# Community-Based Neurobehavioral Rehabilitation Services (CNRS) Provider Quality Self-Assessment

**2025 Edition**

## Instructions

This form is required for organizations enrolled to provide Community-Based Neurobehavioral Rehabilitation Services (CNRS) services.

The CNRS Provider Quality Self-Assessment form is a fillable PDF and the form must remain in that format upon submission. It includes an electronic signature attesting that the information submitted is true, accurate, complete, and verifiable. Organizations are responsible for ensuring signatory authority. The annual CNRS Provider Quality Self-Assessment training and corresponding Frequently Asked Questions (FAQ) addresses some common problems with completing and submitting the self-assessment and can be found at https://hhs.iowa.gov/programs/welcome-iowa-medicaid/iowa-medicaid-programs/hcbs.

Each organization is required to submit an acceptable self-assessment by a designated due date each year. Failure to submit a complete and accurate self-assessment by the designated due date will result in a referral to Iowa Medicaid's Program Integrity Unit for appropriate action, which may include sanctions and disenrollment from Iowa Medicaid.

Below is a brief explanation of each section of the CNRS Provider Quality Self-Assessment form. For full instructions, troubleshooting tips, and training on the annual CNRS Provider Quality Self-Assessment, please follow the links above.

1. **Organizational Details**. Identifies the organization submitting the forms.
2. **Service Locations**. Identifies the locations where your organization provides CNRS.
3. **Self-Assessment Questionnaire**. Provides an outline of all basic standards required by law, rule, industry standards, or best practice. You should read each standard, consider your organization's current situation, and select the most appropriate response.

Selecting **Yes** means your organization meets the standards and would be able to provide verifiable evidence of meeting the standard. You may meet the standard because you are required to by law or rule, organization policy or because your organization does so as best practice or because you are required to by another oversight entity outside of Iowa Medicaid.

Selecting **No** means your organization does not meet the standard but is required to by law, rule, or organization policy or the standard is otherwise necessary for the services your organization is enrolled to provide. If you select No, you must provide a response in the designated box describing your plan to meet the standard(s). A plan is sometimes also known as a "remediation plan", corrective action plan, or "CAP". It describes what the organization will do correct the problem with specific timelines for achieving compliance.

Selecting **NA** means the standard is not required by law, rule, or organization policy and is not otherwise necessary for the services your organization is enrolled to provide.

At the end of each topic, there is an opportunity for your organization to highlight how you meet or exceed the requirements.

4. **Guarantee of Accuracy**. Identifies your organization's pertinent certifications, accreditations, and licensures. The Guarantee of Accuracy also requires your organization to attest that the information and responses are true, accurate, complete, and verifiable.

Questions should be directed to the HCBS Specialist assigned to the county where the parent organization is located. For a complete list of Quality Improvement Organization (QIO) HCBS Quality Oversight Unit contacts and a list of HCBS Specialists by region, please see https://hhs.iowa.gov/programs/welcome-iowa-medicaid/iowa-medicaid-programs/hcbs.

## Links and Resources

- Department of Inspections, Appeals, and Licensing (DIAL) Website, https://dial.iowa.gov
- Iowa Department of Health and Human Services (HHS) Website, https://hhs.iowa.gov
- Brain Injury Rehabilitation Webpage, https://hhs.iowa.gov/medicaid/services-care/brain-injury-rehabilitation
- Provider Services and Provider Enrollment Webpage, https://hhs.iowa.gov/programs/welcome-iowa-medicaid/provider-services/provider-enrollment
- Competency-Based Training (CBT) and Technical Assistance for Long-Term Services and Supports (LTSS) Webpage, https://hhs.iowa.gov/programs/welcome-iowa-medicaid/provider-services/provider-trainings/cbt
- Informational Letters (ILs), https://secureapp.dhs.state.ia.us/impa/Information/Bulletins.aspx
- Iowa Administrative Code and Rules (IAC), https://www.legis.iowa.gov/law/administrativeRules/agencies
- Iowa Code (IC), https://www.legis.iowa.gov/law/statutory
- Code of Federal Regulations (CFR), https://www.ecfr.gov

## 1. Organization Details

Please identify your parent organization by providing the following information using the text entry fields below.

