Provider Enrollment Checklist for Provider Type 83

Personal Care Services - Intermediary Service Organization

The following is a list of required enrollment documents for this provider type.

All three pages of this checklist must be completed and submitted with the other required document(s) for your enrollment or revalidation.

Failure to submit a complete application which includes all 3 pages of this checklist will delay an enrollment decision.

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.

Entity/agency/group name: _____

National Provider Identifier (NPI): _____ Date: _____

Please Check One:

☐ New Enrollment ☐ Revalidation (required every 5 years)

Requirements

Initial each space below to signify that the specified item is attached with your enrollment/revalidation.

_____ Licensure as a Personal Care Agency that is also Intermediary Service Organization (ISO) Certified to provide Personal Care Services in the home as issued by the State of Nevada Department of Health and Human Services Division of Public and Behavioral Health (DPBH).

OR

_____ ISO Certification to provide Personal Care Services in the home as issued by the State of Nevada Department of Health and Human Services Division of Public and Behavioral Health (DPBH) if your application is strictly only to enroll as an Intermediary Service Organization.

_____ Documentation showing Taxpayer Identification Number (SS-4 or CP575 or W-9).

_____ Signed Business Associate Addendum (NMH-3820). The Addendum is available at www.medicaid.nv.gov on the "Provider Enrollment" webpage under "Required Enrollment Documents."

_____ Provider type 83 must complete and submit the Advance Directives Compliance Self-Evaluation & Certification form to DHCFP. This form does not need to be included with your enrollment/revalidation documents. The return email and mailing address to DHCFP are provided at the bottom of the form. The form is available by clicking on the link below and is also available on the Provider Enrollment webpage under "Required Enrollment Documents."

- Advance Directives Compliance Self-Evaluation & Certification (NMH-3827)

Policy Declaration

I hereby declare that as of this date, I have read the current Medicaid Services Manual (MSM) Chapters 100, 3300 and 2600, which can be found by going to http://dhcfp.nv.gov/Resources/AdminSupport/Manuals/MSM/MSMHome/. 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. This entity/agency/group meets all provider qualifications outlined in MSM Chapter 100 and 2600.

Owner/Applicant Signature:_____Date:_____

Personal Care Services - Intermediary Service Organization

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 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, 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 or 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 Chap-ter 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 understand all of the above requirements to become a Nevada Medicaid Personal Care Services-Intermediary Service Organization Provider and all my responsibilities as such, including, my responsibility to furnish qualified personal care attendants, as described in MSM Chapter 3500 and 2600, to all eligible Medicaid and Nevada Check Up recipients my agency may serve.

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:_____

ATTESTATION (*Must be completed and notarized prior to submission*):

Senate Bill (SB) 511 of the 2023 Legislative Session, Section 68, indicates "*Of the amounts appropriated to the Division of Health Care Financing and Policy of the Department of Health and Human Services by section 17 of this act for the Medicaid budget account to fund an increase in the rates paid to providers of personal care services, not less than $16 of the $25 per hour reimbursement rate received by providers must be paid as an hourly wage to direct care workers.*"

Providers are required to pay an hourly wage to direct care workers of at least $16 per hour beginning January 1, 2024, as a condition of receiving the $25 per hour rate.

Personal Care Services - Intermediary Service Organization

To be completed by the owner or person disclosed on the application as having authority for this group:

I, _____, on behalf of, _____, hereby agree and attest to abide by SB511 and the condition of receiving the $25 per hour rate and pay at least $16 per hour to the direct care workers of the above agency who appropriately render services to Medicaid recipients. Upon request and within response time frames, I shall provide all accounting documents to support the implementation and continued compliance with SB511 and this attestation. I understand failure to comply with the requirements of SB511 and the DHCFP may result in contract termination and sanction.

____ I attest that I have the legal authority to represent and act on behalf of the aforementioned provider by signing this attestation form.

_____

Full Name (print), Title

_____

Signature

_____

Date

Subscribed and sworn (or affirmed) to before me on this _____ day of _____, 20_____.

_____ (Seal)

Signature of Notary Public

_____

Title of Officer

Date Commission Expires: _____