

AGING AND DISABILITY SERVICES DIVISION
CBC-MS400 Personal Assistance Services (PAS)

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I. INTRODUCTION

The Aging and Disability Services Division (ADSD) recognizes that many individuals at risk of being placed in a facility for long-term care can be cared for in their homes or communities, preserving independence and ties to family and friends with supportive services.

The Personal Assistance Services (PAS) Program originated in 1985. This program provides community-based, in home services to enable adult persons with severe disabilities to remain in their own homes and avoid placement in a long-term care facility. The provision of home and community-based services are based upon the identified needs of the recipient and available funding. The ADSD will assist recipients with accessing other available services, as needed. Every biennium, the service needs and the available funding for the program are reviewed by the ADSD and presented to the Nevada Legislature for approval.

The State of Nevada is committed to the goal of providing Nevadans with severe disabilities the opportunity to remain in a community setting in lieu of institutionalization. The State of Nevada also understands that people with disabilities can lead satisfying and productive lives when appropriate services and supports are available. The ADSD is committed to the goals of self-sufficiency and independence.

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II. AUTHORITY

Pursuant to NRS 427A.791, the predecessor agency of the ADSD created the PAS program. The goal is to maximize independence and self-determination through community-based supports.

The ADSD has the flexibility to design the program and select a mix of services that best meet the goals of the program. This flexibility is predicated on administrative and legislative support, as well as the availability of funds. The ADSD also acts in accordance to recommendations made by the Subcommittee on Personal Assistance for Persons with Severe Functional Disabilities of the Nevada Commission on Services for Persons with Disabilities as established in NRS 426.731.

PAS policies follow a course of procedures to assure that the requirements of NRS 427A.791 and regulations in NAC 427A.675 – 427A.770 are achieved. The PAS policy addresses:

- Recipient eligibility;
- The services which assist a PAS recipient in sustaining an independent community-based lifestyle; and
- Data management and analysis.

Related Statutes and Regulations:

- Nevada Revised Statutes (NRS) Chapters 200 (Crimes Against the Person); 232 (Department of Health and Human Services); 422A (Welfare and Supportive Services); 426 (Persons with Disabilities); 427A (Services to Aging Persons); 449 (Medical and Other Related Facilities)
- Nevada Administrative Code (NAC) Chapters 426 (Persons with Disabilities); 427A (Services to Aging Persons and Persons with Disabilities); 449 (Medical and Other Related Facilities)

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III. POLICY

Nevada’s PAS Program complies with certain statutory requirements and offers services to eligible recipients to assist them to remain in their home and community.

A. GENERAL ELIGIBILITY CRITERIA

Applicants/recipients must meet and maintain all criteria to be eligible during the period of time the recipient receives PAS.

1. The ADSD determines eligibility for PAS. The ADSD determines program eligibility by confirming the following criteria is met for each applicant:
 - a. Applicants/recipients must be 18 years of age or older;
 - b. Reside in the State of Nevada;
 - c. Meet financial eligibility according to the monthly income guidelines established by NAC 427A.765;
 - d. Be diagnosed as a person with a physical disability by a licensed physician;
 - e. Require assistance in one or more specified areas listed under V.A., PAS Services, Coverage and Limitations;
 - f. Require not more than 35 hours of essential PAS each week;
 - g. Has the ability to supervise ~~Be capable of supervising~~ the attendant who provides the care;
 - h. Has the ability to participate ~~Be capable of participating~~ in a Plan of Care (POC); and
 - i. Demonstrate an understanding and willingness to utilize available personal and financial resources to support service needs before requesting the PAS program.

B. ELIGIBILITY, COVERAGE AND LIMITATIONS

1. The ADSD management monitors the overall purchase of service costs statewide and notifies each office of the availability of funds for processing cases or service authorizations.
2. PAS is limited by legislative mandate and the available funding each fiscal year. When the budget authority has been exhausted, services may be suspended, reduced, or terminated.
3. PAS services may not be provided while a recipient is a resident of any licensed residential facility for groups, homes for individual residential care, assisted living facility or an inpatient of any institution (e.g. hospital, nursing facility, Intermediate Care Facility for Individuals with Intellectual Disabilities or a Related Condition (ICF/IID)).
4. Payment will not be made for services provided outside the State of Nevada.
5. Recipients who are enrolled or elect to enroll in a hospice program may be eligible to remain on the PAS program if they require PAS services to remain in the community. Close coordination between the hospice agency and the PAS case manager is required to prevent any duplication of services. PAS services will only be provided for recipients enrolled in hospice when the need for services is unrelated to the terminal condition and the need exceeds the services provided under the hospice benefit.

