Iowa Department of Human Services

Medically Exempt Attestation and Referral Form

Iowa Medicaid must identify individuals who are eligible for enrollment in the Iowa Health and Wellness Plan and who have enhanced medical needs. These individuals are considered 'Medically Exempt' and may be eligible for more benefits by getting coverage under the Medicaid State Plan.

'Medically Exempt' includes individuals who have a:

- Disabling mental disorder (including adults with serious mental illness)
- Chronic substance use disorders
- Serious and complex medical conditions
- Physical, intellectual or developmental disability that significantly impairs their ability to perform 1 or more activities of daily living
- Disability determination based on Social Security criteria.

The table below provides more detailed definitions of the categories of Medically Exempt individuals.

Instructions: If you have a patient that you believe may meet the definition of a Medically Exempt individual, please fill out the information below and complete each question on the form. Incomplete forms will not be accepted. **Please note that you must obtain the individual's (or legal guardian's) written consent before conveying this information to the Medicaid program.**

Member Information

Member Name	Date
Address	
City	State/ZIP
Telephone	Cell Phone
State ID	
Date of Birth	County of Residence

Please complete each question. If the condition does not apply to the individual, please check not applicable at the top of each question. Incomplete forms will not be accepted. Please note, in order to be consider complete, each category must be appropriately marked.	
1. Individuals with disabling mental disorder	**Not Applicable** The member has a diagnosis of at least one of the following: • Psychotic Disorder; • Schizophrenia; • Schizoaffective Disorder; • Major Depression; • Bipolar Disorder; • Delusional Disorder Obsessive-Compulsive Disorder
2. Individuals with chronic substance use disorder **Important Note**: Individual must have a substance use disorder and meet one of the additional criteria. Please check the applicable criteria.	**Not Applicable** Individuals with a chronic substance use disorder: • The member has a diagnosis of substance use disorder, **AND** • The member meets the severe substance abuse disorder level on the • DSM-V Severity Scale by meeting 6 or more diagnostic criteria, **OR** • The member's current condition meets the medically-monitored or medically-managed intensive inpatient criteria of the ASAM criteria. *"DSM-5" means the 5th edition of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association. "ASAM criteria" means the 2013 edition of The ASAM Criteria: Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions published by the American Society of Addiction Medicine.*
3. Individuals with serious and complex medical conditions **Important Note**: If individual has complex medical condition, must check all applicable criteria.	**Not Applicable** • The individual meets criteria for hospice services, **OR** • The individual has a serious and complex medical condition **AND** • The condition significantly impairs the ability to perform one or more activities of daily living (ADLs) **(Go to Box 7 to describe the impairment in ability to perform ADLs).**
4. Individuals with a physical disability **Important Note**: If individual has a physical disability, must check all applicable criteria.	**Not Applicable** • The individual has a physical disability **AND** • The condition significantly impairs the ability to perform one or more activities of daily living (ADLs) **(Go to Box 7 to describe the impairment in ability to perform ADLs).**

5. Individuals with an intellectual or developmental disability **Important Note**: If individual has a developmental disability, must check all applicable criteria.	**Not Applicable** The individual has an intellectual or developmental disability as defined in IAC 441-24.1. This definition means a severe, chronic disability that: • Is attributable to a mental or physical impairment or combination of mental and physical impairments; • Is manifested before the age of 22; Is likely to continue indefinitely; • Results in substantial functional limitations in three or more of the following areas of major life activity: self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, and economic self-sufficiency; **AND** • Reflects the person's need for a combination and sequence of special, interdisciplinary, or generic services, individualized supports, or other forms of assistance that are of lifelong or extended duration and are individually planned and coordinated; **AND** • The condition significantly impairs the ability to perform one or more activities of daily living (ADLs)* (see below for details on ADLs). **(Go to Box 7 to describe the impairment in ability to perform ADLs).**
6. Individuals with a disability determination*	**Not Applicable** ***Do NOT check this box if the individual has applied for, but not yet received a disability determination** The individual has a current disability designation by the Social Security Administration standards.
7. Use the box below to describe the activities of daily living (ADLs) the member needs assistance with and the frequency of that need. (Examples of ADLs may include but are not limited to bathing and showering, bowel and bladder management, dressing, eating, feeding, functional mobility, personal device care, personal hygiene and grooming and/or toilet hygiene.)	

Provider, Worker, or Referring Entity Information

**** To submit this form, you must be a provider with a current National Provider Identified number, an employee of the Department of Human Services, a designee from a mental health region or a designee from the Department of Corrections.***

Provider/Worker/Entity: Agency or Business Name (Please Print)
Provider/Worker/Entity Name: Individual Completing this Referral (Please Print)
Provider NPI#/Worker License and Type
Telephone
Email

Signature and Date (check the statement below):

I certify that by signing this document I understand that any false statement, omission, or misrepresentation may result in prosecution under state and federal laws. I also certify that I have obtained the individual's written consent to provide the Medicaid program this information.

Use the "Submit Referral Form" button above to submit this form electronically. You may also use the methods below to contact the Iowa Medicaid Enterprise regarding this form.

Telephone Toll Free – (800) 338-8366 In Des Moines (515) 256-4606	**Mail** Iowa Medicaid Enterprise Member Services (Attn: Medically Exempt) PO Box 36510 Des Moines, IA 50315
Fax (515) 725-1351	**Email** IMEMemberServices@dhs.state.ia.us
Website www.dhs.iowa.gov	