Iowa Department of Human Services

PACE Program Level of Care Assessment

Attn: Medical Professional

Please fax this form to Iowa Medicaid Enterprise Medical Services at (515) 725-1349. And send a copy to the admitting PACE program.

Today's Date	Iowa Medicaid Member Name	Social Security Number or State ID #	Birth Date

MEDICAL PROFESSIONAL

Name	Telephone Number with Area Code
Address	

ADMIT TO: ☐ PACE Program Admit Date: _____

Name of PACE Provider	Telephone Number with Area Code
Address	

Diagnoses (please list):	Medications (include dose and frequency):
1.	*May Attach H and P or full med list*
2.	1.
3.	2.
4.	3.
5.	4.
6.	5.
7.	6.
8.	7.

Have alternatives to the PACE program been discussed with the individual? (Check one): ☐ Yes ☐ No

LEVEL OF CARE CRITERIA: Under the Criteron section, check all criterions for which the individual requires assistance; and circle the highest level of intervention needed and /or all that apply. In the Behaviors section, check all applicable descriptions.

Criterion:	Behaviors:
☐ Impaired cognitive decision making	☐ Aggressive toward others
☐ Therapy (PT, OT, Speech)	☐ Disruptive
☐ Medications (requires set up, requires administration)	☐ Wandering
☐ Medications (daily IV, daily IM)	☐ Noncompliant
☐ Ambulation (cane, walker, wheelchair, bed bound)	☐ Sexually-inappropriate
☐ Skin (ulcer, open wound)	☐ Psychosocial (depression, anxiety)
☐ Respiratory (dyspnea with exertion, SOB, O2 dependent, trachea)	☐ Other
☐ Incontinence (bowel, bladder)	☐ No behavioral concerns
☐ Needs assistance with (dressing, bathing, grooming)	
☐ Nutrition (recent weight loss, tube feedings, obesity)	
Please attach additional medical or behavioral information to this form.	

Eligibility: **Check as applicable:**	
☐ Medicaid	☐ Dual Medicaid/Medicare
☐ Medicare	☐ Veteran's Assistance
Signature of Health Care Professional: MD, DO, ARNP or PA	Date

Instructions for Level of Care Certification for PACE Program

Purpose: Form 470-4490, *PACE Program Level of Care Assessment*, provides a mechanism for a medical professional (MD/DO/ARNP/PA) to report level of care needs for a Medicaid member's admission or change in condition for level of care. *Please note: It will be important that the medical professional ensures that the "ADMIT TO" section is complete in addition to the "LEVEL OF CARE CRITERIA" section.*

Source: This form is available on the DHS web site under Provider Forms.

Completion: A provider (MD/DO/ARNP/PA) must complete the form when:

- Medicaid member is going to be admitted to a PACE program.
- Medicaid member has a significant change in condition.

For new admissions, the form must be completed by a medical professional that is not employed, under contract or otherwise associated with the PACE program.

Distribution: Providers will fax the certification for level of care form to the IME Medical Services Unit (515-725-1349) and provide a copy to the enrolling PACE organization.

The form may be faxed by the medical professional completing the form or by others involved in assisting in arranging the services (i.e., PACE 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).

Medical Professional Section

Name, Telephone Number with Area Code, and Address: The medical professional specific information of who is filling out the form.

Admit to: The PACE program for level of care certification.

Admit date: The actual date of admission to the PACE program (MM/DD/YY).

PACE Program Section

Name, Telephone Number with Area Code, and Address: The specific information related to the PACE program.

Diagnoses and Medications: The member specific health information related to diagnoses and medications. A copy of the most current history and physical or medication list may be attached.

Options discussion regarding alternatives to PACE program: Indicate whether the options discussion regarding alternatives has or has not taken place.

Level of care criteria: Care needs of the individual applying for admission or continued stay in a PACE program, as well as additional comments the medical professional may want/need to add.

Eligibility: Identify the eligibility category (categories) that apply to the potential PACE participant.

Signature with Title of Medical Professional MD/DO/PA/ARNP: Signature of the medical professional completing the form.