Iowa Total Care Medicaid HCBS Waiver Provider Application

Basic Information

To avoid delays in the application process, you should:

- Complete all required forms listed below.
- If extra space is needed to answer any questions, please attach any additional pages.
- Type or print all information so that it is legible. Do not use a pencil.
- If any field is not applicable, please enter N/A.
- An incomplete form will delay the application process.
- Attach all required supporting documentation.
- Make sure you read the instructions before completing the application.

Send completed application and all applicable attachments to:

Email: NetworkManagement@IowaTotalCare.com

Facsimile: **1-844-536-2997**

Mail: **Iowa Total Care Attn: Network Contracting**
1370 Timberlake Manor Parkway
Chesterfield, MO 63017

For questions contact:

Network Contracting:
Tel. 1- (855)-688-6589

Individual applicants applying to provide Consumer-Directed Attendant Care (CDAC) must complete and submit the following forms:

- Iowa Total Care Medicaid HCBS Waiver Provider Application (Sections: I and II)
- IRS Form W9 - Signed and Dated
- Iowa State Medicaid Approval Letter and NPI Number
- Copy of General/Professional Liability Insurance in amount of $1M/$3M
- Any applicable certification(s), license(s) or accreditation(s).

Agencies and businesses applying for waiver services must complete the following forms:

- Iowa Total Care Medicaid HCBS Waiver Provider Application (Sections: I and III)
- IRS From W-9 – Signed and Dated
- Iowa State Medicaid Approval Letter and Iowa Medicaid Number
- Copy of General/Professional Liability Insurance in amount of $1M/$3M
- Any applicable certification(s), license(s) or accreditation(s).

Instructions for Completing the Iowa Total Care Medicaid HCBS Waiver Provider Enrollment Application

Reason for Application: Check one box.

I. General Section

1A-C Provider Tax Identification Number; National Provider Identifier (NPI) – Complete this section **only** if you are a current Iowa Medicaid Provider. Enter the NPI for the provider. If you do not have an NPI, enter your ten-digit Iowa Medicaid Provider number (beginning with "X00…). **Iowa Medicaid Number; and CMS Medicare Number if applicable.**

2-7 Demographics: Enter the location information for the provider.

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 Email Address – Enter email address, if available. By providing your email 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 is approved. Providers cannot bill or be paid for service provided prior to the Department of Human Services (DHS) approval of the service enrollment.

15 County of Service – Circle all counties that services will be provided.

II. Individual applicants applying for Consumer-Directed Attendant Care (CDAC)

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 Check each box that applies:

❑ – CDAC waiver types include: Health and Disability (H&D), AIDS/HIV (AH), Elderly (E), Intellectual Disability (ID), and Physical Disability (PD).

❑ – Brain Injury Waiver

18 Sanctions If yes, to any question, please explain on a separate sheet of paper

19-22 Signature – Original signature required. **Date –** Enter the date application is signed

Note: The CDAC provider cannot bill or be paid for service provided prior to Iowa Total Care contract has been .counter-executed and Provider has been issued an effective date

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III. Agencies and businesses applying for waiver services

23 **Tax Identification Number** Enter you Internal Revenue Service (IRS) Tax ID Number

24 **Taxonomy code(s)** Enter the taxonomy code(s)

25 **Sanctions** If yes, to any question, please explain on a separate sheet of paper.

26 Indicate which services you are submitting application for by checking the box next to that service. Under the service you are applying for **check one** of the standards that qualify you or your agency to provide the service. Next to the standard, circle the waiver type for which you are applying and have been approved to provide the service by the Iowa Department of Human Services/Iowa Medicaid Enterprise.

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

28 **Date –** Enter date application is signed. Applications not dated will be returned.

29 **Contact Person –** Enter the name of the person who should be contacted for questions regarding the application

30 **Contact Person Email Address** in the event email correspondence is needed to complete application process.

Once the application process has been received and information verified and approved by Iowa Total Care Credentialing Committee, you will receive notification from the Iowa Total Care if credentialing is approved. Note: although credentialing application will is approved, you will still need to wait until your contract with Iowa Total Care has been counter-executed with an effective date before rendering services to any Iowa Total Care member.

Iowa Total Care Medicaid HCBS Waiver Provider Application

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

Reason for Application: Check one box.

