

# HEART OF IOWA COMMUNITY SERVICES

## MENTAL HEALTH AND DISABILITY SERVICES



## Management Plan Policies and Procedures

*Serving the Counties of Audubon, Dallas, and Guthrie in Iowa*

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## **Introduction and Vision**

Heart of Iowa Community Services (HICS) was formed under Iowa Code Chapter 28E to create a mental health and disability service region in compliance with Iowa Code 331.390. Within this region, HICS will create a regional management plan designed to improve health, hope, and successful outcomes for the adults and children in our region who have mental health disabilities and intellectual/developmental disabilities, including those with multi-occurring, substance use issues, health issues, physical disabilities, brain injuries, and other complex human service needs.

In accordance with the principles enumerated in the legislative redesign, HICS will work in a quality improvement partnership with stakeholders in the region (providers, families, consumers, and partner health and human service systems) to develop a system of care approach that is characterized by the following principles and values:

- Welcoming and customer-oriented
- Person and family driven
- Recovery/resiliency oriented
- Trauma-informed
- Culturally competent
- Multi-occurring capable

## **GUIDING PRINCIPLES**

- ◆ All service participants receiving mental health, intellectual disability, and developmental disability services, including multi-occurring substance use issues, health issues, physical disabilities, brain injuries, and other complex human service needs in the Heart of Iowa Region have a right to live, work, learn, and recreate to full independence and permanence in the community.
- ◆ All service participants have the right to full community integration, and access to community resources and supports, without discrimination or stigmatization.
- ◆ All service participants and their families have a right to full participation in planning for access to needed services and supports, and to exercise reasonable choice in services and providers of services within the context of available resources and legal limitations.
- ◆ All service participants and their families have a right to responsiveness to cultural and linguistic diversity and to accommodation from service providers to overcome physical or cultural barriers to needed services and supports within the context of available resources/reasonable costs.

## **Basic Framework of the Regional MHDS Services Management Plan**

This regional MHDS Services management plan will describe both the framework for system design that HICS will organize, the process for making progress in the direction of that vision, as well as the specific activities within the system that will be funded and monitored directly by HICS.

This Mental Health & Disability Services Management Plan (hereafter referred to as Plan) defines standards for member counties of Heart of Iowa Community Services.

The plan meets the requirements of Iowa Code section 331.439A and provides for cost-effective, individualized services and supports that assist persons with disabilities to be as independent, productive, and integrated into the community as possible, within the constraints of available resources.

This plan is reviewed annually by the Heart of Iowa Governing Board, the Heart of Iowa Community Services Council, and the staff members of Heart of Iowa Community Services. If you have not been a part of any planning committee, and wish to make suggestions for revision, please write to the Chief Executive Officer for the Heart of Iowa Region. The address for that office is located at the bottom of this page.

In compliance with Iowa Administrative Code (IAC) 441-25 the Plan is written in three parts:

- A. **Policies and Procedures Manual**, includes policies and procedures concerning management and administration of the MHDS plan and is divided into three sections:
  - Service Participant Handbook
  - Plan Administration and System Management
  - Appendixes
- B. **Annual Service and Budget Plan for FY14/15**, which describes our vision for the Mental Health/Developmental Disabilities system and how we plan to reach our vision. It will include:
  - Cost of services
  - Local access points,
  - Targeted case management agencies,
  - Plan for ensuring effective crisis prevention and a description of the
  - Scope of services,
  - Projection of need and cost to meet the need, and
  - Provider reimbursement provisions.
- C. **Annual Review** provides an analysis of data concerning services managed for the previous fiscal year and is due December 1<sup>st</sup> of each year. Copies of this review can be obtained by calling our office after December 1.

### **Contact Individual for the Plan:**

Darci Alt  
Chief Executive Officer  
Heart of Iowa Community Services  
25747 N Avenue, Suite D • Adel, IA 50003  
Phone: Office: (515) 993-5869 • Fax: (515) 993-5872  
E-mail : [darci.alt@dallascountyiowa.gov](mailto:darci.alt@dallascountyiowa.gov)

Heart of Iowa Community Services shall maintain local county offices as the foundation to the service delivery system. A current manual is available in each local Heart of Iowa Community Services office and on the County and Department of Human Services Website.

## **A. Organizational Structure**

### **Governing Board** (IC 331.390)

HICS Organizational structure assigns the ultimate responsibility for the non-Medicaid funded MHDS services with the governing board. Member counties will appoint one of its supervisors from the County Board of Supervisors (or designee) and an alternate member from the County Board of Supervisors to serve as a Director on the Governing Board. The Governing Board shall include two ex-officio and non-voting representatives: one representing individuals who utilize mental health and disability services or an actively involved relative of such an individual and one from service providers in the region. No member shall be an employee of the Department of Human Services.

### **MH/DS Advisory Board** (IC 331.390(2)e; 331.392.(2)l; IAC 441-25.14(l)i)

HICS shall encourage stakeholder involvement by having a regional advisory board assist in developing and monitoring the plan, goals and objectives identified for the service system, and to serve as a public forum for other related MH/DS issues. The MH/DS Advisory Board shall represent stakeholders which shall include, but not be limited to, consumers, family members, county officials, and providers.

HICS will maintain advisory groups as the foundation to the Regional Advisory Board. An individual who utilizes mental health and disability services or an actively involved relative of such an individual and an individual representing providers of the county will be appointed to the Regional Advisory Board by each local advisory group.

The Regional Advisory Board will appoint an individual who utilizes mental health and disability services or an actively involved relative of such an individual and individual representing providers of the region to the Regional Governing Board.

### **Chief Executive Officer**

The Governing Board will appoint the Chief Executive officer as referenced in Iowa Code Section 331.438E. The CEO functions are supervised and evaluated by the Governing Board and the CEO is the single point of accountability to the Governing Board.

### **Administrative Team**

The Regional Administrative Team shall consist of the Directors representing member counties.

The Regional Administrative Team shall remain employees of their respective counties. The Regional Administrative Team shall be assigned the Region's administrative responsibilities, including but not limited to claims processing, contracting, and intakes, so that each of the required functions is performed.

## **B. Service System Management**

HICS shall directly administer the Region MH/DS Plan through the HICS offices and contract with service providers to meet the service needs of the consumers. Member counties shall provide adequate credentialed staff to carry out the administration of this Plan. The staff delegated to the perform functions of Coordinators of Disability Services shall have the qualifications required by IC 331.390(3)b and IAC 441-25.12(2)e.

| <b>County Office</b> | <b>Address</b>  | <b>Phone</b>   |
|----------------------|---|----------------|
| Audubon County       | 318 Leroy Street, Audubon, IA 50025                     | (515) 494-8588 |
| Dallas County        | 25747 N Avenue, Ste. D, Adel, IA 50003                  | (515) 993-1736 |
| Guthrie County       | 200 N. 5 <sup>th</sup> Street, Guthrie Center, IA 50115 | (515) 494-8588 |

### **Risk Management and Fiscal Viability** (IC 331.25.21(1)f)

HICS does not intend to contract management responsibility for any aspect of the regional system of care to any agency or entity. The HICS Regional Board shall retain full authority for the regional system of care and the associated fixed budget.

### **Conflict of Interest**

Funding authorization decisions shall be made by the HICS staff, who shall have no financial interest in the services or supports to be provided. In the event that such a situation occurs, that interest must be fully disclosed to the consumers, counties, and other stakeholders.

### **System of Care Approach Plan** (IAC 441-25.21(1)h)

HICS shall provide leadership and management at the local level for designing a regional system of care for Mental Health and Disability Services. The design of the system will be based on the expectation that individuals and families will have multi-occurring issues of all kinds, and will incorporate an organized quality improvement partnership process to achieve the vision defined at the beginning of this Plan.

**We believe in service participant empowerment.** It is essential that individuals have freedom of choice, and take an active role in deciding what services and supports you need and how those services are to be delivered.

The values upon which the Heart of Iowa Mental Health Services System is based include:

1. Living in the community with all the rights and freedoms of all citizens.
2. The opportunity to be productive, for the benefit of oneself and others.
3. The respect of other community members.
4. The support of friends and of providers who deliver creative services.
5. To have the choice of circumstance and occupation, within the natural limits of income and ability.
6. To be responsible and in control of the future.

Our office is called Heart of Iowa Community Services. We act as an entry point to a regional system of services and supports by taking your Funding Application form, determining your eligibility for county funding, evaluating your needs, and working to create and implement your individualized plan. If we cannot fund a service or support for you, we will refer you to an agency that may be able to help you. If you need a service or support that is not in our county management plan, we will work toward

finding a provider to provide that service or support in our community so that it may be available to you in the future.

We enter into contracts with other agencies, organizations and service providers that provide the specific services and supports you may need. The services that Heart of Iowa contracts with include organizations that operate transportation or para-transit systems; hospitals with rehabilitation, mental health, or long-term care facilities; practitioners such as counselors and therapists, home health care agencies, independent living centers, home and community based waiver providers, and job assistance coaches.

**Within this vision, HICS will work in partnership with providers and other stakeholders to develop services that are:**

- Welcoming and accessible
- Able to emphasize integrated screening, early identification and early intervention
- High quality and, wherever possible, evidence based
- Organized into a seamless continuum of community based support
- Individualized to each consumer with planning that expands the involvement of the consumer.
- Provided in the least restrictive, appropriate setting
- Designed to empower individuals and families as partners in their own care
- Designed to leverage multiple financing strategies within the region including increased use of Medicaid funded services and Iowa Health and Wellness Plan
- Supported by provision of training and technical assistance to individuals and families, as well as to providers and other partners.

**Developing an Integrated Multi-Occurring Capable Trauma Informed System of Care:**

**Implementation of Inter-agency and Multi-system Collaboration and Care Coordination** (IAC 441-25.21(1)n; 441-25.21(1)m)

HICS shall maintain a service delivery approach that builds partnerships within a quality improvement framework to create a broad, integrated process for meeting multiple needs. This approach is based on the principles of interagency collaboration; individualized, strengths-based practices; cultural competence; community-based services; accountability; and full participation of individuals served at all levels of the system. HICS shall work to build the infrastructure needed to result in positive outcomes for individuals served.

In order to accomplish this goal, HICS will collaborate with partners in multiple systems of care including substance recovery, brain injury, mental health and intellectual disabilities. HICS also intends to partner with other regions to develop additional services in order to continue to meet the ongoing multi-occurring needs of the individuals with complex needs served by the HICS Region as well as other Regions within the State of Iowa. HICS recommends that all providers participate in this initiative and encourages providers to develop multi-occurring capability for each program provided in the region, and for all staff.

In addition, HICS shall partner with courts to ensure alternatives to commitment and to coordinate funding for services for individuals under commitment. HICS shall collaborate with the Iowa Department of Human Services, Iowa Department of Public Health, Department of Corrections, Iowa Medicaid Enterprises, other regions, service providers, case management, MCOs, consumers, families and advocates to ensure the authorized services and supports are responsive to individuals' needs consistent with system principles, and cost effective.

HICS shall create committees that focus on Training, Outcomes, Service/Resource development, and Quality Improvement, and other committees as indicated, to organize the tasks, activities, and functions associated with building, implementing, and sustaining systems of care.

**Decentralized Service Provisions** (IAC 441-25.21(1)i)

HICS shall strive to provide services in a dispersed manner to meet the standards of core services by utilizing the strengths and assets of the regional service providers.

**Utilization and Access to Service** (IAC 441-25.21(1)d)s

Within the broad system approach outlined above, HICS will oversee access and utilization to services, and population based outcomes, for the MHDS involved population in the region, in order to continuously improve system design and better meet the needs of people with complex challenges.

In order to accomplish this, HICS will integrate planning, administration, financing, and service delivery using utilization reports from both the region and the state including the following:

- inventory of available services and providers
- utilization data on the services

Results will be analyzed to determine if there are gaps in services or if barriers exist due to:

- service offered
- adequate provider network
- restrictions on eligibility
- restrictions on availability
- location

This information will be used for future planning in the annual service budget plan, improving the system of care approach plan, collaboration with agencies, decentralizing service provisions and provider network formation. In addition, the data elements, indicators, metrics and performance improvement for population management will be continuously improved over time as the region develops increasing capability for managing the needs of its population.

**C. Financing and Delivery of Services and Support** (IAC 441-25.21(1))

**NOTE: This section, and the following sections, except for sections I and J, focus specifically on services directly funded by HICS, within the larger system design partnership described in the previous section.**

Non-Medicaid mental health and disability services funding shall be under the control of the Heart of Iowa Community Services (HICS) Governing Board in accordance with Iowa Administrative Code 441-25.13 (331.391). The HICS Governing Board shall retain full authority and financial risk for the Plan. The finances of the Region shall be maintained to limit administrative burden and provide public transparency.

The HICS Chief Executive Officer and Administrative Team (Team) shall prepare a proposed annual budget. The proposed budget shall be reviewed by the HICS governing board for final approval. The Team shall be responsible for managing and monitoring the adopted budget.

Services funded by HICS are subject to change or termination with the development of the regional MH/DS budget each fiscal year for the period of July 1 to June 30.



The HICS Governing Board has designated Dallas County to act as the Regional Fiscal Agent. The HICS Governing Board will determine an amount of projected MH/DS fund balance to be paid to the Regional Fiscal Agent. Member Counties with a fund balance below the percentage determined by the HICS Governing Board may draw funds necessary to bring the fund balance up to the established percentage.

### **Accounting System and Financial Reporting**

The accounting system and financial reporting to the department conforms to Iowa Code 441- 25.13 (2) (331.391) and includes all non-Medicaid mental health and disability expenditures funded by the Region. Information is separated and identified in the most recent Uniform Chart of Accounts approved by the State County Finance Committee including but not limited to the following: expenses for administration; purchase of services; and enterprise costs for which the region is a service provider or is directly billing and collecting payments.

### **Contracting**

HICS will contract with MH/DS providers whose base of operation is in the region. The region may also honor contracts that other regions have with their local providers. HICS may also choose to contract with providers outside of the Region. A contract shall not be required with providers that provide one-time or as needed services.

All approved provider contracts shall be between the provider and the HICS region (rather than individual counties). All contracts shall be annual contracts utilizing the standard regional contracting agreement. Contracts shall be reviewed by the Contracting/Rate Setting (CRS) Committee who shall make a recommendation to the Administrative team. The Administrative team shall make a recommendation to the Governing Board. All contracts must be approved and signed by the Governing Board Chair or designee.

HICS may develop financial incentives and or outcome measures in order to obtain higher performance outcomes and cost effectiveness. The region may utilize vouchers and other non-traditional means to fund services.

Rates utilized for HICS contracts shall be based on designated cost report or based on rates established by the State of Iowa through HCBS Waiver or Habilitation Services. HICS contracted providers shall not accept rates or terms lower than another contracted with HICS from any other region or county.

### **Funding**

Funding shall be provided for appropriate, flexible, cost-effective community services and supports to meet consumer needs in the least restrictive environment possible. HICS recognizes the importance of individualized planning for services and supports to empower all consumers to reach their fullest potential.

An individual who is eligible for publicly funded services and other support must apply for and accept such funding and support. Failure to do so shall render the individual ineligible for regional funds for services that would have been covered under funding, unless the region is mandated by state or federal law to pay for said services.

Individuals, who are in immediate need and are awaiting approval and receipt of assistance under other programs, may be considered eligible if all other criteria are met.

HICS shall be responsible for funding only those services and supports that are authorized in accordance with the process described in the MH/DS Plan, within the constraints of budgeted dollars. HICS shall be the funder of last resort and regional funds shall not replace other funding that is available.

## **D. Enrollment** (IAC441-25.21(1)e)

### **Application and Enrollment**

#### **Intake Process:**

In order to receive Heart of Iowa Mental Health/Disabilities Services funding for desired services, individuals in Heart of Iowa Region must meet certain diagnostic, income, and resource criteria. To start the enrollment process, a written Funding Application form must be completed. You, and/or your legal representative may apply for regional funding for services by contacting any HICS Community Services office or you may contact one of the designated access points (Attachment A) to complete an application (Forms Appendix). Staff members at Heart of Iowa Community Services can help you fill out the Funding Application form. If you like, you can bring along a friend, family member or other individual familiar with your personal matters. All applications shall be forwarded to the Community Services office in the county where the applicant lives. That office shall determine eligibility for funding.

**What information will be asked on the Funding Application form?** You will be asked to provide information about your disability, health, education, work history, income, benefits, insurance, and other matters. The Funding Application form also requires us to gather information about others who live in your household or who are responsible for your support. We will also want to know where you have lived in the past, so we can determine if Heart of Iowa has the responsibility to pay for the services and supports for which you qualify. A copy of the Funding Application form can be found in the Heart of Iowa Community Services Approved Forms section of this document. Please call us if you do not have the complete version of this Plan and would like a Funding Application form.

If further information is needed, you will be requested to sign a release of information form so that we can obtain the information that we need to make a decision regarding the services you have requested.

The HICS application shall be used for all applications. If language or other barriers exist, the access points shall contact an appropriate person to assist the applicant in the intake process or contact the local Community Services office to make such arrangements. The completed application shall be forwarded by access points to the local Community Services office by the end of the business day.

HICS staff shall review the application in a timely manner to determine if all necessary information is present and complete on the application. If the application is incomplete the application shall be returned to the applicant requesting additional information. Failure to respond with necessary information and/or to provide a fully completed application may result in a delay or denial of funding.

#### **Residency**

If an individual has complied with all information requests, your access to services shall not be delayed while awaiting a determination of legal residence. In these instances, HICS shall fund services and later seek reimbursement from the county of legal residence.

*County of residence*” means the county in this state in which, at the time a person applies for or receives services, the person is living and has established an ongoing presence with the declared, good

faith intention of living in the county for a permanent or indefinite period of time. The county of residence of a person who is a homeless person is the county where the homeless person usually sleeps. A person maintains residency in the county in which the person last resided while the person is present in another county receiving services in a hospital, a correctional facility, a halfway house for community-based corrections or substance-related treatment, a nursing facility, an intermediate care facility for persons with an intellectual disability, or a residential care facility, or for the purpose of attending a college or university.

### **Exception to Policy**

Exception to Policy may be considered in cases when a consumer is significantly adversely affected by the regional eligibility policy. To request an Exception to Policy, the consumer or the consumer's service coordinator shall submit the following information:

- Consumer's name
- Current services the consumer is receiving
- The policy for which the exception is being requested
- Reason why the exception should be granted

The HICS staff will review the exception and a response will be given to the consumer and, when appropriate, the service coordinator within 10 working days. Decisions on requests shall be used in the annual report to identify future changes in policy.

### **Confidentiality**

We want to assure you that your privacy will be respected and protected both in and out of our offices. No personal information will be shared with others unless you give us written permission or we are required by law to do so. You will be asked to sign release forms that authorize us to talk with other individuals and organizations. To that end, all persons, including HICS staff, Governing Board, and others with legal access to consumer information, shall have an obligation to keep consumer information confidential. Information shall only be released in accordance with HIPAA and other federal and state laws and in accordance with professional ethics and standards. Confidential information will be released only when it is in the best interest of the consumer to whom the information pertains or when required by law.

Confidential information may be released without written permission of the consumer or their guardian for medical or psychological emergencies and inspection by certifying or licensing agencies of the state or federal government.

Consumer files will be maintained for seven years following termination of service to the consumer.

Procedures to assure confidentiality shall include:

- Consumer's (or their legal guardian's) written consent shall be obtained prior to release of any confidential information, unless an emergency as stated above.
- Information or records released shall be limited to only those documents needed for a specific purpose.
- Consumer, or an authorized representative, shall be allowed to review and copy the consumer record.
- Consumer and related interviews shall be conducted in private settings.
- All discussion and review of consumer's status and/or records by CPC staff, case managers, and others shall be conducted in private settings.

- All paper and computer files shall be maintained in a manner that prevents public access to them.
- All confidential information disposed of shall be shredded.
- Steps shall be taken to assure that all fax, email, and cellular phone transmissions are secure and private.
- Staff shall receive initial and ongoing training concerning confidentiality and staff shall sign a statement agreeing to confidentiality terms.

In order to determine eligibility for regional funding, perform ongoing eligibility review, and to provide service coordination and monitoring, you or your authorized representative shall be requested to sign release forms. Failure to sign or authorize a release of information shall not be an automatic reason for denial; however, HICS staff's inability to obtain sufficient information to make an eligibility determination may result in denial of regional funding.

## **E. Eligibility** (IAC 441-25.21(1)c)

### **GENERAL ELIGIBILITY**

#### **What happens after I submit my completed Funding Application form and supporting documents?**

You may receive funding if you meet our eligibility requirements as follows:

- The individual is at least eighteen years of age.
- **OR.....** An individual who is seventeen years of age, is a resident of this state, and is receiving publicly funded children's services may be considered eligible for services through the regional service system during the three-month period preceding the individual's eighteenth birthday in order to provide a smooth transition from children's to adult services.
- An individual less than 18 years of age and a resident of the state may be considered eligible for those mental health services made available to all or a portion of the residents of the region of the same age and eligibility class under the county management plan of one or more counties of the region applicable prior to formation of the region. Eligibility for services under paragraph "b" is limited to availability of regional service system funds without limiting or reducing core services, and if part of the approved regional service system management plan.
- The individual is a legal resident of the state.

### **FINANCIAL ELIGIBILITY**

The individual complies with financial eligibility requirements in IAC 441-25.16

1. **Income Guidelines:** (IC 331.395.1)
  - a. Gross incomes 150% or below of the current Federal Poverty Guidelines. (Attachment B) At the discretion of the HICS, applicants with income above 150% may be eligible for regional funding with an individual copayment as specified in this manual. (Attachment D)
  - b. The income eligibility standards specified herein shall not supersede the eligibility guidelines of any other federal, state, county, or municipal program. The income guidelines established for programs funded through Medicaid (Waiver programs, Habilitative Services, etc.) shall be followed if different than those established in this manual.

- c. In determining income eligibility, the average monthly income for the past 3 months will be considered, however, recent employment and/or income changes may be considered by the HICS in determining income eligibility. Applicants are expected to provide proof of income (including pay stubs, income tax return, etc.) as requested by HICS.

**2. Resources Guidelines:** (IC 331.395)

- a. An individual must have resources that are equal to or less than \$2,000 in countable value for a single-person household or \$3,000 in countable value for a multi-person household or follow the most recent federal supplemental security income guidelines.
- b. The countable value of all countable resources, both liquid and non-liquid, shall be included in the eligibility determination except as exempted in this sub rule.
- c. A transfer of property or other assets within five years of the time of application with the result of, or intent to, qualify for assistance may result in denial or discontinuation of funding.
- d. The following resources shall be exempt:
  - i. The homestead, including equity in a family home or farm that is used as the individual household's principal place of residence. The homestead shall include all land that is contiguous to the home and the buildings located on the land.
  - ii. One automobile used for transportation.
  - iii. Tools of an actively pursued trade.
  - iv. General household furnishings and personal items.
  - v. Burial account or trust limited in value as to that allowed in the Medical Assistance Program.
  - vi. Cash surrender value of life insurance with a face value of less than \$1,500 on any one person.
  - vii. Any resource determined excludable by the Social Security Administration as a result of an approved Social Security Administration work incentive.

If an individual does not qualify for federally funded or state-funded services or other support, but meets all income, resource, and functional eligibility requirements of this chapter, the following types of resources shall additionally be considered exempt from consideration in eligibility determination:

- A retirement account that is in the accumulation stage.
- A medical savings account.
- An assistive technology account.
- A burial account or trust limited in value as to that allowed in the Medical Assistance Program. An individual who is eligible for federally funded services and other support must apply for and accept such funding and support.

## **Co-payment for services**

Any co-payments or other client participation required by any federal, state, region, or municipal program in which the individual participates shall be required to be paid by the individual. Such co-payments include, but are not limited to:

- Client participation for maintenance in a residential care facility through the state supplementary assistance program.
- The financial liability for institutional services paid by counties as provided in Iowa Code sections 230.15.
- The financial liability for attorney fees related to commitment as provided by Iowa Code section 229.19.

Co-payments in this section are related to core services to target populations as defined in Iowa Code 331.397. No co-payment shall be assessed to individuals with income equal to or less than 150 percent of the federal poverty level, as defined by the most recently revised poverty income guidelines published by the U.S. Department of Health and Human Services.

Individuals with income over the established guidelines may be eligible for services on a sliding fee scale as shown in Attachment D. A co-payment is required for those individuals with incomes between 150%-250% of poverty. This amount is collected by the service agency.

## **Diagnostic Eligibility**

The individual must have a diagnosis or co-occurring diagnosis that includes Mental Illness or Intellectual Disability:

### **1. Mental Illness**

Individuals who at any time during the preceding twelve-month period had a mental health, behavioral, or emotional disorder or, in the opinion of a mental health professional, may now have such a diagnosable disorder. The diagnosis shall be made in accordance with the criteria provided in the most recent diagnostic and statistical manual of mental disorders published by the American Psychiatric Association, and shall not include the manual's "V" codes identifying conditions other than a disease or injury. The diagnosis shall also not include substance-related disorders, dementia, antisocial personality, or developmental disabilities, unless co-occurring with another diagnosable mental illness.

### **2. Intellectual Disability**

Individuals who meet the following three conditions:

1. Significantly sub average intellectual functioning: an intelligence quotient (IQ) of approximately 70 or below on an individually administered IQ test (for infants, a clinical judgment of significantly sub average intellectual functioning) as defined by the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, American Psychiatric Association.
2. Concurrent deficits or impairments in present adaptive functioning (i.e., the person's effectiveness in meeting the standards expected for the person's age by the person's cultural group) in at least two of the following areas: communication, self-care, home living, social and interpersonal skills, use of community resources, self-direction, functional academic skills, work, leisure, health, and safety.
3. The onset is before the age of 18.

The results of a standardized assessment support the need for intellectual disability services of the type and frequency identified in the individual's case plan.

(Criteria from "Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition Revision (DSM IV)," 1994 revision, American Psychiatric Association) or the most recent approved by the State of Iowa.

### **Acceptable verification for Diagnostic requirements**

If a psychological or psychiatric evaluation or other acceptable verification of diagnosis is not available, HICS may refer the applicant to an appropriate mental health professional for evaluation to verify and document a diagnosis.

### **Assistance to Other than Core Populations (IAC441-25.21(1)2)**

If funds are available and the population category was covered in at least one of the county's previous MH/DS plan, HICS shall fund services to individuals who have a diagnosis of a developmental disability other than an intellectual disability and children to the extent allowable by law.

1. *"Persons with developmental disabilities"* means a person with a severe, chronic disability which:
  - a. Is attributable to mental or physical impairment or a combination of mental and physical impairments.
  - b. Is manifested before the person attains the age of 22.
  - c. Is likely to continue indefinitely.
  - d. Results in substantial functional limitations in three or more of the following areas of life activity: self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, and economic self-sufficiency.
  - e. Reflects the person's need for a combination and sequence of services which are of lifelong or extended duration.

### **Notice of Decisions/Timeframes | Notice of Eligibility for Assessment**

Once a fully completed application is received in a HICS County office, HICS staff shall determine if your application meets the general eligibility criteria within 10 days. A Notice of Enrollment shall be sent to you with the decision. You will also receive information on how to schedule the standardized assessment as defined in Section F of this manual within 90 days. You will also be sent a copy of the Region's appeal process and be informed of your right to appeal the decision.

### **Service and Functional Assessment (IAC441-25.21(1)(o))**

The standardized functional assessment methodology designated by the director of human services shall be completed within 90 days of application. The type and frequency of service provided shall be determined by the results of the assessment and identified in your case plan.

### **Service Funding Authorization (IAC441-25.21(1)(o))**

The Notice of Decision shall be sent to you regarding the action taken on your application, reason for the action, service provider, services and units of services approved based on results from the standardized assessment. You will be sent a copy of the Region's appeal process and informed of your right to appeal the decision.

All individuals that receive ongoing MH/DS services shall have an individualized plan which shall identify your needs and desires and set goals with action steps to meet those goals. Eligible individuals that request or accept the service may be referred to a targeted case manager for service coordination. Other individuals shall receive individualized service coordination from HICS staff.

**Re enrollment**

Individuals must reapply for services on at least an annual basis.

**F. Appeals Processes**

**Non Expedited Appeal Process**

Individuals, families, representatives (with the consent of the individual), and providers may appeal the decisions of the region or any of its designees or contractors at any time. Such individuals or organizations may also file a grievance about the actions or behavior of a party associated with the regionally managed system of care at any time.

**How to Appeal:**

Written appeal forms, with a clear description of the appeals, investigation, and disposition process, and the telephone number for submitting a verbal appeal or grievance shall be attached to the Notice of Decision form. Assistance in completing the appeal form shall be provided upon request.

To appeal, a completed appeal form must be sent to the Heart of Iowa Community Services Office that the Notice of Decision was received from (see table below) within ten (10) working days of receipt of the Notice of Decision.

| County Office                     | Address  | Phone          |
|-----------------------------------|--|----------------|
| Audubon County Community Services | 318 Leroy Street<br>Audubon, IA 50025          | (515) 494-8588 |
| Dallas County Community Services  | 25747 N Avenue, Suite D<br>Adel, IA 50003      | (515) 993-5869 |
| Guthrie County Community Services | 200 N. 5th Street,<br>Guthrie Center, IA 50115 | (515) 494-8588 |

**Reconsideration** - The Heart of Iowa Community Services Director or the director’s designee located in the county that sent the Notice of Decision, shall review appeals and grievances. After reviewing an appeal, the Heart of Iowa Community Services Director shall contact the appellant not more than five (5) working days after the written appeal is received. The Heart of Iowa Community Services Director shall collect additional information from the appellant and other sources, if necessary and consent is given. Following a review of additional information and all relevant facts, a written decision shall be issued no later than five (5) working days following the contact with the appellant. A copy of the decision shall be sent to the appellant and/or representative by regular mail.

**Administrative Review** - If a resolution is not agreed upon through Reconsideration step, then the appellant can follow this step and a meeting shall be arranged with the HICS Management Team within ten (10) working days of the final decision of the Reconsideration step. The appellant shall be notified of the meeting time, day, and location of this meeting by regular mail.

During the meeting with the appellant, the HICS Administrative Team shall discuss the facts of the decision and will consider additional information the appellant submits relevant to the appeal. A written decision shall be issued no later than five (5) working days following the date of the meeting. A copy of the decision shall be sent to the appellant and/or representative by regular mail.



If a resolution is not agreed upon through Administrative Review, then the appellant can pursue a hearing through a state Administrative Law Judge (ALJ). The decision of the state ALJ shall be the final decision.

Heart of Iowa Community Services shall not pay legal fees for an appellant. If you cannot afford legal representation, you may contact Legal Services of Iowa at 1-800-532-1275 or <http://www.iowalegalaid.org/>

### **Expedited Appeals Process**

This appeals process shall be performed by a mental health professional who is either the Chief Executive Officer of the Division of Mental Health and Disability Services of the Iowa Department of Human Services or the Chief Executive Officer's designee. The process is to be used when the decision of Heart of Iowa Community Services concerning an individual varies from the type and amount of service identified to be necessary for the individual in a clinical determination made by a mental health professional and the mental health professional believes that the failure to provide the type and amount of service identified could cause an immediate danger to the individual's health and safety.

**How to appeal:** Using the written appeal forms that will be attached to the Notice of Decision form:

1. The appeal shall be filed within 5 days of receiving the notice of decision by Heart of Iowa Community Services. The expedited review, by the Chief Executive Officer or designee shall take place within 2 days of receiving the request, unless more information is needed. There is an extension of 2 days from the time the new information is received
2. The Chief Executive Officer shall issue an order, including a brief statement of findings of fact, conclusions of law, and policy reasons for the order, to justify the decision made concerning the expedited review. If the decision concurs with the contention that there is an immediate danger to the individual's health or safety, the order shall identify the type and amount of service, which shall be provided for the individual. The Chief Executive Officer or designee shall give such notice as is practicable to individuals who are required to comply with the order. The order is effective when issued.
3. The decision of the Chief Executive Officer or designee shall be considered a final agency action and is subject to judicial review in accordance with section 17A.19.

## **G. Provider Network Formation and Management** (IAC 441-25.21 (1j))

HICS shall have a network of service providers to meet the continuum of service needs of individuals. The Region retains the right to select service providers to be a part of the HICS provider network. Providers must be approved HICS MH/DS network providers in order to be eligible for regional funding. (Payment for commitment related sheriff transportation and court-appointed attorneys, and other incidental or temporary services, may be exempt from this policy.)

To be included in the Regional MH/DS provider network, a provider must meet at least one of the following criteria:

- Currently licensed, accredited or certified by the State of Iowa, or
- Currently enrolled as a Medicaid provider, or

- Have a current accreditation by a recognized state or national accrediting body (Joint Commission on Accreditation of Health Care Organization-JCAHO; Council on Rehabilitation Facilities-CARF; etc.
- Currently has a contract with HICS or another Iowa county

All providers included in the HICS MH/DS provider network subject to licensure or accreditation shall meet all applicable standards and criteria. Current network providers that lose their licensure and/or accreditation or are in jeopardy of losing their licensure and/or accreditation may be removed from the provider network and all consumers receiving services from the provider may be transferred to another network provider. If the situation warrants an immediate change in providers, the region shall transfer consumers to another network provider.

In addition to the above, HICS is currently encouraging, and will eventually require, that all providers participate in the quality improvement partnership for system development in the region, to become welcoming, person/family-centered, trauma informed, and multi-occurring capable, and to agree to participate in the Charter activities described in Appendix A.

The current HICS MH/DS network is included in the Annual Service and Budget Plan.

New providers may be added to the provider network if it is determined either a particular consumer will benefit from the service (as determined by the consumer's inter-disciplinary team), or, that the provider will provide service(s) that will enhance the service system. New network providers shall be approved through the following process:

- A referral or request for a new network provider may be made by an individual (or authorized representative), consumer's case manager or social worker, or directly by a provider. All requests to become a member shall be directed to the Region.
- Provider shall complete a Provider Network Application.
- Provider applicant shall be screened by the Region. Provider may be asked to meet for an interview or provide additional information.
- The Region shall inform the provider of acceptance or denial.
- New network providers shall receive appropriate orientation and training concerning HICS's MH/DS Plan.

HICS shall manage the provider network to ensure individual needs are met. HICS shall ensure an adequate number of providers are available to avoid waiting lists by contracting with outpatient mental health providers, Community Mental Health Centers, at least one inpatient psychiatric hospital (currently Mary Greeley Medical Center) and other providers of core services.

### **Designation of Targeted Case Management Providers**

HICS shall offer a choice and access to cost effective conflict free Targeted Case Management and designated Targeted Case Management agencies to offer services to individuals enrolled in the Medicaid Program.

Designated Case Management agencies serving the HICS must be accredited by the Department of Human Services. Targeted Case Managers must meet the qualifications as defined in IAC 441

Targeted Case Management and Service Coordination Services shall meet the following expectations:

- Performance and outcome measures relating to the safety, work performance and community residency of the individuals receiving the service

- Standards including but not limited to social history, assessment, service planning, incident reporting, crisis planning, coordination, and monitoring for individuals receiving the services.
- Methodologies for complying with the requirements of sub rule 25.21 g which may include the use of electronic recording keeping and remote or internet based training

## **H. Quality Management and Improvement**

HICS shall have a quality improvement process that provides for ongoing and periodic evaluation of the service system, and of the providers of services and supports in the system. Stakeholders, with emphasis on consumer input, shall be involved in the development and implementation of the quality improvement program.

### **System Evaluation**

The system evaluation shall include, but not be limited to:

- Evaluation of consumer satisfaction, including empowerment and quality of life;
- Provider satisfaction; patterns of service utilization; responsiveness to consumer needs and desires;
- Improvement of welcoming, person/family centered, hopeful, strength based, trauma informed, multi-occurring capable care;
- Improvement of the ability of providers to work in partnership with each other and with the regional management team to share collective responsibility for the population in the region;
- The number and disposition of consumer appeals and the implementation of corrective action plans based on these appeals;
- Cost-effectiveness;
- Additional outcomes and performance measures outlined by the Department of Human Services.

Annually, HICS Governing Board shall assess the region's performance and develop a list of priority areas needing improvement. All staff shall participate in developing a program plan that includes measurable goals and action steps with a process of collecting data. Based on the data, areas needing improvement shall be addressed.

The HICS Administrative Team shall evaluate the levels of improvement resulting from the program plan and determine if further action is needed with the assistance of staff. This shall be documented in the annual summary.

### **Quality of Provider Services**

The services and supports evaluation shall include, but not be limited to:

- Evaluation of the quality of provider services and supports based on consumer satisfaction and achievement of desired consumer outcomes;
- The number and disposition of appeals of provider actions and the implementation of corrective action plans based on these appeals;
- Cost-effectiveness of the services and supports developed and provided by individual providers.

The evaluations shall ensure that services and supports are provided in accordance with provider contracts.

### **Methods utilized for quality improvement**

- Direct interaction and feedback from consumers, families, providers, case managers, service coordinators, and other stakeholders.
- Needs assessments, satisfaction surveys, and other written questionnaires.
- Use of the CCISC multi-occurring capability toolkit, and program tracking tools to monitor progress on the implementation of multi-occurring capability.
- Establishment and maintenance of a data collection and management information system oriented to the needs of consumers, providers, and other programs or facilities.
- Tracking changes and trends in the disability services system and providing reports to the Department of Human Services annually on or before December 1, for the preceding fiscal year the following information for each individual served:
  - demographic information
  - expenditure data
  - data concerning the services and other support provided to each individual, as specified in administrative rule adopted by the commission.

## **I. Service Provider Payment Provisions** (IAC 441-25.21(1)k)

Each service provider shall provide monthly billing invoices and other information requested of the provider for utilization review. The monthly billings shall include the following information:

- Name and unique identifier of each consumer served during the reporting period.
- Number of units of service delivered to each consumer served.
- When requested, attendance records.
- Unit rate and total cost of the units provided to each individual consumer.
- Copayments or other charges billed to other sources shown as deductions on the billing.
- Actual amount to be charged to the Region for each consumer for the period.

HICS staff shall review the billings and additional utilization information in comparison with service funding authorizations in place. Non-emergency services delivered without service funding authorization shall be deducted from the billing.

All eligible bills shall be paid within 60 days of receipt of required documentation unless unforeseen circumstances exist.

No billings received more than 60 days after the close of the fiscal year in which the service was provided shall be considered for payment by HICS unless there is a statutory obligation. Fiscal year for HICS is July 1 – June 30.

It is the intent of HICS that only HICS staff shall authorize services for residents of the HICS region. Due to that, it is the policy of HICS that if another county, or the State, determines residency in error or approves services for persons who do not have residency in their region, HICS may not assume retroactive payment. When written notification is received by HICS of the error, HICS staff shall authorize services according to the policies and procedures set forth in this manual.

## **J. Waiting List Criteria** (IAC 441-25.21(1)r)

HICS may implement a waiting list if encumbered expenses for a given fiscal year exceed MH/DS funds available. Core Services for target populations shall be considered priority services. Other than core populations funding and priority 2 services (listed in Attachment C) may be placed on the waiting list.

Waiting lists may also be utilized if other than core services or mental health or intellectual disability services requested are unavailable at the time of application.

If placed on a waiting list, the applicant shall be informed on the Notice of Decision form. The notice will identify the approximate time the service may be available to applicant. If unable to estimate such time, the HICS shall state such and will update the applicant at least every 60 days as to the status of their service request.

The waiting list shall be centrally maintained by the Regional office.

Any waiting list that may exist shall be reviewed annually when planning for the future budgeting needs and future development of services.

## **K. Amendments** (IAC 441-25.21(3))

Amendments to this Policy and Procedures Manual shall be reviewed by the Regional Advisory Board who shall make recommendations to the Regional Governance Board. After approval by the Regional Governance Board, amendments shall be submitted to the department of human services for approval at least 45 days before the planned date of implementation.

## Attachment A

### Access Points

HICS shall designate the access points and their function(s) in the enrollment process. An access point is a part of the service system or community that shall be trained to complete the MH/DS funding applications for persons with a disability and forward them to the local Community Services Office.

| <b>Access Point</b>                          | <b>Address</b>   | <b>Phone number</b> |
|--|--|---------------------|
| Adel Mental Health                           | 309 S. 7 <sup>th</sup> Street, Suite C, Adel, IA 50003   | (515) 993-1919      |
| Audubon County Community Services            | 318 Leroy Street, Audubon, IA 50025                      | (515) 494-8588      |
| Audubon County Memorial Hospital             | 515 Pacific Avenue, Audubon, IA 50025                    | (712) 563-2611      |
| Audubon County Jail                          | 318 Leroy St. Ste. 4, Audubon, IA 50025                  | (712) 563-2631      |
| Dallas County Community Services             | 52747 N Avenue, Suite D, Adel, IA 50003                  | (515) 993-5869      |
| Dallas County Hospital                       | 610 – 10 <sup>th</sup> Street, Perry, IA 50220           | (515) 465-3547      |
| Dallas County Jail                           | 201 Nile Kinnick Dr. N, Adel, IA 50003                   | (515) 993-5815      |
| Eyerly Ball Community Mental Health Services | 1301 Center Street, Des Moines, IA 50139                 | (515) 243-5181      |
| Genesis Mental Health                        | 610-10 <sup>th</sup> Street, Perry, IA 50220             | (515) 465-7541      |
| Guthrie County Community Services            | 200 N. 5 <sup>th</sup> Street, Guthrie Center, IA 50115  | (515) 494-8588      |
| Guthrie County Hospital                      | 710 N. 12 <sup>th</sup> Street, Guthrie Center, IA 50115 | (641) 332-2201      |
| Guthrie County Jail                          | 200 N. 5 <sup>th</sup> Street, Guthrie Center, IA 50115  | (641) 747-2214      |
| Hope Wellness Center                         | 706 Cedar Avenue, Woodward, IA 50076                     | (515) 438-2331      |
| Zion Recovery                                | 309 S. 7 <sup>th</sup> Street, Ste. B, Adel, IA 50003    | (515) 993-5243      |

## Attachment B

### 2014 Federal Poverty Guidelines (Monthly) 48 Contiguous States

| Family Size | 100%     | 120%     | 133%     | 135%     | 150%     | 175%     | 185%     | 200%     | 250%     |
|-------------|----------|----------|----------|----------|----------|----------|----------|----------|----------|
| 1           | 972.50   | 1,167.00 | 1,293.43 | 1,312.88 | 1,458.75 | 1,701.88 | 1,799.13 | 1,945.00 | 2,431.25 |
| 2           | 1,310.83 | 1,573.00 | 1,743.41 | 1,769.63 | 1,966.25 | 2,293.96 | 2,425.04 | 2,621.67 | 3,277.08 |
| 3           | 1,649.17 | 1,979.00 | 2,193.39 | 2,226.38 | 2,473.75 | 2,886.04 | 3,050.96 | 3,298.33 | 4,122.92 |
| 4           | 1,987.50 | 2,385.00 | 2,643.38 | 2,683.13 | 2,981.25 | 3,478.13 | 3,676.88 | 3,975.00 | 4,968.75 |
| 5           | 2,325.83 | 2,791.00 | 3,093.36 | 3,139.88 | 3,488.75 | 4,070.21 | 4,302.79 | 4,651.67 | 5,814.58 |
| 6           | 2,664.17 | 3,197.00 | 3,543.34 | 3,596.63 | 3,996.25 | 4,662.29 | 4,928.71 | 5,328.33 | 6,660.42 |
| 7           | 3,002.50 | 3,603.00 | 3,993.33 | 4,053.38 | 4,503.75 | 5,254.38 | 5,554.63 | 6,005.00 | 7,506.25 |
| 8           | 3,340.83 | 4,009.00 | 4,443.31 | 4,510.13 | 5,011.25 | 5,846.46 | 6,180.54 | 6,681.67 | 8,352.08 |

For family units of more than 8 members, add \$4,060 for each additional member.

## Attachment C

### Income Guidelines: (IC 331.395.1)

Gross incomes 150% or below the current Federal Poverty Guidelines. At the discretion of HICS, applicants with income between 150 to 250% may be eligible for regional funding if an exception is deemed appropriate and funds are available.

The income eligibility standards specified herein shall not supersede the eligibility guidelines of any other federal, state, county, or municipal program. The income guidelines established for programs funded through Medicaid (Waiver programs, Habilitation Services, etc.) shall be followed if different than those established in this manual.

In determining income eligibility, the average monthly income for the past 3 months will be considered, however, recent employment and/or income changes may be considered by the HICS in determining income eligibility. Applicants are expected to provide proof of income (including pay stubs, income tax return, etc.) as requested by HICS.

## Attachment D

### Resources: (IC 331.395)

An individual must have resources that are equal to or less than \$2,000 in countable value for a single-person household or \$3,000 in countable value for a multi-person household or follow most recent federal supplemental security income guidelines.

1. The countable value of all countable resources, both liquid and non-liquid, shall be included in the eligibility determination except as exempted in this sub-rule.
2. A transfer of property or other assets within five years of the time of application with the result of, or intent to, qualify for assistance may result in denial or discontinuation of funding.
3. The following resources shall be exempt:
  - a. The homestead, including equity in a family home or farm that is used as the individual household's principal place of residence. The homestead shall include all land that is contiguous to the home and the buildings located on the land.
  - b. One automobile used for transportation.
  - c. Tools of an actively pursued trade.

- d. General household furnishings and personal items.
  - e. Burial account or trust limited in value as to that allowed in the Medical Assistance Program.
  - f. Cash surrender value of life insurance with a face value of less than \$1,500 on any one person.
  - g. Any resource determined excludable by the Social Security Administration as a result of an approved Social Security Administration work incentive.
4. If an individual does not qualify for federally funded or state-funded services or other support, but meets all income, resource, and functional eligibility requirements of this chapter, the following types of resources shall additionally be considered exempt from consideration in eligibility determination:
- a. A retirement account that is in the accumulation stage.
  - b. A medical savings account.
  - c. An assistive technology account.
  - d. A burial account or trust limited in value as to that allowed in the Medical Assistance Program.
5. An individual who is eligible for federally funded services and other support must apply for and accept such funding and support.

**Iowa Administrative Code 441-25.16**



**Service Matrix**

| Priority Services   | Description  | Core Population |    | Non Priority |    | Conditions   |
|---|--|-----------------|----|--------------|----|--|
|   |  | MI              | ID | BI           | DD |  |
| <b>Assessment and Evaluation</b><br>(Psychiatric or Psychological Evaluations and Standard functional Assessment) | The clinical review by a mental health professional of the current functioning of the individual using the service in regard to the individual’s situation, needs, strengths, abilities, desires and goals to determine the appropriate level of care.   | X               |    | X            |    |  |
| <b>Case Management</b><br>(Targeted Case Management and Service Coordination)                                     | Service provided by a case manager who assists individuals in gaining access to needed medical, social, educational, and other services through assessment, development of a care plan, referral, monitoring and follow-up using a strengths-based service approach that helps individuals achieve specific desired outcomes leading to a healthy self-reliance and interdependence with their community.  | X               |    | X            |    | Standardized functional assessment must support the need for services of the type and frequency identified in the individual’s case plan |
| <b>Crisis Evaluation</b>  | The process used with an individual to collect information related to the individual’s history and needs, strengths, and abilities in order to determine appropriate services or referral during an acute crisis episode.  | X               |    | X            |    | Standardized functional assessment must support the need for services of the type and frequency identified in the individual’s case plan |
| <b>Day Habilitation</b>   | Services that assist or support the individual in developing or maintaining life skills and community integration. Services shall enable or enhance the individual’s functioning, physical and emotional health and development, language and communication development, cognitive functioning, socialization and community integration, functional skill development, behavior management, responsibility and self-direction, daily living activities, self-advocacy skills, or mobility. | X               |    | X            |    | Standardized functional assessment must support the need for services of the type and frequency identified in the individual’s case plan |

| Priority Services                    | Description  | Core Population |    | Non Priority |    | Conditions   |
|--------------------------------------|--|-----------------|----|--------------|----|--|
|                                      |  | MI              | ID | BI           | DD |  |
| <b>Family Support</b>                | Services provided by a family support peer specialist that assists the family of an individual to live successfully in the family or community including, but not limited to, education and information, individual advocacy, family support groups, and crisis response.  | X               |    | X            |    | Standardized functional assessment must support the need for services of the type and frequency identified in the individual's case plan |
| <b>Health Homes</b>                  | A service model that facilitates access to an interdisciplinary array of medical care, behavioral health care, and community-based social services and supports for both children and adults with chronic conditions. Services may include comprehensive care management; care coordination and health promotion; comprehensive transitional care from inpatient to other settings, including appropriate follow-up; individual and family support, which includes authorized representatives; referral to community and social support services, if relevant; and the use of health information technology to link services, as feasible and appropriate. | X               |    |              |    | Standardized functional assessment must support the need for services of the type and frequency identified in the individual's case plan |
| <b>Home and Vehicle Modification</b> | A service that provides physical modifications to the home or vehicle that directly address the medical health or remedial needs of the individual that are necessary to provide for the health, welfare, and safety of the member and to increase or maintain independence.   | X               |    |              |    | Standardized functional assessment must support the need for services of the type and frequency identified in the individual's case plan |
| <b>Home Health Aide Services</b>     | Unskilled medical services which provide direct personal care. This service may include assistance with activities of daily living, such as helping the recipient to bathe, get in and out of bed, care for hair and teeth, exercise, and take medications specifically ordered by the physician.  | X               |    | X            |    | Standardized functional assessment must support the need for services of the type and frequency identified in the individual's case plan |

| Priority Services                        | Description  | Core Population |    | Non Priority |    | Conditions  |
|--|--|-----------------|----|--------------|----|---|
|  |  | MI              | ID | BI           | DD |   |
| <b>Job Development</b>                   | Services that assist individuals in preparing for, securing and maintaining gainful, competitive employment. Employment shall be integrated into normalized work settings, shall provide pay of at least minimum wage, and shall be based on the individual's skills, preferences, abilities, and talents. Services assist individuals seeking employment to develop or re-establish skills, attitudes, personal characteristics, interpersonal skills, work behaviors, and functional capacities to achieve positive employment outcomes. | X               |    | X            |    | Standardized functional assessment must support the need for services of the type and frequency identified in the individual's case plan  |
| <b>Medication Management</b>             | Services provided directly to or on behalf of the individual by a licensed professional as authorized by Iowa law including, but not limited to, monitoring effectiveness of and compliance with a medication regimen; coordination with care providers; investigating potentially negative or unintended psychopharmacologic or medical interactions; reviewing laboratory reports; and activities pursuant to licensed prescriber orders.  | X               |    |              |    | Standardized functional assessment must support the need for services of the type and frequency identified in the individual's case plan  |
| <b>Medication Prescribing</b>            | Services with the individual present provided by an appropriately licensed professional as authorized by Iowa law including, but not limited to, determining how the medication is affecting the individual; determining any drug interactions or adverse drug effects on the individual; determining the proper dosage level; and prescribing medication for the individual for the period of time before the individual is seen again.   | X               |    |              |    | Standardized Assessment support the need for this service   |
| <b>Mental Health Inpatient Treatment</b> | Acute inpatient mental health services are 24-hour settings that provide services to individuals With Acute psychiatric conditions. Primary goal is to provide a comprehensive evaluation, rapidly stabilize acute symptoms; address health and safety needs and develop a comprehensive discharge plan to appropriate level of care.  | X               |    |              |    | Available at inpatient mental health services at any state or private mental health unit in Iowa host region contractual rate. In the absence of a contract, HICS shall reimburse at the current Medicaid rate. |

| Priority Services                         | Description  | Core Population |    | Non Priority |    | Conditions   |
|---|--|-----------------|----|--------------|----|--|
|   |  | MI              | ID | BI           | DD |  |
| <b>Mental Health Outpatient Therapy</b>   | Services shall consist of evaluation and treatment services provided on an ambulatory basis for the target population including psychiatric evaluation, medication management and individual, family, and group therapy.   | X               |    |              |    |  |
| <b>Peer Support Services</b>              | A program provided by a peer support specialist including but not limited to education and information, individual advocacy, family support groups, crisis response, and respite to assist individuals in achieving stability in the community.  | X               |    | X            |    | Standardized functional assessment must support the need for services of the type and frequency identified in the individual's case plan |
| <b>Personal Emergency Response System</b> | An electronic device connected to a 24-hour staffed system which allows the individual to access assistance in the event of an emergency.  | X               |    |              |    | Standardized functional assessment must support the need for services of the type and frequency identified in the individual's case plan |
| <b>Prevocational Services</b>             | Services that focus on developing generalized skills that prepare an individual for employment. Prevocational training topics include but are not limited to attendance, safety skills, following directions, and staying on task.   | X               |    | X            |    | Standardized functional assessment must support the need for services of the type and frequency identified in the individual's case plan |
| <b>Respite Services</b>                   | A temporary period of relief and support for individuals and their families provided in a variety of settings. The intent is to provide a safe environment with staff assistance for individuals who lack an adequate support system to address current issues related to a disability. Respite may be provided for a defined period of time; respite is either planned or provided in response to a crisis. | X               |    | X            |    | Standardized functional assessment must support the need for services of the type and frequency identified in the individual's case plan |

| Priority Services   | Description   | Core Population |    | Non Priority |    | Conditions   |
|---|---|-----------------|----|--------------|----|--|
|   |   | MI              | ID | BI           | DD |  |
| <b>Supported Employment</b>   | An approach to helping individuals participate as much as possible in competitive work in integrated work settings that are consistent with the strengths, resources, priorities, concerns, abilities, capabilities, interests, and informed choice of the individuals. Services are targeted for individuals with significant disabilities for whom competitive employment has not traditionally occurred; or for whom competitive employment has been interrupted or intermittent as a result of a significant disability including either individual or group supported employment, or both, consistent with evidence-based practice standards published by the Substance Abuse and Mental Health Services Administration. | X               |    | X            |    | Standardized functional assessment must support the need for services of the type and frequency identified in the individual's case plan |
| <b>Supported Community Living Services</b>  | Services provided in a non-institutional setting to adult persons with mental illness, mental retardation, or developmental disabilities to meet the persons' daily living needs.   | X               |    | X            |    | Standardized functional assessment must support the need for services of the type and frequency identified in the individual's case plan |
| <b>Twenty Four Hour Crisis Response</b>   |   | X               |    | X            |    | Hope Wellness Center   |
| <b>Commitment Related</b><br>(Evaluations, Sheriff Transport, Legal Rep, Mental Health Advocates) | Court ordered services related to mental health commitments   | X               |    | X            |    | Court order  |
| <b>Transportation</b>   | Transportation to day habilitation and vocational programs  | X               |    | X            |    |  |
| <b>Basic Needs</b><br>(Rent, Utilities)   | Assistance for rent, utilities etc.   | X               |    | X            |    |  |
| <b>Information/ Referral Services</b>   | Service that informs individuals of available services and programs   | X               |    |              |    |  |

| Priority Services                  | Description   | Core Population |    | Non Priority |    | Conditions   |
|------------------------------------|---|-----------------|----|--------------|----|--|
|                                    |   | MI              | ID | BI           | DD |  |
| <b>Public Education Services</b>   | To educate the general public about the realities of mental health and mental illness.  | X               |    | X            |    |  |
| <b>Homemaker Services</b>          | Homemaking and personal care services   | X               |    | X            |    | Standardized functional assessment must support the need for services of the type and frequency identified in the individual's case plan |
| <b>Prescription Medicine</b>       | Prescription psychiatric medications for persons having a mental health diagnosis   | X               |    | X            |    | Jail Population and Non-medicaid individuals until they are enrolled in Health Insurance   |
| <b>Residential Care Facilities</b> | Community facility providing care and treatment   | X               |    |              |    | Standardized functional assessment must support the need for services of the type and frequency identified in the individual's case plan |
| <b>Peer Drop In</b>                | Program that offers a safe, supportive environment within the community for individuals who have experienced mental/emotional problems. | X               |    | X            |    |  |

## Attachment F

### Sliding Fee Schedule for Outpatient Services

| 150% | Up to 175% | Up to 200% | Up to 225% | Up to 250% |
|------|------------|------------|------------|------------|
| 0    | 15%        | 30%        | 45%        | 60%        |

### DEFINITIONS

**Access point** -- a provider, public, or private institution, advocacy organization, legal representative, or educational institution with staff trained to complete applications and guide individuals with a disability to needed services”.

**Applicant** -- an individual who applies to receive services and supports from the service system.

**Assessment and evaluation** -- a service as defined in 441-25.1.

**Assistive technology account** -- funds in contracts, savings, trust or other financial accounts, financial instruments, or other arrangements with a definite cash value that are set aside and designated for the purchase, lease, or acquisition of assistive technology, assistive technology services, or assistive technology devices. Assistive technology accounts must be held separately from other accounts. Funds must be used to purchase, lease, or otherwise acquire assistive technology services or devices for a working individual with a disability. Any withdrawal from an assistive technology account other than for the designated purpose becomes a countable resource.

**Authorized representative** -- a person designated by the individual or by Iowa law to act on the individual’s behalf in specified affairs to the extent prescribed by law.

**Chief Executive Officer** -- the individual chosen and supervised by the governing board who serves as the single point of accountability for the mental health and disability services region including, but not limited to, planning, budgeting, monitoring county and regional expenditures, and ensuring the delivery of quality services that achieve expected outcomes for the individuals served.

**Choice** -- the individual or authorized representative chooses the services, supports, and goods needed to best meet the individual’s goals and accepts the responsibility and consequences of those choices.

**Clear lines of Accountability** -- the structure of the governing board’s organization makes it evident that the ultimate responsibility for the administration of the non-Medicaid funded mental health and disability services lies with the governing board and that the governing board directly and solely supervises the organization’s chief executive officer.

**Conflict Free Case Management** -- there is no real or seeming incompatibility between the case managers other interests and the case managers duties to the person served determination for services; establishing funding levels for the individual's services; and include requirements that do not allow the case manager from performing evaluations, assessments, and plans of care if the case manager is related by blood or marriage to the individual or any of the individual's paid caregivers, financially responsible for the individual, or empowered to make financial or health-related decisions on behalf of the individual.

**Community** -- an integrated setting of an individual’s choice”.

**Coordinator of disability services** -- as defined in Iowa Code 331.390.3.b.

**Countable resource** – means all liquid and non-liquid assets owned in part or in whole by the consumer household that could be converted to cash to use for support and maintenance and that the consumer household is not legally restricted from using for support and maintenance.

**County of residence** -- means the county in this state in which, at the time a person applies for or receives services, the person is living and has established an ongoing presence with the declared, good

faith intention of living in the county for a permanent or indefinite period of time. The county of residence of a person who is a homeless person is the county where the homeless person usually sleeps. A person maintains residency in the county in which the person last resided while the person is present in another county receiving services in a hospital, a correctional facility, a halfway house for community-based corrections or substance-related treatment, a nursing facility, an intermediate care facility for persons with an intellectual disability, or a residential care facility, or for the purpose of attending a college or university.

**Empowerment** -- that the service system ensures the rights, dignity, and ability of individuals and their families to exercise choices, take risks, provide input, and accept responsibility.

**Exempt resource** -- a resource that is disregarded in the determination of eligibility for public funding assistance and in the calculation of client participation amounts

**Household** -- for an individual who is 18 years of age or over, the individual, the individual's spouse or domestic partner, and any children, step-children, or wards under the age of 18 who reside with the individual. For an individual under the age of 18, household -- the individual, the individual's parents (or parent and domestic partner), step-parents or guardians, and any children, step-children, or wards under the age of 18 of the individual's parents (or parent and domestic partner), step-parents, or guardians who reside with the individual.

**Income** -- all gross income received by the individual's household, including but not limited to wages, income from self-employment, retirement benefits, disability benefits, dividends, annuities, public assistance, unemployment compensation, alimony, child support, investment income, rental income, and income from trust funds.

**Individual** -- any person seeking or receiving services in a regional service system.

**Individualized services** -- services and supports that are tailored to meet the personalized needs of the individual.

**Liquid assets** -- assets that can be converted to cash in 20 days. These include but are not limited to cash on hand, checking accounts, savings accounts, stocks, bonds, cash value of life insurance, individual retirement accounts, certificates of deposit, and other investments.

**Managed care** -- a system that provides the coordinated delivery of services and supports that are necessary and appropriate, delivered in the least restrictive settings and in the least intrusive manner. Managed care seeks to balance three factors: achieving high-quality outcomes for participants, coordinating access, and containing costs.

**Managed system** -- a system that integrates planning, administration, financing, and service delivery. The system consists of the financing or governing organization, the entity responsible for care management, and the network of service providers.

**Medical savings account** -- an account that is exempt from federal income taxation pursuant to Section 220 of the United States Internal Revenue Code (26 U.S.C. §220) as supported by documentation provided by the bank or other financial institution. Any withdrawal from a medical savings account other than for the designated purpose becomes a countable resource.

**Mental health professional** -- the same as defined in Iowa code section 228.1.

**Non-liquid assets** -- assets that cannot be converted to cash in 20 days. Non-liquid assets include, but are not limited to, real estate, motor vehicles, motor vessels, livestock, tools, machinery, and personal property.

**Population** -- as defined in Iowa Code 331.388.



**Provider** -- an individual, firm, corporation, association, or institution which is providing or has been approved to provide medical assistance, is accredited under Chapter 24, holds a professional license to provide the services, is accredited by an national insurance panel, or holds other national accreditation or certification”.

**Regional Chief Executive Officer or Regional administrative entity** -- the administrative office, or organization formed by agreement of the counties participating in a mental health and disability services region to function on behalf of those counties.

**Regional services fund** -- the mental health and disability regional services fund created in Iowa code section 225C.7A.

**Regional service system management plan** -- the regional service system plan developed pursuant to Iowa Code 331.393 for the funding and administration of non-Medicaid funded mental health and disability services including an annual service and budget plan, a policy and procedure manual, and an annual report and how the region will coordinate with the Department in the provision of mental health and disability services funded under the medical assistance program.

**Resources** -- all liquid and non-liquid assets owned in part or in whole by the individual household that could be converted to cash to use for support and maintenance and that the individual household is not legally restricted from using for support and maintenance.

**Retirement account** -- any retirement or pension fund or account listed in Iowa Code section 627.6(8)“f”.

**Retirement account in the accumulation stage** -- a retirement account into which a deposit was made in the previous tax year. Any withdrawal from a **retirement account becomes a countable resource**.

**Service system** refers to the mental health and disability services and supports administered and paid from the regional services fund.

**State case status** -- the standing of an individual who has no county of residence.

**State commission** -- as defined in Iowa Code 225C.5.

**System of Care** -- the coordination of a system of services and supports to individuals and their families that ensures they optimally live, work, and recreate in integrated communities of their choice.

**System principles** -- practices that include individual choice, community and empowerment.

## **Forms Appendix**

|                                 |         |
|---------------------------------|---------|
| Release of Information          | Page 35 |
| Notice of Service Authorization | Page 36 |
| Exception to Policy             | Page 37 |
| Appeals Form                    | Page 38 |
| Application                     | Page 39 |
| Service Request                 | Page 43 |
| Notice of Privacy Practices     | Page 45 |
| Notice of Enrollment            |         |

# Heart of Iowa Community Services Release of Information

For individuals living in: Audubon, Dallas, and Guthrie Counties

CLIENT: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

I, the undersigned, hereby authorize the staff of Heart of Iowa Community Services to release and / or obtain the information indicated below, regarding the above named consumer, with:

\_\_\_\_\_  
Name of Person or Agency

\_\_\_\_\_  
Complete Mailing Address

The information being released will be used for the following purpose:

- Planning and implementation of Services  Referral for new or other services  
 Coordination of services  Other (Specify) \_\_\_\_\_  
 Monitoring of services \_\_\_\_\_

Your eligibility for services or funding  is  is not dependent upon signing this release. {See CFR 164.508(b)(4)}

**INFORMATION TO BE RELEASED FROM  
COMMUNITY SERVICES:**

Yes No

- SOCIAL HISTORY  
  PROGRESS SUMMARY REPORT  
  INDIVIDUAL COMPREHENSIVE PLAN  
  ANNUAL REVIEW  
  DISCHARGE SUMMARY  
  RE-RELEASE OF 3<sup>RD</sup> PARTY INFO (Specify)  
(Your information will not be re-released without a signed authorization)

\_\_\_\_\_  
  OTHER (Specify) \_\_\_\_\_

FINANCIAL DOCUMENTATION

This authorization shall expire on: \_\_\_\_\_  
(Not to exceed 12 months)

**INFORMATION TO BE OBTAINED FROM  
THE AGENCY INDICATED ABOVE:**

Yes No

- SOCIAL HISTORY  
  EDUCATIONAL / VOCATIONAL PLANS  
  PROGRESS SUMMARY  
  PSYCHOLOGICAL EVALUATION / REPORTS  
  PSYCHIATRIC ASSESSMENT / REPORTS  
  MEDICAL HISTORY  
  TREATMENT PLAN  
  DISCHARGE SUMMARY  
  RE-RELEASE OF 3<sup>RD</sup> PARTY INFO (Specify)

\_\_\_\_\_  
  OTHER (Specify) \_\_\_\_\_

At that time, no express revocation shall be needed to terminate my consent. I understand that this consent is voluntary and I may revoke this consent at any time by sending a written notice to Heart of Iowa Community Services. I understand that any information released prior to the revocation may be used for the purposes listed above and does not constitute a breach of my rights to confidentiality. I understand that any disclosure of information carries with it the potential for un-authorized re-disclosure and once the information is disclosed, it may no longer be protected by federal privacy regulations. I understand that I may review the disclosed information by contacting the recipient named or Heart of Iowa Community Services.

**SPECIFIC AUTHORIZATION FOR RELEASE OF INFORMATION PROTECTED BY STATE OR FEDERAL LAW:**

I specifically authorize the release of data and information relating to Mental Health.

Signature of Client or Legal Guardian: \_\_\_\_\_

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship if NOT The Client

**SPECIFIC AUTHORIZATION FOR RELEASE OF INFORMATION PROTECTED BY STATE OR FEDERAL LAWS:**

I specifically authorize the release of data and information relating to:

- Substance Abuse (must be signed by the consumer)  HIV-Related Information

\_\_\_\_\_  
Client Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Guardian Signature

\_\_\_\_\_  
Date

In order for this information to be released, you must sign here and on the signature line above. \_\_\_\_\_

Copy given to Client on: \_\_\_\_\_ OR Client refused copy on: \_\_\_\_\_

**HEART OF IOWA COMMUNITY SERVICES**

25747 N AVENUE, SUITE D

ADEL, IA 50003

**NOTICE OF DECISION**

**I. --APPLICANT INFORMATION--**

|                             |                               |
|-----------------------------|-------------------------------|
| Applicant's Name & Address: | State ID:                     |
|                             | Applicant CSN ID#: (Optional) |

**II. --SERVICES--**

The decision to approve, deny or pend each of the services listed below is printed in the Authorized Service Decision box. Information on the appeal process is listed on the back of this form.

| Provider Information | Service  | Number of Units | Units Per | Unit Rate | Service Start Date | Service End Date | Authorized Service Decision |
|----------------------|----------|-----------------|-----------|-----------|--------------------|------------------|-----------------------------|
| 1.                   |          |                 |           |           |                    |                  |                             |
|                      | Details: |                 |           |           |                    |                  |                             |
| 2.                   |          |                 |           |           |                    |                  |                             |
|                      | Details: |                 |           |           |                    |                  |                             |
| 3.                   |          |                 |           |           |                    |                  |                             |
|                      | Details: |                 |           |           |                    |                  |                             |

Notes:

**III. --CONTACT INFORMATION--**

|        |                 |
|--------|-----------------|
| Name:  | County Director |
| Phone: |                 |

**IV. --AUTHORIZATION--**

|   |  |        |
|---|--|--------|
| Administrator (Printed):<br>--Authorizing County--        |  | Phone: |
| Administrator (Printed):<br>--County of Legal Residence-- |  | Phone: |
| Administrator Signature:                                  |  | Date:  |
| CPC Administrator Signature:                              |  | Date:  |

**V. --BILLING ADDRESS--**

|   |                                  |
|---|----------------------------------|
| Region to be billed for payment of the approved services: | Heart of Iowa Community Services |
| Address:  |                                  |
| Phone:  | Fax:                             |

**HEART OF IOWA COMMUNITY SERVICES**

25747 N AVENUE, SUITE D  
ADEL, IA 50003

**EXCEPTION TO POLICY**

**I. --APPLICANT INFORMATION--**

|                             |                                  |
|-----------------------------|----------------------------------|
| Applicant's Name & Address: | State ID:                        |
|                             | Applicant CSN ID#:<br>(Optional) |

**II. --CURRENT SERVICES--**

The decision to approve, deny or pend each of the services listed below is printed in the Authorized Service Decision box. Information on the appeal process is listed on the back of this form.

| Provider Information | Service  | Number of Units | Units Per | Unit Rate | Service Start Date | Service End Date | Authorized Service Decision |
|----------------------|----------|-----------------|-----------|-----------|--------------------|------------------|-----------------------------|
| 1.                   |          |                 |           |           |                    |                  |                             |
|                      | Details: |                 |           |           |                    |                  |                             |
| 2.                   |          |                 |           |           |                    |                  |                             |
|                      | Details: |                 |           |           |                    |                  |                             |
| 3.                   |          |                 |           |           |                    |                  |                             |
|                      | Details: |                 |           |           |                    |                  |                             |
| 4.                   |          |                 |           |           |                    |                  |                             |
|                      | Details: |                 |           |           |                    |                  |                             |

**III. --POLICY AND SERVICE FOR WHICH EXCEPTION IS REQUESTED--**

|  |
|--|
|  |
|--|

| Provider Information | Service | Number of Units | Units Per | Unit Rate | Service Start Date | Service End Date | Authorized Service Decision |
|----------------------|---------|-----------------|-----------|-----------|--------------------|------------------|-----------------------------|
|----------------------|---------|-----------------|-----------|-----------|--------------------|------------------|-----------------------------|

**IV. --REASON FOR EXCEPTION--**

|  |
|--|
|  |
|--|

|       |          |      |
|-------|----------|------|
| Name: | Address: |      |
|       | Phone:   | Fax: |

**HEART OF IOWA COMMUNITY SERVICES**

25747 N AVENUE, SUITE D  
ADEL, IA 50003

**APPEAL**

TO: Heart of Iowa Community Services

The reason for this appeal is:

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I, therefore, respectfully make application for a review by Heart of Iowa Community Services of the grievance as stated above.

DATE: \_\_\_\_\_

SIGNATURE OF APPELLANT: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

TELEPHONE (if applicable): \_\_\_\_\_

# HEART OF IOWA COMMUNITY SERVICES

## Funding Application

Date Received: \_\_\_\_\_

**NOTICE: A COPY OF YOUR DRIVER'S LICENSE OR PHOTO ID IS REQUIRED WITH THIS APPLICATION**

Application Date: \_\_\_\_\_

LAST Name: \_\_\_\_\_ FIRST Name: \_\_\_\_\_ MI: \_\_\_\_\_

Phone #: \_\_\_\_\_ Birth Date: \_\_\_\_\_ SSN#: \_\_\_\_\_

Current Address: \_\_\_\_\_  
Street City State Zip County

Primary Language:  English  Spanish  Bosnian  Croatian Sex:  Male  Female

Ethnic Background:  White  African American  Native American  Asian  Hispanic  Other \_\_\_\_\_

Guardian/Conservator appointed by the Court?  Yes  No

Protective Payee Appointed by Social Security?  Yes  No

Legal Guardian  Protective Payee  Conservator  
(Please check those that apply & write in name, address etc.)  
Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone: \_\_\_\_\_

Legal Guardian  Protective Payee  Conservator  
(Please check those that apply & write in name, address etc.)  
Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone: \_\_\_\_\_

Veteran Status:  Yes  No Branch & Type of Discharge: \_\_\_\_\_ Dates of Service: \_\_\_\_\_

Are you currently on commitment?  Yes  No If Yes, please explain: \_\_\_\_\_

Marital Status:  Never married  Married  Divorced  Separated  Widowed

Legal Status:  Voluntary  Involuntary-Civil  Involuntary-Criminal  Probation  Parole  Jail/Prison

Are you a US Citizen & residing in the U.S. legally?  Yes  No

Living Arrangement:  Alone  With relatives  With unrelated persons

Current Residential Arrangement: (Check applicable arrangement)

Private Residence  State Resource Center  ICF  Supported Comm. Living  
 Foster Care/Family Life Home  RCF  ICF/ MR  Correctional Facility  
 Homeless/Shelter/Street  RCF/MR  ICF/PMI  
 State MH  RCF/PMI  Other

Disability Group/Primary Diagnosis:

Mental Illness  Chronic Mental Illness  Intellectual Disability  Developmental Disability  Substance Abuse  Brain Injury

Specific Diagnosis determined by: \_\_\_\_\_ Date: \_\_\_\_\_

Axis I: \_\_\_\_\_ Dx Code: \_\_\_\_\_

Axis II: \_\_\_\_\_ Dx Code: \_\_\_\_\_

If agency referral, name of agency/contact person and contact information: \_\_\_\_\_

Referral Source:

Self  Community Corrections  
 Family/Friend  Social Service Agency  
 Targeted Case Management  Hospital / Physician  
 Other Case Management  RCF/ICF  
 Other \_\_\_\_\_

Education:

Years of Education: \_\_\_\_\_  
GED:  Yes  No  
H.S. Diploma:  Yes  No  
College Degree: \_\_\_\_\_

**Why are you here today? What services do you NEED?** (This section must be completed as part of this application!)

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**CURRENT EMPLOYMENT:** (Check applicable employment)

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Unemployed, available for work | <input type="checkbox"/> Unemployed, unavailable for work | <input type="checkbox"/> Employed, Full time  |
| <input type="checkbox"/> Employed, Part time            | <input type="checkbox"/> Retired                          | <input type="checkbox"/> Student              |
| <input type="checkbox"/> Work Activity                  | <input type="checkbox"/> Sheltered Work Employment        | <input type="checkbox"/> Supported Employment |
| <input type="checkbox"/> Vocational Rehabilitation      | <input type="checkbox"/> Seasonally Employed              | <input type="checkbox"/> Armed Forces         |
| <input type="checkbox"/> Homemaker                      | <input type="checkbox"/> Volunteer                        | <input type="checkbox"/> Other _____          |

**Current Employer:** \_\_\_\_\_ **Position:** \_\_\_\_\_

**Dates of employment:** \_\_\_\_\_ **Hourly Wage:** \_\_\_\_\_ **Hours worked weekly:** \_\_\_\_\_

**HAVE YOU APPLIED FOR ANY PUBLIC PROGRAMS listed below?**

(Please check those you have applied for and the status of your referral)

Has your application has been  Approved or  Denied. (If you appealed the denial, advise of the date of appeal: \_\_\_\_\_).  
Please advise if you have applied for reconsideration. Advise if you have had a hearing with an Administrative Law Judge and the date of the scheduled hearing: \_\_\_\_\_ )

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Social Security _____ | <input type="checkbox"/> SSDI _____         | <input type="checkbox"/> Medicare _____            |
| <input type="checkbox"/> SSI _____             | <input type="checkbox"/> Medicaid _____     | <input type="checkbox"/> DHS Food Assistance _____ |
| <input type="checkbox"/> Veterans _____        | <input type="checkbox"/> Unemployment _____ | <input type="checkbox"/> FIP _____                 |
| <input type="checkbox"/> Other _____           | <input type="checkbox"/> Other _____        |  |

**HEALTH INSURANCE Information:** (Check all that apply)

**PRIMARY Carrier** (pays 1<sup>st</sup>)

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Applicant Pays                        | <input type="checkbox"/> Medicaid        | <input type="checkbox"/> Family Planning only |
| <input type="checkbox"/> Medicare A,B D                        | <input type="checkbox"/> Medically Needy | <input type="checkbox"/> MEPD                 |
| <input type="checkbox"/> No Insurance                          | <input type="checkbox"/> HAWK-I          | <input type="checkbox"/> IA Cares             |
| <input type="checkbox"/> Private Insurance (list below): _____ |  |   |

Company Name \_\_\_\_\_

Address \_\_\_\_\_  
\_\_\_\_\_

Policy Number: \_\_\_\_\_

(or Medicaid/Title 19 or Medicare Claim Number)

**SECONDARY Carrier** (pays 2<sup>nd</sup>)

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Applicant Pays                        | <input type="checkbox"/> Medicaid        | <input type="checkbox"/> Family Planning only |
| <input type="checkbox"/> Medicare A,B, D                       | <input type="checkbox"/> Medically Needy | <input type="checkbox"/> MEPD                 |
| <input type="checkbox"/> No Insurance                          | <input type="checkbox"/> HAWK-I          | <input type="checkbox"/> IA Cares             |
| <input type="checkbox"/> Private Insurance (list below): _____ |  |   |

Company Name \_\_\_\_\_

Address \_\_\_\_\_  
\_\_\_\_\_

Policy Number: \_\_\_\_\_

(or Medicaid/Title 19 or Medicare Claim Number)

**What is the name and location of your current psychiatrist/therapist and location:** \_\_\_\_\_  
\_\_\_\_\_

**What is the name and location of your current Pharmacy?** \_\_\_\_\_



**OTHERS IN HOUSEHOLD:**

| Name | Date of Birth | Relationship |
|------|---------------|--------------|
| 1.   |               |              |
| 2.   |               |              |
| 3.   |               |              |
| 4.   |               |              |
| 5.   |               |              |



**THIS APPLICATION WILL NOT BE CONSIDERED UNLESS THE FOLLOWING INFORMATION IS PROVIDED.**

**NOTICE:** Proof of income will be required with this application – a pay-stub(s) or tax-return will be required.

**Gross Monthly Income (before taxes):**  
(Check Type & fill in amount)

- Social Security
- SSDI
- SSI
- Veteran's Benefits
- Employment Wages
- FIP
- Child Support
- Workers Compensation
- Short-Term Disability
- Annuity Benefits
- Pension/RR Pension
- Other

**Applicant**  
Amount:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Others in Household**  
Amount:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Total Monthly Income:** \_\_\_\_\_

**If you have reported NO income above, how do you pay your bills?** (DO NOT LEAVE BLANK if no income is reported!)

\_\_\_\_\_

\_\_\_\_\_

**Household Resources:** (Check and fill in amount and location):

| Type  | Amount | Bank, Trustee, or Company |
|---|--------|---------------------------|
| <input type="checkbox"/> Cash                               | _____  | _____                     |
| <input type="checkbox"/> Checking Account                   | _____  | _____                     |
| <input type="checkbox"/> Savings Account                    | _____  | _____                     |
| <input type="checkbox"/> Certificates of Deposit            | _____  | _____                     |
| <input type="checkbox"/> Trust Funds                        | _____  | _____                     |
| <input type="checkbox"/> Stocks and Bonds (cash value?)     | _____  | _____                     |
| <input type="checkbox"/> Burial Fund/Life Ins (cash value?) | _____  | _____                     |
| <input type="checkbox"/> Retirement Funds (cash value?)     | _____  | _____                     |
| <input type="checkbox"/> Other _____                        | _____  | _____                     |
| <input type="checkbox"/> Other _____                        | _____  | _____                     |

**Total Resources:** \_\_\_\_\_

**Motor Vehicles:**  Yes  No (include car, truck, motorcycle, boat, Recreational vehicle, etc.)

|                 |  |                  |  |
|-----------------|--|------------------|--|
| 1. Make & Year: |  | Estimated value: |  |
| 2. Make & Year: |  | Estimated value: |  |
| 3. Make & Year: |  | Estimated value: |  |

**Do you, your spouse or dependent children own or are buying the following:**

House including the one you live in  Any other real-estate or land  Other \_\_\_\_\_

If yes to any of the above, please explain: \_\_\_\_\_

**Have you sold or given away any property in the last five (5) years?**  Yes  No **If yes, what did you sell or give away?**



## THIS APPLICATION WILL NOT BE CONSIDERED UNLESS THE FOLLOWING INFORMATION IS PROVIDED.

1. \_\_\_\_\_  
**CURRENT** Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ County \_\_\_\_\_  
Dates of Residency at this address (month/year): \_\_\_\_\_ to \_\_\_\_\_
2. \_\_\_\_\_  
**PREVIOUS** Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ County \_\_\_\_\_  
Dates of Residency at this address (month/year): \_\_\_\_\_ to \_\_\_\_\_
3. \_\_\_\_\_  
**PREVIOUS** Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ County \_\_\_\_\_  
Dates of Residency at this address (month/year): \_\_\_\_\_ to \_\_\_\_\_

**Contact Person:** (including Case Manager, Social Worker, Case Worker, DHS IMW, Agency Staff, Etc.)

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

**Other Interested person(s):**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

As a signatory of this document, I certify that the above information is true and complete to the best of my knowledge, and I authorize County staff to check for verification of the information provided including verification with Iowa county government and the state Iowa Dept. of Human Services (DHS) staff.

I understand that the information gathered in this document is for the use of an Iowa County in establishing my ability to pay for services requested, in assuring the appropriateness of services requested, and in confirming legal residence. I understand that information in this document will remain confidential.

\_\_\_\_\_  
**Applicant's Signature (or Legal Guardian)** **Date**

\_\_\_\_\_  
**Signature of other completing form if not Applicant or legal Guardian** **Date**

**HEART OF IOWA COMMUNITY SERVICES**

25747 N AVENUE, SUITE D

ADEL, IA 50003

Phone (515)-993-5869 | Fax (515)993-5872

**SERVICE AUTHORIZATION REQUEST**

Consumer Name:

D.O.B.:

Therapist/Doctor:

Diagnosis (DSM-IV):

Intake Date:

Next Appointment:

CPC application completed?

Yes

No

Ongoing Services

***This person is currently being seen and we are requesting a written authorization of services covered through your county.***

| Quantity | CPT CODE | Service Requested                      | Rate | Dates of Service |
|----------|----------|--|------|------------------|
|          |          | Initial Therapy Intake                 |      |                  |
|          |          | Initial Psychological Evaluation       |      |                  |
|          |          | Individual Psychotherapy               |      |                  |
|          |          | Psychological Testing                  |      |                  |
|          |          | Individual Psychotherapy (20 – 30 Min) |      |                  |
|          |          | Group Therapy                          |      |                  |
|          |          | Medication Management                  |      |                  |
|          |          | Adult Partial Hospitalization          |      |                  |
|          |          | Other Service (Please Explain)         |      |                  |

Provider Name

Address

Phone #

Requested by:

Date:

***Please note payment will not be paid by Heart of Iowa Community Services until this form is received and a diagnosis for this client is determined. Please submit request for additional funding upon acceptance by the County of Residence.***

**--PLEASE COMPLETE PAGE 2--**

**BASIS FOR DETERMINING DIAGNOSIS:**

**PLAN FOR STABILIZATION:** (What services will be provided in the first 90 days of treatment?)

**CPC USE ONLY:**

This individual has been determined to have ( \_\_\_\_\_ ) County Residency:  Yes  No

This individual has Residency in \_\_\_\_\_ County. Please forward bills to county of Residency.

**Authorized by:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Comments:**

# **NOTICE OF PRIVACY PRACTICES FOR HEART OF IOWA COMMUNITY SERVICES**

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED  
AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.**

***PLEASE REVIEW IT CAREFULLY.***

**If you have any questions about this Notice of Privacy Practices contact  
Heart of Iowa Community Services' privacy officer, Darci Alt at 515-993-1736.**

This Notice of Privacy Practices describes how Heart of Iowa Community Services may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Heart of Iowa Community Services is required to abide by the terms of this Notice of Privacy Practices. Heart of Iowa Community Services may change the terms of this notice, at any time. The new notice will be effective for all protected health information that Heart of Iowa Community Services maintains at that time. Upon request, Heart of Iowa Community Services will provide you with any revised Notice of Privacy Practices.

## **PERMITTED USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION**

Your protected health information may be used and disclosed by Heart of Iowa Community Services for the purpose of providing or accessing health care services or you. Your protected health information may also be used and disclosed to pay your health care bills and to support the business operation of Heart of Iowa Community Services.

The following categories describe ways that Heart of Iowa Community Services is permitted to use and disclose health care information. Examples of types of uses and disclosures are listed in each category. Not every use or disclosure for each category is listed; however, all of the ways Heart of Iowa Community Services is permitted to use and disclose information falls into one of these categories:

### **1) Treatment:**

Heart of Iowa Community Services may use and disclose your protected health information to provide, coordinate or manage your health care and any related services. This includes the coordination or management of your health care with a third party that has already obtained your permission to have access to your protected health information. For example, Heart of Iowa Community Services would disclose your protected health information, as necessary, to a home health agency that provides care to you. Another example is that protected health information may be provided to a facility to which you have been referred to ensure that the facility has the necessary information to treat you.

### **2) Payment**

Heart of Iowa Community Services may use and disclose health care information about you so that the treatment and services you receive may be billed to and payment may be collected from you, an insurance company or a third party. Heart of Iowa Community Services may also discuss your protected health information about a service you are going to receive to determine whether you are eligible for the service, and for undertaking utilization review activities. For example, authorizing a service may require that your relevant protected health information be discussed with a provider to determine your need and eligibility for the service.

### **3) Healthcare Operations**

Heart of Iowa Community Services may use or disclose, as needed, your protected health information in order to support its business activities. These activities include, but are not limited to, quality assessment activities, employee review activities, licensing and conducting or arranging for other business activities. For example, Heart of Iowa Community Services may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment or to provide information about alternate services or other health-related benefits.

Heart of Iowa Community Services may share your protected health information with third party "business associates" that perform various activities (e.g., billing, transcription services) for Heart of Iowa Community Services. Whenever an arrangement between Heart of Iowa

Community Services and a business associate involves the use or disclosure of your protected health information, Heart of Iowa Community Services will have a written contract that contains terms that will protect the privacy of your protected health information.

## **USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION REQUIRING YOUR WRITTEN AUTHORIZATION**

Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke this authorization, at any time, in writing, except to the extent that Heart of Iowa Community Services has taken an action in reliance on the use or disclosure indicated in the authorization.

Heart of Iowa Community Services may use and disclose your protected health information in the following instances. You have the opportunity to agree or object to the use or disclosure of all or part of your protected health information. If you are not present or able to agree or object to the use or disclosure of the protected health information, then Heart of Iowa Community Services may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the protected health information that is relevant to your health care will be disclosed.

### **1) Others Involved in Your Healthcare**

Unless you object, Heart of Iowa Community Services may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, Heart of Iowa Community Services may disclose such information as necessary if Heart of Iowa Community Services, based on its professional judgment, determines that it is in your best interest. Heart of Iowa Community Services may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death. Finally, Heart of Iowa Community Services may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

### **2) Emergencies**

Heart of Iowa Community Services may use or disclose your protected health information in an emergency treatment situation. If this happens, Heart of Iowa Community Services shall try to obtain your acknowledgment of receipt of the Notice of Privacy Practices as soon as reasonably practicable after the delivery of treatment.

## **OTHER PERMITTED AND REQUIRED USES AND DISCLOSURES THAT MAY BE MADE WITHOUT YOUR AUTHORIZATION OR OPPORTUNITY TO OBJECT**

Heart of Iowa Community Services may use or disclose your protected health information in the following situations without your consent or authorization. These situations include:

### **1) Required By Law**

Heart of Iowa Community Services may use or disclose your protected health information to the extent that the use or disclosure is required by law. You will be notified, as required by law, of any such uses or disclosures.

### **2) Public Health**

Heart of Iowa Community Services may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. The disclosure will be made for the purpose of controlling disease, injury or disability. Heart of Iowa Community Services may also disclose your protected health information, if directed by the public health authority, to a foreign government agency that is collaborating with the public health authority.

### **3) Communicable Diseases**

Heart of Iowa Community Services may disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease.

### **4) Health Oversight**

Heart of Iowa Community Services may disclose your protected health information to a health oversight agency for activities authorized by law, such as audits, investigations and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

### **5) Abuse or Neglect**

Heart of Iowa Community Services may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, Heart of Iowa Community Services may disclose your protected health information if it believes that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

### **6) Food and Drug Administration**

Heart of Iowa Community Services may disclose your protected health information to a person or company required by the Food and Drug Administration to report adverse events, product defects or problems, biologic product deviations, track products; to enable product recalls; to make repairs or replacements, or to conduct post marketing surveillance, as required.

## **7) Legal Proceedings**

Heart of Iowa Community Services may disclose protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), in certain conditions in response to a subpoena, discovery request or other lawful process.

## **8) Law Enforcement**

Heart of Iowa Community Services may also disclose protected health information, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes include (1) legal processes and otherwise required by law, (2) limited information requests for identification and location purposes, (3) pertaining to victims of a crime, (4) suspicion that death has occurred as a result of criminal conduct, (5) in the event that a crime occurs on county premises, and (6) medical emergency (not on Heart of Iowa Community Services' premises) and it is likely that a crime has occurred.

## **9) Coroners, Funeral Directors, and Organ Donation**

Heart of Iowa Community Services may disclose protected health information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose protected health information to a funeral director, as authorized by law, in order to permit the funeral director to carry out their duties. We may disclose such information in reasonable anticipation of death. Protected health information may be used and disclosed for cadaveric organ, eye or tissue donation purposes.

## **10) Research**

Heart of Iowa Community Services may disclose your protected health information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.

## **11) Criminal Activity**

Consistent with applicable federal and state laws, Heart of Iowa Community Services may disclose your protected health information, if it believes that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. Heart of Iowa Community Services may also disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.

## **12) Military Activity and National Security**

When the appropriate conditions apply, Heart of Iowa Community Services may use or disclose protected health information of individuals who are Armed Forces personnel (1) for activities deemed necessary by appropriate military command authorities; (2) for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits, or (3) to foreign military authority if you are a member of that foreign military services. Heart of Iowa Community Services may also disclose your protected health information to authorized federal officials for conducting national security and intelligence activities, including for the provision of protective services to the President or others legally authorized.

## **13) Workers' Compensation**

Your protected health information may be disclosed by Heart of Iowa Community Services as authorized to comply with workers' compensation laws and other similar legally-established programs.

## **14) Inmates**

Heart of Iowa Community Services may use or disclose your protected health information if you are an inmate of a correctional facility and Heart of Iowa Community Services created or received your protected health information in the course of providing care to you.

## **15) Required Uses and Disclosures**

Under the law, Heart of Iowa Community Services must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine County compliance with the requirements of 45 C.F.R. section 164.500 et. seq.

## **YOUR RIGHTS**

The following are a list of your rights with respect to your protected health information and a brief description of how you may exercise these rights:

### **• RIGHT TO INSPECT AND COPY YOUR PROTECTED HEALTH INFORMATION**

This means you may inspect and obtain a copy of protected health information about you that is contained in a designated record set for as long as Heart of Iowa Community Services maintains the protected health information. A "designated record set" contains medical and billing records and any other records that Heart of Iowa Community Services uses in making decisions about you.

Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information. Depending on the circumstances, a decision to deny access may be reviewable. In some circumstances, you may have a right to have this decision reviewed. Please contact Heart of Iowa Community Services Privacy Contact if you have questions about access to your medical record.

- **RIGHT TO REQUEST A RESTRICTION OF YOUR PROTECTED HEALTH INFORMATION**

This means you may ask Heart of Iowa Community Services not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Heart of Iowa Community Services is not required to agree to a restriction that you may request. If Heart of Iowa Community Services believes that it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. If Heart of Iowa Community Services does agree to the requested restriction, it may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment. With this in mind, please discuss any restriction you wish to request with Heart of Iowa Community Services. You may request a restriction in writing to Heart of Iowa Community Services Privacy Officer.

- **RIGHT TO REQUEST CONFIDENTIAL COMMUNICATIONS FROM HEART OF IOWA COMMUNITY SERVICES BY ALTERNATIVE MEANS OR AT AN ALTERNATIVE LOCATION**

Heart of Iowa Community Services will accommodate reasonable requests. Heart of Iowa Community Services may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. Heart of Iowa Community Services will not request an explanation from you as to the basis for the request. Please make this request in writing to Heart of Iowa Community Services Privacy Contact.

- **RIGHT TO REQUEST AN AMENDMENT TO YOUR PROTECTED HEALTH INFORMATION**

This means you may request an amendment of protected health information about you in a designated record set for as long as Heart of Iowa Community Services maintains this information. In certain cases, Heart of Iowa Community Services may deny your request for an amendment. If Heart of Iowa Community Services denies your request for amendment, you have the right to file a statement of disagreement with Heart of Iowa Community Services and Heart of Iowa Community Services may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

- **RIGHT TO RECEIVE AN ACCOUNTING OF CERTAIN DISCLOSURES OF YOUR PROTECTED HEALTH INFORMATION**

This right applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this Notice of Privacy Practices. It excludes disclosures Heart of Iowa Community Services may have made to you, to family members or friends involved in your care, or for notification purposes. You have the right to receive specific information regarding these disclosures that occur after April 14, 2003.

- **RIGHT TO OBTAIN A PAPER COPY OF THIS NOTICE**

You have the right to obtain a paper copy of this notice, upon request, even if you have agreed to accept this notice electronically.

- **COMPLAINTS**

You may file a complaint with Heart of Iowa Community Services or the Secretary of Health and Human Services if you believe your privacy rights have been violated by Heart of Iowa Community Services. You may file a complaint against Heart of Iowa Community Services by notifying the Heart of Iowa Community Services privacy officer. Heart of Iowa Community Services will not retaliate against you for filing a complaint.



**HEART OF IOWA COMMUNITY SERVICES  
ACKNOWLEDGMENT  
OF RECEIPT OF  
NOTICE OF PRIVACY PRACTICE**

I, \_\_\_\_\_, do hereby acknowledge receipt of a copy of the Notice of Privacy Practice for Heart of Iowa Community Services.

---

Signature of Consumer

Date

**IN THE EVENT THIS REQUEST IS MADE BY THE INDIVIDUAL’S PERSONAL REPRESENTATIVE:**

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Signature of personal representative

Date

---

Legal authority of personal representative