Home and Community Based Waiver for the Frail Elderly
Specialty 199: Chore Services

Chore services are intermittent in nature and may be authorized as a need arises for the completion of a specific task which otherwise left undone poses a home safety issue. These services are provided only in cases where neither the recipient, nor anyone else in the household, is capable of performing or financially providing for them, and where no other relative, caretaker, landlord, community volunteer/agency or third party payer is capable of, or responsible for, their provision and without these services the recipient would be at risk of institutionalization. This is not a skilled, professional service. This service includes heavy household chores such as cleaning windows and walls; shampooing carpets; tacking down loose rugs and tiles; moving heavy items; minor home repairs; removing trash and debris from the yard; and packing and unpacking boxes.

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

- ☐ Documentation showing Taxpayer Identification Number (SS-4 or CP575 or W-9 or Social Security Card).
- ☐ Proof of Worker's Compensation Insurance.
- ☐ Copy of business license from the Nevada Secretary of State (for in-state providers) or a copy of the Secretary of State business license in the provider's home state (for out-of-state providers)
- ☐ 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. *(if applicable)*
- ☐ 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.

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.

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:_____