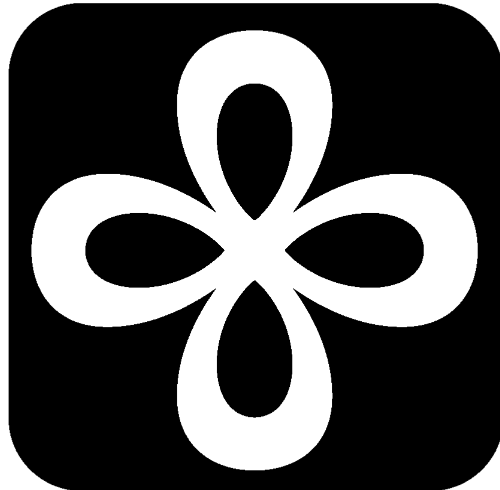
STATE OF IOWA
DEPARTMENT OF HUMAN SERVICES

MEDICAID



Provider Manual

HCBS Physical Disability Waiver

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I. THE HCBS PHYSICAL DISABILITY WAIVER PROGRAM

This chapter describes the federal and state Medicaid requirements a provider must meet to participate in the home- and community-based services (HCBS) physical disability (PD) waiver program.

The Medicaid HCBS waiver programs were established by Congress in 1981. Congress gave the Health Care Financing Administration (HCFA) in the federal Department of Health and Human Services oversight over the waiver programs. HCFA approved Iowa's request for an HCBS waiver for persons with a physical disability for implementation August 1, 1999.

The waiver program allows states to access Medicaid funding to develop and implement an array of community-based services. The services offered through each waiver program must meet public standards for the health, safety, and welfare of the consumers. These services are directed to Medicaid-eligible persons who require a level of care previously provided only in a hospital or nursing facility.

With home- and community-based services, eligible persons are able to remain in or return to their own homes and attain the highest degree of independence possible. The HCBS waiver programs differ from other Medicaid services in that access to services is permitted on an individualized basis and the services are consumer-driven. Service coordination and monitoring ensure that the needs of the consumers are met.

The services offered through each waiver are used in flexible combinations to meet the constant or changing specific needs of each consumer. The services provided through the waiver are limited to those services required to meet the consumer's individualized needs. A consumer may receive a combination of waiver services or a combination of waiver and non-waiver services.

The Department of Human Services, Bureau of Long-Term Care, administers the HCBS waiver programs in Iowa. The Bureau operates under a federally approved State Medicaid Plan. The State Medicaid Plan requires provider certification to ensure that standards for home- and community-based services are met.

The Bureau contracts with Iowa State University for staff assistance for the certification of providers and the ongoing technical assistance for the waiver programs. These "HCBS specialists":

- Are available to help providers meet regulatory requirements.
- Have the regulatory responsibility of quality assurance.
- Are responsible for making recommendations regarding provider certification.
- Assist the Bureau of Health Care Purchasing and Quality Management with the ongoing administration of the waiver programs.
- Provide assistance upon request to consumers and their families, case management agencies, county boards of supervisors, and Department of Human Services staff.

Technical assistance is available to providers throughout the entire process of application, certification, or recertification by contacting the waiver services office at (515) 281-8061.

A. Provider Enrollment

To apply for certification as a waiver service provider, contact the Medicaid fiscal agent by phone at 800-338-7909 or in writing at:

ACS
Provider Relations
PO Box 14422
Des Moines, IA 50306-3422

You will receive an application packet containing:

- Form 470-2917, *Medicaid HCBS Waiver Provider Application*, and instructions for its completion,
- Form 470-2965, *Agreement Between Provider of Medical and Health Services and Iowa Department of Human Services Regarding Participation in Medical Assistance Program*, and
- Form W-9, *Request for Taxpayer Identification Number and Certification.*

Submit the completed application to the same office. The fiscal agent must receive your application for certification at least 90 days before your planned implementation date.

HCBS specialists review the submitted application. They will contact you if they require additional information or clarification. This may include:

- Your current accreditation, evaluations, inspections and reviews by regulatory and licensing agencies and associations.
- Your fiscal capacity to initiate and operate the specified programs on an ongoing basis.
- Your written agreement to work cooperatively with the state and the central point of coordination in the counties you will serve.

HCBS specialists have 60 days from the receipt of your application to determine whether you meet the applicable standards for providing waiver services. (This deadline may be extended by mutual consent.)

When your application is approved, HCBS specialists will recommend enrollment. ACS will provide verification of approval of services, the provider manual and claim forms.

HCBS specialists may conduct an on-site review of a provider at any time that it is determined to be necessary.

B. Facsimile of Form 470-2917

See the following pages for a sample of form 470-2917, *Medicaid HCBS Waiver Provider Application*, and instructions for its completion.

INSTRUCTIONS FOR COMPLETING THE IOWA MEDICAID HCBS WAIVER PROVIDER APPLICATION FORM

I. GENERAL SECTION

1-7 Enter the current provider number, name, and the address of the provider of service. If the billing address is different than the street address, attach the "pay to" address to the form.

8-9 **County Name and Number**. Enter the name and number of the county of residence (if out of state – enter the name and number of the county served).

10 **Phone**. Enter area code and phone number.

11 **Fax**. Enter area code and fax number, if available.

12 **E-mail address**. Enter email address, if available. By providing us with your email address, you agree that we may communicate with you by electronic mail.

13 **Desired Effective Date for Enrollment**. Cannot be retroactive before the first of the month in which the application was signed. Providers cannot bill or be paid for service provided prior to DHS agreement to the service.

14 **HCBS Waiver**. Indicate the HCBS waiver program(s) for which application is being made.

II. INDIVIDUAL APPLICANTS APPLYING FOR CONSUMER-DIRECTED ATTENDANT CARE

If you are applying on behalf of an agency, proceed to section III.

If you are an individual applying for services other than Consumer-Directed Attendant Care, proceed to Section III (**this is not common!**).

15 **Social Security Number**. Enter your social security number here.

16 Indicate that you are applying for Consumer-Directed Attendant Care. Indicate whether you are going to provide the service on the daily or hourly basis (or both).

- Individuals who apply to provide Consumer-Directed Attendant Care are required to submit proof of age and must send in a copy of either a birth certificate **OR** a driver's license. The date of birth must be clearly visible or it will not be accepted.

- All of the forms must be completed. Individuals must fill out the W-9 form. All taxes on income earned from providing CDAC services are the responsibility of the individual providing the service.

Note: The CDAC provider cannot bill or be paid for service provided prior to Department of Human Service written approval of this service. That is indicated by the DHS service worker attaching the HCBS Consumer Directed Attendant Care Agreement, form 470-3372, to the service plan in the Ill and Handicapped, AIDS/HIV, and Elderly and Physical Disability waivers. In the Brain Injury and Mental Retardation waivers, the CDAC Agreement is attached to the service plan and sign off is obtained by sending a form 470-0379 to the Division of Long Term Care in DHS central office. Any payments made prior to the DHS written approval of this service are fraud, and referrals for recovery and prosecution of this federal offense will be made.

17 **Signature**. Original signature required. Applications not properly signed will be returned.

18 **Date**. Enter date application is signed.

III. AGENCIES APPLYING FOR WAIVER SERVICES

15 **Tax ID Number**. Enter your IRS Tax ID number.

16 **Contact Person**. Enter the name of the person who should be contacted for questions in regards to the application.

17-21 Self-explanatory.

22 **Claims in Process Information**. Paid and denied claims will automatically be reported to you. You have three choices regarding suspended claims, i.e. claims currently in process pending resolution of one or more issues. Those choices are:

Y = Print suspended claims only once. You will be notified only once that we have received your claim and that it is in process. You will not be notified about the claim again until it either pays or denies.

A = Print all suspended claims until paid or denied. You will be notified every week about all claims that are in process.

N = Do not print suspended claims. You will receive no notice concerning claims in process until they either pay or deny.

23 **Remittance Sequence**. Choose which sequence your claims will be reported to you. The choices are:

By Recipient Name. Claims will be reported in alphabetic order by recipient's last name.

By Recipient ID. Claims will be reported in numeric order by recipient's Medicaid ID number.

24 Indicate which services under which waivers you are applying for, and which standards you meet. Include with the application the documentation that the specific requirement is met.

25 **Signature**. Original signature required. Applications not properly signed will be returned.

26 **Date**. Enter date application is signed.

Iowa Department of Human Services

Medicaid HCBS Waiver Provider Application

When completed send to: ACS, Inc. Provider Enrollment P.O. Box 14422 Des Moines, IA 50306-3422 **Tel. (800) 338-7909**	**Make sure you have read the instructions before completing this form!**	For questions, contact: HCBS Waiver Program Tel: **(515) 281-8061** email: **akryuch@dhs.state.ia.us**

Individual applicants applying for Consumer-Directed Attendant Care (CDAC), please, complete sections I and II. Agencies applying for services, please, complete sections I and III.

I. GENERAL SECTION

1. Current Provider Number (if already an HCBS provider)	0		
2. Provider Name			
3. Street Address		**4. Suite or Apt. #**	
5. City		**6. State**	
7. Zip Code (9-digit if known)	–		
8. County Name		**9. County Number**	
10. Telephone Number	( ) –		
11. Fax Number	( ) –		
12. E-mail Address (please, print)			
13. Desired Effective Date for Enrollment (MM/DD/YYYY) (THIS DATE CANNOT BE RETROACTIVE BEFORE THE FIRST OF THE MONTH IN WHICH THE APPLICATION IS SIGNED!)	/ /		

14. Indicate the HCBS waiver program(s) for which application is being made

- ❑ Ill & Handicapped (IH)
- ❑ AIDS/HIV (AH)
- ❑ Elderly (E)
- ❑ Mentally Retarded (MR)
- ❑ Brain Injury (BI)*
- ❑ Physical Disability (PD)

* – Those wishing to provide services under the Brain Injury waiver need to submit documentation indicating training or experience with persons with brain injury. Training classes are available through DHS. To receive training call (515) 281-8061.

If you are an individual applicant applying for Consumer-Directed Attendant Care (CDAC), please, proceed to section II. Otherwise, proceed to section III.

II. INDIVIDUAL APPLICANTS APPLYING FOR CONSUMER-DIRECTED ATTENDANT CARE

15. Social Security Number				–			–				

16. Indicate that you are applying for Consumer-Directed Attendant Care (CDAC)

Service and Requirements	Circle the waiver(s) for which you are applying
❑ **04 – Consumer Directed Attendant Care (CDAC)**	
❑ 21 – Individual Applicant must submit a photocopy of birth certificate **OR** driver's license. Must show date of birth. →	IH AH E MR BI PD

Read and sign the following statement:

As a Medicaid provider of consumer-directed attendant care services:

- I understand that if I am the parent or stepparent of a consumer aged 17 or under, or the spouse of a consumer, that I may not provide services to those individuals.
- I understand that I may not provide consumer-directed attendant care services for a consumer for whom I am a caretaker and for whom I am the beneficiary of respite services that are funded by an HCBS waiver.
- I understand that all consumer-directed attendant care service activities are supportive. I must be qualified by prior training and/or experience and/or a certificate of formal training to carry out the consumer's plan of care pursuant to the department approved service plan.
- I understand that I must describe in detail my training and/or experience on form 470-3372, HCBS Consumer-Directed Attendant Care Agreement, and this will be reviewed and approved by the case manager or service worker for appropriateness of training and/or experience prior to provision of services. Form 470-3372 becomes an attachment to and a part of the service plan. I will receive direction and training from consumers for activities to maintain independence that are not medical in nature. I will receive from licensed nurses and therapists on-the-job training and supervision for skilled activities described on form 470-3372. All training and experience must be sufficient to protect the health, welfare, and safety of the consumer.
- I hereby confirm that all information provided by me on this form is true and correct to my best knowledge.

17. Signature

18. Date			/			/				

Note:Once the application process has been completed, you will receive notification from ACS.

III. AGENCIES APPLYING FOR WAIVER SERVICES

15. Tax ID Number ___ ___ – ___ ___ ___ ___ ___ ___ ___

16. Contact Person ❑ Mr ❑ Ms

17. Do you have any <u>HCBS waiver-related</u> provider numbers besides the one shown in question 1? If "yes", please, list them here ❑ Yes ❑ No

18. Has there been any disciplinary action against you by any licensing boards or certification body? ❑ Yes ❑ No

19. Have you ever been excluded from participation in the Medicare Program? If "yes," please explain on a separate piece of paper ❑ Yes ❑ No

20. Type of Practice Code (Please Check One)

- ❑ 01 – Individual Applicant
- ❑ 02 – Partnership
- ❑ 03 – Corporation/Profit Organization
- ❑ 04 – Hospital Based
- ❑ 05 – Government Owned
- ❑ 06 – Not for Profit
- ❑ 07 – Private Owner
- ❑ 08 – HMO
- ❑ 09 – Group
- ❑ 10 – University Affiliated Clinic

21. Type of Ownership Code (Please Check One)

- ❑ 01 – Individual Applicant
- ❑ 02 – Board Member/Commissioner
- ❑ 03 – Sole Ownership
- ❑ 04 – Partner
- ❑ 05 – Corporation
- ❑ 06 – Government Entity
- ❑ 07 – Nonprofit Organization
- ❑ 08 – Trust

Remittance Statement Control – Please read instructions on first page before completing!

22. Claims in Process Information (Check one)

- ❑ Y = Print suspended claims only once
- ❑ A = Print all suspended claims (until paid or denied)
- ❑ N = Do not print suspended claims

23. Remittance Sequence (Check one)

- ❑ 1 = By recipient name
- ❑ 2 = By recipient ID

24. Indicate the service(s) for which you are applying and attach proof that the requirement is met.

Service and Requirements		Circle the waiver(s) for which you are applying
❑ 01 – Adult Day Care		
❑ 01 – CARF Accredited	→	IH AH E BI
❑ 02 – Contract with Veterans Administration	→	IH AH E BI
❑ 03 – JCAHCO Accredited	→	IH AH E BI
❑ 57 – Contract with Department of Elder Affairs	→	IH AH E BI
❑ 58 – Letter of certification from Department of Elder Affairs stating agency meets IDEA-IAC 321 Chapter 24 standards	→	IH AH E BI
❑ 59 – Contract with Area Agency on Aging	→	IH AH E BI
❑ 60 – Letter of certification from Area Agency on Aging stating agency meets IDEA-IAC 321 Chapter 24 standards	→	IH AH E BI
❑ 02 – Assistive Devices		
❑ 61 – Area Agency on Aging as designated in IAC 321 4.4(231)	→	E
❑ 59 – Contract with Area Agency on Aging	→	E
❑ 62 – Letter from Area Agency on Aging stating the organization is qualified to provide the service	→	E
❑ 06 – Medical equipment and supply dealers (Medicaid Provider # ________________________________)	→	E

Service and Requirements		Circle the waiver(s) for which you are applying
❑ 25 – Behavioral Programming		
❑ 46 – Submit policies, procedures, and forms	→	BI
❑ 26 – Case Management		
❑ 47 – Meets 441 IAC – Chapter 24 Case Management	→	BI
❑ 03 – Chore		
❑ 61 – Area Agency on Aging as designated in IAC 321 4.4(231)	→	E
❑ 59 – Subcontract with Area Agency on Aging	→	E
❑ 62 – Letter from Area Agency on Aging stating the organization is qualified to provide the service	→	E
❑ 07 – Community Action Agency as designated in IAC 216A.93	→	E
❑ 08 – Home Health Agency (Medicare Provider # ________________________________)	→	E
❑ 09 – Home Care Agency with Iowa Department of Public Health contract (Contract # ____)	→	E
❑ 10 – Nursing Facility Licensed under 135C Code of Iowa	→	E
❑ 11 – Provider certified under the HCBS MR waiver	→	E
❑ Consumer Directed Attendant Care (CDAC)		
❑ 31 – Assisted Living Provider		
❑ 16 – Assisted Living Program accredited/certified by Department of Elder Affairs	→	E
❑ 29 – Agency, Hour **❑ 30 – Agency, Day**		
❑ 09 – Home Care Agency with Iowa Department of Public Health contract (Contract # ____)	→	IH AH E MR BI PD
❑ 12 – Home Care Agency with written certification from Department of Public Health stating that home care standards and requirements set forth in Department of Public Health rules 641 IAC 80.5(135)-80.7(135) are met	→	IH AH E MR BI PD
❑ 08 – Home Health Agency (Medicare Provider # ________________________________)	→	IH AH E MR BI PD
❑ 13 – Chore provider contracting with an Area Agency on Aging	→	IH AH E MR BI PD
❑ 14 – Chore provider with letter of approval from an Area Agency on Aging stating that the organization is qualified to provide chore.	→	IH AH E MR BI PD
❑ 07 – Community Action Agency as designated in IAC 216A.93	→	IH AH E MR BI PD
❑ 15 – Provider enrolled under HCBS MR or BI Supported Community Living	→	IH AH E MR BI PD
❑ 16 – Assisted Living Program accredited/certified by Department of Elder Affairs	→	IH AH MR BI PD
❑ 17 – Adult Day Care provider contracting with an Area Agency on Aging	→	IH AH E MR BI PD
❑ 67 – Adult Day Care provider – CARF accredited	→	IH AH E MR BI PD
❑ 68 – Adult Day Care provider – JCACHO accredited	→	IH AH E MR BI PD
❑ 19 – Adult Day Care provider with contract with Veterans Administration	→	IH AH E MR BI PD
❑ 63 – Adult Day Care provider with a letter of notification from Department of Elder Affairs stating the provider meets 321 IAC Chapter 25	→	IH AH E MR BI PD
❑ 64 – Adult Day Care provider with a letter of notification from an Area Agency on Aging stating the provider meets 321 IAC Chapter 25	→	IH AH E MR BI PD
❑ Counseling		
❑ 32 – Individual **❑ 33 – Group**		
❑ 22 – Community Mental Health Center (Medicaid Provider # or Certificate of Accreditation ___________________________________)	→	IH AH
❑ 23 – Hospice (Certificate of License or Medicare Provider # ____)	→	IH AH
❑ 24 – Mental Health Service Provider (Certificate of Accreditation)	→	IH AH

