STATE OF IOWA

CHESTER J. CULVER, GOVERNOR
PATTY JUDGE, LT. GOVERNOR

DEPARTMENT OF HUMAN SERVICES
CHARLES J. KROGMEIER, DIRECTOR

March 26, 2010

GENERAL LETTER NO. 6-B-AP-6

ISSUED BY: Bureau of Long Term Care,
Iowa Medicaid Enterprise

SUBJECT: Employees' Manual, Title 6, Chapter B, Appendix, ***STATE SUPPLEMENTARY ASSISTANCE APPENDIX***, Title page, revised; Contents (page 1), revised; page 1, revised; and:

Comm. 47 *State Supplementary Assistance Residential Care Facility Handbook*, revised

Summary

The *State Supplementary Assistance Handbook for Residential Care Facilities* revised to update policies and procedures to reflect current practice. Some of the updates included are:

- Resident application procedures
- Facility billing procedures
- Corrections of legal references, organizational names, addresses and cross-references
- Revisions to the following forms:
  - 470-0443, *Application and Contract Agreement for Residential Care Facilities*
  - 470-0042, *Case Activity Report*
  - 470-0030, *Financial and Statistical Report*
  - 470-0477, *RCF Admission Agreement*
  - 470-0499, *Ten Day Report of Change for FIP and Medicaid*
- Addition of the following new forms:
  - 470-0040, *Credit/Adjustment Request*
  - 470-2927, *Health Services Application*
  - 470-0039, *Iowa Medicaid Long Term Care Claim*
  - 470-3118, *Medicaid Review*
  - 470-1911, *Medical Assistance Eligibility Card*
  - 470-3744, *Provider Inquiry*
  - *Remittance Advice*

Effective Date

Immediately.

Material Superseded

Remove the following pages from Employees' Manual, Title 6, Chapter B, Appendix, and destroy them:

Page	Date
Title page	December 31, 1996
Contents (page 1)	December 31, 1996
1	December 31, 1996
Comm. 47	
Title page	April 1988
Contents (page 1)	April 1988
Contents (page 2)	December 1991
1, 2	June 1994
3	April 1988
4	January 1993
5	June 1994
6-11	April 1988
12	July 1990
13	January 1993
14	April 1988
15	April 1991
16	June 1994
AA-4036-0 (470-0030)	/97
Comm. 48	May 1991
Contents (i)	May 1991
Contents (ii)	June 1997
1	May 1991
2	May 1994
3-4a	March 1993
5-15	May 1991
16, 17	November 1993
18-20	May 1991
21-30	June 1997
PA-1108-6 (470-0443)	10/86
17	August 1987
18	April 1988
PA-2365-6 (470-0477)	1/93
19, 20	April 1988
PA 1107-0 (470-0442)	1/94
21	April 1988
22	August 1987
AA-4166 (470-0042)	12/92
23	January 1993
24	October 1992
PA-3159-0 (470-0490)	4/87

25, 26	August 1987
470-2051	10/89
AA-4163-0	None
27-34	December 1991
AA-4164-0 (470-0040) 35	5/93
36	December 1991
AA-4164-0 (470-0040) 37	5/93
38	December 1991
AA-4165-0 (470-0041)	1/87

Additional Information

The Handbook can be found at:
www.ime.state.ia.us/providers

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

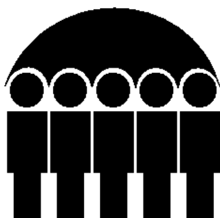
Iowa Medicaid Enterprise
Provider Services
PO Box 36450
Des Moines, IA 50315

Include your vendor number, name, address, provider type, and the general letter number that you are requesting.

If any portion of this manual is not clear, please direct your inquiries to the Iowa Medicaid Enterprise Provider Services Unit.

STATE SUPPLEMENTARY ASSISTANCE

APPENDIX



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Residential Care Facility Handbook, Comm. 47

Purpose

The State Supplementary Assistance *Residential Care Facility Handbook* has been compiled for the purpose of supplying facilities with information on State Supplementary Assistance payments for residential care.

Policies and procedures governing the program are covered in the Handbook. Copies of forms used by the facility and instructions for their completion are also a part of the Handbook.

Source

Facilities can view or download the provider manual from:

www.ime.state.ia.us/providers

Facilities that do not have Internet access, may request a paper copy of this manual by sending a written request to:

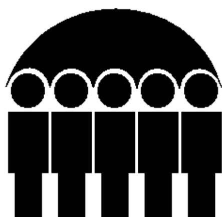
Iowa Medicaid Enterprise
Provider Services
PO Box 36450
Des Moines, IA 50315

Include the facility vendor number, name, address, provider type, and the transmittal number that you are requesting.

Comm. 47 March 2010

STATE SUPPLEMENTARY ASSISTANCE

RESIDENTIAL CARE FACILITY HANDBOOK



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INTRODUCTION

This handbook contains the policies and procedures of the Department of Human Services (referred to as "DHS" or "the Department") that govern participation of a residential care facility in the State Supplementary Assistance Program.

The federal program known as Supplemental Security Income (SSI) provides cash payment to low-income people who are aged, blind, or disabled. The Social Security Administration administers the SSI program.

The State Supplementary Assistance program addresses needs recognized by the states that were not covered when the SSI program was implemented in 1976. States are required to maintain a State Supplementary Assistance program and to pass along any cost of living increases to SSI payments as a condition of receiving federal funding for the Medicaid program.

Iowa's program provides a further income supplement to people whose income is insufficient to meet the cost of care in a residential facility, in-home health-related care, family-life home care, and care of a dependent at home. To be eligible for State Supplementary Assistance, a person must meet the eligibility requirements for SSI, except that the person's income may be too high to qualify for an SSI payment.

Individual eligibility for the program is determined in the Department's local offices. Facility contracts and payments are administered by the Department's Iowa Medicaid Enterprise.

Legal Basis

Title XVI of the Social Security Act, as amended by Public Law 92-603, authorizes the SSI program.

Iowa Code Chapter 249 authorizes the State Supplementary Assistance Program. DHS has adopted rules at 441 Iowa Administrative Code Chapters 50 through 54 to administer the State Supplementary Assistance Program. Residential care facility requirements are contained in 441 Iowa Administrative Code Chapter 54.

The Department of Inspections and Appeals (DIA) has adopted the following rules at 481 Iowa Administrative Code which pertain to residential care facilities:

- Chapter 57 sets standards for licensing residential care facilities;
- Chapter 63 sets standards for licensing of residential care facilities for persons with mental retardation;

- Chapter 62 sets standards for residential care facilities for persons with mental illness;
- Chapter 60 sets physical standards for all types residential care facilities; and
- Chapter 50 and Chapter 56 establish general procedures for licensing, training, and enforcement.

FACILITY PARTICIPATION REQUIREMENTS

Facility License

The facility providing care must be licensed by the Iowa Department of Inspections and Appeals (DIA) as a residential care facility (RCF) or a residential care facility for persons with mental retardation (RCF/MR) or a residential care facility for persons with mental illness (RCF/PMI).

Institutional Status

No State Supplementary Assistance payment can be made to a resident of a tax-supported facility providing residential care, unless the facility is licensed for 16 beds or less.

Tax-supported facilities include county homes and other residential care facilities that are owned or operated by an agency of the federal, state, or local government. These facilities are defined as public institutions by the Supplemental Security Income (SSI) program.

Persons residing in public institutions are not eligible for SSI unless the "institution" has less than 16 beds. Since State Supplementary Assistance recipients must meet all SSI standards except for income, this restriction also applies to the State Supplementary Assistance program.

Application and Contract

Each residential care facility shall complete an *Application and Contract Agreement for Residential Care Facilities*, form 470-0443 (formerly PA-1108-6), when it wishes any of its residents to receive State Supplementary Assistance payments. The purpose of form 470-0443 is:

- To spell out the conditions under which a facility may participate in the State Supplementary Assistance program,
- To describe the responsibilities of the Department and the facility, and
- To serve as an application to participate in the cost-related system of payment for residential care within the State program.

The Department must approve this contract before any payment of assistance funds. The term of the contract is 12 months, subject to renewal.

See Application and Contract Agreement for Residential Care Facilities, Form 470-0443, for a form sample and instructions.

Choice of Payment System

Under the State Supplementary Assistance Program, the operator of a residential care facility has the option of participating in a cost-related system of payment or of accepting a flat per diem rate established by DHS.

This choice is indicated by checking the applicable box on form 470-0443. (*See Application and Contract Agreement for Residential Care Facilities*, Form 470-0443, for a form sample and instructions.)

Flat Per Diem Rate

Facilities that choose the standard per diem rate are not required to file a financial report but must agree to accept the rate as established by DHS.

Cost-Related Payment

Facilities that choose the cost-related system of payment for residential care must submit a financial report annually.

The facility shall complete and submit form 470-0030, *Financial and Statistical Report*, to the Iowa Medicaid Enterprise Provider Audits and Rate Setting Unit no later than three months after the close of the facility's established fiscal year. *See Financial and Statistical Report*, Form 470-0030, for a form sample and instructions.

The Department establishes the cost-related per diem rate for these facilities based on the information submitted. See 441 IAC 54.3(249).

The per diem rate established for recipients of State Supplementary Assistance shall not exceed the average rate established by the facility for the private-pay resident.

Record Keeping

The facility must establish a record keeping system sufficiently complete to permit the recipient, DHS, DIA, and the Social Security Administration to make necessary inquiries and ensure continuity of care that allows for easy access.

Records Needed to Establish Per Diem Rate

The facility shall maintain an accounting system sufficiently complete to permit the Department to make necessary audits. (See *Financial and Statistical Report*, Form 470-0030, for more information.)

Establishment of Personal Case Record

A case folder shall be maintained on each person residing in the facility. This record shall contain at least:

- The physician's statement certifying that the resident does not require nursing services,
- The contract between the facility and the resident, form 470-0477, *RCF Admission Agreement* (formerly PA-2365-6), and
- Proof of expenditures from a resident's "Personal Needs."

See 481 IAC 57.16, 62.1, and 63.17. All entries in the resident's permanent record shall be current, dated, and signed.

Personal Need Allowance Managed by Facility

When the facility manages the personal needs funds of a resident, it shall establish and maintain a system of accounting for expenditures from the resident's funds. This accounting system is subject to audit by a DHS representative and must meet the following standards:

- The personal needs funds shall be deposited in a bank in Iowa that is insured by FDIC. The funds shall be deposited in a single checking account that has in the account name the term "Resident Trust Funds."
  - Personal needs funds shall not mingled with trust funds from any other facility.
  - Personal needs funds shall not be mingled with facility operating funds except for facility funds deposited to cover bank charges, not to exceed $500. Bank service charges for this account are an allowable audit cost if the service cannot be obtained free of charge.
- A separate ledger sheet must be maintained for each resident.
  - When a resident is admitted to the facility, a ledger sheet must be credited with the resident's total incidental money on hand.
  - Thereafter, the ledger must be kept current on a monthly basis. The facility shall show the date, the amount given the resident, and the resident's signature.

- Each time something is purchased for the resident (instead of a direct cash disbursement to the resident) the expenditure item in the ledger must be supported by a signed, dated receipt. The receipt must indicate the article furnished for the resident's benefit.
- Personal funds must not be turned over to persons other than the resident's conservator or other persons selected by the resident.
- With the consent of the resident (if the resident is able and willing to give such consent), the administrator may turn over personal funds belonging to the resident to a close relative or friend to purchase a particular item. However, a signed, itemized, dated receipt shall be included in the resident's files.
- The receipts for each resident must be kept until canceled by Department auditors. The ledger and receipts for each resident must be made available for periodic audits by an accredited Department representative. Audit certification will be made by the Department's representative at the bottom of the ledger sheet; supporting receipts may then be destroyed.

The Department reserves the right to charge back to the facility any maintenance items that are charged to the resident's personal needs account when the charge constitutes double payment. Unverifiable expenditures charged to personal needs accounts may also be charged back to the facility.

Report to Department

The facility must notify the Department's local office when:

- A person enters the facility and wishes to participate in the State Supplementary Assistance program.
- A resident receiving State Supplementary Assistance changes level of care.
- A resident receiving State Supplementary Assistance is discharged from the facility.

Notify the local office by telephone and then follow up by sending form 470-0042, *Case Activity Report,* to the local office immediately. See *Case Activity Report,* Form 470-0042, for a form sample and instructions.

If you become aware of a resident's change in financial circumstances that may affect State Supplementary Assistance eligibility or benefits, notify the local DHS office. The local office then reviews eligibility factors and makes any needed change in the amount of client participation.

RESIDENT ELIGIBILITY

A resident's eligibility for State Supplementary Assistance is determined by staff in the income maintenance unit in the Department's local office.

Physician's Statement

All admissions to residential care facilities shall be based on a written order signed by a physician certifying that:

- The person being admitted does not require nursing services or that
- The person's need for nursing services can be avoided if home and community-based services other than nursing care are provided.

In order to comply with licensing rules, the facility shall assure that each resident is examined by a physician at least every 12 months to determine whether residential care continues to be appropriate.

For a resident to continue to remain be eligible for State Supplementary Assistance payments, the physician's statement certifying that the person requires residential care but does not require nursing services must be updated at least every 12 months. A copy of the new certification dated and signed by a licensed physician is sufficient to verify the continuing need.

Application

State Supplementary Assistance payments for residential care cannot be made until the resident has filed a *Health Services Application*, form 470-2927 or 470-2927(S), with the Department's local office.

Ideally, the application should be filed by the date that the applicant wants to start receiving State Supplementary Assistance benefits. If the application is filed more than 30 days after entering the facility, the applicant will not be able to receive benefits back to the date of entry.

A person who is already a Medicaid member may submit a partially completed application. The person should complete the identifying information and sign and dated the form to show intent to ask for State Supplementary Assistance.

See *Health Services Application*, Form 470-2927 or 470-2927(S), for sample forms and instructions.

Application Processing

The Department's decision with respect to eligibility will be based primarily on information furnished by the applicant. The Department will notify the applicant in writing of additional information or verification that is required to establish eligibility for assistance. The applicant is likely to be asked to furnish:

- ♦ A social security number or proof of having applied for a number.
- ♦ Proof of income and resources.
- ♦ Proof of citizenship and identity for Medicaid purposes.
- ♦ Evidence of disability if the applicant is under age 65.

Failure of the applicant to supply the information or refusal to authorize the Department to secure the information from other sources shall serve as a basis for denial of assistance.

If the applicant is already receiving SSI or the Family Investment Program (FIP), the Social Security Administration has already cleared most eligibility factors.

If it appears that the applicant would be eligible for SSI but is not receiving it, the applicant will be required to apply for SSI in addition to applying for State Supplementary Assistance.

The time needed for eligibility determination may be extended when:

- ♦ There is a delay caused by the Social Security Administration's inability to establish SSI eligibility.
- ♦ There is a delay caused by the local office's inability to establish disability or blindness, in cases where the applicant's or recipient's income exceeds SSI limits.

NOTE: When action on the application is delayed for these reasons, the Department has no responsibility for making State Supplementary Assistance payments until eligibility is established.

If the applicant is eventually found eligible, payment shall be retroactive to the date the applicant became eligible, or 30 days before date of application, whichever is later. However, if the applicant dies before the establishment of SSI eligibility or is found ineligible as a blind or disabled person, the Department shall assume no responsibility for payment.

Eligibility Decision

The Department will issue a notice of decision to notify an applicant or recipient of State Supplementary Assistance of the decisions made on the person's case. This includes:

- When an application is approved or denied.
- When a recipient's client participation changes.
- When assistance is renewed because of a review or redetermination.
- When a recipient transfers from one program to another.
- When assistance is canceled.

For State Supplementary Assistance residential care, the notice will state the effective date of assistance, the amount of money the resident has to contribute toward the cost of care, and how that amount was calculated. The effective date for State Supplementary Assistance shall be no earlier than 30 days before the date the Department received the application.

The original notice is mailed directly to the resident. When the resident has a guardian, conservator, or payee, a copy of the notice is mailed to that person. The facility will receive a copy of the notice only if the facility is payee for the resident's benefits.

If the facility is payee, the facility should take any action required and file the form in the resident's records. No action is required upon receipt of a notice of decision unless the resident or the person acting on the resident's behalf wants to appeal the Department's action. Instructions for how to request an appeal are found on the back of the form.

The Department issues form MA-2139-0 (470-0371), *Facility Card*, to notify the facility of the eligibility decision. The form indicates:

- The facility in which the recipient is residing,
- The first day for which payment may be made, and
- The amount of the recipient's available income being applied to the cost of care. (See Client Participation.)

Simultaneously with the sending of the *Facility Card*, the resident's file is opened for RCF payment.

Admission Agreement

Both the law and licensing rules governing residential care facilities provide that there must be a contract between the facility and each individual resident. The *RCF Admission Agreement,* form 470-0477, serves as this contract and must be present in each resident's record.

This contract shall:

- ♦ State the base rate or scale per day or per month, the services included, and the method of payment.
- ♦ Contain an itemized list of those services, with the specific fee that the resident will be charged and method of payment. This list of services must be related to the resident's current condition and based on the program assessment at the time of admission, determined in consultation with the administrator.
- ♦ Include the total fee to be charged initially to the specific resident.
- ♦ State the conditions whereby the facility may make adjustments to its overall fees for resident care as a result of changing costs.
- ♦ Contain a complete schedule of all offered services for which a fee may be charged in addition to the base rate and
  - State that additional fees may be charged to the resident for nonprescription drugs, other personal supplies, and services by a barber, beautician, etc.;
  - Contain an explanation of the method of assessment of such additional charges and of the method of periodic reassessment, if any, resulting in changing such additional charges;
  - State the method of payment of additional charges; and
  - Stipulate that no further additional fees shall be charged for items not contained in complete schedule of services.
- ♦ Provide that the facility shall give:
  - Written notice to the resident or to the responsible party, when appropriate, of changes in the overall rates of both base and additional charges at least 30 days before the effective date of such changes.
  - Notice to the resident or to the responsible party, when appropriate, of changes in additional charges based on a change in the resident's condition. Notification must occur before the revised additional charges begin.

    If notice is given orally, written notification specifically listing the adjustments made must be also given within a reasonable time, not to exceed one week.
- ♦ State the terms of agreement concerning the holding and charging for a bed when a resident is hospitalized or leaves the facility temporarily for recreational or therapeutic reasons. The terms shall provide that the bed will be held at the request of the resident or the resident's responsible party.
  - The facility shall ask the resident or responsible party if the resident wants the bed held. This request shall be made before the resident leaves or within 48 hours after the resident leaves. The inquiry and the response shall be documented.

- When requested, the facility shall reserve the bed for as long as payments are made in accordance with the contract.

♦ State the conditions under which the involuntary discharge or transfer of a resident would be affected.

♦ State the conditions of voluntary discharge or transfer.

♦ State the terms of agreement in regard to refund of all advance payments in event of transfer, death, or voluntary or involuntary discharge.

♦ Set forth any other matters deemed appropriate by the parties to the contract. No contract shall be drawn or construed so as to relieve the facility of any requirement or obligation imposed upon it by licensing rules.

Each party shall receive a copy of the signed contract.

Eligibility Review

If the resident receives an SSI payment, the Social Security Administration is responsible for reviewing eligibility. If not, the DHS local office will reexamine the resident's eligibility for State Supplementary Assistance:

♦ At least every 12 months, based on the information the resident submits on form 470-3118 or 470-3118(S), *Medicaid Review*, and

♦ When there is a change in the resident's circumstances that may affect eligibility, as reported by the resident or the resident's representative by telephone or by mail. The Department issues form 470-0499, *Ten-Day Report of Change for FIP and Medicaid*, to assist residents in making this report.

PAYMENT POLICIES

State Supplementary Assistance is a supplement to a resident's other income which assures the resident of sufficient funds to meet the cost of care in the residential care facility and to provide a standard allowance to meet personal needs.

The resident retains a portion of the income for personal needs. The resident pays the balance of the income to the facility to be applied to the cost of care. This amount is called "client participation." The facility is responsible for collecting those funds from the resident.

State Supplementary Assistance payments are made directly to the resident unless the recipient has made a written request for another person (or the facility) to be the payee. This request must include an effective date, be signed and dated by the resident, and be on file in the Department's local office.

If a resident agrees to make the facility the payee for the resident's benefits, the income maintenance worker in the local office must make system entries to indicate this. A "guardian file" must be created in the Medicaid Management Information System to direct the payment.

A facility that has assumed the duties of a payee is also responsible for ensuring that the resident responds to all communications from the Department.

Client Participation

Client participation is the amount of the resident's own income that the resident pays to the facility. This amount is supplemented by the State Supplementary Assistance payment to equal the total established charge for the number of days the resident was in the facility during a month.

All resident income determined to be available for client participation shall be applied to the cost of care beginning with the first month of admission.

A resident may have limited client participation in the first month, due to the resident's living expenses in the previous living arrangement. The Department local office determines how much of the resident's income may be protected for other obligations and how much is available for client participation.

The income protected for a person leaving an independent living arrangement never exceeds the SSI payment for a single person (or a couple) at home.

A resident transferring to a residential care facility from a nursing facility, a foster care facility, or another residential care facility shall apply any unused client participation toward the cost of care in the new facility.

Residents should contact their income maintenance worker in the local DHS office if they have questions about the personal needs allowance or their client participation.

Items to Be Furnished by the Facility

DIA licensing rules require that certain items be available in a residential care facility. The facility must provide the following items when payment is accepted from a recipient of State Supplementary Assistance:

- Three or more meals per day, with special diet when ordered by the physician.
- Furnished living and sleeping quarters (see 481 IAC 57.30(4)).
- Laundry, including linens and personal clothing as needed for the resident to present a neat appearance, to be free of odors, and to be comfortable.
- Assistance with personal care, such as grooming, washing hair, and administration of medications, exclusive of nursing care.

- General supervision.
- Provision of activities and socialization experiences to the extent deemed adequate by DIA.

Each facility shall provide a variety of supplies and equipment to fit the needs and interest of the residents. When these items are supplied to residents, they may be included in audit costs. These shall include:

- Books (standard and large print),
- Magazines,
- Newspapers,
- Radio,
- Television, and
- Bulletin boards.

Also appropriate would be:

- Box games,
- Game equipment,
- Piano,
- Song books,
- Craft supplies,
- Audio or video player,
- Outdoor equipment

If ordered by a physician, non-legend drugs (aspirin, cough syrup, etc.) or nonprescription vitamin pills may be furnished by the facility and included in the audit cost. If the individual resident requests such items without an order by a physician, the items may be charged to the resident.

Residents may be charged for over-the-counter drugs not provided by the facility or Medicaid.

Eligibility Based on 31-Day Month

Eligibility is established on the basis of a 31-day month. A resident's income may be such that the resident is eligible for a State Supplementary Assistance payment during a 31-day month, but ineligible for a payment during a month with fewer days. If so, the resident does not receive a payment during the shorter month, but remains eligible for medical coverage.

Days Covered

State Supplementary Assistance payments are made for only that portion of the month when the resident is in the facility (except as specified under Reserve Bed Days Due to Hospitalization and Reserve Bed Days Due to Visits or Vacation).

Payment shall be made for the date of entry, but not for the date of discharge or death. The number of days in a month has a direct bearing on the payment. Payment shall not be made when income is sufficient to pay the cost of care in a month with less than 31 days, but the resident remains eligible for all other benefits of the program.

Reserve Bed Days Due to Hospitalization

Legal reference: 441 IAC 52.1(3)"e" and "f"

State Supplementary Assistance payments may be made to hold a bed for a resident who is absent from the facility due to hospitalization. Payment will be approved for a period not to exceed 20 days of hospitalization per calendar month.

Payment can be made while the resident is in a state mental health institute under the same terms as if the resident were hospitalized. No coding is needed until a resident is discharged or ineligible.

A facility may not collect more client participation than what the State Supplementary Assistance program would pay.

> Ms. J is an RCF State Supplementary Assistance recipient whose total monthly client participation is $155.10. Ms. J enters the hospital on June 1 and returns to the RCF on June 26, for a total of 25 days absence.
>
> The facility will bill for 20 reserve bed days, 5 covered days, and 5 noncovered days. The facility will keep the documentation of reserve bed days for audit purposes.

Reserve Bed Days Due to Visits or Vacation

Legal reference: 441 IAC 52.1(3), 52.1(3)"f," 52.1(3)"e"

When the resident is absent overnight due to a visit or vacation, payment is made to hold the bed for a period not to exceed 30 days during any calendar year.

EXCEPTION: Payments may be made for additional visit days if signed documentation is provided to the RCF that the resident wants additional visit days and the days are for the resident's benefit.

Obtain this documentation whenever the resident is absent for more than the 30-day limit, and keep it in the resident's permanent file. If the facility does not get documentation, the facility must bill the days as non-covered days unless the resident is discharged.

DIA is responsible for ensuring that facilities have justification for State Supplementary Assistance payment for more than 30 days.

If documentation is not available to justify periods of absence in excess of the 30-day annual limit, the facility shall submit a *Case Activity Report*, form 470-0042, to the local DHS office for the Department to terminate the State Supplementary Assistance payment.

Residents are not restricted in how they choose to use the visit days to which they are entitled. They may use their visit days all at once or distributed throughout the calendar year. However, visit or vacation days may not be used to extend a hospital stay beyond 20 days per calendar month.

Supplementation from Other Sources

The State Supplementary Assistance payment, as established by the Department of Human Services, is considered payment in full for the goods and services listed under Items to Be Furnished by the Facility.

There shall be no additional charge made to the resident over and above the State Supplementary Assistance payment. Neither shall there be any additional charge to relatives, other persons, organizations, or agencies. Local governmental agencies may provide funding to support the facility operations.

Any supplemental payment meant to cover these goods and services, regardless of source, shall be considered as income and used to reduce the State Supplementary Assistance payment. County supplementation on behalf of a resident is considered a supplemental payment and is treated as such.

When a resident's other income, including the supplemental payment, reaches the point where the cost of the residential care is met, the State Supplementary Assistance payment is canceled.

When a facility furnishes services over and above the goods and services listed under Items to Be Furnished by the Facility, the facility shall contact the service area manager of the local DHS office for information about funding through county local services allocations.

Personal Needs Allowance

A recipient of State Supplementary Assistance for residential care is entitled to a personal needs allowance. This amount is set aside from the resident's income before determining the amount that the resident pays the facility (known as "client participation").

The personal needs allowance is money designated for the personal use of the resident. The personal needs allowance also includes an amount to cover the average Medicare copayments for a facility resident based on the previous year.

This allowance is seen as a method of improving the quality of life for persons needing residential care. The money can serve as a way for residents to maintain control over part of their lives and environment. It may also be used for transportation to medical providers in the same community.

The resident is the person who will be spending the money and should be informed that the allowance is to cover personal needs. Personal needs include the purchase of clothing and incidentals.

Accumulated personal needs funds are counted toward the resource limit when determining eligibility for SSI or State Supplementary Assistance.

The Department increases the personal needs allowance for residents of residential care facilities at the same percentage and at the same time as federal Social Security and SSI benefits are increased. These changes are communicated to facilities through an Informational Release which may be located at: http://www.ime.state.ia.us/Providers/Bulletins.html

If the resident is unable to manage the personal fund, a guardian, representative payee, or conservator should work with the resident to determine the current needs. When there is no guardian, relative, or other designated person to act on behalf of the resident, the facility may assume the responsibility of managing the personal allowance.

Uses of Personal Needs Allowance

Personal needs money is for the exclusive personal use of the resident. The resident may not be charged for such items as toilet paper or other facility maintenance items. These items are properly included in the computation of the audit cost and the facility payment rate.

The following list illustrates some of the types of items that may be purchased with personal needs funds. This list is not exhaustive, and is in no way intended to restrict the resident's use of the funds. It simply is to illustrate the wide variety of items that the funds may be used for:

- Beauty and barber shop services
- Bibles, prayer books, rosaries, etc.
- Books or a library card
- Camera, film, film development, photo albums
- Cigarettes, cigars, tobacco, lighters, ashtrays, pipes, etc.
- Clothing and jewelry
- Cosmetics (powder, lipsticks, face and hand lotions, individual nail files, perfume and colognes)
- Dry cleaning
- Flowers and plants
- Gifts and cards
- Hair grooming aids
- Liquors.
- Musical instruments and sheet music
- Pictures, posters, glassware knick-knacks, etc.
- Sachets for drawers
- Scrapbooks, stamp albums, coin or postcard collections, etc.
- Shaving equipment, soaps, and lotions
- Shoe polish
- Special treats as diet allows
- Stationery
- Sunglasses (non prescription)
- Tape recorders and tapes
- Taxi fare, bus tickets
- Television sets
- Tickets to movies, concerts, plays
- Watches, clocks, calendars
- Watch repair

Disposition of Unused Personal Funds in Case of Death

When a recipient of State Supplementary Assistance dies in a residential care facility, the funds remaining in this person's personal account shall be treated in the following manner:

- When an estate is opened for the deceased, the funds shall be submitted to the estate administrator. If any part of the resident's personal property is being held by another person, the facility shall advise that person of the estate being opened and shall notify the estate administrator.
- When no estate is opened, the funds shall be released to the person assuming responsibility for the resident's funeral expenses.
- When no estate is opened and there are no living heirs, the funds shall be submitted to the Department to escheat to the state.

It may be advisable for the facility operator to consult with an attorney before releasing the funds.

The facility shall send a written statement of account to the income maintenance worker in the local Department office to be filed in the person's case record.

Billing Procedures

For the Department to determine the amount needed to cover a resident's care, the facility must submit a claim indicating the number of days for which payment shall be made. Billing for previous month should be submitted as soon as possible after the end of the month.

The Iowa Medicaid Enterprise (IME), processes residential care facility claims for payment. Facilities can submit claims either on paper or electronically.

