

Iowa Medicaid 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)

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:

- Form **470-2917 – Medicaid HCBS Waiver Provider Application**
- 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 would like to add services to your existing enrollment:

- Form **470-2917 – Medicaid HCBS Waiver Provider Application**

Instructions for Completing the Iowa Department of Health and Human Services (HHS) Iowa Medicaid HCBS Waiver Provider Enrollment Application

Reason for Application: Check one box.

I. General Section:

- 1 **National Provider Identifier (NPI)**
- 2 **Tax ID Number** – Enter your Internal Revenue Service (IRS) Tax ID number. Providers must include a copy of the signed and date W9 form.
- 4-4a **Legal Business Name and DBA Name** – Ensure that your name listed matches your W9 form.
- 14 **Email Address** –HHS will communicate with you by email.
- 15 **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.
- 23 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 to provide that service. In the right column, circle the waiver for which you are applying. **Please note: Include with the application the documentation supporting the specific requirement that qualifies you or your agency to provide the service.**
- 35 **Signature** – Original signature required. Applications not properly signed will be returned.
- 36 **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.

Enrollment training and sample enrollment materials can be found at:

<https://hhs.iowa.gov/programs/welcome-iowa-medicaid/provider-services/provider-enrollment>

II. Additional Information:

All applicants must complete all questions (unless otherwise noted). If it is not applicable, please write N/A.

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 **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
- 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. Tax ID Number		3. Taxonomy Code
4. Legal Business Name		4a. DBA Name
4b. Street Address		
City	State	ZIP Code (Please enter 9-digit ZIP code, if known)
5. Mailing Address (if different from the street address)		
6. City	7. State	8. ZIP Code (Please enter 9-digit ZIP code, if known)
9. County Name		
11. Telephone Number (daytime)	12. Cell Phone Number (optional)	13. Fax Number (if available)
14. Email Address (if available)		

15. 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**.)

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

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

17. Has the provider ever been sanctioned by Medicaid, Medicare or other state health program? <input type="checkbox"/> Yes <input type="checkbox"/> No	
18. Has there been any disciplinary action against you by any licensing boards, accrediting or certification body? <input type="checkbox"/> Yes <input type="checkbox"/> No	
19. Have you ever been excluded from participating in the Medicaid or Medicare Program? If "yes," please explain on a separate piece of paper. <input type="checkbox"/> Yes <input type="checkbox"/> No	
20. Are you currently enrolled in another state's Medicaid/Chip program? <input type="checkbox"/> Yes – please list the state: <input type="checkbox"/> No	21. Are you currently enrolled with Medicare? <input type="checkbox"/> Yes <input type="checkbox"/> No
22. Type of Ownership Code (Check One)	
<input type="checkbox"/> Individual/Sole proprietor	<input type="checkbox"/> Government
<input type="checkbox"/> Partnership	<input type="checkbox"/> Corporation
	<input type="checkbox"/> Non-profit Organization
	<input type="checkbox"/> Limited Liability Company (LLC)

23. Services and Qualification

- AH – AIDS/HIV Waiver
- BI – Brain Injury Waiver
- CMH – Children’s Mental Health Waiver
- E – Elderly Waiver
- HD – Health and Disability Waiver
- ID – Intellectual Disability Waiver
- PD – Physical Disability Waiver
- MFP – Money Follows the Person

Step 1: In the dark gray section, select the service you want to enroll in				
Step 2: Choose the qualifying standard below				
Step 3. Check the box of waiver(s) for which you are enrolling				
Adult Day Care - 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.	<input type="checkbox"/> AH	BI <input type="checkbox"/> HD	E
Adult Day Care - In the Home				
	Respite Care providers certified under the BI or ID waivers	AH HD	BI ID	E
08	Home Health Agency certified to provide Respite	AH HD	BI ID	E
	Home Care Agency certified to provide Respite	AH HD	BI ID	E

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Supported Community Living providers certified under the BI or ID Waivers to provide Respite		AH HD	BI ID	E
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
Positive Behavioral Support and Consultation				
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)		BI	MFP
95	A behavioral analyst certified by the Behavior Analyst Certification Board (attach certification)		BI	MFP
96	A licensed mental health counselor (attach a copy of the license)			MFP

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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
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 #)	BI			E
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
Attendant Care					
08	Home Health Agency (enter your NPI # _____)	AH HD	BI ID	PD	E

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Step 3. Check the box of waiver(s) for which you are enrolling

13	Chore provider subcontracting with an area agency on aging (attach a copy of the contract)	AH HD	BI ID	PD	E
07	Community Action Agency as designated in IAC 216A.93 (no supporting documentation required)	AH HD	BI ID	PD	E
15	Provider enrolled under HCBS ID or BI Supported Community Living (no supporting documentation required)	AH HD	BI ID	PD	E
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)	AH HD	BI ID	PD	E
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)	AH HD	BI ID	PD	E
Skilled Attendant Care					
08	Home Health Agency (enter your NPI # _____)	AH HD	BI ID	PD	E
13	Chore provider subcontracting with an area agency on aging (attach a copy of the contract)	AH HD	BI ID	PD	E
07	Community Action Agency as designated in IAC 216A.93 (no supporting documentation required)	AH HD	BI ID	PD	E
15	Provider enrolled under HCBS ID or BI Supported Community Living (no supporting documentation required)	AH HD	BI ID	PD	E
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)	AH HD	BI ID	PD	E
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)	AH HD	BI ID	PD	E

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Step 3: Check the box of waiver(s) for which you are enrolling

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)	E
Counseling (Couns)		
22	Community Mental Health Center (attach a copy of the certificate or enter your Medicaid Provider # or Certificate of Accreditation _____)	AH HD
23	Hospice (attach a copy of the license or enter you Certificate of License or Medicare Provider # _____)	AH HD
24	Mental Health Service Provider (attach a copy of the Certificate of Accreditation)	AH HD
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
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

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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
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	BI ID
	Enabling Technology Assessment providers send information packet	BI ID
Home Modifications		
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

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84– Behavioral Health Intervention providers qualified under 441-77.12(249A)	CMH			
Family Training				
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			
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.	AH HD	BI ID	PD	E
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.	AH HD	BI ID	PD	E
Home Delivered Meals (HDM)				
61 Area Agency on Aging as designated in IAC 17 4.4(231) (no supporting documentation required)	AH HD			
59 Subcontract with area agency on aging (attach a copy of the subcontract)	AH HD	BI	E	

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Step 2: Choose the qualifying standard below

Step 3. Check the box of waiver(s) for which you are enrolling

07	Community Action Agency as designated in IAC 216A.93 (no supporting documentation required)	AH HD	BI	E
08	Home Health Agency (enter your NPI # _____)	AH HD	BI	E
26	Hospital (enter your Medicare Provider # _____)	AH HD	BI	E
06	Medical equipment and supply dealers (enter your Medicaid Provider # _____)	AH HD	BI	E
10	Nursing Facility Licensed under 135C Code of Iowa (no supporting documentation required)	AH HD	BI	E
27	Restaurant licensed and inspected under Iowa Code chapter 135F (attach a copy of the license)	AH HD	BI	E
Home Health Aid (HHA)				
08	Home Health Agency (enter your NPI # _____)	AH HD	ID	E
Home Maintenance Support				
39	Community Business (attach current proof of liability and workers compensation coverage)	AH HD		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)	AH HD		E
07	Community Action Agency as designated in IAC 216A.93 (no supporting documentation required)	AH HD		E
08	Home Health Agency (enter your NPI # _____)	AH HD		E
10	Nursing Facility Licensed under 135C Code of Iowa (no supporting documentation required)	AH HD		E
Home Modifications (HM) Vehicle Modifications				
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	

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Step 2: Choose the qualifying standard below

Step 3: Check the box of waiver(s) for which you are enrolling

45	Provider enrolled as a waiver Home/Vehicle Modifications provider under another waiver (no supporting documentation required)	HD	BI	PD	E
39	Community Business (attach current proof of liability and workers compensation coverage)	HD	BI	PD	E
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	
Interim Medical Monitoring & Treatment (IMMT)					
08	Home Health Agency (enter your NPI # _____)	HD	BI ID		
15	Provider enrolled under HCBS ID or BI Supported Community Living (no supporting documentation required)	HD	BI ID		
Medical Day Care for Children					
08	Home Health Agency (enter your NPI # _____)	AH HD	BI ID	CMH	
15	Provider enrolled under HCBS ID or BI Supported Community Living (no supporting documentation required)	AH HD	BI ID	CMH	
29	Provider certified under HCBS ID Respite (no supporting documentation required)	AH HD	BI ID	CMH	
79	Provider certified under HCBS BI Respite (no supporting documentation required)	AH HD	BI ID	CMH	
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

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98	A licensed advanced registered nurse registered as certified in psychiatric mental health (attach license and certification)			MFP
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 # _____)	AH HD	ID	E
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	BI ID	PD E
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	

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Step 2: Choose the qualifying standard below

Step 3. Check the box of waiver(s) for which you are enrolling

73	Be accredited by the Council on Quality and Leadership (attach current certification and most recent survey report)		ID		
Respite					
46	Enrollment criteria met upon Iowa Medicaid approval of policies, procedures, and forms		BI ID	CMH	
29	Provider certified under HCBS ID Respite (no supporting documentation required)	AH HD	BI	CMH	E
79	Provider certified under HCBS BI Respite (no supporting documentation required)	AH HD		CMH	
08	Home Health Agency (enter your NPI # _____)	AH HD	BI ID	CMH	E
26	Hospital (enter your Medicare Provider # _____)	AH HD	BI ID	CMH	E
10	Nursing Facility Licensed under 135C Code of Iowa (no supporting documentation required)	AH HD	BI ID	CMH	E
35	ICF/ID (enter your Medicaid Provider # _____)	AH HD	BI ID	CMH	E
44	Licensed group living foster care facility (attach a copy of the license)	AH HD	BI ID	CMH	E
32	Camps certified by the American Camping Association (attach a copy of the certificate)	AH HD	BI ID	CMH	E
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)	AH HD	BI ID	CMH	E
50	Residential care facility for persons with mental illness licensed by DIAL (attach a copy of the license)	HD	BI ID	CMH	
78	Assisted Living Program certified by the Department of Inspections and Appeals as designated in IAC 481-69	AH HD	BI ID	CMH	E
Companion					
37	Designation by Corporation for National and Community Service (attach documentation substantiating the designation)				E

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Step 3. Check the box of waiver(s) for which you are enrolling

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	BI ID
53 Provider enrolled under HCBS ID SCL (no supporting documentation required)	BI
54 Provider enrolled under HCBS BI SCL (no supporting documentation required)	ID
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 Ill Children (submit copy of Residential Facility for Mentally Ill Children under IAC 441-116 licensure and a plan to come into compliance with IAC 441 77.37(23)“e”(3))	ID
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)	BI ID
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)	BI ID
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)	BI ID

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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)	BI ID		
43	An agency that is accredited by the International Center for Clubhouse Development (attach copy of the certificate of accreditation)	BI ID		
Transportation (Trans)				
38	Regional Transit Agency recognized by Iowa Department of Transportation (no supporting documentation required)	BI ID	PD	E
61	Area Agency on Aging as designated in IAC 17-4.4(231) (no supporting documentation required)	BI ID	PD	E
59	Subcontract with Area Agency on Aging (attach a copy of the subcontract)	BI ID	PD	E
07	Community Action Agency as designated in IAC 216A.93 (no supporting documentation required)	BI ID	PD	E
10	Nursing Facility Licensed under 135C Code of Iowa (no supporting documentation required)	BI ID	PD	E
109	Transportation providers contracting with the nonemergency medical transportation contractor (attach NEMT welcome letter or contract)	BI ID	PD	E
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		

II. Additional Information

24. Website

25. Office Hours

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

26. How many members can you accommodate?	27. Are you accepting new members? <input type="checkbox"/> Yes <input type="checkbox"/> No										
28. Do you have age limitations? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please list:	29. Please specify the sex(s) that you serve: <input type="checkbox"/> Male <input type="checkbox"/> Female										
30. Does this office meet ADA accessibility requirements? <input type="checkbox"/> Yes <input type="checkbox"/> No											
31. Does this office have the following disability access? Building <input type="checkbox"/> Yes <input type="checkbox"/> No Parking <input type="checkbox"/> Yes <input type="checkbox"/> No Restroom <input type="checkbox"/> Yes <input type="checkbox"/> No											
32. Does this office offer the following services for the disabled? TTY <input type="checkbox"/> Yes <input type="checkbox"/> No American Sign Language <input type="checkbox"/> Yes <input type="checkbox"/> No											
33. What foreign languages are spoken by the provider/staff (other than English)?											
Language 1: <input type="checkbox"/> Spoken <input type="checkbox"/> Written <input type="checkbox"/> Provider language <input type="checkbox"/> Staff Language <input type="checkbox"/> Interpreter											
Language 2: <input type="checkbox"/> Spoken <input type="checkbox"/> Written <input type="checkbox"/> Provider language <input type="checkbox"/> Staff Language <input type="checkbox"/> Interpreter											
34. Does your staff have training in Cultural Competency?											
	<input type="checkbox"/> Yes <input type="checkbox"/> No										
Homeless	<input type="checkbox"/> Yes <input type="checkbox"/> No										
Senior Care	<input type="checkbox"/> Yes <input type="checkbox"/> No										
People with Disabilities	<input type="checkbox"/> Yes <input type="checkbox"/> No										
Financially Challenged Patient	<input type="checkbox"/> Yes <input type="checkbox"/> No										
Refugee or Immigrant Patient	<input type="checkbox"/> Yes <input type="checkbox"/> 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.											
35. Signature of Authorized Official											
36. Date	<table border="1" style="width: 100%; height: 20px;"><tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr></table>										
37. Contact Person											
Contact Person Email											
Contact Center Phone Number											