Service and Requirements	Circle the waiver(s) for which you are applying
❑ 34 – Family Counseling	
❑ 22 – Community Mental Health Center (Medicaid Provider # or Certificate of Accreditation ______________________________________) →	BI
❑ 23 – Hospice (Certificate of License or Medicare Provider # ____) →	BI
❑ 24 – Mental Health Service Provider (Certificate of Accreditation) →	BI
❑ 48 – Qualified brain injury professionals as designated in 441 IAC 83.8(249A) →	BI
❑ 07 – Home Delivered Meals	
❑ 61 – Area Agency on Aging as designated in IAC 321 4.4(231) →	IH AH E
❑ 59 – Subcontract with Area Agency on Aging →	IH AH E
❑ 62 – Letter from Area Agency on Aging stating the organization is qualified to provide the service →	IH AH E
❑ 07 – Community Action Agency as designated in IAC 216A.93 →	IH AH E
❑ 09 – Home Care Agency with Iowa Department of Public Health contract (Contract # ____) →	IH AH E
❑ 08 – Home Health Agency (Medicare Provider # _________________________________) →	IH AH E
❑ 26 – Hospital (Medicare Provider # __________________________) →	IH AH E
❑ 06 – Medical equipment and supply dealers (Medicaid Provider # _________________________________) →	IH AH E
❑ 10 – Nursing Facility Licensed under 135C Code of Iowa →	IH AH E
❑ 27 – Restaurant licensed and inspected under Iowa Code chapter 137B →	IH AH E
❑ 08 – Home Health Aide	
❑ 08 – Home Health Agency (Medicare Provider # _________________________________) →	IH AH E MR
❑ 09 – Homemaker	
❑ 09 – Home Care Agency with Iowa Department of Public Health contract (Contract # ____) →	IH AH E
❑ 08 – Home Health Agency (Medicare Provider # _________________________________) →	IH AH E
❑ 10 – Home/Vehicle Modifications (HVM)	
❑ 61 – Area Agency on Aging as designated in IAC 321 4.4(231) →	IH E
❑ 07 – Community Action Agency as designated in IAC 216A.93 →	IH E
❑ 15 – Provider enrolled under HCBS MR or BI Supported Community Living →	IH E MR BI PD
❑ 45 – Provider previously enrolled as a waiver Home/Vehicle Modifications provider →	IH E MR BI PD
❑ 39 – Community Business. Submit current proof of liability and workers compensation coverage →	IH E MR BI PD
❑ Interim Medical Monitoring & Treatment (IMMT)	
❑ 35 – Home Health Agency – HHA Care	**❑ 36 – Home Health Agency – RN Care**
❑ 08 – Home Health Agency (Medicare Provider # _________________________________) →	IH MR BI
❑ 37 – Group Care	
❑ 41 – Licensed child care center →	IH MR BI
❑ 42 – Registered group child care home →	IH MR BI
❑ 43 – Registered family child care home →	IH MR BI
❑ 38 – SCL	
❑ 15 – Provider certified under HCBS Supported Community Living →	IH MR BI

Service and Requirements		Circle the waiver(s) for which you are applying
❑ 11 – Mental Health Outreach		
❑ 22 – Community Mental Health Center (Medicaid Provider # or Certificate of Accreditation ___)	→	E
❑ 12 – Nursing		
❑ 08 – Home Health Agency (Medicare Provider # ___)	→	IH AH E MR
❑ 13 – Nutritional Counseling		
❑ 07 – Community Action Agency as designated in IAC 216A.93	→	IH E
❑ 08 – Home Health Agency (Medicare Provider # ___)	→	IH E
❑ 26 – Hospital (Medicare Provider # ___)	→	IH E
❑ 28 – Licensed dietitian approved by an Area Agency on Aging	→	IH E
❑ 10 – Nursing Facility Licensed under 135C Code of Iowa	→	IH E
❑ 06 – Personal Emergency Response (PERS)		
❑ 39 – Initial Installation ❑ 40 – Monthly		
❑ 25 – Send information pamphlet	→	IH E MR BI PD
❑ 41 – Prevocational Services		
❑ 49 – Meet Commission on Accreditation of Rehabilitation Facilities standards for work adjustment service providers	→	BI
❑ Respite		
❑ 42 – HHA – Specialized ❑ 43 – HHA – Basic Individual ❑ 44 – HHA – Group		
❑ 08 – Home Health Agency (Medicare Provider # ___)	→	IH AH E MR BI
❑ 45 – Non-Facility Care – Specialized ❑ 46 – Non-Facility Care – Basic Individual ❑ 47 – Non-Facility Care – Group		
❑ 29 – Provider certified under HCBS MR Respite	→	IH AH E BI
❑ 46 – Submit policies, procedures, and forms	→	MR BI
❑ 48 – Home Care Agency – Specialized ❑ 49 – Home Care Agency – Basic Individual ❑ 50 – Home Care Agency – Group		
❑ 09 – Home Care Agency with Iowa Department of Public Health contract (Contract # ___)	→	IH AH E MR BI
❑ 51 – Facility Care		
❑ 26 – Hospital (Medicare Provider # ___)	→	IH AH E MR BI
❑ 10 – Nursing Facility Licensed under 135C Code of Iowa	→	IH AH E MR BI
❑ 35 – ICF/MR (Medicaid Provider # ___)	→	IH AH MR BI
❑ 44 – Licensed group living foster care facility	→	IH AH MR BI
❑ 32 – Camp accredited by the American Camping Association	→	IH AH E MR BI
❑ 30 – Adult Day Care Providers	→	IH AH E MR BI
❑ 41 – Licensed child care center	→	IH AH MR BI
❑ 50 – RCF/PMR	→	IH AH MR BI
❑ 17 – Senior Companion		
❑ 37 – Designation by Corporation for National and Community Service	→	E
❑ 19 – Specialized Medical Equipment		
❑ 06 – Medical equipment and supply dealers (Medicaid Provider # ___)	→	BI PD
❑ 40 – Retail and wholesale businesses participating as providers in the Medicaid program (Medicaid Provider # ___)	→	BI PD

Service and Requirements		Circle the waiver(s) for which you are applying
❑ Supported Community Living (SCL)		
❑ 53 – Daily **❑ 54 – Hourly**		
❑ 46 – Submit policies, procedures, and forms	→	MR BI
❑ 53 – Provider enrolled under HCBS MR Supported Community Living	→	BI
❑ 54 – Provider enrolled under HCBS BI Supported Community Living	→	MR
❑ Supported Community Living – 5 Persons (SCL-5)		
❑ 56 – Daily **❑ 57 – Hourly**		
❑ 51 – RCF/MR: a. Submit plan to come into compliance with IAC 441 77.37(14)“d”(1) b. Submit copy of 5 bed RCF/PMR licensure	→	MR
❑ Supported Community Living – 8 Persons (SCL-8)		
❑ 59 – Daily **❑ 60 – Hourly**		
❑ 52 – ICF/MR: a. Submit plan to come into compliance with IAC 441 77.37(14)“d”(1) b. Submit copy of 8 bed ICF/MR licensure	→	MR
❑ 61 – Supported Community Living – Residential-Based (SCL-RB)		
❑ 65 – Group Living Foster Care Facility: a. Submit copy of group living foster care licensure under IAC 441 Chapter 114 b. Submit plan to come into compliance with IAC 441 77.37(23)”e”(3)	→	MR
❑ 66 – Residential Facility for Mentally Retarded Children a. Submit copy of Residential Facility for Mentally Retarded Children under IAC 441 Chapter 116 licensure: b. Submit plan to come into compliance with IAC 441 77.37(23)”e”(3)	→	MR
❑ 15 – Provider enrolled under HCBS MR or BI Supported Community Living	→	MR
❑ Supported Employment		
❑ 63 - Activities to Obtain a Job **❑ 64 - Job Coaching** **❑ 65 - Personal Care** **❑ 66 - Enclave**		
❑ 46 – Submit policies, procedures, and forms	→	MR BI
❑ 55 – Provider certified under HCBS MR Supported Employment	→	BI
❑ 56 – Provider certified under HCBS BI Supported Employment	→	MR
❑ Transportation		
❑ 67 – Regional Transit Authority		
❑ 38 – Regional Transit Agency recognized by Iowa Department of Transportation	→	E BI PD
❑ 68 – Area Agency on Aging		
❑ 61 – Area Agency on Aging as designated in IAC 321 4.4(231)	→	E BI PD
❑ 59 – Subcontract with Area Agency on Aging	→	E BI PD
❑ 62 – Letter from Area Agency on Aging stating the organization is qualified to provide the service	→	E BI PD
❑ 69 – Mile		
❑ 07 – Community Action Agency as designated in IAC 216A.93	→	E BI PD
❑ 10 – Nursing Facility Licensed under 135C Code of Iowa	→	E BI PD

24. Signature of authorized official
25. Date   __ __ / __ __ / __ __ __ __

Note: Once the application process has been completed, you will receive notification from ACS.

C. Changes

Notify the HCBS waiver office of a decision to:

- Not renew enrollment.
- Withdraw from the provision of any waiver service.

The notice must be in writing and must be received by the Bureau of Long-Term Care 30 days before the date of service or program termination.

D. Adding a New Service for Existing Provider

To add a new physical disability waiver service when you are an existing physical disability waiver provider, a new application is required.

Request an application from the Medicaid fiscal agent as identified in Section **I. A. Provider Enrollment**, of this manual.

Attach data necessary to qualify as a provider of that service.

The Department of Human Services must approve the service before ACS adds that category of service to their file. No new provider number is issued. If you do not follow this process, your claims for this new service will be denied.

E. Change in Ownership, Agency Name, or Satellite Offices

If the ownership or name change does not involve the issuance of a new federal tax identification number, the agency is not required to complete a new *Medicaid HCBS Waiver Provider Application*, form 470-2917.

Adding a satellite office does not require the completion of a new waiver provider application if the satellite office uses the main office's provider number for billing purposes. If you choose to have a separate provider number for the satellite office, you must file another waiver application.

II. STANDARDS FOR PROVIDERS OF SERVICE

Providers are eligible to participate in the Medicaid program as approved physical disability waiver service providers based on the standards pertaining to the individual service.

Providers shall maintain the certification listed in the applicable standards in order to remain eligible providers.

A. Consumer-Directed Attendant Care Providers

A public or private agency or an individual working independently as a provider of consumer-directed attendant care must be enrolled to provide waiver services.

The following providers may be enrolled to provide consumer-directed attendant care service:

- ♦ An individual who contracts with the consumer to provide attendant care service and who is:
  - At least 18 years of age.
  - Qualified by training or experience to carry out the consumer's plan of care pursuant to the Department-approved service plan.
  - Not the spouse or guardian of the consumer.
  - Not the recipient of respite services paid through HCBS on behalf of a consumer who receives HCBS.
- ♦ Home care providers that have a contract with the Iowa Department of Public Health or have written certification from the Department of Public Health stating they meet the home care standards and requirements set forth in Department of Public Health rules.
- ♦ Home health agencies that are certified to participate in the Medicare program.

- Chore providers subcontracting with Area Agencies on Aging or with letters of approval from the Area Agencies on Aging stating that the organization is qualified to provide chore services.
- Community action agencies.
- Providers certified under an HCBS waiver for supported community living.
- Assisted living programs that are voluntarily accredited or certified by the Department of Elder Affairs.
- Adult day service providers that:
  - Meet the conditions of participation for adult day care providers under the HCBS ill and handicapped waiver, elderly waiver, AIDS/HIV waiver, or brain injury waiver, and
  - Have provided a point-in-time letter of notification from the Department of Elder Affairs or an Area Agency on Aging stating the provider also meets the requirements of Department of Elder Affairs rules for non-facility-based respite care.

The consumer, parent, guardian, or attorney-in-fact under a durable power of attorney shall be responsible for selecting the person or agency that will provide the components of the attendant care services to be provided.

The Department of Human Services as the single state Medicaid agency has the same oversight responsibility for consumer-directed attendant care providers as it does for providers of any other home- and community-based waiver services.

Providers must demonstrate proficiency in delivery of the services included in a consumer’s service plan. Proficiency must be demonstrated through documentation of prior training and experience or a certificate of formal training.

After the interdisciplinary team and consumer determine the adequacy of the training and experience, the consumer and provider shall complete form 470-3372, *HCBS Consumer-Directed Attendant Care Agreement*. The service worker designated by the county and the Department service worker must review and approve form 470-3372, *HCBS Consumer-Directed Attendant Care Agreement*, before the provision of services. Form 470-3372 becomes an attachment to and part of the service plan.

Consumers will give direction and training for activities to maintain independence, which are not medical in nature. Licensed nurses and therapists will provide on-the-job training and supervision for skilled activities described on form 470-3372. All training and experience must be sufficient to protect the health, welfare and safety of the consumer.

It is recommended that the provider receive certification of training for the following activities that are available from the area community colleges:

- Transferring
- Catheter assistance
- Medication aide

B. Home and Vehicle Modification Providers

The following providers may provide home and vehicle modification:

- Providers eligible to participate as home and vehicle modification providers under any other HCBS waiver.
- Community businesses that have all necessary licenses and permits to operate in conformity with federal, state, and local laws and regulations and that submit verification of current liability and workers' compensation insurance.

C. Personal Emergency-Response System Providers

Personal emergency response system service providers must meet the following standards:

- ♦ The agency must provide an electronic component to transmit a coded signal via digital equipment over telephone lines to a central monitoring station.

  The central monitoring station must operate receiving equipment and be fully staffed by trained attendants, 24 hours a day, seven days per week. The attendants must process emergency calls and ensure the timely notification of appropriate emergency resources to be dispatched to the person in need.

- ♦ The agency, parent agency, institution, or corporation must have the necessary legal authority to operate in conformity with federal, state, and local laws and regulations.
- ♦ The provider must have a governing authority that is responsible for establishing policy and ensuring effective control of services and finances. The governing authority must employ or contract for an agency administrator to whom authority and responsibility for overall agency administration are delegated.
- ♦ The agency or institution must be in compliance with all legislation relating to prohibition of discriminatory practices.
- ♦ The provider must have written policies and procedures established to explain how the service operates, agency responsibilities, client responsibilities and cost information.

D. Specialized Medical Equipment Providers

The following providers may provide specialized medical equipment:

- ♦ Medical equipment and supply dealers participating as providers in the Medicaid program.
- ♦ Retail and wholesale businesses participating as providers in the Medicaid program that provide specialized medical equipment, such as electronic aids and organizers, medicine-dispensing devices, communication devices, bath aids, and environmental control units.

E. Transportation Providers

The following providers may provide transportation:

- ♦ Area Agencies on Aging.
- ♦ Providers with letters of approval from the Area Agencies on Aging stating the organization is qualified to provide transportation services.
- ♦ Community action agencies.
- ♦ Regional transit agencies as recognized by the Iowa Department of Transportation.
- ♦ Licensed nursing facilities.

III. HCBS PHYSICAL DISABILITY WAIVER ELIGIBILITY

Physical disability waiver programs are available to adults who meet income, resources, and service eligibility criteria.

To be eligible for physical disability waiver services, a consumer must:

- ♦ Have a physical disability.
- ♦ Be blind or disabled as determined by the receipt of Social Security disability benefits, or by a disability determination made through the Division of Medical Services.
- ♦ Be ineligible for the HCBS mental retardation waiver.
- ♦ Have the ability to hire, supervise, and fire the provider as determined by the service worker, and be willing to do so; or have a parent or guardian named by probate court or an attorney-in-fact under a durable power of attorney for health care who will take this responsibility on behalf of the consumer.
- ♦ Be eligible for Medicaid.

- Be aged 18 years through 64 years.
- Be a U.S. citizen and Iowa resident.
- Be determined by the Iowa Foundation for Medical Care as in need of skilled nursing or ICF level of care.
- Choose HCBS.

The discharge planner of the facility where the consumer resides shall initiate the application to the county Department of Human Services Income Maintenance Unit, if the consumer is in a facility at time of application.

The income maintenance worker secures a payment slot and coordinates the Medicaid eligibility determination with the service worker and the Iowa Foundation for Medical Care (IFMC).

If the applicant meets Medicaid income and resource eligibility standards, the IFMC determines the applicant's level of care. The service worker determines service eligibility.

When the applicant meets level-of-care requirements, the service worker meets with the consumer to develop a service plan to meet the consumer's needs for services.

A. Securing a Payment Slot and Waiting Lists

To secure a slot for the physical disability waiver, the IM worker must contact the Bureau of Long-Term Care for all applicants. The applicant's name will be entered on the list for an **application** slot.

The total number of persons receiving HCBS physical disability waiver services in the state is limited to the number provided in the waiver approved by the U.S. Department of Health and Human Services.

When the statewide limit of **payment** slots has been reached for all applicants, the Department issues a notice of decision denying service. The notice states that the person is not eligible because the approved waiver limit has been reached, and that the Bureau of Long-Term Care has placed the person's name on a waiting list.

As slots become available, people are selected from the waiting list to maintain the approved number of people on the program, based on their order on the waiting list.

B. Service Planning

Persons receiving physical disability waiver services will receive service management from a DHS service worker.

The service worker and the consumer shall develop and approve a service plan. This plan must be completed before service provision begins and annually thereafter.

The service worker and the consumer identify the consumer's "need for service" based on the consumer's needs and desires, as well as the availability and appropriateness of services.

The service worker does the service planning in coordination with the consumer, or the consumer's legal guardian. Others who may be involved, with the approval by the consumer or the consumer's legal guardian may be:

- ♦ The consumer's family, unless the family's participation is limited by court order or is contrary to the wishes of the consumer (who has not been legally determined to be unable to make decisions independently).
- ♦ All current service providers.
- ♦ Other persons whose appropriateness may be identified through the initial intake or current review.
- ♦ Persons identified by the consumer or family, provided the family's wishes are not in conflict with the desires of the consumer.

The service plan should be revised whenever there is a significant change in the items addressed in it.

The initial service plan must be developed within 60 calendar days of acceptance for service, based on the information currently available.

The service worker must submit the service plan in permanent written form dated and signed by the service worker and by the consumer or the guardian. Any objections to the service plan must be documented in the service plan.

The service plan is available to the consumer and all providers of services in accordance with statutes and regulations on confidentiality. The service plan must be free of professional jargon and be in language that is understandable and usable for the consumer and other persons involved in its development and implementation.

The service plan shall contain the following:

♦ Individualized consumer goals, which are general statements of expected accomplishments to be achieved in meeting the needs identified in the initial intake or current review. These goals must be based on the consumer's strengths, needs, and abilities.

♦ Objectives, which may be prioritized and which are specific, measurable, and time-limited statements of outcomes or accomplishments that are necessary for progress toward each goal.

♦ The specific service activities to be provided to achieve the objectives based on appropriateness, availability, and accessibility of the services and financial resources.

♦ The persons or agencies responsible for providing each service activity.

- The date of initiation, amount, and anticipated duration of each service activity.
- All service funding sources.
- The living arrangements and service settings selected to meet the consumer's needs, the rationale for this determination, and the rationale for any variation from use of least restrictive interventions.
- The persons legally authorized to act on behalf of the consumer, when applicable.
- Client participation in payment for services, if any, including the name of the provider responsible for collecting it, the amount to be collected, and the source of the funds.
- Additional services, resources, and supports that are needed but unavailable.
- Recommendations for guardianship or conservatorship.
- Identification of a crisis intervention plan for the consumer.
- The frequency of contact by the service worker with the consumer and providers of services. The service worker must have face-to-face contact with the consumer at least annually, and quarterly collateral contacts.