The IME provides software for electronic claims submission at no charge. To request this software, contact Iowa Medicaid Enterprise Provider Services at: imeproviderservices@dhs.state.ia.us. The IME also has staff available upon request to assist with any questions or problems.

Facilities that do not submit claims electronically are sent form 470-0039, *Iowa Medicaid Long Term Care Claim*, at the end of each month. The form lists information on State Supplementary Assistance recipients at the facility according to Department records.

Time Frames for Submitting Claims

Claims can be submitted any time during the month for the previous month. However, for residents who are in the facility all month, submit only one claim per month after the end of the month.

Payment will be made for covered dates of service when Iowa Medicaid Enterprise receives the initial claim within one year from the date of services. Claims submitted beyond the one-year limit may be paid only when they are delayed due to delays in receiving third-party payments or retroactive eligibility determinations.

Iowa Medicaid Enterprise generates payments weekly and mails checks every Wednesday. Electronic funds transfers are made each Wednesday evening.

Payment After Resident's Death

Indicate the death of a resident by entering the discharge code for death on the claim. When a resident's death is reported on the claim, the Department issues the check to cover the amount of assistance due the resident for that billing period directly to the facility.

When the resident's death occurs after the close of a billing period but before the receipt of the State Supplementary Assistance check covering that period, immediately report the death to the local DHS office.

When the income maintenance worker reports the death through the computer system, the payee is changed to the facility. If the check has already been issued in the name of the resident, return it and submit the billing for the final month as above.

Report on Submitted Claims

The IME issues a statement for each payment cycle that explains every individual provider claim transaction (including both paid and denied claims). Currently, these statements are mailed hardcopy to most providers. See Remittance Advice for a sample form and detailed field descriptions.

When it is necessary to contact Iowa Medicaid Enterprise with questions, keep the *Remittance Advice* handy. Refer to the transaction control number of the particular claim. This will result in timely, accurate information about the claim in question.

Questions about billing procedures and claims are handled by the IME Provider Services Unit. Contact them by telephone at: 1-800-338-7909 or 515-256-4609. You may also email questions to: imeproviderservices@dhs.state.ia.us

Incorrect Payments

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*. See *Provider Inquiry*, Form 470-3744, for a form sample and instructions.

If the guardian file address needs to be changed, the current payee (the resident, the resident's payee, or the facility if acting as the resident's payee) should contact the income maintenance worker the Department's local office who handles the resident's case.

NOTE: For the facility to receive the State Supplementary Assistance payment directly, the resident must request the facility to act as the resident's payee and must provide a written statement to that effect to be filed in the resident's case record in the Department's local office. The facility then assumes responsibility for:

- Reporting changes about the resident's circumstances,
- Providing necessary verifications, and
- Completing the annual review for the resident.

If a payment was sent to the wrong payee, then the incorrect payee needs to send the payment back to IME before another payment can be issued. If the payment is not returned, the new payee will need to request to have the payment forwarded by the incorrect payee.

To make an adjustment to a claim following receipt of the *Remittance Advice*, use form 470-0040, *Credit/Adjustment Request*. See *Credit/Adjustment Request*, Form 470-0040, for a form sample and instructions. Do **not** use this form when a claim has been denied. Denied claims must be resubmitted.

NOTE: When an incorrect State Supplementary Assistance payment is issued due to an error in the client participation amount entered in the eligibility system, this error must be corrected by the income maintenance worker in the local DHS office.

When the worker adjusts the resident's file to show the month with the correct client participation, the information will be sent to the IME. The IME will reprocess the incorrect month's payment and make an additional payment if necessary.

When the resident's income plus the State Supplementary Assistance payment is more than the amount needed to pay for the resident's care and personal needs allowance, the resident or payee must refund the excess State Supplementary Assistance.

The refund may be sent to the Department's local office or to the IME. The refund must be accompanied by a letter which contains:

- The resident's name and state identification number.
- The amount of overpayment.
- The reason for the refund.

Questions about billing procedures and claims are handled by Provider Services at 1-800-338-7909 or 515-256-4609. You may also email questions to: imeproviderservices@dhs.state.ia.us

FORMS AND INSTRUCTIONS

This handbook contains samples of all forms which must be completed by the facility or which are issued to the facility.

The Department issues the following forms to facilities:

- *Application and Contract Agreement for Residential Care Facilities*, form 470-0443
- *Facility Card*, form MA-2139 (470-0371)
- *Iowa Medicaid Long Term Care Claim*, form 470-0039

The facility is responsible for initiating the following forms:

- *Financial and Statistical Report*, form 470-0030 (if applicable)
- *Case Activity Report*, form 470-0042
- *Provider Inquiry*, form 470-3744 (as needed)
- *Credit/Adjustment Request*, form 470-0040 (as needed)

The Department issues the following forms to residents or their representatives:

- *Health Services Application*, form 470-2927 or 470-2927(S)
- *Medical Assistance Eligibility Card*, form 470-1911
- *Ten-Day Report of Change*, form 470-0499
- *Medicaid Review*, form 470-3118 or 470-3118(S)

Application and Contract Agreement for Residential Care Facilities, Form 470-0443

Each facility that wishes to participate in the State Supplementary Assistance program shall file an *Application and Contract Agreement for Residential Care Facilities*. The facility shall submit a new form annually. (Click here to see a sample of the form.)

The form can be obtained by contacting the Iowa Medicaid Enterprise Provider Services at: 1-800-338-7909 or imeproviderservices@dhs.state.ia.us. The local office is not involved in the process other than to refer the facility to the Iowa Medicaid Enterprise.

Read the terms of the agreement very carefully before the application to participate is signed. By signing the application, the facility is accepting the terms of the agreement. The administrator of the facility shall sign for the facility and the Chief of the Bureau of Long Term Care shall sign for the Department.

Both copies of the form shall be signed in order to furnish each party with a firm contract. Complete and return both copies to the IME Bureau of Long Term Care.

Upon approval, IME retains one copy of the completed form and returns the other copy to the facility.

Iowa Department of Human Services

APPLICATION AND CONTRACT AGREEMENT FOR RESIDENTIAL CARE FACILITIES

I. This contract is between the Iowa Department of Human Services, referred to as the Department, and the

____ , a provider of residential care and
Name of Facility

services, referred to as the facility.

II. The facility accepts the terms of this contract, as evidenced by the following application:

Application Date ____________________ Provider Number ____________________

Name of Residential Care Facility ____

Address ____
(Street) (City) (ZIP)

License No. ______________ Effective ______________ Telephone No. ______________

Type of Organization:

_____ Governmental
_____ Non-profit
_____ Hospital-Based
_____ Individual Owner
_____ Partnership
_____ Corporation
_____ Pseudocorporation
_____ Other

Check the Levels of Care Offered:	**No. of Beds:**
_____ Skilled Nursing	_____
_____ Nursing	_____
_____ Residential	_____
_____ Hospital	_____
_____ Other _________ Type	_____

Total Licensed Bed Capacity ____________

(Complete only if facility is rented or leased)

Lessor ____

Address ____

____

Check One

☐ The facility wishes to participate in the State Supplementary Assistance program under the cost-related system of payment for residential care.

☐ The facility wishes to participate in the flat per diem rate of payment for residential care.

Fiscal Year ____________________

County Number ____________________

Vendor Code ____________________
(Not social security number. It is the number used on federal and state income tax forms.)

Administrator:
Read and sign page 2.

FOR DHS OFFICE USE ONLY
IOWA DEPARTMENT OF HUMAN SERVICES

____
Effective Date of Contract

By: ____
Bureau Chief, Bureau of Long Term Care

____
Date

III. The Facility Agrees:

To provide residential care including room, board, care and services to the State Supplementary Assistance residents according to all rules of the Department.

To have satisfactory policies and procedures for maintaining a medical record on each resident in the facility. This record must contain:

A written statement by a physician which says that the person being admitted requires residential care but does not require nursing services.

A contract between the resident and the facility. This contract shall not contain any provisions which are contrary to the rules of the Department about eligibility, the grant payment for residential care, or refunding of advance payments when the resident dies or leaves the facility. The contract shall not contain any provisions which risk loss of the resident's rights to continued eligibility for assistance.

To accept, as payment in full, the amount allowed through the cost-related reimbursement or flat rate reimbursement system administered by the Department. Reimbursement is limited by the maximum per diem rate established by the Department. The facility agrees to make no additional charge or accept any additional payment for the cost of care from the State Supplementary Assistance resident or any other source.

To submit a *Financial and Statistical Report*, form 470-0030, according to Department rules, when paid under the cost-related system.

To maintain an accounting system to permit the Department to make necessary audits, and to include complete records regarding the resident's personal funds which have been deposited with the facility.

To accept the Department's policy of suspension or cancellation of the facility's right to take part in the State Supplementary Assistance program when the facility fails to maintain proper accounting records.

To maintain a current license to operate as a residential care facility. The facility shall notify the Department immediately of any change in its license.

IV. The Department and the Facility Agree:

That the term of this contract shall be 12 months, subject to renewal, or until the state ceases to fund the program, or until either party gives 60 days notice of termination in writing to the other party.

That the per diem rate shall be set by the Department. The rate shall be in effect until adjustment is indicated by information submitted by the facility in the annual *Financial and Statistical Report* or until an adjustment in per diem rate is required for other reasons.

That this contract shall not be transferable or assignable.

____
Signature of Administrator of Facility

____
Date

INSTRUCTIONS

Fill out and return one copy to:

BUREAU OF LONG TERM CARE
IOWA MEDICAID ENTERPRISE
100 ARMY POST ROAD
DES MOINES IA 50315

Iowa Department of Human Services

Case Activity Report

Complete this form when a Medicaid applicant or member enters or leaves your facility, and when a resident of your facility applies for Medicaid. See the back of this form for instructions.

Fold line **1. Member Data** *Fold line*

Name	Social Security Number	State ID	Date Entered Facility

2. Facility Data

Name	Provider Number/NPI Number	DHS Per Diem	
Address			
City		State	Zip
Signature of Person Completing Form		Date Completed	

3. Level of Care

This information is determined by IME Medical Services Unit, Medicare or by a managed care contractor. For clarification, PMIC must indicate if this is PMIC Mental Health or PMIC Substance Abuse.

Level of Care	Level of Care Process:	Effective Date
	☐ IME Medical Services Unit ☐ Medicare ☐ Managed Care PMIC ☐ Out-of-State Skilled Preapproval	

4. Medicare Information for Skilled Patients in Facilities

Do you expect this stay to be covered by Medicare?	Expected dates of Medicare coverage
☐ No ☐ Yes, see dates:	________ through ________

If there is any change in this coverage, please notify the county DHS office.

5. Discharge Data

Date of Discharge	Reason for Discharge
____________	☐ Died
Last Month in Facility (for residents who transfer to another facility or level of care):	☐ Transferred to another facility (Send form to county DHS office only.)
______ Days in facility	Name ____________
______ Reserve bed days	Level of care, if known ____________
______ Non-covered days	☐ Moved to new living arrangement
______ Total billing days on claim to fiscal agent	Address, if available ____________

470-0042 (Rev. 6/09)

<u>Instructions for Preparing the Case Activity Report</u>:

- When a current resident applies for Medicaid, complete sections 1-3. Enter the first name, middle initial, and last name of the resident as they appear on the *Medical Assistance Eligibility Card*. The state ID number is assigned by the Iowa Department of Human Services and consists of seven digits plus one letter, e.g. 1100234G.
- When a Medicaid applicant or member enters the facility, complete sections 1-3 and section 4, if applicable.
- When there is Medicare coverage and the Medicaid rate is higher than the Medicare rate, complete sections 1 and 4.
- When a Medicaid applicant or member dies or is discharged, complete sections 1 and 5.
- This form must be completed within two business days of the action.
- The administrator or designee responsible for the accuracy of this information should sign in section 2. The date is the date the form is completed and sent to the county Department of Human Services office.

Distribution Instructions for NFs, ICF/MRs, SNFs and Mental Health Institutes:

Mail or fax a copy to your county DHS income maintenance worker. Keep a copy.

Distribution Instructions for PMICs:

Mail or fax a copy to your county DHS income maintenance worker. Keep a copy.

Mail or fax a copy to IME Medical Services <u>ONLY</u> for voluntary placements.

IME Medical Services: Iowa Medicaid Enterprise
100 Army Post Rd, PO Box 36748
Des Moines IA 50315
Fax: 515-725-1355

Distribution Instructions for RCFs:

Mail or fax a copy to your county DHS income maintenance worker. Keep a copy.

Case Activity Report, Form 470-0042

The *Case Activity Report* is used to ensure prompt and accurate reporting on resident activity as it occurs at the facility. (Click here to see a sample of the form.) Forms may be downloaded from the IME Web site at: http://www.ime.state.ia.us/Providers/Forms.html

Complete the form as follows:

- When a Medicaid applicant or member enters the facility, complete Sections 1, 2, and 3.
- When a Medicaid applicant or member dies or is discharged from the facility, complete Sections 1 and 5.

Section 1. Recipient Data: Section 1 contains information on the resident. Use the first name, middle initial, and the last name as it appears on the Medical Assistance Eligibility Card. The "Date Entered Facility" is the date the resident entered the facility for the first time or was readmitted to the facility following a discharge.

Section 2. Facility Data: Section 2 contains information on the facility and the person filling out the form (either the administrator or designee). Your provider number must match the level of care indicated in Section 3. The "DHS Per Diem" is the facility's computed rate. The "Date Completed" is the date the form is completed and sent to the local DHS office.

Section 3. Level of Care: Enter RCF for the level of care.

Section 5. Discharge Data: The income maintenance worker needs the information to calculate client participation for a partial month. Provide information under "Last Month in Facility" only if the resident transfers to another facility or living arrangement (but not home).

- "Reserve bed days" is the number of reserve bed days, up to the maximum, for which the State Supplementary Assistance program will pay.
- "Non-covered days" is the number of days in excess of the reserve bed day limit which will not be covered by State Supplementary Assistance program.
- "Total billing days on claim to fiscal agent" is the total of the previous three lines.

Within two business days of the action, mail the form to the Department local office. Keep a copy for your records.

Credit/Adjustment Request, Form 470-0040

Use form 470-0040, *Credit/Adjustment Request,* to notify the IME to take an action against a claim that has already been paid, 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.

Do not use this form with a claim has been denied. You must resubmit the claim.

Click here to see a sample of the form. Forms may be downloaded from the IME Web site at: http://www.ime.state.ia.us/Providers/Forms.html

Section A:

- ♦ **Claim Adjustment.** Check this box when the IME has paid a claim but there is an adjustment that must be made. Examples of such situations are:
  - You billed a day as a bed-hold day, then later determined that the client had actually returned to the facility on that day.
  - A resident was scheduled to be discharged on a particular day but stayed an additional day, and this was not noted until after the billing month.
- ♦ **Claim Credit.** Check this box when an entire paid claim should be credited back to the Medicaid program. An example is when you received payment for a client who had already been discharged.

Section B:

1. **17-Digit TCN.** For each claim, a "transaction control number" (TCN) is listed on the *Remittance Advice*. Enter that number in this field. See Remittance Advice for instructions on where to find the TCN number on the form.

2. **Provider Number/NPI.** Enter your seven-digit RCF provider number.

3. **Provider Name** and **Address.** Self-explanatory.

4. **8-Digit Member State ID Number.** Enter the resident's Medicaid state identification number in this field. The number will be 7 digits followed by a letter. You can obtain it from the *Remittance Advice*, the resident's *Medical Assistance Eligibility Card*, or the *Facility Card*.

5. **Reason for Adjustment or Credit Request.** Self-explanatory.

Iowa Department of Human Services
Medicaid Program

Credit/Adjustment Request

(If the claim is **DENIED, DO NOT** use this form. Resubmit the corrected claim.)
(Do not use red ink.)
Download this form @ http://www.ime.state.ia.us/docs/470-0040.doc

SECTION A: Check the appropriate box and follow the steps that are outlined.

☐ **Claim Adjustment**

a) Attach a completed claim, **OR**
b) Attach a copy of the remittance advice, with corrections made directly on the remittance, **AND**
c) Complete Sections B and C.

☐ **Claim Credit** (Note: This will result in Medicaid retracting the claim payment.)

a) Attach a remittance copy.
b) Complete Sections B and C.

SECTION B: This section MUST be filled out completely in order to process.

1.	**17-Digit TCN:**		
2.	**Provider NPI Number:**		
3.	**Provider Name:**		
	Address:		
	City:	**State:**	**Zip:**
4.	**8-Digit Member State ID Number:**		
5.	**Reason for Adjustment or Credit:**		

SECTION C: Signature and Date Required

Provider/Representative Signature:
Date:

Return all requests to:

Iowa Medicaid Enterprise
PO Box 36450
Des Moines, IA 50315

470-0040 (Rev. 8/08)

Section C: Provider/Representative Signature and **Date**. The form must be signed and dated by a facility representative.

Send this form to:

Iowa Medicaid Enterprise, Credits and Adjustments
PO Box 36450
Des Moines, Iowa 50315

You can send the *Credit/Adjustment Request* to IME for processing at any time of the month. You must send a copy of the *Remittance Advice* or a copy of the corrected claim with the form.

Facility Card, Form MA-2139 (470-0371)

Form MA-2139-0 (470-0371), *Facility Card*, is issued by the local office income maintenance worker who determines eligibility for State Supplementary Assistance and submits eligibility and payment information. It authorizes payment for care in an RCF. The form is computer-generated in two copies.

MA-2139-0 470-0371

BEG. ELIG. DATE 1ST MO. CLI. PART
END. ELIG. DATE ONGO. CLI. PART

ADMINISTRATOR ______________________

☐ RETAIN FOR YOUR RECORDS ☐ SEND 1 COPY TO THE COUNTY.

Upon receipt of the *Facility Card* for a resident, the RCF shall:

1. Check the information on the form for accuracy. The information shown on the form is the basis for the RCF payment.
2. If there appears to be an error in the beginning eligibility date, the amount of financial participation, or any other item, contact the Department local office as soon as possible.
3. Send one copy of the form to the Department local office. Keep the other copy as a facility record.

Welcome to the
IOWA DEPARTMENT OF HUMAN SERVICES
ELECTRONIC FINANCIAL AND STATISTICAL REPORT

The Financial and Statistical Report is now available in a Version 97 Excel workbook .
The Workbook contains the following 21 worksheets:

Certification	E
Statistical Data	F
A	G
A - 1	H
A - 2	H - 1
B	I
C	I - 1
C - 1	SUPPORTING SCHEDULE (1)
D	SUPPORTING SCHEDULE (2)
D - 1	EDITS
	PRINT

Please refer to the Iowa Department of Human Services Division of Medical Services General Instructions prior to completing the Financial and Statistical Report.

Workbook Structure

The Workbook contains an electronic version of each schedule of the paper version of the Financial and Statistical Report. Supporting schedules (worksheets) may be added to the workbook, but no schedules should be deleted. The tab name assigned to each worksheet corresponds to the related cost report schedule. For example, the tab labeled C contains Schedule C-Schedule of Expenses, H contains Schedule H-Nursing Facility Wages and Hours. Four schedules have been added which are specific to the electronic version: Supporting Schedule (1), Supporting Schedule (2), Edits and Print.

Each worksheet in the Workbook can be accessed by clicking on the corresponding tab at the bottom of the screen. A scroll bar is available at the bottom of the screen to navigate through the tab bar.

Supporting Schedules

Two worksheets, Supporting Schedules 1 and 2, are available within the Workbook so that you may provide additional information if necessary. The worksheets are formatted to fit a single page (81/2" x 11"). If your information is larger than the defined area it may cause your cost report to print incorrectly when utilizing the print buttons provided in the Print worksheet. It is suggested that large files be included in the Workbook by adding a new worksheet at the end of the Workbook after the Print worksheet.

Printing Options

Print options are found in the last tab of the Workbook titled Print. When you click on this tab, you will find two buttons which have been programmed to print paper copies. The top button will print the Financial and Statistical Report and the Edit Report. The bottom button will print the Financial and Statistical Report only. Additional worksheets added to the basic Workbook will need to be printed individually by using the Print option found in the File menu.

The print buttons found in the Print worksheet may not be compatible with certain PC and printer configurations. Therefore, if you experience problems printing, you may need to alter margins, page break settings, etc. in order to print the Financial and Statistical Report.

IOWA DEPARTMENT OF HUMAN SERVICES
FINANCIAL AND STATISTICAL REPORT

[11101] Facility Name	[11201] Federal ID Number

Physical Address (Required)

[12102] Street	[12103] City	[12104] State	[12105] Zip

Period of Report				[12110] County
[13101] From:		[13102] To:		

[14101] Date Facility Entered Program	[14102] Date Owner Acquired Facility	[14120] FYE (mm/dd)

[15101] Type of Control (Check Only One)

GOVERNMENT	NON-PROFIT ORGANIZATION	PROPRIETARY	
☐ State	☐ Church Operated	☐ Individual	☐ Corporation
☐ County	☐ Church Related	☐ Partnership	☐ "S" Corporation
☐ Other	☐ Other Non-Profit		

[16101] VENDOR NUMBER BY TYPE OF FACILITY

No.	Program Type	Vendor Number
1	Nursing Facility	
2	Residential Care Facility	
3	Assisted Living	
4	ICF/MR	
5	RCF/MR	
6	Other	

CERTIFICATION STATEMENT

Misrepresentation or falsification of any information contained in this cost report may be punishable by fine and imprisonment under state or federal law.

I CERTIFY that I have read the above statement and that I have examined the accompanying cost report and supporting schedules. To the best of my knowledge and belief, it is a true and complete statement prepared from the records of the provider in accordance with applicable instructions. I further certify that costs have been properly allocated between or among programs and that no cost has been reported more than once as a reimbursable cost.

[17101] An opinion of a certified public accountant of the fairness of presentation of operating results or revenues and expense is attached. ☐ Yes ☐ No

Questions concerning financial data included in this report should be directed to:

Name	Position/Title	Telephone

Name of Officer or Administrator of Facility	Date
Title / Position	**Telephone**
Name of Preparer	**Date**
Preparer Company Name	**Telephone**

Signature of Preparer	Signature of Officer or Administrator of Facility

IOWA FINANCIAL AND STATISTICAL REPORT

Facility Name:		Vendor No.
Period of Report:	From:	To:

[18101] Accounting Basis (Check only one)

☐ Accrual ☐ Modified Cash ☐ Cash

[19101] Statistical Data

Line No.	Type of Facility	# Authorized Beds Start of Period (1)	# Authorized Beds End of Period (2)	Total Bed Days in Reporting Period (3)	Patient Days in Reporting Period Total (4)	Patient Days in Reporting Period Medicaid (5)	Medicaid Utilization Col 5/4 (6)	Percent Occupancy Col 4/3 (7)	Number of Admissions (8)	Number of Discharges (9)
1	Nursing Facility									
2	RCF									
3	Assisted Living - Grant Funded									
4	Assisted Living - Non-Grant Funded									
5	ICF/MR									
6	RCF/MR									
7	Other									
8	TOTAL									

[20101] Does this facility have an Assisted Living Grant? ☐ Yes ☐ No

[20102] Does this facility have a CCDI Unit? ☐ Yes ☐ No

[21101] Ownership Information

Line No.	Name of Owner (1)	% of Work Week Devoted to Business (2)	Title (3)	Salaries and Wages (4)	Social Security Number (5)	% Ownership in Home (6)
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						

Note: Attach additional schedules as necessary to complete ownership information.

Facility Name:	Vendor No.
Period of Report: From:	To:

SCHEDULE A
TOTAL FACILITY REVENUE

REVENUES	Line No.	Medicaid (1)	Medicare (2)	Private Pay (3)	Other (4)	Total (5)	Nursing Facility (6)	Other (7)	ENTER IN COLUMN 2 SCHEDULE C Adjustment Amount (8)	Line No. (9)
RESIDENT REVENUE CENTERS:										
Routine daily service	211									
Pharmacy-drugs & medications	212									76
Routine medical supplies	213									70
Non-Routine medical supplies	214									71
Laboratory	215									78
X-Ray	216									77
Occupational Therapy	217									56
Physical Therapy	218									57
Speech Therapy	219									58
Respiratory Therapy	220									59
Professional care, physician	221									99
Beauty, barber shop	222									93
Personal purchases for residents	223									94
Activities	224									
Other Ancillary	225									
OTHER REVENUE CENTERS:										
Revenue from meals sold to guest & employee	226									75
Rental Income	227									
Income of telephone charges paid by	228									10
Purchase discounts, if recorded	229									
Revenues from supplies employees	230									
Rebates	231									
Religious Income	232									
Investment Income (see instructions)	233									88
Other	234									
Gifts	235									
Donations	236									
	237									
GROSS REVENUE	238									
DEDUCTIONS FROM REVENUE:										
Free Care and Allowances	239									
Provision for uncollectible accounts	240									
TOTAL DEDUCTIONS	241									
NET REVENUE	242									

AVERAGE PRIVATE PAY RATE	

Facility Name:		Vendor No.:
Period of Report:	From:	To:

SCHEDULE A-1
NF CONVERSION / LTC SERVICE DEVELOPMENT GRANT REVENUE

Assisted Living Grant Revenue

REVENUE	LINE NO.	Medicaid (1)	Waiver (2)	HUD Low Income Credits (3)	HCBS Rent Subsidy (4)	In-Home Care (5)	Private (6)
RESIDENT REVENUE							
Room	240						
Board	241						
Services	242						
Amenities	243						
	244						
Other	245						
Gifts	246						
Donations	247						
	248						
	249						
TOTAL ASSISTED LIVING REVENUE	**250**						

Service Development Grant Revenue

REVENUE	LINE NO.	Medicaid Revenue (1)	Waiver Revenue (2)	Private Revenue (3)	Number of Units Medicaid (4)	Number of Units Waiver (5)	Number of Units Private (6)
PROGRAM REVENUE							
Home Care	251						
Home Delivered Meals	252						
Adult Day Care	253						
Respite Care	254						
Transportation	255						
Chore Services	256						
PACE	257						
Other	258						
	259						
	260						
TOTAL SERVICE DEVELOPMENT GRANT REVENUE	**261**						

Facility Name:		Vendor No.:
Period of Report:	From:	To:

SCHEDULE A - 2
DESCRIPTION OF LIVING UNITS

ASSISTED LIVING - GRANT FUNDED

Line No. (1)	Type of Living Unit (2)	Number of Living Units (3)		Number of Square Feet (4)	Resident Days during Period		Monthly Rental Rate			
					Medicaid Residents (5)	Total Residents (6)	Medicaid Residents (7)		Non-Medicaid Residents (8)	
			One-bedroom							
271	Type A		Two-bedroom				Room		Room	
			Efficiency				Board		Board	
			One-bedroom							
272	Type B		Two-bedroom				Room		Room	
			Efficiency				Board		Board	
			One-bedroom							
273	Type C		Two-bedroom				Room		Room	
			Efficiency				Board		Board	
			One-bedroom							
274	Type D		Two-bedroom				Room		Room	
			Efficiency				Board		Board	
			One-bedroom							
275	Type E		Two-bedroom				Room		Room	
			Efficiency				Board		Board	
			One-bedroom							
276	Type F		Two-bedroom				Room		Room	
			Efficiency				Board		Board	
			One-bedroom							
277	Type G		Two-bedroom				Room		Room	
			Efficiency				Board		Board	
			One-bedroom							
278	Type H		Two-bedroom				Room		Room	
			Efficiency				Board		Board	
			One-bedroom							
279	Type I		Two-bedroom				Room		Room	
			Efficiency				Board		Board	
			One-bedroom							
280	Type J		Two-bedroom				Room		Room	
			Efficiency				Board		Board	

SCHEDULE A - 2
DESCRIPTION OF LIVING UNITS

ASSISTED LIVING - NON-GRANT FUNDED

Line No. (1)	Type of Living Unit (2)	Number of Living Units (3)		Number of Square Feet (4)	Resident Days during Period		Monthly Rental Rate			
					Medicaid Residents (5)	Total Residents (6)	Medicaid Residents (7)		Non-Medicaid Residents (8)	
			One-bedroom							
281	Type A		Two-bedroom				Room		Room	
			Efficiency				Board		Board	
			One-bedroom							
282	Type B		Two-bedroom				Room		Room	
			Efficiency				Board		Board	
			One-bedroom							
283	Type C		Two-bedroom				Room		Room	
			Efficiency				Board		Board	
			One-bedroom							
284	Type D		Two-bedroom				Room		Room	
			Efficiency				Board		Board	
			One-bedroom							
285	Type E		Two-bedroom				Room		Room	
			Efficiency				Board		Board	
			One-bedroom							
286	Type F		Two-bedroom				Room		Room	
			Efficiency				Board		Board	
			One-bedroom							
287	Type G		Two-bedroom				Room		Room	
			Efficiency				Board		Board	
			One-bedroom							
288	Type H		Two-bedroom				Room		Room	
			Efficiency				Board		Board	
			One-bedroom							
289	Type I		Two-bedroom				Room		Room	
			Efficiency				Board		Board	
			One-bedroom							
290	Type J		Two-bedroom				Room		Room	
			Efficiency				Board		Board	

IOWA FINANCIAL AND STATISTICAL REPORT

Facility Name:	Vendor No.:
Period of Report: From	To:

SCHEDULE B
EXPENSE ADJUSTMENTS

DESCRIPTION	LINE NO.	EXPENSE (1)	ALLOWABLE (2)	ENTER IN COLUMN 3, SCHEDULE C Adjustment amount (3)	Line(s) # (4)
NONREIMBURSABLE EXPENSES:					
Provisions for income tax	411				95
Fees paid Board of Directors	412				97
Non-Working officer's salaries	413				98
Travel & Entertainment. See Instructions	414				16
Donations	415				100
Expenses of non-participating facilities	416				
Fund-raising expenses	417				
Pharmacy, drugs, and medications	418				76
Insurance premiums on life of officer, owner	419				96
Other expenses not related to resident care	420				
EXPENSE LIMITATIONS:		**EXPENSE (1)**	**ALLOWABLE (2)**		
Compensation of owners/related parties. See Instructions Position					
Administrator	421				1
Assistant Administrator	422				2
Management Fees	423				13
Nursing Director	424				40
Other	425				
Services, facilities, supplies furnished by organizations related to the facility by common ownership or control					
Rental Equipment	426				
Services & supplies (describe)	427				
	429				
Rental of Facility. See instructions.					
Payments	430				
Lessor's Cost:	431				
Depreciation	432				
Amortization	433				
Interest	434				
Property tax	435				
Other	436				
Return on Equity	437				
Reduction - IF Column 1 < Column 2	438				
Advertising expense in excess of the lesser of $7,200 or an amount computed at 2% of daily revenue	439				17
Allowable Depreciation - Schedule D and D-1	440				84
Interest expense on loans from partners, proprietors, stockholders or related organizations. **See Instructions.**	441				88
EXPENSE ADDITIONS:		**EXPENSE (1)**	**ALLOWABLE (2)**		
Compensation of nonsalaried proprietors and partners or members of religious orders.					
Administrator	442				1
Nursing Director	443				40
Other	444				
TOTAL	445				

NOTE: Enter adjustments on Schedule C on the line for the expense center affected.

