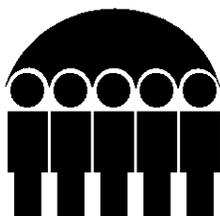


STATE SUPPLEMENTARY ASSISTANCE

RESIDENTIAL CARE FACILITY HANDBOOK



Iowa
Department
of
Human Services

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INTRODUCTION

This handbook contains the policies and procedures of the Department of Human Services (referred to as "DHS" or "the Department") that govern participation of a residential care facility in the State Supplementary Assistance Program.

The federal program known as Supplemental Security Income (SSI) provides cash payment to low-income people who are aged, blind, or disabled. The Social Security Administration administers the SSI program.

The State Supplementary Assistance program addresses needs recognized by the states that were not covered when the SSI program was implemented in 1976. States are required to maintain a State Supplementary Assistance program and to pass along any cost of living increases to SSI payments as a condition of receiving federal funding for the Medicaid program.

Iowa's program provides a further income supplement to people whose income is insufficient to meet the cost of care in a residential facility, in-home health-related care, family-life home care, and care of a dependent at home. To be eligible for State Supplementary Assistance, a person must meet the eligibility requirements for SSI, except that the person's income may be too high to qualify for an SSI payment.

Individual eligibility for the program is determined in the Department's local offices. Facility contracts and payments are administered by the Department's Iowa Medicaid Enterprise.

Legal Basis

Title XVI of the Social Security Act, as amended by Public Law 92-603, authorizes the SSI program.

Iowa Code Chapter 249 authorizes the State Supplementary Assistance Program. DHS has adopted rules at 441 Iowa Administrative Code Chapters 50 through 54 to administer the State Supplementary Assistance Program. Residential care facility requirements are contained in [441 Iowa Administrative Code Chapter 54](#).

The Department of Inspections and Appeals (DIA) has adopted the following rules at 481 Iowa Administrative Code which pertain to residential care facilities:

- ◆ [Chapter 57](#) sets standards for licensing residential care facilities;
- ◆ [Chapter 63](#) sets standards for licensing of residential care facilities for persons with mental retardation;

- ◆ [Chapter 62](#) sets standards for residential care facilities for persons with mental illness;
- ◆ [Chapter 60](#) sets physical standards for all types residential care facilities; and
- ◆ [Chapter 50](#) and [Chapter 56](#) establish general procedures for licensing, training, and enforcement.

FACILITY PARTICIPATION REQUIREMENTS

Facility License

The facility providing care must be licensed by the Iowa Department of Inspections and Appeals (DIA) as a residential care facility (RCF) or a residential care facility for persons with mental retardation (RCF/MR) or a residential care facility for persons with mental illness (RCF/PMI).

Institutional Status

No State Supplementary Assistance payment can be made to a resident of a tax-supported facility providing residential care, unless the facility is licensed for 16 beds or less.

Tax-supported facilities include county homes and other residential care facilities that are owned or operated by an agency of the federal, state, or local government. These facilities are defined as public institutions by the Supplemental Security Income (SSI) program.

Persons residing in public institutions are not eligible for SSI unless the "institution" has less than 16 beds. Since State Supplementary Assistance recipients must meet all SSI standards except for income, this restriction also applies to the State Supplementary Assistance program.

Application and Contract

Each residential care facility shall complete an *Application and Contract Agreement for Residential Care Facilities*, form 470-0443 (formerly PA-1108-6), when it wishes any of its residents to receive State Supplementary Assistance payments. The purpose of form 470-0443 is:

- ◆ To spell out the conditions under which a facility may participate in the State Supplementary Assistance program,
- ◆ To describe the responsibilities of the Department and the facility, and
- ◆ To serve as an application to participate in the cost-related system of payment for residential care within the State program.

The Department must approve this contract before any payment of assistance funds. The term of the contract is 12 months, subject to renewal.

See [Application and Contract Agreement for Residential Care Facilities, Form 470-0443](#), for a form sample and instructions.

Choice of Payment System

Under the State Supplementary Assistance Program, the operator of a residential care facility has the option of participating in a cost-related system of payment or of accepting a flat per diem rate established by DHS.

This choice is indicated by checking the applicable box on form 470-0443. (See [Application and Contract Agreement for Residential Care Facilities, Form 470-0443](#), for a form sample and instructions.)

Flat Per Diem Rate

Facilities that choose the standard per diem rate are not required to file a financial report but must agree to accept the rate as established by DHS.

Cost-Related Payment

Facilities that choose the cost-related system of payment for residential care must submit a financial report annually.

The facility shall complete and submit form 470-0030, *Financial and Statistical Report*, to the Iowa Medicaid Enterprise Provider Audits and Rate Setting Unit no later than three months after the close of the facility's established fiscal year. See [Financial and Statistical Report, Form 470-0030](#), for a form sample and instructions.

The Department establishes the cost-related per diem rate for these facilities based on the information submitted. See [441 IAC 54.3\(249\)](#).

The per diem rate established for recipients of State Supplementary Assistance shall not exceed the average rate established by the facility for the private-pay resident.

Record Keeping

The facility must establish a record keeping system sufficiently complete to permit the recipient, DHS, DIA, and the Social Security Administration to make necessary inquiries and ensure continuity of care that allows for easy access.

Records Needed to Establish Per Diem Rate

The facility shall maintain an accounting system sufficiently complete to permit the Department to make necessary audits. (See [Financial and Statistical Report, Form 470-0030](#), for more information.)

Establishment of Personal Case Record

A case folder shall be maintained on each person residing in the facility. This record shall contain at least:

- ◆ The physician's statement certifying that the resident does not require nursing services,
- ◆ The contract between the facility and the resident, form 470-0477, *RCF Admission Agreement* (formerly PA-2365-6), and
- ◆ Proof of expenditures from a resident's "Personal Needs."

See 481 IAC [57.16](#), [62.1](#), and [63.17](#). All entries in the resident's permanent record shall be current, dated, and signed.

Personal Need Allowance Managed by Facility

When the facility manages the personal needs funds of a resident, it shall establish and maintain a system of accounting for expenditures from the resident's funds. This accounting system is subject to audit by a DHS representative and must meet the following standards:

- ◆ The personal needs funds shall be deposited in a bank in Iowa that is insured by FDIC. The funds shall be deposited in a single checking account that has in the account name the term "Resident Trust Funds."
 - Personal needs funds shall not mingled with trust funds from any other facility.
 - Personal needs funds shall not be mingled with facility operating funds except for facility funds deposited to cover bank charges, not to exceed \$500. Bank service charges for this account are an allowable audit cost if the service cannot be obtained free of charge.
- ◆ A separate ledger sheet must be maintained for each resident.
 - When a resident is admitted to the facility, a ledger sheet must be credited with the resident's total incidental money on hand.
 - Thereafter, the ledger must be kept current on a monthly basis. The facility shall show the date, the amount given the resident, and the resident's signature.

- ◆ Each time something is purchased for the resident (instead of a direct cash disbursement to the resident) the expenditure item in the ledger must be supported by a signed, dated receipt. The receipt must indicate the article furnished for the resident's benefit.
- ◆ Personal funds must not be turned over to persons other than the resident's conservator or other persons selected by the resident.
- ◆ With the consent of the resident (if the resident is able and willing to give such consent), the administrator may turn over personal funds belonging to the resident to a close relative or friend to purchase a particular item. However, a signed, itemized, dated receipt shall be included in the resident's files.
- ◆ The receipts for each resident must be kept until canceled by Department auditors. The ledger and receipts for each resident must be made available for periodic audits by an accredited Department representative. Audit certification will be made by the Department's representative at the bottom of the ledger sheet; supporting receipts may then be destroyed.

The Department reserves the right to charge back to the facility any maintenance items that are charged to the resident's personal needs account when the charge constitutes double payment. Unverifiable expenditures charged to personal needs accounts may also be charged back to the facility.

Report to Department

The facility must notify the Department's local office when:

- ◆ A person enters the facility and wishes to participate in the State Supplementary Assistance program.
- ◆ A resident receiving State Supplementary Assistance changes level of care.
- ◆ A resident receiving State Supplementary Assistance is discharged from the facility.

Notify the local office by telephone and then follow up by sending form 470-0042, *Case Activity Report*, to the local office immediately. See [Case Activity Report, Form 470-0042](#), for a form sample and instructions.

If you become aware of a resident's change in financial circumstances that may affect State Supplementary Assistance eligibility or benefits, notify the local DHS office. The local office then reviews eligibility factors and makes any needed change in the amount of client participation.

RESIDENT ELIGIBILITY

A resident's eligibility for State Supplementary Assistance is determined by staff in the income maintenance unit in the Department's local office.

Physician's Statement

All admissions to residential care facilities shall be based on a written order signed by a physician certifying that:

- ◆ The person being admitted does not require nursing services or that
- ◆ The person's need for nursing services can be avoided if home and community-based services other than nursing care are provided.

In order to comply with licensing rules, the facility shall assure that each resident is examined by a physician at least every 12 months to determine whether residential care continues to be appropriate.

For a resident to continue to remain eligible for State Supplementary Assistance payments, the physician's statement certifying that the person requires residential care but does not require nursing services must be updated at least every 12 months. A copy of the new certification dated and signed by a licensed physician is sufficient to verify the continuing need.

Application

State Supplementary Assistance payments for residential care cannot be made until the resident has filed a *Health Services Application*, form 470-2927 or 470-2927(S), with the Department's local office.

Ideally, the application should be filed by the date that the applicant wants to start receiving State Supplementary Assistance benefits. If the application is filed more than 30 days after entering the facility, the applicant will not be able to receive benefits back to the date of entry.

A person who is already a Medicaid member may submit a partially completed application. The person should complete the identifying information and sign and dated the form to show intent to ask for State Supplementary Assistance.

See [Health Services Application, Form 470-2927 or 470-2927\(S\)](#), for sample forms and instructions.

Application Processing

The Department's decision with respect to eligibility will be based primarily on information furnished by the applicant. The Department will notify the applicant in writing of additional information or verification that is required to establish eligibility for assistance. The applicant is likely to be asked to furnish:

- ◆ A social security number or proof of having applied for a number.
- ◆ Proof of income and resources.
- ◆ Proof of citizenship and identity for Medicaid purposes.
- ◆ Evidence of disability if the applicant is under age 65.

Failure of the applicant to supply the information or refusal to authorize the Department to secure the information from other sources shall serve as a basis for denial of assistance.

If the applicant is already receiving SSI or the Family Investment Program (FIP), the Social Security Administration has already cleared most eligibility factors.

If it appears that the applicant would be eligible for SSI but is not receiving it, the applicant will be required to apply for SSI in addition to applying for State Supplementary Assistance.

The time needed for eligibility determination may be extended when:

- ◆ There is a delay caused by the Social Security Administration's inability to establish SSI eligibility.
- ◆ There is a delay caused by the local office's inability to establish disability or blindness, in cases where the applicant's or recipient's income exceeds SSI limits.

NOTE: When action on the application is delayed for these reasons, the Department has no responsibility for making State Supplementary Assistance payments until eligibility is established.

If the applicant is eventually found eligible, payment shall be retroactive to the date the applicant became eligible, or 30 days before date of application, whichever is later. However, if the applicant dies before the establishment of SSI eligibility or is found ineligible as a blind or disabled person, the Department shall assume no responsibility for payment.

Eligibility Decision

The Department will issue a notice of decision to notify an applicant or recipient of State Supplementary Assistance of the decisions made on the person's case. This includes:

- ◆ When an application is approved or denied.
- ◆ When a recipient's client participation changes.
- ◆ When assistance is renewed because of a review or redetermination.
- ◆ When a recipient transfers from one program to another.
- ◆ When assistance is canceled.

For State Supplementary Assistance residential care, the notice will state the effective date of assistance, the amount of money the resident has to contribute toward the cost of care, and how that amount was calculated. The effective date for State Supplementary Assistance shall be no earlier than 30 days before the date the Department received the application.

The original notice is mailed directly to the resident. When the resident has a guardian, conservator, or payee, a copy of the notice is mailed to that person. The facility will receive a copy of the notice only if the facility is payee for the resident's benefits.

If the facility is payee, the facility should take any action required and file the form in the resident's records. No action is required upon receipt of a notice of decision unless the resident or the person acting on the resident's behalf wants to appeal the Department's action. Instructions for how to request an appeal are found on the back of the form.

The Department issues form MA-2139-0 (470-0371), *Facility Card*, to notify the facility of the eligibility decision. The form indicates:

- ◆ The facility in which the recipient is residing,
- ◆ The first day for which payment may be made, and
- ◆ The amount of the recipient's available income being applied to the cost of care. (See [Client Participation](#).)

Simultaneously with the sending of the *Facility Card*, the resident's file is opened for RCF payment.

Admission Agreement

Both the law and licensing rules governing residential care facilities provide that there must be a contract between the facility and each individual resident. The *RCF Admission Agreement*, form 470-0477, serves as this contract and must be present in each resident's record.

This contract shall:

- ◆ State the base rate or scale per day or per month, the services included, and the method of payment.
- ◆ Contain an itemized list of those services, with the specific fee that the resident will be charged and method of payment. This list of services must be related to the resident's current condition and based on the program assessment at the time of admission, determined in consultation with the administrator.
- ◆ Include the total fee to be charged initially to the specific resident.
- ◆ State the conditions whereby the facility may make adjustments to its overall fees for resident care as a result of changing costs.
- ◆ Contain a complete schedule of all offered services for which a fee may be charged in addition to the base rate and
 - State that additional fees may be charged to the resident for nonprescription drugs, other personal supplies, and services by a barber, beautician, etc.;
 - Contain an explanation of the method of assessment of such additional charges and of the method of periodic reassessment, if any, resulting in changing such additional charges;
 - State the method of payment of additional charges; and
 - Stipulate that no further additional fees shall be charged for items not contained in complete schedule of services.
- ◆ Provide that the facility shall give:
 - Written notice to the resident or to the responsible party, when appropriate, of changes in the overall rates of both base and additional charges at least 30 days before the effective date of such changes.
 - Notice to the resident or to the responsible party, when appropriate, of changes in additional charges based on a change in the resident's condition. Notification must occur before the revised additional charges begin.

If notice is given orally, written notification specifically listing the adjustments made must be also given within a reasonable time, not to exceed one week.
- ◆ State the terms of agreement concerning the holding and charging for a bed when a resident is hospitalized or leaves the facility temporarily for recreational or therapeutic reasons. The terms shall provide that the bed will be held at the request of the resident or the resident's responsible party.
 - The facility shall ask the resident or responsible party if the resident wants the bed held. This request shall be made before the resident leaves or within 48 hours after the resident leaves. The inquiry and the response shall be documented.

- When requested, the facility shall reserve the bed for as long as payments are made in accordance with the contract.
- ◆ State the conditions under which the involuntary discharge or transfer of a resident would be affected.
- ◆ State the conditions of voluntary discharge or transfer.
- ◆ State the terms of agreement in regard to refund of all advance payments in event of transfer, death, or voluntary or involuntary discharge.
- ◆ Set forth any other matters deemed appropriate by the parties to the contract. No contract shall be drawn or construed so as to relieve the facility of any requirement or obligation imposed upon it by licensing rules.

Each party shall receive a copy of the signed contract.

Eligibility Review

If the resident receives an SSI payment, the Social Security Administration is responsible for reviewing eligibility. If not, the DHS local office will reexamine the resident's eligibility for State Supplementary Assistance:

- ◆ At least every 12 months, based on the information the resident submits on form 470-3118 or 470-3118(S), *Medicaid Review*, and
- ◆ When there is a change in the resident's circumstances that may affect eligibility, as reported by the resident or the resident's representative by telephone or by mail. The Department issues form 470-0499, *Ten-Day Report of Change for FIP and Medicaid*, to assist residents in making this report.

PAYMENT POLICIES

State Supplementary Assistance is a supplement to a resident's other income which assures the resident of sufficient funds to meet the cost of care in the residential care facility and to provide a standard allowance to meet personal needs.

The resident retains a portion of the income for personal needs. The resident pays the balance of the income to the facility to be applied to the cost of care. This amount is called "client participation." The facility is responsible for collecting those funds from the resident.

State Supplementary Assistance payments are made directly to the resident unless the recipient has made a written request for another person (or the facility) to be the payee. This request must include an effective date, be signed and dated by the resident, and be on file in the Department's local office.

If a resident agrees to make the facility the payee for the resident's benefits, the income maintenance worker in the local office must make system entries to indicate this. A "guardian file" must be created in the Medicaid Management Information System to direct the payment.

A facility that has assumed the duties of a payee is also responsible for ensuring that the resident responds to all communications from the Department.

Client Participation

Client participation is the amount of the resident's own income that the resident pays to the facility. This amount is supplemented by the State Supplementary Assistance payment to equal the total established charge for the number of days the resident was in the facility during a month.

All resident income determined to be available for client participation shall be applied to the cost of care beginning with the first month of admission.

A resident may have limited client participation in the first month, due to the resident's living expenses in the previous living arrangement. The Department local office determines how much of the resident's income may be protected for other obligations and how much is available for client participation.

The income protected for a person leaving an independent living arrangement never exceeds the SSI payment for a single person (or a couple) at home.

A resident transferring to a residential care facility from a nursing facility, a foster care facility, or another residential care facility shall apply any unused client participation toward the cost of care in the new facility.

Residents should contact their income maintenance worker in the local DHS office if they have questions about the personal needs allowance or their client participation.

Items to Be Furnished by the Facility

DIA licensing rules require that certain items be available in a residential care facility. The facility must provide the following items when payment is accepted from a recipient of State Supplementary Assistance:

- ◆ Three or more meals per day, with special diet when ordered by the physician.
- ◆ Furnished living and sleeping quarters (see [481 IAC 57.30\(4\)](#)).
- ◆ Laundry, including linens and personal clothing as needed for the resident to present a neat appearance, to be free of odors, and to be comfortable.
- ◆ Assistance with personal care, such as grooming, washing hair, and administration of medications, exclusive of nursing care.

- ◆ General supervision.
- ◆ Provision of activities and socialization experiences to the extent deemed adequate by DIA.

Each facility shall provide a variety of supplies and equipment to fit the needs and interest of the residents. When these items are supplied to residents, they may be included in audit costs. These shall include:

- ◆ Books (standard and large print),
- ◆ Magazines,
- ◆ Newspapers,
- ◆ Radio,
- ◆ Television, and
- ◆ Bulletin boards.

Also appropriate would be:

- ◆ Box games,
- ◆ Game equipment,
- ◆ Piano,
- ◆ Song books,
- ◆ Craft supplies,
- ◆ Audio or video player,
- ◆ Outdoor equipment

If ordered by a physician, non-legend drugs (aspirin, cough syrup, etc.) or nonprescription vitamin pills may be furnished by the facility and included in the audit cost. If the individual resident requests such items without an order by a physician, the items may be charged to the resident.

Residents may be charged for over-the-counter drugs not provided by the facility or Medicaid.

Eligibility Based on 31-Day Month

Eligibility is established on the basis of a 31-day month. A resident's income may be such that the resident is eligible for a State Supplementary Assistance payment during a 31-day month, but ineligible for a payment during a month with fewer days. If so, the resident does not receive a payment during the shorter month, but remains eligible for medical coverage.

Days Covered

State Supplementary Assistance payments are made for only that portion of the month when the resident is in the facility (except as specified under [Reserve Bed Days Due to Hospitalization](#) and [Reserve Bed Days Due to Visits or Vacation](#)).

Payment shall be made for the date of entry, but not for the date of discharge or death. The number of days in a month has a direct bearing on the payment. Payment shall not be made when income is sufficient to pay the cost of care in a month with less than 31 days, but the resident remains eligible for all other benefits of the program.

Reserve Bed Days Due to Hospitalization

Legal reference: 441 IAC 52.1(3)"e" and "f"

State Supplementary Assistance payments may be made to hold a bed for a resident who is absent from the facility due to hospitalization. Payment will be approved for a period not to exceed 20 days of hospitalization per calendar month.

Payment can be made while the resident is in a state mental health institute under the same terms as if the resident were hospitalized. No coding is needed until a resident is discharged or ineligible.

A facility may not collect more client participation than what the State Supplementary Assistance program would pay.

Ms. J is an RCF State Supplementary Assistance recipient whose total monthly client participation is \$155.10. Ms. J enters the hospital on June 1 and returns to the RCF on June 26, for a total of 25 days absence.

The facility will bill for 20 reserve bed days, 5 covered days, and 5 noncovered days. The facility will keep the documentation of reserve bed days for audit purposes.

Reserve Bed Days Due to Visits or Vacation

Legal reference: 441 IAC 52.1(3), 52.1(3)"f," 52.1(3)"e"

When the resident is absent overnight due to a visit or vacation, payment is made to hold the bed for a period not to exceed 30 days during any calendar year.

EXCEPTION: Payments may be made for additional visit days if signed documentation is provided to the RCF that the resident wants additional visit days and the days are for the resident's benefit.

Obtain this documentation whenever the resident is absent for more than the 30-day limit, and keep it in the resident's permanent file. If the facility does not get documentation, the facility must bill the days as non-covered days unless the resident is discharged.

DIA is responsible for ensuring that facilities have justification for State Supplementary Assistance payment for more than 30 days.

If documentation is not available to justify periods of absence in excess of the 30-day annual limit, the facility shall submit a *Case Activity Report*, form 470-0042, to the local DHS office for the Department to terminate the State Supplementary Assistance payment.

Residents are not restricted in how they choose to use the visit days to which they are entitled. They may use their visit days all at once or distributed throughout the calendar year. However, visit or vacation days may not be used to extend a hospital stay beyond 20 days per calendar month.

Supplementation from Other Sources

The State Supplementary Assistance payment, as established by the Department of Human Services, is considered payment in full for the goods and services listed under [Items to Be Furnished by the Facility](#).

There shall be no additional charge made to the resident over and above the State Supplementary Assistance payment. Neither shall there be any additional charge to relatives, other persons, organizations, or agencies. Local governmental agencies may provide funding to support the facility operations.

Any supplemental payment meant to cover these goods and services, regardless of source, shall be considered as income and used to reduce the State Supplementary Assistance payment. County supplementation on behalf of a resident is considered a supplemental payment and is treated as such.

When a resident's other income, including the supplemental payment, reaches the point where the cost of the residential care is met, the State Supplementary Assistance payment is canceled.

When a facility furnishes services over and above the goods and services listed under [Items to Be Furnished by the Facility](#), the facility shall contact the service area manager of the local DHS office for information about funding through county local services allocations.

Personal Needs Allowance

A recipient of State Supplementary Assistance for residential care is entitled to a personal needs allowance. This amount is set aside from the resident's income before determining the amount that the resident pays the facility (known as "client participation").

The personal needs allowance is money designated for the personal use of the resident. The personal needs allowance also includes an amount to cover the average Medicare copayments for a facility resident based on the previous year.

This allowance is seen as a method of improving the quality of life for persons needing residential care. The money can serve as a way for residents to maintain control over part of their lives and environment. It may also be used for transportation to medical providers in the same community.

The resident is the person who will be spending the money and should be informed that the allowance is to cover personal needs. Personal needs include the purchase of clothing and incidentals.

Accumulated personal needs funds are counted toward the resource limit when determining eligibility for SSI or State Supplementary Assistance.

The Department increases the personal needs allowance for residents of residential care facilities at the same percentage and at the same time as federal Social Security and SSI benefits are increased. These changes are communicated to facilities through an Informational Release which may be located at:

<http://www.ime.state.ia.us/Providers/Bulletins.html>

If the resident is unable to manage the personal fund, a guardian, representative payee, or conservator should work with the resident to determine the current needs. When there is no guardian, relative, or other designated person to act on behalf of the resident, the facility may assume the responsibility of managing the personal allowance.

Uses of Personal Needs Allowance

Personal needs money is for the exclusive personal use of the resident. The resident may not be charged for such items as toilet paper or other facility maintenance items. These items are properly included in the computation of the audit cost and the facility payment rate.

The following list illustrates some of the types of items that may be purchased with personal needs funds. This list is not exhaustive, and is in no way intended to restrict the resident's use of the funds. It simply is to illustrate the wide variety of items that the funds may be used for:

Beauty and barber shop services	Pictures, posters, glassware
Bibles, prayer books, rosaries, etc.	knick-knacks, etc.
Books or a library card	Sachets for drawers
Camera, film, film development, photo albums	Scrapbooks, stamp albums, coin or postcard collections, etc.
Cigarettes, cigars, tobacco, lighters, ashtrays, pipes, etc.	Shaving equipment, soaps, and lotions
Clothing and jewelry	Shoe polish
Cosmetics (powder, lipsticks, face and hand lotions, individual nail files, perfume and colognes)	Special treats as diet allows
Dry cleaning	Stationery
Flowers and plants	Sunglasses (non prescription)
Gifts and cards	Tape recorders and tapes
Hair grooming aids	Taxi fare, bus tickets
Liquors.	Television sets
Musical instruments and sheet music	Tickets to movies, concerts, plays
	Watches, clocks, calendars
	Watch repair

Disposition of Unused Personal Funds in Case of Death

When a recipient of State Supplementary Assistance dies in a residential care facility, the funds remaining in this person's personal account shall be treated in the following manner:

- ◆ When an estate is opened for the deceased, the funds shall be submitted to the estate administrator. If any part of the resident's personal property is being held by another person, the facility shall advise that person of the estate being opened and shall notify the estate administrator.
- ◆ When no estate is opened, the funds shall be released to the person assuming responsibility for the resident's funeral expenses.
- ◆ When no estate is opened and there are no living heirs, the funds shall be submitted to the Department to escheat to the state.

It may be advisable for the facility operator to consult with an attorney before releasing the funds.

The facility shall send a written statement of account to the income maintenance worker in the local Department office to be filed in the person's case record.

Billing Procedures

For the Department to determine the amount needed to cover a resident's care, the facility must submit a claim indicating the number of days for which payment shall be made. Billing for previous month should be submitted as soon as possible after the end of the month.

The Iowa Medicaid Enterprise (IME), processes residential care facility claims for payment. Facilities can submit claims either on paper or electronically.

The IME provides software for electronic claims submission at no charge. To request this software, contact Iowa Medicaid Enterprise Provider Services at: imeproviderservices@dhs.state.ia.us. The IME also has staff available upon request to assist with any questions or problems.

Facilities that do not submit claims electronically are sent form [470-0039, Iowa Medicaid Long Term Care Claim](#), at the end of each month. The form lists information on State Supplementary Assistance recipients at the facility according to Department records.

Time Frames for Submitting Claims

Claims can be submitted any time during the month for the previous month. However, for residents who are in the facility all month, submit only one claim per month after the end of the month.

Payment will be made for covered dates of service when Iowa Medicaid Enterprise receives the initial claim within one year from the date of services. Claims submitted beyond the one-year limit may be paid only when they are delayed due to delays in receiving third-party payments or retroactive eligibility determinations.

Iowa Medicaid Enterprise generates payments weekly and mails checks every Wednesday. Electronic funds transfers are made each Wednesday evening.

Payment After Resident's Death

Indicate the death of a resident by entering the discharge code for death on the claim. When a resident's death is reported on the claim, the Department issues the check to cover the amount of assistance due the resident for that billing period directly to the facility.

When the resident's death occurs after the close of a billing period but before the receipt of the State Supplementary Assistance check covering that period, immediately report the death to the local DHS office.

When the income maintenance worker reports the death through the computer system, the payee is changed to the facility. If the check has already been issued in the name of the resident, return it and submit the billing for the final month as above.

Report on Submitted Claims

The IME issues a statement for each payment cycle that explains every individual provider claim transaction (including both paid and denied claims). Currently, these statements are mailed hardcopy to most providers. See [Remittance Advice](#) for a sample form and detailed field descriptions.

When it is necessary to contact Iowa Medicaid Enterprise with questions, keep the *Remittance Advice* handy. Refer to the transaction control number of the particular claim. This will result in timely, accurate information about the claim in question.

Questions about billing procedures and claims are handled by the IME Provider Services Unit. Contact them by telephone at: 1-800-338-7909 or 515-256-4609. You may also email questions to: imeproviderservices@dhs.state.ia.us

Incorrect Payments

To inquire as to why a claim was denied or why a claim payment was not what you expected, please complete form 470-3744, *Provider Inquiry*. See [Provider Inquiry, Form 470-3744](#), for a form sample and instructions.

If the guardian file address needs to be changed, the current payee (the resident, the resident's payee, or the facility if acting as the resident's payee) should contact the income maintenance worker the Department's local office who handles the resident's case.

NOTE: For the facility to receive the State Supplementary Assistance payment directly, the resident must request the facility to act as the resident's payee and must provide a written statement to that effect to be filed in the resident's case record in the Department's local office. The facility then assumes responsibility for:

- ◆ Reporting changes about the resident's circumstances,
- ◆ Providing necessary verifications, and
- ◆ Completing the annual review for the resident.

If a payment was sent to the wrong payee, then the incorrect payee needs to send the payment back to IME before another payment can be issued. If the payment is not returned, the new payee will need to request to have the payment forwarded by the incorrect payee.

To make an adjustment to a claim following receipt of the *Remittance Advice*, use form 470-0040, *Credit/Adjustment Request*. See [Credit/Adjustment Request, Form 470-0040](#), for a form sample and instructions. Do **not** use this form when a claim has been denied. Denied claims must be resubmitted.

NOTE: When an incorrect State Supplementary Assistance payment is issued due to an error in the client participation amount entered in the eligibility system, this error must be corrected by the income maintenance worker in the local DHS office.

When the worker adjusts the resident's file to show the month with the correct client participation, the information will be sent to the IME. The IME will reprocess the incorrect month's payment and make an additional payment if necessary.

When the resident's income plus the State Supplementary Assistance payment is more than the amount needed to pay for the resident's care and personal needs allowance, the resident or payee must refund the excess State Supplementary Assistance.

The refund may be sent to the Department's local office or to the IME. The refund must be accompanied by a letter which contains:

- ◆ The resident's name and state identification number.
- ◆ The amount of overpayment.
- ◆ The reason for the refund.

Questions about billing procedures and claims are handled by Provider Services at 1-800-338-7909 or 515-256-4609. You may also email questions to: imeproviderservices@dhs.state.ia.us

FORMS AND INSTRUCTIONS

This handbook contains samples of all forms which must be completed by the facility or which are issued to the facility.

The Department issues the following forms to facilities:

- ◆ *Application and Contract Agreement for Residential Care Facilities*, form 470-0443
- ◆ *Facility Card*, form MA-2139 (470-0371)
- ◆ *Iowa Medicaid Long Term Care Claim*, form 470-0039

The facility is responsible for initiating the following forms:

- ◆ *Financial and Statistical Report*, form 470-0030 (if applicable)
- ◆ *Case Activity Report*, form 470-0042
- ◆ *Provider Inquiry*, form 470-3744 (as needed)
- ◆ *Credit/Adjustment Request*, form 470-0040 (as needed)

The Department issues the following forms to residents or their representatives:

- ◆ *Health Services Application*, form 470-2927 or 470-2927(S)
- ◆ *Medical Assistance Eligibility Card*, form 470-1911
- ◆ *Ten-Day Report of Change*, form 470-0499
- ◆ *Medicaid Review*, form 470-3118 or 470-3118(S)

**Application and Contract Agreement for Residential Care Facilities,
Form 470-0443**

Each facility that wishes to participate in the State Supplementary Assistance program shall file an *Application and Contract Agreement for Residential Care Facilities*. The facility shall submit a new form annually. (Click [here](#) to see a sample of the form.)

The form can be obtained by contacting the Iowa Medicaid Enterprise Provider Services at: 1-800-338-7909 or imeproviderservices@dhs.state.ia.us. The local office is not involved in the process other than to refer the facility to the Iowa Medicaid Enterprise.

Read the terms of the agreement very carefully before the application to participate is signed. By signing the application, the facility is accepting the terms of the agreement. The administrator of the facility shall sign for the facility and the Chief of the Bureau of Long Term Care shall sign for the Department.

Both copies of the form shall be signed in order to furnish each party with a firm contract. Complete and return both copies to the IME Bureau of Long Term Care.

Upon approval, IME retains one copy of the completed form and returns the other copy to the facility.

Case Activity Report, Form 470-0042

The *Case Activity Report* is used to ensure prompt and accurate reporting on resident activity as it occurs at the facility. (Click [here](#) to see a sample of the form.) Forms may be downloaded from the IME Web site at: <http://www.ime.state.ia.us/Providers/Forms.html>

Complete the form as follows:

- ◆ When a Medicaid applicant or member enters the facility, complete Sections 1, 2, and 3.
- ◆ When a Medicaid applicant or member dies or is discharged from the facility, complete Sections 1 and 5.

Section 1. Recipient Data: Section 1 contains information on the resident. Use the first name, middle initial, and the last name as it appears on the Medical Assistance Eligibility Card. The "Date Entered Facility" is the date the resident entered the facility for the first time or was readmitted to the facility following a discharge.

Section 2. Facility Data: Section 2 contains information on the facility and the person filling out the form (either the administrator or designee). Your provider number must match the level of care indicated in Section 3. The "DHS Per Diem" is the facility's computed rate. The "Date Completed" is the date the form is completed and sent to the local DHS office.

Section 3. Level of Care: Enter RCF for the level of care.

Section 5. Discharge Data: The income maintenance worker needs the information to calculate client participation for a partial month. Provide information under "Last Month in Facility" only if the resident transfers to another facility or living arrangement (but not home).

- ◆ "Reserve bed days" is the number of reserve bed days, up to the maximum, for which the State Supplementary Assistance program will pay.
- ◆ "Non-covered days" is the number of days in excess of the reserve bed day limit which will not be covered by State Supplementary Assistance program.
- ◆ "Total billing days on claim to fiscal agent" is the total of the previous three lines.

Within two business days of the action, mail the form to the Department local office. Keep a copy for your records.

Credit/Adjustment Request, Form 470-0040

Use form 470-0040, *Credit/Adjustment Request*, to notify the IME to take an action against a claim that has already been paid, such as when:

- ◆ A paid claim amount needs to be changed, or
- ◆ Money needs to be credited back, or
- ◆ An entire *Remittance Advice* should be canceled.

Do not use this form with a claim has been denied. You must resubmit the claim.

Click [here](#) to see a sample of the form. Forms may be downloaded from the IME Web site at: <http://www.ime.state.ia.us/Providers/Forms.html>

Section A:

- ◆ **Claim Adjustment.** Check this box when the IME has paid a claim but there is an adjustment that must be made. Examples of such situations are:
 - You billed a day as a bed-hold day, then later determined that the client had actually returned to the facility on that day.
 - A resident was scheduled to be discharged on a particular day but stayed an additional day, and this was not noted until after the billing month.
- ◆ **Claim Credit.** Check this box when an entire paid claim should be credited back to the Medicaid program. An example is when you received payment for a client who had already been discharged.

Section B:

1. **17-Digit TCN.** For each claim, a "transaction control number" (TCN) is listed on the *Remittance Advice*. Enter that number in this field. See [Remittance Advice](#) for instructions on where to find the TCN number on the form.
2. **Provider Number/NPI.** Enter your seven-digit RCF provider number.
3. **Provider Name and Address.** Self-explanatory.
4. **8-Digit Member State ID Number.** Enter the resident's Medicaid state identification number in this field. The number will be 7 digits followed by a letter. You can obtain it from the *Remittance Advice*, the resident's *Medical Assistance Eligibility Card*, or the *Facility Card*.
5. **Reason for Adjustment or Credit Request.** Self-explanatory.

Section C: Provider/Representative Signature and Date. The form must be signed and dated by a facility representative.

Send this form to:

Iowa Medicaid Enterprise, Credits and Adjustments
PO Box 36450
Des Moines, Iowa 50315

You can send the *Credit/Adjustment Request* to IME for processing at any time of the month. You must send a copy of the *Remittance Advice* or a copy of the corrected claim with the form.

Facility Card, Form MA-2139 (470-0371)

Form MA-2139-0 (470-0371), *Facility Card*, is issued by the local office income maintenance worker who determines eligibility for State Supplementary Assistance and submits eligibility and payment information. It authorizes payment for care in an RCF. The form is computer-generated in two copies.

MA-2139-0 470-0371	
BEG. ELIG. DATE	1ST MO. CLI. PART
END. ELIG. DATE	ONGO. CLI. PART
ADMINISTRATOR _____	
<input type="checkbox"/> RETAIN FOR YOUR RECORDS	<input type="checkbox"/> SEND 1 COPY TO THE COUNTY.

Upon receipt of the *Facility Card* for a resident, the RCF shall:

1. Check the information on the form for accuracy. The information shown on the form is the basis for the RCF payment.
2. If there appears to be an error in the beginning eligibility date, the amount of financial participation, or any other item, contact the Department local office as soon as possible.
3. Send one copy of the form to the Department local office. Keep the other copy as a facility record.

Financial and Statistical Report, Form 470-0030

Residential care facilities use form 470-0030, *Financial and Statistical Report*, to report costs under the State Supplementary Assistance program. (Nursing facilities and intermediate care facilities for the mentally retarded also use this form to report costs under the Medicaid program.)

Completed financial reports are to be submitted in an electronic format using the State approved Excel template. Facilities may use their own computer-generated cost reports in place of this form with the prior approval of the IME Provider Cost Audits and Rate Setting Unit.

To view a copy of form 470-0030, click [here](#). The template may be downloaded from the IME web site at: www.ime.state.ia.us/Providers/Forms.html

The workbook consists of 21 worksheets:

- ◆ Certification
- ◆ Statistical data
- ◆ Schedule A, Total Facility Revenue
- ◆ Schedule A-1, NF Conversion/LTC Service Development Grant Revenue
- ◆ Schedule A-2, Description of Living Units
- ◆ Schedule B, Expense Adjustments
- ◆ Schedule C, Schedule of Expenses
- ◆ Schedule C-1, Assisted Living Expense Allocation
- ◆ Schedule D, Depreciation and Amortization Expense
- ◆ Schedule D-1, Change of Ownership
- ◆ Schedule E, Comparative Balance Sheet
- ◆ Schedule F, Reconciliation of Equity
- ◆ Schedule G, Related party Transactions
- ◆ Schedule H, Nursing Facility Wages and Hours
- ◆ Schedule H-1, Assisted Living Wages and Hours
- ◆ Schedule I, Full Time Employee Retention and Turnover Rates
- ◆ Schedule I-1, Facility Annual Calculation of Employee Turnover
- ◆ Supporting Schedule (1)
- ◆ Supporting Schedule (2)
- ◆ Edits
- ◆ Print

A residential care facility does **not** complete Schedules A-1, A-2 C-1, H, H-1, I or I-1. Schedules D-1 and G may not be needed, depending on the facility's circumstances.

Reports are required three months after the facility begins to participate in the program and then once a year within three months of the close of facility's fiscal year. The Provider Audits and Rate Setting Unit of Iowa Medicaid Enterprise mails a reminder to facilities when cost reports are due.

Electronic files can be sent by e-mail to the rate setting contractor at costaudit@dhs.state.ia.us or they can be submitted on diskette to:

Iowa Medicaid Enterprise
Attn: Provider Cost Audit
P.O. Box 36450
Des Moines, Iowa 50315

A signed copy of the Certification Statement (page 1 of the financial report) must also be mailed to the rate setting contractor before the due date.

Instructions for Medicaid Financial and Statistical Report for Nursing Facilities is a Department publication which includes detailed instructions for completing the cost report. To view a copy of the instructions, click [here](#). The instructions may be downloaded from the IME web site at: www.ime.state.ia.us/Providers/Forms.html

Health Services Application, Form 470-2927 or 470-2927(S)

Form 470-2927 or 470-2927(S), *Health Services Application*, is designed to enable the applicant to present to the Department's local office the information needed to determine eligibility for State Supplementary Assistance and Medicaid. (Click [here](#) to see a sample of the English form and [here](#) to see a sample of the Spanish form.)

Facilities that want to keep a supply of these forms on hand may obtain them from the local office or may order them from Iowa Prison Industries, Anamosa, Iowa 52205. Facilities can obtain a *Form Order Blank* from Anamosa by calling 1-800-332-7922.

The resident shall complete the application form on or before the date the resident moves into the residential care facility or the date that the resident wants to start receiving State Supplementary Assistance benefits.

The information shall be provided by the resident, and the resident must sign the form unless mentally or physically unable to do so. If the resident has an authorized representative, such as a guardian, conservator, or payee, that person is responsible for furnishing the information and signing the application on the resident's behalf.

This means that if the facility is the payee for the resident's benefits, the facility is responsible for completing the form and providing the required verification.

- ◆ An application form may be partially completed with identifying information, signature and date when:
 - A Medicaid member enters an RCF.
 - An applicant is already receiving an SSI payment (except as noted below).
 - An applicant's income is such that the applicant might be eligible for an SSI payment if a claim was filed.
- ◆ The application form shall be completed in its entirety when:
 - The applicant's income is above the SSI limits.
 - The Social Security Administration did not take the spouse's income and resources into consideration when determining SSI eligibility.
 - The DHS worker feels that not all income has been shown by the Social Security Administration (for example, interest).

The completed application form shall be submitted to the local Department of Human Services office.

Iowa Medicaid Long Term Care Claim, Form 470-0039

Iowa Medicaid Enterprise issues *Iowa Medicaid Long Term Care Claim*, form 470-0039, monthly to facilities that do not bill electronically. (Click [here](#) to see a sample of the form.) This form is also referred to as a "TAD" or Turnaround Document.

The fields on the TAD are completed for each resident according to IME and Medicaid eligibility records. Review the form carefully. Mark any changes or corrections in blue or black ink.

Note any residents who had covered or noncovered leave days or who were discharged during the billing month in red ink in the appropriate fields on the TAD. (No changes are necessary if the resident did not have leave days and was not discharged during the month.)

Each page of the form must be signed and dated by the facility's authorized representative. Keep one copy and return the other copy to IME.

If you need to resubmit a claim, you must use a blank TAD and complete all of the appropriate fields. Blank TADs are provided at the end of each monthly TAD. For resubmitted claims, use the original signature date.

A detailed field-by-field description of each information line follows:

1. **Medicaid I.D.#** The resident's identification number assigned by the Department. This number consists of seven numbers followed by a letter. Obtain this number from the resident's *Facility Card*, form 470-0371 (MA-2139), or the resident's *Medical Assistance Eligibility Card*, form 470-1911.
2. **Name** The resident's last name and first name.
3. **L.O.C. (Level Of Care)** An "R" indicates RCF care.
4. **Termination** Enter the applicable discharge code:
 - A Moved to the hospital
 - B Moved to a skilled nursing facility
 - C Moved to another nursing facility
 - D Moved to an ICF/MR
 - E Moved to an RCF
 - F Moved home with self-care
 - G Moved home with rehabilitation service
 - H Moved home with home health
 - I Moved to other institution
 - J Deceased

5. **Patient Acct.#** You may enter the resident's account number if your facility assign one.
6. **Medicare Coverage** Leave blank.
7. **Facility Admit Date** Enter the date the resident was admitted to the facility if the admission was during the month being claimed.
8. **Facility Disc Date** If the resident was in the facility the entire month, leave this field blank. If the resident was discharged from the facility during the month, enter the last date service was provided. The entry should show month, day, and year, in a six-digit number.
9. **First D.O.S.** (Date of Service) Enter the first date of the month for which payment is being claimed (month, day, and year, in a six-digit number).
10. **Last D.O.S.** (Date of Service) Enter the last date of the month for which payment is being claimed (month, day, and year, in a six-digit number).
11. **Unlabeled Field** Leave this field blank.
12. **Per Diem Rate** This field shows the facility's computed daily rate. This rate may not be the same as the facility's payment rate if the facility's computed rate is above the reimbursement cap. When Iowa Medicaid Enterprise processes the claim, the cap will be applied, and the facility will receive the computed rate or the maximum rate, whichever is lower.
13. **# Days** The number of days for the month being claimed from the first day of the month to the last day of the month.
14. **Amount** The total amount being claimed as determined by multiplying the per diem (field 12) by the number of days (field 13). When the claim is processed, the facility will be reimbursed based on the facility's computed rate or the maximum rate, whichever is lower.
15. **Leave Days/Visit** Enter the number of covered reserve bed days for a resident who was out of the facility for therapeutic leave or home visit. A covered reserve bed day is one that can be paid by State Supplementary Assistance. See [Days Covered](#) for more information.
16. **Leave Days/Hosp.** Enter the number of covered reserve bed days for a resident who was out of the facility for a hospital stay. A covered reserve bed day is one that can be paid by State Supplementary Assistance. See [Days Covered](#) for more information.

17. **Leave Days/Non-Cov.** Enter the number of days that the resident was out of the facility that exceed the reserve bed maximum. These are days that are not reimbursable through the State Supplementary Assistance program.
18. **3rd Party Source** If the resident is covered by other insurance, enter the name of the insurance company.
19. **3rd Party Amount** Enter the amount paid by the insurance towards this claim. Do not enter client participation in this field.
20. **3rd Party Source** If the resident is covered by other insurance, enter the name of the insurance company.
21. **3rd Party Amount** Enter the amount paid by the insurance towards this claim. Do not enter client participation in this field.
22. **Net Amount** Enter the net charge amount, which is the amount claimed (field 14) minus third-party payments (fields 19 and 21)

Medicaid Review, Form 470-3118 or 470-3118(S)

Form 470-3118 or 470-3118(S), *Medicaid Review*, is designed to enable the resident to present to the local Department office the information needed to determine eligibility for State Supplementary Assistance at the time of review.

The Department will mail the form to the resident when a review is due. (Click [here](#) to see a sample of the English form and [here](#) to see a sample of the Spanish form.)

The information shall be provided by the resident, and the resident must sign the form unless mentally or physically unable to do so. However, if the resident has an authorized representative, such as a guardian, conservator, or payee, that person is responsible for furnishing the information and signing the application on the resident's behalf.

This means that if the facility is the payee for the resident's benefits, the facility is responsible for completing the form and providing the required verification.

The completed application form shall be submitted to the local Department of Human Services office.

Medical Assistance Eligibility Card, Form 470-1911

The *Medical Assistance Eligibility Card* contains basic identifying information to enable a provider of medical care to confirm a Medicaid member's eligibility. The member's name, date of birth, and state ID number are printed on a wallet card and key tags. (Click [here](#) to see a sample of the card.)

