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IN-HOME HEALTH-RELATED CARE SERVICES

APPENDIX

Iowa
Department
of
Human Services

Page

Amendment to Provider Agreement, 470-1999

Purpose	The *Amendment to Provider Agreement* records a required reduction in the state supplementation established in the *Provider Agreement*, form 470-0636.
Source	Print or photocopy the sample in the manual for use as needed. (In the on-line manual, click on the blue heading to access the form sample.)
Completion	The service worker assists providers and clients to complete an amendment for each provider agreement before delivery of service at the reduced rate.
Distribution	Keep the original goes in the client case file. Make a copy for the provider and for the client.
Data	**Agreement number**: The seven-digit number for the *Provider Agreement* being amended, as assigned by the local office.
	Reduced by: The percentage that the agreed-upon rate is being reduced.
	On and after and **Beginning**: The date (month-day-year) on which the reduced rate begins.

Authorization to Obtain or Release Health Care Information, 470-3951 and 470-3951(S)

Purpose

Forms 470-3951 and 470-3951(S) are two-way release forms used to get the permission of a client or the client's legally authorized representative to:

- Obtain health information needed to provide service to a client; and
- Release health information about the client to a third party.

Source

The English version of this form is printed in pads of 25 three-part precarboned sets. Order supplies from Iowa Prison Industries at Anamosa. It may also be completed on line using the template on Outlook under "Public Folders/All Public Folders/State Approved Forms/Service."

Print or photocopy supplies of the Spanish version from the sample in the manual. (Click on the blue form number to access the sample electronically.)

Completion

Complete this form when you first meet with a new client or provider. You may complete the identifying information and description of the information being requested or released. The person or the person's personal representative signs the section to give the authorization.

Discuss the authorization and explanation paragraph regarding the use of the form and answer any questions raised. Ensure that the person understands the right to revoke the authorization at any time by completing form 470-3949, *Request to End an Authorization*. Explain the consequences of failure to sign the form.

Distribution

For the client, send one copy to the registered nurse with a self-addressed, stamped envelope enclosed, when you request the physician's plan of care and nurse's provider instructions.

For the provider, send one copy for the provider to take to the physician with form 470-0672, *Provider Health Assessment*.

Keep one copy of the form in the client's case file. The client and provider keep the third copy.

Data

When initiating the form, enter:

- The person's name, state identification number (if any), social security number, date of birth, and parent's or guardian's name, if applicable.
- Your name, address, telephone number, and fax number in the first set of agency information.
- The name or the agency to which the information is being released, or from which the information is being requested, and the agency's address, telephone number and fax number.
- In the "information released may include" section, check the applicable boxes. If the "other" box is checked, describe the information in a specific and meaningful fashion.
- Describe any exceptions or limitations under "other." Sample entry: "The Department may obtain information from, but not release information to, the client's daughter."
- State the purpose for which the information will be used.
- In the "Specific Authorization For Release" section, secure the person or the person's legal representative's initials if mental health AIDS/HIV-related, or substance abuse information is to be obtained or released.

  NOTE: Only the client or the client's legally authorized representative can give consent to release or obtain mental health and AIDS/HIV-related information. Only the client can give consent to release or obtain substance abuse information.

  "Mental health information" means oral, written, or recorded information that indicates the identity of an individual receiving professional services and which relates to the diagnosis, course, or treatment or the individual's mental or emotional condition.

  "Substance abuse" means the use of chemical substances by persons suffering from chemical dependency, persons who are incapacitated by a chemical substance, substance abusers, or chronic substance abusers.

"AIDS" means a medical diagnosis of acquired immunodeficiency syndrome, based on the Center for Disease Control's "Revision of the CDC Surveillance Case Definition for Acquired Immunodeficiency Syndrome." "HIV" means a medical diagnosis of human immunodeficiency virus infection based on a positive HIV-related test.

- ♦ Ask the person to sign and date the form and enter a date when the authorization is to expire.
- ♦ Check the applicable box indicating the relationship of the person who signs the form to the person the information is concerning.
- ♦ Obtain the signature of two witnesses for people who are incapable of signing their name due to a physical or mental disability.

To use the form as the required documentation for the disclosure of mental health information, enter on the back of the form kept in the case file:

- ♦ The date.
- ♦ The name of recipient of information.
- ♦ The information disclosed.
- ♦ The name of the person who disclosed the information.

Health Services Application, 470-2927 and 470-2927(S)

Purpose

Forms 470-2927 and 470-2927(S) are used to apply for State Supplementary Assistance programs and Medicaid. The information contained on the application is used to determine eligibility for assistance.

Source

Form 470-2927 is printed with 30 sets on a pad. The Spanish translation, form 470-2927(S), is printed with 10 sets on a pad. Order supplies from Iowa Prison Industries in Anamosa.

Clients and providers can download this form on the DHS webpage: http://www.dhs.state.ia.us/. Click on "Public Information" and then click on "Forms."

You can also print or photocopy supplies of the forms from the samples in the manual. (Click on the blue form number to access the sample electronically.)

Completion

Give or mail the form to the applicant when assistance is requested. A person wishes to receive assistance for in-home health-related care must complete this application annually.

The client completes the form or enlists the help of some interested party in preparing the form. If there is a guardian, the guardian participates in completing the form and signs for the client.

If the client is mentally incompetent, the form may be completed by a relative, a person in whose home the client resides, or by the service worker, if there is no other person able or willing to file the application.

The client must sign the form unless mentally or physically unable to do so. If the client is mentally competent but unable to sign the application form, an "X" or a thumbprint may be used if witnessed by two persons who know the client.

If the application is not complete when it is filed, it must be fully completed upon the interview with the client or representative.

Distribution	The client submits one copy of the form to the local office. Date-stamp the completed application before sending it to the income maintenance worker. If the client wants a copy of the application, make a photocopy. NOTE: The *Health Services Application* takes the place of the *Application for All Social Services*, form 470-0615 or 470-0615(S), but is kept in the income maintenance case record. You do not need to maintain a copy in your case file.
Data	The form requests information necessary to determine State Supplementary Assistance and Medicaid eligibility.

Individual Client Case Plan, 470-0583

Purpose

Form 470-0583 is used as a record of the plan of care for the individual client receiving in-home health-related care services.

Source

This form may be completed on line using the template in Outlook under "Public Folders/All Public Folders/State Approved Forms/Service."

(In the on line manual, access the form sample by clicking on the blue heading.)

Completion

The worker completes this form to record the client's case plan when a new client is approved to receive in-home health-related care, at the time of the yearly review, and when the service is terminated.

Distribution

File in the case record and send a copy to the client.

Data

Client's Name: Enter the client's name.

Family Name: Enter the client's last name if different from other known family members.

Original Date: Enter the date the original service began.

Worker's Signature and **Date**: Sign your name and enter the date you complete the case plan.

Supervisor's Signature and **Date**: Your supervisor will sign and date the *Individual Client Case Plan* when it is being approved for service.

Client's Signature and Date: When the *Individual Client Case Plan* is complete, agreed to, and understood by the client, have the client check the boxes and sign and date the plan.

Assessment: Summarize the client's situation.

Financial Eligibility: Record reasons the client is financially eligible.

Goals: List goals of the plan.

Objectives: List objectives of the plan.

Specific Services: List services the client will be receiving on the program.

Responsibilities: List responsibilities of the client, the provider, the physician, the supervising nurse, and the Department worker.

Reassessment/Termination: Note if this is a reassessment or termination.

Notice of Decision: Services, 470-0602 and 470-0602(S)

Purpose

The *Notice of Decision: Services* notifies a service applicant or recipient of all actions taken that affect the person's case. The worker uses the form to present the information in a way that meets due process requirements and to document these notifications.

Source

The English and Spanish versions of the form may be completed on line using the template in Outlook under "Public Folders/All Public Folders/State Approved Forms/Service."

The forms may also be printed or photocopied from the samples in the manual and completed manually. (In the on-line manual, access the form by clicking on the blue form number.)

Completion

The worker completes this form to notify clients of eligibility determination and service needs for in-home health-related care for the following case actions:

- An application is approved, denied, or withdrawn.
- Services are renewed as a result of a regular or special review.
- The service is changed.
- Services are terminated.
- A client is required to pay client participation.
- The client participation amount changes.

Distribution

Give the original to the client. Send a copy to the provider. File a copy in the case record.

Data

Identifying Information: The case number may be omitted on applications.

Explanation of Action: Include in this section:

- The action taken;
- The services, if new or changed; and
- The specific basis for the action in words the client can understand.

If services are being reduced, state the reason clearly. For a termination, include the basis for cancellation and the reason for termination.

Manual or Rule References: State the chapter and subsection of the ***Employees' Manual*** and the administrative rule reference that support the action taken.

Fees: For clients with client participation, specify:

- ♦ The service the client participation covers.
- ♦ The amount of the client participation.
- ♦ The period covered by the client participation (e.g., $20 per month).
- ♦ The person to whom the fee is payable.

Physician's Report, 470-0673

Purpose

The *Physician's Report* is used to obtain medical information from a physician about an in-home health-related care client. (It also is used in the family-life home program.) The physician's recommendations and orders regarding the client's level of care and health needs are used for determining eligibility and for developing a plan of care and services.

The *Physician's Report* may also be used as the **plan of care** if the nurse or physician does not use a different form.

Source

Print or photocopy supplies of the form from the sample in the manual. (Click on the blue heading to access the sample electronically.)

If this form is used as the plan of care, you must provide the nurse with a supply of the forms.

Completion

Prepare this form:

- ♦ As early as feasible after an application is completed; and
- ♦ For the nurse's file at least every 60 days thereafter.

Complete the items on the form that precede the consent box. The client and the client's legal guardian complete items in the "Consent For Physician's Release of Information" section, with assistance from the worker, if required. The physician completes the remaining portions of the form.

Distribution

The physician completes the form and sends it to the registered nurse or agency responsible for planning and managing services to the client.

The nurse or agency places the form in the client's file and sends a copy to the service worker for the client's case record.

Provider Agreement, 470-0636

Purpose

The *Provider Agreement* describes the responsibilities of a person providing in-home health-related care services to a client of the Department. The agreement specifies the payment to be made and assures the eligibility of the client.

Source

This form may be completed on line using the template in Outlook under "Public Folders/All Public Folders/State Approved Forms/Service."

You may also print or photocopy supplies of the form from the sample in the manual. (Click on the blue heading to access the sample electronically.)

Completion

The client and worker complete a *Provider Agreement* with each provider the client has. If a provider has more than one client, the provider must have a different agreement for each client.

Every *Provider Agreement* must have a different provider agreement number. Therefore, a client or a provider could each have more than one valid *Provider Agreement*, each with different numbers.

Before the service is delivered, the form shall be signed by:

- The client,
- The provider,
- The worker, and
- The service area manager or designee also signs the form

A new agreement must be completed when any of the following changes occur in the agreement already in force:

- Change in rate of payment,
- Change in the service to be provided,
- Change in the maximum cost, or
- Change of provider.

Distribution

When the form is completed and signed by all parties, the original goes to the person who enters data in the computer. This copy goes to the worker for the case file. Make two more copies to mail to the provider and to the client.

Data

Agreement number: The local office assigns a seven-digit number. (See 16-J, Agreements for Service.)

Case number: The client's case number.

Amendment: Indicates this is an amendment to an agreement already in effect.

Payee name: The name of the payee, if different from the client. Examples of payees are legal conservators, power of attorneys for financial affairs, and protective payees.

Payee telephone number, street address, city, state, and **zip code**: Entered if there is a payee.

Client name, social security number, telephone number, street address, city, state, and **zip code**. Enter on all agreements.

Service provider's name, telephone number, street address, city, state, and zip code. Enter on all agreements.

Family member: Indicates whether the provider is a family member, as defined on the agreement.

Description of specific duties: A brief description of the duties to be performed under this contract.

Provider signature: Indicates approval of contract.

Client signature: Indicates approval of contract.

Service code: 98, for in-home health-related care.

Start date: The date on which the agreement is to begin.

End date: The maximum term of the agreement, no longer than one year.

Unit cost: The dollar amount for the rate agreed upon. Examples: $5.00 per hour (2), or $20.00 per day (4).

Per: The basis for the rate, using one of the following rate codes:

(1) Per 1/2 hour
(2) Per 1 hour
(3) Per 1/2 day
(4) Per 1 day
(5) Per month
(6) Per session or job
(7) Per trip
(8) Per mile
(9) Per meal

Maximum per month DHS: The maximum amount the Department has agreed to provide to the client to purchase the service identified in this agreement.

Maximum per month client: The amount of client participation, if any.

Worker signature and date: Approves payment for the service and certifies that the client is eligible.

Area administrator or designee signature and date: The service area manager or designee certifies the client for the program and gives final approval for the payment.

Provider Health Assessment, 470-0672

Purpose	Form 470-0672 is used to certify all providers for the in-home health-related care program. (It also is used in the family-life home program.)
Source	Providers can download this form on the DHS webpage: http://www.dhs.state.ia.us/. Click on "Public Information" and then click on "DHS Forms." You may also print or photocopy supplies of the form from the sample in the manual. (Click on the blue form number to access the sample electronically.)
Completion	The provider's physician, advanced registered nurse practitioner, or a physician assistant working under the direction of a physician completes one *Assessment* before the initiation of service delivery and annually thereafter. The provider is responsible for delivering the completed form to the worker. The provider assumes full responsibility for any costs that may be incurred in the completion of this form.
Distribution	Keep the completed form in the client's DHS service case record. Make a copy for the provider upon request.

Purchase of Service Provider Invoice, 470-0020

Purpose

This form is used to bill for services provided to clients by individual in-home health care providers.

Source

This form is printed in pads of 25 three-part carbonized sets. Order supplies from Iowa State Industries at Anamosa.

You can print this form off the Department's webpage: http://www.dhs.state.ia.us/. Click on "Public Information" and then click on "Forms."

You may also print or photocopy supplies this form from sample in the manual. (In the on-line, manual, click on the blue heading on this page to access the form sample.)

Completion

The service worker completes this form whenever a local office has payments due for in-home health service. Prepare a billing at the beginning of each month, for services provided during the previous month.

Each page can contain data for up to six clients. The client for whom payment is due must be assigned to the indicated county.

Distribution

Attach the top copy of the form to the *Statement of Services Rendered*, 470-0648, and place it in the case file after entering the data on the computer. Use the remaining copies as needed.

Data

Entries are required only for the following fields:

Billing Period: Enter the first and last date of the billing period, inclusively. Example: 10-1-99 - 10-31-99

State/local: Enter code 'S' for state funds.

County Number/Name: Enter the county number and name. Example: 77 Polk

Case Number: Enter the client's number from the Service Reporting System (SRS), hyphenated after the sixth, eighth, and tenth digits. Example: 123456-00-01-0

Client's Name: Enter the provider agreement number on the odd-numbered lines. Enter the payee name on even-numbered lines, exactly as entered on the POSS System. (In most cases, this is the client.)

Service Beginning Date: For **new** clients, enter the service initiation date. Leave **blank** for ongoing clients.

Service Ending Date: Enter the termination date for clients who are **ending** service. Leave **blank** for ongoing clients.

Service Code: Enter the service code (the same as the code in the POSS System). (Example: 98-01)

Unit Cost: Enter the cost for one unit of service as given in the *Provider Agreement*. (Example: 390.15)

Number of Units: Enter the number of units of service provided during the billing month. The system will accept whole units only. Partial units can be entered only by entering the next whole unit and crediting the excess. (Example: 10 1/2 units is entered as 11 units with a credit amount for 1/2 unit.)

Total Cost: Enter the product of the unit cost and the number of units. (Example: The unit cost is $2.00 and the number of units is 5. The total cost is $10.00)

Credits: Enter any credits for partial units or client participation.

Net Cost: Enter the total cost less credits. (Example: Total cost is $100.00. Credits are $20.00. Net cost is $80.00)

Approval: Enter an authorized local office signature and date to approve the billing.

Service Report, 470-0506

Purpose

The *Service Report* serves as a means of communication between the service section and the income maintenance section. The form allows an exchange of information about a client's eligibility for in-home health-related care, client participation, or termination of services.

Source

This form may be completed on line using the template in Outlook under "Public Folders/All Public Folders/State Approved Forms/Service."

You may also print or photocopy supplies of the form from the sample in the manual. (Click on the blue heading to access the sample electronically.)

Completion

Either the service worker or the income maintenance worker initiates the form, depending on the information being transmitted.

Distribution

The worker initiating the report sends the form to the other worker and keeps a copy as a control.

At the completion of the cycle, the control copy may be destroyed or may be forwarded to the service area manager for review and monitoring purposes.

Data

Identifying Information: The entire first section is completed at the original contact for in-home health-related care. To transmit information on an ongoing case, only the client's name and the social security number or the case number need be entered.

Residential Care: Not applicable.

In-Home Health-Related Care: This section transmits information on five separate actions, as follows:

- **Line 1** indicates whether the client filed a new application, the cost of care and effective date, and the amount of client participation and effective date.

- **Line 2** indicates a change in the cost of care and effective date.
- **Line 3** indicates a change in income and client participation.
- **Line 4** indicates a change in living arrangement.
- **Line 5** indicates changes in eligibility status for financial or service payments or eligibility.

Statement of Services Rendered, 470-0648

Purpose

The *Statement of Services Rendered* provides a means for an individual provider of service to keep a record of services provided to a client and to submit an invoice to the Department for payment.

Source

This form is printed in pads of 25 three-part carbonized sets. Order supplies from Iowa State Industries at Anamosa.

Clients and providers can print this form off the Department's webpage: http://www.dhs.state.ia.us/. Click on "public Information" and then click on "Forms."

You may also print or photocopy supplies of the form from the sample in the manual. (Click on the blue heading to access the sample electronically.)

Completion

The worker supplies the forms to the provider when the *Provider Agreement* is approved.

Providers should complete Section A at the beginning of each month and complete the list of specific services, Section B, each day that services are provided to the client. At the end of each month, the provider completes Section C and the client completes Section D.

Distribution

The client sends the original to the worker for the client file, keeps one copy, and gives one copy to the provider.

Data

Section A. The provider name is on line 1, the client name on line 2, and the month and year service is being provided on line 3.

Section B. A log of time spent during which service was being provided.

- "Specific Service" lists the actual work done.
- "Date" lists the date the work was done.
- "Time Spent" lists the hours of work. (Example: 8:30 - 10:00 a.m.)
- "Total Hours" lists the total number of hours worked each day.

Section C. The total hours for the month, multiplied by the agreed-upon rate, the total charges, signatures, the provider address, and the date this section was completed.

Section D. The client's name goes on line 1, the provider's name on line 2, and the month and year on line 3. The client signs the form and lists the client's address and the date this section was completed.