



Iowa Department of Human Services

Terry E. Branstad
Governor

Kim Reynolds
Lt. Governor

Charles M. Palmer
Director

For Human Services use only:

General Letter No. 8-AP-365
Employees' Manual, Title 8
Medicaid Appendix

April 25, 2014

TARGETED CASE MANAGEMENT MANUAL TRANSMITTAL NO. 14-1

ISSUED BY: Iowa Medicaid Enterprise

SUBJECT: **TARGETED CASE MANAGEMENT MANUAL**, Title page, new; Table of Contents (page 1), new; Chapter III, *Provider-Specific Policies*, Title page, new; Table of Contents (page 1), new; pages 1 through 17, new; and the following forms:

470-4694 *Targeted Case Management Comprehensive Assessment*,
new
470-2486 *Claim for Targeted Medical Care*, revised

Summary

The **TARGETED CASE MANAGEMENT MANUAL** is revised to:

- ◆ Rename the manual from **MR/CMI/DD CASE MANAGEMENT** to **TARGETED CASE MANAGEMENT**.
- ◆ Reformat and revise the chapters on coverage and limitations and billing and payment to reflect the implementation of the Iowa Medicaid Enterprise and the reorganization of the Medicaid "All Providers" manual chapters. This includes:
 - Removing Chapter E. Information on coverage and limitations is now included in Chapter III. *Provider-Specific Policies*.
 - Removing Chapter F. Billing and payment information and forms are now included in Chapter IV. *Billing Iowa Medicaid*.
- ◆ Align with current policies, procedures, and terminology.
- ◆ Ensure that current contact information is provided.
- ◆ Within the manual, the form samples have been removed from the numbered pages and connected to the on-line manual through hypertext links. This will make sure that the most recent version of the form is accessible.

Date Effective

Upon receipt.

Material Superseded

This material replaces the entire Chapter E and Chapter F from **TARGETED CASE MANAGEMENT MANUAL**, which includes the following:

<u>Page</u>	<u>Date</u>
Title page	Undated
Contents (pages 4 and 5)	January 1, 2003
Chapter E	
1-8	January 1, 2003
Chapter F	
1	January 1, 2003
2 (470-2464)	4/90
3-12	January 1, 2003
13 (470-3956)	5/03
14-20	January 1, 2003
21, 22 (470-2486)	10/02
23	January 1, 2003
24 (470-3969)	7/03
25, 26	January 1, 2003
27 (Remittance Advice)	6/12/97
28-30	January 1, 2003
31 (470-3744)	10/02
32 (470-0040)	10/02

Additional Information

The updated provider manual containing the revised pages can be found at:
http://www.dhs.state.ia.us/policyanalysis/PolicyManualPages/Manual_Documents/Provman/casemgm.pdf

If any portion of this manual is not clear, please contact the Iowa Medicaid Enterprise Provider Services Unit at 800-338-7909 or locally (in Des Moines) at 515-256-4609, or email at imeproviderservices@dhs.state.ia.us.

Targeted Case Management

Provider Manual



Iowa Department
of Human Services



Iowa
Department
of Human
Services

Provider

Targeted Case Management

Page

1

Date

April 1, 2014

TABLE OF CONTENTS

[Chapter I. General Program Policies](#)

[Chapter II. Member Eligibility](#)

[Chapter III. Provider-Specific Policies](#)

[Chapter IV. Billing Iowa Medicaid](#)

[Appendix](#)

III. Provider-Specific Policies





TABLE OF CONTENTS

	<u>Page</u>
CHAPTER III. PROVIDER-SPECIFIC POLICIES.....	1
A. ORGANIZATIONS ELIGIBLE TO PARTICIPATE	1
B. COVERAGE OF CASE MANAGEMENT SERVICES	1
1. Eligible Members	2
a. Intellectual Disability.....	2
b. Chronic Mental Illness	3
c. Developmental Disabilities	4
d. Need for Service.....	4
e. Iowa Plan Authorization	5
f. Iowa Plan Decisions	6
2. Service Provisions.....	7
a. Assessment	7
b. Service Plan.....	8
c. Referral and Related Activities	9
d. Monitoring and Follow-Up	9
e. Contacts.....	10
3. Exclusions	11
4. Targeted Case Management, Case Management, and Integrated Health Home Overview Chart.....	12
C. BASIS OF PAYMENT.....	12
1. Targeted Case Management Billable Activities	13
a. Assessment, Social History, and Reassessment.....	13
b. Care Planning.....	13
c. Referrals and Linkage.....	14
d. Monitoring and Follow-Up	14
2. Examples of Non-Billable Activities	15
D. BILLING POLICIES AND CLAIM FORM INSTRUCTIONS	16
 APPENDIX I. Targeted Case Management, Children’s Mental Health, and Integrated Health Home Overview Chart.....	 17



CHAPTER III. PROVIDER-SPECIFIC POLICIES

A. ORGANIZATIONS ELIGIBLE TO PARTICIPATE

Targeted case management (TCM) provider organizations are eligible to participate in the Medicaid program provided that:

- ◆ They meet the standards in 441 Iowa Administrative Code (IAC) Chapter 24 (*Division I, "Core Standards for All Providers on MH/ID/DD Services,"* and *Division II, "Standards for Individual Case Management Services"*), and
- ◆ They are:
 - A county or consortium of counties, or
 - An agency or provider under subcontract to a county or consortium of counties, or
 - An agency or provider under subcontract to the Iowa Department of Human Services (DHS).

NOTE: DHS is eligible to be a case management provider organization.

B. COVERAGE OF CASE MANAGEMENT SERVICES

TCM is a service to manage multiple resources effectively for the benefit of Medicaid members. TCM services assist members in gaining access to appropriate and needed medical and interrelated social, educational, housing, transportation, vocational, and other services. The goal of targeted case management is to ensure that:

- ◆ Necessary evaluations are conducted.
- ◆ Individual services and treatment plans are developed, implemented, monitored, and modified as necessary.
- ◆ Reassessment of member needs and service provision occurs on an ongoing and regular basis (*minimum of once a year*).



1. Eligible Members

Payment will be approved for targeted case management services to:

- ◆ Medicaid members who are 18 years of age or over and have a primary diagnosis of:
 - Intellectual disability, or
 - Developmental disabilities, or
 - Chronic mental illness, unless the member is enrolled in an Integrated Health Home (IHH).
- ◆ Medicaid members under 18 years of age receiving:
 - HCBS Intellectual Disability, or
 - HCBS Children’s Mental Health (CMH) waiver services, unless the member is enrolled in an Integrated Health Home.

Residents of medical institutions are **not** eligible to receive targeted case management services, except for qualified discharge planning activities provided within 60 days of discharge.

a. Intellectual Disability

“Person with intellectual disability” means a person who meets the following three conditions:

- ◆ The person has significantly subaverage intellectual functioning, meaning an intelligence quotient (IQ) of approximately 70 or below on an individually administered IQ test, or for an infant, a clinical judgment of significantly subaverage intellectual functioning.
- ◆ The person has concurrent deficits or impairments in present adaptive functioning, that is, the person’s effectiveness in meeting the standards expected for the person’s age and cultural group. The person must have a deficit or impairment in at least two of the following areas:
 - Communication
 - Self care
 - Home living
 - Social and interpersonal skills
 - Use of community resources



- Self-direction
- Functional academic skills
- Work
- Leisure
- Health
- Safety

- ◆ The onset of this condition is before age 18.

b. Chronic Mental Illness

A person with chronic mental illness means a person who is 18 years of age or over and has a persistent mental or emotional disorder that seriously impairs the person's functioning relative to such primary aspects of daily living as personal relations, living arrangements, or employment.

People with chronic mental illness typically meet at least one of the following criteria:

- ◆ They have undergone psychiatric treatment more intensive than outpatient care more than once in a lifetime (e.g., emergency services, alternative home care, partial hospitalization, or inpatient hospitalization).
- ◆ They have experienced at least one episode of continuous, structured supportive residential care other than hospitalization.

In addition, people with chronic mental illness typically meet at least two of the following criteria on a continuing or intermittent basis for at least two years:

- ◆ They are unemployed, or employed in a sheltered setting, or have markedly limited skills and a poor work history.
- ◆ They require financial assistance for out-of-hospital maintenance and may be unable to procure this assistance without help.
- ◆ They show severe inability to establish or maintain a personal social support system.
- ◆ They require help in basic living skills.
- ◆ They exhibit inappropriate social behavior that results in demand for intervention by the mental health or judicial system.



In atypical instances, a person who varies from these criteria could still be considered to be a person with chronic mental illness. For purposes of this chapter, people with mental disorders resulting from Alzheimer's disease or substance abuse shall not be considered chronically mentally ill.

c. Developmental Disabilities

A person with developmental disabilities means a person with a severe, chronic disability which:

- ◆ Is attributable to mental or physical impairment, or a combination of mental and physical impairment.
- ◆ Is manifested before the person attains the age of 22.
- ◆ Is likely to continue indefinitely.
- ◆ Results in substantial functional limitation in three or more of the following areas of life activities:
 - Self care
 - Receptive and expressive language
 - Learning
 - Mobility
 - Self-direction
 - Capacity for independent living
 - Economic self-sufficiency
- ◆ Reflects the person's need for a combination and sequence of services which are of lifelong or extended duration.

d. Need for Service

The targeted case manager's documentation must show the initial and ongoing need for service based on evidence presented by the provider, including diagnostic reports, documentation of provision of services, and information supplied by the member and other appropriate sources. The evidence shall demonstrate that all of the following criteria are met:

- ◆ The member has a need for TCM to manage multiple resources pertaining to medical and interrelated social and education services for the benefit of the member.



- ◆ The member has functional limitations and lacks the ability to independently access and sustain involvement in necessary services.
- ◆ The member is not receiving other paid benefits under the Medicaid program or under a Medicaid managed health care plan that serve the same purpose as targeted case management.

For members in the intellectual disability or developmental disability population, the case manager documents the need for service by completing the *TCM Service Authorization Form* in ISIS.

For members in the chronic mental illness population who are **not** enrolled with an IHH, TCM services are a covered benefit under the Iowa Plan for Behavioral Health, and require preauthorization by the Iowa Plan contractor. For the chronic mental illness population who are enrolled with an IHH, targeted case management is not a covered service.

e. Iowa Plan Authorization

For members in the chronic mental illness population who are not enrolled with an IHH, the following information must be included in the member's targeted case management file and included in discussions with the Iowa Plan contractor staff. The summary of the services and providers from the case manager's service plan should be a useful resource.

The Iowa Plan contractor will review Iowa Plan documentation on TCM members before calling TCM providers. This may eliminate the need to call the targeted case manager:

- ◆ When there is a stated need for a targeted case manager to manage multiple resources pertaining to medical and interrelated social, housing, transportation, vocational, educational, and other services for the benefit of the member, documentation is needed to show:
 - That the member is accessing multiple services requiring coordination to ensure the member's stability. This includes the identities of the current service providers, or
 - That the member requires the services of a targeted case manager to engage in necessary mental health services because the member is not currently accessing services and requires close follow-up in the community.



Examples of situations where the member has functional limitation and lacks ability to independently access and sustain involvement in necessary services include:

- ◆ The member's current need and history shows poor access to needed mental health services.
- ◆ The member misses necessary medical appointments, including mental health visits.
- ◆ The member's daily life (such as eating, sleeping, thinking, mood, or self-care) is impaired due to a chronic mental illness.
- ◆ The member is not engaged in needed services, as outlined by service plan.
- ◆ The member needs assistance in becoming involved in needed services.
- ◆ The service or the treatment plan is not fully implemented (e.g., the member is not taking medications as prescribed).

f. Iowa Plan Decisions

Targeted case management providers requesting authorization from the Iowa Plan contractor will receive an authorization confirmation by mail within ten working days when the member is determined to be eligible for targeted case management.

When the request is assessed as not meeting one or more of the three criteria, the Iowa Plan contractor will send a non-authorization letter by mail within ten working days of the receipt of necessary information.

Targeted case management providers have the option to appeal the Iowa Plan contractor's non-authorization by submitting a letter requesting a Level 1 appeal by mail to the Iowa Plan contractor within 60 calendar days of the date of the non-authorization letter.

For Level 1 requests that are upheld by the Iowa Plan contractor, notification will be by mail. The targeted case management provider can request a hearing conducted by an administrative law judge. This request must be made by mail within 30 calendar days of the date of the Level 1 decision letter.

Case Management Comprehensive Assessment

Section A: Consumer Information

Consumer

Name: (First, M.I., Last)		Medicaid State ID#	Date Of Birth:
Current Address:			
County of Residence:		County of Legal Settlement:	
Home Phone:	Work Phone:	Cell Phone:	
E-mail:			

Assessor

Name:		Title:	
Agency:			
Address:			
Phone:		E-Mail:	
Signature			Date

Type of Assessment

- Initial
- Annual
- Special
- Demographic Change Only
- Discharge

Date: _____
Reason: _____

Basis of Case Management Eligibility

- CMI MR DD BI Waiver Elderly Waiver CMH Waiver Habilitation MFP

VERIFICATION OF HCBS WAIVER CONSUMER CHOICE: *Complete this section for consumers applying for HCBS Brain Injury Waiver, Children's Mental Health Waiver, Intellectual Disability Waiver.*

Home- and Community-Based Services (HCBS)

My right to choose a Home- and Community-Based program has been explained to me. I have been advised that I may choose: (1) Home- and Community-Based Services or (2) Medical Institutional Services.

I choose: HCBS Medical Institutional Services

Signature of Consumer or Guardian or Durable Power of Attorney for Health Care		Date
--	--	------

Case Management Comprehensive Assessment

Consumer Name:

Interdisciplinary team members consulted (including consumer):

Name	Title (if applicable)	Relationship to Consumer

Additional records reviewed:

Consumer Demographics

Gender: Female Male

Language:

	Yes	No
Speaks English	<input type="checkbox"/>	<input type="checkbox"/>
Understands English	<input type="checkbox"/>	<input type="checkbox"/>
Needs interpreter services	<input type="checkbox"/>	<input type="checkbox"/>
Comments:		

Monthly Income: (Please check all that apply)

Source	Amount
<input type="checkbox"/> SSI	\$
<input type="checkbox"/> SSDI	\$
<input type="checkbox"/> Employment	\$
<input type="checkbox"/> Other (specify):	\$
Comments:	

Court Involvement:

<input type="checkbox"/> Involuntary Commitment <input type="checkbox"/> Probation or Parole <input type="checkbox"/> Child in Need of Assistance (CINA) <input type="checkbox"/> Child Protection <input type="checkbox"/> Delinquency <input type="checkbox"/> Foster Care <input type="checkbox"/> Other (Identify) <input type="checkbox"/> None
Comments:

Case Management Comprehensive Assessment

Consumer Name:

Legal decision maker: (Please check all that apply)

None Guardian Attorney-in-fact Other (Specify):

Name: (First, M.I., Last)		
Address:		
Home Phone:	Work Phone:	Cell Phone:
E-mail:		

Co-Decision Maker (if applicable):

Guardian Attorney-in-fact Other (Specify):

Name: (First, M.I., Last)		
Address:		
Home Phone:	Work Phone:	Cell Phone:
E-mail:		

Financial Decision Maker: (e.g. Conservator or Attorney-in-fact) No Yes (complete below)

Name: (First, M.I., Last)		
Address:		
Home Phone:	Work Phone:	Cell Phone:
E-mail:		

Payee: No Yes (complete below)

Name: (First, M.I., Last)		
Address:		
Home Phone:	Work Phone:	Cell Phone:
E-mail:		

Emergency Contacts:

Primary Contact

Name: (First, M.I., Last)	Relationship:	
Address:		
Home Phone:	Work Phone:	Cell Phone:
E-mail:		

Case Management Comprehensive Assessment

Consumer Name:

Secondary Contact (if applicable):

Name: (First, M.I., Last)		Relationship:
Address:		
Home Phone:	Work Phone:	Cell Phone:
E-mail:		

Complete This Section For Adults (Age 18 and Over)

Veteran: Yes No

Marital Status:

- Never Married
- Married
- Divorced
- Legally Separated
- Widowed
- Unknown or Other – Specify

Spouse's Name:

Comments:

Complete This Section For Children (Age 17 and Under)

With whom does the child live?

(If the child currently lives in a institutional setting, please make note in the comments section below.)

What are the child's parent's names?

Parents marital status: Married Divorced Never married

If the parent's are not living together, what is the non-custodial parent's name and address?

Name:

Street:

City, State, Zip:

Parent's contact information (if different from the child's):

Home Phone:

Work Phone:

Cell Phone:

E-Mail:

Are there siblings in the home? Yes No

Are any siblings receiving waiver services? Yes No

Are there any individuals who are not supposed to have contact with the child? Yes No

If yes, specify:

Other Comments:

Case Management Comprehensive Assessment

Consumer Name:

Medical Information

Diagnoses:

Medical:

Diagnosis	
Name and credential of professional making diagnosis:	Date of diagnosis:
Comments:	

Mental Health (DSM-IV-TR)

Axis 1:	
Axis 2:	
Axis 3:	
Axis 4:	
Axis 5:	
Name and credential of professional making diagnosis:	Date of diagnosis:
Comments:	

Complete this section for consumers applying for or receiving HCBS Intellectual Disability Waiver.

List the most current IQ score, or if the IQ isn't listed, give the consumer's level of functioning within the range of mental retardation (mild, moderate, severe, profound):

IQ: _____ Range: _____ Date of Evaluation: _____

Complete this section for consumers applying for or receiving HCBS Brain Injury Waiver.

Diagnosis: _____ Date Injury Occurred: _____

Health Care Provider Information:

Who is your regular doctor? None

Name	Address	Phone
Date of last visit (if known):	Reason:	

Who is your regular dentist? None

Name	Address	Phone
Date of last visit (if known):	Reason:	

Are you seeing any other doctors, such as a psychiatrist, or specialists of any kind?

Yes (list below) No Don't know

Name	Specialty	Address	Phone

Case Management Comprehensive Assessment

Section B: Medical and Physical Health

Health Conditions

B1. Overall, how would you rate your physical health?

<input type="checkbox"/> Excellent	<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor	<input type="checkbox"/> No Response
Comments:				

B2. Do you have any health problems that require assistance to manage?

<input type="checkbox"/>	Cardiac
<input type="checkbox"/>	Skin Related
<input type="checkbox"/>	G.I. Disorders
<input type="checkbox"/>	Urinary Tract
<input type="checkbox"/>	Weight problems
<input type="checkbox"/>	Evidence of communicable disease
<input type="checkbox"/>	Other – Specify
<input type="checkbox"/>	None
How do they affect you and how long have you had them?	
Comments:	

B3. Any respiratory problems that require assistance to manage?

<input type="checkbox"/>	Ventilator
<input type="checkbox"/>	Oxygen
<input type="checkbox"/>	Suctioning
<input type="checkbox"/>	Tracheotomy
<input type="checkbox"/>	Cardiorespiratory monitor
<input type="checkbox"/>	Chest physiotherapy
<input type="checkbox"/>	Nebulizer treatment
<input type="checkbox"/>	Other – Specify
<input type="checkbox"/>	None
How do they affect you and how long have you had them?	
Comments:	

B4. Do you regularly receive any of the following medical treatments?

			Days per week	Hours per day
Nursing	<input type="checkbox"/> no	<input type="checkbox"/> yes		
Physical Therapy	<input type="checkbox"/> no	<input type="checkbox"/> yes		
Occupational Therapy	<input type="checkbox"/> no	<input type="checkbox"/> yes		
Speech Therapy	<input type="checkbox"/> no	<input type="checkbox"/> yes		
Supervision for Safety	<input type="checkbox"/> no	<input type="checkbox"/> yes		
Diabetes Education	<input type="checkbox"/> no	<input type="checkbox"/> yes		
Dialysis	<input type="checkbox"/> no	<input type="checkbox"/> yes		
Respiratory Treatment	<input type="checkbox"/> no	<input type="checkbox"/> yes		
Catheter Care	<input type="checkbox"/> no	<input type="checkbox"/> yes		
Colostomy Care	<input type="checkbox"/> no	<input type="checkbox"/> yes		
Nasogastric Tube Care	<input type="checkbox"/> no	<input type="checkbox"/> yes		
Other	<input type="checkbox"/> no	<input type="checkbox"/> yes		

Case Management Comprehensive Assessment

Consumer Name:

B5. Hearing

- No hearing impairment.
- Hearing impairment, but managed through assistive devices
- Hearing difficulty at level of conversation.
- Hears only very loud sounds.
- No useful hearing.
- Not determined.

Comments:

B6. Vision

- Has no impairment of vision.
- Vision impairment, but managed through assistive devices
- Has difficulty seeing at level of print (far-sighted).
- Has difficulty seeing obstacles in environment (near-sighted).
- Has no useful vision.
- Not determined.

Comments:

B7. Speech/Communication

- Communicates independently or impairment has been compensated to function independently.
- Communicates with difficulty but can be understood.
- Communicates with sign language, symbol board, written messages, gestures or an interpreter.
- Communicates inappropriate content, makes garbled sounds, or displays echolalia.
- Does not communicate.

Comments:

B8. Sensory Perception (e.g. – taste, smell, tactile, spatial)

- No impairment
- Impaired – Specify

Comments:

B9. Cognitive Status

- Alert and fully oriented
- Alert and oriented with significant alteration on self-concept/mood
- Generally oriented through use of assistive techniques
- Cognitive deficits (e.g. orientation, attention/concentration, perception, memory, reasoning)
- Exhibits mental status changes consistent with psychiatric disorder
- Comatose, but responsive
- Comatose, but unresponsive
- Other – Specify

Comments:

B10. Musculoskeletal/Fine or Gross Motor Skills

- No Impairment of Musculoskeletal/Fine or Gross Motor Skills
- Impaired muscle tone
- Contractures
- Scoliosis
- Paralysis: Hemiplegia Paraplegia Quadriplegia Other (Specify)

Comments:

Case Management Comprehensive Assessment

Consumer Name:

Complete This Section For Adults (Age 18 and Over)

B11. Do you have someone who could stay with you for a while if you were sick or needed help?

Yes (Complete below) No

Name:

Relationship:

Address:

City, State, Zip code:

Phone:

B12. Is there anybody you would **not** want to be involved with your care if you were sick or needed help?

Yes (Complete below) No

Name:

Relationship:

HEALTH CONDITIONS RISK FACTORS	YES	NO
R1. Has the consumer had a seizure in the past year?	<input type="checkbox"/>	<input type="checkbox"/>
R2. Does the consumer have a diagnosis of any other serious medical conditions or other serious health concerns (i.e., diabetes, cerebral palsy, heart condition, etc.)? If yes, list all conditions/concerns:	<input type="checkbox"/>	<input type="checkbox"/>
R3. Does the consumer have any life threatening allergies (such as peanuts, bee stings, or shellfish)?	<input type="checkbox"/>	<input type="checkbox"/>
R4. Is the consumer in need of a primary health care provider (or the provider's contact information is unknown)?	<input type="checkbox"/>	<input type="checkbox"/>
R5. Is the consumer in need of a dentist (or dentist's contact information is unknown)?	<input type="checkbox"/>	<input type="checkbox"/>
R6. Is the consumer in need of a specialist (or the specialist's contact information is unknown)?	<input type="checkbox"/>	<input type="checkbox"/>
R7. Has the consumer had difficulty making, keeping, or following through with appointments in the last year?	<input type="checkbox"/>	<input type="checkbox"/>
R8. In the past year, has the consumer gone to a hospital emergency room? If yes, how many times? Why?	<input type="checkbox"/>	<input type="checkbox"/>
R9. In the past year, has the consumer stayed overnight or longer in a hospital? If yes, how many times? Why?	<input type="checkbox"/>	<input type="checkbox"/>
R10. Is the consumer in need of someone to help if he or she was sick or injured?	<input type="checkbox"/>	<input type="checkbox"/>
Comment on any risk factors marked as "Yes" and address the issue in the Crisis Intervention Plan. Comments:	No. of risks:	

Case Management Comprehensive Assessment

Consumer Name:

Assistive Devices/Special Equipment

B19. Do you use (or need) any of the following special equipment or aids? None

(If a consumer doesn't have an item but needs it, mark the "Needs" box)

Uses	Needs		Uses	Needs	
<input type="checkbox"/>	<input type="checkbox"/>	Dentures	<input type="checkbox"/>	<input type="checkbox"/>	Hospital bed
<input type="checkbox"/>	<input type="checkbox"/>	Cane	<input type="checkbox"/>	<input type="checkbox"/>	Medical phone alert
<input type="checkbox"/>	<input type="checkbox"/>	Walker	<input type="checkbox"/>	<input type="checkbox"/>	Supplies, e.g. Incontinence pads
<input type="checkbox"/>	<input type="checkbox"/>	Wheelchair (manual, electric)	<input type="checkbox"/>	<input type="checkbox"/>	Bedside commode
<input type="checkbox"/>	<input type="checkbox"/>	Brace (leg, back)	<input type="checkbox"/>	<input type="checkbox"/>	Bathing equipment
<input type="checkbox"/>	<input type="checkbox"/>	Helmet	<input type="checkbox"/>	<input type="checkbox"/>	Lift chair
<input type="checkbox"/>	<input type="checkbox"/>	Communication Devices	<input type="checkbox"/>	<input type="checkbox"/>	Transfer equipment
<input type="checkbox"/>	<input type="checkbox"/>	Hearing aid	<input type="checkbox"/>	<input type="checkbox"/>	Adaptive eating equipment
<input type="checkbox"/>	<input type="checkbox"/>	Glasses/contact lenses	<input type="checkbox"/>	<input type="checkbox"/>	Harness/gait belt
<input type="checkbox"/>	<input type="checkbox"/>	Weighted blankets or vest	<input type="checkbox"/>	<input type="checkbox"/>	Other (Specify):

Comments:

ASSISTIVE DEVICES RISK FACTORS	YES		NO	
	3	2	1	0
3 = Frequently 2 = Sometimes 1 = Rarely 0 = Never				
R24. Is the consumer in need of assistance with adaptive equipment (need it purchased, need training, need repairs, etc.)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
R25. Would a power outage interfere with the consumer's necessary adaptive equipment?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Comment on any risk factors marked as "Yes" and address the issue in the Crisis Intervention Plan. Comments:	No. of risks:			

Nutrition

B20. How is your appetite?

<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor

Comments:

B21. Has there been an unexplained weight loss or weight gain in the past year?

<input type="checkbox"/> Yes (specify in comments) <input type="checkbox"/> No

Comments:

B22. Are there health concerns related to your nutrition?

<input type="checkbox"/> Yes (specify in comments) <input type="checkbox"/> No

Comments:

Case Management Comprehensive Assessment

Consumer Name:

B23. Do you have a diagnosed eating disorder (such as overeating, purging, hoarding food)?

- Yes (specify in comments)
 No

ASSESSOR: If no, does the consumer's behavior indicate a possible eating disorder or suggest the need for further evaluation?

