



Level of Care Certification for HCBS Waiver Program

ATTENTION: Fax completed form to IME Medical Services (515) 725-1349.

When completing this form, respond according to what assistance the member needs rather than the availability or member's willingness to accept the assistance.

Medical professionals completing this form must provide a copy to the member.

Today's Date	Iowa Medicaid Member Name	State ID or Social Security #	Birthdate
Provider Name (please print)		Provider Telephone Number with Area Code	
HCBS Program: <input type="checkbox"/> AIDS <input type="checkbox"/> Elderly <input type="checkbox"/> Health & Disability <input type="checkbox"/> Physical Disability			<input type="checkbox"/> Admission <input type="checkbox"/> SSR
<input type="checkbox"/> Attach diagnoses list		<input type="checkbox"/> Attach medication list	

Level of Care Criteria: Mark all that apply. Review each category.

The HCBS waiver program is intended to serve persons who would otherwise require nursing facility placement. Using your medical judgment and knowledge of the person's condition, do you certify this person requires nursing facility level of care? Yes No If yes, provide additional information necessary to support this response.

How does the person complete activities of daily living (eating, personal hygiene, dressing, and toileting) when no assistance is available?

Form should be completed in office with member present.

Was the member seen in the office at the time the form was completed? Yes No

<p>Cognitive</p> <input type="checkbox"/> No problem <input type="checkbox"/> Language barrier <input type="checkbox"/> Short/long term memory problem <input type="checkbox"/> Problems with decision making <input type="checkbox"/> Interferes with ability to do ADLs	<p>Therapy</p> <input type="checkbox"/> Speech therapy <input type="checkbox"/> Occupational therapy <input type="checkbox"/> Physical therapy Duration of therapy expected: _____	<p>Medications</p> <input type="checkbox"/> Independent <input type="checkbox"/> Requires set up <input type="checkbox"/> Needs administered by others <input type="checkbox"/> Daily IV Duration: _____ <input type="checkbox"/> Daily IM Duration: _____ <input type="checkbox"/> Insulin, set dosage <input type="checkbox"/> Insulin, sliding scale <input type="checkbox"/> Frequent lab values <input type="checkbox"/> Age-appropriate
<p>Ambulation</p> <input type="checkbox"/> Independent <input type="checkbox"/> Cane <input type="checkbox"/> Walker <input type="checkbox"/> Wheelchair <input type="checkbox"/> Motorized scooter <input type="checkbox"/> Needs human assistance <input type="checkbox"/> Age-appropriate child <input type="checkbox"/> Restraint used <input type="checkbox"/> Transfer assist	<p>Behaviors</p> <input type="checkbox"/> Noncompliant <input type="checkbox"/> Destructive or disruptive <input type="checkbox"/> Repetitive movements <input type="checkbox"/> Antisocial <input type="checkbox"/> Aggressive or self-injurious <input type="checkbox"/> Anxiety <input type="checkbox"/> Depression <input type="checkbox"/> Requires 24-hour supervision <input type="checkbox"/> None	<p>Tube Feedings</p> <input type="checkbox"/> Tube feeding If requires tube feedings, order: _____

<p align="center">Bathing / Grooming</p> <input type="checkbox"/> Independent <input type="checkbox"/> Has assist devices, independent <input type="checkbox"/> Supervision or cueing needed How often: <input type="checkbox"/> 1-2 x weekly <input type="checkbox"/> 3-4 x weekly <input type="checkbox"/> 5-6 x weekly <input type="checkbox"/> Daily <input type="checkbox"/> Physical assistance needed How often: <input type="checkbox"/> 1-2 x weekly <input type="checkbox"/> 3-4 x weekly <input type="checkbox"/> 5-6 x weekly <input type="checkbox"/> Daily <input type="checkbox"/> Age-appropriate child	<p align="center">Dressing</p> <input type="checkbox"/> Independent <input type="checkbox"/> Has assist devices, independent <input type="checkbox"/> Supervision or cueing needed How often: <input type="checkbox"/> 1-2 x weekly <input type="checkbox"/> 3-4 x weekly <input type="checkbox"/> 5-6 x weekly <input type="checkbox"/> Daily <input type="checkbox"/> Physical assistance needed How often: <input type="checkbox"/> 1-2 x weekly <input type="checkbox"/> 3-4 x weekly <input type="checkbox"/> 5-6 x weekly <input type="checkbox"/> Daily <input type="checkbox"/> Age-appropriate child	<p align="center">Elimination</p> <input type="checkbox"/> Continent <input type="checkbox"/> Bladder incontinence <input type="checkbox"/> Bowel incontinence <input type="checkbox"/> Urinary catheter <input type="checkbox"/> Colostomy/ostomy <input type="checkbox"/> Nephrostomy <input type="checkbox"/> Age-appropriate child <p align="center">Respiratory</p> <input type="checkbox"/> No issue <input type="checkbox"/> O2 use daily <input type="checkbox"/> O2 PRN <input type="checkbox"/> Tracheostomy <input type="checkbox"/> Ventilator <input type="checkbox"/> Suctioning Frequency: _____
<p align="center">Living Arrangement</p> <input type="checkbox"/> Lives alone <input type="checkbox"/> Assisted living <input type="checkbox"/> Lives with family/spouse <input type="checkbox"/> Senior apartment <input type="checkbox"/> Danger to live alone <input type="checkbox"/> Nursing facility	<p align="center">Skin</p> <input type="checkbox"/> Intact <input type="checkbox"/> Ulcer – stage = _____ <input type="checkbox"/> Open wound <input type="checkbox"/> Daily treatment <input type="checkbox"/> Treatment PRN <input type="checkbox"/> Home health for wound care	<p align="center">Eating</p> <input type="checkbox"/> Independent <input type="checkbox"/> Assistive devices <input type="checkbox"/> Requires human assistance excluding meal preparation

I attest the above information is correct.

Signature of Healthcare Professional (MD, DO, ARNP, PA)	Date
Additional comments:	Home services in place: