Iowa Medicaid
Iowa HHS

Level of Care Certification for Facility

PLEASE PRINT OR TYPE
Fax form to: Iowa Medicaid (515) 725-1349
Medical professional completing this form must provide a copy to the admitting facility.

Today's Date	Iowa Medicaid Member Name	Social Security or State ID #	Birth Date
/ /			/ /

Medical Professional completing form (MD, DO, PA-C or ARNP required)

Name	Telephone Number (10 digits)
Address	
Admit to: ☐ Nursing Facility ☐ Intermediate Care Facility for the Intellectually Disabled Discussion occurred regarding alternatives to facility placement? ☐ Yes ☐ No Date of discussion: / /	
Anticipated admission date: / /	Anticipated length of stay: days Time limited stay? ☐ Yes ☐ No

Facility Information (NF or ICF/ID)

Facility Name	
Address	
Telephone Number (10 digits)	Fax Number (10 digits)

ATTACH MEDICATION AND DIAGNOSES LISTS (WITH ICD CODES) SEPARATELY

Skilled Nursing Needs: Check all boxes that apply.

Therapies provided 5 days a week: ☐ Physical ☐ Occupational ☐ Speech Duration expected: _____	**Medications** provided daily: ☐ Intravenous ☐ Intramuscular Drug name, dose, length of treatment: _____	**Stoma care** in early postop phase requiring daily care: ☐ Colostomy ☐ Ileoconduit ☐ Suprapubic catheter site ☐ Ileostomy ☐ Nephrostomy
Respiratory therapy daily: ☐ Nasotracheal suctioning ☐ Tracheostomy care ☐ Ventilator at least 6 hours/day	**Tube feeding**: ☐ More than 26% of calorie intake per day/minimum of 501 cc/day Name/brand, dose, length of treatment: _____	**Wound care** for at least Stage 4 ☐ Sterile dressing change daily ☐ Wound vac care

Functional Limitations: Check all boxes that apply.

Cognition
- ☐ No problem
- ☐ Language barrier
- ☐ Short/long term memory problem
- ☐ Problems with decision making
- ☐ Interferes with ability to do ADLs

BIMS score (if applicable) _____

Dressing
- ☐ Independent
- ☐ Supervision or cueing needed
- ☐ Physical assistance needed

Frequency of needed assistance:
- ☐ 1-2 x weekly
- ☐ 3-4 x weekly
- ☐ >4 x weekly
- ☐ Age appropriate

Medications
- ☐ Independent
- ☐ Requires setup
- ☐ Administered by others
- ☐ Insulin, set dosage
- ☐ Insulin, sliding scale
- ☐ Frequent lab values

Ambulation
- ☐ Independent
- ☐ Cane
- ☐ Walker
- ☐ Wheelchair
- ☐ Motorized scooter
- ☐ Needs human assistance
- ☐ Transfer assist
- ☐ Restraint used

Behaviors
- ☐ None
- ☐ Requires 24-hour supervision
- ☐ Noncompliant
- ☐ Destructive or disruptive
- ☐ Repetitive movements
- ☐ Antisocial
- ☐ Aggressive or self-injurious
- ☐ Anxiety
- ☐ Depression

Bathing/Grooming
- ☐ Independent
- ☐ Independent with assistive devices
- ☐ Supervision or cueing needed
- ☐ Physical assistance needed

Frequency of needed assistance:
- ☐ 1-2 x weekly
- ☐ 3-4 x weekly
- ☐ >4 x weekly
- ☐ Age appropriate

Skin
- ☐ Intact
- ☐ Ulcer - Stage _____
- ☐ Open wound
- ☐ Daily treatment
- ☐ Treatment as needed

Elimination
- ☐ Continent
- ☐ Bladder incontinence
- ☐ Bowel incontinence
- ☐ Urinary catheter
- ☐ Chronic colostomy/ostomy
- ☐ Chronic nephrostomy
- ☐ Age appropriate
- ☐ Physical assistance needed