IOWA FINANCIAL AND STATISTICAL REPORT

Facility Name:	0	Vendor No.:	0
Period of Report: From:	01/00/00	To:	01/00/00

SCHEDULE C SCHEDULE OF EXPENSES

SCHEDULE OF EXPENSES	Line No.	Expenses per General Ledger (1)	Adjustment of Expenses Sch. A. (2)	Adjustment of Expenses Sch. B (3)	Resident Expenses (4)	Allocation Basis (5)	NF (6)	RCF (7)	Assisted Living (8)	ICF/MR (9)	RCF/MR (10)	Other (11)	Total Equals Column 4 (12)
Administrator Wages	1				0								0
Business Office Wages	2				0								0
Employer's taxes (Admin.)	3				0								0
Grp/Life & Retire Benefits (Admin.)	4				0								0
Worker's comp. Insurance (Admin.)	5				0								0
Emp. Advertising / Recruit. (Admin.)	6				0								0
Criminal record checks (Admin.)	7				0								0
Education and training (Admin.)	8				0								0
Supplies (Admin.)	9				0								0
Telephone	10				0								0
Equipment rental (Admin.)	11				0								0
Home office costs	12				0								0
Management fees	13				0								0
Acct., legal & other professional fees	14				0								0
General liability insurance	15				0								0
Travel, entertainment, and auto	16				0								0
Advertising and public relations	17				0								0
	18				0								0
TOTAL ADMINISTRATIVE COSTS	**19**	0	0	0	0		0	0	0	0	0	0	0
Laundry wages	20				0								0
Housekeeping wages	21				0								0
Maintenance wages	22				0								0
Employer's taxes (Environ.)	23				0								0
Grp/Life & Retire Benefits (Environ)	24				0								0
Worker's comp. Insurance (Environ.)	25				0								0
Emp. Advertising / Recruit. (Environ.)	26				0								0
Criminal record checks (Environ.)	27				0								0
Education and training (Environ.)	28				0								0
Supplies , laundry	29				0								0
Supplies, housekeeping	30				0								0
Supplies, maintenance	31				0								0
Utilities	32				0								0
Purchased services, laundry	33				0								0
Purchased services, housekeeping	34				0								0
Purchased services, maintenance	35				0								0
Equipment repairs	36				0								0
Equipment rental (Environ.)	37				0								0
	38				0								0
TOTAL ENVIRONMENTAL SERVICE COSTS	**39**	0	0	0	0		0	0	0	0	0	0	0
D.O.N. wages	40				0								0
R.N. wages	41				0								0
L.P.N. wages	42				0								0
C.N.A. wages	43				0								0
Activities wages	44				0								0
Social service wages	45				0								0
Employer's taxes (Dir. Health)	46				0								0
Grp/Life & Retire Benefits (Dir. Health)	47				0								0
Worker's comp. Insurance (Dir. Health)	48				0								0
Emp. Advertising / Recruit. (Dir. Health)	49				0								0
Criminal record checks (Dir Health)	50				0								0
Education and training (Dir Health)	51				0								0
Certified nursing aide training	52				0								0
Contracted professional social services	53				0								0
Professional support services	54				0								0
Contracted nursing services	55				0								0
Occupational Therapy	56				0								0
Physical Therapy	57				0								0
Speech Therapy	58				0								0
Respiratory Therapy	59				0								0
	60				0								0
TOTAL DIRECT PATIENT CARE COSTS	**61**	0	0	0	0		0	0	0	0	0	0	0
Medical record wages	62				0								0
Medical director	63				0								0
Dietary service wages	64				0								0
Employer's taxes (Support)	65				0								0
Grp/Life & Retire Benefits (Support)	66				0								0
Worker's comp. Insurance (Support)	67				0								0
Emp. Advertising / Recruit. (Support)	68				0								0
Criminal record checks (Support)	69				0								0
Routine supplies,patient care services	70				0								0
Non-routine supplies, patient care services	71				0								0
Supplies, dietary services	72				0								0
Supplies, activities	73				0								0
Supplies, social services	74				0								0
Food and nutritional supplements	75				0								0
Pharmacy services	76				0								0
X-ray services	77				0								0
Laboratory	78				0								0
Professional support services	79				0								0
Equipment rental (Support)	80				0								0
	81				0								0
TOTAL SUPPORT CARE COSTS	**82**	0	0	0	0		0	0	0	0	0	0	0
TOTAL PATIENT CARE SERVICE COSTS	**83**	0	0	0	0		0	0	0	0	0	0	0
Depreciation	84				0								0
Amortization	85				0								0
Real estate taxes	86				0								0
Facility lease	87				0								0
Interest	88				0								0
Property and casualty insurance	89				0								0
Building and grounds repairs	90				0								0
	91				0								0
TOTAL PROPERTY COSTS	**92**	0	0	0	0		0	0	0	0	0	0	0
Beauty and barber shops	93				0								0
Personal purchases for residents	94				0								0
Income taxes	95				0								0
Officer's life insurance	96				0								0
Director fees	97				0								0
Nonworking officers' salaries	98				0								0
Professional care (Physicians)	99				0								0
Contributions	100				0								0
	101				0								0
TOTAL OTHER COSTS	**102**	0	0	0	0		0	0	0	0	0	0	0
TOTAL OF ALL EXPENSES	**103**	0	0	0	0		0	0	0	0	0	0	0

IOWA FINANCIAL AND STATISTICAL REPORT

Facility Name:	0	**Vendor No.:**	0
Period of Report: **From:**	01/00/00	**To:**	01/00/00

Note: This schedule is required only if the facility has an assisted living grant.

SCHEDULE C-1 Assisted Living Expense Allocation

SCHEDULE OF EXPENSES	Line No.	Allocation Basis (1)	Grant Funded Statistic (2)	Non-Grant Funded Statistic (3)	Total Statistic (4)	Grant Funded (5)	Non-Grant Funded (6)	Total Expenses (7)
Administrator Wages	1				0	0	0	0
Business office wages	2				0	0	0	0
Employer's taxes (Admin.)	3				0	0	0	0
Grp/Life & Retire Benefits (Admin.)	4				0	0	0	0
Worker's comp. Insurance (Admin.)	5				0	0	0	0
Emp. Advertising / Recruit. (Admin.)	6				0	0	0	0
Criminal record checks (Admin.)	7				0	0	0	0
Education and training (Admin.)	8				0	0	0	0
Supplies (Admin.)	9				0	0	0	0
Telephone	10				0	0	0	0
Equipment rental (Admin.)	11				0	0	0	0
Home office costs	12				0	0	0	0
Management fees	13				0	0	0	0
Acct., legal & other professional fees	14				0	0	0	0
General liability insurance	15				0	0	0	0
Travel, entertainment, and auto	16				0	0	0	0
Advertising and public relations	17				0	0	0	0
	18				0	0	0	0
TOTAL ADMINISTRATIVE COSTS	**19**					**0**	**0**	**0**
Laundry wages	20				0	0	0	0
Housekeeping wages	21				0	0	0	0
Maintenance wages	22				0	0	0	0
Employer's taxes (Environ.)	23				0	0	0	0
Grp/Life & Retire Benefits (Environ)	24				0	0	0	0
Worker's comp. Insurance (Environ.)	25				0	0	0	0
Emp. Advertising / Recruit. (Environ.)	26				0	0	0	0
Criminal record checks (Environ.)	27				0	0	0	0
Education and training (Environ.)	28				0	0	0	0
Supplies , laundry	29				0	0	0	0
Supplies, housekeeping	30				0	0	0	0
Supplies, maintenance	31				0	0	0	0
Utilities	32				0	0	0	0
Purchased services, laundry	33				0	0	0	0
Purchased services, housekeeping	34				0	0	0	0
Purchased services, maintenance	35				0	0	0	0
Equipment repairs	36				0	0	0	0
Equipment rental (Environ.)	37				0	0	0	0
	38				0	0	0	0
TOTAL ENVIRONMENTAL SERVICE COSTS	**39**					**0**	**0**	**0**
D.O.N. wages	40				0	0	0	0
R.N. wages	41				0	0	0	0
L.P.N. wages	42				0	0	0	0
C.N.A. wages	43				0	0	0	0
Activities wages	44				0	0	0	0
Social service wages	45				0	0	0	0
Employer's taxes (Dir. Health)	46				0	0	0	0
Grp/Life & Retire Benefits (Dir. Health)	47				0	0	0	0
Worker's comp. Insurance (Dir. Health)	48				0	0	0	0
Emp. Advertising / Recruit. (Dir. Health)	49				0	0	0	0
Criminal record checks (Dir Health)	50				0	0	0	0
Education and training (Dir Health)	51				0	0	0	0
Certified nursing aide training	52				0	0	0	0
Contracted professional social services	53				0	0	0	0
Professional support services	54				0	0	0	0
Contracted nursing services	55				0	0	0	0
Occupational Therapy	56				0	0	0	0
Physical Therapy	57				0	0	0	0
Speech Therapy	58				0	0	0	0
Respiratory Therapy	59				0	0	0	0
	60				0	0	0	0
TOTAL DIRECT PATIENT CARE COSTS	**61**					**0**	**0**	**0**
Medical record wages	62				0	0	0	0
Medical director	63				0	0	0	0
Dietary service wages	64				0	0	0	0
Employer's taxes (Support)	65				0	0	0	0
Grp/Life & Retire Benefits (Support)	66				0	0	0	0
Worker's comp. Insurance (Support)	67				0	0	0	0
Emp. Advertising / Recruit. (Support)	68				0	0	0	0
Criminal record checks (Support)	69				0	0	0	0
Routine supplies, patient care services	70				0	0	0	0
Non-routine supplies, patient care services	71				0	0	0	0
Supplies, dietary services	72				0	0	0	0
Supplies, activities	73				0	0	0	0
Supplies, social services	74				0	0	0	0
Food and nutritional supplements	75				0	0	0	0
Pharmacy services	76				0	0	0	0
X-ray services	77				0	0	0	0
Laboratory	78				0	0	0	0
Professional support services	79				0	0	0	0
Equipment rental (Support)	80				0	0	0	0
	81				0	0	0	0
TOTAL SUPPORT CARE COSTS	**82**					**0**	**0**	**0**
TOTAL PATIENT CARE SERVICE COSTS	83					**0**	**0**	**0**
Depreciation	84				0	0	0	0
Amortization	85				0	0	0	0
Real estate taxes	86				0	0	0	0
Facility lease	87				0	0	0	0
Interest	88				0	0	0	0
Property and casualty insurance	89				0	0	0	0
Building and grounds repairs	90				0	0	0	0
	91				0	0	0	0
TOTAL PROPERTY COSTS	92					**0**	**0**	**0**
Beauty and barber shops	93				0	0	0	0
Personal purchases for residents	94				0	0	0	0
Income taxes	95				0	0	0	0
Officer's life insurance	96				0	0	0	0
Director fees	97				0	0	0	0
Nonworking officers' salaries	98				0	0	0	0
Professional care (Physicians)	99				0	0	0	0
Contributions	100				0	0	0	0
	101				0	0	0	0
TOTAL OTHER COSTS	102					**0**	**0**	**0**
TOTAL OF ALL EXPENSES	103					**0**	**0**	**0**

Facility Name:	Vendor No.:
Period of Report: From:	To:

SCHEDULE D
DEPRECIATION AND AMORTIZATION EXPENSE

Description	Line No.	Construction in Process (1)	Asset Cost (2)	Depreciation Allowable in Prior Years (3)	Method (4)	Annual Rate % (5)	Recorded Depreciation Expense (6)	Straight Line Depreciation (7)
EQUIPMENT:								
Building Equipment (fixed)	750							
Department Equipment	751							
Other Equipment	752							
Office Furniture & Fixtures	753							
Motor Vehicles	754							
Equipment	755							
	756							
TOTAL	757							
BUILDINGS:								
Facility	758							
Additions	759							
Other	760							
	761							
Land Improvements	762							
	763							
TOTAL	764							
TOTAL BUILDINGS AND EQUIPMENT	765							

LEASEHOLD IMPROVEMENTS

Description	Line No.	Construction (1)	Cost (2)	Prior Amount (3)	Period (4)	Recorded (5)	Straight Line (6)
	766						
	767						
	768						
	769						
	770						
	771						
TOTAL AMORTIZATION	772						

[77101] Questions:

1. Are the lessor or lessee the same person or group of persons or controlled by the same person or group of persons? ☐ Yes ☐ No
2. Does the lease contain an option to purchase the leased property? ☐ Yes ☐ No

Facility Name:	Vendor No.:
Period of Report: From	To:

SCHEDULE D-1
CHANGE OF OWNERSHIP

[78101] Has the facility changed owners since June 18, 1984?

- ☐ YES — Complete this schedule
- ☐ NO — This schedule does not apply

	Line No.	Previous Owner's Cost (1)	New Purchases Since Change (2)	Depreciation Allowable in Prior Years (3)	Allowable Straight-Line Depreciation (4)
EQUIPMENT:					
Building equipment (fixed)	780				
Department equipment	781				
Other equipment	782				
Office furniture & fixtures	783				
Motor vehicles	784				
	785				
Less equipment not purchased	786				
TOTAL	787				
BUILDINGS:					
Facility	788				
Additions	789				
Other	790				
	791				
Land Improvements	792				
	793				
Less buildings not purchased	794				
TOTAL	795				
TOTAL BUILDINGS AND EQUIPMENT	796				

Facility Name:	Vendor No.:
Period of Report: From:	To:

SCHEDULE E
COMPARATIVE BALANCE SHEET

All information to be taken from the general ledger.	Line No.	Balance at the End of: Current Period (1)	Prior Period (2)
ASSETS:			
Cash	801		
Investments (Money Market Certificate of Deposit, etc.)	802		
Receivable from residents	803		
Receivable from others	804		
Fixed Assets:	805		
Land	806		
Buildings and improvements	807		
Less allowance for depreciation (per books)	808		
Equipment (including motor vehicles)	809		
Less allowance for depreciation (per books)	810		
Leasehold Improvements	811		
Less allowance for amortization	812		
Construction in Process	813		
Other assets	814		
TOTAL ASSETS	815		
LIABILITIES:			
Accounts payable	816		
Accrued taxes (payroll and property)	817		
Other liabilities	818		
	819		
Notes and mortgages payable to officers, stockholders, owners, etc.	820		
Notes and mortgages payable to others	821		
TOTAL LIABILITIES	822		
EQUITY:			
Capital stock	823		
Paid-in surplus	824		
Retained surplus	825		
Partners' and proprietor's capital account(s)	826		
Partners' and proprietor's drawing account(s)	827		
Equity (nonprofit organization)	828		
TOTAL EQUITY	829		
TOTAL LIABILITIES AND EQUITY	830		

Facility Name:	Vendor No.:
Period of Report From:	To:

SCHEDULE F
RECONCILIATION OF EQUITY

	Line No.	Current Period
TOTAL EQUITY BEGINNING OF PERIOD	850	
Add:		
Net revenue from Schedule A	851	
Capital stock issued	852	
Partners' and proprietor's additional investment	853	
Other: Explain	854	
	855	
	856	
Deduct:		
Expenses per general ledger from Schedule C	857	
Capital stock retired	858	
Sub "S" corporation distribution	859	
Partners' and proprietor's withdrawals	860	
Dividends	861	
Other: Explain	862	
	863	
	864	
TOTAL EQUITY END OF PERIOD	865	

Facility Name:	Vendor No.:
Period of Report: From:	To:

SCHEDULE G
RELATED PARTY TRANSACTIONS

[90101] Does this cost report include any costs associated with services, facilities or supplies furnished by a related party or organization?

☐ **Yes - Complete This Schedule** ☐ **No - This Schedule Does Not Apply**

Name of Related Party or Organization (1)	Line No.	Description of Service or Supplies (2)	Amount (3)	Schedule (4)	Line (5)
	900				
	901				
	902				
	903				
	904				
	905				
	906				
	907				
	908				
	909				
	910				
	911				
	912				
	913				
	914				
	915				
	916				
	917				
	918				

Facility Name:	Vendor No.:
Period of Report: From	To:

SCHEDULE H
NURSING FACILITY WAGES AND HOURS

Sch C Line No.	Occupation or Employment Category	Entry Level Hourly Wage (1)	Total Wages Schedule C NF (2)	Total Hours NF (3)	Average Hourly Wage (4)	Average Hours Per Patient Day (5)
1	Administrator wages					
2	Business Office wages					
12	Home office costs					
18						
20	Laundry wages					
21	Housekeeping wages					
22	Maintenance wages					
38						
40	D.O.N. wages					
41	R.N. wages					
42	Licensed Practical Nurses wages					
43	Certified Nurse Aides wages					
44	Activities wages					
45	Social Services wages					
52	Certified nursing aide training wages					
54	Professional support services					
55	Contracted nursing services					
56	Occupational Therapy					
57	Physical Therapy					
58	Speech Therapy					
59	Respiratory therapy					
60						
62	Medical Records Services wages					
63	Medical Director wages					
64	Dietary Service Wages					
81						
91						
93	Beauty and barber shops					
97	Director fees					
98	Nonworking officers' salaries					
99	Professional Care (Physicians)					
101						

IOWA FINANCIAL AND STATISTICAL REPORT

Facility Name:	Vendor No.:
Period of Report: From:	To:

SCHEDULE H - 1
ASSISTED LIVING WAGES AND HOURS

Sch C Line No.	Occupation or Employment Category	Entry Level Hourly Wage (1)	Total Wages Schedule C - 1 Assisted Living (2)	Total Hours Assisted Living (3)	Average Hourly Wage (4)	Average Hours Per Resident Day (5)	Allocation of Staff Time: Assisted Living % of time (6)	Nursing Facility % of time (7)	Service Development % of time (8)	Other % of time (9)
1	Administrator wages									
2	Business Office wages									
12	Home office costs									
18										
20	Laundry wages									
21	Housekeeping wages									
22	Maintenance wages									
38										
40	D.O.N. wages									
41	R.N. wages									
42	Licensed Practical Nurses wages									
43	Certified Nurse Aides wages									
44	Activities wages									
45	Social Services wages									
52	Certified nursing aide training wages									
54	Professional support services									
55	Contracted nursing services									
56	Occupational Therapy									
57	Physical Therapy									
58	Speech Therapy									
59	Respiratory therapy									
60										
62	Medical Records Services wages									
63	Medical Director wages									
64	Dietary Service Wages									
81										
91										
93	Beauty and barber shops									
97	Director fees									
98	Nonworking officers' salaries									
99	Professional Care (Physicians)									
101										

IOWA FINANCIAL AND STATISTICAL REPORT

Facility Name:	**Vendor No.:**
Period of Report: From:	**To:**

SCHEDULE I
FULL TIME EMPLOYEE RETENTION AND TURNOVER RATES

1. Total number of W-2's ________________

2. **Adjustment:** Number of W-2's for temporary or part-time employees ________________

3. Total number of full time employees who worked anytime during the year. ________________

4. **Adjustment:** Number of full time employees hired during the year ________________

5. Total number of full time employees who were employed at the start of the year ________________

6. **Adjustments:** Number of full time employees separated anytime during the year. ________________

7. Number of full time employees who worked the entire year. ________________

Full time employee retention rate ____________________

Full time employee turnover rate ____________________

IOWA FINANCIAL AND STATISTICAL REPORT

Facility Name:	0	Vendor No.:	0
Period of Report: From	01/00/00	To:	01/00/00

SCHEDULE I-1 **Nursing**

Facility Annual Calculation Of Employee Turnover

Total Number of Employees on the First day of each Month														Average for the Year
Sch C Line No.	Job Classification	January	February	March	April	May	June	July	August	September	October	November	December	Total	
1	Administrator													0	0.00
2	Business Office													0	0.00
20	Laundry													0	0.00
21	Housekeeping													0	0.00
22	Maintenance													0	0.00
40	D.O.N.													0	0.00
41	R.N.													0	0.00
42	Licensed Practical Nurses													0	0.00
43	Certified Nurse Aides													0	0.00
44	Activities													0	0.00
45	Social Services													0	0.00
62	Medical Records Services													0	0.00
63	Medical Director													0	0.00
64	Dietary Service													0	0.00
	Other Staff													0	0.00
Total		0	0	0	0	0	0	0	0	0	0	0	0		0.00

Total Number of Terminations Each Month														Average Turnover Rate
Sch C Line No.	Job Classification	January	February	March	April	May	June	July	August	September	October	November	December	Total	
1	Administrator													0	0%
2	Business Office													0	0%
20	Laundry													0	0%
21	Housekeeping													0	0%
22	Maintenance													0	0%
40	D.O.N.													0	0%
41	R.N.													0	0%
42	Licensed Practical Nurses													0	0%
43	Certified Nurse Aides													0	0%
44	Activities													0	0%
45	Social Services													0	0%
62	Medical Records Services													0	0%
63	Medical Director													0	0%
64	Dietary Service													0	0%
	Other Staff													0	0%
Total		0	0	0	0	0	0	0	0	0	0	0	0		0%

Nursing Only		0%

Facility Name:	Vendor No.:
Period of Report: From:	To:

SUPPORTING SCHEDULE (1)

Facility Name:	Vendor No.:
Period of Report: From:	To:

SUPPORTING SCHEDULE (2)

IOWA FINANCIAL AND STATISTICAL REPORT

NAME OF FACILITY: | **VENDOR NUMBER(s):**

PERIOD OF REPORT FROM:
TO:

EDIT CHECKS

Diagnostics Summary - Any differences indicate that numbers are not flowing properly between the schedules.
Note: These amounts will automatically fill in based on your completed Financial and Statistical Report

Schedule Reference	Amount	Reference
Schedule C		
Total Costs		Line 103 Column 4
Total Costs - Allocated		Line 103 Column 12
Difference		
Total Admin Costs		Line 19 Column 4
Total Admin Costs - Allocated		Line 19 Column 12
Difference		
Total Env Costs		Line 39 Column 4
Total Env Costs - Allocated		Line 39 Column 12
Difference		
Total Patient Care Costs		Line 83 Column 4
Total Patient Care Costs - Allocated		Line 83 Column 12
Difference		
Total Property Costs		Line 92 Column 4
Total Property Costs - Allocated		Line 92 Column 12
Difference		
Total Other Costs		Line 102 Column 4
Total Other Costs		Line 102 Column 12
Difference		
Schedule E		
Total Assets		Current Period Column - Total Assets
Total Liabilities & Equity		Current Period Column - Total Liabilities and Equity
Difference		
Schedule F		
Total Equity - Sch E		Current Period Column - Total Equity
Total Equity - Sch F		Total Equity End of Period
Difference		

COMPLETED SCHEDULES

Diagnostics Summary - Any Warning message must be resolved.
Note: Required Schedules will automatically be determined based on your

Schedule	Required	Competed
Vendor Number	Yes	Warning - Schedule must be completed.
Certification Statement	Yes	Warning - Schedule must be completed.
Statistical Data	Yes	Warning - Schedule must be completed.
Schedule A - Total Facility Revenue	Yes	Warning - Schedule must be completed
Schedule A-1	N/A	N/A
Schedule A-2	No	N/A
Schedule C	Yes	Warning - This schedule must be completed.
Schedule C-1	No	N/A
Schedule D	Yes	Warning - Schedule must be completed
Schedule D-1	No	N/A
Schedule E	Yes	Warning - This schedule must be completed.
Schedule F	Yes	Warning - This schedule must be completed.
Schedule G	No	N/A
Schedule H	Yes	Warning - This schedule must be completed.
Schedule H-1	No	N/A
Schedule I	Yes	Warning - This schedule must be completed.
Schedule I-1	Yes	Warning - This schedule must be completed.

COMPLETED QUESTIONS

Diagnostics Summary - Any Warning message must be resolved.
Note: Required Questions will automatically be determined

Schedule	Required	Competed
Certification Statement [15101]	Yes	Warning - Question must be answered
Certification Statement [17101]	Yes	Warning - Question must be answered
Statistical Data [18101]	Yes	Warning - Question must be answered
Statistical Data [20101]	Yes	Warning - Question must be answered
Statistical Data [20102]	Yes	Warning - Question must be answered
Schedule D [77101]	Yes	Warning -Part 1 and 2 must be answered.
Schedule D-1 [78101]	Yes	Warning - Question must be answered
Schedule G [90101]	Yes	Warning - Question must be answered

Financial and Statistical Report, Form 470-0030

Residential care facilities use form 470-0030, *Financial and Statistical Report*, to report costs under the State Supplementary Assistance program. (Nursing facilities and intermediate care facilities for the mentally retarded also use this form to report costs under the Medicaid program.)

Completed financial reports are to be submitted in an electronic format using the State approved Excel template. Facilities may use their own computer-generated cost reports in place of this form with the prior approval of the IME Provider Cost Audits and Rate Setting Unit.

To view a copy of form 470-0030, click here. The template may be downloaded from the IME web site at: www.ime.state.ia.us/Providers/Forms.html
The workbook consists of 21 worksheets:

- Certification
- Statistical data
- Schedule A, Total Facility Revenue
- Schedule A-1, NF Conversion/LTC Service Development Grant Revenue
- Schedule A-2, Description of Living Units
- Schedule B, Expense Adjustments
- Schedule C, Schedule of Expenses
- Schedule C-1, Assisted Living Expense Allocation
- Schedule D, Depreciation and Amortization Expense
- Schedule D-1, Change of Ownership
- Schedule E, Comparative Balance Sheet
- Schedule F, Reconciliation of Equity
- Schedule G, Related party Transactions
- Schedule H, Nursing Facility Wages and Hours
- Schedule H-1, Assisted Living Wages and Hours
- Schedule I, Full Time Employee Retention and Turnover Rates
- Schedule I-1, Facility Annual Calculation of Employee Turnover
- Supporting Schedule (1)
- Supporting Schedule (2)
- Edits
- Print

A residential care facility does **not** complete Schedules A-1, A-2 C-1, H, H-1, I or I-1. Schedules D-1 and G may not be needed, depending on the facility's circumstances.

Reports are required three months after the facility begins to participate in the program and then once a year within three months of the close of facility's fiscal year. The Provider Audits and Rate Setting Unit of Iowa Medicaid Enterprise mails a reminder to facilities when cost reports are due.

Electronic files can be sent by e-mail to the rate setting contractor at costaudit@dhs.state.ia.us or they can be submitted on diskette to:

Iowa Medicaid Enterprise
Attn: Provider Cost Audit
P.O. Box 36450
Des Moines, Iowa 50315

A signed copy of the Certification Statement (page 1 of the financial report) must also be mailed to the rate setting contractor before the due date.

Instructions for Medicaid Financial and Statistical Report for Nursing Facilities is a Department publication which includes detailed instructions for completing the cost report. To view a copy of the instructions, click here. The instructions may be downloaded from the IME web site at: www.ime.state.ia.us/Providers/Forms.html

STATE OF IOWA

IOWA DEPARTMENT OF HUMAN SERVICES DIVISION OF MEDICAL SERVICES

Instructions for the Medicaid Financial and Statistical Report for Nursing Facilities

GENERAL INSTRUCTIONS

These instructions are for use under the provisions of the rate setting criteria for nursing facilities (441 IAC 81) that are certified as Medicaid providers by the State of Iowa, Department of Human Services, Division of Medical Services.

Forms and Information Completed financial reports are to be submitted in an electronic format using the State approved Excel template. The Excel template is available from the Iowa Department of Human Services, Division of Medical Services website at www.dhs.state.ia.us. To access the Excel template from the website use the pull down menu under Organization and select Policy Analysis. From the Policy Analysis screen select Policy Manuals. Under Policy Manuals select Medicaid Provider Manuals and then select Institutional Care. Under Institutional Care select Financial and Statistical Report, Form 470-0030FSR. The financial report should be filed annually for a 12-month period ending with the facility's fiscal year end. The financial report must be submitted to the rate setting contractor no later than three months after the close of the facility's established fiscal year. A signed copy of the Certification Statement (page 1 of the financial report) must also be mailed to the rate setting contractor prior to the due date. Electronic files can be sent by e-mail to the rate setting contractor at costaudit@dhs.state.ia.us or they can be submitted on diskette to:

Iowa Medicaid Enterprise Attn:
Provider Cost Audit
P.O. Box 36450Des Moines, Iowa 50315

Refer to Criteria - Instructions Are Not Comprehensive. These instructions are not intended to be comprehensive. In completing the forms, providers should rely on the criteria as well as other relevant rules and regulations, including generally accepted accounting principles (GAAP). Report dollar amounts as whole numbers, per diem, monthly rental rates and hourly amounts using two decimal places.

CERTIFICATION PAGE 1 Provider Name and Identification Data

[11101] and [12102] through [12105] Facility Name and Address Indicate the exact name of the facility as it appears on the state license. The physical address must be completed.

