Iowa Department of Human Services

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For Human Services use only:

General Letter No. 8-AP-405
Employees' Manual, Title 8
Medicaid Appendix

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HOME- AND COMMUNITY-BASED SERVICES (HCBS) MANUAL TRANSMITTAL NO. 14-1

ISSUED BY: Iowa Medicaid Enterprise

SUBJECT: ***HOME- AND COMMUNITY-BASED SERVICES (HCBS)***, Title page, new; Table of Contents, new;

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

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

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

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

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

Chapter III, ***Provider-Specific Policies***, Title page, new; Table of Contents (pages 1 through 4), new; pages 1 through 173, new; and the following forms:

470-3372	*HCBS Consumer-Directed Attendant Care Agreement*, new
470-4428	*Financial Management Service Agreement*, new
470-4492	*Consumer Choices Option Independent Support Broker Agreement*, new
470-4427	*Consumer Choices Option Employment Agreement*, new
470-4429	*Consumer Choices Option Semi-Monthly Time Sheet*, new
470-2917	*Medicaid HCBS Waiver Provider Application*, new
470-2965	*Iowa Medicaid Provider Agreement General Terms*, new
470-4389	*Consumer-Directed Attendant Care (CDAC) Daily Service Record*, new
470-4694	*Case Management Comprehensive Assessment*, new
470-0664	*Financial and Statistical Report for Purchase of Service Contracts*, new
470-3449	*HCBS Supplemental Schedule D-4*, new
470-2486	*Claim for Targeted Medical Care*, new

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

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

470-3744 *Provider Inquiry*
470-0040 *Adjustment Request*
470-4987 *Recoupment Request*

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

Summary

This letter transmits a new manual for providers of Home- and Community-Based Services (HCBS). The manual is comprised of five sections:

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

Date Effective

Upon receipt.

Material Superseded

None.

Additional Information

The new provider manual can be found at:
http://www.dhs.state.ia.us/policyanalysis/PolicyManualPages/Manual_Documents/Provman/HCBS.pdf

If any portion of this manual is not clear, please contact the Iowa Medicaid Enterprise Provider Services Unit at 800-338-7909 or locally (in Des Moines) at 515-256-4609, or email at imeproviderservices@dhs.state.ia.us.

Home- and Community-Based Services (HCBS)

Provider Manual

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CHAPTER III. PROVIDER-SPECIFIC POLICIES

A. HOME- AND COMMUNITY-BASED SERVICE WAIVERS

Medicaid home- and community-based services (HCBS) are federally approved waiver programs available to individuals who meet the required Medicaid-covered level of care provided in a nursing facility, skilled nursing facility, and intermediate care facility for individuals with an intellectual disability, or hospital. The amount, scope, and duration of the waiver programs are limited to what has been approved by the federal government.

Individuals must have a need for assistance with activities of daily living or need assistance due to their inability to function independently in their home or community related to their disability or age. Once the applicant is approved for the HCBS waiver, an interdisciplinary team is assembled to assist in assessing the needs of the member, identify what services can meet the member's needs, identify who can provide the services, and the amount of services, and cost of services.

If a member selects home- and community-based services, the provision of these services must be based on the assessed service needs of the member and services must be available to meet their needs. The Department requires advance approval for services. The services must also be cost-effective and least costly to meet the needs of the member. Payment will only be made to eligible and enrolled Medicaid HCBS waiver providers. All services and providers must be identified in the service plan for each member accessing waiver services. The Department shall approve the service plan.

1. Legal Basis

Section 2176 of OBRA amended the Social Security Act to create the waiver program. The purpose and intent of a Medicaid waiver is stated in Section 1902(c) of the Social Security Act.

The legal basis for medicaid home- and community-based service waivers is found in Section 1915(c) of the Social Security Act. Public Law 97-35, the Omnibus Budget Reconciliation Act (OBRA) of 1981, contained provisions allowing states to request waivers to provide cost-effective home- and community-based services to eligible people so they can avoid or leave institutionalization.

The OBRA of 1987 established that people residing in nursing homes who meet assessment criteria for specialized services can access waiver programs.

The portions of the Code of Federal Regulations specifically dealing with home- and community-based services are in Title 42, Parts 431.50, 435.3, 435.217, 435.726, 435.735, 440.1, 440.180, 440.250, 441.300 through 441.306, and 441.310. These regulations specify the requirements that the state must meet to be eligible for federal financial participation and, in addition to the Social Security Act, serve as the basis for state law and administrative rules.

All waivers are operated by the designated state Medicaid agency that is the Iowa Medicaid Enterprise (IME). The IME has the authority for the operation of the waiver programs including prior authorization of waiver services and determination of level of care.

There are currently seven HCBS waivers that include:

- AIDS/HIV
- Brain injury (BI)
- Children's mental health (CMH)
- Elderly (EW)
- Health and disability (HD)
- Intellectual disability (ID)
- Physical disability (PD)

2. Definitions

Legal reference:

Waiver Type	Corresponding Iowa Administrative Code
AIDS	441 Iowa Administrative Code (IAC) 83.41(249A)
Brain injury	441 IAC 83.81(249A)
Children's mental health	441 IAC 83.121(249A)
Elderly	441 IAC 83.21(249A)
Health and disability	441 IAC 83.1(249A)
Intellectual disability	441 IAC 83.60(249A)
Physical disability	441 IAC 83.101(249A)

"**Adaptive**" means age-appropriate skills related to taking care of one's self and the ability to relate to others in daily living situations. These skills address limitations that occur in the areas of communication, self-care, home living, social skills, community use, self-direction, safety, functional activities of daily living, leisure, and work.

"**Adaptive behavior**" means the effectiveness or degree with which the individual meets the standards of personal independence and social responsibility expected of the individual's age and social group. Adaptive behavior also refers to the typical performance of individuals without disabilities in meeting environmental expectations.

Adaptive behavior changes according to a person's age, cultural expectations, and environmental demands. Behaviors are skills related to regulating one's own actions including:

- Coping with demands from others,
- Making choices,
- Controlling impulses,
- Conforming conduct to laws, and
- Displaying appropriate socio-sexual behavior.

"**Adult**" means a person aged 18 years or over.

"**AIDS**" means a medical diagnosis of acquired immunodeficiency syndrome based on the Centers for Disease Control, "Revision of the CDC Surveillance Case Definition for Acquired Immunodeficiency Syndrome," August 14, 1987, Vol. 36, No. 1S issue of Morbidity and Mortality Weekly Report."

"**Appropriate**" means that the services or supports or activities provided or undertaken by the organization are relevant and medically necessary to the member's needs, situation, problems, or desires.

"**Assessment**" means the review of the member's current functioning in regard to the member's situation, needs, strengths, abilities, desires, and goals.

"**Attorney-in-fact under a durable power of attorney for health care**" means an individual designated by a durable power of attorney for health care, pursuant to Iowa Code chapter 144B, as an agent to make health care decisions on behalf of an individual and who has consented to act in that capacity.

"**Basic individual respite**" means respite provided on one staff-to-one member ratio without specialized needs requiring the care of a licensed registered nurse or licensed practical nurse.

"**Blind individual**" means an individual who has a central visual acuity of 20/200 or less in the better eye with the use of corrective lens or visual field restriction to 20 degrees or less.

"**Brain injury**" means clinically evident damage to the brain resulting directly or indirectly from trauma, infection, anoxia, vascular lesions or tumor of the brain, not primarily related to degenerative or aging processes, that temporarily or permanently impairs a person's physical, cognitive, or behavioral functions. The person must have a diagnosis from the following list:

- Malignant neoplasms of brain, cerebrum
- Malignant neoplasms of brain, frontal lobe
- Malignant neoplasms of brain, temporal lobe
- Malignant neoplasms of brain, parietal lobe
- Malignant neoplasms of brain, occipital lobe
- Malignant neoplasms of brain, ventricles
- Malignant neoplasms of brain, cerebellum
- Malignant neoplasms of brain, brain stem
- Malignant neoplasms of brain, other part of brain includes midbrain, peduncle, and medulla oblongata
- Malignant neoplasms of brain, cerebral meninges
- Malignant neoplasms of brain, cranial nerves
- Secondary malignant neoplasm of brain
- Secondary malignant neoplasm of other parts of the nervous system including cerebral meninges
- Benign neoplasm of brain and other parts of the nervous system, brain
- Benign neoplasm of brain and other parts of the nervous system, cranial nerves
- Benign neoplasm of brain and other parts of the nervous system, cerebral meninges
- Encephalitis, myelitis, and encephalomyelitis
- Intracranial and intraspinal abscess
- Anoxic brain damage

- Subarachnoid hemorrhage
- Intracerebral hemorrhage
- Other and unspecified intracranial hemorrhage
- Occlusion and stenosis of precerebral arteries
- Occlusion of cerebral arteries
- Transient cerebral ischemia
- Acute, but ill-defined, cerebrovascular disease
- Other and ill-defined cerebrovascular diseases
- Fracture of vault of skull
- Fracture of base of skull
- Other and unqualified skull fractures
- Multiple fractures involving skull or face with other bones
- Concussion, chronic traumatic encephalopathy
- Cerebral laceration and contusion
- Subarachnoid, subdural, and extradural hemorrhage following injury
- Other and unspecified intracranial hemorrhage following injury
- Intracranial injury of other and unspecified nature
- Poisoning by drugs, medicinal, and biological substances
- Toxic effects of substances
- Effects of external causes
- Drowning and nonfatal submersion
- Asphyxiation and strangulation
- Child maltreatment syndrome
- Adult maltreatment syndrome

"**Case management**" means services provided according to rule 441 IAC 90.5(249A) and 441 IAC 90.8(249A).

"**Child**" means a person aged 17 or under.

"**Client participation**" means the amount of the member's income that the person must contribute to the cost of waiver services, exclusive of medical vendor payments, before Medicaid will participate.

"**CMS**" means the Centers for Medicare and Medicaid Services, a division of the U.S. Department of Health and Human Services.

"**Community**" means a natural setting where people live, learn, work, and socialize.

"**Counseling**" means face-to-face mental health services provided to the member and caregiver by a qualified mental health professional as defined pursuant to rule 441 IAC 24.61(225C), to facilitate home management of the member and prevent institutionalization.

"**Deemed status**" means acceptance by the Department of Accreditation or Licensure of a program or service by another accrediting body in lieu of accreditation based on review and evaluation by the Department.

"**Deeming**" means the specified amount of parental or spousal income and resources considered in determining eligibility for a child or spouse according to current supplemental security income guidelines.

"**Department**" means the Iowa Department of Human Services.

"**Direct service**" means therapy, habilitation, rehabilitation activities or support services provided face-to-face to a member within their home or community.

"**Financial participation**" means client participation and medical payments from a third party including veterans' aid and attendance.

"**Fiscal accountability**" means the development and maintenance of budgets and independent fiscal review.

"**Group respite**" is respite provided on a ratio of one staff-to-two or more members.

"**Guardian**" means a guardian appointed in court.

"**HCBS**" means home- and community-based services.

"**Health**" means a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity. This includes the maintenance of one's health including:

- Diet and nutrition;
- Illness identification, treatment and prevention;
- Basic first aid;
- Physical fitness;
- Regular health and wellness screenings; and
- Personal habits.

"**HIV**" means a medical diagnosis of human immunodeficiency virus infection that attacks the immune system, the body's natural defense system, based on a positive HIV-related test.

"**IME**" means the Iowa Medicaid Enterprise.

"**Immediate jeopardy**" means circumstances where it has caused, or is likely to cause, serious injury, harm, impairment, or death to an individual if the circumstances are not immediately corrected.

"**Institution for mental disease**" means a hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services. Whether an institution is an institution for mental diseases is determined by its overall character as that of a facility established and maintained primarily for the care and treatment of individuals with mental diseases, whether or not it is licensed as such.

"Intellectual disability" means a diagnosis of an intellectual disability which shall be made only when the onset of the person's condition was before the age of 18 years and shall be based on an assessment of the person's intellectual functioning and level of adaptive skills. The diagnosis shall be made by a person who is a psychologist or psychiatrist who is professionally trained to administer the tests required to assess intellectual functioning and to evaluate a person's adaptive skills.

A diagnosis of an intellectual disability shall be made in accordance with the criteria provided in the most current Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association.

"**Intermediate care facility for persons with an intellectual disability (ICF/ID)**" means an institution or distinct part of an institution with a primary purpose to provide health or rehabilitative services to three or more individuals, who primarily have an intellectual disability or a related condition and who are not related to the administrator or owner within the third degree of consanguinity, and which meets the requirements of this chapter and federal standards for intermediate care facilities for persons with an intellectual disability established pursuant to the federal Social Security Act, § 1905(c)(d), as codified in 42 U.S.C. § 1936d, which are contained in 42 C.F.R. pt. 483, subpart D, § 410 - 480.

"**Interdisciplinary team**" means a collection of persons with varied backgrounds chosen by the member who meet with the member to develop a service plan to meet the member's need for services. At a minimum the member and case manager or service worker must be part of the interdisciplinary team.

"**Intermittent supported community living service**" means supported community living service provided for not more than 52 hours per month.

"**ISIS**" is the Iowa Department of Human Services' *Individualized Services Information System*.

The purpose of ISIS is to assist workers in the facility and waiver programs in both processing and tracking requests starting with entry from the ABC system through approval or denial.

"**Living unit**" means a single dwelling unit such as an apartment or house.

"**Local office**" means the county Department of Human Services office as described in rule 441 IAC 1.4(2).

"**Licensed practical nurse (LPN)**" means a person licensed to practice nursing in the state of Iowa according to Iowa Code 152.7.

"**Maintenance needs**" means costs associated with rent or mortgage, utilities, telephone, food, and household supplies.

"**Medical assessment**" means a visual and physical screening of the member by an appropriately licensed professional, noting deviations from the norm, and a statement of the member's mental and physical condition. Evaluation of the disease or condition based on the member's subjective report of the symptoms and course of the illness or condition and the examiner's objective findings, including:

- Data obtained through laboratory tests,
- Physical examination,
- Medical history, and
- Information reported by family members and other health care team members.

"**Medical institution**" means a nursing facility, intermediate care facility for persons with an intellectual disability, or hospital which has been approved as a Medicaid vendor.

"**Medical intervention**" means to improve the mental, emotional, or physical functioning of a member's care in the areas of:

- Hygiene,
- Mental and physical comfort,
- Assistance in feeding and elimination, and
- Control of the member's care and treatment to meet the physical and mental needs of the member in compliance with the plan of care in areas of health, prevention, restoration, and maintenance.

"**Medical monitoring**" means observation for the purpose of assessing, preventing, maintaining, and treating disease or illness based on the member's plan of care.

"**Medical necessity**" means the provision of medically necessary medical care, services or supplies while exercising reasonable and prudent clinical judgment. Reasonable and prudent clinical judgment considers whether the care, services or supplies are being provided to a member for the purpose of:

- Evaluating,
- Diagnosing,
- Preventing, or
- Treating an illness, injury, disease or its symptoms.

Services shall be in accordance with standard of good medical practices as determined by DHS or its designated representative. Medically necessary care, services, or supplies shall:

- Be consistent with the diagnosis and treatment of the member's condition.
- Be clinically appropriate, in terms of type, frequency, extent, site, and duration, and considered effective for the member's illness, injury or disease.
- Be in accordance with standards of good medical practice and not considered experimental or investigational.

- Be required to meet the medical need of the member and be for reasons other than the convenience of the member or the member's practitioner or caregiver.
- Be the least costly type of service which would reasonable meet the medical need of the member.
- Be eligible for federal financial participation unless specifically covered by state law or rule.
- Be prescribed or provided with the scope of the licensure of the provider.
- Be provided with full knowledge and consent of the member or someone acting on the member's behalf unless otherwise required by law or court order or in emergency situations.
- Be supplied by a provider who is eligible to participate in the Medicaid program.

"**Member**" means a person who is eligible for Medicaid under rule 441 IAC Chapter 75.

"**Mental health professional**" means a person who meets all of the following conditions:

- Holds at least a master's degree in a mental health field including, but not limited to, psychology, counseling and guidance, psychiatric nursing and social work; or is a doctor of medicine or osteopathic medicine; and
- Holds a current Iowa license when required by the Iowa professional licensure laws (such as a psychiatrist, a psychologist, a marital and family therapist, a mental health counselor, an advanced registered nurse practitioner, a psychiatric nurse, or a social worker); and
- Has at least two years of post-degree experience supervised by a mental health professional in assessing mental health problems, mental illness, and service needs and in providing mental health services.

"**Natural supports**" means services and supports an individual identifies as wanted or needed that are provided at no cost by family, friends, neighbors, and others in the community, or by organizations or entities that serve the general public at no cost to the Medicaid program.

"**Non-legal representative**" means an individual who has been freely chosen by the member to assist the member with the consumer choices option, and who is not:

- A legally appointed guardian of an adult child,
- A conservator,
- An attorney-in-fact under a durable power of attorney for health care, or
- A power of attorney for financial matters, trustee, or representative payee.

A non-legal representative may have budget authority over the individual budget if so authorized by the member.

"**Nursing facility**" means an institution or a distinct part of an institution housing, which is primarily engaged in providing health-related care and services, including rehabilitative services, but which is not engaged primarily in providing treatment or care for mental illness or an intellectual disability. The nursing facility provides continuous nursing care and supervision under the direction of a physician. It is limited to persons who have a physical or mental impairment which restricts their ability to perform essential activities of daily living as outlined in criteria and impede their capacity to live independently. Their physical or mental impairment are such that self-execution of the required nursing care is improbable or impossible.

"**Organizational outcome**" means a demonstration by the organization of actions taken by the organization to provide for services or supports to members.

"**Outcome**" means the result of the performance or nonperformance of a function or process or activity.

"**Physical disability**" means a severe, chronic condition that is attributable to a physical impairment that results in substantial limitations of physical functioning in three or more of the following areas of major life activities:

- Self-care,
- Receptive and expressive language,
- Learning,
- Mobility,
- Self-direction,
- Capacity for independent living, and
- Economic self-sufficiency.

"**Plan of care**" means the individualized goal oriented plan of services developed collaboratively with the member and the service provider. The plan of care is reflective of the service plan developed by the service worker or case manager with the member and the interdisciplinary team.

"**Policies**" means the principles and statements of intent of the organization.

"**Procedures**" means the steps taken to implement the policies of the organization.

"**Process**" means service or support provided by an agency to a member that will allow the member to achieve an outcome. This may include a written, formal, consistent or an informal method that is not written but is a verifiable method.

"**Program**" means a set of related resources and services directed to the accomplishment of a fixed set of goals for qualifying members.

"**Psychiatric medical institutions for children (PMIC)**" means a psychiatric medical institution for children that uses a team of professionals to direct an organized program of diagnostic services, psychiatric services, nursing care, and rehabilitative services to meet the needs of residents in accordance with a medical care plan developed for each resident.

"**Qualified brain injury professional**" means one of the following who meets the educational and licensure or certification requirements for the profession as required in the state of Iowa and who has two years' experience working with people living with a brain injury:

- Psychologist;
- Psychiatrist;
- Physician;
- Registered nurse;
- Certified teacher;
- Social worker;
- Mental health counselor;
- Physical, occupational, recreational, speech therapist; or
- A person with a Bachelor of Arts or science degree in psychology, sociology, or public health or rehabilitation services.

"**Qualified intellectual disability professional**" means a person who has at least one year of experience working directly with persons with an intellectual disability or other developmental disabilities and who is one of the following:

- A doctor of medicine or osteopathy;
- A registered nurse;
- An occupational therapist eligible for certification as an occupational therapist by the American Occupational Therapy Association or another comparable body;
- A physical therapist eligible for certification as a physical therapist by the American Physical Therapy Association or another comparable body;
- A speech-language pathologist or audiologist eligible for certification of Clinical Competence in Speech-Language Pathology or Audiology by the American Speech-Language Hearing Association or another comparable body or who meets the educational requirements for certification and who is in the process of accumulating the supervised experience required for certification;
- A psychologist with a master's degree in psychology from an accredited school;
- A social worker with a graduate degree from a school of social work accredited or approved by the Council on Social Work Education or another comparable body or who holds a bachelor of social work degree from a college or university accredited or approved by the Council of Social Work Education or another comparable body;
- A professional recreation staff member with a bachelor's degree in recreation or in a specialty area such as art, dance, music or physical education;
- A professional dietitian eligible for registration by the American Dietetic Association; or
- A human services professional that must have at least a bachelor's degree in a human services field including, but not limited to, sociology, special education, rehabilitation counseling or psychology.

"**Registered nurse (RN)**" means a person licensed to practice nursing in the state of Iowa according to Iowa Code Chapter 152.

"**Rehabilitation services**" means services designed to restore, improve, or maximize the individual's optimal level of functioning, self-care, self-responsibility, independence, and quality of life and to minimize impairments, related to the identified disabilities.

"**Related condition**" means persons who have a severe, chronic disability that meets all of the following conditions:

- It is attributable to cerebral palsy or epilepsy or any other condition, other than mental illness, found to be closely related to intellectual disability because this condition results in impairment of general intellectual functioning or adaptive behavior similar to that of an intellectual disability and requires treatment or services similar to those required for these persons; and
- It is manifested before the person reaches the age of 22; and
- It is likely to continue indefinitely; and
- Results in substantial functional limitations in three or more of the following areas of major life activities:
  - Self-care
  - Understanding and use of language
  - Learning
  - Mobility
  - Self-direction
  - Capacity for independent living

"**Residential care facility for persons with mental illness (RCF/PMI)**" means a licensed facility that provides accommodation, board, personal assistance and other essential daily living activities to three or more individuals with mental illness for a period exceeding 24 hours.

Members must be able to sufficiently or properly care for themselves, but do not require the services of a registered or licensed practical nurse. These facilities emphasize individualized program planning in an aggressive effort to assist members to a more independent way of life. [Definition is found in Iowa Code Chapter 135C.]

"**Self-direction**" means the opportunity for participants or their representatives to exercise choice and control over the budget, planning, and purchase of self-directed personal assistance services, including the amount, duration, scope, provider, and location of service provision.

"**Serious emotional disturbance**" means a diagnosable mental, behavioral, or emotional disorder that:

- Is of sufficient duration to meet diagnostic criteria for the disorder specified by the most recent version of the Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association; and
- Has resulted in a functional impairment that substantially interferes with or limits a member's role or functioning in family, school, or community activities.

Serious emotional disturbance does not include developmental disorders, substance-related disorders, or conditions or problems classified in DSM as "other conditions that may be a focus of clinical attention" (V codes factors influencing health status), unless those conditions co-occur with another diagnosable serious emotional disturbance.

"**Service coordination**" means activities designed to help individuals and families locate, access, and coordinate a network of natural supports and services that will allow them to live a full life in the community. Included are using natural supports and services, other payment sources, and state plan use before the use of waiver services to provide the most cost effective coordination for the member.

"**Service plan**" means an individualized goal-oriented plan of services written in a language understandable by the member or the member's representative using the service and developed collaboratively by the individual and the interdisciplinary team.

"**Skill development**" means that the service provided is intended to impart an ability or capacity to the member.

"**Skilled nursing facility**" means a facility as defined in 42 CFR 483.5.

"**Specialized respite**" means respite provided on a one staff-to-one member ratio or higher to individuals with specialized medical needs requiring the care, monitoring or supervision of a licensed registered nurse or licensed practical nurse.

"**Staff**" means a person under the direction of the organization to perform duties and responsibilities of the organization.

"**Substantial gainful activity**" means productive activities that add to the economic wealth, or produce goods or services to which the public attaches a monetary value.

"Targeted case management" means services furnished to assist members who are part of a targeted population and who reside in a community setting or are transitioning to a community setting in gaining access to needed medical, social, educational, housing, transportation, vocational, and other services in order to ensure the health, safety, and welfare of the members. Case management is provided to a member on a one-to-one basis by one case manager.

"**Third-party payments**" means payments from an attorney, individual, institution, corporation, or public or private agency that is liable to pay part or all of the medical costs incurred as a result of injury, disease or disability by or on behalf of an applicant or a past or present recipient of medical assistance.

"**Usual caregiver**" means an unpaid person or persons who reside with the member and are available on a 24-hour-per-day basis to assume responsibility for the care of the member.

3. Service Eligibility

Legal reference:

Waiver Type	**Corresponding Iowa Administrative Code**
AIDS	441 IAC 83.42(249A)
Brain injury	441 IAC 83.82(249A)
Children's mental health	441 IAC 83.122(249A)
Elderly	441 IAC 83.22(249A)
Health and disability	441 IAC 83.2(249A)
Intellectual disability	441 IAC 83.61(249A)
Physical disability	441 IAC 83.102(249A)

Services are available and reimbursable only for people who meet eligibility criteria, which include meeting the designated level of care for the waiver. A Department of Human Services income maintenance worker determines that the member meets Medicaid criteria for income and resources. The IME determines the member's level of care.

The member must be certified as being in need of nursing facility, skilled nursing facility, or hospital level of care or as being in need of care in an intermediate care facility for the intellectually disabled. The IME Medical Services Unit shall be responsible for approval of the certification of the level of care.

Eligibility under the waivers is based on the following:

- Income and resource criteria
- Age, disability, or medical need
- Level of institutional care needed
- Need for waiver services
- A determination that the cost of the waiver program does not exceed the established cost limit for the member's level of care. Waiver services are beyond the scope of the Medicaid state plan. Services provided under waivers are not available to other Medicaid members. Provision of these services must be cost-neutral.

Waiver services will not be provided when the member is an inpatient in a medical institution.

4. Slot Assignment

Legal reference:

Waiver Type	Corresponding Iowa Administrative Code
Brain injury	441 IAC 83.82(4)
Children's mental health	441 IAC 83.123(1)
Health and disability	441 IAC 83.3(2)
Intellectual disability	441 IAC 83.61(3)
Physical disability	441 IAC 83.102(3)

Each of the waivers has an allocated number of slots that applicants may access. The income maintenance worker (IMW) is responsible for securing the slot under each of the waivers.

When a payment slot is available, the IME assigns the slot to the applicant. Once assigned, the member and the SW/CM arrange services, unless the applicant is determined to be ineligible.

When there is no available slot, the Department will reject the application, but the person's name is maintained on the applicable waiting list.

5. Summary of Waiver Services

The following comparison chart identifies the services available under each HCBS waiver:

Services by Program	AIDS	BI	CMH	EW	HD	ID	PD
Adult day care	X	X		X	X	X	
Assisted living on-call				X			
Assistive devices				X			
Behavioral programming		X					
Case management services		X		X			
Chore				X			
Consumer choices option (CCO)	X	X		X	X	X	X
Consumer-directed attendant care (CDAC)	X	X		X	X	X	X
Counseling	X				X		
Day habilitation						X	
Environmental modification and adaptive devices			X				
Family and community support			X				
Family counseling and training		X					
Home-delivered meals	X			X	X		
Home health aide	X			X	X	X	
Homemaker	X			X	X		
Home/vehicle modification		X		X	X	X	X
In-home family therapy			X				
Interim medical monitoring and treatment (IMMT)		X			X	X	
Mental health outreach				X			
Nursing	X			X	X	X	
Nutritional counseling				X	X		

Services by Program	AIDS	BI	CMH	EW	HD	ID	PD
Personal emergency response		X		X	X	X	X
Prevocational services		X				X	
Respite services	X	X	X	X	X	X	
Senior companion				X			
Specialized medical equipment		X					X
Supported community living (SCL)		X				X	
Supported community living residential-based (RBSCL)						X	
Supported employment (SE)		X				X	
Transportation		X		X		X	X

6. Waiver Prior Authorization

HCBS service requests that exceed the median cost (units) of each waiver service must be reviewed and approved by the Iowa Medicaid Enterprise (IME).

The IME Medical Services Unit may request additional information from the service worker or case manager via a *Certificate of Medical Necessity* form or other documents such as the service or treatment plan, itemized estimates, service schedules, etc. The Medical Services Unit will need to receive all requested materials before making a decision.

7. Person-Centered Service Planning

Persons receiving ID, elderly, CMH, and in certain cases the BI waiver services, typically have service coordination through a case manager. Members under the AIDS/HIV, HD, and PD waivers require the use of a service worker but may use a case manager in certain circumstances. Members under the CMH waiver have service coordination through a case manager or integrated health home.

The member shall have a service plan approved by the Department which is developed by the interdisciplinary team. This must be completed before service provision and annually thereafter or more often if there is a change in the member's needs.

At initial enrollment the service worker or case manager or integrated health home shall:

- Establish the interdisciplinary team for the member, with the team, identify the member's "need for service" based on the member's needs and desires as well as the availability and appropriateness of services.
- The Medicaid case manager, integrated health home, or Department service worker shall complete an annual review thereafter.

In addition to the service plan, each service provider must document the activities associated with implementing the goals identified in the service plan.

The following criteria are used for the initial and ongoing assessments:

- Members aged 17 or under shall receive services based on development of adaptive, behavioral, or health skills.
- Service plans must be developed or reviewed, to reflect use of all appropriate non-waiver services, so as not to replace or duplicate services.

Interdisciplinary Team

An interdisciplinary team must include the member and either the case manager, integrated health home, or service worker. Other persons on the team may be:

- The parents when the member is a minor.
- The member's legally authorized representative.
- The member's family, unless the family's participation is limited by court order or is contrary to the wishes of the adult member who has not been legally determined to be unable to make decisions independently.
- All current service providers.
- Any other professional representation including, but not limited to:
  - Vocational rehabilitation counselors,
  - Court appointed mental health advocates,
  - Correction officers,
  - Educators, and
  - Other professionals as appropriate.
- Persons identified by the member or family, provided the family's wishes are not in conflict with the desires of the member.

The team shall be convened to develop the initial service plan and annually to revise the service plan, at least annually or whenever there is a significant change in the items addressed in it member's needs or conditions.

8. HCBS Waiver Comprehensive Service Plan

Services must be included in a comprehensive person-centered service plan. The comprehensive person-centered service plan must be developed through a person-centered planning process driven by the member in collaboration with the member's interdisciplinary team, as established with the case manager or integrated health home coordinator.

The member's comprehensive service plan must be updated at least annually and when a change in the member's circumstances or needs change significantly, and at the request of the member.

The comprehensive person-centered plan:

- Includes people chosen by the member.
- Provides necessary information and support to the member to ensure that the member directs the process to the maximum extent possible.
- Is timely and occurs at times and locations of convenience to the member.
- Reflects cultural considerations and uses plain language.
- Includes strategies for solving a disagreement.
- Offers choices to the member regarding services and supports the member receives and from whom.
- Provides method to request updates.
- Conducted to reflect what is important to the member to ensure delivery of services in a manner reflecting personal preferences and ensuring health and welfare.
- Identifies the strengths, preferences, needs (clinical and support), and desired outcomes of the member.
- May include whether and what services are self-directed.
- Includes individually identified goals and preferences related to relationships, community participation, employment, income and savings, healthcare and wellness, education and others.

- Includes risk factors and plans to minimize them.
- Is signed by all individuals and providers responsible for its implementation and a copy of the plan must be provided to the member and the member's representative.

The HCBS waiver written comprehensive service plan documentation:

- Reflects the member's strengths and preferences
- Reflects clinical and support needs
- Includes observable and measureable goals and desired outcomes:
  - Identify interventions and supports needed to meet those goals with incremental action steps, as appropriate.
  - Identify the staff people, businesses, or organizations responsible for carrying out the interventions or supports.
- Identifies for a member receiving home-based habilitation:
  - The member's living environment at the time of enrollment,
  - The number of hours per day of on-site staff supervision needed by the member, and
  - The number of other members who will live with the member in the living unit.
- Reflects providers of services and supports, including unpaid supports provided voluntarily in lieu of waiver or state plan HCBS, including:
  - Name of the provider
  - Service authorized
  - Units of service authorized
- Includes risk factors and measures in place to minimize risk
- Includes individualized backup plans and strategies when needed.
  - Identify any health and safety issues that apply to the member based on information gathered before the team meeting, including a risk assessment.
  - Identify an emergency backup support and crisis response system to address problems or issues arising when support services are interrupted or delayed or the member's needs change.

- Providers of applicable services shall provide for emergency backup staff.
- Includes individuals important in supporting the member.

♦ Includes the names of the individuals responsible for monitoring the plan

♦ Is written in plain language and understandable to the member

♦ Documents who is responsible for monitoring the plan

♦ Documents the informed consent of the member for any restrictions on the member's rights, including maintenance of personal funds and self-administration of medications, the need for the restriction, and either a plan to restore those rights or written documentation that a plan is not necessary or appropriate.

Any rights restrictions must be implemented in accordance with 441 IAC 77.25(4).

♦ Includes the signatures of all individuals and providers responsible
♦ Is distributed to the member and others involved in the plan
♦ Includes purchase and control of self-directed services
♦ Excludes unnecessary or inappropriate services and supports

9. Adverse Service Actions

Legal reference:

Waiver Type	**Corresponding Iowa Administrative Code**
AIDS	441 IAC 83.48(249A)
Brain injury	441 IAC 83.88(249A)
Children's mental health	441 IAC 83.128(249A)
Elderly	441 IAC 83.28(249A)
Health and disability	441 IAC 83.8(249A)
Intellectual disability	441 IAC 83.68(249A)
Physical disability	441 IAC 83.108(249A)

This section contains the conditions that will result in:

- Denial of an individual's application for waiver services,
- Reduction of the amount of waiver services provided, or
- Termination of waiver eligibility.

a. Denial of Application

Legal reference:

Waiver Type	Corresponding Iowa Administrative Code
AIDS	441 IAC 83.48(1)
Brain injury	441 IAC 83.88(1)
Children's mental health	441 IAC 83.128(1)
Elderly	441 IAC 83.28(1)
Health and disability	441 IAC 83.8(1)
Intellectual disability	441 IAC 83.68(1)
Physical disability	441 IAC 83.108(1)

The Department shall deny an application for services when it determines that:

- The member is not eligible for or in need of services.
- Service needs exceed the service unit or reimbursement maximums.
- Service needs are not met by the services provided.
- Needed services are not available or received from qualifying providers.
- The HCBS waiver service is not identified in the member's service plan.
- There is another community resource available to provide the service or a similar service free of charge to the member that will meet the member's needs.
- The Department has not received required documents for the member.
- The member receives services from other Medicaid waiver providers.
- The member or legal representative requests termination from the services.

b. Reduction of Service

Legal reference:

Waiver Type	**Corresponding Iowa Administrative Code**
AIDS	441 IAC 83.48(3)
Brain injury	441 IAC 83.88(2)
Children's mental health	441 IAC 83.128(3)
Elderly	441 IAC 83.28(3)
Health and disability	441 IAC 83.8(3)
Intellectual disability	441 IAC 83.68(2)
Physical disability	441 IAC 83.108(2)

The Department may reduce a particular waiver service when it determines either of the following:

- Continued provision of service at its current level is not necessary. The Department must determine the level to which the service may be reduced without jeopardizing the member's continued progress toward achieving or maintaining the goal.
- Another community resource is available to provide the same or similar service to the member at no financial cost to the member that will meet the member's needs.

c. Termination of Service

Legal reference:

Waiver Type	**Corresponding Iowa Administrative Code**
AIDS	441 IAC 83.48(2)
Brain injury	441 IAC 83.88(3)
Children's mental health	441 IAC 83.128(2)
Elderly	441 IAC 83.28(2)
Health and disability	441 IAC 83.8(2)
Intellectual disability	441 IAC 83.68(3)
Physical disability	441 IAC 83.108(3)

A particular service may be terminated when the Department determines that:

- The specific need to attain the goals and objectives to which the service was directed has been achieved.
- After repeated assessment, it is evident that the family or member is unable to achieve or maintain the goals set forth in the individual client service plan.
- After repeated efforts, it is evident that the family or member is unwilling to accept further service.
- The member's income or resources exceed the financial guidelines.
- Another community resource is available to provide the service or a similar service free of charge to the member that will meet the member's needs.
- The member refuses to allow documentation of eligibility as to need, income, and resources.
- Needed services are not available or received from qualifying providers.
- The HCBS waiver service is not identified in the member's annual service plan.
- The member's service needs are not met by the services provided.
- Needed services exceed the service unit or reimbursement maximums.
- The Department has not received required documents for the member.
- The member receives services from other Medicaid waiver programs.
- The member or legal representative through the interdisciplinary process requests termination from services.
- The member receives care in a hospital, nursing facility, or intermediate care facility for the intellectually disabled for 30 days in any one stay for purposes other than respite care.

B. WAIVER SERVICE DESCRIPTIONS

1. Adult Day Care

Legal reference:

Waiver Type	Corresponding Iowa Administrative Code
AIDS	441 IAC 78.38(7)
Brain injury	441 IAC 78.43(9)
Elderly	441 IAC 78.37(1)
Health and disability	441 IAC 78.34(3)
Intellectual disability	441 IAC 78.41(12)

Adult day care services provide an organized program of supportive care in a group environment to people who need a degree of supervision and assistance on a regular or intermittent basis in a day care center.

Components of this service may include:

- Health-related care
- Social services
- Other related support services

The cost of transportation to and from the day care site may be included in the provider's rate.

2. Assisted Living On-Call

Legal reference:

Waiver Type	Corresponding Iowa Administrative Code
Elderly	441 IAC 78.37(13)

The assisted living on-call service provides staff on call 24 hours per day to meet a member's needs in a manner that promotes maximum dignity and independence and provides safety and security.

3. Assistive Devices

Legal reference:

Waiver Type	**Corresponding Iowa Administrative Code**
Elderly	441 IAC 78.37(13)

Assistive devices means practical equipment to assist members with activities of daily living and instrumental activities of daily living to allow the member more independence. Devices include, but are not limited to:

- Long-reach brush
- Extra-long shoe horn
- Non-slip grippers to pick up and reach items
- Dressing aids
- Transfer boards
- Shampoo rinse tray and inflatable shampoo tray
- Double-handled cup and sipper lid

4. Behavioral Programming

Legal reference:

Waiver Type	**Corresponding Iowa Administrative Code**
Brain injury	441 IAC 78.43(12)

Behavioral programming consists of individually designed strategies to increase the member's appropriate behaviors and decrease the member's maladaptive behaviors that have interfered with the member's ability to remain in the community. Behavioral programming includes:

- A complete assessment of both appropriate and maladaptive behaviors.
- Development of a structured behavioral plan, which should be identified in the member's individual treatment plan.
- Implementation of the behavioral intervention plan.
- Ongoing training and supervision to caregivers and behavioral aides.
- Periodic reassessment of the plan.

Types of appropriate behavioral programming include, but are not limited to:

- Clinical redirection
- Token economies
- Reinforcement
- Extinction
- Modeling
- Over-learning

5. Brain Injury Waiver Case Management

Legal reference:

Waiver Type	**Corresponding Iowa Administrative Code**
Brain injury	441 IAC 78.43(1), 441 IAC 90.5(249A)

Payment for waiver case management shall not be made until the member is enrolled in the waiver. Payment shall be made only for case management services performed on behalf of the member during a month when the member is enrolled in the waiver. Members who are eligible for TCM through state plan Medicaid receive TCM in addition to waiver services and do not receive case management as a waiver service. Members who also receive state plan habilitation services (1915(i)) will receive case management through the habilitation program and not through the brain injury waiver.

For the brain injury waiver, "individual case management services" means activities provided, using an interdisciplinary process, to members with a brain injury to:

- Ensure that the member has received an evaluation and diagnosis,
- Give assistance to the member in obtaining appropriate services and living arrangements,
- Coordinate the delivery of services, and
- Provide monitoring to ensure the continued appropriate provision of services and the appropriateness of the selected living arrangement.

BI case management services shall consist of the following components:

- Intake, which includes ensuring that there is sufficient information to identify all areas of need for services and appropriate living arrangements.
- Assurance that a service plan is developed which addresses the member's total needs for services and living arrangements.
- Assistance to the member in obtaining the services and living arrangements identified in the service plan.
- Coordination and facilitation of decision making among providers to ensure consistency in the implementation of the service plan.
- Monitoring of the services and living arrangements to ensure their continued appropriateness for the member.
- Crisis assistance to facilitate referral to the appropriate providers to resolve the crisis.
- One face-to-face contact with the member every three months.
- One contact per month with the member, the member's legally authorized representative, the member's family, service providers, or other entities or individuals. This contact may be face-to-face or by telephone.

The intent and purpose of the individual case management services are to facilitate the member's access to the service system and to enable members and their families to make decisions on their own behalf by providing:

- Information necessary for decision making.
- Assistance with decision-making and participation in the decision-making process affecting the member.
- Assistance in problem solving.
- Assistance in exercising the member's rights.

The service is to be delivered so as to enhance the capabilities of members and their families to exercise their rights and responsibilities as citizens in the community. The goal is to enhance the ability of the member to:

- Exercise choice,
- Make decisions,
- Take risks which are a typical part of life, and
- Fully participate as a member of the community.

It is essential that the case manager develop a relationship with the member so that the abilities, needs and desires of the member can be clearly identified and communicated and the case manager can help to ensure that the system and specific services are responsive to the needs of the members.

6. Elderly Waiver Case Management

Legal reference:

Waiver Type	**Corresponding Iowa Administrative Code**
Elderly	441 IAC 77.33(21), 441 IAC 90.5(249A)

Payment for waiver case management shall not be made until the member is enrolled in the waiver. Payment shall be made only for case management services performed on behalf of the member during a month when the member is enrolled in the waiver. Members who are eligible for targeted case management through state plan Medicaid receive TCM in addition to waiver services and do not receive case management as a waiver service. Members who also receive state plan habilitation services (1915(i)) will receive case management through the habilitation program and not through the elderly waiver.

Under the elderly waiver, case management services are services that assist Medicaid members who reside in a community setting or are transitioning to a community setting in gaining access to needed medical, social, educational, housing, transportation, vocational, and other appropriate services in order to ensure the health, safety, and welfare of the member.

Case management is provided at the direction of the member and the interdisciplinary team according to the same standards as set for Medicaid targeted case management in relation to service provision and provider requirements. Covered services include:

- Assessment and reassessment of the member's needs,
- Development and review of the member's service plan,
- Service referral and related activities,
- Monitoring and follow-up to ensure:
  - The health, safety, and welfare of the member; and
  - Effective implementation of a service plan that adequately addresses the needs of the member.

- A face-to-face contact with the member every three months and at least one contact per month with the member or the member's representative, family, service providers, or other entities or individuals involved in the member's case.
- A person cannot be the first-line supervisor of both case managers and direct service staff who are providing services to elderly waiver members.

7. Chore Service

Legal reference:

Waiver Type	**Corresponding Iowa Administrative Code**
Elderly	441 IAC 77.37(249A)

Chore services provide assistance with the household maintenance activities as necessary to allow a member to remain in the member's own home safely and independently.

Chore services include the following services:

- Window and door maintenance, such as hanging screen windows and doors, replacing windowpanes, and washing windows
- Minor repairs to walls, floors, stairs, railings, and handles
- Heavy cleaning which includes cleaning attics or basements to remove fire hazards, moving heavy furniture, extensive wall washing, floor care, painting, and trash removal
- Lawn mowing and removal of snow and ice from sidewalks and driveways

Chore services **do not** include leaf raking, bush and tree trimming, trash burning, stick removal, or tree removal.

Iowa Department of Human Services

HCBS Consumer-Directed Attendant Care Agreement

This is an agreement between a consumer of services under a Medicaid home- and community-based services waiver and a consumer-directed attendant care (CDAC) provider.

Name of Consumer		Name of CDAC	

The Iowa Medicaid program will reimburse for CDAC services provided under this agreement when consumer-directed attendant care is part of the consumer's comprehensive service plan and the DHS service worker or case manager has determined that the prior training and experience of the CDAC provider are sufficient to meet the consumer's needs noted in this agreement. However, the consumer agrees not to hold the service worker or case manager responsible for any problems resulting from any deficiency in the provider's training or experience. The CDAC provider must report any health, safety or welfare concerns to the DHS service worker or case manager.

Instructions:

The consumer or the consumer's legal representative must complete this form by entering information describing how the CDAC provider will meet the standards and responsibilities and the agreed-upon rate of payment. **Before the CDAC provider begins providing the CDAC service and receives payment, all the following must occur:**

1. The consumer and/or the consumer's legal representative, and the CDAC provider will decide which services are needed, the number of hours to be provided, and the rate of payment to the CDAC provider.
2. This CDAC agreement must be filled out completely and signed by both the consumer or consumer's legal representative and the CDAC provider to show they approve all the information in the agreement and shall abide by all requirements in the agreement.
3. The original copy of the CDAC agreement is kept by the service worker/case manager and attached to the comprehensive service plan. A copy of the CDAC agreement must be given to and maintained by the consumer, the consumer's legal representative if applicable, the CDAC provider, and to the nurse or therapist supervising the provision of skilled services, if any.
4. The service worker/case manager shall distribute a *Notice of Decision* to the consumer, the consumer's legal representative if applicable, and the CDAC provider showing that the service worker/case manager has approved the CDAC services, the CDAC provider, and the rate of payment.
5. The CDAC provider must provide only the CDAC services as described and approved in the service worker/case manager's comprehensive service plan. The CDAC provider must document the CDAC activities performed on the designated clinical/ medical record form 470-4389 and form 470-4390 for each unit of service prior to submitting a claim for payment. The record must show that the service is necessary due to the consumer's complaint, needs or goals as reflected in the comprehensive service plan. The record must state the CDAC provider's specific actions or activities and the consumer's response to the services rendered, including any observed changes in the consumer's physical or mental health, mood or behavior.

6 The CDAC provider cannot disclose protected health information (PHI). The HIPAA Privacy Rule protects all "*individually identifiable health information*" held or transmitted by a covered entity or its business associate, in any form or media, whether electronic, paper, or oral. "Individually identifiable health information" is information, including demographic data, that relates to:

- The individual's past, present or future physical or mental health or condition,
- The provision of health care to the individual, or
- The past, present, or future payment for the provision of health care to the individual, and
- That identifies the individual or for which there is a reasonable basis to believe can be used to identify the individual.

Individually identifiable health information includes many common identifiers (e.g., name, address, birth date, Social Security Number).

Civil and criminal penalties may be imposed for failure to comply with the Privacy Rule. Civil penalties of $100 per incident, not to exceed $25,000 per year for multiple violations of the identical Privacy Rule requirement in a calendar year. Criminal penalties with fines of $50,000 and up to one-year imprisonment can be imposed for an individual who knowingly obtains or discloses individually identifiable health information. The criminal penalties increase to $100,000 and up to five years imprisonment if the wrongful conduct involves false pretenses, and to $250,000 and up to ten years imprisonment if the wrongful conduct involves the intent to sell, transfer, or use individually identifiable health information for commercial advantage, personal gain, or malicious harm.

Agreement:

The consumer and the CDAC provider agree that:

1 The CDAC provider, as an agency or individual, is not an agent, employee, or servant of the state of Iowa, the Department of Human Services, or any of its employees. It is the CDAC provider's responsibility to determine employment status in regards to income tax and social security. Providers of CDAC service have no recourse to the Department of Human Services to collect payments performed outside of the provisions of this agreement.

2 This agreement will be reviewed annually and when there are significant changes in the consumer's condition or situation.

3 This agreement must be amended and approved by the service worker/case manager whenever there is a change:

(a) Of a CDAC provider,

(b) In the service components to be provided,

(c) In the description of provider activity, or

(d) In the rate of payment

Responsibility: To be completed by the consumer or consumer's legal representative.	
Describe the plan for emergencies, including instructions in calling 911 first in all life-threatening situations. What supports are available to you in case of an emergency or crisis situation? Describe the back-up plan if CDAC services are interrupted or delayed.	
Describe in detail all the CDAC provider's prior training and experience and how you evaluated it.	
Describe how you will manage the CDAC provider's services.	
Describe how you will measure and evaluate the services you receive from your CDAC provider.	

Standards for the CDAC provider: To be completed by the consumer or consumer's legal representative regarding information about your CDAC provider.	**Confirmation of Standard – Please print clearly**
1. Age (must be at least 18 years old as verified by driver's license, state identification card, passport, or other government-issued document) and a citizen of the United States or legal alien (green card or ID 9).	
2. Does the CDAC provider have the necessary skills needed to perform the CDAC services as identified and approved in this agreement? Yes/No	
3. The CDAC provider must be able to document and maintain the fiscal and clinical/medical records he/she provides per Iowa Administrative Code 441 79.3. List evidence of basic math, reading, and writing skills (e.g., high school diploma, GED, etc.).	
4. Insurance or bond for the activities provided	**Please fill out 1 and 2 or circle 3**
upon consumer request	1) Insurance or bonding company:_____
	2) Policy Limit Policy Number:_____
	3) Requirement is waived:_____

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Describe the service activities provided by the CDAC provider. Enter ther amount of time per day and the number of days per week or month required to provide the activity. Enter "Not applicable" (NA) fo components of the CDAC service that will not be provided.

