MEDICAID WAIVER SERVICES

APPENDIX

Iowa Department of Human Services

Page

Forms

Page

Informational Materials

Authorization Form for Payment to Business Agent, Form 470-4510

Purpose

Form 470-4510 is used to authorize the Iowa Medicaid Program to send consumer directed attendant care (CDAC) payments to the American Federation of State, County, and Municipal Employees (AFSCME) for deductions the union is authorized to make for its members. This form is used in the following waivers:

- AIDS/HIV waiver
- Brain injury waiver
- Elderly waiver
- Ill and handicapped waiver
- Intellectual disability waiver
- Physical disability waiver

Source

The form is available on the IME web site at: http://www.ime.state.ia.us/Providers/Forms.html

Completion

The individual CDAC provider shall complete this form if the provider chooses to have Medicaid payments deposited in AFSCME Council 61's bank account for payment of dues and other deductions. AFSCME then pays the balance to the CDAC provider.

Distribution

The individual CDAC provider submits the completed form:

- By mail to the IME Provider Services Unit, P.O. Box 36450, Des Moines, IA 50315; or
- By fax to (515) 725-1155.

Data

The form is partially completed with the direct deposit information. The individual CDAC provider completes the first boxed in section and then signs at the bottom of the form.

Brain Injury Functional Assessment, Form 470-3349

Purpose

Form 470-3349 is used to:

- Verify the consumer's choice for HCBS services.
- Help establish eligibility for waiver services.
- Obtain information on the consumer's needs and abilities, so that the IME Medical Services Unit can determine the "level of care" that the consumer needs.

The form is used for the following waiver:

- BI waiver

Source

Complete this form on line using the template available on the IME web site at: www.ime.state.ia.us/docs/BIFA.doc

Completion

The discharge planner at the facility where the consumer was last a patient completes an original and one copy of the initial form when the consumer makes an initial application for waiver services.

The Medicaid case manager completes the form for every annual review after that. Note that consumers on the BI waiver may progress out of the program. As they become more self-sufficient and independent, they may no longer meet the level of care.

The IME Medical Services Unit sends a letter to the case manager 60 days before to the review due date as a reminder to do this. If the Medical Services Unit has not received the *Assessment* 30 days before the review due date, another letter is sent.

Distribution

Fax the completed form to the BI waiver review coordinator at 515-222-2432. Keep a copy in the consumer's file.

Data

The discharge planner or case manager should complete all items.

Part A Verification of HCBS Consumer Choice

The consumer or guardian or durable power of attorney for health care must:

- Check the box. "I choose: HCBS" before the form is sent to IME. After initial certification for level of care, this section does not need to be checked again.
- Sign the form and fill in the date.

For consumers under the age of 18, parents will complete this section. If the consumer does not have a guardian, completely fill out the consumer's address.

Part B Assessment

Check whether this is an initial review or a continued stay review.

Enter all identifying information about the consumer.

If there is a legal guardian or durable power of attorney for health care, ensure that the following is completed:

- The name of this person.
- The person's address (street, city, state, and zip code).

The IME needs this information because if the consumer does not meet the required level of care, the following people will receive notice of this adverse action:

- Consumer, guardian, or durable power of attorney for health care.
- Case manager or discharge planner.
- Attending physician.
- IM worker.

Complete the remaining items as follows:

- **Agency Providing Services**. The consumer must have an enrolled and certified HCBS BI provider or case manager. If not, the application will be rejected.

- **Attending Physician**. A physician able to answer questions about the consumer. Nurse practitioners and physician assistants do not meet this requirement.
- **Discharge Planner/Case Manager**. Information must be completely and accurately filled in. On approval of the level of care, the person who sends in the assessment form will receive notification via an ISIS milestone.
- **Type of Facility**. Identify where the person is currently living, including the name of the facility, street, city, state, and zip code. If the person is at home, enter "Other "and give the same information.
- **Date Admitted to Facility**. Fill this out if the consumer is coming out of one of the facility types in "Type of Facility." If the person is at home, enter "N/A."
- **Date Injury Occurred**. Fill in the date when the person's brain injury occurred, whether the person is in a facility or not.
- **Brain Injury Related Diagnosis**. Identify the diagnosis. If you are unsure, write in what is in the report summary. You can send in the summary, but you still need to complete this information.

  The assessment will be returned if you write in this section "See diagnosis" and do not include the brain injury information from the report in this section.
- **Other Diagnosis**. Include any information that is not related to the brain injury diagnosis (depression, schizophrenia, spinal cord injury, etc.).
- **Medications**. Identify what the medication is, the route for administering the medication (orally, inhalant, vaginal, rectal, IM, IV, G-tube, etc.) and who gives the medication. (Does the consumer self-medicate, does the mother administer, a nurse, etc.) Example:

NAME	ROUTE
Tegretol – parent administers	Orally
Lamictal – parent administers	Orally
Diamox – parent administers	Orally

- **Services**. Identify the support services a person needs for nursing, physical therapy, occupational therapy, speech therapy, or other therapeutic supports. The service should be ordered and under the direction of a therapist.

  For example: a consumer needs range of motion exercises three times a week for one hour each time. The therapist orders this therapy and trains the family how to provide it. Identify who provides the nursing/therapy, how many days per week, and hours per day. Example:

Services	Needed		Days per Week	Hours per Day
Nursing (nurse)	☐ Yes	☐ No	4 x per week	2 hours per day
Physical therapy (mom)	☐ Yes	☐ No	7 x per week	½ per day
Occupational therapy (mom)	☐ Yes	☐ No	3 x per week	1 hour per day
Speech therapy	☐ Yes	☐ No		
Supervision for safety	☐ Yes	☐ No		
Other:	☐ Yes	☐ No		

List other programs the consumer has, or may apply for, to provide services (ID waiver; ICF/MR, etc.).

Each assessment must be signed by the discharge planner or case manager completing the assessment. If this is a reassessment, sign below the initial signature. Ensure that all information on pages 1 and 2 is still correct.

