Iowa Department of Human Services

Certificate of Medical Necessity for Health and Disability Waiver Cap Increase

Use this form as your cover page. Submit to Medical Services Waiver Prior Authorization via the Iowa Medicaid Portal Access (IMPA) System.
(Please print or type clearly – accuracy is important)

Section A	
Member Name (Last, First, Middle Initial)	
Case Manager Name (Last, First, Middle Initial)	
Member State ID (SID)	**Date of Birth**
Service Plan Dates Covered by Request	
From: (Day/Month/Year)	**To: (Day/Month/Year)**
Attach All Relevant Documentation	
Are Documents Attached?	☐ Yes ☐ No
Number of Pages Including This One	
Type of Review Being Requested	
☐ Initial (Age 21) ☐ Age 22 ☐ Age 23 ☐ Age 24	

Section B – Answer All Questions for Health and Disability Waiver Cap Increase	
☐ Yes ☐ No	In addition to the skilled nursing and/or home health aide provider is there another person who will assist this member with their cares? Outline details in Section C and submit schedule.
☐ Yes ☐ No	Do one or more primary caregivers work outside the home? If yes, list hours worked by caregivers in Section C.
☐ Yes ☐ No	Does this member have an identified health, safety, or welfare risk? Outline in Section C.
☐ Yes ☐ No	Since the last review, has the member acquired any acute conditions that require additional supports? Outline in Section C.
☐ Yes ☐ No	Provide the name and contact information of agency oversight in Section C.

Section C – Narrative Description Justification Request

Provide specific information ***(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 Targeted Case Manager (TCM), Case Manager(CM), Social Worker (SW)

Signature of TCM/CM/SW	**Date**

Section D – Include All of the Following Documentations

- **Comprehensive functional assessment**
- **Case manager or social worker service plan**
- **Home health agency plan of care**
- **One month of service documentation notes**
- **Schedule of service delivery of all services received**
- **List all natural, waiver, and non-waiver support services**