# STATE OF IOWA

IOWA DEPARTMENT OF

INSPECTIONS & APPEALS

Adult Services Bureau
Lucas Building, Third Floor
321 East 12th Street
Des Moines, IA 50319-0083

# ELDER GROUP HOMES

## APPLICATION AND INFORMATION PACKET

REVISED MAY 2015

# ELDER GROUP HOMES
# APPLICATION PACKET INDEX

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SECTION 2: Iowa Code Chapter 231b and Administrative Rules

SECTION 3: Waiver Information

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# SECTION 1:

## GENERAL INFORMATION

## AND

## APPLICATION FORM

## Health Facilities Division
## Mailing Address and Telephone Number

**Iowa Department of Inspections and Appeals**
**Health Facilities Division**
Lucas State Office Building
321 East 12th Street
Des Moines, Iowa 50319-0083
**(515) 281-4115**

Search for any state employee in the State of Iowa Employee Telephone Directory

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## Iowa Department of Inspections and Appeals
## Health Facilities Division
## Contact Information

**Department Director**
Rodney A. Roberts
(515) 281-5457
Rod.Roberts@dia.iowa.gov

**Division Administrator**
Dawn Fisk
(515) 281-4233
Dawn.Fisk@dia.iowa.gov

**Medicare/Medicaid Bureau I**
**Assistant Division Administrator**
Kathy Sutton, Bureau Chief
(515) 281-4245
Kathy.Sutton@dia.iowa.gov

**Medicare/Medicaid Bureau II**
Mindla White, Bureau Chief
(515) 281-3765
Mindla.White@dia.iowa.gov

**Medicare/Medicaid Bureau III**
Kathy Kieler, Bureau Chief
(515) 281-5057
Kathy.Kieler@dia.iowa.gov

**Complaint/Incident Bureau**
Joni Klaassen, Bureau Chief
(515) 281-4227
Joni.Klaassen@dia.iowa.gov

**Medicare Services Bureau**
Mary Spracklin, Bureau Chief
(515) 281-0286
Mary.Spracklin@dia.iowa.gov

**Special Services Bureau**
James Friberg, Bureau Chief
(515) 281-7624
James.Friberg@dia.iowa.gov

**Adult Services Bureau**
James Friberg, Acting Bureau Chief
(515) 281-7624
James.Friberg@dia.iowa.gov

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## Specialty Program Areas

**Clinical Laboratory Improvement Amendments (CLIA) Program**
Nancy Grove
University of Iowa Hygienic Laboratory
(319) 335-4500 or 1-800-421-IOWA
ngrove@uhl.uiowa.edu

**Direct Care Worker Registry**
Greg DeMoss
(515) 281-4077
1-866-876-1997
Greg.DeMoss@dia.iowa.gov

**Training Officer and Resident Assessment Instrument Coordinator**
Susan Odell
(515) 242-5991
Susan.Odell@dia.iowa.gov

**Compliance Officers**
Donna Spencer
(515) 281-4558
Donna.Spencer@dia.iowa.gov

Hema Lindstrom
(515) 281-3079
Hema.Lindstrom@dia.iowa.gov

James Berkley
(515) 281-7624
James.Berkley@dia.iowa.gov

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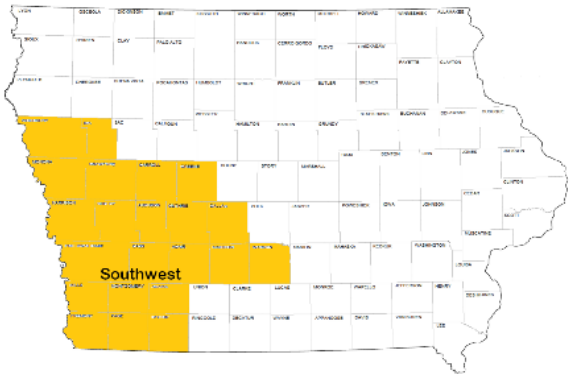
## Medicare/Medicaid Bureau I

**Medicare/Medicaid Bureau I**
**Assistant Division Administrator**
Kathy Sutton
(515) 281-4245
Kathy.Sutton@dia.iowa.gov

**Southwest Iowa**
Sandra Simmons, Program Coordinator
(515) 281-4079
Sandra.Simmons@dia.iowa.gov
Polk County facilities:

- Calvin Manor
- Deerfield Retirement
- Karen Acres
- Kenny Brook
- Polk City Nursing & Rehab
- Ramsey Village
- University Park

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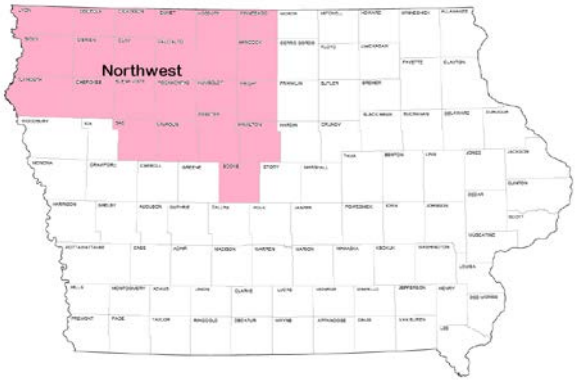
## Medicare/Medicaid Bureau II

**Medicare/Medicaid Bureau II**
Mindla White, Bureau Chief
(515) 281-3765
Mindla.White@dia.iowa.gov

**Northwest Iowa**
Peggy Gilmore, Program Coordinator
(515) 281-3752
Peggy.Gilmore@dia.iowa.gov
Polk County facilities:

- Altoona Nursing & Rehab
- Fleur Heights
- Fountain West
- Iowa Jewish Senior Life
- Iowa Lutheran Hospital
- Park Ridge Nursing & Rehab
- Trinity Center
- Union Park




**Southeast Iowa**
Donna Walters, Program Coordinator
(515) 281-3352
Donna.Walters@dia.iowa.gov

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## Medicare/Medicaid Bureau III

**Medicare/Medicaid Bureau III**

Kathy Kieler, Bureau Chief
(515) 281-5057
Kathy.Kieler@dia.iowa.gov

### East Central Iowa

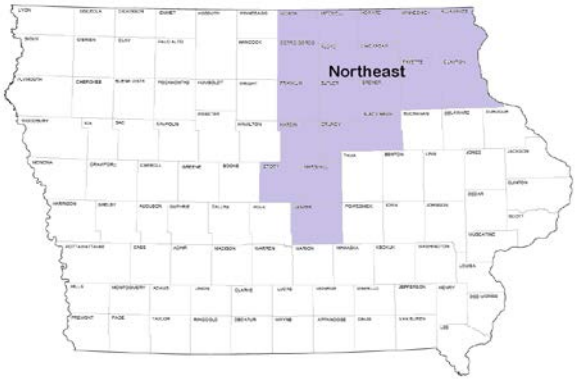
Patrice Fagen
(515) 281-3025
Patrice.Fagen@dia.iowa.gov
Polk County facilities:

- Bishop Drumm
- Genesis Senior Living
- ManorCare of West Des Moines
- Scottish Rite
- Valley View
- Wesley Acres

### Northeast Iowa

Jolyn Meehan, Program Coordinator
(515) 281-4922
Jolyn.Meehan@dia.iowa.gov
Polk County facilities:

- Child Serve
- Mill Pond
- Mitchell Village
- On With Life
- Prime Nursing & Rehab
- Sunny View
- The Rehab of Des Moines
- Urbandale Health Care

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## Complaint/Incident Bureau

**Complaint/Incident Bureau**

Joni Klaassen, Bureau Chief
(515) 281-4227
Joni.Klaassen@dia.iowa.gov

Geri Paul, Program Coordinator
(515) 281-4548
Geri.Paul@dia.iowa.gov

**Nursing Home Complaint Hotline**
1-877-686-0027
**Home Health Agency Hotline**
1-800-383-4920

## Medicare Services Bureau

**Medicare Services Bureau**
Mary Spracklin, Bureau Chief
(515) 281-0286
Mary.Spracklin@dia.iowa.gov

**Hospitals, PPS Units, and Portable X-Ray**
Trish Hubbard, Program Coordinator
(515) 725-0994
Trish.Hubbard@dia.iowa.gov

**Home Health Agencies, Hospices, and Rural Health Clinics**
Rosemary Kirlin, Program Coordinator
(515) 281-4120
Rosemary.Kirlin@dia.iowa.gov

**End-Stage Renal Disease Units, Ambulatory Surgical Centers, CORFs, and Rehabilitation Agencies**
Sandra Wendehl, Program Coordinator
(515) 281-4901
Sandra.Wendehl@dia.iowa.gov

**OASIS Education Program**
Maribeth Freland, OASIS Coordinator
(515) 281-4115
Maribeth.Freland@dia.iowa.gov

## Special Services Bureau

**Special Services Bureau**
James Friberg, Bureau Chief
(515) 281-7624
James.Friberg@dia.iowa.gov

**Intermediate Care Facilities for the Intellectually Disabled**
Catie Campbell, Program Coordinator
(515) 281-3759
Catie.Campbell@dia.iowa.gov

**Licensed Only and Children's Services**
Debra Dixon, Program Coordinator
(515) 281-4081
Deb.Dixon@dia.iowa.gov

## Adult Services Bureau

**Adult Services Bureau**

James Friberg, Acting Bureau Chief
(515) 281-7624
James.Friberg@dia.iowa.gov

Rose Boccella, Program Coordinator
(515) 281-7039
Rose.Boccella@dia.iowa.gov

# IOWA DEPARTMENT OF INSPECTIONS AND APPEALS
## HEALTH FACILITIES DIVISION
### APPLICATION FOR CERTIFICATE

Please answer all questions completely and accurately to avoid unnecessary delays in processing. Return the completed application, with the required fee to the address below 30 days prior to the opening of the program or the expiration of your current certificate. Note: This application is an open record and available to the public.

