

# Nebraska Provider Screening and Enrollment

## Home Care Based Services (HCBS)

### New Enrollment and Revalidations HCBS Providers

Note: If you do not have a username and password, see the appropriate Account Creation Instructions.


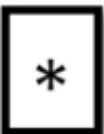



This will be completed at the [Provider Data Management Site \(PDMS\) for Nebraska Medicaid Provider Screening and Enrollment](#)

The steps below will guide you through filling out or updating an application for HCBS providers.

**All applications must be submitted for review when completed.**

Note: HCBS Provider Locations using an EIN are considered Agencies and must have a Type 2 NPI. HCBS Provider Locations using an SSN are considered Individual HCB Providers and must have a Type 1 NPI.

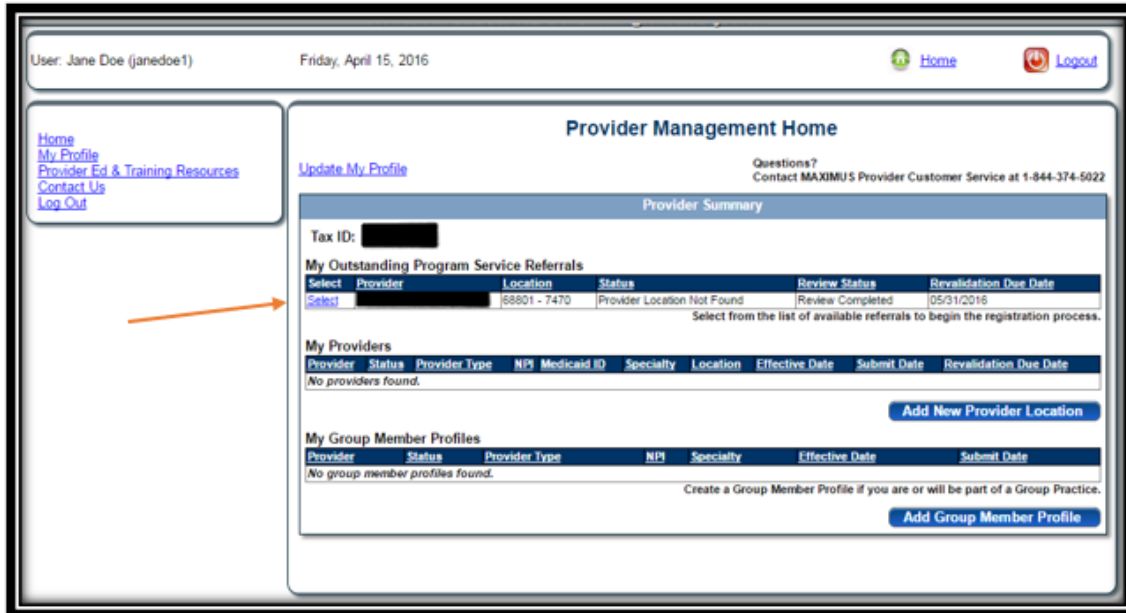
Symbols to watch for:

	A pencil symbol represents the option to EDIT information. Click on the symbol to open the box and allow edits.
	The asterisk symbol represents when a field is REQUIRED.
	The circle with a question mark symbol represents that there is HELP TEXT when you hover over the symbol.
	The plus mark symbol represents the option to ADD information. Click on the symbol to open the box and add information.
	The ex or cross mark symbol represents the option to DELETE information. Click on the symbol to remove the information.

### New HCBS Enrollment- Must have an Existing Referral

Click on **Select** under “My Outstanding Program Service Referrals.”

- If **Select** is not available or if there is no section for “My Outstanding Program Service Referrals” contact your Resource Development Worker for an updated referral.
- If you have already clicked on **Select** and are returning to the portal to continue filling out the application, the **Select** and the referral section will be removed. You will need to select your name under My Providers and **Continue Registration**. If needed, see HCBS Provider Management Home Resources for further directions.



Complete All Required Fields.