<table>
<tr><td colspan="6">Tax Identification Number (TIN) (9 digits):</td></tr>
<tr><td colspan="6">Associated NPI (list all):</td></tr>
<tr><td colspan="6">Organization Name (as registered with Iowa Medicaid):</td></tr>
<tr><td colspan="3">Mailing Address:</td><td colspan="3">Physical Address:</td></tr>
<tr><td>City:</td><td>State:</td><td>Zip:</td><td>City:</td><td>State:</td><td>Zip:</td></tr>
<tr><td colspan="3">County:</td><td colspan="3">County:</td></tr>
<tr><td colspan="3">Executive Director/Administrator:</td><td colspan="3">Title:</td></tr>
<tr><td colspan="3">Email:</td><td colspan="3">Telephone:</td></tr>
<tr><td colspan="3">Self-Assessment Contact:</td><td colspan="3">Title:</td></tr>
<tr><td colspan="3">Email:</td><td colspan="3">Telephone:</td></tr>
<tr><td colspan="6">Organization Website:</td></tr>
</table>

## 2. Service Locations

Complete the fields below to identify each location where your organization provides CNRS.

**If CNRS is provided at the location listed in section 1, include it again in section 2.**

☐ Check this box if organization has more than 9 service locations. If checked, leave section 2. blank. An HCBS Specialist will contact you with an additional document to complete.

| | Location 1 | Location 2 | Location 3 |
|---|---|---|---|
| Location Name | | | |
| Location Address | | | |
| City | | | |
| State | | | |
| NPI-Legacy Number | | | |
| Director/Administrator, Credentials | | | |
| | **Location 4** | **Location 5** | **Location 6** |
| Location Name | | | |
| Location Address | | | |
| City | | | |
| State | | | |
| NPI-Legacy Number | | | |
| Director/Administrator, Credentials | | | |
| | **Location 7** | **Location 8** | **Location 9** |
| Location Name | | | |
| Location Address | | | |
| City | | | |
| State | | | |
| NPI-Legacy Number | | | |
| Director/Administrator, Credentials | | | |

## 3. Self-Assessment Questionnaire

### A. Organizational Standards

**To provide quality services to members, organizations must have sound administrative and organizational practices and a high degree of accountability and integrity.**

**Organizations should have a planned, systematic, organization-wide approach to designing, measuring, evaluating, and improving its level of performance.**

**Use this section to tell us what your organization has in place, or is working to put in place, as it relates to basic standards required by law, rule, industry standards, or best practice.**

#### 1. Purpose and Mission

**Does your organization…**

| | |
|---|---|
| a) Have a mission statement that aligns with the needs, ability, and desires of the members served? | ☐ Yes ☐ No ☐ NA |
| If indicating "No", you must describe a plan to meet the standard(s). Attach additional information as necessary. | |

#### 2. Fiscal Accountability

**Does your organization…**

| | |
|---|---|
| a) Ensure fiscal stability and accountability? | ☐ Yes ☐ No ☐ NA |
| b) Maintain fiscal and corresponding clinical records for a minimum of five years after the date of the last claim? | ☐ Yes ☐ No ☐ NA |
| If indicating "No", you must describe a plan to meet the standard(s). Attach additional information as necessary. | |