☐ You are a **NEW** enrollee in Iowa Total Care (the Tax Identification or Social Security Number has not been enrolled in Iowa Total Care previously)	☐ You are **RE-Credentialing** your Iowa Total Care provider number/participation.	☐ You are **CHANGING** to a new Tax Identification Number (if you are already participating in Iowa Total Care, but have a new Tax Identification Number)	☐ You are **ADDING-ON** additional services to an existing participating Iowa Total Care provider

1. Provider Tax Identification Number if applicable	–
1 A. National Provider Identifier (NPI)	
1 B. Iowa Medicaid Provider Number	
1 C. CMS Medicare Provider Number if applicable	
1 D. Provider Taxonomy Code(s)	
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. Email Address (please, print)	
14. Desired Effective Date for Enrollment (MM/DD/YYYY)	/ /

15. Circle all counties you will be providing services in:

1 Adair	11 Buena Vista	21 Clay	31 Dubuque	41 Hancock	51 Jefferson	61 Madison	71 O'Brien	81 Sac	91 Warren
2 Adams	12 Butler	22 Clayton	32 Emmet	42 Hardin	52 Johnston	62 Mahaska	72 Osceola	82 Scott	92 Washington
3 Allamakee	13 Calhoun	23 Clinton	33 Fayette	43 Harrison	53 Jones	63 Marion	73 Page	83 Shelby	93 Wayne
4 Appanoose	14 Carroll	24 Crawford	34 Floyd	44 Henry	54 Keokuk	64 Marshall	74 Palo Alto	84 Sioux	94 Webster
5 Audubon	15 Cass	25 Dallas	35 Franklin	45 Howard	55 Kossuth	65 Mills	75 Plymouth	85 Story	95 Winnebago
6 Benton	16 Cedar	26 Davis	36 Fremont	46 Humboldt	56 Lee	66 Mitchell	76 Pocahontas	86 Tama	96 Winneshiek
7 Black Hawk	17 Cerro Gordo	27 Decatur	37 Greene	47 Ida	57 Linn	67 Monona	77 Polk	87 Taylor	97 Woodbury
8 Boone	18 Cherokee	28 Delaware	38 Grundy	48 Iowa	58 Louisa	68 Monroe	78 Pottawattamie	88 Union	98 Worth
9 Bremer	19 Chickasaw	29 Des Moines	39 Guthrie	49 Jackson	59 Lucas	69 Montgomery	79 Poweshiek	89 Van Buren	99 Wright
10 Buchanan	20 Clarke	30 Dickinson	40 Hamilton	50 Jasper	60 Lyon	70 Muscatine	80 Ringgold	90 Wapello	

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

II. Application for Individual Consumer-Directed Attendant Care

16. Social Security Number				–			–				

Service and Requirements

17. Check the box(es) below for each HCBS Waiver program for which application is being made:

❑ – **Consumer-Directed Attendant Care (CDAC)** waiver types include: H&D, AH, E, ID, and PD.

❑ – **Brain Injury Waiver;** waiver type is: BI

18. Sanctions:

If yes, to any question below, please explain on a separate sheet of paper.

❑ **YES**	❑ **NO**	Has you or your entity ever been disciplined, fined, excluded from, debarred, suspended, reprimanded, sanctioned, censured, disqualified or otherwise restricted in regard to participation in the Medicare or Medicaid program, or in regard to other federal or state governmental health care plans or programs?
❑ **YES**	❑ **NO**	Have you or has the entity ever voluntarily relinquished or withdrawn, or failed to proceed with an application in order to avoid an adverse action, or to preclude an investigation or while under investigation relating to personal conduct?
❑ **YES**	❑ **NO**	Have you or has the entity ever been subjected to sanctions by a Professional Review Organization (PSRO or PRO), a Third Party Payer or a Regulatory Agency (CLIA, OSHA, etc.)?
❑ **YES**	❑ **NO**	Have you or has the entity's DEA Registration or State Controlled Substance Certificate (if applicable) ever been denied, suspended or revoked for any reason?
❑ **YES**	❑ **NO**	Has an officer of your Organization ever been convicted of, pled guilty to, or pled "no lo contendere" to any felony including an act of violence, child abuse, or a sexual offense?
❑ **YES**	❑ **NO**	Have you or has the corporation, an officer or board member ever been convicted of a felony?

PROVIDER RESPONSIBILITY STATEMENT

I hereby understand that as a prospective/current Iowa Total Care Health Plan provider, I am solely responsible for ensuring that any licensed practitioners under my employment or working in association with my clinical practice are fully qualified and have all necessary licenses required by all relevant laws to legally perform the assigned functions within my practice. Further, I agree that each such individual must be fully presented to Iowa Total Care Health Plan Credentials Committee for their review and approval, and, absent such affirmative approval, Iowa Total Care Health Plan members assigned to my care may not be treated or assisted by such individuals under my employment or associated to my practice without prior approval from Iowa Total Care Health Plan. Further, from time to time, such licensed practitioners may change, as my practice associates. In all such cases, I accept responsibility for notifying Iowa Total Care Health Plan in a timely manner about these new arrangements and will be responsible for fully cooperating in the submission of completed application forms and providing any other information as may be required to satisfy Iowa Total Care Health Plan credentials/re-credentials requirements for all such individuals associated with my practice.

By applying for participation to the Plan, I hereby fully understand that the information submitted in this application shall be held confidential by the Plan and provided only to individuals connected with the Plan on a need to know basis. Notwithstanding the foregoing, I agree to the following:

- ✓ Participation in the credentialing review functions of the Plan.
- ✓ Authorize the Plan and its representatives to consult with prior or current associates and others who may have information bearing on our professional competence, character, health status, ethical qualifications, ability to work cooperatively with others and other qualifications needed for verification of credentials. This includes such primary source verifications as accreditation bodies, professional liability carriers, State and Federal agencies or any other verification entities required by the Plan's accrediting bodies, CMS, DOM, or other State or Federal regulatory agencies.

- ✓ Consent to an inspection by the Plan and its representatives of all documents that may be material to an evaluation of qualifications and competence. This is applicable if the applicant is not accredited by a nationally recognized accrediting body.
- ✓ Consent to the release of such information for credentialing purposes.

Continued from previous page.

- ✓ Release from liability all representatives of the Plan for their acts performed and statements made, in good faith and without malice, in connection with evaluating the application, credentials and qualification for determination of credentialing status.
- ✓ Acknowledge that I, the Applicant, have the burden of producing adequate information for a proper evaluation of our professional, ethical and other qualifications for credentialing purpose and for resolving any doubts about such qualifications.
- ✓ Acknowledge that any material misstatement in, or omissions from, this application constitute cause for denial of credentialing status or cause for summary for revocation or suspension of privileges and/or dismissal from the participating network.

STATEMENT OF APPLICATION/AUTHORIZATION FOR RELEASE OF INFORMATION

In order to evaluate this application for participation in and/or continued participation in the Plan, the Facility hereby gives permission to the Plan to request from other entities information regarding the Facility's credentials and qualifications. This includes consent to contact the Facility's accreditation agencies, State Regulatory and Licensing Departments, professional liability and workers compensation insurance carriers. The Facility understands that the Plan will use this information in a confidential manner on its own behalf and, if applicable, as an agent for one of its affiliated networks in connection with the administration of the Plan.

The Facility certifies that the information provided and the answers to the questions on this application are accurate and complete. While this application is being evaluated, and if this Facility/Subcontractor is selected or retained, after such selection or retention, the Facility agrees to inform the Plan in writing within 15 days of any changes in the information provided and the answers to questions on the application as a result of developments subsequent to the execution of this application.

The Facility agrees that submission of this application does not constitute selection or retention by the Plan on its own behalf or, if applicable, as an agent for one of its affiliated Plans and if the Facility is initially applying for participation, grants this Facility no rights or privileges in any Plan programs or any program or one of its affiliated Plans until such time as this Facility receives notice of selection.

All information submitted in this application is true and complete to the best of my/our knowledge and belief. A photo copy of this original constitutes our written authorization and requests to release any and all documentation relevant to this application. Said photo copy shall have the same force and effect as the signed original.

19. Signature

20. Date			/			/				

21. Contact Name:

22. Contact email address:

III. Agencies and Businesses applying for waiver services

23. Tax ID Number			–							
24. Taxonomy code(s)										

25.Sanctions: **If yes, to any question below, please explain on a separate sheet of paper.**		
❑ **YES**	❑ **NO**	Has your entity ever been disciplined, fined, excluded from, debarred, suspended, reprimanded, sanctioned, censured, disqualified or otherwise restricted in regard to participation in the Medicare or Medicaid program, or in regard to other federal or state governmental health care plans or programs?
❑ **YES**	❑ **NO**	Has the entity ever voluntarily relinquished or withdrawn, or failed to proceed with an application in order to avoid an adverse action, or to preclude an investigation or while under investigation relating to personal conduct?
❑ **YES**	❑ **NO**	Has the entity ever been subjected to sanctions by a Professional Review Organization (PSRO or PRO), a Third Party Payer or a Regulatory Agency (CLIA, OSHA, etc.)?
❑ **YES**	❑ **NO**	Has the entity's DEA Registration or State Controlled Substance Certificate (if applicable) ever been denied, suspended or revoked for any reason?
❑ **YES**	❑ **NO**	Has an officer of your Organization ever been convicted of, pled guilty to, or pled "no lo contendere" to any felony including an act of violence, child abuse, or a sexual offense?
❑ **YES**	❑ **NO**	Has the corporation, an officer or board member ever been convicted of a felony?

26. Indicate the service(s) for which you are applying and attach proof that the requirement is met.	
Service and Requirements	
Adult Day Care (ADC)	
❑ 70 – Certificate for Adult Day 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 on Aging (attach a copy of the certificate)	
→	HD AH E ID BI
Write in the Counties where you provide services in utilizing county codes listed under Section I General Section; number 15	
Assistive Devices (AD)	
❑ 61 – Area Agency on Aging as designated in IAC 321 4.4(231) (no supporting documentation required) →	E
❑ 39 – Community Business (attach current proof of liability and workers compensation coverage) →	E
❑ 60 – Provider that were enrolled as assistive device providers as of June 30, 2010, based on a contract or letter of approval from an area agency on aging (attach a copy of the letter) →	E
❑ 06 – Medical equipment and supply dealers (enter your Medicaid Provider # (NPI)_____) →	E
Write in the Counties where you provide services in utilizing county codes listed under Section I General Section; number 15	

❑ **Behavioral Programming (BP)**			
❑ 17 – Agencies which are certified under the community mental health center standards established by the mental health and developmental disabilities commission, set forth in 441-24, Divisions I and III	→	BI	MFP
❑ 18 – Agencies which are licensed as meeting the hospice standards and requirements set forth in Department of Inspections and Appeals rules 481-53 or which are certified to meet the standards under the Medicare program for hospice programs	→	BI	MFP
❑ 19 – Agencies which are accredited under the mental health service provider standards established by the Mental Health and Disabilities Commission, set forth in 441-24, Divisions I and IV	→	BI	MFP
❑ 08 – Home Health Agency (enter your Medicare Provider #_____)	→	BI	MFP
❑ 20 – Brain injury waiver providers certified pursuant to rule 441-77.39(249A)	→	BI	MFP
❑ 93 – Provider certified under HCBS BI Behavior Programming (no supporting documentation required)	→		MFP
❑ 94 – A licensed psychologist or psychiatrist	→		MFP
❑ 95 – A behavioral analyst certified by the Behavior Analyst Certification Board (attach certification)	→		MFP
❑ 96 – A licensed mental health counselor	→		MFP
❑ 97 – A licensed social worker	→		MFP
❑ 98 – A licensed advanced registered nurse registered as certified in psychiatric mental health	→		MFP
Requires submission of a complete Provider Quality Management Self-Assessment and must submit policies, procedures and forms			
Write in the Counties where you provide services in utilizing county codes listed under Section I General Section; number 15			

❑ **Chore**		
❑ 39 – Community Business (attach current proof of liability and workers compensation coverage)	→	E
❑ 63– Provider that was enrolled as chore providers as of June 30, 2010, based on a contract with or letter of approval from an area agency on aging (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 – Agencies authorized to provide similar services through a contract with the Department of Public Health (IDPH) for public health services (enter your contract #_____)	→	E
❑ 10 – Nursing Facility Licensed under 135C Code of Iowa (no supporting documentation required)	→	E
Write in the Counties where you provide services in utilizing county codes listed under Section I General Section; number 15		

❑ **Consumer Directed Attendant Care (CDAC)**		
Agency		
❑ 09 – Agencies authorized to provide similar services through a contract with the Department of Public Health (IDPH) for public health services (enter your contract #_____)	→	HD AH E ID BI PD
❑ 08 – Home Health Agency (enter your Medicare Provider #_____)	→	HD AH E ID BI PD
❑ 13 – Chore provider subcontracting with an area agency on aging (attach a copy of the contract)	→	HD AH E ID BI PD
❑ 07 – Community Action Agency as designated in IAC 216A.93 (no supporting documentation required)	→	HD AH E ID BI PD
❑ 15 – Provider enrolled under HCBS ID or BI Supported Community Living (no supporting documentation required)	→	HD AH E ID BI PD
❑ 16 – Assisted Living Program accredited/certified by Department of Inspections and Appeals as designated in IAC 481-69 (Requires submission of a completed Provider Quality Management Self-Assessment)	→	HD AH E ID BI PD
❑ 83 – Provider with a certificate for Adult Day Services issued by the Department of Inspections and Appeals confirming that the applicant is in compliance with standards for adult day services programs adopted by the Department on Aging (attach a copy of the certificate)	→	HD AH E ID BI PD
Write in the Counties where you provide services in utilizing county codes listed under Section I General Section; number 15		
❑ **Assisted Living (On Call)**		
❑ 16 – Assisted Living Program accredited/certified by Department of Inspections and Appeals as designated in IAC 481-69 (attach a copy of the certificate)	→	E
Write in the Counties where you provide services in utilizing county codes listed under Section I General Section; number 15		
❑ **Counseling (Couns)**		
❑ 22 – Community Mental Health Center (attach a copy of the certificate or enter your Medicaid Provider # or Certificate of Accreditation _____	→	HD AH
❑ 23 – Hospice (attach a copy of the license or enter you Certificate of License or Medicare Provider #_____)	→	HD AH
❑ 24 – Mental Health Service Provider (attach a copy of the Certificate of Accreditation)	→	HD AH
Write in the Counties where you provide services in utilizing county codes listed under Section I General Section; number 15		
❑ **Crisis Intervention**		
❑ 102 – Community Mental Health Center (attach a copy of the certificate or enter your Medicaid Provider #_____)	→	MFP
❑ 103 – ICF/ID (enter your Medicaid Provider #_____)	→	MFP
❑ 104 – An agency with a contract to provide crisis intervention services with the Department of Human Services (provide documentation)	→	MFP
Write in the Counties where you provide services in utilizing county codes listed under Section I General Section; number 15		

❑ **Day Habilitation (DH)**		
❑ 73 – Be accredited by the Council on Quality and Leadership (attach current certification and most recent survey report)	→	ID
❑ 74 – Be accredited by the Commission on Accreditation of Rehabilitation Facilities for similar services* (attach current CARF certification and most recent CARF survey report)	→	ID
❑ 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)	→	ID
❑ 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.)	→	ID
❑ 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.)	→	ID
Write in the Counties where you provide services in utilizing county codes listed under Section I General Section; number 15		

❑ **Environmental Modifications, Adaptive Devices and Therapeutic Resources**		
❑ 15 – Provider enrolled under HCBS ID or BI Supported Community Living (no supporting documentation required)	→	CMH
❑ 30 – A provider enrolled under the HCBS Children's Mental Health waiver as a Family and Community Support Services provider	→	CMH
❑ 45 – A provider 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
Write in the Counties where you provide services in utilizing county codes listed under Section I General Section; number 15		

❑ **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
❑ 84– Behavioral Health Intervention providers qualified under 441-77.12(249A)	→	CMH
Write in the Counties where you provide services in utilizing county codes listed under Section I General Section; number 15		

❑ **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 – Individuals who meet the definition of qualified brain injury professionals as designated in 441 IAC 83.81(249A)	→	BI
❑ 33 – Agencies certified as brain injury waiver providers pursuant to rule 441-77.39(249A) that employ staff to provide family counseling who meet the definition of a qualified brain injury professional as set forth in rule 441-83.81(294A)	→	BI
Write in the Counties where you provide services in utilizing county codes listed under Section I General Section; number 15		

❑ Financial Management Services (FMS)

❑ 91 – A credit union that is a cooperative, nonprofit, member-owned and member-controlled, and federally insured through and chartered by either the National Credit Union Administration (NCUA) or the credit union division of the Iowa Department of Commerce (Attach documentation from NCUA or IDC). The financial institution shall complete a financial management readiness review and certification conducted by the department or its designee. → HD AH E ID BI PD

❑ 92 – A financial institution chartered by the office of the Comptroller of the Currency, a Bureau of the U.S. Department of the Treasury, and insured by the Federal Deposit Insurance Corporation (FDIC). The financial institution shall complete a financial management readiness review and certification conducted by the department or its designee. → HD AH E ID BI PD

Write in the Counties where you provide services in utilizing county codes listed under Section I General Section; number 15

❑ Habilitation (HAB)

Home- and community-based habilitation services. To be eligible to participate in the Medicaid program as an approved provider of home- and community-based habilitation services, a provider shall meet the general requirements in subrules 77.25(2), 77.25(3), 77.25(4), and 77.25(5) and shall meet the requirements in the subrules applicable to the individual services being provided. → CM HBHS DH PVH SHE

❑ Case management (CM) Service Providers

- ❑ Case management providers must be accredited under 441 Iowa Administrative Code (IAC) Chapter 24.

❑ Home-Based Habilitation (HBH) Service Providers: (providers must meet any of the following)

- ❑ Certified by the Department of Human Services (DHS or Department) to provide supported community living (SCL) under the HCBS intellectual disability (ID) waiver or the brain injury (BI) waiver.
- ❑ Certified under 441 IAC Chapter 24 to provide supported community living.
- ❑ Accredited by the Commission on Accreditation of Rehabilitation Facilities as a community housing or supported living service provider.
- ❑ Accredited by the Council on Accreditation of Services for Families and Children (COA).
- ❑ Accredited by the Council for Quality and Leadership in Supports for People with Disabilities (CQL).
- ❑ Accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO).

❑ Day Habilitation (DH) Service Providers:

- ❑ Accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF) to provide services that qualify as day habilitation.
- ❑ Not accredited by CARF, but has applied for CARF accreditation; process must be completed within 12 months.
- ❑ Accredited by the Council for Quality and Leadership in Supports for People with Disabilities (CQL).
- ❑ Applied for CQL accreditation; process must be completed within 12 months.
- ❑ Certified under 441 IAC Chapter 24 to provide day treatment or supported community living services.
- ❑ Certified by DHS to provide day habilitation under the HCBS intellectual disability (ID) waiver.
- ❑ Accredited by the International Center for Clubhouse Development (ICCD).
- ❑ Accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO).

❑ Prevocational Habilitation (PVH) Service Providers:

- ❑ Accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF) as an organizational employment service provider or community employment service provider.
- ❑ Accredited by the Council for Quality and Leadership in Supports for People with Disabilities (CQL).
- ❑ Accredited by the International Center for Clubhouse Development (ICCD).
- ❑ Certified by the Department to provide prevocational services under the HCBS intellectual disability waiver or brain injury waiver.