- The Tax ID and Category of Individual (SSN) or Organization (EIN) is determined by the referral. Providers using an SSN must be Individuals. Providers using an EIN must be Organizations or Agencies.
- Enter the NFOCUS Referral number exactly as it appears in your email notification. Examples: NFOCUS-9270 or NFOCUS18548

Contact your Resource Development Worker if you did not receive your referral email

The 'Revalidate Registration' form includes the following fields and options:

- Category\*: Individual/Solo (dropdown)
- Provider Type\*: HCBS (dropdown)
- First Name\*: [Redacted]
- Middle Initial: [Redacted]
- Last Name\*: [Redacted]
- Tax ID Type\*:  EIN  SSN
- Tax ID\*: [Redacted]
- Gender\*:  Female  Male  Unknown
- Date of Birth\*: [Redacted]
- Zip Code\*: 68801
- Zip Code Extension\*: 7470
- Referral Number\*: NFOCUS18548

A note at the top right states: '\* Designates a required field'. 'Save' and 'Cancel' buttons are located at the bottom right.

Click **Save**. This will take you to the application.

## Viewing the Provider Enrollment

If you want to return to the home page, you need to re-enter this application or Edit a Key Provider Identifier see the HCBS Provider Management Home Resource.

On the Bottom left side of the page, you will see a list of all the pages you need to complete. Each blue bullet point will change to a green checkmark when it is completed.



## Identification Page

Complete the Provider Information section by selecting the edit symbol. The following box will open:

**Provider Information**

Entity Type  Individual  Organization

Citizenship Status  I am a Citizen of the United States  
 I am a qualified alien under the Federal Immigration and Nationality Act, my immigration status and alien number are as follows:

First Name\* [Redacted]  
Middle Initial [Redacted]  
Last Name\* [Redacted]  
Tax ID\* [Redacted] ?  
Tax ID Type SSN ?  
Gender\*  Female  Male  Unknown  
Date of Birth\* 5/29/1980  
Date of Death  
Provider Type\* HCBS ?  
Effective Date\* 05/14/2010  
Revalidation Date 05/31/2016  
Enrollment Status Not Set Yet

**Save Cancel**

Individuals must select the appropriate citizen status, complete all required fields, and ensure all the information is correct and select **Save**.

Your Citizen Status will determine if an Immigration Status and Alien Number are required. It is recommended that documentation is uploaded to help expedite immigration status screening. Useful information includes Alien Number, SEVIS Identifier, I-94 Number, Passport Number, Naturalization/Citizen Number, Card Number (Green Card, Receipt Number, Permanent Resident Number), or Visa number.

*See the Business/Provider Location Provider-Management Home Resource if a Key Provider Identifier is incorrect.*

Primary Contact Information. On the Identification page, select **Add** or **Edit**. The following box will open:

**Primary Contact Information**

**Provider**

Name\* Jane Doe

The Primary Contact is the main person responsible for the information submitted to Nebraska MLTC.

Title\* Credentialist

Street Address\* 1234 W Main Street

City\* Lincoln

State\* Nebraska

Zip\* 68522

Ext Zip\* 1234

Phone Number\* (402) 555-5555

Phone Extension

Fax Number

Email Address\* provider@test.com

**Save Cancel**

Complete all required fields and select **Save**.

On the Identification page you will not be required to upload any documents unless you are requesting a retro effective date.

Click **Next** to proceed to the next page.

## License and Clasifactions Page on Some HCBS Registrations

### Licenses & Classifications

**Save** **Previous** **Next**

Provider Type: HCBS

**CPR and First Aid**

No CPR and First Aid found

**TBI Training**

I certify that I have completed TBI Training. A TBI Training Verification has been uploaded

**Education and Training**

Abuse, Neglect, and Exploitation and State Law Reporting is required to provide services. Verification requirements include a Certificate of completion or Training verification through previous employer.

Complete professional experience, life experience, or a combination of education, professional, and life experience as a qualification for habilitation service provision.

**A total of four years of education, professional, or life experience (or any combination thereof) is required, unless applicant possesses a Bachelor's Degree in an acceptable field.**

Certified Transcripts must be uploaded if using any education as a qualification.

**Training**

I certify that I have completed the Abuse, Neglect, and Exploitation and State Law Reporting training. A Certificate of completion or Training Verification thru a previous employer will be uploaded.

**Education**

No Education Details Found

**Professional Experience**

Please list all relevant experience. Experience may be used in lieu of or in combination with education equaling 4 or more years. A minimum of 15 hours per week constitutes employment. Volunteer positions such as Sunday School Teachers, 4-H or Scout leaders, etc. can also be applied in this sections.

No Professional Experience Details Found

**Life Experience**

Please describe any meaningful, relevant life experience in teaching or supporting individuals with disabilities. Descriptions of life experience may include 1:1 interactions or regular interactions in a group setting (school club, family friend, family member, etc.). Include number of years for each life experience listed.

No Life Experience Details Found

This page is displayed based on specific service requirements. Fill out all required information. Ensure all certifications are current.

- **License** – Issued by DHHS and should be current
- **CPR and First Aid** - Must be from an approved source. CPR must include hands on skills assessment. They do not have to be from the same course or source

- **Abuse and Neglect Training** - Must be from an approved source. You can also complete the free [DHHS Abuse and Neglect Training Online](#) and upload the certification. The certification does not expire.
- **Education, Life and or Work Experience** - It must total 4 years or 48 months of experience.
  1. **Education** (no degree required, based on credits on an official transcript with classes in psychology, social work, sociology, human services, or related field. Copy of Certified Transcripts required, 8 credits = 1 year)
  2. **Work Experience** in a related industry (can include volunteer work)
  3. **Life Experience** must be related to Developmental Disability (can include volunteer experience)
- **TBI Training** can complete the [DHHS Training](#) and upload the Certification. Does not expire
- **Driver's License** information is not required on this page, but you may be required to supply this if you have an out of state address. If you are Out of State College Student in Nebraska, you may have to supply your driver's license and a copy of you student ID. You will receive notification if this is required or you can upload it now.

Click **Next** to proceed to the next page.

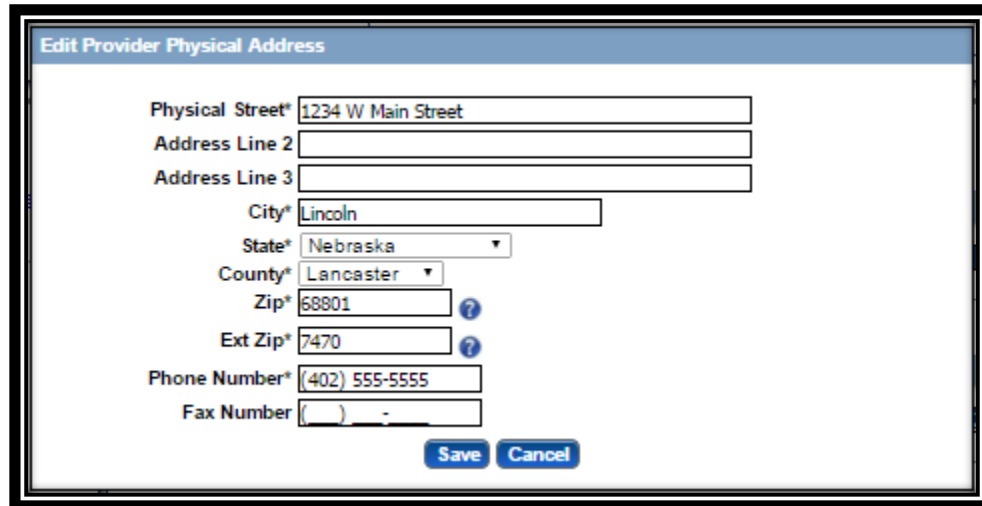
## Practice Locations Page

Provider Physical Address, Bill/Payment Contact Information and Correspondence Information are required sections that need to be completed.

## Provider Physical

The physical address CANNOT be a PO BOX. If you provide services in a client's home **do not enter the client's address**. Enter the address of your Individual Primary Residence or Agency address. Ensure this phone number is current.