Documentation Service Code	**Non-Skilled Service Components To be completed by the consumer or consumer's legal representative.**	**Describe CDAC Provider Activity**	List the amount of time required each day for each activity. (one hour equals one unit)	Number of days service will be provided per month	Total Units for the Line
N1	**Dressing**		0	0	0
N2	**Bathing, grooming, personal hygiene** – includes shaving, hair care, make-up, and oral hygiene		0	0	0
N3	**Meal preparation and feeding** – includes cooking, eating, and feeding assistance (but not the cost of meals themselves)		0	0	0
N4	**Toileting** – includes bowel, bladder and catheter assistance (emptying the catheter bag, collecting a specimen, and cleaning the external area around the catheter)		0	0	0

Documentation Service Code	Non-Skilled Service Components To be completed by the consumer or consumer's legal representative.	Describe CDAC Provider Activity	List the amount of time required each day for each activity. (one hour equals one unit)	Number of days service will be provided per month	Total Units for the Line
N5	**Transferring, ambulation, mobility** – includes access to and from bed or a wheelchair, repositioning, exercising, and mobility in general.		0	0	0
N6	**Essential housekeeping** – activities which are necessary for the health and welfare of the consumer such as grocery shopping, laundry, general cleaning, and routine home maintenance.		0	0	0
N7	**Minor wound care** – includes foot care, skin care, nail care, and skin/nail observation and inspection.		0	0	0

Documentation Service Code	Non-Skilled Service Components To be completed by the consumer or consumer's legal representative.	Describe CDAC Provider Activity	List the amount of time required each day for each activity. (one hour equals one unit)	Number of days service will be provided per month	Total Units for the Line
N8	**Financial and scheduling assistance** – includes money management, cognitive tasks, and scheduling personal business matters.		0	0	0
N9	**Assistance in the workplace** – assistance with self-care tasks, environmental tasks, and medical supports necessary for the consumer to perform a job. Assistance with understanding and completing essential job functions is not included.		0	0	0
N10	**Communication** – includes interpreting, reading services, assistance with communication devices, and supports that address the consumer's unique communication needs.		0	0	0

Documentation Service Code	Non-Skilled Service Components To be completed by the consumer or consumer's legal representative.	Describe CDAC Provider Activity	List the amount of time required each day for each activity. (one hour equals one unit)	Number of days service will be provided per month	Total Units for the Line
N11	**Essential transportation** – assisting or accompanying the consumer in using transportation essential to the health and welfare of the consumer. *		0	0	0

*Transportation may be provided for consumers to conduct business errands, essential shopping, to receive medical services not reimbursed through medical transportation and to travel to and from pwrk or day programs. Note: Transportation costs and waiting time are not reimbursable costs

Documentation Service Code	Non-Skilled Service Components To be completed by the consumer or consumer's legal representative.	Describe CDAC Provider Activity	List the amount of time required each day for each activity. (one hour equals one unit)	Number of days service will be provided per month	Total Units for the Line
N12	**Medication assistance** – includes assisting the consumer in sorting, storing, organizing, and taking medications ordinarily self-administered. It also includes medication equipment maintenance and medication administration. *		0	0	0

* If medication is administered, documentation on the name of the medication, the dosage, and the route of administration must be maintained of the service record form or MAR (medication administration record). (A medication aid course id available through the area community colleges.

Skilled service activities include helping the consumer with any of the following skilled services under the supervision of a licensed nurse or licensed therapist working under the direction of a physician. The cost of this supervision shall be paid from private insurance and other third party payment sources, Medicare, the regular Medicaid program, or the Care for Kids program. The nurse or therapist must retain accountability for actions that are delegated and ensure appropriate assessment, planning, implementation, and evaluation. The nurse or therapist shall make on-site supervisory visits every two weeks. This nurse or therapist agrees to supervise these service components delivered by this CDAC provider:

Name and telephone number of supervising nurse or therapist:					
Documentation Service Code	**Skilled Service Components** To be completed by the consumer, consumer's legal guardian, nurse/therapist, and CDAC provider.	**Describe CDAC Provider Activity**	List the amount of time required each day for each activity. (one hour equals one unit)	Number of days service will be provided per month	Total Units for the Line
S1	Tube feedings if a consumer is unable to eat solid foods.		0	0	0
S2	Assistance with intravenous therapy administered by a licensed nurse.		0	0	0

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Documentation Service Code	**Skilled Service Components** To be completed by the consumer, consumer's legal guardian, nurse/therapist, and CDAC provider.	**Describe CDAC Provider Activity**	List the amount of time required each day for each activity. (one hour equals one unit)	Number of days service will be provided per month	Total Units for the Line
S3	Parenteral injections required more than once a week.		0	0	0
S4	Catheterizations, continuing care of indwelling catheters with supervision of irrigations, and changing of Foley catheters when required.		0	0	0
S5	Respiratory care, including inhalation therapy, tracheotomy care, and ventilator.		0	0	0
S6	Care of decubiti and other ulcerated areas, noting and reporting to the nurse or therapist.		0	0	0

S7	Rehabilitation services *		0	0	0

*Rehabilitation services include Bowel and bladder training, range of motion exercises, ambulation training, restorative nursing services, re-teaching the activity of daily living, respiratory care and breathing programs, reality orientation, reminiscing therapy, re-motivation, and behavior modification.

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Documentation Service Code	**Skilled Service Components** To be completed by the consumer, consumer's legal guardian, nurse/therapist, and CDAC provider.	**Describe CDAC Provider Activity**	List the amount of time required each day for each activity. (one hour equals one unit)	Number of days service will be provided per month	Total Units for the Line
S8	Colostomy care.		0	0	0
S9	Care of medical conditions out of control (includes brittle diabetes and comfort care of terminal conditions).		0	0	0
S10	Post-surgical nurse delegated activities under the supervision of the licensed nurse.		0	0	0
S11	Monitoring reactions to medications requiring close supervision because of a fluctuating physical or psychological condition.		0	0	0
S12	Preparing and monitoring responses to therapeutic diets.		0	0	0

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Documentation Service Code	**Skilled Service Components** To be completed by the consumer, consumer's legal guardian, nurse/therapist, and CDAC provider.	**Describe CDAC Provider Activity**	List the amount of time required each day for each activity. (one hour equals one unit)	Number of days service will be provided per month	Total Units for the Line
S13	Recording and reporting of changes in vital signs to the nurse or therapist.		0	0	0
					Total Units
					0

Enter the number in the 'Total Units' box into the Total Units Per Month box below:

Total Units Per Month
0

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The consumer/consumer's legal representative, the CDAC provider, and the service worker/case manager determine the CDAC provider's rate of pay. The payment of CDAC services must not exceed the fee limits allowed in the CDAC program. The rate of service multiplied by the number of approved units of CDAC services per month cannot exceed the consumer's total monthly budget amount allowed in the consumer's comprehensive service plan. Complete the waiver type and agreed upon reimbursement rate to the provider as follows *(one HCPCS code only)* :

Waiver type: (check one)

AIDS/HIV	Ill & Handicapped	Brain Injury	Mental Retardation	Elderly	Physically Disabled

HCPCS Code	Provider Type	Fee Per Unit	Maximum Units
Ronf	Agency CDAC provider. Not an assisted living CDAC provider.	$ per hour (up to 8 hours per day)	
W1266	Agency CDAC provider. Not an assisted living CDAC provider.	$ per hour (defined as 8 or more hours per day)	
W1267	Individual CDAC provider	$ per hour (up to 8 hours per day)	
W1268	Individual CDAC provider	$ per hour (defined as 8 or more hours per day)	
W2517	Assisted living CDAC provider	$ per month	

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I agree to abide by all the requirements in this CDAC agreement including the following:

- That my criminal and abuse records will be checked for reported or confirmed criminal history or abuse.
- To hold the Department of Human Services harmless against all claims, damages, losses, costs, and expenses, including attorney fees, arising out of the performance of this CDAC agreement by any and all persons.
- To keep both fiscal and designated clinical/medical documentation records of all CDAC services provided which are charged to the medical assistance program and to maintain these CDAC records for at least five years from the date of claims submission. Documentation shall include the following information for each unit of CDAC service provided and billed:

1	Full name of the consumer receiving the CDAC service as it appears on their medical assistance card.
2	Consumer's date of birth.
3	Medical assistance identification number.
4	Full name of the person providing the service. If the provider functions under a professional license or is certified to perform certain tasks, list the title after the provider's name. If the provider does not have a title, enter "CDAC Worker."
5	Agency name (if applicable).
6	Specific date of the CDAC service provided including the day, month, and year.
7	Total units billed for the date of service.
8	Waiver type and service procedure code as identified in this agreement.
9	Duration of the CDAC service provided including the start and end time.
10	The number of units as computed from the start and end time.
11	Specific service activity provided as described in this agreement.
12	Location in which the service was provided.
13	Description of the CDAC service provided as described in this agreement and as authorized in the service worker/case manager comprehensive service plan.
14	Description of the provider's interventions and supports provided and the consumer's response to those interventions and supports.
15	Identification of any health, safety, and welfare concerns.
16	Consumer's signature, provider's signature, and the date.

I hereby confirm that all information provided by me on this form is true and correct to the best of my knowledge.

CDAC Provider Signature	Date	Consumer Signature	Date

ADDITIONAL INFORMATION ON BILLING:

Submit claim forms for all consumer-directed attendant care to Iowa Medicaid Enterprise (IME) Provider Services on form 470-2486, Claim for Targeted Medical Care. Both the consumer and the CDAC provider must sign and date the Claim for Targeted Medical Care. CDAC services must be billed in whole units. Obtain copies of this form from IME Provider Services at 1-800-338-7909 or (515) 725-1004 (Des Moines local number only) or at the IME website: www. ime.state.ia.us. Please refer to your CDAC provider manual for directions on completing the CDAC claim form. Questions may be directed to the Iowa Medicaid Enterprise Provider Services telephone number listed above. Submit claims to IME on a monthly basis on or after the first day of the following month to facilitate payment in a timely manner. To receive payment, submit the claim for an entire month's service. IME has 30 days to process a claim. If a submitted claim contains errors, the payment to the provider may be delayed.

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8. Consumer-Directed Attendant Care (CDAC)

Legal reference:

Waiver Type	Corresponding Iowa Administrative Code
AIDS	441 IAC 78.43(13)
Brain injury	441 IAC 78.43(13)
Elderly	441 IAC 78.37(15)
Health and disability	441 IAC 78.34(7)
Intellectual disability	441 IAC 78.41(8)
Physical disability	441 IAC 78.46(1)

Consumer-directed attendant care services are service activities performed by a person to help a member with self-care tasks that the member would typically do independently if the member were otherwise able. Consumer-directed attendant care services must be cost-effective and necessary to prevent institutionalization.

Members who request consumer-directed attendant care (CDAC) and for whom the interdisciplinary team agrees that CDAC is an appropriate service shall have CDAC included in their service plan.

The member or the legal representative is responsible for:

- Selecting the person or agency that will provide the components of the attendant care services.
- Determining the components of the attendant care services to be provided with the person who is providing the services to the member.
- Completing form 470-3372, *HCBS Consumer-Directed Attendant Care Agreement*, with the provider and signing it. Form 470-3372 must be provided to and signed by the service worker or case manager before services begin. Click here to access the form online.

NOTE: Each provider that is providing the CDAC service must complete and sign a separate *HCBS Consumer-Directed Attendant Care Agreement*, form 470-3372.

Members will give direction and training for activities to maintain independence that are not medical in nature. Licensed nurses and therapists will provide on-the-job training and supervision for skilled activities described in form 470-3372. When CDAC is part of the member's service plan, a copy of the completed form 470-3372 becomes an attachment to and part of the service plan.

Before the provision of services, the service worker or case manager must review and approve form 470-3372 for appropriateness of the services and the number of units of service identified as well as the provider's training and experience. (As the state Medicaid agency, DHS has oversight responsibility for CDAC providers.)

Refer to the previous section on waiver prior authorization (see Waiver Prior Authorization). It is recommended that provisions be made for alternate providers to supplement service provision for emergencies that may arise. These alternate providers should be enrolled and designated in the written service plan. This will allow the alternate service providers to assume the service provision immediately whenever necessary.

a. Covered Services

Legal reference:

Waiver Type	Corresponding Iowa Administrative Code
AIDS	441 IAC 78.38(8)
Brain injury	441 IAC 78.43(13)
Elderly	441 IAC 78.37(15)
Health and disability	441 IAC 78.34(7)
Intellectual disability	441 IAC 78.41(8)
Physical disability	441 IAC 78.46(1)

All consumer-directed attendant care services are supportive services.

Non-skilled service activities may include helping the member with any of the following activities:

- Bathing, shampooing, hygiene, and grooming.
- Tasks, such as handling money and scheduling, that require cognitive or physical assistance.

- Communication essential to the health and welfare of the member, through interpreting and reading services, and use of assistive devices for communication.
- Dressing.
- Housekeeping, laundry, and shopping essential to the member's health care at home.
- Meal preparation, cooking, eating and feeding. Meal preparation and cooking shall be provided only in the member's home.

  NOTE: The actual cost of meals is **not** included.
- Taking medications ordinarily self-administered, including medications ordered by a physician or other qualified health care provider.
- Minor wound care.
- Going to and from place of employment and job-related tasks while the member is on the job site. Transportation for the member and assistance with understanding or performing the essential job functions are not included.
- Access to and from bed or wheelchair, transferring, or ambulating.
- Toileting needs, including bowel, bladder and catheter assistance (emptying the catheter bag, collecting a specimen, and cleaning the external area around the catheter).
- Using transportation essential to the health and welfare of the member, but **not** the cost of transportation for the member or the provider.

Skilled service activities may include helping the member with any of the following skilled services under the supervision of a licensed nurse or licensed therapist working under the direction of a physician:

- Care of decubiti and other ulcerated areas, noting and reporting to the nurse or therapist
- Care of uncontrolled medical conditions, such as brittle diabetes and comfort care of terminal conditions
- Catheterizations, continuing care of indwelling catheters with supervision of irrigations, and changing of Foley catheters when required
- Colostomy care

- Intravenous therapy administered by a licensed nurse
- Monitoring medications requiring close supervision because of fluctuating physical or psychological conditions, e.g., anti-hypertensive, digitalis preparations, mood-altering or psychotropic drugs, or narcotics
- Parenteral injections required more than once a week
- Post-surgical care
- Preparing and monitoring response to therapeutic diets
- Recording and reporting changes in vital signs to the nurse or therapist
- Rehabilitation services, including:
  - Ambulation training
  - Behavior modification
  - Bowel and bladder training
  - Range-of-motion exercises
  - Reality orientation
  - Reminiscing therapy
  - Re-motivation
  - Respiratory care and breathing programs
  - Restorative nursing services
  - Re-teaching the activities of daily living
- Respiratory care, including inhalation therapy and tracheotomy care or tracheotomy care and ventilator
- Tube feedings of members unable to eat solid foods

The licensed nurse or therapist must ensure appropriate assessment, planning implementation, and evaluation for skilled consumer-directed attendant care services. The licensed nurse or therapist must make on-site supervisory visits every two weeks with the provider present.

The cost of the supervision provided by the licensed nurse or therapist must be paid from private insurance and other third-party payment sources, Medicare, the regular Medicaid program, or the Care for Kids program before accessing the HCBS waiver.

b. Relationship to Other Services

When a member has a CDAC service, the CDAC provider cannot receive respite services. An alternative CDAC provider may be used to provide the CDAC services.

Members may be eligible for both a HCBS waiver and the state supplementary assistance in-home health-related care program when:

- They meet the eligibility requirements of each program, and
- Each program provides a different service.

CDAC may not be simultaneously reimbursed with waiver supported employment, work activity, sheltered work, supported community living or respite services, or with Medicaid nursing or home health aide services.

c. Excluded Services and Costs

Services, activities, costs, and time that are not covered as consumer-directed attend care include the following (not an exclusive list):

- Any activity related to supervising a member. Only direct services are billable.
- Any activity that the member is able to perform.
- Costs of food.
- Costs for the supervision of skilled services by the nurse or therapist. The supervising nurse or therapist may be paid from private insurance, Medicare, or other third-party payment sources, or may be paid as another Medicaid service, including early and periodic screening, diagnosis and treatment services.
- Exercise that does not require skilled services.
- Parenting or child care for or on behalf of the member.
- Reminders and cueing.
- Services provided simultaneously with any other similar service regardless of funding source, including other waiver services and state supplementary assistance in-home health-related care services.

9. Consumer Choices Option Services

Legal reference:

Waiver Type	**Corresponding Iowa Administrative Code**
AIDS	441 IAC 78.38(9)
Brain injury	441 IAC 78.43(15)
Elderly	441 IAC 78.37(16)
Health and disability	441 IAC 78.34(13)
Intellectual disability	441 IAC 78.41(15)
Physical disability	441 IAC 78.46(6)

The consumer choices option provides a member with a flexible monthly individual budget that is based on the member's service needs.

Within the individual budget amount, the member shall have the authority to purchase goods and services and may choose to employ providers of service and supports. Components of this service are set forth below:

- **Required service components**. To participate in the consumer choices option, a member must:
  - Hire an independent support broker, and
  - Work with a financial management service provider that is enrolled as a Medicaid HCBS waiver service provider.
- **Optional service components**. A member who elects the consumer choices option may purchase the following services and supports, which shall be provided in the member's home or at an integrated community setting:
  - Self-directed personal care services
  - Self-directed community supports and employment
  - Individual-directed goods and services

A monthly individual budget amount is established for each member based on the assessed needs of the member and the waiver services authorized in the member's service plan. Once authorized, a member may convert a waiver service to create a CCO budget.

The waiver services that may be converted to a CCO budget:

Services by Program	AIDS	BI	EW	HD	ID	PD
Adult day care		X				
Assisted living on-call			X			
Assistive devices			X			
Chore			X			
Consumer-directed attendant care, unskilled	X	X	X	X	X	X
Day habilitation					X	
Home-delivered meals	X		X	X		
Homemaker	X		X	X		
Home/vehicle modification		X	X	X	X	X
Prevocational services		X			X	
Respite services, basic individual	X	X	X	X	X	
Senior companion			X			
Specialized medical equipment		X				X
Supported community living (SCL)		X			X	
Supported employment (SE)		X			X	
Transportation		X	X		X	X

Once selected, the waiver services are entered into the member's service plan for use in CCO. ISIS will automatically calculate a monthly "cap amount" and a "budget amount" based on the type and amount of waiver service entered into the service plan.

The cap amount is used to ensure the member stays within the program dollar limits such as the monthly level of care cap or the annual respite cap in the ID waiver. The budget amount is the amount of funds available to the member to purchase goods and services to meet the member's assessed needs. The member is notified by the CM/SW of the initial budget amount and any change to the monthly budget amount.

The member will use the monthly budget amount to purchase goods and services to meet their assessed needs. The member's assessed needs are considered the type and amount of waiver services that were authorized in the service plan to create the CCO budget. For example, if consumer-directed attendant care services are authorized in the plan and converted to a CCO budget, the budget must be used to meet CDAC needs that have been assessed as needed by the member.

The member using CCO is self-directing their services. This means they have both budget and employer authority. A member has the authority to hire and fire employees, establish wages and purchase goods and services to get their needs met. If a member is efficient in using the monthly budget to get all their assessed needs met and there are additional budget funds remaining, they can use the funds to purchase additional goods and services in the current month or put the funds into a saving account for use in future months.

10. Counseling

Legal reference:

Waiver Type	**Corresponding Iowa Administrative Code**
AIDS	441 IAC 78.38(1)
Health and disability	441 IAC 78.34(6)

Counseling services are face-to-face non-psychiatric mental health services necessary for:

- The management of depression,
- Assistance with the grief process,
- Alleviation of psychosocial isolation, and
- Support to cope with a disability or illness, including terminal illness.

Counseling services can be provided to the member and caregiver to facilitate home management of the member and prevent institutionalization. **NOTE:** Counseling services may be provided to the member's caregiver only when included in the member's approved service plan documented in ISIS.

Counseling services may be provided both for the purposes of:

- Training the member's family or other caregiver to provide care, and
- Helping the member and those caring for the member to adjust to the member's disability or terminal condition.

Services must be provided by a mental health professional. Providers may be:

- Certified community mental health centers,
- Licensed or Medicaid enrolled hospices, or
- Accredited mental health services providers.

Payment will be made for individual and group counseling. Group counseling is based on the group rate divided by six, or, if the number of people in the group exceeds six, by the actual number of people who comprise the group.

11. Day Habilitation

Legal reference:

Waiver Type	**Corresponding Iowa Administrative Code**
Intellectual disability	441 IAC 78.41(14)

Day habilitation means provision of regularly scheduled activities in a non-residential setting, separate from the member's private residence or other residential living arrangement, such as:

- Assistance with acquisition, retention, or improvement in self-help;
- Socialization and adaptive skills that enhance social development; and
- Developing skills in performing activities of daily living and community living.

Activities and environments are designed to foster the acquisition of skills, building positive social behavior and interpersonal competence, greater independence and personal choice. Services are furnished consistent with the member's person-centered plan. Meals provided as part of these services shall not constitute a "full nutritional regimen" (three meals per day).

Day habilitation services focus on enabling the member to attain or maintain the member's maximum potential and shall be coordinated with any needed therapies in the member's person-centered services and supports plan, such as physical, occupational, or speech therapy.

Day habilitation may be furnished in any of a variety of settings in the community other than the member's private residence. Day habilitation services are not limited to fixed-site facilities.

Day habilitation is:

- Delivered in accordance with an approved comprehensive service plan which specifically identifies the specific skills, training, and assistance to be provided, and the amount and frequency with which it will be provided.
- Coordinated with any needed therapies in the member's comprehensive service plan, such as physical therapy, occupational therapy or speech therapy.
- The provision of regularly scheduled activities in a non-residential setting, separate from the member's private residence, sleeping accommodations or other residential living arrangement.
- Face-to-face skill development training and supports, such as:
  - Assistance with the acquisition, retention or improvement of self-help;
  - Socialization and adaptive skills that enhance activities of daily living; and
  - Social development and community participation.
- An organized program of activities designed to foster the acquisition of skills, building positive social behavior and interpersonal competence, greater independence, and personal choice.
- Designed and delivered in a manner that is individualized and focused on enabling the member to attain or maintain the member's maximum potential.
- Provided documents in accordance with 441 IAC Chapters 77, 78, and 79.

Exclusions:

- Day habilitation services shall not be provided in the member's home, except as provided in paragraph *"b"* of 441 IAC 78.14(41). For this purpose, services provided in a residential care facility where the member lives are not considered to be provided in the member's home when services are provided outside of the member's sleeping unit.
- Services shall not include vocational or prevocational services and shall not involve paid work.
- Services shall not duplicate or replace education or related services defined in Public Law 94-142, the Education of the Handicapped Act.
- Services shall not be provided simultaneously with other Medicaid-funded services.

- Supervision or protective oversight.
- Indirect services such as meetings, documentation or collateral contacts.
- Day habilitation may not be provided to members under the age of 16.

Day habilitation is not allowable for:

- Providers who do not meet the provider qualifications for day habilitation due to a lack of accreditation from the Department of Human Services under 441 Chapter 24 to provide day treatment, the Commission on Accreditation of Rehabilitation Facilities (CARF), or the Council on Quality and Leadership (the Council).
- Instances when a provider is not providing for, and delivering an organized program of, skill development in accordance with the member's comprehensive service plan developed by the case manager.
- Activities which do not meet the Medicaid definition for day habilitation, including supervision and time, while the member is asleep and not participating in day habilitation services, as defined in the IAC.
- Services that are delivered in the member's sleeping room or in the hallways of the RCF.
- Insufficient or non-existent documentation to support the amount of time billed to Medicaid.

EXCEPTION: Family training option. Day habilitation services may include training families in treatment and support methodologies or in the care and use of equipment. Family training may be provided in the member's home.

12. Environmental Modification and Adaptive Devices

Legal reference:

Waiver Type	Corresponding Iowa Administrative Code
Children's mental health	441 IAC 78.52(2)

Environmental modifications and adaptive devices include items installed or used within the member's home that address specific, documented health, mental health, or safety concerns.

For each unit of service provided, the case manager or integrated health home shall maintain in the member's case file a signed statement from a mental health professional on the member's interdisciplinary team that the service has a direct relationship to the member's diagnosis of serious emotional disturbance.

13. Family and Community Support Services

Legal reference:

Waiver Type	**Corresponding Iowa Administrative Code**
Children's mental health	441 IAC 78.52(3)

Family and community support services shall support the member and the member's family by the development and implementation of strategies and interventions that will result in the reduction of stress and depression and will increase the member's and the family's social and emotional strength.

Dependent on the needs of the member and the member's family members individually or collectively, family and community support services may be provided to the member, to the member's family members, or to the member and the family members as a family unit.

Family and community support services shall be provided under the recommendation and direction of a mental health professional who is a member of the member's interdisciplinary team.

Family and community support services shall incorporate recommended support interventions, which may include the following:

- Developing and maintaining a crisis support network for the member and for the member's family
- Modeling and coaching effective coping strategies for the member's family
- Building resilience to the stigma of serious emotional disturbance for the member and the family
- Reducing the stigma of serious emotional disturbance by the development of relationships with peers and community members
- Modeling and coaching the strategies and interventions identified in the member's crisis intervention plan as defined in 441 IAC 24.1(225C) for life situations with the member's family and in the community

- Developing medication management skills
- Developing personal hygiene and grooming skills that contributes to the member's positive self-image
- Developing positive socialization and citizenship skills

Family and community support services may include an amount not to exceed the upper limit per 441 IAC 79.1(15)"b"(8) per member per year limit in rule for transportation within the community and purchase of therapeutic resources. Therapeutic resources may include books, training materials, and visual or audio media.

- The interdisciplinary team must have identified the transportation or therapeutic resource as a support need and included it in the case manager's plan.
- The annual amount available for transportation and therapeutic resources must be listed in the member's service plan.
- The member's parent or legal guardian shall submit a signed statement that the transportation or therapeutic resource cannot be provided by the member or the member's family or legal guardian.
- The member's Medicaid case manager or integrated health home shall maintain a signed statement that potential community resources are unavailable and shall list the community resources contacted to fund the transportation or therapeutic resource.
- The transportation or therapeutic resource must not be otherwise eligible for Medicaid reimbursement.

The following components are specifically excluded from family and community support services:

- Vocational services
- Prevocational services
- Supported employment services
- Room and board
- Academic services
- General supervision and member care

14. Family Counseling and Training

Legal reference:

Waiver Type	**Corresponding Iowa Administrative Code**
Brain injury	441 IAC 78.43(10)

Family counseling and training services are face-to-face mental health services provided to the member and the family with whom the member lives (or who routinely provides care to the member) to increase the member's or family members' capabilities to maintain and care for the member in the community.

Family counseling and training may be provided by:

- Community mental health centers
- Hospices (licensed or certified under Medicare)
- Accredited mental health service providers
- Qualified brain injury professionals

"Family" may include spouse, children, friends, or in-laws of the member. It does not include people who are employed to care for the member.

Counseling may include the use of treatment regimens as specified in the individual treatment plan. Periodic training updates may be necessary to safely maintain the member in the community.

Counseling may include helping the member or family members with:

- Crisis
- Coping strategies
- Stress reduction
- Management of depression
- Alleviation of psychosocial isolation
- Support in coping with the effects of a brain injury

Iowa Department of Human Services

Financial Management Service Agreement

_____ agrees to be an
(Name of banking institution or credit union)

Organized Health Care Delivery System Medicaid provider and a provider of Financial Management Services (FMS) for the Iowa Medicaid Enterprise.

_____ agrees to be the
(Name of banking institution or credit union)

Vendor Fiscal/Employer Agent for Consumer Choices Option consumers and legal guardians, as applicable, who are the common law employers of the support service workers they hire directly. As a Vendor Fiscal/Employer Agent operating under section 3504 of the IRS code and Revenue Procedures 70-6 and 2003-70,

_____ agrees to perform
(Name of banking institution or credit union)

the following tasks:

- Establish and manage consumers' directly hired service workers' and FMS documents and files.
- Provide monthly and quarterly status reports for the Department and for consumers, legal guardians, and their individual supports broker that include a summary of expenditures paid and amounts of budgets unused.
- Assist consumers and legal guardians in understanding their fiscal and payroll related responsibilities.
- Assist consumers and legal guardians in completing required federal and state tax and insurance forms.
- Assist consumers and legal guardians in collecting and submitting criminal background, adult and child abuse waivers on potential employees to the Medicaid Department and maintain copies of relevant documentation.
- Assist consumers in verifying directly hired service workers' citizenship or alien status and maintain copies of relevant documentation.
- Prepare and disburses payroll for consumers or their legal guardians who hire support service workers directly. Key employer-related tasks include:
    - Verifying that directly hired support service workers' hourly wages are in compliance with federal and state Department of Labor rules;
    - Collecting, verifying, processing, maintaining copies, and monitoring directly hired support services workers' time sheets to assure it matches the consumer's written individual budget;

- Withholding, filing and paying federal Medicare and Social Security (FICA), federal (FUTA) and federal income tax withholding, and state income tax withholding and state (SUTA) unemployment insurance taxes;
- Computing and processing other benefits, as applicable;
- Preparing and issuing service workers' payroll checks;
- Refunding over collected FICA, when appropriate, to directly hired support service workers and the State (employer portion of over collected FICA);
- Processing all judgments, garnishments, tax levies, or any related holds on directly hired support service workers' pay as may be required by federal, state or local laws, as applicable; and
- Prepare and disburse IRS Forms W-2 and W-3 annually.

♦ Assist consumers and legal guardians in obtaining and renewing worker's compensation insurance policies and paying premiums, as required.

♦ Process and pay invoices for approved goods and services included in the consumers' written individual budgets, maintain documentation and monitor that payments are reflected in the consumer's written individual budget.

♦ Make sure all payments made to directly hired support service workers and vendors that are returned to the FMS provider for any reason are processed in accordance with Iowa State's Abandoned Property Law.

♦ Assist in implementing the State's quality management strategy related to FMS.

♦ Establish an accessible customer service system and communication path for the consumer and the individual support broker.

♦ Provide real time individual budget account balances, at a minimum during normal business hours (9 am – 5 pm, Monday – Friday).

♦ Have the ability to interface with the tracking system chosen by the Iowa Department of Human Services.

As a condition of providing services under this agreement the directly hired support service worker agrees to the following:

♦ The directly hired support service worker of the consumer understands and acknowledges that the consumer or the consumer's guardian (indicate by inserting the person's name and title here _____) is the common law employer.

♦ The directly hired support service worker of the consumer understands and acknowledges that neither the Iowa Medicaid Enterprise nor the Financial Management Service organization is the common law employer and are not responsible for the actions of the common law employer, the consumer, or the legal guardian.

♦ The directly hired support service worker of the consumer or legal guardian understands and acknowledges that funds available for payment are authorized on the consumer's individual budget by the Iowa Department of Human Services, Iowa Medicaid Enterprise, in advance for work performed.

- The directly hired support service worker of the consumer or legal guardian understands and acknowledges that work performed in excess of the authorized amount on the consumer's individual budget will be paid for by the personal funds of the common law employer and not by the Iowa Department of Human Services, Iowa Medicaid Enterprise or the Financial Management Service organization.
- The directly hired support service worker of the consumer or legal guardian meets the necessary skills and requirements to be able to perform the services hired to perform.
- The directly hired support service worker of the consumer or legal guardian is able to successfully communicate with the common law employer (the consumer or legal guardian).
- The directly hired support service worker of the consumer or legal guardian, if providing self-directed personal care services, is sixteen years of age or older. (Employee under the age of eighteen must have a parent co-sign this agreement.)
- The directly hired support service worker of the consumer or legal guardian, if providing the independent support broker service or providing self-directed community supports and employment services, is eighteen years of age or older.
- The directly hired support service worker understands and acknowledges that employees without a valid driver's license may not transport individuals in connection with their employment responsibilities.
- The directly hired support service worker understands and acknowledges that all documents required by the Employment Packet, including the request to obtain a criminal record check and adult and child abuse registry information, must be completed, submitted to and processed by the FMS prior to the employee performing work.
- The directly hired support service worker understands and acknowledges that the results of the criminal record and adult and child abuse registry must be obtained prior to the employee performing work. The FMS will notify the common law employer when this has been obtained.
- The directly hired support service worker agrees to sign and submit to the common law employer (the consumer or legal guardian, as appropriate) a bi-weekly accurate time sheet of all services rendered including the type of service rendered, the date, and the number of services hours delivered (to the nearest quarter hour). Both the common law employer and the employee must sign time sheets. Time sheets need to be submitted to the FMS within five business days from the end of the payroll cycle. Time sheets received after five business days will be paid with the next payroll cycle. Time sheets received after 30 days of the last day of service provided will not be paid. Incorrect time sheets will be returned and will need to be corrected before a paycheck is issued.
- The funds used to pay the directly hired support service worker are Medicaid funds and submission of false information on time sheets may subject the directly hired support service worker to criminal action, in addition to repayment of any funds.

- The directly hired support service worker agrees that Federal income tax withholding, Medicare, Social Security and Iowa State income tax withholding (as applicable) shall be withdrawn from the directly hired support service worker's wages per state and federal laws by the FMS.
- The directly hired support service worker agrees to provide the service as specified by the common law employer (the consumer or legal guardian, as appropriate) on a schedule mutually agreed upon between the common law employer and the employee. Occasional variations in tasks and in the schedule may occur, based on mutual agreement of the parties.
- In the event of illness, emergency or incident preventing the directly hired support service worker from providing scheduled services to the common law employer (the participant or the legal guardian, as appropriate), the directly hired support service worker agrees to notify the common law employer as soon as possible so that the common law employer can obtain their services from someone else.
- The directly hired support service worker agrees to participate in training if required by the common law employer.
- The directly hired support service worker agrees to maintain all information regarding the common law employer in a confidential manner and to respect the common law employer's privacy at all times.

By signing below, the directly hired support service worker certifies that the directly hired support service worker has read and understand the information presented in this agreement and agrees to be bound by the terms of this agreement.

_____ _____
Banking institution or credit union authorized representative Date

_____ _____
Employee of the consumer Date

This form is part of the Employment Packet and must be completed by each hired employee and sent to the FMS with all required paperwork before work can begin.

15. Financial Management Service

Legal reference:

Waiver Type	**Corresponding Iowa Administrative Code**
AIDS	441 IAC 78.38(9)"l"
Brain injury	441 IAC 78.43(15)"l"
Elderly	441 IAC 78.37(16)"l"
Health and disability	441 IAC 78.34(13)"l"
Intellectual disability	441 IAC 78.41(15)"l"
Physical disability	441 IAC 78.46(6)"l"

Members who elect the consumer choices option shall work with a financial institution that meets the following qualifications.

The financial institution shall either:

- Be cooperative, nonprofit, member-owned and member-controlled, and federally insured through and chartered by either the National Credit Union Administration (NCUA) or the Credit Union Division of the Iowa Department of Commerce; or
- Be chartered by the Office of the Comptroller of the Currency, a bureau of the U.S. Department of the Treasury, and insured by the Federal Deposit Insurance Corporation (FDIC).

The financial institution shall complete a financial management readiness review and certification conducted by the Department or its designee.

The financial institution shall obtain an Internal Revenue Service federal employee identification number dedicated to the financial management service.

The financial institution shall enroll as a Medicaid provider.

Before initiation of a consumer choices option service, the member and the employee must enter the designated financial institution on form 470-4428, *Financial Management Service Agreement*. Click here to view the form online.

The financial management service shall perform all of the following services:

- Receive Medicaid funds in an electronic transfer
- Process and pay invoices for approved goods and services included in the individual budget
- Enter the individual budget into the Web-based tracking system chosen by the Department and enter expenditures as they are paid
- Provide real-time individual budget account balances for the member, the independent support broker, and the Department, available at a minimum during normal business hours (9 a.m. to 5 p.m., Monday through Friday)
- Conduct criminal background checks on potential employees pursuant to 441 IAC Chapter 119
- Verify for the member an employee's citizenship or alien status
- Assist the member with fiscal and payroll-related responsibilities, including but not limited to:
  - Verifying that hourly wages comply with federal and state labor rules.
  - Collecting and processing timecards.
  - Withholding, filing, and paying federal, state, and local income taxes, Medicare and Social Security (FICA) taxes, and federal (FUTA) and state (SUTA) unemployment and disability insurance taxes, as applicable.
  - Computing and processing other withholdings, as applicable.
  - Processing all judgments, garnishments, tax levies, or other withholding on an employee's pay as may be required by federal, state, or local laws.
  - Preparing and issuing employee payroll checks.
  - Preparing and disbursing IRS forms W-2 and W-3 annually.
  - Processing federal advance earned income tax credit for eligible employees.
  - Refunding over-collected FICA, when appropriate.
  - Refunding over-collected FUTA, when appropriate.

- Assisting the member in completing required federal, state, and local tax and insurance forms.
- Establishing and managing documents and files for the member and the member's employees.
- Monitoring timecards, receipts, and invoices to ensure that they are consistent with the individual budget.
- Keeping records of all timecards and invoices for each member for a total of five years.
- Providing to the Department, the independent support broker, and the member monthly and quarterly status reports that include a summary of expenditures paid and amount of budget unused.
- Establishing an accessible customer service system and a method of communication for the member and the independent support broker that includes alternative communication formats.
- Establishing a customer services complaint reporting system.
- Developing a policy and procedures manual that is current with state and federal regulations and update as necessary.
- Developing a business continuity plan in the case of emergencies and natural disasters.
- Providing to the Department an annual independent audit of the financial management service.
- Assisting in implementing the state's quality management strategy related to the financial management service.

16. Home and Vehicle Modification

Legal reference:

Waiver Type	Corresponding Iowa Administrative Code
Brain injury	441 IAC 78.43(5)
Elderly	441 IAC 78.37(9)
Health and disability	441 IAC 78.34(9)
Intellectual disability	441 IAC 78.41(4)
Physical disability	441 IAC 78.46(2)

Covered home and vehicle modifications are those physical modifications to the member's home or vehicle that directly address the member's medical or remedial need. Covered modifications must be necessary to provide for the health, welfare, or safety of the member and enable the member to function with greater independence in the home or vehicle.

Modifications that are necessary or desirable without regard to the member's medical or remedial need and that would be expected to increase the fair market value of the home or vehicle are excluded except as specifically included below. (Examples include furnaces, fencing, roof repair, or adding square footage to the residence.) Repairs are also excluded.

Only the following modifications are covered:

- Kitchen counters, sink space, cabinets, and special adaptations to refrigerators, stoves, and ovens
- Bathtubs and toilets to accommodate transfer, special handles and hoses for showerhead, water faucet controls, and accessible showers and sinks
- Ramps, lifts, turnaround space adaptations, grab bars and handrails, new door openings, pocket doors, and widening of doors, halls, and windows
- Modification of existing stairs to widen, lower, raise, or enclose open stairs
- Low-pile carpeting or slip-resistant flooring and exterior hard-surface pathways
- Vehicle lifts, driver-specific adaptations, remote-start systems, including such modifications already installed in a vehicle
- Heightening of existing garage door opening to accommodate modified van
- Keyless entry systems, automatic opening device for home or vehicle door, specialized doorknobs and handles, and special door and window locks
- Fire safety alarm equipment specific for disability
- Voice-activated, sound-activated, light-activated, motion-activated, and electronic devices directly related to the member's disability
- Telecommunications device for the deaf
- Plexiglas replacement for glass windows
- Installation or relocation of controls, outlets, switches, or motion detectors
- Air conditioning and air filtering, if medically necessary

Services shall be included in the member's service plan and shall exceed the Medicaid state plan services. Services shall be performed following prior Department approval of the modification as specified in 441 IAC 79.1(17) and a binding contract between the provider and the member. Service payment is made to the provider following the completion of the approved modifications. All modifications and adaptations must be in accordance with applicable federal, state, and local building and vehicle codes.

Annual limits for home and vehicle modifications may be located in 441 IAC 79.1(2).

All contracts for home or vehicle modification shall be awarded through competitive bidding. The contract shall include:

- The scope of work to be performed,
- The time involved,
- Supplies needed,
- The cost,
- Diagrams of the project whenever applicable, and
- An assurance that the provider has liability and workers' compensation coverage and the applicable permit and license.

The case manager shall submit the certificate of medical necessity, the service plan and the contract, invoice or quotations from the providers to the Iowa Medicaid Enterprise for prior approval before the modification is initiated or the equipment is purchased. Payment shall not be approved for duplicate items.

Whenever possible, three itemized bids for the modification or quotations for equipment purchase shall be presented for review. The amount payable shall be based on the least expensive item that meets the member's medical needs.

Service payment shall be made to the enrolled home or vehicle modification provider. If applicable, payment will be forwarded to the subcontracting agency by the enrolled home or vehicle modification provider following completion of the approved modifications. Payment may be made to certified providers upon satisfactory completion of the service.

Effective July 1, 2014, the amount of approved home and vehicle modification does not add into the monthly waiver maximum. Encumberment no longer applies.

17. Home-Delivered Meals

Legal reference:

Waiver Type	Corresponding Iowa Administrative Code
AIDS	441 IAC 78.38(6)
Elderly	441 IAC 78.37(8)
Health and disability	441 IAC 78.34(11)

Home-delivered meals means meals prepared elsewhere and delivered to a member at the member's residence.

Each meal shall ensure the member receives a minimum of one-third of the daily-recommended dietary allowance, as established by the Food and Nutrition Board of the National Research Council of the National Academy of Sciences. The meal may also be a liquid supplement that meets the minimum one-third standard. A maximum of 2 meals per day or 14 meals per week is allowed.

For billing purposes, meals are broken down as follows:

- Morning meal
- Noon meal
- Evening meal
- Liquid supplement

18. Home Health Aide

Legal reference:

Waiver Type	Corresponding Iowa Administrative Code
AIDS	441 IAC 78.38(2)
Elderly	441 IAC 78.37(3)
Health and disability	441 IAC 78.34(2)
Intellectual disability	441 IAC 78.41(6)

Home health aide services are unskilled medical services that provide direct personal care. This service may include:

- Observation and reporting of physical or emotional needs.
- Assistance with bathing, shampooing (including pediculosis shampooing), or oral hygiene.
- Assistance with toileting.

- Assistance with ambulation.
- Helping a member in and out of bed.
- Re-establishing activities of daily living (including range of motion exercises).
- Assisting with oral medications ordinarily self-administered and ordered by a physician (including application of medicinal skin cream).
- In order to complete a full unit of service, performing incidental household services that are essential to the member's health care at home and necessary to prevent or postpone institutionalization.
- For the HD waiver, accompanying a member to medical services or transport to and from school.

Home health aide daily care may be provided for members who are employed or attending school whose disabling conditions require them to be assisted with morning and evening activities of daily living. Services are to be provided in the home.

Home health services **do not** include:

- Homemaker services, such as cooking and cleaning.
- Services that meet the intermittent guidelines under Medicaid.
- Services that are provided under the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) authority.
- Assistance with homework assignments.

Services may not duplicate any regular Medicaid or waiver services provided under the state plan.

Home health aide services are available to members under the age of 21 through Care for Kids (EPSDT). For members aged 21 or over, the waiver provides coverage for home health aide services that are needed beyond the intermittent home health aide services available through regular Medicaid.

"Intermittent" home health aide services may include up to 28 hours of service per week when services are medically necessary. Intermittent home health aide services must be accessed before waiver home health aide services.

For the **HD** waiver, a nurse may provide home health services in some cases if the health of the member is such that either:

- The agency is unable to place an aide in that situation due to limitations by state law, or
- The agency's Medicare certification requirements prohibit the aide from providing the service.

It is not permitted for the convenience of the provider.

For the **ID and BI** waiver, waiver home health aide services must exceed those activities provided under supported community living. Instruction, supervision, support, or assistance in personal hygiene, bathing, and daily living are activities provided under supported community living.

19. Homemaker Service

Legal reference:

Waiver Type	**Corresponding Iowa Administrative Code**
AIDS	441 IAC 78.38(3)
Elderly	441 IAC 78.37(4)
Health and disability	441 IAC 78.34(1)

Homemaker services are those services provided when the member lives alone or when the person who usually performs these functions for the member needs assistance with performing the functions. (The person who usually performs these functions for the member may be incapacitated or be occupied providing direct care to the member.)

Components of the service are directly related to the care of the member and include only the following:

- Shopping for basic needs items such as food, clothing or personal care items, or drugs
- Maintenance cleaning such as vacuuming, dusting, scrubbing floors, defrosting refrigerators, cleaning stoves, cleaning medical equipment, washing and mending clothes, washing personal items used by the member, and washing dishes
- Planning and preparing balanced meals

Iowa Department of Human Services

Independent Support Broker Agreement

_____ agrees to be an independent support broker for
Independent Support Broker

_____ who is participating in the Consumer Choices Option.
Consumer

The independent support broker acknowledges that they are not the consumers' guardian, conservator, attorney in fact under durable power of attorney for health care, power of attorney for financial matters, trustee or representative payee. The independent support broker further acknowledges that they shall not be paid for any other service to the consumer and that they shall not work for an individual or entity that is providing services to the consumer.

The independent support broker agrees to perform the following services:

- Assists the consumer with developing the consumers' initial and subsequent individual budgets and with making any changes to the individual budget.
- Have monthly contact with the consumer for the first four months of implementation of the individual budget and have quarterly contract thereafter.
- Assist with interviewing potential employees and entities providing services and supports if requested by the consumer.
- Assist the consumer with determining whether a potential employee meets the qualifications necessary to perform the job.
- Assist the consumer with obtaining signed consent from a potential employee to conduct background checks.
- Assist the consumer with negotiating with entities providing services and supports if requested by the consumer.
- Assist the consumer with contracts and payment methods for services and supports if requested by the consumer.
- Assist the consumer with developing an emergency back-up plan. The emergency back-up plan shall also address any health and safety concerns.
- Review expenditures reports from financial management services to ensure that services and supports in the individual budget are being provided.
- Document in writing on the independent support broker time card every contact the broker has with the consumer. Contact documentation shall include information on the extent, which the consumers' individual budget has addressed the consumers' needs and the satisfaction of the consumer.

Either party may terminate this agreement at anytime with or without cause. If either party terminates the agreement, the Financial Management Services and the consumers' case manager/service worker shall be immediately notified. The independent support broker will be paid an hourly rate of $_____ (not to exceed $15.00 an hour). The independent support broker will need permission from the Department of Human Services Iowa Medicaid Enterprise to provide more than 26 hours of service in a 12 month period for the consumer.

Name of Consumer	Date
Name of Independent Support Broker	Date

470-4492 (10/07)

20. Independent Support Broker

Legal reference:

Waiver Type	**Corresponding Iowa Administrative Code**
AIDS	441 IAC 78.38(9)"k"
Brain injury	441 IAC 78.43(15)"k"
Elderly	441 IAC 78.37(16)"k"
Health and disability	441 IAC 78.34(13)"k"
Intellectual disability	441 IAC 78.41(15)"k"
Physical disability	441 IAC 78.46(6)"k"

To participate in the consumer choices option, a member must select an independent support broker who meets the following qualifications:

- The broker must be at least 18 years of age.
- The broker shall not be the:
  - Member's legal representative;
  - Member's guardian, conservator, attorney-in-fact under a durable power of attorney for health care;
  - Power of attorney for financial matters, trustee, or representative payee.
- The broker shall not provide any other paid service to the member.
- The broker shall not work for an individual or entity that is providing services to the member.
- The broker must consent to a criminal background check and child and dependent adult abuse checks. The results shall be provided to the member.
- The broker must complete an independent support brokerage certification approved by the Department.
- The member (and the member's personal representative, if any) and the independent support broker must complete form 470-4492, *Consumer Choices Option Independent Support Broker Agreement*, to formalize the terms of the relationship. Click here to access the form online.

The independent support broker shall perform the following services as directed by the member or the member's representative:

- Assist the member with developing the member's initial and subsequent individual budgets and with making any changes to the individual budget.
- Have monthly contact with the member for the first four months of implementation of the initial individual budget and have quarterly contact thereafter.
- Complete the required employment packet with the financial management service.
- Assist with interviewing potential employees and entities providing services and supports if requested by the member.
- Assist the member with determining whether a potential employee meets the qualifications necessary to perform the job.
- Assist the member with obtaining a signed consent from a potential employee to conduct background checks if requested by the member.
- Assist the member with negotiating with entities providing services and supports if requested by the member.
- Assist the member with contracts and payment methods for services and supports if requested by the member.
- Assist the member with developing an emergency backup plan. The emergency backup plan shall address any health and safety concerns.
- Review expenditure reports from the financial management service to ensure that services and supports in the individual budget are being provided.
- Document in writing on the independent support broker timecard every contact the broker has with the member. Contact documentation shall include information on the extent to which the member's individual budget has addressed the member's needs and the satisfaction of the member.

The unit of service for the independent support broker is one hour. The payment rate may be negotiated between the member and the broker. The independent support broker may be compensated for up to six hours of service for assisting with the implementation of the initial individual budget. The independent support broker shall not be paid for more than 30 hours of service during a 12-month period without prior approval by the Department.

21. Individual-Directed Goods and Services

Legal reference:

Waiver Type	**Corresponding Iowa Administrative Code**
AIDS	441 IAC 78.38(9)"d"
Brain injury	441 IAC 78.43(15)"d"
Elderly	441 IAC 78.37(16)"d"
Health and disability	441 IAC 78.34(13)"d"
Intellectual disability	441 IAC 78.41(15)"d"
Physical disability	441 IAC 78.46(6)"d"

Covered individual directed goods and services are services, equipment or supplies that meet the following requirements:

- The item or service addresses an assessed need or goal identified in the member's service plan.
- The item or service is not otherwise provided through the Medicaid program and is not available through another source.
- The item or service is provided to the member or is directed exclusively toward the benefit of the member.
- The item or service can be accommodated within the member's budget without compromising the member's health and safety.
- The item or service increases the member's independence or substitutes for human assistance, to the extent the expenditures would otherwise be made for that human assistance.
- The item or service promotes opportunities for community living and inclusion.
- The item or service is the least costly to meet the member's needs.

These items or services would primarily be purchased from a community business.

The following are examples of services, equipment or supplies that a member may purchase under individual-directed services and supports:

- Appliances that promote or enhance independence such as shower chairs, dressing devices, special tooth brush, etc.
- Assistive devices such as a microwave oven or special utensils for meals.
- Bus passes, taxi fare, or other transportation services.
- Chore services or handyman services, including heavy cleaning, snow removal, and lawn care.
- Cleaning services from firms or individuals.
- Cooking services or delivery of prepared foods.
- Employee advertising and background checks for potential employees.
- Errand services to assist with banking, shopping or other types of routine tasks, or gas money to have a friend pick up groceries.
- Home modifications such as ramps and grab bars and installation of visual or tactile alarms or wander alarms.
- Laundry services from a laundromat or cleaners.
- Medical equipment not covered by the Medicaid state plan.
- Training that enables the member's employees to deliver services with high levels of quality. Training may be purchased from a variety of sources.
- Vehicle modifications.

Excluded Services

Costs of the following items and services shall **not** be covered by the individual budget:

- Child care services
- Clothing not related to an assessed medical need
- Conference, meeting or similar venue expenses other than the costs of approved services the member needs while attending the conference, meeting or similar venue
- Costs associated with shipping items to the member

- Experimental and non-FDA-approved medications, therapies, or treatments
- Goods or services covered by other Medicaid programs
- Home furnishings such as comforters, linens, or drapes
- Home repairs or home maintenance
- Homeopathic treatments
- Insurance premiums or copayments of any kind, including home insurance, vehicle insurance, etc.
- Items purchased on installment payments
- Motorized vehicles
- Nutritional supplements such as vitamins or herbal supplements
- Personal entertainment items
- Repairs and maintenance of motor vehicles
- Room and board, including rent or mortgage payments
- School tuition
- Service animals
- Services covered by third parties or services that are the responsibility of a non-Medicaid program
- Sheltered workshop services
- Social or recreational purchases not related to an assessed need or goal identified in the member's service plan
- Vacation expenses, other than the costs of approved services the member needs while on vacation

22. In-Home Family Therapy Services

Legal reference:

Waiver Type	Corresponding Iowa Administrative Code
Children's mental health	441 IAC 78.52(4)

In-home family therapy provides skilled therapeutic services to the member and family that will increase their ability to cope with the effects of serious emotional disturbance on the family unit and the familial relationships. The service must support the family by the development of coping strategies that will enable the member to continue living within the family environment.

The goal of in-home family therapy is to maintain a cohesive family unit. In-home family therapy is exclusive of and cannot serve as a substitute for individual therapy, family therapy, or other mental health therapy that may be obtained through the Iowa Plan or other funding sources.

23. Interim Medical Monitoring and Treatment

Legal reference:

Waiver Type	Corresponding Iowa Administrative Code
Brain injury	441 IAC 78.43(14)
Health and disability	441 IAC 78.34(8)
Intellectual disability	441 IAC 78.41(9)

Interim medical monitoring and treatment services are monitoring and treatment of a medical nature requiring specially trained caregivers.

These services:

- Provide experiences for each member's social, emotional, intellectual, and physical development.
- Include developmental care and any special services for a member with special needs.
- Include medical assessment, medical monitoring, and medical intervention as needed on a regular or emergency basis.
- May include supervision during transportation to and from school if not available through other sources.
- Services may not duplicate any regular Medicaid or waiver services provided under the state plan. They may be provided only:
  - In the member's home,
  - In a registered child development home,
  - In a licensed child care center, or
  - During transportation to and from school.

Services can be used only during the following circumstances for the usual caregiver:

- Employment
- Search for employment
- Academic or vocational training
- Hospitalization for physical or mental illness
- Death

When the usual caregiver is experiencing physical or mental illness, document in the case file whether the usual caregiver is unable to care for the child. Base this determination on the usual caregiver's plan of care and on the risk factors to the member if the parent were supervising the member during this time.

The staff-to-member ratio shall not be less than one to six. A maximum of 12 hours of service is available per day.

24. Mental Health Outreach

Legal reference:

Waiver Type	Corresponding Iowa Administrative Code
Elderly	441 IAC 78.37(10)

Mental health outreach services are services provided in a member's home to identify, evaluate, and provide treatment and psychosocial support. The services can be provided only on the basis of a referral from the member's interdisciplinary team.

NOTE: Members enrolled in the Iowa Plan for Behavioral Health should access these services through the Iowa Plan and not the waiver.

25. Nursing Care

Legal reference:

Waiver Type	Corresponding Iowa Administrative Code
AIDS	441 IAC 78.38(4)
Elderly	441 IAC 78.37(5)
Health and disability	441 IAC 78.34(4)
Intellectual disability	441 IAC 78.41(5)

Nursing care services are services provided by licensed agency nurses to members in the home that are ordered by and included in the plan of treatment established by the physician.

The services must be reasonable and necessary to the treatment of an illness or injury. Services should be based on medical necessity of the member and included in the Iowa Board of Nursing scope of practice guidelines. Providers must be home health agencies certified under Medicare. "Intermittent" nursing services are available under the state Medicaid plan when services are medically necessary.

NOTE: State plan intermittent nursing services must be accessed before waiver nursing services.

Service Limitations

- **AIDS** and **HD**. There is no limit on the maximum visits for members at the skilled level of care.
- **Elderly**. A maximum of eight nursing visits per month can be provided for members at the intermediate level of care. There is no limit on the maximum visits for members at the skilled level of care.
- **ID**. A maximum of 10 hours of service per week is covered.

26. Nutritional Counseling

Legal reference:

Waiver Type	Corresponding Iowa Administrative Code
Elderly	441 IAC 78.37(12)
Health and disability	441 IAC 78.34(12)

Nutritional counseling services may be provided for a nutritional problem or condition of such a degree of severity that nutritional counseling beyond that normally expected as part of the standard medical management is warranted.

27. Personal Emergency Response System or Portable Locator System

Legal reference:

Waiver Type	**Corresponding Iowa Administrative Code**
Brain injury	441 IAC 78.43(6)
Elderly	441 IAC 78.37(2)
Health and disability	441 IAC 78.34(10)
Intellectual disability	441 IAC 78.41(3)
Physical disability	441 IAC 78.46(3)

The personal emergency response system allows a member experiencing a medical emergency at home to activate electronic components that transmit a coded signal via digital equipment over telephone lines to a central monitoring station. The necessary components of a system are:

- An in-home medical communications transceiver;
- A remote, portable activator;
- A central monitoring station with backup systems staffed by trained attendants 24 hours per day, seven days per week; and
- Current data files at the central monitoring station containing response protocols and personal, medical, and emergency information for each member.

A portable locator system is an electronic device that transmits a signal to a monitoring device. The system allows a member to access assistance in the event of an emergency and allows law enforcement or the monitoring system provider to locate a member who is unable to request help or to activate a system independently.

The member must be unable to access assistance in an emergency situation due to the member's age or disability. The required components of the portable locator system shall be identified in the member's service plan. Payable units of service are purchase of equipment, an installation or set-up fee, and monthly fees. Maximum units per state fiscal year shall be one equipment purchase, one installation or set-up fee, and 12 months of service.

28. Prevocational Services

Legal reference:

Waiver Type	**Corresponding Iowa Administrative Code**
Brain injury	441 IAC 78.43(11)
Intellectual disability	441 IAC 78.41(13)

Prevocational services are services that provide learning and work experiences, including volunteer work, where the member can develop general, non-job-task-specific strengths and skills that contribute to employability in paid employment in integrated community settings. Services are expected to occur over a defined period of time and with specific outcomes to be achieved, as determined by the member and the member's service and supports planning team through an ongoing person-centered planning process.

Members receiving prevocational services must have employment-related goals in their person-centered services and supports plan. The general habilitation activities must be designed to support such employment goals. Competitive, integrated employment in the community for which a member is compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities, is considered to be the optimal outcome of prevocational services.

Prevocational services should enable each individual to attain the highest level of work in the most integrated setting and with the job matched to the member's interests, strengths, priorities, abilities, and capabilities, while following applicable federal wage guidelines.

Services are intended to develop and teach general skills. Examples include, but are not limited to:

- Ability to communicate effectively with supervisors, co-workers and customers;
- Generally accepted community workplace conduct and dress;
- Ability to follow directions;
- Ability to attend to tasks;
- Workplace problem solving skills and strategies;
- General workplace safety; and
- Mobility training.

Participation in prevocational services is not a required prerequisite for individual or small group supported employment services provided under the waiver. Many members, particularly those transitioning from school to adult activities, are likely to choose to go directly into supported employment. Similarly, the evidence-based Individual Placement and Support (IPS) model of supported employment for members with behavioral health conditions emphasizes rapid job placement in lieu of prevocational services.

Prevocational services may be furnished in any of a variety of settings in the community other than the member's private residence, the provider administrative offices or other settings that have the effect of isolating the member form the greater community.

Prevocational services do not include services that are otherwise available to the member through a state or local education agency or vocational rehabilitation services.

Documentation is maintained in the service plan that justifies why services are not accessed through IVRS.

29. Residential-Based Supported Community Living Services

Legal reference:

Waiver Type	Corresponding Iowa Administrative Code
Intellectual disability	441 IAC 78.41(10)

Residential-based supported community living services (RBSCL) are medical or remedial services provided to children under the age of 18 while living outside their family home. The residential-based living environment is furnished by the residential-based supported community living service provider. The services eliminate barriers to family reunification or develop self-help skills for maximum independence.

Allowable service components are the following:

- **Daily living skills development**. These services develop the child's ability to function independently in the community on a daily basis, including:
  - Training in food preparation,
  - Maintenance of living environment,
  - Time and money management,
  - Personal hygiene, and
  - Self-care.
- **Social skills development**. These services develop a child's communication and socialization skills, including:
  - Interventions to develop a child's ability to solve problems,
  - Resolve conflicts,
  - Develop appropriate relationships with others, and
  - Develop techniques for controlling behavior.
- **Family support development**. These services are necessary to allow a child to return to the child's family or another less restrictive service environment.

  These services must include counseling and therapy sessions that:
  - Involve the child with the child's family at least 50 percent of the time, and
  - Focus on techniques for dealing with the special care needs of the child and interventions needed to alleviate behaviors that are disruptive to the family or other group living unit.
- **Counseling and behavior intervention services**. These are services to halt, control, or reverse stress and social, emotional, or behavioral problems that threaten or have negatively affected the child's stability. Activities under this service component may include counseling and behavior interventions with the child, including interventions to ameliorate problem behaviors.

RBSCL must provide for the ordinary daily-living needs of the child, such as needs for safety and security, social functioning, and other medical care.

RBSCL do not include services associated with vocational needs, academics, day care, Medicaid case management, other case management, or any other services that the child can otherwise obtain through Medicaid. Room and board costs are not reimbursable as RBSCL.

The maximum number of units of RBSCL available per child is 365 daily units per state fiscal year, except in a leap year when 366 daily units are available.

30. Respite Care

Legal reference:

Waiver Type	Corresponding Iowa Administrative Code
AIDS	441 IAC 78.38(5)
Brain injury	441 IAC 78.43(3)
Children's mental health	441 IAC 78.52(5)
Elderly	441 IAC 78.37(6)
Health and disability	441 IAC 78.34(5)
Intellectual disability	441 IAC 78.41(2)

Respite care services are services provided to the member that give temporary relief to the usual caregivers and provide all the necessary care that the usual caregiver would provide during that period. The purpose of respite care is to enable members to remain in their current living situation.

Respite care is not to be provided to members during the hours in which the usual caregiver is employed except when the member is attending a 24-hour residential camp. Respite cannot be provided to a member whose usual caregiver is a consumer-directed attendant care provider or an employee paid through the Consumer Choices Option for the member.

Respite services that are not provided in a facility are divided into three types. These types have separate rates of payment based on staff-to-member ratios and member needs, as follows:

- **Basic individual respite** is respite provided on a ratio of one staff-to-one member. The member does not have specialized medical needs that require the direct services of a registered nurse or licensed practical nurse.
- **Group respite** is respite provided on a ratio of one staff-to-two or more members receiving respite. These members do not have specialized medical needs that require the direct services of a registered nurse or licensed practical nurse.

- **Specialized respite** means respite provided on a staff-to-member ratio of one-to-one or higher to members with specialized medical needs requiring the care, monitoring or supervision of a licensed registered nurse or licensed practical nurse.

The interdisciplinary team shall determine if the member will receive basic individual respite, group respite, or specialized respite as appropriate to the individual needs of the member.

Respite provided outside the member's home or the facility covered by the licensure, certification, accreditation, or contract must:

- Be approved by the parent, guardian, or primary caregiver and the interdisciplinary team.
- Be consistent with the way the location is used by the public.
- Not exceed 72 continuous hours.

A maximum of 14 consecutive days of 24-hour respite care may be reimbursed.

Services provided outside the member's home are not reimbursable if the living unit where respite is provided is reserved for another person on a temporary leave of absence. Respite services shall not be provided simultaneously with other residential, nursing, or home health aide services provided through the medical assistance program.

Under the **ID** waiver, payment for respite services shall not exceed upper annual maximums provided in 441 IAC 79.1(2) per the member's waiver year. Following is an example of how to amend the ISIS service plan to change respite. Member S has been authorized for $7,262 worth of respite dollars from January 1, 2014, to December 31, 2015. Member S has not used all of these dollars. Now Member S wants to go to respite camp in June, and Member S also needs respite through another provider to finish Member S's waiver year. Member S needs $4,000 to do this.

On June 1, 2014, the worker must reduce the dollars that were used from the first period to $3,191, providing this amount was used during the first period. The worker must contact the ISIS Help Desk to change this amount. The total amount of the respite cannot exceed the annual maximum for the ID waiver.

31. Self-Directed Community Supports and Employment

Legal reference:

Waiver Type	**Corresponding Iowa Administrative Code**
AIDS	441 IAC 78.38(9)"d"(2)
Brain injury	441 IAC 78.43(15)"d"(2)
Elderly	441 IAC 78.37(16)"d"(2)
Health and disability	441 IAC 78.34(13)"d"(2)
Intellectual disability	441 IAC 78.41(15)"d"(2)
Physical disability	441 IAC 78.46(6)"d"(2)

Self-directed community supports and employment are services that support the member in developing and maintaining independence and community integration. The following are examples of supports a member can purchase to help the member live and work in the community:

- Career counseling
- Career preparation skills development
- Cleaning skills development
- Cooking skills development
- Grooming skills development
- Job hunting and career placement
- Personal and home skills development
- Safety and emergency preparedness skills development
- Self-direction and self-advocacy skills development
- Social skills development training
- Supports to attend social activities
- Supports to maintain a job
- Time and money management
- Training on use of medical equipment
- Use of public transportation skills development
- Work place personal assistance

See Excluded Services for a list of items that may **not** be purchased as self-directed community supports and employment.

These supports are provided primarily by a member's employee. Members may purchase self-directed community supports and employment from:

- A business providing community supports and employment that has:
  - All the necessary licenses and permits to operate in conformity with federal, state, and local laws and regulations; and
  - Current liability and workers' compensation coverage, as required by law.
- An individual, including a friend or family member, who has all the necessary licenses required by federal, state, and local laws, including a valid driver's license if providing transportation.

All personnel providing self-directed community supports and employment shall:

- Be at least 18 years of age.
- Be able to communicate successfully with the member.
- Not be the recipient of respite services paid through home- and community-based services on behalf of a member who receives home- and community-based services.
- Not be the recipient of respite services paid through the consumer choices option on behalf of a member who receives the consumer choices option.
- Not be the parent or stepparent of a minor child member or the spouse of a member.

Rates and units of services are determined through negotiation between the member and the service provider as allowed within the individual budget. The provider of self-directed community supports and employment shall do the following:

- Specify the responsibilities of the employee and the member. Complete form 470-4427, *Consumer Choices Option Employment Agreement*, with the member. The form shall be completed before the services begin and again if there are any changes. Click here to access the form online.
- Establish payment arrangements with the member and the designated financial institution, and complete form 470-4428, *Financial Management Service Agreement*. Click here to access the form online.

CONSUMER CHOICES OPTION

Iowa Department of Human Services

Employment Agreement

This employment agreement is between _____
(Employer)

AND

_____
(Name of employee)

_____
(Address)

_____ _____
(Phone) (Social security number)

This document must be signed, with a copy to be kept by the employer and the employee. A copy must also be submitted with the Employment Packet to the selected credit union or bank approved to provide the Financial Management Service (hereinafter called FMS). The purpose of this agreement is to establish responsibilities of the parties to each other.

The employee has been hired to provide services to the employer. The boxes checked below identifies the services that the employee is authorized to provide at the direction of the employer. Also, below are the current rates of payment for authorized services provided by the employee.

* Please note next to rate of pay if a payment arrangement different than an hourly payment is made and what that arrangement is.

☐ Independent support broker $_____ per hr

Self-Directed Personal Care Services

☐ Cleaning services $_____ per hr

☐ Homemaking tasks $_____ per hr

☐ Laundry assistance $_____ per hr

☐ Supervision $_____ per hr

☐ Lawn care $_____ per hr

☐ Snow removal $_____ per hr

☐ Showering assistance $_____ per hr

- ☐ Medication management $_____ per hr
- ☐ Personal grooming assistance $_____ per hr
- ☐ Assistance with mobility transfers $_____ per hr
- ☐ Meal preparation $_____ per hr
- ☐ Respite $_____ per hr
- ☐ Shopping $_____ per hr
- ☐ Transportation $_____ per hr

Self-Directed Community and Employment Supports

- ☐ Self-direction and self-advocacy skills development $_____ per hr
- ☐ Training on medical equipment $_____ per hr
- ☐ Personal and home skills development $_____ per hr
- ☐ Time and money management skills development $_____ per hr
- ☐ Social skills development training $_____ per hr
- ☐ Career preparation skills $_____ per hr
- ☐ Career counseling $_____ per hr
- ☐ Job hunting/career placement $_____ per hr
- ☐ Work place personal assistance $_____ per hr
- ☐ Supports to maintain a job $_____ per hr
- ☐ Grooming skills development $_____ per hr
- ☐ Cooking skills development $_____ per hr
- ☐ Cleaning skills development $_____ per hr
- ☐ Utilization of public transportation skills development $_____ per hr
- ☐ Companionship $_____ per hr
- ☐ Supports to attend social activities $_____ per hr
- ☐ Safety and emergency preparedness skills development $_____ per hr
- ☐ Other duties/please describe*: $_____ per hr

* Please note that you may need prior approval from Medicaid to hire an employee to perform duties not included in this list.

Employee Acknowledgments

1. The employee understands and acknowledges that _____ is the employer.
   (Name of employer)

2. The employee understands and acknowledges that neither the Iowa Medicaid Enterprise, the State of Iowa nor the Financial Management Service organization is the employer and that they are not responsible for the actions of the employer.

3. The employee understands and acknowledges that funds available for payment are authorized in the employer's individual budget set by the Iowa Department of Human Services, Iowa Medicaid Enterprise in advance for work performed.

4. The employee understands and acknowledges that work performed in excess of the authorized amount in the employer's individual budget will be paid for by the personal funds of the employer and not by the Iowa Department of Human Services, Iowa Medicaid Enterprise or the Financial Management Service organization.

5. The employee understands that they are **not authorized** to work in excess of 40 hours per week. Per the Iowa Division of Labor, Iowa law only requires overtime if overtime is included in the employment agreement or contract between employer and employee.

6. The employee acknowledges that the employee meets the necessary skills and requirements to be able to perform the services hired to perform.

7. The employee acknowledges that the employee is able to successfully communicate with the employer.

8. The employee acknowledges that if the employee is providing self-directed personal care services, that the employee is sixteen years of age or older. Employees under the age of eighteen must have a parent co-sign this agreement.

9. The employee acknowledges that if the employee is providing the independent support broker service or providing self-directed community supports and employment services, that the employee is eighteen years of age or older.

10. The employee understands and acknowledges that employees without a valid driver's license may not transport individuals in connection with their employment responsibilities.

11. The employee understands and acknowledges that all documents required by the Employment Packet, including the request to obtain a criminal record check and adult and child abuse registry information, must be completed, submitted to and processed by the FMS prior to the employee performing work.

12. The employee understands and acknowledges that the results of the criminal record and adult and child abuse registry must be obtained prior to the employee performing work. The FMS will notify the employer when this has been obtained.

13. The employee will sign and submit to the employer, or the guardian or designated personal representative, a bi-weekly accurate time sheet of all services rendered including the type of service rendered, the date, and the number of service hours delivered (to the nearest quarter hour). Time sheets must be signed by both the employer and employee (or the guardian or designated personal representative). The employee acknowledges that the employee is responsible for submitting time sheets to the FMS within five business days from the end of the payroll cycle. Time sheets received after five business days will be paid with the next payroll cycle. Time sheets received after 30 days of the last day of service provided will not be paid.

14. The employee acknowledges that the funds used to pay the employee are Medicaid funds and that the submission of false information on time sheets may subject the employee to criminal action, in addition to repayment of any funds.

15. The employee acknowledges that federal income tax withholding, Medicare, social security and Iowa state income tax withholding (as applicable) shall be withdrawn from the employee's wages per state and federal laws.

16. The employee agrees to provide the service as specified by the employer on a schedule mutually agreed upon between the employer and employee. Occasional variations in tasks and in the schedule may occur, based on mutual agreement of the parties.

17. In the event of illness, emergency or incident preventing the employee from providing scheduled services to the employer, the employee agrees to notify the employer as soon as possible so that the common law employer can obtain their services from someone else.

18. The employee agrees to participate in training if required by the common law employer.

19. The employee agrees to maintain all information regarding the program participant and the common law employer, if they are not one in the same (when would they ever be different), in a confidential manner and to respect the employer's privacy at all times.

20. The employee acknowledges and understands if the employee is injured in the course of employment, neither the Iowa Medicaid Enterprise, state of Iowa, nor the Financial Management Service is responsible for paying for the injury. I also understand that it is the employer's responsibility to notify the employee if they do not have worker's compensation insurance.

Employer Acknowledgments

1. The employer understands and acknowledges that they are the employer of the support service worker.

2. The employer understands that they may not schedule their employee for more than 40 hours per week. The employer may not authorize overtime payment.

3. The employer agrees to orient and train the employee (directly hired support worker) in providing the services they are hired to perform.

4. The employer agrees to establish a list of tasks to be performed by the employee.

5. The employer agrees to establish a mutually agreeable work schedule for the employee.

6. The employer agrees to provide adequate notice of changes in the employee's work schedule in the event of unforeseen circumstances or emergencies.

7. The employer agrees to timely authorize and sign the employee's accurate time sheets.

8. The employer agrees that the employer is personally responsible for any employee wages or supports that exceed the individual budget.

9. The employer agrees that the employer is responsible for providing worker's compensation insurance, if required, and that if such insurance is not purchased, the employee will be notified. The employer understands that the cost of worker's compensation insurance can be paid from their individual budget.

Both parties acknowledge that this is an employment at will situation and that the employer has not been promised employment for a specific time period. By signing below, the employer and employee certify that they have read and understand the information presented in this agreement and agree to be bound by the terms of this agreement. The employer and employee further acknowledge that either party, with our without cause, may terminate this agreement at any time. If the agreement is terminated by either party, the FMS shall immediately be notified.

_____ _____

Employer's signature Date

If the employer has a legal guardian or has designated a representative, the guardian or representative must also sign. If the employer is a minor, the parent or guardian of the minor must also sign.

_____ _____

Employer's signature Date

_____

Parent/guardian/representative signature

_____ _____

Capacity signing in Date

_____ _____

Employee's signature Date

This form is part of the Employment Packet and must be sent to the FMS with all required paperwork before work can begin.

The following is a list of possible supports that the employee (directly hired support worker) may complete. Indicate the days the supports are to be completed and approximate number of hours to the nearest quarter hour required to complete. If necessary, there is space for you to write in additional instructions for each support. Please list any other approved tasks in the blank spaces provided.

Supports	Sun	Mon	Tues	Wed	Thurs	Fri	Sat
Cleaning services							
Homemaking							
Laundry							
Supervision							
Showering assistance							
Medication management							
Personal grooming							
Assistance with mobility transfers							
Meal preparation							
Respite							
Shopping							
Transportation							
Self directed training and self advocacy skills							
Training on medical equipment							
Personal and home skills training							

Supports	Sun	Mon	Tues	Wed	Thurs	Fri	Sat
Time and money management training							
Social skills development training							
Career preparation skills							
Activities to obtain a job							
Work place personal assistance							
Supports to maintain a job							
Grooming skills development							
Cooking skills development							
Cleaning skills development							
Utilization of public transportation							
Companionship							
Supports to attend social activities							
Safety and emergency preparedness training							

All parties may amend this agreement in writing at anytime.

_____ _____
Employer's signature Date

_____ _____
Parent/guardian/representative signature Date

_____ _____
Employee's signature Date

Employer/Medicaid number: _____

*All fields must be filled out completely or time sheet will be returned.

Consumer Choices Option
Semi-Monthly Time Sheet

Employee*: _____ Social Security number*: _____

Position*: _____ Hourly wage*: _____

Employer's first and last name*: _____

Pay period from: _____

Date*	Start Time*	End Time*	Start Time*	End Time*	Total Hours Worked*	Rate of Pay*	**SERVICE PROVIDED AND NARRATIVE*** Services provided must match service on the individual budget. Please identify in the narrative if hours worked are from the emergency back up plan or from savings. (Use more than one line if needed.)	Note any progress/changes for consumer.

Employer/Medicaid number: _____

*All fields must be filled out completely or time sheet will be returned.

Date*	Start Time*	End Time*	Start Time*	End Time*	Total Hours Worked*	Rate of Pay*	**SERVICE PROVIDED AND NARRATIVE*** Services provided must match service on the individual budget. Please identify in the narrative if hours worked are from the emergency back up plan or from savings. (Use more than one line if needed.)	Note any progress/changes for consumer.

Employer/Medicaid number: _____

*All fields must be filled out completely or time sheet will be returned.

All time recorded on the time sheets needs to be documented to the nearest quarter hour. Time sheets must be received by the Financial Management Service within 30 days of the last day of service provided. Time sheets must be submitted by the 7th/22nd days of the month to be paid by the 15th/last day of the month.

I certify that the person whose name appears on this time sheet has worked the time indicated. I understand that by signing an employee time card which contains false information about hours worked, may make me a party to Medicaid fraud and legal action could occur.

Did the employee perform the job in a respectful and courteous manner?

☐ Never ☐ Seldom ☐ Sometimes ☐ Usually ☐ Always

Comments:

In the event that my total expenses for this bi-monthly period exceeds my approved allocation, I authorize Veridian Credit Union to use any available funds from my savings in order to assure payment of this time sheet. The employer agrees that the employer is responsible for any employee wages or supports that exceed the individual budget and savings or that are not identified on the individual budget and savings.

_____
Employee's Signature

_____
Employer's Signature

_____
Date

_____
Date

- Document the services provided and the time and days when services were provided. Prepare form 470-4429, *Consumer Choices Option Semi-Monthly Time Sheet*, and have it approved by the member. Documentation must detail the amount, duration, and scope of services provided. Click here to access the form online.
- Submit the approved form 470-4429 to the financial management service within 30 days from the date when the service was provided.

32. Self-Directed Personal Care

Legal reference:

Waiver Type	Corresponding Iowa Administrative Code
AIDS	441 IAC 78.38(9)"d"(1)
Brain injury	441 IAC 78.43(15)"d"(1)
Elderly	441 IAC 78.37(16)"d"(1)
Health and disability	441 IAC 78.34(13)"d"(1)
Intellectual disability	441 IAC 78.41(15)"d"(1)
Physical disability	441 IAC 78.46(6)"d"(1)

Self-directed personal care services are services or goods that provide a range of assistance in activities of daily living and incidental activities of daily living that help the member remain in the home and community. The following are examples of services that a member may hire under self-directed personal care:

- Assistance with mobility transfers, dressing, personal grooming, and showering or bathing
- Companionship, supervision, and respite care
- Homemaking tasks, such as maintenance cleaning, laundry, meal preparation, and shopping
- Medication management
- Transportation

See Excluded Services for a list of items that may not be purchased as self-directed personal care services.

The member may purchase self-directed personal care services from:

- A business that has:
  - All the necessary licenses and permits to operate in conformity with federal, state, and local laws and regulations; and
  - Current liability and workers' compensation coverage.
- An individual, including a friend or family member, who has all the necessary licenses required by federal, state, and local laws, including a valid driver's license if providing transportation.

All personnel providing self-directed personal care services shall:

- Be at least 16 years of age.
- Be able to communicate successfully with the member.
- Not be the recipient of respite services paid through home- and community-based services on behalf of a member who receives home- and community-based services.
- Not be the recipient of respite services paid through the consumer choices option on behalf of a member who receives the consumer choices option.
- Not be the parent or stepparent of a minor child member or the spouse of a member.

Rates and units of services are determined through negotiation between the member and the service provider as allowed within the individual budget. The provider of self-directed community supports and employment shall do the following:

- Specify the responsibilities of the employee and the member. Complete form 470-4427, *Consumer Choices Option Employment Agreement*, with the member. The form shall be completed before the services begin and again if there are any changes. Click here to access the form online.
- Establish payment arrangements with the member and the designated financial institution, and complete form 470-4428, *Financial Management Service Agreement*. Click here to access the form online.

- Document the services provided and the time and days when services were provided. Prepare form 470-4429, *Consumer Choices Option Semi-Monthly Time Sheet*, and have it approved by the member. Documentation must detail the amount, duration, and scope of services provided. Click here to access the form online.
- Submit the approved form 470-4429 to the financial management service within 30 days from the date when the service was provided.

33. Senior Companion Services

Legal reference:

Waiver Type	Corresponding Iowa Administrative Code
Elderly	441 IAC 78.37(14)

Senior companion services include nonmedical care supervision, oversight, and respite services. Companions may assist with such tasks as meal preparation, laundry, shopping, and light housekeeping tasks. This service cannot provide hands-on nursing or medical care.

34. Specialized Medical Equipment

Legal reference:

Waiver Type	Corresponding Iowa Administrative Code
Brain injury	441 IAC 78.43(8)
Physical disability	441 IAC 78.46(4)

Specialized medical equipment shall include medically necessary items for personal use by a member that provide for the member's health and safety, such as:

- Electronic aids and organizers
- Medicine dispensing devices
- Communication devices
- Bath aids
- Environmental control units
- Repair and maintenance of items purchased through the waiver

Specialized medical equipment can be covered when it is:

- Identified in the member's approved service plan documented in the Individualized Services Information System (ISIS).
- Not ordinarily covered by Medicaid.
- Not funded by educational or vocational rehabilitation programs.
- Not provided by voluntary means.
- Necessary for the member's health and safety, as documented by a health care professional.

NOTE: Members may receive specialized medical equipment for a maximum yearly usage as defined in 441 IAC 79.1(2).

35. Supported Community Living Services

Legal reference:

Waiver Type	Corresponding Iowa Administrative Code
Brain injury	441 IAC 78.43(2)
Intellectual disability	441 IAC 78.41(1)

Supported community living (SCL) services are provided within the member's home and community, according to the individualized member's needs as identified in the approved service plan documented in the Individualized Services Information System (ISIS).

Services are individualized supportive services provided in a variety of community-based, integrated settings. Members may live in the home of their family or legal representative or in other types of typical community living arrangements. Members may not live in licensed medical facilities.

SCL services are intended to provide for the daily living needs of the member and shall be available on an as needed basis up to 24 hours per day. These services must:

- Be provided in the least restrictive environment possible, and
- Reflect the member's choice of living arrangement and services.

At initial enrollment the service worker, Department Qualified Intellectual Disability Professional (QIDP), case manager paid by the county without Medicaid funds, or Medicaid case manager will establish an HCBS interdisciplinary team for each member.

With the team, this person will identify the member's need for service, based on the member's needs and desires, as well as the availability and appropriateness of services.

The following criteria are used for the initial and ongoing assessments:

- Members aged 17 or under shall receive services based on development of adaptive, behavioral, or health skills.
- Service plans for members aged 20 or under must be developed or reviewed after the individual education plan (IEP) and Care for Kids (EPSDT) plan (if applicable) are developed, so as not to replace or duplicate services covered by those plans.
- Service plans for members aged 20 or under which include SCL services beyond intermittent (52 hours) will not be approved until a home health provider has made a request to cover the service through EPSDT and receives a determination of whether EPSDT is appropriate.

The service worker, Department QIDP, or Medicaid case manager must attach a written request for a variance from the maximum for intermittent SCL with a summary of services and service costs. The request must provide a rationale for requesting service beyond intermittent.

The rationale must contain sufficient information for designee of the Bureau of Long-Term Care to make a decision regarding the need for SCL beyond intermittent.

Service plans must reflect all appropriate non-waiver Medicaid services so as not to duplicate or replace these services. Services shall not be simultaneously reimbursed with other residential services, waiver respite, or Medicaid or waiver nursing or home health aide services.

Services are available at a daily rate to members living outside the home of their family, legal representative, or foster family and for whom a provider has primary responsibility for supervision or structure. A daily rate is applicable when a member has a need for 8 hours or more hours of SCL service per day as averaged over 30 days. This service shall provide supervision or structure in identified periods when another resource is not available.

Services are available at a 15-minute unit rate to members for whom a daily rate is not established. Intermittent service shall be provided from one to three hours a day for no more than four days a week.

Provider budgets shall reflect all staff-to-member ratios and shall reflect costs associated with members' specific support needs for travel and transportation, consulting, instruction, and environmental modifications and repairs, as determined necessary by the interdisciplinary team for each member.

Maintenance and room and board costs are not reimbursable.

The specific support needs must be identified in the member's service plan. The total costs of SCL services shall not exceed $1,570 per member per year. The provider must maintain records to support the expenditures.

Providers serving members for whom a daily rate is established may allocate up to $1,570 per year for member specific support needs. The member specific support needs must be identified in the member's service plan.

- Line 3290 – Other Related Transportation. (Transportation when member is in the vehicle for service plan activities)
- Line 3520 – Other Consultation/Instruction. (Expenses related to the implementation of specific service plan goals) Staff expenses can only be used to cover staff admission to activities when there are neither member nor community resources available, and there is an instructional goal for the member.
- Line 4320 – Other Equipment Repair or Purchase. (The CM is also reviewing and verifying the staffing schedule for the member on page 2 of the individual D-4. The provider must maintain records to support the expenditures.

Example: $1,570 Specific Support Needs Limit Documentation

> Transportation will be provided to allow Helen to access medical services, activities in her community, and in case of an emergency. This will include staff mileage and bus fare. Projected costs of $800 a year for member specific transportation. (Used to support line 3290)
>
> Instructional money of up to $60 will be used to purchase cookbooks needed for Helen to achieve her personal outcome and goal of learning to cook nutritious meals. (Used to support line 3520)

The maximum numbers of units available per member are as follows:

- **BI or ID**: 365 daily units per state fiscal year, except a leap year, when 366 daily units are available.
- **BI or ID**: 11,315 15-minute units per state fiscal year, except a leap year, when 11,346 15-minute units are available.

a. Service Components

The basic components of SCL service, may include, but are not limited to:

- **Personal and home skill training services** are those activities, which assist a member to develop or maintain skills for self-care, self-directness, and care of the immediate environment.
- **Individual advocacy service** is the act or process of representing a person's rights and interests in order to realize the rights to which the person is entitled and to remove barriers to meeting the person's needs.
- **Community skills training services** are activities that assist a person to develop or maintain skills and allow better participation in the community. Services must focus on the following areas as they are applicable to the person being served:
  - **Personal management skills training services** are activities that assist a member to maintain or develop skills necessary to sustain oneself in the physical environment and are essential to the management of one's personal business and property. This includes self-advocacy skills.

Examples of personal management skills include the ability to maintain a household budget, plan and prepare nutritional meals, use community resources (such as public transportation and libraries), and select foods at the grocery store.

- **Socialization** skills training services are activities, which assist a member to develop or maintain skills, which include self-awareness and self-control, social responsiveness, group participation, social amenities, and interpersonal skills.
- **Communication skills training services** are activities that assist a member to develop or maintain skills including expressive and receptive skills in verbal and nonverbal language and the functional application of acquired reading and writing skills.

♦ **Personal environment support services** are activities and expenditures provided to or on behalf of a person in the areas of personal needs in order to allow the person to function in the least restrictive environment.

♦ **Transportation services** are activities and expenditures designed to assist the member to travel from one place to another to obtain services or carry out life's activities.

♦ **Treatment services** are activities designed to assist the member to maintain or improve physiological, emotional, and behavioral functioning, and to prevent conditions that would present barriers to a member's functioning. Treatment services include physical or physiological treatment and psychotherapeutic treatment:

- **Physiological treatment** means activities, including medication regimens, designed to prevent, halt, control, relieve, or reverse symptoms or conditions that interfere with the normal functioning of the human body. These activities shall be provided by or under the supervision of a health care professional certified or licensed to provide the activity specified.
- **Psychotherapeutic treatment** means activities provided to assist a member in the identification or modification of beliefs, emotions, attitudes, or behaviors in order to maintain or improve the member's functioning in response to the physical, emotional, and social environment.

Allowable service activities do not include those associated with vocational services, academics, day care, medical services, Medicaid case management, or other case management.

b. Living Arrangements

A member may choose to live in a variety of living environments. A member may live alone, or with family, friends, other members, or staff. A member may buy or rent a house, trailer, condominium, or an apartment. A member may live in an environment owned by the member, by an agency, or by someone else. A maximum of four persons may reside in a living unit.

Group living units serving five persons must be pre-approved by the Department. Living units serving more than five members must be licensed as a residential care facility. Living units must be located at scattered sites throughout the community, with regard for community norms in geographical proximity of residences.

Members under the age of 18 living outside of the family home must live in a licensed environment.

All residential settings when members receiving HCBS waiver services must meet the following federally established criteria:

- The setting is integrated in, and facilitates the member's full access to, the greater community, including:
  - Opportunities to seek employment and work in competitive integrated settings,
  - Engage in community life,
  - Control personal resources, and
  - Receive services in the community, like individuals without disabilities;
- The setting is selected by the member among all available alternatives and identified in the person-centered service plan;
- A member's essential personal rights of privacy, dignity and respect, and freedom from coercion and restraint are protected;
- Individual initiative, autonomy, and independence in making major life choices, including but not limited to, daily activities, physical environment, and with whom to interact are optimized and not regimented; and
- Individual choice regarding services and supports, and who provides them, is facilitated.

If the residential setting is a provider-owned or controlled residential setting, the following conditions apply:

- Any modifications of the conditions (for example to address the safety needs of a member with dementia) must be supported by a specific assessed need and documented in the person-centered service plan.
- The unit or room is a specific physical place that can be owned, rented, or occupied under a legally enforceable agreement by the member receiving services, and the member has, at a minimum, the same responsibilities and protections from eviction that the tenants have under the landlord and tenant laws of the state, county, city, or other designated entity.
- Each member has privacy in the member's sleeping or living unit.
- Units have lockable entrance doors, with appropriate staff having keys to doors.
- Members share units only at the member's choice.
- Members have the freedom to furnish and decorate their sleeping or living units.
- Members have the freedom and support to control their own schedules and activities, and have access to food at any time.
- Members are able to have visitors of their choosing at any time.
- The setting is physically accessible to the member.

36. Supported Employment Services

Legal reference:

Waiver Type	**Corresponding Iowa Administrative Code**
Brain injury	441 IAC 78.43(4)
Intellectual disability	441 IAC 78.41(7)

a. Supported Employment – Individual Employment Support

Supported employment – individual employment support services are the supports to participants who, due to disabilities, need ongoing support to obtain and maintain an individual job.

These jobs are ordinarily in competitive or customized employment, or self-employment, in an integrated work setting in the general workforce.

Participants are compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities.

The outcome of this service is sustained paid employment at or above the minimum wage in an integrated setting in the general workforce, in a job that meets personal and career goals.

Supported employment services can be provided through many different service models. Some of these models can include evidence-based supported employment for members with mental illness, or customized employment for members with significant disabilities. States may define other models of individualized supported employment that promote community inclusion and integrated employment.

Supported employment – individual employment supports may also include support to establish or maintain self-employment, including home-based self-employment. Supported employment services are individualized and may include any combination of the following services:

- Vocational and job-related discovery or assessment,
- Person-centered employment planning,
- Job placement,
- Job development,
- Negotiation with prospective employers,
- Job analysis,
- Job carving,
- Training and systematic instruction,
- Job coaching,
- Benefits support,
- Training and planning,

- Transportation,
- Asset development and career advancement services, and
- Other workplace support services including services not specifically related to job skill training that enable the waiver participant to be successful in integrating into the job setting.

Supported employment – individual employment supports is not intended for people working in mobile work crews of small groups of people with disabilities in the community. That type of work support is addressed in the core service definition for Supported Employment – Small Group Employment Support.

Transportation between the member's place of residence and the employment site is a component part of supported employment – individual employment supports and small group support services. The cost of this transportation is included in the rate paid to providers of supported employment – individual employment supports services.

Documentation is maintained that the service is not available under a program funded under section 110 of the Rehabilitation Act of 1973 or the IDEA (20 U.S.C. 1401 et seq.).

Federal financial participation is not claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following:

- Incentive payments made to an employer to encourage or subsidize the employer's participation in supported employment, or
- Payments that are passed through to users of supported employment services.

Supported employment is designed to assist members in obtaining and maintaining competitive paid employment. The service consists of intensive, ongoing supports that enable members to perform in a regular work setting.

Services are provided to members who need support because of their disabilities and who are unlikely to obtain competitive employment at or above the minimum wage without the provision of supports.

b. Supported Employment – Small Group Employment Support (Enclave)

Supported employment – small group employment support (enclave) are services and training activities provided in regular business, industry, and community settings for groups of two to eight workers with disabilities. Examples include mobile crews and other business-based workgroups employing small groups of workers with disabilities in employment in the community.

Supported employment – small group employment support must be provided in a manner that promotes integration into the workplace and interaction between participants and people without disabilities in those workplaces. The outcome of this service is sustained paid employment and work experience leading to further career development and individual integrated community-based employment.

For this, a member is compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities.

Small group employment support does not include vocational services provided in facility-based work settings.

Supported employment – small group employment supports may include any combination of the following services:

- Vocational and job-related discovery or assessment,
- Person-centered employment planning,
- Job placement,
- Job development,
- Negotiation with prospective employers,
- Job analysis,
- Training and systematic instruction,
- Job coaching,
- Benefits support,
- Training and planning transportation, and
- Career advancement services.

Other workplace support services may include services not specifically related to job skill training that enable the waiver participant to be successful in integrating into the job setting.

Documentation is maintained that the service is not available under a program funded under section 110 of the Rehabilitation Act of 1973 or the IDEA (20 U.S.C. 1401 et seq.). Federal financial participation is not claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following:

- Incentive payments made to an employer to encourage or subsidize the employer's participation in supported employment, or
- Payments that are passed through to users of supported employment services.

Supported employment has two main components that consists of:

- Activities to obtain a job, and
- Supports to maintain employment.

Activities to obtain a job include the following service components provided to or on behalf of the member:

- **Job development** services are directed toward obtaining competitive employment. The activities provided to the member may include:
  - Job procurement training, including grooming and hygiene, application, resume development, interviewing skills, follow-up letters, and job search activities.
  - Job retention training, including promptness, coworker relations, transportation skills, disability-related supports, job benefits, and an understanding of employee rights and self-advocacy; and customized job development specific to the member.

  A unit of service is a job placement that the member holds for 30 consecutive calendar days or more. A member may receive two units of job development services during a 12-month period.

  Payment for job development may occur when the service has been authorized in the member's service plan.
- **Employer development** services are focused on supporting employers in hiring and retaining members in their workforce and to communicate expectations of the business with the interdisciplinary team. Employer development services may be provided only to members who are reasonably expected to work for no more than 10 hours per week.

The services provided may include:

- Developing relationships with employers and providing leads for members when appropriate.
- Job analysis for a specific job.
- Development of a customized training plan that identifies job-specific skill requirements, employer expectations, teaching strategies, timeframes, and responsibilities.
- Identifying and arranging reasonable accommodations with the employer.
- Providing disability awareness and training to the employer when it is deemed necessary.
- Providing technical assistance to the employer regarding the training progress as identified on the member's customized training plan.

  Most members will receive this service through Iowa Vocational Rehabilitation Services.

  A unit of service is one job placement that the member holds for 30 consecutive calendar days or more. Payment for this service may be made only after the member holds the job for 30 days. A member may receive two units of employer development during a 12-month period.
- Enhanced job search activities are associated with obtaining initial employment after job development services have been provided for a minimum of 30 days; or with assisting the member in changing jobs due to lay-off, termination, or personal choice.

The interdisciplinary team must review and update Iowa Vocational Rehabilitation Services form SES/RA-1, *Supported Employment Readiness Analysis*, to determine if this service remains appropriate for the member's employment goals. Click here to see a sample of this form.

The services provided may include:

- Job opening identification with the member.
- Assistance with applying for a job, including completion of applications or interviews.
- Work site assessment and job accommodation evaluation.

A unit of service is an hour. A maximum of 26 units may be provided in a 12-month period. Iowa Vocational Rehabilitation Services will continue to provide a letter, upon request, confirming that the Medicaid member is not eligible for their funding.

Supports to maintain employment includes the following services provided to or on behalf of the member:

- Individual work-related behavioral management
- Job coaching
- On-the-job or work-related crisis intervention
- Assistance in the use of skills related to sustaining competitive paid employment, including assistance with communication skills, problem solving, and safety
- Assistance with time management
- Assistance with appropriate grooming
- Employment-related supportive contacts
- On-site vocational assessment after employment
- Employer consultation

Example: Due to his bi-polar disorder, Member B has never been employed, but he would like to work. His provider finds that Member B has an interest and aptitude for working with animals.

The provider contacts local pet stores to explain Member B's situation and arranges for a job interview for Member B. These activities would be considered job procurement training and are reimbursable as "job development services."

The employer hires Member B to help take care of the animals. Provider staff works with Member B to assist him in learning his job duties. During the first two weeks, the provider works with Member B at the job site for an hour per day. For the next two weeks, staff assists him every other day.

Staff also makes periodic contact with the employer to check on Member B's performance and identify any trouble areas.

These activities are considered job coaching and employer consultation and would be reimbursable as "supports to maintain employment."

> One day, Member B becomes agitated while at work and yells at another employee. Provider staff responds by coming to the job site and assisting Member B in regaining his composure. The staff finds that Member B was confused about some of his duties and became upset when his co-worker pointed out some things Member B had not done.
>
> Provider staff then assists Member B in communicating about the problem with the employer and co-worker and in clarifying his duties.
>
> These activities are considered work-related crisis intervention and assistance with communication skills and are reimbursable as "supports to maintain employment."

Supported employment can be provided in a variety of community-based settings where people without disabilities work. The majority of co-workers at any employment site with more than two employees must be persons without disabilities.

In the performance of job duties, the member must have daily contact with other employees or members of the public who do not have disabilities, unless the absence of such contact is typical of the job for persons without disabilities.

When supports for maintaining employment are provided to members in a teamwork or "enclave" setting, the team must not include more than eight people with disabilities.

Community transportation options (such as driving oneself, carpools, public transportation, being transported by co-workers, families, volunteers, etc.) shall be attempted before the service provider provides transportation.

37. Transportation

Legal reference:

Waiver Type	Corresponding Iowa Administrative Code
Brain injury	441 IAC 78.43(7)
Elderly	441 IAC 78.37(11)
Intellectual disability	441 IAC 78.41(11)
Physical disability	441 IAC 78.46(5)

Transportation services may be provided for members:

- To conduct business errands and essential shopping,
- To receive medical services not reimbursed through medical transportation,
- To travel to and from work or day programs (BI, ID, and PD), or
- To reduce social isolation.

HCBS waiver transportation services will be authorized and reimbursed at the HCBS transportation provider's NEMT contracted rate or the lesser of the provider's rate or the published weighted average rate paid per mile within the member's MHDS region. These published rates are considered the upper rate limit; providers may charge no more than the published rate per mile.

Transportation providers may not charge a Medicaid member more than they charge other public or private pay riders for the same service.

a. HCBS Transportation and Supported Community Living (SCL) Services

A provider may include the costs of transportation that are directly associated with the provision of SCL services in their reimbursement rate. Transportation is also a stand-alone service in the intellectual disability (ID) and brain injury (BI) waiver programs that provides payment for:

- Transporting a member to conduct business errands,
- Essential shopping,
- To receive medical services,
- To and from work or day programs, and
- To reduce social isolation.

This is the same criteria for transportation when provided as part of the SCL service. A provider may not simultaneously bill for SCL services and transportation (the service) when the provider is including the cost of transportation in the SCL rate. This would be considered double billing Medicaid for the same service.

INSTRUCTIONS FOR COMPLETING THE IOWA MEDICAID HCBS WAIVER PROVIDER APPLICATION FORM

I. GENERAL SECTION

1 **National Provider Identifier –** Complete this section **only** if you are a current Iowa Medicaid Provider. Enter the National Provider Identifier (NPI) for the provider. If you do not have an NPI, enter your ten-digit Iowa Medicaid Provider number (starting with "X00….).

2-7 Enter the location information for the provider.

8-9 **County Name and Number –** Enter the name and number of the county of residence (if out of state – enter the name and number of the county served).

10 **Telephone Number –** Enter area code and phone number.

11 **Cellular Telephone Number –** Enter area code and phone number, if available.

12 **Fax –** Enter area code and fax number, if available.

13 **E-mail Address –** Enter e-mail address, if available. By providing us with your e-mail address, you agree that we may communicate with you by electronic mail.

14 **Desired Effective Date for Enrollment –** This date cannot be retroactive before the first of the month the application is approved. Providers cannot bill or be paid for service provided prior to Department of Human Services (DHS) approval of the service enrollment.

15 Leave Blank (For Future Use)

II. INDIVIDUAL APPLICANTS APPLYING FOR CONSUMER-DIRECTED ATTENDANT CARE (CDAC)

If you are applying on behalf of an agency, proceed to section III.

If you are an individual applying for services other than Consumer-Directed Attendant Care, proceed to Section III. (**This is not common.**)

16 **Social Security Number –** Enter your social security number here.

17 Check each box that applies:

❑ – CDAC waiver types include: Health and Disability (H&D), AIDS/HIV (AH), Elderly (E), Intellectual Disability (ID), and Physical Disability (PD).

- Individuals approved to provide CDAC waiver services will be enrolled in: ID, AH, E, ID, and PD.
- Individuals who apply to provide CDAC are required to submit proof of age and must send in a copy of either a birth certificate **OR** a driver's license. The date of birth must be clearly visible or it will not be accepted.

❑ – Brain Injury Waiver

- Additional documentation is required for those wishing to provide Brain Injury Waiver services. A list of the requirements can be found on page 4 of 12.

Note: The CDAC provider cannot bill or be paid for service provided prior to DHS written approval of this service. That is indicated by the case manager or DHS service worker attaching the *HCBS Consumer-Directed Attendant Care Agreement*, form 470-3372, to the service plan in the AIDS/HIV, Brain Injury, Elderly, Health and Disability, Intellectual Disability, and Physical Disability waivers. Any payments made prior to the case manager's or DHS service worker's written approval of this service will not be paid.

18-19 **Signature –** Original signature required. **Date –** Enter the date application is signed.

III. AGENCIES AND BUSINESSES APPLYING FOR WAIVER SERVICES

16 **Tax ID Number –** Enter your Internal Revenue Service (IRS) Tax ID number.