#### 3. Organizational Oversight

**Does your organization…**

| | |
|---|---|
| a) Have a committee, board, or advisory board to oversee operations? | ☐ Yes ☐ No ☐ NA |
| b) Ensure the committee, board or advisory board receives and uses input from local community stakeholders, employees and members participating in services? | ☐ Yes ☐ No ☐ NA |
| c) Maintain committee or board meeting minutes to demonstrate oversight and active engagement in the organization? | ☐ Yes ☐ No ☐ NA |

| If indicating “No”, you must describe a plan to meet the standard(s). Attach additional information as necessary. | |
|---|---|
| **4. Quality Improvement (QI) Processes**<br>**Does your organization…** | |
| a) Have an established systematic, organization-wide, planned approach to designing, measuring, evaluating, and improving the level of its performance, including the efficiency and effectiveness of service provision? | ☐ Yes<br>☐ No<br>☐ NA |
| b) Ensure results of satisfaction or experience surveys are shared with the public? | ☐ Yes<br>☐ No<br>☐ NA |
| c) Ensure QI activity reports and results are shared with the committee, board, or advisory board at least annually. | ☐ Yes<br>☐ No<br>☐ NA |
| **Does the QI process include…** | |
| d) Discovery (collection and review) of the following minimum information and data topics?<br>▪ Members’ preadmission location of service<br>▪ Members’ length of stay<br>▪ Discharge location<br>▪ Reason for discharge<br>▪ Access to services<br>▪ Incident data<br>▪ Quarterly review of organizational activities and services<br>▪ Satisfaction and experiences with services with members, caregivers or involved family of members, employees, and other stakeholders<br>▪ Review of records at regular intervals to include service documentation, medication records, incident reports, abuse reports, appeals and grievances, and personnel records | ☐ Yes<br>☐ No<br>☐ NA |
| e) Remediation of areas found through the QI process to be in need of improvement? | ☐ Yes<br>☐ No<br>☐ NA |
| f) Improvement, meaning the demonstration of outcomes of discovery and remediation? | ☐ Yes<br>☐ No<br>☐ NA |

If indicating “No”, you must describe a plan to meet the standard(s). Attach additional information as necessary.

Is there anything else you would like to highlight about your organization that would demonstrate how you exceed the basic requirements outlined under organizational standards?

## B. Personnel and Training

**Organizations must have qualified employees and contractors commensurate with the needs of the members served and requirements for the employee’s or contractor’s position.**

**Employees and contractors should be competent to perform duties and interact with members.**

**Use this section to tell us what your organization has in place or is working to put in place related to personnel and training standards required by law, rule, industry standards, or best practice.**

### 1. Employee Screening and Evaluation

**Does your organization…**

| | |
|---|---|
| a) Complete child and dependent adult abuse background checks prior to hiring an applicant or potential contractor? | ☐ Yes ☐ No ☐ NA |
| b) Complete state and federal criminal background checks prior to hiring an applicant or potential contractor? | ☐ Yes ☐ No ☐ NA |
| c) Solicit an evaluation and follow recommendations for hire when a hit is found on a background check? | ☐ Yes ☐ No ☐ NA |
| d) Complete checks of sex offender registries prior to hiring an applicant or potential contractor? | ☐ Yes ☐ No ☐ NA |
| e) Screen applicants and potential contractors for exclusion from participation in federal insurance programs prior to hire? | ☐ Yes ☐ No ☐ NA |
| f) Ensure employees and contractors are minimally qualified by age, education, certification, experience, and training required or recommended for CNRS? | ☐ Yes ☐ No ☐ NA |
| g) Ensure employees and contractors have valid drivers’ licenses as required for the services provided? | ☐ Yes ☐ No ☐ NA |

| | |
|---|---|
| h) Ensure employees and contractors have adequate vehicle insurance as applicable for the services provided? | ☐ Yes ☐ No ☐ NA |
| i) Complete performance evaluations at least annually to ensure employees and contractors are competent to perform duties and interact with members? | ☐ Yes ☐ No ☐ NA |
| If indicating "No", you must describe a plan to meet the standard(s). Attach additional information as necessary. | |