**Iowa Department of Inspections & Appeals**
**Health Facilities Division – Adult Services Bureau**
**Lucas State Office Building – Third Floor**
**321 East 12th Street**
**Des Moines, IA 50319-0083**
**(515) 281-6325**
**Fax: (515) 242-5022**

| FOR OFFICE USE ONLY |
|---|
| Certificate Number: |
| Certificate Fee: |
| Certificate Type |
| Effective Date: |
| Expiration Date: |

**Type of Application**

☐ Initial ☐ Recertification ☐ Amendment* ☐ Change of Ownership

* Please specify the reason for the amendment (i.e., Program name change, % ownership change of an interested party):
_____

| GENERAL INFORMATION | | | |
|---|---|---|---|
| Program Name (doing business as) | | | |
| Previous Name (if applicable) | | | |
| Street Address (physical location) | | | |
| City | County | State | Zip Code |
| Mailing Address (if different from physical address) | | | |
| City | County | State | Zip Code |
| Program Telephone Number | Program FAX Number | E-mail Address | |

| CERTIFICATE TYPE (CHOOSE ONE) AND FEE STRUCTURE | |
|---|---|
| ☐ Assisted Living Program<br>Type of Population: ☐ General and/or ☐ Dementia-Specific<br>☐ Elder Group Home<br>☐ Adult Day Service | ☐ Initial certificate - $750<br>☐ Recertification - $1,000<br>☐ Accreditation via a national body of accreditation (ALP and ADS only) - $125 |
| Total Number of Dwelling Units: _____<br>If an Assisted Living Program, Number of Dwelling Units:<br>General Population _____<br>Dementia-Specific _____<br>Maximum Occupancy: _____ | Fee Enclosed:<br>$ |

Certificate Holder is the ☐ owner(s)/lessor(s), ☐ lessee, or ☐ management company.
The Certificate Holder is the person(s) or business entity ultimately responsible for the operation of the program and with the authority to direct the management and policies of the program.

| ADMINISTRATION | |
|---|---|
| **A. Program Manager** | |
| Name – Program Manager | E-Mail Address |
| Indicate whether the Program Manager is also the **designee** (person authorized to accept personal service and receive registered and certified mail). If "No," complete the Designee section.<br>☐ **Yes** ☐ **No** | |
| **Note**: Any changes to the Program Manager should be reported to the Department in writing within ten (10) business days of the change. | |

| **B. Designee** | | |
|---|---|---|
| Name – Designee | Title | E-Mail Address: |

| OWNERSHIP INFORMATION | | | |
|---|---|---|---|
| **A. Owner(s)/Lessor(s)** | | | |
| Name – Owner(s)/Lessor(s) | | | |
| Street Address (physical location) | | | |
| City | State | Zip Code | County |
| Mailing Address (if different from street address) | | | |
| City | State | Zip Code | County |
| Telephone Number | FAX Number | E-mail Address | |
| Contact Person | | Telephone Number | |

| **B. Type of Organization (check type of organization)** | | |
|---|---|---|
| Governmental | Proprietary | Voluntary Non-Profit |
| ☐ City<br>☐ County<br>☐ State<br>☐ Federal<br>☐ City/County<br>☐ Tribal | ☐ Sole Proprietary<br>☐ Partnership<br>☐ Corporation<br>☐ Limited Liability Company<br>☐ Limited Liability Partnership<br>☐ Trust | ☐ Corporation<br>☐ Church<br>☐ Association<br>☐ Church/Corporation<br>☐ Private Non-Profit<br>☐ Limited Liability Company<br>☐ Limited Liability Partnership<br>☐ Trust |

## C. Interested Parties

List all the names, addresses, and percentages of stock, shares, and partnerships or other equity interest of all officers, members of the board of directors, and trustees, as well as stockholders, partners, or any individuals who have greater than a 10% equity interest in the program. The program shall notify DIA of any changes in the list no later than 10 working days after the effective date of the changes.

| | | | |
|---|---|---|---|
| Name | Title | | Ownership % |
| Street | City | State | Zip Code |
| Name | Title | | Ownership % |
| Street | City | State | Zip Code |
| Name | Title | | Ownership % |
| Street | City | State | Zip Code |
| Name | Title | | Ownership % |
| Street | City | State | Zip Code |
| Name | Title | | Ownership % |
| Street | City | State | Zip Code |
| Name | Title | | Ownership % |
| Street | City | State | Zip Code |
| Name | Title | | Ownership % |
| Street | City | State | Zip Code |

## D. Lessee Information (If the lease includes sub-leases, complete for all parties)

Is the program leased? ☐ Yes ☐ No
If "**Yes**," continue. If "**No**," skip to Section E.

| | | | |
|---|---|---|---|
| Name of Lessee | | | |
| Street Address (physical location) | | | |
| City | State | Zip Code | County |
| Mailing Address (if different from physical location) | | | |
| City | State | Zip Code | County |
| Telephone Number | FAX Number | E-Mail Address | |
| Contact Person | | Telephone Number | |

**E. Type of Organization (check type of organization)**

| Governmental | Proprietary | Voluntary Non-Profit |
|---|---|---|
| ☐ City<br>☐ County<br>☐ State<br>☐ Federal<br>☐ City/County<br>☐ Tribal | ☐ Sole Proprietary<br>☐ Partnership<br>☐ Corporation<br>☐ Limited Liability Company<br>☐ Limited Liability Partnership<br>☐ Trust | ☐ Corporation<br>☐ Church<br>☐ Association<br>☐ Church/Corporation<br>☐ Private Non-Profit<br>☐ Limited Liability Company<br>☐ Limited Liability Partnership<br>☐ Trust |

**F. Interested Parties**

List all the names, addresses, and percentages of stock, shares, and partnerships or other equity interest of all officers, members of the board of directors, and trustees, as well as stockholders, partners, or any individuals who have greater than a 10% equity interest in the program. The program shall notify DIA of any changes in the list no later than 10 working days after the effective date of the changes.

| Name | Title | | Ownership % |
|---|---|---|---|
| Street | City | State | Zip Code |
| Name | Title | | Ownership % |
| Street | City | State | Zip Code |

**G. Subsidiary/Parent Information**

Is the applicant a subsidiary company, either wholly or partially owned by another organization or business?

☐ Yes ☐ No

If "Yes," please provide the following information:

| Legal Business Name – Parent Corporation | | | |
|---|---|---|---|
| DBA (Doing Business As) | | | |
| Type of Ownership | | | |
| Address | City | State | Zip Code |
| Contact Person | | Telephone Number | |

**H. Chain Organization**

Is the applicant under the control of a chain organization?

☐ Yes ☐ No

Chain organization is defined as multiple providers, and/or suppliers owned, leased, or through any other device, controlled by a single business entity (defined as chain home office). Each entity in the chain may have a different owner but the "home office" maintains uniform procedures in each program for handling utilization review, reimbursement, handling admissions, also maintains and controls centrally, providers/suppliers cost reports, etc.

In addition, a chain program would not necessarily be a subsidiary of the parent corporation but the chain program or programs could be owned by different subsidiaries of the same corporation parent.

Name – Chain Organization

If the applicant/licensee is a Limited Liability Company (LLC) or Limited Liability Partnership (LLP):

- Provide the names and addresses of all LLCs, LLPs or any other type of entity that any of the member(s) of the applicant are also members, officers, directors and/or board members.
- Provide an organizational chart exhibiting the legal business names of any and all subsidiaries, LLCs, LLPs involved with the applicant and its members.

## MANAGEMENT COMPANY

Is the operation of the program under a management contract?

☐ Yes ☐ No

If "Yes," provide the following information regarding any management company retained to operate this program.

| Type of Management Company: | ☐ Corporation | ☐ Partnership | ☐ LLC | ☐ Other |
|---|---|---|---|---|
| If "Other," please specify: | | | | |
| Name – Management Company | | | | |
| Name – Contact Person | | | Telephone Number | |
| Address | | City | State | Zip Code |

Please identify officers, directors, trustees or supervisors of the management company. Attach additional pages if necessary.

| Name | | Title | |
|---|---|---|---|
| Address | City | State | Zip Code |
| Name | | Title | |
| Address | City | State | Zip Code |

## FUNDING – FOR ASSISTED LIVING PROGRAMS ONLY

Is the Program considered an Affordable Assisted Living Program, which is built with low-income housing tax credits?

☐ Yes ☐ No

Will the Program participate in the Medicaid Home and Community-Based Services (HCBS) Waiver program?

☐ Yes ☐ No

Will the Program participate in the HCBS Rent Subsidy Waiver or HUD Section 8 Rental Vouchers program?

☐ Yes ☐ No

## STRUCTURE (FILL IN STRUCTURAL INFORMATION SHEET REGARDING DWELLING UNITS)

A. Is the Program attached to one of the following: ☐ RCF ☐ NF ☐ Hospital ☐ Freestanding

B. Is the Program part of a licensed Continuing Care Retirement Community (CCRC)? ☐ Yes ☐ No

C. What is the targeted opening date of the new program? _____

D. For Recertification only:

Have there been any structural modifications to the building since the most recent state certification?

☐ Yes ☐ No

If you answered "Yes," please provide the month and year of completion of the modification(s):

Month/Year: _____

## OTHER BUSINESS/ACTIVITY

Please list all other business(es) or activity(ies) located in the program, such as respite care, physical therapy, occupational therapy, etc.: _____

_____

_____

## TARGET CLIENTELE

Please describe the clientele to be served (i.e. Intellectually Disabled, Brain Injury, Dementia, Elderly, etc.):

_____

_____

_____

## EMERGENCY RESPONSE SYSTEM

Will the program have staff on-site on a 24-hour/day basis to respond to emergency situations?

☐ Yes ☐ No

If you checked "No," please annotate the staff's emergency response time in minutes: _____

## FOOD SERVICE

The Program will serve _____ meals each day in a common dining room.

Meals will be prepared:
☐ On-site, a copy of the food service establishment or nursing facility license is attached
☐ Off-site, a copy of the provider's food service establishment or nursing facility license is attached

## ADVERSE ACTION – TO BE COMPLETED BY NEW APPLICANTS ONLY

Within the last 10 years, has any adverse action(s) initiated by another state license agency (other than Iowa) resulted in the denial (D), suspension (S), or revocation (R) of a license or certificate held by the owner/lessor, lessee, interested parties, parent corporation, "home office" of a chain organization and/or any of the members of a LLC/LLP?

☐ Yes ☐ No

If "Yes," complete the following table. Use abbreviations to describe the type of adverse action.

| Facility Name and Address | City and State | Type of Health Care Provider | Type of Adverse Action | Effective Dates of Adverse Action |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |

## OTHER PROVIDERS

Identify the other types of providers owned by the applicant/licensee.
If more than two, check here ☐ and attach additional pages.

| Name – Provider | | |
|---|---|---|
| City | State | Zip Code |
| Relationship Type (nursing facility, home health agency, community-based residential care facility, hospital, etc.) | | |
| Name – Provider | | |
| City | State | Zip Code |
| Relationship Type (nursing facility, home health agency, community-based residential care facility, hospital, etc.) | | |

## APPLICANT/LICENSEE - TO BE COMPLETED BY NEW APPLICANTS ONLY

If the applicant/licensee has never been licensed to operate a program in the State of Iowa, we request that you provide resumes for each officer (if the applicant is a corporation) or each partner (if partnership) or member (if limited liability company), etc. to assist the Department in determining the applicant's ability to operate a program.

## CONTACT PERSON

Identify the person responsible for completing this application and who can be contacted if we have questions.

| Name | | Title |
|---|---|---|
| Telephone Number | FAX Number | E-Mail Address |

## Disclosures

1. In accordance with 481 IAC 69.4(3), 68.4(3) or 70.4(3), do any of the individuals referred to in the "Interested Parties" sections of this application have, or have they had, any ownership interest in an adult day service program, assisted living program, elder group home, home health agency, licensed health care facility as defined in Iowa Code chapter 135C, or a licensed hospital as defined in Iowa Code chapter 135B, which has been closed in any state due to removal of program, agency, or facility licensure or certification, due to involuntary termination from participation in either the Medicare or Medicaid Program, or have been found to have failed to provide adequate protection or services to prevent abuse or neglect of residents, patients, tenants, or participants.

2. In accordance with 481 IAC rules 68.4(2), 69.4(2), or 70.4(2), have any of the individuals referred to in the "Interested Parties" section of this application been convicted of a felony, aggravated or serious misdemeanor or found in violation of the child abuse or dependent adult abuse laws of any state.

☐ Yes ☐ No

If *"Yes,"* please provide an explanation on a separate sheet of paper.

## AFFIRMATION STATEMENT

I hereby affirm to the best of my knowledge that the information in this application is complete and accurate. I assure the owner(s) of the program named herein will work with the Department of Inspections and Appeals, Department of Public Safety, and others as deemed necessary, to bring the program into full compliance with the requirements of Iowa Code chapters 231B, 231C, or 231D; 481 Iowa Administrative code chapters 67, 68, 69 or 70; and other applicable local, state, and federal regulations.

_____ _____

Authorized Signature and Title Date

# ELDER GROUP HOME
# RESIDENT MANAGER AFFIRMATION STATEMENT

I hereby affirm that the individuals, referred to in the footnote on this page, have not been convicted of a felony or serious misdemeanor or been found in violation of the dependent adult abuse/ child abuse code in any state.

As the owner of the home located at _____
(Address)

I certify that the information contained in this application is accurate to the best of my knowledge. I assure the owner(s) of the EGH program named herein will work with the Iowa Department of Inspections and Appeals, Public Safety, Iowa Department on Aging and others as deemed necessary to bring the EGH program into full compliance with the requirements of Iowa Code Chapter 231B, IAC 481–67 & 68 and applicable local, state and federal codes. Further, I have read, understand, and agree to comply with the regulations for the Elder Group Home Programs contained in the Code of Iowa, Chapter 231B, and the Iowa Administrative Code 481 – Chapters 67 & 68.

_____ _____
(Authorized Signature & Title) (Date)

Subscribed and sworn before me this _____ day of _____, 20____.

(Notary Seal)

Dated at _____
(City, State)

_____
(Signature of Notary)

My Commission Expires:_____

[1] Submit a list including the names, addresses and percentages of stock, shares, partnership or other equity interest of all officers, members of the board of directors, trustees, and of the designated manager, as well as stockholders, partners or any individuals who have greater than a 10% equity interest in the program. The program shall notify DIA of any changes in the list within ten working days of the changes.

# ELDER GROUP HOME
# RESIDENT MANAGER AFFIDAVIT

As the resident manager for the Elder Group Home _____
(Name of EGH)

located at _____,
(Address)

I, _____, attest that I currently am *not* using illegal substances *or* abusing legal substances, *nor* do I have a record of dependent adult, child or domestic abuse. If at any time I am found to have lied on this affidavit *or* to be actively using any illegal substance, abusing any legal substances *or* to be committing dependent adult, child or domestic abuse, I understand that I may no longer serve as a resident manager for any Elder Group Home in the State of Iowa.

_____ _____
(Resident Manager's Signature) (Date)

Subscribed and sworn before me this _____ day of _____, 20____.

(Notary Seal)

Dated at _____
(City, State)

_____
(Signature of Notary)

My Commission Expires:_____

## ELDER GROUP HOME
## RESIDENT MANAGER DISCLOSURE STATEMENT

In accordance with Iowa Code Chapter 231B, IAC 481–67 & 68, do any of the individuals referred to in the footnote on this page, have, or have had an ownership interest in an adult day services program, assisted living program, an elder group home, home health agency or licensed health care facility as defined under Iowa Code section 135C.1, or a licensed hospital under Iowa Code section 135B.1, which has been closed in any state due to the removal of the program, agency, or facility licensure or certification or due to involuntary termination from participation in either the Medicaid or Medicare program; or have been found to have failed to provide adequate protection or services for participants to prevent abuse or neglect?

☐ Yes ☐ No If "Yes" was selected, please provide an explanation below.

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

[1] Submit a list including the names, addresses and percentages of stock, shares, partnership or other equity interest of all officers, members of the board of directors, trustees, and of the designated manager, as well as stockholders, partners or any individuals who have greater than a 5% equity interest in the program. The program shall notify DIA of any changes in the list within ten working days of the changes.

# Elder Group Home (EGH)
# CHECKLIST

NEGH 1/1/10

**COMPLETE THIS CHECKLIST AS IS. PLEASE DO NOT RE-CREATE THIS FORM**

**RETURN THIS CHECKLIST WITH THE APPLICATION FORM**

## I. REQUIRED FEES AND DOCUMENTS

For purposes of brevity, all references to 481 Iowa Administrative Code chapter 67 (General Provisions for Elder Group Homes, Assisted Living Programs, and Adult Day Services), 481 Iowa Administrative Code chapter 68 (Elder Group Homes), and Iowa Code chapters 135C, 231B, 235B, and 235E are annotated by rules/section. **Please refer to the applicable Iowa Administrative Code rules and Iowa Code sections before submitting the required policies and procedures.**

☐ A. Application Form including the resident manager affidavit, affirmation statement and disclosure statement submitted at least 90 calendar days prior to expected date of beginning operation or expiration of current certification period. [68.3(2), 68.4(1)(2)(3)]

☐ B. Proof of Ownership of the Elder Group Home (i.e. copy of the deed to the house)

☐ C. Preliminary Blueprint Plan Review (Optional): $500.00. 231B.17

☐ D. Blueprint Plan Review: $900.00 (Initial Certification Only) 231B.17

☐ E. Two-year Initial Certification Fee: $750.00. [231B.17, 68.3(3)]

☐ F. Two-year Recertification Fee: $1000.00. [231B.17, 68.3(3)]

☐ G. Submit a floor plan of the home and do the following: [68.24]

a. Indicate with an "X" all areas that are not to be used by tenants.

b. Indicate which rooms are the tenant's rooms.

c. Indicate locations of the following items for the tenants: Telephones, Toilets, Doors and Bathtubs & Sinks.

☐ H. If the home was constructed or substantially remodeled after January 1, 1994, submit a signed document (from the cities building inspector) stating the home meets applicable housing codes.

☐ I. If the home's water supply is not provided by a municipal or rural water system, submit signed documentation from the state laboratory that the water supply is safe to drink. [68.25(2)c(1)]

☐ J. The policy and procedure for evaluation of each tenant. A copy of the evaluation tool(s) to be used to identify the functional, cognitive, and health status of each tenant shall be included. [231B.2, 68.4(4), 68.13]

☐ K. The policy and procedures for service plans and the service plan format. [68.4(5), 68.17]

☐ L. The policy and procedure for addressing medication needs of tenants and nurse review. [231B.21, 67.5, 68.4(6), 68.18]

☐ M. The policy and procedure for accidents/incidents, emergency response (pendants, tenant checks etc.) and emergency plans (evacuation policies for fires, tornados, flooding and all other emergency situations). The policy and procedure shall include procedures for notifying legal representatives in emergency situations as applicable. [231B.4, 231B.12, 67.2, 67.4, 67.15, 68.4(7), 68.4(11), 68.24, 68.25]

☐ N. The policy and procedure for food service, including those relating to staffing, nutrition, menu planning, therapeutic diets, and food preparation, service and storage. [68.4(8)]

- ☐ O. The policy and procedure for transportation. [68.4(9), 68.21]
- ☐ P. The policy and procedure for staffing, dementia education and staff training; including, the procedure for employee background checks. [231B.2, 231B.5(m), 67.9, 67.18, 68.4(10), 68.19, 135C.33, 235E]
- ☐ Q. The policy and procedure for managing risk and upholding tenant autonomy when tenant decision making results in poor outcomes for the tenant or others. [ 68.4(12), 68.16(1)h, 68.20]
- ☐ R. The policy and procedure for reporting incidents including dependent adult abuse as required in rule [231B, 235B, 235E, 67.2, 68.4(13)]
- ☐ S. The tenant occupancy agreement, tenant rights and all attachments. [231B.5, 67.3, 68.4(14), 68.12, 68.14, 68.15]
- ☐ T. Structural and life safety reviews. [68.4(11), 68.24, 68.25]
- ☐ U. Policy in regard to reporting Nursing Assistant Work Credit. [231B.20, 67.16]
- ☐ V. Resident Advocate Committees. [231B.19, 68.23]
- ☐ W. Identification of Veteran's Benefit Eligibility. [68.22]
- ☐ X. Tenant Documents [68.16]

## II. SYSTEMS

**A. For recertification**: Submit a signed and dated statement (in letter form) indicating that the systems listed below have been annually inspected and are in proper working order, if the items are applicable. If not applicable, annotate the corresponding box with an "N".

**B. Systems (68.7(2)):**
1. ☐ Heating, Ventilation and Air Conditioning (HVAC) system.
2. ☐ Electrical system (to include artificial lighting system).
3. ☐ Plumbing, water heater, and sewage system.
4. ☐ Cooking area appliances (if applicable).
5. ☐ Garbage disposals (if applicable).
6. ☐ Laundry appliances (if applicable).
7. ☐ Elevator(s) (if applicable).

## III. LICENSES / CERTIFICATES

Send copies only: Items 1, 2 and 3 must be submitted. Items 4 and 5 must be submitted if applicable to the program.

- ☐ 1. Current state license for the entity providing food service (program or outside entity(s)). [68.4(16)]
- ☐ 2. License(s)/certificate(s) for entities if contracted to provide personal care or health-related care. [68.4(15)]
- ☐ 3. Copy of certificate/license of credentials for each employee in the home (i.e. CNA's, RN etc.) [68.19(2)]
- ☐ 4. State license for other business(s)/activity(s) in the program (i.e., beauty salon, barber shop, etc.). [231B.2(7), 67.6]
- ☐ 5. Current CLIA certificate if program staff performs any laboratory testing. (See info sheet)

**RETURN THIS CHECKLIST WITH APPLICATION**

# 481-IAC Chapters 67 & 68 ELDER GROUP HOME PROGRAMS

## EGH CERTIFICATION and RE-CERTIFICATION DOCUMENT REVIEW CHECKLIST

**This checklist may be utilized by an Elder Group Home as a tool to help put together documents required to be submitted to DIA for initial and recertification processing and to ensure the documents contain the minimum requirements set forth by Iowa Code chapter 231B, 481 Iowa Administrative Code chapters 67 and 68, and other applicable law. DIA will use the same checklist to verify the documents contain the minimum requirements. Copies of this checklist may be made for your use.**

**DO NOT RETURN THIS CHECKLIST WITH YOUR DOCUMENTS**

| Y | N | Rule/Code Section | Criteria |
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| | | | **PROGRAM REQUIREMENTS** |
| | | **68.3** | Submit to DIA all information addressed in the Elder Group Home Checklist, as well as in this checklist, at least 90 days prior to certification/recertification. |
| | | **231B.4** | When applying for certification or recertification, contact the Facility Engineer and the State Fire Marshall to initiate their visit to the program. (See Resource Sheet) |
| | | **135C.33** | Insure that all child, dependent adult abuse and criminal records are checked on all employees prior to employment. |
| | | **235B.16(5)b, 67.2, 68.4(14)** | Insure that all employees who require dependent adult and child abuse training have received it within six months of employment and the program has established a policy for reporting abuse allegations. |
| | | **68.26(231B)** | **Landlord and tenant Act.** Iowa Code chapter 562A, the uniform residential landlord and tenant Act, shall apply to all EGHs under this chapter. |
| | | **68.23(231B)** | **Resident Advocate Committees.** Resident advocate committees for EGHs shall be governed by 321—Chapter 9 unless otherwise required in this chapter. |
| | | **68.23(1)** | *Committee placement.* A resident advocate committee shall be established by the commission on aging for each program certified in accordance with this chapter. |
| | | **68.23(2)** | *Committee visitations.* The committee shall visit the program assigned to it within one month of the admission of the first tenant as well as a minimum of once and maximum of four times annually thereafter. |
| | | **68.22(231B)** | **Identification of veteran's benefit eligibility.** |
| | | **68.22(1)** | Within 30 days of a tenant's participation in an elder group home that receives reimbursement through the medical assistance program under Iowa Code chapter 249A, the program shall ask the tenant or the tenant's personal representative whether the tenant is a veteran or whether the tenant is the spouse, widow, or dependent of a veteran and shall document the response. |
| | | **68.22(2)** | If the program determines that the tenant may be a veteran or the spouse, widow, or dependent of a veteran, the program shall report the tenant's name along with the name of the veteran, if applicable, as well as the name of the contact person for this information, to the Iowa Department of Veterans Affairs. When appropriate, the program may also report such information to the Iowa Department of Human Services. |
| | | **68.22(3)** | If a tenant is eligible for benefits through the U.S. Department of Veterans Affairs or other third-party payor, the program first shall seek reimbursement from the identified payor source before seeking reimbursement from the medical assistance program established under Iowa Code chapter 249A. |
| | | **68.16(231B)** | **Tenant Documents.** |
| | | **68.16(1)** | Documentation for each tenant shall be maintained by the program and shall include:<br>*a.* An occupancy record including the tenant's name, birth date, and home address; identification numbers; date of beginning participation; name, address and telephone number of health professional(s); diagnosis; and names, addresses and telephone numbers of family members, friends or other designated people to contact in the event of illness or an emergency;<br>*b.* Application forms;<br>*c.* The initial evaluations and updates;<br>*d.* A nutritional assessment as necessary;<br>*e.* The initial individual service plan and updates;<br>*f.* Signed authorizations for permission to release medical information, photographs, or other media information as necessary; |

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| | | | *g.* A signed authorization for the tenant to receive emergency medical care as necessary;<br>*h.* A signed managed risk policy and signed managed risk consensus agreements, if any;<br>*i.* When any personal or health-related care is delegated to the program, the medical information sheet; documentation of health professionals' orders, such as those for treatment, therapy, and medication; and nurses' notes written by exception;<br>*j.* Medication lists, which shall be maintained in conformance with 481—subrule 67.5(4);<br>*k.* Advance health care directives as applicable;<br>*l.* A complete copy of the tenant's occupancy agreement, including any updates;<br>*m.* A written acknowledgment that the tenant or the tenant's legal representative, if applicable, has been fully informed of the tenant's rights;<br>*n.* A copy of guardianship, durable power of attorney for health care, power of attorney, or conservatorship or other documentation of a legal representative;<br>*o.* Incident reports involving the tenant, including but not limited to those related to medication errors, accidents, falls, and elopements (such reports shall be maintained by the program but need not be included in the tenant's medical record);<br>*p.* A copy of waivers of admission or retention criteria, if any;<br>*q.* When the tenant is unable to advocate on the tenant's own behalf or the tenant has multiple service providers, including hospice care providers, accurate documentation of the completion of routine personal or health-related care is required on task sheets. If tasks are doctor-ordered, the tasks shall be part of the medication administration records (MARs); and<br>*r.* Authorizations for the release of information, if any. |
| | | **68.16(2)** | The program records relating to a tenant shall be retained for a minimum of three years after the transfer or death of the tenant. |
| | | **68.16(3)** | All records shall be protected from loss, damage and unauthorized use. |
| | | **68.25(231B)** | **Structural Standards.** |
| | | **68.25(1)** | The EGH shall be safe, sanitary, well-ventilated, and properly lighted, heated, and cooled; and shall comply with all applicable state and local housing ordinances for family residences and with fire safety rules promulgated by the state fire marshal. |
| | | **68.25(2)** | In addition to meeting the requirements in subrule 68.25(1), the EGH shall meet the following standards:<br>a. General<br>b. Safety<br>c. Sanitation Requirements<br>d. Bedroom Requirements |
| | | | **OCCUPANCY AGREEMENT** |
| | | | **Occupancy Agreement:** |
| | | **231B.5(1)** | An elder group home shall not operate in this state unless a written occupancy agreement, as prescribed in subsection 2, is executed between the elder group home and each tenant or the tenant's legal representative prior to the tenant's occupancy, and unless the elder group home operates in accordance with the terms of the occupancy agreement. The elder group home shall deliver to the tenant or the tenant's legal representative a complete copy of the occupancy agreement and all supporting documents and attachments and shall deliver, at least thirty days prior to any changes, a written copy of changes to the occupancy agreement if any changes to the copy originally delivered are subsequently made, unless otherwise provided in this section. |
| | | **231B.5(2)a-o**<br>**68.12**<br>**68.15** | An elder group home occupancy agreement shall clearly describe the rights and responsibilities of the tenant and the elder group home. The occupancy agreement shall also include but is not limited to inclusion of all of the following information in the body of the agreement or in the supporting documents and attachments:<br>2. An elder group home occupancy agreement shall clearly describe the rights and responsibilities of the tenant and the elder group home. The occupancy agreement shall also include but is not limited to inclusion of all of the following information in the body of the agreement or in the supporting documents and attachments:<br>*a.* A description of all fees, charges, and rates describing tenancy and basic services covered, and any additional and optional services and their related costs.<br>*b.* A statement regarding the impact of the fee structure on third-party payments, and whether third-party payments and resources are accepted by the elder group home.<br>*c.* The procedure followed for nonpayment of fees.<br>*d.* Identification of the party responsible for payment of fees and identification of the tenant's legal representative, if any. |

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| | | | *e.* The term of the occupancy agreement.<br>*f.* A statement that the elder group home shall notify the tenant or the tenant's legal representative, as applicable, in writing at least thirty days prior to any change being made in the occupancy agreement with the following exceptions:<br>(1) When the tenant's health status or behavior constitutes a substantial threat to the health or safety of the tenant, other tenants, or others, including when the tenant refuses to consent to relocation.<br>(2) When an emergency or a significant change in the tenant's condition results in the need for the provision of services that exceed the type or level of services included in the occupancy agreement and the necessary services cannot be safely provided by the elder group home.<br>*g.* A statement that all tenant information shall be maintained in a confidential manner to the extent required under state and federal law.<br>*h.* Occupancy, involuntary transfer, and transfer criteria and procedures, which ensure a safe and orderly transfer.<br>*i.* The internal appeals process provided relative to an involuntary transfer.<br>*j.* The program's policies and procedures for addressing grievances between the elder group home and the tenants, including grievances relating to transfer and occupancy.<br>*k.* A statement of the prohibition against retaliation as prescribed in section 231B.13.<br>*l.* The emergency response policy.<br>*m.* The staffing policy which specifies if nurse delegation will be used, and how staffing will be adapted to meet changing tenant needs.<br>*n.* The refund policy.<br>*o.* A statement regarding billing and payment procedures. |
| | | **231B.5(3)** | Occupancy agreements and related documents executed by each tenant or the tenant's legal representative shall be maintained by the assisted living program in program files from the date of execution until three years from the date the occupancy agreement is terminated. A copy of the most current occupancy agreement shall be provided to members of the general public, upon request. Occupancy agreements and related documents shall be made available for on-site inspection to the department upon request and at reasonable times. |
| | | **68.12(1)** | The occupancy agreement shall be in 12-point type or larger, shall be written in plain language using commonly understood terms, and shall be easy for the tenant or the tenant's legal representative to understand. |
| | | **68.12(2)a-f** | In addition to the requirements of Iowa Code section 231B.5, the written occupancy agreement shall include, but not be limited to, the following information in the body of the agreement or in the supporting documents and attachments:<br>*a.* The telephone number for filing a complaint with the department.<br>*b.* The telephone number for the office of the tenant advocate.<br>*c.* The telephone number for reporting dependent adult abuse.<br>*d.* A copy of the program's statement on tenants' rights.<br>*e.* A statement that the program will notify the tenant at least 90 days in advance of any planned program cessation, which includes voluntary decertification, except in cases of emergency.<br>*f.* A copy of the program's admission and transfer criteria. |
| | | **68.12(3)** | The occupancy agreement shall be reviewed and updated as necessary to reflect any change in services or financial arrangements. |
| | | **68.12(4)** | A copy of the occupancy agreement shall be provided to the tenant or the tenant's legal representative, if any, and a copy shall be kept by the program. |
| | | **68.12(5)** | A copy of the most current occupancy agreement shall be made available to the general public upon request. The basic marketing material shall include a statement that a copy of the occupancy agreement is available to all persons upon request. |
| | | **68.14(231B)** | **Criteria for admission and retention of tenants:** |
| | | **68.14(1)a-j** | *Persons who may not be admitted or retained.* A program shall not knowingly admit or retain a tenant who:<br>*a.* Is bed-bound; or<br>*b.* Requires routine, one-person assistance with standing, transfer or evacuation; or<br>*c.* Is dangerous to self or other tenants or staff, including but not limited to a tenant who:<br>(1) Despite intervention chronically elopes, is sexually or physically aggressive or abusive, or displays unmanageable verbal abuse or aggression; or |

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| | | | (2) Displays behavior that places another tenant at risk; or<br>*d.* Is in an acute stage of alcoholism, drug addiction, or uncontrolled mental illness; or<br>*e.* Is under the age of 18; or<br>*f.* Requires more than part-time or intermittent health-related care; or<br>*g.* Has unmanageable incontinence on a routine basis despite an individualized toileting program; or<br>*h.* Is medically unstable; or<br>*i.* Requires maximal assistance with activities of daily living; or<br>*j.* Is physically or mentally unable to immediately and without aid of another travel a normal path to safety, including the ascent and descent of stairs from the tenant's bedroom or bathroom. |
| | | **68.14(2)** | *Disclosure of additional occupancy and transfer criteria.* A program may have additional occupancy or transfer criteria if the criteria are disclosed in the written occupancy agreement prior to the tenant's occupancy. |
| | | **68.14(3)** | *Assistance with transfer from the program.* A program shall provide assistance to a tenant and the tenant's legal representative, if applicable, to ensure a safe and orderly transfer from the program when the tenant exceeds the program's criteria for admission and retention. |
| | | | **EVALUATION OF TENANT** |
| | | **68.13(231B)** | **Evaluation of each tenant's functional, cognitive and health status:** |
| | | **68.13(1)** | *Evaluation prior to occupancy.* A program shall evaluate each prospective tenant's functional, cognitive and health status prior to the tenant's signing the occupancy agreement and becoming a household occupant to determine the tenant's eligibility for the program, including whether the services needed are available. The cognitive evaluation shall utilize a scored, objective tool. When the score from the cognitive evaluation indicates moderate cognitive decline and risk, the Global Deterioration Scale shall be used at all subsequent intervals, if applicable. If the tenant subsequently returns to the tenant's mildly cognitively impaired state, the program may discontinue the GDS and revert to a scored cognitive screening tool. The evaluation shall be conducted by a health care professional or human service professional. |
| | | **68.13(2)** | *Evaluation within 30 days of occupancy and with significant change.* A program shall evaluate each tenant's functional, cognitive and health status within 30 days of occupancy. A program shall also evaluate each tenant's functional, cognitive and health status as needed with significant change, but not less than annually, to determine the tenant's continued eligibility for the program and to determine any changes to services needed. The evaluation shall be conducted by a health care professional or human service professional. A licensed practical nurse may complete the evaluation via nurse delegation when the tenant has not exhibited a significant change. |
| | | | **SERVICE PLAN** |
| | | **68.17(231B)** | **Service plans:** |
| | | **68.17(1)** | A service plan shall be developed for each tenant based on the evaluations conducted in accordance with subrules 68.13(1) and 68.13(2) and shall be designed to meet the specific service needs of the individual tenant. The service plan shall subsequently be updated at least annually and whenever changes are needed. |
| | | **68.17(2)** | Prior to the tenant's signing the occupancy agreement and becoming a household occupant, a preliminary service plan shall be developed by a health care professional or human service professional in consultation with the tenant and, at the tenant's request, with other individuals identified by the tenant, and, if applicable, with the tenant's legal representative. All persons who develop the plan and the tenant or the tenant's legal representative shall sign the plan. |
| | | **68.17(3)** | When a tenant needs personal care or health-related care, the service plan shall be updated within 30 days of the tenant's occupancy and as needed with significant change, but not less than annually.<br>*a.* If a significant change triggers the review and update of the service plan, the updated service plan shall be signed and dated by all parties.<br>*b.* If a significant change does not exist, the program may, after nurse review, add minor discretionary changes to the service plan without a comprehensive evaluation and without obtaining signatures on the service plan.<br>*c.* If a significant change relates to a recurring or chronic condition, a previous evaluation and service plan of the recurring condition may be utilized without new signatures being obtained. For example, with chronic exacerbation of a urinary tract infection, nurse review is adequate to institute the previously written evaluation and service plan. |

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| | | 68.17(4) | The service plan shall be individualized and shall indicate, at a minimum:<br>*a.* The tenant's identified needs and preferences for assistance;<br>*b.* Any services and care to be provided pursuant to the occupancy agreement;<br>*c.* The service provider(s), if other than the program, including but not limited to providers of hospice care, home health care, occupational therapy, and physical therapy; and<br>*d.* Preferences, if any, of the tenant or the tenant's legal representative for nursing facility care, if the need for nursing facility care presents itself during the elder group home occupancy. |
| | | **MEDICATIONS** | |
| | | **67.5(231B)** | **Each program shall follow its own written medication policy, which shall include the following:** |
| | | **67.5(1)** | The program shall not prohibit a tenant from self-administering medications. |
| | | **67.5(2)** | A tenant shall self-administer medications unless:<br>a. The tenant or the tenant's legal representative delegates in the occupancy agreement or signed service plan any portion of medication setup to the program.<br>b. The tenant delegates medication setup to someone other than the program.<br>c. The program assumes partial control of medication setup at the direction of the tenant. The medication plan shall not be implemented by the program unless the program's registered nurse deems it appropriate under applicable requirements, including those in 655—Chapter 6 governing nurse delegation. The program's registered nurse must agree to the medication plan. |
| | | **67.5(3)** | A tenant shall keep medications in the tenant's possession unless the tenant or the tenant's legal representative, if applicable, delegates in the occupancy agreement or signed service plan partial or complete control of medications to the program. The service plan shall include the tenant's choice related to storage. |
| | | **67.5(4)** | When a tenant has delegated medication administration to the program, the program shall maintain a list of the tenant's medications. If the tenant self-administers medications, the tenant may choose to maintain a list of medications in the tenant's apartment or to disclose a current list of medications to the program for the purpose of emergency response. If the tenant discloses a medication list to the program in case of an emergency, the tenant remains responsible for the accuracy of the list. |
| | | **67.5(5)** | When the medication setup is delegated to the program by the tenant, staff via nurse delegation may transfer medications from the original prescription containers or unit dosing into medication reminder boxes or medication cups. |
| | | **67.5(6)** | When medications are administered traditionally by the program:<br>a. The administration of medications shall be provided by a registered nurse, licensed practical nurse or advanced registered nurse practitioner registered in Iowa or by unlicensed assistive personnel in accordance with requirements in 655—Chapter 6 governing nurse delegation.<br>b. Medications shall be kept in a locked place or container that is not accessible to persons other than employees responsible for the administration or storage of such medications.<br>c. The program shall maintain a list of each tenant's medications and document the medications administered. |
| | | **67.5(7)** | Narcotics protocol shall be determined by the program's registered nurse. |
| | | **231B.21** | **Medication setup- administration and storage of medications.** |
| | | **231B.21(1)** | An Elder Group Home may provide for medication setup if requested by a tenant or the tenant's legal representative. If medication setup is provided following such request, the Elder Group Home shall be responsible for the specific task requested and the tenant shall retain responsibility for those tasks not requested to be provided. |
| | | **231B. 21(2)** | If medications are administered or stored by an elder group home, or if the elder group home provides for medication setup, all of the following shall apply:<br>*a.* If administration of medications is delegated to the elder group home by the tenant or tenant's legal representative, the medications shall be administered by a registered nurse, licensed practical nurse, or advanced registered nurse practitioner licensed or registered in Iowa or by the individual to whom such licensed or registered individuals may properly delegate administration of medications.<br>*b.* Medications, other than those self-administered by the tenant or provided through medication setup, shall be stored in locked storage that is not accessible to persons other than employees responsible for administration or storage of medications.<br>*c.* Medications shall be labeled and maintained in compliance with label instructions and state and federal law. |

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| | | | *d.* A person, other than a person authorized to prescribe prescription drugs under state and federal law, shall not alter the prescription of a tenant.<br>*e.* Medications shall be stored in their originally received containers.<br>*f.* If medication setup is provided by the elder group home at the request of the tenant or tenant's legal representative, or if medication administration is delegated to the elder group home by the tenant or tenant's legal representative, appropriate staff of the elder group home may transfer the medications in the tenant's presence from the original prescription container to medication dispensing containers, reminder containers, or medication cups.<br>*g.* Elder group home assistance with medication administration as specified in the occupancy agreement shall not require the elder group home to provide assistance with the storage of medications. |
| | | | **NURSE REVIEW** |
| | | **68.18** | **Nurse review- If a tenant does not receive personal or health-related care, but an observed significant change in the tenant's condition occurs, a nurse review shall be conducted. If a tenant receives personal or health-related care, the program shall provide for a registered nurse or a licensed practical nurse via nurse delegation:** |
| | | **68.18(1)** | To monitor, at least every 90 days, or after a significant change in the tenant's condition, any tenant who receives program-administered prescription medications for adverse reactions to the medications and to make appropriate interventions or referrals, and to ensure that the prescription medication orders are current and that the prescription medications are administered consistent with such orders; and |
| | | **68.18(2)** | To ensure that health care professionals' orders are current for tenants who receive health care professional-directed care from the program; and |
| | | **68.18(3)** | To assess and document the health status of each tenant, to make recommendations and referrals as appropriate, and to monitor progress relating to previous recommendations at least every 90 days and whenever there are changes in the tenant's health status; and |
| | | **68.18(4)** | To provide the program with written documentation of the activities under the service plan, as set forth in rule 481—68.17(231B), showing the time, date and signature. |
| | | | NOTE: Refer to Table A at the end of this chapter. If the program does not provide personal or health-related care to a tenant, nurse review is not required. |
| | | | **FOOD SERVICE** |
| | | **68.4(8)** | **Food Service:** |
| | | | Staffing, nutrition, menu planning, therapeutic diets and food preparation, service and storage. |
| | | | **STAFFING** |
| | | **67.9(1) (231B)** | A sufficient number of trained staff shall be available at all times to fully meet tenants' identified needs. |
| | | **67.9(2)** | All staff shall be able to implement the accident, fire safety, and emergency procedures. |
| | | **67.9(3)** | Pursuant to Iowa Code section 135C.33, a prospective employee of a program shall have a criminal history check, dependent adult abuse check and child abuse check performed before the prospective employee begins work. If a prospective employee has a criminal history or an abuse history, the prospective employee shall not be employed by the program unless the Department of Human Services has performed an evaluation and determined that the record does not warrant the employment prohibition. Proof of the pre-employment background check shall be maintained in the program's employee file. The program must meet all requirements of Iowa Code section 135C.33 and administrative rules adopted pursuant to Iowa Code section 135C.33 |
| | | **67.9(4)** | The program shall have training and staffing plans on file and shall maintain documentation of training received by program staff. |
| | | **67.9(5)** | Any nursing services shall be provided in accordance with Iowa Code Chapter 152 and 655-Chapter 6. |
| | | **67.9(6)** | A staff member shall not be designated as attorney-in-fact, guardian, conservator, or representative payee for a tenant unless the staff member is related to the tenant by blood, marriage, or adoption. |
| | | **68.19(231B)** | **Staffing: In addition to the general staffing requirements in rule 481—67.9(231B), the following requirements apply to staffing in programs:** |
| | | **68.19(1)** | The program shall be staffed by an on-site manager 24 hours per day, seven days per week. |
| | | **68.19(2)** | Personal care providers shall have completed, at a minimum, a home care aide training program that meets the requirements and criteria established in 641—Chapter 80. |

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| | | 68.19(3) | The owner or management corporation of the program is responsible for ensuring that all personnel employed by or contracting with the program receive training appropriate to assigned tasks and target population. |
| | | 68.19(4) | Personal care providers and nursing staff may be employed by the program or obtained through a contract with a home health agency or other service provider. Regardless of the source, the staff must meet all applicable requirements. |
| | | **67.16(231B)** | **Nursing assistant work credit:** |
| | | 67.16(1) | A person who is certified as a nursing assistant, including a medication aide, and who is supervised by a registered nurse may submit information to the department to obtain credit toward maintaining certification for working in a program. A program may add an employee to the direct care worker registry by calling (515)281-4077 or by registering through the health facilities division Web site at https://dia-hfd.iowa.gov/DIA_HFD/Home .do under the "Documents" tab. |
| | | 67.16(2) | A program shall complete and submit to the department a direct care worker registry application for each certified nursing assistant who works in the program. A registered nurse employed by the program shall supervise the nursing assistant. The application may be obtained by telephone at (515)281-4077 or via the health facilities division Web site at https://dia-hfd.iowa.gov/DIA_HFD/Home .do under the "Documents" tab. |
| | | 67.16(3) | A program shall complete and submit to the department a direct care worker registry quarterly employment report whenever a change in the employment of a certified nursing assistant occurs. The report form may be obtained by telephone at (515)281-4077 or via the health facilities division Web site at https://dia-hfd.iowa.gov/DIA_HFD/Home .do under the "Documents" tab. |
| | | **STAFF TRAINING** | |
| | | **67.18(231B)** | **Training related to Alzheimer's disease and similar forms of irreversible dementia.** |
| | | | Effective July 1, 2010, or when administrative rules are adopted pursuant to Iowa Code section 231.62, whichever is later, all programs shall comply with the requirements set forth in administrative rule to implement Iowa Code section 231.62 for Alzheimer's disease and dementia education. |
| | | **MANAGED RISK** | |
| | | **68.20(231B)** | **Managed risk policy and manages risk consensus agreements- The program shall have a managed risk policy. The managed risk policy shall be provided to the tenant along with the occupancy agreement. The managed risk policy shall include the following:** |
| | | 68.20(1) | An acknowledgment of the shared responsibility for identifying and meeting the needs of the tenant and the process for managing risk and for upholding tenant autonomy when tenant decision making results in poor outcomes for the tenant or others; and |
| | | 68.20(2) | A consensus-based process to address specific risk situations. Program staff and the tenant shall participate in the process. The result of the consensus-based process may be a managed risk consensus agreement. The managed risk consensus agreement shall include the signature of the tenant and the signatures of all others who participated in the process. The managed risk consensus agreement shall be included in the tenant's file. |
| | | **ACCIDENT/EMERGENCY RESPONSE/LIFE SAFETY** | |
| | | **67.2, 67.15, 68.4(11) (231B)** | **Accident, emergency response, and life safety:** |
| | | 67.2(1-2) | A program's policies and procedures must meet the minimum standards set by applicable requirements. The program shall follow the policies and procedures established by a program. All programs shall have policies and procedures related to the reporting of incidents including allegations of dependent adult abuse.<br>(1)The program's policies and procedures on incident reports, at a minimum, shall include the following:<br>*a.* The program shall have available incident report forms for use by program staff.<br>*b.* An incident report shall be in detail and shall be provided on an incident report form.<br>*c.* The person in charge at the time of the incident shall prepare and sign the report.<br>*d.* The incident report shall include statements from individuals, if any, who witnessed the incident.<br>*e.* All accidents or unusual occurrences within the program's building or on the premises that affect tenants shall be reported as incidents.<br>*f.* A copy of the completed incident report shall be kept on file on the program's premises for a minimum of three years. |

| | | | |
|---|---|---|---|
| | | | (2)The program's policies and procedures on allegations of dependent adult abuse shall be consistent with Iowa Code chapter 235E and rules adopted pursuant to that chapter and, at a minimum, shall include:<br>*a.* Reporting requirements for staff and employees, and<br>*b.* Requirements that the victim and alleged abuser be separated. |
| | | **67.15(1-3)** | Emergency removal of tenants. If the Department determines that the health or safety of tenants is in jeopardy and the tenants need to be removed from the program, the Department shall use the following procedures to ensure a safe and orderly transfer.<br>(1)The department shall notify the department of human services, the tenant advocate, the appropriate area agency on aging, and other agencies as necessary and appropriate:<br>*a.* To alert them to the need to transfer tenants from a program;<br>*b.* To request assistance in identifying alternative programs or other appropriate settings; and<br>*c.* To contact the tenants and their legal representatives or family members, if applicable, and others as appropriate, including health care professionals.<br>(2)The department shall notify the program of the immediate need to transfer tenants and of any assistance available, in coordination with the appropriate parties under subrule 67.15(1).<br>(3)The department, in conjunction with other agencies as necessary and appropriate, shall proceed with the transfer of tenants. |
| | | **68.24(1)(a-j)** | The program shall submit to the department and follow written emergency policies and procedures, which shall include the following:<br>a. An emergency plan, which shall include procedures for natural disasters (identify where the plan is located for easy reference);<br>b. Fire safety procedures;<br>c. Other general or personal emergency procedures;<br>d. Provisions for amending or revising the emergency plan;<br>e. Provisions for periodic training of all employees;<br>f. Provisions for fire drills;<br>g. Regulations regarding smoking;<br>h. Monitoring and testing of smoke-control systems;<br>i. Tenant evacuation procedures; and<br>j. Procedures for reporting and documentation. |
| | | **68.24(2)** | The program's structure and procedures and the facility in which a program is located shall meet the requirements adopted for Elder Group Homes in administrative rules promulgated by the state fire marshal. Approval of the state fire marshal indicating that the building is in compliance with these requirements is necessary for certification of a program. |
| | | **68.24(3)** | The programs shall have the means to control the maximum temperature of water at sources accessible by a tenant to prevent scalding and shall control the maximum water temperature for tenants with cognitive impairment or dementia or at a tenant's request. |
| | | | **TRANSPORTATION** |
| | | **68.21(231B)** | **Transportation- When transportation services are provided directly or under contract with the program:** |
| | | **68.21(1)** | The vehicle shall be accessible and appropriate to the tenants who use it, with consideration for any physical disabilities and impairments. |
| | | **68.21(2)** | Every tenant transported shall have a seat in the vehicle, except for a tenant who remains in a wheelchair during transport. |
| | | **68.21(3)** | Vehicles shall have adequate seat belts and securing devices for ambulatory and wheelchair-using passengers. |
| | | **68.21(4)** | Wheelchairs shall be secured when the vehicle is in motion. |
| | | **68.21(5)** | During loading and unloading of a tenant, the driver shall be in the proximate area of the tenants in the vehicle. |
| | | **68.21(6)** | The driver shall have a valid and appropriate Iowa driver's license or commercial driver's license as required by law for the vehicle being utilized for transport. If the driver is licensed in another state, the license shall be valid and appropriate for the vehicle being utilized for transport. The driver shall meet any state or federal requirements for licensure or certification for the vehicle operated. |

# ELDER GROUP HOME - RESOURCE LIST

**Regulatory Body:**
*Department of Inspections & Appeals (DIA)*
Health Facilities Division
Adult Services Bureau
Lucas Building, 3rd Floor
321 E. 12th St.
Des Moines, IA 50319
General Phone: 5151281-6325
Complaint Phone: 1-877-686-0027

- Complaint intake, investigations, monitoring, application fees, initial certification & recertification process, waiver/variance request, quality concerns/rules interpretation

**Life Safety Code Inspection:**
*State Fire Marshal's Office*
Department of Public Safety
Kyle Gorsh, Fire Prevention Supervisor
215 E. 7th St.
Des Moines, IA 50319
Phone : 515-725-6162
Fax : 515-725-6172
gorsh@dps.state.ia.us

*Architectural Plan Review, Evacuation Planning and Life Safety:*
Dept. of Public Safety
State Fire Marshal's Office
Doran Pruisner -
Facility Engineer
21 5 E. 7th St.
Des Moines, IA 50319
Phone: 515-725-6152
Fax: 515-725-6172
Pruisner@dps.state.ia.us

**Tenant Advocate:**
*State Long-Term Care Ombudsman's Office*
Jeanne Yordi
Jessie M. Parker Building
603 E. 12th St., 5th Floor
Des Moines, IA 50319-9025
Phone: 515-725-3327
Toll-Free: 800/532-3213

**Food Service Licensure:**
*Department of Inspections & Appeals*
Lucas Building, 3rd Floor
321 E. 12th St.
Des Moines. IA 50319
Phone: 515-281-6538

**SerSafe Certificates:**
**See Local Area Community Colleges*

**Financial resources for Structures:**
*Community Facilities:*
*USDA/Rural Development*
210 Walnut – Room 873
Des Moines, IA 50309
Phone: 515-284-4663
Toll-Free: 800-670-6553
Fax: 515-284-4821
bill.menner@ia.usda.gov

*Housing Tax Credit Program*
Iowa Finance Authority
2015 Grand Ave.
Des Moines, Iowa 50312
Toll Free: 800-432-7230
Phone: 515-725-4875
Fax: 515-725-4901
www.iowafinanceauthority.gov

*Community Development Programs*
Iowa Dept. of Economic Development
200 E. Grand
Des Moines, IA 50309
Phone: 515-725-3000
Fax: 515-725-3010
info@iowalifechanging.com

*Housing and Urban Development*
210 Walnut – Room 239
Des Moines, IA 50309
Phone: 515-284-4512
Toll-Free: 800-735-2943
TTY: 800-735-2942
Fax: 515-284-4743

**Rent Assistance Program rules:**
*Sec. 8 Rental Assistance*
100 E Euclid Avenue, Suite 101
Des Moines, Iowa 50313
515-323-8950

*HCBS Rent Subsidy*
Iowa Finance Authority
2015 Grand Ave.
Des Moines, Iowa 50312
Toll-Free: 800-432-7230
Phone: 515-725-4875
Fax: 515-725-4901
www.iowafinanceauthority.gov

**Case Management for Frail Elders**
Linda Hildreth, IDA
Jessie Parker Building
603 E. 12th Street – 5th Floor
Des Moines, IA 50319
Phone: 515-725-3321
Fax: 515-725-3300

***Area Coordinators:*** See listing in packet

**General info on financial resources for services:**

*Medicaid Home- and Community-Based Services (HCBS) – waiver program information*
Iowa Medicaid Enterprise
Le Howland
100 Army Post Rd.
Des Moines, IA 50315
Phone: 515-256-4642
lhowland@dhs.state.ia.us

*HCBS-provider enrollment*
Iowa Medicaid Enterprise
Desiree Smith
100 Army Post Rd.
Des Moines, IA 50315
Toll-Free: 800-338-8366
Phone: 515-974-3160
Fax: 515-725-1010
IMEMemberServices@dhs.state.ia.us

*Senior Health Insurance Information Program – (SHIIP)*
330 Maple St.
Des Moines, IA 50319-0065
Toll-Free: 800-351-4664
TTY: 800-735-2942
http://www.shiip.state.ia.us/

**RN Activities & Delegation:**
*Iowa Dept. of Public Health*
Lucas Building, 5th Floor
321 East 12th St.
Des Moines, IA 50319
Phone: 515-242-6383
Toll-Free: 800-308-5986
FAX (515) 242-6384
http://www.idph.state.ia.us

*Iowa Board of Nursing*
RiverPoint Business Park
400 S.W. 8th Street, Suite B
Des Moines, IA 50309-4685
Tel: 515-281-3256
Fax: 515-281-4825

**Cosmetology/Barber Shop License:**
*Iowa Department of Public Health*
Lucas Building, 5th Floor
Cosmetology Board
321 East 12th St.
Des Moines, IA 50319
515-281-4416
www.idph.state.ia.us/licensure

**CCRC/Retirement Communities**
Securities Bureau
Iowa Department of Commerce
330 Maple
Des Moines, IA 5031 9
515-281-5705

*Revised 05262011*

***Benefits***

**State Veterans Benefits**

- Injured Veterans Grant
- Homeownership Assistance
- Property Tax Exemption
- Lifetime Hunting and Fishing
- War Orphan Tuition Assistance
- License Plates
- Vietnam Conflict Bonus
- Trust Fund
- Education
- High School Diploma
- Iowa Veterans Cemetery
- WWII Honor Flight

**Federal Veterans Benefits**

- Federal Benefit Information and Applications

***Services***

**County Veterans Offices**

**VA Medical Centers**

- Des Moines Iowa City Knoxville

**Community Based VA Clinics**

- Bettendorf Dubuque Fort Dodge
- Mason City Sioux City Spirit Lake
- Waterloo

**Vet Centers**

- Cedar Rapids Des Moines
- Omaha Quad Cities Sioux City

**Veterans Employment Services**

- State Employment Services
- Federal Employment Services
- Legal Employment Rights
- Guard and Reserves Support

***Transitional Help***

- PTSD (Posttraumatic Stress Disorder)
- TBI (Traumatic Brain Injury)
- Suicide Prevention & Awareness
- For Families & Loved Ones
- Substance Abuse
- Returning Veterans
- Homelessness
- National Resource Directory (NRD)

***Key Resources***

- 24-Hour Emergency Hotline 1-800-273-8255
- State of Iowa VA Office 1-800-838-4692
- Federal VA Regional Office (IA) 1-800-827-1000
- VA Health Care Eligibility 1-877-222-8387
- Federal VA Benefits
- Federal Applications
- Federal Benefits Handbook

VA BENEFIT INFORMATION FOR FACILITIES & ASB PROGRAMS

VA Benefit Contact Information:
Bob Steben, Nursing Home and Benefit Specialist
515-242-0153
Bob.Steben@iowa.gov

https://www.iowava.org

# EMERGENCY PLANS

**The administration of every assisted living program will have a written emergency plan in effect and readily available at all times to all supervisory personnel within the building. The emergency plan is to be designed for protecting all persons in the event of fire and other personal or general emergencies.**

The plan needs to include a copy of the floor plan and a policy or policies that address the following elements.

1) Identify where Emergency Plan is to be located for easy reference.
2) Fire safety procedures needed to ensure the safety of any tenant.
   a) Post evacuation route maps with exits and areas or refuge identified.
      i) Post throughout building.
      ii) Maps need to be specific to area of the building where posted.
   b) Identification of when persons should remain in place and procedures for accomplishing that.
   c) How to determine when occupants should be evacuated to areas of refuge or out of the building.
   d) Steps to be followed by tenants in the event of fire and evacuation.
   e) Steps to be followed by staff in the vents of fire and evacuation.
   f) Crowd management following evacuation (e.g., how to relate to media, what to do for extended evacuations, how to keep tenants from wandering off or back into building).
   g) Procedures for persons with mobility, vision, hearing and speech impairment conditions.
   h) Keep exit doors unlocked and egress free of obstructions. [Exception: locked exits that release immediately if fire alarm activated.]
   i) Early discovery and extinguishment.
3) Other general or personal emergency procedures needed to ensure the safety of any tenant. (This might be similar to fire safety procedures for incidents such as tornado, flood, wandering, tenant fall, etc.)
   a) 24-hour Personal Emergency Response System.
   b) Identify areas of refuge specific to type of emergency.
4) Provisions for amending or revising the plan upon admission to the assisted living program of any tenant with unusual needs.
5) Provision for periodic training of all employees on their duties and responsibilities under the plan, and the knowledge and skills needed to carry out their duties and responsibilities.
6) Training for all tenants to include:
   a) Proper actions to be taken in case of fire or other emergencies;
   b) Actions to be taken if the primary escape route in blocked;
   c) Fire prevention;
   d) How and when to assist each other without incurring additional personal risk.
7) Fire Drills.
   a) Frequency and Timing. [Minimum: i) 6 drills per year on a bimonthly basis; and ii) at least two drills conducted during the night when residents can reasonably be expected to be sleeping]
   b) All staff and tenants in building participate. [Exception: If the assisted living program has an evacuation capability rating of 'impractical', those tenants who have special health problems (e.g., someone who is in bed with influenza) need not actively participate in the drill.]
   c) May be announced in advance.
   d) Involve the actual evacuation to an assembly point designated in the emergency plan.

e) Provide experience in egressing through all exits and areas of refuge.
f) Timing.
   i) Who will time;
   ii) Target time for evacuation capability rating;
   iii) How and where documented.

8) If applicable, storage and handling of liquefied petroleum gasses.
9) Smoking.
   a) Where allowed.
   b) Post signs.
10) Building and grounds interior/exterior maintenance during all conditions and weather.
11) Furnishings (includes draperies, curtain, other loosely hanging decorations, furniture, mattresses, Christmas decorations).
   a) Owner-purchased furnishing will meet fire safety flame-retardant requirements.
   b) Whether or not tenants will be allowed to bring their own furniture into the assisted living program.
   c) Tenant-owned furniture does not have to meet fire-retardant requirements.
   d) Room dividers (including curtains) may not obstruct sprinkler coverage.
   e) Christmas trees and decorations must be flame retardant.
12) Monitoring and testing of smoke-control systems.
13) Tenant assessment will include identification of tenant's ability to evacuate to place of refuge.
14) Procedures for Reporting and Documentation.
   a) Documentation available for inspection by State Fire Marshal and Iowa Department of Inspections & Appeals.
   b) Include policies and procedures for tenants in Tenant Handbook.
      i) Christmas decorations need to be flame retardant.
      ii) Participation in drills and actual emergency evacuation is expected.

**REPORTS and DOCUMENTATION.**

The State Fire Marshal or his designee may request documentation as confirmation that the Emergency Plan is followed. Reports and documentation that may be requested include:

1) A summary report of priority for assistance in tenant evacuation.
2) Emergency Incidence Log that records:
   a. Incidents of fire, building evacuation, general emergencies (e.g., tornado, flood)
   b. Notification of emergency personnel
   c. Summary of evacuation
   d. Response of emergency personnel
   e. Numbers of staff, tenants, guests participating
   f. Time required to evacuate
3) Building maintenance records
   a. Inspection of plumbing, electrical and mechanical systems, including fire equipment
   b. Testing of smoke-control system
4) Evacuation Plan training records for staff, employer and tenants
5) Owner-purchase of furniture and Christmas decorations. (Possible ways to document include: keeping furniture tags; product information; purchase orders; log)
6) Product information on decorative fire place (if applicable)
7) Log of storage and handling of liquefied petroleum gases, if present.

[**Highlighted** and underlined items required by Life Safety Code. Any plain text is a suggestion.]

# PLAN SUBMITTAL SHEET
## IOWA STATE BUILDING CODE BUREAU

| PROJECT INFORMATION: | APPLICANT INFORMATION: |
|---|---|
| PROJECT NAME: _____ | FIRM NAME: _____ |
| ADDRESS: (Street Address) _____ | Contact Person: _____ |
| CITY, STATE, ZIP CODE: _____ | ADDRESS: (Street Address) _____ |
| COUNTY: _____ | CITY, STATE, ZIP CODE: _____ |
| | Telephone Number: _____ |
| | E-Mail Address: _____ |
| | FAX Number: _____ |

### GENERAL INFORMATION

One set of plans is required to be submitted for review stamped and wet signed.

| | |
|---|---|
| Plan reviewed by code consulting firm? YES NO | |
| Review letter submitted with plans? YES NO | Review letter to follow under separate cover |

Check for Handicapped Review and Insignia Fee ($45) enclosed YES _____ NO _____

**Plans Submitted to local authority for review** YES _____ NO _____
If YES to above, give name of local authority: _____
Are plans submitted ***"Preliminary"*** plans _____ or ***"Final"*** plans _____? (Check one)

**Project was designed to which Building Code(s)?** _____

### GENERAL PROJECT INFORMATION: (See Page 2 for Instructions)

**NOTE**: For Project Type and Plan Type see back of this page.

**PROJECT TYPE:** (Circle number that applies):

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 01 | 02 | 03 | 04 | 05 | 06 | 07 | | 09 | 10 | | 12 |

**PLAN TYPE:** (Circle letter that applies):

| | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| A | B | C | D | E | F | | H | I | J | | L | M |
| N | O | P | | R | S | T | | | | X | Y | Z |

### FIRE PROTECTION FEATURES

**Fire Alarm:** Manual System ___ Smoke Detection ___ Heat Detection ___ Other ___

**Sprinkler:** Total _____ Partial _____ Range Hood System _____ Other _____

| SPECIFIC PROJECT INFORMATION | | | |
|---|---|---|---|
| **Number of Levels** (Including Sub-levels) _____ | **Is there a basement?** YES ____ NO ____ | **Building Addition** _____ Sq. Ft. | **Building Total** _____ Sq. Ft. |
| **Construction Type** (Type I, II-N, III, IV, V, etc) NEW____ | **Construction Type** (Type I, II-N, III, IV, V, etc) EXISTING ____ | **Existing Building** _____ Sq. Ft. | B ____/____ Sq. Ft.<br>1 ____/____ Sq. Ft.<br>2 ____/____ Sq. Ft.<br>3 ____/____ Sq. Ft. |

| A. PROJECT TYPES: | |
|---|---|
| 01 New | 06 Preliminary |
| 02 Renovation | 07 Renovation/Addition |
| 03 Addition | 09 State-owned Project |
| 04 Historic Renovation | 10 Flammable Liquid |
| 05 Accessibility Only | 12 Alternative Means Request |

| B. PLAN TYPES: | |
|---|---|
| A. Accessibility Only | M. Motels, Hotels |
| B. Business | N. Nursing Facilities |
| C. College | O. Owned by the State |
| D. Day Care | P. Propane |
| E. Education (school – public and private [K-12]) | R. Residences – apartments, etc. |
| F. Fire Alarm Plan | S. Sprinkler Plans |
| H. Health Care | T. Tanks – above ground [flammable or combustible liquid product] |
| I. Mechanical & Engineering | X. Miscellaneous |
| J. Jails, Prisons, Corrections | Y. Life Cycle Costing Analysis |
| L. LULA Elevators | Z. Assisted Living |

Handicapped Review and Insignia Code Review fees = total fees (Check or money order [made payable to the "Treasurer", State of Iowa] for $30 for handicapped review and $15 for insignia for a total amount of $45. Amount enclosed: $_____.

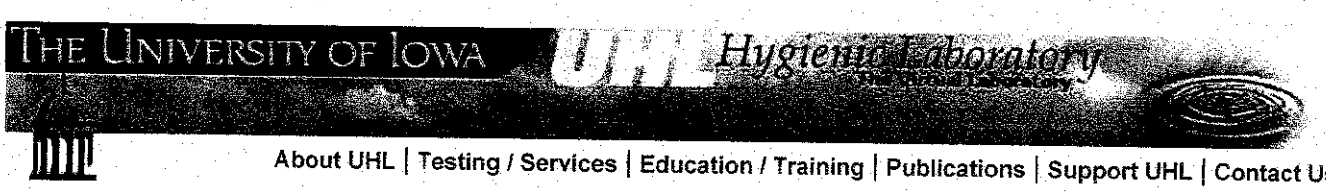
Additional information that will help us review your plans:
_____
_____

| Project estimated cost: | Plan Review Fee: |
|---|---|

| FOR OFFICE USE ONLY | | | |
|---|---|---|---|
| Plan Number | DATE RECEIVED | Method of Payment | Receipt Number (if applicable) |
| | | | |

Please return the completed form with the plan for review to the following address, with the check or money order for any applicable fees attached.

**Department of Public Safety**
**State Fire Marshal's Office**
**215 East 7th Street**
**Des Moines, Iowa 50319**
**Phone: (515)725-6152**
**FAX (515)725-6172**






# Clinical Laboratory Improvement Amendments (CLIA)

Under the Clinical Laboratory Improvement Amendments of 1988 (CLIA '88), 42 CFR 493, the federal law states any laboratory or facility that performs laboratory testing of human specimens for the purpose of providing information for the diagnosis, prevention or treatment of disease or impairment of, or the assessment of the health of, human beings is required to obtain a CLIA certificate and to meet certain requirements.

This rule applies whether or not the facility bills Medicare, Medicaid, other insurance, the patient, or provides the service for no charge. The type of CLIA certificate a laboratory must have depends on the type of testing the laboratory performs.

The University of Iowa Hygienic Laboratory oversees the CLIA Laboratory Program for the State of Iowa, under contract with Iowa Department of Inspections and Appeals and the Centers for Medicare and Medicaid Services. University Hygienic Laboratory provides the staff to administer the program and the laboratory surveyors to conduct clinical laboratory surveys.

The facilities, located within Iowa, must be in compliance with the Federal regulations. Iowa does not have additional state licensure or certification requirements.

If you wish to obtain an application form for a CLIA certificate, go to the Centers for Medicare and Medicaid Services (CMS) web site at www.cms.hhs.gov/clia. If you have questions concerning the CLIA program contact:

Nancy Grove, BS, MT (ASCP)
Senior Laboratory Consultant
University Hygienic Laboratory
102 Oakdale Campus, H101 OH
Iowa City, IA 52242
phone 800.421.IOWA or 319.335.4500
fax 319.335.4555
ngrove@uhl.uiowa.edu

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102 Oakdale Campus, H101 OH
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