



Iowa Department of Human Services

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For Human Services use only:

General Letter No. 8-AP-387

Employees' Manual, Title 8
Medicaid Appendix

June 13, 2014

RESIDENTIAL CARE FACILITIES MANUAL TRANSMITTAL NO. 14-1

ISSUED BY: Iowa Medicaid Enterprise

SUBJECT: **RESIDENTIAL CARE FACILITIES**, Title Page, new; Table of Contents, new;

Chapter I, **General Program Policies**, Title Page, Table of Contents (pages 1, 2, and 3), pages 1 through 50, and the following forms:

470-4166	<i>Iowa Medicaid Provider Form Request</i>
470-5047	<i>Certificate of Medical Necessity for Waiver Assistive Devices</i>
470-5048	<i>Certificate of Medical Necessity for Consumer-Directed Attendant Care</i>
470-5049	<i>Certificate of Medical Necessity for Environmental Modification</i>
470-5050	<i>Certificate of Medical Necessity for Home and Vehicle Modification</i>
470-5051	<i>Certificate of Medical Necessity for Prevocational Services</i>
RC-0113	<i>List of Emergency Diagnosis Codes</i>

Chapter II, **Member Eligibility**, Title Page, Table of Contents (pages 1 and 2), pages 1 through 63, and the following forms:

470-2747	<i>Foster Care Provider Medical Letter</i>
470-2747(S)	<i>Foster Care Provider Medical Letter (Spanish)</i>
470-2979	<i>Proof of Application for Medicaid</i>
470-1911	<i>Medical Assistance Eligibility Card</i>
470-2580	<i>Presumptive Medicaid Eligibility Notice of Decision</i>
470-2580(S)	<i>Presumptive Medicaid Eligibility Notice of Decision (Spanish)</i>
470-4164	<i>IowaCare Medical Card</i>
470-3931	<i>Medically Needy Expense Deletion Request</i>
470-4299	<i>Verification of Emergency Health Care Services</i>
470-4299(S)	<i>Verification of Emergency Health Care Services (Spanish)</i>
470-2927	<i>Health Services Application</i>
470-2927(S)	<i>Health Services Application (Spanish)</i>

- 470-4990 *Application for Authorization to Make Presumptive Medicaid Eligibility Determination for Children*
- 470-2582 *Memorandum of Understanding with a Presumptive Provider for Presumptive Medicaid Eligibility Determinations*
- 470-4855 *Application: Presumptive Health Care Coverage for Children*
- 470-4855(S) *Application: Presumptive Health Care Coverage for Children (Spanish)*
- 470-2579 *Application for Authorization to Make Presumptive Medicaid Eligibility Determinations for Pregnant Women*
- 470-2629 *Presumptive Medicaid Income Calculation*
- 470-3864 *Application for Authorization to Make Presumptive Medicaid Eligibility Determinations (BCCT)*

Chapter III, **Provider-Specific Policies**, Title Page, new; Table of Contents (pages 1 and 2), new; pages 1 through 23, new; and the following forms:

- 470-0443 *Application and Contract for Residential Care Facilities, new*
- 470-0030 *Financial and Statistical Report, new*
- 470-0477 *RCF Admission Agreement, new*
- 470-0042 *Case Activity Report, new*
- 470-3118 *Medicaid Review, new*
- 470-3118(S) *Medicaid Review (Spanish), new*
- 470-2927 *Health Services Application, new*
- 470-2927(S) *Health Services Application (Spanish), new*
- 470-0499 *Ten-Day Report of Change for FIP and Medicaid, new*
- 470-0499(S) *Ten-Day Report of Change for FIP and Medicaid (Spanish), new*

Chapter IV, **Billing Iowa Medicaid**, Title page, Contents (pages 1, 2, and 3), pages 1 through 160, and the following forms:

- 470-3969 *Claim Attachment Control*
- UB-04 *Claim Form (CMS-1450)*
- CMS-1500 *Health Insurance Claim Form*
- ADA 2012 Dental Claim Form*
- 470-0039 *Iowa Medicaid Long Term Care Claim*
- 470-4708 *Medicare Crossover Invoice (Professional)*
- 470-4707 *Medicare Crossover Invoice (Institutional)*
- 470-2486 *Claim for Targeted Medical Care*
- 470-0829 *Request for Prior Authorization*
- 470-3970 *Prior Authorization Attachment Control*
- 470-3744 *Provider Inquiry*
- 470-0040 *Adjustment Request*
- 470-4987 *Recoupment Request*

Appendix, Title Page, Table of Contents, and pages 1 through 22

Summary

This letter transmits a new manual for residential care facilities. The manual is comprised of five sections:

- ◆ Chapter I contains information about Iowa Medicaid administration, coverage, and reimbursement that applies to all types of providers.
- ◆ Chapter II describes the different ways of attaining and demonstrating Medicaid eligibility. It also applies to all provider types.
- ◆ Chapter III explains Medicaid requirements specific to residential care facilities. The chapter:
 - Aligns with current policies, procedures, and terminology.
 - Ensures that current contact information is provided.
 - Includes links to forms to ensure that the most recent version of the form is accessible.
- ◆ Chapter IV contains instructions and forms to bill Iowa Medicaid. It also applies to all provider types.
- ◆ The Appendix contains directories of local offices of the Department of Human Services and the Social Security Administration and EPSDT care and coordination agencies.

Date Effective

Upon receipt.

Material Superseded

None.

Additional Information

The updated provider manual containing the revised pages can be found at:
<http://dhs.iowa.gov/sites/default/files/rcf.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.

Residential Care Facilities

Provider Manual



**Iowa Department
of Human Services**



Iowa
Department
of Human
Services

Provider
Residential Care Facilities

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Date
June 1, 2014

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CHAPTER III. PROVIDER-SPECIFIC POLICIES

A. INTRODUCTION

This provider manual 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 (RCF) in the State Supplementary Assistance (SSA) 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 SSA 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 SSA 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 SSA, 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 SSA program. DHS has adopted rules at 441 Iowa Administrative Code (IAC) Chapters 50 through 54 to administer the SSA program. Please see below to view individual chapters.

- ◆ 441 IAC Chapter 50: Application for Assistance
- ◆ 441 IAC Chapter 51: Eligibility
- ◆ 441 IAC Chapter 52: Payment
- ◆ 441 IAC Chapter 54: Facility Participation



RCF requirements are contained in 441 IAC Chapter 54.

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

- ◆ 481 IAC Chapter 57: Standards for licensing RCFs
- ◆ 481 IAC Chapter 63: Standards for licensing of residential care facilities for the intellectually disabled
- ◆ 481 IAC Chapter 62: Standards for residential care facilities for persons with mental illness
- ◆ 481 IAC Chapter 60: Physical standards for all types of RCFs
- ◆ 481 IAC Chapter 50 and 481 IAC Chapter 56: General procedures for licensing, training, and enforcement

B. FACILITY PARTICIPATION REQUIREMENTS

1. 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 an intellectual disability (RCF/ID) or a residential care facility for persons with mental illness (RCF/PMI).

2. Institutional Status

No SSA 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 SSA recipients must meet all SSI standards except for income, this restriction also applies to the SSA program.

APPLICATION AND CONTRACT AGREEMENT FOR RESIDENTIAL CARE FACILITIES

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

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

Application Date _____ Provider Number _____

Name of Residential Care Facility _____

Address _____
(Street) (City) (ZIP)

License No. _____ Effective _____ Telephone No. _____

Type of Organization:

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

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

Total Licensed Bed Capacity _____

(Complete only if facility is rented or leased)

Lessor _____

Address _____

Check One

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

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

Fiscal Year _____

County Number _____

Vendor Code _____

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

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

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

III. The Facility Agrees:

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

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

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

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

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

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

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

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

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

IV. The Department and the Facility Agree:

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

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

That this contract shall not be transferable or assignable.

Signature of Administrator of Facility

Date

INSTRUCTIONS

Fill out and return one copy to:

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



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

Each RCF shall complete an *Application and Contract Agreement for Residential Care Facilities*, form 470-0443, when it wishes any of its residents to receive SSA payments. Click [here](#) to view the form online. The form also may be requested by contacting IME Provider Services at (800) 338-7909, locally in Des Moines at (515) 256-4609, or by email at imeproviderservices@dhs.state.ia.us. Use the form to:

- ◆ Spell out the conditions under which a facility may participate in the SSA program,
- ◆ Describe the responsibilities of the Department and the facility, and
- ◆ 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.

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.

4. *Choice of Payment System*

Under the SSA program, the operator of an RCF 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.



a. 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.

b. 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 an *Electronic Financial and Statistical Report*, form 470-0030, to the IME Provider Audits and Rate Setting Unit no later than three months after the close of the facility's established fiscal year. Click [here](#) to view the form online.

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 SSA shall not exceed the average rate established by the facility for the private-pay resident.

c. Financial and Statistical Report

RCFs use the *Financial and Statistical Report* to report costs under the SSA program. (Nursing facilities and intermediate care facilities for the intellectually disabled also use this form to report costs under the Medicaid program.)

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 the facility's fiscal year. IME Provider Audits and Rate Setting Unit mails a reminder to facilities when cost reports are due.

Completed financial reports are to be submitted in an electronic format using the state-approved Microsoft® 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.

Click [here](#) to access the state-approved Microsoft® Excel template for electronic submission.

**Welcome to the
IOWA DEPARTMENT OF HUMAN SERVICES
ELECTRONIC FINANCIAL AND STATISTICAL REPORT**

The Financial and Statistical Report is now available in a Version 97 Excel workbook .

The Workbook contains the following 21 worksheets:

Certification	E
Statistical Data	F
A	G
A - 1	H
A - 2	H - 1
B	I
C	I - 1
C - 1	SUPPORTING SCHEDULE (1)
D	SUPPORTING SCHEDULE (2)
D - 1	EDITS
	PRINT

Please refer to the Iowa Department of Human Services Division of Medical Services General Instructions prior to completing the Financial and Statistical Report.

Workbook Structure

The Workbook contains an electronic version of each schedule of the paper version of the Financial and Statistical Report. Supporting schedules (worksheets) may be added to the workbook, but no schedules should be deleted. The tab name assigned to each worksheet corresponds to the related cost report schedule. For example, the tab labeled C contains Schedule C-Schedule of Expenses, H contains Schedule H-Nursing Facility Wages and Hours. Four schedules have been added which are specific to the electronic version: Supporting Schedule (1), Supporting Schedule (2), Edits and Print.

Each worksheet in the Workbook can be accessed by clicking on the corresponding tab at the bottom of the screen. A scroll bar is available at the bottom of the screen to navigate through the tab bar.

Supporting Schedules

Two worksheets, Supporting Schedules 1 and 2, are available within the Workbook so that you may provide additional information if necessary. The worksheets are formatted to fit a single page (8 1/2" x 11"). If your information is larger than the defined area it may cause your cost report to print incorrectly when utilizing the print buttons provided in the Print worksheet. It is suggested that large files be included in the Workbook by adding a new worksheet at the end of the Workbook after the Print worksheet.

Printing Options

Print options are found in the last tab of the Workbook titled Print. When you click on this tab, you will find two buttons which have been programmed to print paper copies. The top button will print the Financial and Statistical Report and the Edit Report. The bottom button will print the Financial and Statistical Report only. Additional worksheets added to the basic Workbook will need to be printed individually by using the Print option found in the File menu.

The print buttons found in the Print worksheet may not be compatible with certain PC and printer configurations. Therefore, if you experience problems printing, you may need to alter margins, page break settings, etc. in order to print the Financial and Statistical Report.

**IOWA DEPARTMENT OF HUMAN SERVICES
FINANCIAL AND STATISTICAL REPORT**

[11101] Facility Name		[11201] Federal ID Number	
Physical Address (Required)			
[12102] Street	[12103] City	[12104] State	[12105] Zip
Period of Report		[12110] County	
[13101] From:	[13102] To:		
[14101] Date Facility Entered Program	[14102] Date Owner Acquired Facility	[14120] FYE (mm/dd)	
[15101] Type of Control (Check Only One)			
GOVERNMENT	NON-PROFIT ORGANIZATION	PROPRIETARY	
<input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other	<input type="checkbox"/> Church Operated <input type="checkbox"/> Church Related <input type="checkbox"/> Other Non-Profit	<input type="checkbox"/> Individual <input type="checkbox"/> Partnership	<input type="checkbox"/> Corporation <input type="checkbox"/> "S" Corporation

[16101] VENDOR NUMBER BY TYPE OF FACILITY		
No.	Program Type	Vendor Number
1	Nursing Facility	
2	Residential Care Facility	
3	Assisted Living	
4	ICF/MR	
5	RCF/MR	
6	Other	

CERTIFICATION STATEMENT

Misrepresentation or falsification of any information contained in this cost report may be punishable by fine and imprisonment under state or federal law.

I CERTIFY that I have read the above statement and that I have examined the accompanying cost report and supporting schedules. To the best of my knowledge and belief, it is a true and complete statement prepared from the records of the provider in accordance with applicable instructions. I further certify that costs have been properly allocated between or among programs and that no cost has been reported more than once as a reimbursable cost.

[17101] An opinion of a certified public accountant of the fairness of presentation of operating results or revenues and expense is attached. Yes No

Questions concerning financial data included in this report should be directed to:		
Name	Position/Title	Telephone
Name of Officer or Administrator of Facility		Date
Title / Position		Telephone
Name of Preparer		Date
Preparer Company Name		Telephone
Signature of Preparer		Signature of Officer or Administrator of Facility

IOWA FINANCIAL AND STATISTICAL REPORT

Facility Name:	Vendor No.
Period of Report: From:	To:

[18101] Accounting Basis (Check only one)

Accrual
 Modified Cash
 Cash

[19101] Statistical Data

Line No.	Type of Facility	# Authorized Beds		Total Bed Days in Reporting Period (3)	Patient Days in Reporting Period		Medicaid Utilization Col 5/4 (6)	Percent Occupancy Col 4/3 (7)	Number of Admissions (8)	Number of Discharges (9)
		Start of Period (1)	End of Period (2)		Total (4)	Medicaid (5)				
1	Nursing Facility									
2	RCF									
3	Assisted Living - Grant Funded									
4	Assisted Living - Non-Grant Funded									
5	ICF/MR									
6	RCF/MR									
7	Other									
8	TOTAL									

[20101] Does this facility have an Assisted Living Grant?
 Yes
 No

[20102] Does this facility have a CCDI Unit?
 Yes
 No

[21101] Ownership Information

Line No.	Name of Owner (1)	% of Work Week Devoted to Business (2)	Title (3)	Salaries and Wages (4)	Social Security Number (5)	% Ownership in Home (6)
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						

Note: Attach additional schedules as necessary to complete ownership information.

IOWA FINANCIAL AND STATISTICAL REPORT

Facility Name:	Vendor No.
Period of Report: From:	To:

SCHEDULE A TOTAL FACILITY REVENUE										
REVENUES	Line No.	Medicaid (1)	Medicare (2)	Private Pay (3)	Other (4)	Total (5)	Nursing Facility (6)	Other (7)	ENTER IN COLUMN 2 SCHEDULE C	
									Adjustment Amount (8)	Line No. (9)
RESIDENT REVENUE CENTERS:										
Routine daily service	211									
Pharmacy-drugs & medications	212									76
Routine medical supplies	213									70
Non-Routine medical supplies	214									71
Laboratory	215									78
X-Ray	216									77
Occupational Therapy	217									56
Physical Therapy	218									57
Speech Therapy	219									58
Respiratory Therapy	220									59
Professional care, physician	221									99
Beauty, barber shop	222									93
Personal purchases for residents	223									94
Activities	224									
Other Ancillary	225									
OTHER REVENUE CENTERS:										
Revenue from meals sold to guest & employee	226									75
Rental Income	227									
Income of telephone charges paid by	228									10
Purchase discounts, if recorded	229									
Revenues from supplies employees	230									
Rebates	231									
Religious Income	232									
Investment Income (see instructions)	233									88
Other	234									
Gifts	235									
Donations	236									
	237									
GROSS REVENUE	238									
DEDUCTIONS FROM REVENUE:										
Free Care and Allowances	239									
Provision for uncollectible accounts	240									
TOTAL DEDUCTIONS	241									
NET REVENUE	242									

AVERAGE PRIVATE PAY RATE	
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IOWA FINANCIAL AND STATISTICAL REPORT

Facility Name:		Vendor No.:	
Period of Report: From:		To:	

**SCHEDULE A-1
NF CONVERSION / LTC SERVICE DEVELOPMENT GRANT REVENUE**

Assisted Living Grant Revenue

REVENUE	LINE NO.	Medicaid (1)	Waiver (2)	HUD Low Income Credits (3)	HCBS Rent Subsidy (4)	In-Home Care (5)	Private (6)
RESIDENT REVENUE							
Room	240						
Board	241						
Services	242						
Amenities	243						
	244						
Other	245						
Gifts	246						
Donations	247						
	248						
	249						
TOTAL ASSISTED LIVING REVENUE	250						

Service Development Grant Revenue

REVENUE	LINE NO.	Medicaid Revenue (1)	Waiver Revenue (2)	Private Revenue (3)	Number of Units Medicaid (4)	Number of Units Waiver (5)	Number of Units Private (6)
PROGRAM REVENUE							
Home Care	251						
Home Delivered Meals	252						
Adult Day Care	253						
Respite Care	254						
Transportation	255						
Chore Services	256						
PACE	257						
Other	258						
	259						
	260						
TOTAL SERVICE DEVELOPMENT GRANT REVENUE	261						

Facility Name:	Vendor No.:
Period of Report: From:	To:

SCHEDULE A - 2 DESCRIPTION OF LIVING UNITS										
ASSISTED LIVING - GRANT FUNDED										
Line No. (1)	Type of Living Unit (2)	Number of Living Units (3)	Number of Square Feet (4)	Resident Days during Period		Monthly Rental Rate				
				Medicaid Residents (5)	Total Residents (6)	Medicaid Residents (7)		Non-Medicaid Residents (8)		
271	Type A		One-bedroom							
			Two-bedroom				Room		Room	
			Efficiency				Board		Board	
272	Type B		One-bedroom							
			Two-bedroom				Room		Room	
			Efficiency				Board		Board	
273	Type C		One-bedroom							
			Two-bedroom				Room		Room	
			Efficiency				Board		Board	
274	Type D		One-bedroom							
			Two-bedroom				Room		Room	
			Efficiency				Board		Board	
275	Type E		One-bedroom							
			Two-bedroom				Room		Room	
			Efficiency				Board		Board	
276	Type F		One-bedroom							
			Two-bedroom				Room		Room	
			Efficiency				Board		Board	
277	Type G		One-bedroom							
			Two-bedroom				Room		Room	
			Efficiency				Board		Board	
278	Type H		One-bedroom							
			Two-bedroom				Room		Room	
			Efficiency				Board		Board	
279	Type I		One-bedroom							
			Two-bedroom				Room		Room	
			Efficiency				Board		Board	
280	Type J		One-bedroom							
			Two-bedroom				Room		Room	
			Efficiency				Board		Board	

SCHEDULE A - 2 DESCRIPTION OF LIVING UNITS										
ASSISTED LIVING - NON-GRANT FUNDED										
Line No. (1)	Type of Living Unit (2)	Number of Living Units (3)	Number of Square Feet (4)	Resident Days during Period		Monthly Rental Rate				
				Medicaid Residents (5)	Total Residents (6)	Medicaid Residents (7)		Non-Medicaid Residents (8)		
281	Type A		One-bedroom							
			Two-bedroom				Room		Room	
			Efficiency				Board		Board	
282	Type B		One-bedroom							
			Two-bedroom				Room		Room	
			Efficiency				Board		Board	
283	Type C		One-bedroom							
			Two-bedroom				Room		Room	
			Efficiency				Board		Board	
284	Type D		One-bedroom							
			Two-bedroom				Room		Room	
			Efficiency				Board		Board	
285	Type E		One-bedroom							
			Two-bedroom				Room		Room	
			Efficiency				Board		Board	
286	Type F		One-bedroom							
			Two-bedroom				Room		Room	
			Efficiency				Board		Board	
287	Type G		One-bedroom							
			Two-bedroom				Room		Room	
			Efficiency				Board		Board	
288	Type H		One-bedroom							
			Two-bedroom				Room		Room	
			Efficiency				Board		Board	
289	Type I		One-bedroom							
			Two-bedroom				Room		Room	
			Efficiency				Board		Board	
290	Type J		One-bedroom							
			Two-bedroom				Room		Room	
			Efficiency				Board		Board	

IOWA FINANCIAL AND STATISTICAL REPORT

Facility Name:		Vendor No.:
Period of Report:	From	To:

SCHEDULE B EXPENSE ADJUSTMENTS					
DESCRIPTION	LINE NO.	EXPENSE (1)	ALLOWABLE (2)	ENTER IN COLUMN 3, SCHEDULE C	
				Adjustment amount (3)	Line(s) # (4)
NONREIMBURSABLE EXPENSES:					
Provisions for income tax	411				95
Fees paid Board of Directors	412				97
Non-Working officer's salaries	413				98
Travel & Entertainment. See Instructions	414				16
Donations	415				100
Expenses of non-participating facilities	416				
Fund-raising expenses	417				
Pharmacy, drugs, and medications	418				76
Insurance premiums on life of officer, owner	419				96
Other expenses not related to resident care	420				
EXPENSE LIMITATIONS:		EXPENSE (1)	ALLOWABLE (2)		
Compensation of owners/related parties. See Instructions					
Position					
Administrator	421				1
Assistant Administrator	422				2
Management Fees	423				13
Nursing Director	424				40
Other	425				
Services, facilities, supplies furnished by organizations related to the facility by common ownership or control					
Rental Equipment	426				
Services & supplies (describe)	427				
	429				
Rental of Facility. See instructions.					
Payments	430				
Lessor's Cost:					
Depreciation	432				
Amortization	433				
Interest	434				
Property tax	435				
Other	436				
Return on Equity	437				
Reduction - IF Column 1 < Column 2					
Advertising expense in excess of the lesser of \$7,200 or an amount computed at 2% of daily revenue	439				17
Allowable Depreciation - Schedule D and D-1	440				84
Interest expense on loans from partners, proprietors, stockholders or related organizations. See Instructions.	441				88
EXPENSE ADDITIONS:		EXPENSE (1)	ALLOWABLE (2)		
Compensation of nonsalaried proprietors and partners or members of religious orders.					
Administrator	442				1
Nursing Director	443				40
Other	444				
TOTAL	445				

NOTE: Enter adjustments on Schedule C on the line for the expense center affected.

IOWA FINANCIAL AND STATISTICAL REPORT

Facility Name:	0	Vendor No.:	0
Period of Report: From:	01/00/00	To:	01/00/00

SCHEDULE C SCHEDULE OF EXPENSES

SCHEDULE OF EXPENSES	Line No.	Expenses per General Ledger (1)	Adjustment of Expenses		Resident Expenses (4)	Allocation Basis (5)	NF (6)	RCF (7)	Assisted Living (8)	ICF/MR (9)	RCF/MR (10)	Other (11)	Total Equals Column 4 (12)
			Sch. A. (2)	Sch. B (3)									
Administrator Wages	1				0								0
Business Office Wages	2				0								0
Employer's taxes (Admin.)	3				0								0
Grp Life & Retire Benefits (Admin.)	4				0								0
Worker's comp. Insurance (Admin.)	5				0								0
Emp. Advertising / Recruit. (Admin.)	6				0								0
Criminal record checks (Admin.)	7				0								0
Education and training (Admin.)	8				0								0
Supplies (Admin.)	9				0								0
Telephone	10				0								0
Equipment rental (Admin.)	11				0								0
Home office costs	12				0								0
Management fees	13				0								0
Acct., legal & other professional fees	14				0								0
General liability insurance	15				0								0
Travel, entertainment, and auto	16				0								0
Advertising and public relations	17				0								0
	18				0								0
TOTAL ADMINISTRATIVE COSTS	19	0	0	0	0		0	0	0	0	0	0	0
Laundry wages	20				0								0
Housekeeping wages	21				0								0
Maintenance wages	22				0								0
Employer's taxes (Environ.)	23				0								0
Grp Life & Retire Benefits (Environ.)	24				0								0
Worker's comp. Insurance (Environ.)	25				0								0
Emp. Advertising / Recruit. (Environ.)	26				0								0
Criminal record checks (Environ.)	27				0								0
Education and training (Environ.)	28				0								0
Supplies, laundry	29				0								0
Supplies, housekeeping	30				0								0
Supplies, maintenance	31				0								0
Utilities	32				0								0
Purchased services, laundry	33				0								0
Purchased services, housekeeping	34				0								0
Purchased services, maintenance	35				0								0
Equipment repairs	36				0								0
Equipment rental (Environ.)	37				0								0
	38				0								0
TOTAL ENVIRONMENTAL SERVICE COSTS	39	0	0	0	0		0	0	0	0	0	0	0
D.O.N. wages	40				0								0
R.N. wages	41				0								0
L.P.N. wages	42				0								0
C.N.A. wages	43				0								0
Activities wages	44				0								0
Social service wages	45				0								0
Employer's taxes (Dir. Health)	46				0								0
Grp Life & Retire Benefits (Dir. Health)	47				0								0
Worker's comp. Insurance (Dir. Health)	48				0								0
Emp. Advertising / Recruit. (Dir. Health)	49				0								0
Criminal record checks (Dir Health)	50				0								0
Education and training (Dir Health)	51				0								0
Certified nursing aide training	52				0								0
Contracted professional social services	53				0								0
Professional support services	54				0								0
Contracted nursing services	55				0								0
Occupational Therapy	56				0								0
Physical Therapy	57				0								0
Speech Therapy	58				0								0
Respiratory Therapy	59				0								0
	60				0								0
TOTAL DIRECT PATIENT CARE COSTS	61	0	0	0	0		0	0	0	0	0	0	0
Medical record wages	62				0								0
Medical director	63				0								0
Dietary service wages	64				0								0
Employer's taxes (Support)	65				0								0
Grp Life & Retire Benefits (Support)	66				0								0
Worker's comp. Insurance (Support)	67				0								0
Emp. Advertising / Recruit. (Support)	68				0								0
Criminal record checks (Support)	69				0								0
Routine supplies, patient care services	70				0								0
Non-routine supplies, patient care services	71				0								0
Supplies, dietary services	72				0								0
Supplies, activities	73				0								0
Supplies, social services	74				0								0
Food and nutritional supplements	75				0								0
Pharmacy services	76				0								0
X-ray services	77				0								0
Laboratory	78				0								0
Professional support services	79				0								0
Equipment rental (Support)	80				0								0
	81				0								0
TOTAL SUPPORT CARE COSTS	82	0	0	0	0		0	0	0	0	0	0	0
TOTAL PATIENT CARE SERVICE COSTS	83	0	0	0	0		0	0	0	0	0	0	0
Depreciation	84				0								0
Amortization	85				0								0
Real estate taxes	86				0								0
Facility lease	87				0								0
Interest	88				0								0
Property and casualty insurance	89				0								0
Building and grounds repairs	90				0								0
	91				0								0
TOTAL PROPERTY COSTS	92	0	0	0	0		0	0	0	0	0	0	0
Beauty and barber shops	93				0								0
Personal purchases for residents	94				0								0
Income taxes	95				0								0
Officer's life insurance	96				0								0
Director fees	97				0								0
Nonworking officers' salaries	98				0								0
Professional care (Physicians)	99				0								0
Contributions	100				0								0
	101				0								0
TOTAL OTHER COSTS	102	0	0	0	0		0	0	0	0	0	0	0
TOTAL OF ALL EXPENSES	103	0	0	0	0		0	0	0	0	0	0	0

IOWA FINANCIAL AND STATISTICAL REPORT

Facility Name:	0	Vendor No.:	0
Period of Report:	From: 01/00/00	To:	01/00/00

Note: This schedule is required only if the facility has an assisted living grant.

SCHEDULE C-1 Assisted Living Expense Allocation								
SCHEDULE OF EXPENSES	Line No.	Allocation Basis (1)	Grant Funded Statistic (2)	Non-Grant Funded Statistic (3)	Total Statistic (4)	Grant Funded (5)	Non-Grant Funded (6)	Total Expenses (7)
Administrator Wages	1				0	0	0	0
Business office wages	2				0	0	0	0
Employer's taxes (Admin.)	3				0	0	0	0
Grp/Life & Retire Benefits (Admin.)	4				0	0	0	0
Worker's comp. Insurance (Admin.)	5				0	0	0	0
Emp. Advertising / Recruit. (Admin.)	6				0	0	0	0
Criminal record checks (Admin.)	7				0	0	0	0
Education and training (Admin.)	8				0	0	0	0
Supplies (Admin.)	9				0	0	0	0
Telephone	10				0	0	0	0
Equipment rental (Admin.)	11				0	0	0	0
Home office costs	12				0	0	0	0
Management fees	13				0	0	0	0
Acct., legal & other professional fees	14				0	0	0	0
General liability insurance	15				0	0	0	0
Travel, entertainment, and auto	16				0	0	0	0
Advertising and public relations	17				0	0	0	0
	18				0	0	0	0
TOTAL ADMINISTRATIVE COSTS	19					0	0	0
Laundry wages	20				0	0	0	0
Housekeeping wages	21				0	0	0	0
Maintenance wages	22				0	0	0	0
Employer's taxes (Environ.)	23				0	0	0	0
Grp/Life & Retire Benefits (Environ.)	24				0	0	0	0
Worker's comp. Insurance (Environ.)	25				0	0	0	0
Emp. Advertising / Recruit. (Environ.)	26				0	0	0	0
Criminal record checks (Environ.)	27				0	0	0	0
Education and training (Environ.)	28				0	0	0	0
Supplies, laundry	29				0	0	0	0
Supplies, housekeeping	30				0	0	0	0
Supplies, maintenance	31				0	0	0	0
Utilities	32				0	0	0	0
Purchased services, laundry	33				0	0	0	0
Purchased services, housekeeping	34				0	0	0	0
Purchased services, maintenance	35				0	0	0	0
Equipment repairs	36				0	0	0	0
Equipment rental (Environ.)	37				0	0	0	0
	38				0	0	0	0
TOTAL ENVIRONMENTAL SERVICE COSTS	39					0	0	0
D.O.N. wages	40				0	0	0	0
R.N. wages	41				0	0	0	0
L.P.N. wages	42				0	0	0	0
C.N.A. wages	43				0	0	0	0
Activities wages	44				0	0	0	0
Social service wages	45				0	0	0	0
Employer's taxes (Dir. Health)	46				0	0	0	0
Grp/Life & Retire Benefits (Dir. Health)	47				0	0	0	0
Worker's comp. Insurance (Dir. Health)	48				0	0	0	0
Emp. Advertising / Recruit. (Dir. Health)	49				0	0	0	0
Criminal record checks (Dir. Health)	50				0	0	0	0
Education and training (Dir. Health)	51				0	0	0	0
Certified nursing aide training	52				0	0	0	0
Contracted professional social services	53				0	0	0	0
Professional support services	54				0	0	0	0
Contracted nursing services	55				0	0	0	0
Occupational Therapy	56				0	0	0	0
Physical Therapy	57				0	0	0	0
Speech Therapy	58				0	0	0	0
Respiratory Therapy	59				0	0	0	0
	60				0	0	0	0
TOTAL DIRECT PATIENT CARE COSTS	61					0	0	0
Medical record wages	62				0	0	0	0
Medical director	63				0	0	0	0
Dietary service wages	64				0	0	0	0
Employer's taxes (Support)	65				0	0	0	0
Grp/Life & Retire Benefits (Support)	66				0	0	0	0
Worker's comp. Insurance (Support)	67				0	0	0	0
Emp. Advertising / Recruit. (Support)	68				0	0	0	0
Criminal record checks (Support)	69				0	0	0	0
Routine supplies, patient care services	70				0	0	0	0
Non-routine supplies, patient care services	71				0	0	0	0
Supplies, dietary services	72				0	0	0	0
Supplies, activities	73				0	0	0	0
Supplies, social services	74				0	0	0	0
Food and nutritional supplements	75				0	0	0	0
Pharmacy services	76				0	0	0	0
X-ray services	77				0	0	0	0
Laboratory	78				0	0	0	0
Professional support services	79				0	0	0	0
Equipment rental (Support)	80				0	0	0	0
	81				0	0	0	0
TOTAL SUPPORT CARE COSTS	82					0	0	0
TOTAL PATIENT CARE SERVICE COSTS	83					0	0	0
Depreciation	84				0	0	0	0
Amortization	85				0	0	0	0
Real estate taxes	86				0	0	0	0
Facility lease	87				0	0	0	0
Interest	88				0	0	0	0
Property and casualty insurance	89				0	0	0	0
Building and grounds repairs	90				0	0	0	0
	91				0	0	0	0
TOTAL PROPERTY COSTS	92					0	0	0
Beauty and barber shops	93				0	0	0	0
Personal purchases for residents	94				0	0	0	0
Income taxes	95				0	0	0	0
Officer's life insurance	96				0	0	0	0
Director fees	97				0	0	0	0
Nonworking officers' salaries	98				0	0	0	0
Professional care (Physicians)	99				0	0	0	0
Contributions	100				0	0	0	0
	101				0	0	0	0
TOTAL OTHER COSTS	102					0	0	0
TOTAL OF ALL EXPENSES	103					0	0	0

IOWA FINANCIAL AND STATISTICAL REPORT

Facility Name:	Vendor No.:
Period of Report: From:	To:

**SCHEDULE D
DEPRECIATION AND AMORTIZATION EXPENSE**

Description	Line No.	Construction in Process (1)	Asset Cost (2)	Depreciation Allowable in Prior Years (3)	Method (4)	Annual Rate % (5)	Recorded Depreciation Expense (6)	Straight Line Depreciation (7)
EQUIPMENT:								
Building Equipment (fixed)	750							
Department Equipment	751							
Other Equipment	752							
Office Furniture & Fixtures	753							
Motor Vehicles	754							
Equipment	755							
	756							
TOTAL	757							

BUILDINGS:								
Facility	758							
Additions	759							
Other	760							
	761							
Land Improvements	762							
	763							
TOTAL	764							
TOTAL BUILDINGS AND EQUIPMENT	765							

LEASEHOLD IMPROVEMENTS								
Description	Line No.	Construction (1)	Cost (2)	Prior Amount (3)	Period (4)	Recorded (5)	Straight Line (6)	
	766							
	767							
	768							
	769							
	770							
	771							
TOTAL AMORTIZATION	772							

[77101] Questions:

1. Are the lessor or lessee the same person or group of persons or controlled by the same person or group of persons? Yes No

2. Does the lease contain an option to purchase the leased property? Yes No

IOWA FINANCIAL AND STATISTICAL REPORT

Facility Name:	Vendor No.:
Period of Report: From	To:

**SCHEDULE D-1
CHANGE OF OWNERSHIP**

[78101] Has the facility changed owners since June 18, 1984?

