IOWA HHS

Iowa Department of Health and Human Services

Provider Agreement

Provider Number	State ID	Amendment ☐ Yes ☐ No	
Payee Name (if applicable)		Telephone Number ( )	
Payee Street Address	City	State	Zip Code
Client Name	Client Social Security Number	Telephone Number ( )	
Client Street Address	City	State	Zip Code
Service Provider Name	Provider Social Security Number	Telephone Number ( )	
Service Provider Street Address	City	State	Zip Code

Instructions for Emergency Situations (to be maintained in the home and in the client file): Information/Instruction contained in the Physician's Report/Health Care Plan (if applicable)	
Physician Name:	Physician Phone:
Supervising Practitioner (if applicable) Name:	Supervising Practitioner Phone:
IHHRC Service Worker Name:	IHHRC Service Worker Phone:
Family/Significant Other Name:	Family/Significant Other Phone:
Family/Significant Other Name:	Family/Significant Other Phone:
The following hospital will be used:	
The following ambulance service will be used:	

Description of Specific Duties	**Number of 15-Minute Units per Month**	**Rate Per Unit**	**Total**
Personal care		$	$
Homemaker		$	$
Medication supervision		$	$
Food preparation		$	$
Transportation		$	$
Other:		$	$
		Total	$

The client is a member of my family (a parent, stepparent, child, stepchild, brother, stepbrother, sister, stepsister, lineal ancestor, or lineal descendent, or such person by marriage or adoption).
☐ Yes ☐ No

The IHHRC care provider is listed as the agent and the IHHRC client is listed as the principal in a healthcare Power of Attorney document
☐ Yes ☐ No

The supervising practitioner for skilled services will also be paid as a IHHRC provider for the IHHRC client
☐ Yes ☐ No

NOTE: If it is determined by the service worker that the terms of the provider agreement have not been met by the client or the provider, the state supplementary assistance payment may be terminated.

I certify that I will provide the services as stated above before submitting the billing for payment. I will not request additional payment from the client. The client is the sole payee for payments made under this program. The client is responsible for making payment to the provider, except when either of the following circumstances applies:

- The client has a legally designated person to handle finances, such as a:
  - Conservator
  - Representative payee
  - Financial Power of attorney ☐ Yes ☐ No

I understand payments I receive may be taxable as income for federal and state purposes.

Provider Signature	Date

I certify that this agreement is at my request and approval. I understand that either I or my payee is responsible for paying the provider for services rendered.

Client (or authorized representative) Signature	Date

Start Date	End Date	Unit Cost	Per 15 minutes
Billable Per Month HHS		Client Participation (CP)	

Based on current available information, this client meets the eligibility for reimbursement for in-home health services. Services may be provided until the provider receives notice to discontinue due to ineligibility, expiration of agreement, or other cause.

Service Worker Signature	Date
Area Administrator or Designee	Date