

Instructions for Certification for Level of Care Home and Community Based Services (HCBS)

- Purpose:** Form 470-4392, *Certification for Level of Care Home and Community Based Services (HCBS)*, provides a mechanism for a Medical Professional (MD/DO/ARNP/PA) to report a Medicaid member's admission, change in condition or annual assessment for level of care. Providers are encouraged to conduct the level of care process during a routine or preventative office visit. See informational letter number **XXX**
- Source:** This form is available on the DHS website under provider forms.
- Completion:** A provider (MD/DO/ARNP/PA) must complete the form when:
- Medicaid member is going to receive services provided in their home or community.
 - Medicaid member has a significant change in condition.
 - Medicaid member has an annual assessment.
- Distribution:** Providers fax / email the certification for level of care form to the IME Medical Services unit (515-725-1349) or imeltc@dhs.state.ia.us and provide a copy to the Medicaid member.
- The form may be faxed by the medical professional completing the form or by others involved in assisting in arranging the services (i.e. facility staff, hospital discharge planner, case manager or family member). The IME Medical Services unit will make a level of care determination upon receipt of the form.**
- Data:**
- Today's Date:** The actual date the form is completed. (MM/DD/YY)
- Iowa Medicaid Member Name:** The Medicaid member's first, middle initial and last name as it appears on the eligibility card.
- Social Security Number or State ID#:** The member's social security number or State ID number as it appears on the eligibility card.
- Birth date:** The Medicaid member's birth date (MM/DD/YY)
- Name, Telephone Number with Area Code:** The medical professional specific information of who is filling out the form.
- Admit to HCBS Waiver:** Contains the specific Medicaid home and community based (HCBS) waiver type.
- Diagnoses and Medications:** The member specific health information related to diagnoses and medications, Supporting documentation, H&P along with a medication list may be submitted with the form in order to complete the review.
- Level of care criteria: Mandatory** criterion sections. Please review each category and check all applicable criteria. Please check **all** that apply, as well as additional comments the medical professional may want/need to add.
- Signature with Title of Medical Professional MD/DO/PA/ARNP:** The signature of the medical professional completing the form.