Functional Assessment

If you check a deficit area, identify under "Additional Notes" what the deficit is, the type of support (verbal prompt, physical intervention, etc.) needed by the consumer for the deficit, and who provides this support. Example:

Maladaptive/Inappropriate Behavior

Functional Assessment	Assessment 1	Additional Notes
1. Self-injurious	X	Assessment # 1
2. Verbal aggression	X	Consumer has tried to commit suicide three times in the last month. Parent intervened and consumer was hospitalized.
3. Physical aggression	X	
4. Destruction		
5. Stereotypical behavior		
6. Antisocial behavior		
7. Noncompliance	X	
8. Disruption		Also, consumer shouts obscenities at others when angry and must be verbally prompted to stop. This occurs several times per week. Parents give prompts at home and staff give prompts at work.
9. Depressive symptoms		
10. Elopement		
11. Aberrant sexual behavior		
12. Mood swings		
13. Eating disorders		
14. Inappropriate/ excessive liquid consumption		
15. Abuse of chemicals or alcohol		Physical restraints are used because the consumer hits and kicks others at work. Staff initiate the interventions, which includes nonviolent hands-on restraints by staff.
16. Obsessive/ compulsive behavior		
17. Anxiety		
18. Other – specify in additional notes		

When assessing children, compare the child's status to normal developmental milestones for the child's chronological age. For instance, at age three months, an infant should be able to visually track an object, lift his or her head, and begin to coo.

Using information from school and special education supports is helpful when identifying deficit areas and interventions.

For skilled nursing (SNF) and intermediate (ICF) levels of care, it is essential to identify deficits and needed supports under Item 7, Activities of Daily Living.

For ICF/MR level of care, you need to have data to support mental retardation or that this is a "person with a related condition." Under Iowa law, this means "an individual who has a severe, chronic disability that meets all the following conditions:

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

COGNITIVE / MENTAL STATUS This section addresses a person's awareness of the environment, attention and concentration, memory abilities, reasoning, and the capacity for self-direction. Deficits occur when the person does not have the capabilities to consistently address these issues.

For children, review the age appropriate abilities for concentration/attention, memory, reasoning (right from wrong, etc.), and decision making.

MALADAPTIVE / INAPPROPRIATE BEHAVIORS Different behaviors are identified by examples. For self-injurious behavior, issues such as hitting, slapping, head banging, biting, hair pulling, scratching, and suicidal tendencies are delineated.

Use the examples under each behavioral issue to assist with deficit identification. Then identify the interventions needed under "Additional Notes" for these deficits.

INTELLECTUAL / VOCATIONAL / SOCIAL For intellectual components, this section addresses the ability to complete age appropriate intellectual skills: telling time, reading, writing, numbers, memory, and other cognitive skills. For a child, depending on the age, this could include identifying colors, animals, objects, etc.

The vocational part of this section relates to work skills for adults: ability to travel to and from work independently, attendance, following verbal or written directions attending to tasks, and completing steps within a task.

For children, the vocational component relates to school issues, if the child is in a preschool or school program: Is the child able to follow directions at an age appropriate level? Is the child's attention span within the normal range? Can the child communicate needs?

The social aspect of this area addresses the ability to travel in the community. This area also includes the ability to safely use the community at an age appropriate level.

The form identifies some of the components for this section, such as transportation, community skills, shopping, safety, money skills, social/interpersonal skills, and leisure/recreational activities.

For children, review age appropriate data to see if the child is within the normal functioning range. If not, identify the deficit area and what supports are necessary because of the deficit.

This section also identifies telephone usage, which can include the ability to dial a phone number and converse on the phone. Sexuality awareness also falls under this topic.

MOBILITY / AMBULATION This area of the form addresses the person's ability to move, balance, and ambulate. For an infant, this could include crawling, rolling over, standing, and other ambulating milestones. A one-month-old child would not be expected to be rolling over, but this is a normal skill for a six-month-old.

Note that a person using a wheelchair is not necessarily dependent, if the person is able to do this without interventions from others. The use of walker, cane, or other assistive devices is a deficit only if the person needs support from others to use the device.

MUSCULOSKELETAL / FINE OR GROSS MOTOR This section includes the person's abilities to hold, grasp, manipulate an object; to move fluidly, and also addresses skeletal abnormalities and their physical impact. If deficit areas exist, identify the interventions need to assist the person to complete these skills.

Fine motor skills may include picking up an object, writing with a pen, and pushing a button or using a lever control on a wheelchair. Gross motor skills could include the ability to balance, walk, stand, etc.

Muscular and skeletal deficits could include the ability to stretch out a leg or an arm, straighten the body, bend over, etc. A child's deficits should be gauged with age-appropriate abilities. Paralysis deficits should be addressed.

SENSORY / COMMUNICATION This section includes the abilities to see, hear, talk, taste, smell, and touch. For example, people who cannot feel the difference between hot and cold could easily be burned, suffer from frostbite, or cut themselves.

For speech, the guidelines are can the person communicate his or her needs or does the person need someone to interpret their words. As with other areas, children should be assessed on an age appropriate level for speech.

A three-month-old cannot be expected to say words, but should begin to coo. A child or adult may not be able to speak, but can sufficiently sign or use a word board. In this instance, there would not be a deficit. But, if the child could not adequately use these without interventions, then a deficit should be identified along with the support needed.

People with visual and hearing impairments are in deficit only if they are unable to adequately function without support from someone else.

ACTIVITIES OF DAILY LIVING Correctly identifying deficits and needed supports for this area is vital for the SNF and ICF level of care. There are two main topics for this section. They are:

- Self-help skills: Dressing and undressing, washing or bathing, oral hygiene, hair care, shaving, menses care, and other self-help skills. In distinguishing these issues, be specific. A person may have the ability to wash his or her hair, but not comb it.
- Domestic skills:
  - Home skills (cleaning, dusting, vacuuming, home repair, snow shoveling, etc.)
  - Clothes care and laundry (sorting and folding laundry, washing and drying clothes, and putting clothes in closets and drawers)
  - Food preparation (chooses what to eat, knows what the ingredients are, shops for food, prepares the food, sets and clears the table, stores food, and cleans up the cooking area)

  Domestic skills are addressed in the last three bullets. If a person is not able to complete the entire skill, identify the deficit area and the support needed.

Case Management Comprehensive Assessment, Form 470-4694

Purpose

Form 470-4694 is used to:

- Identify the waiver consumer's areas of deficits, strengths, and preferences;
- Identify any barriers to maintaining the consumer's current level of functioning;
- Identify health and safety risks to reduce the risk of harm through interventions, resources, and service activities;
- Determine the need for any medical, social, educational, housing, transportation, vocational or other services; and
- Provide the foundation for developing the comprehensive service plan and the crisis intervention plan.

This form is used in the following waivers:

- Brain injury waiver
- Children's mental health waiver
- Elderly waiver
- Intellectual disability waiver

Source

The form and directions are available on the IME web site at: http://www.ime.state.ia.us/HCBS/TargetedCaseManagement.html

Completion

The case manager shall complete this form upon the consumer's application for waiver services. The form shall be completed with the assistance of the consumer or of the consumer's parent or guardian.

Distribution

Submit one copy to the IME Medical Services Unit for the level of care determination. Keep a copy in the consumer's file.

Data

The assessment is divided into domain areas for:

- Consumer information;
- Medical and physical health;
- Mental health, behavioral, and substance use;
- Housing and environment;
- Social;
- Transportation;
- Education; and
- Vocational.

Certificate of Medical Necessity for Consumer-Directed Attendant Care, Form 470-5048

Purpose

Form 470-5048 is used as a cover sheet to report and organize information needed by the IME Medical Services Unit to support a request for authorization to purchase consumer-directed attendant care using waiver funds. This form is used in the following waivers:

- AIDS/HIV waiver
- Brain injury waiver
- Elderly waiver
- Ill and handicapped waiver
- Intellectual disability waiver
- Physical disability waiver

Source

Complete this form on line using the template available at the IME web page: http://www.ime.state.ia.us/Providers/Forms

Completion

The case manager or service worker will receive an ISIS milestone prompt to submit this prior authorization form and supporting information to the IME when consumer-directed attendant care is entered on a member's case plan for:

- More than 17 units a month for daily service, or
- More than 41 units a month for hourly services.

Distribution

The case manager or service worker faxes the completed form and all additional required documentation to the IME Medical Service Unit's waiver prior authorization staff at 515-725-1388.

The Medical Services Unit must receive the requested materials and approve the service level before the service can be initiated. The decision will be communicated to the worker through ISIS.

Data

The form records the identity of the member and the case manager or service worker, the service plan dates, the type of review being requested, who will be giving the service and for how long, and the justification for the request. The additional documentation needed is listed on the form.

Certificate of Medical Necessity for Environmental Modification, Form 470-5049

Purpose	Form 470-5049 is used as a cover sheet to report and organize information needed by the IME Medical Services Unit to support a request for authorization to purchase environmental modification using waiver funds. This form is used in the following waiver: ♦ Children's mental health waiver
Source	Complete this form on line using the template available at the IME web page: http://www.ime.state.ia.us/Providers/Forms
Completion	When environmental modification is entered on a CMH waiver member's case plan in ISIS, the case manager will receive a milestone prompt to submit this form and supporting information to the IME.
Distribution	The case manager faxes the completed form and all additional required documentation to the IME Medical Service Unit's waiver prior authorization staff at 515-725-1388. The Medical Services Unit must receive the requested materials and approve the service level before the service can be initiated. The decision will be communicated to the worker through ISIS.
Data	The form records the identity of the member and case manager, the service plan dates, the type of review being requested, information about the structure to be modified and the modification, and the justification for the request. The additional documentation needed is listed on the form.

Certificate of Medical Necessity for Home and Vehicle Modification, Form 470-5050

Purpose

Form 470-5050 is used as a cover sheet to report and organize information needed by the IME Medical Services Unit to support a request for authorization to purchase home or vehicle modification using waiver funds. This form is used in the following waivers:

- Brain injury waiver
- Elderly waiver
- Ill and handicapped waiver
- Intellectual disability waiver
- Physical disability waiver

Source

Complete this form on line using the template available at the IME web page: http://www.ime.state.ia.us/Providers/Forms

Completion

When home and vehicle modification is entered on a member's case plan in ISIS, the case manager or service worker will receive a milestone prompt to submit this form and supporting information to the IME.

Distribution

The case manager or service worker faxes the completed form and all additional required documentation to the IME Medical Service Unit's waiver prior authorization staff at 515-725-1388.

The Medical Services Unit must receive the requested materials and approve the service level before the service can be initiated. The decision will be communicated to the worker through ISIS.

Data

The form records the identity of the member and the case manager or service worker, the service plan dates, the type of review being requested, information about the structure or vehicle to be modified and the modification, and the justification for the request. The additional documentation needed is listed on the form.

Certificate of Medical Necessity for Prevocational Services, Form 470-5051

Purpose	Form 470-5051 is used as a cover sheet to report and organize information needed by the IME Medical Services Unit to support a request for authorization to purchase prevocational services using waiver funds. This form is used in the following waivers: ♦ Brain injury waiver ♦ Intellectual disability waiver
Source	Complete this form on line using the template available at the IME web page: http://www.ime.state.ia.us/Providers/Forms
Completion	When prevocational services is entered on a member's case plan in ISIS, the case manager will receive a milestone prompt to submit this form and supporting information to the IME.
Distribution	The case manager faxes the completed form and all additional required documentation to the IME Medical Service Unit's waiver prior authorization staff at 515-725-1388. The Medical Services Unit must receive the requested materials and approve the service level before the service can be initiated. The decision will be communicated to the worker through ISIS.
Data	The form records the identity of the member and case manager, the service plan dates, the type of review being requested, information on the member's past experience with prevocational services, and the justification for the request. The additional documentation needed is listed on the form.

Certificate of Medical Necessity for Waiver Assistive Devices, Form 470-5047

Purpose	Form 470-5047 is used as a cover sheet to report and organize information needed by the IME Medical Services Unit to support a request for authorization to purchase an assistive device using waiver funds. This form is used in the following waiver: ♦ Elderly waiver
Source	Complete this form on line using the template available at the IME web page: http://www.ime.state.ia.us/Providers/Forms
Completion	When assistive devices are entered on an elderly waiver member's case plan in ISIS, the case manager will receive a milestone prompt to submit this form and supporting data to IME.
Distribution	The case manager faxes the completed form and all additional required documentation to the IME Medical Service Unit's waiver prior authorization staff at 515-725-1388. The Medical Services Unit must receive the requested materials and approve the service before the service can be initiated. The decision will be communicated to the worker through ISIS.
Data	The form records the identity of the member and case manager, the service plan dates, the type of review being requested, why the device is needed, whether it is otherwise available, and the justification for the request. The additional documentation needed is listed on the form.

Consumer Choices Option Individual Budget, Form 470-4431

Purpose

Form 470-4431 provides a procedure for implementing the consumer choices option. The form identifies how the member's individual budget amount will be used on a monthly basis. This form is used in the following waivers:

- AIDS/HIV waiver
- Brain injury waiver
- Elderly waiver
- Ill and handicapped waiver
- Intellectual disability waiver
- Physical disability waiver

Source

The financial management service sends this form to each member enrolled or seeking to be enrolled under the consumer choices option. The form is also available on the IME web site at: http://www.ime.state.ia.us/HCBS/HCBSConsumerOptions.html

Completion

The member (or the member's legal representative) and the independent support broker complete the form:

- Upon initiation of the consumer choices option, and
- Whenever there are any changes.

The form needs to be signed by:

- The member (or the member's legal representative)
- The member's personal representative, if any
- The independent support broker
- A representative of the financial management service

Distribution

The member, with the assistance of the independent support broker, must distribute the completed budget before services are provided. The financial management service must receive the form no later than the 25th of the month before services are to begin.

Data

This form identifies:

- The employees working with the member, including the independent support broker (ISB) and the member's representative if applicable.
- The activities, financial management service fees, employee rate per hour, number of hours provided, taxes, and monthly cost for services.
- Individual directed goods and services by description, cost per item or service, frequency, and monthly costs.
- Services identified for savings by description, total cost, start and end dates, and monthly costs.
- The specific needs of the member.
- An emergency backup plan.

Consumer Choices Option Non-Payroll Reimbursement Request, Form 470-5019

Purpose

Form 470-5019 provides a method for the member or the member's personal representative to be reimbursed for an item or service under consumer choices option that is preauthorized in the service plan. This form is used in the following waivers:

- AIDS/HIV waiver
- Brain injury waiver
- Elderly waiver
- Ill and handicapped waiver
- Intellectual disability waiver
- Physical disability waiver

Source

The financial management service issues this form to the member (or the member's legal representative) when the *Consumer Choices Option Individual Budget*, form 470-4431, indicates goods or services to be purchased directly by the member. The form is also available on the IME web site at: http://www.ime.state.ia.us/HCBS/HCBSConsumerOptions.html

Completion

The member completes this form when the member directly pays for consumer choices option services or goods up front. The independent support broker may assist the member with this form. If the service was provided by an employee, the employee must also sign the form.

Distribution

The member, representative, or independent support broker sends the form to the financial management service provider with receipts for all purchases and invoices for all services.

If the financial management service receives the form by the 7th of the month, reimbursement will be issued by the 15th of the month. If the financial management service receives the form by the 22nd of the month, reimbursement will be issued by the end of the month.

Data

The form lists the date of each service or purchase, a description of the item purchased or the service provided and the amount to be paid for each item or service.

Consumer Choices Option Semi-Monthly Time Sheet, Form 470-4429

Purpose

Form 470-4429 provides a procedure for authorizing payment to an employee under the consumer choices option. This form is used in the following waivers:

- AIDS/HIV waiver
- Brain injury waiver
- Elderly waiver
- Ill and handicapped waiver
- Intellectual disability waiver
- Physical disability waiver

Source

The financial management service sends a supply of this form to each member who has entered into a *Consumer Choices Option Employment Agreement* with an employee. The form is also available on the IME web site at: http://www.ime.state.ia.us/HCBS/HCBSConsumerOptions.html

Completion

Each employee under the consumer choices option completes the time sheet each time the employee works for the member.

At the end of each billing period (or upon termination of the employee), the member (or personal representative) signs off on the time sheet and submits it for payment. The billing periods run from the 1st through the 15th of each month and the 16th through the last day of the month

Distribution

The member shall submit the form 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.

Data

The signature on this form by the member (or personal representative) certifies that the information on this form reflects that the employee has actually provided these services at this date, time, number of hours, rate of pay, and type of service listed.

Consumer-Directed Attendant Care Daily Service Record, Form 470-4389

Purpose	Form 470-4389 provides the medical (clinical) record for services performed under consumer-directed attendant care. This form is used in the following waivers: ♦ AIDS/HIV waiver ♦ Brain injury waiver ♦ Elderly waiver ♦ Ill and handicapped waiver ♦ Intellectual disability waiver ♦ Physical disability waiver
Source	The IME Provider Services Unit issues a supply of this form to the CDAC provider at the time of enrollment. The provider may photocopy or print a supply from that sample or print the form from the IME web site at: http://www.ime.state.ia.us/HCBS/CDAC_index.html
Completion	The provider of consumer-directed attendant care completes a separate form for each date of service. The member must sign the form to verify that the services were received.
Distribution	The provider must keep the form for five years for audit purposes.
Data	The provider is directed to record: ♦ The time spent with the member, ♦ The code for each service performed, ♦ The actual hours of service performed, ♦ A description of the services performed, and ♦ The provider's evaluations and observations.

Delegation of Budget Authority, Form 470-4430

Purpose

Form 470-4430 is used to delegate the budget authority under the consumer choices option from the member to a person chosen by the member. This form is used in the following waivers:

- AIDS/HIV waiver
- Brain injury waiver
- Elderly waiver
- Ill and handicapped waiver
- Intellectual disability waiver
- Physical disability waiver

Source

The financial management service issues the form upon request to members who want to delegate duties to another person. The form is also available on the IME web site at: http://www.ime.state.ia.us/HCBS/HCBSConsumerOptions.html

Completion

The form is completed by the member and signed by both the member and the personal representative. The service worker, case manager, or independent support broker may assist if needed.

Distribution

Copies should be given to the member, the personal representative, the independent support broker, the financial management service, and any employee or vendor who will be dealing with the representative. A copy of this form needs to be kept in the member's service file.

Data

The member must designate whether responsibility is being delegated in each of the following areas:

- Signing contracts with employees and vendors
- Determining amount to be paid for services
- Scheduling services
- Authorizing payments
- Reallocating funds

Employment Agreement, Form 470-4427

Purpose

Form 470-4427 serves as the contract between the member and the member's employee under the consumer choices option. This form is used in the following waivers:

- AIDS/HIV waiver
- Brain injury waiver
- Elderly waiver
- Ill and handicapped waiver
- Intellectual disability waiver
- Physical disability waiver

Source

The financial management service issues this form to the member (or the member's legal representative) when the *Consumer Choices Option Individual Budget*, form 470-4431, indicates that the member will hire employees to perform services. The form is also available on the IME web site at: http://www.ime.state.ia.us/HCBS/HCBSConsumerOptions.html

Completion

This form must be completed with each employee, including the independent support broker:

- Upon initiation of service for under the consumer choices option, and
- Whenever there are any changes in payment rates or duties.

The member is responsible for completion of the form and getting all required signatures, with the assistance of the independent support broker if needed.

The form needs to be signed by the member (or the member's personal representative) and the employee. The form is sent to the financial management service provider.

Distribution

The member or independent support broker gives a copy of the form to the employee and to the financial management service provider. Form 470-4431, *Consumer Choices Option Individual Budget*, must be completed before services are provided or employees can be reimbursed.

Data

The form specifies:

- Each service to be performed by that employee.
- The hourly rate for each service.
- The employee responsibilities under the agreement.
- The employer's responsibilities under the agreement
- The schedule for the services to be performed.

Financial Management Service Agreement, Form 470-4428

Purpose

Form 470-4428 documents the agreement between the employee under consumer choices option and the financial management service. This form is used in the following waivers:

- AIDS/HIV waiver
- Brain injury waiver
- Elderly waiver
- Ill and handicapped waiver
- Intellectual disability waiver
- Physical disability waiver

Source

The financial management service issues this form to the member (or the member's legal representative) when the *Consumer Choices Option Individual Budget*, form 470-4431, indicates that the member will hire employees to perform services. The form is also available on the IME web site at: http://www.ime.state.ia.us/HCBS/HCBSConsumerOptions.html

Completion

The member gives this form to each employee to be hired under the consumer choices option. This form needs to be completed:

- Upon initiation of the consumer choices option, and
- Whenever there is a change in financial management service or in the conditions of the agreement.

The form needs to be signed by each employee and by a representative of the financial management service.

Distribution

Give copies of the signed form to the member, the financial management service, and the employee. Form 470-4431, *Consumer Choices Option Individual Budget*, must be completed before services are provided or employees can be reimbursed.

Data

The form lists the responsibilities of the financial management service and the conditions of employment for the employee.

HCBS Consumer-Directed Attendant Care Agreement, Form 470-3372

Purpose

Form 470-3372 provides a procedure for implementing consumer-directed attendant care. Services provided pursuant to this agreement between the member and the provider are to be reimbursed by the Iowa Medicaid Program when consumer-directed attendant care is part of the member's service plan. The form is used for the following waivers:

- AIDS/HIV waiver
- Brain injury waiver
- Elderly waiver
- Ill and handicapped waiver
- Intellectual disability waiver
- Physical disability waiver

Source

Print supplies of this form from the IME web site at: http://www.ime.state.ia.us/HCBS/CDAC_index.html

Completion

Issue the form to each member to be enrolled into the consumer-directed attendant care service. The member (or the member's legal representative) and the provider hired by the member prepare the form before the consumer-directed attendant care begins. The service worker or case manager may assist as needed.

Distribution

The member, service worker, or case manager makes three photocopies of the completed form. The original goes to the service worker or case manager.

The member keeps one copy, one copy goes to the provider, and when applicable, one copy goes to the supervising nurse or therapist. The member must distribute the completed agreement before services are provided.

Attach the original form 470-3372 to the service plan and file them in the member case file.

Independent Support Broker Agreement, Form 470-4492

Purpose	Form 470-4492 documents the agreement between the member and the independent support broker under the consumer choices option. The form is used for the following waivers: ♦ AIDS/HIV waiver ♦ Brain injury waiver ♦ Elderly waiver ♦ Ill and handicapped waiver ♦ Intellectual disability waiver ♦ Physical disability waiver
Source	The form is available on the IME web site at: http://www.ime.state.ia.us/HCBS/HCBSConsumerOptions.html
Completion	The form is completed by the member (or the member's personal representative when applicable) and the independent support broker: ♦ Upon initiation of the consumer choices option, ♦ Whenever there is a change in an independent support broker, or ♦ Whenever there is rate change for the independent support broker. The form must be signed by the member (or personal representative when applicable) and the independent support broker.
Distribution	The member (or personal representative) and the independent support broker each get a copy.
Data	The form lists the duties of the independent support broker, the rate of payment, and the conditions of terminating the agreement.

Individual Client Case Plan, Form 470-0583

Purpose

Form 470-0583 may be used as a record of the plan of care for an adult member receiving home- and community-based waiver services. The form may be used in the following waivers:

- AIDS/HIV waiver
- Brain injury waiver
- Elderly waiver
- Ill and handicapped waiver
- Intellectual disability waiver
- Physical disability waiver

Source

DHS staff may complete this form on line using the template in Outlook under "Public Folders/All Public Folders/State Approved Forms/Service." Other providers may replicate this form or use a different format for the case plan.

Completion

The worker completes this form to record the member's case plan when:

- An adult member applies to receive waiver services,
- At the time of the member's yearly review, and
- When the member's service is terminated.

Distribution

File in the case record and send a copy to the member.

