Iowa Individual Consumer Directed Attendant Care (CDAC) Checklist

Waiver Services (*Please check all waivers you provide services for)*			
☐	AIDS - HIV	☐	Health and Disability
☐	Brain Injury	☐	Intellectual Disability
☐	Elderly	☐	Physical Disability

Brain Injury (BI) (*Please check all credentials/certifications/ accreditations you have to provide services)*	
☐	Training Certificate(s)
☐	*Licensure/Accreditation (BI Specialist, RN, LPN, Etc.)
☐	Resume with job description and employment dates
☐	*Signed and dated personal statement

It is not a requirement to have Licensure or Accreditation to provide services under the Brain Injury waiver. If you are not licensed or accredited as one of the above, please provide a Personal Statement (on pg. 2) detailing your experience and support of the person(s) you have taken care of in the past.

Applicant NPI: X _____

As an applicant to be an Individual CDAC provider for the Brain Injury Waiver, you must provide one or more of the following:

1. **Licensure/Accreditation:**
   Please provide proof of Licensing or Accreditation for the following if applicable:

   - Brain Injury Specialist
   - Registered Nurse
   - Licensed Practical Nurse
   - Occupational Therapist
   - Physical Therapist
   - Certified Nursing Assistant

2. **Personal Statements must include one or more of the following:**

   - Detailed information on your experience with working hands on direct care with persons with a Brain Injury Diagnosis. Include employment history, dates, and on the job training/in services that are applicable.
   - That you reside in the household of the member, and/or are the parent of the member who will be receiving services. You must demonstrate that the instruction for the members care has been provided by a brain injury professional.
   - List the types of assistance and support you have been providing to the member and the length of time that these services have been performed.

Personal Statements:

Iowa Individual Consumer Directed Attendant Care (CDAC) Application

All Individual CDAC providers please complete:

1. Provider Name (Individual who will be providing services):

   Last: _____ MI:____ First: _____

   Maiden Name: _____Other Names Used: _____

2. Date of Birth : _____

3. Social Security Number (SSN): _____4.*NPI._____

   *Provider should have received an NPI from IME. Number will start with an X000

5. List all states where you have lived longer than one month (if applicable): _____

   _____

   _____

6. List all names and aliases that you have used in your life:_____

7. Address where Provider can be reached: _____

   _____

8. Phone Number: _____ Email: _____

9. Preferred Method of Contact: ☐ Phone ☐ Email ☐ Mail

Please disclose whether you, an agent, or managing employee has a "final adverse action" related to you or that person's involvement in any program under Medicare, Medicaid, or Title XX. "Final adverse actions" include convictions, exclusions, revocation, suspensions or any ongoing investigations.

Check one:

☐ **No**, I (or any agent or managing employees) have not received final adverse action related to any program under Medicare, Medicaid or the Title XX services program.

☐ **Yes**, I (or any agent or managing employees) have received final adverse action related to any program under Medicare, Medicaid, or the Title XX services program. Who is the adverse action against?

IOWA DEPARTMENT OF HUMAN SERVICES
REQUEST & ACKNOWLEDGEMENT TO CONDUCT REGISTRY AND RECORD CHECK

I understand and acknowledge that the Iowa Department of Human Services (hereinafter "Department") is required by statute to conduct Child Abuse Registry, Dependent Adult Abuse Registry, Sexual Offender Registry checks and DCI/FBI Criminal History Record checks for specific categories of persons who have direct contact with the department's clients or provide Department approved services for the Department's clients and herby request the Department conduct such a Registry and Record check regarding me.

Nothing within this form shall be construed as a guarantee to have direct contact with the Department's clients or provide Department approved services for the Department's clients.

SEXUAL OFFENDER REGISTRY

I hereby request and give permission to the Department to conduct a Sexual Offender Registry check. I further give permission to the Department to conduct such a registry check at any time while I have direct contact with the department's clients or provide Department approved services for the Department's clients.

Signature _____ Date _____

CHILD ABUSE REGISTRY

I hereby request and give permission to the Department to conduct a Child Abuse Registry check. I further give permission to the Department to conduct such a registry check at any time while I have direct contact with the department's clients or provide Department approved services for the Department's clients.

Signature _____ Date _____

DEPENDENT ADULT ABUSE REGISTRY

I hereby request and give permission to the Department to conduct a Dependent Adult Abuse Registry. I further give permission to the Department to conduct such a registry check at any time while I have direct contact with the department's clients or provide Department approved services for the Department's clients.

Signature _____ Date _____

CRIMINAL HISTORY RECORD

I hereby request and give permission to the Department to conduct a DCI and FBI Criminal History Record check. I further give permission to the Department to conduct such a registry check at any time while I have direct contact with the department's clients or provide Department approved services for the Department's clients.

Signature _____ Date _____

INFORMATION REQUIRED FOR REGISTRY AND RECORD CHECK
PLEASE TYPE or PRINT LEGIBLY

Last Name	First Name	Middle Name	Maiden Name (if applicable)
Alias (if applicable)	Alias (if applicable)	Alias (if applicable)	Alias (if applicable)
			HCBS Waiver Provider (CDAC)
Date of Birth	Gender	Social Security Number (###-##-####)	Reason for Check
Address		Address 2	
City		State	ZIP

For DHS Employees, Volunteers, or Contractors only: Position:

Institution: Serv. Area: CSCMR: Cent. Off.:

Applicant NPI: X_____

Self-Agent or managing employee: _____

If you answered YES, please attach a separate sheet with a detailed explanation of the final adverse action. Include with your explanation:

a. Nature of the adverse action
b. Date(s)
c. Person charged with the adverse action
d. Names of others involved and final adverse actions

Final Adverse Actions include the following:

Criminal Offenses include:

- Felony convictions, guilty pleas and adjudicated pre-trial diversions; financial crimes, such as extortion, embezzlement, income tax evasion, insurance fraud and other similar crimes for which the individual was convicted, including guilty pleas and adjudicated pre-trial diversions; any felony that placed the Medicaid program or its beneficiaries at immediate risk (such as a malpractice suit that results in a conviction of criminal neglect or misconduct); and any felonies that would result in a mandatory exclusion under Section 1128(a) of the Social Security Act.
- Misdemeanor conviction, under federal or state law, related to: (1) the delivery of an item or service under Medicare or a state health care program, or (2) the abuse or neglect of a patient in connection with the delivery of a health care item or service.
- Misdemeanor conviction, under federal or state law, related to theft, fraud, embezzlement, breach of fiduciary duty, or other financial misconduct in connection with the delivery of a health care item or service.
- Felony or misdemeanor conviction, under federal or state law, relating to the interference with or obstruction of any investigation into any criminal offense described in 42 C.F.R. Section 1001.101 or 1001.201.
- Felony or misdemeanor conviction, under federal or state law, relating to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance.

Exclusions, Revocations, or Suspensions include:

- Revocation or suspension of a license to provide health care by any state licensing authority. This includes the surrender of such a license while a formal disciplinary proceeding was pending before a state licensing authority.
- Revocation or suspension of accreditation.
- Suspension or exclusion from participation in, or any sanction imposed by, a federal or state health care program, or any debarment from participation in any Federal Executive Branch procurement or non-procurement program.
- Current Medicare or a state health care program payment suspension under any Medicare or a state health care program billing number.
- Medicare or a state health care program revocation of any Medicare or a state health care program billing number.

APPLICANT'S NAME: _____ **DATE:** _____

Pursuant to *Iowa Code 135C.33* please be advised that a criminal history check by the Department of Public Safety and a child and dependent adult abuse record check by the Department of Human Services must be completed on all provider applicants.

Do you have a record of founded child or dependent adult abuse or have you ever been convicted of a crime (including traffic offenses) in this state or any other state?

Please check the appropriate response.	☐ **YES** ☐ **NO**

If YES, attach a separate sheet with each abuse. List:

a. Original charge
b. The result of the charge, including but not limited to whether the charge was founded or unfounded, resulted in a formal conviction, deferred judgment, probation, acquittal, or exoneration
c. All the relevant location and dates.

AmeriHealth Caritas Iowa will request the Department of Human Services to perform an evaluation to determine whether the crime would prohibit the applicant's involvement with the organization.

The Department of Human Services has final authority in determining employability of the applicant.

Please sign below to acknowledge that you have been notified of the above information and that you understand a criminal record or founded abuse will delay and possibly prohibit your candidacy for enrollment as a provider.

STATEMENT:

Misrepresentation or falsification of any information in, or related to, this document may be punishable by criminal, civil (including a false claims lawsuit) and/or administrative action, fine and/or imprisonment under federal and/or state law.

CERTIFICATION:

I HEREBY CERTIFY that I have read the above statement, and that I have examined this document and all accompanying documents, and that to the best of my knowledge and belief, each is true, correct, and complete. I further certify that I am duly qualified to participate as a provider in that program. I PROMISE to apprise AmeriHealth Caritas Iowa immediately of any material changes to this application and provide true, correct, and complete answers to any subsequent questions of me by AmeriHealth Caritas Iowa related to or arising out of this application.

Signature: _____ Date: _____

CDAC APPLICATION REMINDERS CHECKLIST

☐ **COPY OF CURRENT DRIVER'S LICENSE – PLEASE ATTACH COPY WITH APPLICATION**

☐ **COPY OF SOCIAL SECURITY CARD – PLEASE ATTACH COPY WITH APPLICATION**

☐ **COMPLETED APPLICATION**

☐ **COPIES OF CURRENT LICENSURE OR CERTIFICATION IF APPLICABLE (IE. RN, LPN, EMT, CNA, ETC.)**

For Brain Injury Waiver Applicants ONLY please provide additionally (listed on Pg. 2):

☐ **COPY OF RESUME**

☐ **COPY OF TRAINING CERTIFICATE YOU WOULD HAVE RECEIVED THROUGH IME**

☐ **COPIES OF CURRENT LICENSURE OR CERTIFICATION IF APPLICABLE (IE. RN, LPN, EMT, CNA, ETC.)**

Applicant NPI: X _____