- Yes (specify in comments)
 No

Comments:

B24. Do you have any problems that make it difficult to eat? Yes (complete below) No

<input type="checkbox"/> Dental problems	<input type="checkbox"/> Can't eat certain foods
<input type="checkbox"/> Swallowing problems	<input type="checkbox"/> Problem with gag reflex
<input type="checkbox"/> Texture Aversions	<input type="checkbox"/> Sensitive stomach/nausea
<input type="checkbox"/> Taste problems	<input type="checkbox"/> Tube feeding (some or all of the time)
<input type="checkbox"/> Any other eating problems? (Describe)	

Comments:

B25. Are you on a special diet: Yes (complete below) No

<input type="checkbox"/> Low salt	<input type="checkbox"/> Calorie supplement
<input type="checkbox"/> Low fat	<input type="checkbox"/> Gluten Free
<input type="checkbox"/> Low sugar	<input type="checkbox"/> Milk/lactose free
<input type="checkbox"/> Weight Loss	<input type="checkbox"/> Altered Consistency
<input type="checkbox"/> Other special diet? (Describe)	

Comments:

NUTRITION RISK FACTORS 3 = Frequently 2 = Sometimes 1 = Rarely 0 = Never	YES		NO	
	3	2	1	0
R26. Is the consumer at risk of choking or other problems when eating?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
R27. Is the consumer's health at risk due to poor nutrition (e.g.- eating disorder, refusal to eat, inability to afford nutritious food, etc.)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
R28. Is the consumer (or the caretaker) ever non-compliant with the prescribed diet?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
R29. Would the consumer's health be at risk if his or her diet is not strictly followed?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Comment on any risk factors marked as "Yes" and address the issue in the Crisis Intervention Plan. Comments:	No. of risks:			

Case Management Comprehensive Assessment

Consumer Name:

Daily Living Skills

B26. Daily Living Skills

Activity	Independent	Supervision or Verbal Prompts/Cueing	Physical Assistance	Total Dependence	Frequency	
					Daily	Intermittent
a. Eating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Grooming & personal hygiene	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Bathing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Dressing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Mobility in bed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Transferring	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. Walking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. Stair climbing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i. Mobility with wheelchair	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Comments (note use of assistive devices or adaptive equipment needed to demonstrate skill):

B27. Toilet Use

<input type="checkbox"/> Continent – Bowel and bladder <input type="checkbox"/> Continent with verbal or physical prompts <input type="checkbox"/> Continent except for specified periods of time (e.g. enuresis) <input type="checkbox"/> Incontinent – bladder <input type="checkbox"/> Incontinent – bowel <input type="checkbox"/> Catheter or -ostomy (e.g. suprapubic catheter, colostomy, ileostomy) <input type="checkbox"/> Inappropriate toileting habits (e.g. fails to close door, use toilet paper, or wash hands, etc.)
Comments:

DAILY LIVING SKILLS RISK FACTORS	YES		NO	
	3	2	1	0
3 = Frequently 2 = Sometimes 1 = Rarely 0 = Never				
R30. Is the consumer's health at risk due to poor hygiene?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
R31. Is the consumer at risk for falling? In the past year has the consumer fractured a bone? If yes, how did this occur?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
R32. Is the consumer at risk of being dropped or injured during transfer?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Comment on any risk factors marked as "Yes" and address the issue in the Crisis Intervention Plan. Comments:	No. of risks:			

Case Management Comprehensive Assessment

Consumer Name:

Consumer Needs, Wants, and Desired Results Related to Medical and Physical Health
<p>What are your strengths and abilities related to your medical and physical health?</p> <p><i>ASSESSOR:</i> List any other strengths and abilities not mentioned by the consumer or guardian:</p> <p>Do you have any other needs related to your medical and physical health that haven't been addressed above?</p> <p><i>ASSESSOR:</i> List any other needs related to medical and physical health not mentioned by the consumer or guardian.</p> <p>Do you have any wants related to your medical and physical health?</p> <p>What are your desired results related to your medical and physical health?</p>

Case Management Comprehensive Assessment

Section C: Mental Health, Behavioral & Substance Use

Emotional and Mental Health

C1. Have you ever been diagnosed with a mental illness?

<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, what is it?

C2. Have you received mental health services in the past?

<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, describe:

C3. Are you currently receiving any mental health services or counseling?

<input type="checkbox"/> Yes (If yes, complete below) <input type="checkbox"/> No	
Provider Name and Address	Comments

C4. Emotional Assessment. How have you been feeling during the past month?

	Yes	No
Are you satisfied with your life today?	<input type="checkbox"/>	<input type="checkbox"/>
Have you been depressed or very unhappy?	<input type="checkbox"/>	<input type="checkbox"/>
Have you been feeling like you have too much energy or can't stop being busy?	<input type="checkbox"/>	<input type="checkbox"/>
Have you been anxious?	<input type="checkbox"/>	<input type="checkbox"/>
Have you had mood swings?	<input type="checkbox"/>	<input type="checkbox"/>
Have you had difficulty sleeping?	<input type="checkbox"/>	<input type="checkbox"/>
Have you felt unmotivated or felt a lack of energy?	<input type="checkbox"/>	<input type="checkbox"/>
Have you felt lonely or isolated?	<input type="checkbox"/>	<input type="checkbox"/>
Comments:		

C5. ASSESSOR: Other mental health symptoms.

	Yes	No
Has the consumer had hallucinations (seen or heard things that weren't really there)?	<input type="checkbox"/>	<input type="checkbox"/>
Has the consumer reported feelings of paranoia?	<input type="checkbox"/>	<input type="checkbox"/>
Has the consumer had delusions (irrational thoughts that weren't true)?	<input type="checkbox"/>	<input type="checkbox"/>
Comments:		

Case Management Comprehensive Assessment

Consumer Name:

Complete This Section For Children (Age 17 and Under)

C6. Has the child experienced difficulty in interpersonal relationships within the family?

Yes No

Comments:

C7. Does the parent/guardian exhibit mental health related concerns?

Yes No

If yes, is he/she currently receiving treatment and following through with treatment?

Yes No

Comments:

Behavioral

C8. **ASSESSOR:** Behavioral Assessment.

Behavioral Issue	Does not exhibit	Has been modified to socially acceptable levels	May require verbal or physical intervention
Has episodes of disorientation, being withdrawn, or similar behaviors	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Noncompliance with rules or directions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Physically abusive to self	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Verbally aggressive toward others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Physically aggressive toward others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Exhibits disruptive behavior (e.g. arguing, shouting, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Exhibits destructive behavior (e.g. destroying property, burning, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Exhibits stereotypical, repetitive behavior (e.g. rocking, twirling fingers or objects, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Obsessive/compulsive behavior	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Antisocial behavior (e.g. lying, stealing, inappropriate touching, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Wanders into private areas, or habitually elopes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Acts in a sexually inappropriate or aggressive manner	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Engages in excessive liquid consumption	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Comments:			

Alcohol/Tobacco/Substance Use

C9. Do you drink any alcoholic beverages?

Yes

No

If yes, on average, counting beer, wine, and other alcoholic beverages, how many drinks do you have each day?

Comments:

C10. Do you smoke or use tobacco?

Yes

No

If yes, how much and how often? (*frequency per day*)

Comments:

C11. Has tobacco use caused you any problems?

Yes

No

If yes, please describe:

Comments:

Case Management Comprehensive Assessment

Consumer Name:

C12. Do you use any other illegal substances such as marijuana, cocaine, or amphetamines?

<input type="checkbox"/> Yes
<input type="checkbox"/> No
If yes, specify:
Comments:

C13. Are the people who are involved in your life (spouse, parents/guardian, friends, etc.) concerned about your alcohol/tobacco/substance use?

<input type="checkbox"/> Yes
<input type="checkbox"/> No
If yes, explain:
Comments:

C14. Do you live with or spend time with a person that has alcohol/substance abuse concerns, including misuse of prescription medication? (For children, this includes the parent/guardian)

<input type="checkbox"/> Yes
<input type="checkbox"/> No
If yes, specify:
Comments:

C15. ASSESSOR: Does the person need education about substance use/abuse?

<input type="checkbox"/> Yes
<input type="checkbox"/> No
If yes, please describe:
Comments:

C16. ASSESSOR: Are you concerned about the person's alcohol/tobacco/substance use?

<input type="checkbox"/> Yes
<input type="checkbox"/> No
Comments:

MENTAL HEALTH/BEHAVIORAL/SUBSTANCE USE RISK FACTORS	YES		NO	
	3	2	1	0
<small>3 = Within the last 6 months 2 = Within the last year 1 = more than 1 year ago 0 = Never</small>				
R33. Has the consumer ingested foreign objects or been diagnosed with PICA?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
R34. Has alcohol use caused the consumer any problems?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
R35. Has substance use caused the consumer any problems?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
R36. Has the consumer engaged in self-injurious behaviors?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
R37. Has the consumer left or attempted to leave home or other supervised activities without permission, or when it would be unsafe to do so?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
R38. Has the consumer been aggressive toward others?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
R39. Has the consumer used weapons or objects to hurt self or others? <i>(If 3 or 2, assure that referral has been made to a qualified mental health professional)</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
R40. Has the consumer threatened suicide or made suicidal gestures? <i>(If 3 or 2, assure that referral has been made to a qualified mental health professional)</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Case Management Comprehensive Assessment

Consumer Name:

MENTAL HEALTH/BEHAVIORAL/SUBSTANCE USE RISK FACTORS <small>3 = Within the last 6 months 2 = Within the last year 1 = more than 1 year ago 0 = Never</small>	YES		NO	
	3	2	1	0
R41. Has the consumer attempted suicide? <i>(If 3 or 2, assure that referral has been made to a qualified mental health professional)</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
R42. Has the consumer engaged in criminal behavior?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
R43. Has the consumer had a significant life change or event occur?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
R44. Does the consumer have a history of other life-threatening behaviors? Specify:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Comment on any risk factors marked as "Yes" and address the issue in the Crisis Intervention Plan. Comments:	No. of risks:			

C17. **ASSESSOR:** In your opinion would this person benefit from a:

<input type="checkbox"/> Mental health referral
<input type="checkbox"/> Mental health evaluation
<input type="checkbox"/> Substance abuse referral
<input type="checkbox"/> Substance abuse evaluation
<input type="checkbox"/> Referral for a behavioral assessment
<input type="checkbox"/> Other (specify):
<input type="checkbox"/> None
Comments:

Consumer Needs, Wants, and Desired Results Related to Mental Health, Behavior, or Substance Abuse
What are your strengths and abilities related to mental health, behavior, or substance abuse? ASSESSOR: List any other strengths and abilities not mentioned by the consumer or guardian: Do you have any other needs related to mental health, behavior, or substance abuse that haven't been addressed above? ASSESSOR: List any other needs related to mental health, behavior, or substance abuse not mentioned by the consumer or guardian. Do you have any wants related to mental health, behavior, or substance abuse? What are your desired results related to mental health, behavior, or substance abuse?

Case Management Comprehensive Assessment

Section D: Housing and Environment

D1. What is your current housing type?

<input type="checkbox"/> Own Home (includes parent/guardian's home for children) <input type="checkbox"/> Friend/Relative Home <input type="checkbox"/> Foster Care <input type="checkbox"/> RB-SCL <input type="checkbox"/> RCF <input type="checkbox"/> RCF-PMI <input type="checkbox"/> RCF-MR <input type="checkbox"/> ICF-MR <input type="checkbox"/> ICF/Nursing Facility <input type="checkbox"/> MHI <input type="checkbox"/> Skilled Nursing Facility <input type="checkbox"/> Homeless <input type="checkbox"/> Jail <input type="checkbox"/> Other (specify):
Comments:

D2. What is your current living arrangement?

<input type="checkbox"/> Living Alone <input type="checkbox"/> Living with Family/Friend <input type="checkbox"/> Living with Spouse/Significant Other <input type="checkbox"/> Living with Parents <input type="checkbox"/> Living in Congregate Setting <input type="checkbox"/> Other (specify):
Comments:

D3. Would you like to continue to live where you do now, or is there somewhere else you would prefer to live?

<input type="checkbox"/> Continue to live here <input type="checkbox"/> Don't know <input type="checkbox"/> Prefer to live elsewhere (Specify and briefly describe the barriers, if any:)
Comments:

D4. Is there someone who regularly helps you care for your home or yourself, or who regularly helps with errands or other things? (For children, do NOT include the parent/guardian, but do include others who assist the parent/guardian.)

<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, how often?
Caregiver's Name:

D5. Do you have any home modifications? Check all that apply:

<input type="checkbox"/> Safe Room	<input type="checkbox"/> Shatter Proof Windows
<input type="checkbox"/> Door/Window Alarms	<input type="checkbox"/> Fenced yard
<input type="checkbox"/> Wheelchair Ramp	<input type="checkbox"/> None
<input type="checkbox"/> Other (specify):	
Are any home modifications needed?	
<input type="checkbox"/> Yes (specify):	
<input type="checkbox"/> No	

Case Management Comprehensive Assessment

Consumer Name:

Complete This Section For Children (Age 17 and Under)

(If the child is currently living in a institutional setting, skip questions D6 through D9 and not the living situation in the comment section below.)

D6. Does the family with whom the child is residing have a stable housing situation? Yes No
If not, does the family need assistance in identifying additional resources?

D7. Does the parent/guardian have a physical disability that impairs his/her ability to meet the child's needs? Yes No
If yes, what have the parents done to ensure the child's needs are being met consistently?

D8. Does the family have adequate financial resources? Yes No
If not, does the family need assistance in identifying additional resources?

D9. Does the child have his or her own money? Yes No
Where does it come from?

Other Comments:

Independent Living Skills

D10. How well can you prepare meals for yourself? (Meals may include sandwiches, pre-cooked meals and TV dinners.)

- Need no help or supervision
- Need some help or occasional supervision
- Need a lot of help or constant supervision
- Can't do it at all

Comments:

D11. Do you know your telephone number?

<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A
------------------------------	-----------------------------	------------------------------

D12. Do you know your address?

<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A
------------------------------	-----------------------------	------------------------------

D13. ASSESSOR: Can this consumer be left without supervision?

<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A
------------------------------	-----------------------------	------------------------------

If yes, for how long?

D14. How well are you able to answer the telephone?

- Need no help or supervision
- Need some help or occasional supervision
- Need a lot of help or constant supervision
- Can't do it at all

Comments:

D15. How well are you able to make a telephone call?

- Need no help or supervision
- Need some help or occasional supervision
- Need a lot of help or constant supervision
- Can't do it at all

Comments:

Case Management Comprehensive Assessment

Consumer Name:

D16. How well can you handle your own money? (understands use of money, can pay for things, can pay bills, can balance the checkbook, etc. as appropriate for age)

- Need no help or supervision
- Need some help or occasional supervision
- Need a lot of help or constant supervision
- Can't do it at all

Comments:

D17. How well can you manage shopping for food and other things you need?

- Need no help or supervision
- Need some help or occasional supervision
- Need a lot of help or constant supervision
- Can't do it at all

Comments:

Complete This Section For Adults (Age 18 and Over)

D18. How well can you manage to do light housekeeping, like dusting or sweeping?

- Need no help or supervision
- Need some help or occasional supervision
- Need a lot of help or constant supervision
- Can't do it at all

Comments:

D19. How well can you do heavy housekeeping, like yard work, or emptying the garbage?

- Need no help or supervision
- Need some help or occasional supervision
- Need a lot of help or constant supervision
- Can't do it at all

Comments:

D20. How well can you do your own laundry, including putting clothes in the washer or dryer, starting and stopping the machine, and drying the clothes?

- Need no help or supervision
- Need some help or occasional supervision
- Need a lot of help or constant supervision
- Can't do it at all

Comments:

D21. *ASSESSOR*: Does the consumer have deficits that pose a threat to his/her ability to live in the community?

- Yes
- No
- Unsure

Case Management Comprehensive Assessment

Consumer Name: _____

Complete This Section For Children (Age 17 and Under)

D22. Does the child do chores? Yes No
If yes, what are they?

How independent is the child in completing chores?

- Need no help or supervision
- Need some help or occasional supervision
- Need a lot of help or constant supervision
- Can't do it at all

Comments:

HOUSING AND ENVIRONMENTAL SAFETY RISK FACTORS	Yes	No		
R45. Would this consumer's health be at risk if a paid provider or natural support person did not show up to provide scheduled services?	<input type="checkbox"/>	<input type="checkbox"/>		
R46. Is the consumer at risk at home because of any of these conditions:				
structural damage	<input type="checkbox"/>	<input type="checkbox"/>		
barriers to accessibility (steps, etc.)	<input type="checkbox"/>	<input type="checkbox"/>		
electrical hazards	<input type="checkbox"/>	<input type="checkbox"/>		
signs of careless smoking	<input type="checkbox"/>	<input type="checkbox"/>		
insects or pests	<input type="checkbox"/>	<input type="checkbox"/>		
poor lighting	<input type="checkbox"/>	<input type="checkbox"/>		
insufficient water or no hot water	<input type="checkbox"/>	<input type="checkbox"/>		
insufficient heat	<input type="checkbox"/>	<input type="checkbox"/>		
fire hazards	<input type="checkbox"/>	<input type="checkbox"/>		
tripping hazards	<input type="checkbox"/>	<input type="checkbox"/>		
unsanitary conditions	<input type="checkbox"/>	<input type="checkbox"/>		
R47. Does the consumer need to be supervised at all times?	<input type="checkbox"/>	<input type="checkbox"/>		
R48. Is the consumer without means of communication (no phone or PERS)?	<input type="checkbox"/>	<input type="checkbox"/>		
For the following items use: 3 = Frequently 2 = Sometimes 1 = Rarely 0 = Never				
R49. Is the consumer unable to respond to emergencies independently? If consumer is never left alone, mark not applicable: <input type="checkbox"/> N/A	3	2	1	0
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
R50. Is the consumer physically stronger than any of his/her caregivers?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
R51. Does the consumer lack awareness of dangerous/emergency situations?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
R52. Does the consumer put him/herself in danger due to careless or risky behaviors (careless smoking, leaving doors unlocked, etc.)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
R53. Is the consumer isolated (lack of transportation, lack of social network)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
R54. Is the consumer's neighborhood unsafe (high risk of crime, etc.)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
R55. Is the consumer at risk in the community due to unsafe behaviors?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Comment on any risk factors marked as "Yes" and address the issue in the Crisis Intervention Plan. Comments:	No. of risks:			

