Iowa Department of Human Services

Application and Contract Agreement for Residential Care Facilities

This contract is between the Iowa Department of Human Services, referred to as the Department,

and the _____

(Name of Facility)

a provider of residential care and services, referred to as the facility.

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

Application Date:		Provider Number:
Name of Residential Care Facility:		
Address:		
City	State:	Zip:
License Number:	Effective:	Telephone:

Type of Organization:

- ☐ Governmental
- ☐ Non-profit
- ☐ Hospital-based
- ☐ Individual owner
- ☐ Partnership
- ☐ Corporation
- ☐ Pseudo corporation
- ☐ Other

Check the Levels of Care Offered: **Number of Beds**

Skilled Nursing: _____
Nursing: _____
Residential: _____
Hospital: _____
Other: Type: _____
Total Licensed Bed Capacity: _____

Complete only if facility is rented or leased:

Lessor:		
Address:		
City:	State:	Zip:

Fiscal Year: _____

County: _____

Vendor Code: _____

(This is the number used on federal and state tax forms, not social security number.)

For DHS Office use only

Effective date of contract: _____

By Bureau Chief Long Term Care:

_____

Date: _____

Administrator:
Read and sign this page

III. The Facility Agrees:

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

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

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

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

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

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

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

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

IV. The Department and the Facility Agree:

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

That the per diem rate shall be set by the Department. The rate shall be in effect until an adjustment in per diem rate is required by legislative action or administrative rules.

That this contract shall not be transferable or assignable.

Signature of Administrator of Facility	Date

INSTRUCTIONS
Fill out and return to:

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