Data

Client's Name: Enter the member's name.

Family Name: Enter the member's last name if different from other known family members.

Original Date: Enter the date the original service began.

Worker's Signature and **Date**: Sign your name and enter the date you complete the case plan.

Supervisor's Signature and **Date**: Your supervisor will sign and date the *Individual Client Case Plan* when it is being approved for service.

Client's Signature and Date: When the *Individual Client Case Plan* is complete, agreed to, and understood by the member, have the member check the boxes and sign and date the plan.

Assessment: Summarize the member's situation.

Financial Eligibility: Record reasons the member is financially eligible.

Goals: List goals of the plan.

Objectives: List objectives of the plan.

Specific Services: List services the member will be receiving on the program.

Responsibilities: List responsibilities of the member, the provider, the physician, the supervising nurse, and the Department worker.

Reassessment/Termination: Note if this is a reassessment or termination.

Informed Consent and Risk Agreement, Form 470-4289

Purpose	Form 470-4289 documents the member's understanding and acceptance of the responsibilities in using the consumer choices option for waiver services. The form is used for the following waivers: ♦ AIDS/HIV waiver ♦ Brain injury waiver ♦ Elderly waiver ♦ Ill and handicapped waiver ♦ Intellectual disability waiver ♦ Physical disability waiver
Source	The form is available on the IME web site at: http://www.ime.state.ia.us/HCBS/HCBSConsumerOptions.html
Completion	The service worker or case manager issues the form to each member who requests the consumer choices option. The form needs to be signed by the member or the member's guardian, if applicable. Send a notice of decision when any changes in the monthly budget amount occur.
Distribution	Keep a copy of this form in the member's service file and give a copy to the member.
Data	The form identifies the monthly budget amount, its allowable uses, the member's responsibility to pay for services provided that exceed the individual budget, and the member's responsibility to sign off on verification of the services provided.

Iowa Medicaid Critical Incident Report, Form 470-4698

Purpose

Form 470-4698 provides a consistent statewide process of identifying, classifying and reporting major incidents, which enables the Department to conducting trend analysis reviews and reports on those incidents. This form is used in the following waivers:

- AIDS/HIV waiver
- Brain injury waiver
- Children's mental health waiver
- Elderly waiver
- Ill and handicapped waiver
- Intellectual disability waiver
- Physical disability waiver

Source

Waiver providers may complete this report electronically through the Iowa Medicaid Portal Application (IMPA). The report form is also available on the IME web site at: http://www.ime.state.ia.us/docs/CriticalIncidentReportform470-4698.pdf

Completion

The Medicaid HCBS waiver service provider completes this form when:

- A major incident occurs, or
- A staff member becomes aware of a major incident.

Distribution

The provider submits the completed report to the Department's Bureau of Long-Term Care either:

- By direct data entry into the IMPA, or
- By faxing or mailing the report according to the directions on the form.

Data

The following information shall be reported:

- The name of the member involved.
- The date and time the incident occurred.
- A description of the incident.

- The names of all provider staff and others who:
  - Were present at the time of the incident, or
  - Responded after becoming aware of the incident.

  Maintain the confidentiality of other members or non-members who were present by the use of initials or other means.
- The action that the provider staff took to manage the incident.
- The resolution of or follow-up to the incident.
- The date the report is made and the handwritten or electronic signature of the person making the report.

User instructions for the critical incident report web tool are located at: http://www.ime.state.ia.us/docs/IMPAIncidentReportWebToolUserGuide.pdf

Level of Care Certification for HCBS Waiver Program, Form 470-4392

Purpose

Form 470-4392 provides a mechanism for a medical professional to report a consumer's waiver application, change in condition, or annual assessment for level of care. The form is used in the following waivers:

- AIDS/HIV waiver
- Elderly waiver
- Ill and handicapped waiver
- Physical disability waiver

Source

This form is available on the DHS IME website under provider forms.

Completion

A physician (M.D. or D.O.), advanced registered nurse practitioner, or physician assistant must complete the form when:

- The applicant requests to receive waiver services.
- The waiver member has a significant change in condition.
- The waiver member has an annual assessment.

Distribution

The provider faxes the certification form to the IME Medical Services Unit at 515-725-1349 and provides a copy to the consumer.

The form may be faxed by the professional completing the form or by others involved in assisting in arranging the services (i.e., facility staff, hospital discharge planner, case manager, services worker, or family member).

The IME Medical Services Unit will make a level of care determination upon receipt of the form.

Data

Today's Date: The actual date the form is completed (MM/DD/YY).

Iowa Medicaid Member Name: The applicant or member's first, middle initial, and last name.

Social Security Number or State ID #: The applicant or member's social security number or state identification number.

Birth Date: The applicant or member's birth date (MM/DD/YY).

Name, Telephone Number with Area Code and Address: The specific information on the medical professional who is filling out the form.

Admit to Medicaid HCBS Waiver: Contains the specific Medicaid home- and community-based (HCBS) waiver type.

Diagnoses and Medications: The member-specific health information related to diagnoses and medications.

Level of care criteria: All reasons that apply for admission, significant change in condition or continued stay for a waiver, as well as additional comments the medical professional may want or need to add.

Signature of Medical Professional with Title MD/DO/PA/ARNP: The signature of the medical professional completing the form.

Medicaid County Billing Remittance, Form 470-3668

Purpose

The *Medicaid County Billing Remittance* is the invoice used for billing the county for the nonfederal share of the service cost in the following waivers:

- Brain injury waiver
- Intellectual disability waiver

Source

The Iowa Association of Counties issues the form monthly to each county with adult members that have had bills paid for waiver services. The form is issued electronically and contains data provided by the Iowa Medicaid Enterprise.

Completion

The county central point of coordination (CPC) or designee completes the form by entering a contact person name and phone number. If the county disputes part of the billing, the CPC or designee will complete the blanks on the first page to provide the following information for each dispute:

- Member name
- Member state identification number
- Dates of service
- Amount billed
- Amount paid
- Amount not paid
- Reason for nonpayment

Distribution

The county central point of coordination or designee sends the first page of the form to DHS cashier along with the payment for the undisputed portions of the bill.

