Provider Enrollment Checklist for Provider Type 38

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

## Specialty 214: Supported Environment

**BEHAVIORAL CONSULTATION, TRAINING AND INTERVENTION:** Behavioral consultation, training and intervention services provide behaviorally based assessment and intervention for recipients, as well as support, training and consultation to family members, caregivers, paid residential support staff, or jobs and day training staff. This service also includes participation in the development and implementation of the Person Centered Plan (PCP) and/or Positive Behavior Support Plans necessary to improve a recipient's independence and inclusion in their community, increase positive alternative behaviors, and/or address challenging behavior. Services are not covered under State Plan services and are provided by professionals in psychology, behavior analysis and related fields. Services may be provided in the participant's home, school, workplace or in the community.

**NURSING SERVICES:** There are three components of Nursing Services: Medical Management, Nursing Assessment, and Direct Services (over and above State Plan). Medical Management is geared toward the development of health services support plans; training of direct support staff or family members to carry out treatment; monitoring of staff knowledge and competence to improve health outcomes; assistance with revision of health support plans in response to new or revised treatment orders or lack of positive outcomes of current supports by staff. Nursing Assessment is completed by an RN to identify the needs, preferences, and abilities of the recipient. The assessment includes: an interview with the recipient; and/or their designated representative/LRI, an observation by the nurse to consider the symptoms and signs of condition, verbal and nonverbal communication skills, medical and social history, medication and any other information available. Direct Services provide routine medical and health care services that are integral to meeting the daily needs of participants. This includes the routine administration of medication by an RN or LPN in a community setting, including home or work, as described and approved in the recipient's PCP, tending to the needs of recipients who are ill, and providing care to recipients who have ongoing medical needs. LPNs must be under the supervision of a RN licensed in the state.

**NUTRITION COUNSELING SERVICES:** Nutrition Counseling Services include assessment of the recipient's nutritional needs, development, and/or revision of recipient's nutritional plan, counseling and nutritional intervention, and observation and technical assistance related to the successful implementation of the nutritional plan. These services include training, education and consultation for recipients, family members, or support staff involved in the day-to-day support of the recipient; comprehensive assessment of nutritional needs; development, implementation and monitoring of the nutritional plan incorporated in the PCP, including updating and making changes to the plan as needed; aid in menu planning and making healthy options; provide monthly case notes on nutritional activities and summaries of progress on the nutritional plan.

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) Approval Letter. (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) Approval Letter. (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:_____