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6. Any applicant/recipient who is eligible for Medicaid benefits will not be eligible for PAS. Applicants/recipients who are potentially eligible for Medicaid must apply for Medicaid benefits.
7. The PAS program will not be authorized when a recipient is receiving services through another ADSD program. The recipient cannot receive services under two or more programs at the same time.
8. The Applicant/recipient must be a U.S. Citizen, or an alien legally admitted for permanent residency. The applicant/recipient must also reside in the State of Nevada and services will only be providing while residing at home.

In addition, Social Security numbers must be provided by every applicant/recipient. Verification by the ADSD is required and can include:

- a. Copy of Social Security Card;
- b. Copy of Social Security check;
- c. Letter from the Social Security Administration (SSA); or
- d. Copy of the SSA benefit award letter.
 - Failure to comply with these requirements may result in denial, suspension or termination from the PAS program.

C. PERSONAL CARE REPRESENTATIVE (PCR)

1. A recipient who is unable to direct their own services may opt to utilize a Personal Care Representative (PCR). This individual directs the day-to-day care of the recipient, hires, manages and schedules personal assistants, assumes responsibility for training, and manages all paperwork functions. In addition, the PCR assumes all medical liability associated with directing the recipient's care. The PCR must:
 - a. Effectuate, as much as possible, the decision the individual would make for himself/herself;
 - b. Accommodate the individual, to the extent necessary that they can participate as fully as possible in all decisions that affect them;
 - c. Give due consideration to all information including the recommendations of other interested and involved parties;
 - d. Embody the guiding principles of self-determination;
 - e. Must be capable of making choices about Activities of Daily Living (ADLs), understand the impact of these choices and assume responsibility for the choices;
 - f. Be present in the home during the provision of care and available to direct care on a consistent basis; and
 - g. Sign daily records, in lieu of the recipient signing, to verify services have been provided.
2. A PCR is not eligible to receive reimbursement for activities. A PCR cannot be the recipient's paid Personal Care Assistant (PCA). It is not allowable for individuals such as a care coordinator or an employee of an agency to assume this role.

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D. INTAKE AND ASSESSMENT

The ADSD has developed policies and procedures to ensure fair and adequate access to the PAS program.

1. Referral Process

- a. An inquiry or referral for the program may be made by a potential applicant or by another party on behalf of the potential applicant by contacting the local ADSD office and providing the required information to complete a referral to the PAS program. The required information is as follows:
 - i. Completed Application (CBC-100)
 - ii. Physicians Statement declaring physical disability
 - iii. Proof of all income
- b. Qualified ADSD staff in each local office will review referrals and contact applicants and/or the applicant's family within seven (7) working days to verify the information provided and the types of services needed.
- c. If there is indication the potential applicant meets all the required eligibility criteria, a face-to-face interview with the applicant will be scheduled with a qualified ADSD staff within 20 calendar days of the referral date.
- d. If it is determined the applicant does not meet the required eligibility criteria, a face-to-face interview will not be scheduled, and the applicant will be denied in writing and referred to other agencies and programs as appropriate. The applicant will be advised to contact the ADSD if there is a change in condition or support system.
- e. If the applicant is going onto the waiting list, a screening will be completed to determine appropriateness for the program.
- f. If the person is not going onto a waiting list, an assessment will be conducted to determine appropriate services.

2. Disability Screening and Eligibility Determination

- a. At the time of the face-to-face home visit, qualified ADSD staff will obtain documentation to substantiate eligibility criteria for the PAS program is met. A State Application for Assistance may also be completed to determine financial eligibility if it was not requested/returned prior to the face to face home visit.
- b. The Initial assessment is conducted by the ADSD designated staff at the location where the services are offered whenever possible. Financial documentation is obtained and imminent risk(s) identified.
- c. The applicant and/or authorized representative will sign an Authorization for Release of Information form acknowledging ADSD may release information about the recipient to providers of services, and others to access needed services. This form is required
- d. Qualified ADSD staff will inform the applicant and/or authorized representative that, pursuant to NRS 232.357, the Divisions within the Nevada Department of Health and Human Services may share confidential information without a signed Authorization for Release of Information.

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- e. The applicant/recipient will be given the right to choose the PAS program in lieu of placement in a long-term care facility. If the applicant and/or authorized representative prefers placement in a long-term care facility, the applicant will be provided information and education regarding facility placement. The referral for the PAS program will then be closed and the recipient will be notified in writing of the closure.
- f. If it is determined the applicant does not meet the required eligibility criteria, the applicant will be notified in writing and referred to other agencies and programs as appropriate. The applicant will be advised to contact the ADSD if there is a change in condition or support system.

3. Wait List/No Funds Are Available

If funding is not available, a Wait List will be utilized. When funding becomes available, the applicant will be processed for the program based on their Wait List placement and the date of referral.

The Following Wait List priorities are in ranking order:

1. A person who has a condition that is terminal and is not expected to live for more than one (1) year;
2. A person receiving acute or extended care in an institutional setting and who would be able to function in a setting where they control and manage daily activities;
3. A person who is experiencing a crisis as determined by the program manager due to an unanticipated change in their circumstances;
4. A person who has a traumatic brain injury;
5. A person who requires assistance with at least two (2) of the following tasks:
 - a. Bathing;
 - b. Toileting; or
 - c. Eating
6. All other applicants.

4. Assessment Process

- a. The applicant/recipient will be assessed for services, support system, and available resources, and a written plan of care (POC) developed. The POC is based on the assessment of the applicant's functional and service needs;
- b. The applicant/recipient, his or her family, and/or Legally Responsible Individual (LRI) should participate in the development of the POC;
- c. The POC is subject to approval by the ADSD Social Services Manager, or appointed ADSD position, dependent upon the appropriateness of services and availability of funds;
- d. Recipients will be given free choice of contracted provider agencies that are available to provide the services needed. A copy of the POC will be given to the chosen service provider;
- e. All forms must be complete with signatures and dates where required.

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5. Effective Date for PAS Services

Approval and an effective date of service will be given once all eligibility requirements are verified as meeting the criteria, and funding is available. If the applicant is in an institution, the effective date cannot be prior to the date of discharge from the institution.

6. Administrative Case Management

The ADSD staff is responsible for monitoring the provision of services included in the individual's POC. In addition, the ADSD staff is responsible for completing and performing certain administrative activities, which include

- a. Intake referral;
- b. Preliminary and ongoing assessments, evaluations and completion of forms required for service eligibility;
- c. Development of the POC which identifies the services utilized through the PAS program, and must reflect the recipient's needs.
- If services documented on a POC are approved by the recipient and the case manager and the recipient signature cannot be obtained due to extenuating circumstances, services can commence with verbal approval from the recipient. Case managers must document the reason they are not able to sign, and they are accepting the recipient's verbal approval in the case notes, and obtain the recipient signature on the POC as soon as possible.
- d. Reassessment of eligibility and the need for the PAS program.
- e. Coordination of multiple services and/or providers;
- f. Documentation for case files prior to applicant's eligibility;
- g. Outreach activities to educate recipients on how to access the PAS program;
- h. Communication of the POC to all affected providers;
- i. Service authorizations;
- j. Contacting PAS participants monthly by phone or e-mail, and quarterly face to face visits to monitor the overall provision of services to ensure needs are being met;
- k. Assuring that the recipient retains freedom of choice in the provision of services;
- l. Notifying all affected providers of any unusual occurrence or change in status of a recipient;

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- m. Notifying all affected providers of any recipient complaints regarding delivery of service or specific provider staff; or
- n. Notifying all affected providers if a recipient requests a change in the provider staff or provider agency.

7. Reassessment for Services

The recipient's functional status, support system, and needs addressed by the POC must be reassessed annually or more often as needed. Reassessments must be completed within 12 months of the approval date. For purposes of reassessing PAS recipients, annually means not to exceed 365 days. The recipient must also be reassessed when there is a significant change in his/her condition. The assessment/reassessment is conducted by ADSD qualified staff during a face-to-face visit utilizing a Functional Assessment (FA) tool.

E. FINANCIAL ELIGIBILITY

Income may not exceed the institutional guidelines established by the Division of Welfare and Supportive Services (DWSS) of the Department of Health and Human Services (DHHS).

During the initial assessment and reassessment process, the designated ADSD staff will:

- a. Complete the ADSD State Application for Assistance with the applicant/recipient and/or a LRI;
- b. Obtain verification of gross income. All income is considered when determining eligibility, other than income excluded pursuant to NAC 427A.765. Any money deposited in a bank account is considered income for the month it is deposited and thereafter is considered an asset;
- c. Not consider resources in determining eligibility;
- d. Determine if an applicant/recipient is required to pay a part of the cost for services provided by the PAS program pursuant to NAC 427.765;
- e. Obtain supporting financial documentation; and
- f. Submit the application and supporting financial documentation to the designated ADSD Social Services Manager for approval and/or renewal.

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IV. PROVIDER QUALIFICATIONS AND RESPONSIBILITIES

All service providers must obtain and maintain a provider agreement with the ADSD. This includes general compliance with all insurance, workers compensation, and other requirements in accordance with NAC 449.

All service providers must comply with any additional specifications described in the Scope of Work of the agreement and/or as described under each specific service outlined in this chapter.

In addition, all service providers must cooperate with the ADSD and/or state or federal reviews or inspections.

The ADSD maintains a provider agreement with provider agencies, not with individual persons. If an individual wishes to provide personal care services to a recipient, they must enroll with an Intermediary Service Organization (ISO) pursuant to NRS 449.4304.

A. PROVIDER AGREEMENT AND LICENSING

All providers must provide the ADSD with verification of compliance with the following requirements at the time of the provider agreement application, its renewal, and upon request:

1. Enrollment with The Division of Health Care Financing and Policy (DHCFP) as a Provider Type (PT) 30, 58 with a specialty code 189, or 83
 - a. PT 30 and 58 enrollment is for non-medical personal care services;
 - b. PT 83 enrollment is for personal care services offered through an ISO;
2. Provider Agreement Application;
3. Signed Scope of Work for each service provided;
4. Master Services Provider Agreement;
5. Business Associate Addendum;
6. Reference Checklist for required insurance
7. Insurance must list the ADSD as an additional insured; and
8. Must include coverage for sexual molestation and physical abuse;
9. Signed acknowledgement of the Community Based Care Provider Billing Manual;
10. Notification of utilization of current or former Nevada State employees;
11. Enrollment vendor number through the State Controller's Office; and
12. No exclusion from the National Exclusions Database through the Federal Office of Inspector General United States Department of Health and Human Services.
 - Failure to provide all required documentation may cause the provider's agreement application/renewal to be denied and/or result in termination of an ongoing contract.

B. CRIMINAL BACKGROUND CHECKS

1. All employees and volunteers of providers contracted with the ADSD, including owners, officers, administrators, managers, and consultants must undergo state and federal criminal

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background checks a minimum of every five (5) years, and as indicated, to ensure no convictions of applicable offenses have been incurred. Documentation of the request, and applicable results, must be maintained in the personnel record and made available to the ADSD upon request. All personnel, including volunteers, must have the criminal background check initiated by the hiring/employing agency through the Nevada Department of Public Safety prior to the provision of any reimbursable services to a PAS recipient. Providers are required to initiate diligent and effective follow-up for results of background checks within 90 days of submission of fingerprints and continue until results are received.

2. The ADSD will not enroll any entity convicted of a felony or misdemeanor for any offense which the state agency determines is inconsistent with the best interests of recipients. Such determinations are solely the responsibility of the ADSD.
3. The ADSD will deny a provider service agreement to any applicant, or may suspend or revoke all associated provider contracts of any provider if:
 - a. The applicant or service provider has been convicted of any offense enumerated in NRS 449.174; or
 - b. The applicant, or service provider, upon receiving information resulting from the criminal background check, or from any other source, continues to employ a person who has been convicted of an offense listed in NRS 449.174. The hiring/employing agency must take timely and appropriate action on the results of the background check as outlined on the Division of Public and Behavioral Health (DPBH) website.
4. If an employee believes that the information provided as a result of the criminal background check is incorrect, he or she must immediately inform the employing agency or the ADSD (respectively) in writing. An employing agency, or the ADSD, that is so informed within five (5) days, may give the employee a reasonable amount of time, but not more than 60 days, to provide corrected information. The employee must be removed from providing services to any ADSD recipient until the issue has been resolved.

C. EMPLOYMENT STANDARDS

All employees and volunteers providing direct services must meet all provisions pursuant to NAC 449:

1. Be at least 18 years of age;
2. Demonstrate the ability to read, write, and communicate with the recipient;
3. Have the skills to perform services as described on the POC;
4. Be tolerant of varied life styles;
5. Be able to identify emergency situations and respond accordingly;
6. Be able to document services provided;
7. Be able to maintain confidentiality; and
8. Demonstrate a mature attitude toward work assignments and the needs of the recipient

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D. TRAINING

All employees and volunteers providing direct services to a PAS recipient are required to participate in and successfully complete an approved training program. The training program shall include basic training, periodic and continuing in-service training, and on-the-job instruction and supervision. Each employee or volunteer must be evaluated and be determined competent prior to providing care to a PAS recipient.

In addition, all licensed personal care agencies contracted with the ADSD must arrange training for all staff in accordance with regulations established by NAC 449.

Training must include the following subjects:

1. Policies, procedures and expectations of the agency relevant to the provider, including recipient's and provider's rights and responsibilities;
2. Record keeping and reporting including billing and daily record documentation;
3. Information about the specific needs and goals of the recipients to be served;
4. Confidentiality; and
5. Any other training as designated by the ADSD.

E. RECORD KEEPING AND BILLING PROCEDURES

Providers may only provide and bill for services that have been identified in the POC, and that have been authorized by the ADSD.

The provider must maintain medical and financial records, supporting documents, and all other records relating to services provided under this program. The provider must retain records for a period pursuant to the State record retention policy. These records must be maintained by the provider for at least six (6) years after the date the claim is paid. If any litigation, claim or audit is started before the expiration of the retention period provided by the ADSD, records must be retained until all litigation, claims, or audit findings have been determined. Overpayments are subject to recovery by the ADSD.

1. The provider must maintain all required records for each employee of the agency, regardless of the length of employment.
2. The provider must maintain the required record for each recipient who has been provided services, regardless of length of service period.

The daily record is documentation by a provider, indicating the type of service provided and the time spent. This record is utilized to support the subsequent billing for those services. The documentation includes the recipient's initials daily with a full signature of the recipient on each record. If the recipient is unable to provide a signature due to a cognitive and/or physical limitation, this will be clearly documented in the recipient file. The caregiver will initial after the daily services are delivered, with a full signature of the caregiver on each daily record.

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Each provider must accurately complete and sign the daily record for each recipient served. Claims for services provided must be submitted in accordance to the guidelines established by the ADSD Provider Billing Manual which will be made available upon award of the contract with the ADSD.

Providers may use electronic signatures on the daily record documentation, but using an electronic signature does not remove the provider's responsibility for providing accurate and verifiable documentation of services provided and the time spent providing those services.

If a provider elects to use electronic signatures, they must have weekly printouts of the daily record in the recipient's file.

At a minimum, the provider must document the following on all daily records in order to validate the service given and the time spent providing the service:

1. Consistent service delivery within program requirements and services outlined on the POC;
2. Amount of services provided to recipients;
3. When services were delivered (actual date and time in/out);
4. Signature of recipient or authorized representative; and
5. The caregiver, employee or volunteer must sign the daily record form.

If the recipient is unable to sign due to a cognitive and/or physical limitation, this will be clearly documented in the recipient's file.

F. IMPROPER BILLING PRACTICES

Any provider or its agent(s) that is found to have engaged in improper billing practices may be subject to recoupment, denial or termination from participation in the PAS program.

The findings and conclusions of any investigation or audit shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state or local laws. Improper billing practices may include, but are not limited to:

1. Submitting claims for unauthorized visits;
2. Submitting claims for services not provided; for example, billing a visit when the recipient was not at home, but the provider was at the recipient's residence;
3. Submitting claims for visits without documentation to support the claims billed. Acceptable documentation for each visit billed shall include the nature and extent of services, the care provider's signature, the month, day, year, and exact time in and out of the recipient's home. Providers shall submit or produce requested documentation upon request;
4. Submitting claims for unnecessary visits or visits that are more than amount, authorized;

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5. Submitting claims for the full authorized number of units when the actual amount of service delivery was less;
6. Submitting claims for services provided by an unqualified individual; or
7. Submitting claims for services that are not authorized and outlined in the POC.

G. SERIOUS OCCURRENCE REPORTING

The Provider must submit through the online Serious Occurrence portal, or via form NMO-3430A, all serious occurrences involving the recipient, the provider's staff, or anything affecting the provider's ability to deliver services. Serious occurrences must be reported within 24 hours of discovery. The documentation supporting the serious occurrence must be maintained in the recipient's file. A follow up SOR form will be completed by the ADSD social worker within five (5) working days and maintained in the Statewide SOR Database.

Serious occurrences involving either the provider's staff or recipient may include, but are not limited to the following:

1. Suspected physical or verbal abuse;
2. Unexplained hospital visit'
3. Suicide threat or attempt;
4. Elopement from an inpatient setting;
5. Sexual harassment or sexual abuse;
6. Injuries requiring medical intervention;
7. Criminal activity;
8. Any event which is reported to Child or Elder Protective Services or law enforcement agencies;
9. Death of the recipient;
10. Theft or exploitation;
11. Medical or Medication errors; and
12. Loss of contact with the recipient.

H. WITHDRAW OF SERVICES

A Provider Agency may withdraw from providing services for the following reasons:

1. The recipient or other person in the household subjects the caregiver to physical or verbal abuse, sexual harassment, and/or exposure to the use of illegal substances, illegal situations, or threats of physical harm;
2. The recipient is ineligible for PAS services;

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3. The place of service is considered unsafe for the provision of services;
4. The recipient requests services to end;
5. The recipient or PCR refuses services offered in accordance with the approved POC;
6. The recipient is non-cooperative with the establishment of delivery of services, including providing accurate and timely submission of required forms;
7. The provider is no longer able to provide services as authorized (i.e., no qualified staff);
8. The recipient requires a higher level of services than those provided within the scope of the caregiver; or
9. The recipient refuses services of the caregiver based solely or partly based on race, color, national origin, gender, religion, age, disability (including AIDS and AIDS- related conditions), political beliefs or sexual orientation of the caregiver.

Provider Agency's notification responsibilities:

1. Immediate Termination - The Provider may terminate PCS immediately for reasons 1 through 4 above.
2. Advance Notice Termination - The Provider must provide at least five (5) calendar days advance written notice to recipients when PAS services are terminated for reasons 5 - 9 above.

In all cases, the Provider is responsible for making reasonable attempts to ensure continuity and appropriateness of care through referrals to other providers when appropriate.

The provider must notify the recipient and all other appropriate individuals and agencies when services are to be terminated. The ADSD case manager must be notified by telephone within one (1) working day. The Provider must submit written documentation within five (5) working days.

The Provider will send a written notice advising the ADSD case manager of the effective date of the action of the termination of service, the basis for the action, and intervention/resolution(s) attempted prior to terminating services.

The provider is not required to send a written notice if the recipient has chosen to terminate services.

A Provider's inability to provide services for a specific recipient does not constitute termination or denial from the PAS program. The recipient may choose another provider.

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V. PAS SERVICES

The ADSD determines which services will be offered under the PAS Program. Providers and recipients must agree to comply with all program requirements for service provision. Services must be directed to the individual recipient and related to their health and welfare.

A. COVERAGE AND LIMITATIONS

Under the PAS program, the following services can be covered if identified in the POC as necessary to avoid institutionalization. A person must require assistance in one or more of the following areas.

1. Toileting/Elimination of wastes from the body;
2. Dressing and undressing;
3. Bathing and grooming;
4. Preparation and eating of meals;
5. Getting in and out of bed;
6. Repositioning while asleep;
7. The use of prosthetic devices and other medical equipment;
8. Moving about, including, without limitation, assisting a person:
 - a. Moving from a wheelchair, bed or other piece of furniture;
 - b. Ambulation;
 - c. Exercises to increase the range of motion;
9. Essential laundry;
10. Light housekeeping;
11. Support services for independent living if the person has an injury to the brain and the services do not exceed 14 hours per week; or
12. Other minor needs directly related to maintenance of personal hygiene.

The Division may not approve more than 35 hours of essential personal care each week.

If a portion of the 35 hours or less of essential personal care was allocated to a recipient for a week is not used by that recipient in the week, the ADSD may authorize:

1. Temporary emergency care to another recipient if his or her disability is exacerbated or he or she has a short-term illness not related to the disability.
2. Respite care to relieve a family member who provides care for a person on the waiting list.
3. 120 hours or less per year of respite care to relieve a family member who provides care for a recipient.

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The recipient cannot receive any PAS services while in a licensed residential facility for groups, homes for individual residential care, assisted living facility or an inpatient of any institution (e.g. hospital, nursing facility, ICF/IID).

The following coverage and limitations will also apply:

1. Mileage Authorization Request
 - a. Mileage for travel to and from a recipient's home or for shopping is not reimbursable.
2. The following Instrumental Activities of Daily Living (IADL's) are covered services when no LRI is available and capable. Services must be directed to the individual recipient and related to their health and welfare.
 - a. Meal preparation: Service includes shopping, storing, preparing and serving food;
 - b. Laundry: Services include washing, drying and folding the recipient's personal laundry and linens (sheets, towels, etc.). Ironing is not a covered service;
 - c. Light housekeeping: Services might include changing the recipient's bed linens, dusting, or vacuuming the recipient's living area.
3. Reimbursement to Family Members
 - a. Payments will not be made for services provided by a recipient's immediate family or LRI.
 - The PAS program may reimburse immediate family members for providing PAS services in hardship situations. Hardship includes residing in an area that lacks qualified providers for a specific service, or existing providers lack the capacity to staff the service. The Social Services Manager must give prior approval and will monitor provider capacity to make necessary changes as to provider assignments as staffing becomes available.
 - In the case of a hardship approval, reimbursement will not be made directly to family members for any PAS services. Family members must become employees of a contracted ISO or Personal Care Agency and must meet all prescribed provider qualifications.
 - PRIOR TO OCTOBER 1, 2011: Legally Responsible Individuals (LRI) approved to receive payments will continue until such time the PAS recipient is terminated from the PAS program.
 - ON OR AFTER OCTOBER 1, 2011: Payments will not be made for services provided by a recipient's LRI for PAS cases approved on or after this date.
4. Reimbursement to Caregivers Residing with the Recipient

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Payments will not be made for IADLs that are covered services within PAS, when an LRI or caregiver resides in the home. Services must be directed to the individual recipient and related to the recipient's health and welfare.

5. Self-Directed (~~DS~~ SD) Model

The SD model is a service delivery option which allows the recipient to direct personal care services. Entry into this model must be approved by the ADSD.

The recipient must have the ability to express the desire to direct their personal care services and an understanding of the responsibilities involved with this model. Only a recipient or an LRI has the right to request this delivery model.

A recipient has the option of selecting a PCR to direct services on the recipient's behalf. The ~~PCF~~ PCR cannot be reimbursed for providing personal care or acting as the PCR.

