

Nevada Medicaid and Nevada Check Up

Instructions for Completing Form FA-24

(Authorization Request for Personal Care Services (PCS))

To stay current with policy and documentation updates, we recommend that you visit www.medicaid.nv.gov weekly and be sure to read any messages included on your Remittance Advice.

Finding the Form and Instructions Online

Form FA-24 and these instructions are online at www.medicaid.nv.gov (select “Forms” from the “Providers” menu, and scroll down until you see form FA-24 and instructions FA-24-I).

General Form Instructions

All form fields must be completed (with the exception of Section 1). Write/type “N/A” in a field if the item does not apply (e.g., Legally Responsible Individual (LRI) Name).

Please print or type information on this form. If information is illegible, processing may be delayed. You can enter information directly into the form on your computer clicking in any field and typing. You can check and uncheck the check boxes by clicking them.

When you are finished completing the form, submit the request online using the Provider Web Portal.

If the FA-24 is incomplete, the authorization request may be pended for additional information and you will need to upload a corrected FA-24 to the same authorization. DO NOT create a new authorization. The received date is the date a completed correct request is received. The date of receipt of incorrect or incomplete requests is not valid. To avoid uncovered dates of service, please complete the FA-24 in its entirety the first time it is submitted. Only a completed FA-24 will be processed. If the information is not received within 30 calendar days, the request will be denied and a notice of decision will be sent.

Completing the Form

This section describes the information to enter in each form field.

DATE OF REQUEST: Enter the date you submit the form to Nevada Medicaid.

SECTION 1: FOR NEVADA MEDICAID USE ONLY

Please leave this section blank (to be completed by Nevada Medicaid staff only).

SECTION 2: PURPOSE OF REQUEST

Check one of these boxes to indicate the type of prior authorization you are requesting.

- Update Visit (annual) – Check this box to request a recipient’s regular, yearly Functional Assessment Service Plan Review.
- Significant Change in Condition – Check this box if the recipient’s condition has changed significantly. Documentation is required in the Comments section and must indicate the significant change and how it directly impacts the recipient’s ability to perform their ADL’s.
- Temporary Service Authorization (up to 8 weeks)
- One-Time Service – Check this box if you are requesting a one-time service that is in addition to the recipient’s current service plan.
- Information Only – Check this box if you are providing this information only and this is not a new request. Please enter the type of information you are providing under the “Information Only” checkbox and provide explanation and details in Section 5 Comments.

- Cancel Authorization – Check this box to cancel the recipient’s current authorization.
 - Agency’s last date of service – Enter the date the authorization should be cancelled.
 - Reason – Check the box that describes the reason for canceling the authorization.
 - Recipient Ineligible – If the recipient has become ineligible for services, check this box to cancel their existing authorization.
 - Recipient Expired – Check this box if you are canceling the authorization because the recipient expired.
 - Other – Check this box if you are canceling the authorization for a reason not listed above. Enter the reason for cancellation in the space provided.

SECTION 3: CONTACT INFORMATION

RECIPIENT INFORMATION

- Last Name and First Name – Enter the recipient’s name as it appears on their Medicaid card.
- Recipient Medicaid ID – Enter 11-digit number shown on the front of the recipient’s Medicaid card.
- Date of Birth – Enter the recipient’s Date of Birth (DOB).
- Translator Required – Check this box if English is not the primary language of the recipient and a translator is needed.
- Language – If a translator is needed, enter the recipient’s primary language.
- Address (including City, State and Zip Code fields) – Enter the recipient’s home address.
- Phone – Enter the recipient’s phone number. If the recipient does not have a phone number, enter “N/A” in this field.
- **Note:** Verify the address and phone number are current, whether or not they match the information on file with Nevada Medicaid. If the recipient has moved, remind him/her to update address and phone number with the Division of Welfare and Supportive Services (DWSS).

PCS AGENCY INFORMATION

- Enter the PCS Agency that will be providing the PCS to the recipient, including Name, City, NPI/API, Phone and Fax numbers.

LEGALLY RESPONSIBLE INDIVIDUAL (LRI) INFORMATION

Complete this section whether or not the recipient has an LRI. The definition of an LRI is: An Individual who is legally responsible to provide medical support, including spouses of recipients, legal guardians [not power of attorney (POA)], and parents of minor recipients, including stepparents, foster parents and adoptive parents. If the LRI is not available or capable, complete and attach form FA-24B (LRI Availability Determination for the Personal Care Services Program)

You must include the contact information of a recipient’s legally responsible individual when submitting a functional assessment service plan request for a recipient who is unable to speak on his or her own behalf or who is less than 18 years of age.

- Does recipient have an LRI? If the definition of the LRI is met, answer Yes and complete the LRI Information section. If the answer is No, proceed to Alternate Contact Information. This question must be answered with either a Yes or No response. If the Unknown option is selected, the request will be pended for additional information and the provider will have 30 days to submit a corrected FA-24 along with any required documentation. Please see [Web Announcement 1461](#) at

www.medicaid.nv.gov for additional information.