Case Management Comprehensive Assessment

Consumer Name:

Abuse/Neglect

D23. **ASSESSOR:** Does the consumer have a history of incidents that have resulted in injury or threat of injury in the past year?
(Consult incident reports as necessary)

<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, are the causes of the incidents covered in the Crisis Intervention Plan? <input type="checkbox"/> Yes <input type="checkbox"/> No (specify why not):

ABUSE/NEGLECT RISK FACTORS	YES		NO	
	3	2	1	0
3 = Within the last 6 months 2 = Within the last year 1 = more than 1 year ago 0 = Never				
R56. Has the consumer been physically abused?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
R57. Has the consumer been sexually abused?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
R58. Has the consumer been emotionally or psychologically abused?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
R59. Is there evidence of neglect to the consumer by a caregiver?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
R60. Is there evidence of neglect by the consumer (self neglect)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
R61. Has the consumer been denied basic necessities?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
R62. Has the consumer witnessed abuse or neglect of another person, including domestic violence?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
R63. Would the consumer be an "easy target"?	<input type="checkbox"/>		<input type="checkbox"/>	
Comment on any risk factors marked as "Yes" and address the issue in the Crisis Intervention Plan. Comments:	No. of risks:			

Consumer Needs, Wants, and Desired Results Related to Housing and Environment
<p>What are your strengths and abilities related to your housing and environment?</p> <p><i>ASSESSOR:</i> List any other strengths and abilities not mentioned by the consumer or guardian:</p> <p>Do you have any other needs related to your housing and environment that haven't been addressed above?</p> <p><i>ASSESSOR:</i> List any other needs related to housing and environment not mentioned by the consumer or guardian.</p> <p>Do you have any wants related to your housing and environment?</p> <p>What are your desired results related to your housing and environment?</p>

Case Management Comprehensive Assessment

Section E: Social

E1. Do you feel you need help with social skills?

- Yes
 No

Comments:

E2. What is a typical day like for you? (or ask: What do you usually do, starting from the morning?)

What, if anything, would you change about your typical day?

Comments:

E3. What activities or things do you enjoy doing?

Are there activities you enjoy that you would like to do more frequently?

- Yes
 No

If yes, what are they?

Is anything needed to support or help you to do these activities?

- Yes
 No

If yes, what?

Comments:

E4. If you choose to practice a religion, are able to attend as often as desired?

- Yes (Specify where):
 No
 N/A

Comments:

E5. ASSESSOR: Does the consumer have knowledge or self-concept of his or her own sexuality appropriate to age level?

- Yes
 No

Comments:

E6. Do you communicate with friends, relatives, or others (not including paid helpers) as often as you would want?

- Yes
 No

By what means (phone, email, etc)? How Often?

Comments:

Case Management Comprehensive Assessment

Consumer Name:

Complete This Section For Adults (Age 18 and Over)

E7. Do you spend time with others who do not live with you as often as you would want?

Yes No

Comments:

E8. Do you have someone to confide in when you have a problem?

Yes No

If yes, specify name and relationship:

Complete This Section For Children (Age 17 and Under)

E9. Who are your friends?

E10. What do you like to do with them?

E11. Where do you see your friends?

E12. Do you and your parents agree on your choice of friends?

Yes No

If no, why not?

Consumer Needs, Wants, and Desired Results Related to Social Functioning

What are your strengths and abilities related to your social functioning?

ASSESSOR: List any other strengths and abilities not mentioned by the consumer or guardian:

Do you have any other needs related to your social functioning that haven't been addressed above?

ASSESSOR: List any other needs related to social functioning not mentioned by the consumer or guardian.

Do you have any wants related to your social functioning?

What are your desired results related to your social functioning?

Case Management Comprehensive Assessment

Section F: Transportation

F1. Do you need help with transportation?

- Yes
 No

If yes, when and where:

F2. How do you get to the places you want to go? (Check all that apply).

- Walk
 Bicycle
 Drive
 Take a bus or taxi
 Friend or family member drives
 Staff/Provider
 Other:

Comments:

F3. How well are you able to use public transportation or drive to places beyond walking distance?

- Need no help or supervision
 Need some help or occasional supervision
 Need a lot of help or constant supervision
 Not Available
 Can't do it at all

Comments:

F4. Are there any vehicle modifications needed?

- Yes
 No

If yes, specify:

Comments:

Consumer Needs, Wants, and Desired Results Related to Transportation

What are your strengths and abilities related to transportation?

ASSESSOR: List any other strengths and abilities not mentioned by the consumer or guardian:

Do you have any other needs related to transportation that haven't been addressed above?

ASSESSOR: List any other needs related to transportation not mentioned by the consumer or guardian.

Do you have any wants related to transportation?

What are your desired results related to transportation?

Case Management Comprehensive Assessment

Section G: Education

G1. Are you currently in school?

<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, specify where: If no, and the consumer is a child, why not?
Comments:

G2. If in school, are you involved in any extra-curricular activities?

<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A If yes, specify:
Comments:

G3. ASSESSOR: Is the consumer able to:

	Yes	No	Comments
Read?	<input type="checkbox"/>	<input type="checkbox"/>	
Write?	<input type="checkbox"/>	<input type="checkbox"/>	
Sign his/her name?	<input type="checkbox"/>	<input type="checkbox"/>	

G4. Are you interested in furthering your education?

<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what area do you want to further your education in?
Comments:

G5. Do you need assistance or support in gaining access to educational services?

<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please specify what type of assistance is needed:
Comments:

G6. ASSESSOR: Does the consumer have any intellectual or cognitive difficulties?

<input type="checkbox"/> No intellectual problems
<input type="checkbox"/> Has difficulties but is able to function with minimal assistance or adaptive devices
<input type="checkbox"/> Has intellectual problems requiring verbal or physical assistance (check all that apply): <ul style="list-style-type: none"> <input type="checkbox"/> Difficulty with or unable to tell time <input type="checkbox"/> Does not know survival words or signs <input type="checkbox"/> Problems with reading <input type="checkbox"/> Problems with writing <input type="checkbox"/> Difficulty with number skills <input type="checkbox"/> Difficulty with reasoning and problem solving <input type="checkbox"/> Memory problems <input type="checkbox"/> Other – specify

Case Management Comprehensive Assessment

Consumer Name:

Complete This Section For Adults (Age 18 and Over)

G7. What is the highest level of education you have completed?

- | | |
|--|---|
| <input type="checkbox"/> Less than High School | <input type="checkbox"/> Trade School |
| <input type="checkbox"/> Some High School | <input type="checkbox"/> Some College |
| <input type="checkbox"/> GED | <input type="checkbox"/> College Graduate |
| <input type="checkbox"/> Graduated Special Education | <input type="checkbox"/> Graduate Degree |
| <input type="checkbox"/> High School Graduate | <input type="checkbox"/> Unknown |

Comments:

Complete This Section For Children (Age 17 and Under)

G8. What grade are you in? N/A

G9. Do you like school?

- Yes
 No
 N/A

If no, why not?

G10. ASSESSOR: Is the child following the school's attendance policy?

- Yes
 No
 N/A

If no, what are the circumstances?

G11. ASSESSOR: Does the child have a Special Education Plan?

- Yes (specify): IEP 504 Plan
 No
 N/A

G12. ASSESSOR: Is there an aide or mentor assigned to the child?

- Yes
 No
 N/A

G13. ASSESSOR: Is the child on target to graduate with his or her class?

- Yes
 No
 N/A

Case Management Comprehensive Assessment

Consumer Name:

Consumer Needs, Wants, and Desired Results Related to Education
<p>What are your strengths and abilities related to education?</p> <p><i>ASSESSOR:</i> List any other strengths and abilities not mentioned by the consumer or guardian:</p> <p>Do you have any other needs related to education that haven't been addressed above?</p> <p><i>ASSESSOR:</i> List any other needs related to education not mentioned by the consumer or guardian.</p> <p>Do you have any wants related to education?</p> <p>What are your desired results related to education?</p>

Case Management Comprehensive Assessment

Section H: Vocational

Complete this section for consumers age 14 or older.

H1. Do you work?

- Yes
- No
- N/A

Comments:

Questions for consumers who are currently working:

H2. What is your current work setting?

	Where Employed:
<input type="checkbox"/> Competitive employment: full-time	
<input type="checkbox"/> Competitive employment: part-time	
<input type="checkbox"/> Supported Employment	
<input type="checkbox"/> Enclave	
<input type="checkbox"/> Sheltered work	

If competitively employed, do you use natural supports in the work environment? Yes No

Comments:

H3. Are you happy in your current job?

- Yes
- No

If no, what job would you like to do?

Why does this job appeal to you?

Comments:

Questions for consumers who are not currently working:

H4. Are you able to work in the community?

