Provider Enrollment Checklist for Provider Type 39

Adult Day Health Care Center

Adult Day Health Care centers provide assistance with the activities of daily living, medical equipment and medication administration. Services include care coordination, nursing services, nutritional assessment, and training or assistance in activities of daily living or instrumental activities of daily living, social activities and meals. This service may be reimbursed at a daily per diem rate, or a unit rate, depending on the authorized hours.

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

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.

- ☐ Licensure as an Adult Day Care Facilities (ADC) agency issued by the State of Nevada Department of Health and Human Services Division of Public and Behavioral Health (DPBH).
- ☐ Copy of business license from the Nevada Secretary of State.
- ☐ Documentation showing Taxpayer Identification Number (SS-4 or CP575 or W-9).
- ☐ 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 4070 Silver Sage Dr, Carson City, NV 89701.
- ☐ Proof of Worker's Compensation Insurance.
- ☐ Proof of Commercial Crime Insurance for employee dishonesty with a minimum of $25,000 per loss. Policy must name DHCFP as an additional insured.
- ☐ Do you provide transportation in any owned, leased, hired and non-owned vehicles?

  ☐ Yes ☐ No If you answered "Yes" you must provide 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 https://www.medicaid.nv.gov on the "Provider Enrollment" webpage under "Required Enrollment Documents."

Adult Day Health Care Center

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

HCBS Final Regulation Declaration

The Centers for Medicare and 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//www.dhcfp.nv.gov/Home/HCBS/FinalRegulation/ and by selecting "*Summary of HCBS Settings Requirement*" 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 or Director signature: _____ Date: _____

Policy Declaration

I hereby declare that I have read the current MSM Chapters 100 and 1800 as of the date above and understand this policy and how it relates 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 may occur from time to time and with applicable state and federal laws. This entity meets all provider qualifications outlined in MSM Chapters 100 and 1800. I also understand that I am responsible for ensuring that all owners, administrators, managing employees, and all other employees providing direct services have a fingerprint-based criminal background check through the Department of Public Safety and Federal Bureau of Investigation. Failure to comply may result in administrative action including recoupment of Medicaid reimbursement and/or termination from the Medicaid program.

Owner or Director signature: _____ Date: _____

Changes in Medicaid Information

If your Clinical Supervisor changes or any other pertinent information changes from what is presented above and on your enrollment application, you are required to notify Nevada Medicaid within the time frame established in MSM Chapter 100, Section 103.3(A). Changes or additions in Clinical or Direct Supervision may be re ported using this form. 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, Medicaid providers, and any pending contract approval, are required to report, in writing withinthe time frame established in MSM Chapter 100, Section 103.3(A), 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.)

Adult Day Health Care Center

I hereby accept Nevada Medicaid's change notification requirements:

Owner or Director 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). Examples of fraudulent acts, false claims and abusive billing practices are listed in MSM Chapter 3300. Alleged fraud, abuse or improper payment may be reported by calling (775) 687-8405.

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 or Director signature: _____ Date: _____

Owner/Director 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/Director signature: _____Date: _____

Resources:

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