="checkbox"/> 3 - 4 X weekly <input type="checkbox"/> > 4 X weekly <input type="checkbox"/> Age-appropriate child	<p style="text-align: center;">Behaviors</p> <input type="checkbox"/> Noncompliant <input type="checkbox"/> Destructive or disruptive <input type="checkbox"/> Repetitive movements <input type="checkbox"/> Antisocial <input type="checkbox"/> Aggressive or self injurious <input type="checkbox"/> Anxiety <input type="checkbox"/> Depression <input type="checkbox"/> Requires 24 hour supervision <input type="checkbox"/> None	<p style="text-align: center;">Respiratory</p> <input type="checkbox"/> No issue <input type="checkbox"/> O2 use daily <input type="checkbox"/> O2 PRN <input type="checkbox"/> Trach <input type="checkbox"/> Ventilator <input type="checkbox"/> Suctioning Frequency:	<p style="text-align: center;">Skin</p> <input type="checkbox"/> Intact <input type="checkbox"/> Ulcer - stage = _____ <input type="checkbox"/> Open wound <input type="checkbox"/> Daily treatment <input type="checkbox"/> Treatment PRN <input type="checkbox"/> Home Health for wound care
<p style="text-align: center;">Tube Feedings</p> <input type="checkbox"/> Tube feeding If requires tube feedings, order:			

I attest the above information is correct. Signature of Healthcare Professional (MD, DO, ARNP, PA): _____

DATE: _____

Additional Comments:	Home services in place:
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Instructions for Certification for Level of Care Home and Community Based Services (HCBS)

- Purpose:** Form 470-4392, *Certification for Level of Care Home and Community Based Services (HCBS)*, provides a mechanism for a Medical Professional (MD/DO/ARNP/PA) to report a Medicaid member's admission, change in condition or annual assessment for level of care. Providers are encouraged to conduct the level of care process during a routine or preventative office visit. See informational letter number **XXX**
- Source:** This form is available on the DHS website under provider forms.
- Completion:** A provider (MD/DO/ARNP/PA) must complete the form when:
- Medicaid member is going to receive services provided in their home or community.
 - Medicaid member has a significant change in condition.
 - Medicaid member has an annual assessment.
- Distribution:** Providers fax / email the certification for level of care form to the IME Medical Services unit (515-725-1349) or imeltc@dhs.state.ia.us and provide a copy to the Medicaid member.
- The form may be faxed by the medical professional completing the form or by others involved in assisting in arranging the services (i.e. facility staff, hospital discharge planner, case manager or family member). The IME Medical Services unit will make a level of care determination upon receipt of the form.**
- Data:**
- Today's Date:** The actual date the form is completed. (MM/DD/YY)
- Iowa Medicaid Member Name:** The Medicaid member's first, middle initial and last name as it appears on the eligibility card.
- Social Security Number or State ID#:** The member's social security number or State ID number as it appears on the eligibility card.
- Birth date:** The Medicaid member's birth date (MM/DD/YY)
- Name, Telephone Number with Area Code:** The medical professional specific information of who is filling out the form.
- Admit to HCBS Waiver:** Contains the specific Medicaid home and community based (HCBS) waiver type.
- Diagnoses and Medications:** The member specific health information related to diagnoses and medications, Supporting documentation, H&P along with a medication list may be submitted with the form in order to complete the review.
- Level of care criteria:** **Mandatory** criterion sections. Please review each category and check all applicable criteria. Please check **all** that apply, as well as additional comments the medical professional may want/need to add.
- Signature with Title of Medical Professional MD/DO/PA/ARNP:** The signature of the medical professional completing the form.