IOWA Health and Human Services

Certificate of Medical Necessity for Adult Day Care (ADC) in the Family Home

Use this form as your cover page. Submit to Medical Services Waiver Prior Authorization via the Iowa Medicaid Portal Access (IMPA) System. (Please print or type clearly – accuracy is important)

Section A	
1. Member Name (Last) (First) (Initial)	**2. Member State ID (SID)**
3. Case Manager	**4. Member Date of Birth**
5. Service Plan Dates Covered by Request:	
From: (Day/Month/Year)	**To: (Day/Month/Year)**
6. Attach All Relevant Documentation	
Are Documents Attached?	☐ Yes ☐ No
7. Type of Review Being Requested:	
☐ Initial ☐ Continued Stay Review (CSR)	

Section B Answer ALL Questions 1 through 11 for Medical Daycare for Children Services	
☐ Yes ☐ No	1. Does the member reside with the primary caregiver? Outline in Section C.
☐ Yes ☐ No	2. Is the primary caregiver working outside the home, working from home, attending school, attending vocational training, or otherwise regularly absent and unable to provide care? Outline in Section C.
☐ Yes ☐ No	3. Is the ADC being provided in the member's home?
☐ Yes ☐ No	4. Outline the need for ADC in Section C.
☐ Yes ☐ No	5. Do any of the primary caregivers provide other paid waiver services to the member (i.e. CDAC, respite, SCL)? Outline in Section C.
☐ Yes ☐ No	6. Does the member have safety concerns? Outline in Section C.
☐ Yes ☐ No	7. Does the member require assistance with ADLs and/or skilled services? Outline in Section C.
☐ Yes ☐ No	8. Does the member receive other waiver or non-waiver services? Outline in Section C.
☐ Yes ☐ No	9. Is the provider related to the member? Outline in Section C.
☐ Yes ☐ No	10. Does the member share residence with another member receiving waiver services? Outline in Section C.
☐ Yes ☐ No	11. Are the ADC units increased in this service plan? Outline rationale in Section C.

Section C Narrative Description Justification Request

Provide specific information and use additional sheet if necessary.

IMPORTANT NOTE: In evaluating requests for prior authorization, the need for treatment or services will be considered from the standpoint of medical necessity only. An approval of this request does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish eligibility at the time of service.

Requesting Case Manager

Signature of TCM/CM/SW **Date**

Section D Include ALL of the following documentation

- **SIS or InterRAI Assessment**
- **Comprehensive Person-Centered Service Plan**
- **Home health agency plan of care, if applicable**
- **List all natural, waiver, and non-waiver support services**