Click the **Edit** symbol. The following box will open:



The screenshot shows a form titled "Edit Provider Physical Address" with the following fields and values:

Physical Street*	1234 W Main Street
Address Line 2	
Address Line 3	
City*	Lincoln
State*	Nebraska
County*	Lancaster
Zip*	68801
Ext Zip*	7470
Phone Number*	(402) 555-5555
Fax Number	( ) -

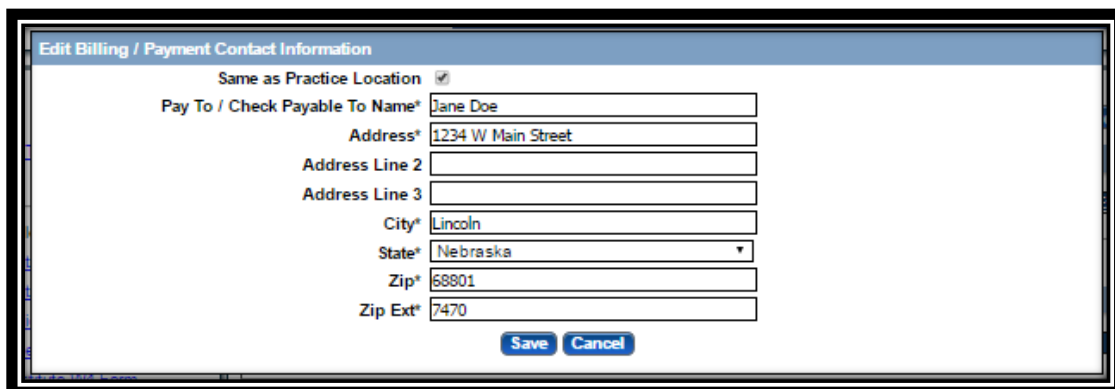
Buttons: Save, Cancel

Complete all required fields, confirm all information is correct, and select Save.

See the HCBS Provider Management Home Resource if a Key Provider Identifier is incorrect, including the Zip Code.

## Billing/Payment Contact Information

Click the **Add** or **Edit** symbol. The following box will open:



The screenshot shows a form titled "Edit Billing / Payment Contact Information" with the following fields and values:

Same as Practice Location	<input checked="" type="checkbox"/>
Pay To / Check Payable To Name*	Jane Doe
Address*	1234 W Main Street
Address Line 2	
Address Line 3	
City*	Lincoln
State*	Nebraska
Zip*	68801
Zip Ext*	7470

Buttons: Save, Cancel

Complete all required fields, confirm all information is correct, and select **Save**.

## Correspondence Information

Click the **Add** symbol. The following box will open:

Complete All required fields, confirm all information is correct, and select Save. Ensure this phone number is current.

You will not be required to upload any documents on the Practice Locations page.

Select **Next** to proceed to the next page.

## Provider Directory Information Page

The Provider Screening and Enrollment system now collects Provider Directory information. Responses to the questions will be included on [the public Medicaid Provider Directory on the DHHS website](#), as required by the Centers for Medicare and Medicaid Services (CMS). Questions are optional, but providers are responsible for ensuring the accuracy of their information and for updating it regularly in the Provider Data Management System (PDMS).

## Services Page

The Program Service Code(s) that the provider is authorized to provide will be present on this page. No action is required. Select **Next**.

Services	Service Type Code	Service Type Name	Start Date	End Date
AD Waiver	1001	CHORE	08/14/2010	

You will not be required to upload any documents on the Services page.

## Household Members Page

NOT ALL PROVIDERS WILL HAVE THIS PAGE.

Some INDIVIDUAL HCBS providers are required to list Household Members living in their home. You do not have to list the provider. You do not need to list the client if you only have one client in the home. If more than one client is in the home, you must list all clients that are 13 years of age or older.

List ALL other people that live at the Provider's Physical Address by selecting **ADD**.

Name	Date of Birth	Household Status	Sex
No household members found			

When all Household Members are entered click **Next**.

You will not be required to upload any documents on the Household Members page.

## Ownership and Controlling Interest and Conviction Disclosure Page

Expand the "Owner Information" section by clicking on the small white plus or minus as needed.

**Ownership/Controlling Interest and Conviction Disclosure** Save Previous Next

Click on the section header to expand or collapse the panel.

**- Instructions**

Completion of this form is required as mandated by the Centers for Medicare and Medicaid Services, Department of Health and Human Services and applicable regulations as found at 42 CFR 455.100 through 42. CFR 455.106. Disclosure must be made at the time of enrollment or contracting with the Department, at the time of survey, or within 35 days of a written request from the Department. It is the provider's responsibility to ensure all information is accurate and to report any changes as required by law by completing a new Ownership and Disclosure form.

**+ Definitions**

**- Owner Information**

No owner information found.

List the name, address, Federal Tax Identification Number (FTIN) (for corporations) or Social Security Number (SSN) and Date of Birth (DOB) (for persons) with an ownership or control interest in the disclosing entity or in any subcontractor in which the disclosing entity has direct or indirect ownership of 5% or more. If you are an Individual Billing Provider enrolling with an SSN, please list yourself.

**- Managing Employee**

No managing employee information found.

List any person(s) who holds a position of managing employee within the disclosing entity. If you are an Individual Billing Provider enrolling with an SSN, please list yourself.

**+ Additional Addresses**

**- Questions**

Are any of the above mentioned persons related to one another as a spouse, parent, child, or sibling?

Yes  No

Does any person, business, organization or corporations with an ownership or control interest have an ownership or controlling interest of 5% or more in any other Nebraska Medicaid Provider?

Yes  No

Does any person have ownership or control interest in the disclosing entity(provider), or is an agent or employee of the disclosing entity (provider) who has ever been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, Waivers, CHIP or the Title XX services since the inception of these programs.

Yes  No

Complete the Ownership Information by selecting **Add** or **Edit**. You can edit existing information or delete it using the RED X.

Notes: Individual HCBS will list themselves as the owner at 100%.

Owner Information			
Type	Name	Title	Percentage
Person	[REDACTED]		100

List the name, address, Federal Tax Identification Number (FTIN) (for corporations) or Social Security Number (SSN) and Date of Birth (DOB) (for persons) with an ownership or control interest in the disclosing entity including any person who holds a position of managing employee within the disclosing entity.

Owner Information

Provider

Owner Type\*

Name of Individual or Organization\*

Birth Date\*

SSN\*

Percentage of Ownership\*

Title

Address\*

Suite/Dept/Floor

City\*

State\*

Zip\*

Ext Zip

Make all necessary changes and select **Save**.

*It is common to have multiple owners and managing employees. At least one Managing Employee is required*

Complete the Additional Addresses section if necessary.

Complete the Questions section and click **Next**.

Note: If only one owner is listed, the first question will be answered "No."

Other sections are optional. Use your own discretion. You will not be required to upload any documents on the Ownership and Controlling Interest page.

## Substitute W4 or W9 Form

**Individuals** will have a Substitute W4 Form.

Fill out all Applicable fields. Marital Status and Allowances are required. Contact your Resource Development worker If you have questions about withholdings.

Click **Next**.

### Substitute W4 Form

[Save](#) [Previous](#) [Next](#)

Information from the Identification page displayed below.  
 Corrections to this information must be made in the Organization/Individual Identification and Primary Contact sections of the Identification page.

Legal Business Name [REDACTED]  
 Tax ID [REDACTED]  
 DBA

\*\*Please visit <http://www.irs.gov> to obtain a copy of the W4 with instructions.

Marital Status    
 Note: If married, but legally separated, or spouse is a nonresident alien, select "Single".

If your last name differs from that shown on your social security card, check here. You must call 1-800-772-1213 for a replacement card.

Total number of allowances you are claiming

Additional amount, if any, you want withheld from each paycheck

I claim exemption from withholding for 2015, and I certify that I meet both of the following conditions for exemption.

- Last year I had a right to a refund of all federal income tax withheld because I had no tax liability, and
- This year I expect a refund of all federal income tax withheld because I expect to have no tax liability.

If you meet both conditions, indicate "Exempt" here.  Exempt

**Organizations/Agencies** will complete a Substitute W9 Form.

Select the appropriate Tax Classification and Profit Status.

Click **Next**.

### Substitute W9 Form

[Save](#) [Take Action](#) [Previous](#) [Next](#)

Information from the Identification page displayed below.  
 Corrections to this information must be made in the Organization/Individual Identification and Primary Contact sections of the Identification page.

Legal Business Name Wendy Andorf-Blum

\*\*Please visit <http://www.irs.gov> to obtain a copy of the W9 with instructions.

**Tax Classification**

Select the most appropriate category below:

- 1. Individual/Sole Proprietor or LLC
- 2. Corporation
- 3. S Corporation
- 4. Partnership
- 5. Trust/Estate
- 6. Limited Liability Corporation
- 7. Limited Liability S Corporation
- 8. Limited Liability Partnership
- 9. State, County or City (Government Entity)

**Profit Status**

Select the most appropriate category below:

- 01 - 501(C)(3) Non-Profit
- 02 - For Profit, Closely Held
- 03 - For Profit, Publicly Traded
- 04 - Other
- 99 - Unknown

You will not be required to upload any documents on the Substitute W4 or W9 page.

## ACH Authorization Page

Select your payment method.

The screenshot shows the 'ACH Authorization' page. On the left is a navigation menu with links: Home, My Profile, Provider Ed & Training Resources, Contact Us, and Log Out. Below these are sections for 'Provider File' with links for Identification, Practice Locations, Services, Owner Information, Substitute W4 Form, ACH Authorization (highlighted), and Agreements. The main content area is titled 'ACH Authorization' and contains a form with the following elements: a 'Please mark your choice:' section with radio buttons for 'Direct Deposit' and 'ReliaCard'; an 'Uploaded Documents' section with a 'Choose File' button and 'No file chosen' text; a table with 'Name' and 'Description' headers; an 'Upload file' button; and 'Save', 'Previous', and 'Next' buttons at the bottom right. An orange arrow points to the 'Direct Deposit' radio button, and another points to the 'Next' button.

### Direct Deposit

If you select Direct Deposits: Only select the Check Box in the Direct Deposit section if you bank is outside the United State.

The screenshot shows the 'ACH Authorization' page with the 'Banking Information' section. It includes an 'Instructions' section with the following text: 'READ INSTRUCTIONS BEFORE COMPLETING' and a list of instructions regarding EFT enrollment, Medicaid providers, NACHA standard CCD+ format, and fraud mitigation. Below the instructions is a checkbox: 'Check here if the bank is outside of the United States. Per 1902(a)(80) of the Social Security Act, the State shall not provide any payment to any financial institution or entity located outside the United States.' The 'Banking Information' section contains a table with the following data:

Financial Institution Name	City	Account Number	Account Type
US BANK	Lincoln	*****g**	Checking

Below the table is a 'Confirm' section with the text: 'By selecting the confirmation box below, the submitting individual is attesting and acknowledging on behalf of the Nebraska Medicaid Provider listed above that:' and a list of statements: 'He or she is authorized to complete and submit this Enrollment Form.' and 'The information provided is accurate and true.' A checkbox is checked with the text: 'I confirm the information provided is true and accurate.' An orange arrow points to this checkbox.

Click **Add** to enter your checking or saving information for deposits. Complete all required fields and click **Save**.

Check the "I confirm the Information provided is true and accurate" and click **Next**.

## ReliaCard

If you select ReliaCard: Click **Add** to enter the ReliaCard Authorization information.

Complete all required fields and click **Save**.

Check the "I confirm the Information provided is true and accurate" and click **Next**.

You will not be required to upload any documents on the ACH Authorization page.

**Confirm**

By selecting the confirmation box below, the submitting individual is attesting and acknowledging on behalf of the Nebraska Medicaid Provider listed above that:

- He or she is authorized to complete and submit this Enrollment Form.
- The information provided is accurate and true.

I confirm the information provided is true and accurate.

**Uploaded Documents**

Name	Description	File Name	Page Name	Username
No uploaded documents found.				

No file chosen

Name

Description

**ACH Authorization (43127)**

## Agreements Page

Click on each **“Click here to view the entire agreement.”** A separate tab will show on your web browser that contains each agreement.

Place a checkmark in the “I agree’ or “I attest” boxes.

Note: The check box is only accessible after clicking the web link.

**Agreements**

**Provider Participation Agreement**

By signing the Provider Participation Agreement, the applicant agrees to adhere to all the conditions listed and is aware that the applicant may be denied entry to or terminated from the program if any conditions are violated.

[Click here to view the entire agreement.](#)     I agree to the terms and conditions in the Participation Agreement.

**Ownership Disclosure Acknowledgement**

By checking 'I accept' I certify that I have read the Ownership Disclosure Acknowledgement on behalf of myself or the entity that I represent and by this certification agree to bind myself or said entity by these provisions.

[Click here to view the entire agreement.](#)     I attest I can legally bind this Provider Entity, and that all the information provided in the Ownership section of this application is true and accurate to the best of my knowledge.

**United States Citizenship Attestation**

By checking 'I accept' I certify that I have read the US Citizenship Acknowledgement on behalf of myself or the entity that I represent and by this certification agree to bind myself or said entity by these provisions.

[Click here to view the entire agreement.](#)     I attest that my response and the information provided regarding my status as either a United States citizen or a qualified alien under the federal Immigration and Nationality Act and any related application for public benefits are true, complete, and accurate and I understand that this information may be used to verify my lawful presence in the United States.

**Provider Release of Information Felony/Misdemeanor Statement**

I agree that information provided can be used to obtain information to complete background checks which are required for approval as a provider. Form MC-199 is used to obtain information to complete background checks which are required for approval as a provider. This form is used to allow potential and renewing providers and/or their employees to self-disclose any current charges, pending indictments or any convictions they have had. Individual providers must complete the form every 12 months before their provider service agreement may be signed or renewed. For providers who provide the service in their home, each household member must also complete the form at the same time. Assisted Living providers must have each employee complete this form annually.

Answer all the questions on the Agreements page.

**Questions**

Is the provider an entity identified on the System for Award Management (SAM) website as debarred, suspended, proposed for debarment, excluded or disqualified under the nonprocurement common rule, or otherwise declared ineligible from receiving Federal contracts, certain subcontracts, and certain Federal assistance and benefits?

No  Yes

If 'YES' a comment is required.

Is the provider, any facility, employee or contractor providing services under this Agreement identified on the OIG list of Excluded Individuals/Entities website as excluded from receiving payment by a Federal health care program?

No  Yes

If, 'YES' a comment is required.

Has there ever been disciplinary action against this provider license by a licensing board in any state?

No  Yes

If 'YES' a comment is required.

Has the provider ever been sanctioned or terminated by Medicare, Nebraska Medicaid, or any state health program as defined in 42 U.S.C. § 1320a-7?

No  Yes


If, 'YES' a comment is required.

In compliance with Title 8 U.S.C. § 1324a, has employment eligibility been verified for all employees of this provider OR for individual providers, do you attest that you are in the United States legally and eligible to work per Pub.L. no. 104-193 (1997)?

No  Yes

If 'NO' a comment is required.

**Signature**

Please enter the characters in the image above: 

Enter password:

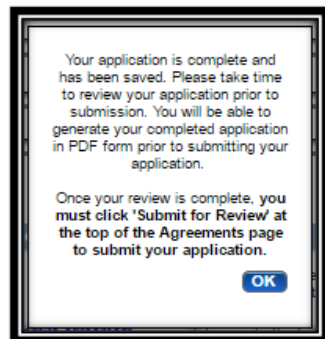
The password requested is your user login password.

In the Signature section, enter the characters in the image (if applicable)

Note: characters are not case sensitive.

Enter the password used to log into the portal and click **Save**.

This message will be displayed when the application is successfully saved:



Click **OK**.

[Submit for Review](#)

Click **"Generate a PDF"** if you wish to save or print a PDF of the application.

You MUST hit “**Submit for Review**” to successfully complete the application process.

The screenshot shows a web interface with a header section titled "Actions:" containing two buttons: "Submit for Review" and "Generate PDF". An orange arrow points to the "Submit for Review" button. Below this is a section titled "Agreements" with "Save" and "Previous" buttons. Under "Agreements", there is a sub-section for "Provider Participation Agreement" with explanatory text and a checkbox labeled "I agree to the terms and conditions in the Participation Agreement." which is checked. A link "Click here to view the entire agreement." is also present.

When finished the following screen will be displayed: Changes to your registration are not permitted while the enrollment is being reviewed. New Enrollments and Revalidations are not completed until fully processed. This will result in a Welcome Email and a new Revalidation Date. Watch for email communication.

The screenshot shows a "Submission Confirmation" screen. On the left is a navigation menu with links: "Home", "My Profile", "Provider Ed & Training Resources", "Contact Us", and "Log Out". The main content area contains the text: "You have successfully submitted your registration to Nebraska Medicaid. Please allow at least 10 days for processing before attempting to submit any changes." Below this text is a button labeled "Return to Home Page".