



# Iowa Department of Human Services

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January 9, 2015

## GENERAL LETTER NO. 16-J-AP-14

ISSUED BY: Bureau of Child Welfare and Community Services  
Division of Adult, Children and Family Services

SUBJECT: Employees' Manual, Title 16, Chapter J, ***IN-HOME HEALTH-RELATED CARE SERVICES APPENDIX***, Title page, revised; Contents (page 1), revised; pages 1 through 21, revised; and the following forms:

470-3951	<i>Authorization to Obtain or Release Health Care Information</i> , revised
470-3951(S)	<i>Authorization to Obtain or Release Health Care Information (Spanish)</i> , revised
470-2927	<i>Health Services Application</i> , revised
470-2927(S)	<i>Health Services Application (Spanish)</i> , revised
470-0583	<i>Individual GYfj JW Plan</i> , revised
470-0636	<i>Provider Agreement</i> , revised
W-9	<i>Request for Taxpayer Identification Number and Certification</i> , new
470-5044	<i>Service Worker Comprehensive Assessment</i> , new
470-0648	<i>Statement of Services Rendered</i> , revised

## Summary

Chapter 16-J-Appendix is revised to enter the In-Home Health-Related Care program into the ISIS system. These changes impact how payments are made to clients or their payee. Services, payments, and providers will now be entered into the ISIS system.

## Effective Date

Immediately.

## Material Superseded

This material replaces the following pages from Employees' Manual, Title 16, Chapter J, Appendix:

<u>Page</u>	<u>Date</u>
Title page	October 17, 2008
Contents (page 1)	October 17, 2008
1, 2	October 17, 2008

470-3951	8/03
470-3951(S)	10/07
3, 4	October 17, 2008
470-2927	6/08
470-2927(S)	1/08
5, 6	October 17, 2008
470-0583	8/08
7, 8	October 17, 2008
9	April 29, 2011
10-12	October 17, 2008
470-0636	12/05
13, 14	October 17, 2008
15	October 22, 2010
16	October 17, 2008
17, 18	October 17, 2008
470-0506	1/03
19, 20	October 17, 2008
470-0648	3/00
21	October 17, 2008

**Additional Information**

Destroy any existing supplies of 470-3951, dated before 12/09. Order supplies of 470-3951, dated 12/09, from Anamosa in the usual manner.

Destroy any existing supplies of 470-2927 and 470-2927(S), both dated before 12/12. Order supplies of 470-2927 and 470-2927(S), both dated 12/12, from Anamosa in the usual manner.

Destroy any existing supplies of 470-0648, dated 3/00. Order supplies of 470-0648, dated 10/14, from Anamosa in the usual manner.

Refer questions about this general letter to your area service administrator.

Revised January 9, 2015

Employees' Manual  
Title 16  
Chapter J Appendix

# **IN-HOME HEALTH-RELATED CARE SERVICES**

## **APPENDIX**



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**[Amendment to Provider Agreement, 470-1999](#)**

Purpose	The <i>Amendment to Provider Agreement</i> records a required reduction in the state supplementation established in the <i>Provider Agreement</i> , form 470-0636.
Source	Print or photocopy the sample in the manual for use as needed. (Click on the blue form number to access the sample electronically.)
Completion	The DHS service worker assists providers and clients to complete an amendment for each provider agreement before delivery of service at the reduced rate.
Distribution	Place the original <i>Provider Agreement</i> in the client case file. Make a copy for the provider and for the client.
Data	Enter a change in the rate when client participation changes.

**Authorization to Obtain or Release Health Care Information, 470-3951 and 470-3951(S)**

Purpose	<p>Forms 470-3951 and 470-3951(S) are two-way release forms used to get the permission of a client or the client's legally authorized representative to:</p> <ul style="list-style-type: none"><li>◆ Obtain health information needed to provide service to a client; and</li><li>◆ Release health information about the client to a third party.</li></ul> <p>Use the form to obtain permission from the provider regarding the client's health status. Have the provider sign the form. Give a copy of the signed form to the provider to be submitted along with form 470-0672, <i>Provider Health Assessment</i>, to the provider's health care professional.</p>
Source	<p>The English version of this form is printed in pads of 25 three-part precarbonated sets. Order supplies from Iowa Prison Industries at Anamosa. Form 470-3951 may also be completed on line using the template on Outlook under "Public Folders/All Public Folders/State Approved Forms/Service."</p> <p>Print or photocopy supplies of the Spanish version, form 470-3951(S), from the sample in the manual. (Click on the blue form number to access the sample electronically.)</p>
Completion	<p>Complete this form when first meeting with a new client and the provider. Complete the identifying information and description of the information being requested or released. The client or the client's personal representative signs the section to give the authorization. The provider also signs the section to give authorization when completing the form. Update this form annually.</p> <p>Discuss the authorization and explain the use of the form. Make sure that the person understands the right to revoke the authorization at any time by completing form 470-3949, <i>Request to End an Authorization</i>.</p>

Distribution

Fax or scan a copy to the supervising registered nurse with a request for the physician's plan of care and supervising registered nurse's provider instructions.

Place a copy of the form in the client's DHS service case file. The person completing the form should also keep a copy.

Data

When initiating the form, enter:

- ◆ The person's name, state identification number (if any), social security number, date of birth, and parent's or guardian's name, if applicable.
- ◆ The name of the agency to release and receive information is the Iowa Department of Human Services. Enter the address, telephone number, and fax number.
- ◆ Enter the name or the agency to which the information is being released, or from which the information is being requested, and the agency's address, telephone number, and fax number.
- ◆ In the "information released may include" section, check the applicable boxes. If the "other" box is checked, describe the specific information being requested.
- ◆ Describe any exceptions or limitations under "other."  
Sample entry: "The Department may obtain information from, but not release information to, the client's daughter."
- ◆ State the purpose for which the information will be used.
- ◆ In the "Specific Authorization For Release" section, secure the person or the person's legal representative's initials if mental health, AIDS/HIV-related, or substance abuse information is to be obtained or released.

NOTE: Only the person or the person's legally authorized representative can give consent to release or obtain mental health, AIDS/HIV-related, or substance abuse information.

"Mental health information" means oral, written, or recorded information that indicates the identity of an individual receiving professional services and which relates to the diagnosis, course, or treatment or the individual's mental or emotional condition.

"Substance abuse" means the use of chemical substances by persons suffering from chemical dependency, persons who are incapacitated by a chemical substance, substance abusers, or chronic substance abusers.

"AIDS" means a medical diagnosis of acquired immunodeficiency syndrome, based on the Center for Disease Control's "Revision of the CDC Surveillance Case Definition for Acquired Immunodeficiency Syndrome." "HIV" means a medical diagnosis of human immunodeficiency virus infection based on a positive HIV-related test.

- ◆ Ask the person to sign and date the form and enter a date when the authorization is to expire.
- ◆ Check the applicable box indicating the relationship of the person who signs the form to the person the information is concerning.
- ◆ Obtain the signature of two witnesses for people who are incapable of signing their name due to a physical or mental disability.

To use the form as the required documentation for the disclosure of mental health information, document on the back of the form which is kept in the DHS service case file:

- ◆ The date.
- ◆ The name of recipient of information.
- ◆ The information disclosed.
- ◆ The name of the person who disclosed the information.

**AUTHORIZATION TO OBTAIN OR RELEASE HEALTH CARE INFORMATION**

Client Name:	ID#:	SS#:
Date of Birth:	Parent/Guardian:	

**I authorize the following individual or agency to share written and oral information (two-way or reciprocal release) about my needs and the services I receive . . .**

Name or agency to release and receive information:	
Address:	
City/State/Zip:	
Phone:	Fax:

**With the following individual or agency:**

Name or agency to receive and release information:	
Address:	
City/State/Zip:	
Phone:	Fax:

- The information released or shared may include:**
- |   |   |   |   |  |
|---|---|---|---|--|
| <input type="checkbox"/> Discharge summary  | <input type="checkbox"/> Family data photos           | <input type="checkbox"/> Social history | <input type="checkbox"/> Lab results        | <input type="checkbox"/> Psychological reports         |
| <input type="checkbox"/> Diagnosis/allergies                                      | <input type="checkbox"/> X-ray/imaging reports        | <input type="checkbox"/> Team notes     | <input type="checkbox"/> Medication history | <input type="checkbox"/> Treatment and aftercare plans |
| <input type="checkbox"/> Initial assessment                                       | <input type="checkbox"/> Immunization record          | <input type="checkbox"/> School records | <input type="checkbox"/> Court documents    | <input type="checkbox"/> History & physical exam       |
| <input type="checkbox"/> Receiving phone calls                                    | <input type="checkbox"/> Evaluation & recommendations |   |   |  |
| <input type="checkbox"/> Consultation reports from (doctor/specialty name): _____ |   |   |   |  |
| <input type="checkbox"/> Other (please specify): _____                            |   |   |   |  |

**Other (note exceptions or limits to this release):**

**This information is being used ONLY for (state purpose):**

<b>SPECIFIC AUTHORIZATION FOR RELEASE</b>	<b>Type of Information</b>	<b>Authorizing Initials</b>
<b>I authorize the release of the information listed at the right, which requires specific consent under federal law:</b>	Mental health evaluation/treatment*	
	AIDS/HIV-related	
	Substance abuse**	

This authorization is valid for information already in existence and any information that may be generated while this authorization is effective. I understand that I have the right to see any information that is disclosed pursuant to this authorization for release. I may request to see this information during normal business hours. I understand that I can revoke my authorization at any time by completing form 470-3949, Request to Revoke an Authorization. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization shall expire on the date specified below. If I fail to specify an expiration date, this authorization will expire in six months after the date it is signed. I understand that authorizing the disclosure of this information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that if the persons or organization authorized to receive this information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations. However, there may be other federal or state laws that require the information to remain confidential. If I have questions about disclosure of my health information, I can contact (name) \_\_\_\_\_ at (phone) \_\_\_\_\_. I have read this form, or it has been read and explained to me, and I understand its content.

Authorizing signature:	Date:	Expiration date:
Relationship to client: <input type="checkbox"/> Self <input type="checkbox"/> Legal representative <input type="checkbox"/> Nearest living relative <input type="checkbox"/> Other (specify below)		
<input type="checkbox"/> Not Required	Witness signature:	
<input type="checkbox"/> Required	Witness signature:	

A photocopy of this signed authorization shall have the same force and effect as this original.

**RECORD OF DISCLOSURES**  
(Required for mental health information)

Date	Name of Recipient	Contents Disclosed	Sent By
1.			
2.			
3.			
4.			
5.			
*	Only a person 18 years of age or older or a person's legal representative can authorize release of mental health information.		
**	Only the subject can authorize release of substance abuse information unless the subject is of such age and mental maturity that they are unable to authorize release.		

**Notice to Recipients of Mental Health Information**

In accordance with "Disclosure of Mental Health and Psychological Information" (Iowa Code, Chapter 228), a recipient of mental health information may further disclose this information only with the written authorization of the subject or the subject's legal representative or as otherwise provided in Chapters 228 and 229. Unauthorized disclosure is unlawful and civil damages and criminal penalties may apply. Federal confidentiality rules (42 CFR Part 2) restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

**Notice to Recipients of Substance Abuse Information**

This information has been disclosed from records whose confidentiality is protected by federal law. Iowa Code, Chapter 125 and federal regulations (42 CFR, Part 2) prohibit any further disclosure without the specific written authorization of the person to whom the information pertains, or as otherwise permitted by such statute and regulations. A general authorization for the release of medical or other information is not sufficient for this purpose. Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

**Notice to Recipients of HIV-Related Testing Information**

This information has been disclosed to you from records whose confidentiality is protected by state law. State law prohibits you from making any further disclosure of the information without specific written consent of the person to whom it pertains, or as otherwise permitted by law. A general authorization for the release of medical or other information is not sufficient for this purpose. (Iowa Code Section 141A.9) Federal confidentiality rules (42 CFR, Part 2) restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

**Policy Regarding Discrimination, Harassment, Affirmative Action and Equal Employment Opportunity**

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.

For assistance or consultation you may contact the IDHS Diversity Program Unit. Complaints should be filed promptly, but in most instances, no later than 180 days of the alleged discriminatory act. If you feel DHS has discriminated against or harassed you, you can send a letter of complaint to:

Iowa Department of Human Services, Administrator, Diversity Program Unit, 1305 E. Walnut, Des Moines IA 50319-0114; phone (800) 972-2017; fax (515) 281-4243.

**AUTHORIZATION TO OBTAIN OR RELEASE HEALTH CARE INFORMATION  
(AUTORIZACIÓN PARA OBTENER O PROPORCIONAR INFORMACIÓN SOBRE EL CUIDADO DE LA SALUD)**

Nombre del cliente:	Nº de documento:	Nº de Seguro social:
Fecha de nacimiento:	Padre/Tutor:	

**Autorizo a la siguiente persona o agencia a compartir información tanto escrita como oral (*información ida y vuelta o recíproca*) con respecto a mis necesidades y a los diferentes servicios que recibo. . .**

Nombre de la agencia que proporcionará y recibirá información:	Oficina del condado
Dirección:	
Ciudad/Estado/Código postal:	
Teléfono:	Fax:

**Para la siguiente persona o agencia:**

Nombre de la agencia que proporcionará y recibirá información:	
Dirección:	
Ciudad/Estado/Código postal:	
Teléfono:	Fax:

La información proporcionada o recibida puede incluir:

- |  |  |  |  |
|--|--|--|--|
| <input type="checkbox"/> Informes psicológicos   | <input type="checkbox"/> Resumen de descargo               | <input type="checkbox"/> Resumen del expediente clínico    | <input type="checkbox"/> Estado de admisión          |
| <input type="checkbox"/> Resultados del laboratorio  | <input type="checkbox"/> Tratamientos y planes pos-cuidado | <input type="checkbox"/> Fotografías de datos familiares   | <input type="checkbox"/> Antecedentes sociales       |
| <input type="checkbox"/> Comentarios del equipo  | <input type="checkbox"/> Historial de medicamentos         | <input type="checkbox"/> Diagnóstico/alergias              | <input type="checkbox"/> Rayos X/informes por imagen |
| <input type="checkbox"/> Certificado de vacunas  | <input type="checkbox"/> Informes escolares                | <input type="checkbox"/> Historial y chequeo físico        | <input type="checkbox"/> Evaluación inicial          |
| <input type="checkbox"/> Evaluación y recomendaciones  |  | <input type="checkbox"/> Documentos legales                |  |
| <input type="checkbox"/> Informes de consultas emitidos por parte de (nombre del médico/especialista): |  | <input type="checkbox"/> Recepción de llamadas telefónicas |  |
| <input type="checkbox"/> Otros (especifique):  |  |  |  |

**Otros (tenga en cuenta las excepciones y limitaciones relacionadas con el suministro de información):**

**Esta información se utiliza ÚNICAMENTE para (indique fin):**

<b><u>AUTORIZACIÓN ESPECIAL PARA EL SUMINISTRO DE INFORMACIÓN</u></b>	<b>Tipo de información</b>	<b>Iniciales de Autorización</b>
Autorizo el suministro de la información proporcionada a la derecha, la cual necesita autorización específico, como lo estipula la ley federal:	Tratamiento/evaluación de salud mental*	
	Enfermedades relacionadas con VIH/SIDA	
	Abuso de sustancias**	

La presente autorización es válida para la información ya existente o para todo tipo de información que podría aparecer durante el período de efectividad de esta autorización. Entiendo que tengo el derecho de leer todo tipo de información proporcionada en relación con esta autorización para su posterior suministro. Es posible que pueda solicitar esta información durante el horario de trabajo normal. Entiendo de igual manera que podré modificar esta autorización en cualquier momento con sólo completar el formulario 470-3949, Request to Revoke an Authorization (Solicitud para Revocar una Autorización). Entiendo además que esta revocación no se aplicará a la información que ya ha sido proporcionada como respuesta a esta autorización. Entiendo que dicha modificación no se aplicará a mi compañía de seguros ya que la ley otorga a la aseguradora correspondiente el derecho de impugnar una demanda según lo estipulado en mi póliza. A menos que se determine lo contrario, esta autorización perderá toda la validez el día que se indica más abajo. Si no especifico una fecha de vencimiento determinada, esta autorización vencerá a los seis meses a partir de la fecha en la cual se firme. Entiendo que el suministro de esta información se autoriza por propia voluntad. Puedo negarme a firmar esta autorización. Entiendo que si las personas u organizaciones autorizadas a recibir esta información no fueran un plan médico o un profesional de la salud, la información divulgada ya no estaría protegida por las normas federales de privacidad. Sin embargo, podrían existir otras leyes federales o estatales que exijan que dicha información permanezca confidencial. Si tuviera alguna duda con respecto al suministro de información relacionada con mi salud, deberé comunicarme con (nombre) \_\_\_\_\_ llamando al (teléfono) \_\_\_\_\_. He leído este formulario, o el mismo se me ha leído o explicado, y afirmo entender su contenido.

Firma de autorización:	Fecha:	Fecha de vencimiento:
Relación con el cliente:	<input type="checkbox"/> Uno mismo	<input type="checkbox"/> Representante legal
	<input type="checkbox"/> Pariente más cercano	<input type="checkbox"/> Otro (especificar debajo)
<input type="checkbox"/> Opcional	Firma del testigo:	
<input type="checkbox"/> Obligatorio	Firma del testigo:	

La copia de esta autorización firmada tendrá la misma validez que el original.

## RECORD OF DISCLOSURES (INFORME DE DIVULGACIÓN)

(Para información de salud mental)

Fecha	Nombre del destinatario	Contenidos proporcionados	Enviado por
1.			
2.			
3.			
4.			
5.			

\* El suministro de información sobre salud mental sólo podrá ser autorizado por personas mayores de 18 años o por el representante legal de una persona.

\*\* El suministro de información sobre abuso de sustancias podrá ser autorizado únicamente por la persona en cuestión, a menos que la edad y nivel de madurez mental de la persona demuestren que la misma no está capacitada para autorizar el suministro de tal información.

### AVISO A LOS DESTINATARIOS DE INFORMACIÓN SOBRE SALUD MENTAL

De acuerdo con la sección "Suministro de información psicológica y de salud mental" (Código de Iowa, Capítulo 228), el destinatario de información sobre salud mental podrá continuar proporcionando información únicamente si obtiene una autorización de la persona afectada o del representante legal de dicha persona, o tal como lo estipulen los Capítulos 228 y 229. El suministro de información no autorizada se considera ilegal. Como consecuencia y ante este delito, podrían aplicarse ciertas penalizaciones criminales y civiles. Las reglas federales de confidencialidad (42 CFR Parte 2) limitan el uso de esta información con el fin de llevar a cabo una investigación penal o bien para procesar a cualquier paciente drogadicto o alcohólico.

### AVISO A LOS DESTINATARIOS DE INFORMACIÓN SOBRE ABUSO DE SUSTANCIAS

Esta información ha sido proporcionada a partir de los informes cuya confidencialidad se encuentra protegida por ley federal. El Código de Iowa, Capítulo 25, y las reglas federales (42 CFR, Parte 2) prohíben cualquier tipo de suministro de información adicional sin la previa autorización por escrito de la persona a quien pertenece esta información, o de otra forma permitido por dichos estatutos y reglamentos. Para este propósito, se requerirá mucho más que una autorización general para el suministro de información médica u otro tipo de información. Las reglas federales limitan el uso de esta información con el fin de llevar a cabo una investigación penal o bien para procesar a cualquier paciente drogadicto o alcohólico.

### AVISO A DESTINATARIOS DE INFORMACIÓN SOBRE PRUEBAS DE VIH

Esta información se le ha proporcionado a partir de los informes cuya confidencialidad se encuentra protegida por ley estatal. La ley estatal le prohíbe continuar suministrando información sin el previo consentimiento de la persona afectada, o de algún otro modo permitido por la ley. Para este propósito, se requerirá mucho más que una autorización general para el suministro de información médica u otro tipo de información. (Código Iowa, Sección 141<sup>a</sup>.9) Las reglas federales de confidencialidad (42 CFR Parte 2) limitan el uso de esta información con el fin de llevar a cabo una investigación penal o bien para procesar a cualquier paciente drogadicto o alcohólico.

### POLÍTICA RELATIVA A LA DISCRIMINACIÓN, EL ACOSO, LA ACCIÓN AFIRMATIVA, Y LA OPORTUNIDAD IGUALITARIA DE EMPLEO

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 de sexual, identidad de género, religión, edad, incapacidad, creencia política o estatus de veterano.

Para recibir asistencia o hacer una consulta, puede comunicarse con IDHS Diversity Program Unit. Los reclamos deben ser presentados puntualmente, pero en la mayoría de los casos, antes de transcurridos 180 días de ocurrida la acción discriminatoria alegada. Si usted considera que el IDHS le ha discriminado o acosado, puede enviar una carta quejándose a:

Iowa Department of Human Services, Administrator, Diversity Program Unit, 1305 E. Walnut, Des Moines IA 50319-0114; teléfono (800) 972-2017; fax (515) 281-4243.

**Health Services Application, 470-2927 and 470-2927(S)**

Purpose	Forms 470-2927 and 470-2927(S) are used to apply for State Supplementary Assistance programs and Medicaid. The information contained on the application is used to determine eligibility for assistance.
Source	Form 470-2927 is printed with 30 sets on a pad. The Spanish translation, form 470-2927(S), is printed with 10 sets on a pad. Order supplies from Iowa Prison Industries in Anamosa.  Copies may also be printed or photocopied from the samples in the manual. (Click on the blue form number to access the sample electronically.)
Completion	Provide or mail the form to the applicant when assistance is requested. A person wishing to receive assistance for in-home health-related care must complete this application annually.  The client completes the form or may enlist help in preparing the form.  If the client is mentally incompetent, the form may be completed by a relative, a person in whose home the client resides, or by the DHS service worker.  The client must sign the form unless mentally or physically unable to do so. If the client is mentally competent but unable to sign the application form, an "X" or a thumbprint may be used if witnessed by two persons who know the client.  If the application is not complete when it is filed, it must be fully completed upon the interview with the client or representative.

Distribution

The client submits one copy of the form to the local office. Date-stamp the completed application before sending it to the income maintenance worker. Provide a copy for the client upon request.

NOTE: The *Health Services Application* takes the place of the *Application for All Social Services*, form 470-0615 or 470-0615(S). The form is kept in the income maintenance case record. A copy of the form is not required to be kept in the DHS service case file.

Data

The form requests information necessary to determine State Supplementary Assistance and Medicaid eligibility.

# 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**

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### **INFORMATION FOR ADULTS AND CHILDREN APPLYING FOR MEDICAL ASSISTANCE**

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- 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.

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### **MORE INFORMATION FOR ADULTS APPLYING FOR MEDICAL ASSISTANCE**

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- 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.

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

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- 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		
<b>Check the program(s) you would like to receive:</b> <input type="checkbox"/> <b>Medical Assistance (Title 19 or Medicaid)</b> <input type="checkbox"/> <b>Maternal and Children Health Services</b> <input type="checkbox"/> <b>Facility</b> <input type="checkbox"/> <b>Medicare Savings Program</b> <input type="checkbox"/> <b>Waiver</b> <input type="checkbox"/> <b>WIC</b> <input type="checkbox"/> <b>Breast and Cervical Cancer Treatment</b> <input type="checkbox"/> <b>Foster Care/Subsidized Adoption</b> <input type="checkbox"/> <b>State Supplementary Assistance</b> <input type="checkbox"/> <b>Iowa Family Planning Network (IFPN)</b>				
<b>IF YOU NEED MORE ROOM TO ANSWER ANY OF THE FOLLOWING QUESTIONS, ATTACH EXTRA PAGES.</b>				

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 Capitulo 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		
<b>Marcar los programas que usted quiere recibir:</b> <input type="checkbox"/> <b>Medical Assistance (Title 19 or Medicaid)</b> <input type="checkbox"/> <b>Maternal and Children Health Services</b> <input type="checkbox"/> <b>Facility</b> <input type="checkbox"/> <b>Medicare Savings Program</b> <input type="checkbox"/> <b>Waiver</b> <input type="checkbox"/> <b>WIC</b> <input type="checkbox"/> <b>Breast and Cervical Cancer Treatment</b> <input type="checkbox"/> <b>Foster Care/Subsidized Adoption</b> <input type="checkbox"/> <b>State Supplementary Assistance (Renuncia)</b> <input type="checkbox"/> <b>Iowa Family Planning Network</b>				
<b>SI USTED NECESITA MAS ESPACIO PARA CONTESTAR CUALQUIERA DE LAS SIGUIENTES PREGUNTAS, ADJUNTAR HOJAS ADICIONALES</b>				

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?	Condición de extranjero	Etnicidad*	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

[Individual Service Plan, 470-0583](#)

Purpose	The <i>Individual Service Plan</i> is used as a record of the plan of care for the individual client receiving in-home health-related care services.
Source	This form may be completed on line using the template in Outlook under "Public Folders/All Public Folders/State Approved Forms/Service."  (Click on the blue form number to access the sample electronically.)
Completion	The DHS service worker completes an <i>Individual Service Plan</i> when a new client is approved to receive in-home health-related care and annually thereafter. Update the plan if there are any changes in services and when the service is terminated.
Distribution	File in the DHS service case record. Send a copy to the client.
Data	<b>Member's Name:</b> Enter the client's name.  <b>Waiver Type:</b> Click on the dropdown box to select the waiver type or in-home health-related care (IHHRC).  <b>SID #:</b> Enter the client's state identification number.  <b>Original Service Plan Date:</b> Enter the date the original service began.  <b>Updated:</b> Enter the date the case plan is updated.  <b>Assessment – Date of Home Visit:</b> Enter the date of the home visit.  <b>Introduction:</b> Enter the demographic information about the client, including power of attorney and emergency contact.  <b>Medical Information:</b> Enter diagnosis, and physicians or other providers, and how often they are seen.  <b>Medications:</b> Enter current medications, hospitalizations, etc.

**Level of Care:** Enter the date that the physician's information was received.

**Health Status/ADLS:** Enter information regarding which areas require assistance and what assistance is needed.

**Additional Comments:** Enter other pertinent information about the client in a narrative format.

**Team Communication:** Enter a goal for each service provided by the IHHRC program.

**Safety and Crisis Plan:** Address all safety concerns that are present in the home environment.

NOTE: If there is a safety issue that was addressed with the client, but the client chooses to do nothing about that safety, issue document that in the case plan (under additional comments).

**Service:** List all services both formal and informal that the client receives.

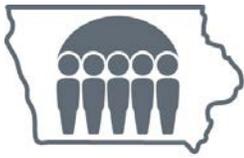
**Responsibilities:** List the responsibilities of all members of the team.

EXAMPLE: A client's goal may be to communicate with DHS if there is a change in circumstances, i.e., the client moves, income changes, etc.

**Signatures:** Enter the DHS service worker's and the DHS supervisor's names. The DHS service worker and DHS supervisor must sign and date the form.

**Member's Signature:** The client must sign and check the appropriate box to indicate that the client agrees.

NOTE: Document in the client narrative if the client refuses to sign the case plan.



## Individual Service Plan

Waiver Type:

Member's Name		SID #
Original Service Plan Date	Updated	Termination Summary Date

<b>Assessment</b>	Date of Home Visit
-------------------	--------------------

### INTRODUCTION:

Name:	DOB:
Address:	
Phone number:	Marital status:
Resides with:	Employment:
Income:	Source:
Insurance:	Drives: <input type="checkbox"/> Yes <input type="checkbox"/> No
Interpreter needed: <input type="checkbox"/> Yes <input type="checkbox"/> No	Name: Phone #:
POA: <input type="checkbox"/> Yes <input type="checkbox"/> No	Name: Phone #:
Emergency contact: Name:	Phone #:

### MEDICAL INFORMATION:

Diagnosis:	
Physicians/Providers	How Often Seen

Medications:
Who sets up: Self: <input type="checkbox"/> Other: <input type="checkbox"/>
Comment:
Hospitalizations since last service plan:
Critical incidents since last service plan:
Have you had any recent injuries due to your medical condition? <input type="checkbox"/> Yes <input type="checkbox"/> No
Explain:

### LEVEL OF CARE:

Date of last LOC certification:	LOC determined:
---------------------------------	-----------------

### HEALTH STATUS/ADLS:

Assistance required:	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, explain:
Dressing:	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, explain:
Bathing:	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, explain:
Meals:	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, explain:
Feeding self:	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, explain:
Toileting:	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, explain:
Transfers:	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, explain:
Minor wound care:	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, explain:
Finances/scheduling:	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, explain:
Transportation:	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, explain:

Medication management:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, explain:
Housekeeping:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, explain:
Laundry:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, explain:
Communication:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, explain:
Shopping:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, explain:
Assistive devices:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, explain:

**ADDITIONAL COMMENTS:**

Please use this section for any additional information that is pertinent to the care of this member that is not stated elsewhere.

Comments:

**TEAM COMMUNICATION:**

All services were mutually agreed upon by all parties. Service worker will communicate eligibility/activation of specific services as well as any modifications to the service plan with all parties and providers.

1.	<b>Goal:</b>		
	<b>Objective:</b>		
	Action Steps	Start Date	Complete Date
2.	<b>Goal:</b>		
	<b>Objective:</b>		
	Action Steps	Start Date	Complete Date
3.	<b>Goal:</b>		
	<b>Objective:</b>		
	Action Steps	Start Date	Complete Date
4.	<b>Goal:</b>		
	<b>Objective:</b>		
	Action Steps	Start Date	Complete Date
5.	<b>Goal:</b>		
	<b>Objective:</b>		
	Action Steps	Start Date	Complete Date
6.	<b>Goal:</b>		
	<b>Objective:</b>		
	Action Steps	Start Date	Complete Date

**SAFETY AND CRISIS PLAN:**

Phone available at all times:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Capable of contacting 911:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Caretakers capable of assisting:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Knows what to do in case of a fire, tornado, earthquake, or other natural emergency:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Capable of getting out of the home unassisted:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Home is handicapped accessible:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Barriers during emergency situations:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Explain:		

Service (formal and informal)	Funding Source	Name of Provider and Number (any pay source):	Service Frequency (units, days per month)	Rate	Service Effective Dates Where Applicable
					From: To:

Natural supports:

**Responsibilities**

**Provider Agency:**

**Member and Family:**

**Department of Human Services:**

**Reassessment/Termination**

Annual Level of Care to be determined by Iowa Medicaid Enterprise in correspondence with the member's medical team and the Department of Human Services.

**Signatures**

I certify that the above information is true and correct to the best of my knowledge.

Worker's Name	Supervisor's Name	
Worker's Signature		Date
Supervisor's Signature		Date

Please check:  I agree  I disagree

Member's Signature	Date
--------------------	------

**Notice of Decision: Services, 470-0602 and 470-0602(S)**

Purpose	The <i>Notice of Decision: Services</i> notifies a service applicant or recipient of all actions taken that affect the person's case. Due process requirements are met when a <i>Notice of Decision: Services</i> is issued.
	For approvals, renewal, reviews or changes print the NOD from ISIS. For cancellations or denials hand write the NOD.
Source	The English and Spanish versions of the form may be completed on line using the template in Outlook under "Public Folders/All Public Folders/State Approved Forms/Service."  The forms may also be printed or photocopied from the samples in the manual and completed manually. (Click on the blue form number to access the sample electronically.)
Completion	The DHS service worker completes this form to notify clients of eligibility determination and service needs for in-home health-related care for the following case actions: <ul style="list-style-type: none"><li>◆ An application is approved, denied, or withdrawn.</li><li>◆ Services are renewed as a result of an annual or a special review.</li><li>◆ The service is changed.</li><li>◆ Services are terminated.</li><li>◆ Client participation is required, or the amount changes, or it is to be paid to a different provider.</li></ul>
Distribution	Give the original to the client. Send a copy to the provider. File a copy in the DHS service case record.

Data

**Identifying Information:** State identification number (SID #).

**Explanation of Action:** Include in this section:

- ◆ The action taken;
- ◆ The services, if new or changed; and
- ◆ The specific basis for the action in words the client can understand.

If services are being reduced, state the reason clearly. For a termination, include the basis for cancellation and the reason for termination.

**Manual or Rule References:** State the chapter and subsection of the *Employees' Manual* and the administrative rule reference that support the action taken.

**Fees:** For clients with client participation, specify:

- ◆ The service and the person to whom the client participation is paid.
- ◆ The amount of the client participation.
- ◆ The period covered by the client participation (e.g., \$20 per month).

### Physician's Report, 470-0673

Purpose	<p>The <i>Physician's Report</i> is used to obtain medical information from a physician about an in-home health-related care client. (This form is also used in the family-life home program.) The physician's recommendations and orders regarding the client's level of care and the client's health needs are used for determining eligibility and for developing a plan of care and services.</p> <p>The <i>Physician's Report</i> may also be used as the <b>health care plan</b> if the supervising registered nurse or physician does not use a different form.</p>
Source	<p>Print or photocopy supplies of the form from the sample in the manual. (Click on the blue form number to access the sample electronically.)</p> <p>If this form is used as the plan of care, provide the supervising registered nurse with a supply of the forms.</p>
Completion	<p>Prepare this form:</p> <ul style="list-style-type: none"><li>◆ Upon receipt of referral.</li><li>◆ If the form is being used as a plan of care, the physician completes this form every 60 days thereafter.</li><li>◆ Annually at review.</li></ul> <p>Complete the items on the form that precede the consent box. The client and the client's legal guardian complete items in the "Consent for Physician's Release of Information" section, with assistance from the DHS service worker, if required. The physician completes the remaining portions of the form.</p>
Distribution	<p>The physician completes the form and sends it to the registered supervising nurse or agency responsible for planning and managing services to the client.</p> <p>The supervising registered nurse or agency maintains the form in the client's file and sends a copy to the DHS service worker for the client's service file.</p>

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[Provider Agreement, 470-0636](#)

**Purpose** The *Provider Agreement* describes the responsibilities of a person providing in-home health-related care services to a client of the Department. The agreement specifies the payment to be made to each provider by the client. The Department assures the eligibility of the client.

**Source** This form may be completed on line using the template in Outlook under "Public Folders/All Public Folders/State Approved Forms/Service."

Supplies of the form may also be printed or photocopied from the sample in the manual. (Click on the blue form number to access the sample electronically.)

**Completion** The client and worker complete a *Provider Agreement* with each provider the client has. If a provider has more than one client, the provider must have a different agreement for each client.

A client may have more than one valid *Provider Agreement*, with each having a different number as providers will be assigned their own provider number.

Before the service is initiated and annually thereafter, the form shall be signed by:

- ◆ The client,
- ◆ The provider,
- ◆ The DHS service worker, and
- ◆ The service area manager or designee.

A new agreement must be completed when any of the following changes occur:

- ◆ Rate of payment
- ◆ Service to be provided
- ◆ Maximum cost
- ◆ Provider
- ◆ Who receives the client participation

Distribution

When the form is completed and signed by all parties the information is entered in ISIS. The original copy goes to the DHS service worker for the service case file. Mail a copy to the provider and to the client.

Data

**Provider number:** ISIS generates the provider number after the DHS service worker enters all information into ISIS. (Information is entered in ISIS under the provider tab.)

NOTE: The provider may already be a traditional Medicaid provider. Search the provider name before entering new information.

**State ID:** Enter the client's state identification number.

**Amendment:** Indicates this is an amendment to an agreement already in effect.

**Payee name:** Enter the name of the payee, if different from the client. Examples of payees are legal conservators, power of attorneys for financial affairs, and protective payees.

**Payee telephone number, street address, city, state, and zip code:** Entered if there is a payee.

**Client name, social security number, telephone number, street address, city, state, and zip code.** Enter on all agreements.

**Service provider's name, telephone number, street address, city, state, and zip code.** Enter on all agreements.

**Family member:** Indicates whether the provider is a family member, as defined on the agreement.

**Description of specific duties:** Enter the specific service codes that will be provided:

- R0001 Personal care number of 15 minute units  
Rate per unit total
- R0002 Homemaker number of 15 minute units rate
- R0003 Medication supervision number of 15 minute units  
rate
- R0004 Food preparation number of 15 minute units
- R0005 Transportation number of 15 minute units
- R0006 Other

**Provider signature and date:** Indicates approval of contract.

**Client signature and date:** Indicates approval of contract.

**Start date:** The date on which the agreement is to begin.

**End date:** The maximum term of the agreement, no longer than one year.

**Unit cost:** The dollar amount for the rate agreed upon.  
Example: \$2.00 per 15 minute increment.

**Per:** The basis for the rate. Use 15 minutes.

**Billable per month DHS:** The maximum amount the Department has agreed to provide to the client to purchase the service identified in this agreement.

**Client participation (CP):** The amount of client participation, if any.

**DHS service worker signature and date:** Approves payment for the service and certifies that the client is eligible.

**Area administrator or designee signature and date:** The service area manager or designee certifies the client for the program and gives final approval for the payment.



## Provider Agreement

Provider Number		State ID		Amendment <input type="checkbox"/> Yes <input type="checkbox"/> No	
Payee Name			Telephone Number ( )		
Payee Street Address		City		State	Zip Code
Client Name		Client Social Security Number		Telephone Number ( )	
Client Street Address		City		State	Zip Code
Service Provider Name		Provider Social Security Number		Telephone Number ( )	
Service Provider Street Address		City		State	Zip Code

The client is a member of my family (a parent, stepparent, child, stepchild, brother, stepbrother, sister, stepsister, lineal ancestor, or lineal descendent, or such person by marriage or adoption).  Yes  No

Description of Specific Duties	Number of 15-Minute Units per Month	Rate Per Unit	Total
Personal care		\$	\$
Homemaker		\$	\$
Medication supervision		\$	\$
Food preparation		\$	\$
Transportation		\$	\$
Other:		\$	\$
<b>Total</b>			\$

I certify that I will provide the services as stated above before submitting the billing for payment. I will not request additional payment from the client. **Payments I receive may be taxable as income for federal and state purposes.**

Provider Signature	Date
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I certify that this agreement is at my request and approval.

Client (or authorized representative) Signature	Date
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Start Date	End Date	Unit Cost	Per 15 minutes
Billable Per Month DHS		Client Participation (CP)	

Based on current available information, this client meets the eligibility for reimbursement for in-home health services. Services may be provided until the provider receives notice to discontinue due to ineligibility, expiration of agreement, or other cause.