- Yes
- No

Comments:

H5. Do you want to work in the community?

- Yes
- No

If yes what job would you like to do?

Why does this job appeal to you?

Comments:

Case Management Comprehensive Assessment

Consumer Name:

Question for consumers who are working, or who are not working but are willing and able to work:

H6. Do you need help in any of the following areas?

	Yes	No
Looking for and obtaining a job	<input type="checkbox"/>	<input type="checkbox"/>
Job interviewing	<input type="checkbox"/>	<input type="checkbox"/>
Attending work as scheduled	<input type="checkbox"/>	<input type="checkbox"/>
Arriving to work on time and returning to work after lunch and breaks	<input type="checkbox"/>	<input type="checkbox"/>
Being appropriately dressed and groomed for work	<input type="checkbox"/>	<input type="checkbox"/>
Accepting work assignments and completing them according to instructions	<input type="checkbox"/>	<input type="checkbox"/>
Independently initiating work	<input type="checkbox"/>	<input type="checkbox"/>
Attending to work tasks without distraction	<input type="checkbox"/>	<input type="checkbox"/>
Following written directions	<input type="checkbox"/>	<input type="checkbox"/>
Performing a 1-step task	<input type="checkbox"/>	<input type="checkbox"/>
Performing a 2-3 step task	<input type="checkbox"/>	<input type="checkbox"/>
Communicating wants or needs	<input type="checkbox"/>	<input type="checkbox"/>
Timely informing employer when going to miss work	<input type="checkbox"/>	<input type="checkbox"/>
Accepting changes in schedule or routine	<input type="checkbox"/>	<input type="checkbox"/>
Getting along with co-workers	<input type="checkbox"/>	<input type="checkbox"/>
Other, including any barriers to obtaining employment:		
Comments:		

Consumer Needs, Wants, and Desired Results Related to Vocational Functioning
<p>What are your strengths and abilities related to your vocational functioning?</p> <p><i>ASSESSOR:</i> List any other strengths and abilities not mentioned by the consumer or guardian:</p> <p>Do you have any other needs related to your vocational functioning that haven't been addressed above?</p> <p><i>ASSESSOR:</i> List any other needs related to vocational functioning not mentioned by the consumer or guardian.</p> <p>Do you have any wants related to your vocational functioning?</p> <p>What are your desired results related to your vocational functioning?</p>



2. Service Provisions

Payment will be made for targeted case management functions described in 441 Iowa Administrative Code 90.5(249A), including:

- ◆ [Assessment](#)
- ◆ [Service plan](#)
- ◆ [Referral and related activities](#)
- ◆ [Monitoring and follow-up](#)
- ◆ [Contacts](#)

a. Assessment

The targeted case manager shall perform a comprehensive assessment and periodic reassessment of the member's individual needs using form 470-4694, *Targeted Case Management Comprehensive Assessment*. Click [here](#) to access the form online.

This will aid the case manager in determining the need for any medical, social, educational, housing, transportation, vocational or other services. The comprehensive assessment shall address all of the member's areas of need, strengths, preferences, and risk factors, considering the member's physical and social environment.

A face-to-face reassessment must be conducted at a minimum annually and more frequently if changes occur in the member's condition. The assessment and reassessment activities include the following:

- ◆ Making annual updates to the member's history (including social history)
- ◆ Identifying the needs of the member and completing related documentation
- ◆ Gathering information from other sources, such as family members, medical providers, social workers, legally authorized representatives, and others as necessary to form a complete assessment of the member



b. Service Plan

The targeted case manager shall develop and periodically revise a service plan based on the comprehensive assessment. This shall include a crisis intervention plan based on the risk factors identified in the risk assessment portion of the comprehensive assessment.

The case manager shall ensure the active participation of the member and work with the member or the member's legally authorized representative and other sources to choose providers and develop goals. This service plan shall:

- ◆ Document the parties participating in the development of the plan.
- ◆ Specify the goals and actions to address the medical, social, educational, housing, transportation, vocational or other services needed by the member.
- ◆ Identify a course of action to respond to the member's assessed needs, including identification of all providers, services to be provided, and time frames for services.
- ◆ Document services identified to meet the needs of the member which the member declined to receive.
- ◆ Include an individualized crisis intervention plan that identifies the supports available to the member in an emergency. A crisis intervention plan shall identify:
 - Any health and safety issues applicable to the individual member based on the risk factors identified in the member's comprehensive assessment.
 - An emergency backup support and crisis response system, including emergency backup staff designated by providers, to address problems or issues arising when support services are interrupted or delayed or the member's needs change.
 - After-hours contact information for all persons or resources identified for the member and an alternate contact to be used in the event that an individual provider not employed by an agency is not present to provide services as scheduled; or



- After-hours contact information for an on-call system for the provider of targeted case management to ensure that in the event of an emergency, members have access to a targeted case manager 24 hours per day including weekends and holidays.
- ◆ Include a discharge plan.
- ◆ Be revised at least annually and more frequently if significant changes occur in the member's medical, social, educational, housing, transportation, vocational or other service needs or risk factors.

c. Referral and Related Activities

The targeted case manager shall perform activities to help the member obtain needed services, such as scheduling appointments for the member, and activities that help link the member with medical, social, educational, housing, transportation, vocational or other service providers. The targeted case manager shall also help link the member with programs that are capable of providing services to address identified needs and risk factors and to achieve goals specified in the service plan.

d. Monitoring and Follow-Up

The targeted case manager shall perform activities and make contacts that are necessary to ensure the health, safety, and welfare of the member and to ensure that the service plan is effectively implemented and adequately addresses the needs of the member. At a minimum, monitoring shall include assessing the member, the places of service (including the member's home when applicable), and all services. Monitoring may also include review of service provider documentation. Monitoring shall be conducted to determine whether:

- ◆ Services are being furnished in accordance with the member's service plan, including the amount of service provided and the member's attendance and participation in the service.
- ◆ The member has declined services in the service plan.
- ◆ Communication is occurring among all providers to ensure coordination of services.



- ◆ Services in the service plan are adequate, including the member's progress toward achieving the goals and actions determined in the service plan.
- ◆ There are changes in the needs or status of the member. Follow-up activities shall include making necessary adjustments in the service plan and service arrangements with providers.

e. Contacts

Targeted case management contacts shall occur as frequently as necessary and shall be conducted and documented as follows:

- ◆ The targeted case manager shall have at least one face-to-face contact with the member every three months.
- ◆ The targeted case manager shall have at least one contact per month with the member, the member's legally authorized representative, the member's family, service providers, or other such entities or individuals.

This contact may be face-to-face or by telephone. The contact may also be by written communication, including letters, email, and fax, when the written communication directly pertains to the needs of the member. A copy of any written communication must be maintained in the case file.

- ◆ The targeted case manager may bill for contacts with non-eligible persons if the contacts are directly related to identifying the member's needs and care as necessary for the purpose of helping the member:
 - Access services,
 - Identify needs and supports to assist the member in obtaining services,
 - Provide targeted case managers with useful feedback, and
 - Alert targeted case managers to changes in the member's needs.



- ◆ When applicable, documentation of targeted case management contacts shall include:
 - The name of the service provider.
 - The need for and occurrences of coordination with other targeted case managers within the same agency or of referral or transition to another targeted case management agency.

3. Exclusions

Payment shall not be made for activities otherwise within the definition of targeted case management when any of the following conditions exist:

- ◆ The activities are an integral component of another covered Medicaid service. This includes care coordination through an IHH except during a 30 day transition time from TCM to IHH care coordination.
- ◆ The activities constitute the direct delivery of underlying medical, social, educational, housing, transportation, vocational or other services to which a member has been referred. Such services include, but are not limited to:
 - Services under parole and probation programs
 - Public guardianship programs
 - Special education programs
 - Child welfare and child protective services
 - Foster care programs
- ◆ The activities are integral to the administration of foster care programs, including but not limited to, the following:
 - Research gathering and completion of documentation required by the foster care program
 - Assessing adoption placements
 - Recruiting or interviewing potential foster care parents
 - Serving legal papers
 - Home investigations
 - Providing transportation
 - Administering foster care subsidies
 - Making placement arrangements



The activities for which a member may be eligible are integral to the administration of another nonmedical program, such as a guardianship, child welfare or child protective services, parole, probation, or special education program, except for case management that is included in an individualized education program or individualized family service plan consistent with Section 1903(c) of the Social Security Act.

- ◆ The activities duplicate institutional discharge planning.

4. Targeted Case Management, Case Management, and Integrated Health Home Overview Chart

See [Appendix I](#) regarding service coordination and monitoring of TCM, CM, and IHH waivers.

C. BASIS OF PAYMENT

The basis of payment for targeted case management services is a targeted case management activity of 15 minutes in duration. The following rounding rules apply when billing for services:

- ◆ 1 through 7 minutes of service should be rounded down to zero.
- ◆ 8 through 14 minutes of service should be rounded up to 15 minutes.

Providers shall add the total minutes of service provided for the day and then round once. The rate is established on the basis of cost information submitted to the Iowa Medicaid Enterprise Cost Audit Unit.