❑ **Supported Employment Habilitation (SEH) Service Providers: Certified by the Department to provide supported employment services under the HCBS ID or BI waiver.** ❑ Accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF) as an employment service provider or community employment service provider. ❑ Accredited by the Council on Accreditation of Services for Families and Children (COA). ❑ Accredited by the Council for Quality and Leadership in Supports for People with Disabilities (CQL). ❑ Accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). ❑ Accredited by the International Center for Clubhouse Development (ICCD).		
Write in the Counties where you provide services in utilizing county codes listed under Section I General Section; number 15		
❑ Home Delivered Meals (HDM)		
❑ 61 – Area Agency on Aging as designated in IAC 17 4.4(231) (no supporting documentation required)	→	HD AH E
❑ 59 – Subcontract with area agency on aging (attach a copy of the subcontract)	→	HD AH E
❑ 07 – Community Action Agency as designated in IAC 216A.93 (no supporting documentation required)	→	HD AH E
❑ 09 – Agencies authorized to provide similar services through a contract with the Department of Public Health (IDPH) for public health services (enter your contract #_____)	→	HD AH E
❑ 08 – Home Health Agency (enter your Medicare Provider #_____)	→	HD AH E
❑ 26 – Hospital (enter your Medicare Provider #_____)	→	HD AH E
❑ 06 – Medical equipment and supply dealers (enter your Medicaid Provider #_____)	→	HD AH E
❑ 10 – Nursing Facility Licensed under 135C Code of Iowa (no supporting documentation required)	→	HD AH E
❑ 27 – Restaurant licensed and inspected under Iowa Code chapter 135F (attach a copy of the license)	→	HD AH E
Write in the Counties where you provide services in utilizing county codes listed under Section I General Section; number 15		
❑ Home Health Aide (HHA)		
❑ 08 – Home Health Agency (enter your Medicare Provider #_____)	→	HD AH E ID
Write in the Counties where you provide services in utilizing county codes listed under Section I General Section; number 15		
❑ Homemaker (HM)		
❑ 09 – Agencies authorized to provide similar services through a contract with the Department of Public Health (IDPH) for public health services (enter your contract #_____)	→	HD AH E
❑ 08 – Home Health Agency (enter your Medicare Provider #_____)	→	HD AH E
Write in the Counties where you provide services in utilizing county codes listed under Section I General Section; number 15		

❑ Home Modifications (HM)	**❑ Vehicle Modifications (VM)**	
❑ 61 – Area Agency on Aging as designated in IAC 17 4.4(231) (no supporting documentation required)	→	HD E
❑ 07 – Community Action Agency as designated in IAC 216A.93 (no supporting documentation required)	→	HD E
❑ 15 – Provider enrolled under HCBS ID or BI Supported Community Living (no supporting documentation required)	→	ID
❑ 45 – Provider enrolled as a waiver Home/Vehicle Modifications provider under another waiver (no supporting documentation required)	→	HD AH E BI PD
❑ 39 – Community Business (attach current proof of liability and workers compensation coverage)	→	HD AH E BI PD
Write in the Counties where you provide services in utilizing county codes listed under Section I General Section; number 15		

❑ 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
❑ 41 – Mental Health professionals licensed pursuant to 645-Chapter 31, 240, or 280 or possessing an equivalent license in another state	→	CMH
Write in the Counties where you provide services in utilizing county codes listed under Section I General Section; number 15		
❑ Interim Medical Monitoring & Treatment (IMMT)		
❑ 08 – Home Health Agency (enter your Medicare Provider #_____)	→	HD ID BI
❑ 15 – Provider enrolled under HCBS ID or BI Supported Community Living (no supporting documentation required)	→	HD ID BI
Write in the Counties where you provide services in utilizing county codes listed under Section I General Section; number 15		
❑ Mental Health Outreach (MHO)		
❑ 22 – Community Mental Health Center	→	E MFP
❑ 94 – A licensed psychologist or psychiatrist	→	MFP
❑ 95 – A behavioral analyst certified by the Behavior Analyst Certification Board	→	MFP
❑ 96 – A licensed mental health counselor	→	MFP
❑ 97 – A licensed social worker	→	MFP
❑ 98 – A licensed advanced registered nurse registered as certified in psychiatric mental health	→	MFP
Write in the Counties where you provide services in utilizing county codes listed under Section I General Section; number 15		
❑ Nurse Delegation (ND)		
❑ 08 – Home Health Agency (enter your Medicare Provider #_____)	→	MFP
❑ 106 – A nurse licensed by the Iowa Nursing Board as a registered or license practical nurse pursuant to IAC 655	→	MFP
Write in the Counties where you provide services in utilizing county codes listed under Section I General Section; number 15		
❑ Nursing (N)		
❑ 08 – Home Health Agency (enter your Medicare Provider #_____)	→	HD AH E ID
Write in the Counties where you provide services in utilizing county codes listed under Section I General Section; number 15		
❑ Nutritional Counseling (NC)		
❑ 07 – Community Action Agency as designated in IAC 216A.93 (no supporting documentation required)	→	HD E
❑ 08 – Home Health Agency (enter your Medicare Provider #_____)	→	HD E
❑ 26 – Hospital (enter your Medicare Provider #_____)	→	HD 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)	→	HD E
❑ 10 – Nursing Facility Licensed under 135C Code of Iowa (no supporting documentation required)	→	HD E
Write in the Counties where you provide services in utilizing county codes listed under Section I General Section; number 15		
❑ Personal Emergency Response (PERS)		
❑ 25 – Send Informational Pamphlet		HD E ID BI PD
Write in the Counties where you provide services in utilizing county codes listed under Section I General Section; number 15		

