INSTRUCTIONS FOR COMPLETING THE IOWA MEDICAID HCBS WAIVER PROVIDER APPLICATION FORM

I. GENERAL SECTION

1-7 Enter the current provider number (leave this field blank if you have no provider number at this time), name, and the address of the provider of service.

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

10 **Telephone Number**. Enter area code and phone number.

11 **Cellular Telephone Number**. Enter area code and phone number, if available.

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

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

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

15 **HCBS Waiver**. Indicate the HCBS waiver program(s) for which application is being made. You may apply for more than one waiver type. Waiver types marked in this question should be the same as the ones circled in question 17 (for individuals) or question 25 (for agencies and businesses).

II. INDIVIDUAL APPLICANTS APPLYING FOR CONSUMER-DIRECTED ATTENDANT CARE

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

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

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

17 Indicate that you are applying for Consumer-Directed Attendant Care by checking the service and standard boxes.

- Individuals who apply to provide Consumer-Directed Attendant Care are required to submit proof of age and must send in a copy of either a birth certificate **OR** a driver's license. The date of birth must be clearly visible or it will not be accepted.
- All of the forms must be completed. Individuals must fill out the W-9 form. All taxes on income earned from providing CDAC services are the responsibility of the individual providing the service.

Note: The CDAC provider cannot bill or be paid for service provided prior to Department of Human Service written approval of this service. That is indicated by the DHS service worker attaching the *HCBS Consumer-Directed Attendant Care Agreement*, form 470-3372, to the service plan in the Ill and Handicapped, AIDS/HIV, Elderly, and Physical Disability waivers. Any payments made prior to the DHS written approval of this service are fraud, and referrals for recovery and prosecution of this federal offense will be made.

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

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

III. AGENCIES AND BUSINESSES APPLYING FOR WAIVER SERVICES

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

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

18-22 Self-explanatory.

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

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

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

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

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

By Member Name. Claims will be reported in alphabetic order by member's last name.

By Member ID. Claims will be reported in numeric order by member's Medicaid ID number.

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

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

27 **Date**. Enter date application is signed. Applications that are not dated will be returned.

Iowa Department of Human Services

Medicaid HCBS Waiver Provider Application

When completed send to:		For questions, contact:
Iowa Medicaid Enterprise Provider Services P.O. Box 36450 Des Moines, IA 50315	**Make sure you have read the instructions before completing this form!**	Provider Services **Tel. (800) 338-7909 or (515) 725-1004 (local)**

Individual applicants applying to provide Consumer-Directed Attendant Care (CDAC) should complete sections I and II. Agencies and businesses applying to provide waiver services should complete sections I and III.

I. GENERAL SECTION

1. Current Provider Number (if already an HCBS provider)	0						

2. Provider Name

3. Mailing Address

4. Street Address (if different from the mailing address)

5. City | **6. State**

7. Zip Code (please enter 9-digit zip code, if known) _ _ _ _ _ – _ _ _ _

8. County Name | **9. County Number**

10. Telephone Number (daytime) ( ) –

11. Cellular Telephone Number (optional) ( ) –

12. Fax Number (if available) ( ) –

13. E-mail Address (please, print)

14. Desired Effective Date for Enrollment (MM/DD/YYYY) (THIS DATE CANNOT BE RETROACTIVE BEFORE THE FIRST OF THE MONTH IN WHICH THE APPLICATION IS SIGNED!) / /

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

- Ill & Handicapped (IH) ☐
- AIDS/HIV (AH) ☐
- Elderly (E) ☐
- Children's Mental Health (CMH) ☐
- Mentally Retarded (MR) ☐
- Brain Injury (BI)* ☐
- Physical Disability (PD) ☐

* – Those wishing to provide services under the Brain Injury waiver need to submit documentation indicating training or experience with persons with brain injury. Training classes are available through DHS. A list of available times and locations is available online at: http://www.dhs.state.ia.us/dhs2005/dhs_homepage/medical_assistance/medical_insurance/help_ownhome.html.

Agencies applying for Home and Vehicle Modifications (HVM), Specialized Medical Equipment (SME), Personal Emergency Response (PERS), and Transportation under the BI waiver are exempt from the training requirement.

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

II. INDIVIDUAL APPLICANTS APPLYING FOR CONSUMER-DIRECTED ATTENDANT CARE

16. Social Security Number				–			–				

17. Indicate that you are applying for Consumer-Directed Attendant Care (CDAC) by checking boxes below and circling the waiver(s) for which you are applying.

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

* A requirement of the BI waiver program is that all providers attend a six hour BI "train the trainer" inservice prior to certification. There is no charge to you for this training. This training can be waived if you have experience or training in working with persons with brain injuries. If you have the experience or training in this area, please submit written documentation with this application.

Upon receipt of the documentation, it will be reviewed for approval. If the documentation is found to be insufficient, you will be required to take BI training. Your application will be forwarded on to an HCBS Regional Specialist who will coordinate the required BI training. The specialist will be in contact with you to inform you of upcoming BI training in your area. You cannot become a BI waiver provider without attending the required training or having the training waived through your experience and training.

A list of available training times and locations can be found on the HCBS website at: http://www.dhs.state.ia.us/MedicalServices/hcbs_waivers.asp.

Read and sign the following statement:

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

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

18. Signature

19. Date			/			/				

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

III. AGENCIES AND BUSINESSES APPLYING FOR WAIVER SERVICES

16. Tax ID Number	–
17. Contact Person ❑ Mr. ❑ Ms.	
18. Do you have any HCBS waiver-related provider numbers in addition to the one shown in question 1? If "yes," please, list them here.	❑ Yes ❑ No
19. Has there been any disciplinary action against you by any licensing boards or certification body?	❑ Yes ❑ No
20. Have you ever been excluded from participation in the Medicare Program? If "yes," please explain on a separate piece of paper.	❑ Yes ❑ No

21. Type of Practice Code (Check One)

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

22. Type of Ownership Code (Check One)

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

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

23. Claims in Process Information (Check one)

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

24. Remittance Sequence (Check one)

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

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

Service and Requirements		Circle the waiver(s) for which you are applying
❑ 01 – Adult Day Care (ADC)		
❑ 70 – Certificate for Adult Day Care services issued by the Department of Inspections and Appeals confirming that the applicant is in compliance with the standards for adult day services programs adopted by the Department of Elder Affairs (attach a copy of the certificate)	→	IH AH E MR BI
❑ 02 – Assistive Devices (AD)		
❑ 61 – Area Agency on Aging as designated in IAC 321 4.4(231) (no supporting documentation required)	→	E
❑ 59 – Contract with Area Agency on Aging (attach a copy of the contract)	→	E
❑ 62 – Letter from Area Agency on Aging stating the organization is qualified to provide the service (attach a copy of the letter)	→	E
❑ 06 – Medical equipment and supply dealers (enter your Medicaid Provider # ______________________________)	→	E
❑ 25 – Behavioral Programming (BP)		
❑ 46 – You will be contacted in regards to submitting policies, procedures, and forms	→	BI