- YES** Complete this schedule
 NO This schedule does not apply

	Line No.	Previous Owner's Cost (1)	New Purchases Since Change (2)	Depreciation Allowable in Prior Years (3)	Allowable Straight-Line Depreciation (4)
EQUIPMENT:					
Building equipment (fixed)	780				
Department equipment	781				
Other equipment	782				
Office furniture & fixtures	783				
Motor vehicles	784				
	785				
Less equipment not purchased	786				
TOTAL	787				
BUILDINGS:					
Facility	788				
Additions	789				
Other	790				
	791				
Land Improvements	792				
	793				
Less buildings not purchased	794				
TOTAL	795				
TOTAL BUILDINGS AND EQUIPMENT	796				

IOWA FINANCIAL AND STATISTICAL REPORT

Facility Name:	Vendor No.:
Period of Report: From:	To:

**SCHEDULE E
COMPARATIVE BALANCE SHEET**

All information to be taken from the general ledger.	Line No.	Balance at the End of:	
		Current Period (1)	Prior Period (2)
ASSETS:			
Cash	801		
Investments (Money Market Certificate of Deposit, etc.)	802		
Receivable from residents	803		
Receivable from others	804		
Fixed Assets:	805		
Land	806		
Buildings and improvements	807		
Less allowance for depreciation (per books)	808		
Equipment (including motor vehicles)	809		
Less allowance for depreciation (per books)	810		
Leasehold Improvements	811		
Less allowance for amortization	812		
Construction in Process	813		
Other assets	814		
TOTAL ASSETS	815		
LIABILITIES:			
Accounts payable	816		
Accrued taxes (payroll and property)	817		
Other liabilities	818		
	819		
Notes and mortgages payable to officers, stockholders, owners, etc.	820		
Notes and mortgages payable to others	821		
TOTAL LIABILITIES	822		
EQUITY:			
Capital stock	823		
Paid-in surplus	824		
Retained surplus	825		
Partners' and proprietor's capital account(s)	826		
Partners' and proprietor's drawing account(s)	827		
Equity (nonprofit organization)	828		
TOTAL EQUITY	829		
TOTAL LIABILITIES AND EQUITY	830		

IOWA FINANCIAL AND STATISTICAL REPORT

Facility Name:	Vendor No.:
Period of Report From:	To:

**SCHEDULE F
RECONCILIATION OF EQUITY**

	Line No.	Current Period
TOTAL EQUITY BEGINNING OF PERIOD	850	
Add:		
Net revenue from Schedule A	851	
Capital stock issued	852	
Partners' and proprietor's additional investment	853	
Other: Explain	854	
	855	
	856	
Deduct:		
Expenses per general ledger from Schedule C	857	
Capital stock retired	858	
Sub "S" corporation distribution	859	
Partners' and proprietor's withdrawals	860	
Dividends	861	
Other: Explain	862	
	863	
	864	
TOTAL EQUITY END OF PERIOD	865	

Facility Name:	Vendor No.:
Period of Report: From:	To:

**SCHEDULE G
RELATED PARTY TRANSACTIONS**

[90101] Does this cost report include any costs associated with services, facilities or supplies furnished by a related party or organization?

Yes - Complete This Schedule

No - This Schedule Does Not Apply

Name of Related Party or Organization (1)	Line No.	Description of Service or Supplies (2)	Amount (3)	Schedule (4)	Line (5)
	900				
	901				
	902				
	903				
	904				
	905				
	906				
	907				
	908				
	909				
	910				
	911				
	912				
	913				
	914				
	915				
	916				
	917				
	918				

IOWA FINANCIAL AND STATISTICAL REPORT

Facility Name:	Vendor No.:
Period of Report: From	To:

**SCHEDULE H
NURSING FACILITY WAGES AND HOURS**

Sch C Line No.	Occupation or Employment Category	Entry Level Hourly Wage (1)	Total Wages Schedule C NF (2)	Total Hours NF (3)	Average Hourly Wage (4)	Average Hours Per Patient Day (5)
1	Administrator wages					
2	Business Office wages					
12	Home office costs					
18						
20	Laundry wages					
21	Housekeeping wages					
22	Maintenance wages					
38						
40	D.O.N. wages					
41	R.N. wages					
42	Licensed Practical Nurses wages					
43	Certified Nurse Aides wages					
44	Activities wages					
45	Social Services wages					
52	Certified nursing aide training wages					
54	Professional support services					
55	Contracted nursing services					
56	Occupational Therapy					
57	Physical Therapy					
58	Speech Therapy					
59	Respiratory therapy					
60						
62	Medical Records Services wages					
63	Medical Director wages					
64	Dietary Service Wages					
81						
91						
93	Beauty and barber shops					
97	Director fees					
98	Nonworking officers' salaries					
99	Professional Care (Physicians)					
101						

IOWA FINANCIAL AND STATISTICAL REPORT

Facility Name:	Vendor No.:
Period of Report: From:	To:

**SCHEDULE H - 1
ASSISTED LIVING WAGES AND HOURS**

Sch C Line No.	Occupation or Employment Category	Entry Level Hourly Wage (1)	Total Wages Schedule C - 1 Assisted Living (2)	Total Hours Assisted Living (3)	Average Hourly Wage (4)	Average Hours Per Resident Day (5)	Allocation of Staff Time			
							Assisted Living % of time (6)	Nursing Facility % of time (7)	Service Development % of time (8)	Other % of time (9)
1	Administrator wages									
2	Business Office wages									
12	Home office costs									
18										
20	Laundry wages									
21	Housekeeping wages									
22	Maintenance wages									
38										
40	D.O.N. wages									
41	R.N. wages									
42	Licensed Practical Nurses wages									
43	Certified Nurse Aides wages									
44	Activities wages									
45	Social Services wages									
52	Certified nursing aide training wages									
54	Professional support services									
55	Contracted nursing services									
56	Occupational Therapy									
57	Physical Therapy									
58	Speech Therapy									
59	Respiratory therapy									
60										
62	Medical Records Services wages									
63	Medical Director wages									
64	Dietary Service Wages									
81										
91										
93	Beauty and barber shops									
97	Director fees									
98	Nonworking officers' salaries									
99	Professional Care (Physicians)									
101										

IOWA FINANCIAL AND STATISTICAL REPORT

Facility Name:	Vendor No.:
Period of Report: From:	To:

**SCHEDULE I
FULL TIME EMPLOYEE RETENTION AND TURNOVER RATES**

- 1. Total number of W-2's _____
- 2. **Adjustment:** Number of W-2's for temporary or part-time employees _____
- 3. Total number of full time employees who worked anytime during the year. _____
- 4. **Adjustment:** Number of full time employees hired during the year _____
- 5. Total number of full time employees who were employed at the start of the year _____
- 6. **Adjustments:** Number of full time employees separated anytime during the year. _____
- 7. Number of full time employees who worked the entire year. _____

Full time employee retention rate	_____
Full time employee turnover rate	_____

IOWA FINANCIAL AND STATISTICAL REPORT

Facility Name:	0	Vendor No.:	0
Period of Report: From	01/00/00	To:	01/00/00

SCHEDULE I-1 **Nursing**
Facility Annual Calculation Of Employee Turnover

Total Number of Employees on the First day of each Month														Average for the Year	
Sch C Line No.	Job Classification	January	February	March	April	May	June	July	August	September	October	November	December	Total	
1	Administrator													0	0.00
2	Business Office													0	0.00
20	Laundry													0	0.00
21	Housekeeping													0	0.00
22	Maintenance													0	0.00
40	D.O.N.													0	0.00
41	R.N.													0	0.00
42	Licensed Practical Nurses													0	0.00
43	Certified Nurse Aides													0	0.00
44	Activities													0	0.00
45	Social Services													0	0.00
62	Medical Records Services													0	0.00
63	Medical Director													0	0.00
64	Dietary Service													0	0.00
	Other Staff													0	0.00
Total		0	0	0	0	0	0	0	0	0	0	0	0	0	0.00

Total Number of Terminations Each Month														Average Turnover Rate	
Sch C Line No.	Job Classification	January	February	March	April	May	June	July	August	September	October	November	December	Total	
1	Administrator													0	0%
2	Business Office													0	0%
20	Laundry													0	0%
21	Housekeeping													0	0%
22	Maintenance													0	0%
40	D.O.N.													0	0%
41	R.N.													0	0%
42	Licensed Practical Nurses													0	0%
43	Certified Nurse Aides													0	0%
44	Activities													0	0%
45	Social Services													0	0%
62	Medical Records Services													0	0%
63	Medical Director													0	0%
64	Dietary Service													0	0%
	Other Staff													0	0%
Total		0	0	0	0	0	0	0	0	0	0	0	0	0	0%

Nursing Only		0%
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IOWA FINANCIAL AND STATISTICAL REPORT

Facility Name:	Vendor No.:
Period of Report: From:	To:

SUPPORTING SCHEDULE (1)

IOWA FINANCIAL AND STATISTICAL REPORT

Facility Name:	Vendor No.:
Period of Report: From:	To:

SUPPORTING SCHEDULE (2)

IOWA FINANCIAL AND STATISTICAL REPORT

NAME OF FACILITY:	VENDOR NUMBER(s):
PERIOD OF REPORT	FROM: TO:

EDIT CHECKS

Diagnostics Summary - Any differences indicate that numbers are not flowing properly between the schedules.
Note: These amounts will automatically fill in based on your completed Financial and Statistical Report

Schedule Reference	Amount	Reference
Schedule C		
Total Costs		Line 103 Column 4
Total Costs - Allocated		Line 103 Column 12
Difference		
Total Admin Costs		Line 19 Column 4
Total Admin Costs - Allocated		Line 19 Column 12
Difference		
Total Env Costs		Line 39 Column 4
Total Env Costs - Allocated		Line 39 Column 12
Difference		
Total Patient Care Costs		Line 83 Column 4
Total Patient Care Costs - Allocated		Line 83 Column 12
Difference		
Total Property Costs		Line 92 Column 4
Total Property Costs - Allocated		Line 92 Column 12
Difference		
Total Other Costs		Line 102 Column 4
Total Other Costs		Line 102 Column 12
Difference		

Schedule E		
Total Assets		Current Period Column - Total Assets
Total Liabilities & Equity		Current Period Column - Total Liabilities and Equity
Difference		

Schedule F		
Total Equity - Sch E		Current Period Column - Total Equity
Total Equity - Sch F		Total Equity End of Period
Difference		

COMPLETED SCHEDULES

Diagnostics Summary - Any Warning message must be resolved.
Note: Required Schedules will automatically be determined based on your

Schedule	Required	Completed
Vendor Number	Yes	Warning - Schedule must be completed.
Certification Statement	Yes	Warning - Schedule must be completed.
Statistical Data	Yes	Warning - Schedule must be completed.
Schedule A - Total Facility Revenue	Yes	Warning - Schedule must be completed
Schedule A-1	N/A	N/A
Schedule A-2	No	N/A
Schedule C	Yes	Warning - This schedule must be completed.
Schedule C-1	No	N/A
Schedule D	Yes	Warning - Schedule must be completed
Schedule D-1	No	N/A
Schedule E	Yes	Warning - This schedule must be completed.
Schedule F	Yes	Warning - This schedule must be completed.
Schedule G	No	N/A
Schedule H	Yes	Warning - This schedule must be completed.
Schedule H-1	No	N/A
Schedule I	Yes	Warning - This schedule must be completed.
Schedule I-1	Yes	Warning - This schedule must be completed.

COMPLETED QUESTIONS

Diagnostics Summary - Any Warning message must be resolved.
Note: Required Questions will automatically be determined

Schedule	Required	Completed
Certification Statement [15101]	Yes	Warning - Question must be answered
Certification Statement [17101]	Yes	Warning - Question must be answered
Statistical Data [18101]	Yes	Warning - Question must be answered
Statistical Data [20101]	Yes	Warning - Question must be answered
Statistical Data [20102]	Yes	Warning - Question must be answered
Schedule D [77101]	Yes	Warning -Part 1 and 2 must be answered.
Schedule D-1 [78101]	Yes	Warning - Question must be answered
Schedule G [90101]	Yes	Warning - Question must be answered

RCF ADMISSION AGREEMENT

_____ and
Facility

_____ Resident

The base rate shall be \$ _____ (per day)(per month). The services provided for in the base rate shall include room, board, linens and bedding, supervision and other personal services which are required for health, safety and wellbeing of the resident.

The base rate shall **not** include those items and services entered in the attached listing which has been prepared by the facility.

No additional fees shall be charged for items not listed or subsequently agreed to in writing by both parties. The resident may be charged for nonprescription drugs, personal supplies, and services by a barber, beautician, etc.

Payments shall be made in advance of care, payable by the

_____ day of each month. The amount of \$ _____ shall be paid on the date of admission. The resident shall be charged for the day of admission, but not the day of discharge.

The facility shall inform the resident or resident's guardian in writing of changes in the overall rates of both base and additional charges at least 30 days before the effective date of the change.

The facility shall inform the resident or resident's guardian of changes in additional charges based on a change in the resident's condition before the date the revised additional charges begin. If communicated orally, notification shall follow in writing within 7 days, listing the specific adjustments made.

If the resident dies or leaves the facility, the facility shall refund to the resident or resident's guardian any payments made in advance for the days after the resident leaves, including the date of death or discharge.

Any charge for supplies, outside services, or personal purchases shall be deducted from any refund due.

A facility shall not involuntarily discharge or transfer a resident from a facility except: (1) for medical reasons; (2) for the resident's welfare or that of other residents; (3) for nonpayment. The resident requires 30 days advance notice in writing of termination of this contract.

The resident or the resident's guardian shall have the right at all times to discharge the resident from the facility voluntarily, provided the person in charge of the facility is given proper notification so that a proper transfer or discharge can be made. The facility requires 14 days advance notice of planned discharge or transfer of a resident.

If a resident has a temporary absence from a facility for medical treatment, the facility shall hold the bed open for a minimum of ten days upon request and receive full payment for the absent period.

Payment will be made for periods the resident is absent overnight for the purpose of visitation or vacation in accordance with IAC 441--52.1(3) "e".

The facility may not relocate residents from one room to another unless deemed necessary by an appropriate qualified staff member for the following reason: (1) because of incompatibility with other roommates, (2) for the welfare of the residents of the facility, (3) for medical, nursing, or psychosocial reasons, (4) to allow a new admission to the facility which would otherwise not be possible due to separation of roommates by sex, (5) to allow transfer of a private paying resident who becomes eligible for State Supplementary Assistance from a private room to a semi private room or from one semiprivate room to another, or (6) because of reasonable administrative decisions regarding the use of the building.

Unreasonable and unjustified reasons for changing a resident's room without the agreement of the resident or responsible party include: (1) change from private pay status to State Supplementary Assistance, except as outlined in paragraph 5 above, (2) punishment, (3) discrimination on the basis of race or religion.

