Provider Enrollment Checklist for Provider Type 58

## Waiver for People with Physical Disabilities
## Specialty 048: Assisted Living

Assisted living services are all inclusive services which may include any and all activities of daily living (ADL's) and instrumental activities of daily living (IADL's) and medication oversight (to the extent permitted under state law).

Services provided by a third party, such as skilled nursing care provided by home health, or personal care services provided by a licensed agency, must be coordinated with the assisted living facility.

The following is a list of required enrollment documents for this provider type. A copy of each document listed below and this checklist must be included with your Provider Enrollment/Revalidation.

If you have any questions, please contact Provider Customer Service at (877) 638-3472 from 8:00 a.m. to 5:00 p.m. Monday through Friday.

- ☐ Licensure as an agency to provide Residential Facilities for Groups 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.
- ☐ 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."

**Complete the following declaration and attestations, and provide this signed checklist with your Provider Enrollment/Revalidation.**

**Policy Declaration**

I hereby declare that as of this date, I have read the current Medicaid Services Manual (MSM) Chapters 100 and 2300, 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 employees, owners, administrators or managing employees providing direct services have a fingerprint-based criminal background check through the Department of Public Safety and Federal Bureau of Investigation. I will review and ensure those receiving the criminal background check do not have a record of any offense that affects their enrollment as a provider to the Medicaid program. Failure to comply may result in administrative action including recoupment of Medicaid reimbursement, and/or termination from the Medicaid program.

I hereby accept Nevada Medicaid's Policy requirements:

Owner/Applicant Printed Name:_____

Owner/Applicant Signature:_____Date:_____

**Waiver for People with Physical Disabilities**
**Specialty 048: Assisted Living**

**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 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:_____

**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 http://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:_____

**Waiver for People with Physical Disabilities**
**Specialty 048: Assisted Living**

**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:_____