17 **Taxonomy code –** Enter the taxonomy code.

18-22 **Self-explanatory**.

23 **Claims in Process Information –** Paid and denied claims will automatically be reported to you. You have three choices regarding suspended claims, i.e., claims currently in process pending resolution of one or more issues. Those choices are:

Y = Print suspended claims only once. You will be notified only once that we have received your claim and that it is in process. You will not be notified about the claim again until it either pays or denies.

A = Print all suspended claims until paid or denied. You will be notified every week about all claims that are in process.

N = Do not print suspended claims. You will receive no notice concerning claims in process until they either pay or deny.

24 **Remittance Sequence –** Choose which sequence your claims will be reported to you. The choices are:

By Member Name = Claims will be reported in alphabetic order by member's last name.

By Member ID = Claims will be reported in numeric order by member's Medicaid identification number.

25 Indicate which services you are applying for by checking the box next to that service. Under the service you are applying for, check <u>one</u> of the standards that make you or your agency qualified to provide that service. Next to the standard, circle the waiver type for which you are applying. Include with the application the documentation supporting the specific requirement that makes you or your agency qualified to provide the service.

26 **Signature –** Original signature required. Applications not properly signed will be returned.

27 **Date –** Enter date application is signed. Applications not dated will be returned.

28 **Contact Person –** Enter the name of the person who should be contacted for questions regarding the application.

NOTE: Those wishing to provide services under the Brain Injury Waiver need to submit documentation indicating training or experience working with persons with an identified brain injury. The following services are exempt from the Brain Injury Waiver training requirement: Home or Vehicle Modification (HVM), Specialized Medical Equipment (SME), Personal Emergency Response (PERS), and Transportation.

Once the application process has been completed, you will receive notification from the Iowa Medicaid Enterprise.

Iowa Department of Human Services

Medicaid HCBS Waiver Provider Application

When completed send to:		For questions, contact:
Iowa Medicaid Enterprise Provider Services P.O. Box 36450 Des Moines, IA 50315	**Make sure you have read the instructions before completing this form**	Provider Services **Tel. (800) 338-7909 or (515) 256-4609 (local), option 2**

Individual applicants applying to provide Consumer-Directed Attendant Care (CDAC) should complete sections I and II. Agencies and businesses applying to provide waiver services should complete sections I and III.

I. GENERAL SECTION

1. National Provider Identifier (NPI) (if you are not currently a Medicaid provider, leave blank)	
2. Provider Name	
3. Mailing Address	
4. Street Address (if different from the mailing address)	
5. City	**6. State**
7. Zip Code (please enter 9-digit zip code, if known)	–
8. County Name	**9. County Number**
10. Telephone Number (daytime)	( ) –
11. Cellular Telephone Number (optional)	( ) –
12. Fax Number (if available)	( ) –
13. E-mail Address (please, print)	
14. Desired Effective Date for Enrollment (MM/DD/YYYY) (THIS DATE WILL NOT BE RETROACTIVE BEFORE THE FIRST OF THE MONTH IN WHICH THE APPLICATION IS APPROVED)	/ /
15. Leave Blank (For Future Use)	

If you are an individual applying for Consumer-Directed Attendant Care (CDAC), please proceed to section II. Otherwise, proceed to section III.

II. APPLICATION FOR INDIVIDUAL CONSUMER-DIRECTED ATTENDANT CARE

16. Social Security Number				–			–				

Service and Requirements

17. Check the box(es) below for each HCBS Waiver program for which application is being made:

❑ – **Consumer Directed Attendant Care (CDAC)** waiver types include: H&D, AH, E, ID and PD.

- Individual Applicant (Attach a photocopy of birth certificate **OR** driver's license. The document must show name and date of birth.)

❑ – **Brain Injury Waiver**:

Those wishing to provide CDAC services under the Brain Injury Waiver must submit documentation indication training or experience working with persons with and identified brain injury.

To demonstrate that you meet the criteria to be enrolled as a Brain Injury Waiver provider, please submit one or more of the following:

- Training certificates;
- Credentials (Brain injury specialist, RN, LPN, OT, PT, CNA license);
- Resumé including a detailed description of job duties and employment start and end dates;
- A signed and dated personal statement from the applicant detailing experience working hands on direct care with persons with a brain injury diagnosis;
- A signed and dated personal statement you reside in the household of the member, and/or are the parent of the member who will be receiving the CDAC services and demonstrate that you have provided instruction on the care of the individual member a brain injury professional;
- A signed and dated personal statement that you been providing direct care to a person with a brain injury. List the types of assistance and support you have provided and the length of time that you have been providing those services;
- Online training: Read and answer the questions and print off the completed course and submit to demonstrate that you read and complete the questions. The website is: http://www.neuroskills.com/edu/ceufunction3.shtml

Upon receipt of the documentation, it will be reviewed for approval. If the documentation is found to be insufficient, you will be required to take an approved training for individuals with a brain injury. You cannot become a Brain Injury Waiver provider without attending training or having the training waived through your experience and outside training.

Read and sign the following statement:

As a Medicaid provider of consumer-directed attendant care services:

- I understand that if I am the parent or stepparent of a consumer aged 17 or under, or the spouse of a consumer, that I may not provide services to those individuals.
- I understand that I may not provide consumer-directed attendant care services for a consumer for whom I am a caretaker and for whom I am the beneficiary of respite services that are funded by an HCBS waiver.
- I understand that all consumer-directed attendant care service activities are supportive. I must be qualified by prior training and/or experience and/or a certificate of formal training to carry out the consumer's plan of care pursuant to the department approved service plan.
- I understand that I must describe in detail my training and/or experience on form 470-3372, *HCBS Consumer-Directed Attendant Care Agreement*, and this will be reviewed and approved by the Medicaid case manager or service worker for appropriateness of training and/or experience prior to provision of services. Form 470-3372 becomes an attachment to and a part of the service plan. I will receive direction and training from consumers for activities to maintain independence that are not medical in nature. I will receive from licensed nurses and therapists on-the-job training and supervision for skilled activities described on form 470-3372. All training and experience must be sufficient to protect the health, welfare, and safety of the consumer.
- I have made a copy of this application for my own records.

STATEMENT
MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION IN, OR RELATED TO, THIS APPLICATION MAY BE PUNISHABLE BY CRIMINAL, CIVIL (INCLUDING A FALSE CLAIMS LAWSUIT) AND/OR ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL AND/OR STATE LAW.

CERTIFICATION
I HEREBY CERTIFY that I have read the above statement, and that I have examined this application and all accompanying documents, and that to the best of my knowledge and belief, each is true, correct, and complete. I further certify that I am familiar with the laws and regulations governing the medical assistance program (Iowa Medicaid) and that I am duly qualified to participate as a provider in that program. I PROMISE to apprise Iowa Medicaid immediately of any material changes to this application and provide true, correct, and complete answers to any subsequent questions of me by Iowa Medicaid related to or arising out of this application.

18. Signature

19. Date			/			/				

III. AGENCIES AND BUSINESSES APPLYING FOR WAIVER SERVICES

16. Tax ID Number			–							

17. Taxonomy code

18. Has the provider ever been sanctioned by Medicaid, Medicare or other state health program? ❑ Yes ❑ No

19. Has there been any disciplinary action against you by any licensing boards, accrediting or certification body? ❑ Yes ❑ No

20. Have you ever been excluded from participation in the Medicaid or Medicare Program? If "yes," please explain on a separate piece of paper. ❑ Yes ❑ No

21. Type of Practice Code (Check One)

- ❑ 01 – Individual Applicant
- ❑ 02 – Partnership
- ❑ 03 – Corporation/Profit Organization
- ❑ 04 – Hospital Based
- ❑ 05 – Government Owned
- ❑ 06 – Not for Profit
- ❑ 07 – Private Owner
- ❑ 08 – HMO
- ❑ 09 – Group
- ❑ 10 – University Affiliated Clinic

22. Type of Ownership Code (Check One)

- ❑ 01 – Individual Applicant
- ❑ 02 – Board Member/Commissioner
- ❑ 03 – Sole Ownership
- ❑ 04 – Partner
- ❑ 05 – Corporation
- ❑ 06 – Government Entity
- ❑ 07 – Nonprofit Organization
- ❑ 08 – Trust

Remittance Statement Control – Please read instructions on second page before completing!

23. Claims in Process Information (Check one)	**24. Remittance Sequence (Check one)**
❑ Y = Print suspended claims only once	❑ 1 = By member name
❑ A = Print all suspended claims (until paid or denied)	❑ 2 = By member ID
❑ N = Do not print suspended claims	

25. Indicate the service(s) for which you are applying and attach proof that the requirement is met.

Service and Requirements		Circle the waiver(s) for which you are applying
❑ Adult Day Care (ADC)		
❑ 70 – Certificate for Adult Day services issued by the Department of Inspections and Appeals confirming that the applicant is in compliance with the standards for adult day services programs adopted by the Department on Aging (attach a copy of the certificate) Requires submission of a complete Provider Quality Management Self-Assessment	→	HD AH E ID BI
❑ Assistive Devices (AD)		
❑ 61 – Area Agency on Aging as designated in IAC 321 4.4(231) (no supporting documentation required)	→	E
❑ 39 – Community Business (attach current proof of liability and workers compensation coverage)	→	E
❑ 60 – Provider that were enrolled as assistive device providers as of June 30, 2010 based on a contract or letter of approval from an area agency on aging (attach a copy of the letter)	→	E
❑ 06 – Medical equipment and supply dealers (enter your Medicaid Provider # (NPI) _____)	→	E

❑ Behavioral Programming (BP)			
❑ 17 – Agencies which are certified under the community mental health center standards established by the mental health and developmental disabilities commission, set forth in 441-24, Divisions I and III	→	BI	MFP
❑ 18 – Agencies which are licensed as meeting the hospice standards and requirements set forth in Department of Inspections and Appeals rules 481-53 or which are certified to meet the standards under the Medicare program for hospice programs	→	BI	MFP
❑ 19 – Agencies which are accredited under the mental health service provider standards established by the Mental Health and Disabilities Commission, set forth in 441-24, Divisions I and IV	→	BI	MFP
❑ 08 – Home Health Agency (enter your Medicare Provider # _____)	→	BI	MFP
❑ 20 – Brain injury waiver providers certified pursuant to rule 441-77.39(249A)	→	BI	MFP
❑ 93 – Provider certified under HCBS BI Behavior Programming (no supporting documentation required)	→		MFP
❑ 94 – A licensed psychologist or psychiatrist (attach a copy of the license)	→		MFP
❑ 95 – A behavioral analyst certified by the Behavior Analyst Certification Board (attach certification)	→		MFP
❑ 96 – A licensed mental health counselor (attach a copy of the license)	→		MFP
❑ 97 – A licensed social worker (attach a copy of the license)	→		MFP
❑ 98 – A licensed advanced registered nurse registered as certified in psychiatric mental health (attach license and certification)	→		MFP
Requires submission of a completed Provider Quality Management Self-Assessment You will be contacted in regards to submitting policies, procedures, and forms			
❑ Case Management (CM)			
❑ 47 – Meets 441 IAC-24 Case Management (enter your case management # _____)	→	E	BI
❑ 86 – An agency or individual that is accredited through the Commission on Accreditation of Rehabilitation Facilities for case management services (attach current certification and most recent CARF survey report)	→	E	
❑ 87 – An agency or individual that is accredited through the Council on Quality and Leadership (attach current certification and most recent survey report)	→	E	
❑ 88 – An agency or individual that is accredited through Joint Commission on Accreditation of Health Care Organizations (attach current certification and most recent survey report)	→	E	
❑ 89 – An agency or individual that meets Iowa Administrative Code 321 Chapter 21 for case management services and is approved by the Department of Aging (must submit a letter from Department of Aging that the requirements are met)	→	E	
❑ 90 – An agency or individual that meets Iowa Administrative Department of Public Health in the counties that provide case management according to IAC 641-80.6(1) and has a current contract with the Iowa Department of Public Health	→	E	
Elderly Waiver requires submission of a completed Provider Quality Management Self-Assessment			
❑ Chore			
❑ 39 – Community Business (attach current proof of liability and workers compensation coverage)	→	E	
❑ 63– Provider that was enrolled as chore providers as of June 30, 2010, based on a contract with or letter of approval from an area agency on aging (attach a copy of the letter)	→	E	
❑ 07 – Community Action Agency as designated in IAC 216A.93 (no supporting documentation required)	→	E	
❑ 08 – Home Health Agency (enter your Medicare Provider # _____)	→	E	
❑ 09 – Agencies authorized to provide similar services through a contract with the Department of Public Health (IDPH) for public health services (enter your contract #_____)	→	E	
❑ 10 – Nursing Facility Licensed under 135C Code of Iowa (no supporting documentation required)	→	E	

❑ Consumer Directed Attendant Care (CDAC)

❑ Agency

❑ 09 – Agencies authorized to provide similar services through a contract with the Department of Public Health (IDPH) for public health services (enter your contract #_____)	→	HD AH E ID BI PD
❑ 08 – Home Health Agency (enter your Medicare Provider # _____)	→	HD AH E ID BI PD
❑ 13 – Chore provider subcontracting with an Area Agency on Aging (attach a copy of the contract)	→	HD AH E ID BI PD
❑ 07 – Community Action Agency as designated in IAC 216A.93 (no supporting documentation required)	→	HD AH E ID BI PD
❑ 15 – Provider enrolled under HCBS ID or BI Supported Community Living (no supporting documentation required)	→	HD AH E ID BI PD
❑ 16 – Assisted Living Program accredited/certified by Department of Inspections and Appeals as designated in IAC 481-69 (Requires submission of a completed Provider Quality Management Self-Assessment)	→	HD AH ID BI PD
❑ 83 – Provider with a certificate for Adult Day Services issued by the Department of Inspections and Appeals confirming that the applicant is in compliance with standards for adult day services programs adopted by the Department on Aging (attach a copy of the certificate)	→	HD AH E ID BI PD
Requires submission of a completed Provider Quality Management Self-Assessment		

❑ Assisted Living On-Call

❑ 16 – Assisted Living Program accredited/certified by Department of Inspections and Appeals as designated in IAC 481-69 (attach a copy of the certificate)	→	E

❑ Counseling (Couns)

❑ 22 – Community Mental Health Center (attach a copy of the certificate or enter your Medicaid Provider # or Certificate of Accreditation _____)	→	HD AH
❑ 23 – Hospice (attach a copy of the license or enter you Certificate of License or Medicare Provider # _____)	→	HD AH
❑ 24 – Mental Health Service Provider (attach a copy of the Certificate of Accreditation)	→	HD AH
Requires submission of a completed Provider Quality Management Self-Assessment		

❑ Crisis Intervention

❑ 102 – Community Mental Health Center (attach a copy of the certificate or enter your Medicaid Provider # _____)	→	MFP
❑ 103 – ICF/ID (enter your Medicaid Provider # _____)	→	MFP
❑ 104 – An agency with a contract to provide crisis intervention services with the Department of Human Services (provide documentation)	→	MFP

❑ Day Habilitation (DH)

❑ 73 – Be accredited by the Council on Quality and Leadership (attach current certification and most recent survey report)	→	ID
❑ 74 – Be accredited by the Commission on Accreditation of Rehabilitation Facilities for similar services* (attach current CARF certification and most recent CARF survey report)	→	ID
❑ 75 – Be accredited by the Commission on Accreditation of Rehabilitation Facilities, but not for similar services*, until next regularly scheduled accreditation at which time the applicant will present documentation to the department that the similar service* requirement is met. HCBS waiver approval will be granted through the expiration date of the current CARF certification (attach current CARF certification and most recent CARF survey report)	→	ID
❑ 76 – Previous application for CARF accreditation. Conditional HCBS waiver approval will be granted for a maximum of 12 months from the date of CARF application (Submit a copy of the CARF application. You will be contacted in regards to submitting policies and procedures applicable to day habilitation.)	→	ID
❑ 77 – Previous application for Council on Quality and Leadership accreditation. Conditional HCBS waiver approval will be granted for a maximum of 12 months from the date of Council application (Submit a copy of the Council application.)	→	ID
Requires submission of a completed Provider Quality Management Self-Assessment		
* Similar services include Personal and Social services, Community Integration services, Community Based Rehabilitation, and Adult Day Care		

❑ Environmental Modifications, Adaptive Devices and Therapeutic Resources		
❑ 15 – Provider enrolled under HCBS ID or BI Supported Community Living (no supporting documentation required)	→	CMH
❑ 30 – A provider enrolled under the HCBS Children's Mental Health waiver as a Family and Community Support Services provider	→	CMH
❑ 45 – A provider enrolled as a waiver Home/Vehicle Modifications provider (no supporting documentation required)	→	CMH
❑ 39 – Community Business (attach current proof of liability and workers compensation coverage)	→	CMH
❑ 40 – Retail and wholesale businesses participating as providers in the Medicaid program (enter your Medicaid Provider # _____)	→	CMH
❑ Family and Community Supports (FCSS)		
❑ 22 – Community Mental Health Center (attach a copy of the certificate or enter your Medicaid Provider # or Certificate of Accreditation _____)	→	CMH
❑ 84– Behavioral Health Intervention providers qualified under 441-77.12(249A)	→	CMH
Requires submission of a completed Provider Quality Management Self-Assessment		
❑ Family Counseling (FC)		
❑ 22 – Community Mental Health Center (attach a copy of the certificate or enter your Medicaid Provider # or Certificate of Accreditation _____)	→	BI
❑ 23 – Hospice (attach a copy of the license or enter your Certificate of License or Medicare Provider# _____)	→	BI
❑ 24 – Mental Health Service Provider (attach a copy of the Certificate of Accreditation)	→	BI
❑ 48 – Individuals who meet the definition of qualified brain injury professionals as designated in 441 IAC 83.81(249A)	→	BI
❑ 33 – Agencies certified as brain injury waiver providers pursuant to rule 441-77.39(249A) that employ staff to provide family counseling who meet the definition of a qualified brain injury professional as set forth in rule 441-83.81(294A)	→	BI
Requires submission of a completed Provider Quality Management Self-Assessment		
❑ Financial Management Services		
❑ 91 – A credit union that is a cooperative, nonprofit, member-owned and member-controlled, and federally insured through and chartered by either the National Credit Union Administration (NCUA) or the credit union division of the Iowa Department of Commerce (Attach documentation from NCUA or IDC). The financial institution shall complete a financial management readiness review and certification conducted by the department or its designee	→	HD AH E ID BI PD
❑ 92 – A financial institution chartered by the office of the Comptroller of the Currency, a Bureau of the U.S. Department of the Treasury, and insured by the Federal Deposit Insurance Corporation (FDIC). The financial institution shall complete a financial management readiness review and certification conducted by the department or its designee.	→	HD AH E ID BI PD
❑ Home Delivered Meals (HDM)		
❑ 61 – Area Agency on Aging as designated in IAC 17 4.4(231) (no supporting documentation required)	→	HD AH E
❑ 59 – Subcontract with Area Agency on Aging (attach a copy of the subcontract)	→	HD AH E
❑ 07 – Community Action Agency as designated in IAC 216A.93 (no supporting documentation required)	→	HD AH E
❑ 09 – Agencies authorized to provide similar services through a contract with the Department of Public Health (IDPH) for public health services (enter your contract #_____)	→	HD AH E
❑ 08 – Home Health Agency (enter your Medicare Provider # _____)	→	HD AH E
❑ 26 – Hospital (enter your Medicare Provider # _____)	→	HD AH E
❑ 06 – Medical equipment and supply dealers (enter your Medicaid Provider # _____)	→	HD AH E
❑ 10 – Nursing Facility Licensed under 135C Code of Iowa (no supporting documentation required)	→	HD AH E
❑ 27 – Restaurant licensed and inspected under Iowa Code chapter 135F (attach a copy of the license)	→	HD AH E

❑ **Home Health Aide (HHA)**	
❑ 08 – Home Health Agency (enter your Medicare Provider # _____)	HD AH E ID
❑ **Homemaker (HM)**	
❑ 09 – Agencies authorized to provide similar services through a contract with the Department of Public Health (IDPH) for public health services (enter your contract #_____) →	HD AH E
❑ 08 – Home Health Agency (enter your Medicare Provider # _____) →	HD AH E
❑ **Home Modifications (HM)** ❑ **Vehicle Modifications (VM)**	
❑ 61 – Area Agency on Aging as designated in IAC 17 4.4(231) (no supporting documentation required) →	HD E
❑ 07 – Community Action Agency as designated in IAC 216A.93 (no supporting documentation required) →	HD E
❑ 15 – Provider enrolled under HCBS ID or BI Supported Community Living (no supporting documentation required) →	ID
❑ 45 – Provider enrolled as a waiver Home/Vehicle Modifications provider under another waiver (no supporting documentation required) →	HD E ID BI PD
❑ 39 – Community Business (attach current proof of liability and workers compensation coverage) →	HD E ID BI PD
❑ **In-Home Family Therapy (IHFT)**	
❑ 22 – Community Mental Health Center (attach a copy of the certificate or enter your Medicaid Provider # or Certificate of Accreditation _____) →	CMH
❑ 41 – Mental Health professionals licensed pursuant to 645-Chapter 31, 240, or 280 or possessing an equivalent license in another state. →	CMH
Requires submission of a completed Provider Quality Management Self-Assessment	
❑ **Interim Medical Monitoring & Treatment (IMMT)**	
❑ 08 – Home Health Agency (enter your Medicare Provider # _____) →	HD ID BI
❑ 15 – Provider enrolled under HCBS ID or BI Supported Community Living (no supporting documentation required) →	HD ID BI
Requires submission of a completed Provider Quality Management Self-Assessment	
❑ **Mental Health Outreach (MHO)**	
❑ 22 – Community Mental Health Center (attach a copy of the certificate of accreditation) →	E MFP
❑ 94 – A licensed psychologist or psychiatrist (attach a copy of the license) →	MFP
❑ 95 – A behavioral analyst certified by the Behavior Analyst Certification Board (attach certification) →	MFP
❑ 96 – A licensed mental health counselor (attach a copy of the license) →	MFP
❑ 97 – A licensed social worker (attach a copy of the license) →	MFP
❑ 98 – A licensed advanced registered nurse registered as certified in psychiatric mental health (attach license and certification) →	MFP
Requires submission of a completed Provider Quality Management Self-Assessment	
❑ **Nurse Delegation (ND)**	
❑ 08 – Home Health Agency (enter your Medicare Provider # _____) →	MFP
❑ 106 – A nurse licensed by the Iowa Nursing Board as a registered or license practical nurse pursuant to IAC 655 (attach a copy of the license) →	MFP
❑ **Nursing (N)**	
❑ 08 – Home Health Agency (enter your Medicare Provider # _____) →	HD AH E ID
❑ **Nutritional Counseling (NC)**	
❑ 07 – Community Action Agency as designated in IAC 216A.93 (no supporting documentation required) →	HD E
❑ 08 – Home Health Agency (enter your Medicare Provider # _____) →	HD E
❑ 26 – Hospital (enter your Medicare Provider # _____) →	HD E
❑ 28 – Licensed dietitian approved by an Area Agency on Aging (attach a copy of the license and the letter from an Area Agency on Aging) →	HD E
❑ 10 – Nursing Facility Licensed under 135C Code of Iowa (no supporting documentation required) →	HD E

❑ Personal Emergency Response (PERS)								
❑ 25 – Send information pamphlet	→	HD		E	ID	BI	PD	
❑ Prevocational Services (Prevoc)								
❑ 49 – Meet Commission on Accreditation of Rehabilitation Facilities standards for work adjustment service providers (attach current certificate and most recent survey report)	→					BI		
❑ 69 – Be accredited by the Commission on Accreditation of Rehabilitation Facilities under standards for work adjustment service providers or organizational employment service providers (attach current certificate and most recent survey report)	→				ID			
❑ 73 – Be accredited by the Council on Quality and Leadership (attach current certification and most recent survey report)	→				ID			
Providers accredited as an organizational employment service provider will need an approved exception to policy Requires submission of a completed Provider Quality Management Self-Assessment								
❑ Respite								
❑ 29 – Provider certified under HCBS ID Respite (no supporting documentation required)	→	HD	AH	E		BI		CMH
❑ 79 – Provider certified under HCBS BI Respite (no supporting documentation required)	→	HD	AH					CMH
❑ 08 – Home Health Agency (enter your Medicare Provider # _____)	→	HD	AH	E	ID	BI		CMH
❑ 09 – Agencies authorized to provide similar services through a contract with the Department of Public Health (IDPH) for public health services (enter your contract #_____)	→				ID			CMH
❑ 26 – Hospital (enter your Medicare Provider # _____)	→	HD	AH	E	ID	BI		CMH
❑ 10 – Nursing Facility Licensed under 135C Code of Iowa (no supporting documentation required)	→	HD	AH	E	ID	BI		CMH
❑ 35 – ICF/ID (enter your Medicaid Provider # _____)	→	HD	AH		ID	BI		CMH
❑ 44 – Licensed group living foster care facility (attach a copy of the license)	→	HD	AH		ID	BI		CMH
❑ 32 – Camps certified by the American Camping Association (attach a copy of the certificate)	→	HD	AH	E	ID	BI		CMH
❑ 30 – Provider with a certificate for Adult Day Care services issued by the Department of Inspections and Appeals confirming that the applicant is in compliance with the standards for adult day services programs adopted by the Department on Aging (attach a copy of the certificate)	→	HD	AH	E	ID	BI		CMH
❑ 50 – Residential care facility for persons with mental retardation licensed by DIA (attach a copy of the license)	→	HD			ID	BI		CMH
❑ 78 – Assisted Living Program certified by the Department of Inspections and Appeals as designated in IAC 481-69	→	HD	AH	E	ID	BI		CMH
Requires submission of a completed Provider Quality Management Self-Assessment You will be contacted in regards to submitting policies, procedures, and forms								
❑ Senior Companion (SC)								
❑ 37 – Designation by Corporation for National and Community Service (attach documentation substantiating the designation)	→			E				
❑ Specialized Medical Equipment (SME)								
❑ 06 – Medical equipment and supply dealers (enter your Medicaid Provider # _____)	→					BI	PD	
❑ 40 – Retail and wholesale businesses participating as providers in the Medicaid program (enter your Medicaid Provider # _____)	→					BI	PD	
❑ Supported Community Living (SCL)								
❑ 53 – Provider enrolled under HCBS ID SCL (no supporting documentation required)	→					BI		
❑ 54 – Provider enrolled under HCBS BI SCL (no supporting documentation required)	→				ID			
Requires submission of a completed Provider Quality Management Self-Assessment You will be contacted in regards to submitting policies, procedures, and forms								

❑ **Residential-Based Supported Community Living (RBSCL)**		
❑ 65 – Group Living Foster Care Facility (submit copy of group living foster care licensure under IAC 441-114 and a plan to come into compliance with IAC 441 77.37(23)“e”(3))	→	ID
❑ 66 – Residential Facility for Mentally Retarded Children (submit copy of Residential Facility for Mentally Retarded Children under IAC 441-116 licensure and a plan to come into compliance with IAC 441 77.37(23)“e”(3))	→	ID
Requires submission of a completed Provider Quality Management Self-Assessment		
❑ **Supported Employment (SE)**		
❑ 31 – An agency that is accredited by the commission on Accreditation of Rehabilitation Facilities as an organizational employment service provider, a community employment service provider, or a provider of a similar service (attach copy of the certificate of accreditation)	→	ID BI
❑ 34 – An agency that is accredited by the Council on Accreditation of Services for Families and Children for similar services (attach copy of the certificate of accreditation)	→	ID BI
❑ 36 – An agency that is accredited by the Joint Commission on Accreditation of Healthcare Organizations for similar services (attach copy of the certificate of accreditation)	→	ID BI
❑ 42 – An agency that is accredited by the Council on Quality and Leadership in Supports for People with Disabilities for similar services (attach copy of the certificate of accreditation)	→	ID BI
❑ 43 – An agency that is accredited by the International Center for Clubhouse Development (attach copy of the certificate of accreditation)	→	ID BI
Requires submission of a completed Provider Quality Management Self-Assessment		

❑ **Transportation (Trans)**		
❑ **Regional Transit Authority**		
❑ 38 – Regional Transit Agency recognized by Iowa Department of Transportation (no supporting documentation required)	→	E ID BI PD
❑ **Area Agency on Aging**		
❑ 61 – Area Agency on Aging as designated in IAC 17-4.4(231) (no supporting documentation required)	→	E ID BI PD
❑ 59 – Subcontract with Area Agency on Aging (attach a copy of the subcontract)	→	E ID BI PD
❑ **Mile**		
❑ 07 – Community Action Agency as designated in IAC 216A.93 (no supporting documentation required)	→	E ID BI PD
❑ 10 – Nursing Facility Licensed under 135C Code of Iowa (no supporting documentation required)	→	E ID BI PD
❑ 109 – Transportation providers contracting with the nonemergency medical transportation contractor	→	E ID BI PD
❑ 72 – Contract with county government (attach a copy of the contract)	→	ID
❑ 110 – Accredited provider contracting with the nonemergency medical transportation contractor	→	ID
❑ 111– Provider with purchase of service contracts to provide transportation pursuant to 441 Chapter 150	→	BI

STATEMENT
MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION IN, OR RELATED TO, THIS APPLICATION MAY BE PUNISHABLE BY CRIMINAL, CIVIL (INCLUDING A FALSE CLAIMS LAWSUIT) AND/OR ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL AND/OR STATE LAW.

CERTIFICATION

I HEREBY CERTIFY that I have read the above statement, and that I have examined this application and all accompanying documents, and that to the best of my knowledge and belief, each is true, correct, and complete. I further certify that I am familiar with the laws and regulations governing the medical assistance program (Iowa Medicaid) and that I am duly qualified to participate as a provider in that program. I PROMISE to apprise Iowa Medicaid immediately of any material changes to this application and provide true, correct, and complete answers to any subsequent questions of me by Iowa Medicaid related to or arising out of this application.

26. Signature of Authorized Official										
27. Date			/			/				
28. Contact Person										

Iowa Department of Human Services

Iowa Medicaid Provider Agreement General Terms

This Agreement is between the State of Iowa, Department of Human Services (the "Department"), and the Provider or Group Provider and its members or Practitioner(s) (the "Provider"). The operations management responsibility for the Iowa Medicaid Program is through the Iowa Medicaid Enterprise (the "IME").

Section 1. Provider Agrees to:

1.1 Adhere to professional standards and levels of service as set forth in all applicable local, State and Federal laws, statutes, rules and regulations as well as administrative policies and procedures set forth by the Department relating to the Provider's performance under this Agreement.

1.2 Abide, to the extent required, by the provisions of:

1.2.1 Title VI of the Civil Rights Act of 1964 as amended (42 U.S.C. § 2000e), which prohibits discrimination against any employee or applicant for employment or an applicant or member of services, on the basis of race, religion, color, national origin, age or sex.

1.2.2 Section 504 of the Rehabilitation Act of 1973, (29 U.S.C. § 794) as well as the terms, conditions and requirements of Americans with Disabilities Act of 1990 (P.L. 101-336), 42 U.S.C. 12101, and associated regulations found at 28 C.F.R. §§ 36.101 through 36.999, which prohibit discrimination against disabled persons.

1.2.3 The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and associated regulations found at 45 C.F.R. parts 160 and 164, and all laws protecting the confidentiality of patient information.

1.3 Comply with applicable Federal, State and local laws, regulations, administrative rules, and executive orders when performing services under the Agreement, including without limitation, all laws applicable to the prevention of discrimination in employment, and business permits and licenses that may be required to perform services under the Agreement.

1.4 Comply with all applicable Federal and State laws, administrative rules and written policies of the Iowa Medicaid program, including but not limited to Title XIX of the Social Security Act (as amended), the Code of Federal Regulations, the Federal anti-kickback statute and the Stark law, the provisions of the Code of Iowa and administrative rules of the Iowa Department of Human Services and written Department policies, including but not limited to, policies contained in the Iowa Medicaid Provider Manual, and the terms of this Agreement. This section neither creates nor negates due process rights of either party.

1.5 Comply with the applicable advance directive requirements for hospitals, nursing facilities, providers of home health care and personal care services, hospices and HMOs specified in 42 C.F.R. §§ 489.100 through 489.104 and 42 C.F.R. § 417.436. For hospital, facility and home health agency providers, the Provider shall provide all members with written information regarding their rights to make health care decisions, including the right to accept or refuse treatment and the right to execute advance directives (durable power-of-attorney for health care decisions and declarations).

1.5.1 Check the program exclusion status of individuals and entities prior to entering into employment or contractual relationships. Provider agrees to check the HHS-OIG website (http://exclusions.oig.hhs.gov/ or https://oig.hhs.gov/exclusions/index.asp) by the name of any individual or entity for their exclusion status before the Provider hires or enters into any contractual relationship with the person or entity. In addition, Provider agrees to check the HHS-OIG website monthly to capture exclusions and reinstatements that have occurred since the last search. Provider must report to the IME any exclusion information discovered through such searches.

The Department is generally prohibited from paying for any items or services furnished, ordered, or prescribed by excluded individuals or entities. This payment ban applies to any items or services reimbursable under the Medicaid program that are furnished by an excluded individual or entity, and extends to (1) all methods of reimbursement, whether payment results from itemized claims, cost reports, fee schedules, or a prospective payment system, (2) payment for administrative or management services not directly related to patient care, but that are a necessary component of providing items and services to Medicaid members, when those payments are reported on a cost report or are otherwise payable by the Medicaid program; and (3) payment to cover an excluded individual's salary, expenses or fringe benefits, regardless of whether they provide direct patient care, when those payments are reported on a cost report or are otherwise payable by the Medicaid program. In addition, no Medicaid payments can be made for any items or services directed or prescribed by an excluded physician or other authorized person when the individual or entity furnishing the services either knew or should have known of the exclusion. This prohibition applies even when the Medicaid payment itself is made to another provider, practitioner or supplier that is not excluded. *See* 42 C.F.R. § 1001.1901(b).

1.6 In accordance with 42 C.F.R. § 455.104, Provider shall report ownership and control information as follows:

1.6.1 *What disclosures must be provided*. Provider shall report the following:

1.6.1.1 The name and address of any person (individual or corporation) with an ownership or control interest in the Provider. The address for corporate entities must include as applicable primary business address, every business location, and P.O. Box address.

1.6.1.2 The date of birth and Social Security Number (in the case of an individual).

1.6.1.3 Other tax identification number (in the case of a corporation) with an ownership or control interest in the Provider or in any subcontractor in which the Provider has a 5 percent or more interest.

1.6.1.4 Whether the person (individual or corporation) with an ownership or control interest in the Provider is related to another person with ownership or control interest in the Provider as a spouse, parent, child, or sibling; or whether the person (individual or corporation) with an ownership or control interest in any subcontractor in which the disclosing entity has a 5 percent or more interest is related to another person with ownership or control interest in the disclosing entity as a spouse, parent, child, or sibling.

1.6.1.5 The name of any other disclosing entity (or fiscal agent or managed care entity) in which the owner of the disclosing entity (or fiscal agent or managed care entity) has an ownership or control interest.

1.6.1.6 The name, address, date of birth, the Social Security Number of any managing employee of the disclosing entity (or fiscal agent or managed care entity).

1.6.2 *When the disclosures must be provided*. Disclosures from Provider are due:

1.6.2.1 Upon Provider submitting the proposal in accordance with the State's procurement process.

1.6.2.2 Upon Provider executing a Provider Agreement with the State.

1.6.2.3 Upon renewal or extension of the Provider Agreement.

1.6.2.4 Within 35 days after any change in ownership of Provider.

1.6.3 *To Whom Must the Disclosures Be Provided*. All disclosures must be provided to the Department.

1.6.4 *Consequences for Failure to Provide Required Disclosures*. Federal financial participation (FFP) is not available in payments made to a provider that fails to disclose ownership or control information as required by law.

1.7 Provider will furnish to the Department or to the Secretary of HHS on request, information related to business transactions in accordance with 42 C.F.R. § 455.105. Specifically, Provider will:

1.7.1 Submit, within 35 days of the date on a request by the Secretary or the Department, full and complete information about:

1.7.1.1 the ownership of any subcontractor with whom the Provider has had business transaction totaling more than $25,000 during the 12-month period ending on the date of the request; and

1.7.1.2 Any significant business transactions between the Provider and any wholly owned supplier, or between the Provider and any subcontractor, during the 5-year period ending on the date of the request.

1.7.2 FFP is not available in expenditures for services furnished by providers who fail to comply with a request made by the Secretary or the Medicaid agency under paragraph 1.8 of this section or under 42 C.F.R. §420.205.

1.8 In accordance with 42 C.F.R. § 455.106, Provider shall disclose information on persons convicted of crimes as follows:

1.8.1 *Information that must be disclosed*. Upon signing this Agreement and prior to renewal of the Agreement, or at any time upon written request by the Department, Provider must disclose to the Department the identity of any person who:

1.8.1.1 Has ownership or control interest in the Provider, or is an agent or managing employee of the Provider; and

1.8.1.2 Has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the title XX program since the inception of those programs.

1.8.2 Notification to Inspector General.

1.8.2.1 The Department must notify the Inspector General of the HHS of any disclosures made under subsection 1.9.1 of this Agreement within 20 working days from the date it receives the information.

1.8.2.2 The Department will also promptly notify the Inspector General of HHS of any action it takes on the Provider's application for participation in the program.

1.8.3 *Denial or Termination of Provider Agreement/Provider Status*.

1.8.3.1 The Department may refuse to enter into or renew an Agreement with a Provider if the Provider or any person who has an ownership or control interest in the Provider, or who is an agent or managing employee of the Provider, has been convicted of a criminal offense related to that person's involvement in any program established under Medicare, Medicaid or the title XX program.

1.8.3.2 The Department may refuse to enter into or may terminate the Agreement if it determines that the Provider did not fully and accurately make any disclosure required under subsection 1.9.1 of this Agreement.

1.9 Comply, to the extent required, with 42 U.S.C. § 1396a(a)(68), and the requirements of the False Claims Act by:

1.9.1 Establishing written policies for all employees that include detailed information about the False Claims Act and the other provisions set forth in 42 U.S.C. § 1396a(a)(68). The policies must include detailed information about the Provider's policies and procedures for detecting and preventing waste, fraud, and abuse.

1.9.2 Including in any employee handbook a specific discussion of the laws described in the written policies, the rights of employees to be protected as whistleblowers, and a specific discussion of the Provider's policies and procedures for detecting and preventing fraud, waste, and abuse.

1.10 Comply with those Federal requirements and assurances for recipients of Federal grants provided in OMB Standard Form 424B (4-88) applicable to the Provider. The Provider is responsible for determining which requirements and assurances are applicable to the Provider. The Provider shall provide for the compliance of any subcontractors with applicable Federal requirements and assurances.

1.11 Be aware of and acknowledge that payment of claims will be from Federal and State funds and that any falsification or concealment of a material fact may be prosecuted under Federal and State law.

1.12 Comply with 42 U.S.C. § 1395cc(j) by disclosing any current or previous affiliation (directly or indirectly) with a provider of medical or other items or services or supplier that has uncollected debt, has been or is subject to a payment suspension under a Federal health care program, has been excluded from participation under Medicare, Medicaid or title XXI programs or has had its billing privileges denied or revoked.

1.13 Meet, on a continuing basis, the State and Federal licensure, certification or other regulatory requirements for Provider's specialty, including all provisions of the State of Iowa Medical Assistance law, or any rule or regulation promulgated pursuant thereto.

1.14 Refrain from conduct prohibited by 31 U.S.C. § 1352 and 45 C.F.R. § 93.100 et seq., which restrict the payments of federally appropriated funds to any person for influencing or attempting to influence an officer or employee of any agency, a member of the U.S. Congress, an officer or employee of the U.S. Congress, or an employee of a member of the U.S. Congress in connection with the awarding of any Federal contract, the making of any cooperative agreement, or the extension, continuation, renewal, amendment or modification of any Federal contract, grant, loan, or cooperative agreement.

1.15 For Provider Groups: To warrant that the group has authority to bind all member providers to this Provider Agreement; to provide the Department with names of practitioners in the group with proof of current licensure for each practitioner; to provide name(s) of individual(s) with authority to sign billings on behalf of the group; and to provide each member Provider with a copy of this Agreement.

Section 2. Reimbursement

2.1 The Provider acknowledges that this Agreement is based on the Provider's performance of the services contemplated hereunder. Department agrees to pay for medically necessary goods and/or services actually and properly provided to the Department-enrolled Medicaid member. All such goods and/or services must have been rendered by Provider in accordance with Federal and State law and the State policies and procedures set forth in the Iowa Medicaid Provider Manual. Financial obligations of the State of Iowa are contingent upon funds for that purpose being appropriated.

2.2 The Provider agrees to pursue the member's other health coverage prior to submitting a claim for goods and/or services to the IME. This includes but is not limited to Medicare, private insurance, medical benefits provided by employers and unions, worker compensation, and any other third party insurance.

2.3 The Provider receiving payment shall accept payment from the Department (and any applicable co-pay) as payment in full on behalf of the member, and agrees not to bill, retain or accept payments for any additional amounts except as provided for in paragraph 2.2 above;

2.4 The Provider shall immediately repay the Department in full for any claims where the Provider received payment from another party after being paid by the Department. In the event that the Provider owes the State any sum under the terms of this Agreement, any other Agreement, pursuant to any other debt subject to the law of set off, the State may set off the sum owed to the State against any sum owed by the State to the Provider in the State's sole discretion, unless

otherwise required by law. The Provider agrees that this provision constitutes proper and timely notice under the law of set off.

2.5 The Provider shall report and return any overpayment by the later of a) 60 days after the date on which the overpayment is identified or b) the date any corresponding cost report is due, if applicable.

2.6 The Department may make any necessary adjustment to payments to the Provider in order to satisfy any past-due obligations of a provider that has the same taxpayer identification number, regardless of whether the Provider is assigned a different billing number or national provider identification number.

2.7 The Department may withhold payments, in whole or in part, upon receipt of reliable evidence of fraud or willful misrepresentation as specified in 42 C.F.R. § 455.23. Department shall fully document the reliable evidence it evaluated in making a decision to withhold payment. If the Department has evidence of fraud or willful misrepresentation on the part of the Provider, the Department may notify the Provider of the temporary suspension of this Agreement. If Provider has been notified of the temporary suspension of this Agreement, Provider may not bill for services rendered to eligible members during the period of the suspension.

Section 3. Notices

With the exception of amendments made pursuant to § 5.10 of this Agreement, all written notices or communication shall be deemed to have been given when delivered in person; or, if sent to address on file by first-class United States mail, proper postage prepaid. Provider shall notify the Department and/or IME within thirty-five (35) days of any change that must be reported pursuant to a notice or disclosure requirement contained in this Agreement, including but not limited to (1) suspension, revocation or limitations placed on the Provider's license or certifications, (2) indictment, arrest or conviction for a criminal offense related to the provision of goods and/or services under a federally-funded health care program, (3) change in ownership or control, and (4) change in address or addition to or removal of practitioners or any other information pertinent to the receipt of Department funds.

Section 4. Records

4.1 The Provider shall maintain books, records and documents which sufficiently and properly document and calculate all charges billed to the Department throughout the term of this Agreement for a period of at least five (5) years following the date of final payment or completion of any required audit. Records to be maintained include both financial records and service records. The Provider shall permit the Auditor of the State of Iowa or any authorized representative of the State and where federal funds are involved, the Comptroller General of the United States or any other authorized representative of the United States government, to access and examine, audit, excerpt and transcribe any directly pertinent books, documents, papers, electronic or optically stored and created records or other records of the Provider relating to orders, invoices or payments or any other documentation or materials pertaining to this Agreement, wherever such records may be located. The Provider shall not impose a charge for audit or examination of the Provider's books and records.

4.2 Provider shall maintain adequate medical, financial, and administrative records as stated in the Iowa Medicaid Provider Manual relating to all goods and/or services rendered by Provider under this Agreement. In order to perform its utilization management, quality improvement activities, audits and fraud control unit activities, the Department and/or the IME, Federal employees, and/or authorized representatives shall be given access to the business or facility and all related member information and records, including claims records, and information regarding payments claimed by the Provider for furnishing services under this Agreement. The Provider shall provide copies of such records free of charge and in a timeframe consistent with 441 Iowa Admin. Code § 79.3 or as otherwise agreed to by Provider and the Iowa Medicaid Program.

Section 5. Miscellaneous

5.1 Incorporation of Documents. Both parties mutually agree that the Department Provider Enrollment Application submitted and signed by the Provider is incorporated by reference into this Agreement and is a part hereof as though fully set forth herein. The Provider agrees to notify the Iowa Medicaid Enterprise Provider Services Unit, P.O. Box 36450, Des Moines, IA 50315 within 30 days of a change in any of the information in the Provider Enrollment Application.

5.2 Independent Contractor. Provider is an independent contractor providing goods and/or services paid for by the Department. Neither the Provider nor any of the Provider's employees, agents and any subcontractors performing under this Agreement are employees or agents of the State of Iowa or any agency, division or department of the State. Neither the Provider nor its employees shall be considered employees of the Department or the State of Iowa for federal or state tax purposes. The Department will not withhold taxes on behalf of the Provider (unless required by law). The Provider is solely responsible for and shall meet all legal requirements, including payment of all applicable taxes, workers compensation, unemployment and other premiums, deductions, withholdings, overtime and other amounts, which may be legally required with respect to the Provider, and the employment of all persons providing goods and/or services under this Agreement.

5.3 Certification Regarding Sales and Use Tax. By executing this Agreement, the Provider certifies it is either (a) registered with the Iowa Department of Revenue, collects, and remits Iowa sales and use taxes as required by Iowa Code chapter 423; or (b) not a "retailer" or a "retailer maintaining a place of business in the state" as those terms are defined in Iowa Code subsections 423.1(42) & (43). The Provider also acknowledges that the Department may declare the Agreement void if the above certification is false. The Provider also understands that fraudulent certification may result in the Department or its representative filing for damages for breach of contract.

5.4 Assignment/Change of Control. This Agreement may not be assigned, transferred or conveyed in whole or in part without the prior written consent of the Department. For the purpose of construing this clause, a transfer of a controlling interest in the Provider shall be considered an assignment.

5.5 Choice of Law and Forum. The laws of the State of Iowa shall govern and determine all matters arising out of or in connection with this Agreement without regard to the choice of law provisions of Iowa law. In the event of any proceeding of a quasi-judicial or judicial nature is commenced in connection with this Agreement, the proceeding shall be brought and maintained in Polk County District Court for the State of Iowa, Des Moines, Iowa or in the United States District Court for the Southern District of Iowa, Central Division, Des Moines, Iowa wherever jurisdiction is appropriate. This provision shall not be construed as waiving any immunity to suit or liability including without limitation sovereign immunity in State or Federal court, which may be available to the Department or the State of Iowa.

5.6 Drug Free Workplace. The Provider shall provide a drug free workplace in accordance with the Drug Free Workplace Act of 1988 and all applicable regulations.

5.7 Not a Joint Venture. Nothing in this Agreement shall be construed as creating or constituting the relationship of a partnership, joint venture, (or other association of any kind or agent and principal relationship) between the parties hereto. Each party shall be deemed to be an independent contractor contracting for services and acting toward the mutual benefits expected to be derived from the Agreement. No party, unless otherwise specifically provided for herein, has the authority to enter into any contract or create an obligation or liability on behalf of, in the name of, or binding upon another party to this Agreement.

5.8 Severability. If any provision of this Agreement is determined by a court of competent jurisdiction to be invalid or unenforceable, such determination shall not affect the validity or enforceability of any other part or provision of this Agreement.

5.9 Third Party Beneficiaries. There are no third-party beneficiaries to this Agreement. This Agreement is intended only to benefit the State, the Department, and the Provider.

5.10 Amendment. The Department may amend this Agreement from time to time by posting an updated version on the Provider Services website at: http://www.ime.state.ia.us/Providers/index.html and providing notice of the amended Agreement to the Provider by issuing a bulletin/informational letter. The Provider shall be deemed to have accepted the amendment, unless the Provider notifies the Department of its non-acceptance of the new provisions of the Agreement within 30 days of the notice. Such notice of non-acceptance of the amendment shall constitute notice of termination of this Agreement effective upon receipt of such notice.

5.11 Supersedes Former Agreements. Once the Department enrolls the Provider, this Agreement supersedes and replaces any existing contracts between the parties related to the provision of health care goods and/or services to members of the Iowa Medicaid Program.

5.12 This Agreement shall remain in full force and effect to the end of the specified term or until terminated or canceled pursuant to administrative rules published by the Department. All obligations of the Department and the Provider incurred or existing under this Agreement as of the date of expiration, termination or cancellation will survive the termination, expiration or conclusion of this Agreement.

5.13 The parties to this Agreement hereby expressly indicate their mutual intent to incorporate into this Agreement all applicable laws, rules, regulations, guidance, and policies as those laws, rules, regulations, guidance, and policies existed at the time of Agreement execution as well as all future amendments, changes, and additions to all applicable laws, rules, regulations, guidance, and policies. The parties to this Agreement expressly reject any proposition that future changes in applicable law, rule, regulation, guidance, and policy are inapplicable to this Agreement and the parties' performance pursuant to the Agreement.

Section 6. Termination

6.1 The Provider may terminate this Agreement at any time. Payments will be made for goods and/or services rendered up to and including the date of termination. The Provider will promptly supply all information necessary for the reimbursement of any outstanding claims.

6.2 The Department may terminate this Agreement, upon thirty (30) days written advance notice to the Provider of goods and/or services after it has determined:

6.2.1 The Provider of goods and/or services is not substantially complying with the provision of the Agreement as set forth herein; or,

6.2.2 The Provider of goods and/or services has not submitted any claims for goods and/or services rendered to members of the Iowa Medicaid program for a period of twenty-four (24) months. In such cases, the Department will notify the Provider of goods and/or services that unless the Provider notifies the Department within a period of thirty (30) calendar days from receipt of such notice, the Department will assume the Provider of goods and/or services wishes to voluntarily terminate its participation in the Iowa Medicaid Program. Providers who do not submit any claims in 48 months will be terminated as providers without further notification.