❑ **Prevocational Services (Prevoc)**		
❑ 49 – Be accredited by The Commission on Accreditation of Rehabilitation Facilities as an organizational employment service provider or a community employment service provider. (attach current certificate and most recent survey report)	→	BI
❑ 69 – Be accredited by The Commission on Accreditation of Rehabilitation Facilities as an organizational employment or a community employment service provider. (attach current certificate and most recent survey report)	→	ID
❑ 73 – Be accredited by the Council on Quality and Leadership in supports for people with disabilities (attach current certification and most recent survey report)	→	ID
Write in the Counties where you provide services in utilizing county codes listed under Section I General Section; number 15		

❑ **Respite**		
❑ 46 – Enrollment criteria met upon IME approval of policies, procedures, and forms	→	ID BI CMH
❑ 29 – Provider certified under HCBS ID Respite (no supporting documentation required)	→	HD AH E BI CMH
❑ 79 – Provider certified under HCBS BI Respite (no supporting documentation required)	→	HD AH CMH
❑ 08 – Home Health Agency (enter your Medicare Provider #_____)	→	HD AH E ID BI CMH
❑ 09 – Agencies authorized to provide similar services through a contract with the Department of Public Health (IDPH) for public health services (enter your contract #_____)	→	ID CMH
❑ 26 – Hospital (enter your Medicare Provider #_____)	→	HD AH E ID BI CMH
❑ 10 – Nursing Facility Licensed under 135C Code of Iowa (no supporting documentation required)	→	HD AH E ID BI CMH
❑ 35 – ICF/ID (enter your Medicaid Provider #_____)	→	HD AH ID BI CMH
❑ 44 – Licensed group living foster care facility (attach a copy of the license)	→	HD AH ID BI CMH
❑ 32 – Camps certified by the American Camping Association (attach a copy of the certificate)	→	HD AH E ID BI CMH
❑ 30 – Provider with a 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 on Aging (attach a copy of the certificate)	→	HD AH E ID BI CMH
❑ 50 – Residential care facility for persons with mental retardation licensed by DIA (attach a copy of the license)	→	HD ID BI CMH
❑ 78 – Assisted Living Program certified by the Department of Inspections and Appeals as designated in IAC 481-69	→	HD AH E ID BI CMH
Write in the Counties where you provide services in utilizing county codes listed under Section I General Section; number 15		

❑ **Senior Companion (SC)**		
❑ 37 – Designation by Corporation for National and Community Service (attach documentation substantiating the designation)	→	E
Write in the Counties where you provide services in utilizing county codes listed under Section I General Section; number 15		

❑ **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
Write in the Counties where you provide services in utilizing county codes listed under Section I General Section; number 15		

❑ **Supported Community Living (SCL)**		
❑ 46 – Enrollment criteria met upon IME approval of policies, procedures, and forms	→	ID BI
❑ 53 – Provider enrolled under HCBS ID SCL (no supporting documentation required)	→	BI
❑ 54 – Provider enrolled under HCBS BI SCL (no supporting documentation required)	→	ID
Write in the Counties where you provide services in utilizing county codes listed under Section I General Section; number 15		

❑ **Residential-Based Supported Community Living (RBSCL)**

❑ 65 – Group Living Foster Care Facility (submit copy of group living foster care licensure under IAC 441-114 and a plan to come into compliance with IAC 441 77.37(23)"e"(3))	→	ID
❑ 66 – Residential Facility for Mentally Retarded Children (submit copy of Residential Facility for Mentally Retarded Children under IAC 441-116 licensure and a plan to come into compliance with IAC 441 77.37(23)"e"(3))	→	ID
Write in the Counties where you provide services in utilizing county codes listed under Section I General Section; number 15		
❑ Supported Employment (SE)		
❑ 31 – An agency that is accredited by the commission on Accreditation of Rehabilitation Facilities as an organizational employment service provider, a community employment service provider, or a provider of a similar service (attach copy of the certificate of accreditation)	→	ID BI
❑ 34 – An agency that is accredited by the Council on Accreditation of Services for Families and Children for similar services (attach copy of the certificate of accreditation)	→	ID BI
❑ 36 – An agency that is accredited by the Joint Commission on Accreditation of Healthcare Organizations for similar services (attach copy of the certificate of accreditation)	→	ID BI
❑ 42 – An agency that is accredited by the Council on Quality and Leadership in Supports for People with Disabilities for similar services (attach copy of the certificate of accreditation)	→	ID BI
❑ 43 – An agency that is accredited by the International Center for Clubhouse Development (attach copy of the certificate of accreditation)	→	ID BI
Write in the Counties where you provide services in utilizing county codes listed under Section I General Section; number 15		
❑ Transportation (Trans)		
❑ 38 – Regional Transit Agency recognized by Iowa Department of Transportation (no supporting documentation required)	→	E ID BI PD
❑ 61 – Area Agency on Aging as designated in IAC 17-4.4(231) (no supporting documentation required)	→	E ID BI PD
❑ 59 – Subcontract with Area Agency on Aging (attach a copy of the subcontract)	→	E ID BI PD
❑ 07 – Community Action Agency as designated in IAC 216A.93 (no supporting documentation required)	→	E ID BI PD
❑ 10 – Nursing Facility Licensed under 135C Code of Iowa (no supporting documentation required)	→	E ID BI PD
❑ 109 – Transportation providers contracting with the nonemergency medical transportation contractor (attach NEMT welcome letter or contract)	→	E ID BI PD
❑ 72 – Contract with county government (attach a copy of the contract)	→	ID
❑ 111 – Provider with purchase of service contracts to provide transportation pursuant to 441 Chapter 150	→	BI
❑ 71 – Accredited provider of home- and community-based services	→	ID
Write in the Counties where you provide services in utilizing county codes listed under Section I General Section; number 15		

