



Iowa Department of Human Services  
**Application for Certification to Become  
a Qualified Entity (QE)**

This form is to be used by providers as an application to be certified by the Iowa Department of Human Services (DHS) as a Qualified Entity (QE) to make presumptive eligibility (PE) determinations.

**Please check an eligibility category (check all that apply)**

- Parents/Caretaker Relatives  
Individuals 19-64 years old  
Former Foster Care Children  
Children  
Pregnant Women
- Children
- Pregnant Women
- Breast & Cervical  
Cancer Treatment  
Patients

<b>Provider / Organization Name</b>		<b>Date</b>
<b>Address</b>		
<b>City</b>		<b>State / Zip</b>
<b>Telephone</b>	<b>NPI Number</b>	
<b>Contact Name</b>	<b>Contact Email</b>	
<b>Admin Name</b>	<b>Admin Email</b>	

- Please check here if you agree to receive future relevant provider information from the Iowa Medicaid Enterprise (IME) using this email address. This email address will not be given out and will not be used for any other purpose.

**Are you currently enrolled as an Iowa Medicaid provider?**

- YES       NO

**HOSPITAL GROUPS**

If you are an Iowa Medicaid enrolled hospital, you will be able to complete PE determinations for the following eligibility categories if you are certified as a QE:

- Parents and Caretaker Relatives
- Individuals 19 to 64 years old
- Former Foster Care Children under the age of 26
- Children
- Pregnant Women

**PREGNANT WOMEN**

If you are an eligible provider and if you are certified as a QE, you will be able to complete PE determinations for the eligibility category Pregnant Women.

**Please check all the appropriate boxes in order for Iowa Medicaid to determine if you can be certified as a QE for this eligibility category.**

**1. Do you provide the following services?**

- |   |     |    |
|---|-----|----|
| A. Rural health clinic services                                       | Yes | No |
| B. Clinic services furnished by or under the direction of a physician | Yes | No |

**2. Do you receive direct funds (not subcontract) under any of the following?**

- |  |     |    |
|--|-----|----|
| A. Migrant health centers (under Section 329 or 330 of the Public Health Services Act)         | Yes | No |
| B. Community health centers (under Section 329 or 330 of the Public Health Services Act)       | Yes | No |
| C. Maternal and child health centers (under Title V of the Social Security Act)                | Yes | No |
| D. Health services for urban Indians (under Title V of the Indian Health Care Improvement Act) | Yes | No |

*If yes, attach a copy of the award letter or other verification of funding.*

**3. Do you participate in any of the following programs?**

- |   |     |    |
|---|-----|----|
| A. Special Supplemental Food Programs for Women, Infants and Children (WIC) | Yes | No |
| B. Commodity Supplemental Food Program                                      | Yes | No |
| C. A state perinatal program  | Yes | No |

*If yes, attach a copy of documentation showing your agency's participation in the program.*

**4. Are you an Indian Health Service or a health program or facility operated by a tribe or tribal organization under the Indian Self Determination Act?**

- |     |    |
|-----|----|
| Yes | No |
|-----|----|

**For provider eligibility reviews only:**

If your answer to Question 1,2,3, or 4 above recently changed from Yes to No, list the service/funding/program participation that changed and the date of the change in the space provided below:

**CHILDREN**

If you are an eligible provider and if you are certified as a QE, you will be able to complete PE determinations for the eligibility category Children.

Please indicate your provider type:

Rural Health Clinics	Family Planning Centers
Local Education Agencies	Screening Centers
Maternal Health Centers	Area Education Agencies
Federally Qualified Health Centers (FQHC)	Nurse Practitioner - Advanced
Hospitals	Early Access Services Coordinators
Physicians	Indian Health Services

**BREAST & CERVICAL CANCER TREATMENT PATIENTS (BCCT)**

If you are an eligible provider and if you are certified as a QE, you will be able to complete PE determinations for the eligibility category BCCT.

1. Are you under contract with the Iowa Department of Public Health as lead agency for the Breast and Cervical Cancer Early Detection Program?

Yes                  No

If yes, please indicate which county(ies):

2. Do you have a cooperative agreement with the Iowa Department of Public Health under the Center for Disease Control and Prevention Breast and Cervical Cancer Early Detection Program to receive reimbursement for providing breast or cervical cancer screening or diagnostic services to participants in the Care for Yourself Breast and Cervical Cancer Early Detection Program?

Yes                  No

**Signature and Date** (print name and date then read and check the statement below)

By signing this document I understand that any false statement, omission or misrepresentation may result in prosecution under state and federal laws.

This form will be reviewed and a decision to approve or deny will be made. An email will be sent by IME Provider Enrollment when this process is complete to the email address listed on this form. This should take no more than 2 business days. Contact IME Provider Enrollment at 1-800-338-7909 for assistance in completing this form.

**You may fill out, print, and mail or fax the completed form to:**

Iowa Medicaid Enterprise  
 Provider Services Unit  
 PO Box 36450  
 Des Moines, IA 50315  
 Fax to (515) 725-1155  
 Email: [IMEMPEPsupport@dhs.state.ia.us](mailto:IMEMPEPsupport@dhs.state.ia.us)