6.3 The Department may terminate this Agreement in accordance with 441 Iowa Admin. Code chapter 79.

6.4 The Department may terminate this Agreement immediately after it has determined the Provider's State license or certification under Title XVIII of the Social Security Act (Medicare) has been terminated or suspended by a competent authority.

6.5 Absent early termination of this Agreement pursuant to the provisions of this Section, this Agreement shall remain in full force and effect for a term of five (5) years from the effective date established during the enrollment process.

Section 7. Business Associate Agreement

All Providers who are MediPASS patient managers, Wellness patient managers, Health Home Providers, and/or Accountable Care Organizations are Business Associates of the Department. ("Business Associate Provider"). The Business Associate Provider performs certain services on behalf of the Department pursuant to this Provider Agreement that require the exchange of information that is protected by the Health Insurance Portability and Accountability Act of 1996, as amended, and the federal regulations published at 45 CFR part 160 and 164. The Business Associate Provider agrees to comply with the Business Associate Agreement Addendum (BAA), and any amendments thereof, as posted to the Department's website: http://dhs.iowa.gov/hipaa. This BAA, and any amendments thereof, is incorporated into the Provider Agreement by reference.

Section 8. Qualified Service Organization

Providers who are also Business Associates acknowledge that they may be receiving, storing, processing, or otherwise dealing with confidential patient records from programs covered by 42 CFR part 2. Such Business Associate Providers acknowledge that they are fully bound by those regulations as a "Qualified Service Organization." The term "Qualified Service Organization" as used in this Agreement has the same meaning as the definition set forth in 42 CFR § 2.11. Business Associate Providers will resist in judicial proceedings any efforts to obtain access to patient records covered by 42 C.F.R. part 2 except as permitted by these regulations.

Provider:	
Provider Business Entity Name:	
Federal Tax ID or Social Security #:	
Authorized Official's Name:	**Title:**
Authorized Official Signature:	**Date:**

b. Non-Emergency Medical Transportation (NEMT) and Waiver Transportation Services

Transportation of waiver members to non-emergency medical services may be provided either as a waiver service or through the NEMT broker. All waiver transportation must be authorized in the service plan.

C. PROVIDER ENROLLMENT

1. Certification and Enrollment of New Providers

To apply for enrollment as a waiver service provider, contact IME Provider Services by phone at (800) 338-7909 or locally in Des Moines at (515) 256-4609, or in writing at:

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

The IME Provider Services Unit provides telephone support to answer any billing questions from providers. The number is (800) 338-7909 or locally in Des Moines at (515) 256-4609.

Upon request, an application packet will be sent containing:

- Form 470-2917, *Medicaid HCBS Waiver Provider Application*, and instructions for its completion, and
- Form 470-2965, *Iowa Medicaid Provider Agreement General Terms*, and
- Form W-9, Request for Taxpayer Identification Number and Certification, and
- Providers must complete child abuse, dependent adult abuse, and criminal background screenings pursuant to Iowa Code section 135C.33(5)"a"(1) before employment of a staff member who will provide direct care.

Submit the completed application to the IME Provider Services address listed previously. The IME must receive the application for enrollment at least 90 days before the planned implementation date.

The IME Provider Enrollment Unit will review the submitted application and any required documentation necessary to qualify as a provider of the service for which application is being made. This may include:

- Current accreditations, evaluations, inspections, and reviews by regulatory and licensing agencies and associations policies, procedures and forms.
- All providers must demonstrate the fiscal capacity to provide services on an ongoing basis.

Deemed status is available for agencies accredited in good standing as a provider of a similar service by:

- The Council on Accreditation of Rehabilitation Facilities (CARF), or
- The Council on Accreditation of Services for Families and Children (COA), or
- The Joint Commission on Accreditation of Healthcare Organizations (JCAHO), or
- The Council on Quality and Leadership in Supports for People with Disabilities (the Council).

"Similar service" means the CARF-accredited, COA-accredited, JCAHO-accredited, or Council-accredited service is provided in the least restrictive environment, promotes independence, provides consumer choice, and includes all other service elements as described in the this manual for the specific service.

If seeking deemed status, submit copies of current CARF, COA, JCAHO, or Council accreditation and the evaluations which show the agency to be in good standing. "Good standing" means the accreditation is current and unconditional.

If substantial compliance with required standards at the time of the review is demonstrated and remains unconditionally accredited by CARF or the Council, deemed status for this service will continue for the duration of the national body's accreditation period.

NOTE: If deemed status has been granted due to CARF or Council accreditation, but when a new CARF or Council survey is completed, the agency is not recertified for two or three years (as applicable). The agency must notify the Department regarding its status. HCBS specialists may complete an on-site review to determine if the agency is to remain eligible for waiver certification, based on:

- The fiscal capacity to initiate and operate the specified programs on an ongoing basis.
- A written agreement to work cooperatively with the state and the counties that will be served. This is requested of those applying for all certified services and is not specific to deemed status.

The Provider Enrollment Unit has 60 days from the receipt of all required documentation and completed background checks for individual CDAC to determine whether the provider meets the applicable standards for providing waiver services. (This deadline may be extended by mutual consent.)

When an application is approved, Provider Services will recommend enrollment. Review of a provider may occur at any time that it is determined to be necessary.

2. Adding a New Service for Existing Provider

A new application is required to add a new waiver service for an existing waiver provider. Access form 470-2917, *Medicaid HCBS Waiver Provider Application*, online or contact the IME Provider Enrollment Unit at (800) 338-7909, or locally in Des Moines at (515) 256-4609 for an application to be mailed. When completing the new application, attach documentation necessary to qualify as a provider of the service.

The Department must approve the service before the Provider Enrollment Unit adds that category of service to the provider. No new provider number is issued. **NOTE:** Claims will be denied if this process is not followed.

3. Changes

The Provider Enrollment Unit must be notified when:

- Enrollment is not renewed.
- The provision of any waiver service is withdrawn.
- A new service under a specific waiver is added.

Notice must be in writing and must be received by the Provider Services Unit 30 days before the date of service or program termination.

4. Change in Ownership, Agency Name, or Satellite Offices

If the ownership or name change does not involve the issuance of a new federal tax identification number, the agency is not required to complete a new *Medicaid HCBS Waiver Provider Application*, form 470-2917.

Adding a satellite office does not require the completion of a new waiver provider application if the satellite office uses the main office's provider number for billing purposes. If the agency chooses to have a separate provider number for the satellite office, it must submit another waiver application for that office.

5. Recertification

The agency must be recertified when its current certification ends. The agency must demonstrate substantial continued compliance with standards for recertification to occur. The HCBS specialist initiates recertification.

The recertification procedures for supported community living, supported employment, behavioral programming, and certified respite services are initiated:

- Before the expiration of the current certification, and
- Determination of compliance with Iowa Administrative Code service standards or determination that the agency remains accredited by a recognized national accrediting body.

6. Deemed Status Providers

If the agency is accredited for similar services, its certification continues as long as it maintains current accreditation as outlined in Certification and Enrollment of New Providers. Submit reports from the accrediting body to the HCBS specialist as documentation of continued accreditation. The HCBS specialists may conduct an on-site review to evaluate compliance with required standards.

7. Certified Providers

If the agency is certified without deemed status, specialists will conduct an on-site review in conjunction with the HCBS quality management activities.

The HCBS specialists will look at member files, personnel records, and the organization's implementation of policies and procedures to ensure that the service has the greatest impact on members and provides opportunities to improve service outcomes. The HCBS specialists will hold an exit conference with the agency to share preliminary findings of the review.

Following the review, HCBS specialists will issue a review report, noting service strengths and deficiencies, within 30 business days unless the agency and the specialist mutually agree to extend that time frame. A provider acknowledgement identifying that the agency has received the review report and will actively work to correct the areas noted in the report is required.

Corrective action plans are required when the necessary criteria are not met. The corrective action plans will be monitored to ensure their implementation. The specialist will determine if this monitoring will be done through the submission of written reports or as an on-site review.

D. STANDARDS FOR PROVIDERS OF SERVICE

Providers are eligible to participate in the Medicaid program as approved waiver service providers based on the standards pertaining to the individual service.

Providers must have written policies and procedures according to state and federal laws for intake, admission, service coordination, discharge, and referral. "Service coordination" means activities designed to help individuals and families locate, access, and coordinate a network of supports and services that will allow them to live a full life in the community. This is specific to certified services.

Providers must also have written policies and procedures and a staff training program for the identification and reporting of child and dependent adult abuse to the Department.

Providers and their staff must complete child abuse, dependent adult abuse, and criminal background screenings pursuant to Iowa Code section 249A.29 before the provision of direct care services to members of any waiver program.

Providers and contracting entities are required to check the program exclusion status of individuals and entities before entering into employment or contractual relationships. To determine whether an individual or entity is excluded, search the HHS-OIG website at: http://exclusions.oig.hhs.gov/.

An excluded individual or an entity employing or contracting with an excluded individual or entity that submits a claim for reimbursement to a federal health care program, or causes such a claim to be submitted, may be subject to civil money penalties and other damages for each item or service furnished during the period that the person or entity was excluded (section 1128A(a)(1)(D) of the Social Security Act).

Providers should search the HHS-OIG website monthly to capture exclusions and reinstatements that have occurred since the last search. Claims paid by the Medicaid program for services rendered by an excluded individual or entity are subject to repayment. Providers may also be subject to penalties by the OIG. Providers can search the HHS-OIG website by the name of any individual or entity. An additional listing of parties excluded from any federal payment is the System for Award Management (SAM) at: https://www.sam.gov. It is recommended that this listing be checked as well.

Enrollment carries no assurance that the approved provider will receive funding. Payment for services will be made to a provider only upon Department approval of the provider and of the service the provider is authorized to provide on an individual member basis.

The IME shall review compliance with standards for initial enrollment. Review of a provider may occur at any time.

The Department may request any information from the prospective service provider that is pertinent to arriving at an enrollment decision. This information may include:

- Current accreditations.
- Evaluations.
- Inspection reports.
- Reviews by regulatory and licensing agencies and associations.
- Evidence of financial sustainability.

All Medicaid providers are expected to adhere to the state and federal rules applicable to each service and business operation including the Department of Labor, Fair Labor Standards Act.

1. Home- and Community-Based Services (HCBS) Provider Quality Management Self-Assessment

The Home- and Community-Based Services (HCBS) Provider Quality Management Self-Assessment process was developed as a way for the state to gather data to support the quality framework performance measures as required by the Centers for Medicare and Medicaid Services (CMS). The provider self-assessment process mirrors a CMS review process by requiring waiver providers to develop a quality improvement system of monitoring their own performance and then "showing" the state how it provides quality oversight.

The first step in the provider self-assessment process is to identify a core set of policies and procedures for all waiver providers based on the services they provide. The policies and procedures are the foundation of a provider's performance and guide them on the provision of waiver services. The state has identified a minimal set of policies and procedures based on the CMS assurances, Iowa Administrative Code requirements, laws found in the Iowa Code, federal regulations, and best practices identified through previous quality oversight activities of HCBS providers.

The provider self-assessment requires a provider to identify the applicable policies and procedures that have been established by the agency upon enrollment to ensure compliance with laws, rules, regulations, and best practices. A provider may also identify any of the standards in the self-assessment that are not applicable to its daily operations.

Once the core policies and procedures have been established through the self-assessment, the HCBS Quality Oversight staff uses four methods of discovery to verify the implementation of a provider's quality performance activities:

- Annual self-assessment,
- Targeted review,
- Focused review, and
- Periodic review.

These reviews may be completed via a desk or on-site review.

The Provider Quality Management Self-Assessment reflects this process as well as information obtained from provider input. The focus of the Provider Quality Management Self-Assessment and subsequent review activities are to assist providers in regulatory compliance and quality improvement. This system of provider oversight is required for all Medicaid providers enrolled to provide the following home- and community-based services:

- **AIDS/HIV waiver**. Agency consumer-directed attendant care (CDAC), respite, adult day care, counseling;
- **Brain injury waiver**. Behavior programming, agency CDAC, respite, supported community living (SCL), supported employment, prevocational, Interim Medical Monitoring and Treatment (IMMT), adult day care, family counseling, and training;
- **Children's mental health waiver**. Family and community support services, in-home family therapy, respite;
- **Elderly waiver**. Agency CDAC (including assisted living providers), respite, adult day care, case management (including those that are Chapter 24 accredited), mental health outreach;
- **Intellectual disability waiver**. Agency CDAC, respite, SCL, supported employment, prevocational, IMMT, adult day care, day habilitation, residential-based supported community living (RBSCL);

- **Health and disability waiver**. Respite, agency CDAC, IMMT, adult day care, counseling;
- Physical disability waiver. Agency CDAC;
- **Habilitation services**. Day habilitation, home-based habilitation, prevocational habilitation, supported employment habilitation.

In addition, supported community living (pursuant to 441 IAC 77.37(249A) providers must meet the outcome-based standards set forth below. Respite and supported employment providers must meet the organizational standards in Outcome 1.

Organizational outcome-based standards for HCBS ID and BI providers are as follows:

- Outcome 1:
  - The organization demonstrates the provision and oversight of high-quality supports and services to members.
  - The organization demonstrates a defined mission commensurate with member's needs, desires, and abilities.
  - The organization establishes and maintains fiscal accountability.
  - The organization has qualified staff commensurate with the needs of the members they serve. These staff demonstrate competency in performing duties and in all interactions with members.
  - The organization provides needed training and supports to its staff. This training includes at a minimum:
    - Member rights
    - Confidentiality
    - Provision of member medication
    - Identification and reporting of child and dependent adult abuse
    - Member support needs

- The organization demonstrates methods of evaluation:
  - Past performance is reviewed
  - Current functioning is evaluated
  - Plans are made for the future based on the evaluation and review
- Members and their legal representatives have the right to appeal the provider's implementation of the 20 outcomes, or staff or contractual person's action that affects the member. The provider shall distribute the policies for member appeals and procedures to members.
- The provider shall have written policies and procedures and a staff training program for the identification and reporting of child and dependent adult abuse to the Department of Human Services.
- The governing body has an active role in the administration of the agency.
- The governing body receives and uses input from a wide range of local community interests and member representation and provides oversight that ensures the provision of high-quality supports and services to members.

Outcome-based standards for **rights and dignity** are as follows:

- Outcome 2: Members are valued.
- Outcome 3: Members live in positive environments.
- Outcome 4: Members work in positive environments.
- Outcome 5: Members exercise their rights and responsibilities.
- Outcome 6: Members have privacy.
- Outcome 7: When there is a need, members have support to exercise and safeguard their rights.
- Outcome 8: Members decide which personal information is shared and with whom.
- Outcome 9: Members make informed choices about where they work.
- Outcome 10: Members make informed choices on how they spend their free time.

- Outcome 11: Members make informed choices about where and with whom they live.
- Outcome 12: Members choose their daily routine.
- Outcome 13: Members are a part of community life and perform varied social roles.
- Outcome 14: Members have a social network and varied relationships.
- Outcome 15: Members develop and accomplish personal goals.
- Outcome 16: Management of member's money is addressed on an individualized basis.
- Outcome 17: Members maintain good health.
- Outcome 18: The member's living environment is reasonably safe in the member's home and community.
- Outcome 19: The member's desire for intimacy is respected and supported.
- Outcome 20: Members have an impact on the services they receive.

Provider standards for each service under the HCBS waivers are listed in the following pages.

2. Adult Day Care Providers

Legal reference:

Waiver Type	Corresponding Iowa Administrative Code
AIDS	441 IAC 77.34(7)
Brain injury	441 IAC 77.39(20)
Elderly	441 IAC 77.33(1)
Health and disability	441 IAC 77.30(3)
Intellectual disability	441 IAC 77.37(25)

Adult day care providers shall be agencies that are certified by the Department of Inspections and Appeals as being in compliance with the standards for adult day services programs at 481 IAC Chapter 70.

3. Assisted Living On-Call Providers

Legal reference:

Waiver Type	**Corresponding Iowa Administrative Code**
Elderly	441 IAC 77.33(23)

Assisted living on-call service providers shall be assisted living programs that are certified by the Department of Inspections and Appeals under 481 IAC Chapter 69.

4. Behavioral Programming Providers

Legal reference:

Waiver Type	**Corresponding Iowa Administrative Code**
Brain injury	441 IAC 77.39(23)

Behavioral programming providers shall be required to have experience with or training regarding the special needs of members with a brain injury.

In addition, they must meet the following requirements:

- Behavior assessment, and development of an appropriate intervention plan, and periodic reassessment of the plan, and training of staff who shall implement the plan must be done by a qualified brain injury professional as defined in rule 441 IAC 83.81(249A). Formal assessment of the member's intellectual and behavioral functioning must be done by a licensed psychologist or a psychiatrist who is certified by the American Board of Psychiatry.
- Implementation of the plan and training and supervision of caregivers, including family members, must be done by behavioral aides who have been trained by a qualified brain injury professional as defined in rule 441 IAC 83.81(249A) and who are employees of one of the following:
  - Agencies which are certified under the community mental health center standards established by the Mental Health and Developmental Disabilities Commission, set forth in 441 IAC 24, Divisions I and III.
  - Agencies which are licensed as meeting the hospice standards and requirements set forth in Department of Inspections and Appeals rules 481 IAC Chapter 53 or which are certified to meet the standards under the Medicare program for hospice programs.

- Agencies which are accredited under the mental health service provider standards established by the Mental Health and Disabilities Commission, set forth in 441 IAC 24, Divisions I and IV.
- Home health aide providers meeting the standards set forth in rule 441 IAC 77.33(3). Home health aide providers certified by Medicare shall be considered to have met these standards.
- Brain injury waiver providers certified pursuant to rule 441 IAC 77.39(249A).

NOTE: See Home- and Community-Based Services (HCBS) Provider Quality Management Self-Assessment for a list of outcome-based standards that apply to the providers of behavioral management services.

5. Case Management Service Providers

Legal reference:

Waiver Type	Corresponding Iowa Administrative Code
Brain injury	441 IAC 77.39(12)
Elderly	441 IAC 77.33(21)

Case management provider organizations are eligible to participate in the Medicaid HCBS elderly and intellectual disability waiver programs provided that it:

- Is accredited by the Mental Health, Intellectual Disability, Developmental Disabilities, and Brain Injury Commission as meeting the standards for case management services in 441 IAC Chapter 24; or
- Is accredited through the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) to provide case management; or
- Is accredited through the Council on Accreditation of Rehabilitation Facilities (CARF) to provide case management; or
- Is accredited through the Council on Quality and Leadership in Supports for People with Disabilities (CQL) to provide case management; or
- Is approved by the Department on Aging as meeting the standards for case management services in 17 IAC 21; or
- Is authorized to provide similar services through a contract with the Department of Public Health (IDPH) for local public health services and that it:
  - Meets the qualifications for case managers in 641 IAC 80.6(1); and
  - Provides a current IDPH local public health services contract number.

A case management provider shall not provide direct services to the member. The Department and the Centers for Medicare and Medicaid Services deem the provision of direct services to case management members to be a conflict of interest. A person cannot be the first-line supervisor of both case managers and direct service staff who are providing services to elderly waiver members. The provider must have written conflict of interest policies that include, but are not limited to:

- Specific procedures to identify conflicts of interest.
- Procedures to eliminate any conflict of interest that is identified.
- Procedures for handling complaints of conflict of interest, including written documentation.

If the case management provider organization subcontracts case management services to another entity:

- That entity must also meet the provider qualifications in this subrule, and
- The contractor is responsible for verification of compliance.

Case management provider organizations are eligible to participate in the Medicaid HCBS brain injury waiver program provided that they meet the standards in 441 IAC Chapter 24 and they are the Department of Human Services, a county or consortium of counties, or a provider under subcontract to the Department or a county or consortium of counties.

6. Chore Service Providers

Legal reference:

Waiver Type	Corresponding Iowa Administrative Code
Elderly	441 IAC 77.33(7)

The following providers may provide chore services:

- Home health agencies certified under Medicare.
- Community action agencies as designated in Iowa Code section 216A.93.
- Agencies authorized to provide similar services through a contract with the Iowa Department of Public Health (IDPH) for local public health services. The agency must provide a current IDPH local public health services contract number.

- Nursing facilities licensed pursuant to Iowa Code chapter 135C.
- Providers that were enrolled as chore providers as of June 30, 2010, based on a subcontract with or letter of approval from an area agency on aging.
- Community businesses that are engaged in the provision of chore services and that:
  - Have all necessary licenses and permits to operate in conformity with federal, state, and local laws and regulations, and
  - Submit verification of current liability and workers' compensation coverage, as required by law.

7. Consumer Choices Option Providers

Providers under the consumer choices option fall under the following categories of providers listed below.

a. Financial Management Service

Legal reference:

Waiver Type	Corresponding Iowa Administrative Code
AIDS	441 IAC 77.34(9)
Brain injury	441 IAC 77.39(26)
Elderly	441 IAC 77.33(16)
Health and disability	441 IAC 77.30(13)
Intellectual disability	441 IAC 77.37(28)
Physical disability	441 IAC 77.41(7)

Members who elect the consumer choices option shall work with a financial institution that meets the following qualifications.

The financial institution shall either:

- Be cooperative, nonprofit, member-owned and member-controlled, and federally insured through and chartered by either the National Credit Union Administration, or by the credit union division of the Iowa Department of Commerce; or

- Be chartered by the Office of the Comptroller of the Currency, a bureau of the U.S. Department of the Treasury, and insured by the Federal Deposit Insurance Corporation (FDIC).
  - The financial institution shall complete a financial management readiness review and certification conducted by the Department or its designee.
  - The financial institution shall obtain an Internal Revenue Service federal employee identification member dedicated to the financial management service.
  - The financial institution shall enroll as a Medicaid provider.

b. Independent Support Brokerage

Legal reference:

Waiver Type	**Corresponding Iowa Administrative Code**
AIDS	441 IAC 77.34(10)
Brain injury	441 IAC 77.39(27)
Elderly	441 IAC 77.33(17)
Health and disability	441 IAC 77.30(14)
Intellectual disability	441 IAC 77.37(29)
Physical disability	441 IAC 77.41(8)

Members who elect this consumer choices option shall work with an independent support broker who meets the following qualifications:

- The broker must be at least 18 years of age.
- The broker shall not be the legal representative under a durable power of attorney for health care, power of attorney for financial matters, trustee, or representative payee.
- The broker shall not provide any other paid service to the member.
- The broker shall not work for an individual or entity that is providing services to the member.
- The broker must consent to a criminal background check and child and dependent adult abuse checks. The results shall be provided to the member.
- The broker must complete an independent support brokerage training approved by the Department.

c. Self-Directed Personal Care

Legal reference:

Waiver Type	Corresponding Iowa Administrative Code
AIDS	441 IAC 77.34(11)
Brain injury	441 IAC 77.39(28)
Elderly	441 IAC 77.33(18)
Health and disability	441 IAC 77.30(15)
Intellectual disability	441 IAC 77.37(30)
Physical disability	441 IAC 77.41(9)

Members who elect the consumer choices option may choose to purchase self-directed personal care services from an individual or business.

A business providing self-directed personal care services shall:

- Have all the necessary licenses and permits to operate in conformity with federal, state, and local laws and regulations;
- Have current liability and workers' compensation coverage; and
- An individual providing self-directed personal care services shall have all the necessary licenses required by federal, state, and local laws, including a valid driver's license if providing transportation.

All personnel providing self-directed personal care services shall:

- Be at least 16 years of age, and
- Be able to communicate successfully with the member, and
- Not be the recipient of respite services paid through home- and community-based services on behalf of a member who receives home- and community-based services, and
- Not be the recipient of respite services paid through the consumer choices option on behalf of a member who receives the consumer choices option, and
- Not be the parent or stepparent of a minor child member or the spouse of a member.

The provider of self-directed personal care services shall:

- Prepare timecards or invoices approved by the Department that identify what services were provided and the time when services were provided.
- Submit invoices and timesheets to the financial management service no later than 30 calendar days from the date when the last service in the billing period was provided. Payment shall not be made if invoices and timesheets are received after this 30-day period

d. Individual-Directed Goods and Services

Legal reference:

Waiver Type	**Corresponding Iowa Administrative Code**
AIDS	441 IAC 77.34(12)
Brain injury	441 IAC 77.39(29)
Elderly	441 IAC 77.33(19)
Health and disability	441 IAC 77.30(16)
Intellectual disability	441 IAC 77.37(31)
Physical disability	441 IAC 77.41(10)

Members who elect the consumer choices option may choose to purchase individual-directed goods and services from an individual or business.

A business providing individual-directed goods and services shall:

- Have all the necessary licenses and permits to operate in conformity with federal, state, and local laws and regulation; and
- Have current liability and workers' compensation coverage; and
- Have all the necessary licenses required by federal, state, and local laws, including a valid driver's license if providing transportation.

All personnel providing individual-directed goods and services shall:

- Be at least 18 years of age, and
- Be able to communicate successfully with the member, and

- Not be the recipient of respite services paid through home- and community-based services on behalf of a member who receives home- and community-based services, and
- Not be the recipient of respite services paid through the consumer choices option on behalf of a member who receives the consumer choices option, and
- Not be the parent or stepparent of a minor child member or the spouse of the spouse of a member.

The provider of individual-directed goods and services shall:

- Prepare timecards or invoices approved by the Department that identify what services were provided and the time when services were provided.
- Submit invoices and timesheets to the financial management service no later than 30 calendar days from the date when the last service in the billing period was provided. Payment shall not be made if invoices and timesheets are received after this 30-day period.

e. Self-Directed Community Supports and Employment

Legal reference:

Waiver Type	**Corresponding Iowa Administrative Code**
AIDS	441 IAC 77.34(13)
Brain injury	441 IAC 77.39(30)
Elderly	441 IAC 77.33(20)
Health and disability	441 IAC 77.30(17)
Intellectual disability	441 IAC 77.37(32)
Physical disability	441 IAC 77.41(11)

Members who elect the consumer choices option may choose to purchase self-directed community supports and employment from an individual or business.

A business providing community supports and employment shall:

- Have all the necessary licenses and permits to operate in conformity with federal, state, and local laws and regulations; and
- Have current liability and workers' compensation coverage; and

- A person providing self-directed community supports and employment shall have all the necessary licenses required by federal, state, and local laws, including a valid driver's license if providing transportation.

All personnel providing self-directed community supports and employment shall:

- Be at least 18 years of age, and
- Be able to communicate successfully with the member, and
- Not be the recipient of respite services paid through home- and community-based services on behalf of a member who receives home- and community-based services, and
- Not be the recipient of respite services paid through the consumer choices option on behalf of a member who receives the consumer choices option, and
- Not be the parent or stepparent of a minor child member or the spouse of a member the spouse of a member.

The provider of self-directed community supports and employment shall:

- Prepare time sheet or invoices approved by the Department that identify what services were provided and the time when services were provided.
- Submit invoices and time sheets to the financial management service within 30 days from the date when the service was provided.

8. Consumer-Directed Attendant Care Providers

Legal reference:

Waiver Type	Corresponding Iowa Administrative Code
AIDS	441 IAC 77.34(8)
Brain injury	441 IAC 77.39(24)
Elderly	441 IAC 77.33(15)
Health and disability	441 IAC 77.30(7)
Intellectual disability	441 IAC 77.37(21)
Physical disability	441 IAC 77.41(2)

A public or private agency or an individual working independently as a provider of consumer-directed attendant care must be enrolled to provide waiver services.

The following providers may be enrolled to provide consumer-directed attendant care service:

- An individual who contracts with the member to provide attendant care service and who is:
  - At least 18 years of age.
  - Qualified by training or experience to carry out the member's plan of care pursuant to the Department-approved service plan.
  - Not the spouse of the member, or a parent or stepparent of a member aged 17 or under.
  - Not the recipient of respite services paid through HCBS on behalf of a member who receives HCBS waiver services.
- Agencies authorized to provide similar services through a contract with the IDPH for local public health services. The agency must provide a current IDPH local public health services contract number.
- Home health agencies that are certified to participate in the Medicare program.
- Chore providers subcontracting with the Department on Aging.
- Community action agencies as designated in Iowa Code section 216A.93.
- Providers certified under an HCBS waiver for supported community living.
- Assisted living programs that are voluntarily accredited or certified by the Department of Inspections and Appeals under Chapters 69 and 70.
- The member or the legal representative of the member shall be responsible for selecting the person or agency that will provide the components of the attendant care services to be provided.

The Department of Human Services as the single state Medicaid agency has the same oversight responsibility for consumer-directed attendant care providers as it does for providers of any other home- and community-based waiver services.

Providers must demonstrate proficiency in delivery of the services included in a member's service plan. Proficiency must be demonstrated through documentation of prior training and experience or a certificate of formal training.

After the interdisciplinary team and member determine the adequacy of the training and experience, the member and provider shall complete form 470-3372, *HCBS Consumer-Directed Attendant Care Agreement*. Click here to access the form online.

The service worker or case manager must review and approve form 470-3372, *HCBS Consumer-Directed Attendant Care Agreement*, before the provision of services. Form 470-3372 becomes an attachment to and part of the service plan. Providers must document the delivery of services on form 470-4389. Click here to access the form online.

Members will give direction and training for activities to maintain independence, which are not medical in nature. Licensed nurses and therapists will provide on-the-job training and supervision for skilled activities described on form 470-3372. All training and experience must be sufficient to protect the health, welfare, and safety of the member.

It is recommended that the provider receive certification of training for the following:

- Transferring
- Catheter assistance
- Medication aide

The role of the service worker or case manager is to assure that CDAC:

- Services are needed.
- Times and frequency are related to assessed needs.
- Agreement 470-3372 includes only payable CDAC services.
- Services are delivered as outlined in the agreement.

This would be especially needed in cases where the CDAC provider is the parent or guardian of an adult child.

Iowa Department of Human Services

Consumer-Directed Attendant Care (CDAC) Daily Service Record

1. Provider name (first, middle initial, last)	**2.** Agency name (If an agency)	**3.** Daily date of service (month, day, year)
4. Consumer name (first, middle initial, last)	**5.** Consumer's Medicaid ID number	**6.** Location(s) where service was given

7. Time I was with the consumer (circle am/pm)	**8. Service Code**	**9. Actual hours of CDAC services** (list time worked and being billed)	**10. Description of the services I performed for the consumer**	**11. Describe the consumer's response to services provided in box 10.**
Start Time ___:___ am pm **End Time** ___:___ am pm				
Start Time ___:___ am pm **End Time** ___:___ am pm				
Start Time ___:___ am pm **End Time** ___:___ am pm				
12. Total hours				

Service codes from CDAC Service Agreement. Choose from the list below. Enter the code in the "Service code" box 8 to show the service you provided.

Non-Skilled Services: N1 – Dressing **N2** – Bathing, grooming, personal hygiene **N3** – Meal preparation & feeding **N4** – Toileting
N5 – Transferring, ambulation, mobility **N6** – Essential housekeeping **N7** – Minor wound care **N8** – Financial and scheduling assistance
N9 – Assistance in the workplace **N10** – Communication **N11** – Essential transportation **N12** – Medication assistance

Skilled Services: S1 – Tube feedings **S2** – Intravenous therapy assistance **S3** – Parenteral injections **S4** – Catheterizations
S5 – Respiratory care **S6** – Care of decubiti and other areas **S7** – Rehabilitation services **S8** – Colostomy care
S9 – Care of medical conditions **S10** – Post-surgical nurse delegated activities **S11** – Monitoring reactions to medication
S12 – Prepare/monitor therapeutic diets **S13** – Recording and reporting of changes in vital signs to the nurse or therapist

13. Provider's Signature	**14.** Date

This form is to record the services you provide. It is required that you fill out one of these forms every day that you provide services. Your billings may be audited and if you do not have this form to support what you billed and were paid for, you may have to repay the Medicaid program. This form will be used as the record for what you have done. Make sure that the form is filled out COMPLETELY.

This form must be maintained during the time that the member is receiving services and a minimum of five years from the last claim submission date, even if you are no longer providing services.

You should use the form as a tool to keep a record of what you do. You provide very important care to your consumer. Part of your role is also to monitor how your consumer is doing. Is the customer safe at home? Is the customer's health getting worse? Is there anything going on to be concerned about? Use this record to keep track of how your consumer does every day. Over time you might see a pattern. **Contact the consumer's case manager if you are concerned regarding these services.**

Directions: Fill out this form every time you provide services to your consumer. The CDAC Agreement (form 470-3372) lists the services you are authorized to provide. After you finish performing the service, fill out this form. If you need more space to enter your information, you may use another form for the same date of service. If you use more than one form for a date of service, you must still complete all of the fields on the other forms, including the required signatures. Use a new form for each shift. This form must be completed in English.

Box by box instructions:

1. Provider name: Enter your name – first, middle initial, and last name.
2. Agency name (if an agency): If you are an agency waiver provider, enter the agency name.
3. Daily date of service: Enter the month, day, and year on which the service took place. It is required that you fill out a CDAC Daily Service Record form every day that you provide service.
4. Consumer name: Enter the name of the person you are providing services for – first name, middle initial, and last name.
5. Consumer's Medicaid ID number: Enter the Medicaid ID number of the person you are providing services for.
6. Location(s) where service was given: Enter the places where you performed the service. For example: home, work, school, etc.
7. Time I was with the consumer: Enter the time you began and ended each shift. You do not need to enter start and end times every time you perform a service (toileting, meal preparation, etc.). You will enter one start time and one end time to make a record of your shift. Make sure to use am/pm.
8. Service codes: Enter the service code (found in the list at the bottom of the page) that corresponds to the service you provided. These codes must match what you have been approved to perform in your CDAC Agreement. You may have several codes in this field.
9. Actual hours of CDAC services: Enter the hours and minutes you actually provided for the service code you entered in box 8. (Note: The amount of time entered in box 9 may be less than the full span of time entered in box 7.)
10. Description of the services I performed for the consumer: Explain what you did for the member.
11. Describe the consumer's response to services provided in box 10 and any changes you saw with the consumer or service.
12. Total hours: Enter the number of hours you provided for the approved CDAC services described on the form. If you need to use more than one form, only put the total number of hours provided for each separate form.
13. Provider's signature: The actual provider of service.
14. Date: Enter the date of service on which the form was signed. This date should match the date of service entered in box 3.

9. Counseling Providers

Legal reference:

Waiver Type	**Corresponding Iowa Administrative Code**
AIDS	441 IAC 77.34(1)
Health and disability	441 IAC 77.30(6)

Counseling providers shall be:

- Agencies certified under the community mental health center standards established by the Mental Health and Developmental Disabilities Commission set forth in Department of Human Services rules 441 IAC 24, Divisions I and III.
- Agencies that are either:
  - Licensed as meeting the hospice requirements set forth in Department of Inspections and Appeals rule 481 IAC 53, or
  - Certified to meet the standards under the Medicare program for hospice programs.
- Agencies accredited under the mental health service provider standards established by the Mental Health and Developmental Disabilities Commission set forth in 441 IAC 24, Divisions I and IV.

10. Family Counseling and Training Providers

Legal reference:

Waiver Type	**Corresponding Iowa Administrative Code**
Brain injury	441 IAC 77.39(21)

Family counseling and training providers shall be one of the following:

- Providers that are certified under the community mental health center standards established by the Mental Health and Developmental Disabilities Commission set forth in 441 IAC 24, Divisions I and III, and that employ staff to provide family counseling and training who meet the definition of qualified brain injury professional as set forth in rule 441 IAC 83.81(249A).
- Providers licensed as meeting the hospice standards and requirements set forth in Department of Inspections and Appeals rules in 481 IAC 53 or certified to meet the standards under the Medicare program for hospice programs, and that employ staff who meet the definition of qualified brain injury professional as set forth in rule 441 IAC 83.81(249A).

- Providers accredited under the mental health service provider standards established by the Mental Health and Developmental Disabilities Commission set forth in 441 IAC 24, Divisions I and IV, and that employ staff to provide family counseling and training who meet the definition of qualified brain injury professional as set forth in rule 441 IAC 83.81(249A).
- Individuals who meet the definition of qualified brain injury professional as set forth in rule 441 IAC 83.81(249A).
- Agencies certified as brain injury waiver providers pursuant to 441 IAC 77.39(249A) that employ staff to provide family counseling who meet the definition of a qualified brain injury professional as set forth in rule 441 IAC 83.81(249A).

11. Home and Vehicle Modification Providers

Legal reference:

Waiver Type	**Corresponding Iowa Administrative Code**
Brain injury	441 IAC 77.39(16)
Elderly	441 IAC 77.33(9)
Health and disability	441 IAC 77.30(9)
Intellectual disability	441 IAC 77.37(17)
Physical disability	441 IAC 77.41(3)

The following providers may provide home and vehicle modifications:

- Department on Aging as designated in 321 IAC 4.4(231).
- Community action agencies as designated in Iowa Code section 216A.93.
- Providers eligible to participate as:
  - Home and vehicle modification providers under the elderly waiver,
  - Enrolled as home and vehicle modification providers under the physical disability waiver, or
  - Certified as home and vehicle modification providers under the intellectual disability or brain injury waiver.
- Community businesses that have all necessary licenses and permits to operate in conformity with federal, state, and local laws and regulations, and that submit verification of current liability and workers' compensation coverage, as required by law.

12. Home-Delivered Meals Providers

Legal reference:

Waiver Type	Corresponding Iowa Administrative Code
AIDS	441 IAC 77.34(6)
Elderly	441 IAC 77.33(8)
Health and disability	441 IAC 77.30(11)

The following providers qualify to provide home-delivered meals:

- Area agencies on aging as designated in 17 IAC 4.4(231). Home-delivered meals providers subcontracting with area agencies on aging.
- Community action agencies as designated in Iowa Code section 216A.93.
- Nursing facilities licensed pursuant to Iowa Code chapter 135C.
- Restaurants licensed and inspected under Iowa Code chapter 137F.
- Hospitals enrolled as Medicaid providers.
- Home health aide providers meeting the standards set forth in 441 IAC 77.33(3).
- Medical equipment and supply dealers certified to participate in the Medicaid program.
- Home care providers meeting the standards set forth in 441 IAC 77.33(4).

13. Home Health Aide Providers

Legal reference:

Waiver Type	Corresponding Iowa Administrative Code
AIDS	441 IAC 77.34(2)
Elderly	441 IAC 77.33(3)
Health and disability	441 IAC 77.30(2)
Intellectual disability	441 IAC 77.37(20)

Home health aide providers shall be home health agencies that are certified to participate in the Medicare program as home health agencies and which have an HCBS agreement with the Department.

14. Homemaker Providers

Legal reference:

Waiver Type	Corresponding Iowa Administrative Code
AIDS	441 IAC 77.34(3)
Elderly	441 IAC 77.33(4)
Health and disability	441 IAC 77.30(1)

Homemaker providers are agencies that meet one of the following two criteria:

- Authorized to provide similar services through a contract with the IDPH for local public health services. The agency must provide a current IDPH local public health services contract number.
- Agencies that are certified to participate in the Medicare program.

15. Interim Medical Monitoring and Treatment (IMMT) Providers

Legal reference:

Waiver Type	Corresponding Iowa Administrative Code
AIDS	441 IAC 77.39(25)
Health and disability	441 IAC 77.30(8)
Intellectual disability	441 IAC 77.37(22)

The following providers may provide interim medical monitoring and treatment services:

- Child care facilities, which are defined as child care centers licensed pursuant to 441 IAC Chapter 109, preschools, or child development homes registered pursuant to 441 IAC Chapter 110.
- Home health agencies certified to participate in the Medicare program.
- Supported community living providers certified according to 441 IAC 77.37(14) or 441 IAC 77.39(13).

Staff members providing interim medical monitoring and treatment services to members shall meet all of the following requirements:

- Be at least 18 years of age, and
- Not be the spouse of the member or a parent or stepparent of the member if the member is aged 17 or under, and

- Not be a usual caregiver of the member, and
- Be qualified by training or experience to provide medical intervention or intervention in a medical emergency necessary to carry out the member's plan of care. The training or experience required must be determined by the member's usual caregivers and a licensed medical professional on the member's interdisciplinary team and must be documented in the member's service plan.

16. Nursing Care Providers

Legal reference:

Waiver Type	Corresponding Iowa Administrative Code
AIDS	441 IAC 77.34(4)
Elderly	441 IAC 77.33(5)
Health and disability	441 IAC 77.30(4)
Intellectual disability	441 IAC 77.37(19)

Nursing care providers shall be agencies that are certified to participate in the Medicare program as home health agencies.

17. Nutritional Counseling Providers

Legal reference:

Waiver Type	Corresponding Iowa Administrative Code
Elderly	441 IAC 77.33(12)
Health and disability	441 IAC 77.30(12)

The following providers may provide nutritional counseling by a licensed dietitian under 645 IAC Chapter 81:

- Hospitals enrolled as Medicaid providers
- Community action agencies as designated in Iowa Code section 216A.93.ed in Iowa Code section 216A.93
- Nursing facilities licensed pursuant to Iowa Code chapter 135C
- Home health agencies certified by Medicare
- Independently licensed dietitians approved by the Department on Aging

18. Personal Emergency Response Services and Portable Locator Providers

Legal reference:

Waiver Type	**Corresponding Iowa Administrative Code**
Brain injury	441 IAC 77.39(17)
Elderly	441 IAC 77.33(2)
Health and disability	441 IAC 77.30(10)
Intellectual disability	441 IAC 77.37(18)
Physical disability	441 IAC 77.41(4)

Personal emergency response system and portable locator providers shall be agencies which meet the conditions of participation set forth in 441 IAC 77.33(2) to maintain certification.

19. Residential-Based Supported Community Living Service Providers

Legal reference:

Waiver Type	**Corresponding Iowa Administrative Code**
Intellectual disability	441 IAC 77.37(23)

The Department shall contract only with public or private agencies to provide RBSCL.

Subject to the requirements of this rule, the following agencies may provide RBSCL:

- Agencies licensed as group living foster care facilities under 441 IAC Chapter 114.
- Agencies licensed as residential facilities for intellectually disabled children under 441 IAC Chapter 116.
- All agencies providing RBSCL that meet the following conditions:
  - The agency shall provide orientation training on the agency's purpose, policies, and procedures within one month of hire or contracting for all employed and contracted treatment staff and must provide 24 hours of training during the first year of employment or contracting.

- The agency must also provide at least 12 hours of training per year after the first year of employment for all employed and contracted treatment staff. Annual training shall include, at a minimum, training on children's intellectual disability and developmental disabilities services and children's mental health issues.
- Identification and reporting of child abuse shall be covered in training at least every five years, in accordance with Iowa Code section 232.69.

♦ The agency must have standards for the rights and dignity of children that are age-appropriate. These standards shall include the following:

- Children, their families, and their legal representatives decide what personal information is shared and with whom children are a part of family and community life and perform varied social roles.
- Children have family connections, a social network, and varied relationships.
- Children develop and accomplish personal goals.
- Children are valued.
- Children live in positive environments.
- Children exercise their rights and responsibilities.
- Children make informed choices about how they spend their free time.
- Children choose their daily routine.

♦ The agency must use methods of self-evaluation by which:

- Past performance is reviewed,
- Current functioning is evaluated, and
- Plans are made for the future based on the review and evaluation.

♦ The agency must have a governing body that receives and uses input from a wide range of local community interests and member representatives and provides oversight that ensures the provision of high-quality supports and services to children.

♦ Children, their parents, and their legal representatives must have the right to appeal the service provider's application of policies or procedures or any staff person's action that affects the member. The service provider shall distribute the policies for member appeals and procedures to children, their parents, and their legal representatives.

As a condition of participation, all providers of RBSCL must have the following on file:

- Current accreditations, evaluations, inspections, and reviews by applicable regulatory and licensing agencies and associations
- Documentation of the fiscal capacity of the provider to initiate and operate the specified programs on an ongoing basis
- The provider's written agreement to work cooperatively with the Department

As a condition of participation, all providers of RBSCL must develop, review, and revise service plans for each child, as follows:

- The provider's service plan shall be developed in collaboration with the social worker or case manager, child, family, and, if applicable, the foster parents, unless a treatment rationale for the lack of involvement of one of these parties is documented in the plan. The service provider shall document the dates and content of the collaboration on the service plan. The service provider shall provide a copy of the service plan to the family and the case manager, unless otherwise ordered by a court of competent jurisdiction.
- Initial service plans shall be developed after services have been authorized and within 30 calendar days of initiating services.

The provider's service plan shall identify the following:

- Strengths and needs of the child.
- Goals to be achieved to meet the needs of the child.
- Objectives for each goal that are specific, measurable, and time-limited and include indicators of progress toward each goal.
- Specific service activities to be provided to achieve the objectives.
- The persons responsible for providing the services. When daily living and social skills development is provided in a group care setting, designation may be by job title.
- Date of service initiation and date of individual service plan development.
- Service goals describing how the child will be reunited with the child's family and community.

Case Management Comprehensive Assessment

Section A: Consumer Information

Consumer

Name: (First, M.I., Last)	Medicaid State ID#	Date Of Birth:
Current Address:		
County of Residence:	County of Legal Settlement:	
Home Phone:	Work Phone:	Cell Phone:
E-mail:		

Assessor

Name:	Title:
Agency:	
Address:	
Phone:	E-Mail:
Signature	Date

Type of Assessment

☐ Initial
☐ Annual
☐ Special
☐ Demographic Change Only Date:
☐ Discharge Date: Reason:

Basis of Case Management Eligibility

☐ CMI ☐ MR ☐ DD ☐ BI Waiver ☐ Elderly Waiver ☐ CMH Waiver ☐ Habilitation ☐ MFP

VERIFICATION OF HCBS WAIVER CONSUMER CHOICE: *Complete this section for consumers applying for HCBS Brain Injury Waiver, Children's Mental Health Waiver, Intellectual Disability Waiver.*

Home- and Community-Based Services (HCBS)

My right to choose a Home- and Community-Based program has been explained to me. I have been advised that I may choose: (1) Home- and Community-Based Services or (2) Medical Institutional Services.

I choose: ☐ HCBS ☐ Medical Institutional Services

Signature of Consumer or Guardian or Durable Power of Attorney for Health Care	Date

Case Management Comprehensive Assessment

Consumer Name:

Interdisciplinary team members consulted (including consumer):

Name	Title (if applicable)	Relationship to Consumer

Additional records reviewed:

Consumer Demographics

Gender: ☐ Female ☐ Male

Language:

	Yes	No
Speaks English	☐	☐
Understands English	☐	☐
Needs interpreter services	☐	☐
Comments:		

Monthly Income: (Please check all that apply)

Source	Amount
☐ SSI	$
☐ SSDI	$
☐ Employment	$
☐ Other (specify):	$
Comments:	

Court Involvement:

☐ Involuntary Commitment ☐ Probation or Parole ☐ Child in Need of Assistance (CINA) ☐ Child Protection ☐ Delinquency ☐ Foster Care ☐ Other (Identify) ☐ None
Comments:

Case Management Comprehensive Assessment

Consumer Name:

Legal decision maker: (Please check all that apply)

☐ None ☐ Guardian ☐ Attorney-in-fact ☐ Other (Specify):

Name: (First, M.I., Last)		
Address:		
Home Phone:	Work Phone:	Cell Phone:
E-mail:		

Co-Decision Maker (if applicable):

☐ Guardian ☐ Attorney-in-fact ☐ Other (Specify):

Name: (First, M.I., Last)		
Address:		
Home Phone:	Work Phone:	Cell Phone:
E-mail:		

Financial Decision Maker: (e.g. Conservator or Attorney-in-fact) No ☐ Yes ☐(complete below)

Name: (First, M.I., Last)		
Address:		
Home Phone:	Work Phone:	Cell Phone:
E-mail:		

Payee: No ☐ Yes ☐(complete below)

Name: (First, M.I., Last)		
Address:		
Home Phone:	Work Phone:	Cell Phone:
E-mail:		

Emergency Contacts:

Primary Contact

Name: (First, M.I., Last)		Relationship:
Address:		
Home Phone:	Work Phone:	Cell Phone:
E-mail:		

Case Management Comprehensive Assessment

Consumer Name:
Secondary Contact (if applicable):

Name: (First, M.I., Last)		Relationship:
Address:		
Home Phone:	Work Phone:	Cell Phone:
E-mail:		

Complete This Section For Adults (Age 18 and Over)

Veteran: ☐ Yes ☐ No

Marital Status:
☐ Never Married
☐ Married Spouse's Name:
☐ Divorced
☐ Legally Separated
☐ Widowed
☐ Unknown or Other – Specify
Comments:

Complete This Section For Children (Age 17 and Under)

With whom does the child live?
(*If the child currently lives in a institutional setting, please make note in the comments section below.*)

What are the child's parent's names?

Parents marital status: ☐ Married ☐ Divorced ☐ Never married
If the parent's are not living together, what is the non-custodial parent's name and address?
Name:
Street:
City, State, Zip:

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

Home Phone:
Work Phone:
Cell Phone:
E-Mail:

Are there siblings in the home? ☐ Yes ☐ No

Are any siblings receiving waiver services? ☐ Yes ☐ No

Are there any individuals who are not supposed to have contact with the child? ☐ Yes ☐ No
If yes, specify:

Other Comments:

Case Management Comprehensive Assessment

Consumer Name:

Medical Information

Diagnoses:

Medical:

Diagnosis	
Name and credential of professional making diagnosis:	Date of diagnosis:
Comments:	

Mental Health (DSM-IV-TR)

Axis 1:	
Axis 2:	
Axis 3:	
Axis 4:	
Axis 5:	
Name and credential of professional making diagnosis:	Date of diagnosis:
Comments:	

Complete this section for consumers applying for or receiving HCBS Intellectual Disability Waiver.
List the most current IQ score, or if the IQ isn't listed, give the consumer's level of functioning within the range of mental retardation (mild, moderate, severe, profound):

IQ: Range: Date of Evaluation:

Complete this section for consumers applying for or receiving HCBS Brain Injury Waiver.

Diagnosis: Date Injury Occurred:

Health Care Provider Information:

Who is your regular doctor? ☐ None

Name	Address	Phone
Date of last visit (if known):	Reason:	

Who is your regular dentist? ☐ None

Name	Address	Phone
Date of last visit (if known):	Reason:	

Are you seeing any other doctors, such as a psychiatrist, or specialists of any kind?