Service and Requirements	Circle the waiver(s) for which you are applying					
	IH	AH	E	MR	BI	PD
❑ 26 – Case Management (CM)						
❑ 47 – Meets 441 IAC – Chapter 24 Case Management (enter your case management # ______________________________) →					BI	
❑ 03 – Chore						
❑ 61 – Area Agency on Aging as designated in IAC 321 4.4(231) (no supporting documentation required) →			E			
❑ 59 – Subcontract with Area Agency on Aging (attach a copy of the subcontract) →			E			
❑ 62 – Letter from Area Agency on Aging stating the organization is qualified to provide the service (attach a copy of the letter) →			E			
❑ 07 – Community Action Agency as designated in IAC 216A.93 (no supporting documentation required) →			E			
❑ 08 – Home Health Agency (enter your Medicare Provider # ______________________________) →			E			
❑ 09 – Home Care Agency with Iowa Department of Public Health contract (attach a copy of the contract or enter your Contract # ______________________________) →			E			
❑ 10 – Nursing Facility Licensed under 135C Code of Iowa (no supporting documentation required) →			E			
❑ 11 – Provider certified under the HCBS MR waiver (no supporting documentation required) →			E			
❑ 04 – Consumer Directed Attendant Care (CDAC)						
❑ 31 – Assisted Living Provider						
❑ 16 – Assisted Living Program accredited/certified by Department of Elder Affairs (attach a copy of the certificate) →			E			
❑ 29 – Agency						
❑ 09 – Home Care Agency with Iowa Department of Public Health contract (attach a copy of the contract or enter your Contract # ______________________________) →	IH	AH	E	MR	BI	PD
❑ 12 – Home Care Agency with written certification from Department of Public Health stating that home care standards and requirements set forth in Department of Public Health rules 641 IAC 80.5(135)-80.7(135) are met (attach a copy of the certificate) →	IH	AH	E	MR	BI	PD
❑ 08 – Home Health Agency (enter your Medicare Provider # ______________________________) →	IH	AH	E	MR	BI	PD
❑ 13 – Chore provider contracting with an Area Agency on Aging (attach a copy of the contract) →	IH	AH	E	MR	BI	PD
❑ 14 – Chore provider with letter of approval from an Area Agency on Aging stating that the organization is qualified to provide chore (attach a copy of the letter) →	IH	AH	E	MR	BI	PD
❑ 07 – Community Action Agency as designated in IAC 216A.93 (no supporting documentation required) →	IH	AH	E	MR	BI	PD
❑ 15 – Provider enrolled under HCBS MR or BI Supported Community Living (no supporting documentation required) →	IH	AH	E	MR	BI	PD
❑ 16 – Assisted Living Program accredited/certified by Department of Elder Affairs (attach a copy of the certificate) →	IH	AH		MR	BI	PD
❑ 83 – IH, AH, E, or BI waiver(s) provider of Adult Day Care services with a letter of notification from the Department of Elder Affairs stating the provider meets the requirements of Department of Elder Affairs rules in 321-Chapter 25 (attach a copy of the letter) →	IH	AH	E	MR	BI	PD
❑ 84 – IH, AH, E, or BI waiver(s) provider of Adult Day Care services with a letter of notification from an Area Agency on Aging stating the provider meets the requirements of Department of Elder Affairs rules in 321-Chapter 25 (attach a copy of the letter) →	IH	AH	E	MR	BI	PD
❑ 05 – Counseling (Couns)						
❑ 22 – Community Mental Health Center (attach a copy of the certificate or enter your Medicaid Provider # or Certificate of Accreditation ______________________________) →	IH	AH				
❑ 23 – Hospice (attach a copy of the license or enter you Certificate of License or Medicare Provider # ______________________________) →	IH	AH				
❑ 24 – Mental Health Service Provider (attach a copy of the Certificate of Accreditation) →	IH	AH				