## 2. Training and Qualifications

**Does your organization train employees and contractors on the following required or recommended topics within the identified timeframes?**

| | |
|---|---|
| a) Prior to the commencement of direct service provision: | |
| 1) The designated Traumatic Brain Injury Training (modules 1-2) | ☐ Yes ☐ No ☐ NA |
| 2) Members' rights | ☐ Yes ☐ No ☐ NA |
| 3) Confidentiality and privacy | ☐ Yes ☐ No ☐ NA |
| 4) Individualized rehabilitation treatment plans | ☐ Yes ☐ No ☐ NA |
| 5) Major mental health disorder basics | ☐ Yes ☐ No ☐ NA |
| b) Within 30 days of the commencement of direct service provision: | |
| 1) Cardiopulmonary resuscitation (CPR) | ☐ Yes ☐ No ☐ NA |
| 2) First-aid | ☐ Yes ☐ No ☐ NA |
| 3) Fire prevention and reaction | ☐ Yes ☐ No ☐ NA |
| 4) Universal precautions | ☐ Yes ☐ No ☐ NA |

| | |
|---|---|
| 5) The organization's policy related to identifying and reporting abuse | ☐ Yes<br>☐ No<br>☐ NA |
| c) Within the first 6 months of the commencement of direct service provision: | |
| 1) The promotion of a program structure and support for persons served so they can relearn or regain skills for community inclusion and access | ☐ Yes<br>☐ No<br>☐ NA |
| 2) Compensatory strategies to assist in managing ADL's (activities of daily living) | ☐ Yes<br>☐ No<br>☐ NA |
| 3) Quality of life issues | ☐ Yes<br>☐ No<br>☐ NA |
| 4) Behavioral supports and identification of antecedent triggers | ☐ Yes<br>☐ No<br>☐ NA |
| 5) Health and medication management | ☐ Yes<br>☐ No<br>☐ NA |
| 6) Dietary and nutritional programming | ☐ Yes<br>☐ No<br>☐ NA |
| 7) Assistance with identifying and utilizing assistive technology | ☐ Yes<br>☐ No<br>☐ NA |
| 8) Substance abuse and addiction issues | ☐ Yes<br>☐ No<br>☐ NA |
| 9) Self-management and self-interaction skills | ☐ Yes<br>☐ No<br>☐ NA |
| 10) Flexibility in programming to meet members' individual needs | ☐ Yes<br>☐ No<br>☐ NA |
| 11) Teaching adaptive and compensatory strategies to address cognitive, behavioral, physical, psychosocial, and medical needs | ☐ Yes<br>☐ No<br>☐ NA |
| 12) Community accessibility and safety | ☐ Yes<br>☐ No<br>☐ NA |

| | |
|---|---|
| 13) Household maintenance | ☐ Yes<br>☐ No<br>☐ NA |
| 14) Support to the member's family or support system related to the member's neurobehavioral care | ☐ Yes<br>☐ No<br>☐ NA |
| 15) The designated Child and/or Dependent Adult Abuse and Mandatory Reporting training (within 6 months of hire or by having proof of the completion of the training prior to hire) | ☐ Yes<br>☐ No<br>☐ NA |
| d) Within12 months of the commencement of direct service provision: | |
| 1) An approved, nationally recognized certified brain injury specialist training | ☐ Yes<br>☐ No<br>☐ NA |
| e) Annually or as otherwise required: | |
| 1) Fire prevention and reaction | ☐ Yes<br>☐ No<br>☐ NA |
| 2) Universal precautions | ☐ Yes<br>☐ No<br>☐ NA |
| 3) Cardiopulmonary resuscitation (CPR) (prior to expiration of the certification) | ☐ Yes<br>☐ No<br>☐ NA |
| 4) First-aid | ☐ Yes<br>☐ No<br>☐ NA |
| 5) The designated Child and/or Dependent Adult Abuse and Mandatory Reporting additional training at least every 3 years after the initial training | ☐ Yes<br>☐ No<br>☐ NA |
| f) Does the organization ensure that the program administrator is a Certified Brain Injury Specialist Trainer (CBIST) through the Academy of Certified Brain Injury Specialists or a certified brain injury specialist under the direct supervision of a CBIST or a qualified brain injury professional as defined in rule 441 IAC 83.81(249A) with additional certification as approved by the department? | ☐ Yes<br>☐ No<br>☐ NA |

| | |
|---|---|
| g) Does the organization ensure that a minimum of 75% of the organization's administrative and direct care personnel:<br>▪ have a bachelor's degree in human services-related field; or<br>▪ have an associate degree in human services with two years of experience working with individuals with brain injury; or<br>▪ are in the process of seeking a degree in the human services field with two years of experience working with individuals with brain injury; or<br>▪ are a certified brain injury specialist or have other brain injury certification as approved by the department. | ☐ Yes<br>☐ No<br>☐ NA |
| If indicating "No", you must describe a plan to meet the standard(s). Attach additional information as necessary. | |
| Is there anything else you would like to highlight about your organization that would demonstrate how you exceed the basic requirements outlined under personnel and training? | |

## C. Policies and Procedures

Organizations should have a core set of policies and procedures based on the services for which they are enrolled to provide. The policies and procedures are the foundation of an organization's performance and guide them in the provision of services.

Policies and procedures should outline the organization's day-to-day operations, ensure compliance with laws and regulations, and give guidance to staff. Organizations must carry out their policies and procedures so that members receive fair, equal, consistent, and positive service experiences.

Use this section to tell us what your organization has in place or is working to put in place related to topics listed below required by law, rule, industry standards, or best practice.

### 1. Incidents and Incident Reporting

| | |
|---|---|
| a) Does your organization have written policies or procedures related to recognizing and reporting major and minor incidents in accordance with applicable IAC? | ☐ Yes<br>☐ No<br>☐ NA |
| b) Does your organization maintain evidence incidents are reported according to the policy? | ☐ Yes<br>☐ No<br>☐ NA |
| c) Does your organization track and analyze data at least annually, related to incidents and unexpected occurrences involving death, serious physical or psychological injury, or the risk thereof to identify trends and to ensure the health and safety of members? | ☐ Yes<br>☐ No<br>☐ NA |

| | |
|---|---|
| If indicating “No”, you must describe a plan to meet the standard(s). Attach additional information as necessary. | |
| **2. Appeals and Grievances** | |
| a) Does your organization have written policies and procedures related to filing and resolving appeals and grievances? | ☐ Yes ☐ No ☐ NA |
| b) Does your organization maintain evidence that you followed your written policies and procedures related to appeals and grievances? | ☐ Yes ☐ No ☐ NA |
| c) Does your organization ensure that members or their legal representatives receive information about the organization’s appeals and grievance processes at admission and annually thereafter? | ☐ Yes ☐ No ☐ NA |
| If indicating “No”, you must describe a plan to meet the standard(s). Attach additional information as necessary. | |
| **3. Treatment Planning** | |
| a) Does your organization have written policies and procedures related to treatment planning? | ☐ Yes ☐ No ☐ NA |
| b) Does your organization ensure that treatment plans: | |
| 1) Are individualized and mutually developed by the member and the member’s treatment team? | ☐ Yes ☐ No ☐ NA |
| 2) Include the member’s strengths, barriers, and interests? | ☐ Yes ☐ No ☐ NA |
| 3) Include goals which are based on the member’s need for services? | ☐ Yes ☐ No ☐ NA |
| 4) Include neurobehavioral challenges and environmental needs as identified in the member’s individual standardized comprehensive functional neurobehavioral assessment? | ☐ Yes ☐ No ☐ NA |
| 5) Are evaluated by the member and the member’s treatment team for progress towards treatment goals regularly and no less than quarterly? | ☐ Yes ☐ No ☐ NA |
| 6) Are revised as the member’s status or needs change to reflect the member’s progress and response to treatment? | ☐ Yes ☐ No ☐ NA |

