IOWA | Health and Human Services

Iowa Medicaid Universal Home- and Community-Based (HCBS) Waiver Provider Application

Basic Information

To avoid delays in the enrollment process, you should:

- Complete all required forms listed below.
- If extra space is needed to answer any questions, please attach any additional pages.
- Type or print all information so that it is legible. Do not use a pencil.
- If any field is not applicable, please enter N/A.
- An incomplete form will delay the approval process.
- Attach all required supporting documentation.
- Make sure you read the instructions before completing the application.

Mail completed application and all applicable attachments to:

Iowa Medicaid
Provider Services
P.O. Box 36450
Des Moines, IA 50315

For Iowa Medicaid questions contact:

Provider Services, Enrollment:
Tel. (800) 338-7909 option 2 or
(515) 256-4609 option 2 (local)

MCO Contact Information:

Wellpoint/Amerigroup
Attn: Provider Relations
4800 Westown Parkway, Ste. 200
West Des Moines, IA 50266
Phone #: 800-454-3730
Fax #: 855-832-7289
Email Address: IAProviderQuestions@amerigroup.com

Iowa Total Care
Attn: Network Development and Maintenance
1080 Jordan Creek Parkway, Suite 400 South
West Des Moines, IA 50266
Phone #: 833-404-1061
Fax #: 833-208-1397

Molina Healthcare of Iowa
Attn: Provider Contracting
500 SW 7th St, Suite 304
Des Moines, IA 50309
Phone #: 844-236-1464
Fax #: 855-275-3082
Email: IAProviderContracts@molinahealthcare.com

Agencies and businesses applying for HCBS waiver services must complete the following forms for Iowa Medicaid:

If you are enrolling in the Medicaid program for the first time or already enrolled, but you have a new Tax Identification Number, the following forms are required:

- Form **470-2917 – Medicaid HCBS Waiver Provider Application** (Sections: I and III. If intending to contract and credential with the MCOs, complete section IV.)
- Form **470-2965 – Provider Agreement**
- Form **470-4202 – EFT**
- IRS Form **W-9**
- Form **470-5112 – Designated Contact Person**

Medicaid enrolled HCBS waiver Agencies and businesses adding additional HCBS waiver services:

If you are already enrolled and active, to add services to your existing enrollment the following form is required:

- Form **470-2917 – Medicaid HCBS Waiver Provider Application** (Sections: I and III)

Instructions for Completing the Iowa Department of Human Services Iowa Medicaid Universal HCBS Waiver Provider Enrollment Application

Reason for Application: Check one box.

Managed Care Organization (MCO): Check the box next to each MCO plan that you want your enrollment application submitted to.

I. General Section: Important Reminders

1 **National Provider Identifier (NPI)** (If you are not currently a Medicaid provider and do not qualify to register for an NPI, leave blank.)

2-3a **Legal Business Name and DBA Name** – Ensure that your name listed matches your W9 form.

13 **Email Address –** Enter email address, if available. By providing your email 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 in which the application is **approved**. Providers cannot bill or be paid for service provided prior to the Department of Health and Human Services (HHS) approval of the service enrollment.

III. Agencies and businesses applying for HCBS waiver services: Important Reminders

16 **Tax ID Number –** Enter your Internal Revenue Service (IRS) Tax ID number. Providers must include a copy of the signed and date W9 form.

24 Indicate which HCBS Waiver and which HCBS waiver services you are applying for by checking the box next to that service. Under the service you are applying for check **one** of the standards that qualify you or your agency 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 qualifies you or your agency to provide the service.

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

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

NOTE: Those wishing to provide services under the Brain Injury Waiver must submit documentation indicating training and 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.

The Provider Quality Self-Assessment Form 470-4547 is required when enrolling for services that require submission of a complete Provider Quality Management Self-Assessment and/or submission of policies, procedures and forms. Training and the current Provider Quality Self-Assessment form are located here: https://hhs.iowa.gov/programs/welcome-iowa-medicaid/iowa-medicaid-programs/hcbs

Enrollment training and sample enrollment materials can be found at:
https://hhs.iowa.gov/programs/welcome-iowa-medicaid/provider-services/provider-enrollment

IV. Additional MCO Credentialing Information: Important Reminders

If you are interested in credentialing and contracting with the MCOs, please complete the remainder of the application. In order for the MCOs to complete the credentialing process, you must first be fully approved as an enrolled provider with Iowa Medicaid. All applicants must complete all questions (unless otherwise noted). If it is not applicable, please write N/A.

36 **Professional Liability / Malpractice Liability / General Liability coverage** – A copy of your Certificate of Liability Insurance must be included with the submission of the application to the MCOs.

Once the application process has been approved, you will receive notification from the Iowa Medicaid and the MCOs.

Iowa Medicaid Universal HCBS Waiver Provider Application

I. General Section

Reason for Application: Check one box.

☐ You are a **NEW** enrollee in Iowa Medicaid (the Tax Identification or Social Security Number has not been enrolled in Medicaid)	☐ You are **REACTIVATING** your Iowa Medicaid provider number	☐ You are **CHANGING** to a new Tax Identification Number (if you are already enrolled, but have a new Tax Identification Number)	☐ You are **ADDING-ON** additional services to an existing enrolled Iowa Medicaid provider

Please indicate which MCO(s) Iowa Medicaid should share your application with:

☐ Iowa Total Care
☐ Wellpoint/Amerigroup Iowa
☐ Molina of Iowa

By checking the box above, I authorize the Iowa Medicaid Program to share this application and all information contained herein with each MCO indicated above. I understand that despite Iowa Medicaid sharing this application with each MCO indicated above, this does not dissolve me of my responsibility to initiate the contracting and credentialing with each MCO with whom I wish to contract.

1. National Provider Identifier (NPI)	
2. Legal Business Name	
3a. DBA Name	
3b. Mailing Address	
4. Street Address (if different from the mailing address)	
Billing/remittance 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. Email Address (please, print)	
14. Desired Enrollment Effective Date with Iowa Medicaid (MM/DD/YYYY) (THIS DATE WILL NOT BE RETROACTIVE BEFORE THE FIRST OF THE MONTH IN WHICH THE APPLICATION IS APPROVED. THE MCO EFFECTIVE DATE IS DEFINED IN THE PROVIDER'S CONTRACT WITH THE MCO AND MAY VARY FROM THE REQUESTED IOWA MEDICAID APPLICATION EFFECTIVE DATE.)	/ /

15. Check boxes for all counties you will be providing services in:

☐ ALL	☐ Buchanan	☐ Clarke	☐ Dickinson	☐ Hamilton	☐ Jasper	☐ Lyon	☐ Muscatine	☐ Ringgold	☐ Wapello
☐ Adair	☐ Buena Vista	☐ Clay	☐ Dubuque	☐ Hancock	☐ Jefferson	☐ Madison	☐ O'Brien	☐ Sac	☐ Warren
☐ Adams	☐ Butler	☐ Clayton	☐ Emmet	☐ Hardin	☐ Johnston	☐ Mahaska	☐ Osceola	☐ Scott	☐ Washington
☐ Allamakee	☐ Calhoun	☐ Clinton	☐ Fayette	☐ Harrison	☐ Jones	☐ Marion	☐ Page	☐ Shelby	☐ Wayne
☐ Appanoose	☐ Carroll	☐ Crawford	☐ Floyd	☐ Henry	☐ Keokuk	☐ Marshall	☐ Palo Alto	☐ Sioux	☐ Webster
☐ Audubon	☐ Cass	☐ Dallas	☐ Franklin	☐ Howard	☐ Kossuth	☐ Mills	☐ Plymouth	☐ Story	☐ Winnebago
☐ Benton	☐ Cedar	☐ Davis	☐ Fremont	☐ Humboldt	☐ Lee	☐ Mitchell	☐ Pocahontas	☐ Tama	☐ Winneshiek
☐ Black Hawk	☐ Cerro Gordo	☐ Decatur	☐ Greene	☐ Ida	☐ Linn	☐ Monona	☐ Polk	☐ Taylor	☐ Woodbury
☐ Boone	☐ Cherokee	☐ Delaware	☐ Grundy	☐ Iowa	☐ Louisa	☐ Monroe	☐ Pottawattamie	☐ Union	☐ Worth
☐ Bremer	☐ Chickasaw	☐ Des Moines	☐ Guthrie	☐ Jackson	☐ Lucas	☐ Montgomery	☐ Poweshiek	☐ Van Buren	☐ Wright

