Home and Community Based Services Waiver for Structured Family Caregiving (SFCG)

Specialty 895: Structured Family Caregiving

Structured Family Caregiving (SFCG) is a waiver service provided to people who are suffering from dementia and/or related conditions. The recipient has the option to receive personal care and related supports from a primary caregiver who lives in the same private residence as the recipient.

SFCG is provided in a private residence and affords all the rights, dignity and qualities of living in a private residence.

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

All four 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 four pages of this checklist will delay an enrollment decision.

If you have any questions, please contact the Provider Customer Service 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

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 83 (Personal Care Services - Intermediary Service Organization).

OR

_____ Nevada Medicaid Provider Type 30 (Personal Care Services – Provider Agency)

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).

_____ 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.

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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/

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.

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:

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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: _____Date: _____

Owner/Authorized Representative Signature: _____Date: _____

Owner/Authorized Representative Attestation

I understand all of the above requirements to become a Nevada Medicaid SFCG Waiver Provider and all my responsibilities as such, including my responsibility to ensure only qualified personal care attendants provide SFCG services, as described in MSM Chapter 2400. The provider agency must provide the required training specific to dementia and related conditions (as mentioned above) to SFCG caregivers prior to working directly with SFCG Waiver recipients.

Have established procedures for the administration of structured caregiver assessments and the delivery of support that is individualized to the needs of each caregiver.

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: Per Assembly Bill (AB) 208 AB208, the provider agency is required to provide the SFCG caregiver a daily stipend that is at least 65% of the per diem rate paid to the Provider Agency.

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 all requirements set forth by DHCFP and AB 208 which was approved by Centers for Medicare & Medicaid Services (CMS) in the Structured Family Caregiving Waiver. I understand that failure to comply with the requirements of AB 208 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, Title (print)

_____

Signature

_____

Date