Home and Community Based Services Waiver for Structured Family Caregiving (SFCG) Specialty 191: Respite

Respite services are provided to participants unable to care for themselves. Respite is furnished on a short-term basis due to the absence or need for relief of the primary caregiver for the participant. Services are provided in the participant's home or place of residence. The respite caregiver may perform general assistance with ADLs and IADLs and/or provide supervision to functionally impaired recipients to provide temporary relief for a primary caregiver. Respite care is limited to 336 hours per waiver year per individual.

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 three pages of this checklist will delay an enrollment decision.

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.

Requirements

Currently Enrolled Providers

For providers who are currently enrolled as one of the Nevada Medicaid Provider types below, please initial each space to signify that the specified item is attached with your enrollment/revalidation. Then proceed to page two to complete the Training Requirements, Policy Declaration and Attestation sections.

_____ Nevada Medicaid Provider Type 30 (Personal Care Services – Provider Agency) or 83 (Personal Care Services - Intermediary Service Organization).

OR

_____ Nevada Medicaid Provider Type 48 (Frail Elderly Waiver) or 58 (Physically Disabled Waiver)

New Medicaid Provider

For new applicants who are not enrolled with Nevada Medicaid, please initial each space below, attach required documentation and complete all pages.

_____ 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) with an endorsement as an Intermediary Service Organization (ISO).

_____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 4070 Silver Sage Dr, Carson City, NV 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

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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."

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

AND

_____Complete the following Training Requirements, Policy Declaration and Attestation sections.

Prior to initial enrollment and revalidation, Provider Agency must provide a **Certificate of Completion equaling 12 hours or more** of training hours from one of the following resources:

1. ***Dementia Engagement, Education, and Research (DEER) Care Partner Training*** *https://deerprogram.org/* Each module is 3 hours. Providers must complete a minimum of 4 modules to obtain the Certificate of Completion equaling 12 hours. The following links below are training modules under the DEER Program that you can choose from:
    - Bravo Zulu https://deerprogram.org/bravo-zulu/
    - Dementia Conversations https://deerprogram.org/dementia-conversations/
    - Dementia Friendly Nevada https://deerprogram.org/dementia-friendly-nevada/
    - Dementia Friends https://deerprogram.org/dementia-friends/
    - Dementia Self-Management https://deerprogram.org/dementia-self-management/
    - ICECAP Nevada https://deerprogram.org/icecap-nevada/
2. ***Powerful Tools for Caregivers*****:** https://www.powerfultoolsforcaregivers.org/

All providers must complete the following declaration and attestations and provide this signed checklist with your provider enrollment or revalidation.

Policy Declaration

I hereby declare that as of this date, I have read the current Medicaid Services Manual (MSM) Chapters 100 and 2400, 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. 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.

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Owner/Authorized Representative Printed Name: _____

Owner/Authorized Representative Signature: _____Date: _____

Changes in Medicaid Information

If your information changes from what is presented above and on your enrollment application, you are required to notify Nevada Medicaid within thirty (30) calendar days. Changes in business ownership must be reported by resubmitting a new enrollment application and indicating an 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 Updated Provider tool.

Per MSM Chapter 100 Provider Section 103.3: Medicaid providers and applicants must report within 30 calendar days, any change in ownership, address, or addition or removal of practitioners, or any information that may impact the conditions of participation or is pertinent to the receipt of Medicaid funds. Changes must be reported through the method described in the online Provider Enrollment Information Booklet. 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/Authorized Representative Printed Name: _____

Owner/Authorized Representative Signature: _____Date: _____

Reporting Fraud

Providers have an obligation to report to the Division of Health Care Financing and Policy (DHCFP) any suspicion of fraud, waste, or abuse in DHCFP programs, including fraud, waste, or abuse associated with recipients or other providers (MSM Chapter 3300). Examples of fraudulent acts, false claims and abusive billing practices are listed in MSM Chapter 3300. Alleged fraud, waste, abuse or improper payment may be reported by contacting the Surveillance Utilization Review (SUR) Unit at https://dhcfp.nv.gov/Resources/PI/ContactSURSUnit/ or by calling (775) 687-8405.

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/Authorized Representative Printed Name: _____

Owner/Authorized Representative Signature: _____Date: _____

Owner/Authorized Representative 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/Authorized Representative Printed Name: _____

Owner/Authorized Representative Signature: _____ Date: _____

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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.

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_____.