When the payment is received, staff in the Division of Fiscal Management enter the payment and the disputed amounts into the accounts receivable. Division staff will follow up on disputed amounts until a resolution is achieved.

Data

The first page of the billing contains the waiver name, the county name, the invoice number, the billing date, and the total amount from the detailed billing.

The detailed billing pages contain the name, state identification number, beginning and ending dates of service, and amount billed for each member with legal settlement in that county, along with a total amount for all charges.

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

Purpose

The *Notice of Decision: Services* notifies a waiver applicant or member of all actions taken that affect the person's case. The worker uses the form to present the information in a way that meets due process requirements and to document these notifications for the following waivers:

- AIDS/HIV waiver
- Brain injury waiver
- Children's mental health waiver
- Elderly waiver
- Ill and handicapped waiver
- Intellectual disability waiver
- Physical disability waiver

Source

DHS staff may complete the English and Spanish versions of the form on line using the templates in Outlook under "Public Folders/All Public Folders/State Approved Forms/Service."

The forms may also be printed or photocopied from the samples in the manual and completed manually. (Access the form by clicking on the blue form number.)

Completion

The case manager or service worker completes this form to notify consumers of eligibility determination and need for waiver services for the following case actions:

- An application is approved, denied, or withdrawn.
- Services are renewed as a result of a regular or special review.
- The service is changed.
- Services are terminated.
- A member is required to pay client participation.
- The client participation amount changes.

Distribution

Give the original to the member. File a copy in the case record.

Data

Identifying Information: The case number may be omitted on applications.

Explanation of Action: Include in this section:

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

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

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

Fees: For members with client participation, specify:

- The service the client participation covers.
- The amount of the client participation.
- The period covered by the client participation (e.g., $20 per month).
- The person to whom the fee is payable.

Request for Medicaid Services Data Changes and Verifications, Form 470-3923

Purpose

The purpose of the *Request for Medicaid Services Data Changes and Verifications* form is to transmit requests to add, change, or terminate ISIS Service Plan/Service Spans Request information when the information can't be submitted directly through ISIS entries. The form is used in the following waivers:

- AIDS/HIV waiver
- Brain injury waiver
- Children's mental health waiver
- Elderly waiver
- Ill and handicapped Waiver
- Intellectual disability waiver
- Physical disability waiver

Source

This form is available as a template in the public state-approved forms folder on Outlook. Supplies of the form may also be printed as needed from the sample in the manual.

Completion

A service worker or case manager prepares the form when:

- The service plan/service span in ISIS has a date that is earlier than the effective date of the change that needs to be completed in ISIS.

  For example, the effective date on the service plan request is October 1 and this member now needs to have an active service plan with an effective date of August 15.

- The waiver needs to be approved and closed but can't be entered in ISIS because the dates for services are prior to the current month.

  For example, the current month is November. On November 15, the worker determines that waiver should have been approved effective September 6 and then canceled effective October 20.

- A change occurs to any information on the form and this information cannot be passed to ISIS because the information is for historical purposes.

The worker must input the corrected service plan information into ISIS for the current month even though the dates are incorrect.

On this form the worker must complete all previous information that is to be changed along with the correct information. The ISIS maintenance team will then change the services to the appropriate dates as specified on the form.

The information must be submitted on this form before additions or corrections can be made to the ISIS Service Plan/Service Span Request. Use the same form for additional changes for this same member. Use a different form for each new member.

Distribution

Make a copy of the original and send via e-mail to:

- Non DHS employees: isishelpdesk@dhs.state.ia.us
- DHS employees through Outlook: DHS, ISIS Help Desk

Data

Part I **Consumer State ID, Consumer Name, Case Number, Worker Name, Worker Number, Worker Phone Number**: Enter the member's state identification number, name and case number from ISIS. Enter your name, worker number, and your office telephone number including the area code.

Part 2 **Program Type**: Write in the correct program type.

Part 3 **Level of Care**: Write in the correct level of care.

LOC Date: Write in the correct LOC date.

Part 4 **Current Program Request Dates (Dates Come From IABC)**: Start Date, End Date: Enter the dates that are on the program request line in the ISIS program. Remember the end date field may be blank.

Current Service Plan Dates (Dates Come From SW/CM): Start Date, End Date: Enter the correct start date or end date as it appears on the ISIS program.

Correct Service Plan Dates: Start Date, End Date: Enter the correct start date and end date.

Information Currently Shown on the ISIS System (service spans): Begin Date, End Date, Procedure Code, Provider No., Site No., Rate/Unit, No. of Units/Mo., Billable Units/Mo., 1st Month CP, and Ongoing CP:

Enter all of the information currently shown in these fields on the ISIS program. On the form this request is listed twice to allow you the opportunity to make two corrections for the **same** member. Use a different form for each new member.

Correct Information: Begin Date, End Date, Procedure Code, Provider No., Site No., Rate/Unit, No. of Units/Mo., Billable Units/Mo., 1st Month CP, and Ongoing CP:

Enter the correct information needed in these fields for the ISIS program. On the form, this request is listed twice to allow you the opportunity to make two corrections for the **same** member. Use a different form for each new member.

Service Worker Comprehensive Assessment, Form 470-5044

Purpose

Form 470-5044 is used to:

- Identify the waiver consumer's areas of deficits, strengths, and preferences;
- Identify any barriers to maintaining the consumer's current level of functioning;
- Identify health and safety risks to reduce the risk of harm through interventions, resources, and service activities;
- Determine the need for any medical, social, educational, housing, transportation, vocational or other services; and
- Provide the foundation for developing the comprehensive service plan and the crisis intervention plan.

This form is used in the following waivers:

- AIDS/IV waiver
- Ill and handicapped waiver
- Physical disability waiver

Source

Print the form from the sample in the manual as needed.

Completion

The service worker shall give the form to the consumer upon the consumer's application for waiver services and follow up with the consumer for completion. The consumer or the consumer's parent or guardian must sign the form.

A new assessment must be completed annually.

Distribution

Fax the completed form to the IME Medical Services Unit at 515-725-1388 for the level of care determination or prior approval of specific services. Keep a copy in the case record.

Data

The assessment collects information on:

- Worker and consumer information;
- Medical and physical health;
- Kinds of services needed;
- Parent and school information for children; and
- Interdisciplinary team members and court involvement.

Comm. 270, Are Home & Community Based Services Right for You?

Purpose	Comm. 270 explains what services are available under Iowa's Medicaid home- and community-based services waivers, including the: ♦ AIDS/HIV waiver ♦ Brain injury waiver ♦ Children's mental health waiver ♦ Elderly waiver ♦ Ill and handicapped waiver ♦ Intellectual disability waiver ♦ Physical disability waiver
Source	Department local offices may order supplies of this brochure from Iowa State Industries at Anamosa. Other agencies should request supplies of the brochure from the Department local office.
Distribution	Issue the brochure to anyone who requests information about waiver services, including consumers, providers, family members, and health organizations, as needed.
Data	Comm. 270 gives information on service coordination, individual planning, and quality assurance for home- and community-based services. The pamphlet talks about easy access and flexible supports for a person-centered approach and explains the consumer choices option.

Comm. 271 and Comm. 271(S), Is the Consumer Choices Option for You?

Purpose	Comm. 271 and 271(S) provide information about the consumer choices option, which can be used for managing some services under the following waivers: ♦ AIDS/HIV waiver ♦ Brain injury waiver ♦ Elderly waiver ♦ Ill and handicapped waiver ♦ Intellectual disability waiver ♦ Physical disability waiver
Source	This English or Spanish version of this flier may be printed from the IME web site at: http://www.ime.state.ia.us/HCBS/HCBSConsumerOptions.html (listed as "Consumer Choices Option Fact Sheet")
Distribution	Issue the flier to anyone who requests information about the consumer choices option, including consumers, providers, family members, and health organizations, as needed.
Data	The flier gives basic information on the consumer choices option, lists several questions to consider in deciding whether to pursue that option, and identifies the web site for obtaining more information.

Comm. 278, Allowable Services and Supports in Individual Budgets

Purpose	Comm. 278 explains the services that may be purchased using the consumer choices option individual budget, which is available under the following waivers: ♦ AIDS/HIV waiver ♦ Brain injury waiver ♦ Elderly waiver ♦ Ill and handicapped waiver ♦ Intellectual disability waiver ♦ Physical disability waiver
Source	This flier may be printed from the IME web site at: http://www.ime.state.ia.us/HCBS/HCBSConsumerOptions.html
Distribution	Issue the flier to anyone who requests information about the consumer choices option, including consumers, providers, family members, and health organizations, as needed.
Data	The flier explains the services that may be purchased and the provider qualifications for: ♦ Self-directed personal care, ♦ Self-directed community and employment supports, and ♦ Individual-directed goods and services. The flier also explains the approval process for other supports, goods, and services.

Comm. 280 and Comm. 280(S), Medicaid Home and Community-Based Services: Consumer Choices Option

Purpose	Comm. 280 and Comm. 280(S) are the handbook for using the consumer choices option, which is available under the following waivers: ♦ AIDS/HIV waiver ♦ Brain injury waiver ♦ Elderly waiver ♦ Ill and handicapped waiver ♦ Intellectual disability waiver ♦ Physical disability waiver
Source	Department offices may order supplies of the English version of this handbook from Iowa State Industries at Anamosa. Other agencies should request supplies of the handbook from the Department local office. The content of the English or Spanish version may be printed from the IME web site at: http://www.ime.state.ia.us/HCBS/HCBSConsumerOptions.html (listed as "CCO Brochure" or "Consumer Choices Option Consumer Brochure")
Distribution	Issue the handbook to waiver consumers, their family members, providers of disability or aging services, and other interested persons, as needed.
Data	The handbook addresses: ♦ Guiding principles, ♦ Life choices, ♦ Getting started in waiver services, ♦ Choosing an independent support broker, ♦ Planning the individual budget, ♦ Designing supports, ♦ Paying for services, and ♦ Creating quality of life.

Comm. 406, Consumer-Directed Attendant Care (CDAC) Member Handbook

Purpose	Comm. 406 explains the operation of the consumer-directed attendant care service from the consumer's point of view. CDAC is available under the following waivers: ♦ AIDS/HIV waiver ♦ Brain injury waiver ♦ Elderly waiver ♦ Ill and handicapped waiver ♦ Intellectual disability waiver ♦ Physical disability waiver
Source	The handbook may be printed from the IME web site at: http://www.ime.state.ia.us/HCBS/CDAC_index.html (listed as "CDAC Consumer Handbook")
Distribution	Issue the handbook to waiver consumers using consumer-directed attendant care, their family members, and other interested persons, as needed.
Data	The handbook addresses: ♦ Possible CDAC services, ♦ How to get services, ♦ Where services can be delivered, ♦ Finding a provider, ♦ The agreement with the provider, ♦ Paying the provider, ♦ Retaining the provider, ♦ Problems that may arise, ♦ Abuse, neglect and financial exploitation, and ♦ Emergency planning.

Comm. 408, Consumer-Directed Attendant Care (CDAC) Provider Handbook

Purpose

Comm. 408 explains the operation of the consumer-directed attendant care service from the provider's point of view. CDAC is available under the following waivers:

- AIDS/HIV waiver
- Brain injury waiver
- Elderly waiver
- Ill and handicapped waiver
- Intellectual disability waiver
- Physical disability waiver

Source

The handbook may be printed from the IME web site at: http://www.ime.state.ia.us/HCBS/CDAC_index.html (listed as "CDAC Provider Handbook")

Distribution

Issue the handbook to providers of consumer-directed attendant care and other interested persons, as needed.

Data

The handbook addresses:

- Possible CDAC services,
- Provider qualifications,
- How to become enrolled as a provider,
- Where services can be delivered,
- Guidelines for Medicaid coverage,
- The agreement with the member,
- Service documentation,
- Billing procedures,
- Suggestions for providing care,
- Emergency planning, and
- Taxes.