☐ Yes (list below) ☐ No ☐ Don't know

Name	Specialty	Address	Phone

Case Management Comprehensive Assessment

Section B: Medical and Physical Health

Health Conditions

B1. Overall, how would you rate your physical health?

☐ Excellent	☐ Good	☐ Fair	☐ Poor	☐ No Response
Comments:				

B2. Do you have any health problems that require assistance to manage?

☐ Cardiac
☐ Skin Related
☐ G.I. Disorders
☐ Urinary Tract
☐ Weight problems
☐ Evidence of communicable disease
☐ Other – Specify
☐ None

How do they affect you and how long have you had them?

Comments:

B3. Any respiratory problems that require assistance to manage?

☐ Ventilator
☐ Oxygen
☐ Suctioning
☐ Tracheotomy
☐ Cardiorespiratory monitor
☐ Chest physiotherapy
☐ Nebulizer treatment
☐ Other – Specify
☐ None

How do they affect you and how long have you had them?

Comments:

B4. Do you regularly receive any of the following medical treatments?

			Days per week	Hours per day
Nursing	☐ no	☐ yes		
Physical Therapy	☐ no	☐ yes		
Occupational Therapy	☐ no	☐ yes		
Speech Therapy	☐ no	☐ yes		
Supervision for Safety	☐ no	☐ yes		
Diabetes Education	☐ no	☐ yes		
Dialysis	☐ no	☐ yes		
Respiratory Treatment	☐ no	☐ yes		
Catheter Care	☐ no	☐ yes		
Colostomy Care	☐ no	☐ yes		
Nasogastric Tube Care	☐ no	☐ yes		
Other	☐ no	☐ yes		

Consumer Name:

B5. Hearing

- ☐ No hearing impairment.
- ☐ Hearing impairment, but managed through assistive devices
- ☐ Hearing difficulty at level of conversation.
- ☐ Hears only very loud sounds.
- ☐ No useful hearing.
- ☐ Not determined.

Comments:

B6. Vision

- ☐ Has no impairment of vision.
- ☐ Vision impairment, but managed through assistive devices
- ☐ Has difficulty seeing at level of print (far-sighted).
- ☐ Has difficulty seeing obstacles in environment (near-sighted).
- ☐ Has no useful vision.
- ☐ Not determined.

Comments:

B7. Speech/Communication

- ☐ Communicates independently or impairment has been compensated to function independently.
- ☐ Communicates with difficulty but can be understood.
- ☐ Communicates with sign language, symbol board, written messages, gestures or an interpreter.
- ☐ Communicates inappropriate content, makes garbled sounds, or displays echolalia.
- ☐ Does not communicate.

Comments:

B8. Sensory Perception (e.g. – taste, smell, tactile, spatial)

- ☐ No impairment
- ☐ Impaired – Specify

Comments:

B9. Cognitive Status

- ☐ Alert and fully oriented
- ☐ Alert and oriented with significant alteration on self-concept/mood
- ☐ Generally oriented through use of assistive techniques
- ☐ Cognitive deficits (e.g. orientation, attention/concentration, perception, memory, reasoning)
- ☐ Exhibits mental status changes consistent with psychiatric disorder
- ☐ Comatose, but responsive
- ☐ Comatose, but unresponsive
- ☐ Other – Specify

Comments:

B10. Musculoskelatal/Fine or Gross Motor Skills

- ☐ No Impairment of Musculoskelatal/Fine or Gross Motor Skills
- ☐ Impaired muscle tone
- ☐ Contractures
- ☐ Scoliosis

Paralysis: ☐ Hemiplegia ☐ Paraplegia ☐ Quadriplegia ☐ Other (Specify)

Comments:

Case Management Comprehensive Assessment

Consumer Name:

Complete This Section For Adults (Age 18 and Over)

B11. Do you have someone who could stay with you for a while if you were sick or needed help?

☐ Yes (Complete below) ☐ No

Name: Relationship:

Address:

City, State, Zip code:

Phone:

B12. Is there anybody you would **not** want to be involved with your care if you were sick or needed help?

☐ Yes (Complete below) ☐ No

Name: Relationship:

HEALTH CONDITIONS RISK FACTORS	YES	NO
R1. Has the consumer had a seizure in the past year?	☐	☐
R2. Does the consumer have a diagnosis of any other serious medical conditions or other serious health concerns (i.e., diabetes, cerebral palsy, heart condition, etc.)? If yes, list all conditions/concerns:	☐	☐
R3. Does the consumer have any life threatening allergies (such as peanuts, bee stings, or shellfish)?	☐	☐
R4. Is the consumer in need of a primary health care provider (or the provider's contact information is unknown)?	☐	☐
R5. Is the consumer in need of a dentist (or dentist's contact information is unknown)?	☐	☐
R6. Is the consumer in need of a specialist (or the specialist's contact information is unknown)?	☐	☐
R7. Has the consumer had difficulty making, keeping, or following through with appointments in the last year?	☐	☐
R8. In the past year, has the consumer gone to a hospital emergency room? If yes, how many times? Why?	☐	☐
R9. In the past year, has the consumer stayed overnight or longer in a hospital? If yes, how many times? Why?	☐	☐
R10. Is the consumer in need of someone to help if he or she was sick or injured?	☐	☐
Comment on any risk factors marked as "Yes" and address the issue in the Crisis Intervention Plan. Comments:	No. of risks:	

Case Management Comprehensive Assessment

Consumer Name:

Medication Use

B13. Are you currently taking any *prescription* medication? ☐ Yes (complete below) ☐ No

Medication Name	Dosage	Frequency	Purpose
Comments:			

B14. Are you currently taking any *over-the-counter* medications on a regular basis (pain relievers, vitamins, laxatives, etc.)? ☐ Yes (complete below) ☐ No

Medication Name	Dosage	Frequency	Purpose
Comments:			

Consumer Name:

Complete this section only if the consumer is taking medications.

B15. Are any of your medications kept in a special place, like a locked container or the refrigerator?
☐ Yes ☐ No
Comments:

B16. What pharmacy do you use?

B17. How do you remember to take your medications? (Check all that apply.)
☐ By following directions ☐ Calendar ☐ RN Set-up
☐ Caregiver gives them ☐ Bubble wrap/Blister Pack ☐ Pill Minder
☐ Medpass Machine ☐ Egg Carton, envelopes ☐ Other:
Comments:

B18. How well do you self-administer medication?
☐ With no help or supervision
☐ With some help or occasional supervision
☐ With a lot of help or constant supervision
☐ Unable to administer own medications/caregiver gives them
Comments:

MEDICATION ERROR RISK FACTORS 3 = Frequently 2 = Sometimes 1 = Rarely 0 = Never	YES		NO	
	3	2	1	0
R11. Has the consumer had problems with not taking or not receiving medications on time?	☐	☐	☐	☐
R12. Has the consumer had problems with taking or being given the incorrect number of medications?	☐	☐	☐	☐
R13. Has the consumer had problems with medications not being refilled on time?	☐	☐	☐	☐
R14. Have there been issues with medications not being re-evaluated timely?	☐	☐	☐	☐
R15. Has the consumer had significant side effects from medications?	☐	☐	☐	☐
R16. Has the consumer had significant medication changes in the past year?	☐	☐	☐	☐
R17. Has the consumer refused or spit out medications?	☐	☐	☐	☐
R18. Have there been problems with drug interactions?	☐	☐	☐	☐
R19. Has the consumer experienced health problems because of missing/refusing medications?	☐	☐	☐	☐
R20. Has the consumer misused prescription or over-the-counter medications (i.e., taken too many at once)?	☐	☐	☐	☐
R21. Has the consumer taken another person's prescription medications?	☐	☐	☐	☐
R22. Has the consumer used out-dated medications?	☐	☐	☐	☐
R23. Has the consumer used multiple pharmacies or multiple physicians in the past year?	☐	☐	☐	☐
Comment on any risk factors marked as "Yes" and address the issue in the Crisis Intervention Plan. Comments:	No. of risks:			

Case Management Comprehensive Assessment

Consumer Name:

Assistive Devices/Special Equipment

B19. Do you use (or need) any of the following special equipment or aids? None ☐

(If a consumer doesn't have an item but needs it, mark the "Needs" box)

Uses	Needs		Uses	Needs	
☐	☐	Dentures	☐	☐	Hospital bed
☐	☐	Cane	☐	☐	Medical phone alert
☐	☐	Walker	☐	☐	Supplies, e.g. Incontinence pads
☐	☐	Wheelchair (manual, electric)	☐	☐	Bedside commode
☐	☐	Brace (leg, back)	☐	☐	Bathing equipment
☐	☐	Helmet	☐	☐	Lift chair
☐	☐	Communication Devices	☐	☐	Transfer equipment
☐	☐	Hearing aid	☐	☐	Adaptive eating equipment
☐	☐	Glasses/contact lenses	☐	☐	Harness/gait belt
☐	☐	Weighted blankets or vest	☐	☐	Other (Specify):
Comments:					

ASSISTIVE DEVICES RISK FACTORS 3 = Frequently 2 = Sometimes 1 = Rarely 0 = Never	YES		NO	
	3	2	1	0
R24. Is the consumer in need of assistance with adaptive equipment (need it purchased, need training, need repairs, etc.)?	☐	☐	☐	☐
R25. Would a power outage interfere with the consumer's necessary adaptive equipment?	☐	☐	☐	☐
Comment on any risk factors marked as "Yes" and address the issue in the Crisis Intervention Plan. Comments:	No. of risks:			

Nutrition

B20. How is your appetite?

☐ Good ☐ Fair ☐ Poor
Comments:

B21. Has there been an unexplained weight loss or weight gain in the past year?

☐ Yes (specify in comments) ☐ No
Comments:

B22. Are there health concerns related to your nutrition?

☐ Yes (specify in comments) ☐ No
Comments:

Consumer Name:

B23. Do you have a diagnosed eating disorder (such as overeating, purging, hoarding food)?

☐ Yes (specify in comments) ☐ No *ASSESSOR:* If no, does the consumer's behavior indicate a possible eating disorder or suggest the need for further evaluation? ☐ Yes (specify in comments) ☐ No
Comments:

B24. Do you have any problems that make it difficult to eat? ☐ Yes (complete below) ☐ No

☐ Dental problems	☐ Can't eat certain foods
☐ Swallowing problems	☐ Problem with gag reflex
☐ Texture Aversions	☐ Sensitive stomach/nausea
☐ Taste problems	☐ Tube feeding (some or all of the time)
☐ Any other eating problems? (Describe)	
Comments:	

B25. Are you on a special diet: ☐ Yes (complete below) No ☐

☐ Low salt	☐ Calorie supplement
☐ Low fat	☐ Gluten Free
☐ Low sugar	☐ Milk/lactose free
☐ Weight Loss	☐ Altered Consistency
☐ Other special diet? (Describe)	
Comments:	

NUTRITION RISK FACTORS 3 = Frequently 2 = Sometimes 1 = Rarely 0 = Never	YES		NO	
	3	2	1	0
R26. Is the consumer at risk of choking or other problems when eating?	☐	☐	☐	☐
R27. Is the consumer's health at risk due to poor nutrition (e.g.- eating disorder, refusal to eat, inability to afford nutritious food, etc.)?	☐	☐	☐	☐
R28. Is the consumer (or the caretaker) ever non-compliant with the prescribed diet?	☐	☐	☐	☐
R29. Would the consumer's health be at risk if his or her diet is not strictly followed?	☐	☐	☐	☐
Comment on any risk factors marked as "Yes" and address the issue in the Crisis Intervention Plan. Comments:	No. of risks:			

Case Management Comprehensive Assessment

Consumer Name:

Daily Living Skills

B26. Daily Living Skills

Activity	Independent	Supervision or Verbal Prompts/Cueing	Physical Assistance	Total Dependence	Frequency	
					Daily	Intermittent
a. Eating	☐	☐	☐	☐	☐	☐
b. Grooming & personal hygiene	☐	☐	☐	☐	☐	☐
c. Bathing	☐	☐	☐	☐	☐	☐
d. Dressing	☐	☐	☐	☐	☐	☐
e. Mobility in bed	☐	☐	☐	☐	☐	☐
f. Transferring	☐	☐	☐	☐	☐	☐
g. Walking	☐	☐	☐	☐	☐	☐
h. Stair climbing	☐	☐	☐	☐	☐	☐
i. Mobility with wheelchair	☐	☐	☐	☐	☐	☐
Comments (note use of assistive devices or adaptive equipment needed to demonstrate skill):						

B27. Toilet Use

☐ Continent – Bowel and bladder
☐ Continent with verbal or physical prompts
☐ Continent except for specified periods of time (e.g. enuresis)
☐ Incontinent – bladder
☐ Incontinent – bowel
☐ Catheter or -ostomy (e.g. suprapubic catheter, colostomy, ileostomy)
☐ Inappropriate toileting habits (e.g. fails to close door, use toilet paper, or wash hands, etc.)

Comments:

DAILY LIVING SKILLS RISK FACTORS 3 = Frequently 2 = Sometimes 1 = Rarely 0 = Never	YES		NO	
	3	2	1	0
R30. Is the consumer's health at risk due to poor hygiene?	☐	☐	☐	☐
R31. Is the consumer at risk for falling? In the past year has the consumer fractured a bone? If yes, how did this occur?	☐	☐	☐	☐
R32. Is the consumer at risk of being dropped or injured during transfer?	☐	☐	☐	☐
Comment on any risk factors marked as "Yes" and address the issue in the Crisis Intervention Plan. Comments:	No. of risks:			

Consumer Name:

Consumer Needs, Wants, and Desired Results Related to Medical and Physical Health
What are your strengths and abilities related to your medical and physical health? *ASSESSOR*: List any other strengths and abilities not mentioned by the consumer or guardian: Do you have any other needs related to your medical and physical health that haven't been addressed above? *ASSESSOR*: List any other needs related to medical and physical health not mentioned by the consumer or guardian. Do you have any wants related to your medical and physical health? What are your desired results related to your medical and physical health?

Section C: Mental Health, Behavioral & Substance Use

Emotional and Mental Health

C1. Have you ever been diagnosed with a mental illness?

☐ Yes ☐ No
If yes, what is it?

C2. Have you received mental health services in the past?

☐ Yes ☐ No
If yes, describe:

C3. Are you currently receiving any mental health services or counseling?

☐ Yes (If yes, complete below) ☐ No	
Provider Name and Address	Comments

C4. Emotional Assessment. How have you been feeling during the past month?

	Yes	No
Are you satisfied with your life today?	☐	☐
Have you been depressed or very unhappy?	☐	☐
Have you been feeling like you have too much energy or can't stop being busy?	☐	☐
Have you been anxious?	☐	☐
Have you had mood swings?	☐	☐
Have you had difficulty sleeping?	☐	☐
Have you felt unmotivated or felt a lack of energy?	☐	☐
Have you felt lonely or isolated?	☐	☐
Comments:		

C5. *ASSESSOR:* Other mental health symptoms.

	Yes	No
Has the consumer had hallucinations (seen or heard things that weren't really there)?	☐	☐
Has the consumer reported feelings of paranoia?	☐	☐
Has the consumer had delusions (irrational thoughts that weren't true)?	☐	☐
Comments:		

Consumer Name:

Complete This Section For Children (Age 17 and Under)

C6. Has the child experienced difficulty in interpersonal relationships within the family?
☐ Yes ☐ No
Comments:

C7. Does the parent/guardian exhibit mental health related concerns?
☐ Yes ☐ No
If yes, is he/she currently receiving treatment and following through with treatment?
☐ Yes ☐ No
Comments:

Behavioral

C8. *ASSESSOR:* Behavioral Assessment.

Behavioral Issue	Does not exhibit	Has been modified to socially acceptable levels	May require verbal or physical intervention
Has episodes of disorientation, being withdrawn, or similar behaviors	☐	☐	☐
Noncompliance with rules or directions	☐	☐	☐
Physically abusive to self	☐	☐	☐
Verbally aggressive toward others	☐	☐	☐
Physically aggressive toward others	☐	☐	☐
Exhibits disruptive behavior (e.g. arguing, shouting, etc.)	☐	☐	☐
Exhibits destructive behavior (e.g. destroying property, burning, etc.)	☐	☐	☐
Exhibits stereotypical, repetitive behavior (e.g. rocking, twirling fingers or objects, etc.)	☐	☐	☐
Obsessive/compulsive behavior	☐	☐	☐
Antisocial behavior (e.g. lying, stealing, inappropriate touching, etc.)	☐	☐	☐
Wanders into private areas, or habitually elopes	☐	☐	☐
Acts in a sexually inappropriate or aggressive manner	☐	☐	☐
Engages in excessive liquid consumption	☐	☐	☐
Comments:			

Alcohol/Tobacco/Substance Use

C9. Do you drink any alcoholic beverages?

☐ Yes ☐ No
If yes, on average, counting beer, wine, and other alcoholic beverages, how many drinks do you have each day?
Comments:

C10. Do you smoke or use tobacco?

☐ Yes ☐ No
If yes, how much and how often? *(frequency per day)*
Comments:

C11. Has tobacco use caused you any problems?

☐ Yes ☐ No
If yes, please describe:
Comments:

Consumer Name:

C12. Do you use any other illegal substances such as marijuana, cocaine, or amphetamines?

☐ Yes ☐ No
If yes, specify:
Comments:

C13. Are the people who are involved in your life (spouse, parents/guardian, friends, etc.) concerned about your alcohol/tobacco/substance use?

☐ Yes ☐ No
If yes, explain:
Comments:

C14. Do you live with or spend time with a person that has alcohol/substance abuse concerns, including misuse of prescription medication? (For children, this includes the parent/guardian)

☐ Yes ☐ No
If yes, specify:
Comments:

C15. *ASSESSOR:* Does the person need education about substance use/abuse?

☐ Yes ☐ No
If yes, please describe:
Comments:

C16. *ASSESSOR:* Are you concerned about the person's alcohol/tobacco/substance use?

☐ Yes ☐ No
Comments:

MENTAL HEALTH/BEHAVIORAL/SUBSTANCE USE RISK FACTORS 3 = Within the last 6 months 2 = Within the last year 1 = more than 1 year ago 0 = Never	YES		NO	
	3	2	1	0
R33. Has the consumer ingested foreign objects or been diagnosed with PICA?	☐	☐	☐	☐
R34. Has alcohol use caused the consumer any problems?	☐	☐	☐	☐
R35. Has substance use caused the consumer any problems?	☐	☐	☐	☐
R36. Has the consumer engaged in self-injurious behaviors?	☐	☐	☐	☐
R37. Has the consumer left or attempted to leave home or other supervised activities without permission, or when it would be unsafe to do so?	☐	☐	☐	☐
R38. Has the consumer been aggressive toward others?	☐	☐	☐	☐
R39. Has the consumer used weapons or objects to hurt self or others? *(If 3 or 2, assure that referral has been made to a qualified mental health professional)*	☐	☐	☐	☐
R40. Has the consumer threatened suicide or made suicidal gestures? *(If 3 or 2, assure that referral has been made to a qualified mental health professional)*	☐	☐	☐	☐

Case Management Comprehensive Assessment

Consumer Name:

MENTAL HEALTH/BEHAVIORAL/SUBSTANCE USE RISK FACTORS 3 = Within the last 6 months 2 = Within the last year 1 = more than 1 year ago 0 = Never	YES		NO	
	3	2	1	0
R41. Has the consumer attempted suicide? *(If 3 or 2, assure that referral has been made to a qualified mental health professional)*	☐	☐	☐	☐
R42. Has the consumer engaged in criminal behavior?	☐	☐	☐	☐
R43. Has the consumer had a significant life change or event occur?	☐	☐	☐	☐
R44. Does the consumer have a history of other life-threatening behaviors? Specify:	☐	☐	☐	☐
Comment on any risk factors marked as "Yes" and address the issue in the Crisis Intervention Plan. Comments:	No. of risks:			

C17. *ASSESSOR:* In your opinion would this person benefit from a:

☐ Mental health referral
☐ Mental health evaluation
☐ Substance abuse referral
☐ Substance abuse evaluation
☐ Referral for a behavioral assessment
☐ Other (specify):
☐ None
Comments:

Consumer Needs, Wants, and Desired Results Related to Mental Health, Behavior, or Substance Abuse
What are your strengths and abilities related to mental health, behavior, or substance abuse? *ASSESSOR*: List any other strengths and abilities not mentioned by the consumer or guardian: Do you have any other needs related to mental health, behavior, or substance abuse that haven't been addressed above? *ASSESSOR*: List any other needs related to mental health, behavior, or substance abuse not mentioned by the consumer or guardian. Do you have any wants related to mental health, behavior, or substance abuse? What are your desired results related to mental health, behavior, or substance abuse?

Section D: Housing and Environment

D1. What is your current housing type?

☐ Own Home (includes parent/guardian's home for children) ☐ Friend/Relative Home ☐ Foster Care ☐ RB-SCL ☐ RCF ☐ RCF-PMI ☐ RCF-MR ☐ ICF-MR ☐ ICF/Nursing Facility ☐ MHI ☐ Skilled Nursing Facility ☐ Homeless ☐ Jail ☐ Other (specify):
Comments:

D2. What is your current living arrangement?

☐ Living Alone ☐ Living with Family/Friend ☐ Living with Spouse/Significant Other ☐ Living with Parents ☐ Living in Congregate Setting ☐ Other (specify):
Comments:

D3. Would you like to continue to live where you do now, or is there somewhere else you would prefer to live?

☐ Continue to live here ☐ Don't know ☐ Prefer to live elsewhere (Specify and briefly describe the barriers, if any:)
Comments:

D4. Is there someone who regularly helps you care for your home or yourself, or who regularly helps with errands or other things? (For children, do NOT include the parent/guardian, but do include others who assist the parent/guardian.)

☐ Yes ☐ No
If yes, how often? Caregiver's Name:

D5. Do you have any home modifications? Check all that apply:

☐ Safe Room	☐ Shatter Proof Windows
☐ Door/Window Alarms	☐ Fenced yard
☐ Wheelchair Ramp	☐ None
☐ Other (specify):	
Are any home modifications needed? ☐ Yes (specify): ☐ No	

Consumer Name:

Complete This Section For Children (Age 17 and Under)
(*If the child is currently living in a institutional setting, skip questions D6 through D9 and not the living situation in the comment section below.*)

D6. Does the family with whom the child is residing have a stable housing situation? ☐ Yes ☐ No
If not, does the family need assistance in identifying additional resources?

D7. Does the parent/guardian have a physical disability that impairs his/her ability to meet the child's needs? ☐ Yes ☐ No
If yes, what have the parents done to ensure the child's needs are being met consistently?

D8. Does the family have adequate financial resources? ☐ Yes ☐ No
If not, does the family need assistance in identifying additional resources?

D9. Does the child have his or her own money? ☐ Yes ☐ No
Where does it come from?

Other Comments:

Independent Living Skills

D10. How well can you prepare meals for yourself? (Meals may include sandwiches, pre-cooked meals and TV dinners.)

☐ Need no help or supervision
☐ Need some help or occasional supervision
☐ Need a lot of help or constant supervision
☐ Can't do it at all

Comments:

D11. Do you know your telephone number?

☐ Yes	☐ No	☐ N/A

D12. Do you know your address?

☐ Yes	☐ No	☐ N/A

D13. *ASSESSOR*: Can this consumer be left without supervision?

☐ Yes	☐ No	☐ N/A
If yes, for how long?		

D14. How well are you able to answer the telephone?

☐ Need no help or supervision
☐ Need some help or occasional supervision
☐ Need a lot of help or constant supervision
☐ Can't do it at all

Comments:

D15. How well are you able to make a telephone call?

☐ Need no help or supervision
☐ Need some help or occasional supervision
☐ Need a lot of help or constant supervision
☐ Can't do it at all

Comments:

Consumer Name:

D16. How well can you handle your own money? (understands use of money, can pay for things, can pay bills, can balance the checkbook, etc. as appropriate for age)

- ☐ Need no help or supervision
- ☐ Need some help or occasional supervision
- ☐ Need a lot of help or constant supervision
- ☐ Can't do it at all

Comments:

D17. How well can you manage shopping for food and other things you need?

- ☐ Need no help or supervision
- ☐ Need some help or occasional supervision
- ☐ Need a lot of help or constant supervision
- ☐ Can't do it at all

Comments:

Complete This Section For Adults (Age 18 and Over)

D18. How well can you manage to do light housekeeping, like dusting or sweeping?

- ☐ Need no help or supervision
- ☐ Need some help or occasional supervision
- ☐ Need a lot of help or constant supervision
- ☐ Can't do it at all

Comments:

D19. How well can you do heavy housekeeping, like yard work, or emptying the garbage?

- ☐ Need no help or supervision
- ☐ Need some help or occasional supervision
- ☐ Need a lot of help or constant supervision
- ☐ Can't do it at all

Comments:

D20. How well can you do your own laundry, including putting clothes in the washer or dryer, starting and stopping the machine, and drying the clothes?

- ☐ Need no help or supervision
- ☐ Need some help or occasional supervision
- ☐ Need a lot of help or constant supervision
- ☐ Can't do it at all

Comments:

D21. *ASSESSOR:* Does the consumer have deficits that pose a threat to his/her ability to live in the community?

☐Yes ☐No ☐Unsure

Consumer Name:

Complete This Section For Children (Age 17 and Under)

D22. Does the child do chores? ☐ Yes ☐ No

If yes, what are they?

How independent is the child in completing chores?

☐ Need no help or supervision
☐ Need some help or occasional supervision
☐ Need a lot of help or constant supervision
☐ Can't do it at all

Comments:

HOUSING AND ENVIRONMENTAL SAFETY RISK FACTORS	Yes		No	
R45. Would this consumer's health be at risk if a paid provider or natural support person did not show up to provide scheduled services?	☐		☐	
R46. Is the consumer at risk at home because of any of these conditions:				
structural damage	☐		☐	
barriers to accessibility (steps, etc.)	☐		☐	
electrical hazards	☐		☐	
signs of careless smoking	☐		☐	
insects or pests	☐		☐	
poor lighting	☐		☐	
insufficient water or no hot water	☐		☐	
insufficient heat	☐		☐	
fire hazards	☐		☐	
tripping hazards	☐		☐	
unsanitary conditions	☐		☐	
R47. Does the consumer need to be supervised at all times?	☐		☐	
R48. Is the consumer without means of communication (no phone or PERS)?	☐		☐	
For the following items use: 3 = Frequently 2 = Sometimes 1 = Rarely 0 = Never				
R49. Is the consumer unable to respond to emergencies independently? If consumer is never left alone, mark not applicable: ☐ N/A	3 ☐	2 ☐	1 ☐	0 ☐
R50. Is the consumer physically stronger than any of his/her caregivers?	☐	☐	☐	☐
R51. Does the consumer lack awareness of dangerous/emergency situations?	☐	☐	☐	☐
R52. Does the consumer put him/herself in danger due to careless or risky behaviors (careless smoking, leaving doors unlocked, etc.)?	☐	☐	☐	☐
R53. Is the consumer isolated (lack of transportation, lack of social network)?	☐	☐	☐	☐
R54. Is the consumer's neighborhood unsafe (high risk of crime, etc.)?	☐	☐	☐	☐
R55. Is the consumer at risk in the community due to unsafe behaviors?	☐	☐	☐	☐
Comment on any risk factors marked as "Yes" and address the issue in the Crisis Intervention Plan. Comments:	No. of risks:			

Consumer Name:

Abuse/Neglect

D23. *ASSESSOR*: Does the consumer have a history of incidents that have resulted in injury or threat of injury in the past year? (Consult incident reports as necessary)

☐ Yes ☐ No
If yes, are the causes of the incidents covered in the Crisis Intervention Plan? ☐ Yes ☐ No (specify why not):

ABUSE/NEGLECT RISK FACTORS 3 = Within the last 6 months 2 = Within the last year 1 = more than 1 year ago 0 = Never	YES		NO	
	3	2	1	0
R56. Has the consumer been physically abused?	☐	☐	☐	☐
R57. Has the consumer been sexually abused?	☐	☐	☐	☐
R58. Has the consumer been emotionally or psychologically abused?	☐	☐	☐	☐
R59. Is there evidence of neglect to the consumer by a caregiver?	☐	☐	☐	☐
R60. Is there evidence of neglect by the consumer (self neglect)?	☐	☐	☐	☐
R61. Has the consumer been denied basic necessities?	☐	☐	☐	☐
R62. Has the consumer witnessed abuse or neglect of another person, including domestic violence?	☐	☐	☐	☐
R63. Would the consumer be an "easy target"?	☐		☐	
Comment on any risk factors marked as "Yes" and address the issue in the Crisis Intervention Plan. Comments:	No. of risks:			

Consumer Needs, Wants, and Desired Results Related to Housing and Environment
What are your strengths and abilities related to your housing and environment? *ASSESSOR*: List any other strengths and abilities not mentioned by the consumer or guardian: Do you have any other needs related to your housing and environment that haven't been addressed above? *ASSESSOR*: List any other needs related to housing and environment not mentioned by the consumer or guardian. Do you have any wants related to your housing and environment? What are your desired results related to your housing and environment?

Section E: Social

E1. Do you feel you need help with social skills?

☐ Yes
☐ No

Comments:

E2. What is a typical day like for you? *(or ask:* What do you usually do, starting from the morning?)

What, if anything, would you change about your typical day?

Comments:

E3. What activities or things do you enjoy doing?

Are there activities you enjoy that you would like to do more frequently?
☐ Yes
☐ No
If yes, what are they?

Is anything needed to support or help you to do these activities?
☐ Yes
☐ No
If yes, what?

Comments:

E4. If you choose to practice a religion, are able to attend as often as desired?

☐ Yes (Specify where):
☐ No
☐ N/A

Comments:

E5. *ASSESSOR*: Does the consumer have knowledge or self-concept of his or her own sexuality appropriate to age level?

☐ Yes
☐ No

Comments:

E6. Do you communicate with friends, relatives, or others (not including paid helpers) as often as you would want?

☐ Yes
☐ No

By what means (phone, email, etc)? How Often?

Comments:

Consumer Name:

Complete This Section For Adults (Age 18 and Over)

E7. Do you spend time with others who do not live with you as often as you would want?
☐ Yes ☐ No
Comments:

E8. Do you have someone to confide in when you have a problem?
☐ Yes ☐ No
If yes, specify name and relationship:

Complete This Section For Children (Age 17 and Under)

E9. Who are your friends?
E10. What do you like to do with them?
E11. Where do you see your friends?
E12. Do you and your parents agree on your choice of friends?
☐ Yes ☐ No
If no, why not?

Consumer Needs, Wants, and Desired Results
Related to Social Functioning

What are your strengths and abilities related to your social functioning?

ASSESSOR: List any other strengths and abilities not mentioned by the consumer or guardian:

Do you have any other needs related to your social functioning that haven't been addressed above?

ASSESSOR: List any other needs related to social functioning not mentioned by the consumer or guardian.

Do you have any wants related to your social functioning?

What are your desired results related to your social functioning?

Section F: Transportation

F1. Do you need help with transportation?

☐ Yes ☐ No
If yes, when and where:

F2. How do you get to the places you want to go? (Check all that apply).

☐ Walk ☐ Bicycle ☐ Drive ☐ Take a bus or taxi ☐ Friend or family member drives ☐ Staff/Provider ☐ Other:
Comments:

F3. How well are you able to use public transportation or drive to places beyond walking distance?

☐ Need no help or supervision ☐ Need some help or occasional supervision ☐ Need a lot of help or constant supervision ☐ Not Available ☐ Can't do it at all
Comments:

F4. Are there any vehicle modifications needed?

☐ Yes ☐ No If yes, specify:
Comments:

Consumer Needs, Wants, and Desired Results Related to Transportation
What are your strengths and abilities related to transportation? *ASSESSOR*: List any other strengths and abilities not mentioned by the consumer or guardian: Do you have any other needs related to transportation that haven't been addressed above? *ASSESSOR*: List any other needs related to transportation not mentioned by the consumer or guardian. Do you have any wants related to transportation? What are your desired results related to transportation?

Section G: Education

G1. Are you currently in school?

☐ Yes ☐ No If yes, specify where: If no, and the consumer is a child, why not?
Comments:

G2. If in school, are you involved in any extra-curricular activities?

☐ Yes ☐ No ☐ N/A If yes, specify:
Comments:

G3. *ASSESSOR:* Is the consumer able to:

	Yes	No	Comments
Read?	☐	☐	
Write?	☐	☐	
Sign his/her name?	☐	☐	

G4. Are you interested in furthering your education?

☐ Yes ☐ No If yes, what area do you want to further your education in?
Comments:

G5. Do you need assistance or support in gaining access to educational services?

☐ Yes ☐ No If yes, please specify what type of assistance is needed:
Comments:

G6. *ASSESSOR:* Does the consumer have any intellectual or cognitive difficulties?

☐ No intellectual problems
☐ Has difficulties but is able to function with minimal assistance or adaptive devices
☐ Has intellectual problems requiring verbal or physical assistance (check all that apply): ☐ Difficulty with or unable to tell time ☐ Does not know survival words or signs ☐ Problems with reading ☐ Problems with writing ☐ Difficulty with number skills ☐ Difficulty with reasoning and problem solving ☐ Memory problems ☐ Other – specify

Consumer Name:

Complete This Section For Adults (Age 18 and Over)

G7. What is the highest level of education you have completed?

- ☐ Less than High School
- ☐ Some High School
- ☐ GED
- ☐ Graduated Special Education
- ☐ High School Graduate
- ☐ Trade School
- ☐ Some College
- ☐ College Graduate
- ☐ Graduate Degree
- ☐ Unknown

Comments:

Complete This Section For Children (Age 17 and Under)

G8. What grade are you in? ☐ N/A

G9. Do you like school?

- ☐ Yes
- ☐ No
- ☐ N/A

If no, why not?

G10. *ASSESSOR:* Is the child following the school's attendance policy?

- ☐ Yes
- ☐ No
- ☐ N/A

If no, what are the circumstances?

G11. *ASSESSOR:* Does the child have a Special Education Plan?

- ☐ Yes (specify): ☐ IEP ☐ 504 Plan
- ☐ No
- ☐ N/A

G12. *ASSESSOR:* Is there an aide or mentor assigned to the child?

- ☐ Yes
- ☐ No
- ☐ N/A

G13. *ASSESSOR:* Is the child on target to graduate with his or her class?

- ☐ Yes
- ☐ No
- ☐ N/A

Case Management Comprehensive Assessment

Consumer Name:

Consumer Needs, Wants, and Desired Results Related to Education
What are your strengths and abilities related to education? *ASSESSOR*: List any other strengths and abilities not mentioned by the consumer or guardian: Do you have any other needs related to education that haven't been addressed above? *ASSESSOR*: List any other needs related to education not mentioned by the consumer or guardian. Do you have any wants related to education? What are your desired results related to education?

Section H: Vocational

Complete this section for consumers age 14 or older.

H1. Do you work?

☐ Yes ☐ No ☐ N/A
Comments:

Questions for consumers who are currently working:

H2. What is your current work setting?

	Where Employed:
☐ Competitive employment: full-time	
☐ Competitive employment: part-time	
☐ Supported Employment	
☐ Enclave	
☐ Sheltered work	
If competitively employed, do you use natural supports in the work environment? ☐ Yes ☐ No	
Comments:	

H3. Are you happy in your current job?

☐ Yes ☐ No If no, what job would you like to do? Why does this job appeal to you?
Comments:

Questions for consumers who are not currently working:

H4. Are you able to work in the community?

☐ Yes ☐ No
Comments:

H5. Do you want to work in the community?

☐ Yes ☐ No If yes what job would you like to do? Why does this job appeal to you?
Comments:

Consumer Name:

Question for consumers who are working, or who are not working but are willing and able to work:

H6. Do you need help in any of the following areas?

	Yes	No
Looking for and obtaining a job	☐	☐
Job interviewing	☐	☐
Attending work as scheduled	☐	☐
Arriving to work on time and returning to work after lunch and breaks	☐	☐
Being appropriately dressed and groomed for work	☐	☐
Accepting work assignments and completing them according to instructions	☐	☐
Independently initiating work	☐	☐
Attending to work tasks without distraction	☐	☐
Following written directions	☐	☐
Performing a 1-step task	☐	☐
Performing a 2-3 step task	☐	☐
Communicating wants or needs	☐	☐
Timely informing employer when going to miss work	☐	☐
Accepting changes in schedule or routine	☐	☐
Getting along with co-workers	☐	☐
Other, including any barriers to obtaining employment:		
Comments:		

Consumer Needs, Wants, and Desired Results Related to Vocational Functioning
What are your strengths and abilities related to your vocational functioning? *ASSESSOR*: List any other strengths and abilities not mentioned by the consumer or guardian: Do you have any other needs related to your vocational functioning that haven't been addressed above? *ASSESSOR*: List any other needs related to vocational functioning not mentioned by the consumer or guardian. Do you have any wants related to your vocational functioning? What are your desired results related to your vocational functioning?

Individuals qualified to provide all services identified in the service plan shall review the services identified in the service plan to ensure that the services are necessary, appropriate, and consistent with the identified needs of the child, as listed on form 470-4694, *Case Management Comprehensive Assessment*. Click here to access the form online.

The service worker or case manager shall review all service plans to determine progress toward goals and objectives 90 calendar days from the initiation of services and every 90 calendar days thereafter for the duration of the services.

At a minimum, the provider shall submit written reports to the service worker or case manager at six-month intervals and when changes to the service plan are needed.

The person-centered service plan shall be revised when any of the following occur:

- Service goals or objectives have been achieved.
- Progress toward goals and objectives is not being made.
- Changes have occurred in the identified service needs of the child, as listed on form 470-4694, *Case Management Comprehensive Assessment.*
- The service plan is not consistent with the identified service needs of the child, as listed in the service plan.

The service plan shall be signed and dated by qualified staff of each reviewing provider after each review and revision.

Any revisions of the service plan shall be made in collaboration with the child, family, case manager, and, if applicable, the foster parents and shall reflect the needs of the child. The service provider shall provide a copy of the revised service plan to the family and case manager, unless otherwise ordered by a court of competent jurisdiction.

The RBSCL service provider shall also furnish residential-based living units for all recipients of the RBSCL. Living units provided may be of no more than four beds.

20. Respite Care Providers

Legal reference:

Waiver Type	**Corresponding Iowa Administrative Code**
AIDS	441 IAC 77.34(5)
Brain injury	441 IAC 77.39(14)
Children's mental health	441 IAC 77.46(5)
Elderly	441 IAC 77.33(6)
Health and disability	441 IAC 77.30(5)
Intellectual disability	441 IAC 77.37(15)

The following agencies may provide respite services:

- Home health agencies that are certified to participate in the Medicare program
- Respite providers certified under the HCBS ID or BI waiver
- Nursing facilities, intermediate care facilities for the intellectually disabled, and hospitals enrolled as providers in the Iowa Medicaid program
- Group living foster care facilities for children licensed by the Department according to:
  - 441 IAC Chapter 112, and
  - 441 IAC Chapter 114, and
  - 441 IAC Chapter 115, and
  - 441 IAC Chapter 116
- Camps certified by the American Camping Association
- Home care agencies that meet the conditions of participation set forth in 441 IAC 77.30(1)
- Adult day care providers that meet the conditions of participation set forth in 441 IAC 77.30(3)
- Residential care facilities for persons with an intellectual disability licensed by the Department of Inspections and Appeals
- Assisted living programs certified by the Department of Inspections and Appeals

Respite providers shall meet the following conditions:

- Providers shall maintain the following information that shall be updated at least annually:
  - The member's name, birth date, age, address, and the telephone number of each parent, guardian or primary caregiver
  - An emergency medical care release
  - Emergency contact telephone numbers such as the number of the member's physician and the parents, guardian, or primary caregiver
  - The member's medical issues, including allergies
  - The member's daily schedule which includes the member's preferences in activities or foods or any other special concerns
- Procedures shall be developed for the dispensing, storage, authorization, and recording of all prescription and nonprescription medications administered. Home health agencies must follow Medicare regulations for medication dispensing.
- All medications shall be stored in their original containers, with the accompanying physician's or pharmacist's directions and label intact. Medications shall be stored so they are inaccessible to members and the public. Nonprescription medications shall be labeled with the member's name.
- In the case of medications that are administered on an ongoing, long-term basis, authorization shall be obtained for a period not to exceed the duration of the prescription.

Policies shall be developed for:

- Notifying the parent, guardian or primary caregiver of any injuries or illnesses that occur during respite provision. A parent's, guardian's or primary caregiver's signature is required to verify receipt of notification requiring the parent, guardian or primary caregiver to notify the respite provider of any injuries or illnesses that occurred before the respite provision.
- Documenting activities and times of respite. This documentation shall be made available to the parent, guardian or primary caregiver upon request.
- Ensuring the safety and privacy of the member. Policies shall at a minimum address threat of fire, tornado, or flood and bomb threats.

A facility providing respite under this subrule shall not exceed the facility's licensed capacity, and services shall be provided in locations consistent with licensure.

Respite provided outside the member's home or the facility covered by the licensure, certification, accreditation, or contract must be approved by the parent, guardian or primary caregiver and the interdisciplinary team and must be consistent with the way the location is used by the general public. Respite in these locations shall not exceed 72 continuous hours.

21. Senior Companions Providers

Legal reference:

Waiver Type	Corresponding Iowa Administrative Code
Elderly	441 IAC 77.33(14)

Senior companion programs designated by the Corporation for National and Community Service may provide senior companion service.

22. Specialized medical equipment providers

Legal reference:

Waiver Type	Corresponding Iowa Administrative Code
Brain injury	441 IAC 77.39(19)
Physical disability	441 IAC 77.41(5)

The following providers may provide specialized medical equipment:

- Medical equipment and supply dealers participating as providers in the Medicaid program
- Retail and wholesale businesses participating as providers in the Medicaid program which provide specialized medical equipment as defined 441 IAC 78.43(8)

23. Supported Community Living Providers

Legal reference:

Waiver Type	**Corresponding Iowa Administrative Code**
Brain injury	441 IAC 77.39(13)
Intellectual disability	441 IAC 77.37(14)

The Department will contract only with public or private agencies to provide the supported community living service. The Department does not recognize individuals as service providers under the supported community living program.

Providers of services meeting the definition of foster care shall also be licensed according to:

- 441 IAC Chapter 108, and
- 441 IAC Chapter 112, and
- 441 IAC Chapter 114, and
- 441 IAC Chapter 115, and
- 441 IAC Chapter 116

Providers of service may employ or contract with individuals meeting the definition of foster family homes to provide supported community living services. These individuals shall be licensed according to:

- 441 IAC Chapter 112, and
- 441 IAC Chapter 113

All supported community living providers shall meet the following requirements:

- The provider shall demonstrate how the provider will meet the outcomes and processes in rule 441 IAC 77.37(249A) for each of the members being served. The provider shall supply timelines showing how the provider will come into compliance within one year of certification, based on the following rules:
  - 441 IAC 77.37(249A), and
  - 441 IAC 77.41(249A), and
  - 441 IAC 83.60(249A) to 441 IAC 83.70(249A), and
  - 441 IAC 79.1(15)

These timelines shall include:

- Implementation of necessary staff training and member input.
- Implementation of provider system changes to allow for flexibility in staff duties, services based on what each individual needs, and removal of housing as part of the service.

The provider shall demonstrate that systems are in place to measure outcomes and processes for members before certification can be given.

♦ The Department shall approve living units designed to serve four members except as necessary to prevent an overconcentration of supported community living units in a geographic area.

♦ The Department shall approve a living unit designed to serve five persons subject to both of the following conditions:

- Approval will not result in an overconcentration of supported community living units in a geographic area.
- The county in which the living unit is located provides to the Bureau of Long-Term Care verification in writing that the approval is needed to address one or more of the following issues:
  - The quantity of services currently available in the county is insufficient to meet the need, or
  - The quantity of affordable rental housing in the county is insufficient, or
  - Approval will result in a reduction in the size or quantity of larger congregate settings.

The Bureau of Long-Term Care shall approve the five-person home application based on the letter of support from the county and the requirement to maintain the geographical distribution of supported community living programs to avoid an overconcentration of programs in an area.

24. Supported Employment Providers

Legal reference:

Waiver Type	**Corresponding Iowa Administrative Code**
Brain injury	441 IAC 77.39(15)
Intellectual disability	441 IAC 77.37(16)

The following agencies may provide supported employment services:

- An agency that is accredited by the Commission on Accreditation of Rehabilitation Facilities as:
  - An organizational employment service provider,
  - A community employment service provider, or
  - A provider of a similar service.
- An agency that is accredited by the Council on Accreditation of Services for Families and Children for similar services.
- An agency that is accredited by the Joint Commission on Accreditation of Healthcare Organizations for similar services.
- An agency that is accredited by the Council on Quality and Leadership in Supports for People with Disabilities for similar services.
- An agency that is accredited by the International Center for Clubhouse Development.

Providers responsible for the payroll of members shall have policies that include, but are not limited to:

- Member vacation, sick leave, and holiday compensation;
- Procedures for payment schedules and pay scale;
- Procedures for provision of workers' compensation insurance;
- Procedures for the determination and review of commensurate wages;
- Department of Labor requirements.

The Department will contract only with public or private agencies to provide supported employment services. The Department does not recognize individuals as service providers under the supported employment program.

25. Transportation providers

Legal reference:

Waiver Type	Corresponding Iowa Administrative Code
Brain injury	441 IAC 77.39(18)
Elderly	441 IAC 77.33(11)
Intellectual disability	441 IAC 77.37(24)
Physical disability	441 IAC 77.41(6)

The following providers may provide transportation:

- Accredited providers of home- and community-based services
- Regional transit agencies as recognized by the Iowa Department of Transportation
- Transportation providers that contract with county governments
- Community action agencies as designated in Iowa Code section 216A.93
- Nursing facilities licensed under Iowa Code chapter 135C
- Area agencies on aging as designated in rule 17 IAC 4.4(239), subcontractors of area agencies on aging
- Providers with purchase of service contacts to provide transportation pursuant to 441 Chapter 150
- Transportation providers contracting with the nonemergency medical transportation contractor

26. Maintenance of Records

Legal reference: 441 IAC 79.3(1), 441 IAC 79.3(2)

A provider of a service that is charged to the medical assistance program shall maintain complete and legible records as required in this rule. Failure to maintain records or failure to make records available to the Department or to its authorized representative timely upon request shall result in claim denial or recoupment.

27. Provider Requirements for Service Documentation

Legal reference: 441 IAC 79.3(2)"c"(3)

Providers shall maintain service and fiscal records necessary to fully disclose the extent of services furnished to members. Records shall specify by service date the procedures performed, together with information concerning progress of treatment.

28. Service Documentation

The record for each service provided shall include information necessary to substantiate that the service was provided and shall include the following:

- The specific procedures or treatments performed.
- The complete date of the service, including the beginning and ending date if the service is rendered over more than one day.
- The complete time of the service, including the beginning and ending time (including AM and PM designation) if the service is billed on a time-related basis. For those time-related services billed using Current Procedural Terminology (CPT) codes, the total time of the service shall be recorded, rather than the beginning and ending time.
- The location where the service was provided if otherwise required on the billing form, or in:
  - 441 IAC 77.30(5)"c" or "d,"
  - 441 IAC 77.33(6)"d,"
  - 441 IAC 77.34(5)"d,"
  - 441 IAC 77.37(15)"d,"
  - 441 IAC 77.39(13)"e,"
  - 441 IAC 77.39(14)"d,"
  - 441 IAC 77.46(5)"i," or
  - 441 IAC 78.9(10)"a"(1).
- The name, dosage, and route of administration of any medication dispensed or administered as part of the service.
- Any supplies dispensed as part of the service.
- The first and last name and professional credentials, if any, of the person providing the service. The signature of the person providing the service, or the initials of the person providing the service if a signature log indicates the person's identity.

For 24-hour care, documentation for every shift of the services provided, including the member's response to the services provided and the person who provided the services.

29. Outcome of Service

Legal reference: 441 IAC 79.3(2)"c"(4)

The medical record shall indicate the member's progress in response to the services rendered, including any changes in treatment, alteration of plan of care, or diagnosis.

30. Basis of Service

Legal reference: 441 IAC 79.3(2)"d"

The medical record must include, but is not limited to, the items specified below (unless the listed item is not routinely received or created in connection with the particular service or activity and is not required to document the reason for performing the service or activity, its medical necessity, or the level of care associated with it).

Basis for service requirements for specific services other than case management include:

- Notice of decision for case manager's or service worker's service authorization
- Provider's and the *Comprehensive Person-Centered Service Plan* (initial and subsequent)
- Service documentation, logs, notes, or narratives
- Mileage and transportation logs
- Log of meal delivery
- Invoices or receipts
- Form 470-3372, *HCBS Consumer-Directed Attendant Care Agreement*
- Form 470-4389, *Consumer-Directed Attendant Care (CDAC) Daily Service Record*

Case management services, including HCBS case management services:

- Form 470-3956, *MR/CMI/DD Case Management Service Authorization Request*, for services authorized before May 1, 2007.
- Notice of decision for service authorization.
- Service notes or narratives.
- Social history.
- Comprehensive service plan.
- Reassessment of member needs.
- Incident reports in accordance with 441 IAC 24.4(5).

E. AUDITS OR REVIEW OF PROVIDER RECORDS

Any Medicaid provider may be audited or reviewed at any time at the discretion of the Department.

Authorized representatives of the Department shall have the right, upon proper identification, to audit or review the clinical and fiscal records of the provider to determine whether:

- The Department has correctly paid claims for goods or services.
- The provider has furnished the services to Medicaid members.
- The provider has retained clinical and fiscal records that substantiate claims submitted for payment.
- The goods or services provided were in accordance with Iowa Medicaid policy.

Requests for provider records by the IME Program Integrity Unit shall include form 470-4479, *Program Integrity Unit Documentation Checklist*, listing the specific records that must be provided for the audit or review pursuant to paragraph 441 IAC 79.3(2)"d" to document the basis for services or activities provided.

Audit or Review Procedures

The Department will select the method of conducting an audit or review and will protect the confidential nature of the records being audited or reviewed. The provider may be required to furnish records to the Department. Unless the Department specifies otherwise, the provider may select the method of delivering any requested records to the Department.

Upon a written request for records, the provider must submit all responsive records to the Department or its authorized agent within 30 calendar days of the mailing date of the request, except as provided below:

- The Department may grant an extension to the required submission date of up to 15 calendar days upon written request from the provider or the provider's designee. The request must:
  - Establish good cause for the delay in submitting the records, and
  - Be received by the Department before the date the records are due to be submitted.

  NOTE: "Good cause" has the same meaning as in Iowa Rule of Civil Procedure 1.977.

  - The Department may grant a request for an extension of the time limit for submitting records at its discretion. The Department shall issue a written notice of its decision.
  - The provider may appeal the Department's denial of a request to extend the time limit for submission of requested records according to the procedures in 441 IAC Chapter 7.
  - The Department may elect to conduct announced or unannounced on-site reviews or audits. Records must be provided upon request and before the end of the on-site review or audit.
  - For an announced on-site review or audit, the Department's employee or authorized agent may give as little as one day's advance notice of the review or audit and the records and supporting documentation to be reviewed.
  - Notice is not required for unannounced on-site reviews and audits.
  - In an on-site review or audit, the conclusion of that review or audit shall be considered the end of the period within which to produce records.

- Audit or review procedures may include, but are not limited to, the following:
  - Comparing clinical and fiscal records with each claim.
  - Interviewing members who received goods or services and employees of providers.
  - Examining third-party payment records.
  - Comparing Medicaid charges with private-patient charges to determine that the charge to Medicaid is not more than the customary and prevailing fee.
  - Examining all documents related to the services for which Medicaid was billed.

If the Department concludes from an audit or review that an overpayment has occurred, the Department will issue a preliminary finding of a tentative overpayment and inform the provider of the opportunity to request a reevaluation.

If a provider disagrees with the preliminary finding of a tentative overpayment, the provider may request a reevaluation by the Department and may present clarifying information and supplemental documentation.

A provider may appeal the finding and order of repayment and withholding of payments pursuant to 441 IAC Chapter 7. However, an appeal shall not stay the withholding of payments or other action to collect the overpayment. Evidence shall not be admissible in any subsequent contested case proceeding or other action relating to, or arising out of, the finding and order for repayment of any overpayment under 441 IAC 79.4(6). Examples of admissible evidence include, but are not limited to, records, clarifying information, or supplemental documentation that was not provided to the Department in a timely manner as stated in 441 IAC 79.4(3) or (5). The purpose of the appeal is to verify whether the Department correctly calculated any overpayment based on the information provided to the Department during its audit or review.

F. AUTHORIZATION FOR PROVISION OF SERVICES

All services are provided to eligible members according to the member's individualized need as identified in the service plan and based on the type of waiver the member receives. Before service provision, the provider must obtain documentation of service authorization. The documentation should include a copy of the Notice of Decision that would include:

- The name of the provider,
- The provider number,
- The service and procedure code,
- The number of units to be provided,
- The approved rate for each service, and
- The dates of the specific service.

The following sections list the general exclusion and limitations of waiver services, then detail the coverage requirements for each specific service.

Exclusions

- **Services Otherwise Available**

  Members may use services available under the regular State Medicaid Plan in addition to using the waiver services. When a service is available through the state plan, the member must first access the state plan before accessing the waiver. When the same or similar service is available from an alternate source free of charge, the member must use that service before using the waiver services.

  Home health aide and nursing care services are available to people aged 20 or under through the Care for Kids (EPSDT) program when the need for home health aide service exceeds the service available through regular Medicaid.

  Nursing and home health aide services for people aged 21 and over may be reimbursed through the waiver only after the regular State Medicaid Plan or alternate source reimbursement limits are met.

  Members must obtain durable medical equipment available under the state Medicaid program, if applicable, before accessing the waiver's home and vehicle modification, assistive device or specialized medical equipment service.

- **Duplicate Services**

  A member may be enrolled in only one waiver program at a time. For example, a person enrolled in the HCBS health and disability waiver may not be enrolled in the HCBS intellectual disability waiver at the same time.

  Costs for waiver services are not reimbursable while the member is in a medical institution (hospital or nursing facility).

  Services may not be simultaneously reimbursed for the same time period. For example, only one provider may be reimbursed for one service during a specified hour, even if two providers arrive at the member's home at the same time to provide different services.

  Waiver members may also access state plan HCBS habilitation services. A waiver member who is enrolled in the state plan HCBS habilitation program must access the state plan services available through habilitation before accessing the waiver services.

  Participation in both HCBS waiver and state plan HCBS habilitation programs is not considered duplicative when the member accesses different services under each program. For example a member may access transportation through the waiver and supported employment through state plan habilitation.

- **Services Provided Before Eligibility Determination**

  Before the Department will reimburse for HCBS waiver services, the following conditions must be met:

  - The provider must be an enrolled Medicaid provider.
  - The member must have received both service and financial eligibility approval.
  - The member and their interdisciplinary team has met to develop the service plan.
  - A service plan has been completed and signed by the member or the parent or guardian and the service worker, case manager, or integrated health home.

- The member or the parent or guardian must be given informed choice of the following:
  - The type of waiver the member receives
  - The provider for each service the member receives
  - Where the member works
  - Where the member resides
  - Where and how the member spends their free time
  - The member's daily routine
  - To have an impact on the services the member receives

G. QUALITY MANAGEMENT ACTIVITIES

Legal reference: 441 IAC 77.37(13)

HCBS quality reviewers may evaluate the following provider documentation in conjunction with quality reviews:

- Personnel records,
- Member service records,
- Agency policies and procedures,
- Evidence to support implementation of agency policy and quality improvement activities, and
- Other information as requested.

HCBS quality reviewers may interview the following:

- Agency staff;
- Members accessing the services and their legal representatives;
- Case managers, service workers, or integrated health home;
- Agency board members; and
- Others deemed appropriate, consistent with the confidentiality safeguards of state and federal laws.

The HCBS program may issue commendations, recommendations, corrective actions or sanctions as a result of the review.

Corrective action shall be required when noncompliance with the agency policies, Iowa Code, Iowa Administrative Code, or Federal Code of Regulations are identified. A compliance review of any corrective action will occur within 60 business days of the HCBS program's approval of the plan.

The following activities apply to providers of the services under the HCBS program:

- **Self-assessment**. Providers are required to annually submit the *Provider Quality Management Self-Assessment* to the Department by December 1. The provider will verify the accuracy of the self-assessment through the submission of the Guarantee of Accuracy statement.
- **Focused review**. Providers will submit evidence of the implementation of provider policies upon request from the HCBS program. The HCBS program may issue commendations, recommendations, corrective actions or sanctions as a result of the review.
- **Targeted review**. Reviews shall occur at the discretion of the Department. The HCBS program may issue commendations, recommendations, corrective actions, or sanctions as a result of the review.
- **Periodic on-site review**. Reviews shall occur on a cyclical basis of at least once every five years. Periodic on-site reviews shall be conducted with providers that are currently providing services to members or have provided services in the previous 12 months of the on-site review notice.

H. INCIDENT REPORTING

Legal reference: 441 IAC 77.37(8)

As a condition of participation in the medical assistance program, HCBS waiver service providers must comply with the requirements of Iowa Code sections 232.69 and 235B.3 regarding the reporting of child abuse and dependent adult abuse and with the incident management and reporting requirements in this subrule.

EXCEPTION: The conditions in this subrule do not apply to providers of goods and services purchased under the consumer choices option or providers of home and vehicle modification, home-delivered meals or personal emergency response.

"**Major incident**" means an occurrence involving a member enrolled in waiver services that:

- Results in a physical injury to or by the member that requires a physician's treatment or admission to a hospital;
- Results in the death of the member;

- Results in emergency mental health treatment for the member;
- Results in the intervention of law enforcement;
- Results in a report of child abuse pursuant to Iowa Code section 232.69 or a report of dependent adult abuse pursuant to Iowa Code section 235B.3;
- Constitutes a prescription medication error or a pattern of medication errors that leads to the outcome in bullets 1, 2, 3, and 5 above;
- Involves a member's location being unknown by provider staff who are assigned protective oversight.

"**Member**" means a person who has been determined to be eligible for Medicaid under 441 IAC Chapter 83.

"**Minor incident**" means an occurrence involving a member enrolled in waiver services that is not a major incident and that:

- Results in the application of basic first aid,
- Results in bruising,
- Results in seizure activity,
- Results in injury to self, to others or to property, and
- Constitutes a prescription medication error.

1. Reporting Procedure for Minor Incidents

Minor incidents may be reported in any format designated by the provider. When a minor incident occurs or a staff member becomes aware of a minor incident, the staff member shall submit the completed incident report to the staff member's supervisor within 72 hours of the incident. The completed report shall be maintained by the provider in a centralized file with a notation in the member's file.

2. Reporting Procedure for Major Incidents

When a major incident occurs or a staff member becomes aware of a major incident:

- The staff member shall notify the following persons of the incident by the end of the next business day:
  - The staff member's supervisor;
  - The member and the member's legal guardian, as applicable; and
  - The member's service worker.

- By the end of the next business day the staff member who observed or first became aware of the incident shall also report as much information as is known about the incident to the IME by direct data entry into the Iowa Medicaid Portal Access (IMPA). The following information shall be reported:
  - The name of the member involved;
  - The date, time, and location where the incident occurred or was discovered;
  - A description of the incident;
  - The names of all provider staff and others who were present at the time of the incident or who responded after becoming aware of the incident. The confidentiality of other Medicaid eligible or non-Medicaid-eligible persons who were present must be maintained by the use of initials or other means; and
  - The action that the provider staff took to manage the incident; and
  - The type of incident as defined in 441 IAC Chapter 77.

Submission of the initial report will generate a workflow in the Individualized Services Information System (ISIS) for follow-up by the case manager, service worker or integrated health home. When complete information about the incident is not available at the time of the initial report, the provider must submit follow-up reports within five business days. The completed report shall be maintained by the provider in a centralized file with a notation in the member's file.

The investigation findings and resolution of the incident shall be reported in the IMPA system within 30 calendar days of the initial report.

I. FINANCIAL PARTICIPATION

Persons must contribute their predetermined financial participation to the cost of HCBS waiver services or other Medicaid services, as applicable.

1. Client Participation and Financial Participation

Legal reference:

Waiver Type	Corresponding Iowa Administrative Code
All waiver types	441 IAC 75.16(249A)
AIDS	441 IAC 83.44(1)
Brain injury	441 IAC 83.84(1)
Children's mental health	441 IAC 83.124(249A)
Elderly	441 IAC 83.24(1)
Health and disability	441 IAC 83.4(1)
Intellectual disability	441 IAC 83.63(1)
Physical disability	441 IAC 83.104(1)

When determining eligibility, the income maintenance worker gives the member maintenance needs allowance which is 300 percent of the maximum SSI grant for a member. If the member's income exceeds this amount, the member is not eligible for HCBS services.

The case manager or service worker must assign client participation to one or more of the wavier services listed in the ISIS service plan. The notice of decision sent to the member and the provider must show the amount of client participation that the member must pay to the provider for services rendered.

If a member has client participation (veteran's aid and attendance or a Medicaid qualifying trust) which covers all or part of the cost of a service, the provider must bill the member for their portion of the client participation. After client participation has been met, then the provider bills Medicaid the difference in this amount by subtracting off the amount of client participation.

The case manager or service worker makes an entry on the member's *Notice of Decision: Services*, form 470-0602, in the section entitled "Fees" when the member has client participation. In addition, the case manager or service worker should show the amount or source of client participation in the case plan.

NOTE: Under the **CMH** waiver, client participation is identified as financial participation. A member must contribute to the cost of children's mental health waiver services to the extent of the member's total income less 300 percent of the maximum monthly payment for one person under the federal Supplemental Security Income (SSI) program.

2. Limit on Payment

Legal reference:

Waiver Type	**Corresponding Iowa Administrative Code**
AIDS	441 IAC 83.44(2)
Brain injury	441 IAC 83.84(2)
Elderly	441 IAC 83.24(2)
Health and disability	441 IAC 83.4(2)
Intellectual disability	441 IAC 83.63(2)
Physical disability	441 IAC 83.104(2)

If for any month, the sum of the third-party payment and client participation equals or exceeds the reimbursement established by the service worker, Medicaid will make no payments to waiver service providers. However, Medicaid will make payments to other medical vendors as applicable.

3. Third-Party Payments

Legal reference:

Waiver Type	**Corresponding Iowa Administrative Code**
All waiver types	441 IAC 75.2(2)
AIDS	441 IAC 83.44(2)
Brain injury	441 IAC 83.84(2)
Elderly	441 IAC 83.24(2)
Health and disability	441 IAC 83.4(2)
Intellectual disability	441 IAC 83.63(2)
Physical disability	441 IAC 83.104(2)

Payment will be approved only for those services or for that part of a given service for which no medical resources exist. The provider must inform the Department by a notation on the claim form that other coverage exists but did not cover the service being billed, or that payment was denied.

If a member has insurance that covers all or part of a service, the insurance company must be billed before billing Medicaid for the service.

J. BASIS OF PAYMENT

Legal reference: 441 IAC 79.1(15)

The design of the cost principles, administrative rules, and support of reporting for HCBS waiver services reflects the Department's intent to establish rates for care based on "necessary and reasonable" costs of providing the services within the established standards.

Reimbursable costs must meet two tests:

- Necessary. Essential to the provision of home- and community-based waiver services and to the achievement of service requirements and outcomes.
- Reasonable. At levels considered appropriate for the provision of quality care in Iowa within the established standards.

The basis of payment for services rendered by providers of services participating with the HCBS waivers is either a system based on the provider's allowable costs of operation or a fee schedule (Medicare or Medicaid). Providers of service must accept reimbursement based upon the Department's methodology without making any additional charge to the member (except for designated copayments).

1. Types of Reimbursement

a. Fee Schedules

Fees for the various procedures involved are determined by the Department with advice and consultation from the appropriate professional group. The fees are intended to reflect the amount of resources (time, training, experience) involved in each procedure. Individual adjustments will be made periodically to correct any inequity or to add new procedures or eliminate or modify others.

If product cost is involved in addition to service, reimbursement is based either on a fixed fee, wholesale cost, or on actual acquisition cost of the product to the provider, or product cost is included as part of the fee schedule. Providers on fee schedules are reimbursed the lower of:

- The actual charge made by the provider of service, or
- The maximum allowance under the fee schedule for the item of service in question.

b. Fee for Service with Cost Settlement

Providers shall be reimbursed on the basis of a payment rate for a 15-minute unit of service based on reasonable and proper costs for service provision. Providers are reimbursed throughout each fiscal year on the basis of a projected unit rate for each participating provider. The projected rate is based on reasonable and proper costs of operation, pursuant to federally accepted reimbursement principles (generally Medicare or OMB A-87 principles).

Payments are subject to annual retrospective cost settlement based on submission of actual costs of operation and service utilization data by the provider on form 470-0664, *Financial and Statistical Report for Purchase of Service Contracts*. The cost settlement represents the difference between the amount received by the provider during the year for covered services and the amount supported by the actual costs of doing business, determined in accordance with an accepted method of cost appointment.

c. Retrospectively Limited Prospective Rate (See 79.1(15))

Providers are reimbursed on the basis of a rate for a unit of service calculated prospectively for each participating provider (and, for supported community living daily rates, for each member or site) based on projected or historical costs of operation subject to the maximums listed in subrule 441 IAC 79.1(2) and to retrospective adjustment pursuant to subparagraph 79.1(1)"e"(3).

- The prospective rates for new providers who have not submitted six months of cost reports will be based on a projection of the provider's reasonable and proper costs of operation until the provider has submitted an annual cost report that includes a minimum of six months of actual costs.
- The prospective rates paid established providers who have submitted an annual report with a minimum of a six-month history are based on reasonable and proper costs in a base period and are adjusted annually for inflation.

- The prospective rates paid to both new and established providers are subject to:
  - Maximums listed in subrule 441 IAC 79.1(2), and
  - Retrospective adjustment based on the provider's actual, current costs of operation as shown by financial and statistical reports submitted by the provider. Retrospective adjustments shall not exceed reasonable and proper costs actually incurred by more than 4.5 percent.

  HCBS providers must submit a cost report for waiver services using form 470-0664, *Financial and Statistical Report for Purchase of Service Contracts*. All financial and statistical reports must meet the specifications described in this section and in 441 IAC 79.1(15). The provider completes the form or is responsible for its content, regardless if it is prepared by someone outside the agency.

2. Maintenance and Retention of Financial and Statistical Record

The financial information included in form 470-0664 must be taken from financial and statistical records and must be verifiable by qualified auditors. To provide the required cost data and not impair comparability, maintain financial and statistical records in a consistent manner from one period to another.

Sufficient financial and statistical records should be maintained to document the validity of reports submitted to the Department. This includes program and census data. Failure to maintain records to support cost reports may result in removal of costs or termination of the provider's HCBS certification.

These records include, but are not limited to:

- All bank statements and vendor invoices (paid and unpaid)
- Payroll information
- General ledger reconciliation to financial and statistical report
- Expense allocation schedules
- Time studies to support expense allocations
- Financial statements or audit reports (if any)
- Loan agreements and other contracts

- Capital asset schedules including information to calculate depreciation on a straight line method
- Documentation of units of services provided to members
- Reviewable, legible census reports
- Board of director's minutes (if applicable)

All financial and statistical reports, and records to support them, should be maintained for a minimum of five years after final notification of rate and cost report reconciliation. Reports and records should be made available to authorized representatives and agents of the Department and of the United States Department of Health and Human Services, upon request.

3. Submission of the Financial and Statistical Reports

Form 470-0664 is due to the Department by September 30 of each year for rate setting and reconciliation of rate reimbursement. A provider may obtain a 30–day extension for submission of the cost reports by submitting a written request to the Iowa Medicaid Enterprise, Provider Cost Audit and Rate Setting Unit, by September 30. No extensions will be granted beyond one month.

Failure to submit a report by September 30, or by an approved extended deadline, shall reduce payment to 76 percent of the current rate. The reduced rate shall be paid for no longer than three months, after which time no further payments will be made.

If the organization has multiple-program agencies, a cost allocation schedule, prepared in accordance with regulations and generally accepted accounting principles must also be submitted. The Department may require that an opinion of a certified public accountant, or public accountant, accompany the report when adjustments made to previous reports indicate noncompliance with reporting instructions.

Email form 470-0664 to costaudit@dhs.state.ia.us.

An original copy of the signed *Certification Page* must be received by the IME for the report to be complete. Send the *Certification Page*, with an original signature of an officer of the facility, to:

Iowa Medicaid Enterprise
Provider Cost Audit and Rate Setting Unit
PO Box 36450
Des Moines, IA 50315

If a provider chooses to leave the HCBS program or no longer provides retrospectively limited prospective HCBS services, notify the Iowa Medicaid Enterprise within 30 days of the last day of services. A final cost report must be submitted within 60 days of termination for reconciliation of rate reimbursement.

After initial HCBS certification, submit the following documents for projected rate determination when one of the following changes is made:

- Adding or updating supported community living with a daily rate:
  - *HCBS Supplemental Schedule D-4* from form 470-3449
- Adding supported community living with a 15-minute rate:
  - *Certification Page* from form 470-0664
  - *Schedule D* from form 470-0664
  - *Supplemental Schedules D-1*, *D-2*, and *D-3* from form 470-0664
- Adding supported employment for activities to obtain a job with a 15-minute rate:
  - *Certification Page* from form 470-0664
  - *Schedule D* from form 470-0664
  - *Supplemental Schedules D-1*, *D-2*, and *D-3* from form 470-0664
- Adding family and community support services for the children's mental health waiver with a 15-minute rate:
  - *Certification Page* from form 470-0664
  - *Schedule D* from form 470-0664
  - *Supplemental Schedules D-1*, *D-2*, and *D-3* from form 470-0664

HCBS Supplemental Schedule D-4 projected worksheets from form 470-3449 must be signed and dated by an Officer or Administrator of the agency. *HCBS Supplemental Schedule D-4* (*Individual Daily Rate Worksheets*) from form 470-3449 must also be signed by the member's case manager.

Completed and signed projected rate worksheets should be emailed to costaudit@dhs.state.ia.us, or sent to the following address:

Iowa Medicaid Enterprise
Provider Cost Audit and Rate Setting
PO Box 36450
Des Moines, IA 50315

Iowa Department of Human Services

FINANCIAL AND STATISTICAL REPORT FOR PURCHASE OF SERVICE CONTRACTS

CERTIFICATION PAGE

Agency Name			IRS ID No.
Address			Contract No.
City		State	Zip Code
Period of Report:	From	To	Date of Fiscal Year End
Administrator Name			Telephone No.
Name of Person to Contact if Questions About the Report			Telephone No.

Does agency have an independent audit? ❑ Yes, for year ending _____ ❑ No

Has a copy of the latest independent audit been submitted? ❑ Yes ❑ No

A. Type of Control: ❑ Government ❑ Nonprofit Organization ❑ Proprietary

B. Accounting Basis: ❑ Accrual ❑ Modified Cash ❑ Cash

C. Statistical Data for Period of Report:

1. Service code.							
2. If subject to licensure, number of clients licensed for.							
3. Number of units of service (licensed or staffed)							
a. Type of unit (hourly, daily, etc.)							
4. Total number of units of service provided.							
5. Total number of units of service provided for:							
a. DHS clients							
b. Other clients							
6. Percent of units provided to unit capacity (divide line 4 by line 3)							
7. Are the rates received from non-DHS clients the same as, or more than, POS rates for the same service: Circle yes or no, for each service. If no, explain.:	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No

D. Form of Certification by Officer or Administrator of Provider Agency:

I CERTIFY that I have examined the accompanying schedules of revenues and expenses and the calculation of cost of service prepared for this agency and that to the best of my knowledge and belief they are true and correct. I also certify that these schedules were prepared from the books and records of the facility in accordance with instructions contained in this report, and the allowable cost of care excludes expenses that were not necessary to provide this care.

Signature Officer or administrator of facility	
Title Officer or Administrator	Date

E. Statement of Preparer (if other than agency)

I have prepared this report and to the best of my knowledge and belief, it represents true and accurate data of the agency for the period stated above.

Signature of Preparer	Date

F. Statement of Project Manager

I have reviewed this report prior to submitting it to the State (Department of Human Services, Bureau of Purchased Services, Purchase of Service Unit).

Signature of Project Manager	Date

Provider Agency		
Period of Report	From	To

SCHEDULE A: REVENUE REPORT

Revenues:	**Total Revenue**	**Revenue for Schedule D Expense Deduction***
Fee for Service:		
Iowa State Department of Human Services	$	
County Board of Supervisors		
Private Clients		
Department of Education (Voc Rehab) (service fees only)		
United Way (service fees only)		
Social Security, SSI, SSA		
Other		
Service, Reimbursement or Investment Income:		
Work Services Revenues	$	$
Food Reimbursement (DOE)		
Investment Income		
Other (attach schedule)		
Contributions: (Schedule must be attached:)		
United Way: Contributions not restricted or appropriated** to a specific individual	$	
Restricted to specific individuals*		$
Other: Contributions not restricted or appropriated** to a specific individual		
Restricted to specific individuals*		$
Government Grants:		
Total Revenue	$	*$

* Income which must be deducted from total service expense on Schedule D.

** Agencies must have documentation or support which identifies purposes of contributions reported.

Provider Agency		
Period of Report	From	To

SCHEDULE B: STAFF NUMBERS AND WAGES

Job Classification and Title	Number of Staff			Gross Wages
	Full Time	Part Time	FTEs	
Administrative #2110 Job Title _____				
Administrative Total.....				
Professional #2120 Job Title _____				
Professional Total.....				
Direct Client Care #2130 Job Title _____				
Direct Client Care Total.....				
Clerical #2150 Job Title _____				
Clerical Total				
Other Staff Wages #2190 Job Title _____				
Other Staff Wages Total.....				
Total: ALL JOB CLASSIFICATIONS AND TITLES.....				

The maximum amount of wages chargeable to Purchase of Services for any one employee is $40,000 annually. If an employee is paid in excess of $40,000, the excess must be reported as "Other Nonreimburseable Costs" in column 3 of Schedule D or charged to Excluded Services (use column 5 of Schedule D).

Provider Agency		
Period of Report	From	To

SCHEDULE C: PROPERTY AND EQUIPMENT DEPRECIATION AND RELATED PARTY PROPERTY COSTS

PROVIDER -OWNED EQUIPMENT BUILDINGS

Description:	Original Cost	Depreciation Recorded Prior Years	Method	Annual % Rate	Recorded Depreciation Expense	Straight-Line Depr.
Equipment:						
Building equipment						
Departmental equipment						
Other equipment _____						
Office furniture and fixtures						
Motor vehicles _____						
Total						
Buildings:						
Buildings						
Additions						
Leasehold improvements _____						
Other _____						
Total						
Total Equipment and Buildings						

RELATED PARTY PROPERTY COST

1. Is any property being leased from a party "related to provider" using the definitions in the contract and the Provider Handbook? ❑ Yes ❑ No

2. Schedule of Lessor's Costs:

   If answer to number 1 is yes, provide lessor's costs in the space below.

Depreciation on property _____

Property taxes _____

Mortgage interest on property _____

Insurance _____

Other (describe) _____

Total _____

Provider Agency		
Period of Report	From	To

SCHEDULE D: EXPENSE REPORT

						Direct Service Cost					
		1	2	3	4	5	6	7	8	9	10
Acc No.	Account Title	Total Expense	Fund-Raising Cost	Other Nonreim-burseable Costs	Adjusted Cost: Col 1 minus Cols 2 & 3						Indirect Service Cost
2110	Administrative Staff										
2120	Professional Direct Staff										
2130	Other Direct Staff										
2150	Clerical Staff										
2190	Other Staff										
2100	**TOTAL WAGES**										
2210	Health Benefits										
2220	Retirement Plan										
2290	Other Benefits										
2200	**TOTAL BENEFITS**										
2310	FICA Expense										
2320	Unemployment										
2350	Worker's Compensation Insurance										
2300	**TOTAL PAYROLL TAXES**										
2450	Medical and Psych. Serv. Purchased										
2470	Audit and Accounting										
2480	Attorney Fees										
2490	Other Nonmedical										
2400	**TOTAL PROFESSIONAL FEES**										
2510	Office Supplies										
2530	Medical Supplies										
2540	Recreation and Craft Supplies										
2550	Food										
2590	Other Supplies										
2500	**TOTAL SUPPLIES**										
2600	**TELEPHONE AND TELEGRAPH**										
2700	**POSTAGE AND SHIPPING**										
2810	Rent of Space										
2820	Buildings and Grounds Supplies										
2830	Utilities										
2840	Care of Buildings and Grounds										
2870	Interest										
2880	Insurance and Property Taxes										
2890	Other Occupancy Expense										
2800	**TOTAL OCCUPANCY EXPENSE**										

Provider Agency		
Period of Report	From	To

SCHEDULE D: EXPENSE REPORT

		Direct Service Cost									
		11	12	13	14	15	16	17	18	19	20
Acc No.	**Account Title**										
2110	Administrative Staff										
2120	Professional Direct Staff										
2130	Other Direct Staff										
2150	Clerical Staff										
2190	Other Staff										
2100	**TOTAL WAGES**										
2210	Health Benefits										
2220	Retirement Plan										
2290	Other Benefits										
2200	**TOTAL BENEFITS**										
2310	FICA Expense										
2320	Unemployment										
2350	Worker's Compensation Insurance										
2300	**TOTAL PAYROLL TAXES**										
2450	Medical and Psych. Serv. Purchased										
2470	Audit and Accounting										
2480	Attorney Fees										
2490	Other Nonmedical										
2400	**TOTAL PROFESSIONAL FEES**										
2510	Office Supplies										
2530	Medical Supplies										
2540	Recreation and Craft Supplies										
2550	Food										
2590	Other Supplies										
2500	**TOTAL SUPPLIES**										
2600	**TELEPHONE AND TELEGRAPH**										
2700	**POSTAGE AND SHIPPING**										
2810	Rent of Space										
2820	Buildings and Grounds Supplies										
2830	Utilities										
2840	Care of Buildings and Grounds										
2870	Interest										
2880	Insurance and Property Taxes										
2890	Other Occupancy Expense										
2800	**TOTAL OCCUPANCY EXPENSE**										

Provider Agency		
Period of Report	From	To

SCHEDULE D: EXPENSE REPORT

					Direct Service Cost						
		1	2	3	4	5	6	7	8	9	10
Acc No.	**Account Title**	**Total Expense**	**Fund-Raising Costs**	**Other Nonreim-burseable Costs**	**Adjusted Cost: Col 1 minus Cols 2 & 3**						**Indirect Service Cost**
3100	**OUTSIDE PRINTING AND ART WORK**										
3210	Mileage and Auto Rental										
3250	Agency Vehicles Expense										
3280	Automobile Insurance										
3290	Other Related Transportation										
3200	**TOTAL TRANSPORTATION**										
3310	Staff Development and Training										
3320	Annual Meeting and Business Conf.										
3300	**TOTAL CONFERENCES AND CONVENTIONS**										
3400	**SUBSCRIPTIONS AND PUBLICATIONS**										
3510	Clothing and Personal Needs										
3520	Other										
3500	**TOTAL ASSISTANCE**										
4100	**ORGANIZATION MEMBERSHIPS**										
4200	**AWARDS AND GRANTS**										
4310	Agency Vehicle Repair										
4320	Other Equipment Repair or Purchase										
4300	**TOTAL EQUIPMENT REPAIRS & PURCHASE**										
4410	Agency Vehicles										
4420	Equipment										
4480	Buildings and Leasehold										
4400	**TOTAL DEPRECIATION**										
4910	Moving and Recruitment										
4920	Liability Insurance										
4930	Miscellaneous										
4900	**TOTAL MISCELLANEOUS**										
	TOTAL EXPENSES										
ALLOCATION OF INDIRECT SERVICE COSTS											
Total Service or Maintenance Cost After Allocation of Indirect											
* Program Income or Reimbursements											
* United Way Contributions Restricted to Specific Individuals											
* Other Contributions Restricted to Specific Individuals											
* Government Grants											
Total Service or Maintenance Cost After Deductions											
Units of Service											
UNIT COST											

Provider Agency		
Period of Report	From	To

SCHEDULE D: EXPENSE REPORT

		Direct Service Cost									
		11	12	13	14	15	16	17	18	19	20
Acc No.	Account Title										
3100	**OUTSIDE PRINTING AND ART WORK**										
3210	Mileage and Auto Rental										
3250	Agency Vehicles Expense										
3280	Automobile Insurance										
3290	Other Related Transportation										
3200	**TOTAL TRANSPORTATION**										
3310	Staff Development and Training										
3320	Annual Meeting and Business Conf.										
3300	**TOTAL CONFERENCES AND CONVENTIONS**										
3400	**SUBSCRIPTIONS AND PUBLICATIONS**										
3510	Clothing and Personal Needs										
3520	Other										
3500	**TOTAL ASSISTANCE**										
4100	**ORGANIZATION MEMBERSHIPS**										
4200	**AWARDS AND GRANTS**										
4310	Agency Vehicle Repair										
4320	Other Equipment Repair or Purchase										
4300	**TOTAL EQUIPMENT REPAIRS & PURCHASE**										
4410	Agency Vehicles										
4420	Equipment										
4480	Buildings and Leasehold										
4400	**TOTAL DEPRECIATION**										
4910	Moving and Recruitment										
4920	Liability Insurance										
4930	Miscellaneous										
4900	**TOTAL MISCELLANEOUS**										
	TOTAL EXPENSES										
ALLOCATION OF INDIRECT SERVICE COSTS											
Total Service or Maintenance Cost After Allocation of Indirect											
* Program Income or Reimbursements											
* United Way Contributions Restricted to Specific Individuals											
* Other Contributions Restricted to Specific Individuals											
* Government Grants											
Total Service or Maintenance Cost After Deductions											
Units of Service											
UNIT COST											

Provider Agency		
Period of Report	From	To

SCHEDULE E: COMPARATIVE BALANCE SHEET

ASSETS, LIABILITIES, AND EQUITY	BALANCE AT END OF	
	Current Period	Prior Period
ASSETS:		
Cash	$	$
Receivable from clients		
Receivable from others		
Property and equipment:		
Land		
Buildings and equipment		
Less allowance for depreciation		
Net property and equipment		
Investments and other assets		
TOTAL ASSETS		
LIABILITIES AND EQUITY:		
Accounts payable	$	$
Accrued taxes (payroll and property)		
Other liabilities		
Notes and mortgages		
Total liabilities		
Equity or fund balance		
TOTAL LIABILITIES AND EQUITY.....		

RECONCILIATION OF EQUITY OR FUND BALANCE

TOTAL EQUITY OR FUND BALANCE BEGINNING OF PERIOD	$
Add:	
TOTAL REVENUE from Schedule A	$
Other revenue. Explain	
Deduct:	
TOTAL EXPENSES from Schedule D	
Other expenses. Explain	
TOTAL EQUITY OR FUND BALANCE END OF PERIOD	$

Provider Agency		Vendor No.
Period of Report:	From	To

SCHEDULE F: COST ALLOCATION PROCEDURES

(To be completed by providers which offer more than one service)

Costs are allocatable to a particular service, such as a grant, project, or other activity, in accordance with the relative benefits received. A cost is allocatable to a service if it is treated consistently with other costs incurred for the same purpose in like circumstances, and if it:

(1) Is incurred specifically for the service,

(2) Benefits the service and can be distributed in reasonable proportion to the benefits received, and

(3) Is necessary to the overall operation of the organization, although a direct relationship to a particular service cannot be shown.

Any cost allocatable to a particular service under the above principles may not be shifted to other services to overcome funding deficiencies or to avoid other restrictions imposed by law or terms of an award.

DIRECT COSTS:	Yes	No
1. Do you have a cost allocation plan which describes the methods you use in distributing joint costs to services or activities?	❑	❑
2. If you do not have a cost allocation plan describing the methods followed, do you have accounting workpapers available to support joint direct cost allocations?	❑	❑
3. Is your method of allocating joint service cost consistently followed from year to year?	❑	❑
4. Are costs allocated to services in reasonable proportion to benefits received?	❑	❑
5. Are service income deductions allocated in a manner which is consistent with the costs incurred in generating the income?	❑	❑
6. Additional comments regarding allocation of joint service costs:	❑	❑

INDIRECT COST:

1. Are indirect costs distributed on a basis of total direct service or cost?	❑	❑

2. If indirect costs are not allocated on the basis of total direct service costs, what was the basis used?

3. Is the basis for distributing indirect cost the same as that used in the previous year?	❑	❑

Provider Agency		
Period of Report	From	To

SCHEDULE G: SUPPLEMENTAL ALLOCATION REPORT, PART 1

A	B	C	D	E	F	G	
		Shelter Care					
Account Number	Account Title	Allowable Attribution Cost	Allowable Allocation of Cost	Total Costs	Allocation of Total Cost to: Maintenance	Allocation of Total Cost to: Service	Basis of Allocation
from 2190	Food Service & Maintenance Workers Salaries					**********	Definition
% of 2200	Food Service & Maintenance Workers Benefits					**********	Definition
% of 2300	Food Service & Maintenance Workers Payroll Taxes					**********	Definition
2130	Direct Care Staff Salaries						Time
% of 2200	Direct Care Staff Benefits						Time
% of 2300	Direct Care Staff Payroll Taxes						Time
from 2120	Other Direct Staff (C1 in/pgm. Supv/SW-Thpst/Nurse)						Time
% of 2200	Other Direct Staff Benefits						Time
% of 2300	Other Direct Staff Payroll Taxes						Time
from 2110	Other Admin. Staff (Clinical/Pgm Supv or Mgr) Salaries						Time
% of 2200	Clinical Supervisor Benefits						Time
% of 2300	Clinical Supervisor Payroll Taxes						Time
2450	Medical & Psychological Services Purchased				**********		Definition
2490	Other Non-Medical Services Purchased				**********		Definition
2530	Medical Supplies					**********	Definition
2540	Recreation ("Family-Like") & Craft Supplies					**********	Definition
	Formalized Non "Family-Like" Recreation				**********		Definition
2550	Food					**********	Definition
3510+352	Clothing, Personal Needs, School Supplies, and Other					**********	Definition
2810	Rent of Space						Sq Ft. -
2820	Building and Grounds Supplies						Sq Ft. -
2830	Utilities						Sq Ft. -
2840	Care of Building and Grounds						Sq Ft. -
2870	Interest on Building and Grounds						Sq Ft. -
2880	Insurance and Property Taxes						Sq Ft. -
2890	Other Occupancy Expenses						Sq Ft. -
Schedule G	Part 1 TOTALS						Sq Ft. -Use
			Service/Maintenance Percentages				

Provider Agency		
Period of Report	From	To

SCHEDULE G: SUPPLEMENTAL ALLOCATION REPORT, PART 2

Residual Cost NOT Included in Schedule G, Part 1	Gross Total Attributable to: Shelter
Remainder of Program Direct Costs (Total Program Schedule D Direct - Part 1 Direct) Remainder of Program Indirect Cost (Total Program Schedule D Direct - Part 1 Indirect)	
PROGRAM TOTALS for PART 2	

UNIT COST DETERMINATION

SERVICE PERCENTAGE FROM SCHEDULE G PART 1	
TOTAL PART 2 SERVICE COST	
TOTAL SERVICE COST FROM PART 1	
GRAND TOTAL SERVICE COST	
DEDUCTIONS FROM SERVICE COST FROM SCHEDULE D	
GRAND TOTAL SERVICE COST AFTER DEDUCTIONS	

MAINTENANCE PERCENTAGE FROM SCHEDULE G PART 1	
TOTAL PART 2 MAINTENANCE COST	
TOTAL MAINTENANCE COST FROM PART 1	
GRAND TOTAL MAINTENANCE COST	
DEDUCTIONS FROM MAINTENANCE COST FROM SCHEDULE D	
GRAND TOTAL MAINTENANCE COST AFTER DEDUCTIONS	
UNITS OF SERVICE	
SERVICE COST PER UNIT	
MAINTENANCE COST PER UNIT	
TOTAL COST PER UNIT	`

ALLOCATION OF STAFF TIME WORK SHEET

(Use separate form for each staff type)

TYPE OF STAFF: _____

Enter the percent of time spent on maintenance activities here:	_____	LINE 1
Enter the percent of the time spent on service activities here:	_____	LINE 2
Add line 1 and line 2 and enter result here:	_____	LINE 3
Divide line 1 by line 3 and enter result here:	_____	LINE 4
Divide line 2 by line 3 and enter result here:	_____	LINE 5
Enter the percent of time spent on administrative activities here:	_____	LINE 6
Multiply line 4 by line 6 and enter result here:	_____ (This is the percentage of administrative time allocated to maintenance.)	LINE 7
SUBTRACT line 7 from line 6 and enter result here:	_____ (This is the percentage of administrative time allocated to service.)	LINE 8
ADD line 1 and line 7 and enter result here:	_____ (This is the total percentage of time allocated to maintenance. Use this percentage to allocate staff cost to maintenance.)	
ADD line 2 and line 8 and enter result here:	_____ (This is the total percentage of time allocated to service. Use this percentage to allocate staff cost to service.)	

* The combined percent of time spent on maintenance, service, and administrative activities should total 100%.

Iowa Department of Human Services
Supplemental Schedule D-4 Instructions

The purpose of HCBS Supplemental Schedule D-4, "Daily Rate Worksheet," is to calculate the unit daily rate cost per living site. Costs reported by site should be consistent with those reported on Schedule D, less any adjustment for the limit on indirect administrative costs. The Schedule D-4 consists of two parts:

1. Site Daily Rate Worksheet
    a. Sum total of the Individual Daily Rate Worksheets which calculates the average daily rate fo the ID, RBSCL, or BI site
    b. Separate Site Daily Rate Worksheets must be submitted for an ID, RBSCL, and/or BI site
    c. Completed and submitted by the provider
2. Individual Daily Rate Worksheet
    a. Completed for each member living at the site
    b. Completed by the interdisciplinary team including the case manager and the provider
    c. Submitted by the provider

Submit a Schedule D-4 for the site rate(s) (Site Daily Rate Worksheet) along with separate schedules for each member (Individual Daily Rate Worksheet). The Individual Daily Rate Worksheets must be submitted for each member even if all members share the same rate at the site.

Supplemental Schedule D-4 should be completed for the following reasons:

1. To establish a daily rate for a New Site.
2. To change a daily rate due to significant changes in the cost per unit for a member due to
    a. change in member service needs
    b. change in members at the site.

A "significant" change occurs when a member's functioning level changes or a vacancy in unable to be filled within 30 days.

A supplemental Schedule D-4 may be submitted no more than once every three (3) months for the above reasons. The projected rate established will **not** be inflated by the consumer price index (CPI).

<u>No rate changes should be authorized in ISIS until review of the rate (D-4) and/or service plan are approved</u>

Site Daily Rate Worksheet

There are two pages to the Site Daily Rate Worksheet. Site Page 1 will list all members living at the site, regardles of funding. Site Page 2 will consolidate expenses for each site rate needed. If the site serves members on differer waiver types (ID, BI, etc.), the provider will submit more than one Site Page 2.

Page 1
Effective Date: Effective date requested for the rates

Provider Name: Agency name

NPI: 10 digit NPI Number

Site Rate / Individual Rate: Check box to indicate if rate(s) requested is a Site or Individual Rate(s).

New Site: Check box if the Schedule D-4 is being submitted to establish a daily rate for new site.

Existing Site Change: Check box if the Schedule D-4 is being submitted to change an existing site rate.

Site Name: If the Schedule D-4 is being submitted to change an existing site rate, include the Site Name of the site being changed (e.g. SCL-A(1), SCL-BI A(1), RBSCL-A(1)).

Site Address: Enter the street address of the site.

Site City: Enter the city of the site.

Explanation of Changes: If the Schedule D-4 is being submitted to change an existing site rate, include an explanation of the significant changes in the living site situation.

List all Members living at the site: Each member living at the site, regardless of funding, will be included in the table. The table should include each member ID, member name, and case manager name. The table will also include if the member is funded by Money Follows the Person (MFP) and Waiver Type related to the services provided to each member. Waiver Type categories are ID, BI, RBSCL, Hab, County, or Private Pay.

Page 2 - More than one Site Page 2 worksheet will be submitted if the site has members for multiple waiver types (ID, BI, etc.)

Effective Date: Effective date requested for the rates

Provider Name: Agency name

NPI: 10 digit NPI Number

Site Name: If the Schedule D-4 is being submitted to change an existing site rate, include the Site Name of the site being changed (e.g. SCL-A(1), SCL-BI A(1), RBSCL-A(1)).

Waiver Type: Enter waiver type (ID, BI, RBSCL) for the site rate being submitted. Ensure only expenses and units for the appropriate waiver type are entered.

Consolidated Site Expenses, Units and Unit Cost for all Members (for specific waiver type): Sum the amounts on the Individual Daily Rate Worksheets, by line item for the specific waiver type. Show the lower of actu indirect costs or the 20% limit and add it to total direct costs. Divide total costs by the units of service provided to calculate a unit cost. Each separate Site Daily Rate Worksheet will only include expenses and units for that specific waiver type.

Certification: The Officer or Administrator of the Agency will sign and date the Site Daily Rate worksheet to certify that the schedule is true and correct. It will also certify that the schedules were prepared in accordance with instructions and that only allowable costs necessary to provide the care are included in the site rate.

Individual Daily Rate Worksheet

The provider and case manager will work together to submit the Individual Daily Rate Worksheet. An Individual Daily Rate Worksheet will be completed for all members living at the site, regardless of funding.

Effective Date: Effective date requested for the rates

Provider Name: Agency name

NPI: 10 digit NPI Number

Site Name: If the Schedule D-4 is being submitted to change an existing site rate, include the Site Name of the site being changed (e.g. SCL-A(1), SCL-BI A(1), RBSCL-A(1)).

Member Name: Name of member

Member ID: Medicaid ID number of member

Case Manager: Name of case manager responsible for member service plan

Indicate if Member had a change in service plan (Y/N): Complete a separate Individual Daily Rate worksheet for every member living in the site. Answer yes for each member where a change in service plan occurred to necessitate the rate change.

Provide explanation of the change: If the member had a change in service plan which has resulted in a change in rate, include an explanation of the service plan changes and how the changes affected the individual rate.

Line 2120 - Professional Direct Staff: Enter salary expense of professional direct staff hours related to the specific needs of the member. Also include the number of direct hours associated with the salary. This does not include administrative time. Administrative time is spent on general management of program operations and is not a direct cost. Professional direct staff provide assistance and support to direct support staff, may provide some direct service to the member in the absence of direct support staff, and may supervise some direct support staff activities. Examples of positions include program directors, program supervisors, team leaders, and coordinators.

Line 2130 - Other Direct Staff: Enter salary expense of other direct staff hours related to the specific needs of the member. Also include the number of direct hours associated with the salary. Other direct staff provide direct support and assistance to the member. The number of direct support hours corresponding to direct wages should be supported by the staff ratios and services listed in the Individual Service Plan. Direct support wages must reflec all direct support hours provided by agency personnel on behalf of the member.

Line 2200 – Direct Staff Benefits: Enter benefit expense associated with the employees included on Lines 2120 and 2130.

Line 2300 – Direct Staff Payroll Taxes: Enter payroll tax expense associated with the employees included on Lines 2120 and 2130.

Line 3210 - Mileage and Auto Rental: Enter staff mileage expense, lease payments, or short-term rental expense for transportation when member is not in the vehicle. For mileage reimbursement for business use of an employee's personal vehicle, enter the estimated number of miles and the rate paid per mile corresponding to the expense. Mileage reimbursement is limited to $0.39 per mile. Expense should be specific to the service being provided and be related to the waiver program. Provide explanation of expense and estimates used (mileage).

Line 3250 - Agency Vehicles Expense: Enter expense for operation and maintenance of agency-owned vehicles for transportation when member is not in the vehicle. The estimate can be calculated by multiplying number of miles by a rate per mile. Miles and the rate per mile must be entered on the Schedule D-4. The expense can also be estimated based on actual yearly cost of the agency vehicle. If based on actual cost, include a description of the vehicle expenses (e.g. maintenance, insurance, registration, parking expense, etc.) Expense should be specific to the service being provided and be related to the waiver program.

Line 3290 - Other Related Transportation: Include expense attributable to the actual transporting of the member (provided by staff, taxi, car pool, or bus fare) to allow member access to community resources and opportunities. Needs must be identified in the member service plan. This item is subject to the $1,570 limit on member needs items.

Line 3520 – Other: Include consultation expenses (such as an interpreter) and expenses directly related to the implementation of specific goals identified in the member's service plan. Needs must be identified in the member identified in the member service plan. These can include behavior programming and training, reinforcement for behavior modification, and/or socialization. This item is subject to the $1,570 limit on member needs items.

Line 4320 – Other Equipment Repair and Purchase: Include expense amounts for the modification or repair of the member's living unit based on specific member needs. Expenses included may provide for reasonable accommodation of the behaviors of the member in rental units. For member-owned units, minor maintenance expenses may be included. Also, include household furnishings needed by the member. If the member needs furniture and does not have any or cannot access any through other resources, that expense can be included here. Any property expenses related to providing room and board are not reimbursable. Needs must be identified in the member service plan. This item is subject to the $1,570 limit on member needs items.

Lines 3290, 3520 and 4320 are for member specific support expenses needed for travel and transportation, consulting, instruction, and environmental modifications and repairs, as determined necessary by the inter-disciplinary team for each member. The assessed specific support expense needs must be specifically identified in the Medicaid case manager's service plan. The total costs of all three lines shall not exceed $1,570 per member per year, and the provider must maintain records to support the expenditures.

The service plan should also document the absence of member or community resources available to cover the needs and expenses. Payment should first be sought from the member; second, from other natural and community resources; and third, from the HCBS program. The agency is responsible for tracking member costs individually to ensure the cost remains within the limit. Maintain documentation to track the costs per member adequately.

The $1,570 limit on member needs items is not intended to cover the costs of staff's meals or to cover the cost of staff participation in activities, e.g. bowling, refreshments, etc. The money can be used for staff admission to activities, e.g. play, festival, when there are not member or community resources available, and there is an instructional goal for the member in the service plan.

Case Manager service plan documentation on support expenses must be specific. The use of support expenses must be an assessed need and reviewed annually by the interdisciplinary team to determine if it is a continued member need. Goals must be established for use of instructional money. The provider and case manager must maintain records of the support expenditure. Documentation in the service plan should include the need of the member, the projected expense, and the supporting calculations used to project the expense.

Examples:

- Transportation will be provided to allow Helen to access medical services, activities in her community, and in case of an emergency. This will include staff mileage and bus fare. Projected costs of $800 a year for member specific transportation.
- Instructional money of up to $60 will be utilized to purchase cookbooks needed for Helen to achieve her personal outcome and goal of learning to cook nutritious meals.
- Helen will access up to $50 a month of support dollars to help pay for the costs of participating in activities in her community with friends. This is a personal outcome and goal for Helen.

Total Direct Expense: Sum of Line 2120 through Line 4320.

Indirect Expense: Indirect expense is limited to 20% of Total Direct Expense. However, provider should budget indirect expense based on historical information. If the agency indirect expense is historically below 20% of Total Direct Expense, it is not appropriate to budget 20% indirect expense without a business explanation of the increase in expense.

Total Cost: Sum of Total Direct Expense and Indirect Expense.

Number of Units to be Provided: Enter the number of daily units provided.

Unit Cost: Total Cost divided by Number of Units Provided.

Staffing Schedule: Provide an individualized staffing schedule for each member which supports the salary expense and hours included on the first page of the Individual Daily Rate Worksheet. An already developed staffing spreadsheet or document can be attached to the Individual Daily Rate Worksheet. The staffing schedule should include times of day, staff to member ratios, any other services provided to the member (e.g. day programs, work programs, member alone time), and total hours.

It is recognized that a staffing schedule of a member does change based on member needs and should be flexible to support changes for the member. The staffing schedule information is meant to be as detailed as possible from an overall schedule standpoint knowing that there will be modifications and changes. The schedule submitted should support the hours and salary expense included on the first page of the Individual Daily Rate Worksheet taking the member's needs and flexibility into consideration.