When the LRI section of form FA-24 is marked Yes, it is now mandatory for the PCS agency to submit form [FA-24B \(Legally Responsible Individual \(LRI\) Availability Determination for the Personal Care Services Program\)](#) when submitting FA-24. Both forms must be submitted and the forms must be uploaded as separate attachments when submitted through the Provider Web Portal. The documentation below must be included:

Employed LRI

- Annual proof of employment, which must:
 - Be written within 6 months of the new request
 - List the days per week and hours per day the LRI works
 - Be on company letterhead

Note: Paycheck stubs may be required to confirm employment

Disabled LRI

- A copy of the permanent disability note (FA-24B) with each request
- For temporary disabilities, an updated FA-24B prior to expiration of the current disability note

- LRI Name – Enter the name of the recipient’s LRI.
- Phone – Enter the LRI’s phone number.
- Relationship to Recipient – Enter the LRI’s relationship to the recipient, e.g., spouse, parent.
- Does LRI reside with recipient? Indicate yes or no.
- Is the LRI also on PCS Program? Indicate if the LRI is also receiving services in the PCS program. If you check yes, please indicate how many PCS hours per week the LRI receives.
- LRI Employment Status – Check the appropriate status. If the LRI is employed, indicate how many hours per week the LRI works and how many days off the LRI has per week.

ALTERNATE CONTACT INFORMATION

Complete this section to provide an alternate contact in the event the recipient and LRI are unavailable.

- Alternate Contact Name – Enter the name of the alternate contact person.
- Phone – Enter the alternate contact person’s phone number.
- Relationship to Recipient – Enter the contact person’s relationship to the recipient.
- Can this person be contacted in case we are unable to contact recipient – Indicate yes or no.

SECTION 4: DIAGNOSES AND INCIDENTS

DIAGNOSIS/DIAGNOSES AFFECTING THE INDIVIDUAL’S ABILITY TO COMPLETE TASKS

- Indicate up to nine diagnoses for this recipient.
- Is anyone else in the home receiving PCS at this time? – Indicate if anyone in the home is currently receiving PCS, and identify who is receiving the services.

INCIDENTS, INCLUDING A SUMMARY OF ALL REPORTED SERIOUS OCCURRENCES, WITHIN THE PAST 90 DAYS

Indicate the incidents that have occurred for this recipient. Check all that apply.

- Hospitalization – Indicate discharged date or anticipated discharge date.
- Recent Fall.
- Surgery – Indicate type of surgery.
- Loss of non-paid caregiver.
- New Medical Condition/Diagnosis – Please specify.
- Addition or loss of other services – Please specify.
- Provide a summary of all reported serious occurrences for the last 90 days. This is a mandatory field. If this section is not completed, the form will be returned to the provider. Identify the amount, type and severity of incidents, which includes but is not limited to, falls and hospitalizations. This section does not change the requirement that serious occurrences must be reported to the Division of Health Care Financing and Policy (DHCFP) District Office Care Coordination Unit within 24 hours of discovery.
- If no serious occurrences were reported, please check the “No Serious Occurrences” box.

SECTION 5: COMMENTS

Enter additional comments that would assist the assessor in completing this request, including the reason for the request.

SECTION 6: PERSON COMPLETING/SUBMITTING THIS REQUEST

Provide the name and telephone number of the person completing the request. This person will be contacted with questions if needed.

SECTION 7: PERSONAL CARE ATTENDANT (PCA) INFORMATION

An LRI cannot be a PCA. All fields in SECTION 7 are mandatory and must be completed.

- PCA Name – Enter the name of the PCA to be used as an alternate contact if needed.
- PCA Phone Number – The PCA’s phone number cannot be the agency’s phone number.
- Check the appropriate box that corresponds to the PCA’s relationship to the recipient and if they reside with the recipient:
 - PCA is a relative and resides in the home.
 - Enter the PCA’s relationship to the recipient in the space provided.
 - PCA is a relative but does not reside in the home.
 - Enter the PCA’s relationship to the recipient in the space provided.
 - PCA is not a relative but resides in the home.
 - PCA is not a relative and does not reside in the home.

SECTION 8: ADDITIONAL COMMENTS

Enter additional comments that would assist the assessor in completing this request.

How to Submit the Form

After completing the form, submit it through the Provider Web Portal.

Questions

If you have any questions about PCS program requirements or completing this form, contact Nevada Medicaid at (800) 525-2395. This telephone number is also listed near the top of the form.

Additional Resources

The Billing Guidelines for Provider Types 30 and 83 provides information regarding functional assessments and proper billing procedures. These guidelines are online at www.medicaid.nv.gov (select “Billing Information” from the “Providers” menu).