C. Need for Service

Consumers are required to use a minimum of at least one unit per quarter of consumer directed attendant care service or personal emergency response service to participate in the waiver program.

The total monthly cost of the physical disability waiver services shall not exceed $621.00 per month.

D. Adverse Service Actions

This section contains the conditions that will result in:

- The denial of a consumer's application for waiver services.
- Reduction of the amount of waiver services provided.
- Termination of waiver eligibility.

1. **Denial of Application**

The Department must deny an application for HCBS physical disability waiver services when it determines that:

- All of the medically necessary service needs cannot be met in a home- or community-based setting.
- Service needs exceed the service unit or reimbursement maximums.
- Service needs are not met by the services provided.
- Needed services are not available or received from qualifying providers.
- A physical disability waiver service is not identified in the applicant's service plan.
- There is another community resource available to provide the service or a similar service free of charge to the applicant that will meet the applicant's needs.
- The consumer receives services from other Medicaid waiver providers.
- The consumer or legal representative requests termination from the services.

2. **Reduction of Service**

A particular physical disability waiver service may be reduced when the Department determines either of the following:

- Continued provision of service at its current level is not necessary. The Department must determine the level to which the service may be reduced without jeopardizing the client's continued progress toward achieving or maintaining the goal.
- Another community resource is available to provide the same or similar service to the consumer that will meet the consumer's needs at no financial cost to the consumer.

3. Termination of Service

A particular HCBS physical disability waiver service may be terminated when the Department determines that:

- ♦ The client’s income or resources exceed the financial guidelines, or
- ♦ Another community resource is available to provide the service or a similar service free of charge to the consumer that will meet the consumer’s needs, or
- ♦ The consumer refuses to allow documentation of eligibility as to need, income, and resources, or
- ♦ Needed services are not available or received from qualifying providers, or
- ♦ The physical disability waiver service is not identified in the consumer’s annual service plan, or
- ♦ Service needs are not met by the services provided, or
- ♦ Services needed exceed the service unit or reimbursement maximums, or
- ♦ Completion or receipt of required documents by the Department or the medical facility discharge planner for the physical disability waiver program has not occurred, or
- ♦ The consumer receives services from other Medicaid providers, or
- ♦ The consumer or legal representative through the interdisciplinary process requests termination from the services.

IV. COVERED SERVICES

All services are provided to eligible consumers according to the individualized consumer need as identified in the service plan. Prior to service provision, you must obtain documentation of services, units, rates and time period authorized. The documentation should include the following:

- A copy of the Notice of Decision
- A copy of the Service Plan

The following sections list the general exclusion and limitations of waiver services, then detail the coverage requirements for each specific service.

A. Exclusions

1. Services Otherwise Available

Consumers may use services available under the regular State Medicaid Plan in addition to using the waiver services. When the same or similar service is available from an alternate source free of charge, the consumer must use that service before using the waiver services.

Consumers must obtain durable adaptive equipment available under the State Medicaid program, if applicable, before accessing the waiver's home and vehicle modification or specialized medical equipment services.

2. Duplicate Services

A person may be enrolled in only one waiver program at a time. For example, a person enrolled in the HCBS physical disability waiver may not be enrolled in the HCBS ill and handicapped waiver at the same time.

Costs for waiver services are not reimbursable while the consumer is in a medical institution (hospital or nursing facility).

Services may not be simultaneously reimbursed for the same time period. For example, only one provider may be reimbursed for one service during a specified hour, even if two providers arrive at the consumer's home at the same time to provide different services.

3. Services Provided Before Eligibility Determination

Before the Department will reimburse you for HCBS physical disability waiver services, the following conditions must be met:

- You must be an enrolled Medicaid provider, and
- The consumer must have received both service and financial eligibility approval.

B. Consumer-Directed Attendant Care

Consumer-directed attendant care services are service activities performed by a person to help a consumer with self-care tasks that the consumer would typically do independently if the consumer were otherwise able.

Consumers who request consumer-directed attendant care (CDAC) and for whom the interdisciplinary team agrees that consumer-directed attendant care is an appropriate service shall have consumer-directed attendant care included in their service plan.

Consumer-directed attendant care may not be simultaneously reimbursed with any other HCBS waiver services.

The consumer, parent, guardian or attorney-in-fact under a durable power of attorney for health care determines the components of the attendant care services to be provided with the person who is providing the services to the consumer.

If the consumer has a guardian or attorney-in-fact under a durable power of attorney for health care, the care plan shall address how consumer-directed attendant care services will be monitored to ensure the consumer's needs are being adequately met.

If the consumer has a guardian or attorney-in-fact under a durable power of attorney for health care, the guardian or attorney-in-fact shall sign the claim form in place of the consumer, indicating that the service has been provided as presented on the claim.

The consumer, parent, guardian, or the attorney-in-fact under a durable power of attorney for health care must complete and sign form 470-3372, *HCBS Consumer-Directed Attendant Care Agreement*, when consumer-directed attendant care is part of the consumer's individualized service plan. A copy of the completed agreement must be provided to the service worker or case manager before services begin.

The consumer, parent, guardian or attorney-in-fact under a durable power of attorney for health care shall be responsible for selecting the person or agency that will provide the components of the attendant care services. It is recommended that provisions be made for alternate attendant care service providers to supplement service provision for emergency situations that may arise. These alternate providers should be enrolled and designated in the service plan developed by the service worker or Medicaid case manager. This will allow the alternate service providers to immediately assume the attendant care service provision whenever necessary. Each provider that is providing the consumer directed attendant care service must complete and sign a separate *Consumer-Directed Attendant Care Agreement*.

A unit of service is 1 hour (up to 7 hours), or one 8- to 24-hour day provided by an individual or an agency. Bill each service in whole units.

1. Non-Skilled Covered Services

All consumer-directed attendant care services are supportive. The service activities may include helping the consumer with any of the following non-skilled service activities:

- Dressing.
- Bath, shampoo, hygiene and grooming.
- Access to and from bed or wheelchair, transferring, ambulation and mobility in general.

- Toilet assistance, including bowel, bladder and catheter assistance which includes emptying the catheter bag, collecting a specimen, and cleaning the external area around the catheter.
- Meal preparation, cooking, eating and feeding assistance, but not the actual cost of meals.
- Housekeeping services that are essential to the consumer's health care at home.
- Medications ordinarily self-administered, including those ordered by a physician or other qualified health care provider, except for antihypertensives, digitalis preparation, mood altering or psychotropic drugs, or narcotics.
- Minor wound care that does not require skilled nursing care.
- Assistance needed to go to, or return from, a place of employment, and assistance with job-related tasks while the consumer is on the job-site. The cost of transportation for the consumer and assistance with understanding or performing the essential job functions are not included.
- Cognitive assistance with tasks such as handling money and scheduling.
- Fostering communication through interpreting and reading services, as well as assistance in the use of assistive devices for communication.
- Assisting or accompanying a consumer in using transportation essential to the health and welfare of the consumer, but not the cost of transportation for the consumer or the provider.

The service activities may not include parenting or child care for or on behalf of the consumer. The consumer-directed attendant care payment does not include the costs of room and board or the cost of transportation.

When a consumer has a consumer-directed attendant care service, the consumer-directed attendant care provider cannot receive respite services. An alternative consumer-directed attendant care provider may be used to provide the consumer-directed attendant care services.

2. Skilled Services Covered

The service activities may include helping the consumer with any of the following skilled services under the supervision of a licensed nurse or licensed therapist working under the direction of a physician. The licensed nurse or therapist shall retain accountability for actions that are delegated.

- Tube feedings of consumers unable to eat solid foods.
- Assistance with intravenous therapy which is administered by a registered nurse.
- Parenteral injections required more than once a week.
- Catheterizations, continuing care of indwelling catheters with supervision of irrigations, and changing of Foley catheters when required.
- Respiratory care, including inhalation therapy and tracheotomy care or tracheotomy care and ventilator.
- Care of decubiti and other ulcerated areas, noting and reporting to the nurse or therapist.
- Rehabilitation services, including, but not limited to, bowel and bladder training, range-of-motion exercises, ambulation training, restorative nursing services, reteaching the activities of daily living, respiratory care and breathing programs, reality orientation, reminiscing therapy, remotivation, and behavior modification.
- Colostomy care.
- Care of medical conditions such as brittle diabetes and comfort care of terminal conditions.
- Post-surgical nurse-delegated activities under the supervision of the licensed nurse.
- Monitoring reactions to medications requiring close supervision because of fluctuating physical or psychological conditions, e.g., antihypertensives, digitalis preparations, mood-altering or psychotropic drugs, or narcotics.
- Preparing and monitoring response to therapeutic diets.
- Recording and reporting of changes in vital signs to the nurse or therapist.

The licensed nurse or therapist must ensure appropriate assessment, planning implementation and evaluation. The licensed nurse or therapist must make on-site supervisory visits every two weeks with the provider present.

The cost of the supervision provided by the licensed nurse or therapist must be paid from private insurance and other third-party payment sources, Medicare, the regular Medicaid program, or the Care for Kids program before accessing the HCBS waiver.

3. Services Provided by Assisted Living Program

When consumer-directed attendant care is provided by an assisted living program, please note the following:

- ♦ The service worker or case manager should be aware of and have knowledge of the specific services included in the assisted living program contract to ensure that:
  - Assisted living program services are not duplicative of consumer-directed attendant care services.
  - Consumer's needs are being addressed.
  - Consumer's unmet needs are included in the care plan.
- ♦ Consumer-directed attendant care payment does not include cost of room and board.
- ♦ Each consumer must be determined by IFMC to meet ICF/MR level of care.
- ♦ The consumer-directed attendant care fee is calculated based on the needs of the consumer and may differ from individual to individual.
- ♦ A consumer has the right to choose another provider of waiver services when living in an assisted living facility.

4. Fascimile of Form 470-3372

See the following pages for a fascimile of form 470-3372, *HCBS Consumer-Directed Attendant Care Agreement*.

HCBS CONSUMER-DIRECTED ATTENDANT CARE AGREEMENT

This is an agreement between a consumer of services under a Medicaid home- and community-based services waiver and the provider of consumer-directed attendant care.

Name of Consumer	Name of Provider

The Iowa Medicaid Program will reimburse services provided under this agreement when consumer-directed attendant care is part of the consumer's case plan and the social worker or case manager has determined that the prior training and experience of the provider are sufficient to meet the consumer's needs noted in this agreement. However, the consumer agrees not to hold the social worker or case manager responsible for any problems resulting from any deficiency in the provider's training or experience. The Medicaid agency is responsible to insure the health and welfare of the consumer.

Instructions:

The consumer or the consumer's guardian completes this form by entering information about how the provider will meet the standards and responsibilities and the agreed-upon rate of payment. The agreement must be completed and the copies distributed **before** the provider begins providing the service. Both the consumer and the provider must sign the form to signify that they agree to its provisions.

Photocopy of the completed form is given to the consumer, to the provider , and to the nurse or therapist supervising the provision of skilled services, if any.

The original is kept by the service worker or case manager and attached to the care plan.

Agreement:

The consumer and the provider agree that:

1. The provider, as an agency or self-employed contractor, 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 provider's responsibility to determine employment status in regards to income tax and social security. Providers of service have no recourse to the Department of Human Services to collect payments due as a result of the agreement between the consumer and the provider of consumer-directed attendant care.

2. This agreement will be reviewed at least annually and whenever there are significant changes in the consumer's situation.

3. This agreement will be renegotiated whenever there is a change: (a) of provider, (b) in the service components to be provided, or (c) in the description of provider activity.

RESPONSIBILITY:	HOW RESPONSIBILITY IS MET
Describe the plan for emergencies, including instruction in calling 911 first in all life-threatening situations.	
Describe in detail all of the provider's prior training and experience and how you evaluated it.	
Describe your provisions for managing the provider's services.	
Describe the performance standards for the provider.	
STANDARDS FOR THE PROVIDER:	**CONFIRMATION OF STANDARD**
1. Age (must be at least 18 years old)	
2. Social Security number:	
3. Evidence of basic math, reading, and writing skills (e.g. high school diploma, GED, etc.):	
4. Skills possessed as necessary to perform the attendant care components specified in this agreement:	
5. Evidence of the capability to perform the health maintenance activities specified in this agreement (experience, training, or statement of willingness to receive training before providing care)	
6. Insurance or bond for the activities provided upon consumer request.	❑ Insurance or bonding company: ____________________ Policy limit: $____________________ Policy number: ____________________ ❑ Requirement is waived:

Describe the components of care to be provided. Enter "Not Applicable" (NA) for components that will not be provided. You may use the letters S (Satisfactory), NI (Needs Improvement) and U (Unsatisfactory) in the column on the right when reviewing the quality of the care provided.

NON-SKILLED SERVICE COMPONENTS	**DESCRIPTION OF PROVIDER ACTIVITY**	**EVALUATION**		
		S	**NI**	**U**
Dressing.				
Bath, shampoo, hygiene, and grooming.				
Access to and from bed or a wheelchair, transferring, ambulation, and mobility in general. (Certification of training which includes demonstration of competence for transferring is available. See **Note** below.)				
Toilet assistance, including bowel, bladder, and catheter assistance which includes emptying the catheter bag, collecting a specimen, and cleaning the external area around the catheter. (Certification of training which includes demonstration of competence for catheter assistance is available. See **Note** below.)				
Meal preparation, cooking, eating and feeding assistance (but not the cost of meals themselves).				
Housekeeping services which are essential to the consumer's health care at home.				

Note: Certification is available through the community colleges. There is no funding available through the waivers to cover this training cost.

NON-SKILLED SERVICE COMPONENTS (continued)	DESCRIPTION OF PROVIDER ACTIVITY	EVALUATION		
		S	NI	U
Medications ordinarily self-administered, including those ordered by a physician or other qualified health care providers which are not antihypertensives, digitalis preparations, mood altering, or psychotropic drugs or narcotics. (A medication aide course is available through the area community colleges.)				
Minor wound care which does not require skilled nursing care.				
Assistance needed to go to or return from a place of employment but not assistance to the consumer while the consumer is on the job site.				
Cognitive assistance with money handling and scheduling tasks.				
Fostering communication through interpreting and reading services, as well as assistive devices for communication.				
Assisting or accompanying the consumer in using transportation essential to the health and welfare of the consumer, but not the cost of transportation.				

Service activities include helping the consumer with any of the following skilled services under the supervision of a licensed nurse or licensed therapist working under the direction of a physician. The cost of this supervision shall be paid from private insurance and other third party payment sources, Medicare, the regular Medicaid program, or the Care for Kids program. The nurse or therapist must retain accountability for actions that are delegated and ensure appropriate assessment, planning, implementation, and evaluation.

The nurse or therapist shall make on-site supervisory visits every two weeks, with the provider present and document to this record. This nurse or therapist agrees to supervise these service components delivered by this provider:

Name and telephone number of supervising nurse or therapist:

Describe the components of skilled care to be provided. Enter "Not Applicable" (NA) for components that will not be provided. You may use the letters S (Satisfactory), NI (Needs Improvement) and U (Unsatisfactory) in the column on the right when reviewing the quality of the care provided.

SKILLED SERVICE COMPONENTS	**DESCRIPTION OF PROVIDER ACTIVITY**	**EVALUATION**		
		S	**NI**	**U**
Tube feedings of consumers unable to eat solid foods.				
Assistance with intravenous therapy administered by a licensed nurse.				
Parenteral injections required more than once a week.				
Catheterizations, continuing care of indwelling catheters with supervision of irrigations, and changing of Foley catheters when required.				
Respiratory care, including inhalation therapy and tracheotomy care or tracheotomy care and ventilator.				

SKILLED SERVICE COMPONENTS (continued)	DESCRIPTION OF PROVIDER ACTIVITY	EVALUATION		
		S	NI	U
Care of decubiti and other ulcerated areas, noting and reporting to the nurse or therapist.				
Rehabilitation services includes bowel and bladder training, range of motion exercises, ambulation training, restorative nursing services, reteaching the activity of daily living, respiratory care and breathing programs, reality orientation, reminiscing therapy, remotivation, and behavior modification.				
Colostomy care.				
Care of medical conditions out of control (includes brittle diabetes and comfort care of terminal conditions).				
Postsurgical nurse delegated activities under the supervision of the licensed nurse.				

SKILLED SERVICE COMPONENTS (continued)	DESCRIPTION OF PROVIDER ACTIVITY	EVALUATION S	NI	U
Monitoring reactions to medications requiring close supervision because of fluctuating physical or psychological conditions, e.g. hypertensives, digitalis preparations, mood-altering or psychotropic drugs, or narcotics. A medication aid course is available through the area community colleges.				
Preparing and monitoring response to therapeutic diets.				
Recording and reporting of changes in vital signs to the nurse or therapist.				

The basis of reimbursement is the fee agreed upon between the consumer and the provider, within the upper limits allowed in the program and as established in the case plan or individual comprehensive plan (ICP). The agreed upon reimbursement rate to the provider is as follows (*complete one line only*):

HCPCS Code	Provider Type	Fee per Unit	Maximum Units	Upper Limit
W1265	Agency provider not an assisted living provider	$____________ per hour, up to	_______hours	$18.49 per hour (1-7 hrs)
W1266	Agency provider not an assisted living provider	$____________ per day, up to	______ days	$106.82 per day (8-24 hrs)
W1267	Individual provider	$____________ per hour, up to	______ hours	$12.33 per hour (1-7 hrs)
W1268	Individual provider	$____________ per day, up to	______ days	$71.90 per day (8-24 hrs)
W2517	Assisted living provider	$____________ per month	1 month	$1,052 per month, not to exceed $34.60 per day

Consumer Signature	Date

I agree to the services written in this form and:

- To submit to a criminal records check.
- That my protective services records may be checked for reported or confirmed abuse.
- 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 agreement by any and all persons.

______________________________________ Provider Signature

______________________________________ Date

ADDITIONAL INFORMATION ON BILLING:

Each service must be billed in whole units. Submit billings for all consumer-directed attendant care to ACS (the Medicaid fiscal agent) on form 470-2486, *Claim for Targeted Medical Care*. Both the consumer and the provider must sign and date the *Claim for Targeted Medical Care*. Obtain copies of this form from ACS, Provider Relations, at 1-800-338-7909.

Submit claims to ACS on a monthly basis to facilitate payment in a timely manner. To receive payment monthly, submit the claim for an entire month's service by the tenth of the month following the month of service. EXAMPLE: Ten hours of consumer-directed attendant care service was provided during the month of June. The claim for June's service should be submitted by the tenth day of July.

C. Home and Vehicle Modifications

Covered home and vehicle modifications are those physical modifications to the consumer's home or vehicle listed below that directly address the consumer's medical or remedial need. Covered modifications must be necessary to provide for the health, welfare, or safety of the consumer and enable the consumer to function with greater independence in the home or vehicle.

Modifications that are necessary or desirable without regard to the consumer's medical or remedial need and that would be expected to increase the fair market value of the home or vehicle, such as furnaces, fencing, roof repair, or adding square footage to the residence, are excluded except as specifically included below. Repairs are also excluded. Only the following modifications are covered:

- Kitchen counters, sink space, cabinets, special adaptations to refrigerators, stoves and ovens.
- Bathtubs and toilets to accommodate transfer, special handles and hoses for shower heads, water faucet controls, and accessible showers and sink areas.
- Grab bars and handrails.
- Turnaround space adaptions.
- Ramps, lifts, and door, hall and window widening.
- Fire safety alarm equipment specific for disability.
- Voice-activated, sound-activated, light-activated, motion-activated, and electronic devices directly related to the consumer's disability.
- Vehicle lifts, driver-specific adaptations, remote-start systems, including such modifications already installed in a vehicle.
- Keyless entry systems.
- Automatic opening device for home or vehicle door.
- Special door and window locks.
- Specialized doorknobs and handles.

- Plexiglas replacement for glass windows.
- Modification of existing stairs to widen, lower, raise or enclose open stairs.
- Motion detectors.
- Low-pile carpeting or slip-resistant flooring.
- Telecommunications device for the deaf.
- Exterior hard-surface pathways.
- New door opening.
- Pocket doors.
- Installation or relocation of controls, outlets, switches.
- Air conditioning and air filtering if medically necessary.
- Heightening of existing garage door opening to accommodate modified van.
- Bath chairs.

A unit of service is the completion of needed modifications or adaptations.

All modifications and adaptations shall be provided in accordance with applicable federal, state, and local building and vehicle codes.

Services shall be performed following Department approval of a binding contract between the enrolled home and vehicle modification provider and the consumer. The contract shall include, at a minimum:

- The work to be performed.
- Cost.
- Time frame for work completion.
- Assurance of liability and workers' compensation coverage.

Service payment shall be made to the enrolled home and vehicle modification provider. If applicable, payment will be forwarded to the subcontracting agency by the enrolled home and vehicle modification provider following completion of the approved modifications.

Services shall be included in the consumer's service plan and shall exceed the Medicaid state plan services.

D. Personal Emergency Response Services

The personal emergency response system allows a consumer experiencing a medial emergency at home to activate electronic components that transmit a coded signal via digital equipment over telephone lines to a central monitoring station. The necessary components of a system are:

- ♦ An in-home medical communications transceiver.
- ♦ A remote, portable activator.
- ♦ A central monitoring station with backup systems staffed by trained attendants 24 hours per day, seven days per week.
- ♦ Current data files at the central monitoring station containing response protocols and personal, medical and emergency information for each consumer.

The service shall be identified in the consumer's service plan.

A unit is a one-time installation fee or one month of service. Maximum units per state fiscal year are the initial installation and 12 months of service.

E. Specialized Medical Equipment

Specialized medical equipment includes medically necessary items for personal use by consumers that provide for health and safety of the consumer and which are not ordinarily covered by Medicaid, are not funded by educational or vocational rehabilitation programs, and are not provided by voluntary means.

This includes, but is not limited to: electronic aids and organizers, medicine-dispensing devices, communication devices, bath aids and non-covered environmental control units. This includes repair and maintenance of items purchased through waiver in addition to initial purchase cost.

Consumers may receive specialized medical equipment up to $500 per month until a maximum yearly usage of $6000 has been reached.

The need for specialized medical equipment shall be documented by a health care professional as necessary for the consumer's health and safety and identified in the consumer's service plan.

F. Transportation

Transportation services may be provided for consumers to conduct business errands and essential shopping, to receive medical services not reimbursed through Medicaid as medical transportation, to travel to and from work or day programs, and to reduce social isolation.

A unit of service is either per mile for regional transit providers or per trip when using a rate established by an Area Agency on Aging. Reimbursement will be at the lowest cost service rate consistent with the consumer's needs.

V. BASIS OF PAYMENT

A *Financial and Statistical Report for Purchase of Service Contracts* is required for the following types of respite providers:

- Home health agencies providing group respite.
- Non-facility providers of specialized, basic individual, and group respite.
- Camps.
- Home care agencies providing specialized, basic individual, and group respite.

Providers reconciling respite services are not required to submit the HCBS supplemental schedule D-4 from form 470-3449.

All financial and statistical reports must meet the specifications described in this section. You must complete the form or have responsibility for its content, if it is prepared by someone outside the agency.

A. Maintenance and Retention of Financial and Statistical Records

The financial information included in forms 470-0664 and 470-3449 must be taken from your financial and statistical records and must be verifiable by qualified auditors. To provide the required cost data and not impair comparability, you must maintain financial and statistical records in a consistent manner from one period to another.

Maintain sufficient financial and statistical records to document the validity of reports you submit to the Department. This includes program and census data. Failure to maintain records to support your cost reports may result in termination of your HCBS certification.

These records include, but are not limited to:

- All canceled checks, deposit slips, and invoices (paid and unpaid).
- Audit reports (if any).
- Board of director's minutes (if applicable).
- Capital asset schedules.
- Documentation of units of services provided to consumers.
- General ledger reconciliation to financial and statistical report.
- Loan agreements and other contracts.
- Payroll information.
- Reviewable, legible census reports.

Maintain these forms and all financial and statistical records to support them for a minimum of five years. Make these reports and records available to authorized representatives and agents of the Department and of the United States Department of Health and Human Services, upon request.

B. Submission of the Financial and Statistical Reports

Forms 470-0664 and 470-3449 are due in to the Department by September 30 of each year for reconciliation of respite rate reimbursement. You may obtain a 30-day extension for submitting the cost reports by submitting a letter to the Bureau of Long-Term Care by September 30. No extensions will be granted beyond 30 days.

Failure to submit a report by September 30 or an extended deadline granted shall reduce payment to 76 percent of the current rate. The reduced rate shall be paid for not longer than three months, after which time no further payments will be made.

If you have multiple-program agencies, you must also submit a cost allocation schedule, prepared in accordance with generally accepted accounting principles.

The Department may require that an opinion of a certified public accountant or public accountant accompany the report when adjustments made to prior reports indicate noncompliance with reporting instructions.

Forward the original and one copy, both having original signatures of an officer of the facility, to:

Ryun, Givens, Wenthe & Co
1641 48th St, Suite 150
West Des Moines, Iowa 50266-6722

If you choose to leave the HCBS program or terminate a service, submit a final cost report within 60 days of termination for reconciliation of respite rates.

C. Facsimiles of Forms 470-0664 and 470-3449

See the following pages for samples of the *Financial and Statistical Report for Purchase of Service Contracts*, form 470-0664, and the *Supplemental Schedule*, form 470-3449.

Iowa Department of Human Services

FINANCIAL AND STATISTICAL REPORT FOR PURCHASE OF SERVICE CONTRACTS

CERTIFICATION PAGE

Agency Name			IRS ID No.
Address			Contract No.
City		State	Zip Code
Period of Report:	From	To	Date of Fiscal Year End
Administrator Name			Telephone No.
Name of Person to Contact if Questions About the Report			Telephone No.

Does agency have an independent audit? ❑ Yes, for year ending ____________ ❑ No

Has a copy of the latest independent audit been submitted? ❑ Yes ❑ No

A. Type of Control: ❑ Government ❑ Nonprofit Organization ❑ Proprietary

B. Accounting Basis: ❑ Accrual ❑ Modified Cash ❑ Cash

C. Statistical Data for Period of Report:

1. Service code.							
2. If subject to licensure, number of clients licensed for.							
3. Number of units of service (licensed or staffed)							
a. Type of unit (hourly, daily, etc.)							
4. Total number of units of service provided.							
5. Total number of units of service provided for:							
a. DHS clients							
b. Other clients							
6. Percent of units provided to unit capacity (divide line 4 by line 3)							
7. Are the rates received from non-DHS clients the same as, or more than, POS rates for the same service: Circle yes or no, for each service. If no, explain:	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No

D. Form of Certification by Officer or Administrator of Provider Agency:

I CERTIFY that I have examined the accompanying schedules of revenues and expenses and the calculation of cost of service prepared for this agency and that to the best of my knowledge and belief they are true and correct. I also certify that these schedules were prepared from the books and records of the facility in accordance with instructions contained in this report, and the allowable cost of care excludes expenses that were not necessary to provide this care.

Signature Officer or administrator of facility	
Title Officer or Administrator	Date

E. Statement of Preparer (if other than agency)

I have prepared this report and to the best of my knowledge and belief, it represents true and accurate data of the agency for the period stated above.

Signature of Preparer	Date

F. Statement of Project Manager

I have reviewed this report prior to submitting it to the State (Department of Human Services, Bureau of Purchased Services, Purchase of Service Unit).

Signature of Project Manager	Date

Provider Agency		
Period of Report	From	To

SCHEDULE A: REVENUE REPORT

Revenues:	Total Revenue	Revenue for Schedule D Expense Deduction*
Fee for Service:		
Iowa State Department of Human Services	$	
County Board of Supervisors		
Private Clients		
Department of Education (Voc Rehab) (service fees only)		
United Way (service fees only)		
Social Security, SSI, SSA		
Other		
Service, Reimbursement or Investment Income:		
Work Services Revenues	$	$
Food Reimbursement (DOE)		
Investment Income		
Other (attach schedule)		
Contributions: (Schedule must be attached:)		
United Way: Contributions not restricted or appropriated** to a specific individual	$	
Restricted to specific individuals*		$
Other: Contributions not restricted or appropriated** to a specific individual		
Restricted to specific individuals*		$
Government Grants:		
Total Revenue	$	*$

* Income which must be deducted from total service expense on Schedule D.

** Agencies must have documentation or support which identifies purposes of contributions reported.

Provider Agency		
Period of Report	From	To

SCHEDULE B: STAFF NUMBERS AND WAGES

Job Classification and Title	Number of Staff			Gross Wages
	Full Time	Part Time	FTEs	
Administrative #2110 Job Title				
Administrative Total				
Professional #2120 Job Title				
Professional Total				
Direct Client Care #2130 Job Title				
Direct Client Care Total...				
Clerical #2150 Job Title				
Clerical Total..				
Other Staff Wages #2190 Job Title				
Other Staff Wages Total				
Total: ALL JOB CLASSIFICATIONS AND TITLES				

The maximum amount of wages chargeable to Purchase of Services for any one employee is $40,000 annually. If an employee is paid in excess of $40,000, the excess must be reported as "Other Nonreimburseable Costs" in column 3 of Schedule D or charged to Excluded Services (use column 5 of Schedule D).

Provider Agency		
Period of Report	From	To

SCHEDULE C: PROPERTY AND EQUIPMENT DEPRECIATION AND RELATED PARTY PROPERTY COSTS

PROVIDER -OWNED EQUIPMENT BUILDINGS

Description:	Original Cost	Depreciation Recorded Prior Years	Method	Annual % Rate	Recorded Depreciation Expense	Straight-Line Depr.
Equipment:						
Building equipment						
Departmental equipment						
Other equipment ______						
Office furniture and fixtures						
Motor vehicles ______						
Total						
Buildings:						
Buildings						
Additions						
Leasehold improvements ______						
Other ______						
Total						
Total Equipment and Buildings						

RELATED PARTY PROPERTY COST

1. Is any property being leased from a party "related to provider" using the definitions in the contract and the Provider Handbook? ❑ Yes ❑ No

2. Schedule of Lessor's Costs:

   If answer to number 1 is yes, provide lessor's costs in the space below.

Depreciation on property	______
Property taxes	______
Mortgage interest on property	______
Insurance	______
Other (describe)	______
Total	______

Provider Agency		
Period of Report	From	To

SCHEDULE D: EXPENSE REPORT

						Direct Service Cost					
		1	2	3	4	5	6	7	8	9	10
Acc No.	**Account Title**	**Total Expense**	**Fund-Raising Cost**	**Other Nonreim-burseable Costs**	**Adjusted Cost: Col 1 minus Cols 2 & 3**						**Indirect Service Cost**
2110	Administrative Staff										
2120	Professional Direct Staff										
2130	Other Direct Staff										
2150	Clerical Staff										
2190	Other Staff										
2100	**TOTAL WAGES**										
2210	Health Benefits										
2220	Retirement Plan										
2290	Other Benefits										
2200	**TOTAL BENEFITS**										
2310	FICA Expense										
2320	Unemployment										
2350	Worker's Compensation Insurance										
2300	**TOTAL PAYROLL TAXES**										
2450	Medical and Psych. Serv. Purchased										
2470	Audit and Accounting										
2480	Attorney Fees										
2490	Other Nonmedical										
2400	**TOTAL PROFESSIONAL FEES**										
2510	Office Supplies										
2530	Medical Supplies										
2540	Recreation and Craft Supplies										
2550	Food										
2590	Other Supplies										
2500	**TOTAL SUPPLIES**										
2600	**TELEPHONE AND TELEGRAPH**										
2700	**POSTAGE AND SHIPPING**										
2810	Rent of Space										
2820	Buildings and Grounds Supplies										
2830	Utilities										
2840	Care of Buildings and Grounds										
2870	Interest										
2880	Insurance and Property Taxes										
2890	Other Occupancy Expense										
2800	**TOTAL OCCUPANCY EXPENSE**										

Provider Agency		
Period of Report	From	To

SCHEDULE D: EXPENSE REPORT

		Direct Service Cost									
		11	12	13	14	15	16	17	18	19	20
Acc No.	**Account Title**										
2110	Administrative Staff										
2120	Professional Direct Staff										
2130	Other Direct Staff										
2150	Clerical Staff										
2190	Other Staff										
2100	**TOTAL WAGES**										
2210	Health Benefits										
2220	Retirement Plan										
2290	Other Benefits										
2200	**TOTAL BENEFITS**										
2310	FICA Expense										
2320	Unemployment										
2350	Worker's Compensation Insurance										
2300	**TOTAL PAYROLL TAXES**										
2450	Medical and Psych. Serv. Purchased										
2470	Audit and Accounting										
2480	Attorney Fees										
2490	Other Nonmedical										
2400	**TOTAL PROFESSIONAL FEES**										
2510	Office Supplies										
2530	Medical Supplies										
2540	Recreation and Craft Supplies										
2550	Food										
2590	Other Supplies										
2500	**TOTAL SUPPLIES**										
2600	**TELEPHONE AND TELEGRAPH**										
2700	**POSTAGE AND SHIPPING**										
2810	Rent of Space										
2820	Buildings and Grounds Supplies										
2830	Utilities										
2840	Care of Buildings and Grounds										
2870	Interest										
2880	Insurance and Property Taxes										
2890	Other Occupancy Expense										
2800	**TOTAL OCCUPANCY EXPENSE**										

Provider Agency		
Period of Report	From	To

SCHEDULE D: EXPENSE REPORT

		1	2	3	4	5	6	7	8	9	10
					Direct Service Cost						
Acc No.	**Account Title**	**Total Expense**	**Fund-Raising Costs**	**Other Nonreim-burseable Costs**	**Adjusted Cost: Col 1 minus Cols 2 & 3**						**Indirect Service Cost**
3100	**OUTSIDE PRINTING AND ART WORK**										
3210	Mileage and Auto Rental										
3250	Agency Vehicles Expense										
3280	Automobile Insurance										
3290	Other Related Transportation										
3200	**TOTAL TRANSPORTATION**										
3310	Staff Development and Training										
3320	Annual Meeting and Business Conf.										
3300	**TOTAL CONFERENCES AND CONVENTIONS**										
3400	**SUBSCRIPTIONS AND PUBLICATIONS**										
3510	Clothing and Personal Needs										
3520	Other										
3500	**TOTAL ASSISTANCE**										
4100	**ORGANIZATION MEMBERSHIPS**										
4200	**AWARDS AND GRANTS**										
4310	Agency Vehicle Repair										
4320	Other Equipment Repair or Purchase										
4300	**TOTAL EQUIPMENT REPAIRS & PURCHASE**										
4410	Agency Vehicles										
4420	Equipment										
4480	Buildings and Leasehold										
4400	**TOTAL DEPRECIATION**										
4910	Moving and Recruitment										
4920	Liability Insurance										
4930	Miscellaneous										
4900	**TOTAL MISCELLANEOUS**										
TOTAL EXPENSES											
ALLOCATION OF INDIRECT SERVICE COSTS											
Total Service or Maintenance Cost After Allocation of Indirect											
* Program Income or Reimbursements											
* United Way Contributions Restricted to Specific Individuals											
* Other Contributions Restricted to Specific Individuals											
* Government Grants											
Total Service or Maintenance Cost After Deductions											
Units of Service											
UNIT COST											

Provider Agency		
Period of Report	From	To

SCHEDULE D: EXPENSE REPORT

Direct Service Cost

Acc No.	Account Title	11	12	13	14	15	16	17	18	19	20
3100	**OUTSIDE PRINTING AND ART WORK**										
3210	Mileage and Auto Rental										
3250	Agency Vehicles Expense										
3280	Automobile Insurance										
3290	Other Related Transportation										
3200	**TOTAL TRANSPORTATION**										
3310	Staff Development and Training										
3320	Annual Meeting and Business Conf.										
3300	**TOTAL CONFERENCES AND CONVENTIONS**										
3400	**SUBSCRIPTIONS AND PUBLICATIONS**										
3510	Clothing and Personal Needs										
3520	Other										
3500	**TOTAL ASSISTANCE**										
4100	**ORGANIZATION MEMBERSHIPS**										
4200	**AWARDS AND GRANTS**										
4310	Agency Vehicle Repair										
4320	Other Equipment Repair or Purchase										
4300	**TOTAL EQUIPMENT REPAIRS & PURCHASE**										
4410	Agency Vehicles										
4420	Equipment										
4480	Buildings and Leasehold										
4400	**TOTAL DEPRECIATION**										
4910	Moving and Recruitment										
4920	Liability Insurance										
4930	Miscellaneous										
4900	**TOTAL MISCELLANEOUS**										
	TOTAL EXPENSES										
ALLOCATION OF INDIRECT SERVICE COSTS											
Total Service or Maintenance Cost After Allocation of Indirect											
* Program Income or Reimbursements											
* United Way Contributions Restricted to Specific Individuals											
* Other Contributions Restricted to Specific Individuals											
* Government Grants											
Total Service or Maintenance Cost After Deductions											
Units of Service											
UNIT COST											

Provider Agency		
Period of Report	From	To

SCHEDULE E: COMPARATIVE BALANCE SHEET

ASSETS, LIABILITIES, AND EQUITY	BALANCE AT END OF	
	Current Period	Prior Period
ASSETS:		
Cash	$	$
Receivable from clients		
Receivable from others		
Property and equipment:		
Land		
Buildings and equipment		
Less allowance for depreciation		
Net property and equipment		
Investments and other assets		
TOTAL ASSETS		
LIABILITIES AND EQUITY:		
Accounts payable	$	$
Accrued taxes (payroll and property)		
Other liabilities		
Notes and mortgages		
Total liabilities		
Equity or fund balance		
TOTAL LIABILITIES AND EQUITY		

RECONCILIATION OF EQUITY OR FUND BALANCE

TOTAL EQUITY OR FUND BALANCE BEGINNING OF PERIOD	$
Add:	
TOTAL REVENUE from Schedule A	$
Other revenue. Explain	
Deduct:	
TOTAL EXPENSES from Schedule D	
Other expenses. Explain	
TOTAL EQUITY OR FUND BALANCE END OF PERIOD	$

Provider Agency		Vendor No.
Period of Report:	From	To

SCHEDULE F: COST ALLOCATION PROCEDURES

(To be completed by providers which offer more than one service)

Costs are allocatable to a particular service, such as a grant, project, or other activity, in accordance with the relative benefits received. A cost is allocatable to a service if it is treated consistently with other costs incurred for the same purpose in like circumstances, and if it:

(1) Is incurred specifically for the service,

(2) Benefits the service and can be distributed in reasonable proportion to the benefits received, and

(3) Is necessary to the overall operation of the organization, although a direct relationship to a particular service cannot be shown.