Additional Explanations: Provide any additional explanations for needed changes in services and/or expenses (e.g. ratios of mid management staff to members on caseload, percentage of time charged, changes in hourly wages of staff, description of staffing patterns, changes in benefit expense, changes in payroll tax expenses, etc.)

If the agency has seen an increase in expenses (e.g. benefits, taxes, average hourly wages, etc.) which has contributed to an increase in the individual rates and the site rate, including an explanation of the increased will help review of the rate calculations and support the need for an increased rate.

Certification: The Officer or Administrator of the Agency will sign and date each Individual Daily Rate worksheet to certify that the schedule is true and correct. The Administrator will also certify that the schedules were prepared in accordance with instructions and that only allowable costs necessary to provide the care are included in the individual member rate.

The Case Manager will sign and date each applicable Individual Daily Rate worksheet to certify the staffing schedule is true and correct. The Case Manager will also certify that the schedules were prepared in accordance with instructions and that only allowable member specific costs as identified in the case plan and necessary to provide care are included in the individual member rate.

Submission of the Site Daily Rate Worksheet and Individual Daily Rate Worksheets

Contact Provider Cost Audit and Rate Setting at 866-863-8610, 515-256-4610 or email costaudit@dhs.state.ia.us with questions.

All completed worksheets should be sent to the Iowa Medicaid Enterprise Provider Cost Audit and Rate Setting Unit.

Email: costaudit@dhs.state.ia.us

Fax: 515-725-1353

Mail:
Iowa Medicaid Enterprise
Provider Cost Audit and Rate Setting Unit
P.O. Box 36450
Des Moines, IA 50315

Iowa Department of Human Services **SITE DAILY RATE WORKSHEET**

HCBS SUPPLEMENTAL SCHEDULE D-4 TO FORM SS-1703-0 Effective Date: _____

Provider Name: _____

NPI _____

Site Rate ☐ New Site ☐ Site Name _____

Individual Rates ☐ Existing Site ☐

Site Address: _____

Site City: _____

If Existing Site Change, provide explanation of changes.

_____

_____

_____

_____

_____

List all Members living at the site including Name, Member ID, Case Manager, Service Procedure Code and indicate if the member is funded by MFP

Member ID	Member Name	Case Manager	MFP (Y/N)	Waiver Type

Iowa Department of Human Services **SITE DAILY RATE WORKSHEET**

HCBS SUPPLEMENTAL SCHEDULE D-4 TO FORM SS-1703-0 Effective Date: 1/0/1900

Provider Name: _____

NPI _____

Site Name _____

Waiver Type _____

Consolidated Site Expenses, Units, and Unit Cost for all Members included in Daily Rate

Form 1703-0 Line:	
2120 - Professional Direct Staff	
2130 - Other Direct Staff	
2200 - Direct Staff Benefits	
2300 - Direct Staff Payroll Taxes	
3210 - Mileage and Auto Rental	
3250 - Agency Vehicle Expenses	
3290 - Other Related Transportation	
3520 - Other (Consultation Expenses)	
4320 - Other Equipment Repair and Purchase	
Total Direct Expense	$ -
Indirect Expense (limited to 20% of direct expense)	
Total Cost	$ -
Number of Units to be Provided	
Unit Cost	$ -

I certify that I have examined the accompanying schedules of expenses and the calculation of cost of service prepared for this agency and that to the best of my knowledge and belief they are true and correct. I also certify that these schedules were prepared in accordance with instructions contained in this report and the allowable cost of care excludes expenses that were not necessary to provide this care.

SIGNED (Officer or Administrator of Agency)	Date

Contact Provider Cost Audit and Rate Setting at 866-863-8610, 515-256-4610 or email costaudit@dhs.state.ia.us with questions. All completed worksheets should be sent to the Iowa Medicaid Enterprise at the following e-mail address: costaudit@dhs.state.ia.us, fax 515-725-1353 or mail to: Iowa Medicaid Enterprise, Provider Cost Audit and Rate Setting Unit, P.O. Box 36450, Des Moines, IA 50315.

Iowa Department of Human Services

HCBS SUPPLEMENTAL SCHEDULE D-4 **INDIVIDUAL DAILY RATE WORKSHEET**

TO FORM SS-1703-0 Effective Date: 1/0/1900

Provider Name: _____ Member Name: _____

NPI _____ Member ID: _____

Site Name: _____ Case Manager: _____

Indicate if the Member had a change in service plan (Y/N) _____

Provide explanation of the change:

_____

_____

_____

_____

_____

Form 1703-0 Line:

2120 - Professional Direct Staff Direct Hours _____

2130 - Other Direct Staff Direct Hours _____

2200 - Direct Staff Benefits

2300 - Direct Staff Payroll Taxes

3210 - Mileage and Auto Rental Number of Miles _____ Rate Paid / Mile _____

Provide explanation of expense: _____

_____

3250 - Agency Vehicle Expenses Number of Miles _____ Rate Paid / Mile _____

Provide explanation of expense: _____

_____

***Provide a description of specific expenses listed for each line. Identify other resources sought, but not available for these expenses. Expenses included on Lines 3290, 3520 and 4320 below must be included in the member's specific service plan. The sum of these lines is limited to $1,570 annually per member.**

3290 - Other Related Transportation*

Included in Member Service Plan (Y/N) _____

_____

_____

_____

3520 - Other (Consultation Expenses)*

Included in Member Service Plan (Y/N) _____

_____

_____

_____

4320 - Other Equipment Repair and Purchase*

Included in Member Service Plan (Y/N) _____

_____

_____

_____

Total Direct Expense $ -

Indirect Expense (limited to 20% of direct expense)

Total Cost $ -

Number of Units to be Provided

Unit Cost $ -

Iowa Department of Human Services Member Name:

Provider Name: Site:

Provide the staffing schedule for the member Daily Rate on the Individual Daily Rate Worksheet. This should include times of day, staff to member ratios, other services provided to the member (e.g. day/work programs), and total hours. A separate spreadsheet or document can also be attached to this form.

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Time Span							
Ratio							
Hours							
Time Span							
Ratio							
Hours							
Time Span							
Ratio							
Hours							
Time Span							
Ratio							
Hours							
Time Span							
Ratio							
Hours							
Total Hours	-	-	-	-	-	-	-

Provide any additional explanations for needed changes in services and/or expenses (i.e. ratio of mid management staff to members on caseload, percentage of time charged, changes in hourly wages of staff, description of staffing pattern, changes in benefit expenses, changes in payroll tax expenses, etc.)

I certify that I have examined the accompanying schedules prepared for this member and to the best of my knowledge and belief they are true and correct. I also certify these schedules were prepared in accordance with instructions contained in this report and the allowable cost of care excludes expenses not necessary to provide this care.

SIGNED (Officer or Administrator of Agency)	Date

I certify I have examined the accompanying schedules prepared for this member. I also certify the staffing schedule and member specific expenses, as identified in the case plan, were prepared in accordance with instructions containec in this report and the member specific allowable cost of care excludes expenses not necessary to provide this care.

SIGNED (Case Manager)	Date

4. Forms 470-0664 and 470-3449

Click here to view a form 470-0664, *Financial and Statistical Report for Purchase of Service Contracts*.

Click here to view form 470-3449, *HCBS Supplemental Schedule D-4*.

a. Instructions for *HCBS Supplemental Schedule D-4*, Form 470-3449

The purpose of *HCBS Supplemental Schedule D-4*, form 470-3449, *Daily Rate Worksheet*, is to calculate a unit daily rate cost per living site. Costs reported by site should be consistent with those reported on *Schedule D* from form 470-0664.

Projected prospective rates are based on projected reasonable and proper costs of operation for a 12–month period.

The *HCBS Supplemental Schedule D-4*, form 470-3449, consists of two parts:

- *Site Daily Rate Worksheet*
  - Sum total of the *Individual Daily Rate Worksheets* which calculates the average daily rate for the separate ID, RBSCL, or BI site
  - Separate *Site Daily Rate Worksheet* must be submitted for an ID, RBSCL, or BI site
  - Completed, signed, and submitted by the provider
- *Individual Daily Rate Worksheet*
  - Completed for each member living at the site
  - Completed and signed by the interdisciplinary team including the provider and the case manager
  - Submitted by the provider

Submit a *HCBS Supplemental Schedule D-4*, form 470-3449, for the site rates (*Site Daily Rate Worksheet*) along with separate schedules for each member (*Individual Daily Rate Worksheet*). The *Individual Daily Rate Worksheets* must be submitted for each member even if all members share the same rate at the site.

Supplemental Schedule D-4 should be completed for the following reasons:

- To establish a daily rate for a new site.
- To change a daily rate due to significant changes in the cost per unit for a member due to:
  - Change in member service needs.
  - Change in members at the site.

A "significant" change occurs when a member's functioning level changes or a vacancy is unable to be filled within 30 days. Give a full explanation of the changes in the living site situation on the schedule. Also give reasons for a request to exceed the unique rate maximum.

A *Supplemental Schedule D-4* may be submitted no more than once every three months for the above reasons. The projected rate established will not be inflated by an inflation factor.

A provider can choose to either bill member rates or an average site rate for each member at the living site. Regardless of choice, both site and individual daily rate worksheets for each member living at the site must be submitted with each projected *Supplemental Schedule D-4*.

b. Instructions for *Site Daily Rate Worksheet*

- **Effective Date**. Effective date requested for the rates.
- **Provider Name**. Agency name.
- **NPI**. 10-digit NPI number.
- **Site Rate/Individual Rate**. Check box to indicate if rates requested are site or individual rates.

- **New Site**. Check box if the *Supplemental Schedule D-4* is being submitted to establish a daily rate for a new site.
- **Existing Site Change**. Check box if the *Supplemental Schedule D-4* is being submitted to change an existing site rate.
- **Site Name**. If the *Supplemental Schedule D-4* is being submitted to change an existing site rate, include the site name of the site being changed.
- **Site Address and City**. Enter street address and city of site.
- **Explanation of Changes**. If the *Supplemental Schedule D-4* is being submitted to change an existing site rate, include an explanation of the significant changes in the living site situation.
- **List all Members living at the site**. Each member living at the site, regardless of funding, must be included in the table. The table will include member identification, member name, case manager name, and funding (e.g., Money Follows the Person, ID, BI, county, private pay, or habilitation).
- **Waiver Type**. Enter waiver type (e.g., ID, BI, RBSCL) for the site rate being submitted. Ensure only expenses and units for the appropriate waiver type are entered.

Sum the amounts from the *Individual Daily Rate Worksheets*, by line item for each specific waiver type. Show the lower of actual indirect costs or the 20 percent limit and add it to total direct costs. Then divide total costs by the units of service provided to calculate a unit cost. Each separate *Site Daily Rate Worksheet* will only include expenses and units for that specific waiver type.

c. Instructions for *Individual Daily Rate Worksheet*

- **Effective Date**. Effective date requested for the rates.
- **Provider Name**. Agency name.
- **NPI**. 10-digit NPI number.
- **Site Name**. If the *Supplemental Schedule D-4* is being submitted to change an existing site rate, including the site name of the site being changed.
- **Member Name**. Name of member.

- **Member ID**. Medicaid identification number of member.
- **Case Manager**. Name of case manager responsible for member service plan.
- **Indicate if member had a change in service plan**. A separate *Individual Daily Rate Worksheet* is completed for every member living at the site. "Y" is entered if a service plan change for this member has occurred to necessitate the rate change.
- **Explanation of Changes**. If the member had a change in service plan which has resulted in a change in rate, include an explanation of the service plan changes and how the changes affected the individual rate.
- **Show direct costs by line item**. Use actual costs for members and living sites not undergoing any significant change. Use projected costs if there are no representative historical costs available or for a member or living site that undergoes a significant change during the reporting period.
- **Project the costs on an annual period:** Line 3290 – Other Related Transportation, Line 3520 – Other Assistance, and Line 4320 – Other Equipment Repair and Purchase, are for member-specific support expenses and shall not exceed $1,570 reimbursement per member per year. The provider must maintain records to support the expenditures.
- **Show the lower of actual indirect costs or the 20 percent limit**. Add it to total direct costs, then divide total costs by the units of service provided to calculate a unit cost.
- **Staffing Schedule:** Provide an individual staffing schedule for each member, which supports the salary expense and hours included on the *Individual Daily Rate Worksheet*. The schedule should include times of day, staff to member ratios, any other services provided to the member, and total hours. Provide any additional explanations for needed changes in services or expenses submitted on the worksheets.

d. Instructions for *Financial and Statistical Report for Purchase of Service Contracts*, Form 470-0664

Enter identifying information at the top of each schedule. Enter the NPI number with the full NPI – Taxonomy – ZIP. All information called for in the schedules must be furnished unless it does not apply to the agency.

The cost reporting period is from July 1 through June 30. For providers participating in the program as of July 1, the report covers the 12-month period of July 1 through June 30. For those entering the program after July 1, the reporting period is from the beginning of providing waiver services through June 30.

Adjustments to convert to an accrual basis of accounting are required if records are maintained on another accounting basis. The intent of these adjustments is to obtain information concerning costs of providing care and services to members on a basis that is consistent and comparable among providers of the service.

Providers who are providing other program services, not contracted for under HCBS contracts, should complete the cost apportionment in accordance with recognized methods and procedures for a reasonable presentation of expenses attributable to services provided under the contract. Costs reported under the waiver shall not be reported as reimbursable costs under any other funding source. Costs incurred for other services shall not be reported as reimbursable costs under the waiver.

If an out-of-county supported community living service paid at 15-minute rates is maintained, both in-county and out-of-county rates must be submitted. In- and out-of-county rates may be set up through an initial projection and then maintain special reporting on the annual *Financial and Statistical Report*.

Travel time needs to be accumulated by "in" and "out" counties. SCL 15-minute costs will be allocated between the in- and out-of-county designations based on travel time. SCL 15-minute units also need to be accumulated on an "in-county" versus an "out-of-county" basis in order to continue to set two separate rates.

e. Instructions for *Certification Page*

The purpose of the *Certification Page* is to report agency statistical information and record the signature of an authorized officer of the agency.

- **Agency Name and Address**. Enter the official name and address of the agency. Generally this is the name and address which appears on the license or official agency letterhead.
- **IRS ID No**. Enter the number assigned the facility for tax purposes (federal withholding, etc.).
- **Contract No**. Enter the contract number assigned at certification.
- **Period of report**. Enter the dates for which the current information is being provided.
- **Date of Fiscal Year End**. Enter the ending date for the fiscal year.
- **Names and Telephone Numbers**. Self-explanatory.
- **Audit**. Indicate if the agency has a certified public accounting firm to perform an audit of its financial statements. Forward a copy of the latest independent audit to the Department when available.
- **Type of Control**. Indicate the ownership under which the agency is conducted.
- **Accounting Basis**. Indicate the basis on which records are maintained.
  - **Accrual**. Recording revenue when earned and expenses when incurred.
  - **Modified Cash**. Combination of certain cash and accrual method of accounting.
  - **Cash**. Recording revenue when received and expenses when paid.

  NOTE: If an accrual basis of accounting is not used, amounts must be adjusted to the accrual basis. Keep the accounting work papers used in adjusting records from cash, or other basis, to accrual.

- **Statistical Data**. Enter service codes as entered on *Schedule D*. Each waiver program and living site should be shown separately.

  Enter the appropriate number of units provided during the reporting period. Billable time means direct support contact with the member. For daily units, the number of units of services staffed should be based upon a 365-day period (366 days during a leap year).

  Hours are totaled at the end of the month and partial units are rounded up to the next unit.

- **Signatures**. The report must be reviewed and signed by an authorized officer or administrator of the agency. If the report is prepared by someone other than an employee of the agency, that person must sign as preparer.

f. Instructions for *Schedule A*

The purpose of *Schedule A: Revenue Report* is to report total agency income and show detailed income from specific services and programs. Report all revenues, including those from excluded or non-home- and community-based waiver programs.

Report the total revenues or gross income in the column headed "Total Revenue." Revenue categories are provided on the schedule for the most common sources. If additional categories are necessary, submit accompanying schedules.

The column titled "Revenue for Schedule D Expense Deduction" is used to report those revenues which are required to be deducted from service costs. Revenue which is required to be deducted should be entered in both the "Total Revenue" column and also in the "Revenue for Expense Deduction" column. Revenue offset amounts should be shown on *Schedule D* after costs have been properly allocated.

Income which must be offset against service cost includes, but is not limited to, all service income generated for that service up to the amount of service cost, such as reimbursements for certain expenses (excluding fees for services) and income from investments.

Revenues are generally broken down into three classifications for purposes of completing this report:

- **Fees for services**. Represent income earned as a result of performing services to or for members. The fees might be paid by third parties on behalf of members for whom services were performed.
- **Service, reimbursement or investment income**. Includes, but is not limited to, program revenues from:
  - The sale of products,
  - Food reimbursements from the Department of Education, and
  - Investment income that is not from restricted or appropriated contributions and is held separate and not commingled with other funds.

  Additional other income items may be applicable. If so, identify them accordingly or support them by an accompanying schedule.
- **Contributions**. Must be accompanied by a schedule showing the contribution and anticipated designation by the agency. No private moneys contributed to the agency shall be included in the Department's reimbursement rate determination, unless the moneys are contributed for services provided to specific individuals for whom the reimbursement rate is established by the Department as follows:
  - **Restricted or Appropriated**. Include funds which are either appropriated by the provider through formal board action or restricted by the donor. This includes interest from the contribution, when this interest is also restricted or appropriated, and is held separate, nor commingled with other funds.
  - **Not Restricted or Appropriated**. Include donations which are not appropriated or designated by the provider through board action or restriction by the donor.
  - **Government Grants**. Government grants should be explained on an accompanying schedule which sets forth the source of funding, the purpose and the period of the grant, and the program to which the grant pertains.

- **Government Grants**. Shall be reported as Other Programs expense on *Schedule D* or awarded amounts should be used to offset grant funded expenses, dependent upon the facts and circumstances of each grant.

  If a government grant is related to costs not shown as costs in a service, the grant income is not used in rate determination.

  Contributions that are restricted for capital expenditures, designated to fund service operating deficits or non-reimbursable costs, or provided to fund a required operating reserve are not required to be deducted from service expenses on *Schedule D*.

g. Instructions for *Schedule B*

The purpose of *Schedule B: Staff Numbers and Wages* is to report full-time equivalent numbers of staff and wages by job title.

- **Job Classification and Title**. Enter the job titles in the space provided on the left. All personnel must be separated into the following job classifications:
  - 2110 Administrative
  - 2120 Professional
  - 2130 Direct Client Care
  - 2150 Clerical
  - 2190 Other Staff Wages
- **Number of Staff**. Enter the number of people working full time or part time, and the total full-time equivalents (FTEs) for each job title.

Examples based on 2,080 hours per 1.0 FTE:

1. A full-time employee (1.0 FTE) starts in January. The worked FTE to be reported on *Schedule B* for the fiscal year would be:

   (1.0 FTE ÷ 12 months X 6 months) = 0.50 FTE

2. A full-time employee (1.0 FTE) starts in November. The worked FTE to be reported on *Schedule B* for the fiscal year would be:

   (1.0 FTE ÷ 12 months X 8 months) = 0.67 FTE

3. A part-time employee starts in January. The employee works 24 hours per week (24 hours ÷ 40 hours = 0.60 FTE). The worked FTE to be reported on *Schedule B* for the fiscal year would be:

   (0.60 FTE ÷ 12 months X 6 months) = 0.30 FTE

4. A part-time employee starts in March. The employee works 16 hours per week (16 hours ÷ 40 hours = 0.40 FTE). The worked FTE to be reported on *Schedule B* for the fiscal year would be:

   (0.40 FTE ÷ 12 months X 4 months) = 0.13 FTE

5. A part-time employee working 24 hours per week (24 hours ÷ 40 hours = 0.60 FTE) becomes a full-time employee (1.0 FTE) starting in November. The worked FTE to be reported on *Schedule B* for the fiscal year would be:

   (0.60 FTE ÷ 12 months X 4 months) = 0.20 FTE plus

   (1.0 FTE ÷ 12 months X 8 months) = 0.67 FTE = 0.87 FTE

- **Gross Wages**. Enter the gross wages for all full-time and part-time staff for each job title. Make sure the salaries and wages correspond with the respective salary lines on *Schedule D* (Lines 2110 – 2190). (In the electronic version of these forms, this link is automatic.)

Providers are required to maintain supporting documentation identifying the number, type of staff, and FTE's devoted to HCBS services and to each individual HCBS service. If staff is responsible for both direct and administrative duties, appropriate time studies must be kept to support allocations.

h. Instructions for *Schedule C*

The purpose of *Schedule C: Property and Equipment Depreciation and Related Party Property Cost* is to report information related to depreciable assets. *Schedule C* includes the original acquisition costs, capital improvements, and depreciation on buildings and equipment owned by the provider. If property is being leased from a related party, information regarding the lessor's costs must be submitted on *Schedule C*.

The totals reported on *Schedule C* are reported on *Schedule D*, Line 4400. Ongoing expenses, such as maintenance and repairs for property, are entered on *Schedule D* under Line 2800 (occupancy) or Line 4300 (repair expenses). Ensure the depreciation expenses correspond with the respective depreciation lines on *Schedule D* (Lines 4410 – 4480). (In the electronic version of these forms, this link is automatic.)

NOTE: Any property expenses related to providing room and board are not reimbursable under administrative rule for the HCBS waiver program and should be either shown as an Other Program on *Schedule D* of the cost report, or offset as a non-reimbursable expense.

Calculate depreciation expense on a straight-line basis over the estimated useful life of the assets. Follow the most recent edition of the Estimated Useful Lives of Depreciable Hospital Assets, published by the American Hospital Association, for depreciation.

If a depreciable asset has, at the time of its acquisition, an estimated useful life of at least 2 years and a historical cost of at least $5,000, its cost must be capitalized and written off ratably over the estimated useful life of the asset using one of the approved methods of depreciation. If a depreciable asset has a historical cost of less than $5,000, or if the asset has a useful life of less than 2 years, its cost is allowable in the year it is acquired.

When items are purchased as an integrated system, all items must be considered as a single asset when applying the capitalization threshold. Items that have a stand-alone functional capability may be considered on an item-by-item basis. For example, an integrated system of office furniture (interlocking panels, desktops that are supported by locking into panels) must be considered as a single asset when applying the threshold. Stand-alone office furniture (e.g., chairs, free standing desks) will be considered on an item-by-item basis.

Instructions are provided for each column in the section on Provider-Owned Equipment and Buildings:

- **Original Cost**. Record the property and equipment at its original cost.
- **Depreciation Recorded Prior Years**. Obtain this information by adding the depreciation accumulated from prior years less any disposals.
- **Method**. Enter the method used by the agency in calculating its depreciation.

- **Annual Percentage Rate**. Enter the annual percentage rate used in calculating the depreciation.
- **Recorded Depreciation Expense**. Enter the total amount of depreciation recorded on the agency's books.
- **Straight-Line Depreciation**. Enter the amount of depreciation for the property and equipment on a straight-line basis. If the agency uses a method other than straight-line for its books, then the amount in this column will be different from the "Recorded Depreciation Expense" column.
- **Related Party Property Costs**. A "related party" is defined as an organization related through control, form ownership, capital investment, directorship, or other means. Organizations are required to disclose their financial and statistical records to determine whether a related party relationship exists and to document the validity of costs.

  If property is leased from a related party, the reimbursable Medicaid expense is the lesser of rent expense paid or the actual property cost incurred by the related party landlord. The difference must be classified as a non-reimbursable cost on *Schedule D*. A schedule of lessor's cost is included on *Schedule C* for purposes of identifying the actual cost incurred by the related party landlord.

i. Instructions for *Schedule D*

The purpose of *Schedule D: Expense Report* is to report total agency expenses and assign or allocate those expenses to the various services provided by an agency. The allocation of costs per service includes all costs for the agency, and should be consistent with the costs included on the general ledger.

Reflect on this schedule the total cost of operation for all programs and services the agency provided, as opposed to only reflecting the costs of HCBS services.

The line numbers for expenditures are not intended to be all-inclusive in detailing expenses of a provider. The numbering system used on this schedule is not important, other than to have a basis of identifying object expenses in a manner that is uniform for reporting purposes.

HCBS uses several supplemental schedules to further clarify the application of these expenses.

In addition to the columns for HCBS services, *Schedule D* includes:

- A column for the direct costs of programs and services rendered other than HCBS.
- A column available for reflecting all indirect costs that cannot be directly attributed to any one program or service.

The inclusion of all agency costs on this schedule is required so that:

- The allocation or apportionment of costs to all services and programs of the agency may be observed together as one overall calculation.
- Consistency in the cost assignments and allocations can be reviewed from one fiscal period to the next.

(1) Column Descriptions

- **Total Expense (Column 1)**. This column shows the total operating costs of the agency. The expenses reported in this column should equal the total expenses included in the agency's audited financial statements, general ledger, or working trial balance. Any difference between the amounts shown in this column and the audited financial statements, general ledger or working trial balance must be disclosed in a supplemental schedule.
- **Fund-Raising Costs (Column 2)**. Use this column to show any adjustment to remove costs related to fundraising activities from allowable costs.
- **Other Non-reimbursable Costs (Column 3)**. Use this column to show any adjustments or reclassifications related to costs that are not reimbursed by the HCBS program. Examples of non-reimbursable costs include, but are not limited to:
  - Difference between book depreciation expense and that under the straight-line method
  - Expenses not related to providing member care (personal expenses)

- Costs of member items provided that exceeds the $1,570 limit per member (see Instructions for *Supplemental Schedule D-1* for the member item limit calculation).
- Costs in excess of the state mileage reimbursement rate
- Expenses related to revenue from allowable costs
- Bad debt

Use the non-reimbursable column to reclassify costs, such as moving agency vehicle depreciation to a direct cost line when the vehicle is used solely for the HCBS program, can be used.

- **Adjusted Costs (Column 4)**. This column shows costs that are allowable and allocable to HCBS programs, other programs, and indirect administrative costs. Calculate the balance of the expenses after deducting the items reflected in Columns 2 and 3 (fund-raising and non-reimbursable costs).
- **Indirect Service Costs (Column 5)**. This column should include those service and administrative expenses that cannot be directly related to any specific service or program. These costs will be allocated across all programs and services after all other costs have been apportioned. Indirect costs after adjustments for fund-raising and non-reimbursable costs should be shown in column 5. Some examples of indirect administrative costs include, but are not limited to:
  - Receptionist position
  - Office supplies
  - Telephone
  - Rent for administrative office
  - Property or liability insurance

  To the extent possible, itemize indirect cost by line item or account. All line items may be used as appropriate to report indirect costs. All indirect costs should be shown by line item in column 5 and then allocated in total to the various programs. Each agency is responsible for developing an acceptable method of distributing the indirect service costs to the various programs and supporting its rationale.

  The standard method for allocating indirect costs to different programs and services is based on the total of accumulated direct costs for each program or service before the indirect cost allocation.

If an alternate method of allocating indirect costs (e.g., a weighted allocation favoring certain services) is justified, it may be used. Supporting documentation must be maintained and submitted for that alternate allocation basis to be used.

- **Other Program Costs (Column 6)**. This column should include the consolidated direct costs of all other programs and services rendered by the agency. Supporting working papers for the costs reflected in this column must be maintained. These working papers must be organized by individual location or site, in detail by program or service, and in an easily audited format. The Iowa Medicaid Enterprise may conduct periodic audits of this information.
- **Direct Service Cost (Beginning with column 7)**. Use these columns for direct costs for each of the services or service sites provided, as defined below. Direct costs should be reported by 15-minute service and by site.

  In this accounting procedure, "direct" service expense include all direct personnel involved in a service. It includes the supervisor of that service or the appropriate prorated share of the supervisor's time. Expenses other than wages and fringe benefits can be charged as direct service expense if they are identifiable to a specific member (i.e., hands-on, one-on-one member contact). Examples of non-billable direct costs include, but are not limited to:

  - Mileage costs for travel to and from the member site.
  - Time spent in staff meetings related to a particular member or HCBS service.
  - Time spent documenting services provided.

(2) Account Title Descriptions

This section includes additional instructions for reporting selected line items.

- **Line 2120 – Professional Direct Staff**. These positions provide assistance and support to direct support staff, may provide some direct service to the member in the absence of direct support staff, and may supervise some direct support staff activities. Examples of positions include program directors, program supervisors, team leaders, and coordinators.

  Calculate the salary expense related to this line item by multiplying the position's salary by the percentage of time spent in the specific program. This does not include administrative time. Administrative time is spent on general management of program operations and is not a direct cost. Administrative salaries should be placed on Line 2110 – Administrative.

  Ongoing time reports should be kept which support the allocation of salaries between direct and administrative time. Direct time should include member or site information which can be traced to billing records. If ongoing time reports are not kept, periodic time studies may be used to allocate direct salary and wage costs.

- **Line 2130 – Other Direct Staff**. These positions provide direct support and assistance to the members. The wage amount is cash compensation and may also include noncash compensation of room and board, when applicable.

  Direct support wages must reflect all direct support hours provided by agency personnel, including time spent on progress notes, phone calls, and staffing meetings. Travel time to and from the service site should be accumulated separately from direct service time. Documentation should be available to support the travel time.

  This item also includes contract services that provide direct support and assistance to members. The position is instead of, or in addition to, a direct support employee. Contract payments are made to people who are not employees of the agency.

The total number of direct support and contracted hours corresponding to the direct wages must equal the direct support hours listed in the service plan.

- **Line 2290 – Other Benefits**. This item includes other benefits provided for employees, excluding travel and training costs.
- **Line 3210 – Mileage and Auto Rental**. This item includes staff mileage and vehicle lease and rent expense when a member is not in the vehicle. If the expense is related to a specific member, assign the expense to the specific site or code. If the expense is applicable to all agency functions, report the expense in the indirect service cost column. Mileage cost reported is limited to the state employee reimbursement rate.
- **Line 3250 – Agency Vehicles Expense**. Include actual expense for operation and maintenance of agency-owned vehicles when a member is not in the vehicle.

  Vehicle usage must be tracked in order to support allocation of expense between services, programs, and specific lines of the cost report. Support should also include member and site information to properly support expense allocations.
- **Line 3290 – Other Related Transportation**. All transportation costs incurred for the transportation of members for service plan-related services or activities are to be reported on Line 3290. Costs on Line 3290 may include, but are not limited to, mileage paid to employees for business use of a personal vehicle, agency vehicle expense, or costs associated with public transportation.

  Member transportation expense for purposes not identified in the service plan is not reimbursable through the HCBS waiver programs. The expense for these other purposes should be reported in the Excluded Costs/Other Non-Reimbursable Costs column.

  Providers are responsible for tracking the expense incurred for the transportation of members for service plan-related services using a reasonable method.

  Refer to Informational Letter No. 1252 dated June 19, 2013, for additional cost report guidance from the Department on transportation expenses.

- **Line 3520 – Other**. HCBS waiver supported community living, children's mental health services, and home-based habilitation direct expenses in Line 3520 should include costs related to member consulting and member instruction, as specified in the member's service plan. Member consulting and instruction expense for purposes not identified in the service plan is not reimbursable through the HCBS waiver and habilitation service programs. The expense for these other purposes should be reported in the Excluded Costs/Other Non-Reimbursable Costs column.

  Member consulting may include, but is not limited to:

  - Behavior programming and training.
  - Consulting with specialists for conditions specific to the member. Examples include autism and brain injury.

  Member instruction may include, but is not limited to:

  - Reinforcement for behavior modification such as the purchase of rewards as identified in the service plan to reinforce the achievement of a service plan goal.
  - Programming and socialization activities, which may include expense for both the member and staff member, but must be necessary for the achievement of a goal. Staff member admission to a sporting or cultural event is necessary, but snacks are not. Staff member participation in a group bowling activity is not necessary.

  See Instructions for *Supplemental Schedule D-1*.

- **Line 4320 – Other Equipment Repair and Purchase**. HCBS waiver supported community living and children's mental health services direct expense in Line 4320 should include the cost of member environmental modification and repairs and member environmental furnishings as specified in the member service plan. Member environmental modification, repairs, and furnishing expenses not identified in the member's service plan are not reimbursable through the HCBS waiver program. Expenses for these other purposes should be reported in the Other Non-Reimbursable Costs column.

Examples of allowable HCBS waiver expenses in this line may include, but are not limited to:

- Modification and repair of the living area due to specific needs of the member. **NOTE:** Wheelchair lifts, ramps, and repairs due to destruction of property by the member that are not covered under home and vehicle modification.
- Items required to establish a home for a member moving out of a group facility, including bed and mattress, dresser, and kitchen supplies.

All items should be needs, not wants, which are necessary to meet the basic needs of the HCBS waiver member.

Reimbursement for member environmental modification and repairs and member environmental furnishings is ONLY available for the HCBS waiver program. There is no provision for reimbursement of these expenses in the habilitation services program. These expenses incurred for a habilitation services member should be reported as an Excluded Cost on *Schedule D* of the Habilitation Services cost report.

See Instructions for *Supplemental Schedule D-1*.

j. Instructions for *Supplemental Schedule D-1*

The purpose of HCBS *Supplemental Schedule D-1: Calculation of Member Cost Limits* is to calculate an average cost per member for member needs items and to determine the reasonableness of these items.

A member is eligible for $1,570 of member items on an annual basis. The 12-month total of *Schedule D*, Line 3290 – Other Related Transportation; Line 3520 – Other; and Line 4320 – Other Equipment Repair and Purchase; cannot exceed $1,570 per member. These costs need to be accumulated on an annual basis, with adjustments made for any excesses over the limit.

These expenses are defined as specific costs associated to the member. First seek all payment of these expenses from the member; second, from community resources; and third, from the HCBS program. The agency is responsible for tracking member costs individually to ensure the cost remains within the limit. Maintain documentation to track the costs per member adequately.

Complete a column for each living site or service. Carry over the member item costs from *Schedule D*. Divide the total costs by the number of unduplicated members at each living site or service for the current period. Compare the amount per member against the limitation of $1,570 for each service per living site. Multiply any excess by the number of unduplicated members to obtain the total variance.

k. Instructions for *Supplemental Schedule D-2*

The purpose of HCBS *Supplemental Schedule D-2: Calculation of Indirect Cost Limits* is to calculate the 20 percent indirect administrative cost limit of direct costs and to compare actual indirect costs allocated to HCBS services with that limit. This schedule compares actual indirect costs allocated to a living site or service against the limitation of indirect expense to 20 percent of direct costs.

The line items classified as direct service expenses are:

- Line 2120 – Professional Direct Staff
- Line 2130 – Other Direct Staff
- Line 2200 – Total Benefits for Direct Staff
- Line 2300 – Payroll Taxes for Direct Staff
- Line 3210 – Mileage and Auto Rental
- Line 3250 – Agency Vehicle Expense
- Line 3290 – Other Related Transportation
- Line 3520 – Other Assistance
- Line 4320 – Other Equipment Repair and Purchase

Complete a column for each living site or service. Carry over the total expense by facility and service from the total expense line on *Schedule D*. This is the total expense, including the direct expense and the allocation of the indirect expense but before any income deductions. Any variance calculation on *Schedule D-1* is also deducted. Carry over direct costs from the corresponding lines on *Schedule D* for each HCBS program and service. Calculate indirect costs by subtracting these direct expenses from the total.

Calculate the limit of 20 percent of direct costs using the subtotal of the direct costs lines. Compare this limitation against the calculated indirect expense. Carry forward any excess over the 20 percent limit to *Supplemental Schedule D-3*.

I. Instructions for *Supplemental Schedule D-3*

The purpose of HCBS *Supplemental Schedule D-3: Reconciliation of Costs and Payments* is to document cost per visit by service and to compare costs incurred to payments received. All prospective rates are subject to retrospective adjustment based on reconciliation of provider's reasonable and proper actual service costs with the revenues received for those services.

File only one schedule for the HCBS program, showing all HCBS services. Complete a column for each living site or service. Carry to this schedule the direct costs plus indirect costs less any deductions on *Schedule D*. Also include any adjustments calculated on *Schedule D-1* and *Schedule D 2*. Then calculate total net costs per service code.

The next section of the schedule compares Medicaid's portion of the costs on the report to revenues billed from the Medicaid program. Use the lower of the adjusted costs per unit computed in the first part of schedule or the capped rate for the service multiplied by DHS units as the DHS cost to compare against revenues billed.

"Revenues billed" means payments received for a service category provided in the specified period and payments accrued, but expected to be received, for those services provided in the same period. These revenue figures come from provider records. Include only those payments received or expected to be received for the current period.

A balance due the Medicaid program may occur. Revenues exceeding adjusted actual costs by more than 2.5 percent shall be remitted to the IME Medical Services Unit. Providers who do not reimburse revenues exceeding 2.5 percent of actual costs 30 days after notice is given by the Department will have this amount deducted from future payments and may be subject to penalties and interest.

m. Instructions for *Schedule E*

The purpose of *Schedule E: Comparative Balance Sheet* is to report the balance sheet of the provider as of the end of the reporting period.

- **Assets, Liabilities, and Equity**. The total assets must equal the total liabilities and equity.
- **Balance at End of Current Period**. Enter the amount in effect for the last day of the reporting period.
- **Balance at End of Prior Period**. Enter the amount in effect for the last day of the previous reporting period.
- **Reconciliation of Equity or Fund Balance**. The "add" and "deduct" entries should provide an explanation of any difference in the total equity of fund balance between the beginning and end of period.
- **Total Equity or Fund Balance Beginning of Period**. This amount should be the same as the total liabilities and equity for the "balance at end of prior period." Add revenues from *Schedule A* and deduct expenses from *Schedule D*.
- **Total Equity or Fund Balance End of Period**. This amount should be the same as the total liabilities and equity for the "balance at end of current period."

n. Instructions for *Schedule F*

The purpose of *Schedule F: Cost Allocation Procedures* is to report other supplemental information related to agency operations and accounting procedures. Complete *Schedule F* when the agency provides more than one service or service component.

Cost allocations are required for direct costs benefiting more than one service or service component and for the provider's indirect costs. "Direct" costs are those which are directly identifiable to services or components. "Indirect" costs, although they may benefit all services, generally are not readily identifiable with each service or service component. (See *HCBS Supplemental Schedule D-4* for examples.)

The schedule provides questions about methods used in allocating expenses that benefit more than one service or service component. The basis used in allocating these costs should be supported. Prior approval of the cost allocation plan from the regional office may be required.

5. Rates Based Upon the Submitted Report

New providers who have not submitted an annual report including at least six months of actual, historical costs shall be paid prospective rates based on projected reasonable and proper costs of operation for a 12–month period as reported in form 470-0664 (15-minute services) and form 470–3449 (daily services). After a provider has submitted an annual report including at least six months of actual, historical costs, prospective rates shall be determined as for an established provider.

Providers who have submitted an annual report including at least six months of actual, historical costs shall be paid prospective rates based on reasonable and proper costs in a base period, as adjusted for inflation. The base period shall be the period covered by the first financial and statistical reports submitted to the Department after 1997 that include at least six months of actual, historical costs.

Reasonable and proper costs in the base period are inflated by a percentage of the increase in the consumer price index for all urban consumers for the preceding 12 month period ending June 30, based on the months included in the base period, to establish the initial prospective rate for an established provider.

After establishment of the initial prospective rate for an established provider, the rate is adjusted annually, effective for the third month after the month during which the annual cost report is submitted to the Department. The annual inflation factor is equal to the change in consumer price index for all urban consumers for the preceding 12–month period ending June 30.

- **15-minute rates** are based on the lesser of the actual cost per unit of the current period reported on *Supplemental Schedule D-3* of 470-0664, the calculated base rate from the previous year, or the maximum reimbursement rate.
  - An inflation factor will be added to the cost per unit of the current and previous reporting period, not to exceed the maximum reimbursement rate.
  - No actual cost per unit rates will be set based on the annual cost report if the period reported is less than six months.
  - No inflation factor will be added to projected rates.

- **Daily rates** are based on the actual cost per unit of the current period reported on *Schedule D-3* of form 470-0664 for each site, the calculated base rate from the previous year, or the maximum reimbursement rate.
  - An inflation factor will be added to the cost per unit of the current and previous reporting period, not to exceed the maximum reimbursement rate.
  - The IME Medical Services Unit may grant variations when cost-effective and in accordance with the service plan.
  - No actual cost per unit rates will be set based on the annual cost report if the period reported is less than six months.

Projected rates will continue to be effective for providers with less than six months of actual cost data. Supported community living daily site rates that have been revised since the initial rate projection continue to be in effect if so noted on the submitted form 470-3449, *HCBS Supplemental Schedule D-4*.

K. PROCEDURE CODES AND NOMENCLATURE

Providers must use procedure codes to bill for waiver services. Use the following procedure codes to identify waiver services in the waiver service plan.

Service	AIDS	BI	CMH	Elderly	HD	ID	PD	Modifier
Adult day care; half day	S5101	S5101		S5101	S5101	S5101		None
Adult day care; full day	S5102	S5102		S5102	S5102	S5102		None
Adult day care; extended day	S5105	S5105		S5105	S5105	S5105		None
Adult day care; hourly	S5100	S5100		S5100	S5100	S5100		None
Assisted living on-call services				T2031				None
Assistive devices per item				S5199				None
Behavioral programming (i.e., health and behavioral intervention); 15 minute unit		96152						None

Service	AIDS	BI	CMH	Elderly	HD	ID	PD	Modifier
Behavioral programming (i.e., mental health plan development); 15 minute unit		H0032						None
Behavioral programming (mental health assessment); 15 minute unit		H0031						None
Case management (targeted or waiver); 15 minute unit		T1016	T1017	T1016		T1017		None
CDAC (agency); 15 minute unit	S5125	S5125		S5125	S5125	S5125	S5125	No modifier = unskilled Modifier U3 = skilled
CDAC (individual); 15 minute unit	T1019	T1019		T1019	T1019	T1019	T1019	No modifier = unskilled Modifier U3 = skilled
Chore; 15 minute unit				S5120				None
Counseling (individual); 15 minute unit	H0004				H0004			None
Counseling (group); 15 minute unit	96153				96153			None
Day habilitation; per day						T2020		None
Day habilitation; 15 minute unit						T2021		None
Environmental modifications and adaptive devices (home modification); per item				S5165				None
Environmental modifications and adaptive devices (personal care items); per item				S5199				None
Environmental modifications and adaptive devices (specialized supply); per item				T2028				None

Service	AIDS	BI	CMH	Elderly	HD	ID	PD	Modifier
Family and community support; 15 minute unit			H2021					None
Family counseling and training; 15 minute unit		H2021						None
Financial management services; per month	T2025	T2025		T2025	T2025	T2025	T2025	None
Home-delivered morning meals; per meal	S5170			S5170	S5170			UF required
Home-delivered liquid supplemental meal; two cans per meal	S5170			S5170	S5170			UJ required
Home-delivered noon meals: per meal	S5170			S5170	S5170			UG required
Home-delivered evening meals; per meal	S5170			S5170	S5170			UH required
Home health aide; 15 minute unit	T1021			T1021	T1021	S9122		None
Homemaker; 15 minute unit	S5130			S5130	S5130			None
Home and vehicle modification (home modifications only); per service		S5165		S5165	S5165	S5165	S5165	None
Home and vehicle modification (vehicle modifications only); per service		T2039	T2039	T2039	T2039	T2039	T2039	None
IMMT (HH agency home health aide); 15 minute unit		T1004				T1004	T1004	None
IMMT (HH agency RN); 15 minute unit		T1002				T1002	T1002	None
IMMT (HH agency LPN); 15 minute unit		T1003				T1003	T1003	None
IMMT (SCL and child care center); 15 minute unit		T1004				T1004	T1004	Requires use of U3

Service	AIDS	BI	CMH	Elderly	HD	ID	PD	Modifier
IMMT (group); 15 minute unit		T1004						
In-home family therapy; 15 minute unit			H0046					None
Mental health outreach; 15 minute unit				H0036				None
Nursing (RN); 15 minute unit	T1030			T1030	T1030	T1030	S9123 hour	
Nursing (LPN); 15 minute unit	T1031			T1031	T1031	T1031	S9124 hour	
Nutritional counseling (initial); 15 minute unit				97802	97802			None
Nutritional counseling (subsequent); 15 minute unit				97803	97803			None
Personal emergency response (initial fee for install)		S5160		S5160	S5160	S5160	S5160	None
Personal emergency response (monthly)		S5161		S5161	S5161	S5161	S5161	None
Prevocational services (daily)		T2014				T2014		None
Prevocational services; per hour		T2015				T2015		None
Respite (HH agency, specialized); 15 minute unit	S5150	S5150	S5150	S5150	S5150	S5150		Specialized requires use of U3; individual must not have a modifier
Respite (HH agency, basic individual); 15 minute unit	S5150	S5150	S5150	S5150	S5150	S5150		Specialized requires use of U3; individual must not have a modifier
Respite (HH agency group); 15 minute unit	T1005	T1005	T1005	T1005	T1005	T1005		None
Respite (home/non-facility, specialized); 15 minute unit	S5150	S5150	S5150	S5150	S5150	S5150		Specialized requires use of U3; individual must not have a modifier

Service	AIDS	BI	CMH	Elderly	HD	ID	PD	Modifier
Respite (home/non-facility basic individual); 15 minute unit	S5150	S5150	S5150	S5150	S5150	S5150		Specialized requires use of U3; individual must not have a modifier
Respite (home non-facility, group); 15 minute unit	T1005	T1005	S5150	T1005	T1005	T1005		None
Respite (hospital or NF) • RCF • Adult day care • Child care facility • ICF/ID • Foster group care 15 minute unit	T1005	T1005	T1005	T1005	T1005	T1005		U3 required
Respite (resident camp); 15 minute unit	T2036	T2036	T2036	T2036	T2036	T2036		None
Respite (group day camp)	T2037	T2037	T2037	T2037	T2037	T2037		
Senior companion; 15 minute unit				S5135				None
Specialized medical equipment; per item		T2029					T2029	None
Supported community living; daily		H2016				H2016		ID waiver requires use of HI; BI waiver must not have a modifier
Supported community living; 15 minute unit		H2015				H2015		ID waiver requires use of HI; BI waiver must not have a modifier
Supported community living (residential-based); daily						H2016		Requires use of U3 for RBCSL
Supported employment (job development)		T2018				T2018		UC required (limit to one unit)
Supported employment (employer development		H2024				H2024		UC required (limit to one unit)

Claim for Targeted Medical Care

(If handwritten, use blue or black ink only. **Accuracy** is important.)
This form may be downloaded at http://www.ime.state.ia.us/Providers/claims.html

Member Information

1. Medicaid ID Number	2. Member's Name

Provider Information

3. NPI Provider Number	4. Provider's Name
5. Provider Address	
6. Zip Code	7. Taxonomy Code

Other Information

8. Other Health Insurance ☐ Yes ☐ No	9. Other Health Insured Denied ☐ Yes ☐ No
10. Other Health Insurance Payment	11. Client Participation Amount

Services

12. Procedure Code	13. Modifier	14. Place of Service	15. First Date	16. Last Date	17. Units	18. Total Line Charge
				19. Total Claim Charges		

Authorized Signature(s)

I certify that the statements on the back apply to this bill and are made a part of it.	*For consumer-directed attendant care claims only.*
Provider Signature Date	Member/Guardian Signature Date

MEDICAID PAYMENTS

(PROVIDER CERTIFICATION)

I hereby agree:

To keep such records as are necessary to disclose fully the extent of services provided to individuals under the Iowa Medicaid Program, as specified in the Provider Manual and the Iowa Administrative Code.

To furnish records and other information regarding any payments claimed for providing such services as the Iowa Department of Human Services, its designee or Health and Human Services may request.

To accept, as payment in full, subject to audit, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductibles, coinsurance, copayment, and spenddown.

To comply with the provisions of the Civil Rights Act of 1964 and Section 504 of the Rehabilitation Act of 1973.

I certify that:

The services shown on the front of this form were rendered to the consumer and were medically indicated and necessary for the health of the patient.

The charges for these services are just, unpaid, actually due according to law and program policy and not in excess of regular fees.

The information provided on the front of this claim is true, accurate, and complete.

I understand that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

PLACE OF SERVICE CODES

11	Office	51	Inpatient psychiatric facility
12	Home	53	Community mental health center
21	Inpatient hospital	54	Intermediate care facility/MR
22	Outpatient hospital	55	Residential substance abuse treatment facility
23	ER room hospital	56	Residential psychiatric treatment facility
24	Ambulatory surgical center	61	Comp inpatient rehab facility
31	Skilled nursing facility	62	Comp outpatient rehab facility
32	Nursing facility	71	Public health clinic
33	Custodial care facility	99	Other
34	Hospice		

Complete claim form instructions and a printable version of this form are available on our website: http://www.ime.state.ia.us/Providers/claims.html

Service	AIDS	BI	CMH	Elderly	HD	ID	PD	Modifier
Supported employment (enhanced job search); 15 minute unit		H2019				H2019		None
Supported employment (job coaching); 15 minute unit		H2025				H2025		None
Supported employment (enclave); 15 minute unit		H2023				H2023		None
Transportation; per mile		S0215		S0215		S0215	S0215	None
Transportation; 1-way trip		T2003		T2003		T2003	T2003	None
Workman's compensation	T2025	T2025		T2025	T2025	T2025	T2025	UC required

L. BILLING POLICIES AND CLAIM FORM INSTRUCTIONS

Claims for waiver providers are billed on the *Claim for Targeted Medical Care*, form 470-2486. Click here to view the form online.

Copies of this form may be obtained from IME Provider Services at (800) 338-7909 or, in the Des Moines area at (515) 256-4609, or at the bottom of the IME Provider Services webpage at http://dhs.iowa.gov/ime/Providers/claims-and-billing/ClaimsPage. Claims submitted electronically shall be filed on the Accredited Standards (ASC) X12N 837 transaction, Health Care Claim.

Refer to Chapter IV. *Billing Iowa Medicaid* for claim form instructions, all billing procedures, and a guide to reading the Iowa Medicaid Remittance Advice statement.

The Billing Manual can be located online at:
http://dhs.iowa.gov/sites/default/files/All-IV.pdf