

HOME- AND COMMUNITY-BASED SERVICES ASSESSMENT OR REASSESSMENT

PART A VERIFICATION OF HCBS CONSUMER CHOICE

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| Home- and Community-Based Services (HCBS) | |
| My right to choose a home- and community-based program has been explained to me. I have been advised that I may choose: (1) Home- and Community-Based Services or (2) Medical Institutional Services. I choose: <input checked="" type="checkbox"/> HCBS <input type="checkbox"/> Medical Institutional Services | |
| Signature of Consumer or Guardian or Durable Power of Attorney for Health Care | Date |

PART B ASSESSMENT **Initial Review** **Continued Stay Review**

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|-------------|--------------------------------------|--|
| Client Name | Parent/Guardian Name (if applicable) | Home Telephone No. Work Telephone No. Mother/father work (if applicable) |
|-------------|--------------------------------------|--|

Address

| | | |
|-----------------------------|--|------------------------|
| Birth Date (Month/Day/Year) | Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female | Social Security Number |
|-----------------------------|--|------------------------|

| | | |
|-----------------------|--|------------------|
| Health Care Coverage: | Medicare <input type="checkbox"/> Yes <input type="checkbox"/> No | Medicare Number |
| | Medicaid <input type="checkbox"/> Yes <input type="checkbox"/> No | Medicaid Number |
| | Insurance <input type="checkbox"/> Yes <input type="checkbox"/> No | Insurance Number |

Insurance Name

| | |
|-------------------|------------------|
| Primary Physician | Telephone Number |
|-------------------|------------------|

Primary Physician Address

| | |
|--|--|
| Home Health Agency or Respite Provider Name | Home Health Agency or Respite Provider Name |
| Address | Address |

| | |
|--|--|
| Telephone Number <i>n/a</i> | Telephone Number <i>n/a</i> |
|--|--|

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|--|---|
| Income Maintenance Worker Iowa Dept. of Human Services Name | Service Worker - Iowa Dept. of Human Services Name |
| Address | Address |

| | |
|-----------------------------|-----------------------------|
| Telephone Number | Telephone Number |
|-----------------------------|-----------------------------|

~~Child Health Specialty Clinics Nurse (if applicable)~~

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|--------------------|-----------------------------|
| Name | Telephone Number |
| Address | |

This questionnaire was developed jointly by the Iowa Department of Human Services, the Iowa Foundation for Medical Care, and the Child Health Specialty Clinics. The purpose of this form is to provide information for the required determination and redetermination of the level of care certified by the Iowa Foundation for Medical Care for the Iowa Department of Human Services' waiver programs and to assist in service planning. Some information may be shared with other health care providers involved in your care.

Please complete and return this form promptly. Your signature is verification that the information is correct. **Keep a completed copy of this assessment for your records. You will be asked to update this assessment annually.** A self-addressed, stamped envelope is enclosed for reassessments. If you have questions, please contact the Iowa Foundation for Medical Care Home- and Community-Based Services waiver representative at 1-800-383-1173.

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| Signature of person completing this form | Date |
|--|------|

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| Signature of person completing this form | Date |
|--|------|