If relocation within the facility is necessary, the resident shall be notified at least 48 hours prior to the transfer. The reason shall be explained. The resident's guardian shall be notified as soon as possible. Notification shall be documented in the resident's record and signed by the resident or residents's guardian. (Chapter 63.34(2) a, b and c).

Prior to admission, the resident shall deliver to the facility a current physical and medical history. It shall be certified by a licensed physician and indicate the resident's required level of care.

The resident, or resident's guardian shall be responsible for all medical expenses ordered by the attending physician, and for optional services or goods delivered to resident by providers other than this facility.

All terms of this Agreement are subject to the provisions of Chapter 135C of the Code of Iowa.

Admitted and Agreed to by:

Signature of Administrator of Facility

Title

Date

I acknowledge receipt of a copy of this Agreement.

Resident

Date

Guardian or Conservator

Address of Guardian or Conservator

Telephone No.

Date

Iowa Department of Human Services

ADDITION TO ADMISSION AGREEMENT
Recipients of State Supplementary Assistance

In addition to the Admission Agreement, the _____ facility and _____, resident agree to these terms:

1. The facility agrees to provide all services required by the terms of its license, the rules in the Iowa Administrative Code governing the license, the terms of the Application and Contract Agreement for Residential Care Facilities, the requirements in the Department of Human Services Handbook for Residential Care Facilities and the rules in the Iowa Administrative Code governing the payment of State Supplementary Assistance.
2. The facility agrees to furnish the recipient's room as required by licensing rules without additional charges to the recipient or to any person acting on the recipient's behalf. When the recipient wishes to provide an item of room equipment, the facility may grant this request.
3. The facility agrees to provide personal services, including necessary supervision or assistance with moving about, grooming, hair washing, shaving, personal hygiene, bathing, getting in and out of bed, dressing, feeding and with medication that can be self-administered. Personal laundry services shall be provided as a part of the goods and services paid through the program.
4. The facility agrees to make no additional charge for this care, over and above the rate established by the Department, nor to accept any additional payments by other persons, organizations or governmental units to cover this care. Additional payment for services which go beyond those required of a residential care facility may be allowed with approval of the Department of Human Services.
5. The Resident agrees to pay for this care according to Department of Human Services policy; that is, to retain _____ per month to cover personal needs and to make all other income (including State Supplementary Assistance payments received on approximately the 20th day of the month following the month of service) available to the facility furnishing this care. (In addition to the personal needs allowance of _____ per month, a resident who is employed may retain \$65.00 per month of the earnings to cover work expense plus one-half of the remaining earned income.)
6. If the facility manages the personal needs account of the recipient, the facility agrees to abide by the policy established by the Department of Human Services relative to the handling of the recipient's personal funds.
7. The facility shall allow the recipient to be absent from the facility for periods of hospitalization and visitation, and shall bill for these days and provide documentation as required by Department of Human Services policy.

Signature of Administrator of Facility

Signature of Recipient, Guardian or Conservator

Title

If other than recipient, indicate relationship

Date

Address for mailing purposes

Telephone Number



NOTE: An RCF 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.

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.

Electronic files can be sent by email 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
PO Box 36450
Des Moines, IA 50315

5. 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.

a. 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](#) for more information.

b. 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,
- ◆ A fully completed *RCF Admission Agreement*, form 470-0477, (formerly PA-2365-6), signed by both the facility and the resident, and
- ◆ Proof of expenditures for a resident's "Personal Needs."

Click [here](#) to view form 470-0477 online.



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

c. 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 be comingled with trust funds from any other facility.
 - Personal needs funds shall not be comingled 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 a purchase is made through the checking account on behalf of 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.
- ◆ 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.

6. Report to Department

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

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

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

If a resident's financial circumstances change in a manner that may affect SSA 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.



7. **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 view the form online. 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). The 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 SSA 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 SSA program.
- ◆ “Total billing days on claim to fiscal agent” is the total of the previous three lines.

Within two business days of the member’s death or discharge from the facility, mail the form to the Department’s local office. Keep a copy for the facility’s records.



Case Activity Report

Complete this form when a Medicaid applicant or member enters or leaves your facility, and when a resident of your facility applies for Medicaid. See the back of this form for instructions.

1. Member Data

Name		Date Entered Facility
Social Security Number	State ID	Case Number

2. Facility Data

Provider Number/NPI Number	Facility Type:		
	<input type="checkbox"/> Nursing facility	<input type="checkbox"/> Skilled nursing facility	<input type="checkbox"/> Swingbed
	<input type="checkbox"/> ICF/ID	<input type="checkbox"/> PMIC	<input type="checkbox"/> Hospice
	<input type="checkbox"/> PACE	<input type="checkbox"/> RCF	<input type="checkbox"/> MHI
Name		DHS Per Diem	
Street Address	City	State	Zip
Signature of Person Completing Form		Date Completed	
Contact Name		Contact Phone Number	

3. Level of Care

This information is determined by IME Medical Services Unit, Medicare or by a managed care contractor. For clarification, PMIC must indicate if this is PMIC mental health or PMIC substance abuse. Do not complete this section for hospice.

Level of Care	Level of Care Process:	Effective Date
	<input type="checkbox"/> IME Medical Services <input type="checkbox"/> Medicare	
	<input type="checkbox"/> Managed care <input type="checkbox"/> Utilization Board	
	<input type="checkbox"/> Out-of-state skilled preapproval	

4. Medicare Information for either Skilled Patients or Hospice Patients in Facilities

If there is any change in this coverage, please notify the county DHS office.

Do you expect this stay to be covered by Medicare?	Expected dates of Medicare coverage
<input type="checkbox"/> No <input type="checkbox"/> Yes, see dates:	_____ through _____

5. Discharge Data

Date of Discharge _____	Reason for Discharge
<u>Last Month in Facility</u> (for residents who transfer to another facility or level of care):	<input type="checkbox"/> Died
_____ Days in facility	<input type="checkbox"/> Hospital stay (less than 10 days, form is not required)
_____ Reserve bed days	<input type="checkbox"/> Transferred to another facility
_____ Non-covered days	Name _____
_____ Total billing days on claim to fiscal agent	Level of care, if known _____
	<input type="checkbox"/> Moved to new living arrangement
	Address, if available _____

If you have any questions, please contact IME Provider Services, 1-800-338-7909, locally 515-256-4609, or by email at imeproviderservices@dhs.state.ia.us.

Instructions for Preparing the Case Activity Report:

- ◆ When a current resident applies for Medicaid, complete sections 1, 2, and 3. Enter the resident's first name, middle initial, and last name as they appear on the *Medical Assistance Eligibility Card*. The state ID number is assigned by the Iowa Department of Human Services and consists of seven digits plus one letter, e.g. 1100234G.
- ◆ When a Medicaid applicant or member enters the facility or changes level of care, complete sections 1, 2, and 3 and, if applicable, section 4.
- ◆ When there is Medicare coverage and the Medicaid rate is higher than the Medicare rate, complete sections 1, 2, and 4.
- ◆ When a Medicaid applicant or member dies or is discharged, complete sections 1, 2, and 5.
- ◆ This form must be completed within two business days of the action.
- ◆ The administrator or designee responsible for the accuracy of this information should sign in section 2.

Distribution Instructions for NFs, Hospice, Community ICF/IDs, SNFs, and Swingbed:

Mail, email or fax a copy to the DHS Centralized Facility Eligibility Unit. Keep a copy.

Centralized Facility Eligibility Unit
Imaging Center 1
Iowa Department of Human Services
417 E. Kanesville Blvd.
Council Bluffs, IA 51503-4470
Fax: 515-564-4040 email: facilities@dhs.state.ia.us

Note: Form 470-2618, *Election of Medicaid Hospice Benefit*, must accompany this *Case Activity Report* for hospice patients.

Distribution Instructions for PMICs:

Mail, email or fax a copy to the DHS Centralized Facility Eligibility Unit. Keep a copy.

Centralized Facility Eligibility Unit – PMIC
Imaging Center 1
Iowa Department of Human Services
417 E. Kanesville Blvd.
Council Bluffs, IA 51503-4470
Fax: 515-564-4040 email: CSAPMIC@dhs.state.ia.us

Distribution Instructions for PACE:

Mail, email or fax a copy to the Woodbury Adult Intake Team. Keep a copy.

Woodbury Adult Intake Team
Imaging Center 1
Iowa Department of Human Services
417 E. Kanesville Blvd.
Council Bluffs, IA 51503-4470
Fax: 515-564-4014 email: 97cmz2@dhs.state.ia.us

Distribution Instructions for RCFs, MHIs, and State Resource Centers:

Mail or fax a copy to your county DHS income maintenance worker. Keep a copy.



C. RESIDENT ELIGIBILITY

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

1. Physician's Statement

All admissions to RCFs shall be based on a written order signed by a physician certifying the person being admitted does not require nursing services.

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 SSA 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.

2. Application

SSA 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 SSA 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 date the form to show intent to ask for SSA.

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



a. *Medicaid Review, Form 470-3118 or 470-3118(S)*

Medicaid Review, form 470-3118 or 470-3118(S), is designed to enable the resident to present to the local Department office the information needed to determine eligibility for SSA at the time of review. The Department will mail the form to the resident when a review is due.

- ◆ Click [here](#) to view the English version of the form.
- ◆ Click [here](#) to view the Spanish version of the 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.

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

The *Health Services Application*, form 470-2927 or 470-2927(S), is designed to enable the applicant to present to the Department's local office the information needed to determine eligibility for SSA and Medicaid.

- ◆ Click [here](#) to view the English version of the form.
- ◆ Click [here](#) to view the Spanish version of the 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
PO Box 430
Anamosa, IA 52205

Facilities can obtain a *Form Order Blank* from Anamosa by calling (800) 332-7922.

Medicaid Review

County Number:

Worker Name:

Case Number:

Phone No.:

Instructions

It is time for your eligibility for Medicaid or State Supplementary Assistance to be reviewed. You must answer the questions on this form and **sign Page 4**. Use only blue or black ink. Then, return it to the imaging center address by

Be sure to send proof of your expenses, income and assets. Send copies because we cannot return originals to you.

If you leave a space blank, we will take that to mean that you have no information to give us. You may be asked to prove what you tell us. Please use an additional sheet of paper, if needed. Most of the information that we ask for is required. You do not have to answer questions that are marked as optional. Your answers are used to decide if you can continue to get Medicaid. If you do not return the form by the due date or give us information, your Medicaid may stop. Call us if you have any questions.

Information About Your Family

List yourself and the people who live in your home.

Name (First, Last)	Relationship to You	Age	Social Security Number
	Self		

Tell us if your mailing or living address changed from the address shown above.

Mailing address			Living address		
City	State	Zip Code	City	State	Zip Code

Do you have a guardian, conservator, or representative? If yes, print their names here: _____

Expenses

To get the most help you can, tell us about your expenses. **Send proof of your expenses.**

Medical expenses

If you pay for health insurance, write in how much you pay:

Amount \$ _____ per month

If you started or changed health insurance, write in the name of the new company:

If your health insurance ended, write in the date it stopped:

Date: _____

List anyone in your home who has ongoing medical bills that Medicaid does not pay:

Who: _____

Relationship to you: _____

Other expenses

List your share of any day care paid for a child or a disabled adult who lives with you:

Who gets care: _____

Amount \$ _____ per month

If anyone currently pays child support, give the following information:

Who pays: _____

Amount \$ _____ per month

Income

List income of the people in your home. This includes you, your spouse, and your unmarried children under the age of 18 who are living with you or who are living in a nursing home.

Where the Money Comes From	Who Gets the Money	Gross Amount Per Month
Social Security, Social Security Disability, or SSI		
Veterans, Pensions or Retirement Benefits		
Unemployment, Worker's Compensation or Disability		
Child Support or Alimony		
Cash Medical Support		
Money from Friends or Relatives		
Money from Interest or Dividends		
Money You Get from Contracts		
Money From Work Before Taxes (Gross)		
Self-Employment or Odd Jobs		
Tips, Bonuses and Commissions		
Other:		

List the name of all employers: _____

Send proof of your money from work for the past 30 days.

Do you work for anyone who pays you in the form of food, clothing or shelter? Yes No

Does anyone give you food, clothing or shelter? Yes No

Assets

List all cars, trucks, boats, campers, motorcycles or other licensed or unlicensed vehicles that anyone in your home owns or is buying:

Make	Model	Year	Value or Worth	Amount Owed

List the total money everyone in your home has in:

Type	Who	Bank or Location	Amount
Cash			
Bank/Credit Union Accounts (Checking, savings, etc.)			
Stocks, bonds, savings certificates, IRAs, Keogh or other assets			
Nursing home account			
Other			

Send your most recent bank statement with this form.

List anyone in your home who has or owns any land, buildings or houses other than the house you live in: _____

List anyone in your home who has or has sold a conservatorship, trust or life estates: _____

If you bought, changed, or disposed of life insurance, a burial contract, or a burial plot in the past year, tell us about the change: _____

If you got an inheritance or turned down an inheritance, list the following:

When? _____ Amount \$ _____

If anyone gave away anything of value, transferred anything for less than its value, or added someone else's name to a resource, tell us:

When? _____ What? _____

Other Changes or Comments

Your Signature

I understand that if the children on this application are not eligible for Medicaid, this application may be referred to the **hawk-i** program to see if the children could get **hawk-i** health care coverage.

I certify, under penalty of perjury, that:

- My answers are correct and complete to the best of my knowledge.
- I kept the information on page 7 and 8.

Your Signature or Mark	Phone Number	Today's Date
Signature of Person, If Any, Who Helped Complete the Form	Relationship/Phone Number	Today's Date

Remember to send proof of your expenses, income and assets.

Addendum to Application and Review Forms for Release of Information

OPTIONAL Release of Information

Help Us Help You!

You do not have to sign this, but it will help us get information we need to help you, without having to get your signature on specific requests.

You should know that:

- We may need more information to decide if you can get assistance.
- If more information is needed from you, you will get a letter telling you what we need and the date you must get it to us.
- You are responsible to get the information or to ask us for help to get it.
- If you do not give us the information or ask for help by the due date, your application may be denied or your assistance may stop.
- We may be able to use the release below to get the information we need. **But you still have to provide information we request or ask us for help.**
- We may attach a copy of this release to a form that asks other people or organizations (like your employer) for specific information needed about you or others in your household.

Print and sign your name below to give us permission to get needed information.

RELEASE OF INFORMATION

I hereby authorize any person or organization to give the Iowa Department of Human Services requested information about me or other members of my household.

A copy of this release is as valid as the original.

This release does not apply to protected health information.

This release is good for 12 months from the date signed.

Your Name (please print clearly)

Other Adult Name (please print clearly)

Signature or Mark

Signature or Mark

Date

Keep this page for your records.

You Have the Right to Appeal

You, or the person helping you, may request an appeal hearing if you do not agree with any action taken on your case. To appeal in writing do **one** of the following:

- Fill out an appeal electronically at <https://dhssecure.dhs.state.ia.us/forms/>, **or**
- Write a letter telling us why you think a decision is wrong, **or**
- Fill out an Appeal and Request for Hearing form. You can get this form at your county DHS office.

Send or take your appeal to the Department of Human Services, Appeals Section, 5th Floor, 1305 E Walnut Street, Des Moines, Iowa 50319-0114. If you need help filing an appeal, ask your county DHS office.

You can represent yourself. Or, you can have a friend, relative, lawyer or someone else act on your behalf.

You may contact your county DHS office about legal services. You may have to pay for these legal services. If you do, your payment will be based on your income. You may also call Iowa Legal Aid at (800) 532-1275. If you live in Polk County, call (515) 243-1193.

You Will Not Be Discriminated Against

It is the policy of the Iowa Department of Human Services (DHS) to provide equal treatment in employment and provision of services to applicants, employees and clients without regard to race, color, national origin, sex, sexual orientation, gender identity, religion, age, disability, political belief or veteran status.

If you feel DHS has discriminated against or harassed you, please send a letter detailing your complaint to:

Iowa Department of Human Services, Office of Human Resources, Hoover Building – 1st Floor, 1305 E. Walnut, Des Moines IA 50319-0114; fax (515) 281-4243, or via e-mail stopit@dhs.state.ia.us

Changes You Need to Tell Us About

Within 10 days of the date the change happens, you must tell the DHS county office about changes, such as:

- Income, including any one-time payments you get
- Resources, which includes getting an inheritance or a one-time payment of past due child support
- Someone moving in or out of your home
- Your health insurance coverage
- You file an insurance claim or get an attorney to recover bills paid by Medicaid
- Someone is no longer disabled

Things You Need to Know

By signing this form, you give permission to release confidential information to the Quality Control unit or Investigations unit. You must cooperate with them to keep your benefits.

You will have to pay back any benefits you got or that was paid to a third party on your behalf for which you were not eligible.

Section 1128B of the Social Security Act provides federal penalties for fraudulent acts and false reporting in connection with these programs.

Anyone who gets, tries to get, or helps any other person get assistance to which they are not entitled, is guilty of violating the laws of the State of Iowa. This includes, but is not limited to, Iowa Code Chapters 249, 249A and 249F.

You must give the social security numbers for everyone who wants Medicaid. This is required by Section 1137(a)(1) of the Social Security Act and 42 CFR 435.910. We use social security numbers to:

- Identify people who apply for or get Medicaid
- Verify income and eligibility for Medicaid
- Match records with other agencies

By signing this application, you give your permission for DHS to share:

- The status of your Medically Needy case, the amount of your spenddown, and the bills used to meet your spenddown with the provider whose bills are being used.
- If the Medicaid for Employed People with Disabilities (MEPD) premium has been paid by the due date with your Medical provider.

You agree to assign medical payments from a third party to the Medicaid agency for you and others who are eligible for Medicaid for whom you legally can assign benefits. You also agree to cooperate in obtaining medical payments from third parties.

Medicaid Review (Revisión de Medicaid)

Número del condado:

Nombre del trabajador:

Número de caso:

Teléfono del trabajador:

Instrucciones

Es hora de que su elegibilidad para Medicaid o para State Supplementary Assistance (Asistencia Complimentaria del Estado) sea revisada. Usted debe responder las preguntas de este formulario y **firmar la página 4**. Utilizo solo tinta azul o negro. A continuación, volver a la dirección del centro de formación de imágenes por

Asegúrese de enviar prueba de sus gastos, ingresos y activos. Envía copias porque no podemos volver a los originales que.

Si deja un espacio en blanco, entenderemos que significa que no tiene información para suministrarlos. Se le puede pedir que pruebe lo que nos dice. Por favor utilice una hoja de papel adicional si lo necesita. La mayoría de la información que solicitamos es obligatoria. Usted no tiene que contestar las preguntas que están marcadas como opcionales. Sus respuestas son usadas para decidir si puede seguir recibiendo Medicaid. Si no regresa el formulario antes de la fecha límite o no nos proporciona información, su Medicaid puede suspenderse. Llámenos si tiene alguna pregunta.

Información Acerca de su Familia

Lístese usted y las personas que viven en su hogar.

Nombre (Nombre, Apellido)	Relación con Usted	Edad	Número de Seguridad Social
	Usted		

Infórmenos si su dirección postal o de residencia es diferente de la que se indica anteriormente.

Dirección postal			Dirección en la que vive		
Ciudad	Estado	Código Postal	Ciudad	Estado	Código Postal

¿Tiene usted un guardián, curador o representante? Si es sí, escribir sus nombres:

Gastos

Para obtener la mayor cantidad de ayuda, infórmenos sobre sus gastos. **Envíe prueba de sus gastos.**

Gastos médicos

Si usted paga un seguro de salud, escriba cuánto paga: Cantidad \$ _____ por mes

Si inició o cambió el seguro de salud, escriba el nombre de la nueva compañía: _____

Si su seguro de salud terminó, escriba la fecha en que lo hizo: Fecha: _____

Liste a cualquiera en su hogar que tenga facturas médicas en curso, que Medicaid no pague:

Quién: _____ Relación con usted: _____

Otros gastos

Mencione su participación en el pago por el cuidado diurno de un niño o adulto discapacitado que viva con usted:

¿Quién recibe el cuidado? _____ Cantidad \$ _____ por mes

Si alguien paga el mantenimiento del niño, suministre la siguiente información:

¿Quién paga? _____ Cantidad \$ _____ por mes

Ingreso

Liste el ingreso de las personas que viven en su hogar. Esto le incluye a usted, a su cónyuge y a hijos solteros menores de 18 años, que vivan con usted o que vivan en una institución de enfermería especializada.

De Dónde Proviene el Dinero	Quién Obtiene el Dinero	Cantidad Bruta Mensual
Seguridad Social, Incapacidad de la Seguridad Social o SSI		
Beneficios de Veteranos, Pensiones o Jubilación		
Desempleo, Indemnización del Trabajador o Incapacidad		
Mantenimiento de Niños o Pensión de Alimentos		
Dinero para ayuda médica		
Dinero de Amigos o Parientes		
Dinero de Intereses o Dividendos		
Dinero Obtenido de Contratos		
Dinero del Trabajo sin Incluir Impuestos (Bruto)		
Trabajo Independiente o Trabajos Ocasionales		
Propinas, Bonos y Comisiones		
Otros:		

Nombre a todos los empleadores: _____

Enviar pruebas de su dinero del trabajo de los últimos 30 días.

¿Trabaja usted para alguien que le paga en forma de alimentación, ropa o albergue? Sí. No

¿Alguien le suministra alimentación, ropa, or albergue? Sí. No

Activos

Liste todos los autos, camiones, barcos, camperos, motocicletas y cualquier otro vehículo con o sin licencia que cualquiera en su hogar posea o esté comprando:

Marca	Modelo	Año	Valor o avalúo	Monto de la deuda

Mencione el total de dinero que todos tienen en:

Tipo	Quién	Banco o ubicación	Cantidad
Efectivo			
Cuentas bancarias o de unions de crédito (Corrientes, de ahorros, etc.)			
Acciones, bonos, certificados de ahorro, IRAs, Keogh u otros activos			
Cuenta del ancianato			
Otros			

Envíe su estado de cuenta bancaria más reciente junto con este formulario.

Liste a cualquier miembro de su hogar que tenga o posea algún terreno, edificios o casas distintas de la casa en que vive: _____

Liste a cualquier miembro de su hogar que tenga o haya vendido bienes en custodia, en fideicomiso o en usufructo: _____

Si usted compró, cambió o dispuso de un seguro de vida, un contrato funerario o un lote funerario durante el último año, infórmenos acerca del cambio: _____

Si recibió o rechazó una herencia, mencione lo siguiente:

¿Cuándo? _____ Cantidad \$ _____

Si alguien ha regalado algo de valor, transferido algo por menos de su valor, o a añadido el nombre de alguien más a un recurso, infórmenos:

¿Cuándo? _____ ¿Qué? _____

Otros Cambios o Comentarios

Su Firma

Entiendo que, si los niños que están en esta solicitud no son elegibles para recibir Medicaid, esta solicitud puede ser enviada al programa **hawk-i** para ver si pueden obtener la cobertura de salud **hawk-i**.

Certifico, bajo la gravedad del juramento, que:

- Mis respuestas son correctas y completas según mi leal saber y entender.
- Guardé la información en la páginas 7 y 8.

Su firma o marca	Número de teléfono	Fecha de hoy
Firma de la persona que ayudó a llenar el formulario, si la hay	Relación/teléfono	Fecha de hoy

Acuérdese de enviar prueba de sus gastos, ingresos y activos.

**Addendum to Application and Review Forms for Release of Information
(Adenda de los Formularios de Solicitud y Revisión para Divulgación de Información)**

Divulgación de Información OPCIONAL

¡Ayúdenos a ayudarle!

No es obligatorio que firme esta autorización, pero nos ayudaría a obtener la información que necesitamos para ayudarle, y no tendríamos que pedirle que firme solicitudes específicas.

Debe saber que:

- Podríamos necesitar más información para decidir si puede obtener asistencia.
- Si necesitáramos que nos proporcione más información, recibirá una carta informándole qué necesitamos y la fecha en debe entregarla.
- Es su responsabilidad conseguir dicha información o pedirnos que le ayudemos a conseguirla.
- Si no nos proporciona dicha información ni nos pide ayuda antes de la fecha de entrega de la misma, su solicitud podría ser denegada o la asistencia podría terminar.
- Podríamos utilizar la siguiente autorización para obtener la información necesaria. **Pero aún así, deberá conseguir la información que le solicitemos o pedirnos ayuda para conseguirla.**
- Podríamos adjuntar una copia del mismo a otros formularios para solicitarles a otras personas u organizaciones (como, por ejemplo, su empleador) que nos proporcionen información específica sobre usted o los miembros de su grupo familiar.

Escriba su nombre en letra de imprenta y firme debajo para autorizarnos a obtener la información necesaria.

**DIVULGACIÓN DE INFORMACIÓN
(Release of Information)**

Por la presente autorizo a cualquier individuo u organización a entregar a Department of Human Services de Iowa la información solicitada sobre mi persona o mi grupo familiar.

(I hereby authorize any person or organization to give the Iowa Department of Human Services requested information about me or other members of my household.)

Una copia de esta autorización es tan válida como el original.

(A copy of this release is as valid as the original.)

Esta autorización no es válida en el caso de información protegida referida a la salud.

(This release does not apply to protected health information.)

Esta autorización es válida por 12 meses a partir de la fecha de mi firma.

(This release is good for 12 months from the date signed.)

Su nombre (en imprenta legible)
(Your Name – please print clearly)

Nombre de otro adulto (en imprenta legible)
(Other Adult Name – please print clearly)

Firma o marca
(Signature or Mark)

Firma o marca
(Signature or Mark)

Fecha
(Date)

Mantener esta página para sus archivos.

Usted Tiene Derecho a Apelar

Usted o quien le esté ayudando, puede solicitar una audiencia de apelación en caso que usted no esté de acuerdo con alguna acción tomada en su caso. Para apelar por escrito, haga **una** de las siguientes cosas:

- Llene una apelación electrónicamente en <https://dhssecure.dhs.state.ia.us/forms/>, ó
- Escriba una carta en la que nos diga por qué cree que la decisión está errada, o
- Llene un formulario de Apelación y Solicitud de Audiencia. Puede obtener este formulario en la oficina del DHS de su condado.

Envíe o lleve su apelación al Department of Human Services, Appeals Section, 5th Floor, 1305 E Walnut Street, Des Moines, Iowa 50319-0114. Si necesita ayuda para llenar una apelación, solicítela en la oficina del DHS de su condado.

Usted puede representarse a sí mismo(a). O puede hacer que un amigo, pariente, abogado o alguien más actúe en su nombre.

Puede contactar su oficina del DHS del condado para obtener servicios legales. Es posible que deba pagar por estos servicios legales. Si lo hace, su pago se basará en su ingreso. También puede llamar a Iowa Legal Aid al (800) 532-1275. Si vive en Polk County, llame al (515) 243-1193.

No Será Discriminado

Es política del Iowa Department of Human Services ofrecer trato igualitario en cuanto a empleo y ofrecimiento de servicios a los solicitantes, empleados y clientes, sin importar su raza, color, nacionalidad, sexo, orientación sexual, identidad de género, religión, edad, incapacidad, creencia política o estatus de veterano.

Si cree que DHS le ha discriminado o acosado, le agradeceremos que envíe una carta explicando detalladamente su queja a:

Iowa Department of Human Services, Office of Human Resources, Hoover Building – 1st Floor, 1305 E. Walnut, Des Moines IA 50319-0114; fax (515) 281-4243, o a través de correo electrónico a stopit@dhs.state.ia.us

Cambios Que Debe Informarnos

Dentro de los 10 días siguientes a que el cambio ocurra, deberá informar a la oficina del DHS del condado acerca de cambios como:

- Ingresos, incluyendo pagos por una única vez que usted reciba
- Recursos, que incluyen la obtención de una herencia o pagos atrasados de apoyo infantil
- Alguien que se entre a vivir o salga de su hogar
- La cobertura de su seguro de salud
- Si usted reclama un seguro o consigue un abogado para recuperar facturas pagadas por Medicaid
- Alguien que ya no esté incapacitado

Cosas Que Debe Saber

Mediante la firma de este formulario, usted concede permiso para revelar información confidencial a las unidades de Quality Control o Investigations. Usted debe cooperar con ellos para mantener sus beneficios.

Usted deberá rembolsar cualquier beneficio que obtuvo o que fue pagado a una tercera persona en su nombre si no era elegible para ello. Mis activos pueden estar sujetos a ser recuperados por el Estado.

La Sección 1128B de la Social Security Act establece penas federales para actos fraudulentos e informaciones falsas en relación con estos programas.

Cualquiera que obtenga, intente obtener, o ayude a otra persona a obtener asistencia a la cual no tiene derecho, es culpable de violación de las leyes del Estado de Iowa. Esto incluye, pero no se limita a los Capítulos 239B, 243, 249, 249A y 249F del Código de Iowa.

Usted debe suministrar los números de seguridad social de todo aquel que desee Medicaid. Esto lo requiere la sección 1137(a)(1) de la Ley de Seguridad Social y 42 CFR 435.910. Nosotros usamos los números de seguridad social para:

- Identificar personas que solicitan u obtienen Medicaid
- Verificar el ingreso y la elegibilidad para Medicaid
- Cruzar registros con otras agencias

Mediante la firma de esta solicitud, usted otorga permiso al DHS para que comparta:

- El estado de su caso de Medically Needy (Médicamente Necesitado), el monto de sus gastos, y las facturas usadas para reducir esos gastos con el proveedor.
- Si la prima de Medicaid para Personas Discapacitadas Empleadas (MEPD por su sigla en inglés) ha sido pagada antes de la fecha de vencimiento a su proveedor de atención médica.

Usted acepta asignar a la agencia Medicaid los pagos de gastos médicos realizados por un tercero para usted y otras personas que sean elegibles para Medicaid y para las cuales pueda legalmente asignar beneficios. También acepta cooperar para obtener pagos de terceros para gastos médicos.

INSTRUCTIONS FOR HEALTH SERVICES APPLICATION

Complete this form if you live in Iowa and want to get:

- ◆ **Medical Assistance (Title 19 or Medicaid)** – provides health care coverage
 Other programs within Medical Assistance Program are:
 - Facility Care – helps pay your nursing home cost
 - Medicaid for children in foster care or subsidized adoption
 - Waiver – helps keep people at home and not in a nursing home
 - Medicare Savings Program – pays all or part of your Medicare premium
 - State Supplementary Assistance (State Supp) – help for people who are at least 65 or disabled.
- ◆ **WIC (Special Supplemental Nutrition Program for Women, Infants and Children)** – helps with checks that can be used at Iowa grocery stores and pharmacies to buy healthy foods for pregnant and postpartum women, and children under the age of 5. If you would like to apply for WIC, call 1-800-532-1579 or 515-281-6650 or visit the WIC website <http://www.idph.state.ia.us/wic/families.asp> for more information about making an appointment with your local WIC agency.
- ◆ **Maternal and Child Health** – provides health care services for children under the age of 21 and women of childbearing age.

If you want to get Food Assistance or cash assistance through the Family Investment Program (FIP), please complete the *Health and Financial Support Application*, form 470-0462, or in Spanish 470-0462(S).

Please do not let fear of the Immigration and Naturalization Service (INS) keep you from getting help for your family. Getting help will not keep you from gaining lawful, permanent residence, U.S. citizenship, or from sponsoring relatives.

To apply for help, follow these four easy steps:

- 1. Complete the Application**
 Fill out and sign the application. Use blue or black ink. Please be truthful. If you are helping someone else, answer the questions for that person.
- 2. File the Application**
 To find out where to mail the application, call 877-347-5678. The date your help starts is based on the date the DHS office gets your application.
- 3. Provide Any Needed Proof**
 See the table below for what is needed. Including copies of the proof will help speed up the processing of your application.
- 4. An Interview May Be Needed**
 An interview may not be needed if you are applying only for a child. Adults applying for help may be asked to have an interview.

Proof You Need to Send

In addition to your application, please provide any proof needed for the program(s) you are applying for.

	Medical Assistance	Facility or Waiver	Medicare Savings Program	Foster Care-Sub Adoption	State Supp Assistance	WIC	Maternal and Child Services
Proof of who you are (ID): driver's license, birth certificate, etc.	✓	✓	✓	✓	✓	✓	✓
Proof you are a U.S. citizen or national (birth certificate with ID, U.S. passport, etc.)	✓	✓	✓	✓	✓		
Proof you have applied for a Social Security Number (if you don't already have one)	✓	✓	✓	✓	✓		
Proof of any health insurance premium paid: bill, pay stub showing deduction, etc.		✓		✓	✓		
Proof of income* or any other money coming into your household	✓	✓	✓	✓	✓	✓	✓
Proof of child care, dependent adult care costs, child support or alimony paid	✓		✓	✓	✓		
Most recent statements for any bank accounts: checking, credit union, savings, etc.**	✓	✓	✓	✓	✓		
Proof of current value of stocks/bonds, life insurance, certificates of deposit, trusts**	✓	✓	✓	✓	✓		
Proof of current living address						✓	✓

* Pay stubs from the last 30 days if you are employed or federal income tax records if you are self-employed. Award letters for Social Security Benefits, Veterans Benefits, etc.

** May not be needed if just applying for a child.

RIGHTS AND RESPONSIBILITIES – READ AND KEEP THIS SHEET

INFORMATION FOR ADULTS AND CHILDREN APPLYING FOR MEDICAL ASSISTANCE

- I understand I assume full responsibility for the accuracy of the statements on this form. I understand the Department of Human Services (DHS) will use this statement to determine my eligibility for Medical Assistance.
- I understand my eligibility will not be affected by my race, creed, color, national origin, age, disability, or sex, except where this is restricted by law.
- I understand that I have the right to a hearing if this application is denied or not acted upon promptly or if services granted are terminated, reduced, or suspended. I understand that I can get a hearing by making a request in writing to my local DHS office and that I may represent myself or use a lawyer, relative, friend, or other spokesperson.
- I am aware that my case may be picked by the Department for a complete Quality Control or other review of my eligibility for assistance. If my case is selected for verification, I will cooperate fully in the verification. I hereby authorize all persons to release confidential information concerning my eligibility to a DHS reviewer. I understand that failure to cooperate with such a review can result in denial or cancellation of benefits.
- I will notify DHS within ten days of any changes in medical benefits or health insurance coverage. In addition, I understand that I am to notify my medical providers (doctors, pharmacist, etc.) if another party may be liable to pay my medical expenses. I will notify DHS within ten days if I file an insurance claim or retain an attorney to seek payment for injuries and medical expenses resulting from those injuries that otherwise would be paid by Medicaid. Failure to comply with my responsibilities can give the Department cause to deny or terminate Medicaid eligibility.
- I agree to assign medical payments from a third party to the Medicaid agency for myself and others who are eligible for Medicaid, for whom, I legally can assign benefits. I also agree to cooperate in obtaining medical payments from third parties.
- I understand that I am to reimburse the Department for any money paid to me or paid to a provider on my behalf to which I was not entitled.
- I further understand that the Department will provide documents or claim forms describing the services paid by Medicaid upon my request or the request of an attorney acting on my behalf. Such documents may also be provided to a third party when necessary to establish the extent of the Department's claim for reimbursement.
- I understand that federal and state law and rules permit access by authorized federal and state officials to Medicaid providers' records. I also fully understand that my acceptance of Medicaid is my consent for these authorized persons to have access to my medical and health care records during the time I am eligible for Medicaid, as necessary to verify appropriate Medicaid payment.
- I give my permission to tell my medical providers the status for my Medically Needy case, including the amount of my spenddown and their bills used to meet spenddown, or when a premium is due for Medicaid for Employed People with Disabilities.
- If I become enrolled in a managed health care plan, I consent to disclosure of medical information, including any clinical mental health or substance abuse information, by my medical providers to the HMO, PHP, other managed care providers or to the authorized administrative body contracted by the managed care provider to determine appropriateness, quality, or utilization of services I received while enrolled in managed health care.
- I understand that if Medical Assistance is approved, support payments intended for medical costs must be assigned and paid to the Department of Human Services to the extent of the benefits I receive. I understand that the Department may intervene, according but not limited to, Iowa Code Chapters 252A, 252B, 252C, 252D, 598, and 600B, to make claim and secure support from any person or party who may be responsible for my support or that of my children. I understand that if I receive Medicaid, the Department will pursue non-medical support for myself and my children upon my request. Medical support services include the establishment of paternity and the establishment and enforcement of medical support.
- I am aware that Section 1128B of the Social Security Act provides federal penalties for fraudulent acts and false reporting. Anyone who obtains, or tries to obtain, or helps any other person to obtain public assistance to which the person is not entitled is guilty of violating the laws of the state of Iowa. These laws include, but are not limited to, Iowa Code Chapters 243, 239B, 249A, and 249A.
- I understand and agree that I will need to provide the Department with either documentation from the Citizenship and Immigration Service (CIS) or other documents the Department considers to be proof of the immigration status of each person in my household who is not a United States citizen or national. I understand that alien status may be subject to verification with CIS, which will require submission of certain information from this application form to CIS. I further understand that information received from CIS may affect my household's eligibility and level of benefits.
- If I filled out a separate application for food assistance and that application was referred to the Food Stamp Investigation Unit, I will cooperate with the investigation in order to receive Medicaid when the investigation involves income, resources and household composition that affect my Medicaid eligibility.
- I understand that the facts I give determine financial eligibility. A medical certification is also needed prior to approval for certain Medical Assistance programs. To determine medical certification, the Iowa Medicaid Enterprise (IME) Medical Services may need to contact my physician. I authorize my physician or health care provider to release information to IME Medical Services for this purpose. I agree to allow DHS to disclose the filing of this application to my nursing facility in order to obtain the level of care determination necessary for eligibility. A copy of this form received by fax will be given the same effect as the original.

MORE INFORMATION FOR ADULTS APPLYING FOR MEDICAL ASSISTANCE

- I will notify the LOCAL DHS office of any change in my information on this application, including but not limited to, anticipated income or property such as an inheritance, lump-sum payments on delinquent child support, or any change in income or living arrangements of myself or any other member of my family. If I have any doubt whether a particular change in circumstances is information that must be reported, I shall report this to my LOCAL office no later than ten days from the date the change occurs. I also understand that I am to pay back to the Department any money received by me or paid to a vendor on my behalf to which I was not entitled.
- I understand payments under the Medical Insurance Program (Part B of Medicare) will be made directly to the physicians and medical suppliers on any future unpaid bills for medical and other health services furnished me while eligible for Medicaid.
- I authorize the DHS to share information from this application, and information about my condition from the designated Assessment Tool with IME Medical Services for all home and community based service (HCBS) waivers and the Area Agency on Aging Case Management Team for my HCBS elderly waiver services
- If you made the State of Iowa a remainder beneficiary on an annuity, in order to qualify for Medicaid payment of long-term care, the State of Iowa will get any benefits remaining in the annuity, up to the amount of Medicaid benefits paid.

INFORMATION FOR THOSE APPLYING FOR WIC OR MATERNAL AND CHILD HEALTH SERVICES

- I understand that a declaration of income and persons in my family and living in my household is necessary to ensure that federal and state funds are directed to those persons least able to secure services from other sources.
- I understand that the Maternal and Child Health Director of the Iowa Department of Public Health, the WIC Director, or their designees shall have access to all information available from records maintained by the agency providing maternal health, child health, or WIC services.

Iowa Department of Human Services
HEALTH SERVICES APPLICATION

HOUSEHOLD INFORMATION – Complete for all programs				
First Name		Middle Name	Last Name	
Home Address		City	State	County Zip Code
Mailing Address (if different from above) OR Payee or Representative's Name & Address				
Home Phone Number ()		Message Number ()	Name of Message Contact Person	
Check the program(s) you would like to receive: <input type="checkbox"/> Medical Assistance (Title 19 or Medicaid) <input type="checkbox"/> Maternal and Children Health Services <input type="checkbox"/> Facility <input type="checkbox"/> Medicare Savings Program <input type="checkbox"/> Waiver <input type="checkbox"/> WIC <input type="checkbox"/> Breast and Cervical Cancer Treatment <input type="checkbox"/> Foster Care/Subsidized Adoption <input type="checkbox"/> State Supplementary Assistance <input type="checkbox"/> Iowa Family Planning Network (IFPN)				
IF YOU NEED MORE ROOM TO ANSWER ANY OF THE FOLLOWING QUESTIONS, ATTACH EXTRA PAGES.				

Starting with yourself, list all the people who live in your home and mark the box **yes** or **no** if you are applying for that person. If you choose no, you only need to list their name, relationship to you and their date of birth.

NAME (First, Middle, Last)	Are you applying for this person?	How is this person related?	Disabled	Gender	Birth Date	Social Security Number	Medicaid State ID Number (if known)	Birth State	U.S. Citizen?	If Alien, Status	Ethnicity*	Race**	If a child, is a parent <u>NOT</u> living with them?	Currently on Medicaid?	Other health insurance available?
	<input type="checkbox"/> Yes <input type="checkbox"/> No	SELF	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Male <input type="checkbox"/> Female					<input type="checkbox"/> Yes <input type="checkbox"/> No				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Male <input type="checkbox"/> Female					<input type="checkbox"/> Yes <input type="checkbox"/> No				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Male <input type="checkbox"/> Female					<input type="checkbox"/> Yes <input type="checkbox"/> No				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Male <input type="checkbox"/> Female					<input type="checkbox"/> Yes <input type="checkbox"/> No				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Male <input type="checkbox"/> Female					<input type="checkbox"/> Yes <input type="checkbox"/> No				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

We have to ask your ethnicity and race, but you don't have to answer. Your answer won't affect how much you get or how soon. If you answer, use the following coding:

* Ethnicity: H = Hispanic or Latino; N = Not Hispanic or Latino

** Race (Choose all that apply): W = White; B = Black or African American; A = Asian; I = American Indian or Alaskan Native; N = Native Hawaiian or other Pacific Islander.

Did anyone receive medical care in the past three months? Yes No Who? _____ What months? _____

List anyone who is in the military, a veteran, or a spouse of a veteran: _____

Is anyone fleeing to avoid prosecution, custody, or jail for a felony crime? Yes No Is anyone violating a condition of probation or parole? Yes No

Is anyone in or expecting to go to jail or prison? Yes No

List pregnant persons who live in your home _____ Due Date (MMDDYY) _____

List the name of your health insurance provider _____

INCOME: List all income the people living in your home get. Include income from work, self-employment, Social Security, Veteran’s Benefits, unemployment insurance, child support, worker’s compensation, railroad retirement, IPERS, pensions, civil service, cash from friends or relatives, and any other income you get.

Person who received money	Employer or income source	Amount before taxes or deductions	How often is this amount paid?	Is this income expected to continue? If ‘NO,’ explain:
			<input type="checkbox"/> Weekly <input type="checkbox"/> Every other week <input type="checkbox"/> Monthly <input type="checkbox"/> Twice a month <input type="checkbox"/> Other _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Weekly <input type="checkbox"/> Every other week <input type="checkbox"/> Monthly <input type="checkbox"/> Twice a month <input type="checkbox"/> Other _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Weekly <input type="checkbox"/> Every other week <input type="checkbox"/> Monthly <input type="checkbox"/> Twice a month <input type="checkbox"/> Other _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Weekly <input type="checkbox"/> Every other week <input type="checkbox"/> Monthly <input type="checkbox"/> Twice a month <input type="checkbox"/> Other _____	<input type="checkbox"/> Yes <input type="checkbox"/> No

RESOURCES: A resource is cash or anything that can be changed to cash. List all resources and the amount or value. Include cash on hand, checking accounts, vehicles, life insurance, stocks, bonds, certificates of deposits (CDs), trust funds, retirement accounts, burial contracts, burial spaces, annuities, etc. If only applying for medical coverage for a child, resources may not be counted.

Person with Resource	Type of Resource	Amount or Value	Location (bank’s name and address, home, etc.)

Did anyone in your home sell or give away anything of value for less than its value within the last five years? Yes No

Does anyone in your home pay child support or alimony for a person who does not live with you? Yes No

If yes, who pays? _____ Amount? _____

Does anyone in your home pay for someone to care for a child or disabled adult? Yes No

If yes, how much is paid? _____ How often? _____ To whom? _____

Is the Child Support Recovery Unit already helping you get or enforce a child support or a medical support? Yes No

If no, the Child Support Recovery Unit can help you get child support or health insurance from an absent parent. They can also help locate absent parents and their employer, establish paternity, or establish paternity or modify support orders. **Do you want help from Child Support Recovery with any of these items?** Yes No

Are you willing to cooperate with us to get medical insurance or medical support from any parent not in the home? (You are not required to cooperate if you only want Medicaid for a child.) Yes No

Name & address of parent not in the home:	Date of birth of this parent:	Social Security number of this parent:	Name of the parent's children:	County where court order is filed, if any:	Is the parent court ordered to pay cash medical support?

SOCIAL SECURITY NUMBER (SSN)

You must fill in the SSN of all persons listed on this application to get Medical Assistance. Section 1137(a) (1) of the Social Security Act and 42 CFR 435.910 requires this. If you do not want Medicaid, you do not have to give us your SSN. The SSN will be used:

- To check income, eligibility and amount of Medical Assistance payments to be made on your behalf.
- To determine another person's right to Medical Assistance.
- To comply with Federal law which requires release of information from Medicaid records.
- To match with records in other agencies such as: Social Security Administration, Internal Revenue Services, and Iowa Workforce Development. These matches may be done by computer or on an individual basis.

My rights and responsibilities were provided to me on the back of the instructions for this Health Services Application. I have read and removed the Rights and Responsibilities sheet from this Health Services Application for my future use.

I understand that if the children on this application are not eligible for Medicaid, this application may be referred to the **hawk-i** program to see if the children could get **hawk-i** health care coverage.

I CERTIFY, UNDER PENALTY OF PERJURY, THAT THESE STATEMENTS ARE CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF.

Signature or mark of applicant

Date

Signature or mark of other parent or stepparent in the home

Date

Signature of person, if any, who helped complete this form

Date

Addendum to Application and Review Forms for Release of Information

OPTIONAL Release of Information

Help Us Help You!

You do not have to sign this, but it will help us get information we need to help you, without having to get your signature on specific requests.

You should know that:

- We may need more information to decide if you can get assistance.
- If more information is needed from you, you will get a letter telling you what we need and the date you must get it to us.
- You are responsible to get the information or to ask us for help to get it.
- If you do not give us the information or ask for help by the due date, your application may be denied or your assistance may stop.
- We may be able to use the release below to get the information we need. **But you still have to provide information we request or ask us for help.**
- We may attach a copy of this release to a form that asks other people or organizations (like your employer) for specific information needed about you or others in your household.

Print and sign your name below to give us permission to get needed information.

RELEASE OF INFORMATION

I hereby authorize any person or organization to give the Iowa Department of Human Services requested information about me or other members of my household.

A copy of this release is as valid as the original.

This release does not apply to protected health information.

This release is good for 12 months from the date signed.

Your Name (please print clearly)

Other Adult Name (please print clearly)

Signature or Mark

Signature or Mark

Date

INSTRUCCIONES PARA SOLICITUD DE SERVICIOS MÉDICOS

Completa esta forma si vive en Iowa y quiere obtener:

- ◆ Medical Assistance (Title 19 o Medicaid) – proporciona cobertura médica
 - Otros programas dentro del Medical Assistance Program son:
 - Facility Care – le ayuda a pagar los costos de casa para ancianos
 - Medicaid para niños bajo el cuidado de un hogar adoptivo o en adopción subvencionada
 - Waiver – ayuda a permanecer en sus hogares y no en casas para ancianos
 - Medicare Savings Program – paga todo o parte de su prima de Medicare
 - State Supplementary Assistance (State Supp) (Asistencia Estatal Complementaria) – ayuda para personas con 65 años o más o personas discapacitadas
- ◆ WIC (Programa especial de nutrición complementaria para mujeres, bebés y niños) – le brinda asistencia con cheques que puede utilizar en tiendas y farmacias de Iowa para comprar alimentos sanos para mujeres durante el embarazo y el posparto, y para niños menores de 5 años. Si desea presentar la solicitud para WIC, llame al teléfono 1-800-532-1579 o al 515-281-6650, o visite la página web de WIC: <http://www.idph.state.ia.us/wic/families.asp> para averiguar cómo hacer una cita en la agencia local de WIC.
- ◆ Maternal and Child Health – proporciona servicios de atención médica para niños menores de 21 años y mujeres en edad fértil.

Si desea obtener asistencia para alimentos (Food Assistance) o dinero en efectivo a través del programa Family Investment Program (FIP), complete la solicitud Health and Financial Support Application, formulario 470-0462 (en inglés) o 470-0462(S) (en español).

Por favor no deje que el temor del Immigration and Naturalization Service (INS) no le permita obtener ayuda para su familia. Obtener ayuda no le quita el poder obtener residencia permanente legalmente, ciudadanía de los E.U.A., o de poder patrocinar a sus parientes.

Para aplicar por ayuda, seguir los cuatro pasos fáciles:

1. **Completar la Solicitud**
Complete el formulario y fírmelo. Use tinta azul o negra. Por favor, sea honesto. Si está ayudando a otra persona, responda las preguntas para dicha persona.
2. **Llene la Solicitud**
Llame al teléfono 877-347-5678 para averiguar dónde debe enviar la solicitud. La fecha de inicio de la asistencia dependerá de la fecha en que la oficina de DHS reciba el formulario de solicitud.
3. **Proporcione Cualquier Prueba Necesaria**
Ver la tabla a continuación para lo que se necesite. Incluyendo copias de las pruebas que ayudara a apresurar el proceso de su solicitud.
4. **Se puede Necesitar Una Entrevista**
Una entrevista puede no ser necesario si usted está solicitando para un niño. Los adultos que soliciten ayuda se le puede pedir a tener una entrevista.

