



Home & Community Based Waiver – Individuals with Intellectual Disabilities and Related Conditions

Specialty 214: Supported Environment

Specialty code 214: Supported Environment includes any of the following services:

SUPPORTED EMPLOYMENT: Supported Employment Individual Employment Support are services for participants who, due to their disability, need intensive, ongoing supports in order to obtain and maintain a job in competitive, customized employment, or self-employment, in an integrated work setting within the general workforce for which the individual is compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities.

BEHAVIORAL CONSULTATION, TRAINING AND INTERVENTION: Behavioral consultation, training and intervention services provide behaviorally based assessment and intervention for participants, 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 Individual Support Plans and/or positive behavior support plans, necessary to improve an individual's independence and inclusion in their community, increase positive alternative behaviors, and/or address challenging behavior. Services are not covered by 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.

NON-MEDICAL TRANSPORTATION: Non-Medical Transportation services are offered in order to enable waiver recipients to gain access to community services, activities and resources that are identified in the Individual Support Plan. Non-medical transportation services allow individuals to engage in normal day-to-day, non-medical activities such as going to the grocery store or bank, participating in social events and other civic activities, or attending a worship service. Whenever possible, family, neighbors, friends or community agencies are utilized to provide this service without charge. This service is in addition to the medical transportation service offered under the Medicaid State Plan, which includes transportation to medical appointments and can be arranged at least 48 hours in advance, as well as for emergency medical transportation. This service will not duplicate or impact the amount, duration and scope of the medical transportation benefit provided under the Medicaid State Plan.

NURSING SERVICES: Nursing 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 nurses, tending to the needs of participants who are ill, and providing care to participants who have ongoing medical needs. Routine nursing services are within the scope of the State's Nurse Practice Act and are provided by a registered professional nurse, or licensed practical nurse under the supervision of a registered nurse, licensed to practice in the State. These services are long-term, occur at least once monthly, and are necessary to maintain or improve an individual's general health and welfare in the community.

NUTRITION COUNSELING SERVICES: Nutrition Counseling Services include assessment of an individual's nutritional needs, development, and/or revision of an individual'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 individuals, family members, or support staff involved in the day-to-day support of the participant; comprehensive assessment of nutritional needs; development, implementation and monitoring of the nutritional plan incorporated into the participant's Individual Support Plan, including updating and making changes to the plan as needed; aid in menu planning and making healthy options; nutritional education and consultation; and developing quarterly summaries of progress on the nutritional plan.



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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/Re-Enrollment Packet. 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.

- Aging and Disability Services Division (ADSD) Provisional Certification. (Please contact the Regional Center 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)
- National Provider Identifier (NPI) validation: Printed page from the NPPES NPI Registry displaying the provider’s NPI or a printed copy of the email confirmation showing the provider’s NPI
- Signed Business Associate Addendum (NMH-3820). 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/Re-Enrollment Packet.

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://dhcftp.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.

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 HP Enterprise Services (HPES) within five working days. Changes in business ownership must be reported by resubmitting a completed enrollment application. All other changes may be reported by completing the relevant sections of form FA-33. All forms are online at www.medicaid.nv.gov and must be submitted to HPES.

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: _____



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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: _____

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: _____