



Home- and Community-Based Services (HCBS) Consumer-Directed Attendant Care (CDAC) Agreement

This is an agreement between a member of services under a Medicaid HCBS waiver and a CDAC provider.

Name of Member:	Name of CDAC Provider:
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The Iowa Medicaid program will reimburse for CDAC services provided under this agreement when CDAC is part of the member's comprehensive service plan and the DHS service worker or case manager has determined that the prior training and experience of the CDAC provider are sufficient to meet the member's needs noted in this agreement. However, the member agrees not to hold the service worker or case manager responsible for any problems resulting from any deficiency in the provider's training or experience. The CDAC provider must report any health, safety or welfare concerns to the DHS service worker or case manager.

Instructions

The member or the member's legal representative must complete this form by entering information describing how the CDAC provider will meet the standards and responsibilities and the agreed-upon rate of payment. **Before the CDAC provider begins providing the CDAC service and receives payment, all the following must occur:**

1. The member and/or the member's legal representative, and the CDAC provider will decide which services are needed, the number of units to be provided, and the rate of payment to the CDAC provider.
2. This CDAC agreement must be filled out completely and signed by both the member or member's legal representative, service worker/case manager and the CDAC provider to show they approve all the information in the agreement and shall abide by all requirements in the agreement.
3. The original copy of the CDAC agreement is kept by the service worker/case manager and attached to the comprehensive service plan. A copy of the CDAC agreement must be given to and maintained by the member, the member's legal representative if applicable, the CDAC provider, and to the nurse or therapist supervising the provision of skilled services, if any.
4. The service worker/case manager shall distribute a Notice of Decision to the member, the member's legal representative if applicable, and the CDAC provider showing that the service worker/case manager has approved the CDAC services, the CDAC provider, the number of approved units, and the rate of payment.

Member Name:

5. The CDAC provider must provide only the CDAC services as described in the CDAC agreement and approved in the service worker/case manager's comprehensive service plan. The CDAC provider must document the CDAC activities performed on the designated clinical/medical record form 470-4389 for each unit of service prior to submitting a claim for payment. The record must show that the service is necessary due to the member's complaint, needs or goals as reflected in the comprehensive service plan. The record must state the CDAC provider's specific actions or activities and the member's response to the services rendered, including any observed changes in the member's physical or mental health, mood or behavior.
6. The CDAC provider cannot disclose protected health information (PHI). The HIPAA Privacy Rule protects all "individually identifiable health information" held or transmitted by a covered entity or its business associate, in any form or media, whether electronic, paper, or oral. "Individually identifiable health information" is information, including demographic data, that relates to:
 - The individual's past, present or future physical or mental health or condition,
 - The provision of health care to the individual, or
 - The past, present, or future payment for the provision of health care to the individual, and
 - That identifies the individual or for which there is a reasonable basis to believe can be used to identify the individual.

Individually identifiable health information includes many common identifiers (e.g., name, address, birth date, Social Security Number). Civil and criminal penalties may be imposed for failure to comply with the Privacy Rule. Civil penalties of \$100 per incident, not to exceed \$25,000 per year for multiple violations of the identical Privacy Rule requirement in a calendar year. Criminal penalties with fines of \$50,000 and up to one-year imprisonment can be imposed for an individual who knowingly obtains or discloses individually identifiable health information. The criminal penalties increase to \$100,000 and up to five years imprisonment if the wrongful conduct involves false pretenses, and to \$250,000 and up to ten years imprisonment if the wrongful conduct involves the intent to sell, transfer, or use individually identifiable health information for commercial advantage, personal gain, or malicious harm.

Member Name:

Agreement:

The member and the CDAC provider agree that:

1. The CDAC provider, as an agency or individual, is not an agent, employee, or servant of the state of Iowa, the Department of Human Services, or any of its employees. It is the CDAC provider's responsibility to determine employment status in regards to income tax and social security. Providers of CDAC service have no recourse to the Department of Human Services to collect payments performed outside of the provisions of this agreement.
2. This agreement will be reviewed annually and when there are significant changes in the member's condition or situation.
3. This agreement must be amended and approved by the service worker/case manager whenever there is a change:
 - a) of a CDAC provider,
 - b) in the service components to be provided,
 - c) in the description of provider activity,
 - d) in the rate of payment,
 - e) in the number of approved units

Responsibility: To be completed by the member or member's legal representative	
Describe the plan for emergencies, including instructions in calling 911 first in all life-threatening situations. What supports are available to you in case of an emergency or crisis situation? Describe the back-up plan if CDAC services are interrupted or delayed.	
Describe in detail all the CDAC provider's prior training and experience and how you evaluated it.	
Describe how you will manage the CDAC provider's services.	
Describe how you will measure and evaluate the services you receive from your CDAC provider.	