Comprobantes que debe enviar

Ademas de su solicitud, por favor proporcione cualquier prueba necesaria para el programa(s) que se estén solicitando.

	Medical Assistance	Facility or Waiver	Medicare Savings Program	Foster Care-Sub Adoption	State Supp Assistance	WIC	Maternal and Child Services
Prueba de quién es (I.D.) licencia de manejar, acta de nacimiento, etc.	✓	✓	✓	✓	✓	✓	✓
Prueba de que es ciudadano(a) o nacional de los EE.UU. (certificado de nacimiento, pasaporte de los EE.UU., etc.)	✓	✓	✓	✓	✓		
Prueba de solicitud para Número de Social Security (si aún no tiene uno)	✓	✓	✓	✓	✓		
Prueba de cualquier prima pagada de seguro médico: cuenta, talón de cheque demostrando la deducción, etc.		✓		✓	✓		
Prueba de ingreso * o cualquier dinero que entre en su hogar	✓	✓	✓	✓	✓	✓	✓
Prueba costos de cuidado para niños, adultos, manutención de niños/conyugue	✓		✓	✓	✓		
Reportes mensuales bancarios mas recientes; cheques, unión de crédito, ahorros, etc. **	✓	✓	✓	✓	✓		
Prueba del valor actual de valores/bonos, seguros de vida, certificados de deposito, fideicomisos **	✓	✓	✓	✓	✓		
Prueba de la presente dirección de domicilio						✓	✓

* Talón de cheque de los últimos 30 días si esta trabajando o récords de impuesto de ingreso federal si se tiene negocio propio. Cartas de Beneficios de Social Security, Beneficios de Veteranos, etc.

** Pueda que no sea necesario si solo esta solicitando por un niño.

DERECHOS Y RESPONSABILIDADES - LEA Y CONSERVE ESTA HOJA

INFORMACIÓN PARA ADULTOS Y NIÑOS SOLICITANDO PARA MEDICAL ASSISTANCE

- Yo tengo entendido que yo asumo total responsabilidad por la certeza de las declaraciones en esta forma. Yo entiendo que el Department of Human Services (DHS) usara esta declaración para determinar mi elegibilidad para Medical Assistance.
- Entiendo que mi elegibilidad no se verá afectada por mi raza, credo, color, origen nacional, edad, discapacidad o sexo, excepto cuando esto sea restringido por la ley.
- Yo tengo entendido que yo tengo el derecho de una audiencia si esta solicitud es negada o no es manejada rápidamente o si los servicios otorgados son cancelados, reducidos o suspendidos. Entiendo que puedo obtener una audiencia solicitándola por escrito a la oficina local del DHS y que puedo representarme a mí mismo, pedir la ayuda de un abogado, pariente, amigo u otro portavoz.
- Yo se que mi caso puede ser escogido por el Departamento para una completa revisión de Quality Control o cualquier otra de la elegibilidad para asistencia. Si mi caso es seleccionado para verificación, yo cooperare en total para la verificación. Yo en esta forma doy mi autorización a todas las personas para divulgar información confidencial relacionada con mi elegibilidad a una persona que revise para DHS. Yo entiendo que fallar en cooperar con dicha persona puede resultar en la negación o cancelación de los beneficios.
- Le notificaré a DHS en el plazo de 10 días sobre cualquier tipo de cambio con respecto a beneficios médicos o cobertura del seguro médico. Además, entiendo que debo notificarles a mis proveedores de servicios médicos (médicos, farmacéutico, etc.) si un tercero es responsable de pagar mis gastos médicos. Le notificaré a DHS en el plazo de 10 días si presento un reclamo al seguro o contrato un abogado con el fin de presentar una demanda por lesiones o por los gastos médicos resultantes de dichas lesiones que, de lo contrario, serían pagados por Medicaid. La falta de cumplimiento con mis obligaciones será causal suficiente para que el Departamento deniegue o rescinda mi elegibilidad para Medicaid.
- Acepto entregar a la agencia Medicaid los pagos de gastos médicos realizados por terceros para mí y otras personas elegibles para Medicaid, para las cuales yo estoy legalmente autorizada a asignar beneficios. Además, acepto cooperar para obtener pagos de gastos médicos provenientes de terceros.
- Yo entiendo que yo debo reembolsar al Department por cualquier dinero pagado a mi o pagado a un proveedor a mi favor al cual yo no tenga derecho.
- Es mas yo entiendo que el Department puede proporcionar documentos o formas de demanda describiendo los servicios pagados por Medicaid cuando yo lo pida o a la petición de un abogado actuando a mi favor. Dichos documentos puedan también ser proporcionados a una tercera parte cuando sea necesario para establecer el punto en que la demanda del Department sea reembolsada.
- Yo entiendo que las leyes Federales y Estatales y las reglas permiten el acceso a oficiales Federales y Estatales autorizados para récords de Medicaid. Yo también entiendo en su totalidad que mi aceptación de Medicaid es mi consentimiento para que estas personas autorizadas tengan acceso a mis récords de atención medica durante el tiempo que yo sea elegible para Medicaid, como sea necesario para verificar los pagos apropiados de Medicaid.
- Concedo autorización para revelar a quienes me proporcionan asistencia médica el estado de mi caso de Medically Needy (Médicamente Necesitado), incluyendo el monto de mi Spenddown (la parte no cubierta por Medicaid), o en los casos que deba una prima a Medicaid for Employed People with Disabilities (Medicaid por Personas Discapacitadas Empleadas).
- Si yo quedo registrado en un plan de cuidado medico manejado, yo doy consentimiento de la divulgación de información medica, incluyendo cualquier salud mental clínica o información de abuso de sustancia, por mis proveedores médicos al HMO, PHP, otros proveedores de cuidado medico manejado o al cuerpo administrativo autorizado contratado por el proveedor de cuidado medico manejado para determinar apropiacion, calidad, o utilización de servicios que yo he recibido cuando estuve registrado en el cuidado medico manejado.
- Entiendo que, si se aprueba mi pedido de Ayuda Médica, los pagos de dicha ayuda para cubrir los costos médicos deben asignarse y pagarse al Department of Human Services en la medida de los beneficios que reciba. Entiendo que el Departamento puede intervenir, de acuerdo a, pero sin limitarse a, los Capítulos 252A, 252B, 252C, 252D, 598 y 600B del Código de Iowa, para presentar un reclamo y garantizar la ayuda de parte de toda persona o parte que pueda ser responsable de mi manutención o la de mis hijos. Entiendo que, si recibo Medicaid, el Departamento buscará obtener asistencia no médica para mi persona y para mis hijos, en caso de que lo pida. Los servicios de ayuda médica incluyen la determinación de la paternidad y la determinación y exigencia de la ayuda médica.
- Yo se que la Sección 1128B del Social Security Act dice que los castigos Federales por actos fraudulentos y por reportes falsos. Cualquiera que obtenga, o trate de obtener, o ayuda a otra persona a obtener asistencia publica a la cual la persona no tiene derecho es culpable de violación de las leyes del Estado de Iowa. Estas leyes incluyen, pero no están limitadas a, Código de Iowa Capítulo 243, 293B, 249 A, y 249A.
- Yo entiendo y estoy de acuerdo que yo necesitare proporcionar al Department con cualquier documentación de Ciudadania e Immagracion Servicios (CIS) o cualquier otro documento que el Department considere ser prueba de mi situación de inmigración de cada persona en mi hogar que no sea un ciudadano de los Estados Unidos o nacional. Yo entiendo que la situación de extranjero puede ser sujeta a verificación con CIS, lo cual puede requerir la entrega de cierta información de esta solicitud a CIS. Yo además entiendo que la información recibida de CIS puede afectar la elegibilidad de mi hogar y el nivel de beneficios.
- Si diligencia una solicitud separada para asistencia alimenticia, y dicha aplicación es remitida a la Food Stamp Investigation Unit (Unidad de Investigación de Estampillas de Alimentos), cooperaré con la investigación para recibir Medicaid cuando la investigación se refiera a ingresos recursos y composición del hogar que pueda afectar mi elegibilidad para Medicaid.
- Yo entiendo que los hechos que yo proporcione determinaran mi elegibilidad financiera. Una certificación medica es también necesaria antes de la aprobación para ciertos programas de Medical Assistance. Para determinar la certificación medica, el Iowa Medicaid Enterprise (IME) Medical Services puede necesitar contactar a mi medico. Yo autorizo o mi medico a mi proveedor de cuidado médico el divulgar información a IME Medical Services para este proposito. Yo estoy de acuerdo de permitir a DHS el divulgar el registro de esta solicitud a mi facilidad de cuidado a fin de obtener el nivel de determinación de cuidado necesario por elegibilidad. Una copia de este formulario recibido por fax tendrá el mismo efecto que el original.

MAS INFORMACIÓN PARA ADULTOS SOLICITANDO PARA ASISTENCIA MEDICA

- Notificaré a la oficina del DHS LOCAL acerca de cualquier cambio en la información de esta aplicación, incluyendo, pero sin limitarse a ingresos anticipados o propiedad tales como una herencia, pagos integrales para el apoyo a niños delincuentes, o cualquier cambio en el ingreso o en mi vivienda o en la de cualquier otro miembro de mi familia. Si tengo alguna duda sobre si un cambio particular en las circunstancias, es información que debe ser informada, reportaré eso a mi oficina LOCAL dentro de los diez días siguientes a la fecha en que el cambio se presente. Yo también entiendo que yo debo reembolsar al Department cualquier dinero recibido por mi o pagado a un vendedor a mi nombre al cual yo no tenga derecho.
- Yo entiendo que los pagos bajo el Medical Insurance Program (Part B de Medicare) se haran directamente a los médicos y a los proveedores médicos de cualquier factura no pagada por servicios de atención medica que se me haya proporcionado cuando tenia elegibilidad de Medicaid.
- Yo autorizo a DHS a proporcionar información de esta solicitud, información sobre de mi condición del designado Assesment Tool con IME Medical Services para todos los servicios a mi hogar y comunidad (HCBS) renuncias de derecho y el Area Agency en Aging Case Management Team para mi HCBS renuncia de mis derechos de servicios para persona de edad avanzada.

INFORMACIÓN PARA AQUELLOS SOLICITANDO PARA WIC O SERVICIOS MATERNIDAD Y CUIDADO PARA NIÑOS

- Yo entiendo que una declaración de ingreso y personas en mi familia y viviendo en mi hogar es necesario para asegurar que fondos Federales y Estatales sean dirigidos a esas personas que tengan menos habilidad para asegurar servicios de otros recursos. Yo entiendo que el Maternal and Child Health Director of the Iowa Department of Public Health, el Director de WIC, o sus asignados deberán tener acceso a toda la información disponible de los récords que son mantenidos por la agencia proporcionando salud maternal, salud a niños, o servicios WIC.

HEALTH SERVICES APPLICATION (SOLICITUD DE SERVICIOS MÉDICOS)

INFORMACIÓN DEL HOGAR - Completar para todos los programas				
Primer Nombre	Segundo Nombre	Apellido Nombre		
Dirección del Hogar	Ciudad	Estado	Condado	Código
Dirección Postal (si es diferente a la anterior) O Nombre y Dirección del Pagador				
Numero Tel. Hogar ()	Número Mensajería ()	Nombre del Mensaje Persona Contacto		
Marcar los programas que usted quiere recibir: <input type="checkbox"/> Medical Assistance (Title 19 or Medicaid) <input type="checkbox"/> Maternal and Children Health Services <input type="checkbox"/> Facility <input type="checkbox"/> Medicare Savings Program <input type="checkbox"/> Waiver <input type="checkbox"/> WIC <input type="checkbox"/> Breast and Cervical Cancer Treatment <input type="checkbox"/> Foster Care/Subsidized Adoption <input type="checkbox"/> State Supplementary Assistance (Renuncia) <input type="checkbox"/> Iowa Family Planning Network				
SI USTED NECESITA MAS ESPACIO PARA CONTESTAR CUALQUIERA DE LAS SIGUIENTES PREGUNTAS, ADJUNTAR HOJAS ADICIONALES				

A partir de ti mismo, una lista de todas las personas que viven en su casa y marque la casilla de sí o no, si usted está solicitando para esa persona. Si decide que no, sólo es necesario a la lista su nombre, relación con usted y su fecha de nacimiento.

NOMBRE (Primer, Segundo, Apellido)	¿Solicita por esta persona?	¿Cual relación con esta persona?	¿Disabilidad?	Sexo	Fecha Nacimiento	Nº de Social Security	Nº de Estado ID de Medicaid (si lo sabe)	Estado de nacimiento	¿Es ciudadano norteamericano?	Condi- cion de extranjero	Etnici- dad*	Raza **	¿Si es niño, los padres NO viven con el?	¿Actualmente tiene Medicaid?	¿Otro seguro médico disponible?
	<input type="checkbox"/> Si <input type="checkbox"/> No	MISMO	<input type="checkbox"/> Si <input type="checkbox"/> No	<input type="checkbox"/> Masc. <input type="checkbox"/> Fem.					<input type="checkbox"/> Si <input type="checkbox"/> No				<input type="checkbox"/> Si <input type="checkbox"/> No	<input type="checkbox"/> Si <input type="checkbox"/> No	<input type="checkbox"/> Si <input type="checkbox"/> No
	<input type="checkbox"/> Si <input type="checkbox"/> No		<input type="checkbox"/> Si <input type="checkbox"/> No	<input type="checkbox"/> Masc. <input type="checkbox"/> Fem.					<input type="checkbox"/> Si <input type="checkbox"/> No				<input type="checkbox"/> Si <input type="checkbox"/> No	<input type="checkbox"/> Si <input type="checkbox"/> No	<input type="checkbox"/> Si <input type="checkbox"/> No
	<input type="checkbox"/> Si <input type="checkbox"/> No		<input type="checkbox"/> Si <input type="checkbox"/> No	<input type="checkbox"/> Masc. <input type="checkbox"/> Fem.					<input type="checkbox"/> Si <input type="checkbox"/> No				<input type="checkbox"/> Si <input type="checkbox"/> No	<input type="checkbox"/> Si <input type="checkbox"/> No	<input type="checkbox"/> Si <input type="checkbox"/> No
	<input type="checkbox"/> Si <input type="checkbox"/> No		<input type="checkbox"/> Si <input type="checkbox"/> No	<input type="checkbox"/> Masc. <input type="checkbox"/> Fem.					<input type="checkbox"/> Si <input type="checkbox"/> No				<input type="checkbox"/> Si <input type="checkbox"/> No	<input type="checkbox"/> Si <input type="checkbox"/> No	<input type="checkbox"/> Si <input type="checkbox"/> No
	<input type="checkbox"/> Si <input type="checkbox"/> No		<input type="checkbox"/> Si <input type="checkbox"/> No	<input type="checkbox"/> Masc. <input type="checkbox"/> Fem.					<input type="checkbox"/> Si <input type="checkbox"/> No				<input type="checkbox"/> Si <input type="checkbox"/> No	<input type="checkbox"/> Si <input type="checkbox"/> No	<input type="checkbox"/> Si <input type="checkbox"/> No

Debemos preguntarle su origen étnico y raza, pero usted no está obligado/a a contestar. Su respuesta no afectará cuánto reciba o con qué rapidez. Si contesta, utilice la siguiente codificación:

* Origen étnico: H = Hispano o Latino; N = No Hispano ni Latino

** Raza (Seleccione todas las que correspondan): W = Blanca; B = Negra o Afroamericana; A = Asiática; I = Amerindia o Nativas de Alaska; N = Nativas de Hawai u otras islas del Pacífico.

¿Alguien recibió atención médica en los últimos tres meses? Si No ¿Quién? _____ ¿Que meses? _____

Lista de cualquier persona que está en el ejército, un veterano o el cónyuge de un veterano _____

¿Hay alguien huyendo para evitar persecución, custodia, o en la cárcel por un delito mayor? Si No

¿Hay alguien violando una condición de libertad condicional o libertad condicional? Si No

¿Hay alguien en o esperando para ir a la cárcel o prisión? Si No

Lista de embarazadas que viven en su casa _____ Fecha de Entrega (MMDDYY) _____

Escriba el nombre de su proveedor de seguro médico _____

INGRESOS: Indique los ingresos de todas las personas que viven con usted. Incluya ingresos laborales en relación de dependencia, por cuenta propia, Social Security, pensión a ex combatientes (Veteran's Benefits), seguro de desempleo, manutención de menores, indemnización por accidentes laborales (Worker's Compensation), jubilación de empleados ferroviarios, IPERS, jubilación, administración pública, dinero en efectivo recibido de amigos o familiares, y cualquier otro tipo de ingresos.

Persona que recibe el dinero	Patron o fuente de Ingreso	Cantidad antes de impuestos o deducciones	¿Qtan seguido se paga?	¿Se espera que este ingreso continúe? Si NO explicar:
			<input type="checkbox"/> Semanal <input type="checkbox"/> Semana terciada <input type="checkbox"/> Mensual <input type="checkbox"/> Dos al mes <input type="checkbox"/> Otro _____	<input type="checkbox"/> Si <input type="checkbox"/> No
			<input type="checkbox"/> Semanal <input type="checkbox"/> Semana terciada <input type="checkbox"/> Mensual <input type="checkbox"/> Dos al mes <input type="checkbox"/> Otro _____	<input type="checkbox"/> Si <input type="checkbox"/> No
			<input type="checkbox"/> Semanal <input type="checkbox"/> Semana terciada <input type="checkbox"/> Mensual <input type="checkbox"/> Dos al mes <input type="checkbox"/> Otro _____	<input type="checkbox"/> Si <input type="checkbox"/> No
			<input type="checkbox"/> Semanal <input type="checkbox"/> Semana terciada <input type="checkbox"/> Mensual <input type="checkbox"/> Dos al mes <input type="checkbox"/> Otro _____	<input type="checkbox"/> Si <input type="checkbox"/> No

RECURSOS: Un recurso es dinero en efectivo o cualquier cosa que pueda canjearse por dinero. Enumerar todos los recursos y la cantidad o valor. Incluya dinero en efectivo disponible, cuentas corrientes, vehículos, seguros de vida, títulos valores, bonos, certificados de depósitos (CDs), fondos fiduciarios, cuentas de jubilación, contratos de entierro, espacios de entierro, anualidades, etc. Si solo se aplica la cobertura por un niño, los recursos no deberán contarse.

Persona con Recurso	Tipo de Recurso	Cantidad o Valor	Lugar (nombre del banco, y dirección, hogar, etc.)

¿Alguna de las personas que viven con usted vendió o cedió algo de valor por menos de su valor en los últimos 5 años? Si No

¿Alguien en el hogar paga manutención para niños o conyugue para una persona que no viva con ustedes? Si No

Si es si, ¿quién paga? _____ ¿Cantidad? _____

Alguien en el hogar paga a alguien para que cuide a un niño o aun adulto incapacitado? Si No

Si es si, ¿quién paga? _____ Que tan seguido? _____ ¿A quien? _____

¿La Unidad de Recuperación de Apoyo Infantil ya le está ayudando a obtener o exigir pagos de manutención infantil o ayuda médica? Sí No

Si respondió que no, Child Support Recovery Unit (Unidad de recuperación de manutención de menores) puede ayudarle a conseguir que el padre ausente abone manutención o seguro médico. También pueden ayudarle a localizar al padre ausente y a su empleador, a determinar la paternidad o a modificar órdenes judiciales de manutención. **¿Desea que Child Support Recovery le ayude con alguno de estos temas?** Sí No

¿Está dispuesto a cooperar con nosotros para obtener cobertura o ayuda médica de parte del padre que no vive en el hogar? (No tiene la obligación de cooperar si sólo desea obtener Medicaid para un menor) Sí No

Nombre y domicilio del padre que no vive en el hogar:	Fecha de nacimiento de este padre:	Número de seguro social de este padre:	Nombre de los hijos de este padre:	Condado en el cual se presentó la orden del tribunal, si la hubiere:	¿El padre tiene la orden de un tribunal de pagar dinero para la ayuda médica?

NUMERO DE SOCIAL SECURITY (SSN)

Debe poner el SSN de todas las personas mencionadas en esta solicitud para obtener Medical Assistance. La Sección 1137(a)(1) del Social Security Act y el 42 CFR 435.910 requiere esto. Si usted no quiere Medicaid, usted no tiene que darnos su SSN. El SSN será utilizado:

- Para checar el ingreso, elegibilidad y la cantidad de pagos de Medical Assistance que se harán a su favor.
- Para determinar el derecho de otras personas a Medical Assistance.
- Para cumplir con las leyes Federales que requieren divulgación de información para récords de Medicaid.
- Para comparar con récords en otras agencias tales como: Social Security Administration, Internal Revenue Services, y Iowa Workforce Development. Estas comparaciones de pueden hacer por una computadora e un base individual.

Mis derechos y responsabilidades me serán proporcionados en la parte de atrás de las instrucciones de esta Health Services Application. He leído y quitado la hoja de Derechos y Responsabilidades de la Solicitud de Servicios de Salud para mi uso futuro.

Entiendo que, si los niños que están en esta solicitud no son elegibles para recibir Medicaid, esta solicitud puede ser enviada al programa **hawk-i** para ver si pueden obtener la cobertura de salud **hawk-i**.

YO CERTIFICO QUE ESTAS DECLARACIONES SON CORRECTAS A LO MEJOR DE MI CONOCIMIENTO Y CREENCIA.

Firma o marca del solicitante

Fecha

Firma o marca de otro padre o padrastro
en el hogar

Fecha

Firma de la persona, si hay que haya
ayudado a completar esta forma

Fecha

**Addendum to Application and Review Forms for Release of Information
(Anexo a los Formularios de Solicitud y Revisión para Divulgar Información)**

Divulgación de Información - OPCIONAL

¡Ayúdenos a ayudarle!

No tiene obligación de firmar esta autorización, pero nos ayudaría a obtener la información que necesitamos para ayudarle y no tendríamos que pedirle que firme ciertas solicitudes.

Debe saber que:

- Podríamos necesitar más información para decidir si puede obtener asistencia.
- Si necesitáramos que nos proporcione más información, recibirá una carta informándole qué necesitamos y la fecha en que debe entregarla.
- Es su responsabilidad conseguir dicha información o pedirnos que le ayudemos a conseguirla.
- Si no nos proporciona dicha información ni nos pide ayuda antes de la fecha de entrega de la misma, su solicitud podría ser denegada o la asistencia podría terminar.
- Podríamos utilizar esta autorización para obtener la información necesaria. **Pero aún así, deberá conseguir la información que le solicitemos o pedirnos ayuda para conseguirla.**
- Podríamos adjuntar una copia de la autorización a otros formularios para solicitarles a otras personas u organizaciones (como, por ejemplo, su empleador) que nos proporcionen determinada información sobre usted o su grupo familiar.

Escriba su nombre en letra de imprenta y firme para autorizarnos a obtener la información necesaria.

DIVULGACIÓN DE INFORMACIÓN

Por la presente autorizo a cualquier individuo u organización a entregar a Department of Human Services de Iowa la información solicitada sobre mi persona o mi grupo familiar.

Una copia de esta autorización es tan válida como el original.

Esta autorización no es válida en el caso de información médica protegida.

Esta autorización es válida por 12 meses a partir de la fecha de mi firma.

Su nombre (en imprenta legible)

Nombre de otro adulto (en imprenta legible)

Firma o marca

Firma o marca

Fecha



The resident shall complete the application form on or before the date the resident moves into the RCF or the date that the resident wants to start receiving SSA 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).

3. 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 SSA.

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, or
- ◆ 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 SSA 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.

4. Eligibility Decision

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

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



For SSA 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 SSA 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.

5. *RCF Admission Agreement, Form 470-0477*

Both the law and licensing rules governing RCFs 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. Click [here](#) to view the form online. Requirements for this contract are found in Iowa Administrative Code (IAC) for the Department of Inspections and Appeals at 481 IAC 57.14.

This contract meets the licensing requirements set by the Department of Inspections and Appeals. Page 2 of the form meets the additional requirements of the SSA program.

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 SSA, 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 SSA than the facility charges private-paying residents.

Under the SSA 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 SSA 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 SSA 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 representative.

6. 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 SSA:

- ◆ At least every 12 months, based on the information the resident submits on the *Medicaid Review*, form 470-3118 or 470-3118(S), 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.



Ten-Day Report of Change for FIP and Medicaid

Tell Us About Your Changes

You must tell us when something changes. You can report your change by mail, phone, fax, or e-mail to:

FAX:
e-mail:

You will need to tell us within ten days of the change. If you have applied for FIP or Medicaid, but we have not made a decision on your application yet, you must tell us about your changes within five days of the change.

If you don't tell us when changes happen, we may give you too much or not enough FIP or Medicaid. Or, give you benefits that you should not have gotten. If so, you will have to pay back what you got in error.

Instructions

Check the box next to your change. If you have more than one change to tell us about, check all the boxes that apply. Tell us about the change on the backside of this form and return it to the Department of Human Services (DHS) office listed above.

Changes in address, work or your ability to work must be reported to both your DHS worker and your PROMISE JOBS worker. You will also need to send proof of the change you reported.

Where You Live or Who You Live With

I have:

- A new mailing or living address.
- Someone moving into my home. This includes the birth of a child or the return of a parent or spouse to the home.
- Someone moving out of my home or going into a nursing home.

Money Your Household Gets

Someone in my home:

- Will start or stop a job. **Note:** People who are age 65 and over or disabled must also report a change in income from work. This includes a change in the rate of pay or number of hours worked.
- Will start or stop getting unemployment benefits, social security income, pensions, child support or alimony, gifts, loans, school loans or grants, etc. **Note:** People who are age 65 and older or disabled must also report a change in the amount of money they receive from these sources.
- Will get a one-time payment such as back child support, an inheritance or an insurance settlement.

Household Expenses

Someone in my home:

- Pays for child or adult care costs.
- Is being billed for school expenses, conservator fees, or medical fees.
- Pays court-ordered child support.

Assets or Resources

Someone in my home:

- Got another car, truck, boat, or motorcycle or got rid of one.
- Bought or sold a house or land.
- Opened or closed a bank account or a retirement account.
- Got an insurance policy or got rid of one.

Medical Coverage

Someone in my home:

- Had a change in their health insurance premium amount.
- Started or stopped paying premiums, including Medicare premiums.
- Started getting other medical insurance or current medical insurance was dropped.

Other Changes

Someone in my home:

- Got a Social Security Number.
- Who is a child, has enrolled in school or dropped out of school.

Explain Your Change

Use this space to explain the changes that you checked.

Name	Phone Number ()
Address	
Social Security Number	Date Completed



Ten-Day Report of Change for FIP and Medicaid (Informe de cambios de diez días para FIP y Medicaid)

Infórmenos sobre sus cambios

Usted debe informarnos cuando algo cambie. Usted puede informar su cambio por correo, teléfono, fax, o correo electrónico a:

FAX:
e-mail:

Usted deberá informarnos acerca del cambio dentro de los diez días siguientes. Si ha solicitado FIP o Medicaid, pero aún no hemos tomado una decisión sobre su solicitud, debe informarnos sobre sus cambios en un plazo de cinco días a partir del cambio.

Si no nos informa cuando sucedan los cambios, es posible que le demos demasiado o no suficiente FIP o Medicaid. O, que le demos beneficios que no debía haber recibido. Si es así, usted deberá pagar lo que recibió por error.

Instrucciones

Marque la casilla que está al lado de su cambio. Si tiene más de un cambio, infórmenos acerca de ellos, marque todas las casillas que apliquen. Infórmenos sobre el cambio en el reverso de este formulario y devuélvalo a su oficina local del Department of Human Services (DHS).

Los cambios de dirección, trabajo o de su capacidad para trabajar deben ser informados tanto a su trabajador del DHS como a su trabajador de PROMISE JOBS. También deberá enviar prueba del cambio que reportó.

Dónde vive o con quién vive

Yo tengo:

- Una nueva dirección postal o dirección de vivienda.
- Alguien que se mudará a mi hogar. Esto incluye el nacimiento de un niño/a o el regreso de un padre o cónyuge al hogar.
- A alguien que sale de mi hogar o va a un asilo de ancianos.

Dinero que obtiene su hogar

Alguien en mi hogar:

- Empezará o dejará un trabajo. **Nota:** Las personas de 65 años o más, o los discapacitados también deben reportar un cambio en el ingreso por trabajo. Esto incluye un cambio en el salario o en el número de horas trabajadas.
- Empezará o dejará de recibir beneficios de desempleo, ingreso de seguridad social, pensiones, manutención infantil o pensión alimenticia, regalos, préstamos, créditos o becas escolares, etc. **Nota:** Las personas de 65 años o más, o los discapacitados también deben reportar un cambio en el ingreso que reciben de estas fuentes.
- Recibirá un pago único como atrasos de manutención infantil, una herencia o una conciliación por seguro.

Gastos del hogar

Alguien en mi hogar:

- Paga los gastos de atención de niños o adultos.
- Recibe facturas por gastos escolares, gastos de curador o gastos médicos.
- Paga manutención infantil ordenada por la corte.

Activos o recursos

Alguien en mi hogar:

- Adquirió otro auto, camión, bote o motocicleta o se deshizo de uno.
- Compró o vendió una casa o terreno.
- Abrió o cerró una cuenta bancaria o una cuenta de pensión.
- Obtuvo una póliza de seguros o se deshizo de una.

Cobertura médica

Alguien en mi hogar:

- Cambió el monto de su prima de seguro de salud.
- Inició el pago o detuvo el pago de primas, incluyendo primas de Medicare.
- Empezó a recibir otro seguro médico o el actual seguro médico fue abandonado.

Otros cambios

Alguien en mi hogar:

- Obtuvo un número de seguridad social.
- Que es un menor, se inscribió en la escuela o la abandonó.

Explique su cambio

Utilice este espacio para explicar los cambios que ha marcado.

Nombre	Número de teléfono ()
Dirección	
Número de Seguridad Social	Fecha de terminación



7. *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*, form 470-0499 or 470-0499(S), 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 view the English version of the form.
- ◆ Click [here](#) to view the Spanish version of the 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 the 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.

D. BASIS OF PAYMENT

SSA is a supplement to a resident's other income which assures the resident of sufficient funds to meet the cost of care in the RCF 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.

SSA 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 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.

1. 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 SSA 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 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 an RCF from a nursing facility, a foster care facility, or another RCF shall apply any unused client participation toward the cost of care in the new facility.

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

2. Items to Be Furnished by the Facility

DIA licensing rules require that certain items be available in an RCF. The facility must provide the following items when payment is accepted from a recipient of SSA:

- ◆ 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; and
- ◆ 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
- ◆ 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.



3. 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 SSA 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.

4. Days Covered

SSA 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.

a. Reserve Bed Days Due to Hospitalization

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

SSA 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 SSA program would pay.

Example:

Ms. Doe is an RCF SSA recipient whose total monthly client participation is \$155.10. Ms. Doe 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 non-covered days. The facility will keep the documentation of reserve bed days for audit purposes.



b. Reserve Bed Days Due to Visits or Vacation

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

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 SSA 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 Department to terminate the SSA 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.

5. Supplementation from Other Sources

The SSA 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 SSA 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 SSA 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 SSA 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 regional mental health and disability management system for information about funding through county local services allocations.

6. Personal Needs Allowance

A recipient of SSA 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 SSA.



The Department increases the personal needs allowance for residents of RCFs 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 Informational Letters. Click [here](#) to view a listing of informational letters.

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 representative payee to act on behalf of the resident, the facility may assume the responsibility of managing the personal allowance if the resident is unable to do so independently.

a. 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.

b. Disposition of Unused Personal Funds in Case of Death

When a recipient of SSA dies in an RCF, 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 to be filed in the person's case record.



7. 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 IME processes RCF claims for payment. Facilities must submit claims electronically.

The IME provides software for electronic claims submission at no charge. To request this software, email IME Provider Services at: imeproviderservices@dhs.state.ia.us. For other questions about billing, contact IME Provider Services at (800) 338-4609.

a. 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.

The IME generates payments weekly and mails checks every Wednesday. Electronic funds transfers are made each Wednesday evening.

b. 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.

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When the resident's death occurs after the close of a billing period but before the receipt of the SSA check covering that period, immediately report the death to the Department using the *Case Activity Report*, form 470-0042. Click [here](#) to view the form online.

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.

E. BILLING POLICIES AND CLAIM FORM INSTRUCTIONS

Iowa Medicaid enrolled nursing facilities and RCFs bill for services electronically as an institutional claim on a monthly basis. The IME offers free electronic billing software; PC-ACE Pro 32, available through www.edissweb.com. Click [here](#) for more information on how to obtain PC-ACE software or to view help resources.

For other questions about billing, contact IME Provider Services at (800) 338-4609.