Worker Signature	Date
Area Administrator or Designee	Date

**[Provider Health Assessment, 470-0672](#)**

Purpose	Form 470-0672 is used to certify all providers for the in-home health-related care program. (It also is used in the family-life home program.)
Source	Print or photocopy supplies of the form from the sample in the manual. (Click on the blue form number to access the sample electronically.)
Completion	The provider's physician, advanced registered nurse practitioner, or a physician assistant working under the direction of a physician completes one <i>Assessment</i> before the initiation of service delivery and annually thereafter.
	The provider is responsible for delivering the completed form to the DHS service worker. The provider assumes full responsibility for any costs that may be incurred in the completion of this form.
Distribution	Keep the completed form in the client's DHS service case record. Make a copy for the provider upon request.

[Purchase of Service Provider Invoice, 470-0020](#)

Purpose	<p>This form is used to process:</p> <ul style="list-style-type: none"><li>◆ Payments for the previous fiscal year and</li><li>◆ The last payment for a client who has died.</li></ul>
Source	<p>This form is printed in pads of 25 three-part carbonized sets. Order supplies from Iowa State Industries at Anamosa.</p> <p>Supplies of the form may also be printed or photocopied from the sample in the manual. (Click on the blue form number to access the sample electronically.)</p>
Completion	<p>The DHS service worker completes this form when a bill is submitted after the end of the (carry over period for the previous) fiscal year, or when a client has died before the last payment is made to the provider.</p>
Distribution	<p>Submit a W-9 form for the provider, the original statement of services rendered signed by the provider, and the invoice to the address listed below. Keep a copy of the W-9, statement of services rendered, and the invoice in the DHS service file.</p> <p>Department of Human Services Bureau of Purchasing, Payments, Receipts and Payroll 1305 E. Walnut Street Des Moines, Iowa 50319</p> <p>Or scan this information and email it to: <a href="mailto:inhomehealthdemographic@dhs.state.ia.us">inhomehealthdemographic@dhs.state.ia.us</a></p>
Data	<p><b>Billing Period:</b> Enter the first and last date of the billing period, inclusively. Example: 10-1-99 - 10-31-99</p> <p><b>State/Local:</b> Enter code 'S' for state funds.</p> <p><b>County No. and Name:</b> Enter the county number and name. Example: 77 Polk</p> <p><b>Agreement No.:</b> Enter the provider number generated by ISIS.</p>

**Provider Name:** Enter the provider's name.

**Provider Addr:** Enter the provider's address.

**City/State/Zip:** Enter the city, state, and zip code.

**Case Number:** Enter the client's state identification number.

**Client's Name:** Enter the client or payee name exactly as entered on the ISIS system. (In most cases, this is the client.)

**Service Beginning:** For **new** clients, enter the service initiation date. Leave **blank** for ongoing clients.

**Service Ending:** Enter the termination date for clients who are **ending** service. Leave **blank** for ongoing clients.

**Service Code:** Enter the appropriate service code (i.e., R0001).

**Unit Cost:** Enter the cost for one unit of service as given in the *Provider Agreement*. (Example: 2.00 per 15 minutes)

**No. of Units:** Enter the number of units of service provided during the billing month.

EXAMPLE: 10 15-minute units per month

**Total Cost:** Enter the product of the unit cost and the number of units. (Example: The unit cost is \$2.00 and the number of units is 5. The total cost is \$10.00)

**Credits:** Enter any credits for overpayment or client participation.

**Net Cost:** Enter the total cost less credits. (Example: Total cost is \$100.00. Credits are \$20.00. Net cost to the Department is \$80.00.)

**Totals:** Enter the total amount due the client.

**Approval:** Enter an authorized local office signature and date to approve the billing.

**Request for Taxpayer Identification Number and Certification, W-9**

Purpose	<p>The <i>Request for Taxpayer Identification Number and Certification</i>, form W-9, is used to obtain the client's social security number and legal name as registered with the Internal Revenue Service (IRS).</p> <p>NOTE: The W-9 form is also used to obtain the provider's social security number when the client passes away before the last payment is made to the provider.</p>
Source	<p>Click on the blue form number to access the form electronically.</p>
Completion	<p>The DHS service worker provides the form to the client before completion of the provider agreement.</p>
Distribution	<p>The DHS service worker sends the original form signed by the client to the address listed below. Keep a copy for the DHS service file.</p> <p>Department of Human Services Bureau of Purchasing, Payments, Receipts and Payroll 1305 E. Walnut Street Des Moines, Iowa 50319</p> <p>Or scan this information and email it to: <a href="mailto:inhomehealthdemographic@dhs.state.ia.us">inhomehealthdemographic@dhs.state.ia.us</a>.</p>
Data	<p>The client follows the instructions provided with the form.</p>

## Request for Taxpayer Identification Number and Certification

**Give Form to the  
 requester. Do not  
 send to the IRS.**

<b>Print or type See Specific Instructions on page 2.</b>	Name (as shown on your income tax return)	
	Business name/disregarded entity name, if different from above	
	Check appropriate box for federal tax classification: <input type="checkbox"/> Individual/sole proprietor <input type="checkbox"/> C Corporation <input type="checkbox"/> S Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Trust/estate  <input type="checkbox"/> Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=partnership) ▶ _____  <input type="checkbox"/> Other (see instructions) ▶ _____	
	<input type="checkbox"/> Exempt payee	
	Address (number, street, and apt. or suite no.)	Requester's name and address (optional)
City, state, and ZIP code		
List account number(s) here (optional)		

### Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on the "Name" line to avoid backup withholding. For individuals, this is your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 3. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN* on page 3.

Social security number									

**Note.** If the account is in more than one name, see the chart on page 4 for guidelines on whose number to enter.

Employer identification number									

### Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding, and
3. I am a U.S. citizen or other U.S. person (defined below).

**Certification instructions.** You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions on page 4.

<b>Sign Here</b>	Signature of U.S. person ▶	Date ▶
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### General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

#### Purpose of Form

A person who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) to report, for example, income paid to you, real estate transactions, mortgage interest you paid, acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA.

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN to the person requesting it (the requester) and, when applicable, to:

1. Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),
2. Certify that you are not subject to backup withholding, or
3. Claim exemption from backup withholding if you are a U.S. exempt payee. If applicable, you are also certifying that as a U.S. person, your allocable share of any partnership income from a U.S. trade or business is not subject to the withholding tax on foreign partners' share of effectively connected income.

**Note.** If a requester gives you a form other than Form W-9 to request your TIN, you must use the requester's form if it is substantially similar to this Form W-9.

**Definition of a U.S. person.** For federal tax purposes, you are considered a U.S. person if you are:

- An individual who is a U.S. citizen or U.S. resident alien,
- A partnership, corporation, company, or association created or organized in the United States or under the laws of the United States,
- An estate (other than a foreign estate), or
- A domestic trust (as defined in Regulations section 301.7701-7).

**Special rules for partnerships.** Partnerships that conduct a trade or business in the United States are generally required to pay a withholding tax on any foreign partners' share of income from such business. Further, in certain cases where a Form W-9 has not been received, a partnership is required to presume that a partner is a foreign person, and pay the withholding tax. Therefore, if you are a U.S. person that is a partner in a partnership conducting a trade or business in the United States, provide Form W-9 to the partnership to establish your U.S. status and avoid withholding on your share of partnership income.

The person who gives Form W-9 to the partnership for purposes of establishing its U.S. status and avoiding withholding on its allocable share of net income from the partnership conducting a trade or business in the United States is in the following cases:

- The U.S. owner of a disregarded entity and not the entity,
- The U.S. grantor or other owner of a grantor trust and not the trust, and
- The U.S. trust (other than a grantor trust) and not the beneficiaries of the trust.

**Foreign person.** If you are a foreign person, do not use Form W-9. Instead, use the appropriate Form W-8 (see Publication 515, Withholding of Tax on Nonresident Aliens and Foreign Entities).

**Nonresident alien who becomes a resident alien.** Generally, only a nonresident alien individual may use the terms of a tax treaty to reduce or eliminate U.S. tax on certain types of income. However, most tax treaties contain a provision known as a “saving clause.” Exceptions specified in the saving clause may permit an exemption from tax to continue for certain types of income even after the payee has otherwise become a U.S. resident alien for tax purposes.

If you are a U.S. resident alien who is relying on an exception contained in the saving clause of a tax treaty to claim an exemption from U.S. tax on certain types of income, you must attach a statement to Form W-9 that specifies the following five items:

1. The treaty country. Generally, this must be the same treaty under which you claimed exemption from tax as a nonresident alien.
2. The treaty article addressing the income.
3. The article number (or location) in the tax treaty that contains the saving clause and its exceptions.
4. The type and amount of income that qualifies for the exemption from tax.
5. Sufficient facts to justify the exemption from tax under the terms of the treaty article.

**Example.** Article 20 of the U.S.-China income tax treaty allows an exemption from tax for scholarship income received by a Chinese student temporarily present in the United States. Under U.S. law, this student will become a resident alien for tax purposes if his or her stay in the United States exceeds 5 calendar years. However, paragraph 2 of the first Protocol to the U.S.-China treaty (dated April 30, 1984) allows the provisions of Article 20 to continue to apply even after the Chinese student becomes a resident alien of the United States. A Chinese student who qualifies for this exception (under paragraph 2 of the first protocol) and is relying on this exception to claim an exemption from tax on his or her scholarship or fellowship income would attach to Form W-9 a statement that includes the information described above to support that exemption.

If you are a nonresident alien or a foreign entity not subject to backup withholding, give the requester the appropriate completed Form W-8.