Respiratory
- ☐ No issue
- ☐ O2 use daily
- ☐ O2 as needed

Eating
- ☐ Independent
- ☐ Assistive devices
- ☐ Requires human assistance
- ☐ Age appropriate

Additional comments: _____

Signature with title of medical professional completing certification form (MD, DO, PA-C, ARNP):

Nursing Facilities Only

Did the member come to the NF from a recent acute hospital stay? ☐ Yes ☐ No

Member's living situation prior to acute hospitalization:
☐ Own residence ☐ Family/relative home ☐ Other (describe):

Will member be applying for HCBS waiver services? ☐ Yes ☐ No

ICF/ID Facilities Only: To be completed by admitting facility or case manager.

Name of Facility Contact Person	Telephone Number (10 digits)
D&E (preadmission evaluation) date: / /	Date psychological evaluation completed *(must be completed before admission but no more than 3 months prior to admission):* / /
ID diagnosis (mild, moderate, severe) or related condition:	FSIQ Score: _____
Full Name of Diagnosing Psychologist	

Check areas in which the member would benefit from ICF/ID programming/treatment:

☐ Ambulation and mobility	☐ Sensorimotor
☐ Musculoskeletal disabilities/paralysis	☐ Intellectual/vocational/social
☐ Activities of daily living (ADLs)	☐ Maladaptive behaviors
☐ Elimination	☐ Health care
☐ Eating skills	☐ Alternative level of care assessment

Signature with title of person completing ICF/ID information:

Instructions for Level of Care for Facility

Purpose — Form 470-4393, *Level of Care Certification for Facility*, provides a mechanism for a medical professional (MD/DO/ARNP/PA-C) to report level of care needs for a Medicaid member's admission or change in condition for level of care.

Source — This form is available on the HHS website under Provider Forms.

Completion — A provider (MD/DO/ARNP/PA-C) must complete the form when a:

- Medicaid member is going to be admitted to a NF or ICF/ID.
- Medicaid member residing in a NF or ICF/ID has a significant change in condition.

Distribution — Providers fax the certification for level of care form to the Iowa Medical Services Unit (515-725-1349) and provides a copy to the admitting facility.

The form may be faxed by the medical professional completing the form or by others involved in arranging the services (facility staff, hospital discharge planner, case manager or family member). The Iowa Medical Services Unit will make a level of care determination upon receipt of the form.

Data — **Today's Date:** The date the form is completed (MM/DD/YYYY).

Iowa Medicaid Member Name: The Medicaid member's first name, middle initial, and last name as it appears on the eligibility card.

Social Security or State ID #: The member's social security number or state identification number as it appears on the eligibility card.

Birth Date: The Medicaid member's birth date (MM/DD/YYYY) as it appears on the eligibility card.

Medical Professional Section

Name, Telephone Number with Area Code, and Address: Specific information about the medical professional filling out the form.

Admit to: The type of facility, attestation of, and date of discussion about alternatives to facility placement.

Anticipated admission date: The expected or actual date of admission to the facility (MM/DD/YYYY) and anticipated stay.

Facility Information

Facility Name, Address, Telephone and Fax Numbers with Area Code: The facility specific information related to the level of care certification.

ATTACH MEDICATION AND DIAGNOSES LISTS (WITH ICD CODES) SEPARATELY: Provide current medication and diagnoses lists as separate attachments.

Skilled Nursing Needs: Check all boxes that apply to the member regarding skilled nursing needs for therapy, medications, wound care, stoma care, ventilator, tracheostomy care or tube feedings. Also complete functional limitations section below.

Functional Limitations: Check all boxes that apply to the member's functional abilities.

Additional comments: Additional pertinent comments from the medical professional.

Signature with title of medical professional (MD/DO/PA/ARNP) completing the form.

Nursing Facilities Only: Previous hospital placement, previous living situation, and plan for waiver application.

ICF/ID Facilities Only: Facility contact name and telephone number, preadmission evaluation date, ID diagnosis with FSIQ score, full name of diagnosing psychologist. Check all areas in which the member would benefit from ICF/ID admission or subsequent service.

Signature of person completing ICF/ID information.