The member is instructed to keep the permanent card and present it when receiving medical services. The card does not guarantee Medicaid eligibility.

Information on appeal rights, payment of medical bills, the Department's right to recover payments made or make a claim against another responsible for member's medical cost, and when a member should contact the IME Member Services Unit is included on or with the card.

The *Medical Assistance Eligibility Card* is issued to the member directly. The first card is mailed at the time of initial approval to the case name and mailing address. This includes members residing in a residential care facility.

The Department will issue replacement cards:

- ◆ Annually in July of each year for current members.
- ◆ Upon a member's request, as necessary.

The local office or the IME Member Services Unit can generate replacement cards through a web-based system. Circumstances under which a replacement card is necessary include:

- ◆ The card has been lost, stolen, or damaged;
- ◆ The member did not receive the initial or annual replacement card; or
- ◆ The member's name changes.

Provider Inquiry, form 470-3744

Form 470-3744, *Provider Inquiry*, offers a standard procedure for inquiring as to why a claim was denied or why a claim payment was not what you expected.

(Click [here](#) to see a sample of the form.) Forms may also be downloaded from the IME Web site at: <http://www.ime.state.ia.us/Providers/Forms.html>

Attach copies of the claim, the *Remittance Advice*, and any supporting documentation you want to have considered, such as additional medical records and send to:

Iowa Medicaid Enterprise, Provider Inquiry
PO Box 36450
Des Moines, Iowa 50315

RCF Admission Agreement, Form 470-0477

The *RCF Admission Agreement* is designed to serve as a legal contract between a residential care facility and the resident of the facility. It meets the licensing requirements set by the Department of Inspections and Appeals. Page 2 of the form meets the additional requirements of the State Supplementary Assistance Program. (Click [here](#) to see a sample of the form.)

The facility shall initiate the form before or at the time of a person's admission to the facility. Page 1 shall be completed for all residents. It must be completed and signed by an authorized representative of the facility and the resident or the resident's guardian. The law requires that the form be completed in duplicate: one copy for the facility and one copy for the resident.

The "Base Rate" amount must be inserted each time the form is completed and the correct time frame circled.

When the resident receives State Supplementary Assistance, the base rate shall be the facility's cost-related per diem, unless that rate is higher than the rate established for private-paying residents. The Department will not pay more for the care of a recipient of State Supplementary Assistance than the facility charges private-paying residents.

Under the State Supplementary Assistance Program, residents moving from an independent living arrangement to an RCF may retain enough of the first month's income to meet maintenance or living expenses connected with the previous living arrangement. A State Supplementary Assistance recipient who transfers from one facility to another may have a refund from the first facility which should be shown as the amount to be paid on admission to the second facility.

In such cases, the income maintenance worker shall determine how much of the resident's income is available for the first-month client participation. Verification of the amount can be obtained from the local Department office.

Page 2 shall be completed for residents who receive State Supplementary Assistance payments. The amount of the resident's personal needs allowance shall be entered.

One copy shall be retained by the facility and filed in the resident's personal file. The other copy shall be given to the resident or the resident's guardian.

Remittance Advice

The IME issues a *Remittance Advice* (RA) for each payment cycle that explains every individual provider claim transaction.

Note that claim credits or recoupments (reversed) appear as regular claims, with the exception that the transaction control number contains a "1" in the twelfth position and reimbursement appears as a negative amount.

An adjustment to a previously paid claim produces two transactions on the RA. The first appears as a credit to negate the claim; the second is the replacement or adjusted claim, containing a "2" in the twelfth position of the transaction control number.

If the total of the credit amounts exceeds that of reimbursement made, the resulting difference (amount of credit - the amount of reimbursement) is carried forward and no payment is issued. Subsequent reimbursement will be applied to the credit balance, as well, until the credit balance is exhausted.

The RA is separated into categories indicating the status of those claims listed:

- ◆ **Paid**, indicating all processed claims, credits, and adjustments for which there is full or partial reimbursement.
- ◆ **Denied**, representing all processed claims for which no reimbursement is made.
- ◆ **Suspended** claims in process, reflecting claims which are currently in process pending resolution of one or more issues (recipient eligibility determination, reduction of charges, third party benefit determination, etc.). These claims have not yet been paid or denied.

Suspended claims may or may not print depending on which of these options you have specified:

- ◆ Print suspended claims only once.
- ◆ Print all suspended claims until paid or denied.
- ◆ Do not print suspended claims.

(Click [here](#) to see a sample of the form, with the fields identified by the indicator in the first column.) A detailed description of each information field follows:

	Field Name	Field Description
A	R.A. No.	Unique number assigned to this Remittance Advice
B	Warrant Number	Check number (Usually zeros. Contact IME for the check number if necessary.)
C	Provider Name	Name of the residential care facility as registered with IME
D	Provider Address	Address registered with IME for the mailing of the Remittance Advice and paper checks
E	Important IME Information	Reminders and updates from IME
F	Run Date	Date the Remittance Advice was created
G	Date Paid	Date the Remittance Advice was mailed and the payment was released
H	Prov. Number	RCF vendor number of the provider
I	Page	Page number
J	Number of Claims	Number of claims processed for each defined status
K	Billed Amount of All Claims	Total dollar amount of claims billed for each defined status
L	Subtotal Amount Paid	Amount paid for each defined status
M	Amount of Deposit	Total payment amount for claims paid on this remittance advice
N	EOB Code	Explanation of benefits (EOB) code or denial code
O	EOB Description	Description of the denial EOB
P	Number of Claims Posting EOB	Number of claims that denied for the EOB code described
Q	Number of Claims on Page	Total number of claims on this page
R	Total Billed Amt on Page	Total billed amount of all claims on this page
S	Total Other Sources on Page	Total third-party insurance payments listed on this page
T	Total Payments on Page	Total dollar amount paid for the claims listed on this page

	Field Name	Field Description
1	Member Name	Name of the State Supplementary Assistance recipient as shown on the Medical Assistance Eligibility Card (last name and first name or initial)
2	Member ID	The State Supplementary Assistance recipient's state identification number (7-digits + a letter)
3	Transaction Control Number	The 17-digit transaction control number that IME assigned to this claim
4	Svc-Date	The beginning and ending dates of the period billed
5	Covered Days	The number of days billed
6	Hospital Days	The number of hospital leave days billed
7	Noncovered Days	The number of noncovered days billed
8	Visit Days	The number of other leave days billed
9	Billed Amount	The total amount billed to State Supplementary Assistance
10	Other Sources	The third-party insurance payment or spenddown amount applied
11	Payment	Total amount paid by State Supplementary Assistance
12	EOB	Explanation of Benefits (EOB) code, if denied. A description of the code can be found on the summary page of the remittance advice (Field O)
13	Previous Date Paid	The claim was paid previously on the given Remittance Advice date
14	Conflicting-TCN	The transaction control number of the previously paid claim
15	Claim Credit	The amount of the claim being credited or recouped
16	Claim Adjustment	The amount of the claim being adjusted or reprocessed
17	NET	Difference paid or recouped from claim credit or adjustment
18	Adj-R	Reason code indicating the reason for the adjustment
19	TCN-To-Credit	The transaction control number of the claim being credited or recouped

Ten-Day Report of Change for FIP and Medicaid, Form 470-0499 or 470-0499(S)

The *Ten-Day Report of Change for FIP and Medicaid* may be used by the resident or the resident's representative to report changes in eligibility factors. Failure to make a timely report may result in loss of benefits for the resident. (Click [here](#) to see a sample of the English form and [here](#) to see a sample of the Spanish form.)

The Department issues the form to the resident:

- ◆ Upon approval of the application,
- ◆ At the time of review,
- ◆ When requested, and
- ◆ As a replacement when the local office receives a completed form.

