Iowa Department of Human Services

Level of Care Certification for HCBS Waiver Program

ATTENTION: Fax completed form to IME Medical Services (515) 725-1349.

When completing this form, respond according to what assistance the member needs rather than the availability or member's willingness to accept the assistance.
Medical professionals completing this form must provide a copy to the member.

Today's Date	Iowa Medicaid Member Name	State ID or Social Security #	Birthdate
Provider Name (please print)		Provider Telephone Number with Area Code	

HCBS Program: ☐ AIDS ☐ Elderly ☐ Health & Disability ☐ Physical Disability ☐ Admission ☐ SSR

☐ Attach diagnoses list ☐ Attach medication list

Level of Care Criteria: Mark all that apply. Review each category.

The HCBS waiver program is intended to serve persons who would otherwise require nursing facility placement. Using your medical judgment and knowledge of the person's condition, do you certify this person requires nursing facility level of care? ☐ Yes ☐ No If yes, provide additional information necessary to support this response.

How does the person complete activities of daily living (eating, personal hygiene, dressing, and toileting) when no assistance is available?

Form should be completed in office with member present.

Was the member seen in the office at the time the form was completed? ☐ Yes ☐ No

Cognitive
- ☐ No problem
- ☐ Language barrier
- ☐ Short/long term memory problem
- ☐ Problems with decision making
- ☐ Interferes with ability to do ADLs

Therapy
- ☐ Speech therapy
- ☐ Occupational therapy
- ☐ Physical therapy

Duration of therapy expected: _____

Medications
- ☐ Independent
- ☐ Requires set up
- ☐ Needs administered by others
- ☐ Daily IV
  Duration:_____
- ☐ Daily IM
  Duration:_____
- ☐ Insulin, set dosage
- ☐ Insulin, sliding scale
- ☐ Frequent lab values
- ☐ Age-appropriate

Ambulation
- ☐ Independent
- ☐ Cane
- ☐ Walker
- ☐ Wheelchair
- ☐ Motorized scooter
- ☐ Needs human assistance
- ☐ Age-appropriate child
- ☐ Restraint used
- ☐ Transfer assist

Behaviors
- ☐ Noncompliant
- ☐ Destructive or disruptive
- ☐ Repetitive movements
- ☐ Antisocial
- ☐ Aggressive or self-injurious
- ☐ Anxiety
- ☐ Depression
- ☐ Requires 24-hour supervision
- ☐ None

Tube Feedings
- ☐ Tube feeding

If requires tube feedings, order: _____

Bathing / Grooming

- ☐ Independent
- ☐ Has assist devices, independent
- ☐ Supervision or cueing needed
  - How often:
    - ☐ 1-2 x weekly
    - ☐ 3-4 x weekly
    - ☐ 5-6 x weekly
    - ☐ Daily
- ☐ Physical assistance needed
  - How often:
    - ☐ 1-2 x weekly
    - ☐ 3-4 x weekly
    - ☐ 5-6 x weekly
    - ☐ Daily
- ☐ Age-appropriate child

Dressing

- ☐ Independent
- ☐ Has assist devices, independent
- ☐ Supervision or cueing needed
  - How often:
    - ☐ 1-2 x weekly
    - ☐ 3-4 x weekly
    - ☐ 5-6 x weekly
    - ☐ Daily
- ☐ Physical assistance needed
  - How often:
    - ☐ 1-2 x weekly
    - ☐ 3-4 x weekly
    - ☐ 5-6 x weekly
    - ☐ Daily
- ☐ Age-appropriate child

Elimination

- ☐ Continent
- ☐ Bladder incontinence
- ☐ Bowel incontinence
- ☐ Urinary catheter
- ☐ Colostomy/ostomy
- ☐ Nephrostomy
- ☐ Age-appropriate child

Respiratory

- ☐ No issue
- ☐ O2 use daily
- ☐ O2 PRN
- ☐ Tracheostomy
- ☐ Ventilator
- ☐ Suctioning
  - Frequency:_____

Living Arrangement

- ☐ Lives alone
- ☐ Assisted living
- ☐ Lives with family/spouse
- ☐ Senior apartment
- ☐ Danger to live alone
- ☐ Nursing facility

Skin

- ☐ Intact
- ☐ Ulcer – stage = _____
- ☐ Open wound
- ☐ Daily treatment
- ☐ Treatment PRN
- ☐ Home health for wound care

Eating

- ☐ Independent
- ☐ Assistive devices
- ☐ Requires human assistance excluding meal preparation

I attest the above information is correct.

Signature of Healthcare Professional (MD, DO, ARNP, PA)	Date

Additional comments:	Home services in place: