Home and Community Based Services Waiver for Structured Family Caregiving (SFCG) Specialty 303: Private Case Management Services

Case Management services assist eligible and active Waiver recipients in gaining access to needed Waiver and other State Plan services, as well as needed medical, social, education or other services, regardless of the funding source for the services to which access is gained. Case Managers are responsible for ongoing monitoring of the provision of services included in the individual's Person-Centered Service Plan (PCSP). The following is a list of enrollment documents and requirements for this provider type. A copy of each document listed below must be included with your provider enrollment or revalidation. Revalidation is required every five (5) years.

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 48, 57 and 59 (Waiver for Frail Elderly, Elderly in Adult Residential Care and Assisted Living Waivers).

OR

_______ Nevada Medicaid Provider Type 58 (Physical Disability Waiver)

New Medicaid Provider

For new applicants who are not enrolled with Nevada Medicaid, please provide the following required documentation below and complete all pages.

Entity/Group

- ☐ Meet all requirements to enroll and maintain status as an approved Medicaid provider, pursuant to the DHCFP Medicaid Services Manual (MSM), Chapter 100 and Chapter 2400, as applicable.
- ☐ Documentation showing Taxpayer Identification Number (SS-4 or CP575 or W-9)
- ☐ Nevada Secretary of State Business License
- ☐ Proof of Worker’s Compensation Insurance
- ☐ Proof of Unemployment 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.
- ☐ The policy must name DHCFP as an additional insured.

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Do you provide transportation in any owned, leased, hired and non-owned vehicles?

☐ Yes ☐ No

If you answered “yes” you must provide 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 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 https://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 the 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 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. Failure to comply may result in administrative action including recoupment of Medicaid reimbursement, and/or termination from the Medicaid program. Failure to comply may result in administrative action including recoupment of Medicaid reimbursement, and/or termination from the Medicaid program.

Once fully enrolled as a Medicaid provider, I understand and agree that the state may conduct provider reviews to validate that the above requirements detailed in Chapter 2400 are met.

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.

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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: _____________

HCBS Final Regulation Declaration

The Centers for Medicare and 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 https://dhcfp.nv.gov/home/hcbs/finalregulation/ and by selecting "Summary of HCBS Settings Requirement" 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/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: _____________

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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: ____________