**What is backup withholding?** Persons making certain payments to you must under certain conditions withhold and pay to the IRS a percentage of such payments. This is called “backup withholding.” Payments that may be subject to backup withholding include interest, tax-exempt interest, dividends, broker and barter exchange transactions, rents, royalties, nonemployee pay, and certain payments from fishing boat operators. Real estate transactions are not subject to backup withholding.

You will not be subject to backup withholding on payments you receive if you give the requester your correct TIN, make the proper certifications, and report all your taxable interest and dividends on your tax return.

#### **Payments you receive will be subject to backup withholding if:**

1. You do not furnish your TIN to the requester,
2. You do not certify your TIN when required (see the Part II instructions on page 3 for details),
3. The IRS tells the requester that you furnished an incorrect TIN,
4. The IRS tells you that you are subject to backup withholding because you did not report all your interest and dividends on your tax return (for reportable interest and dividends only), or
5. You do not certify to the requester that you are not subject to backup withholding under 4 above (for reportable interest and dividend accounts opened after 1983 only).

Certain payees and payments are exempt from backup withholding. See the instructions below and the separate Instructions for the Requester of Form W-9.

Also see *Special rules for partnerships* on page 1.

### **Updating Your Information**

You must provide updated information to any person to whom you claimed to be an exempt payee if you are no longer an exempt payee and anticipate receiving reportable payments in the future from this person. For example, you may need to provide updated information if you are a C corporation that elects to be an S corporation, or if you no longer are tax exempt. In addition, you must furnish a new Form W-9 if the name or TIN changes for the account, for example, if the grantor of a grantor trust dies.

### **Penalties**

**Failure to furnish TIN.** If you fail to furnish your correct TIN to a requester, you are subject to a penalty of \$50 for each such failure unless your failure is due to reasonable cause and not to willful neglect.

**Civil penalty for false information with respect to withholding.** If you make a false statement with no reasonable basis that results in no backup withholding, you are subject to a \$500 penalty.

**Criminal penalty for falsifying information.** Willfully falsifying certifications or affirmations may subject you to criminal penalties including fines and/or imprisonment.

**Misuse of TINs.** If the requester discloses or uses TINs in violation of federal law, the requester may be subject to civil and criminal penalties.

### **Specific Instructions**

#### **Name**

If you are an individual, you must generally enter the name shown on your income tax return. However, if you have changed your last name, for instance, due to marriage without informing the Social Security Administration of the name change, enter your first name, the last name shown on your social security card, and your new last name.

If the account is in joint names, list first, and then circle, the name of the person or entity whose number you entered in Part I of the form.

**Sole proprietor.** Enter your individual name as shown on your income tax return on the “Name” line. You may enter your business, trade, or “doing business as (DBA)” name on the “Business name/disregarded entity name” line.

**Partnership, C Corporation, or S Corporation.** Enter the entity's name on the “Name” line and any business, trade, or “doing business as (DBA) name” on the “Business name/disregarded entity name” line.

**Disregarded entity.** Enter the owner's name on the “Name” line. The name of the entity entered on the “Name” line should never be a disregarded entity. The name on the “Name” line must be the name shown on the income tax return on which the income will be reported. For example, if a foreign LLC that is treated as a disregarded entity for U.S. federal tax purposes has a domestic owner, the domestic owner's name is required to be provided on the “Name” line. If the direct owner of the entity is also a disregarded entity, enter the first owner that is not disregarded for federal tax purposes. Enter the disregarded entity's name on the “Business name/disregarded entity name” line. If the owner of the disregarded entity is a foreign person, you must complete an appropriate Form W-8.

**Note.** Check the appropriate box for the federal tax classification of the person whose name is entered on the “Name” line (Individual/sole proprietor, Partnership, C Corporation, S Corporation, Trust/estate).

**Limited Liability Company (LLC).** If the person identified on the “Name” line is an LLC, check the “Limited liability company” box only and enter the appropriate code for the tax classification in the space provided. If you are an LLC that is treated as a partnership for federal tax purposes, enter “P” for partnership. If you are an LLC that has filed a Form 8832 or a Form 2553 to be taxed as a corporation, enter “C” for C corporation or “S” for S corporation. If you are an LLC that is disregarded as an entity separate from its owner under Regulation section 301.7701-3 (except for employment and excise tax), do not check the LLC box unless the owner of the LLC (required to be identified on the “Name” line) is another LLC that is not disregarded for federal tax purposes. If the LLC is disregarded as an entity separate from its owner, enter the appropriate tax classification of the owner identified on the “Name” line.

**Other entities.** Enter your business name as shown on required federal tax documents on the "Name" line. This name should match the name shown on the charter or other legal document creating the entity. You may enter any business, trade, or DBA name on the "Business name/disregarded entity name" line.

**Exempt Payee**

If you are exempt from backup withholding, enter your name as described above and check the appropriate box for your status, then check the "Exempt payee" box in the line following the "Business name/disregarded entity name," sign and date the form.

Generally, individuals (including sole proprietors) are not exempt from backup withholding. Corporations are exempt from backup withholding for certain payments, such as interest and dividends.

**Note.** If you are exempt from backup withholding, you should still complete this form to avoid possible erroneous backup withholding.

The following payees are exempt from backup withholding:

1. An organization exempt from tax under section 501(a), any IRA, or a custodial account under section 403(b)(7) if the account satisfies the requirements of section 401(f)(2),
  2. The United States or any of its agencies or instrumentalities,
  3. A state, the District of Columbia, a possession of the United States, or any of their political subdivisions or instrumentalities,
  4. A foreign government or any of its political subdivisions, agencies, or instrumentalities, or
  5. An international organization or any of its agencies or instrumentalities.
- Other payees that may be exempt from backup withholding include:
6. A corporation,
  7. A foreign central bank of issue,
  8. A dealer in securities or commodities required to register in the United States, the District of Columbia, or a possession of the United States,
  9. A futures commission merchant registered with the Commodity Futures Trading Commission,
  10. A real estate investment trust,
  11. An entity registered at all times during the tax year under the Investment Company Act of 1940,
  12. A common trust fund operated by a bank under section 584(a),
  13. A financial institution,
  14. A middleman known in the investment community as a nominee or custodian, or
  15. A trust exempt from tax under section 664 or described in section 4947.

The following chart shows types of payments that may be exempt from backup withholding. The chart applies to the exempt payees listed above, 1 through 15.

IF the payment is for . . .	THEN the payment is exempt for . . .
Interest and dividend payments	All exempt payees except for 9
Broker transactions	Exempt payees 1 through 5 and 7 through 13. Also, C corporations.
Barter exchange transactions and patronage dividends	Exempt payees 1 through 5
Payments over \$600 required to be reported and direct sales over \$5,000 <sup>1</sup>	Generally, exempt payees 1 through 7 <sup>2</sup>

<sup>1</sup> See Form 1099-MISC, Miscellaneous Income, and its instructions.

<sup>2</sup> However, the following payments made to a corporation and reportable on Form 1099-MISC are not exempt from backup withholding: medical and health care payments, attorneys' fees, gross proceeds paid to an attorney, and payments for services paid by a federal executive agency.

**Part I. Taxpayer Identification Number (TIN)**

**Enter your TIN in the appropriate box.** If you are a resident alien and you do not have and are not eligible to get an SSN, your TIN is your IRS individual taxpayer identification number (ITIN). Enter it in the social security number box. If you do not have an ITIN, see *How to get a TIN* below.

If you are a sole proprietor and you have an EIN, you may enter either your SSN or EIN. However, the IRS prefers that you use your SSN.

If you are a single-member LLC that is disregarded as an entity separate from its owner (see *Limited Liability Company (LLC)* on page 2), enter the owner's SSN (or EIN, if the owner has one). Do not enter the disregarded entity's EIN. If the LLC is classified as a corporation or partnership, enter the entity's EIN.

**Note.** See the chart on page 4 for further clarification of name and TIN combinations.

**How to get a TIN.** If you do not have a TIN, apply for one immediately. To apply for an SSN, get Form SS-5, Application for a Social Security Card, from your local Social Security Administration office or get this form online at [www.ssa.gov](http://www.ssa.gov). You may also get this form by calling 1-800-772-1213. Use Form W-7, Application for IRS Individual Taxpayer Identification Number, to apply for an ITIN, or Form SS-4, Application for Employer Identification Number, to apply for an EIN. You can apply for an EIN online by accessing the IRS website at [www.irs.gov/businesses](http://www.irs.gov/businesses) and clicking on Employer Identification Number (EIN) under Starting a Business. You can get Forms W-7 and SS-4 from the IRS by visiting [IRS.gov](http://IRS.gov) or by calling 1-800-TAX-FORM (1-800-829-3676).

If you are asked to complete Form W-9 but do not have a TIN, write "Applied For" in the space for the TIN, sign and date the form, and give it to the requester. For interest and dividend payments, and certain payments made with respect to readily tradable instruments, generally you will have 60 days to get a TIN and give it to the requester before you are subject to backup withholding on payments. The 60-day rule does not apply to other types of payments. You will be subject to backup withholding on all such payments until you provide your TIN to the requester.

**Note.** Entering "Applied For" means that you have already applied for a TIN or that you intend to apply for one soon.

**Caution:** *A disregarded domestic entity that has a foreign owner must use the appropriate Form W-8.*

**Part II. Certification**

To establish to the withholding agent that you are a U.S. person, or resident alien, sign Form W-9. You may be requested to sign by the withholding agent even if item 1, below, and items 4 and 5 on page 4 indicate otherwise.

For a joint account, only the person whose TIN is shown in Part I should sign (when required). In the case of a disregarded entity, the person identified on the "Name" line must sign. Exempt payees, see *Exempt Payee* on page 3.

**Signature requirements.** Complete the certification as indicated in items 1 through 3, below, and items 4 and 5 on page 4.

**1. Interest, dividend, and barter exchange accounts opened before 1984 and broker accounts considered active during 1983.** You must give your correct TIN, but you do not have to sign the certification.

**2. Interest, dividend, broker, and barter exchange accounts opened after 1983 and broker accounts considered inactive during 1983.** You must sign the certification or backup withholding will apply. If you are subject to backup withholding and you are merely providing your correct TIN to the requester, you must cross out item 2 in the certification before signing the form.

**3. Real estate transactions.** You must sign the certification. You may cross out item 2 of the certification.

**4. Other payments.** You must give your correct TIN, but you do not have to sign the certification unless you have been notified that you have previously given an incorrect TIN. "Other payments" include payments made in the course of the requester's trade or business for rents, royalties, goods (other than bills for merchandise), medical and health care services (including payments to corporations), payments to a nonemployee for services, payments to certain fishing boat crew members and fishermen, and gross proceeds paid to attorneys (including payments to corporations).

**5. Mortgage interest paid by you, acquisition or abandonment of secured property, cancellation of debt, qualified tuition program payments (under section 529), IRA, Coverdell ESA, Archer MSA or HSA contributions or distributions, and pension distributions.** You must give your correct TIN, but you do not have to sign the certification.

### What Name and Number To Give the Requester

For this type of account:	Give name and SSN of:
1. Individual	The individual
2. Two or more individuals (joint account)	The actual owner of the account or, if combined funds, the first individual on the account <sup>1</sup>
3. Custodian account of a minor (Uniform Gift to Minors Act)	The minor <sup>2</sup>
4. a. The usual revocable savings trust (grantor is also trustee) b. So-called trust account that is not a legal or valid trust under state law	The grantor-trustee <sup>1</sup> The actual owner <sup>1</sup>
5. Sole proprietorship or disregarded entity owned by an individual	The owner <sup>3</sup>
6. Grantor trust filing under Optional Form 1099 Filing Method 1 (see Regulation section 1.671-4(b)(2)(i)(A))	The grantor*
For this type of account:	Give name and EIN of:
7. Disregarded entity not owned by an individual	The owner
8. A valid trust, estate, or pension trust	Legal entity <sup>4</sup>
9. Corporation or LLC electing corporate status on Form 8832 or Form 2553	The corporation
10. Association, club, religious, charitable, educational, or other tax-exempt organization	The organization
11. Partnership or multi-member LLC	The partnership
12. A broker or registered nominee	The broker or nominee
13. Account with the Department of Agriculture in the name of a public entity (such as a state or local government, school district, or prison) that receives agricultural program payments	The public entity
14. Grantor trust filing under the Form 1041 Filing Method or the Optional Form 1099 Filing Method 2 (see Regulation section 1.671-4(b)(2)(i)(B))	The trust

<sup>1</sup> List first and circle the name of the person whose number you furnish. If only one person on a joint account has an SSN, that person's number must be furnished.

<sup>2</sup> Circle the minor's name and furnish the minor's SSN.

<sup>3</sup> You must show your individual name and you may also enter your business or "DBA" name on the "Business name/disregarded entity" name line. You may use either your SSN or EIN (if you have one), but the IRS encourages you to use your SSN.

<sup>4</sup> List first and circle the name of the trust, estate, or pension trust. (Do not furnish the TIN of the personal representative or trustee unless the legal entity itself is not designated in the account title.) Also see *Special rules for partnerships* on page 1.

\*Note. Grantor also must provide a Form W-9 to trustee of trust.

**Note.** If no name is circled when more than one name is listed, the number will be considered to be that of the first name listed.

### Secure Your Tax Records from Identity Theft

Identity theft occurs when someone uses your personal information such as your name, social security number (SSN), or other identifying information, without your permission, to commit fraud or other crimes. An identity thief may use your SSN to get a job or may file a tax return using your SSN to receive a refund.

To reduce your risk:

- Protect your SSN,
- Ensure your employer is protecting your SSN, and
- Be careful when choosing a tax preparer.

If your tax records are affected by identity theft and you receive a notice from the IRS, respond right away to the name and phone number printed on the IRS notice or letter.

If your tax records are not currently affected by identity theft but you think you are at risk due to a lost or stolen purse or wallet, questionable credit card activity or credit report, contact the IRS Identity Theft Hotline at 1-800-908-4490 or submit Form 14039.

For more information, see Publication 4535, Identity Theft Prevention and Victim Assistance.

Victims of identity theft who are experiencing economic harm or a system problem, or are seeking help in resolving tax problems that have not been resolved through normal channels, may be eligible for Taxpayer Advocate Service (TAS) assistance. You can reach TAS by calling the TAS toll-free case intake line at 1-877-777-4778 or TTY/TDD 1-800-829-4059.

#### Protect yourself from suspicious emails or phishing schemes.

Phishing is the creation and use of email and websites designed to mimic legitimate business emails and websites. The most common act is sending an email to a user falsely claiming to be an established legitimate enterprise in an attempt to scam the user into surrendering private information that will be used for identity theft.

The IRS does not initiate contacts with taxpayers via emails. Also, the IRS does not request personal detailed information through email or ask taxpayers for the PIN numbers, passwords, or similar secret access information for their credit card, bank, or other financial accounts.

If you receive an unsolicited email claiming to be from the IRS, forward this message to [phishing@irs.gov](mailto:phishing@irs.gov). You may also report misuse of the IRS name, logo, or other IRS property to the Treasury Inspector General for Tax Administration at 1-800-366-4484. You can forward suspicious emails to the Federal Trade Commission at: [spam@uce.gov](mailto:spam@uce.gov) or contact them at [www.ftc.gov/idtheft](http://www.ftc.gov/idtheft) or 1-877-IDTHEFT (1-877-438-4338).

Visit [IRS.gov](http://IRS.gov) to learn more about identity theft and how to reduce your risk.

### Privacy Act Notice

Section 6109 of the Internal Revenue Code requires you to provide your correct TIN to persons (including federal agencies) who are required to file information returns with the IRS to report interest, dividends, or certain other income paid to you; mortgage interest you paid; the acquisition or abandonment of secured property; the cancellation of debt; or contributions you made to an IRA, Archer MSA, or HSA. The person collecting this form uses the information on the form to file information returns with the IRS, reporting the above information. Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation and to cities, states, the District of Columbia, and U.S. possessions for use in administering their laws. The information also may be disclosed to other countries under a treaty, to federal and state agencies to enforce civil and criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism. You must provide your TIN whether or not you are required to file a tax return. Under section 3406, payers must generally withhold a percentage of taxable interest, dividend, and certain other payments to a payee who does not give a TIN to the payer. Certain penalties may also apply for providing false or fraudulent information.



## Service Worker Comprehensive Assessment

This form helps the Iowa Medicaid Enterprise to have a clear picture of your medical and daily care needs. It is important for you to complete and return this form so we can determine whether or not you qualify for a home- and community-based services (HCBS) waiver.

This form may be completed by you or by someone who cares for you. Read the instructions carefully and answer each question. If you need more space, use the back of the form. If you need help completing this form, contact the worker listed below. **Be sure to sign this form on page 9 before returning it.** Once you have completed the form, please return it to:

Worker name:		Title: Social Worker II	
Agency: Department of Human Services			
Address:			
City:		State: IA	ZIP code:
Phone:		Email:	
Signature:		Date:	

### Tell us about yourself:

Name:		Date of birth:	Medicaid ID number:
Current address:			County:
City:		State:	ZIP code:
Home phone:		Work phone:	Cell phone:
Email address:		Height:	Weight:
Gender: <input type="checkbox"/> M <input type="checkbox"/> F	Marital status:		Veteran: <input type="checkbox"/> Yes <input type="checkbox"/> No

Do you have a job or do volunteer work?  Yes  No

If yes, list where you go to work, how often, and what you do there:

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Do you drive?  Yes  No

Do you live alone?  Yes  No

If not, please use the chart below to tell us who lives in your household. (If you need more lines, please list in the narrative on Page 7.)

Name:	Relationship to you:	Age:	Does this person help care for you?
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No

Has anyone moved in or out of the house in the last year?  Yes  No

If yes, who? \_\_\_\_\_

**Emergency contact:**

Name:		Relationship:
Address:		
City:	State:	ZIP code:
Home phone:	Work phone:	Cell phone:
Email address:		

Does anyone not in your household care for you (unpaid)?  Yes  No

<b>Name:</b>		<b>Relationship:</b>
Address:		
City:	State:	ZIP code:
Home phone:	Work phone:	Cell phone:
Email address:		

Is there anyone that you would **not** want to be involved with your care if you were sick or needed help?  Yes  No

Name:	Relationship:
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**Tell us about your medical care:**

Doctor's name:		Phone number:		
Office name/address:				
Dentist's name:				
Eye doctor's name:				
<b>Services:</b> Do you receive any of the following services?		Days Per Week	Provider Name	Provider Phone
Nursing:	<input type="checkbox"/> Yes <input type="checkbox"/> No			
Physical therapy:	<input type="checkbox"/> Yes <input type="checkbox"/> No			
Occupational therapy:	<input type="checkbox"/> Yes <input type="checkbox"/> No			
Speech therapy:	<input type="checkbox"/> Yes <input type="checkbox"/> No			
Supervision for safety:	<input type="checkbox"/> Yes <input type="checkbox"/> No			
Diabetes education:	<input type="checkbox"/> Yes <input type="checkbox"/> No			
Respiratory treatment:	<input type="checkbox"/> Yes <input type="checkbox"/> No			
Nasogastric tube care:	<input type="checkbox"/> Yes <input type="checkbox"/> No			
Other (specify):	<input type="checkbox"/> Yes <input type="checkbox"/> No			

Do you have a plan for home therapy?  Yes  No

If so, what therapist oversees this plan? \_\_\_\_\_

**Assistive devices:** In this section, check whether or not you use the device listed. On the line for each item, provide details including how often it is used and who helps if needed.

Oxygen:	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Tracheostomy:	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Ventilator:	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Pull-ups or Depends:	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Glasses:	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Hearing aids:	<input type="checkbox"/> Yes <input type="checkbox"/> No	

**Medical conditions and equipment:** Check whether or not you have the condition or use the equipment listed. On the line for each item, provide details regarding how often the condition occurs or the equipment needs to be used and who helps if needed.

Allergies:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Blood sugar checks:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bowel program:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Catheter:	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Who changes and how often? Check type: <input type="checkbox"/> Indwelling <input type="checkbox"/> Urethral <input type="checkbox"/> Suprapubic
Chest percussion:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Colostomy bag:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Control of bladder:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Control of bowels:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dialysis:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dietary needs:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Feeding pump:	<input type="checkbox"/> Yes <input type="checkbox"/> No
G-tube:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Implanted port:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Inhalation therapy:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Injections:	<input type="checkbox"/> Yes <input type="checkbox"/> No
IV therapy:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Open wound:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Rashes:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Seizures:	<input type="checkbox"/> Yes <input type="checkbox"/> No

If you answered yes to any of the items on page 4, please give a detailed explanation about those items.

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**Mobility:** Please indicate your need for the following devices or help. Mark 'yes' or 'no' and use the line for each item to explain how often the device or assistance is needed and who helps.

Help transferring to or from chair, bed, stool:	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Assistance in or out of a vehicle:	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Positioning:	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Someone to stand near when walking or transferring:	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Slide board:	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Mechanical lift:	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Walker:	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Cane:	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Wheelchair:	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Brace:	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Helmet:	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Crutches:	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Communication devices:	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Weighted blankets or vest:	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Harness or gait belt:	<input type="checkbox"/> Yes <input type="checkbox"/> No	

**Wound care:** Please describe any wound care you are receiving.

Type of Wound	Types of Treatment	How often is dressing changed?	Who provides treatment?
Bed sore:			
Surgical wound:			
Other open area:			

**Activities of daily living:** For each activity listed, place a check mark to state whether you can do the activity alone, can do it with help such as a verbal reminder, help from a device or piece of equipment, or help from someone else, or you cannot do it. On the next line, please write what kind of help you need, who helps you, and how often help is required (daily, weekly, etc.)

	No help needed	Verbal reminder	Help from a device	Help from a person	Dependent
Bathing or showering:	<input type="checkbox"/>				
Washing or combing hair:	<input type="checkbox"/>				
Shaving:	<input type="checkbox"/>				
Brushing teeth or denture care:	<input type="checkbox"/>				
Putting on or taking off clothes:	<input type="checkbox"/>				
Buttoning or zipping clothing:	<input type="checkbox"/>				
Putting shoes or socks on:	<input type="checkbox"/>				
Making meals:	<input type="checkbox"/>				
Eating:	<input type="checkbox"/>				

	No help needed	Verbal reminder	Help from a device	Help from a person	Dependent
Toileting:	<input type="checkbox"/>				
Transportation:	<input type="checkbox"/>				
Housekeeping:	<input type="checkbox"/>				
Laundry:	<input type="checkbox"/>				
Shopping:	<input type="checkbox"/>				
Communication:	<input type="checkbox"/>				
Money management:	<input type="checkbox"/>				
Medication management:	<input type="checkbox"/>				

**Other services:** Please use the chart below to tell us about any other services that you receive (such as nursing, home health, in-home health-related care, etc.):

Type of service	Provider name	Provider phone	How often is service received?

**Complete this section for children (ages 17 and under).**

*(If the child currently lives in an institutional setting, please note this in the narrative section.)*

Parent's marital status:       Married                       Divorced                       Never married

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

Home phone:	Work phone:
Cell phone:	Email address:

If the parents are not living together, what is the noncustodial parent's name and address?

Name:		Phone:
Address:		
City:	State:	ZIP code:

Is your child involved with area education agency (AEA) services?       Yes       No

Are any siblings receiving waiver service?       Yes       No

School name:	Grade:	IEP: <input type="checkbox"/> Yes <input type="checkbox"/> No
Name of school contact:		Phone number:

**Please complete the section below for all ages:**

**Narrative:**

Please use the space below and on the following page to tell us more about yourself. Include some information about a "typical" day in your life. Who helps you? What they do and when? Do you feel safe in your home? Include any risk factors you have that were not identified by the questions on this form and tell how these are addressed.

If you are completing this for your child, please include any behavioral or safety concerns. Also explain the types of help that your child requires on a regular basis and how your child's needs may differ from other children of the same age.

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**The following sections are to be completed by the service worker only.**

Complete this section only if the member is taking medications.

1. Are any medications kept in a special place, like a locked container or the refrigerator?  Yes  No
2. What pharmacy does the member use? \_\_\_\_\_
3. How does the member remember to take medications? (check all that apply)
  - By following directions       Calendar       RN set-up       Caregiver administers
  - Bubble wrap or blister pack       Pill minder       Medpass machine       Egg carton/envelopes
  - Other

Comments:

\_\_\_\_\_

4. How well does the member self-administer medication?
  - Independent       Verbal prompt       Device       Caregiver administers
  - Can take independently with someone checking to make sure medication is taken

Comments:

\_\_\_\_\_

\_\_\_\_\_

**Interdisciplinary team members consulted (including member):**

Name	Title (if applicable)	Relationship to member

Additional records reviewed:

\_\_\_\_\_

\_\_\_\_\_

**Court Involvement:**

- None       Child in need of assistance (CINA)
- Involuntary commitment       Child protection
- Probation or parole       Delinquency
- Other (Identify) \_\_\_\_\_       Foster care

Comments:

\_\_\_\_\_

\_\_\_\_\_

**[Service Worker Comprehensive Assessment, 470-5044](#)**

Purpose	The <i>Service Worker Comprehensive Assessment</i> makes an initial assessment of the client's medical and daily care needs.
Source	Print or photocopy the sample in the manual for use as needed. (Click on the blue form number to access the form electronically.)
Completion	Complete the assessment at the time of application and annually thereafter.
Distribution	Keep the original in the client's DHS service case file.
Data	<p>The DHS service worker completes the worker's name and DHS address in the first section of the form. The DHS service worker also completes page 10 if applicable.</p> <p>The client completes the other sections on the form where applicable including:</p> <ul style="list-style-type: none"><li>◆ Demographic information and living arrangements,</li><li>◆ Emergency contact information,</li><li>◆ Household care,</li><li>◆ Personal medical care,</li><li>◆ Services,</li><li>◆ Assistive devices,</li><li>◆ Medical conditions and equipment,</li><li>◆ Mobility,</li><li>◆ Wound care,</li><li>◆ Activities of daily living,</li><li>◆ Other services,</li><li>◆ Children (17 and under), and</li><li>◆ The narrative sections.</li></ul> <p>The client may request assistance from the provider or designate another party to assist in completing the form. The DHS service worker may also assist the client in completing the form.</p> <p>The client or designee assisting the client in completing the form for the client should certify it by signing and dating the form.</p>

**Statement of Services Rendered, 470-0648**

Purpose	The <i>Statement of Services Rendered</i> provides a means for an individual provider of service to keep a record of services provided to a client and to submit an invoice to the Department for payment.
Source	<p>This form is printed in pads of 25 three-part carbonized sets. Order supplies from Iowa State Industries at Anamosa.</p> <p>Supplies of the form may also be printed or photocopied from the sample in the manual. (Click on the blue form number to access the sample electronically.)</p>
Completion	<p>The DHS service worker supplies the forms to the client and provider when the <i>Provider Agreement</i> is approved.</p> <p>Providers should complete Section A at the beginning of each month. Complete the list of specific services, Section B, and each day that services are provided to the client. At the end of each month, the provider completes Section C and the client completes Section D. If there is more than one provider, complete a statement of services rendered for each provider.</p>
Distribution	The client sends the original to the DHS service worker for the client's service file. Clients should keep one copy for themselves and give one copy to the provider.
Data	<p><b>Section A.</b> Enter the provider's name, client's name and state identification number, and the dates (month and year) that service has been provided.</p> <p><b>Section B.</b> A log of time spent during which service was being provided.</p> <ul style="list-style-type: none"><li>◆ "Specific Services" lists the actual work done.</li><li>◆ "Rate" lists the rate of payment for the specific service.</li></ul>



### Statement of Services Rendered

A. I, \_\_\_\_\_, provider number \_\_\_\_\_, provided the following services for \_\_\_\_\_ during the month of \_\_\_\_\_.

**B.**

Specific Services	Rate	Units	Monthly Total
R0001 Personal care			
R0002 Homemaker			
R0003 Medication supervision			
R0004 Food preparation			
R0005 Transportation			
R0006 Other			
<b>TOTAL</b>			

Provider's Signature	Date
Client's Signature	Date

C. Client participation \_\_\_\_\_ + DHS payment \_\_\_\_\_ = Total bill \_\_\_\_\_

D. I, \_\_\_\_\_, certify that I received the above mentioned services from \_\_\_\_\_ for the month of \_\_\_\_\_.

Signature	Date
Signature	Date

- ◆ "Unit" lists the units of work for the specific service.  
(Example: 8:30 - 10:00 am should be broken down into six 15-minute units)
- ◆ "Monthly Units" lists the total dollar amount due to the provider for the specific service.
- ◆ Total row is the total number of units worked and the total payment due to the provider.
- ◆ "Signature." The provider signs and dates the first line. The client signs and dates the second line.

**Section C.** The total bill (amount due to the provider) equals client participation plus the DHS payment.

**Section D.** The client's name goes on line 1, the provider's name on line 2, and the month and year on line 3. The client signs the form and writes the date this section was completed.