Instructions for Completing Form FA-24A

(the Coordination of Hospice and Waiver or Personal Care Services (PCS) Form)

To stay current with policy and documentation updates, we recommend that you visit the website 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-24A (the "Coordination of Hospice and Waiver or Personal Care Services (PCS)" form) and these instructions are online at www.medicaid.nv.gov (select “Forms” from the "Providers" menu and scroll down the page until you see Form Numbers FA-24A and FA-24A-I).

General Form Instructions

The Hospice Agency is responsible for completing Form FA-24A to request waiver services or PCS. Form FA-24A along with the Individualized Hospice Care Plan will be utilized in the approval process.

Please print or type information on this form. If information is illegible, processing may be delayed.

You can type information directly into the form with your computer keyboard by clicking in any field and typing. You can check and uncheck the checkboxes by clicking on them. When you are finished, save or print the document as usual.

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.

NOTES

Providers may use this section to communicate any special requests or additional information the Nevada Medicaid reviewers may find helpful.

RECIPIENT INFORMATION

- Last Name, First Name, Middle Initial: Enter the recipient’s name as it appears on their Medicaid card.
- Recipient ID: Enter the 11-digit number shown on the front of the recipient’s Medicaid card.
- 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.
- DOB: Enter the recipient’s Date of Birth (DOB).
- Phone: Enter the recipient’s phone number. If the recipient does not have a phone number, enter “N/A” in this field.
- Address: Enter the address of the recipient's primary residence.
- Name of person to contact to schedule assessment, if other than the recipient: Enter the first and last name of the person who will arrange the appointment time and place for the recipient's assessment.
- Contact Phone: Enter the phone number of the person who will arrange the appointment time and place for the recipient's assessment.
- Has this recipient utilized personal care services in the past? Check the “Yes” box if the recipient has

had personal care service in the past or currently has this service. Check the "No" box if the recipient has never had personal care services.

HOSPICE AGENCY INFORMATION

- Name: Enter the name of the Hospice Agency through which services will be provided.
- NPI: Enter the Hospice Agency's 10-digit National Provider Identifier (NPI).
- Phone: Enter the Hospice Agency's phone number (including area code).
- Fax: Enter the Hospice Agency's fax number (including area code).
- Case Manager Name: Enter the first and last name of the recipient's hospice case manager.
- Case Manager Phone: Enter the phone number of the recipient's hospice case manager.

PCS AGENCY INFORMATION *(if applicable)*

- Name: Enter the name of the PCS Agency that will provide the requested PCS.
- NPI: Enter the PCS Agency's 10-digit NPI.
- Phone: Enter the Agency's phone number including area code.
- Fax: Enter the Agency's Fax number including area code.

WAIVER SERVICES INFORMATION *(if applicable)*

- Waiver Name: Enter the name of the waiver in which the recipient is enrolled.
- Administering Agency: Enter the name of the State Agency responsible for administering the waiver benefits.
- Waiver Case Manager: Enter the name of the State Agency's waiver case manager.
- Phone: Enter the waiver case manager's phone number.
- Fax: Enter the waiver case manager's fax number.

ACTIVITIES OF DAILY LIVING

Each row shows an Activity of Daily Living (ADL) and each column shows days/times in which assistance with the ADL the can be provided.

*** It is critical that the completed form show all services being provided and indicate, by use of the letters "H," "F" and "O" who is providing these services.**

Time periods are considered: AM = 8am to Noon Mid = 12noon to 4pm PM = 4pm to 8pm

For each ADL that is performed by or with the assistance of a person other then the recipient, enter one of the following letters in the corresponding day and time box.

- Enter "H" if the ADL is assisted or done by a hospice employee.
- Enter "F" if the ADL is assisted or done by a family member.
- Enter "O" for "Other" if the ADL is assisted or done by a provider that is not from Hospice and is not a family member.
- If the activity is performed only by the recipient or NOT performed, leave the box empty.

Recipient Last Name, First Name, Middle Initial: Enter the recipient's name as it appears on their Medicaid card.

LEGALLY RESPONSIBLE ADULT (LRA) INFORMATION

- Not Applicable (No LRA): Check this box if the recipient is an adult who is able and responsible for their own decision making. *If you check this box, skip the remainder of this section and go directly to the "Rationale for Services" section.*

If the recipient has an LRA, complete the rest of this section.

- LRA Name: Enter the first and last name of the LRA.
- LRA Phone: Enter the LRA's phone number including area code.
- Is the LRA available and capable of assisting with all necessary ADLs/IADLs? The "Yes" or the "No" box must be checked.
  - If you checked the "Yes" box, skip the rest of this section and go to "*Rationale for Services"* section.
  - If you checked the "No" box, then check one of the following two boxes to explain why the LRA is unable to assist with care-giving:
    - Box 1: The LRA is *not available* due to employment and/or school.

      Enter the name and physical address of the employer/school.

      Provide the employer/school phone number including area code.

      Provide the hours of Employment/School Attendance. For example, "8am-4:30pm, Monday-Friday."
    - Box 2: The LRA is *not capable* of assisting with necessary ADLs/IADLs. If this box is checked, there must be a **physician's certification** describing the LRA's incapacity. The physician's certification must be submitted with form FA-24A.

RATIONALE FOR SERVICES

PCS may not duplicate Hospice services provided for the terminal condition. It is the Hospice Agency's responsibility to ensure there is no duplication of service.

- Enter the terminal diagnosis: Enter the diagnosis for which Hospice will cover the recipient.
- Enter non-terminal condition: Enter the condition or disability for which PCS are needed.
- Enter date the recipient began receiving hospice services: Enter the date that Hospice recorded as the beginning date of Hospice services.
- Describe requested services and give rationale for each. (Services must be related to non-terminal condition): List PCS that the recipient will require and explain why the recipient needs assistance for each task.

How to Submit the Form

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

Questions

If you have any questions about completing this form or about requirements for Care Coordination, please call Nevada Medicaid at (800) 525-2395.