[11201] Federal ID Number Enter your federal nine digit taxpayer identification number utilized for submitting you tax returns to the Internal Revenue Service as XXXXXXXXX.

[13101] and [13102] Period of Report Indicate the beginning and ending dates of the financial and statistical data as MM/DD/YYYY.

[12110] County Report the county in which the facility is physically located.

[14101] Date Facility Entered Program Enter the date the facility first received licensed approval to participate in the Medicaid Program as MM/DD/YYYY.

[14102] Date Owner Acquired Facility Enter the date the facility was acquired by the current owner/operator of the facility as MM/DD/YYYY.

[14120] FYE Report the facilities fiscal year end for tax reporting purposes as MM/DD.

[15101] Type of Control Indicate the ownership or organization type under which the facility is operated. (Check one only)

[16101] Vendor Number Enter the seven-digit number assigned to the facility by the Department of Human Services. Facilities that offer more than one level of care should report the vendor number for each level of care. It is very important that the provider's vendor number be stated correctly on the proper line by program type. The incorrect reporting of a vendor number can delay the review process.

Certification Statement After adequate review of the completed form, an authorized officer of the facility must be reported on the certification statement. If a paid preparer is utilized to complete the forms, name and company name of preparer must also be reported. Indicate in question [17101] if an opinion of a certified public accountant is attached.

CERTIFICATION PAGE 2 Accounting Basis, Statistical and Ownership Data

[18101] Accounting Basis Indicate which accounting basis is used by the facility by selecting the applicable method. The three methods are described as follows:

Accrual: Recording revenue when earned and expenses when incurred.

Modified Cash: Recording revenue when received and expenses when incurred.

Cash: Recording revenue when received and expenses when paid, after giving effect to adjustments for asset purchases, etc. and depreciation.

If you do not use the accrual basis of accounting, you must adjust recorded amounts to the accrual basis. This is necessary to obtain information that is comparable among facilities.

For example, when expenses are incurred in the last month of a reporting period but are paid in the first month of the following reporting period, include them in the report period in which they are incurred, and not the report period in which they are paid.

Include expenses that pertain to a whole year (such as dues, property taxes, insurance premiums, professional fees, and similar items). Take and price inventories of supplies and adjust expense accounts at the end of each reporting period.

[19101] Statistical Data Line 1 - NF must include all authorized licensed Medicaid, Medicare certified, and dual licensed Medicare/Medicaid nursing facility beds. This would include all beds on which MDS transmissions are required. Non-authorized licensed comprehensive care nursing facility beds in which MDS transmissions have been completed and submitted must be reported on Line 1 - NF. All other beds must be reported on Lines 2 through 6 in the appropriate type of service. This would include all beds on which MDS transmissions are not required. Non-authorized licensed comprehensive care nursing facility beds in which MDS transmissions have not been submitted must be reported on Line 6 - Other. All data reported in the financial report must be consistent with the number of beds reported in the Statistical Data.

Number of Authorized Beds Start of Period Report the number of authorized licensed beds at the beginning of the reporting period for each type of service.

Number of Authorized Beds End of Period Report the number of authorized licensed beds at the end of the reporting period for each type of service.

Total Bed Days in Reporting Period Total bed days available should equal the number of beds reported multiplied by the number of days in the reporting period.

Patient Days in Reporting Period The number of patient days should be based on census logs maintained by the provider. A "patient day" is that period of service rendered a resident based on the census of patient status at midnight at the end of each day. It is essential that this statistic be accurate and not an estimate of days of care provided.

Maintain a daily census summary to ensure the needed statistical accuracy. This summary must show the resident count at the beginning of the day, admissions, discharges, and resident count at the end of the day.

The Total Column 4 must include all private-pay and public assistance residents occupying a bed or paying for reserve bed days in the facility during the reporting period. Include the day of discharge only when the resident was admitted the same day.

The Medicaid Column 5 must include all Medicaid residents occupying a bed or paying for reserve bed days in the facility during the reporting period. Include the day of discharge only when the resident was admitted the same day.

Number of Admissions Report the number of resident admissions for the reporting period from the daily census summaries.

Number of Discharges Report the number of resident discharges for the reporting period from the daily census summaries.

Questions [20101] and [20102] Indicate whether the facility has an assisted living grant or CCDI unit by selecting yes or no to each question.

<u>[21101] Ownership Information</u> Enter complete and accurate ownership information, including all individuals holding a five percent or greater interest. Include the owners' name, percentage of work week the owner devoted to business for the facility during the reporting period, Owners' Title, Owners' Salaries and Wages expense for the reporting period, Owners' Social Security Number, and Owners' Percentage Ownership in the facility.

SCHEDULE A – TOTAL FACILITY REVENUE

List revenues as recorded in the general books and records. Routine and ancillary revenues from all payer sources should be reported on the appropriate lines and columns. The revenues reported in Column (5) Total should be allocated between Column (6) Nursing Facility and Column (7) Other based upon the gross amount charged to each resident classification. For example, if an assisted living resident generates gross charges for routine daily service, the associated revenues should be reported in Column (7) Other. Revenues are affected to a great extent by the accounting basis and procedures used. Expense recoveries that are a credit to expense accounts should not be reclassified as revenues for purposes of this report.

Enter revenues related to services rendered which are not obligations of the State in Column 8 to the extent of the related expense. These items include beauty and barbershop and personal purchases for residents. Also enter in Column 8 revenues from items and services which are available to residents through other Medicaid vendors.

Apply revenues not related to resident care (Other Revenue Centers) as a reduction of the related expense. Enter on Schedule A in Column 8:

- The cost, if known (such as employee meals or telephone expense).
- The gross revenue, if costs cannot be determined.

Investment income adjustment is necessary only if interest expense is incurred and only to the extent of the interest expense.

Handle income from the sale of craft products as follows:

- When the income is minimal and the raw materials are furnished by either the resident or the facility, the income need not be applied as a reduction in expense.
- When the income is substantial and the income is turned over to the facility to offset the cost of raw materials, apply the income as an offset of the indicated craft expense.

Apply laundry revenue to laundry expense.

Open lines are provided for entry of sundry sources of revenue not directly related to residents, such as pay telephone commissions, contributions and grants received, etc. These items need not be applied as a reduction of expense.

Report hospice agency revenues on Schedule A under "Other Revenue Centers" as an add-on line item under "Other." Extend this same amount into Column 8 of Schedule A, as it will be used as an expense offset on Schedule C. The cross-reference line item for this expense offset on Schedule C should be line 81. A description of the adjustment would be "Hospice Reimbursement." Record the amount in Column 8 as a Schedule A adjustment.

Report accounts receivable charged off or provision for uncollectable accounts on Schedule A as a deduction from gross revenue. However, if the facility accounts for such revenue deductions as an administrative expense, enter the amounts on Schedule B as "other expense not related to patient care."

The amounts entered on Schedule A, Column 8, are transferred to Schedule C, Column 2. The totals of these columns on both schedules should agree.

For more information on how to apply these instructions to routine services, pharmacy items, medical supplies, ancillary services, and personal needs items, see the explanatory sections that follow.

<u>Routine Services</u>

Classify revenue from residents sufficiently in the accounting records to allow preparation of the schedule. Routine daily service revenue should be reported in the appropriate columns as gross revenue by primary payer source (i.e., if the primary payer is Medicare and the Medicaid program pay for co-insurance, then the gross routine service revenue should be reported in the Medicare column). It is essential that "routine daily service" represent only the established charge of daily care, excluding additional charges for other services, if any.

Charges for routine services must include all items of services, equipment, and supplies which facilities incur in the provision of routine services. Examples of services and supplies that must be included in routine services are:

- Residents' rooms and furnishings (as required by licensing rules), including maintenance.⁄General care and supervision of residents.

- Necessary supervision or assistance with eating, dressing, bathing, grooming, and moving about.
- Laundry services, including washing personal clothing.
- Provision of activities and socialization experience for residents.

Pharmacy Items

Approved legend drugs requiring a prescription by law and insulin are paid for directly by Medicaid. Costs of these items must be billed by and paid to a retail pharmacy or a facility having a retail pharmacy license. If the facility pays for these costs and is subsequently reimbursed, these reimbursements must offset the expense.

The following items are also provided to residents by the pharmacy and billed by the pharmacy directly to Medicaid:

- Catheter (indwelling Foley)
- Colostomy and ileostomy appliances
- Colostomy and ileostomy care dressings, liquid adhesive, and adhesive tape
- Diabetic supplies (needles and syringe, disposable or reusable, testape, Clinitest
- tablets and Clinistix)
- Disposable catheterization tray or sets⁄Disposable irrigation trays or sets (sterile)
- Disposable saline enemas
- Insulin
- Prescription drugs and devices
- Vitamin pills, prescription (prior approval required)

If the facility pays for these costs and is subsequently reimbursed, those reimbursements must offset the expense.

Non-Routine Medical Supplies, Occupational Therapy, Physical Therapy, Speech Therapy, Respiratory Therapy

Therapy revenue and non-routine medical supply revenue should be reported in the appropriate column by actual payment source (i.e., Medicaid, Medicare, Private Pay or Other). Although non-routine medical supplies and therapy services are reimbursed through the per diem rate, revenue for Medicaid therapy services and Medicaid non-routine medical supplies should be reported in Column (1) of Schedule A using gross charges consistently applied to all payer types. The total amount of Medicaid therapy and Medicaid non-routine medical supply revenue should then be netted to zero with a contractual adjustment on Line 240 (Provision for uncollectible accounts).

Ancillary Services

A revenue classification “miscellaneous” or “sundry” ordinarily requires an analysis and determination of the amounts included which represent expense recoveries or income to be applied as a reduction to the related expense.

The following items and services are available to residents through other Medicaid programs, and are billed by the supplying vendor. If the facility pays for these costs and is subsequently reimbursed, those reimbursements must offset the expense.

- Ambulance service
- Audiologist services
- Braces and prosthetic devices
- Chiropractor services
- Dental work and equipment
- Hearing aid batteries and cords
- Hearing aid repairs
- Hearing aids
- Hospital services
- Modifications to orthopedic shoes
- Optician and optometrist services
- Occupational or physical therapy provided in a doctor’s office or hospital outpatient clinic
- Physician services
- Podiatrist services
- Repair of medical equipment and appliances
- Skilled services
- X-rays, laboratory work

Personal Needs Items

Residents may choose to purchase personal needs items through the facility. Revenues from these items must offset the related expenses account.

Licensing rules for facilities require that the facility provide materials for activity programs and recreation. Items purchased for general use by the facility should be included in routine service costs and should not be charged to residents.

A resident may purchase a wheelchair from personal needs funds to be used exclusively by the resident. A wheelchair purchased by a resident reverts to the resident’s estate or to relatives upon death.

A resident may purchase a television set or an air conditioner from personal needs funds for use in the resident’s room only. Appliances must revert to the resident’s estate or to relatives. Reasonable charges for electricity for use of appliances are allowable personal needs fund charges, if a like amount is included in Schedule C as a reduction in cost for utilities (Line 32).

In NFs and ICF/MRs, if nonlegend drugs or nonprescription vitamin pills are ordered by a physician, they must be included in routine service charges and are an allowable cost. If a resident requests these items and the items are not ordered by a physician, they may be

charged to the resident.

AVERAGE PRIVATE PAY RATE

The average private pay rate should reflect the average usual and ordinary charge for private pay residents for like levels of service during the reporting period. To compute the average private pay rate, accumulate the total monthly charges for all nursing facility private-pay residents for the reporting period. Divide this sum by the total nursing facility patient days for all nursing facility private-pay residents for the same reporting period. "Total monthly charges" include the basic charge plus all charges for extra care, services, or supplies that are covered by the Medicaid per diem rate.

SCHEDULE A-1 – NF CONVERSION/LTC SERVICE DEVELOPMENT GRANT REVENUE

Assisted Living Grant Revenue

Report revenue associated with assisted living grant units only. Revenue should be separated by Medicaid, Waiver, HUD low income credits, HCBS rent subsidy, In-home care and private pay.

Service Development Grant Revenue

Report revenue associated with a service development grant only. Revenue should be reported in columns 1, 2 and 3 separated by Medicaid, Waiver and private pay. Report in columns 4, 5, and 6 the number of Medicaid, Waiver and private pay units for each type of service provided.

SCHEDULE A-2 – DESCRIPTION OF LIVING UNITS

Assisted Living Grant Funded

Only complete this schedule if the facility has an assisted living grant. Facilities that do not have an assisted living grant do not need to complete this schedule.

For each type of unit submitted in your architectural and feasibility study, report in

Column 3 the number of units for each room configuration indicating the room configuration as a one-bedroom, two-bedroom or efficiency. The schedule allows for up to ten (10) types of room configurations.

Report in Column 4 the square footage for each room configuration.

Report in Column 5 the total Medicaid resident days occupying each room configuration.

Report in Column 6 the total resident days occupying each room configuration.

Report in Column 7 the average monthly room rental rate and average monthly board rate charged Medicaid residents during the reporting period for each room configuration.

Report in Column 8 the average monthly room rental rate and average monthly board rate charged Non-Medicaid residents during the reporting period for each room configuration.

Assisted Living Non-Grant Funded

Complete this schedule if the facility has an assisted living grant and has separate non-granted funded assisted living units. Facilities that do not have an assisted living grant do not need to complete this schedule.

For each type of non-grant funded unit submitted in your architectural and feasibility study, report in Column 3 the number of units for each room configuration in the applicable row indicating the room configuration as a one-bedroom, two-bedroom or efficiency. The schedule allows for up to ten (10) types of room configurations.

Report in Column 4 the square footage for each room configuration.

Report in Column 5 the total Medicaid resident days occupying each room configuration.

Report in Column 6 the total resident days occupying each room configuration.

Report in Column 7 the average monthly room rental rate and average monthly board rate charged Medicaid residents during the reporting period for each room configuration.

Report in Column 8 the average monthly room rental rate and average monthly board rate charged Non-Medicaid residents during the reporting period for each room configuration.

SCHEDULE B: EXPENSE ADJUSTMENTS

Certain expenses must be eliminated or limited because they are not normally incurred in providing patient care. Rules concerning these expenses are set forth below. The amounts entered on Schedule B are transferred to Schedule C, Column 3. The totals of these columns on both schedules must agree.

The following expenses are not reimbursable:

- Income Taxes. Federal and state income taxes are not allowable as reimbursable costs.
- Fees Paid Directors and Nonworking Officers' Salaries. Fees paid to directors and nonworking officers' salaries are not allowable as reimbursable costs.
- Bad Debts**.** Bad debts are amounts considered to be uncollectable from accounts and notes receivable which were created or acquired in providing services. Bad Debts are not an allowable cost.
- Courtesy Allowances**.** Courtesy allowances are reductions in charges made by the provider of services because of the indigence or medical indigence of the resident. Courtesy allowances are not an allowable cost.
- Entertainment**.** Entertainment for which the resident is required to pay is not included as

an allowable cost. Entertainment provided by the facility for participation of all residents who are physically and mentally able to participate is an allowable expense. Examples are as follows:

- Birthday parties.
- Outside entertainers, exclusive of volunteer groups (religious, high school, community groups, etc.).
- Activity director salary, unless working as a volunteer.
- Expenses incurred in the activities program are an allowable expense. (See also the instructions for Personal Needs Items under Schedule A.)
- Concerts, athletic events, shows and other entertainment which require an outlay of funds by the facility are allowable expenses.

- ♦ Loan Acquisition Fees and Standby Fees. Loan acquisition fees and standby fees are not considered part of the current expense of resident care, but should be amortized over the life of the related loan.
- ♦ Capital Expenditures. Providers constructing new facilities or expanding existing facilities must receive certificate of need approval from the Iowa Department of Public Health. When prior approval is not obtained, depreciation, interest on borrowed funds and other costs attributable to such capital expenditures are not allowed as reimbursable expenses.
- ♦ Legal Fees. Reasonable legal fees are an allowable cost when directly related to patient care. Legal fees related to defense against threatened state license revocation or Medicaid decertification are allowable costs only up to the date a final appeal decision is issued. However, in no case will legal fees related to Medicaid decertification be allowable costs for more than 120 days following the decertification date.

The following sections give more detailed information on the limits for:

- ♦ Travel expenses.
- ♦ Compensation of owners and related parties.
- ♦ Items furnished by related organizations.
- ♦ Rental costs.
- ♦ Depreciation.
- ♦ Interest.

Travel

Personal travel and entertainment expenses are not allowable as reimbursable costs. Prorate expenses such as rental or depreciation of vehicles and travel expenses that include both business and personal expense.

Maintain records to substantiate the indicated charges. Amounts that appear excessive may be limited after considering the specific circumstances. Guidelines relating to this area are as follows:

- ♦ No commuter travel (from private residence to facility and return) is allowed as an audit cost in computing the facility's per diem rate. This includes owners, owner-administrators, administrators, assistant administrators, nursing directors, and all other employees of the facility.
- ♦ The expense of one car, one van, or both, designated for use in transporting residents

is an allowable cost. (This restriction on number of vehicles does not apply to ICF/MRs.) Travel related to resident care is allowable. Document all expenses by a sales slip, invoice, or other document describing the expense and identifying the vehicle.

- Travel for which the resident is required to pay must not be included as a travel expense. If the expense cannot be identified and eliminated from other travel expense, revenue from this source must be included on Schedule A and must offset expense on Schedule C.
- Expenses associated with association business meetings are allowable if limited to individual members of associations that are members of a national affiliate.
- Expenses associated with workshops, symposiums, and meetings which provide administrators or department heads with hourly credits required to comply with continuing education requirements for licensing are also allowable expenses.
- Travel of an emergency nature required for the purchase of supplies or for repairs for machinery, building or equipment is an allowable travel expense.
- Allowable expenses for resident transport, business meetings, continuing education and emergencies (as described above) are limited to six percent of total administrative expense. This restriction does not apply to ICF/MRs.

At the annual contract review, each facility must verify that it either:

- Has a transportation plan approved by the Iowa Department of Transportation (DOT),
- Has notification that it is exempt, is awaiting response from the DOT, or
- Has been notified that its plan is in noncompliance with requirements of the DOT.

If the facility has a noncompliant plan, the transportation cost of the facility is not allowed in computing the allowable per diem rate of the facility. Statements indicating exemption or compliance are subject to follow-up audit review by the Department. If supportive documentation cannot be produced, then transportation cost will be disallowed.

Compensation of Owners or Related Parties

Owners of provider organizations often render services as managers, administrators, or in other capacities. In such cases, it is equitable that reasonable compensation for the services rendered be an allowable cost. To do otherwise would disadvantage these owners in comparison with providers employing persons to perform a similar service.

Ordinarily, compensation paid to proprietors is a distribution of profits. However, where a proprietor renders necessary services for the facility, the facility is in effect employing the proprietor's services. A reasonable compensation for these services is an allowable cost.

For corporate providers, the salaries of owners who are employees are subject to the same requirements of reasonableness of compensation, which may be determined by reference to, or in comparison with, compensation paid for comparable services and responsibilities in comparable facilities or other appropriate means.

A reasonable allowance of compensation for services of owners or related parties is an allowable cost, provided the services are actually performed in a necessary function. Maintain adequate time records to justify reported expenses. Adjustments may be necessary to provide compensation

as an expense for non-salaried working proprietors and partners.

The following persons are considered related parties:

- ♦ Husband and wife;
- ♦ Natural parent, child and sibling;
- ♦ Adopted child and adoptive parent;
- ♦ Grandparent and grandchild;
- ♦ Stepparent, stepchild, stepbrother, and stepsister;
- ♦ Father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, and sister-in-law.

Compensation means the total benefit received by the owner or related party for the services the proprietor renders to the facility. It includes:

- ♦ Salaries for managerial, administrative, professional and other services.

- ♦ Amounts incurred by the facility for personal benefits of the proprietor e.g., health insurance, food or meals, personal utilities, taxes, yard care, etc.

- ♦ The cost of assets and services which the proprietor receives from the facility e.g. life insurance, key man insurance, personal care, etc.

- ♦ Deferred compensation.

Members of religious orders serving under an agreement with their administrative office are allowed salaries equal to those paid to persons performing comparable services. If the facility provides maintenance to such persons (room, board, clothing, etc.) deduct the value of these benefits from the amount otherwise allowed for a person not receiving maintenance.

Necessary means that the function:

- ♦ Is such that if the owner or related party had not rendered the service, the facility would have to employ another person to perform the service.
- ♦ Is pertinent to the operation and sound conduct of the facility.

Reasonable means that the compensation allowance:

- ♦ Is an amount that would ordinarily be paid for comparable services by comparable facilities.
- ♦ Depends upon the facts and circumstances of each case.

Federal financial participation is available for owner’s compensation, provided the schedules of payment established by the Department do not exceed the combined payments received by providers from the intermediaries and beneficiaries under Medicare for furnishing comparable services under comparable circumstances.

Guidelines for determining reasonableness have been established based upon a review of compensation of owners and nonowners with the assistance of the regional Health and Human Services office. These guidelines are as follows:

- Administrator: A monthly base maximum compensation is allowed for an administrator, plus a given amount for each licensed bed over 60, not to exceed a set limit per month. An administrator is considered to be involved in ownership of a facility when the administrator holds an interest of five percent or more.
- Assistant administrator: A maximum monthly compensation is allowed for an assistant administrator for a home having a licensed capacity of 151 or more beds.
- Nursing director: The maximum allowed compensation for a director of nursing is 60 percent of the amount allowed for the administrator, or a set amount per month, whichever is greater.
- Other employees: Compensation amounts for other employees must be reasonable and necessary.

Contact the Division of Medical Services for current limits. A notice is issued to all facilities concerning these limits.

Management fees are computed on the same basis as the owner-administrator's salary, but the amount paid the resident administrator is deducted. If the parent company can separately identify accounting costs, these costs are allowed.

Expenses related to patient care which are incurred by a central office on behalf of the facility are allowable to the extent that the cost would be allowed if paid directly by the facility.

Items Furnished by Related Organizations

Costs of supplies furnished by a related party or organization are reimbursable if included at the costs to the related party or organization. However, such costs must not exceed the price of comparable supplies that could be purchased elsewhere. Complete Schedule G, Related Party Transactions, to indicate all items purchased from related parties.

Related to the facility means that the facility, to a significant extent, is associated or affiliated with, or has control of, or is controlled by the organization furnishing the services, facilities, or supplies.

Common ownership means that a person or persons possess significant ownership or equity in the facility and the institution or organization serving the provider.

Control means that a person or an organization has power, directly or indirectly, to significantly influence or direct the actions or policies of an organization or institution.

Where the facility obtains items of service, facilities, or supplies, from an organization, even though it is a separate legal entity, and the organization is owned or controlled by the owners of the provider, in effect the items are obtained from itself.

One example is a corporation building a facility and then leasing it to another corporation controlled by the owner. Reimbursable cost should not exceed the costs for these items to the

supplying organization.

However, if the price in the open market for comparable services, facilities, or supplies is lower than the cost to the supplier, the allowable cost to the facility will not exceed the market price.

An exception is provided to this general principle if the facility demonstrates by convincing evidence:

- That the supplying organization is a bona vide separate organization.
- That a substantial part of its business activity of the type carried on with the facility is transacted with others than the facility.
- That there is an open, competitive market for the type of services, facilities, or supplies furnished by the organization.
- That the services, facilities, or supplies are those which commonly are obtained by institutions such as the facility from other organizations and are not a basic element of patient care originally furnished directly to patients by such institutions.
- That the charge of the facility is in line with the charge for such services, facilities, or supplies in the open market and no more than the charge made under comparable circumstances to others by the organization for such services, facilities, or supplies.

In such cases, the charges by the supplier for the services, facilities, or supplies are an allowable costs.

Rental Costs

When an operator of a participating facility enters into an agreement to rent the facility from the former owner or operator, rental expense must be determined by identifiable property costs and by relationship of the provider to the landlord.

When the provider rents from a nonrelated party, the amount of rental expense must be based on the identified cost of the facility, plus the landlord's other expenses, and a reasonable rate of return, not to exceed actual rent payments.

When the provider rents from a related party, the amount of rental expense must be no more than the amortized cost of the facility plus the landlord's other expenses.

Advertising

Advertising expense is allowed not to exceed the lesser of $7,200 or an amount computed at 2% of daily revenue.

Depreciation

Depreciation based upon tax cost may be included as a resident cost using only the straight-line method of computation and recognizing the estimated useful life of the asset. When accelerated methods of computation have been elected for income tax purposes, an adjustment must be made.

With any change of ownership of a nursing facility or ICF/MR, including lease arrangement, no increase in the value of the property is allowed in determining the Medicaid rate for the new owner. (Facilities having a change in ownership complete Schedule D-1 for each reporting period.)

For RCFs, the new owner or operator must either:

- ♦ Continue with previous owner's depreciation schedule, or
- ♦ Set up a new depreciation schedule using the amount obtained by deducting the depreciation expenses incurred since July 1, 1980, from the value of depreciable real property. The value will be the sale price or appraised value, whichever is less. (441 IAC 54.3(12)"c")

Interest

Necessary and proper interest on both current and capital indebtedness is an allowable cost.

Interest means the cost incurred for the use of borrowed funds. Interest on current indebtedness is the cost incurred for funds borrowed for a relatively short term. This is usually for such purposes as working capital for normal operating expenses.

Interest on capital indebtedness is the cost incurred for funds borrowed for capital purposes, such as acquisition of facilities and equipment and capital investments. Generally, loans for capital purposes are long-term loans.

Necessary means that the interest:

- ♦ Is incurred on a loan made to satisfy a financial need of the provider. Loans which result in excess funds or which provide investments are not considered necessary.
- ♦ Is incurred on a loan made for a purpose reasonably related to patient care. Loans made for the purpose of acquiring capital stock and treasury stock are not considered reasonably related to patient care.
- ♦ Is reduced by investment income, except where such income is from restricted or unrestricted gifts and grants, which are held separate and not mingled with other funds. Income from funded depreciation or a provider's qualified pension fund is not used to reduce interest expense.

Proper means that interest:

- ♦ Is incurred at a rate not in excess of what a prudent borrower would have had to pay in the money market existing when the loan was made.
- ♦ Is paid to a lender not related through control or ownership or personal relationship to the borrowing organization.

To be allowable, interest expense generally must be incurred on indebtedness established with

a lender or lending organization not related through control, ownership, or personal relationship to the borrower.

Presence of any of these factors affect the "bargaining" process that usually accompanies the making of a loan, and could suggest an agreement on higher rates of interest or of unnecessary loans.

However, under some circumstances, interest on loans to providers by lenders or lending organization related through control, ownership, or personal relationship to the borrower is allowable as a cost at a rate not in excess of the current interest rate at the time the loan was made. The current interest rate is intended to mean what an investor could receive on funds invested in the locality.

Loans must be made under terms and conditions that a prudent borrower would make in arms-length transactions with lending institutions. The intent of this provision is to ensure that loans are legitimate and needed, and that the interest rate is reasonable.

Where the general fund of a provider "borrows" from a donor-restricted fund and pays interest to the restricted fund, this interest expense is an allowable cost.

The same treatment is accorded interest paid by the general fund on money "borrowed" from the funded depreciation account of the provider or from the provider's qualified pension fund. If a provider operated by members of a religious order borrows from the order, interest paid to the order is an allowable cost.

Where funded depreciation is used for purposes other than improvement, replacement, or expansion of facilities or equipment related to patient care, allowable interest expense is reduced to adjust for offsets not made in prior years from earnings on funded depreciation.

A similar treatment is accorded deposits in the provider's qualified pension fund when such deposits are used for other than the purpose for which the fund was established.

Change of Facility Ownership

The person responsible for transfer of ownership or for termination is responsible for submission of a final *Financial and Statistical Report* through the date of the transfer or termination. No payment to the new owner will be made until formal notice of the change is received.

The following situations are defined as transfer of ownership:

- When a facility is owned by a partnership, the removal, addition, or substitution of a partner, in the absence of an express statement to the contrary, dissolves the old partnership and creates a new partnership which is not a party to the previously executed agreement. A transfer of ownership has occurred.
- When a facility is a sole proprietorship, a transfer of title and property to another party constitutes a change of ownership.

- When a facility is a corporation, neither a transfer of corporate stock nor a merger of one or more corporation with the participating corporation surviving is a transfer of ownership. A consolidation of two or more corporations resulting in the creation of a new corporate entity constitutes a change of ownership.
- When a participating facility is leased, a transfer of ownership is considered to have taken place. When the entire facility is leased, the total agreement with the lessor terminates. When only part of the facility is leased, the agreement remains in effect with respect to the unleased portion, but terminates with respect to the leased portion.

With any change of ownership of a NF or ICF/MR (including lease agreements), no increase in the value of the property will be allowed in determining the Medicaid rate for the new owner. When filing the first cost report, the new owner must either:

- Continue the schedule of depreciation and interest established by the previous owner, OR
- Choose to claim interest expense using amortization of the actual rate of interest.

The results of the interest expense calculation must not be higher than would be allowed under Medicare principles of reimbursement. Interest must be applied to the allowed depreciable value established by the previous owner, less any down payment made by the new owner.

Other acquisition costs of the new owner will not be allowed. These include legal fees, accounting and administrative costs, travel costs, and the costs of feasibility studies attributable to the negotiation or settlement of the sale or purchase of the property.

In general, follow the provisions of Section 1861 (v)(1)(0) of the Social Security Act regarding payment allowed under Medicare principles of reimbursement at the time of a change of ownership, except that there is no provision for return on equity or recapture of depreciation.

A new owner or lessee wishing to claim a new rate of interest must submit documentation that verifies:

- The amount of down payment made,
- The actual rate of interest, and
- The number of years required for repayment with the next cost report.

In the absence of the necessary supportive documentation, interest and other property costs for all facilities that have changed or will change ownership must continue at the rate allowed the previous owner.

SCHEDULE C - EXPENSES

- Administrative costs
- Environmental services
- Direct patient care costs
- Support care costs

- ♦ Property costs
- ♦ Other costs

The accounts under these categories are segregated to provide required statistical information. All expense carried on the provider's general ledger must be entered in Column 1.

Column 2 and 3 (Adjustment of Expenses) reflect adjustments from Schedule A and B for items which are not allowable as costs to provide resident care. Expense adjustments that are a reduction to expense should be input as a negative amount. Column 4 must reflect expenses related to resident care.

Costs allocated to certain line items on Schedule C are limited. See SCHEDULE B: EXPENSE ADJUSTMENTS for an explanation of these limits.

The following is a description of each line of Schedule C.

Administrative Costs

LINE 1: ADMINISTRATOR WAGES. Salary of the facility administrator including regular pay, overtime pay, sick pay, holiday pay, vacation pay, bonus, and other compensation expense for the reporting period. See Schedule B instructions for limits that may apply.

LINE 2: BUSINESS OFFICE WAGES. Salaries and wages for other administrative positions, such as assistant administrator, bookkeeper, and clerical support. Include in this line all regular pay, overtime pay, sick pay, holiday pay, vacation pay, bonus, and other compensation expense for the reporting period.

LINE 3: EMPLOYER'S TAXES (ADMINISTRATIVE). Payroll taxes related to the salaries and wages included in lines 1 and 2.
LINE 4: GROUP HEALTH, LIFE, AND RETIREMENT BENEFITS (ADMINISTRATIVE). Health, life and retirement benefits related to the salaries and wages in lines 1 and 2. (Report officer's life insurance on line 93.)

LINE 5: WORKER'S COMP INSURANCE (ADMINSTRATIVE). Worker's compensation insurance expenses related to the salaries and wages in lines 1 and 2.

LINE 6: EMPLOYMENT ADVERTISING AND RECRUITMENT (ADMINISTRATIVE). Costs of advertising for hiring of administrative positions.

LINE 7: CRIMINAL RECORD CHECKS (ADMINISTRATIVE). Costs associated with conducting criminal record checks for positions included in lines 1 and 2.

LINE 8: EDUCATION AND TRAINING (ADMINISTRATIVE). Costs of training seminars and courses, such as registration fees, course materials, and associated travel and lodging costs.

LINE 9: SUPPLIES (ADMINISTRATIVE). Expenses for administrative operations such as computer, postage, copier, and printing supplies.

LINE 10: TELEPHONE. Expenses for telephone and paging services.

LINE 11: EQUIPMENT RENTAL (ADMINISTRATIVE). Rent expense for equipment used to support administrative operations.

LINE 12: HOME OFFICE COSTS. Costs of essential services provided from a central location.

Facilities with the home office or principal headquarters that receive essential services from this office must annually provide a copy of their general ledger trial balance. These facilities must also provide a copy of their grouping schedules that demonstrate how the accounts on their trial balance are grouped by the individual line items on their cost reports.

These schedules must demonstrate the basis for allocation of home office costs of the specific line items on each facility cost report, including compliance and limitations on:

- Owner and related party compensation
- Purchase of services from related parties
- Allocation methods to Iowa nursing facilities and other businesses
- Travel and transportation costs
- Advertising
- Director's fees and related expenses
- Contributions
- Income tax

LINE 13: MANAGEMENT FEES. Costs for management fees of a facility.

LINE 14: ACCOUNTING COSTS, LEGAL, AND OTHER PROFESSIONAL FEES. Costs for contracted accounting, legal, or other administrative professional services.

LINE 15: GENERAL LIABILITY INSURANCE. Expense of general liability insurance.

LINE 16: TRAVEL, ENTERTAINMENT, AND AUTO. Costs for entertainment and travel, other than related to education above, and expense for facility vehicles when not providing transportation for patients. These expenses are limited to 6% of line 19 minus this line. See Schedule B instructions for other limits that may apply.

LINE 17: ADVERTISING AND PUBLIC RELATIONS. Costs for general advertising of services, marketing, development, promotion, and public relations. This line is limited to the lesser of $7,200 or an amount computed at 2% of daily revenue.

LINE 18: BLANK. Use this line for any miscellaneous administrative costs that do not fit the definitions of the lines above. If more than one type of cost is included in this line, please provide

a worksheet detailing the costs involved. Amounts reported on unlabeled line 18 should be described in the space provided.

LINE 19: TOTAL ADMINISTRATIVE COSTS. Represents the total of all costs reported in lines 1 through 18.

Environmental Service Costs

LINE 20: LAUNDRY WAGES. Salaries and wages for positions that provide laundry services. Include in this line all regular pay, overtime pay, sick pay, holiday pay, vacation pay, bonus, and other compensation expense for the reporting period.

LINE 21: HOUSEKEEPING WAGES. Salaries and wages for positions that provide housekeeping services. Include in this line all regular pay, overtime pay, sick pay, holiday pay, vacation pay, bonus, and other compensation expense for the reporting period.

LINE 22: MAINTENANCE WAGES. Salaries and wages for positions that provide maintenance services. Include in this line all regular pay, overtime pay, sick pay, holiday pay, vacation pay, bonus, and other compensation expense for the reporting period.

LINE 23: EMPLOYERS TAXES (ENVIRONMENTAL). Payroll taxes related to the salaries and wages in lines 20, 21, and 22.

LINE 24: GROUP HEALTH, LIFE, AND RETIREMENT BENEFITS (ENVIRONEMENTAL). Health, life and retirement benefits related to the salaries and wages in lines 20, 21, and 22.

LINE 25: WORKER'S COMP INSURANCE (ENVIRONMENTAL). Worker's compensation insurance expenses related to the salaries and wages in lines 20, 21, and 22.

LINE 26: EMPLOYMENT ADVERTISING AND RECRUITMENT (ENVIRONMENTAL). Costs of advertising for hiring of environmental service positions.
LINE 27: CRIMINAL RECORD CHECKS (ENVIRONMENTAL). Costs associated with conducting criminal record checks for positions included in lines 20, 21, and 22.

LINE 28: EDUCATION AND TRAINING (ENVIRONMENTAL). Costs of training seminars and course, including registration fees, course materials, and associated travel and lodging costs.

LINE 29: SUPPLIES, LAUNDRY. Expenses for supplies used to provide laundry services.

LINE 30: SUPPLIES, HOUSEKEEPING. Expenses for supplies used to provide housekeeping services.

LINE 31: SUPPLIES, MAINTENANCE. Expenses for supplies used to provide maintenance services.

LINE 32: UTILITIES. Electricity, gas, water, sewer, and other utility expenses.

LINE 33: PURCHASED SERVICE, LAUNDRY. Cost of outside contractors to provide laundry services.

LINE 34: PURCHASED SERVICES, HOUSEKEEPING. Cost of outside contractors to provide housekeeping services.

LINE 35: PURCHASED SERVICES, MAINTENANCE. Cost of outside contractors to provide maintenance services.

LINE 36: EQUPMENT REPAIRS. Expenses related to equipment service agreements and to repairing facility equipment.

LINE 37: EQUIPMENT RENTAL (ENVIRONMENTAL). Rental expense of equipment used to support environmental services, such as floor scrubbers.

LINE 38: BLANK. Use this line for miscellaneous environmental services costs that do not fit the definitions of the lines above. If more than one type of cost is included in this line, please provide a schedule detailing the costs included. Amounts reported on unlabeled line 38 should be described in the space provided.

LINE 39: TOTAL ENVIRONEMENTAL SERVICE COSTS. The total of all costs in lines 20 through 38.

<u>Direct Patient Care Costs</u>

LINE 40: D.O.N. WAGES. Salaries and wages for the director of nursing and assistant director of nursing. Include in this line all regular pay, overtime pay, sick pay, holiday pay, vacation pay, bonus, and other compensation expense for the reporting period.
LINE 41: R.N. WAGES. Salaries and wages for registered nurses. Include in this line all regular pay, overtime pay, sick pay, holiday pay, vacation pay, bonus, and other compensation expense for the reporting period.

LINE 42: L.P.N. WAGES. Salaries and wages for licensed professional nurses. Include in this line all regular pay, overtime pay, sick pay, holiday pay, vacation pay, bonus, and other compensation expense for the reporting period.

LINE 43: C.N.A. WAGES. Salaries and wages for certified nurse aides and certified medication aides. Include in this line all regular pay, overtime pay, sick pay, holiday pay, vacation pay, bonus, and other compensation expense for the reporting period.

LINE 44: ACITIVITIES WAGES. Salaries and wages for positions providing activity services. Include in this line all regular pay, overtime pay, sick pay, holiday pay, vacation pay, bonus, and other compensation expense for the reporting period.

LINE 45: SOCIAL SERVICE WAGES. Salaries and wages for positions providing social services. Reports costs associated with a chaplain on this line. Include in this line all regular pay, overtime pay, sick pay, holiday pay, vacation pay, bonus, and other compensation expense for the reporting period.

LINE 46: EMPLOYERS TAXES (DIRECT HEALTH). Payroll taxes related to the salaries and wages include in lines 40 through 45.

LINE 47: GROUP HEALTH, LIFE, AND RETIREMENT BENEFITS (DIRECT HEALTH). Health, life and retirement benefits related to the salaries and wages in lines 40 through 45.

LINE 48: WORKER'S COMP INSURANCE (DIRECT HEALTH). Worker's compensation and professional liability insurance expense related to the salaries and wages in lines 40 through 45.

LINE 49: EMPLOYMENT ADVERTISING AND RECRUITING (DIRECT HEALTH). Advertising for hiring of patient care service positions in lines 40 through 45. Hiring bonuses are reported on this line.

LINE 50: CRIMINAL RECORD CHECKS (DIRECT HEALTH). Costs associated with conducting a criminal record check for positions included in lines 40 through 45.

LINE 51: EDUCATION, TRAINING (DIRECT HEALTH). Cost of training seminars and courses, registration fees, course materials, and associated travel and lodging costs for patient care services training except certified nurse aid training relating to certification.

LINE 52: CERTIFIED NURSE AIDE TRAINING. Costs of training courses for certification of nurse aides. Do no include other types of training costs in this line. The federal government reimburses costs associated with CNA training at a different rate than other facility costs. Although this does not affect individual facility's reimbursement rate, it does affect the federal funding for the Iowa Medicaid program.
LINE 53: CONTRACTED PROFESSIONAL SOCIAL SERVICES. Costs for outside contractors to provide social services.

LINE 54: PROFESSIONAL SUPPORT SERVICES. Costs for professional support services, such as those of a quality assurance nurse.

LINE 55: CONTRACTED NURSING SERVICES. Costs for outside contractors to provide nursing services.

LINE 56: OCCUPATIONAL THERAPY. Costs to provide occupational therapy services whether provided by outside contractor or by in house employees. Include in this line all regular pay, overtime pay, sick pay, holiday pay, vacation pay, bonus, and other compensation expense for the reporting period.

LINE 57: PHYSICAL THERAPY. Costs to provide physical therapy services whether provided by outside contractors or by in house employees. Include in this line all regular pay, overtime pay, sick pay, holiday pay, vacation pay, bonus, and other compensation expense for the reporting period.

LINE 58: SPEECH THERAPY. Costs to provide speech therapy services whether provided by outside contractors or by in house employees. Include in this line all regular pay, overtime pay, sick pay, holiday pay, vacation pay, bonus, and other compensation expense for the reporting period.

LINE 59: RESPIRATORY THERAPY. Costs to provide respiratory therapy services whether provided by outside contractors or by in house employees. Include in this line all regular pay, overtime pay, sick pay, holiday pay, vacation pay, bonus, and other compensation expense for the reporting period.

LINE 60: BLANK. Use this line for miscellaneous patient care service costs that do not fit the definitions of the lines above. If more than one type of cost is included in this line, please provide a worksheet detailing the costs involved. Amounts reported on unlabeled line 60 should be described in the space provided.

LINE 61: TOTAL DIRECT PATIENT CARE. The total costs from lines 40 through 60.

Support Care Costs

LINE 62: MEDICAL RECORD WAGES. Salaries and wages for positions responsible for maintaining medical records. Include in this line all regular pay, overtime pay, sick pay, holiday pay, vacation pay, bonus, and other compensation expense for the reporting period.

LINE 63: MEDICAL DIRECTOR. Expenses associated with medical director services.

LINE 64: DIETARY SERVICE WAGES. Salaries and wages for positions that provide dietary services such as dietary supervisors, dietary aides, cooks, and dishwaters. Include in this line all regular pay, overtime pay, sick pay, holiday pay, vacation pay, bonus, and other compensation expense for the reporting period.
LINE 65: EMPLOYERS TAXES (SUPPORT). Payroll taxes related to the salaries and wages included in lines 62 through 64.

LINE 66: GROUP HEALTH, LIFE AND RETIRMENET BENEFITS (SUPPORT). Health, life and retirement benefits related to the salaries and wages in lines 62 through 64.

LINE 67: WORKER’S COMP INSURANCE (SUPPORT). Worker’s compensation insurance expense related to the salaries and wages in lines 62 through 64.

LINE 68: EMPLOYMENT ADVERTISING AND RECRUITMENT (SUPPORT). Costs of advertising for hiring of support care positions in lines 62 through 64.

LINE 69: CRIMINAL RECORD CHECKS (SUPPORT). Costs associated with conducting a criminal record check for positions included in lines 62 through 64.

LINE 70: ROUTINE SUPPLIES, PATIENT CARE SERVICES. Costs of medical supplies that are customarily used to provide patient care services. Routine supplies are usually included in the staff’s supplies and not designated for a specific resident.

LINE 71: NON-ROUTINE SUPPLIES, PATIENT CARE SERVICES. Costs of medical supplies that are identifiable to individual residents. Non-routine supplies are usually furnished at the direction of the resident’s physician.

LINE 72: SUPPLIES, DIETARY SERVICES. Costs of non-food supplies necessary to provide dietary services.

LINE 73: SUPPLIES, ACTIVITIES. Costs of supplies used as part of the facility's activities program.

LINE 74: SUPPLIES, SOCIAL SERVICES. Costs of supplies used to deliver social services in the facility.

LINE 75: FOOD AND NUTRITIONAL SUPPLEMENTS. Food and nutritional supplement costs.

LINE 76: PHARMACY SERVICES. Costs of drugs and pharmaceuticals. Reduce any expenses for providing services to private pay residents by the related revenue.

LINE 77: X-RAY SERVICES. X-ray expenses.

LINE 78: LABORATORY. Laboratory services expenses.

LINE 79: PROFESSIONAL SUPPORT SERVICES. Costs for outside contractors to provide professional support services. Report contracted dietary consultant fees here.

LINE 80: EQUIPMENT RENTAL (PATIENT CARE). Rental expense of equipment used to support the patient care services area, such as beds, special chairs, and lifts.
LINE 81: BLANK. Use this line for any other miscellaneous support services costs that does not fit the definitions of the lines above. If more than one type of cost is included in this line, please provide a schedule detailing the costs involved Amounts reported on unlabeled line 81 should be described in the space provided.

LINE 82: TOTAL SUPPORT CARE COSTS. Total costs from lines 62 through 81.

LINE 83: TOTAL PATIENT CARE SERVICES. The sum of lines 61 and 82.

Property Costs

LINE 84: DEPRECIATION. Facility depreciation for equipment and buildings. Adjust these costs on Schedule B to convert book depreciation, if other than straight-line, to the straight-line method of depreciation.

The amounts on this line should be consistent with the total amount reported on Schedule D or D-1. See Schedule B instructions for limits that may apply.

LINE 85: AMORTIZATION. Amortization costs for the facility on leasehold improvements, start up costs, etc.

LINE 86: REAL ESTATE TAXES. Property taxes incurred for the facility.

LINE 87: FACILITY LEASE. Rent expenses for lease of the facility only. Include expenses related to rental of facility equipment on the equipment rental lines of the other sections. Facility rent is limited. See instructions under Schedule B for an explanation of the limits.

LINE 88: INTEREST. Necessary and proper interest incurred on facility loans. Interest paid to a

related party is not an allowable expense. Interest expense should be reduced by investment income. See Schedule B instructions for limits that may apply.

LINE 89: PROPERTY AND CASUALTY INSURANCE. Property and casualty insurance on the facility buildings and equipment.

LINE 90: BUILDING AND GROUNDS REPAIRS. Costs for repairing the facility's building and grounds.

LINE 91: BLANK. Use this line for any other miscellaneous property costs that do not fit the definitions of the lines above. If more than one type of cost is included in this line, please provide a schedule detailing the costs involved. Amounts reported on unlabeled line 91 should be described in the space provided.

LINE 92: TOTAL PROPERTY COSTS. Total costs from lines 84 through 91.

Other Costs

LINE 93: BEAUTY AND BARBER SHOP. Costs to provide beauty and barber shop services at the facility. These costs are not reimbursable, and should be offset 100%.
LINE 94: PERSONAL PURCHASES FOR RESIDENTS. Cost of personal items purchased for patients at the facility. These costs are not reimbursable, and should be offset 100%.

LINE 95: INCOME TAXES. Income tax expense incurred during the period. These costs are not reimbursable, and should be offset 100%.

LINE 96: OFFICER'S LIFE INSURANCE. Costs to maintain a key man insurance policy on an officer or administrator where the facility is the beneficiary. These costs are not reimbursable, and should be offset 100%.

LINE 97: DIRECTOR'S FEES. Fees incurred for the board of directors. These costs are not reimbursable, and should be offset 100%.

LINE 98: NON-WORKING OFFICER'S SALARIES. Salaries and wages paid to officers who did not work at the facility. These costs are not reimbursable, and should be offset 100%.

LINE 99: PROFESSIONAL CARE – PHYSICIANS. Payments made to physicians for other than medical director services. These costs are not reimbursable, and should be offset 100%.

LINE 100: CONTRIBUTIONS. Donations and contributions made by the facility. These costs are not reimbursable, and should be offset 100%.

LINE 101: BLANK. Use this line for any other miscellaneous costs that do not fit the definitions of the lines above. Amounts reported on unlabeled line 101 should be described in the space provided.

LINE 102: TOTAL OTHER COSTS. The total costs from lines 93 through 101.

LINE 103: TOTAL OF ALL EXPENSES. The total costs from lines 19, 39, 83, 92, and 102.

SCHEDULE C-1 – ASSISTED LIVING EXPENSE ALLOCATION

Only complete this schedule if the facility has an assisted living grant. Facilities that do not have an assisted living grant do not need to complete this schedule.

Report in column 1 the allocation basis statistic utilized to allocate assisted living expenses between grant funded and non-grant funded expenses for each line where assisted living costs are reported on Schedule C, Column 8. (example: square feet, number of rooms, resident days)

Acceptable allocation bases for cost reporting purposes are those bases that are:

- Relevant -- The allocation base must have some significant relationship to the cost report line in question.
- Reliable -- The allocation base must be a faithful representation that is verifiable and unbiased.
- Consistent -- The allocation base must be determined and applied consistently from one period to the next, unless extraordinary circumstances indicate a change to a more appropriate measure.

Report in column 2 the numeric value of the allocation percentage used to allocate costs to the grant funded unit for each line where assisted living costs are reported on Schedule C, Column 8.

Report in column 3 the numeric value of the allocation percentage used to allocate costs to the non-grant funded unit for each line where assisted living costs are reported on Schedule C, Column 8.

Columns 5, 6 and 7 will be calculated based on the allocation statistics reported in columns 1, 2 and 3.

SCHEDULE D – DEPRECIATION AND AMORTIZATION EXPENSE

Equipment and Building:

Report construction in process in Column 1

Report assets costs in column 2. These costs should not include construction in process and agree

with Schedule E – Comparative Balance Sheet, Lines 807 and 809.

Report in column 3 the accumulated depreciation expense at the beginning of the reporting period. This expense should agree with Schedule E – Comparative Balance Sheet, Lines 808 and 810, Column 2.

Report in column 4 the method utilized for depreciating assets per the provider's books.

Report in column 5 the annual percentage of depreciation expense utilizing the depreciation methodology described in column 4.

Report in column 6 the provider depreciation expense for the report period per the provider's books.

Report in column 7 the asset depreciation expense for the reporting period utilizing a straight line depreciation methodology. This expense should agree with Schedule C, Line
81.

Leasehold Improvements:

Report construction in process in Column 1

Report leasehold improvement costs in column 2. These costs should not include construction in process and should agree with Schedule E – Comparative Balance Sheet, Lines 811.

Report in column 3 the accumulated amortization expense at the beginning of the reporting period. This expense should agree with Schedule E – Comparative Balance Sheet, Lines 812, Column 2.

Report in column 4 the number of months the leasehold improvements are amortized.

Report in column 5 the provider amortization expense for the report period per the provider's books.

Report in column 6 the asset amortization expense for the reporting period utilizing a straight line amortization methodology. This expense should agree with Schedule C, Line
82.

SCHEDULE D-1 - CHANGE OF OWNERSHIP

This schedule must be completed if the facility has changed ownership since June 18, 1984.

Report allowable assets costs of the previous owner in column 1.

Report allowable asset costs purchased and placed in service subsequent to the change of ownership in column 2. This must not include other acquisition costs of the new owner such as

legal fees, accounting and administrative costs, travel costs, and the costs of feasibility studies attributable to the negotiation or settlement of the sale or purchase of the property.

Report in column 3 the accumulated depreciation expense at the beginning of the reporting period on the assets and reported in columns 1 and 2 utilizing a straight line depreciation methodology.

Report in column 4 the depreciation expense for the reporting period on the assets reported in columns 1 and 2 utilizing a straight line depreciation methodology.

SCHEDULE E – COMPARATIVE BALANCE SHEET

Report balance sheet information on Schedule E. Account balances should be reported as of the beginning and end of the financial reporting period. In most cases, the beginning of period balances should agree with the end of period balances from the prior year financial report. General ledger account balances should be summarized on the lines of Schedule E that best describe the nature of the accounts. It is essential that general ledger accounts are summarized on Schedule E in a consistent manner. Total equity must equal the total from Schedule F – Reconciliation of Equity.

SCHEDULE F – RECONCILIATION OF EQUITY

Schedule F presents the reconciliation of owners' equity between the beginning and end of the reporting period. In most cases, the beginning of period balances Line 850 (Total Equity Beginning of Period) will equal the end of period balances Line 865 (Total Equity End of Period) from the prior year financial report. Total revenue must be disclosed on Line 851 (Net revenues from Schedule A) and should agree with total revenue reported on Schedule A. The amount reported on Line 857 (Expenses per general ledger from Schedule C) should agree with total expenses reported on Schedule C. Amounts reported on unlabeled Lines 855, 856, 863 and 864 should be described in the space provided.

SCHEDULE G – RELATED PARTY TRANSACTIONS

This schedule must be completed if you include costs, services, facilities or supplies furnished by a related party or organization on the financial report.

Name of Related Party or Organization Report in column 1 the name of each related party or organization using a separate line for each related party transaction.

Description of Service or Supplies Report in column 2 a description of the service or supply

provided by the related party or organization for each related party transaction.

Amount Report in column 3 the amount of revenue, expense, asset cost, etc for each related party transaction.

Schedule Report in column 4 the schedule for which each related party transaction is reported.

Line Report in column 5 the schedule line number for which each related party transaction is reported.

SCHEDULE H – NURSING FACILITY WAGES AND HOURS

This schedule should include wages and hours for the nursing facility employees only. Wages and hours paid for non-nursing facility services should not be included on Schedule H. Wages and hours for outside contractors only need to be reported for outsidecontractors performing nursing services. Wages and hours do not need to be reported for outside contractors performing non-nursing services. Contracted services hours and wage rates for nursing services should be derived from invoices submitted by outside or temporary staffing agencies. This information is necessary to determine the nursing facility accountability measures.

Entry Level Hourly Wage For each line from Schedule C listed, calculate the corresponding starting hourly wage based upon the most current wage scales established as of the end of the financial reporting period. The basis for these calculations should remain consistent between periods.
Total Wages Schedule C - NF For each line from Schedule C listed, report the corresponding total nursing facility wages that should match the wages reported on Schedule C, Column 6.

Total Hours NF For each line from Schedule C listed, report the corresponding total nursing facility hours for the reporting period including continuing education, in-service training time, vacation, sick and holiday time.

Average Hourly Wage For each line from Schedule C listed, enter the corresponding average hourly wage during the financial reporting period. Calculate this amount by dividing the total wages by the total hours recorded. The basis for these calculations should remain consistent between periods.

Average Hours Per Patient Day For each line from Schedule C listed, enter the corresponding ratio to demonstrate staffing patterns during the financial reporting period. Calculate this amount by dividing the total hours recorded by the nursing facility patient days in the financial reporting period. The basis for these calculations should remain consistent between periods.

SCHEDULE H-1 – ASSISTED LIVING WAGES AND HOURS

This schedule should be completed only if the facility has an assisted living grant. Include wages and hours for the assisted living employees only. Wages and hours paid for non-assisted living services should not be included on Schedule H-1. Wages and hours for outside contractors only need to be reported for outside contractors performing nursing services. Wages and hours do not need to be reported for outside contractors performing non-nursing services. Contracted services hours and wage rates should be derived from invoices submitted by outside or temporary staffing agencies.

Entry Level Hourly Wage For each line from Schedule C listed, calculate the corresponding starting hourly wage based upon the most current wage scales established as of the end of the financial reporting period. The basis for these calculations should remain consistent between periods.

Total Wages Schedule C-1 –Assisted Living For each line from Schedule C listed report the corresponding total assisted living wages that should match the wages reported on Schedule C-1.

Total Hours Assisted Living For each line from Schedule C listed report the corresponding total assisted living hours for the reporting period including continuing education, in-service training time, vacation, sick and holiday time.

Average Hourly Wage For each line from Schedule C listed, enter the corresponding average hourly wage during the financial reporting period. Calculate this amount by dividing the total wages by the total hours recorded. The basis for these calculations should remain consistent between periods.

Average Hours Per Resident Day For each line from Schedule C listed, enter the corresponding ratio to demonstrate staffing patterns during the financial reporting period. Calculate this amount by dividing the total hours recorded by the assisted living resident days in the financial reporting period. The basis for these calculations should remain consistent between periods.

Allocation of Staffing Time For each line in which staff performed services for assisted living and other programs, report the percentage of time spent performing services for each program i.e. assisted living, nursing facility, service development and other. Lines where staff spent all of their time performing services for the assisted living program should report 100% in the assisted living column. Documentation supporting this allocation must be maintained by the provider and available upon request by the Division or its contractors.

SCHEDULE I – FULL TIME EMPLOYEE RETENTION AND TURNOVER RATES

While many providers only provide care to nursing facility residents, some provide services to other resident types (e.g. assisted living, residential, etc.). In this situation, the total number of W-2s reported should correspond with the total salaries and wages reported on Schedule C of the financial report for all service settings.

Total number of W-2s Report the total number of W-2s issued for the most recently completed calendar year.

Adjustment: Number of W-2s for temporary or part-time employees Report the number of temporary or part-time employees (based on company policy) included in the total number of W-2's on Schedule I, Line 1.

Total number of full time employees who worked anytime during the year Report the total number of full time employees who worked during the most recently completed calendar year.

Adjustment: Number of full time employees hired during the year Report the number of full time employees hired after January 1 of the most recently completed calendar year included in the total number of full time employees reported on Schedule I, Line 3.

Total number of full time employees who were employed at the start of the year Report the total number of full time employees who were employed on January 1 of the most recently completed calendar year.

Adjustment: Number of full time employees separated anytime during the year Report the total number of full time employees whose employment was terminated for any reason during the most recently completed calendar year.

Number of full time employees who worked the entire year Report the total number of full time employees who were employed on January 1 of the most recently completed calendar year and worked the entire calendar year.

SCHEDULE I-1 – NURSING FACILITY ANNUAL CALCULATION OF EMPLOYEE TURNOVER

The total number of employees and total number of terminations for each month should be reflective of the nursing facility employees only. The data reported should correspond to the total salaries and wages reported on Schedule H of the financial report. This report should correspond to each facilities individual fiscal year end.

Total Number of Employees on the First day of each Month The total number of employees working in each job classification on the first day of the month should be reported. Employees are only those that receive payroll checks. The number should include full time, part time and seasonal / casual employees. The count should not include consultant, contract, or agency staff.

An "Other" Category is provided for those employees that may not fit the listed classifications. However, report each employee only once. Organizations that employ licensed therapists should include them here.

Assistant Administrator(s) or Assistant Director(s) of Nursing should be included with those classifications.

Direct Care workers other than Certified Nurse Aides, such as Medication or Rehab Aides, should be classified and reported with the Certified Nurse Aides.

Total Number of Terminations Each Month Report the total number of employees whose employment was terminated, for that type of service, for any reason during the month. This includes reporting terminations for employees whose salaries may be reported on different lines of the cost report. For example, a Certified Nurse Aide is considered terminated on line 43, during the month finished additional classes and became a Licensed Practical Nurse. That employee then is added to line 42 as an employee on the first day of the next month.

INSTRUCTIONS FOR HEALTH SERVICES APPLICATION

Complete this form if you live in Iowa and want to get:

- ♦ Medical Assistance (Title 19 or Medicaid) – provides health care coverage
  Other programs within Medical Assistance Program are:
  - Facility Care – helps pay your nursing home cost
  - Medicaid for children in foster care or subsidized adoption
  - Waiver – helps keep people at home and not in a nursing home
  - Medicare Savings Program – pays all or part of your Medicare premium
  - State Supplementary Assistance (State Supp) – help for people who are at least 65 or disabled.
- ♦ WIC (Special Supplemental Nutrition Program for Women, Infants and Children) – helps with checks for special foods that can be used at Iowa grocery stores and pharmacies for pregnant and postpartum women, and children under the age of 5.
- ♦ Maternal and Child Health – provides health care services for children under the age of 21 and women of childbearing age.

This is not the right form if you want to get Food Assistance or cash assistance through the Family Investment Program (FIP).

Please do not let fear of the Immigration and Naturalization Service (INS) keep you from getting help for your family. Getting help will not keep you from gaining lawful, permanent residence, U.S. citizenship, or from sponsoring relatives.

To apply for help, follow these four easy steps:

1. **Complete the Application**
   Fill out and sign the application. Please be truthful. If you are applying for someone else, answer the questions as they relate to that person.
2. **File the Application**
   Mail or take it to the Department of Human Services (DHS) in your county. The date your help starts is based on the date the DHS office gets your application. Do not wait.
3. **Provide Any Needed Proof**
   See the table below for what is needed. Including copies of the proof will help speed up the processing of your application.
4. **An Interview May Be Needed**
   An interview may not be needed if you are applying only for a child. All adults applying for help must have an interview.

Needed Proof by Program In addition to your application, please provide any proof needed for the program(s) you are applying for.	**Medical Assistance**	**Facility or Waiver**	**Medicare Savings Program**	**Foster Care-Sub Adoption**	**State Supp**	**WIC**	**Maternal and Child Services**
Proof of who you are (ID): driver’s license, birth certificate, etc.	✓	✓	✓	✓	✓	✓	✓
Proof you are a U.S. citizen or national (birth certificate with ID, U.S. passport, etc.)	✓	✓	✓	✓	✓		
Proof you have applied for a Social Security Number (if you don’t already have one)	✓	✓	✓	✓	✓		
Proof of any health insurance premium paid: bill, pay stub showing deduction, etc.		✓		✓	✓		
Proof of income* or any other money coming into your household	✓	✓	✓	✓	✓	✓	✓
Proof of child care, dependent adult care costs, child support or alimony paid	✓		✓	✓	✓		
Most recent statements for any bank accounts: checking, credit union, savings, etc.**	✓	✓	✓	✓	✓		
Proof of current value of stocks/bonds, life insurance, certificates of deposit, trusts**	✓	✓	✓	✓	✓		
Proof of current living address						✓	✓

* Pay stubs from the last 30 days if you are employed or federal income tax records if you are self-employed. Award letters for Social Security Benefits, Veterans Benefits, etc.

** May not be needed if just applying for a child.

RIGHTS AND RESPONSIBILITIES – READ AND KEEP THIS SHEET

INFORMATION FOR ADULTS AND CHILDREN APPLYING FOR MEDICAL ASSISTANCE

- I understand I assume full responsibility for the accuracy of the statements on this form. I understand the Department of Human Services (DHS) will use this statement to determine my eligibility for Medical Assistance.
- I understand my eligibility will not be affected by my race, creed, color, national origin, age, disability, or sex, except where this is restricted by law.
- I understand that I have the right to a hearing if this application is denied or not acted upon promptly or if services granted are terminated, reduced, or suspended. I understand that I can get a hearing by making a request in writing to my local DHS office and that I may represent myself or use a lawyer, relative, friend, or other spokesperson.
- I am aware that my case may be picked by the Department for a complete Quality Control or other review of my eligibility for assistance. If my case is selected for verification, I will cooperate fully in the verification. I hereby authorize all persons to release confidential information concerning my eligibility to a DHS reviewer. I understand that failure to cooperate with such a review can result in denial or cancellation of benefits.
- I will notify my LOCAL DHS office within ten days of any changes in medical benefits or health insurance coverage. In addition, I understand that I am to notify my medical providers (doctors, pharmacist, etc.) if another party may be liable to pay my medical expenses. I will notify my LOCAL DHS office within ten days if I file an insurance claim or retain an attorney to seek payment for injuries and medical expenses resulting from those injuries that otherwise would be paid by Medicaid. Failure to comply with my responsibilities can give the Department cause to deny or terminate Medicaid eligibility.
- I agree to assign medical payments from a third party to the Medicaid agency for myself and others who are eligible for Medicaid, for whom, I legally can assign benefits. I also agree to cooperate in obtaining medical payments from third parties.
- I understand that I am to reimburse the Department for any money paid to me or paid to a provider on my behalf to which I was not entitled.
- I further understand that the Department will provide documents or claim forms describing the services paid by Medicaid upon my request or the request of an attorney acting on my behalf. Such documents may also be provided to a third party when necessary to establish the extent of the Department's claim for reimbursement.
- I understand that federal and state law and rules permit access by authorized federal and state officials to Medicaid providers' records. I also fully understand that my acceptance of Medicaid is my consent for these authorized persons to have access to my medical and health care records during the time I am eligible for Medicaid, as necessary to verify appropriate Medicaid payment.
- I give my permission to tell my medical providers the status for my Medically Needy case, including the amount of my spenddown and their bills used to meet spenddown, or when a premium is due for Medicaid for Employed People with Disabilities.
- If I become enrolled in a managed health care plan, I consent to disclosure of medical information, including any clinical mental health or substance abuse information, by my medical providers to the HMO, PHP, other managed care providers or to the authorized administrative body contracted by the managed care provider to determine appropriateness, quality, or utilization of services I received while enrolled in managed health care.
- I understand that if Medical Assistance is approved, support payments intended for medical costs must be assigned and paid to the Department of Human Services to the extent of the benefits I receive. I understand that the Department may intervene, according but not limited to, Iowa Code Chapters 252A, 252B, 252C, 252D, 598, and 600B, to make claim and secure support from any person or party who may be responsible for my support or that of my children. I understand that if I receive Medicaid, the Department may pursue non-medical support for myself and my children unless I notify the Department that services unrelated to medical support are not wanted. Medical support services include the establishment of paternity and the establishment and enforcement of medical support.
- I am aware that Section 1128B of the Social Security Act provides federal penalties for fraudulent acts and false reporting. Anyone who obtains, or tries to obtain, or helps any other person to obtain public assistance to which the person is not entitled is guilty of violating the laws of the state of Iowa. These laws include, but are not limited to, Iowa Code Chapters 243, 239B, 249A, and 249A.
- I understand and agree that I will need to provide the Department with either documentation from the Immigration and Naturalization (INS) or other documents the Department considers to be proof of the immigration status of each person in my household who is not a United States citizen or national. I understand that alien status may be subject to verification with INS, which will require submission of certain information from this application form to INS. I further understand that information received from INS may affect my household's eligibility and level of benefits.
- If I filled out a separate application for food assistance and that application was referred to the Food Stamp Investigation Unit, I will cooperate with the investigation in order to receive Medicaid when the investigation involves income, resources and household composition that affect my Medicaid eligibility.
- I understand that the facts I give determine financial eligibility. A medical certification is also needed prior to approval for certain Medical Assistance programs. To determine medical certification, the Iowa Medicaid Enterprise (IME) Medical Services may need to contact my physician. I authorize my physician or health care provider to release information to IME Medical Services for this purpose. I agree to allow DHS to disclose the filing of this application to my nursing facility in order to obtain the level of care determination necessary for eligibility. A copy of this form received by fax will be given the same effect as the original.

MORE INFORMATION FOR ADULTS APPLYING FOR MEDICAL ASSISTANCE

- I will notify the LOCAL DHS office of any change in my information on this application, including but not limited to, anticipated income or property such as an inheritance, lump-sum payments on delinquent child support, or any change in income or living arrangements of myself or any other member of my family. If I have any doubt whether a particular change in circumstances is information that must be reported, I shall report this to my LOCAL office no later than ten days from the date the change occurs. I also understand that I am to pay back to the Department any money received by me or paid to a vendor on my behalf to which I was not entitled.
- I understand payments under the Medical Insurance Program (Part B of Medicare) will be made directly to the physicians and medical suppliers on any future unpaid bills for medical and other health services furnished me while eligible for Medicaid.
- I authorize the DHS to share information from this application, and information about my condition from the designated Assessment Tool with IME Medical Services for all home and community based service (HCBS) waivers and the Area Agency on Aging Case Management Team for my HCBS elderly waiver services.

INFORMATION FOR THOSE APPLYING FOR WIC OR MATERNAL AND CHILD HEALTH SERVICES

- I understand that a declaration of income and persons in my family and living in my household is necessary to ensure that federal and state funds are directed to those persons least able to secure services from other sources.
- I understand that the Maternal and Child Health Director of the Iowa Department of Public Health, the WIC Director, or their designees shall have access to all information available from records maintained by the agency providing maternal health, child health, or WIC services.

Iowa Department of Human Services

HEALTH SERVICES APPLICATION

HOUSEHOLD INFORMATION – Complete for all programs				
First Name	Middle Name	Last Name		
Home Address	City	State	County	Zip Code
Mailing Address (if different from above) OR Payee or Representative's Name & Address				
Home Phone Number ( )	Message Number ( )	Name of Message Contact Person		

Check the program(s) you would like to receive:

- ❑ **Medical Assistance (Title 19 or Medicaid)**
  - ❑ **Facility** ❑ **Medicare Savings Program** ❑ **Waiver**
  - ❑ **Foster Care/Subsidized Adoption** ❑ **State Supplementary Assistance**
- ❑ **Maternal and Children Health Services**
- ❑ **WIC**
- ❑ **Iowa Family Planning Network**

IF YOU NEED MORE ROOM TO ANSWER ANY OF THE FOLLOWING QUESTIONS, ATTACH EXTRA PAGES.

Start with yourself, then list all the people who live in your home.

NAME (First, Middle, Last)	Are you applying for this person?	How is this person related?	Medical services received in past 3 months? What month(s)?	Social Security Number	Sex	Birth Date	Birth State	Last Grade Completed	Citizen	Ethnicity*	Race**	If a child, is a parent NOT living with them?	Other health insurance available?
	❑ Yes ❑ No	SELF	❑ Yes ❑ No Month(s):		❑ Male ❑ Female				❑ Yes ❑ No			❑ Yes ❑ No	❑ Yes ❑ No
	❑ Yes ❑ No		❑ Yes ❑ No Month(s):		❑ Male ❑ Female				❑ Yes ❑ No			❑ Yes ❑ No	❑ Yes ❑ No
	❑ Yes ❑ No		❑ Yes ❑ No Month(s):		❑ Male ❑ Female				❑ Yes ❑ No			❑ Yes ❑ No	❑ Yes ❑ No
	❑ Yes ❑ No		❑ Yes ❑ No Month(s):		❑ Male ❑ Female				❑ Yes ❑ No			❑ Yes ❑ No	❑ Yes ❑ No
	❑ Yes ❑ No		❑ Yes ❑ No Month(s):		❑ Male ❑ Female				❑ Yes ❑ No			❑ Yes ❑ No	❑ Yes ❑ No

We have to ask your ethnicity and race, but you don't have to answer. Your answer won't affect how much you get or how soon. If you answer, use the following coding:

* Ethnicity: H = Hispanic or Latino; N = Not Hispanic or Latino

** Race (Choose all that apply): W = White; B = Black or African American; A = Asian; I = American Indian or Alaskan Native; N = Native Hawaiian or other Pacific Islander.

List pregnant persons who live in your home ____________________ Due Date (MMDDYY) ____________________

Are you interested in family planning services for females in your household who are at least 13 or under 45 years of age? ❑ Yes ❑ No

INCOME: List all income the people living in your home get. Include income from work, self-employment, Social Security, Veteran's Benefits, unemployment insurance, child support, worker's compensation, railroad retirement, IPERS, pensions, civil service, cash from friends, or relatives, etc.

Person who received money	Employer or income source	Amount before taxes or deductions	How often is this amount paid?	Is this income expected to continue? If 'NO,' explain:
			❑ Weekly ❑ Every other week ❑ Monthly ❑ Twice a month ❑ Other ____________	❑ Yes ❑ No
			❑ Weekly ❑ Every other week ❑ Monthly ❑ Twice a month ❑ Other ____________	❑ Yes ❑ No
			❑ Weekly ❑ Every other week ❑ Monthly ❑ Twice a month ❑ Other ____________	❑ Yes ❑ No
			❑ Weekly ❑ Every other week ❑ Monthly ❑ Twice a month ❑ Other ____________	❑ Yes ❑ No

RESOURCES: A resource is cash or anything that can be changed to cash. List all resources and the amount or value. Include cash on hand, checking accounts, vehicles, life insurance, stocks, bonds, certificates of deposits (CDs), trust funds, retirement accounts, burial contracts, burial spaces, annuities, etc. If only applying for medical coverage for a child, resources may not be counted.

Person with resource	Type of resource	Amount or Value	Location (bank's name and address, home, etc.)

If you made the State of Iowa a remainder beneficiary on an annuity, in order to qualify for Medicaid payment of long-term care, the State of Iowa will get any benefits remaining in the annuity, up to the amount of Medicaid benefits paid.

Did anyone in your home sell or give away anything of value in the last 60 months? (This includes real and personal property; real estate; income; inheritance, etc.)
❑ Yes ❑ No

Does anyone in your home pay child support or alimony for a person who does not live with you? ❑ Yes ❑ No
If yes, who pays? __________________________ Amount? _______________

Does anyone in your home pay for someone to care for a child or disabled adult? ❑ Yes ❑ No
If yes, how much is paid? _______________ How often? _______________ To whom? __________________________

Are you willing to cooperate to get medical support? ❑ Yes ❑ No (Answer if you are a parent or caretaker applying for self and a child.)

INFORMATION ABOUT THE PARENT(S) NOT LIVING IN THE HOME: List the name of any parent who is not living with you and the children you are applying for, who they are the parent of, their date of birth, and social security number. A child can still get medical assistance if you do not provide this information.

Name of parent not living in the home:	Name of children of this parent:	Date of birth of this parent:	Social security number of this parent:

SOCIAL SECURITY NUMBER (SSN)

You must fill in the SSN of all persons listed above on this application to get Medical Assistance. Section 1137(a)(1) of the Social Security Act and 42 CFR 435.910 requires this. If you do not want Medicaid, you do not have to give us your SSN. The SSN will be used:

- To check income, eligibility and amount of Medical Assistance payments to be made on your behalf.
- To determine another person's right to Medical Assistance.
- To comply with Federal law which requires release of information from Medicaid records.
- To match with records in other agencies such as: Social Security Administration, Internal Revenue Services, and Iowa Workforce Development. These matches may be done by computer or on an individual basis.

My rights and responsibilities were provided to me on the back of the instructions for this Health Services Application. I have read and removed the instruction sheet from this Health Services Application for my future use.

I CERTIFY THAT THESE STATEMENTS ARE CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF.

Signature or mark of applicant Date

Signature or mark of other parent or stepparent in the home Date

Signature of person, if any, who helped complete this form Date

INSTRUCCIONES PARA SOLICITUD DE SERVICIOS MÉDICOS

Completa esta forma si vive en Iowa y quiere obtener:

- Medical Assistance (Title 19 o Medicaid) – proporciona cobertura médica

  Otros programas dentro del Medical Assistance Program son:
  - Facility Care – le ayuda a pagar los costos de casa para ancianos
  - Medicaid para niños bajo el cuidado de un hogar adoptivo o en adopción subvencionada
  - Waiver – ayuda a permanecer en sus hogares y no en casas para ancianos
  - Medicare Savings Program – paga todo o parte de su prima de Medicare
  - State Supplementary Assistance (State Supp) (Asistencia Estatal Complementaria) – ayuda para personas con 65 años o más o personas discapacitadas

- WIC (Programa Especial Suplemental de Nutrición para Mujeres, Infantes, y Niños) – ayuda con cheques para alimentos especiales que pueden ser utilizados en tiendas en Iowa y farmacias para mujeres embarazadas y post parto, y niños menores de 5 años.

- Maternal and Child Health – proporciona servicios de atención medica para niños menores de 21 años y mujeres en edad fértil.

Este no es el formulario adecuado si desea obtener Food Assistance (Asistencia Alimenticia) o ayuda en dinero a través del Family Investment Program (FIP).

Por favor no deje que el temor del Immigration and Naturalization Service (INS) no le permita obtener ayuda para su familia. Obtener ayuda no le quitara el poder obtener residencia permanente legalmente, ciudadanía de los E.U.A., o de poder patrocinar a sus parientes.

Para aplicar por ayuda, seguir los cuatro pasos fáciles:

1. **Completar la Solicitud**
   Llenar y firmar la solicitud. Por favor diga la verdad. Si está aplicando por alguien más, conteste las preguntas que tienen que ver con esa persona.
2. **Llene la Solicitud**
   Enviar por correo al Department of Human Services (DHS) en su condado. La fecha en que se inicia su ayuda está basada en la fecha en que la oficina de DHS reciba su solicitud. No espere.
3. **Proporcione Cualquier Prueba Necesaria**
   Ver la tabla a continuación para lo que se necesite. Incluyendo copias de las pruebas que ayudara a apresurar el proceso de su solicitud.
4. **Se puede Necesitar Una Entrevista**
   Una entrevista pueda no ser necesaria si está solicitando solo por un niño. Todos los adultos que solicitan ayuda deben tener una entrevista.

Prueba Necesaria para el Programa

Ademas de su solicitud, por favor proporcione cualquier prueba necesaria para el programa(s) que se estén solicitando.

	Medical Assistance	Facility or Waiver	Medicare Savings Program	Foster Care-Sub Adoption	State Supp	WIC	Maternal and Child Services
Prueba de quién es (I.D.) licencia de manejar, acta de nacimiento, etc.	✓	✓	✓	✓	✓	✓	✓
Preuba de que es ciudadano(a) o nacional de los EE.UU. (certificado de nacimiento, pasaporte de los EE.UU., etc.)	✓	✓	✓	✓	✓		
Prueba de solicitud para Número de Social Security (si aún no tiene uno)	✓	✓	✓	✓	✓		
Prueba de cualquier prima pagada de seguro médico: cuenta, talón de cheque demostrando la deducción, etc.		✓		✓	✓		
Prueba de ingreso * o cualquier dinero que entre en su hogar	✓	✓	✓	✓	✓	✓	✓
Prueba costos de cuidado para niños, adultos, manutención de niños/conyugue	✓		✓	✓	✓		
Reportes mensuales bancarios mas recientes; cheques, unión de crédito, ahorros, etc. **	✓	✓	✓	✓	✓		
Prueba del valor actual de valores/bonos, seguros de vida, certificados de deposito, fideicomisos **	✓	✓	✓	✓	✓		
Prueba de la presente dirección de domicilio						✓	✓

* Talón de cheque de los últimos 30 días si esta trabajando o récords de impuesto de ingreso federal si se tiene negocio propio. Cartas de Beneficios de Social Security, Beneficios de Veteranos, etc.

** Pueda que no sea necesario si solo esta solicitando por un niño.

DERECHOS Y RESPONSABILIDADES - LEA Y CONSERVE ESTA HOJA

INFORMACIÓN PARA ADULTOS Y NIÑOS SOLICITANDO PARA MEDICAL ASSISTANCE

- Yo tengo entendido que yo asumo total responsabilidad por la certeza de las declaraciones en esta forma. Yo entiendo que el Department of Human Services (DHS) usara esta declaración para determinar mi elegibilidad para Medical Assistance.
- Entiendo que mi elegibilidad no se verá afectada por mi raza, credo, color, origen nacional, edad, discapacidad o sexo, excepto cuando esto sea restringido por la ley.
- Yo tengo entendido que yo tengo el derecho de una audiencia si esta solicitud es negada o no es manejada rápidamente o si los servicios otorgados son cancelados, reducidos o suspendidos. Entiendo que puedo obtener una audiencia solicitándola por escrito a la oficina local del DHS y que puedo representarme a mí mismo, pedir la ayuda de un abogado, pariente, amigo u otro portavoz.
- Yo se que mi caso puede ser escogido por el Departamento para una completa revisión de Quality Control o cualquier otra de la elegibilidad para asistencia. Si mi caso es seleccionado para verificación, yo cooperare en total para la verificación. Yo en esta forma doy mi autorización a todas las personas para divulgar información confidencial relacionada con mi elegibilidad a una persona que revise para DHS. Yo entiendo que fallar en cooperar con dicha persona puede resultar en la negación o cancelación de los beneficios.
- Notificaré a la oficina del DHS LOCAL, en un plazo no mayor a diez días sobre cualquier cambio en los beneficios médicos o en el cubrimiento del seguro de salud. Además, yo entiendo que yo debo notificar a mi proveedor médico (doctores, farmacia, etc.) si alguna otra parte pueda ser responsable de pagar mis gastos médicos. Notificaré a la oficina del DHS LOCAL , en un plazo no mayor a diez días, si presento una reclamación o contrato a un abogado para solicitar la indemnización por heridas y gastos médicos que resulten de aquellas heridas, que de otra forma hubieran sido cubiertos por Medicaid. Fallar en cumplir con mis responsabilidades puede dar al Department causa de negar o terminar mi elegibilidad de Medicaid.
- Acepto entregar a la agencia Medicaid los pagos de gastos médicos realizados por terceros para mí y otras personas elegibles para Medicaid, para las cuales yo estoy legalmente autorizada a asignar beneficios. Además, acepto cooperar para obtener pagos de gastos médicos provenientes de terceros.
- Yo entiendo que yo debo reembolsar al Department por cualquier dinero pagado a mi o pagado a un proveedor a mi favor al cual yo no tenga derecho.
- Es mas yo entiendo que el Department puede proporcionar documentos o formas de demanda describiendo los servicios pagados por Medicaid cuando yo lo pida o a la petición de un abogado actuando a mi favor. Dichos documentos puedan también ser proporcionados a una tercera parte cuando sea necesario para establecer el punto en que la demanda del Department sea reembolsada.
- Yo entiendo que las leyes Federales y Estatales y las reglas permiten el acceso a oficiales Federales y Estatales autorizados para récords de Medicaid. Yo también entiendo en su totalidad que mi aceptación de Medicaid es mi consentimiento para que estas personas autorizadas tengan acceso a mis récords de atención medica durante el tiempo que yo sea elegible para Medicaid, como sea necesario para verificar los pagos apropiados de Medicaid.
- Concedo autorización para revelar a quienes me proporcionan asistencia médica el estado de mi caso de Medically Needy (Médicamente Necesitado), incluyendo el monto de mi Spenddown (la parte no cubierta por Medicaid), o en los casos que deba una prima a Medicaid for Employed People with Disabilities (Medicaid por Personas Discapacitadas Empleadas).
- Si yo quedo registrado en un plan de cuidado medico manejado, yo doy consentimiento de la divulgación de información medica, incluyendo cualquier salud mental clínica o información de abuso de substancia, por mis proveedores médicos al HMO, PHP, otros proveedores de cuidado medico manejado o al cuerpo administrativo autorizado contractado por el proveedor de cuidado medico manejado para determinar aproporcion, calidad, o utilización de servicios que yo he recibido cuando estuve registrado en el cuidado medico manejado.
- Yo entiendo que si el Medical Assistance es aprobado, pagos de apoyo intencionados para costos médicos deberán ser asignados y pagados por el Department of Human Services al punto de que los beneficios que yo reciba. Yo entiendo que el Department puede intervenir, conforme pero no limitandose, al Código de Iowa Capitulo 252ª, 252B,252C, 252D, 598, y 600B, para hacer reclamo y asegurar el apoyo de cualquier persona o parte que pudiera ser responsable por mi manutención o de mis hijos. Yo entiendo que si yo recibo Medicaid, el Department puede pedir manutención no-medica para mi y mis hijos a menos que yo notifique al Department que los servicios relacionados al apoyo medico no son deseados. Servicios de apoyo medico incluyen el establecimiento de paternidad y el establecimiento y obligación de apoyo medico.
- Yo se que la Sección 1128B del Social Security Act dice que los castigos Federales por actos fraudulentos y por reportes falsos. Cualquiera que obtenga, o trate de obtener, o ayuda a otra persona a obtener asistencia publica a la cual la persona no tiene derecho es culpable de violación de las leyes del Estado de Iowa. Estas leyes incluyen, pero no están limitadas a, Código de Iowa Capitulo 243, 293B, 249 A, y 249A.
- Yo entiendo y estoy de acuerdo que yo necesitare proporcionar al Department con cualquier documentación de Immigration and Naturalization (INS) o cualquier otro documento que el Department considere ser prueba de mi situación de inmigración de cada persona en mi hogar que no sea un ciudadano de los Estados Unidos o nacional. Yo entiendo que la situación de extranjero puede ser sujeta a verificación con INS, lo cual puede requerir la entrega de cierta información de esta solicitud a INS. Yo además entiendo que la información recibida de INS puede afectar la elegibilidad de mi hogar y el nivel de beneficios.
- Si diligencio una solicitud separada para asistencia alimenticia, y dicha aplicación es remitida a la Food Stamp Investigation Unit (Unidad de Investigación de Estampillas de Alimentos), cooperaré con la investigación para recibir Medicaid cuando la investigación se refiera a ingresos recursos y composición del hogar que pueda afectar mi elegibilidad para Medicaid.
- Yo entiendo que los hechos que yo proporcione determinaran mi elegibilidad financiera. Una certificación medica es también necesaria antes de la aprobación para ciertos programas de Medical Assistance. Para determinar la certificación medica, el Iowa Medicaid Enterprise (IME) Medical Services puede necesitar contactar a mi medico. Yo autorizo o mi medico a mi proveedor de cuidado médico el divulgar información a IME Medical Services para este proposito. Yo estoy de acuerdo de permitir a DHS el divulgar el registro de esta solicitud a mi facilidad de cuidado a fin de obtener el nivel de determinación de cuidado necesario por elegibilidad. Una copia de este formulario recibido por fax tendrá el mismo efecto que el original.

MAS INFORMACIÓN PARA ADULTOS SOLICITANDO PARA ASISTENCIA MEDICA

- Notificaré a la oficina del DHS LOCAL acerca de cualquier cambio en la información de esta aplicación, incluyendo, pero sin limitarse a ingresos anticipados o propiedad tales como una herencia, pagos integrales para el apoyo a niños delincuentes, o cualquier cambio en el ingreso o en mi vivienda o en la de cualquier otro miembro de mi familia. Si tengo alguna duda sobre si un cambio particular en las circunstancias, es información que debe ser informada, reportaré eso a mi oficina LOCAL dentro de los diez días siguientes a la fecha en que el cambio se presente. Yo también entiendo que yo debo reembolsar al Department cualquier dinero recibido por mi o pagado a un vendedor a mi nombre al cual yo no tenga derecho.
- Yo entiendo que los pagos bajo el Medical Insurance Program (Part B de Medicare) se haran directamente a los médicos y a los proveedores médicos de cualquier factura no pagada por servicios de atención medica que se me haya proporcionado cuando tenia elegibilidad de Medicaid.
- Yo autorizo a DHS a proporcionar información de esta solicitud, información sobre de mi condición del designado Assesment Tool con IME Medical Services para todos los servicios a mi hogar y comunidad (HCBS) renuncias de derecho y el Area Agency en Aging Case Management Team para mi HCBS renuncia de mis derechos de servicios para persona de edad avanzada.

INFORMACIÓN PARA AQUELLOS SOLICITANDO PARA WIC O SERVICIOS MATERNIDAD Y CUIDADO PARA NIÑOS

- Yo entiendo que una declaración de ingreso y personas en mi familia y viviendo en mi hogar es necesario para asegurar que fondos Federales y Estatales sean dirigídos a esas personas que tengan menos habilidad para asegurar servicios de otros recursos.
- Yo entiendo que el Maternal and Child Health Director of the Iowa Department of Public Health, el Director de WIC, o sus asignados deberán tener acceso a toda la información disponible de los récords que son mantenidos por la agencia proporcionando salud maternal, salud a niños, o servicios WIC.

Iowa Department of Human Services

HEALTH SERVICES APPLICATION (SOLICITUD DE SERVICIOS MÉDICOS)

INFORMACIÓN DEL HOGAR - Completar para todos los programas				
Primer Nombre	Segundo Nombre	Apellido Nombre		
Dirección del Hogar	Ciudad	Estado	Condado	Código
Dirección Postal (si es diferente a la anterior) O Nombre y Dirección del Pagador				
Numero Tel. Hogar ( )	Número Mensajería ( )	Nombre del Mensaje Persona Contacto		

Marcar los programas que usted quiere recibir:

- ❑ **Medical Assistance (Title 19 or Medicaid)**
  - ❑ **Facility** ❑ **Medicare Savings Program** ❑ **Waiver**
  - ❑ **Foster Care/Subsidized Adoption** ❑ **State Supplementary Assistance** (Renuncia)
- ❑ **Maternal and Children Health Services**
- ❑ **WIC**
- ❑ **Iowa Family Planning Network**

SI USTED NECESITA MAS ESPACIO PARA CONTESTAR CUALQUIERA DE LAS SIGUIENTES PREGUNTAS, ADJUNTAR HOJAS ADICIONALES

Empezar con usted mismo, entonces enumera todas las personas que viven en su hogar.

NOMBRE (Primer, Segundo, Apellido)	¿Solicita por esta persona?	¿Cual relación con esta persona?	¿Servicios recibidos en 3 meses? ¿cuales meses?	Social Security Number	Genero	Fecha Nacimiento	Estad o de nacim iento	Ultimo grado de escuela	Ciudada no	Raza *	¿si es niño, los padres NO viven con el?	Otro Seguro Medico Disponible?
	❑ Si ❑ No	MISMO	❑ Si ❑ No Meses:		❑ Masc. ❑ Fem.				❑ Si ❑ No		❑ Si ❑ No	❑ Si ❑ No
	❑ Si ❑ No		❑ Si ❑ No Meses:		❑ Masc. ❑ Fem.				❑ Si ❑ No		❑ Si ❑ No	❑ Si ❑ No
	❑ Si ❑ No		❑ Si ❑ No Meses:		❑ Masc. ❑ Fem.				❑ Si ❑ No		❑ Si ❑ No	❑ Si ❑ No
	❑ Si ❑ No		❑ Si ❑ No Meses:		❑ Masc. ❑ Fem.				❑ Si ❑ No		❑ Si ❑ No	❑ Si ❑ No
	❑ Si ❑ No		❑ Si ❑ No Meses:		❑ Masc. ❑ Fem.				❑ Si ❑ No		❑ Si ❑ No	❑ Si ❑ No

Debemos preguntarle su origen étnico y raza, pero usted no está obligado/a a contestar. Su respuesta no afectará cuánto reciba o con qué rapidez. Si contesta, utilice la siguiente codificación:

* Origen étnico: H = Hispano o Latino; N = No Hispano ni Latino

** Raza (Seleccione todas las que correspondan): W = Blanca; B = Negra o Afroamericana; A = Asiática; I = Amerindia o Nativas de Alaska; N = Nativas de Hawai u otras islas del Pacífico.

Liste las personas embarazadas que viven en su hogar ____________________ Plazo (MMDDAA) ____________

____________________ ____________

¿Está usted interesado en servicios de planificación familiar para las mujeres de su hogar que tengan entre 13 y 45 años de edad? ❑ Si ❑ No

INGRESO: Enumere todo el ingreso que las personas que viven en su hogar obtiene. Incluye ingresos laborales, como trabajador independiente, la Seguridad Social, Beneficios para Veteranos, Seguro de desempleo, sostenimiento de niños, indemnizaciones de trabajadores, Retiro de los Ferrocarriles, IPERS, servicio civil, dinero de amigos o parientes, etc.

Persona que recibe el dinero	**Patrón o fuente de Ingreso**	**Cantidad antes de impuestos o deducciones**	**¿Que tan seguido se paga?**	**¿Se espera que este ingreso continúe? si NO explicar:**
			❑ Semanal ❑ Semana terciada ❑ Mensual ❑ Dos al mes ❑ Otro ______________________	❑ Si ❑ No
			❑ Semanal ❑ Semana terciada ❑ Mensual ❑ Dos al mes ❑ Otro ______________________	❑ Si ❑ No
			❑ Semanal ❑ Semana terciada ❑ Mensual ❑ Dos al mes ❑ Otro ______________________	❑ Si ❑ No
			❑ Semanal ❑ Semana terciada ❑ Mensual ❑ Dos al mes ❑ Otro ______________________	❑ Si ❑ No

RECURSOS: Un recurso es dinero en efectivo o cualquier cosa que pueda canjearse por dinero. Enumerar todos los recursos y la cantidad o valor. Incluya dinero en efectivo disponible, cuentas corrientes, vehículos, seguros de vida, títulos valores, bonos, certificados de depósitos (CDs), fondos fiduciarios, cuentas de jubilación, contratos de entierro, espacios de entierro, anualidades, etc. Si solo se aplica la cobertura por un niño, los recursos no deberán contarse.

Persona con recurso	Tipo de recurso	Cantidad o Valor	Lugar (nombre del banco, y dirección, hogar, etc.)

Si usted designó al Estado de Iowa como beneficiano residual de una anualidad, a fin de calificar para un pago de Medicaid de un cuidado de largo plazo, el Estado de Iowa obtendrá cualquier beneficio restante de la anualidad, hasta el monto de los beneficios pagados por Medicaid.

¿Alguien en su hogar vendió o cedió algo de valor en los últimos 60 meses? (Esto incluye propiedades reales o personales, bienes inmobiliarios, ingresos, herencias, etc.) ❑ Si ❑ No

¿Alguien en el hogar paga manutención para niños o conyugue para una persona que no viva con ustedes? ❑ Si ❑ No

Si es si, ¿quién paga? ________________ ¿Cantidad? ________________

Alguien en el hogar paga a alguien para que cuide a un niño o aun adulto incapacitado? ❑ Si ❑ No

Si es si, ¿quién paga? ________________ Que tan seguido? ________________ ¿A quien? ___________________________

¿Está dispuesto a cooperar para obtener apoyo medico? ❑ Si ❑ No (Contestar si usted es padre o quien está cuidando y está solicitando por si mismo y un niño.)

INFORMACIÓN SOBRE DE LOS PADRES QUE NO VIVEN EN EL HOGAR: Dar el nombre de cualquiera de los padres que no estén viviendo con usted y los niños por quién esta solicitando, quienes son estos padres, sus fechas de nacimiento, números de social security. Un niño puede obtener asistencia médica si usted no proporciona esta información.

Nombre del padre que no vive en casa:	Nombre del hijo de este padre:	El padre nació, fecha:	Número de Social Security de este padre:

NUMERO DE SOCIAL SECURITY (SSN)

Debe poner el SSN de todas las personas mencionadas en esta solicitud para obtener Medical Assistance. La Sección 1137(a)(1) del Social Security Act y el 42 CFR 435.910 requiere esto. Si usted no quiere Medicaid, usted no tiene que darnos su SSN. El SSN será utilizado:

- Para checar el ingreso, elegibilidad y la cantidad de pagos de Medical Assistance que se harán a su favor.
- Para determinar el derecho de otras personas a Medical Assistance.
- Para cumplir con las leyes Federales que requieren divulgación de información para récords de Medicaid.
- Para comparar con récords en otras agencias tales como: Social Security Administration, Internal Revenue Services, y Iowa Workforce Development. Estas comparaciones de pueden hacer por una computadora e un base individual.

Mis derechos y responsabilidades me serán proporcionados en la parte de atrás de las instrucciones de esta Health Services Application. Yo he leído y quitado la hoja de las instrucciones de esta Health Services Application para mi uso futuro.

YO CERTIFICO QUE ESTAS DECLARACIONES SON CORRECTAS A LO MEJOR DE MI CONOCIMIENTO Y CREENCIA.

Firma o marca del solicitante	Fecha	Firma o marca de otro padre o padrastro en el hogar	Fecha	Firma de la persona, si hay que haya ayudado a completar esta forma	Fecha

Health Services Application, Form 470-2927 or 470-2927(S)

Form 470-2927 or 470-2927(S), *Health Services Application*, is designed to enable the applicant to present to the Department's local office the information needed to determine eligibility for State Supplementary Assistance and Medicaid. (Click here to see a sample of the English form and here to see a sample of the Spanish form.)

Facilities that want to keep a supply of these forms on hand may obtain them from the local office or may order them from Iowa Prison Industries, Anamosa, Iowa 52205. Facilities can obtain a *Form Order Blank* from Anamosa by calling 1-800-332-7922.

The resident shall complete the application form on or before the date the resident moves into the residential care facility or the date that the resident wants to start receiving State Supplementary Assistance benefits.

The information shall be provided by the resident, and the resident must sign the form unless mentally or physically unable to do so. If the resident has an authorized representative, such as a guardian, conservator, or payee, that person is responsible for furnishing the information and signing the application on the resident's behalf.

This means that if the facility is the payee for the resident's benefits, the facility is responsible for completing the form and providing the required verification.

- An application form may be partially completed with identifying information. signature and date when:
  - A Medicaid member enters an RCF.
  - An applicant is already receiving an SSI payment (except as noted below).
  - An applicant's income is such that the applicant might be eligible for an SSI payment if a claim was filed.
- The application form shall be completed in its entirety when:
  - The applicant's income is above the SSI limits.
  - The Social Security Administration did not take the spouse's income and resources into consideration when determining SSI eligibility.
  - The DHS worker feels that not all income has been shown by the Social Security Administration (for example, interest).

The completed application form shall be submitted to the local Department of Human Services office.

Iowa Medicaid Long Term Care Claim, Form 470-0039

Iowa Medicaid Enterprise issues *Iowa Medicaid Long Term Care Claim,* form 470-0039, monthly to facilities that do not bill electronically. (Click here to see a sample of the form.) This form is also referred to as a "TAD" or Turnaround Document.

The fields on the TAD are completed for each resident according to IME and Medicaid eligibility records. Review the form carefully. Mark any changes or corrections in blue or black ink.

Note any residents who had covered or noncovered leave days or who were discharged during the billing month in red ink in the appropriate fields on the TAD. (No changes are necessary if the resident did not have leave days and was not discharged during the month.)

Each page of the form must be signed and dated by the facility's authorized representative. Keep one copy and return the other copy to IME.

If you need to resubmit a claim, you must use a blank TAD and complete all of the appropriate fields. Blank TADs are provided at the end of each monthly TAD. For resubmitted claims, use the original signature date.

A detailed field-by-field description of each information line follows:

1. **Medicaid I.D.#** The resident's identification number assigned by the Department. This number consists of seven numbers followed by a letter. Obtain this number from the resident's *Facility Card*, form 470-0371 (MA-2139), or the resident's *Medical Assistance Eligibility Card*, form 470-1911.

2. **Name** The resident's last name and first name.

3. **L.O.C. (Level Of Care)** An "R" indicates RCF care.

4. **Termination** Enter the applicable discharge code:

   A Moved to the hospital
   B Moved to a skilled nursing facility
   C Moved to another nursing facility
   D Moved to an ICF/MR
   E Moved to an RCF
   F Moved home with self-care
   G Moved home with rehabilitation service
   H Moved home with home health
   I Moved to other institution
   J Deceased

IOWA MEDICAID
LONG TERM CARE CLAIM

FOR MONTH OF :

PROCESSING DATE:

IME
P.O. BOX 150001
Des Moines, IA 50315

PROVIDER I.D. NUMBER:

PAGE NUMBER:

	1. Medicaid I.D. #	2. Name: Last	First	MI	3. L.O.C.	4. Termination	5. Patient Acct. #	6. Medicare Coverage
1	7. Facility Admit Date	8. Facility Disc Date	9. First D.O.S.	10. Last D.O.S.	11.	12. Per Diem Rate	13. # Days	14. Amount
	15. Leave Days/Visit	16. Leave Days/Hosp.	17. Leave Days/Non-Cov.	18. 3rd Party Source	19. 3rd Party Amount	20. 3rd Party Source	21. 3rd Party Amount	22. Net Amount
	1. Medicaid I.D. #	2. Name: Last	First	MI	3. L.O.C.	4. Termination	5. Patient Acct. #	6. Medicare Coverage
2	7. Facility Admit Date	8. Facility Disc Date	9. First D.O.S.	10. Last D.O.S.	11.	12. Per Diem Rate	13. # Days	14. Amount
	15. Leave Days/Visit	16. Leave Days/Hosp.	17. Leave Days/Non-Cov.	18. 3rd Party Source	19. 3rd Party Amount	20. 3rd Party Source	21. 3rd Party Amount	22. Net Amount
	1. Medicaid I.D. #	2. Name: Last	First	MI	3. L.O.C.	4. Termination	5. Patient Acct. #	6. Medicare Coverage
3	7. Facility Admit Date	8. Facility Disc Date	9. First D.O.S.	10. Last D.O.S.	11.	12. Per Diem Rate	13. # Days	14. Amount
	15. Leave Days/Visit	16. Leave Days/Hosp.	17. Leave Days/Non-Cov.	18. 3rd Party Source	19. 3rd Party Amount	20. 3rd Party Source	21. 3rd Party Amount	22. Net Amount
	1. Medicaid I.D. #	2. Name: Last	First	MI	3. L.O.C.	4. Termination	5. Patient Acct. #	6. Medicare Coverage
4	7. Facility Admit Date	8. Facility Disc Date	9. First D.O.S.	10. Last D.O.S.	11.	12. Per Diem Rate	13. # Days	14. Amount
	15. Leave Days/Visit	16. Leave Days/Hosp.	17. Leave Days/Non-Cov.	18. 3rd Party Source	19. 3rd Party Amount	20. 3rd Party Source	21. 3rd Party Amount	22. Net Amount
	1. Medicaid I.D. #	2. Name: Last	First	MI	3. L.O.C.	4. Termination	5. Patient Acct. #	6. Medicare Coverage
5	7. Facility Admit Date	8. Facility Disc Date	9. First D.O.S.	10. Last D.O.S.	11.	12. Per Diem Rate	13. # Days	14. Amount
	15. Leave Days/Visit	16. Leave Days/Hosp.	17. Leave Days/Non-Cov.	18. 3rd Party Source	19. 3rd Party Amount	20. 3rd Party Source	21. 3rd Party Amount	22. Net Amount
	1. Medicaid I.D. #	2. Name: Last	First	MI	3. L.O.C.	4. Termination	5. Patient Acct. #	6. Medicare Coverage
6	7. Facility Admit Date	8. Facility Disc Date	9. First D.O.S.	10. Last D.O.S.	11.	12. Per Diem Rate	13. # Days	14. Amount
	15. Leave Days/Visit	16. Leave Days/Hosp.	17. Leave Days/Non-Cov.	18. 3rd Party Source	19. 3rd Party Amount	20. 3rd Party Source	21. 3rd Party Amount	22. Net Amount

IMPORTANT

READ CERTIFICATION STATEMENT ON THE REVERSE SIDE
THE PERSON WHOSE SIGNATURE APPEARS BELOW CERTIFIES THAT HE/SHE IS AUTHORIZED TO SIGN THIS INVOICE AND THAT HE/SHE HAS READ AND WILL COMPLY WITH ALL OF THE TERMS AND CONDITIONS WHICH ARE CONTAINED IN THE CERTIFICATION STATEMENT WHICH APPEARS ON THE REVERSE SIDE OF THIS INVOICE.

TOTAL
THIS PAGE

SIGNATURE/INSTITUTIONAL REPRESENTATIVE　　DATE

IA DHS AA-4163-0/470-0039 (REV. 5/05)

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 State's Title XIX Medical Assistance (Medicaid) program specified in the provider manual and the Iowa Administrative Code and to furnish records and other information regarding any payments claimed for providing such services as the Iowa Department of Human Services or its designee may request. I further agree 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.

SIGNATURE OF AUTHORIZED REPRESENTATIVE: I certify that the services shown on the reverse side were rendered to the patient and medically indicated and necessary to the health of the patient, the charges for such service are just, unpaid and actually due according to law and program policy and not in excess of regular fees, the information provided on the reverse side of this claim is true, accurate and complete.

I agree to comply with the provisions or the Civil Rights Act of 1964 and Section 504 of the Rehabilitation Act of 1973.

I understand that payment and satisfaction of this claim will be from Federal and/or State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

IME
P.O. BOX 150001
Des Moines, IA 50315

(Fold Here)

(Fold Here)

5. **Patient Acct.#** You may enter the resident's account number if your facility assign one.

6. **Medicare Coverage** Leave blank.

7. **Facility Admit Date** Enter the date the resident was admitted to the facility if the admission was during the month being claimed.

8. **Facility Disc Date** If the resident was in the facility the entire month, leave this field blank. If the resident was discharged from the facility during the month, enter the last date service was provided. The entry should show month, day, and year, in a six-digit number.

9. **First D.O.S**. (Date of Service) Enter the first date of the month for which payment is being claimed (month, day, and year, in a six-digit number).

10. **Last D.O.S**. (Date of Service) Enter the last date of the month for which payment is being claimed (month, day, and year, in a six-digit number).

11. **Unlabeled Field** Leave this field blank.

12. **Per Diem Rate** This field shows the facility's computed daily rate. This rate may not be the same as the facility's payment rate if the facility's computed rate is above the reimbursement cap. When Iowa Medicaid Enterprise processes the claim, the cap will be applied, and the facility will receive the computed rate or the maximum rate, whichever is lower.

13. # **Days** The number of days for the month being claimed from the first day of the month to the last day of the month.

14. **Amount** The total amount being claimed as determined by multiplying the per diem (field 12) by the number of days (field 13). When the claim is processed, the facility will be reimbursed based on the facility's computed rate or the maximum rate, whichever is lower.

15. **Leave Days/Visit** Enter the number of covered reserve bed days for a resident who was out of the facility for therapeutic leave or home visit. A covered reserve bed day is one that can be paid by State Supplementary Assistance. See Days Covered for more information.

16. **Leave Days/Hosp**. Enter the number of covered reserve bed days for a resident who was out of the facility for a hospital stay. A covered reserve bed day is one that can be paid by State Supplementary Assistance. See Days Covered for more information.

17. **Leave Days/Non-Cov**. Enter the number of days that the resident was out of the facility that exceed the reserve bed maximum. These are days that are not reimbursable through the State Supplementary Assistance program.

18. **3rd Party Source** If the resident is covered by other insurance, enter the name of the insurance company.

19. **3rd Party Amount** Enter the amount paid by the insurance towards this claim. Do not enter client participation in this field.

20. **3rd Party Source** If the resident is covered by other insurance, enter the name of the insurance company.

21. **3rd Party Amount** Enter the amount paid by the insurance towards this claim. Do not enter client participation in this field.

22. **Net Amount** Enter the net charge amount, which is the amount claimed (field 14) minus third-party payments (fields 19 and 21)

Iowa Department of Human Services

Medicaid Review

County Number

Worker Name

Case Number

Phone No.

Instructions

It is time for your eligibility for Medicaid or State Supplementary Assistance to be reviewed. You must answer the questions on this form and **sign Page 4**. Then, return it to the county office by . **Be sure to send proof of your expenses, income and assets.** Call us if you have any questions.

If you leave a space blank, we will take that to mean that you have no information to give us. You may be asked to prove what you tell us. Please use an additional sheet of paper, if needed.

Most of the information that we ask for is required. You do not have to answer questions that are marked as optional. Your answers are used to decide if you can continue to get Medicaid. If you do not return the form by the due date or give us information, your Medicaid may stop.

Information About Your Family

List yourself and the people who live in your home.

Name (First, Last)	Relationship to You	Birth Date	Social Security Number

Tell us if your mailing or living address changed from the address shown above.

Mailing address			Living address		
City	State	Zip Code	City	State	Zip Code

Do you have a guardian, conservator, or representative? If yes, write their names here: ____________________

Expenses

To get the most help you can, tell us about your expenses. **Send proof of your expenses.**

Medical expenses

If you pay for health insurance, write in how much you pay: Amount $ ____________ per month

If you started or changed health insurance, write in the name of the new company: ______________________________

If your health insurance ended, write in the date it stopped: Date: ____________

List anyone in your home who has ongoing medical bills that Medicaid does not pay:

Who: ________________________ Relationship to you: ________________

Other expenses

List your share of any day care paid for a child or a disabled adult who lives with you:

Who gets care: ________________ Amount $ ____________ per month

If anyone currently pays child support, give the following information:

Who pays: ________________ Amount $ ____________ per month

Income

List income of the people in your home. This includes you, your spouse, and your unmarried children under the age of 18 who are living with you or who are living in a nursing home.

Where the Money Comes From	Who Gets the Money	Gross Amount Per Month
Social Security, Social Security Disability, or SSI		
Veterans, Pensions or Retirement Benefits		
Unemployment, Worker's Compensation or Disability		
Child Support or Alimony		
Money from Friends or Relatives		
Money from Interest or Dividends		
Money You Get from Contracts		
Money From Work Before Taxes (Gross)		
Self-Employment or Odd Jobs		
Tips, Bonuses and Commissions		
Other:		

List the name of all employers: ____________________

Send proof of your money from work for the last 3 months. If you are getting Medically Needy with a family, send proof of your money from work for the past 30 days.

Do you work for anyone who pays you in the form of food, clothing or shelter? ❑ Yes ❑ No

Does anyone give you food, clothing or shelter? ❑ Yes ❑ No

Assets

List all cars, trucks, boats, campers, motorcycles or other licensed or unlicensed vehicles that anyone in your home owns or is buying:

Make	Model	Year	Value or Worth	Amount Owed

List the total money everyone in your home has in:

Type	Who	Bank or Location	Amount
Cash			
Bank/Credit Union Accounts (Checking, savings, etc.)			
Stocks, bonds, savings certificates, IRAs, Keogh or other assets			
Nursing home account			
Other			

Send your bank statements from the last 3 months with this form.

List anyone in your home who has or owns any land, buildings or houses other than the house you live in: ____________________

List anyone in your home who has or has sold a conservatorship, trust or life estates: ____________________

If you bought, changed, or disposed of life insurance, a burial contract, or a burial plot in the past year, tell us about the change: ____________________

If you got an inheritance or turned down an inheritance, list the following:

When? ______________________ Amount $_____________________________

If anyone gave away anything of value, transferred anything for less than its value, or added someone else's name to a resource, tell us:

When? ______________________ What? ______________________________

Other Changes or Comments

____

____

____

____

Your Signature

I certify, under penalty of perjury, that:

- My answers are correct and complete to the best of my knowledge.
- I kept the information on page 5.

Your Signature or Mark	Phone Number	Today's Date
Signature of Person, If Any, Who Helped Complete the Form	Relationship/Phone Number	Today's Date

Remember to send proof of your expenses, income and assets.

You Have the Right to Appeal

You, or the person helping you, may request an appeal hearing if you do not agree with any action taken on your case. To appeal in writing do **one** of the following:

- Fill out an appeal electronically at https://dhssecure.dhs.state.ia.us/forms/, **or**
- Write a letter telling us why you think a decision is wrong, **or**
- Fill out an Appeal and Request for Hearing form. You can get this form at your county DHS office.

Send or take your appeal to the Department of Human Services, Appeals Section, 5th Floor, 1305 E Walnut Street, Des Moines, Iowa 50319-0114. If you need help filing an appeal, ask your county DHS office.

You can represent yourself. Or, you can have a friend, relative, lawyer or someone else act on your behalf.

You may contact your county DHS office about legal services. You may have to pay for these legal services. If you do, your payment will be based on your income. You may also call Iowa Legal Aid at (800) 532-1275. If you live in Polk County, call (515) 243-1193.

You Will Not Be Discriminated Against

It is the policy of the Iowa Department of Human Services (DHS) to provide equal treatment in employment and provision of services to applicants, employees and clients without regard to race, color, national origin, sex, religion, age, disability, political belief or veteran status.

If you feel DHS has discriminated against or harassed you, you can send a letter of complaint to:
Iowa Department of Human Services, Administrator, Diversity Program Unit, 1305 E. Walnut, Des Moines IA 50319-0114; phone (800) 972-2017; fax (515) 281-4243.

Changes You Need to Tell Us About

Within 10 days of the date the change happens, you must tell the DHS county office about changes, such as:

- Income, including any one-time payments you get
- Resources, which includes getting an inheritance or a one-time payment of past due child support
- Someone moving in or out of your home
- Your health insurance coverage
- You file an insurance claim or get an attorney to recover bills paid by Medicaid
- Someone is no longer disabled

Things You Need to Know

By signing this form, you give permission to release confidential information to the Quality Control unit or Investigations unit. You must cooperate with them to keep your benefits.

You will have to pay back any benefits you got or that was paid to a third party on your behalf for which you were not eligible.

Section 1128B of the Social Security Act provides federal penalties for fraudulent acts and false reporting in connection with these programs.

Anyone who gets, tries to get, or helps any other person get assistance to which they are not entitled, is guilty of violating the laws of the State of Iowa. This includes, but is not limited to, Iowa Code Chapters 249, 249A and 249F.

You must give the social security numbers for everyone who wants Medicaid. This is required by Section 1137(a)(1) of the Social Security Act and 42 CFR 435.910. We use social security numbers to:

- Identify people who apply for or get Medicaid
- Verify income and eligibility for Medicaid
- Match records with other agencies

By signing this application, you give your permission for DHS to share:

- The status of your Medically Needy case, the amount of your spenddown, and the bills used to meet your spenddown with the provider whose bills are being used.
- The premium due date for Medicaid for Employed People with Disabilities (MEPD) with your medical provider.

You agree to assign medical payments from a third party to the Medicaid agency for you and others who are eligible for Medicaid for whom you legally can assign benefits. You also agree to cooperate in obtaining medical payments from third parties.

Iowa Department of Human Services

Medicaid Review
(Revisión de Medicaid)

Número del condado

Nombre del trabajador

Número de caso

Teléfono del trabajador

Instrucciones

Es hora de que su elegibilidad para Medicaid o para State Supplementary Assistance (Asistencia Complementaria del Estado) sea revisada. Usted debe responder las preguntas de este formulario y **firmar la página 4**. Luego regréselo a la oficina del condado antes del
Asegúrese de enviar prueba de sus gastos, ingresos y activos. Llámenos si tiene alguna pregunta.

Si deja un espacio en blanco, entenderemos que significa que no tiene información para suministrarnos. Se le puede pedir que pruebe lo que nos dice. Por favor utilice una hoja de papel adicional si lo necesita.

La mayoría de la información que solicitamos es obligatoria. Usted no tiene que contestar las preguntas que están marcadas como opcionales. Sus respuestas son usadas para decidir si puede seguir recibiendo Medicaid. Si no regresa el formulario antes de la fecha límite o no nos proporciona información, su Medicaid puede suspenderse.

Información Acerca de su Familia

Lístese usted y las personas que viven en su hogar.

Nombre (Nombre, Apellido)	Relación con Usted	Fecha de Nacimiento	Número de Seguridad Social

Infórmenos si su dirección postal o de residencia es diferente de la que se indica anteriormente.

Dirección postal			Dirección en la que vive		
Ciudad	Estado	Código Postal	Ciudad	Estado	Código Postal

¿Tiene usted un guardián, curador o representante? En caso afirmativo, escriba aquí su nombre: ______________________

Gastos

Para obtener la mayor cantidad de ayuda, infórmenos sobre sus gastos. **Envíe prueba de sus gastos.**

Gastos médicos

Si usted paga un seguro de salud, escriba cuánto paga: Cantidad $ ______________ por mes

Si inició o cambió el seguro de salud, escriba el nombre de la nueva compañía: ______________________________________

Si su seguro de salud terminó, escriba la fecha en que lo hizo: Fecha: ______________

Liste a cualquiera en su hogar que tenga facturas médicas en curso, que Medicaid no paga:

Quién: ____________________________ Relación con usted: __________________

Otros gastos

Mencione su participación en el pago por el cuidado diurno de un niño o adulto discapacitado que viva con usted:

¿Quién recibe el cuidado? ___________________ Cantidad $ ______________ por mes

Si alguien paga el mantenimiento del niño, suministre la siguiente información:

¿Quién paga? ___________________ Cantidad $ ______________ por mes

Ingreso

Liste el ingreso de las personas que viven en su hogar. Esto le incluye a usted, a su cónyuge y a hijos solteros menores de 18 años, que vivan con usted o que vivan en una institución de enfermería especializada.

De Dónde Proviene el Dinero	Quién Obtiene el Dinero	Cantidad Bruta Mensual
Seguridad Social, Incapacidad de la Seguridad Social o SSI		
Beneficios de Veteranos, Pensiones o Jubilación		
Desempleo, Indemnización del Trabajador o Incapacidad		
Mantenimiento de Niños o Pensión de Alimentos		
Dinero de Amigos o Parientes		
Dinero de Intereses o Dividendos		
Dinero Obtenido de Contratos		
Dinero del Trabajo sin Incluir Impuestos (Bruto)		
Trabajo Independiente o Trabajos Ocasionales		
Propinas, Bonos y Comisiones		
Otros:		

Nombre a todos los empleadores: ______________________________

Envíe prueba del dinero que recibe por su trabajo para los últimos 3 meses. Si usted está recibiendo beneficios de Medically Needy (médicamente necesitados) con una familia, envíe prueba del dinero que recibe por su trabajo para los últimos 30 días.

¿Trabaja usted para alguien que le paga en forma de alimentación, ropa o albergue? ❑ Sí. ❑ No

¿Alguien le suministra alimentación, ropa, or albergue? ❑ Sí. ❑ No

Activos

Liste todos los autos, camiones, barcos, camperos, motocicletas y cualquier otro vehículo con o sin licencia que cualquiera en su hogar posea o esté comprando:

Marca	Modelo	Año	Valor o avalúo	Monto de la deuda

Mencione el total de dinero que todos tienen en:

Tipo	Quién	Banco o ubicación	Cantidad
Efectivo			
Cuentas bancarias o de unions de crédito (Corrientes, de ahorres, etc.)			
Acciones, bonos, certificados de ahorro, IRAs, Keogh u otros activos			
Cuenta del ancianato			
Otros			

Envíe sus extractos bancarios de los últimos 3 meses con este formulario.

Liste a cualquier miembro de su hogar que tenga o posea algún terreno, edificios o casas distintas de la casa en que vive: ______________________________

Liste a cualquier miembro de su hogar que tenga o haya vendido bienes en custodia, en fideicomiso o en usufructo: ______________________________

Si usted compró, cambió o dispuso de un seguro de vida, un contrato funerario o un lote funerario durante el último año, infórmenos acerca del cambio:______________________________

Si recibió o rechazó una herencia, mencione lo siguiente:

¿Cuándo? ______________________ Cantidad $______________________________

Si alguien ha regalado algo de valor, transferido algo por menos de su valor, o a añadido el nombre de alguien más a un recurso, infórmenos:

¿Cuándo? ______________________ ¿Qué? _________________________________

Otros Cambios o Comentarios

____

____

____

____

Su Firma

Certifico, bajo la gravedad del juramento, que:

- Mis respuestas son correctas y completas según mi leal saber y entender.
- Conservé la información de la pagina 5.

Su firma o marca	Número de teléfono	Fecha de hoy
Firma de la persona que ayudó a llenar el formulario, si la hay	Relación/teléfono	Fecha de hoy

Acuérdese de enviar prueba de sus gastos, ingresos y activos.

Usted Tiene Derecho a Apelar

Usted o quien le esté ayudando, puede solicitor una audiencia de apelación en caso que usted no esté de acuerdo con alguna acción tomada en su caso. Para apelar por escrito, haga **una** de las siguientes cosas:

- Llene una apelación electrónicamente en https://dhssecure.dhs.state.ia.us/forms/, **ó**
- Escriba una carta en la que nos diga por qué cree que la decisión está errada, **o**
- Llene un formulario de Apelación y Solicitud de Audiencia. Puede obtener este formulario en la oficina del DHS de su condado.

Envíe o lleve su apelación al Department of Human Services, Appeals Section, 5th Floor, 1305 E Walnut Street, Des Moines, Iowa 50319-0114. Si necesita ayuda para llenar una apelación, solicítela en la oficina del DHS de su condado.

Usted puede representarse a sí mismo(a). O puede hacer que un amigo, pariente, abogado o alguien más actúe en su nombre.

Puede contactar su oficina del DHS del condado para obtener servicios legales. Es posible que deba pagar por estos servicios legales. Si lo hace, su pago se basará en su ingreso. También puede llamar a Iowa Legal Aid al (800) 532-1275. Si vive en Polk County, llame al (515) 243-1193.

No Será Discriminado

Es política del Iowa Department of Human Services ofrecer trato igualitario en cuanto a empleo y ofrecimiento de servicios a los solicitantes, empleados y clientes, sin importar su raza, color, nacionalidad, sexo, religión, edad, incapacidad, creencia política o estatus de veterano.

Si usted considera que el IDHS le ha discriminado o acosado, puede enviar una carta quejándose a:

Iowa Department of Human Services, Administrator, Diversity Program Unit, 1305 E. Walnut, Des Moines IA 50319-0114; teléfono (800) 972-2017; fax (515) 281-4243.

Cambios Que Debe Informarnos

Dentro de los 10 días siguientes a que el cambio ocurra, deberá informar a la oficina del DHS del condado acerca de cambios como:

- Ingresos, incluyendo pagos por una única vez que usted reciba
- Recursos, que incluyen la obtención de una herencia o pagos atrasados de apoyo infantil
- Alguien que se entre a vivir o salga de su hogar
- La cobertura de su seguro de salud
- Si usted reclama un seguro o consigue un abogado para recuperar facturas pagadas por Medicaid
- Alguien que ya no esté incapacitado

Cosas Que Debe Saber

Mediante la firma de este formulario, usted concede permiso para revelar información confidencial a las unidades de Quality Control o Investigations. Usted debe cooperar con ellos para mantener sus beneficios.

Usted deberá rembolsar cualquier beneficio que obtuvo o que fue pagado a una tercera persona en su nombre si no era elegible para ello. Mis activos pueden estar sujetos a ser recuperados por el Estado.

La Sección 1128B de la Social Security Act establece penas federales para actos fraudulentos e informaciones falsas en relación con estos programas.

Cualquiera que obtenga, intente obtener, o ayude a otra persona a obtener asistencia a la cual no tiene derecho, es culpable de violación de las leyes del Estado de Iowa. Esto incluye, pero no se limita a los Capítulos 239B, 243, 249, 249A y 249F del Código de Iowa.

Usted debe suministrar los números de seguridad social de todo aquel que desee Medicaid. Esto lo requiere la sección 1137(a)(1) de la Ley de Seguridad Social y 42 CFR 435.910. Nosotros usamos los números de seguridad social para:

- Identificar personas que solicitan u obtienen Medicaid
- Verificar el ingreso y la elegibilidad para Medicaid
- Cruzar registros con otras agencias

Mediante la firma de esta solicitud, usted otorga permiso al DHS para que comparta:

- El estado de su caso de Medically Needy (Médicamente Necesitado), el monto de sus gastos, y las facturas usadas para reducir esos gastos con el proveedor.
- La fecha de pago de la prima de Medicaid for Employed People with Disabilites (Medicaid para Personas Incapacitadas Empleadas) (MEPD) a su proveedor médico.

Usted acepta asignar a la agencia Medicaid los pagos de gastos médicos realizados por un tercero para usted y otras personas que sean elegibles para Medicaid y para las cuales pueda legalmente asignar beneficios. También acepta cooperar para obtener pagos de terceros para gastos médicos.

Medicaid Review, Form 470-3118 or 470-3118(S)

Form 470-3118 or 470-3118(S), *Medicaid Review*, is designed to enable the resident to present to the local Department office the information needed to determine eligibility for State Supplementary Assistance at the time of review.

The Department will mail the form to the resident when a review is due. (Click here to see a sample of the English form and here to see a sample of the Spanish form.)

The information shall be provided by the resident, and the resident must sign the form unless mentally or physically unable to do so. However, if the resident has an authorized representative, such as a guardian, conservator, or payee, that person is responsible for furnishing the information and signing the application on the resident's behalf.

This means that if the facility is the payee for the resident's benefits, the facility is responsible for completing the form and providing the required verification.

The completed application form shall be submitted to the local Department of Human Services office.

Medical Assistance Eligibility Card, Form 470-1911

The *Medical Assistance Eligibility Card* contains basic identifying information to enable a provider of medical care to confirm a Medicaid member's eligibility. The member's name, date of birth, and state ID number are printed on a wallet card and key tags. (Click here to see a sample of the card.)

The member is instructed to keep the permanent card and present it when receiving medical services. The card does not guarantee Medicaid eligibility.

Information on appeal rights, payment of medical bills, the Department's right to recover payments made or make a claim against another responsible for member's medical cost, and when a member should contact the IME Member Services Unit is included on or with the card.

The *Medical Assistance Eligibility Card* is issued to the member directly. The first card is mailed at the time of initial approval to the case name and mailing address. This includes members residing in a residential care facility.

The Department will issue replacement cards:

- Annually in July of each year for current members.
- Upon a member's request, as necessary.

The local office or the IME Member Services Unit can generate replacement cards through a web-based system. Circumstances under which a replacement card is necessary include:

- The card has been lost, stolen, or damaged;
- The member did not receive the initial or annual replacement card; or
- The member's name changes.

Polk County DHS\Carpenter
1900 Carpenter
Des Moines IA 50314

Here are your new Medicaid cards!

Remove your ID card, your ID key tags and this information card. Read and keep this card as it has important information on the back. Please present any of the ID cards when you receive medical services.

JOHN DOE
Street Address
Our Town IA 500210000

TEST

03105 9175002 0000 0000005 0000001 208 2 237

THIS IS YOUR PERMANENT MEDICAL ID CARD. KEEP THIS CARD.

Members: Show this card to your medical provider when you need services. If you have questions or you lost your card, call our Member Services Call Center at: 1-800-338-8366 (If you live in the Des Moines area call 725-1003)

THIS CARD DOES NOT GUARANTEE ELIGIBILITY OR PAYMENT FOR SERVICES

Providers: You need to verify eligibility status of this cardholder before providing services. You can get current eligibility status by calling our Eligibility Verification System (ELVS) at 1-800-338-7752 (in the Des Moines area 323-9639) or at our website: https://ime-ediss.noridian.com/iowasxchange/LogonDisplay.do

TO BECOME A REGISTERED PROVIDER VISIT THE EDISS HOME PAGE AT: http://www.edissweb.com/cgp/supp_docs/ia_medicaid.html

470-1911 (Rev. 7/07)

Providers:
You need to verify eligibility status of this cardholder before providing services. You can get current eligibility status by calling our Eligibility Verification System (ELVS) at 1-800-338-7752 (in the Des Moines area 323-9639) or at our website:
https://imeediss.noridian.com/iowasxchange/LogonDisplay.do

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https://imeediss.noridian.com/iowasxchange/LogonDisplay.do

You do not have to pay medical bills that Medicaid should pay. You should make sure your provider has all of your insurance information in order to submit a claim.

Call Iowa Medicaid Enterprise Member Services at **1-800-338-8366** (Des Moines area, call 725-1003) if:

- You have lost your card.
- You get a bill from a doctor, hospital or other medical provider, unless it is for a co-payment.
- You can't get medical services because Medicaid did not pay another bill.

You will get a letter within 30 days that tells you if Medicaid will pay the bill. If Medicaid does not pay the bill, you have the right to file an appeal.

The Iowa Medicaid Enterprise (IME) does not need your permission to:

- Recover medical payments made on your behalf, or
- Make a claim against another person or company that may be responsible for paying the cost of your medical expense

Your help is appreciated. You will get documents that show what medical services have been paid for if you or your attorney asks for them. These documents may also be shared with an attorney or insurance company to prove the amount of the IME's claim.

Iowa Department of Human Services
Iowa Medicaid Program

PROVIDER INQUIRY

Please check the type of inquiry below:

☐ Inquiry about payment or medical determination of a **specific claim** (TCN below)

☐ **General Issue** regarding Medicaid policy (an example TCN may be reference below)

Attach supporting documentation. Check applicable boxes:

☐ Claim form ☐ Remittance copy ☐ Other pertinent information for possible claim reprocessing

INQUIRY

1. **17-DIGIT TCN** * Required if about a specific claim

2. NATURE OF INQUIRY:

Date ____ Provider Signature:	MAIL TO: IME Provider Services P. O. BOX 36450 DES MOINES IA 50315	Date ____ IME Signature:

Provider Please Complete:

Provider NPI#

Member ID#

Phone Number

Name

Address

City State Zip Code

(FOR IME USE ONLY)

PR Inquiry Log #

Received Date Stamp:

Provider Inquiry, form 470-3744

Form 470-3744, *Provider Inquiry*, offers a standard procedure for inquiring as to why a claim was denied or why a claim payment was not what you expected.

(Click here to see a sample of the form.) Forms may also be downloaded from the IME Web site at: http://www.ime.state.ia.us/Providers/Forms.html

Attach copies of the claim, the *Remittance Advice*, and any supporting documentation you want to have considered, such as additional medical records and send to:

> Iowa Medicaid Enterprise, Provider Inquiry
> PO Box 36450
> Des Moines, Iowa 50315

RCF Admission Agreement, Form 470-0477

The *RCF Admission Agreement* is designed to serve as a legal contract between a residential care facility and the resident of the facility. It meets the licensing requirements set by the Department of Inspections and Appeals. Page 2 of the form meets the additional requirements of the State Supplementary Assistance Program. (Click here to see a sample of the form.)

The facility shall initiate the form before or at the time of a person's admission to the facility. Page 1 shall be completed for all residents. It must be completed and signed by an authorized representative of the facility and the resident or the resident's guardian. The law requires that the form be completed in duplicate: one copy for the facility and one copy for the resident.

The "Base Rate" amount must be inserted each time the form is completed and the correct time frame circled.

When the resident receives State Supplementary Assistance, the base rate shall be the facility's cost-related per diem, unless that rate is higher than the rate established for private-paying residents. The Department will not pay more for the care of a recipient of State Supplementary Assistance than the facility charges private-paying residents.

Under the State Supplementary Assistance Program, residents moving from an independent living arrangement to an RCF may retain enough of the first month's income to meet maintenance or living expenses connected with the previous living arrangement. A State Supplementary Assistance recipient who transfers from one facility to another may have a refund from the first facility which should be shown as the amount to be paid on admission to the second facility.

In such cases, the income maintenance worker shall determine how much of the resident's income is available for the first-month client participation. Verification of the amount can be obtained from the local Department office.

Page 2 shall be completed for residents who receive State Supplementary Assistance payments. The amount of the resident's personal needs allowance shall be entered.

One copy shall be retained by the facility and filed in the resident's personal file. The other copy shall be given to the resident or the resident's guardian.

RCF ADMISSION AGREEMENT

______________________________________ and
Facility

____
Resident

The base rate shall be $____________ (per day)(per month). The services provided for in the base rate shall include room, board, linens and bedding, supervision and other personal services which are required for health, safety and wellbeing of the resident.

The base rate shall **not** include those items and services entered in the attached listing which has been prepared by the facility.

No additional fees shall be charged for items not listed or subsequently agreed to in writing by both parties. The resident may be charged for nonprescription drugs, personal supplies, and services by a barber, beautician, etc.

Payments shall be made in advance of care, payable by the

____

day of each month. The amount of $________________ shall be paid on the date of admission. The resident shall be charged for the day of admission, but not the day of discharge.

The facility shall inform the resident or resident's guardian in writing of changes in the overall rates of both base and additional charges at least 30 days before the effective date of the change.

The facility shall inform the resident or resident's guardian of changes in additional charges based on a change in the resident's condition before the date the revised additional charges begin. If communicated orally, notification shall follow in writing within 7 days, listing the specific adjustments made.

If the resident dies or leaves the facility, the facility shall refund to the resident or resident's guardian any payments made in advance for the days after the resident leaves, including the date of death or discharge.

Any charge for supplies, outside services, or personal purchases shall be deducted from any refund due.

A facility shall not involuntarily discharge or transfer a resident from a facility except: (1) for medical reasons; (2) for the resident's welfare or that of other residents; (3) for nonpayment. The resident requires 30 days advance notice in writing of termination of this contract.

The resident or the resident's guardian shall have the right at all times to discharge the resident from the facility voluntarily, provided the person in charge of the facility is given proper notification so that a proper transfer or discharge can be made. The facility requires 14 days advance notice of planned discharge or transfer of a resident.

If a resident has a temporary absence from a facility for medical treatment, the facility shall hold the bed open for a minimum of ten days upon request and receive full payment for the absent period.

Payment will be made for periods the resident is absent overnight for the purpose of visitation or vacation in accordance with IAC 441--52.1(3)"e".

The facility may not relocate residents from one room to another unless deemed necessary by an appropriate qualified staff member for the following reason: (1) because of incompatibility with other roommates, (2) for the welfare of the residents of the facility, (3) for medical, nursing, or psychosocial reasons, (4) to allow a new admission to the facility which would otherwise not be possible due to separation of roommates by sex, (5) to allow transfer of a private paying resident who becomes eligible for State Supplementary Assistance from a private room to a semi private room or from one semiprivate room to another, or (6) because of reasonable administrative decisions regarding the use of the building.

Unreasonable and unjustified reasons for changing a resident's room without the agreement of the resident or responsible party include: (1) change from private pay status to State Supplementary Assistance, except as outlined in paragraph 5 above, (2) punishment, (3) discrimination on the basis of race or religion.

If relocation within the facility is necessary, the resident shall be notified at least 48 hours prior to the transfer. The reason shall be explained. The resident's guardian shall be notified as soon as possible. Notification shall be documented in the resident's record and signed by the resident or residents's guardian. (Chapter 63.34(2) a, b and c).

Prior to admission, the resident shall deliver to the facility a current physical and medical history. It shall be certified by a licensed physician and indicate the resident's required level of care.

The resident, or resident's guardian shall be responsible for all medical expenses ordered by the attending physician, and for optional services or goods delivered to resident by providers other than this facility.

All terms of this Agreement are subject to the provisions of Chapter 135C of the Code of Iowa.

Admitted and Agreed to by:

____
Signature of Administrator of Facility

____
Title

____
Date

I acknowledge receipt of a copy of this Agreement.

____
Resident Date

____
Guardian or Conservator

____
Address of Guardian or Conservator

____
Telephone No.

____
Date

Iowa Department of Human Services

ADDITION TO ADMISSION AGREEMENT
Recipients of State Supplementary Assistance

In addition to the Admission Agreement, the ______________________________ facility and ______________________________, resident agree to these terms:

1. The facility agrees to provide all services required by the terms of its license, the rules in the Iowa Administrative Code governing the license, the terms of the Application and Contract Agreement for Residential Care Facilities, the requirements in the Department of Human Services Handbook for Residential Care Facilities and the rules in the Iowa Administrative Code governing the payment of State Supplementary Assistance.

2. The facility agrees to furnish the recipient's room as required by licensing rules without additional charges to the recipient or to any person acting on the recipient's behalf. When the recipient wishes to provide an item of room equipment, the facility may grant this request.

3. The facility agrees to provide personal services, including necessary supervision or assistance with moving about, grooming, hair washing, shaving, personal hygiene, bathing, getting in and out of bed, dressing, feeding and with medication that can be self-administered. Personal laundry services shall be provided as a part of the goods and services paid through the program.

4. The facility agrees to make no additional charge for this care, over and above the rate established by the Department, nor to accept any additional payments by other persons, organizations or governmental units to cover this care. Additional payment for services which go beyond those required of a residential care facility may be allowed with approval of the Department of Human Services.

5. The Resident agrees to pay for this care according to Department of Human Services policy; that is, to retain______________ per month to cover personal needs and to make all other income (including State Supplementary Assistance payments received on approximately the 20th day of the month following the month of service) available to the facility furnishing this care.

   (In addition to the personal needs allowance of______________________per month, a resident who is employed may retain $65.00 per month of the earnings to cover work expense plus one-half of the remaining earned income.)

6. If the facility manages the personal needs account of the recipient, the facility agrees to abide by the policy established by the Department of Human Services relative to the handling of the recipient's personal funds.

7. The facility shall allow the recipient to be absent from the facility for periods of hospitalization and visitation, and shall bill for these days and provide documentation as required by Department of Human Services policy.

____
Signature of Administrator of Facility

____
Signature of Recipient, Guardian or Conservator

____
Title

____
If other than recipient, indicate relationship

____
Date

____
Address for mailing purposes

______________________________Telephone Number

Remittance Advice

The IME issues a *Remittance Advice* (RA) for each payment cycle that explains every individual provider claim transaction.

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 RA. 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 payment is issued. Subsequent reimbursement will be applied to the credit balance, as well, until the credit balance is exhausted.

The RA is separated into categories indicating the status of those claims listed:

- **Paid**, indicating all processed claims, credits, and adjustments for which there is full or partial reimbursement.
- **Denied**, representing all processed claims for which no reimbursement is made.
- **Suspended** claims in process, reflecting claims which are currently in process pending resolution of one or more issues (recipient eligibility determination, reduction of charges, third party benefit determination, etc.). These claims have not yet been paid or denied.

Suspended claims may or may not print depending on which of these options you have specified:

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

(Click here to see a sample of the form, with the fields identified by the indicator in the first column.) A detailed description of each information field follows:

A

R.A. NO.: 00000000

B

WARRANT NUMBER: 0000000

C

PROVIDER NAME

D

PROVIDER ADDRESS
PO BOX XXX
ANYTOWN IA 00000-0000

---- NEWSLETTER UPDATE ----

******************IMPORTANT IME INFORMATION***************************

E

IMPORTANT INFORMATION AND REMINDERS FROM IME WILL BE POSTED IN THIS SECTION

OF THE REMITTANCE ADVICE.

FOR QUESTIONS CONTACT PROVIDER SERVICES AT 1-800-338-7909 OR IN THE DES MOINES AREA AT 515-725-1004. E-MAIL: IMEPROVIDERSERVICES@DHS.STATE.IA.US

RUN DATE: MM/DD/YY
F

C A B G H I

TO: PROVIDER NAME R.A. NO.: 0000000 WARR NO.: 9999999 DATE PAID: MM/DD/YY PROV. NUMBER: 0000000000 PAGE: 2

```
*** PATIENT NAME **** RECIPIENT                             FIRST     LAST    COVD HOSP NCOV VISIT    BILLED  OTHER      PAID BY
LAST           FI   MI IDENT NUM  TRANS-CONTROL-NUMBER   SVC DATE SVC DATE DAYS DAYS DAYS  DAYS     AMT.  SOURCES    MCAID    EOB EOB

               * * *  CLAIM TYPE:  LONG TERM CARE                 * * *  CLAIM STATUS:  PAID

ORIGINAL CLAIMS:

        1               2                3                        4           5    6     7     8     9        10          11
MEMBERLAST    FIRST  0000000F  3-00000-00-000-0000-00 MM/DD/YY MM/DD/YY 28    0     0     0  0000.00   0000.00    0000.00
                                                                                                                            12
TYLER         MARY   0000000B  0-00000-00-000-0000-00 MM/DD/YY MM/DD/YY 31    0     0     0  0000.00      0.00       0.00   1
PREVIOUS-DATE-PAID: MM/DD/YY CONFLICTING-TCN: 3-00000-00-000-0000-00
                        13                       14

ADJUSTMENT CLAIMS:

NORTHWAY      MERIL  0000000E  0-00000-00-000-0000-00 MM/DD/YY MM/DD/YY 28    0     0     0  0000.00-  0000.00-   0000.00-  15

NORTHWAY      MERIL  0000000E  0-00000-00-000-0000-00 MM/DD/YY MM/DD/YY 28    0     0     0  0000.00      00.00    0000.00  16
 ADJ-R: 84  TCN-TO-CREDIT: 3-00000-00-000-0000-00                 NET                                    0000.00  17
       18                19

                 4 CLAIMS - THIS CLAIM TYPE / THIS CLAIM STATUS.  TOTALS...  00000.00   00000.00   00000.00
                 Q                                                              R          S          T
```

C A B G H I

TO: PROVIDER NAME DDS R.A. NO.: 00000000 WARR NO.: 0000000 DATE PAID: MM/DD/YY PROV. NUMBER: 0000000000 PAGE: 2

REMITTANCE T O T A L S		J		K	L
PAID ORIGINAL CLAIMS:	NUMBER OF CLAIMS	0	----------	0,000.00	0,000.00
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 EFT DEPOSIT:	--				0,000.00 M

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

		COUNT
000	EXPLANATION (EOB) OF DENIAL CODE	1
N	O	P

	Field Name	Field Description
A	R.A. No.	Unique number assigned to this Remittance Advice
B	Warrant Number	Check number (Usually zeros. Contact IME for the check number if necessary.)
C	Provider Name	Name of the residential care facility as registered with IME
D	Provider Address	Address registered with IME for the mailing of the Remittance Advice and paper checks
E	Important IME Information	Reminders and updates from IME
F	Run Date	Date the Remittance Advice was created
G	Date Paid	Date the Remittance Advice was mailed and the payment was released
H	Prov. Number	RCF vendor number of the provider
I	Page	Page number
J	Number of Claims	Number of claims processed for each defined status
K	Billed Amount of All Claims	Total dollar amount of claims billed for each defined status
L	Subtotal Amount Paid	Amount paid for each defined status
M	Amount of Deposit	Total payment amount for claims paid on this remittance advice
N	EOB Code	Explanation of benefits (EOB) code or denial code
O	EOB Description	Description of the denial EOB
P	Number of Claims Posting EOB	Number of claims that denied for the EOB code described
Q	Number of Claims on Page	Total number of claims on this page
R	Total Billed Amt on Page	Total billed amount of all claims on this page
S	Total Other Sources on Page	Total third-party insurance payments listed on this page
T	Total Payments on Page	Total dollar amount paid for the claims listed on this page

	Field Name	Field Description
1	Member Name	Name of the State Supplementary Assistance recipient as shown on the Medical Assistance Eligibility Card (last name and first name or initial)
2	Member ID	The State Supplementary Assistance recipient's state identification number (7-digits + a letter)
3	Transaction Control Number	The 17-digit transaction control number that IME assigned to this claim
4	Svc-Date	The beginning and ending dates of the period billed
5	Covered Days	The number of days billed
6	Hospital Days	The number of hospital leave days billed
7	Noncovered Days	The number of noncovered days billed
8	Visit Days	The number of other leave days billed
9	Billed Amount	The total amount billed to State Supplementary Assistance
10	Other Sources	The third-party insurance payment or spenddown amount applied
11	Payment	Total amount paid by State Supplementary Assistance
12	EOB	Explanation of Benefits (EOB) code, if denied. A description of the code can be found on the summary page of the remittance advice (Field O)
13	Previous Date Paid	The claim was paid previously on the given Remittance Advice date
14	Conflicting-TCN	The transaction control number of the previously paid claim
15	Claim Credit	The amount of the claim being credited or recouped
16	Claim Adjustment	The amount of the claim being adjusted or reprocessed
17	NET	Difference paid or recouped from claim credit or adjustment
18	Adj-R	Reason code indicating the reason for the adjustment
19	TCN-To-Credit	The transaction control number of the claim being credited or recouped

Ten-Day Report of Change for FIP and Medicaid, Form 470-0499 or 470-0499(S)

The *Ten-Day Report of Change for FIP and Medicaid* may be used by the resident or the resident's representative to report changes in eligibility factors. Failure to make a timely report may result in loss of benefits for the resident. (Click here to see a sample of the English form and here to see a sample of the Spanish form.)

The Department issues the form to the resident:

- Upon approval of the application,
- At the time of review,
- When requested, and
- As a replacement when the local office receives a completed form.

Keep the form until a reportable change occurs; then resident or the resident's representative shall complete the form and send it to the local DHS office.

When the RCF is the payee, the RCF shall complete the form for the resident. Facilities that are payees for resident's benefits are responsible for monitoring the resident's financial situation and making the required reports.

Facilities that wish to maintain a supply of these forms may order them from Iowa Prison Industries, Anamosa, Iowa 52205. Facilities can obtain a *Form Order Blank* from Anamosa by calling 1-800-332-7922.

Iowa Department of Human Services

Ten-Day Report of Change for FIP and Medicaid

Tell Us About Your Changes

You must tell us when something changes. You can report your change by mail, phone, fax, e-mail, or in person to:

Phone:
FAX:
e-mail:

You will need to tell us within ten days of the change. If you have applied for FIP or Medicaid, but we have not made a decision on your application yet, you must tell us about your changes within five days of the change.

If you don't tell us when changes happen, we may give you too much or not enough FIP or Medicaid. Or, give you benefits that you should not have gotten. If so, you will have to pay back what you got in error.

Instructions

Check the box next to your change. If you have more than one change to tell us about, check all the boxes that apply. Tell us about the change on the backside of this form and return it to the Department of Human Services (DHS) office listed above.

Changes in address, work or your ability to work must be reported to your DHS worker. You will also need to send proof of the change you reported.

Where You Live or Who You Live With

I have:

- ☐ A new mailing or living address.
- ☐ Someone moving into my home. This includes the birth of a child or the return of a parent or spouse to the home.
- ☐ Someone moving out of my home or going into a nursing home.

Money Your Household Gets

Someone in my home:

- ☐ Will start or stop a job. **Note:** People who are age 65 and over or disabled must also report a change in income from work. This includes a change in the rate of pay or number of hours worked.
- ☐ Will start or stop getting unemployment benefits, social security income, pensions, child support or alimony, gifts, loans, school loans or grants, etc. **Note:** People who are age 65 and older or disabled must also report a change in the amount of money they receive from these sources.
- ☐ Will get a one-time payment such as back child support, an inheritance or an insurance settlement.

Household Expenses

Someone in my home:

- ☐ Pays for child or adult care costs.
- ☐ Is being billed for school expenses, conservator fees, or medical fees.
- ☐ Pays court-ordered child support.

Assets or Resources

Someone in my home:

- ☐ Got another car, truck, boat, or motorcycle or got rid of one.
- ☐ Bought or sold a house or land.
- ☐ Opened or closed a bank account or a retirement account.
- ☐ Got an insurance policy or got rid of one.

Medical Coverage

Someone in my home:

- ☐ Had a change in their health insurance premium amount.
- ☐ Started or stopped paying premiums, including Medicare premiums.
- ☐ Started getting other medical insurance or current medical insurance was dropped.

Other Changes

Someone in my home:

- ☐ Got a Social Security Number.
- ☐ Who is a child, has enrolled in school or dropped out of school.

Explain Your Change

Use this space to explain the changes that you checked.

Name	Phone Number ( )
Address	
Social Security Number	Date Completed

Iowa Department of Human Services

Ten-Day Report of Change for FIP and Medicaid
(Informe de cambios de diez días para FIP y Medicaid)

Infórmenos sobre sus cambios

Usted debe informarnos cuando algo cambie. Usted puede informar su cambio por correo, teléfono, fax, correo electrónico o personalmente a:

Teléfono:
FAX:
e-mail:

Usted deberá informarnos acerca del cambio dentro de los diez días siguientes. Si ha solicitado FIP o Medicaid, pero aún no hemos tomado una decisión sobre su solicitud, debe informarnos sobre sus cambios en un plazo de cinco días a partir del cambio.

Si no nos informa cuando sucedan los cambios, es possible que le demos demasiado o no suficiente FIP o Medicaid. O, que le demos beneficios que no debía haber recibido. Si es así, usted deberá pagar lo que recibió por error.

Instrucciones

Marque la casilla que está al lado de sui cambio. Si tiene más de un cambio, infórmenos acerca de ellos, marque todas las casillas que apliquen. Infórmenos sobre el cambio en el reverso de este formulario y devuélvalo a su oficina local del Department of Human Services (DHS).

Los cambios de dirección, trabajo o de su capacidad para trabajar deben ser informados tanto a su trabajador del DHS. También deberá enviar prueba del cambio que reportó.

Dónde vive o con quién vive

Yo tengo:

- ☐ Una nueva dirección postal o dirección de vivienda.
- ☐ Alguien que se mudará a mi hogar. Esto incluye el nacimiento de un niño/a o el regreso de un padre o cónyuge al hogar.
- ☐ A alguien que sale de mi hogar o va a un asilo de ancianos.

Dinero que obtiene su hogar

Alguien en mi hogar:

- ☐ Empezará o dejará un trabajo. **Nota:** Las personas de 65 años o más, o los discapacitados también deben reportar un cambio en el ingreso por trabajo. Esto incluye un cambio en el salario o en el número de horas trabajadas.
- ☐ Empezará o dejará de recibir beneficios de desempleo, ingreso de seguridad social, pensiones, manutención infantil o pensión alimenticia, regalos, préstamos, créditos o becas escolares, etc. **Nota:** Las personas de 65 años o más, o los discapacitados también deben reportar un cambio en el ingreso que reciben de estas fuentes.
- ☐ Recibirá un pago único como atrasos de manutención infantil, una herencia o una conciliación por seguro.

Gastos del hogar

Alguien en mi hogar:

- ☐ Paga los gastos de atención de niños o adultos.
- ☐ Recibe facturas por gastos escolares, gastos de curador o gastos médicos.
- ☐ Paga manutención infantil ordenada por la corte.

Activos o recursos

Alguien en mi hogar:

- ☐ Adquirió otro auto, camión, bote o motocicleta o se deshizo de uno.
- ☐ Compró o vendió una casa o terreno.
- ☐ Abrió o cerró una cuenta bancaria o una cuenta de pensión.
- ☐ Obtuvo una póliza de seguros o se deshizo de una.

Cobertura médica

Alguien en mi hogar:

- ☐ Cambió el monto de su prima de seguro de salud.
- ☐ Inició el pago o detuvo el pago de primas, incluyendo primas de Medicare.
- ☐ Empezó a recibir otro seguro médico o el actual seguro médico fue abandonado.

Otros cambios

Alguien en mi hogar:

- ☐ Obtuvo un número de seguridad social.
- ☐ Que es un menor, se inscribió en la escuela o la abandonó.

Explique su cambio

Utilice este espacio para explicar los cambios que ha marcado.

Nombre	Número de teléfono ( )
Dirección	
Número de Seguridad Social	Fecha de terminación