Any cost allocatable to a particular service under the above principles may not be shifted to other services to overcome funding deficiencies or to avoid other restrictions imposed by law or terms of an award.

DIRECT COSTS:	Yes	No
1. Do you have a cost allocation plan which describes the methods you use in distributing joint costs to services or activities?	❑	❑
2. If you do not have a cost allocation plan describing the methods followed, do you have accounting workpapers available to support joint direct cost allocations?	❑	❑
3. Is your method of allocating joint service cost consistently followed from year to year?	❑	❑
4. Are costs allocated to services in reasonable proportion to benefits received?	❑	❑
5. Are service income deductions allocated in a manner which is consistent with the costs incurred in generating the income?	❑	❑
6. Additional comments regarding allocation of joint service costs:	❑	❑

INDIRECT COST:

	Yes	No
1. Are indirect costs distributed on a basis of total direct service or cost?	❑	❑

2. If indirect costs are not allocated on the basis of total direct service costs, what was the basis used?

	Yes	No
3. Is the basis for distributing indirect cost the same as that used in the previous year?	❑	❑

Provider Agency		
Period of Report	From	To

SCHEDULE G: SUPPLEMENTAL ALLOCATION REPORT, PART 1

A	B	C	D	E	F	G	
		Shelter Care					
Account Number	Account Title	Allowable Attribution Cost	Allocation of Cost	Total Costs	Allocation of Total Cost to: Maintenance	Service	Basis of Allocation
from 2190	Food Service & Maintenance Workers Salaries					**********	Definition
% of 2200	Food Service & Maintenance Workers Benefits					**********	Definition
% of 2300	Food Service & Maintenance Workers Payroll Taxes					**********	Definition
2130	Direct Care Staff Salaries						Time
% of 2200	Direct Care Staff Benefits						Time
% of 2300	Direct Care Staff Payroll Taxes						Time
from 2120	Other Direct Staff (C1 in/pgm. Supv/SW-Thpst/Nurse)						Time
% of 2200	Other Direct Staff Benefits						Time
% of 2300	Other Direct Staff Payroll Taxes						Time
from 2110	Other Admin. Staff (Clinical/Pgm Supv or Mgr) Salaries						Time
% of 2200	Clinical Supervisor Benefits						Time
% of 2300	Clinical Supervisor Payroll Taxes						Time
2450	Medical & Psychological Services Purchased				***********************		Definition
2490	Other Non-Medical Services Purchased				***********************		Definition
2530	Medical Supplies					***********************	Definition
2540	Recreation ("Family-Like") & Craft Supplies					***********************	Definition
	Formalized Non "Family-Like" Recreation				***********************		Definition
2550	Food					***********************	Definition
3510+352	Clothing, Personal Needs, School Supplies, and Other					***********************	Definition
2810	Rent of Space						Sq Ft. -
2820	Building and Grounds Supplies						Sq Ft. -
2830	Utilities						Sq Ft. -
2840	Care of Building and Grounds						Sq Ft. -
2870	Interest on Building and Grounds						Sq Ft. -
2880	Insurance and Property Taxes						Sq Ft. -
2890	Other Occupancy Expenses						Sq Ft. -
Schedule	Part 1 TOTALS						Sq Ft. -Use
		Service/Maintenance Percentages					

Provider Agency		
Period of Report	From	To

SCHEDULE G: SUPPLEMENTAL ALLOCATION REPORT, PART 2

	Gross Total Attributable to:
Residual Cost NOT Included in Schedule G, Part 1	Shelter
Remainder of Program Direct Costs (Total Program Schedule D Direct - Part 1 Direct) Remainder of Program Indirect Cost (Total Program Schedule D Direct - Part 1 Indirect)	
PROGRAM TOTALS for PART 2	

UNIT COST DETERMINATION

SERVICE PERCENTAGE FROM SCHEDULE G PART 1	
TOTAL PART 2 SERVICE COST	
TOTAL SERVICE COST FROM PART 1	
GRAND TOTAL SERVICE COST	
DEDUCTIONS FROM SERVICE COST FROM SCHEDULE D	
GRAND TOTAL SERVICE COST AFTER DEDUCTIONS	

MAINTENANCE PERCENTAGE FROM SCHEDULE G PART 1	
TOTAL PART 2 MAINTENANCE COST	
TOTAL MAINTENANCE COST FROM PART 1	
GRAND TOTAL MAINTENANCE COST	
DEDUCTIONS FROM MAINTENANCE COST FROM SCHEDULE D	
GRAND TOTAL MAINTENANCE COST AFTER DEDUCTIONS	

UNITS OF SERVICE __________

SERVICE COST PER UNIT __________

MAINTENANCE COST PER UNIT __________

TOTAL COST PER UNIT __________

ALLOCATION OF STAFF TIME WORK SHEET

(Use separate form for each staff type)

TYPE OF STAFF: ______________________________

Enter the percent of time spent on maintenance activities here: ____________ LINE 1

Enter the percent of the time spent on service activities here: ____________ LINE 2

Add line 1 and line 2 and enter result here: ____________ LINE 3

Divide line 1 by line 3 and enter result here: ____________ LINE 4

Divide line 2 by line 3 and enter result here: ____________ LINE 5

Enter the percent of time spent on administrative activities here: ____________ LINE 6

Multiply line 4 by line 6 and enter result here: ____________ LINE 7
(This is the percentage of administrative time allocated to maintenance.)

SUBTRACT line 7 from line 6 and enter result here: ____________ LINE 8
(This is the percentage of administrative time allocated to service.)

ADD line 1 and line 7 and enter result here: ____________
(This is the total percentage of time allocated to maintenance. Use this percentage to allocate staff cost to maintenance.)

ADD line 2 and line 8 and enter result here: ____________
(This is the total percentage of time allocated to service. Use this percentage to allocate staff cost to service.)

* The combined percent of time spent on maintenance, service, and administrative activities should total 100%.

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Iowa Department of Human Services

SUPPLEMENTAL SCHEDULE

HCBS SUPPLEMENTAL SCHEDULE-D-1 TO FORM 470-0664

CALCULATION OF CONSUMER ITEM LIMITS

(Complete one schedule for each living site or program)

Program					
Column(s) From Schedule D					
From Schedule D: Line 3290 - Other Related Transportation					
Line 3520 - Other					
Line 4320 - Other Equipment Repair and Purchase					
Total					
Divided by the Number of Unduplicated Consumers (from provider records					
Average Amount per Consumer					
Limit	1570	1570	1570	1570	1570
Variance					

This calculates an average per consumer. The facility is still responsible for justifying actual costs per consumer that exceed the limit.

HCBS SUPPLEMENTAL SCHEDULE-D-2 TO FORM 470-0664

CALCULATION OF INDIRECT COST LIMITS

(Complete one schedule for each living site/program)

Program					
Column(s) from Schedule D					
Total Service or Maint. Cost After Allocation of Indirect					
Less: Direct Costs (HCBS program columns only): Line 2120 - Professional Direct Staff					
Line 2130 - Other Direct Staff					
Line 2200 - Total Benefits for Direct Staff					
Line 2300 - Payroll Taxes for Direct Staff					
Line 3210 - Mileage and Auto Rental					
Line 3250 - Agency Vehicle Expense					
Line 3290 - Other Related Transportation					
Line 3520 - Other					
Line 4320 - Other Equipment Repair and Purchase					
Subtotal of Direct Cost					
Calculated Indirect Cost (Total Costs Net of Direct Costs)					
Limitation (20% of the Subtotal of Direct Cost)					
Difference (to Schedule D-3 if exceeds limit)					

HCBS SUPPLEMENTAL SCHEDULE-D-3 TO FORM 470-0664

RECONCILIATION OF COST AND PAYMENTS

(Complete by including all programs)

Program					
Column(s) From Schedule D					
Unadjusted Total Cost After Deductions-Schedule D					
Less: Adjustment for Indirect Cost - Schedule D-2					
Adjusted Costs					
Divided by Total Units (certification page section C, line 4)					
Total Unit Cost					
Lower of Unit Cost or Maximum Reimbursement Rate					
Multiplied by DHS Units (certification page section C, line 5)					
Total DHS Cost					
Comparison of Costs and Payments: Revenues Billed (from provider records)*					
Less DHS Cost (above)					
Subtotal					
Less DHS Cost X 2.5%					
Balance Due Medicaid Program **(If negative, no balance is due.)**					

*For reconciliation of revenues billed, see page 2.

HCBS SUPPLEMENTAL SCHEDULE-D-3 TO FORM 470-0664

RECONCILIATION OF COST AND PAYMENTS

(Complete by including all programs)

Programs					
Column(s) From Schedule D					
Total Payments Received for Current Period					
Payments Not Yet Received for Current Period					
Total Revenues Billed					

Note: The section below need not be completed for the reporting period ended 6/30/97. This information will need to be collected for future reporting periods.

FOR USE IN CALCULATION OF IN- AND OUT-OF-COUNTY RATES FOR SCL HOURLY SERVICES:

Travel Allocation	**In**	**Out**	**Total**
Time Spent			

HCBS SUPPLEMENTAL SCHEDULE-D-4
TO FORM 470-0664

For Projected Rates:

Effective date ____________

❑ All Consumers-Site Rate
OR
❑ Consumer ________ of ________

DAILY RATE WORKSHEET

Site Name: ____________

No. of Consumers Served: ____________

Form 1703-0 Line:

2120 - Professional Direct Staff (Direct Hours ________)	________
2130 - Other Direct Staff (Direct Hours ________)	________
2200 - Direct Staff Benefits	________
2300 - Direct Staff Payroll Taxes	________
3210 - Mileage and Auto Rental (Numbers of Miles ________)	________
3250 - Agency Vehicle Expense (Number of Miles ________)	________
3290 - Other Related Transportation*	________
3520 - Other (Consultation Expenses)*	________
4320 - Other Equipment Repair and Purchase*	________
Total Direct Expense	________
Indirect Expense (limited to 20% of direct expense)	________
Total Cost	________
Number of Units Provided	________
Unit Cost	________

*The sum of these lines is limited to $1570 annually per customer

Request to Exceed the Unique Rate Maximum:

Explanation of reasons for exceeding maximum (i.e. ratio of mid management staff to consumers on caseload or percentage of time charged. Hourly wage of direct staff, description of staffing pattern, description of other support services and resources sought and not available, description of expenses listed in lines 3290, 3520, and 4320 and identification of other resources sought and not available.)

For Projected Rates:

I certify that I have examined the accompanying schedules of expenses and the calculation of cost of service prepared for this agency and that to the best of my knowledge and belief they are true and correct. I also certify that these schedules were prepared in accordance with instructions contained in this report and the allowable cost of care excludes expenses that were not necessary to provide this care.

SIGNED (Officer or Administrator of Facility)	Date

HCBS SUPPORTED COMMUNITY LIVING INITIAL HOURLY RATE CALCULATION SUPPORTIVE WORKSHEET

Part A: Billable Hours (for an annual period)

ITEM	Instructions	Column 1	Column 2
TOTAL AVAILABLE HOURS: ___FTEs X 2,080 hours/year	From FSR: Schedule B (professional and direct only);-should equal D-4, 2120 + 2130		
VACATION & HOLIDAYS (subtract): ___FTEs X____days X 8 hours/days =	FTEs (same as above); number of days for vacation and holidays per year		
SICK LEAVE (subtract): ___FTEs X____days X 8 hours/days =	FTEs (same as above); average sick leave usage per year per person		
ADMINISTRATION (subtract): ___% X___hours (see total available hours shown above)=	% of time professional and direct staff spend doing administrative work		
TRAVEL (to consumer locations): (subtract): In county _____%X____hours (see total available hours shown above)= Out of county ___%X____hours (see total available hours shown above)=	% of time professional and direct staff spend traveling from site to site in county and, if applicable, out of county		
UNBILLABLE HOURS (subtract): ___% X___hours (see total available hours shown above)=	% of down time: time when planned activity cannot or did not occur (maximum of 5%)		
TOTAL ANNUAL BILLABLE HOURS			

Part B: Hourly Rate

DIRECT COST (annual amount)	From 470-0664, Schedule D		
INDIRECT COST	From 470-0664, Schedule D (maximum is 20% of direct)		
TOTAL HOURLY COST	Sum of direct and indirect		
DIVIDED BY TOTAL BILLABLE HOURS FROM ABOVE			
HOURLY RATE			

Use Column 1 for calculating the hourly rate for supported community living services provided in the county in which you are located.

Use Column 2 for calculating the hourly rate for supported community living services provided in any other county. (The assumption is that there will be one hourly rate for out-of-county supported community living services, whether it is for one county or twenty counties.)

Signature	Signature
HCBS Agency	CPC County

D. Instructions for Completing Financial and Statistical Reports

Enter identifying information at the top of each schedule. All information called for in the schedules must be furnished unless it does not apply to your agency.

The cost reporting period is from July 1 through June 30. For providers participating in the program as of July 1, the report covers the 12-month period of July 1 through June 30. For those entering the program after July 1, the reporting period is from the beginning of providing brain injury waiver services through June 30.

New providers not having historical costs may complete the report using projected costs. Only the certification page and Schedule D of form 470-0664 and the *Supplemental Schedule* (form 470-3449) are required.

Adjustments to convert to an accrual basis of accounting are required if your records are maintained on another accounting basis. The intent of these adjustments is to obtain information concerning costs of providing care and services to consumers on a basis that is fair and comparable among providers of the service.

Providers who are also providing services not contracted for under the home- and community-based brain injury waiver contracts should complete the cost apportionment in accordance with recognized methods and procedures for a fair presentation of expense attributable to services provided under the contract. Costs reported under the waiver shall not be reported as reimbursable costs under any other funding source. Costs incurred for other services shall not be reported as reimbursable costs under the waiver.

Reporting of in-county and out-of-county rates is required for agencies that maintain an out-of-county supported community living service (SCL) paid at hourly rates. In- and out-of-county rates may be set up through an initial projection and then maintained by special reporting on the annual *Financial and Statistical Report*. “In-county” is the county where the main office is located. “Out-of-county” is all other counties where services are provided.

Travel time needs to be accumulated by "in" and "out" counties. SCL hourly costs will be allocated between the in and out of county designations based on travel time. Hourly units provided for SCL also need to be accumulated on an "in county" versus an "out of county" basis in order to continue to set two separate rates.

1. Certification Page

The purpose of the certification page is to report agency statistical information and record the signature of authorized officer of the agency.

Agency Name and **Address:** Enter the official name and address of the agency. Generally this is the name and address which appears on the license or official agency letterhead.

IRS ID No.: Enter the number assigned the facility for tax purposes (federal withholding, etc.).

Contract No.: Enter the contract number assigned at certification.

Period of Report: Enter the dates for which the current information is being provided.

Date of Fiscal Year End: Enter the ending date for your fiscal year.

Names and Telephone Numbers: Self-explanatory.

Audit: Indicate if the agency had a certified public accounting firm perform an audit of its financial statements. Forward a copy of the latest independent audit to the Department when available.

Type of Control: Indicate the ownership under which the agency is conducted.

Accounting Basis: Indicate the basis on which you keep your books.

- Accrual: Recording revenue when earned and expenses when incurred.
- Modified Cash: Combination of certain cash and accrual method of accounting.
- Cash: Recording revenue when received and expenses when paid.

If you do not use the accrual basis of accounting, you must adjust record amounts to the accrual basis. Keep the accounting work papers used in adjusting your records from cash to accrual.

Statistical Data: Enter service codes as entered on Schedule D. Each program and living site should be shown separately.

Enter the appropriate number of units for the reporting period. Billable time means direct support contact with the consumer. For daily units, the number of units of services staffed should be based upon a 365-day period (366 days during a leap year).

Total hours at the end of the month. Round partial units up to the next unit. Divide billable hours equally among consumers when the consumer to staff ratio is greater than 1:1.

Signatures: The report must be reviewed and signed by an authorized officer or administrator of the agency. If the report is prepared by someone other than an employee of the agency, that person must sign.

2. Schedule A

The purpose of Schedule A, Revenue Report, is to report total agency income and the income allocated to the specific services and programs. Report all revenues, including those from excluded or non-home- and community-based brain injury waiver programs.

Report the total revenues or gross income in the column headed "Total Revenue." Revenue categories are provided on the schedule for the most common sources. If additional categories are necessary, submit accompanying schedules.

Revenues are generally broken down into three classifications for purposes of completing this report: fees for service, other income, and contributions. These revenue sources are further explained as follows:

♦ Fees for services represent income earned by the provider as a result of performing services to or for consumers. The fees might be paid by third parties on behalf of consumers for which services were performed.

♦ Service, reimbursement or investment income includes program revenues from the sale of products, food reimbursements for the Department of Education, and investment income which is not from restricted or appropriated contributions and which is held separate and not commingled with other funds. Additional other income items may be applicable. If so, identify them accordingly or support them by an accompanying schedule.

♦ Contributions include all United Way funding, other donations, and government grants that are not designated as fees for services. They shall be accompanied by a schedule showing the contribution and anticipated designation by the agency and shall be reported as restricted or appropriated as follows:

- Restricted or Appropriated: Include funds which are either appropriated by the provider through formal board action or restricted by the donor. This includes interest from the contribution, when this interest is also restricted or appropriated and is held separate and not commingled with other funds.

- Not Restricted or Appropriated: Include donations which are not appropriated or designated by the provider through board action or restriction by the donor.
- Government Grants: Government grants should be explained on an accompanying schedule which sets forth the source of funding, the purpose and the period of the grant, and the program to which the grant pertains.

3. Schedule B

The purpose of Schedule B, Staff Numbers and Wages, is to report full-time equivalent numbers of staff and wages by job title.

Job Classification and Title: Enter the job titles in the space provided on the left. All personnel must be separated into the following job classifications:

- 2110 Administrative
- 2120 Professional
- 2130 Direct Client Care
- 2150 Clerical
- 2190 Other Staff Wages

Number of Staff: Enter the number of persons working full time or part time, and the total full-time equivalents (FTEs) for each job title. (For example, a person working half time has an FTE of 0.5.)

Gross Wages: Enter the gross wages for all full-time and part-time staff for each job title.

After the columns are completed, enter subtotals and total as indicated.

4. Schedule C

The purpose of Schedule C, Property and Equipment Depreciation and Related Party Property Cost, is to report information related to depreciable assets. Schedule C includes the original acquisition costs, capital improvements, and depreciation on buildings and equipment owned by the provider. If property is being leased from a related party, information regarding the lessor's costs must be submitted on Schedule C.

The totals reported on Schedule C are reported on Schedule D, account 4400. Ongoing expenses, such as maintenance and repairs for this property, are entered on Schedule D under subheadings for either 2800 (occupancy) or 4300 (repair expenses).

Note: Any property expenses related to providing room and board are not reimbursable under rule HCBS brain injury waiver program and should be excluded.

Calculate depreciation expense on a straight-line basis over the estimated useful life of the assets. Follow The Estimated Useful Lives of Depreciable Hospital Assets, published by the American Hospital Association, for depreciation.

If a depreciable asset has at the time of its acquisition an estimated useful life of at least 2 years and a historical cost of at least $5,000, its cost must be capitalized and written off ratably over the estimated useful life of the asset using one of the approved methods of depreciation. If a depreciable asset has a historical cost of less than $5,000, or if the asset has a useful life of less than 2 years, its cost is allowable in the year it is acquired.

When items are purchased as an integrated system, all items must be considered as a single asset when applying the capitalization threshold. Items that have a stand alone functional capability may be considered on an item-by-item basis. For example, an integrated system of office furniture (interlocking panels, desktops that are supported by locking into panels) must be considered as a single asset when applying the threshold. Stand alone office furniture (e.g., chairs, free standing desks) will be considered on an item-by-item basis.

Instructions are provided for each column in the section on Provider-Owned Equipment and Buildings:

Original Cost: Record the property and equipment at its original cost.

Depreciation Recorded Prior Years: Obtain this information by adding the depreciation accumulated from prior years less any disposals.

Method: Enter the method used by the agency in calculating its depreciation.

Annual % Rate: Enter the annual percentage rate used in calculating the depreciation.

Recorded Depreciation Expense: Enter the total amount of depreciation recorded on the agency's books.

Straight-Line Depreciation: Enter the amount of depreciation recorded on the property on a straight-line basis if the agency uses a method other than straight-line for its books.

Related Party Property Costs: A "related party" is defined as an organization related through control, form ownership, capital investment, directorship, or other means. Organizations are required to disclose their financial and statistical records to determine whether a related party relationship exists and to document the validity of costs.

If property is leased from a related party, the rent expense must be classified as a nonreimbursable cost on Schedule D, with the actual cost of the property substituted. A schedule of lessor's cost is included on Schedule C for purposes of identifying the actual cost incurred by the related party landlord.

5. **Schedule D**

The purpose of Schedule D, Expense Report, is to report total agency expenses and allocate those expenses to the various services provided by an agency. The allocation of costs per service includes all costs for your agency and should be consistent with the costs included on your general ledger.

The account numbers for expenditures are not intended to be all-inclusive in detailing expenses of a provider. The numbering system used on this schedule is not important, other than to have a basis of identifying object expenses in a manner that is uniform for reporting purposes.

HCBS uses several supplemental schedules to further clarify the application of these expenses.

a. Column Descriptions

Total Expense (Column 1): This column shows the total operating costs of the agency.

Fund-Raising Costs (Column 2): Use this column to show any adjustment to remove costs related to fund raising activities from allowable costs.

Other Nonreimbursable Costs (Column 3): Use this column to show any adjustments or reclassifications related to costs that are not reimbursed by the HCBS program. Examples of nonreimbursable costs include:

- Difference between book depreciation expense and that under the straight line method.
- Expenses not related to providing consumer care (personal expenses).
- Costs of consumer items provided that exceeds the $1570 limit per consumer. (See **Schedule D-1** for the consumer item limit calculation.)

You can use the nonreimbursable column to reclassify costs, such as:

- ♦ Moving agency vehicle depreciation to a direct cost line when the vehicle is used solely for the HCBS program.
- ♦ Moving food costs that are provided to the consumer at the provider site under the respite program.

Adjusted Costs (Column 4): This column shows costs that are allowable and allocable to HCBS programs, other programs, and indirect administrative costs. Indicate the balance of the expenses after deducting the items reflected in Columns 2 and 3 (fund-raising and nonreimbursable costs).

Direct Service Cost (Column 5 through 9 and 11 through 20, as needed): Use these columns for direct costs for each of the services or service sites provided, as defined below. Report direct costs by hourly service and by site.

In this accounting procedure, "direct" service expense include all direct personnel involved in a service. It includes the supervisor of that service or the appropriate prorated share of the supervisor's time. Expenses other than wages and fringe benefits can be charged as direct service expense if they are identifiable to a specific **consumer** (e.g. hands-on, one-on-one consumer contact). Examples of nonbillable direct costs:

- ♦ Mileage costs for travel to and from the consumer site
- ♦ Time spent in staff meetings related to a particular consumer/HCBS service
- ♦ Time spent documenting services provided

Include in direct costs only the following specified line items related to the direct wages allocated:

- Line 2120: Professional Direct Care Staff
- Line 2130: Other Direct Staff
- Lines 2210-2290: Direct Staff Benefits
- Lines 2310-2350: Direct Staff Payroll Taxes
- Line 3210: Mileage and Auto Rental
- Line 3250: Agency Vehicle Expense
- Line 3290: Other Related Transportation
- Line 3520: Other
- Line 4320: Other Equipment Repair and Purchase

Show indirect costs in Column 10 **only**. Do not include indirect administrative costs in Columns 5-9.

Indirect Service Costs (Column 10): This column should include those service and administrative expenses that cannot be directly related to any specific service. Indirect costs after adjustments for fund-raising and nonreimbursable costs should be shown in column 10. Some examples of indirect administrative cost are:

- Staff development and training
- Receptionist position
- Office supplies
- Telephone
- Rent for administrative office
- Property or liability insurance

All indirect costs should be shown by line item in column 10 and then allocated in total to the various programs. Each agency is responsible for developing an acceptable method of distributing the indirect service costs to the various programs and supporting its rationale.

All line items may be used as appropriate to report indirect costs in column 10. All lines not specifically addressed under direct costs (above) should be used only for costs indirectly associated with the brain injury waiver program. There may be some cases where it is necessary to show indirect column 10 costs for those lines previously discussed as direct cost lines.

Indirect costs are limited to 20% of direct costs. See **Supplemental Schedule D-2** for calculation of the limit and any necessary adjustment.

b. Accounting Title Descriptions

This section includes additional instructions for reporting selected line items.

Line 2120: Professional Direct Staff. These positions provide assistance and support to direct support staff, may provide some direct service to the consumer in the absence of direct support staff, and may supervise some direct support staff activities. Examples of positions include program directors, program supervisors, team leaders, and coordinators.

Calculate the salary expense related to this line item by multiplying the position's salary by the percentage of time spent in the specific program. This does not include administrative time. Administrative time is spent on general management of program operations and is not a direct cost.

Line 2130: Other Direct Staff. These positions provide direct support and assistance to the consumers. The wage amount is cash compensation and may also include noncash compensation of room and board, when applicable.

Direct support wages must reflect all direct support hours provided by agency personnel, including time spent on progress note, phone calls, and staffing meetings. Travel time to and from the service site should be accumulated separately from direct service time. Documentation should be available to support the travel time.

This item also includes contract services that provide direct support and assistance to consumers. The position is instead of, or in addition to, a direct support employee. Contract payments are made to persons who are not employees of the agency.

The total number of direct support and contracted hours corresponding to the direct wages must equal the direct support hours listed in the service plan.

Line 2290: Other Benefits. This item includes other benefits provided for employees, excluding travel and training costs.

Line 3210: Mileage and Auto Rental. This item includes staff mileage and expense. Mileage to and from the service site may be included as an indirect expense. Mileage cost reported is limited to the DHS employee reimbursement rate (currently 24¢ per mile).

Line 3250: Agency Vehicles Expense. Include expense for operation and maintenance of agency-owned vehicles used for the brain injury waiver program. Employee mileage to and from the service site in an agency vehicle may be included as a direct cost. Mileage cost reported is limited to the DHS employee reimbursement rate (currently 24¢ per mile).

Line 3290: Other Related Transportation. Include expense attributable to the actual transporting of the consumer (provided by staff, taxi, car pool, and bus fare) to allow the consumer to have access to community resources and opportunities. For supported community living, this item cannot pay for any mode of transportation that provides transportation to work. (This item is subject to the limit on consumer needs items. See **Supplemental Schedule D-1**.)

Line 3520: Other. Include consultation expenses (such as an interpreter) and expenses directly related to the implementation of instructional activities identified in the consumer's service plan. (This item is subject to the limit on consumer needs items. See **Supplemental Schedule D-1**.)

Line 4320: Other Equipment Repair and Purchase. Include expense amounts for the modification or repair of the consumer's living unit. Expenses included may provide for reasonable accommodation of the behaviors of the consumer in rental units. For consumer-owned units, minor maintenance expenses may be included. Also, include household furnishings needed by the consumer. (This item is subject to the limit on consumer needs items. See **Supplemental Schedule D-1**.)

Line 3310: Staff Development and Training. Include all registration, tuition costs, travel, and living expenses incurred by the agency in sending staff members or volunteers to regional and national conferences or to workshops or institutes. Also show the travel and other costs incurred by an agency in bringing in an outside consultant to conduct a training institute in the agency for conferences or institutes in this item. All training should be classified as an indirect expense in column 10.

6. Supplemental Schedule D-1

The purpose of HCBS Supplemental Schedule D-1, Calculation of Consumer Cost Limits, is to calculate an average cost per consumer for consumer needs items and to determine the reasonableness of these items.

A consumer is eligible for $1570 of consumer items on an annual basis. The 12-month total of Schedule D lines 3290, Other Related Transportation; 3520, Other; and 4320, Other Equipment Repair and Purchase, cannot exceed $1570 per consumer. These costs need to be accumulated on an annual basis, with adjustments made for any excesses over the limit.

These expenses are defined as specific costs associated to the consumer. First seek all payment of these expenses from the consumer; second, from community resources; and third, from the HCBS program. The agency is responsible for tracking consumer costs individually to ensure the cost remains within the limit. Maintain documentation to track the costs per consumer adequately.

Complete a column for each living site or service. Carry over the consumer item costs from Schedule D. Divide the total costs by the number of unduplicated consumers at each living site for the current period. Compare the amount per consumer against the limitation of $1570 for each service per living site. Multiply any excess by the number of unduplicated consumers to obtain the total variance.

7. Supplemental Schedule D-2

The purpose of HCBS Supplemental Schedule D-2, Calculation of Indirect Cost Limits, is to calculate the indirect administrative cost limit of 20% of direct costs and to compare actual indirect costs allocated to HCBS services to that limit. This schedule compares actual indirect costs allocated to a living site or service against the limitation of indirect expense to 20% of direct costs.

Complete a column for each living site or service. Carry over the total expense by facility and service from the total expense line on Schedule D. This is the total expense, including the direct expense and the allocation of the indirect expense but before any income deductions. Carry over direct costs from the corresponding lines on Schedule D for each HCBS program and service. Calculate indirect costs by subtracting these direct expenses from the total.

Calculate the limit of 20% of direct costs using the subtotal of the direct costs lines. Compare this limitation against the calculated indirect expense. Carry forward any excess over the 20% limit to Supplemental Schedule D-3.

8. Supplemental Schedule D-3

The purpose of HCBS Supplemental Schedule D-3, Reconciliation of Costs and Payments, is to document cost per visit by service and to compare costs incurred to payments received. All prospective rates are subject to retrospective adjustment based on reconciliation of provider's reasonable and proper actual service costs with the revenues received for those services.

File only one schedule for the HCBS program, showing all HCBS services. Carry to this schedule the direct costs plus indirect costs less any deduction on Schedule D. Costs may be combined into columns by service code. Also include any adjustment calculated on Schedule D-2. Then calculate total net costs of the other schedule adjustments per service code.

The next section of the schedule compares Medicaid's portion of the costs on the report to revenues billed from the Medicaid program. Use the lower of the adjusted costs per unit computed in the first part of schedule or the capped rate for the service multiplied by DHS units as the DHS cost to compare against revenues billed.

"Revenues billed" means payments received for a service category provided in the specified period and payments accrued, but expected to be received, for those services provided in the same period. These revenue figures come from provider records. Include only those payments received or expected to be received for the current period.

A balance due the Medicaid program may occur. Revenues exceeding adjusted actual costs by more than 2.5 percent shall be remitted to the Division of Medical Services. The balance due should be remitted when the *Financial and Statistical Report* is filed. Providers who do not reimburse revenues exceeding 2.5 percent of actual costs 30 days after notice is given by the Department will have this amount deducted from future payments.

9. Supplemental Schedule D-4

The purpose of HCBS Supplemental Schedule D-4, Daily Rate Worksheet, is to calculate the unit daily rates cost per living site. Costs reported by site should be consistent with those reported on Schedule, less any adjustment for the limit on indirect administrative costs.

If separate rates are needed for different consumers at a site, submit a Schedule D-4 for the site rate along with separate schedules for each consumer. (For the mental retardation waiver, this could include consumers with different counties of legal settlement.) Indicate the number of consumers at the site and the site name.

Show direct costs by line item. Use actual costs for living sites not undergoing any significant change. Use projected costs if there are no representative historical costs available. Project the costs on an annual period. Complete spaces to show direct hours and miles. Show the lower of actual indirect costs or the 20% limit and add it to total direct costs. Then divide total costs by the units of service provided to calculate a unit cost.

For a living site that undergoes a significant change during the reporting period, this schedule may be submitted based on projected costs. A "significant" change occurs when a consumer's functioning level changes or you are unable to fill a vacancy within 30 days. Give a full explanation of the changes in the living site situation at the bottom of the schedule. Also give reasons for a request to exceed the unique rate maximum.

A living site rate may be adjusted no more than once every 3 months for the above reasons. The projected rate will not be inflated by the consumer price index (CPI).

10. Schedule E

The purpose of Schedule E, Comparative Balance Sheet, is to report the balance sheet of the provider as of the end of the reporting period.

Under "Assets, Liabilities, and Equity," the total assets must equal the total liabilities and equity.

Balance at End of Current Period: Enter the amount in effect for the last day of the reporting period.

Balance at End of Prior Period: Enter the amount in effect for the last day of the previous reporting period.

Under "Reconciliation of Equity or Fund Balance," the "add" and "deduct" entries should provide an explanation of any difference in the total equity of fund balance between the beginning and end of period.

Total Equity or Fund Balance Beginning of Period: This amount should be the same as the total liabilities and equity for the "balance at end of prior period." Add revenues from Schedule A and deduct expenses from Schedule D.

Total Equity or Fund Balance End of Period: This amount should be the same as the total liabilities and equity for the "balance at end of current period."

11. Schedule F

The purpose of Schedule F, Cost Allocation Procedures, is to report other supplemental information related to agency operations and accounting procedures. Complete Schedule F when your agency provides more than one service or service component.

Cost allocations are required for direct costs benefiting more than one service or service component and for the provider's indirect costs. "Direct" costs are those which are directly identifiable to services or components. "Indirect" costs, although they may benefit all services, generally are not readily identifiable with each service or service component. (See **Schedule D** for examples.)

The schedule provides questions about methods used in allocating expenses that benefit more than one service or service component. You should be able to support the basis used in allocating these costs. You may be required to obtain prior approval of the cost allocation plan from the regional office.

E. Rates Based Upon the Submitted Report

New providers who have not submitted an annual report including at least 6 months of actual, historical costs shall be paid prospective rates based on projected reasonable and proper costs of operation for a 12-month period as reported in forms SS-1703-0 and 470-3449. After a provider has submitted an annual report including at least six months of actual, historical costs, prospective rates shall be determined as for an established provider.

Providers who have submitted an annual report including at least six months of actual, historical costs shall be paid prospective rates based on reasonable and proper costs in a base period, as adjusted for inflation. The base period shall be the period covered by the first financial and statistical reports submitted to the Department after 1997 that include at least six months of actual, historical costs.

Reasonable and proper costs in the base period are inflated by a percentage of the increase in the consumer price index for all urban consumers for the preceding 12-month period ending June 30, based on the months included in the base period, to establish the initial prospective rate for an established provider.

After establishment of the initial prospective rate for an established provider, the rate is adjusted annually, effective for the third month after the month during which the annual cost report is submitted to the Department. The annual adjustment is equal to the increase in the consumer price index for all urban consumers for the preceding 12-month period ending June 30.

Hourly rates are based on the lesser of the actual cost per unit of the base period reported on Supplemental Schedule D-3 of 470-3449 or the unit maximum.

- ♦ An inflation factor will be added to the cost per unit of the previous reporting period not to allow the rate to exceed the unit maximum.
- ♦ No actual cost per unit rates will be set if the period reported is less than six months.
- ♦ No inflation factor will be added to projected rates.

Daily rates are based on the actual cost per unit of the base period reported on Schedule D-4 of form 470-3449 for each site, not to exceed the maximum unit rate.

- ♦ The Bureau of Long-Term Care may grant variations when cost-effective and in accordance with the service plan.
- ♦ No actual cost-per-unit rates will be set if the period reported is less than six months.
- ♦ An inflation factor is added to the cost per unit of the previous reporting period, not to exceed the unit maximum.

No rates are set for home and vehicle modification. This service is based upon one-time expenditures and not on a per-unit rate.

Projected rates will continue to be effective for providers with less than six months of actual cost data. Supported community living daily site rates that have been revised since the initial rate projection continue to be in effect if so noted on the submitted *Supplemental Schedule*, form 470-3449.

VI. CLIENT PARTICIPATION

The following sections explain:

- ♦ Requirements for third-party payments
- ♦ Limits on waiver payment when there is third-party liability

A. Third Party Payments

Consumers may be eligible to receive third-party vendor payments to cover the costs of some or all waiver services. This includes payments by Medicare, private health insurance, county government, or Veterans Administration aid and attendance. Generally, third-party vendor payments are paid directly to the provider. However, some third-party vendor payments are paid directly to the consumer.

Generally, a consumer eligible for physical disability waiver services under a FMAP-related, SSI-related, or 300% coverage group will not have client participation.

However, third-party medical payments that are intended to meet the costs of waiver services and which are paid directly to the consumer are counted for client participation.

The income maintenance worker determines the amount of the client participation and verifies third party liability, if any, and informs the consumer's service worker or Medicaid case manager.

