Home and Community Based Waiver for the Frail Elderly
Specialty 039: Homemaker Services

Homemaker services are provided when the individual regularly responsible for homemaker activities is temporarily absent or unable to manage the home. Homemaker services are provided by agencies under contract with the Division of Health Care Financing and Policy (DHCFP). Homemaker services include general cleaning; shopping for food and needed supplies; planning and preparing varied meals; washing, ironing and mending the recipient's personal laundry; accompanying the recipient to homemaker activities such as shopping or the laundromat; and routine clean-up after up to two household pets.

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.

- ☐ 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).
- ☐ 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 a 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."
- ☐ 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."

All providers must complete the following declaration and attestations, and provide this signed checklist with your Provider Enrollment/Re-Enrollment Packet.

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Policy Declaration

I hereby declare that as of this date, I have read the current Medicaid Services Manual (MSM) Chapters 100 and 2200, 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 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/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 https://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:_____

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:_____