Member Name:

Standards for the CDAC provider: To be completed by the member or member's legal representative regarding information about your CDAC provider.	Confirmation of Standard – Please print clearly
1. Age (must be at least 18 years old as verified by driver's license, state identification card, passport, or other government-issued document) and a citizen of the United States or legal alien (green card or ID 9).	
2. Does the CDAC provider have the necessary skills needed to perform the CDAC services as identified and approved in this agreement? Yes/No	
3. The CDAC provider must be able to document and maintain the fiscal and clinical/medical records he/she provides per 441 Iowa Administrative Code 79.3(249A). List evidence of basic math, reading, and writing skills (e.g., high school diploma, GED, etc.). All records must be created in English and must be legible.	
4. Insurance or bond for the activities provided upon member request.	Please fill out 1 and 2 or circle 3 1) Insurance or bonding company 2) Policy limit policy number 3) Requirement is waived

Member Name:

Describe the service activities provided by the CDAC provider. Enter the amount of time per day and the number of days per week or month required to provide the activity. Enter "Not applicable" (NA) for components of the CDAC service that will not be provided. *Reminders, cueing, and supervision are not billable CDAC services.

	Non-Skilled Service Components. To be completed by the member or member's legal representative.	Describe CDAC Provider Activity as allowable by the Iowa Administrative Code.	List the amount of time required each day for each activity.	Number of days service will be provided per month.	Total minutes for the line.
N1	Dressing				
N2	Bathing, grooming, personal hygiene – includes shaving, hair care, make-up, and oral hygiene.				
N3	Meal preparation and feeding – includes cooking, eating, and feeding assistance (but not the cost of meals themselves).				
N4	Toileting – includes bowel, bladder, and catheter assistance (emptying the catheter bag, collecting a specimen, and cleaning the external area around the catheter).				
N5	Transferring, ambulation, mobility – includes access to and from bed or a wheelchair, repositioning, and mobility in general.				
N6	Essential housekeeping – activities which are necessary for the health and welfare of the member such as grocery shopping, laundry, general cleaning.				
N7	Minor wound care – includes foot care, skin care, nail trimming, and skin/nail observation and inspection.				

Member Name:

	Non-Skilled Service Components. To be completed by the member or member's legal representative.	Describe CDAC Provider Activity as allowable by the Iowa Administrative Code.	List the amount of time required each day for each activity.	Number of days service will be provided per month.	Total minutes for the line.
N8	Financial and scheduling assistance – includes money management, cognitive tasks, and scheduling personal business matters.				
N9	Assistance in the workplace – assistance with self-care tasks, environmental tasks, and medical supports necessary for the member to perform a job. Assistance with understanding and completing essential job functions is not included.				
N10	Communication – includes interpreting, reading services, assistance with communication devices, and supports that address the member's unique communication needs. This does not include reading mail, newspapers or helping the member 'talk' to friends.				
N11	Essential transportation – assisting or accompanying the member in using transportation essential to the health and welfare of the member.				
N12	Medication assistance – includes assisting the member in sorting, storing, organizing, and taking medications ordinarily self-administered. It also includes medication equipment maintenance and medication administration.				

Member Name:

Describe the service activities provided by the CDAC provider. Enter the amount of time per day and the number of days per week or month required to provide the activity. Enter "Not applicable" (NA) for components of the CDAC service that will not be provided. *Reminders, cueing, and supervision are not billable CDAC services.

	Skilled Service Components. To be completed by the member, member's legal guardian, nurse/ therapist, and CDAC provider.	Describe CDAC Provider Activity as allowable by the Iowa Administrative Code.	List the amount of time required each day for each activity.	Number of days service will be provided per month.	Total minutes for the line.
S1	Tube feedings if a member is unable to eat solid foods.				
S2	Assistance with intravenous therapy administered by a licensed nurse.				
S3	Parenteral injections required more than once a week.				
S4	Catheterizations, continuing care of indwelling catheters with supervision of irrigations, and changing of Foley catheters when required.				
S5	Respiratory care, including inhalation therapy, tracheotomy care, and ventilator.				
S6	Care of decubiti and other ulcerated areas, noting and reporting the nurse or therapist.				
S7	Rehabilitation services. Rehabilitation services include bowel and bladder training, range of motion exercises, ambulation training, restorative nursing services, re-teaching the activities of daily living, respiratory and breathing programs, reality orientation, reminiscing therapy, re-motivation, and behavior modification.				

Member Name:

	Skilled Service Components. To be completed by the member, member's legal guardian, nurse/ therapist, and CDAC provider.	Describe CDAC Provider Activity as allowable by the Iowa Administrative Code.	List the amount of time required each day for each activity.	Number of days service will be provided per month.	Total minutes for the line.
S8	Colostomy care.				
S9	Care of medical conditions out of control (includes brittle diabetes and comfort care of terminal conditions) when hospice is not utilized.				
S10	Post-surgical nurse delegated activities under the supervision of the licensed nurse.				
S11	Monitoring medication requiring close supervision because of a fluctuating physical or psychological condition.				
S12	Preparing and monitoring responses to therapeutic diets.				
S13	Recording and reporting of changes in vital signs to the nurse or therapist.				
Total Minutes					

Enter the number in the "Total Units" box into the Total Units Per Month box below:

Member Name:

The member/member's legal representative, the CDAC provider, and the service worker/case manager determine the CDAC provider's rate of pay. The payment of CDAC services must not exceed the fee limits allowed in the CDAC program. The rate of service multiplied by the number of approved units of CDAC services per month cannot exceed the member's total monthly budget allowed in the member's comprehensive service plan. Complete the waiver type and agreed upon reimbursement rate to the provider as follows:

Waiver type (check one):					
<input type="checkbox"/> AIDS/HIV	<input type="checkbox"/> Health and Disability	<input type="checkbox"/> Brain Injury	<input type="checkbox"/> Intellectual Disability	<input type="checkbox"/> Elderly	<input type="checkbox"/> Physically Disabled

HCPS Code	Provider Type	Fee Per Unit	Maximum Units
S5125	Agency CDAC provider	\$ per 15 min.	
S5125 U3	Agency CDAC provider – skilled	\$ per 15 min.	
T1019	Individual CDAC provider	\$ per 15 min.	
T1019 U3	Individual CDAC provider - skilled	\$ per 15 min.	

Member Name:

I agree to abide by all the requirements in this CDAC agreement including the following:

- That my criminal and abuse records will be checked for reported or confirmed criminal history or abuse and to keep the Department informed of changes to criminal and abuse records.
- To hold the Department of Human Services harmless against all claims, damages, losses, costs, and expenses, including attorney fees, arising out of the performance of this CDAC agreement by any and all persons.
- To keep both fiscal and designated clinical/medical documentation records of all CDAC services provided which are charged to the medical assistance program and to maintain these CDAC records for at least five years from the date of claims submission. Documentation shall include the following information for each unit of CDAC service provided and billed:
 1. Full name of the member receiving the CDAC service as it appears on their medical assistance card.
 2. Member's date of birth.
 3. Medical assistance identification number.
 4. Full name of the person providing the service. If the provider functions under a professional license or is certified to perform certain tasks, list the title after the provider's name. If the provider does not have a title, enter "CDAC Worker."
 5. Agency name (if applicable).
 6. Specific date of the CDAC service provided including the day, month, and year.
 7. Total units billed for the date of service.
 8. Waiver type and service procedure code as identified in this agreement.
 9. Location in which the service was provided including address.
 10. Description of the CDAC service provided as described in this agreement and as authorized in the service worker/case manager comprehensive service plan.
 11. Description of the provider's interventions and supports provided and the member's response to those interventions and supports.
 12. Identification of any health, safety, and welfare concerns.

I hereby confirm that all information provided by me on this form is true and correct to the best of my knowledge.

CDAC Provider Signature	Date
Member Signature	Date
Case Manager/DHS Service Worker Signature	Date

Member Name:

Additional Information on Billing:

Submit all claims for all Consumer-Directed Attendant Care (CDAC) on form 470-2486, *Claim for Targeted Medical Care*. CDAC services must be billed in whole units and both the member and provider must sign and date the claim. Claims should be submitted on a monthly basis following the month that services were provided. The IME has 30 days to process a claim. If a submitted claim contains errors, payment to the provider may be delayed. Questions regarding the form or to order blank forms, contact Provider Services at 1-800-338-7909 or locally (in the Des Moines area) at 515-256-4609. The downloadable version as well as instructions for completing the form is available on the DHS website at <https://dhs.iowa.gov/ime/Providers/claims-and-billing/ClaimsPage>.

Member Name: