Aging and Disability Services Division

Community Based Care

Personal Assistance Services (PAS)

PAS-ISO - Request for Self-Directed Skilled Services

DATE OF REQUEST: _____ /______ /______

NOTES:			
SECTION 1: Contact Information			
PURPOSE OF REQUEST			
☐ Initial ☐ Reauthorization			
RECIPIENT INFORMATION			
Last Name, First Name, Middle Initial:			
Date of Birth:			
Address:			
City:	State:	Zip Code:	Phone:
Check the appropriate box: ☐ The recipient has no Legally Responsible Individual (LRI) and is able to self-direct their own care. ***(If this option is checked, complete Section 4; do not complete Section 5)*** ☐ The recipient is not able to direct their own care, and the LRI or Personal Care Representative understands that they must be present to direct the care while it occurs and cannot be the paid caregiver for the recipient. ***(If this option is checked, complete Section 5; do not complete Section 4)***			
LEGALLY RESPONSIBLE INDIVIDUAL (LRI) INFORMATION	*Complete this section if this definition of an LRI is met: Individuals who are 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 LRI is not available or not capable, complete and attach form CBC-LRI (LRI Availability Determination)***		
LRI Name *(if applicable)*:		Relationship to Recipient:	
LRI Address:			
City:	State:	Zip Code:	Phone:
PERSONAL CARE REPRESENTATIVE INFORMATION	*Complete this section if recipient is unable to direct his/her own care and has no legally responsible individual available or capable to perform or direct the care.* ***The Personal Care Representative cannot be the Personal Care Assistant.***		
Contact Name (*other than recipient*):		Relationship to Recipient:	
Contact Address:			
City:	State:	Zip Code:	Phone:
ISO PROVIDER INFORMATION			
ISO Provider Name:			
API:			
Phone:		Fax:	

Section 2 must be completed by a Physician, Physician's Assistant (PA) or Advanced Practice Registered Nurse (APRN)

SECTION 2: Request for Medically Necessary Skilled Services

RECIPIENT *(Last Name, First Name, Middle Initial):*

I, the undersigned, do hereby certify the following statements about my patient (listed above) are true to the best of my knowledge:

- The services I am requesting are simple and would usually be performed by the individual if not for the patient's disability.
- I have determined that my patient's condition is stable and predictable.

The personal care assistant agrees to refer the patient back to my attention when:

1. The condition of the patient changes or a new medical condition develops;
2. My patient or their personal care or legal representative becomes unable to self-direct the services/care authorized;
3. The progress or condition of the patient after the provision of a service is different than expected;
4. An emergency situation develops;
5. Any other situation described by me occurs: (describe) ____
   ____

I will complete a new PAS-ISO for the following reasons:

- The patient/recipient's condition changes in regard to stable and predictable.
- Annually.

Note: Per NRS 629.091, a provider of health care who determines in good faith that a personal care assistant has complied with and meets the requirements of NRS 629.091 is not liable for civil damages as a result of any act or omission, not amounting to gross negligence, committed by him in making such a determination and is not liable for any act or omission of the personal assistant.

I hereby authorize a personal care assistant who has met the requirements as outlined in NRS 629.091 to perform the following service(s) under the direction of my patient or their personal care or legal representative. I authorize these services to continue until *(date)* __________________________, at which time I wish to have my patient's condition re-evaluated by myself or by ____. The services listed must address a medical need, i.e., wound care, bowel care with suppository or digital stimulation, etc., and describe the complexity of the recipient's care and the frequency of the skilled intervention.

		Frequency of Service	Instructions/Steps to Complete the Task(s)
Skilled Service: *Wound Care*	EXAMPLE ONLY		
Diagnosis: *Decubitus Ulcer Stage 1*		*1xDay*	*Clean with H202, apply prescription ointment, apply duoderm*
1	**Skilled Service:**		
	Diagnosis:		
2	**Skilled Service:**		
	Diagnosis:		

SECTION 2: Request for Medically Necessary Skilled Services *(continued)*

RECIPIENT *(Last Name, First Name, Middle Initial)*:

		Frequency of Service	Instructions/Steps to Complete the Task(s)
3	**Skilled Service:**		
	Diagnosis:		
4	**Skilled Service:**		
	Diagnosis:		
5	**Skilled Service:**		
	Diagnosis:		
6	**Skilled Service:**		
	Diagnosis:		
7	**Skilled Service:**		
	Diagnosis:		
8	**Skilled Service:**		
	Diagnosis:		
9	**Skilled Service:**		
	Diagnosis:		
10	**Skilled Service:**		
	Diagnosis:		

Health Care Provider's Signature and Attestation: I certify the statements on this form are true and certify that I have read NRS 629.091 (reproduced in Section 7 of this form).

Health Care Provider: Please cross out any rows above that have been left blank.

Signature:	**Date:**
Printed Name:	**Title:**

***Section 3 is to be completed by a "Provider of health care" which is a physician licensed pursuant to chapter 630, 630A or 633 of NRS, a dentist, a registered nurse, a licensed practical nurse, a physical therapist or an occupational therapist.**

Section 3: Confirmation of PCA Competency

RECIPIENT *(Last Name, First Name, Middle Initial)***:**

*Complete this section for **each** authorized Personal Care Assistant (PCA). Each time a new PCA is hired to perform skilled services for this recipient during an approved authorization period, the new PCA must sign the existing Section 6 and complete a new Section 3. All currently authorized PCA's must have a completed Section 3 and Section 6 on file with the ISO.*

Name of PCA:

Skilled services this PCA may perform for the above listed recipient: *(Do not list non-skilled services, for example, mouth care, incontinence cleanup, bathing and transferring. The skilled services listed below must be in the Request for Medically Necessary Skilled Services.)*

1.

2.

3.

4.

5.

6.

7.

8.

9.

10.

I have reviewed with the Personal Care Assistant the reasons outlined in Section 2 for when the patient should be referred back to the health care provider requesting services.

Note: Per NRS 629.091, a provider of health care who determines in good faith that a Personal Care Assistant has complied with and meets the requirements of NRS 629.091 is not liable for civil damages as a result of any act or omission, not amounting to gross negligence, committed by him in making such a determination and is not liable for any act or omission of the personal assistant.

I, the undersigned health care provider, have determined that the above listed Personal Care Assistant has the knowledge, skill and ability to competently perform the services listed above.

Health Care Provider's Signature

Signature:	**Date:**
Printed Name:	**Title:**

Section 4 will be completed if the recipient is able to direct their own care; if the recipient is unable to direct their own care, please leave this section blank and complete Section 5. Recipient and ISO Provider signatures needed.

Section 4: Recipient Agreement

RECIPIENT *(Last Name, First Name, Middle Initial)***:**

I, the undersigned Recipient, do hereby attest the following:

For SKILLED SERVICES: I understand the specific medical, nursing or home health care self directed option as defined by NRS 629.091.

Services provided through an ISO are designed to allow me to self-direct, manage and take responsibility for my specific medical, nursing or home health care services. I must have the ability and desire to self-direct my care, to choose the ISO provider, to select personal care assistants through the ISO, to arrange the personal care assistant's schedule and to direct the personal care assistant in the delivery of specific medical, nursing or home health care services.

I must be capable of making choices about my specific medical, nursing or home health care services, understand the impact of these choices and assume responsibility for these choices. I am capable of directing all the tasks related to the personal care assistant service delivery.

I may direct the personal care assistant to provide only the specific medical, nursing or home health care services approved on the service plan, and as authorized by my health care provider.

I agree to hold the State of Nevada harmless from any such liability whatsoever for any injuries, damages, loss, whether physical or financial, associated with or resulting from self-directing my care in this option.

I am responsible for developing a backup plan and for obtaining backup coverage in the absence of a regularly scheduled personal care assistant.

The ISO is the employer of record for personal care assistants. I am responsible for reviewing and verifying delivery records to ensure the service plan has been followed, thereby authorizing Aging and Disability Services Division (ADSD) to be billed.

I must obtain recertification for continued participation if my condition changes in regard to stable and predictable. This will require that a functional assessment, service plan, and all forms associated with self direction of specific medical, nursing or home health care services be completed.

I may discontinue this option at any time and receive my specific medical, nursing or home health care services through a Home Health Agency, if eligible to do so and there is a Home Health Agency available to provide care.

I agree to contact my physician if any of the following occur:

1. My condition changes or a new medical condition develops;
2. I become unable to direct the services/care authorized;
3. My progress or condition after the provision of services is different than expected; and/or
4. An emergency situation develops.

The ISO Provider agrees to notify the Health Care Provider if:

1. The condition of the recipient changes or a new medical condition develops.
2. The recipient or their personal care or legal representative becomes unable to self direct the services/care authorized.
3. The progress or the condition of the recipient after the provision of a service is different than expected.
4. An emergency develops.

Recipient's and ISO Provider's Signatures

Recipient's Signature:	**Date:**
ISO Provider Name: *(please print)*	
ISO Provider Signature:	**Date:**

The information contained in this form, including attachments, is privileged and confidential and is only for the use of the individual or entities named on this form. If the reader of this form is not the intended recipient or the employee or agent responsible to deliver it to the intended recipient, the reader is hereby notified that any dissemination, distribution or copying of this communication is strictly prohibited. If this communication has been received in error, the reader shall notify sender immediately and shall destroy all information received. This referral/request is not a guarantee of payment.

Section 5 will only be completed if the recipient is unable to direct his/her own care and a Personal Care Representative (PCR) has been appointed. The Personal Care Representative cannot be the Personal Care Assistant.

Section 5: Personal Care Representative Agreement

RECIPIENT *(Last Name, First Name, Middle Initial):*

Name of Personal Care Representative:

I, the undersigned Personal Care Representative, do hereby attest the following:

_________________________________ *(name of recipient or LRI)* has chosen me to direct the delivery of specific medical, nursing or home health care services through an Intermediary Service Organization (ISO), as defined in NRS 629.091 (reproduced in Section 7 of this form). I have the ability and desire to direct, manage and take responsibility to direct his/her care, to choose the ISO provider, to select personal care assistants (PCAs), to arrange the PCA's schedule and to be present to direct the PCA in the delivery of specific medical, nursing or home health care services.

As the PCR, I must be capable of making choices about specific medical, nursing or home health care service needs, understand the impact of these choices, assume responsibility for these choices, and be capable of directing all the tasks related to specific medical, nursing or home health care services delivery.

I will direct the PCA to provide only the specific medical, nursing or home health care services approved on the active/current authorization.

As the PCR, I agree to hold the State of Nevada harmless from any liability whatsoever for any injuries, damages, loss, whether physical or financial, associated with or resulting from directing the recipient's care in this option.

As the PCR, I am not eligible to receive reimbursement for acting as a PCR or for providing specific medical, nursing or home health care services, and that I must be present when services are delivered.

As the PCR, I am responsible for developing a back-up plan and for obtaining backup coverage for the recipient in the absence of a regularly scheduled PCA.

The ISO is the employer of record for PCAs.

As the PCR, I am responsible for reviewing and verifying service delivery records of the recipient to ensure the authorized services have been provided, thereby authorizing the State of Nevada to be billed. Misrepresentation within these documents constitutes fraud per NRS 422.540 (reproduced in Section 7 of this form).

As the PCR, I am responsible for selecting, scheduling and managing all PCAs who will provide services for the recipient according to the Request for Medically Necessary Skilled Services.

A newly completed PAS-ISO must be submitted annually for consideration of continued services.

I may discontinue the option to direct the recipient's skilled services at any time and the recipient may receive specific medical, nursing or home health care services through a Home Health Agency, if eligible to do so and there is a Home Health Agency available to provide care.

I agree to refer the patient back to the physician when:

- The condition of the patient changes or a new medical condition develops;
- The patient or their personal care or legal representative becomes unable to self-direct the services/care authorized;
- The progress or condition of the patient after the provision of a service is different than expected; and/or
- An emergency situation develops.

Personal Care Representative's and ISO Provider's Signatures

Personal Care Representative Signature:	**Date:**
Personal Care Representative Name: *(please print)*	
ISO Provider Signature:	**Date:**
ISO Provider Name: *(please print)*	

Section 6 requires signatures of the recipient, LRI or PCR (if applicable), ISO Provider, and the Personal Care Assistant(s) listed in section 3,

SECTION 6: Required Signatures	
RECIPIENT *(Last Name, First Name, Middle Initial):*	
• By signing this form, I have read and understood Section 2, the Request for Medically Necessary Skilled Services. • By signing this form, I understand I am not an employee of Aging and Disability Services Division (ADSD) or the requesting Health Care Provider.	
Recipient Signature:	**Date:**
Recipient Name: *(please print)*	
LRI or Personal Care Representative Signature:	**Date:**
LRI or Personal Care Representative Name: *(please print)*	
ISO Provider Signature:	**Date:**
ISO Provider Name: *(please print)*	
Personal Care Assistant Signature:	**Date:**
Personal Care Assistant Name: *(please print)*	
Personal Care Assistant Signature:	**Date:**
Personal Care Assistant Name: *(please print)*	
Personal Care Assistant Signature:	**Date:**
Personal Care Assistant Name: *(please print)*	
Personal Care Assistant Signature:	**Date:**
Personal Care Assistant Name: *(please print)*	
Personal Care Assistant Signature:	**Date:**
Personal Care Assistant Name: *(please print)*	

Section 7: Applicable Nevada Revised Statutes (NRS)

NRS 422.540 Offenses regarding false claims, statements or representations; penalties.

1. A person, with the intent to defraud, commits an offense if with respect to the Plan the person:
   (a) Makes a claim or causes it to be made, knowing the claim to be false, in whole or in part, by commission or omission;
   (b) Makes or causes to be made a statement or representation for use in obtaining or seeking to obtain authorization to provide specific goods or services, knowing the statement or representation to be false, in whole or in part, by commission or omission;
   (c) Makes or causes to be made a statement or representation for use by another in obtaining goods or services or services pursuant to the plan, knowing the statement or representation to be false, in whole or in part, by commission or omission; or
   (d) Makes or causes to be made a statement or representation for use in qualifying as a provider, knowing the statement or representation to be false, in whole or in part, by commission or omission.
2. A person who commits an offense described in subsection 1 shall be punished for a:
   (a) Category D felony, as provided in NRS 193.130, if the amount of the claim or the value of the goods or services obtained or sought to be obtained was greater than or equal to $650.00.
   (b) Misdemeanor if the amount of the claim or the value of the goods or services obtained or sought to be obtained was less than $650.00. Amounts involved in separate violations of this section committed pursuant to a scheme or continuing course of conduct may be aggregated in determining the punishment.
3. In addition to any other penalty for a violation of the commission of an offense described in subsection 1, the court shall order the person to pay restitution.

(Added to NRS by 1991, 1049; A 1997, 457, 2011, 174)

NRS 629.091 Personal assistant authorized to perform certain services for person with disability if approved by provider of health care; requirements.

1. Except as otherwise provided in subsection 4, a provider of health care may authorize a person to act as a personal assistant to perform specific medical, nursing or home health care services for a person with a disability without obtaining any license required for a provider of health care or his assistant to perform the service if:
   (a) The services to be performed are services that a person without a disability usually and customarily would personally perform without the assistance of a provider of health care;
   (b) The provider of health care determines that the personal assistant has the knowledge, skill and ability to perform the services competently;
   (c) The provider of health care determines that the procedures involved in providing the services are simple and the performance of such procedures by the personal assistant does not pose a substantial risk to the person with a disability;
   (d) The provider of health care determines that the condition of the person with a disability is stable and predictable; and
   (e) The personal assistant agrees with the provider of health care to refer the person with a disability to the provider of health care if:
      (1) The condition of the person with a disability changes or a new medical condition develops;
      (2) The progress or condition of the person with a disability after the provision of the service is different than expected;
      (3) An emergency situation develops; or
      (4) Any other situation described by the provider of health care develops.
2. A provider of health care that authorizes a personal assistant to perform certain services shall note in the medical records of the person with a disability who receives such services:
   (a) The specific services that he has authorized the personal assistant to perform; and
   (b) That the requirements of this section have been satisfied.
3. After a provider of health care has authorized a personal assistant to perform specific services for a person with a disability, no further authorization or supervision by the provider is required for the continued provision of those services.
4. A personal assistant shall not:
   (a) Perform services pursuant to this section for a person with a disability who resides in a medical facility.
   (b) Perform any medical, nursing or home health care service for a person with a disability which is not specifically authorized by a provider of health care pursuant to subsection 1.
   (c) Except if the services are provided in an educational setting, perform services for a person with a disability in the absence of the parent or guardian of, or any other person legally responsible for, the person with a disability, if the person with a disability is not able to direct his own services.
5. A provider of health care who determines in good faith that a personal assistant has complied with and meets the requirements of this section is not liable for civil damages as a result of any act or omission, not amounting to gross negligence, committed by him in making such a determination and is not liable for any act or omission of the personal assistant.
6. As used in this section:
   (a) "Guardian" means a person who has qualified as the guardian of a minor or an adult pursuant to testamentary or judicial appointment, but does not include a guardian ad litem.
   (b) Parent" means a natural or adoptive parent whose paternal rights have not been terminated.
   (c) "Personal assistant" means a person who, for compensation and under the direction of:
      (1) A person with a disability;
      (2) A parent or guardian of, or any other person legally responsible for, a person with a disability who is under the age of 18 years; or
      (3) A parent, spouse, guardian or adult child of a person with a disability who suffers from a cognitive impairment, performs services for the person with a disability to help him maintain his independence, personal hygiene and safety.
   (d) "Provider of health care" means a physician licensed pursuant to chapter 630, 630A or 633 of NRS, a dentist, a registered nurse, a licensed practical nurse, a physical therapist or an occupational therapist.

(Added to NRS by 1995, 749; A 2005, 69)