PROVIDER RESPONSIBILITY STATEMENT

I hereby understand that as a prospective/current Iowa Total Care Health Plan provider, I am solely responsible for ensuring that any licensed practitioners under my employment or working in association with my clinical practice are fully qualified and have all necessary licenses required by all relevant laws to legally perform the assigned functions within my practice. Further, I agree that each such individual must be fully presented to Iowa Total Care Health Plan Credentials Committee for their review and approval, and, absent such affirmative approval, Iowa Total Care Health Plan members assigned to my care may not be treated or assisted by such individuals under my employment or associated to my practice without prior approval from Iowa Total Care Health Plan. Further, from time to time, such licensed practitioners may change, as my practice associates. In all such cases, I accept responsibility for notifying Iowa Total Care Health Plan in a timely manner about these new arrangements and will be responsible for fully cooperating in the submission of completed application forms and providing any other information as may be required to satisfy Iowa Total Care Health Plan credentials/re-credentials requirements for all such individuals associated with my practice.

By applying for participation to the Plan, I hereby fully understand that the information submitted in this application shall be held confidential by the Plan and provided only to individuals connected with the Plan on a need to know basis. Notwithstanding the foregoing, I agree to the following:

- ✓ Participation in the credentialing review functions of the Plan.
- ✓ Authorize the Plan and its representatives to consult with prior or current associates and others who may have information bearing on our professional competence, character, health status, ethical qualifications, ability to work cooperatively with others and other qualifications needed for verification of credentials. This includes such primary source verifications as accreditation bodies, professional liability carriers, State and Federal agencies or any other verification entities required by the Plan's accrediting bodies, CMS, DOM, or other State or Federal regulatory agencies.
- ✓ Consent to an inspection by the Plan and its representatives of all documents that may be material to an evaluation of qualifications and competence. This is applicable if the applicant is not accredited by a nationally recognized accrediting body.
- ✓ Consent to the release of such information for credentialing purposes.

Continued from previous page.

- ✓ Release from liability all representatives of the Plan for their acts performed and statements made, in good faith and without malice, in connection with evaluating the application, credentials and qualification for determination of credentialing status.
- ✓ Acknowledge that I, the Applicant, have the burden of producing adequate information for a proper evaluation of our professional, ethical and other qualifications for credentialing purpose and for resolving any doubts about such qualifications.
- ✓ Acknowledge that any material misstatement in, or omissions from, this application constitute cause for denial of credentialing status or cause for summary for revocation or suspension of privileges and/or dismissal from the participating network.

STATEMENT OF APPLICATION/AUTHORIZATION FOR RELEASE OF INFORMATION

In order to evaluate this application for participation in and/or continued participation in the Plan, the Facility hereby gives permission to the Plan to request from other entities information regarding the Facility's credentials and qualifications. This includes consent to contact the Facility's accreditation agencies, State Regulatory and Licensing Departments, professional liability and workers compensation insurance carriers. The Facility understands that the Plan will use this information in a confidential manner on its own behalf and, if applicable, as an agent for one of its affiliated networks in connection with the administration of the Plan.

The Facility certifies that the information provided and the answers to the questions on this application are accurate and complete. While this application is being evaluated, and if this Facility/Subcontractor is selected or retained, after such selection or retention, the Facility agrees to inform the Plan in writing within 15 days of any changes in the information provided and the answers to questions on the application as a result of developments subsequent to the execution of this application.

The Facility agrees that submission of this application does not constitute selection or retention by the Plan on its own behalf or, if applicable, as an agent for one of its affiliated Plans and if the Facility is initially applying for participation, grants this Facility no rights or privileges in any Plan programs or any program or one of its affiliated Plans until such time as this Facility receives notice of selection.

All information submitted in this application is true and complete to the best of my/our knowledge and belief. A photo copy of this original constitutes our written authorization and requests to release any and all documentation relevant to this application. Said photo copy shall have the same force and effect as the signed original.

***Name of Provider*_____**
27. Signature of Authorized Official
28. Date
29. Contact Person
30. Contact Person email address: