Provider Enrollment Checklist for Provider Type 58

Waiver for People with Physical Disabilities Specialty 191: Respite Care

Respite services are provided to participants unable to care for themselves. Respite is furnished on a short-term basis due to the absence or need for relief of the primary caregiver for the participant. Services are provided in the participant's home or place of residence. The respite caregiver may perform general assistance with ADLs and IADLs and/or provide supervision to functionally impaired recipients to provide temporary relief for a primary caregiver. Respite care is limited to 120 hours per waiver year per individual.

The following is a list of required enrollment documents for this provider type.

All three pages of this checklist must be completed and submitted with the other required document(s) for your enrollment or revalidation.

Failure to submit a complete application which includes all three pages of this checklist will delay an enrollment decision.

If you have any questions, please contact Provider Customer Service at (877) 638-3472 from 8:00 a.m. to 5:00 p.m. Monday through Friday.

- ☐ Current enrollment as a Provider Type 30 (Personal Care Services-Provider Agency) or 83 (Personal Care Services-Intermediary Service Organization) in the Nevada Medicaid program.

OR EACH OF THE FOLLOWING

- ☐ Licensure as a Personal Care Attendant agency issued by the State of Nevada Department of Health and Human Services Division of Public and Behavioral Health (DPBH). If you checked this box, proceed to page 2 and complete the Policy Declaration and Attestation sections. You do not need to include the documents listed below with your Provider Enrollment/Revalidation.
- ☐ Documentation showing Taxpayer Identification Number (SS-4 or CP575 or W-9 or Social Security Card).
- ☐ Proof of Worker's Compensation Insurance.
- ☐ Proof of Commercial General Liability Insurance of not less than $2 million general aggregate and $1 million each occurrence, with the Nevada Division of Health Care Financing and Policy (DHCFP) named as an additional insured. DHCFP's address is 1100 E. William St., Ste. 101, Carson City, Nevada 89701.
- ☐ Proof of Commercial Crime Insurance for employee dishonesty with minimum of $25,000 per loss. Policy must name DHCFP as an additional insured.
- ☐ Proof of Business Automobile Insurance, with a minimum coverage of $750,000 combined single limit for bodily injury and property damage for any owned, leased, hired and non-owned vehicles used in the performance of the Medicaid provider's Contract. The policy must name DHCFP as an additional insured and shall be endorsed to include the following language: "The State of Nevada shall be named as an additional insured with respect to liability arising out of the activities performed by, or on behalf of the Contractor, including automobiles owned, leased, hired or borrowed by the Contractor."
- ☐ Signed Business Associate Addendum (NMH-3820). The Addendum is available at www.medicaid.nv.gov on the "Provider Enrollment" webpage under "Required Enrollment Documents."

All providers must complete the following declaration and attestations, and provide this signed checklist with your provider enrollment or revalidation.

Waiver for People with Physical Disabilities Specialty 191: Respite Care

Policy Declaration

I hereby declare that as of this date, I have read the current Medicaid Services Manual (MSM) Chapters 100 and 2300, which can be found by going to http://dhcfp.nv.gov and selecting "Medicaid Manuals" from the Index box. I attest that I understand these Policies and how they relate to my scope of practice. I acknowledge that, as a Nevada Medicaid contracted provider, I am responsible for complying with the MSM, with any updates to this Policy as it may occur from time to time and with all applicable state and federal laws. I also understand that I am responsible for ensuring that all employees, owners, administrators or managing employees providing direct services have a fingerprint-based criminal background check through the Department of Public Safety and Federal Bureau of Investigation. I will review and ensure those receiving the criminal background check do not have a record of any offense that affects their enrollment as a provider to the Medicaid program. Failure to comply may result in administrative action including recoupment of Medicaid reimbursement, and/or termination from the Medicaid program.

Owner/Applicant Signature:_____Date:_____

Information Changes

If your information changes from what is presented above and on your enrollment application, you are required to notify Nevada Medicaid within five working days. Changes in business ownership must be reported by resubmitting a new enrollment application and indicating ownership change. All ownership changes must include documentation of the purchase agreement. All other changes must be reported by using the Provider Web Portal at https://www.medicaid.nv.gov/hcp/provider/Home/tabid/135/Default.aspx. After logging in, click on the "Revalidate – Update Provider" link under Provider Services. The Online Provider Enrollment User Manual Chapter 3 Revalidation and Updates on the Provider Enrollment webpage at https://www.medicaid.nv.gov provides instructions on navigating the Update Provider tool.

Per MSM Chapter 100, Section 103.3: Medicaid providers, and any pending contract approval, are required to report, in writing within five working days, any change in ownership, address, or addition or removal of practitioners, or any other information pertinent to the receipt of Medicaid funds. Failure to do so may result in termination of the contract at the time of discovery.

I hereby accept Nevada Medicaid's change notification requirements:

Owner/Applicant Signature:_____Date:_____

Reporting Fraud

Providers have an obligation to report to the Division of Health Care Financing and Policy (DHCFP) any suspicion of fraud or abuse in DHCFP programs, including fraud or abuse associated with recipients or other providers (MSM Chapter 3300, Section 3303.1B.1). Examples of fraudulent acts, false claims and abusive billing practices are listed in MSM Chapter 3300, Section 3303.1A.2. Alleged fraud, abuse or improper payment may be reported by calling (775) 687-8405 or completing the form on the DHCFP website at http://dhcfp.nv.gov/Resources/PI/ContactSURSUnit/.

I understand that Nevada Medicaid payments are made from federal and state funds and that any falsification, or concealment of a material fact, may be prosecuted under federal and state laws.

I hereby agree to abide by Nevada Medicaid's fraud reporting requirements.

Owner/Applicant Signature:_____Date:_____

Waiver for People with Physical Disabilities Specialty 191: Respite Care

Owner/Applicant Attestation

I certify under penalty of perjury under the laws of the State of Nevada, that the information I have provided is true and correct and that I have read, understood, and agree to comply with all parts of this Provider Enrollment Checklist.

Owner/Applicant Signature:_____Date:_____

ATTESTATION (*Must be completed and notarized prior to submission*):

Senate Bill (SB) 511 of the 2023 Legislative Session, Section 68, indicates "Of the amounts appropriated to the Division of Health Care Financing and Policy of the Department of Health and Human Services by section 17 of this act for the Medicaid budget account to fund an increase in the rates paid to providers of personal care services, not less than $16 of the $25 per hour reimbursement rate received by providers must be paid as an hourly wage to direct care workers."

Providers are required to pay an hourly wage to direct care workers of at least $16 per hour beginning January 1, 2024, as a condition of receiving the $25 per hour rate.

To be completed by the owner or person disclosed on the application as having authority for this group:

I, _____, on behalf of, _____, hereby agree and attest to abide by SB511 and the condition of receiving the $25 per hour rate and pay at least $16 per hour to the direct care workers of the above agency who appropriately render services to Medicaid recipients. Upon request and within response time frames, I shall provide all accounting documents to support the implementation and continued compliance with SB511 and this attestation. I understand failure to comply with the requirements of SB511 and the DHCFP may result in contract termination and sanction.

____ I attest that I have the legal authority to represent and act on behalf of the aforementioned provider by signing this attestation form.

_____

Full Name (print), Title

_____

Signature

_____

Date

Subscribed and sworn (or affirmed) to before me on this _____ day of _____, 20_____.

_____ (Seal)

Signature of Notary Public

_____

Title of Officer

Date Commission Expires: _____