Iowa Department of Human Services
Iowa Medicaid Enterprise (IME)

# Instructions for Form 470-5422
# Intermediate Care Facilities for Individuals with an Intellectual Disability Calculation Worksheet

For all intermediate care facilities for persons with an intellectual disability (ICFs/ID) licensed in Iowa under 481 IAC Chapter 64, including facilities not certified to participate in the Medicaid program, shall pay a quarterly assessment to the Department, as determined under this division.

## Provider Name and Identification Data

*NPI Number*. Report the entity's National Provider ID (NPI). It is very important that this number corresponds to those on file with the IME Provider Services department so that your entity can be correctly identified and the fee be attributed to your facility.

**If multiple sites are included under one umbrella NPI, please provide a listing of all sites covered by the worksheet.**

*Facility Name and Address*. Indicate the exact name of the facility as it appears on the state license. The physical address must be completed.

**If multiple sites are included under one form, please provide the name and address of the overall entity.**

*Federal ID Number*: Enter your federal nine digit taxpayer identification number used for submitting your tax returns to the Internal Revenue Service as XXXXXXXXX.

**If multiple sites are included under one form, please provide the Federal ID of the overall entity.**

## Quarter of Report

Check the box to the left of the quarter dates for this report.

## Revenue Information

For each line A through F, please report the amount of funds received for ICF/ID routine services from the named entity. The amount of revenue should include, but is not limited to, funds paid by Medicaid Managed Care, Medicaid fee-for-service, and client participation. The only source of revenue not subject to the fee is that from Medicare. The revenue should be what was received during the period, regardless of the dates of service.

## Calculation of Assessment Amount

*H. Revenue for calculation*: Report the sum of the revenue from all sources above.

**Note:** This field will automatically calculate based on information provided in the **Revenue Information** section.

*I. Assessment percentage:* Per 441 Iowa Administrative Code Chapter 36, the percentage is 5.5%.

*J. Total assessment owed to Iowa Medicaid:* The assessment amount owed is the product of total revenue from H and the assessment percentage from I.

**Note:** This field will automatically calculate based on information provided in H and I above.

**This form and a check for the total quality assurance assessment owed are due no later than 30 days after quarter end.**

Completed forms should be submitted to the following address:

Iowa Medicaid Enterprise
PO Box 36450
Des Moines, IA 50315

An electronic copy of the **form only** should be submitted to costaudit@dhs.state.ia.us.

If a package is sent requiring a signature (i.e., certified mail or overnight), send to:

Iowa Medicaid Enterprise
100 Army Post Road
Des Moines, IA 50315

Facilities whose form is received after 30 days from the end of the quarter will be required to pay a penalty in the amount of 1.5% of the quality assurance assessment owed for each month or portion of a month the payment is overdue.

Questions concerning this form should be addressed to Provider Cost Audit at 1-866-863-8610, or (515) 256-4610, or to costaudit@dhs.state.ia.us.

## Certification Statement

After adequate review of the completed form, the certification statement must be signed by a responsible person having authorization from the controlling body (board, owner, etc.) of the facility to make such representations. The certification statement submitted must contain **original signatures**.

# Intermediate Care Facilities for Individuals with an Intellectual Disability Calculation Worksheet

This form should be completed by intermediate care facilities for individuals with an intellectual disability licensed under Iowa Code 135C.1.

## Provider Name and Identification Data

| NPI Number | Federal ID Number | | |
|---|---|---|---|
| Name of Entity | | | |
| Physical Address: Street | City | State | Zip Code |

## Quarter of Report

☐ July 1 through September 30
☐ October 1 through December 31
☐ January 1 through March 31
☐ April 1 through June 30

## Revenue Information (all ICF/ID revenue regardless of payer)

| | Total |
|---|---|
| A. Amount received from Amerigroup Iowa | $ |
| B. Amount received from AmeriHealth Caritas Iowa | $ |
| C. Amount received from UnitedHealthcare Plan of the River Valley | $ |
| D. Amount received from individuals for client participation | $ |
| E. Amount received from Medicaid Fee-for-Service | $ |
| F. Amount received from private pay individuals and private insurance companies | $ |
| G. Amount received from other sources | $ |

## Calculation of Assessment Amount

| | | |
|---|---|---|
| H. | Revenue for calculation (sum of A through G from above) | $ 0.00 |
| I. | Assessment percentage | 5.5% |
| J. | Total assessment owed to Iowa Medicaid (H * I) | $ 0.00 |

**This form and check are due no later than 30 days after the quarter end.**

Make check payable and mail to: Iowa Medicaid Enterprise
PO Box 36450
Des Moines, IA 50315

## Certification Statement

I certify that to the best of my knowledge and belief the information taken from the records of the provider is true, accurate, complete, and verifiable. I understand that this information is submitted for the purpose of calculating the assessment for intermediate care facilities for individuals with an intellectual disability, and the ultimate collection of the assessment will be based upon the information contained herein. I understand that any person that submits false, misleading, or incomplete information, responses, or representations may be subject to criminal, civil, or administrative liability under applicable federal or state law. Declaration of preparer is based on all information of which the preparer has any knowledge.

| Name of Authorized Person | Title/Position | Telephone Number |
|---|---|---|
| Signature of Authorized Person | Date | Address of Authorized Person |
| Name of Preparer | Title/Position | Telephone Number of Preparer |
| Signature of Preparer | Date | Address of Preparer |