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. Are you currently enrolled in another state's Medicaid/Chip program?
- ☐ Yes – please list the state and what program:
- ☐ No

22. Are you currently enrolled with Medicare?
- ☐ Yes – please list your Medicare number:
- ☐ No

23. Type of Ownership Code (Check One)

☐	☐ Partnership	☐ Nonprofit Organization
☐ Limited Partnership	☐ Corporation	☐ Limited Liability Company (LLC)
☐ Sole Ownership	☐ Cooperative	

Contacts:	Primary	Secondary	Credentialing	Billing
Name				
Title				
Phone				
Fax				
Email				

Service and Requirements	Circle the waiver(s) for which you are applying
☐ **Adult Day Care (ADC) licensed center**	
☐ 70 – Adult day care providers shall be agencies that are certified by the Department of Inspections and Appeals and Licensing (DIAL) as being in compliance with the standards for adult day services programs at IAC 481—Chapter 70. →	HD AH E ID BI
☐ **Adult Day Care (ADC) in the Home**	HD AH E ID BI
Respite Care providers certified under the BI or ID waivers	HD AH E ID BI
Home Health Agency certified to provide Respite	HD AH E ID BI
Home Care Agency certified to provide Respite	HD AH E ID BI
Supported Community Living providers certified under the BI or ID Waivers to provide Respite	HD AH E ID BI
Requires submission of a complete Provider Quality Management Self-Assessment and must submit policies, procedures, and forms	HD AH E ID BI
☐ **Assistive Devices (AD)**	
☐ 61 – Area agencies on aging as designated according to department on aging rules IAC 17—4.4(231)) →	E
☐ 39 – Community businesses that are engaged in the provision of assistive devices and that Submit verification of current 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

Service and Requirements		Circle the waiver(s) for which you are applying	
☐ 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 NPI# _____)	→	BI	MFP
☐ 20 – Brain injury waiver providers certified pursuant to rule 441-77.39(249A)	→	BI	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
Agencies which are accredited by a department-approved, nationally-recognized accreditation organization as a specialty brain injury rehabilitation service provider			
Requires submission of a complete Provider Quality Management Self-Assessment and must submit policies, procedures and forms			
☐ Case Management (CM)			
☐ 47 – An Agency that that is accredited by the Department of Health and Human Services Behavioral Health services division as meeting the standards for case management services in IAC 441 Chapter 24: (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 in Supports for People with Disabilities (CQL) to provide case management (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 to provide case management (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	
An Agency that is approved by the Department on Aging as meeting the standards for case management services in IAC 17- Chapter 21:		E	
An agency or individual that is authorized to provide similar services through a contract with the department of public health for local public services and that: 1. meets the qualifications for case managers in IAC 641- 80.3(7)and 2. provides a current IDPH contract number		E	
Requires submission of a complete Provider Quality Management Self-Assessment and must submit policies, procedures, and forms			
☐ 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 NPI # _____)	→	E	
☐ 10 – Nursing Facility Licensed under 135C Code of Iowa (no supporting documentation required)	→	E	

Service and Requirements		Circle the waiver(s) for which you are applying
☐ **Consumer Directed Attendant Care (CDAC)**		
Agency		
☐ 08 – Home Health Agency (enter your NPI # _____)	→	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 E 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 complete Provider Quality Management Self-Assessment and must submit policies, procedures, and forms		
☐ **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) Requires submission of a complete Provider Quality Management Self-Assessment and must submit policies, procedures, and forms	→	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 complete Provider Quality Management Self-Assessment and must submit policies, procedures, and forms		
☐ **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

Service and Requirements		Circle the waiver(s) for which you are applying
☐ **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 regard 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 complete Provider Quality Management Self-Assessment and must submit policies, procedures, and forms *Similar services include Personal and Social services, Community Integration services, Community Based Rehabilitation.		
Enabling Technology for Remote Support		
☐ 15 – Provider enrolled under HCBS ID or BI Supported Community Living (no supporting documentation required)		BI ID
☐ Enabling Technology Equipment Providers that meet the Enabling Technology service standards – send information packet		
☐ Enabling Technology Assessment providers – send information packet		
☐ **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 complete Provider Quality Management Self-Assessment and must submit policies, procedures, and forms		
☐ **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 complete Provider Quality Management Self-Assessment and must submit policies, procedures, and forms		

Service and Requirements		Circle the waiver(s) for which you are applying
☐ Financial Management Services (FMS)		
☐ 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
☐ 08 – Home Health Agency (enter your NPI # _____)	→	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 NPI # _____)	→	HD AH E ID
☐ Homemaker (HM)		
☐ 08 – Home Health Agency (enter your NPI # _____)	→	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 BI PD
☐ 39 – Community Business (attach current proof of liability and workers compensation coverage)	→	HD E 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 complete Provider Quality Management Self-Assessment and must submit policies, procedures, and forms		

Service and Requirements		Circle the waiver(s) for which you are applying
☐ **Interim Medical Monitoring & Treatment (IMMT)**		
☐ 08 – Home Health Agency (enter your NPI # _____)	→	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 complete Provider Quality Management Self-Assessment and must submit policies, procedures, and forms		
☐ **Medical Day Care for Children**		
☐ 08 – Home Health Agency (enter your NPI # _____)	→	AIDS/HIV, BI, CMH, HD, ID
☐ 15 – Provider enrolled under HCBS ID or BI Supported Community Living (no supporting documentation required)	→	AIDS/HIV, BI, CMH, HD, ID
☐ 29 – Provider certified under HCBS ID Respite (no supporting documentation required)	→	AIDS/HIV, BI, CMH, HD, ID
☐ 79 – Provider certified under HCBS BI Respite (no supporting documentation required)	→	AIDS/HIV, BI, CMH, HD, ID
☐ **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 complete Provider Quality Management Self-Assessment and must submit policies, procedures, and forms		
☐ **Nurse Delegation (ND)**		
☐ 08 – Home Health Agency (enter your NPI # _____)	→	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 NPI # _____)	→	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 NPI # _____)	→	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
Requires submission of a complete Provider Quality Management Self-Assessment and must submit policies, procedures, and forms		

Service and Requirements		Circle the waiver(s) for which you are applying
☐ Respite		
☐ 46 – Enrollment criteria met upon Iowa Medicaid approval of policies, procedures, and forms	→	ID BI CMH
☐ 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 NPI # _____)	→	HD AH E ID BI 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 complete Provider Quality Management Self-Assessment		
☐ 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)		
☐ 46 – Enrollment criteria met upon Iowa Medicaid approval of policies, procedures, and forms	→	ID BI
☐ 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 complete Provider Quality Management Self-Assessment		
☐ 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 complete Provider Quality Management Self-Assessment and must submit policies, procedures, and forms		

Service and Requirements		Circle the waiver(s) for which you are applying
☐ 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 complete Provider Quality Management Self-Assessment and must submit policies, procedures, and forms		
☐ Transportation (Trans)		
☐ 38 – Regional Transit Agency recognized by Iowa Department of Transportation (no supporting documentation required)	→	E ID BI PD
☐ 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
☐ 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 (attach NEMT welcome letter or contract)	→	E ID BI PD
☐ 72 – Contract with county government (attach a copy of the contract)	→	ID
☐ 111 – Provider with purchase of service contracts to provide transportation pursuant to 441 Chapter 150	→	BI
☐ 71 – Accredited provider of home- and community-based services	→	ID

IV. Additional MCO Credentialing Information

If you are interested in credentialing and contracting with the MCOs, please complete the remainder of the application. In order for the MCOs to complete the credentialing process, you must first be fully approved as an enrolled provider with Iowa Medicaid.

25. Website

26. Office Hours

Weekday	From	To	Weekday	From	To
Sunday			**Monday**		
Tuesday			**Wednesday**		
Thursday			**Friday**		
Saturday					

27. How many members can you accommodate?

28. Are you accepting new members? ☐ Yes ☐ No

29. Do you have age limitations? ☐ Yes ☐ No
If yes, please list:

30. Please specify the sex(s) that you serve: ☐ Male ☐ Female

31. Does this office meet ADA accessibility requirements? ☐ Yes ☐ No

32. Do the following have disability access?

Building ☐ Yes ☐ No **Parking** ☐ Yes ☐ No **Restroom** ☐ Yes ☐ No

33. Does this office provider offer the following services for the disabled?

TTY ☐ Yes ☐ No **American Sign Language** ☐ Yes ☐ No

34. What foreign languages are spoken by the provider/staff (other than English)?

Language 1: ☐ Spoken ☐ Written ☐ Provider language ☐ Staff Language ☐ Interpreter

Language 2: ☐ Spoken ☐ Written ☐ Provider language ☐ Staff Language ☐ Interpreter

35. Does your staff have training in Cultural Competency? ☐ Yes ☐ No

Homeless ☐ Yes ☐ No Senior Care ☐ Yes ☐ No People with Disabilities ☐ Yes ☐ No

Financially Challenged Patient ☐ Yes ☐ No Refugee or Immigrant Patient ☐ Yes ☐ No

36 Professional Liability / Malpractice Liability / General liability coverage

Name of Carrier and Phone Number:	Effective Date:	Expiration Date:
Coverage type: ☐ Occurrence-based ☐ Claims-based	Amount per incident: $	Amount in aggregate: $
Name of Carrier and Phone Number:	Effective Date:	Expiration Date:
Coverage type: ☐ Occurrence-based ☐ Claims-based	Amount per incident: $	Amount in aggregate: $
Name of Carrier and Phone Number:	Effective Date:	Expiration Date:
Coverage type: ☐ Occurrence-based ☐ Claims-based	Amount per incident: $	Amount in aggregate: $

37. Accreditation: Please provide documentation supporting the completion of an on-site survey within the accreditation period performed by a government, regulatory or accrediting authority. If accredited by Joint Commission of Accreditation of Health Care Organizations (JCAHO), please supply a copy of the Official Accreditation Decision Report. If one of the other acceptable types of accreditations, please enclose a copy of the certificate.

☐ JCAHO
☐ Accreditation Commission of Health Care, Inc.
☐ Commission on Accreditation of Rehabilitation Facilities
☐ Council on Quality and Leadership
☐ International Center for Clubhouse Development
☐ Other:
☐ CMS or State Agency Review or Certification. If State agency, please list:

38. Other credentialing questions (if yes to any of the following questions, please include an explanation on a separate sheet):

Has the provider's license to do business in any applicable jurisdiction ever been denied, restricted, suspended, reduced or not renewed? ☐ Yes ☐ No

Has the provider's professional liability coverage ever been cancelled but not renewed? ☐ Yes ☐ No

Has the provider been denied accreditation by its selected accrediting body, or had its accreditation status reduced, suspended, revoked or in any way revised by the accrediting body? ☐ Yes ☐ No

Has the provider had any history of loss or limitation of privileges or disciplinary activity? ☐ Yes ☐ No

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 also attest that I am the duly authorized representative of the Provider. 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.

25. Signature of Authorized Official

26. Date | | | / | | | / | | | | |

27. Contact Person