Keep the form until a reportable change occurs; then resident or the resident's representative shall complete the form and send it to the local DHS office.

When the RCF is the payee, the RCF shall complete the form for the resident. Facilities that are payees for resident's benefits are responsible for monitoring the resident's financial situation and making the required reports.

Facilities that wish to maintain a supply of these forms may order them from Iowa Prison Industries, Anamosa, Iowa 52205. Facilities can obtain a *Form Order Blank* from Anamosa by calling 1-800-332-7922.



TERRY E. BRANSTAD, GOVERNOR

DEPARTMENT OF HUMAN SERVICES

CHARLES M. PALMER, DIRECTOR

December 31, 1996

GENERAL LETTER NO. 6-B-AP-4

ISSUED BY: Bureau of Eligibility/HIPP, Division of Medical Services

SUBJECT: Employees' Manual, Title 6, Chapter B, *State Supplementary Assistance Appendix*, Title page, new; Contents (page 1), new; and page 1, new.

Summary

Comm. 47, the *State Supplementary Assistance Handbook for Residential Care Facilities*, is transferred to new 6-B-Appendix to stay with policies for the State Supplementary Assistance program. Instead of reprinting the *Handbook*, we ask you to move it from Title 5 Appendix to this new Appendix.

Effective Date

January 1, 1997

Material Superseded

None

Additional Information

Please contact your regional benefit payment administrator if you need additional information.



TERRY E. BRANSTAD, GOVERNOR

DEPARTMENT OF HUMAN SERVICES

CHARLES M. PALMER, DIRECTOR

May 20, 1997

GENERAL LETTER NO. 6-B-AP-5

ISSUED BY: Division of Medical Services, Program Services Bureau

SUBJECT: Employees' Manual Title 6, Chapter B, *State Supplementary Assistance Appendix, Handbook for Residential Care Facilities*, Form AA-4036, *Financial and Statistical Report*, revised, and Comm 48, *Instructions for Form AA-4036-0, Financial and Statistical Report*, Contents, page ii, revised, pages 21-23, revised, and pages 24-30, new.

Summary

Schedule C of the *Financial and Statistical Cost Report*, form AA-4036 has been revised to reflect changes mandated by the Iowa Legislature. Nursing facilities (NFs), intermediate care facilities for persons with mental retardation (ICFs-MR), residential care facilities (RCFs), and residential care facilities for persons with mental retardation (RCFs-MR) must use this revised cost report form for cost reporting periods beginning July 1, 1997 and after.

The overall layout of the revised form is the same as the previous version. The difference is that line items have been added to the expense reporting section, and section names have been changed. Areas of revision include:

- Relabeling section headings into *Administrative Costs, Environmental Services, Patient Care Costs, Property Costs, and Other Costs*. The *Patient Care* section has been further subdivided into Direct Health Care Costs and Support Care Costs.
- Listing of employer taxes, group health, life, and retirement benefits, employment advertising, and education and travel expenses in each section.
- Addition of lines for costs associated with conducting criminal record checks.

These changes reflect the recommendations of a study committee convened in the summer of 1996 as directed by the General Assembly. Participants included representatives from the nursing home associations, as well as legislators and staff from several state agencies. The General Assembly mandated that the recommendations of the committee that related to a revised cost report be implemented beginning July 1, 1997.

The changes in Schedule C do **not** affect:

- ◆ Schedules A, B, D, E, F, or G.
- ◆ How the form is filled out.
- ◆ When the reports must be submitted.
- ◆ How a facility's per diem is calculated.
- ◆ The limits currently in place for certain line items, as explained in the instructions for Schedule B (such as the advertising limit and the limit on an owner/administrator salary).

Effective Date

July 1, 1997

Material Superseded

Remove the following pages from the *Handbook for Residential Care Facilities* (Comm.47) and destroy them:

- ◆ Form AA-4036-0, *Financial and Statistical Report*, dated 2/92 (following page 16)
- ◆ Contents (page ii) and pages 21 and 22 of Comm. 48, dated May 1991
- ◆ Page 23 of Comm. 48, dated July 1992

Additional Information

Questions can be directed to the Program Services Bureau at (515) 281-8526. Additional copies of form AA-4036-0 will be available from Iowa State Industries at Anamosa by July 1, 1997.



STATE OF IOWA

CHESTER J. CULVER, GOVERNOR
PATTY JUDGE, LT. GOVERNOR

DEPARTMENT OF HUMAN SERVICES
CHARLES J. KROGMEIER, DIRECTOR

March 26, 2010

GENERAL LETTER NO. 6-B-AP-6

ISSUED BY: Bureau of Long Term Care,
Iowa Medicaid Enterprise

SUBJECT: Employees' Manual, Title 6, Chapter B, Appendix, **STATE SUPPLEMENTARY ASSISTANCE APPENDIX**, Title page, revised; Contents (page 1), revised; page 1, revised; and:

Comm. 47 *State Supplementary Assistance Residential Care Facility Handbook*, revised

Summary

The *State Supplementary Assistance Handbook for Residential Care Facilities* revised to update policies and procedures to reflect current practice. Some of the updates included are:

- ◆ Resident application procedures
- ◆ Facility billing procedures
- ◆ Corrections of legal references, organizational names, addresses and cross-references
- ◆ Revisions to the following forms:
 - 470-0443, *Application and Contract Agreement for Residential Care Facilities*
 - 470-0042, *Case Activity Report*
 - 470-0030, *Financial and Statistical Report*
 - 470-0477, *RCF Admission Agreement*
 - 470-0499, *Ten Day Report of Change for FIP and Medicaid*
- ◆ Addition of the following new forms:
 - 470-0040, *Credit/Adjustment Request*
 - 470-2927, *Health Services Application*
 - 470-0039, *Iowa Medicaid Long Term Care Claim*
 - 470-3118, *Medicaid Review*
 - 470-1911, *Medical Assistance Eligibility Card*
 - 470-3744, *Provider Inquiry*
 - *Remittance Advice*

Effective Date

Immediately.

Material Superseded

Remove the following pages from Employees' Manual, Title 6, Chapter B, Appendix, and destroy them:

<u>Page</u>	<u>Date</u>
Title page	December 31, 1996
Contents (page 1)	December 31, 1996
1	December 31, 1996
Comm. 47	
Title page	April 1988
Contents (page 1)	April 1988
Contents (page 2)	December 1991
1, 2	June 1994
3	April 1988
4	January 1993
5	June 1994
6-11	April 1988
12	July 1990
13	January 1993
14	April 1988
15	April 1991
16	June 1994
AA-4036-0 (470-0030)	/97
Comm. 48	May 1991
Contents (i)	May 1991
Contents (ii)	June 1997
1	May 1991
2	May 1994
3-4a	March 1993
5-15	May 1991
16, 17	November 1993
18-20	May 1991
21-30	June 1997
PA-1108-6 (470-0443)	10/86
17	August 1987
18	April 1988
PA-2365-6 (470-0477)	1/93
19, 20	April 1988
PA 1107-0 (470-0442)	1/94
21	April 1988
22	August 1987
AA-4166 (470-0042)	12/92
23	January 1993
24	October 1992
PA-3159-0 (470-0490)	4/87

25, 26	August 1987
470-2051	10/89
AA-4163-0	None
27-34	December 1991
AA-4164-0 (470-0040) 35	5/93
36	December 1991
AA-4164-0 (470-0040) 37	5/93
38	December 1991
AA-4165-0 (470-0041)	1/87

Additional Information

The Handbook can be found at:

www.ime.state.ia.us/providers

If you do not have Internet access, you may request a paper copy of this material by sending a written request to:

Iowa Medicaid Enterprise
Provider Services
PO Box 36450
Des Moines, IA 50315

Include your vendor number, name, address, provider type, and the general letter number that you are requesting.

If any portion of this manual is not clear, please direct your inquiries to the Iowa Medicaid Enterprise Provider Services Unit.