Providers are required to submit a projected cost report by July 1 of each year. This form is used to establish a projected rate for the new fiscal year, thus, avoiding underpayment or overpayment. A cost report showing actual costs shall be submitted 90 days after each state fiscal year end. Providers may contact the Iowa Medicaid Enterprise Cost Audit Unit for a copy of the cost report form and instructions for completion.

State and local government entities that enroll in the Medicaid program as case management providers must establish their rates in accordance with the cost principles contained in the Office of Management and Budget Circular No. A-87, "Cost Principles for State and Local Governments." Targeted Case Management agencies include the costs of translation and interpretation services in their cost reports. Translation and interpretation services are not separately billable by Targeted Case Management agencies.



1. Targeted Case Management Billable Activities

Below are listed those activities that are billable case and targeted case management activities when done by a targeted case manager or targeted case management supervisor. Any activity undertaken by an employee who is not a targeted case manager or targeted case manager supervisor is not a billable activity. This listing is not meant to be all-inclusive.

a. Assessment, Social History, and Reassessment

Legal reference: 441 IAC 90.5(1)"a"

- ◆ Taking member history.
- ◆ Gathering and reviewing information pertaining to the member's history from any source, including obtaining and verifying diagnoses.
- ◆ Completing *Risk Assessments* and the *Targeted Case Management Comprehensive Assessment*.
- ◆ Completing program assessments in order to determine service needs.
- ◆ Researching funding sources, including non-Medicaid sources for services needed before the service plan implementation.
- ◆ Dictating, writing, editing, and updating the assessment and social history documents.
- ◆ Dictating, writing, typing, and signing narrative entries to document assessment and social history activities.
- ◆ Contacts to establish or verify initial Title XIX eligibility (e.g., calls to income maintenance workers). Checking eligibility via ISIS or ELVS is not billable as this is not a person-to-person contact.

b. Care Planning

Legal reference: 441 IAC 90.5(1)"b"

- ◆ Reviewing progress on previous goals.
- ◆ Completing activities to request funding, from all sources, for services (including exceptions to policy).
- ◆ Planning for development or revision of the member's comprehensive service plan (e.g., scheduling the meeting with the member, determining who the member wants to attend, etc.).



- ◆ Conducting the comprehensive service plan meeting.
- ◆ Dictating, writing, typing, and signing of the comprehensive service plan document.
- ◆ Dictating, writing, typing, and signing narrative entries to document care planning activities.
- ◆ Completing forms (paper or electronic) that are required to ensure access to, or funding of, needed services. (e.g., entering service plan and specific service information in ISIS).
- ◆ Closing a case and associated activities completed before the date of closing (e.g., writing a discharge summary, identifying other services that will be needed after discharge, making referrals to other agencies or providers).
- ◆ Joint treatment planning with the Iowa Plan contractor.

c. Referrals and Linkage

Legal reference: 441 IAC 90.5(1)"c"

- ◆ Scheduling appointments for members with other providers.
- ◆ Dictating, writing, typing, and signing narrative entries to document referral activities.
- ◆ Researching service options for a member, including coordination with funders and providers, including completion of referral documents and related contacts.
- ◆ Contacts to complete service arrangements (e.g., arranging transportation, etc.).

d. Monitoring and Follow-Up

Legal reference: 441 IAC 90.5(1)"d"

- ◆ Monitoring and follow up, to determine whether services are being furnished in accordance with the member's care plan. This includes time spent reviewing service provider files.
- ◆ Monitoring and follow up, to determine whether the services in the care plan are adequate to meet the needs of the member.
- ◆ Monitoring and follow up, to determine whether there are changes in the needs or status of the member.



- ◆ Making necessary adjustments in the care plan and service arrangements with providers to address changes in needs or status of the member.
- ◆ Dictating, writing, typing, and signing case record entries to document the monitoring activities.
- ◆ Completing forms or reports to ensure the health and safety of the member, including *Incident Report* review, processing, and follow-up.

2. Examples of Non-Billable Activities

- ◆ Travel time
- ◆ Paid time off (vacation, sick leave, etc.)
- ◆ Activities provided by anyone other than a person who meets the qualifications to be a targeted case manager, even if they are working under the supervision of a targeted case manager
- ◆ Unsuccessful attempts to contact the member or collaterals (e.g., a home visit when member is not at home or leaving a voice mail message for the member or collateral)
- ◆ Services provided by more than one targeted case manager to the same member at the same time
- ◆ Staff meetings, trainings, and supervision
- ◆ Time spent in case review for Quality Assurance purposes
- ◆ Contacts with support staff within the agency
- ◆ Scheduling targeted case manager's appointments
- ◆ Bill submission and collection activities
- ◆ Checking Medicaid or service eligibility in ISIS or ELVS
- ◆ Calls to the ISIS helpdesk
- ◆ Preparing and mailing Notice of Decisions (NODs)
- ◆ All preauthorization activities required by the Iowa Plan contractor
- ◆ Filing



D. BILLING POLICIES AND CLAIM FORM INSTRUCTIONS

Paper claims for targeted case management are billed on form 470-2486, *Claim for Targeted Medical Care*.

Click [here](#) to view a sample of the claim form.

Click [here](#) to view billing instructions for the claim form.

The IME supports the electronic submission of claims. Through electronic submission, submission and processing errors can be reduced. Information regarding electronic submission of claims is located on the Iowa Medicaid website. Click [here](#) to view this information.

Bill the IME for each service rendered to each member using applicable charges or the rate determined by the Division of Medical Services.

Submit claims to the IME on a monthly basis to facilitate payment in a timely manner. To receive payment monthly, submit the claim for the month's service by the tenth of the month following the month of service.

Refer to [Chapter IV. Billing Iowa Medicaid](#) for claim form instructions, all billing procedures, and a guide to reading the Iowa Medicaid Remittance Advice statement.

The Billing Manual can be located online at:

http://www.dhs.state.ia.us/policyanalysis/PolicyManualPages/Manual_Documents/Provman/all-iv.pdf.

MEDICAID PAYMENTS
(PROVIDER CERTIFICATION)

I hereby agree:

To keep such records as are necessary to disclose fully the extent of services provided to individuals under the Iowa Medicaid Program, as specified in the Provider Manual and the Iowa Administrative Code.

To furnish records and other information regarding any payments claimed for providing such services as the Iowa Department of Human Services, its designee or Health and Human Services may request.

To accept, as payment in full, subject to audit, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductibles, coinsurance, copayment, and spenddown.

To comply with the provisions of the Civil Rights Act of 1964 and Section 504 of the Rehabilitation Act of 1973.

I certify that:

The services shown on the front of this form were rendered to the consumer and were medically indicated and necessary for the health of the patient.

The charges for these services are just, unpaid, actually due according to law and program policy and not in excess of regular fees.

The information provided on the front of this claim is true, accurate, and complete.

I understand that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

PLACE OF SERVICE CODES

- | | |
|-------------------------------|---|
| 11 Office | 51 Inpatient psychiatric facility |
| 12 Home | 53 Community mental health center |
| 21 Inpatient hospital | 54 Intermediate care facility/MR |
| 22 Outpatient hospital | 55 Residential substance abuse treatment facility |
| 23 ER room hospital | 56 Residential psychiatric treatment facility |
| 24 Ambulatory surgical center | 61 Comp inpatient rehab facility |
| 31 Skilled nursing facility | 62 Comp outpatient rehab facility |
| 32 Nursing facility | 71 Public health clinic |
| 33 Custodial care facility | 99 Other |
| 34 Hospice | |

Complete claim form instructions and a printable version of this form are available on our website: <http://www.ime.state.ia.us/Providers/claims.html>



APPENDIX I.

**Targeted Case Management, Children’s Mental Health, and
Integrated Health Home Overview Chart**

Program	Member Status	Case Management Provided By	Service Authorization	Billing Submitted To
Habilitation	Medically Needy	CM as a habilitation services when the member does not qualify for TCM	IME Medical Services Unit (MSU)	IME
	Iowa Plan eligible	When the member does not qualify for TCM, CM as a habilitation service funded through the Iowa Plan until the member is attributed and enrolled in an IHH	Magellan of Iowa	Magellan of Iowa
Habilitation and HCBS Brain Injury or Elderly Waivers	Iowa Plan eligible	Targeted Case Management as a state plan service	Habilitation services: Magellan of Iowa Waiver services: IME	Magellan of Iowa Waiver services: IME
Habilitation and HCBS AIDS/HIV, Health and Disability or Physical Disability Waivers	Iowa Plan eligible	CM as a habilitation service funded through the Iowa Plan	Habilitation services: Magellan of Iowa Waiver services: IME	Magellan of Iowa Waiver services: IME
Children’s Mental Health Waiver	Medically Needy	Targeted Case Management as a state plan service	IME MSU	IME
	Iowa Plan eligible	TCM service funded through the Iowa Plan until the member is attributed and enrolled in an Integrated Health Home (IHH) * See IHH transition white paper.	CMHW Services: IME TCM: Magellan	Waiver services: IME
HCBS AIDS/HIV, Health and Disability or Physical Disability Waivers	Not Iowa Plan eligible	Service coordination provided by a service worker	Waiver services: IME	Waiver services: IME