This option is utilized by accessing services through an ISO, which provides oversight of provider qualifications and processes service claims for reimbursement. The ISO is the employer of record and the recipient is the managing employer. This allows the recipient of the PCR to recruit, hire, train, supervise and schedule the personal care attendant. All individuals seeking this type of self-directed program will be responsible to follow policies and procedures established by the Medicaid Services Manual Chapter 3500.

6. Non-covered Services

The PAS program offers intermittent services designed to delay or prevent institutionalization. Examples of non-covered services include but are not limited to any service:

- a. Determined could reasonably be performed by the recipient;
- b. Not on the recipient's POC;
- c. Provided to someone other than the intended recipient;
- d. Requiring the technical or professional skill that state statute or regulation mandates must be performed by a health care professional licensed or certified by the state unless enrolled in the ISO model;
- e. Providing for the care of pets, except in cases where the animal is a certified service animal;
- f. Providing transportation or escort services;
- g. Lifeline;
- h. Chore;
- i. Companion;
- j. Daycare;
- k. Services normally provided by an LRI, PCR, or caregiver; or
- l. Maintaining an entire household, such as cleaning areas of the home not used directly by the recipient.

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B. RECIPIENT RESPONSIBILITIES

The recipient or the recipient's authorized representative will:

1. Demonstrate an understanding and willingness to utilize available personal and financial resources to support service needs;
2. Apply, pursue and or accept other benefits including Medicaid if eligible;
3. Disclose all income and cooperate with all eligibility determinations;
4. Notify the provider(s) and the ADSD of any change in eligibility;
5. Notify the provider(s) and the ADSD staff of current insurance information, including the name of the insurance coverage, such as Medicare or private insurance;
6. Notify the provider(s) and the ADSD staff of changes in medical status, service needs, address or location changes, and/or any change in status of the LRI;
7. Treat all providers and their staff members respectfully;
8. Sign the daily record(s)/provider visit form(s) to verify that services were provided, and not falsify records when services were not received;
9. Notify the provider and/or the ADSD staff when scheduled visits cannot be kept or services are no longer required;
10. Notify the provider agency and/or the ADSD staff of any missed appointments by the provider agency staff;
11. Notify the provider agency and the ADSD staff of any unusual occurrences, complaints regarding delivery of services or specific staff, or to request a change in caregiver or provider agency;
12. Furnish the provider agency with a copy of an Advance Directive;
13. Not request any provider to perform services, or work more than the hours authorized in the POC;
14. Not request a provider to work or clean for a non-recipient, family or household members, or pets that are not certified service animals;
15. Contact the ADSD staff to request a change of provider agency, if desired;
16. Complete, sign and submit all required forms; and
17. Recipients who share in the cost of services are required to make their co-payment to the ADSD by the due date identified on the mailed invoice.

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VI. ADMINISTRATIVE REVIEW

A. SUSPENSION OF SERVICES

Except in the case of death of a recipient, the ADSD will notify the recipient and/or their representative, in writing, if the recipient's case is being suspended. The notice will include:

1. The reason for the suspension;
2. A statement of the rights of the recipient to an Administrative Review; and
3. The process for filing a request for an Administrative Review.

An applicant may have their service(s)/eligibility suspended for any of the following reasons:

1. If a recipient is admitted to a hospital or long-term care facility and it is likely the recipient will be eligible for the PAS program within 60 days from the day of admission, a recipient's case may be suspended instead of closed.
 - a. If at the end of 45 days from the date of admission the recipient has not been removed from suspended status, the case must be closed. The ADSD will send a letter to the recipient or the recipient's LRI on the 45th day of suspension identifying the 60th day of suspension as the effective date of termination, and the reason for the termination.
2. A recipient has failed to pay his/her established co-payment amount by the due date indicated on the mailed invoice.

Services will not be covered or reimbursed while the recipient's case is in suspension status.

B. RELEASE FROM SUSPENSION STATUS

If a recipient has been released from the hospital, or long-term care facility before 60 days have elapsed, within five (5) working days of the recipient's discharge, the qualified ADSD case manager must:

1. Complete a new LOC and Social Health Assessment if there has been a significant change in the recipient's condition or it appears the recipient may not meet the LOC required for long-term care placement.
2. Complete a new POC if there has been a change in needed services. If a change in functional need is expected to resolve in less than 30 days, a new POC is not necessary. Documentation of the temporary change and date of resolution must be made in the case manager's notes.
3. Contact the service provider(s) to reestablish services and provide documentation of any change in service authorizations.

If a recipient has satisfied their past-due co-payment amount within 30 days from the date of suspension, the PAS program may be reinstated.

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C. DENIAL OF APPLICATION

Except in the case of death of a recipient, the ADSD will notify the recipient and/or their representative, in writing, if the recipient's case is being denied. The notice will include:

1. The reason for the denial;
2. A statement of the rights of the recipient to an Administrative Review; and
3. The process for filing a request for an Administrative Review.

An applicant may be denied for the PAS program, for any of the following reasons:

1. The applicant does not have a physical disability according to NRS 427A.791.
2. The applicant has failed to demonstrate a need for at least one service offered through the PAS program.
3. The needs of the applicant exceed the service that can be provided through the PAS program.
4. The applicant and/or their representative failed to cooperate with the ADSD in verifying eligibility for services, establishing and/or implementing the POC, or implementing services.
5. The ADSD has lost contact with the applicant.
6. The applicant has moved out of state.
7. Another agency, person or program is available to provide the service.
8. The applicant is in a long-term care facility (e.g. hospital, nursing facility, ICF/ID) and discharge within 30 days is not anticipated.
9. The applicant and/or their representative have withdrawn the request for the PAS program.
10. The applicant and/or their representative have participated in activities intended to defraud the PAS program.
11. The applicant and/or their representative failed to provide all required documentation.
12. The applicant does not meet the financial eligibility criteria.

D. REDUCTION OF SERVICES

Except in the case of death of a recipient, the ADSD will notify the recipient and/or their representative, in writing, if the recipient's case is being reduced. The notice will be given at least 15 days before the services are to be reduced, and will include:

1. The effective date the case is reduced;
2. The reason for the reduction;
3. A statement of the rights of the recipient to an Administrative Review; and
4. The process for filing a request for an Administrative Review.

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A recipient's services may be reduced for the following reasons:

1. The recipient no longer requires the number of service hours, which were previously provided.
2. The recipient no longer needs a service previously provided.
3. Another agency, program or the recipient's support system can provide the service.
4. The recipient and/or their representative have requested the reduction of services.
5. Change or clarification of policy.
6. Funding is no longer available.

E. TERMINATION OF SERVICES

Except in the case of death of a recipient, the ADSD will notify the recipient and/or their representative, in writing, if the recipient's case is being terminated. The notice will be given at least 15 days before the services are to be terminated, and will include:

1. The effective date the case is terminated;
2. The reason for the termination;
3. A statement of the rights of the recipient to an Administrative Review; and
4. The process for filing a request for an Administrative Review.

A recipient's services may be terminated for the following reasons:

1. The recipient is deceased.
2. The recipient fails to pay his share of the cost of such service.
3. The recipient has failed to demonstrate a continued need for at least one service offered through the PAS program.
4. The recipient does not meet the financial eligibility criteria.
5. The recipient and/or their LRI has failed to cooperate with the ADSD in verifying eligibility for services, establishing and/or implementing the POC, or implementing provision of services.
6. The ADSD has lost contact with the recipient.
7. The recipient has moved out of state.
8. Another agency, program, or the recipient's support system will provide the service.
9. The recipient is in a long-term care facility (e.g. hospital, nursing facility, ICF/IID), or group home and discharge within 60 days is not anticipated.
10. The recipient and/or their LRI have requested termination of the PAS program.
11. The recipient and/or their LRI have participated in activities designed to defraud the PAS program.

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12. Change or clarification of policy.
13. Funding is no longer available.
14. The needs of the recipient exceed the service that can be provided through the PAS program.
15. The recipient and/or their authorized representative have failed to notify the ADSD of changes in income that would affect the recipient's eligibility.
16. The ADSD has filed the number of positions allocated to the PAS Program through funding available. The applicant has been placed on the Waiting List and will be contacted with a position is available.

F. ADMINISTRATIVE REVIEW REQUEST

1. An Administrative Review is a process that provides an applicant/recipient the opportunity to appeal an adverse action taken by the ADSD. An applicant/recipient may file an appeal according to the procedures and regulations established by NAC 427A.775-427A.789. An Administrative Review may be requested when:
 - a. Services are denied, terminated, or reduced without concurrence, except when the action occurs due to a lack of available funding for the PAS program.
 - b. There is a grievance regarding the delivery, quality, duration or scope of service(s) being provided.
 - c. An applicant/recipient has not been given a choice between home and community-based services and institutional care, or a choice between service providers.

The applicant will receive a copy of the Statement of Understanding and a copy of the Administrative Review Process during the initial assessment visit. If an applicant is denied, terminated, suspended or services have been reduced for the PAS program, a letter will be sent which includes information on the Administrative Review process

- Refer to CBC-MS500 for more details.

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VII. QUALITY ASSURANCE

Quality Assurance is a method that allows for review of services provided to recipients, quality of services provided to recipients, and identifying areas for improvement.

The ADSD established Quality Management Programs will be utilized to assist in assuring recipients are receiving required services.

Serious Occurrence Reports will be reviewed by the ADSD Quality Assurance Program following CBC procedure.