Iowa Medicaid Enterprise

Certificate of Medical Necessity for Consumer-Directed Attendant Care

Use this form as your cover page. Fax to Medical Services Waiver Prior Authorization 515-725-1388.

(Please print or type clearly – accuracy is important)

Section A

1. Member Name (Last) (First) (Initial)		2. Case Manager Name
3. Medicaid SID #	4. Date of Birth	5. Service Plan Dates Covered by Request

From			To		
Month	Day	Year	Month	Day	Year

6. Name of Item Requested:

7. Type of Review Being Requested:
- ☐ Initial
- ☐ Continued Stay Review (CSR)
- ☐ Revised form
- ☐ Re-review

Remember to attach all documentation.

8. Documentation attached? ☐ Yes ☐ No **(see Section D)**

9. Number of pages including this one:

Section B Answer ALL Questions 1 through 9 for CDAC Services

☐ Yes ☐ No	1. Besides the CDAC provider is there another person who will assist this member with ADL or IADL cares? Outline details in Section C and submit schedule.
☐ Yes ☐ No	2. Does this member live with the CDAC provider? Outline relationship and provide total number of people in household in Section C.
☐ Yes ☐ No	3. Do one or more primary caregivers work outside the home? If yes, list hours worked by caregivers in Section C.
☐ Yes ☐ No	4. Are CDAC hours increased in this service plan? Outline rationale in Section C.
☐ Yes ☐ No	5. Does this member have an identified health, safety, or welfare risk? Outline in Section C.
☐ Yes ☐ No	6. Does this member have an acute condition with expectation to improve in one year? Outline in Section C.
☐ Yes ☐ No	7. Is the CDAC provider assigned to perform skilled services? Provide name and contact information of agency oversight in Section C.
☐ Yes ☐ No	8. Is this member employed? Is the member receiving CDAC services during hours of employment? Outline in Section C.
☐ Yes ☐ No	9. Does this member share residence with another recipient of waiver CDAC services? Does the CDAC provider provide services to more than one member in the household? Are there any services occurring at the same time? Outline in Section C.

Section C Narrative Description Justification Request

Provide specific information and use additional sheet if necessary.

IMPORTANT NOTE: In evaluating requests for prior authorization, the need for treatment or services will be considered from the standpoint of medical necessity only. An approval of this request does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish eligibility at the time of service.

Requesting Case Manager

Signature of TCM/CM/SW Date

Section D Include ALL of the Following Documentation

- Comprehensive functional assessment
- Case manager or social worker service plan
- Home health agency plan of care, if applicable
- List all natural, waiver, and non-waiver support services
- Supported community living providers service plan, if applicable
- HCBS consumer-directed attendant care agreement