Service and Requirements	Circle the waiver(s) for which you are applying
❑ 70 – Day Habilitation (DH)	
❑ 73 – Be accredited by the Council on Quality and Leadership (attach current certification and most recent survey report) →	MR
❑ 74 – Be accredited by the Commission on Accreditation of Rehabilitation Facilities for similar services* (attach current CARF certification and most recent CARF survey report) →	MR
❑ 75 – Be accredited by the Commission on Accreditation of Rehabilitation Facilities, but not for similar services*, until next regularly scheduled accreditation at which time the applicant will present documentation to the department that the similar service* requirement is met. HCBS waiver approval will be granted through the expiration date of the current CARF certification (attach current CARF certification and most recent CARF survey report) →	MR
❑ 76 – Previous application for CARF accreditation. Conditional HCBS waiver approval will be granted for a maximum of 12 months from the date of CARF application (Submit a copy of the CARF application. You will be contacted in regards to submitting policies and procedures applicable to day habilitation.) →	MR
❑ 77 – Previous application for Council on Quality and Leadership accreditation. Conditional HCBS waiver approval will be granted for a maximum of 12 months from the date of Council application (submit a copy of the Council application. You will be contacted in regards to submitting policies and procedures applicable to day habilitation.) →	MR
* - Similar services include Personal and Social services, Community Integration services, Community Based Rehabilitation, and Adult Day Care	
❑ 71 – Environmental Modifications, Adaptive Devices and Therapeutic Resources	
❑ 15 – Provider enrolled under HCBS MR or BI Supported Community Living (no supporting documentation required) →	CMH
❑ 45 – Provider previously enrolled as a waiver Home/Vehicle Modifications provider (no supporting documentation required) →	CMH
❑ 39 – Community Business (attach current proof of liability and workers compensation coverage) →	CMH
❑ 40 – Retail and wholesale businesses participating as providers in the Medicaid program (enter your Medicaid Provider # ______________________________) →	CMH
❑ 72 – Family and Community Supports (FCSS)	
❑ 22 – Community Mental Health Center (attach a copy of the certificate or enter your Medicaid Provider # or Certificate of Accreditation ______________________________) →	CMH
❑ 24 – Mental Health Service Provider (attach a copy of the Certificate of Accreditation) →	CMH
❑ 85 – RTSS Provider (attach a copy of the Certificate of Accreditation for Skill Development) →	CMH
❑ 34 – Family Counseling (FC)	
❑ 22 – Community Mental Health Center (attach a copy of the certificate or enter your Medicaid Provider # or Certificate of Accreditation ______________________________) →	BI
❑ 23 – Hospice (attach a copy of the license or enter your Certificate of License or Medicare Provider# ______________________________) →	BI
❑ 24 – Mental Health Service Provider (attach a copy of the Certificate of Accreditation) →	BI
❑ 48 – Qualified brain injury professionals as designated in 441 IAC 83.8(249A) →	BI
❑ 07 – Home Delivered Meals (HDM)	
❑ 61 – Area Agency on Aging as designated in IAC 321 4.4(231) (no supporting documentation required) →	IH AH E
❑ 59 – Subcontract with Area Agency on Aging (attach a copy of the subcontract) →	IH AH E
❑ 62 – Letter from Area Agency on Aging stating the organization is qualified to provide the service (attach a copy of the letter) →	IH AH E
❑ 07 – Community Action Agency as designated in IAC 216A.93 (no supporting documentation required) →	IH AH E
❑ 09 – Home Care Agency with Iowa Department of Public Health contract (attach a copy of the contract or enter your Contract # ______________________________) →	IH AH E
❑ 08 – Home Health Agency (enter your Medicare Provider # ______________________________) →	IH AH E
❑ 26 – Hospital (enter your Medicare Provider # ______________________________) →	IH AH E
❑ 06 – Medical equipment and supply dealers (enter your Medicaid Provider # ______________________________) →	IH AH E
❑ 10 – Nursing Facility Licensed under 135C Code of Iowa (no supporting documentation required) →	IH AH E
❑ 27 – Restaurant licensed and inspected under Iowa Code chapter 137F (attach a copy of the license) →	IH AH E

Service and Requirements	Circle the waiver(s) for which you are applying						
❑ 08 – Home Health Aide (HHA)							
❑ 08 – Home Health Agency (enter your Medicare Provider # ______________________________) →	IH	AH	E	MR			
❑ 09 – Homemaker (HM)							
❑ 09 – Home Care Agency with Iowa Department of Public Health contract (attach a copy of the contract or enter your Contract # ________________________________) →	IH	AH	E				
❑ 08 – Home Health Agency (enter your Medicare Provider # ______________________________) →	IH	AH	E				
❑ 10 – Home/Vehicle Modifications (HVM)							
❑ 61 – Area Agency on Aging as designated in IAC 321 4.4(231) (no supporting documentation required) →	IH		E				
❑ 07 – Community Action Agency as designated in IAC 216A.93 (no supporting documentation required) →	IH		E				
❑ 15 – Provider enrolled under HCBS MR or BI Supported Community Living (no supporting documentation required) →	IH		E	MR	BI	PD	
❑ 45 – Provider previously enrolled as a waiver Home/Vehicle Modifications provider (no supporting documentation required) →	IH		E	MR	BI	PD	
❑ 39 – Community Business (attach current proof of liability and workers compensation coverage) →	IH		E	MR	BI	PD	
❑ 73 – In-Home Family Therapy (IHFT)							
❑ 22 – Community Mental Health Center (attach a copy of the certificate or enter your Medicaid Provider # or Certificate of Accreditation ______________________________) →							CMH
❑ 24 – Mental Health Service Provider (attach a copy of the Certificate of Accreditation) →							CMH
❑ 85 – RTSS Provider (attach a copy of the Certificate of Accreditation for Therapy and Counseling) →							CMH
❑ 21 – Interim Medical Monitoring & Treatment (IMMT)							
❑ 08 – Home Health Agency (enter your Medicare Provider # ______________________________) →	IH			MR	BI		
❑ 80 – Child care center registered pursuant to 441—Chapter 110 (attach a copy of the license) →	IH			MR	BI		
❑ 81 – Preschool registered pursuant to 441—Chapter 110 (attach a copy of the license) →	IH			MR	BI		
❑ 82 – Child development home registered pursuant to 441—Chapter 110 (attach a copy of the license) →	IH			MR	BI		
❑ 15 – Provider enrolled under HCBS MR or BI Supported Community Living (no supporting documentation required) →	IH			MR	BI		
❑ 11 – Mental Health Outreach (MHO)							
❑ 22 – Community Mental Health Center (attach a copy of the certificate or enter your Medicaid Provider # or Certificate of Accreditation ________________________________) →			E				
❑ 12 – Nursing (N)							
❑ 08 – Home Health Agency (enter your Medicare Provider # ______________________________) →	IH	AH	E	MR			
❑ 13 – Nutritional Counseling (NC)							
❑ 07 – Community Action Agency as designated in IAC 216A.93 (no supporting documentation required) →	IH		E				
❑ 08 – Home Health Agency (enter your Medicare Provider # ______________________________) →	IH		E				
❑ 26 – Hospital (enter your Medicare Provider # ________________________________) →	IH		E				
❑ 28 – Licensed dietitian approved by an Area Agency on Aging (attach a copy of the license and the letter from an Area Agency on Aging) →	IH		E				
❑ 10 – Nursing Facility Licensed under 135C Code of Iowa (no supporting documentation required) →	IH		E				
❑ 06 – Personal Emergency Response (PERS)							
❑ 25 – Send information pamphlet →	IH		E	MR	BI	PD	

Service and Requirements	Circle the waiver(s) for which you are applying						
☐ 41 – Prevocational Services (Prevoc)							
☐ 49 – Meet Commission on Accreditation of Rehabilitation Facilities standards for work adjustment service providers (attach current CARF certification and most recent CARF survey report) →					BI		
☐ 69 – Be accredited by the Commission on Accreditation of Rehabilitation Facilities under standards for work adjustment service providers or organizational employment service providers (attach current CARF certification and most recent CARF survey report) →				MR			
☐ 73 – Be accredited by the Council on Quality and Leadership (attach current certification and most recent survey report) →				MR			
☐ 20 – Respite							
☐ 46 – You will be contacted in regards to submitting policies, procedures, and forms →				MR	BI		CMH
☐ 29 – Provider certified under HCBS MR Respite (no supporting documentation required) →	IH	AH	E		BI		CMH
☐ 79 – Provider certified under HCBS BI Respite (no supporting documentation required) →	IH	AH					CMH
☐ 08 – Home Health Agency (enter your Medicare Provider # ______________________________) →	IH	AH	E	MR	BI		CMH
☐ 09 – Home Care Agency with Iowa Department of Public Health contract (attach a copy of the contract or enter your Contract # ______________________________) →	IH	AH	E	MR	BI		CMH
☐ 26 – Hospital (enter your Medicare Provider # ______________________________) →	IH	AH	E	MR	BI		CMH
☐ 10 – Nursing Facility Licensed under 135C Code of Iowa (no supporting documentation required) →	IH	AH	E	MR	BI		CMH
☐ 35 – ICF/MR (enter your Medicaid Provider # ______________________________) →	IH	AH		MR	BI		CMH
☐ 44 – Licensed group living foster care facility (attach a copy of the license) →	IH	AH		MR	BI		CMH
☐ 32 – Camp accredited by the American Camping Association (attach a copy of the certificate) →	IH	AH	E	MR	BI		CMH
☐ 30 – Adult Day Care Providers (no supporting documentation is required) →	IH	AH	E	MR	BI		CMH
☐ 50 – Residential care facility for persons with mental retardation licensed by DIA (attach a copy of the license) →	IH			MR	BI		CMH
☐ 80 – Child care center registered pursuant to 441-Chapter 110 (attach a copy of the license) →	IH	AH		MR	BI		CMH
☐ 81 – Preschool registered pursuant to 441-Chapter 110 (attach a copy of the license) →	IH	AH		MR	BI		CMH
☐ 82 – Child development home registered pursuant to 441-Chapter 110 (attach a copy of the license) →	IH	AH		MR	BI		CMH
☐ 78 – Assisted Living Program certified by the Department of Inspections and Appeals →	IH	AH	E	MR	BI		CMH
☐ 17 – Senior Companion (SC)							
☐ 37 – Designation by Corporation for National and Community Service (attach documentation substantiating the designation) →			E				
☐ 19 – Specialized Medical Equipment (SME)							
☐ 06 – Medical equipment and supply dealers (enter your Medicaid Provider # ______________________________) →					BI	PD	
☐ 40 – Retail and wholesale businesses participating as providers in the Medicaid program (enter your Medicaid Provider # ______________________________) →					BI	PD	
☐ 52 – Supported Community Living (SCL)							
☐ 46 – You will be contacted in regards to submitting policies, procedures, and forms →				MR	BI		
☐ 53 – Provider enrolled under HCBS MR SCL (no supporting documentation required) →					BI		
☐ 54 – Provider enrolled under HCBS BI SCL (no supporting documentation required) →				MR			
☐ 55 – Supported Community Living – 5 Persons (SCL-5)							
☐ 51 – RCF/MR (submit plan to come into compliance with IAC 441 77.37(14)"d"(1) and a copy of 5 bed RCF/PMR licensure) →				MR			
☐ 58 – Supported Community Living – 8 Persons (SCL-8)							
☐ 52 – ICF/MR (submit plan to come into compliance with IAC 441 77.37(14)"d"(1) and a copy of 8 bed ICF/MR licensure) →				MR			

Service and Requirements		Circle the waiver(s) for which you are applying
❑ **61 – Supported Community Living – Residential-Based (SCL-RB)**		
❑ 65 – Group Living Foster Care Facility (submit copy of group living foster care licensure under IAC 441 Chapter 114 and a plan to come into compliance with IAC 441 77.37(23)“e”(3))	→	MR
❑ 66 – Residential Facility for Mentally Retarded Children (submit copy of Residential Facility for Mentally Retarded Children under IAC 441 Chapter 116 licensure and a plan to come into compliance with IAC 441 77.37(23)“e”(3))	→	MR
❑ **62 – Supported Employment (SE)**		
❑ 46 – You will be contacted in regards to submitting policies, procedures, and forms	→	MR BI
❑ 55 – Provider certified under HCBS MR Supported Employment (no supporting documentation required)	→	BI
❑ 56 – Provider certified under HCBS BI Supported Employment (no supporting documentation required)	→	MR
❑ **18 – Transportation (Trans)**		
❑ **67 – Regional Transit Authority**		
❑ 38 – Regional Transit Agency recognized by Iowa Department of Transportation (no supporting documentation required)	→	E MR BI PD
❑ **68 – Area Agency on Aging**		
❑ 61 – Area Agency on Aging as designated in IAC 321 4.4(231) (no supporting documentation required)	→	E MR BI PD
❑ 59 – Subcontract with Area Agency on Aging (attach a copy of the subcontract)	→	E MR BI PD
❑ 62 – Letter from Area Agency on Aging stating the organization is qualified to provide the service (attach a copy of the letter)	→	E MR BI PD
❑ **69 – Mile**		
❑ 07 – Community Action Agency as designated in IAC 216A.93 (no supporting documentation required)	→	E MR BI PD
❑ 10 – Nursing Facility Licensed under 135C Code of Iowa (no supporting documentation required)	→	E MR BI PD
❑ 71 – Accredited HCBS provider (no supporting documentation required)	→	MR
❑ 72 – Contract with county government (attach a copy of the contract)	→	MR

26. Signature of Authorized Official	
27. Date	/ /

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