| | |
|---|---|
| 7) Are submitted to Iowa Medicaid for approval within 30 days of admission (initial plan only)? | ☐ Yes<br>☐ No<br>☐ NA |
| 8) Do not exceed 180 days? | ☐ Yes<br>☐ No<br>☐ NA |
| If indicating “No”, you must describe a plan to meet the standard(s). Attach additional information as necessary. | |
| **4. Restrictive Interventions** | |
| a) Does your organization have written policies and procedures related to the use of restrictive interventions, specifically restraints, rights restrictions, crisis intervention and behavioral intervention in accordance with applicable IAC? | ☐ Yes<br>☐ No<br>☐ NA |
| b) If your organization allows for the use of physical holds, restraints, or other physical intervention techniques, do policies and procedures governing their use include all the following?<br>▪ Definitions of the use of physical restraint such as the specific types of interventions allowed and specific circumstances when physical intervention may be used.<br>▪ Designation of and qualifications and special training required for staff who may authorize or administer restraints.<br>▪ A description of methods used to monitor and control the use of restraints. | ☐ Yes<br>☐ No<br>☐ NA |
| c) Are restrictive interventions implemented in accordance with applicable IAC which requires that members always receive kind and considerate care and are free from mental, physical, sexual, and verbal abuse, exploitation, neglect, and physical injury? | ☐ Yes<br>☐ No<br>☐ NA |
| d) When a physical restraint is used, is it documented including all the following information?<br>▪ A general description of the circumstances leading to the use of the restraint and what happened during and after the use of the physical restraint.<br>▪ Rationale for the use of the restraint.<br>▪ A description from the responsible staff of the staff’s actions and procedures used to protect the member’s rights and ensure safety.<br>▪ Identification of who authorized the restraint.<br>▪ Identification of when the use of the restraint was authorized (i.e., prior to or immediately after). | ☐ Yes<br>☐ No<br>☐ NA |

| | |
|---|---|
| e) Does your organization ensure that the member's primary care provider, Interdisciplinary Team (IDT), and the member's responsible party are notified when a physical restraint is used? | ☐ Yes ☐ No ☐ NA |
| f) Does your organization ensure that members or their responsible parties are provided informed consent for any restrictive interventions that may be required to protect the health and safety of the member? | ☐ Yes ☐ No ☐ NA |
| If indicating "No", you must describe a plan to meet the standard(s). Attach additional information as necessary. | |
| **5. Members' Rights and Responsibilities** | |
| a) Does the organization have written policies and procedures related to member rights and responsibilities? | ☐ Yes ☐ No ☐ NA |
| b) Does the policy address the member's right to be fully informed of their rights and responsibilities as a resident and of all rules governing their conduct and responsibilities? | ☐ Yes ☐ No ☐ NA |
| c) Are member rights and responsibilities communicated in writing within 5 days of admission member and staff expectations. | ☐ Yes ☐ No ☐ NA |
| d) Are member rights and responsibilities presented in a language understandable to the individual member? | ☐ Yes ☐ No ☐ NA |
| e) Are members made aware of their rights with 5 days of admission and within 30 days of changes to the written rights and responsibilities?<br>**(A statement must be signed by the member or the member's responsible party and maintained in the member's record indicating an understanding of rights and responsibilities.)** | ☐ Yes ☐ No ☐ NA |
| f) Is the list of member's rights prominently posted in written format, in a location that is available to all members? | ☐ Yes ☐ No ☐ NA |
| If indicating "No", you must describe a plan to meet the standard(s). Attach additional information as necessary. | |
| **6. Documentation of Services** | |
| a) Does your organization have written policies and procedures related to service documentation? | ☐ Yes ☐ No ☐ NA |
| b) Does service documentation identify the specific service(s) being provided? | ☐ Yes ☐ No ☐ NA |

| | |
|---|---|
| c) Does service documentation identify the member receiving the service(s), including the first and last name? | ☐ Yes ☐ No ☐ NA |
| d) Is the complete date and time of the service documented, including the beginning and ending time and beginning and ending date if the service(s) is rendered over more than one day? | ☐ Yes ☐ No ☐ NA |
| e) Is the location where the service(s) was provided documented as applicable? | ☐ Yes ☐ No ☐ NA |
| f) When transportation is provided as part of the service(s), is the name, date, purpose of the trip, and total miles documented? | ☐ Yes ☐ No ☐ NA |
| g) Are incidents, illnesses, unusual or atypical occurrences that occur during service provision documented when applicable? | ☐ Yes ☐ No ☐ NA |
| h) When medication is administered or supplies are dispensed as part of the service(s), is the name, dosage, and route of administration documented? | ☐ Yes ☐ No ☐ NA |
| i) Does service documentation legibly identify the person providing the service(s) including first and last name, any applicable credentials and signature or initials if verifiable to a signature log? | ☐ Yes ☐ No ☐ NA |
| j) Does the service documentation demonstrate that the service is provided as defined and authorized? | ☐ Yes ☐ No ☐ NA |
| k) Does service documentation for each service provide information necessary to substantiate that the service was provided? | ☐ Yes ☐ No ☐ NA |
| If indicating “No”, you must describe a plan to meet the standard(s). Attach additional information as necessary. | |

## 7. Member Outcomes

| | |
|---|---|
| a) Does the organization have written policies and procedures related to outcome- based standards? | ☐ Yes ☐ No ☐ NA |
| b) Does the organization maintain evidence that members are valued? | ☐ Yes ☐ No ☐ NA |
| c) Do members or their responsible party provide consent regarding which personal information is shared and with whom? | ☐ Yes ☐ No ☐ NA |

| | |
|---|---|
| d) Does the organization maintain evidence that members receive assistance with accessing financial management services as needed? | ☐ Yes ☐ No ☐ NA |
| e) Does the organization maintain evidence that members receive assistance with obtaining preventative, appropriate, and timely medical and dental care? | ☐ Yes ☐ No ☐ NA |
| f) Does the organization maintain evidence that the members' living environment is reasonably safe and located in the community? | ☐ Yes ☐ No ☐ NA |
| g) Does the organization maintain evidence that each member's desire for intimacy is respected and supported? | ☐ Yes ☐ No ☐ NA |
| If indicating "No", you must describe a plan to meet the standard(s). Attach additional information as necessary. | |
| Is there anything else you would like to highlight about your organization that would demonstrate how you exceed the basic requirements outlined under policies and procedures? | |

## 4. Guarantee of Accuracy

In submitting this CNRS Provider Quality Self-Assessment and signing this Guarantee of Accuracy, the organization and all signatories jointly and severally certify that the information and responses contained within are true, accurate, complete, and verifiable. Further, the organization and all signatories each acknowledge (1) familiarity with the laws and regulations governing the Iowa Medicaid program; (2) the responsibility to request technical assistance from the appropriate HCBS Specialist in order to achieve compliance with the standards listed within this assessment; (3) the Department, or an authorized representative, may conduct desk or on-site reviews on a periodic basis, as initiated by random sampling or as a result of a complaint.

**NOTICE: Any person that submits a false statement, response, or representation; or any false, incomplete, or misleading information, may be subject to criminal, civil, or administrative liability.**

Identify the licensure or accreditation held for each location. Include only those which qualify your agency to provide CNRS including the start and end dates of each.

| Location | Accreditation/Licensure | Start Date | End Date |
|---|---|---|---|
| **1.** | | | |
| **2.** | | | |
| **3.** | | | |
| **4.** | | | |
| **5.** | | | |
| **6.** | | | |
| **7.** | | | |
| **8.** | | | |
| **9.** | | | |

Is your organization in good standing with the identified accreditation or licensing entity?

☐ Yes ☐ No

**If your organization received less than the maximum level of accreditation or licensure with the identified accreditation or licensing entity, you must also provide the review results and any remediation plans when submitting this CNRS Provider Quality Self-Assessment.**

| Printed Name of Organization | Printed Name of Executive Director |
|---|---|
| Printed Signature* of Executive Director | Date |

***By typing my name, I am electronically signing this document in accordance with Iowa Code Chapter 554D.**