People who are eligible for waiver services under the Medicaid program, including those who currently have a health insurance policy, are encouraged to apply for the Health Insurance Premium Payment (HIPP) Program for Iowa Medicaid recipients. The HIPP Medicaid program pays for private health insurance for Medicaid-eligible people when it is determined to be cost-effective. The program pays for the cost of premiums, coinsurance, and deductibles.

B. Limit on Payment

The service worker will notify you of any client participation and whether there is third-party liability. The consumer is responsible for paying applicable client participation and administering third-party vendor payments. You are responsible for billing any third party or collecting from the consumer.

Bill Medicaid only for the difference between the client participation or third-party liability amounts and the cost for services. Bill waiver services showing third-party payments or client participation, even if no third-party or client participation payments are made.

Medicaid pays the balance of the cost of waiver services, up to the established limit, after third-party payment and client participation have been applied to the cost of services. If the consumer has an unused portion of client participation, the consumer retains the unused portion. Client participation is not carried over to the next month.

VII. PROCEDURE CODES AND MAXIMUM REIMBURSEMENT RATES

The following chart indicates the maximum possible reimbursement rate for all waiver services. The maximum service rates indicated may not reflect your actual costs. Therefore, if your actual costs do not meet the maximum rate identified, you must charge the general public the lesser rate. The lesser rate will be used to calculate the amount that you will bill to ACS for waiver services provided.

Each service must be billed in whole units.

You are responsible for communicating current service rates to the service worker or case manager who is responsible for writing a service plan for each individual receiving waiver services. Because the service plan authorizes waiver services, current service rates must be included.

HCPCS Code	Service	Basis of Reimbursement	Upper Limits
W1265	Consumer directed attendant care agency, hourly	Fee agreed upon by consumer and provider	$18.49 per hour not to exceed daily rate of $106.82 (1-7 hours)
W1266	Consumer directed attendant care agency, daily	Fee agreed upon by consumer and provider	$106.82 per day (8-24 hours)
W1267	Consumer directed attendant care individual, hourly	Fee agreed upon by consumer and provider	$12.33 per hour not to exceed the daily rate of $71.90 (1-7 hours)
W1268	Consumer directed attendant care individual, daily	Fee agreed upon by consumer and provider	$71.90 per day (8-24 hours)
W1407	Personal emergency response system, monthly	Fee schedule	$35.95 per month
W1408	Emergency response system, initial one-time fee	Fee schedule	$46.22 initial one-time fee
W1417	Home and vehicle modification	Fee schedule	$500 per month, not to exceed $6000 per year
W1418	Specialized medical equipment	Fee schedule	$500 per month, not to exceed $6000 per year
W1414	Transportation	Fee schedule	$0.29 per mile

I. INSTRUCTIONS AND CLAIM FORM

A. Instructions for Completing the Claim Form

Submit billings for all case management services to the Medicaid fiscal agent, ACS, on the *Claim for Targeted Medical Care*, Iowa Medicaid program, form 470-2486. Copies of this form may be obtained from ACS at (515) 327-5120 or (800) 338-7909.

Bill ACS for each service rendered to each consumer (recipient) using applicable charges or the rate determined by the Bureau of Long-Term Care. The cost limits are presented in Chapter E, Section **VII: PROCEDURE CODES AND MAXIMUM REIMBURSEMENT RATES**. The maximum Medicaid rates are reviewed annually by the state legislature and, with the Governor's approval, are established effective July 1 for each state fiscal year.

Submit claims to ACS on a monthly basis to facilitate payment in a timely manner. To receive payment monthly, submit the claim for the month's service by the tenth of the month following the month of service. **Example:** A recipient received 24 hours of waiver service during the month of June. The claim for June's service should be submitted by the tenth day of July.

The following table contains information to aid in the completion of the *Claim for Targeted Medical Care*, form 470-2486. The table matches field numbers and names on the form, giving a brief description of what information is needed, and whether providing information in that field is required, optional or conditional of the individual recipient's situation.

A star (*) in the instructions area of the table indicates a new item or change in policy for Iowa Medicaid providers.

Note: For Electronic Media Claim (EMC) submitters, refer to your EMC specifications for appropriate claim completion instructions.

Training in completing the claim form is available from ACS. Call ACS at the number listed above and request a field representative. A field representative will return your call and schedule a visit with you.

LOCATOR #/FIELD REQUIREMENTS		LOCATOR NAME	TARGETED MEDICAL CARE CLAIM FORM DESCRIPTION AND INSTRUCTIONS
1	**R**	**STATE ID**	Enter the recipient's Medicaid identification number, found on the *Medical Assistance Eligibility Card*. This number consists of seven digits and an ending letter. (For example, 1234567A)
1a	**R**	**CONSUMER ACCOUNT #**	Enter the patient account number assigned by you.
2	**R**	**CONSUMER'S NAME**	Enter the last name, first name, and middle initial of the recipient. Use the *Medical Assistance Eligibility Card* for verification.
3	**R**	**TREATING PROVIDER NUMBER**	Enter your seven-digit Medicaid identification number.
4	**R**	**TREATING PROVIDER NAME**	Enter your name.
5	**R**	**TREATING PROVIDER ADDRESS**	Enter your address.
6	**R**	**PAY-TO PROVIDER NUMBER***	Enter your seven-digit Medicaid identification number.
7		**PAY-TO PROVIDER NAME**	No entry required.
8	**C**	**OTHER INSURANCE: YES**	If the medical resource codes indicate there is other insurance coverage, or if you are aware of other coverage that will pay, check YES. Enter the amount the other insurance paid in box 12.
		OTHER INSURANCE: NO	Leave blank.
9	**C**	**OTHER INSURANCE DENIED: YES**	If the other insurance denied, check YES. (Be sure to also check YES in box 8.)

		OTHER INSURANCE DENIED: NO	Leave blank.
10		**SERVICES:**	
10A	**R**	**PROCEDURE CODE**	Enter the appropriate five-digit procedure code.
10B			Leave blank.
10C	**O**	**PROCEDURE DESCRIPTION**	Enter a complete description of the service performed.
10D	**R**	**PLACE OF SERVICE**	* Enter one of the two-digit codes as follows: 11 Office 12 Home 21 Inpatient hospital 22 Outpatient hospital 23 Emergency room - hospital 24 Ambulatory surgical center 25 Birthing center 26 Military treatment facility 31 Skilled nursing facility 33 Custodial care facility 34 Hospice 41 Ambulance - land 42 Ambulance - air or water 51 Inpatient psychiatric facility 52 Psychiatric facility partial hospitalization 53 Community mental health center 54 Intermediate care facility/mentally retarded 55 Residential substance abuse treatment facility 56 Psychiatric residential treatment center 61 Comprehensive inpatient rehabilitation facility 62 Comprehensive outpatient rehabilitation facility 65 End-stage renal disease treatment 71 State of local public health clinic 72 Rural health clinic 81 Independent laboratory 99 Other unlisted facility

10E	**R**	**FIRST DATE OF SERVICE** *	For the first month of service, enter the first date of service. In subsequent months, enter the first date of the calendar month for which the charge was incurred. The entry must be six digits (MM/DD/YY, for example 03/01/02). If there is client participation from the patient, only one calendar month can be billed per claim form. The county human services worker will inform you if you are to collect client participation from the patient.
10F	**R**	**LAST DATE OF SERVICE** *	Enter the last day of the calendar month that was entered in 10E. For the last month of service, enter the last date service was provided. The entry must be six digits (MM/DD/YY, for example 03/31/02). If there is client participation from the patient, only one calendar month can be billed on each claim form. The county human services worker will inform you if you are to collect client participation from the patient.
10G	**R**	**PROVIDER RATES** *	Enter the rate that you have been authorized in the Care Plan to bill Iowa Medicaid. This may be an hourly, daily, monthly, per visit, or per trip, depending on the service provided. Refer to Chapter E for unit rate descriptions.
10H	**R**	**UNITS** *	Enter the applicable number of units of service depending upon the procedure code you are billing. Bill only for services that you have provided. Round units for the entire month to the nearest whole number. Refer to Chapter E for procedure code descriptions.
10I		**TOTAL CHARGES** *	Multiply your provider rate (10G) times the number of units of service (10H). Enter the total charge for the month being billed.

11	**R**	**TOTAL CHARGE**	Enter the total change for all services being billed on this claim form.
12	**C**	**THIRD PARTY LIABILITY** *	Enter any insurance payments you have received for this claim. DO NOT enter Iowa Medicaid payments in this box.
13	**C**	**CLIENT PARTICIPATION** *	If you have been instructed by the county human services worker to collect a client participation amount from the recipient, enter it here. Otherwise, leave this box blank.
14	**R**	**BALANCE DUE**	Subtract the amounts in boxes 12 and 13 from the amount in box 11 and enter the amount due from the Medicaid program.
	R	**PROVIDER SIGNATURE**	Enter the signature of the authorized representative. If the signature is computer-generated block letters, the signature must be initialed. A signature stamp may be used.
	R	**DATE** *	Enter the date that the claim form is originally signed. If the claim form must be resubmitted, enter the original signature date.
	R	**CONSUMER/ GUARDIAN SIGNATURE**	For consumer-directed attendant care claims, the consumer (or the consumer's guardian, if applicable) must sign here.
	R	**DATE** *	Enter the date that the claim form is originally signed. If the claim form must be resubmitted, enter the original signature date.

B. Facsimile of Claim for Targeted Medical Services, Form 470-2486

(See the following pages.)

C. Claim Attachment Control, Form 470-3969

If you want to submit electronically a claim that requires an attachment, you must submit the attachment on paper using the following procedure:

- Staple the additional information to form 470-3969, *Claim Attachment Control*. (See the page following the claim form for an example of this form.)
- Complete the “attachment control number” with the same number submitted on the electronic claim. ACS will accept up to 20 characters (letters or digits) in this number. If you do not know the attachment control number for the claim, please contact the person in your facility responsible for electronic claims billing.
- Do not attach a paper claim.
- Mail the *Claim Attachment Control* with attachments to:

  ACS State Healthcare
  P.O. Box 14422
  Des Moines, IA 50306-3422

Once ACS receives the paper attachment, it will manually be matched up to the electronic claim using the attachment control number and then processed.

Iowa Medicaid Program

Claim Attachment Control

Please use this form when submitting a claim electronically which requires an attachment. The attachment can be submitted on paper along with this form. The "Attachment Control Number" submitted on this form must be the same "attachment control number" submitted on the electronic claim. Otherwise the electronic claim and paper attachment cannot be matched up.

Attachment Control Number

Provider Name ____

Pay-to-Provider Number

Recipient Name ____

Recipient State ID Number

Date of Service _____/_____/_________

Type of Document

____

____

____

RETURN THIS DOCUMENT WITH ATTACHMENTS TO:
ACS State Healthcare
P.O. Box 14422
Des Moines, IA 50306-3422

Iowa Department of Human Services

CLAIM FOR TARGETED MEDICAL CARE

(Please type. Accuracy is important.)

CHECK ONE:

- ❑ A = ILL & HANDICAPPED WAIVER
- ❑ B = AIDS WAIVER
- ❑ C = ELDERLY WAIVER
- ❑ D = MR WAIVER
- ❑ E = RESERVED
- ❑ F = BRAIN INJURY WAIVER
- ❑ G = CASE MGT
- ❑ H = RESERVED
- ❑ I = RESERVED
- ❑ J = RESERVED
- ❑ P = PHYSICAL DISABILITY WAIVER

(A) CONSUMER INFORMATION:

STATE ID:	1	CONSUMER ACCT #:	1a
CONSUMER'S NAME:	2 LAST	FIRST	MI

(B) PROVIDER INFORMATION:

TREATING PROVIDER NUMBER / NAME:	3	/ 4
TREATING PROVIDER ADDRESS: (STREET, CITY, STATE, ZIP)	5	
PAY - TO PROVIDER NUMBER / NAME:	6	/ 7

8 **OTHER INSURANCE:** ❑ YES ❑ NO

9 **OTHER INSURANCE DENIED:** ❑ YES ❑ NO

10 (C) SERVICES:

A. PROC CODE	B.	C. PROCEDURE DESCRIPTION	D. * PLACE OF SVC	E. FIRST DATE MM/DD/YY	F. LAST DATE MM/DD/YY	G. PROVIDER RATES	H. UNITS	I. TOTAL CHARGES
				___/___/___	___/___/___			
				___/___/___	___/___/___			
				___/___/___	___/___/___			
				___/___/___	___/___/___			
				___/___/___	___/___/___			
				___/___/___	___/___/___			

* PLACE OF SERVICE (REFER TO CODES ON BACK)

I certify that the statements on the back apply to this bill and are made a part of it.

PROVIDER SIGNATURE	DATE

TOTAL CHARGE:	11
THIRD PARTY LIABILITY:	12
CLIENT PARTICIPATION:	13
BALANCE DUE:	14

For consumer-directed attendant care claims only:

CONSUMER/GUARDIAN SIGNATURE	DATE

MEDICAID PAYMENTS

(PROVIDER CERTIFICATION)

I hereby agree:

- To keep such records as are necessary to disclose fully the extent of services provided to individuals under the Iowa Medicaid Program, as specified in the Provider Manual and the Iowa Administrative Code.
- To furnish records and other information regarding any payments claimed for providing such services as the Iowa Department of Human Services, its designee or Health and Human Services may request.
- To accept, as payment in full, subject to audit, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductibles, coinsurance, copayment, and spenddown.
- To comply with the provisions of the Civil Rights Act of 1964 and Section 504 of the Rehabilitation Act of 1973.

I certify that:

- The services shown on the front of this form were rendered to the consumer and were medically indicated and necessary for the health of the patient.
- The charges for these services are just, unpaid, actually due according to law and program policy and not in excess of regular fees.
- The information provided on the front of this claim is true, accurate, and complete.

I understand that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

PLACE OF SERVICE CODES

11 Office
12 Home
21 Inpatient hospital
22 Outpatient hospital
23 ER room hospital
24 Ambulatory surgical center
31 Skilled nursing facility
32 Nursing facility
33 Custodial care facility
34 Hospice
51 Inpatient psychiatric facility
53 Community mental health center
54 Intermediate care facility/MR
55 Residential substance abuse treatment facility
56 Residential psychiatric treatment facility
61 Comp inpatient rehab facility
62 Comp outpatient rehab facility
71 Public health clinic
99 Other

II. REMITTANCE ADVICE AND FIELD DESCRIPTIONS

A. Remittance Advice Explanation

To simplify your accounts receivable reconciliation and posting functions, you will receive a comprehensive *Remittance Advice* with each Medicaid payment. The *Remittance Advice* is also available on magnetic computer tape for automated account receivable posting.

The *Remittance Advice* is separated into categories indicating the status of those claims listed below. Categories of the *Remittance Advice* include paid, denied and suspended claims. PAID indicates all processed claims, credits and adjustments for which there is full or partial reimbursement. DENIED represents all processed claims for which no reimbursement is made. SUSPENDED reflects claims which are currently in process pending resolution of one or more issues (recipient eligibility determination, reduction of charges, third party benefit determination, etc.).

Suspended claims may or may not print depending on which option was specified on the *Medicaid Provider Application* at the time of enrollment. You chose one of the following:

- Print suspended claims only once.
- Print all suspended claims until paid or denied.
- Do not print suspended claims.

Note that claim credits or recoupments (reversed) appear as regular claims with the exception that the transaction control number contains a “1” in the twelfth position and reimbursement appears as a negative amount. An adjustment to a previously paid claim produces two transactions on the *Remittance Advice*. The first appears as a credit to negate the claim; the second is the replacement or adjusted claim, containing a “2” in the twelfth position of the transaction control number.

If the total of the credit amounts exceeds that of reimbursement made, the resulting difference (amount of credit - the amount of reimbursement) is carried forward and no check is issued. Subsequent reimbursement will be applied to the credit balance, as well, until the credit balance is exhausted.

An example of the *Remittance Advice* and a detailed field-by-field description of each informational line follows. It is important to study these examples to gain a thorough understanding of each element as each *Remittance Advice* contains important information about claims and expected reimbursement.

Regardless of one's understanding of the *Remittance Advice*, it is sometimes necessary to contact the fiscal with questions. When doing so, keep the *Remittance Advice*, handy and refer to the transaction control number of the particular claim. This will result in timely, accurate information about the claim in question.

B. Facsimile of Remittance Advice and Detailed Field Descriptions

(See the following page.)

IAMC8000-R001 (CP-0-12)
AS OF 05/19/97

IOWA DEPARTMENT OF HUMAN SERVICES
MEDICAID MANAGEMENT INFORMATION SYSTEM

RUN DATE 06/12/97

R E M I T T A N C E   A D V I C E

(1.) TO: (2.) R.A. NO.: 0000022 (3.) DATE PAID: 05/19/97 (4.) PROVIDER NUMBER: PAGE: 1

**** PATIENT NAME **** LAST	FIRST MI	RECIP ID / LINE	TRANS-CONTROL-NUMBER / SVC-DATE	PROC/MODS	UNITS	BILLED AMT.	OTHER SOURCES	PAID BY MCAID	COPAY AMT.	MED RCD NUM / PERF. PROV.	S	EOB EOB
			* * * CLAIM TYPE: WAIVER			* * * CLAIM STATUS: PAID						
ORIGINAL CLAIMS:			(7.)			(8.)	(9.)	(10.)	(11.)			(14.)
(5.)		(6.)	4-96326-00-131-0055-00		(18.)	9359.15	0.00	9359.15	0.00	(12.)	(13.)	000 000
		01	08/01/95	W1300	31	1519.31	0.00	1519.31	0.00		B	000 000
		02	09/01/95	W1300	30	1470.30	0.00	1470.30	0.00		B	000 000
		(15.) 03	(16.) 10/01/95	W1300 (17.)	31	1862.79	0.00	1862.79	0.00		B	000 000
		04	11/01/95	W1300	30	1802.70	0.00	1802.70	0.00		B	000 000
		05	12/01/95	W1300	31	1862.79	0.00	1862.79	0.00		B	000 000
		06	01/01/96	W1300	14	841.26	0.00	841.26	0.00		B	900 000
			4-96340-00-102-0034-00			5197.71	0.00	0.00	0.00			000 000
		01	09/09/96	W1300	22	2157.54	0.00	0.00	0.00		K	000 000
		02	10/01/96	W1300	31	3040.17	0.00	0.00	0.00		K	000 000

REMITTANCE T O T A L S (19.)

PAID ORIGINAL CLAIMS:	NUMBER OF CLAIMS	2	14,556.86	9,359.15
PAID ADJUSTMENT CLAIMS:	NUMBER OF CLAIMS	0	0.00	0.00
DENIED ORIGINAL CLAIMS:	NUMBER OF CLAIMS	0	0.00	0.00
DENIED ADJUSTMENT CLAIMS:	NUMBER OF CLAIMS	0	0.00	0.00
PENDED CLAIMS (IN PROCESS):	NUMBER OF CLAIMS	0	0.00	0.00
AMOUNT OF CHECK:				9,359.15

---- THE FOLLOWING IS A DESCRIPTION OF THE EXPLANATION OF BENEFIT (EOB) CODES THAT APPEAR ABOVE:

900 THE CLAIM IS IN SUSPENSE. DO NOT RESUBMIT THE CLAIM.

C. Remittance Statement Field Description

1. Pay-to provider name as specified on the *Medicaid Provider Enrollment Application*.
2. *Remittance Advice* number.
3. Date claim paid.
4. Medicaid (Title XIX) pay-to provider number.
5. Recipient last and first name.
6. Recipient Medicaid ID number.
7. Transaction control number assigned by fiscal agent to each claim. Please use this number when making inquiries about claims.
8. Total charges submitted by provider.
9. Total amount applied to this claim from other resources, i.e., other insurance or spenddown.
10. Total amount paid by Medicaid for this claim.
11. Total amount of recipient copayment deducted from this claim.
12. Medical record number as assigned by provider/Medicaid ID number of provider performing services.

13. Allowed charge source code.

B	Billed charge	**F**	Fee schedule
K	Denied	**N**	Provider charge rate
P	Group therapy	**Q**	EPSDT total screen over 17 years
R	EPSDT total under 18 years	**S**	EPSDT partial over 17 years
T	EPSDT partial under 18 years	**U**	Gynecology fee
V	Obstetrics fee	**W**	Child fee

14. Explanation of benefits code indicates the reason for claim denial. Refer to explanation at end of the remittance for each EOB code in the *Remittance Advice*.

15. Line item number.

16. The first date of service for the procedure billed.

17. The procedure code for the service billed.

18. The number of units of service rendered.

19. Remittance totals (found at the end of the *Remittance Advice*).

    - Number of paid original claims, amount billed, and amount allowed and paid.
    - Number of paid adjusted claims, amount billed, and amount allowed and paid.
    - Number of denied original claims, amount billed, and amount allowed and paid.
    - Number of denied adjusted claims, amount billed, and amount allowed and paid.
    - Number of pended claims (in process), amount billed, and amount allowed.
    - Amount of check.

20. Description of individual explanation of benefits codes. The EOB code leads, followed by important information and advice.

III. PROBLEMS WITH SUBMITTED CLAIMS

To inquire as to why a claim was denied or why a claim payment was not what you expected, please complete form 470-3744, *Provider Inquiry*. Attach copies of the claim, the *Remittance Advice*, and any supporting documentation you want to have considered, such as additional medical records. Send these to:

ACS, Attn: Provider Inquiry
PO Box 14422
Des Moines, Iowa 50306-3422

To make an adjustment to a claim following receipt of the *Remittance Advice*, use form 470-0040, *Credit/Adjustment Request*. Use the *Credit/Adjustment Request* to notify the fiscal agent to take an action against a paid claim, such as when:

- ♦ A paid claim amount needs to be changed, or
- ♦ Money needs to be credited back, or
- ♦ An entire remittance *advice* should be canceled.

Send this form to:

ACS, Attn: Credits and Adjustments
PO Box 14422
Des Moines, Iowa 50306-3422

Do **not** use this form when a claim has been denied. Denied claims must be resubmitted.

A. Facsimile of Provider Inquiry, 470-3744

You can obtain this form by printing or copying the sample in the manual or contacting the fiscal agent. A facsimile of the form follows.

B. Facsimile of Credit/Adjustment Request, 470-0040

You can obtain this form by printing or copying the sample in the manual or contacting the fiscal agent. A facsimile of the form follows.

Page 16 was intentionally left blank.

Iowa Medicaid Program

PROVIDER INQUIRY

Attach supporting documentation. Check applicable boxes: ❒ Claim copy ❒ Remittance copy
❏ Other pertinent information for possible claim reprocessing.

INQUIRY A

1. **17-DIGIT TCN** | | | | | | | | | | | | | | | | | |

2. **NATURE OF INQUIRY**

____
____
____

(Please do not write below this line)
FISCAL AGENT RESPONSE

____
____

INQUIRY B

1. **17–DIGIT TCN** | | | | | | | | | | | | | | | | | |

2. **NATURE OF INQUIRY**

____
____
____

(Please do not write below this line)
FISCAL AGENT RESPONSE

____
____

Provider Signature/Date:	**MAIL TO: ACS** **P. O. BOX 14422** **DES MOINES IA 50306-3422**	**ACS Signature/Date:**

Provider Please Complete:

7-digit Medicaid Provider ID#____________________

Telephone____________________

Name
Street
City, St
Zip

(FOR ACS USE ONLY)

PR Inquiry Log #______________

Received Date Stamp:

Page 18 was intentionally left blank.

Iowa Medicaid Program

CREDIT/ADJUSTMENT REQUEST

Do **not** use this form if your claim was denied. Resubmit denied claims.

SECTION A: Check the most appropriate action and complete steps for that request.

❑ **CLAIM ADJUSTMENT**
- Attach a complete copy of claim. (If electronic, use next step.)
- Attach a copy of the Remittance Advice with corrections in **red ink**.
- Complete Sections B and C.

❑ **CLAIM CREDIT**
- Attach a copy of the Remittance Advice.
- Complete Sections B and C.

❑ **CANCELLATION OF ENTIRE REMITTANCE ADVICE**
- Use only if all claims on Remittance Advice are incorrect. This option is rarely used.
- Attach the check and Remittance Advice.
- Skip Section B. Complete Section C.

SECTION B:

1. 17-digit TCN																	

2. Pay-to Provider #:

4. 8-character Iowa Medicaid Recipient ID: (e.g., 1234567A)

3. Provider Name and Address:

5. Reason for Adjustment or Credit Request:

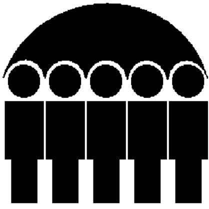
SECTION C:

Provider/Representative Signature:

Date:

FISCAL AGENT USE ONLY: REMARKS/STATUS

Return All Requests To: **ACS**
PO Box 14422
Des Moines, IA 50306-3422



Iowa Department of Human Services

For Human Services use only:

General Letter No. 8-AP-112
Employees' Manual, Title 8
Medicaid Appendix

May 10, 1999

HCBS PHYSICAL DISABILITY WAIVER MANUAL TRANSMITTAL NO. 99-1

ISSUED BY: Division of Medical Services, Iowa Department of Human Services

SUBJECT: ***HCBS Physical Disability Waiver Manual***, Title page, new; Table of Contents (pages 4 and 5), new; Chapter A, *Description of Manual;* Chapter B, *General Information About the Program*; Chapter C, *Recipient Eligibility*; Chapter D, *General Program Policies*; Chapter E, *Coverage and Limitations,* 1 through 34, new*;* Chapter F, *Billing and Payment*, pages 1 through 13, new.

This general letter transmits the Medicaid provider policies for the home- and community-based services physical disability waiver.

Chapter A through D contain general information about the Medicaid program.

Chapter E describes the federal and state Medicaid requirements a provider must meet to participate in the HCBS physical disability waiver program.

Chapter F describes the billing procedures a provider must follow to receive payment for waiver services provided.

Effective Date

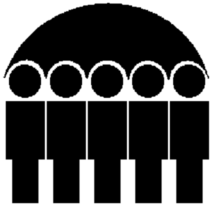
April 1, 1999

Material Superseded

None

Additional Information

If any portion of this manual is not clear, please direct your inquiries to Consultec, fiscal agent for the Department of Human Services.



Iowa Department of Human Services

For Human Services use only:

General Letter No. 8-AP-125
Employees' Manual, Title
Medicaid Appendix

September 27, 1999

HCBS PHYSICAL DISABILITY WAIVER MANUAL TRANSMITTAL NO. 99-2

ISSUED BY: Division of Medical Services, Iowa Department of Human Services

SUBJECT: SUBJECT: ***HCBS Physical Disability Waiver Manual***, Table of Contents (page 4), revised; Chapter E, *Coverage and Limitations*, pages 1, 7 through 11, 13, and 21 through 28, revised.

This general letter transmits changes to the Medicaid provider policies for the home- and community-based services physical disability waiver:

- ♦ Community businesses may enroll directly with Medicaid as home and vehicle modification providers.
- ♦ Form 470-3372, *HCBS Consumer Directed Attendant Care Agreement*, is revised to move the section on provider records checks and hold-harmless agreement to the end of the form and eliminate the requirement for two signatures by the provider.

Date Effective

October 1, 1999

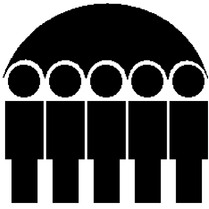
Material Superseded

Remove the following pages from ***HCBS Physical Disability Waiver Manual*** and destroy them:

Page	Date
Table of Contents (page 4)	April 1, 1999
Chapter E	
1, 7-11, 13	April 1, 1999
21-27	6/98
28	April 1, 1999

Additional Information

If any portion of this manual is not clear, please direct your inquiries to Consultec, fiscal agent for the Department of Human Services.



Iowa Department of Human Services

For Human Services use only:

General Letter No. 8-AP-140
Employees' Manual, Title 8
Medicaid Appendix

March 6, 2000

HCBS PHYSICAL DISABILITY WAIVER MANUAL TRANSMITTAL NO. 00-1

ISSUED BY: Division of Medical Services, Iowa Department of Human Services

SUBJECT: ***HCBS Physical Disability Waiver Manual***, Chapter E, *Coverage and Limitations,* page 33, revised.

Summary

The Iowa Legislature appropriated increases in reimbursement rates to several Medicaid provider types effective July 1, 1999. This manual release updates procedure codes that received a 2% increase to the rates or rate caps.

Any changes in rates must be ordered and approved in the consumers' service plans before billing. For services that have rates established through the financial and statistical cost reporting process, rates cannot be changed until cost reporting is complete for FY 1999.

Effective Date

July 1, 1999

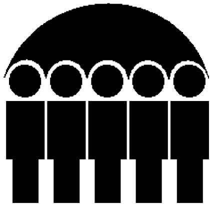
Material Superseded

Remove and destroy the following from ***HCBS Physical Disability Waiver Manual:***

Page	Date
Chapter E	
33	April 1, 1999

Additional Information

If any portion of this manual is not clear, please direct your inquiries to Consultec, fiscal agent for the Department of Human Services.



Iowa Department of Human Services

For Human Services use only:

General Letter No. 8-AP-157
Employees' Manual, Title 8
Medicaid Appendix

September 15, 2000

HCBS PHYSICAL DISABILITY WAIVER MANUAL TRANSMITTAL NO. 00-2

ISSUED BY: Division of Medical Services, Iowa Department of Human Services

SUBJECT: ***HCBS Physical Disability Waiver Manual***, Table of Contents (page 5) revised; and Chapter F, *Billing and Payment*, page 4, revised, and pages 14 through 19, new.

Summary

The changes to Chapter F revise claim completion instructions for client participation to match narrative instructions and add two forms to be used to resolve problems with submitted claims.

Effective Date

April 1, 2000

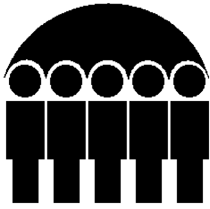
Material Superseded

Remove the following pages from the ***HCBS Physical Disability Waiver Manual*** and destroy them:

Page	Date
Table of Contents (page 5)	April 1, 1999
Chapter F	
4	July 1, 1999

Additional Information

If any portion of this manual is not clear, please direct your inquiries to Consultec, fiscal agent for the Department of Human Services.



Iowa Department of Human Services

For Human Services use only:

General Letter No. 8-AP-169
Employees' Manual, Title 8
Medicaid Appendix

June 22, 2001

HCBS PHYSICAL DISABILITY WAIVER SERVICES MANUAL TRANSMITTAL NO. 01-1

ISSUED BY: Division of Medical Services, Iowa Department of Human Services

SUBJECT: ***HCBS PHYSICAL DISABILITY WAIVER SERVICES MANUAL***, Table of Contents (pages 4 and 5), revised; (page 6), new; Chapter E, *Coverage and Limitations*, pages 1 through 34, revised; pages 35 through 86, new; and Chapter F, *Billing and Payment*, pages 1 and 4, revised.

Summary

This letter transmits changes to the HCBS physical disability waiver effective July 1, 2000, February 1, 2001, and May 1, 2001.

The following changes were effective July 1, 2000:

♦ The reimbursement rates or rate caps for attendant care and personal emergency response providers were increased by 0.7 percent. Provider agencies are responsible for communicating rate changes to consumers' service workers and case managers. Changes in rates must be ordered and approved in the consumers' service plans prior to billing.

The following change was effective February 1, 2001:

♦ The 30-day institutional stay requirement is eliminated. All slots are available on a first-come, first-served basis.

The following changes were effective May 1, 2001:

♦ Adult day service providers enrolled to provide consumer-directed attendant care services are no longer required to submit a detailed cost report.

♦ People who have durable power of attorney for medical care are added to the list of people who can agree to consumer-directed attendant care services on behalf of a consumer.

♦ Allowable home and vehicle modification service providers are redefined to add community businesses as a provider type. Policy is revised to specifically define covered home and vehicle modifications. Only the modifications listed will be covered.

♦ Policy governing consumer-directed attendant care services is revised to allow the assistance of consumers with job-related tasks, at the direction of the Health Care Financing Administration.

♦ The terms "individual comprehensive plan" and "case plan" are replaced by "service plan" throughout the manual.

Dates Effective

July 1, 2000, February 1, 2001, and May 1, 2001

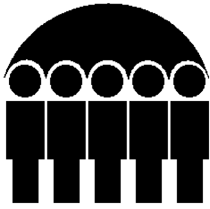
Material Superseded

Remove the following pages from the ***HCBS PHYSICAL DISABILITY WAIVER SERVICES MANUAL***, and destroy them:

Page	Date
Table of Contents	
4	October 1, 1999
5	April 1, 2000
Chapter E	
1	October 1, 1999
2-6	April 1, 1999
7-13	October 1, 1999
14-20	April 1, 1999
21-28	7/99
29-32	April 1, 1999
33	July 1, 1999
34	April 1, 1999
Chapter F	
1	April 1, 1999
4	April 1, 2000

Additional Information

If any portion of this manual is not clear, please direct your inquiries to Consultec, fiscal agent for the Department of Human Services.



For Human Services use only:

General Letter No. 8-AP-210
Employees' Manual, Title 8
Medicaid Appendix

May 5, 2003

HCBS PHYSICAL DISABILITY WAIVER MANUAL TRANSMITTAL NO. 03-1

ISSUED BY: Bureau of Long-Term Care

SUBJECT: ***HCBS PHYSICAL DISABILITY WAIVER MANUAL***, Chapter E, *Coverage and Limitations*, pages 2, 3, 5 through 12, 13, 19, 20, 31 through 38, 44, 83, and 85, revised; and page 12a, new, Chapter F, *Billing and Payment*, pages 1, 4, 5, 7, 8, 14, 17, and 19, revised.

This manual is revised to:

- Update form 470-2917, *Medicaid HCBS Waiver Provider Application*, which has been revised to change its layout and structure and to provide more clarity in completion. The instructions are revised to comply with the new layout.
- Update form 470-2486, *Claim for Targeted Medical Care*, which has been revised to include a column that identifies the specific rate for any Medicaid service. This revision will assist the provider in computing accurate total charges.
- Change references from "Consultec" to "ACS" and from "Division of Medical Services" to "Bureau of Long-Term Care."

Date Effective

Upon receipt

Material Superseded

Remove the following pages from ***HCBS PHYSICAL DISABILITY WAIVER MANUAL*** and destroy them:

Page	Date
Chapter E	
2, 3	July 1, 2000
5-12 (470-2917)	5/01
13	July 1, 2000
19	February 1, 2001
20	July 1, 2000
31-38 (470-3372)	9/00
44, 83, 85	July 1, 2000

Chapter F

Page	Date
1, 4	July 1, 2000
5	April 1, 1999
7, 8 (470-2486)	2/99
14	April 1, 2000
17 (470-3744)	4/00
19 (470-0040)	4/00

Additional Information

The updated provider manual containing the revised pages can be found at:

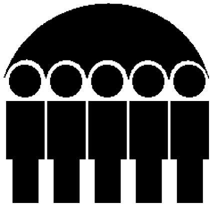
www.dhs.state.ia.us/policyanalysis

If you do not have Internet access, you may request a paper copy of this manual transmittal by sending a written request to:

ACS
Manual Transmittal Requests
PO Box 14422
Des Moines, IA 50306-3422

Include your Medicaid provider number, name, address, provider type, and the transmittal number that you are requesting.

If any portion of this manual is not clear, please direct your inquiries to ACS, fiscal agent for the Department of Human Services.



Iowa Department of Human Services

For Human Services use only:

General Letter No. 8-AP-228
Employees' Manual, Title 8
Medicaid Appendix

August 14, 2003

HCBS PHYSICAL DISABILITY WAIVER MANUAL TRANSMITTAL NO. 03-2

ISSUED BY: Bureau of Long-Term Care

SUBJECT: ***HCBS PHYSICAL DISABILITY WAIVER MANUAL***, Table of Contents, page 5, revised; Chapter E, *Coverage and Limitations*, pages 70, and 71, revised; Chapter F, *Billing and Payment*, pages 6, 17, and 19, revised; and page 6a, new.

Summary

Chapter E has been revised to:

- Provider Manual for the ***HCBS PHYSICAL DISABILITY WAIVER MANUAL*** has been revised to update the policy for depreciation for providers under the waiver who complete a cost report. The cost threshold will now be $5000 instead of $500. If a depreciable asset has at the time of it acquisition an estimated useful life of at least two years and a historical cost of at least $5000, its cost must be capitalized and written off ratably over the estimated useful life of the asset using one of the approved methods of depreciation.
- The Health Insurance Portability and Accountability Act of 1996 (HIPAA) mandated uniform national standards for health information. Consequently, Iowa Medicaid initiated a review of all local "W" HCPCS codes that are unique to Iowa Medicaid. These local codes are being replaced by HCPCS Level II codes. The codes for home health aide and nursing are being changed for the waivers.

Chapter F has been revised to:

- Add instructions for form 470-3969, *Claim Attachment Control*, used to submit paper attachments for an electronic claim.

Date Effective

Immediately

Material Superseded

Remove the following pages from ***HCBS PHYSICAL DISABILITY WAIVER MANUAL*** and destroy them:

Page	Date
Table of Contents (page 5)	July 1, 2000
Chapter E	
70, 71	July 1, 2000
Chapter F	
6	April 1, 1999
17 (470-3744)	10/02
19 (470-0040)	10/02

Additional Information

The updated provider manual containing the revised pages can be found at:

www.dhs.state.ia.us/policyanalysis

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ACS
Manual Transmittal Requests
PO Box 14422
Des Moines, IA 50306-3422

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