IOWA HHS

Iowa Department of Health and Human Services

Statement of Services Rendered

A. I, _____, provider number _____, provided the following services for
IHHRC provider name

_____ during the month of _____.
IHHRC client name month and year.

B. Only document services which were **provided and authorized** during the month.

Specific Services	Rate	Units	Monthly Total
R0001 Personal care			
R0002 Homemaker			
R0003 Medication supervision			
R0004 Food preparation			
R0005 Transportation			
R0006 Other			
TOTAL			

IHHRC Provider's Signature	Date

C. I, _____, certify that I received the above mentioned services from
IHHRC Client Name

_____ for the month of _____.
IHHRC Provider Name Month/Year

Pursuant to Iowa Administrative Code 441-177.11(7) If the recipient is not following the program requirements or cooperating with the program objectives, including but not limited to, a failure to provide information to program representatives, termination of In-Home Health-Related Care Services shall occur.

IHHRC Client Signature	Date

D. Client participation _____ + DHS payment _____ = Total bill _____