Nevada Medicaid and Nevada Check Up

Instructions for Completing Form FA-24W

(Waiver Staff / Case Managers Authorization Request for Personal Care Services (PCS))

Form FA-24W is to be completed by provider type 48 (Home and Community Based Waiver for the Frail Elderly) and 58 (Home and Community Based Waiver for Persons with Physical Disabilities) waiver case managers to request Personal Care Services for their recipients.

To stay current with policy and documentation updates, please visit www.medicaid.nv.gov weekly and also be sure to read any messages included on your Remittance Advice.

Finding the Form and Instructions Online

Form FA-24W and these instructions are online at www.medicaid.nv.gov (select "Forms" from the "Providers" menu, and scroll down until you see form FA-24W and instructions FA-24W-I).

General Form Instructions

All form fields must be completed (with the exception of Section 1 and Section 8). Write/type "N/A" in a field if the item does not apply (e.g., Legally Responsible Individual (LRI) Name).

Please print or type information on this form. If information is illegible, processing may be delayed. You can enter information directly into the form on your computer clicking in any field and typing. You can check and uncheck the checkboxes by clicking them.

When you are finished completing the form, email the request to nv.mmis.pcs@gainwelltechnologies.com.

If the FA-24W is incomplete, the authorization request may be pended for additional information and you will need to upload a corrected FA-24W to the same authorization. DO NOT create a new authorization. The received date is the date a completed correct request is received. The date of receipt of incorrect or incomplete requests is not valid. To avoid uncovered dates of service, please complete the FA-24W in its entirety the first time it is submitted. Only a completed FA-24W will be processed. If the information is not received within 30 calendar days, the request will be denied and a notice of decision will be sent.

Completing the Form

The following sections describe the information to enter in each form field.

SECTION 1: FOR NEVADA MEDICAID USE ONLY

Please leave this section blank (to be completed by Nevada Medicaid staff only).

SECTION 2: DATE OF REQUEST AND REQUEST TYPE

Date of Request: Enter the date you submit the form to Nevada Medicaid.

Request Type: Check one of these boxes to indicate the type of prior authorization you are requesting.

- Initial – Check this box to request a recipient's initial Functional Assessment Service Plan Review.
- Significant Change (new assessment) – Check this box if the recipient's condition has changed significantly. Documentation is required in the Comments section and must indicate the significant change and how it directly impacts the recipient.
- Temporary Increase – Check this box if the request is a temporary increase in services.

SECTION 3: CONTACT INFORMATION

RECIPIENT INFORMATION

- Last Name and First Name – Enter the recipient's name as it appears on their Medicaid card.
- Recipient Medicaid ID – Enter 11-digit number shown on the front of the recipient's Medicaid card.
- Date of Birth – Enter the recipient's Date of Birth (DOB).
- Translator Required – Check the Yes box if English is not the primary language of the recipient and a translator is needed. Check No if a translator is not needed.
- Language – If a translator is needed, enter the recipient's primary language.
- Address (including City, State and Zip Code fields) – Enter the recipient's home address.
- Phone Number – Enter the recipient's phone number. If the recipient does not have a phone number, enter "N/A" in this field.
    - **Note:** Verify the address and phone number are current, whether or not they match the information on file with Nevada Medicaid. If the recipient has moved, remind them to update their address and phone number with the Division of Welfare and Supportive Services (DWSS).
- Current Living Arrangement: Check the recipient's applicable living arrangement.

LEGALLY RESPONSIBLE INDIVIDUAL (LRI) INFORMATION

Complete this section if the following definition of an LRI is met. The definition of an LRI is: An Individual who is legally responsible to provide medical support, including spouses of recipients, legal guardians [not power of attorney (POA)], and parents of minor recipients, including stepparents, foster parents and adoptive parents. If the LRI is not available or capable, complete and attach form FA-24B (Legally Responsible Individual (LRI) Availability Determination for the Personal Care Services Program).

You must include the contact information of a recipient's legally responsible individual for a recipient who is unable to speak on his or her own behalf or who is less than 18 years of age.

- Does recipient have an LRI? If the definition of the LRI is met, answer Yes and complete the LRI Information section. If the answer is No, proceed to Alternate Contact Information. This question must be answered with either a Yes or No response. If the Unknown option is selected, the request will be pended for additional information and the provider will have 30 days to submit a corrected FA-24W along with any required documentation. Please see Web Announcement 1461 at www.medicaid.nv.gov for additional information.

  When the LRI section of form FA-24W is marked Yes, it is now mandatory for the PCS agency to submit form FA-24B (Legally Responsible Individual (LRI) Availability Determination for the Personal Care Services Program) when submitting FA-24W. Both forms must be submitted and the forms must be uploaded as separate attachments when submitted through the Provider Web Portal. The documentation below must be included:

  Employed LRI
  - Annual proof of employment, which must:
    - Be written within 6 months of the new request.
    - List the days per week and hours per day the LRI works.
    - Be on company letterhead.

  Note: Paycheck stubs may be required to confirm employment.

  Disabled LRI
  - A copy of the permanent disability note (FA-24B) with each request.
  - For temporary disabilities, an updated FA-24B prior to expiration of the current disability note.

- LRI Name – Enter the name of the recipient's LRI.
- Phone Number – Enter the LRI's phone number.
- Relationship to Recipient – Enter the LRI's relationship to the recipient, e.g., spouse, parent.
- Does LRI reside with the recipient? Indicate Yes or No.
- Is the LRI also on PCS Program? Indicate if the LRI is also receiving services in the PCS program. If you check Yes, please indicate how many PCS hours per week the LRI receives.
- LRI Employment Status – Check the appropriate status. If the LRI is employed, indicate how many hours per week the LRI works and how many days off the LRI has per week.

ALTERNATE CONTACT INFORMATION

Complete this section to provide an alternate contact in the event the recipient and LRI are unavailable.

- Alternate Contact Name – Enter the name of the alternate contact person.
- Phone Number – Enter the alternate contact person's phone number.
- Relationship to Recipient – Enter the contact person's relationship to the recipient.
- Can this person be contacted in case we are unable to contact recipient – Indicate Yes or No.

PCS AGENCY INFORMATION

Enter the name of the recipient's PCS agency:

- PCS Agency Name
- NPI/API
- Phone Number

CASE MANAGER INFORMATION

Enter the name and direct phone number for the recipient's case manager. If the individual is associated with a business (i.e., hospital, government agency, etc.), enter the business or entity name:

- Case Manager Name and Phone Number
- Entity Name and Phone Number

SECTION 4: REASON FOR REFERRAL

- Place a checkmark next to each task the individual needs assistance with.
- Is this recipient at risk of institutionalization if services are not provided as soon as possible? Select Yes or No.

SECTION 5: DIAGNOSES AND INCIDENTS

DIAGNOSIS/DIAGNOSES AFFECTING THE INDIVIDUAL'S ABILITY TO COMPLETE TASKS

- Enter up to nine diagnoses for this recipient.
- Is anyone else in the home receiving PCS at this time? – Indicate if anyone in the home is currently receiving PCS, and identify who is receiving the services.

INCIDENTS WITHIN PAST 90 DAYS

Indicate the incidents that have occurred for this recipient. Check all that apply.

- Hospitalization – Indicate discharged date or anticipated discharge date.
- Recent Fall.
- Surgery – Indicate type of surgery.
- Loss of non-paid caregiver.
- New Medical Condition/Diagnosis – Please specify.
- Addition of other services – Please specify.
- Other – Specify any other incidents not listed above.

OTHER SERVICES CURRENTLY RECEIVED

Indicate other services this recipient is currently receiving regardless of funding. Check all that apply. Add any other services not already specified.

SECTION 6: COMMENTS

Enter general comments that would assist the assessor in completing an accurate assessment, including the reason for the request.

SECTION 7: PERSON COMPLETING FORM

Provide the following information of the person completing this request, if different from the case manager. This person will be contacted with questions if needed.

- Name
- Date
- Entity Name
- Phone Number

SECTION 8: CLINICAL REVIEWER DETERMINATION

Please leave this section blank (to be completed by Nevada Medicaid staff only).

How to Submit the Form

After completing the form, email it to nv.mmis.pcs@gainwelltechnologies.com.

Questions

If you have any questions about PCS program requirements or completing this form, contact Nevada Medicaid at (800) 525-2395.