Iowa Medicaid Enterprise

Certificate of Medical Necessity for Prevocational Services

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 Prevocational Services

☐ Yes ☐ No	1. Is this member currently receiving prevocational services? If yes, outline history on program in Section C.
☐ Yes ☐ No	2. Has this member ever received sheltered workshop, enclave, or supported employment? If yes, outline history in Section C.
☐ Yes ☐ No	3. Has this member volunteered or had competitive employment? If yes, outline history in Section C.
☐ Yes ☐ No	4. What are the long-term employment goals? Outline in Section C.
☐ Yes ☐ No	5. Have goals been updated or changed in the last 12 months? If yes, outline in Section C.
☐ Yes ☐ No	6. Does the prevocational service plan indicate that the services teach job-ready skills? List the services performed in Section C.
☐ Yes ☐ No	7. Has this member been denied from the Vocational Rehabilitation Division? If yes, enclose denial documentation.
☐ Yes ☐ No	8. If enrolled in school, are programs available through the school that provide the same types of skill development? If yes, outline in Section C.
☐ Yes ☐ No	9. Has progress been made to justify prevocational services? If yes, outline in Section C.

Section C Narrative Description

Justification for 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 management or social worker service plan
- Denial documentation from Division of Vocational Rehabilitation
- Supported employment readiness assessment (prevocational assessment of needs)
- Time study reports for three years for initial reviews or past 12 months for a CSR. If less than requested duration, include all time in prevocational services
- Prevocational goals, objectives, and results for three years for initial reviews or past 12 months for a CSR. If less that requested duration, include all prevocational services
- Prevocational provider's service plan
- Individualized Education Program, if enrolled in school and applicable