Provider Enrollment Checklist for Provider Type 38

Home & Community Based Services (HCBS) Waiver for Individuals with Intellectual and Developmental Disabilities

Specialty 212: Habilitation-Prevocational

PREVOCATIONAL: This service provides for learning and work experience, which may include volunteer work, where a recipient can develop general, non-job or task-specific strengths and skills that contribute to employability in paid employment within integrated community settings. Services are expected to occur over a defined period of time and with specific outcomes to be achieved, as identified in the recipient's Person Centered Plan (PCP).

SUPPORTED EMPLOYMENT: There are two sub-categories of Supported Employment – Individual Supported Employment and Small Group Supported Employment: Individual Employment Supports are services for participants who, due to their disability, need intensive, ongoing supports to obtain and maintain a job that meets their personal and career goals in competitive, customized employment, or self-employment; and Small Group Employment Supports are services and training activities provided in regular business, industry, and community settings of two to eight workers with disabilities. Examples include mobile crews which employ small groups of recipients in integrated employment in the community.

The desired outcome of Supported Employment services is sustained paid employment and work experience leading to further career development and individual integrated community-based employment for which the recipient is compensated at or above the minimum wage, but not less than the customary wage and level benefits paid by the employer of the same or similar work performed by individuals without disabilities.

CAREER PLANNING: Career Planning is a person-centered, comprehensive employment planning and support service that provides individuals with assistance to obtain, maintain or advance in competitive employment or self-employment. It is time-limited and focuses on engaging a recipient in identifying a career direction and developing a plan for achieving competitive, integrated employment with pay at or above the state's minimum wage.

The following is a list of required enrollment documents for this provider type. A copy of each document listed below must be included with your provider enrollment or revalidation.

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

Resources: The Provider Enrollment webpage provides instruction materials that will assist providers with enrolling in Nevada Medicaid.

Facility/Group

- ☐ Aging and Disability Services Division (ADSD) Jobs and Day Training Services or Community Training Center Certification. (Please contact the Regional Center(s) you wish to affiliate with for information on their certification process. Contact information can be located at: http://adsd.nv.gov/Contact/Contact_DevServices/)
- ☐ Documentation showing Taxpayer Identification Number (SS-4 or CP575 or W-9)
- ☐ Nevada Secretary of State Business License
- ☐ Signed Business Associate Addendum (NMH-3820) if your business is NOT a HIPAA "covered entity." The Addendum is available at www.medicaid.nv.gov on the "Provider Enrollment" webpage under "Required Enrollment Documents."

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Individual

- ☐ Aging and Disability Services Division (ADSD) Jobs and Day Training Services or Community Training Center Certification. (Please contact the Regional Center(s) you wish to affiliate with for information on their certification process. Contact information can be located at: http://adsd.nv.gov/Contact/Contact_DevServices/)
- ☐ Documentation showing Taxpayer Identification Number (W-9)
- ☐ Signed Business Associate Addendum (NMH-3820) if your business is NOT a HIPAA "covered entity." The Addendum is available at www.medicaid.nv.gov on the "Provider Enrollment" webpage under "Required Enrollment Documents."

Complete the following declaration and attestations, and provide this signed checklist with your provider enrollment or revalidation.

Policy Declaration

I hereby declare that as of this date, I have read the current Medicaid Services Manual (MSM) Chapters 100 and 2100, which can be found by going to http://dhcfp.nv.gov and selecting "Manuals" from the "Resources" menu. 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.

Owner/Applicant Printed Name:_____

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 Printed Name:_____

Owner/Applicant Signature:_____Date:_____

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HCBS Final Regulation Declaration

The Centers for Medicare & Medicaid Services (CMS) has issued a regulation regarding several sections of the Medicaid law under which states offer Home and Community Based Services (HCBS). The regulation reflects CMS' intent to ensure that individuals receiving services and supports through Medicaid's HCBS programs have full access to the benefits of community living and can receive services in the most integrated setting possible.

I hereby declare that as of this date, I have read the HCBS Final Regulations Settings Requirements which can be found at https://dhcfp.nv.gov/home/hcbs/finalregulation/ and by selecting "*HCBS Settings Requirements Provider Information"* from the links on the page. I attest that I understand the settings requirements and how they relate to my scope of practice. I acknowledge that, as a Medicaid waiver provider, I am responsible for complying with the HCBS Final Regulation and with any updates to the Settings Requirements as they may occur from time to time.

Owner/Applicant Printed Name:_____

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 Printed Name:_____

Owner/Applicant Signature:_____Date:_____

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 Printed Name:_____

Owner/Applicant Signature:_____Date:_____