

Nebraska Provider Screening and Enrollment






Home Care Based Services (HCBS)

New Enrollment and Revalidations for Providers New to the Portal

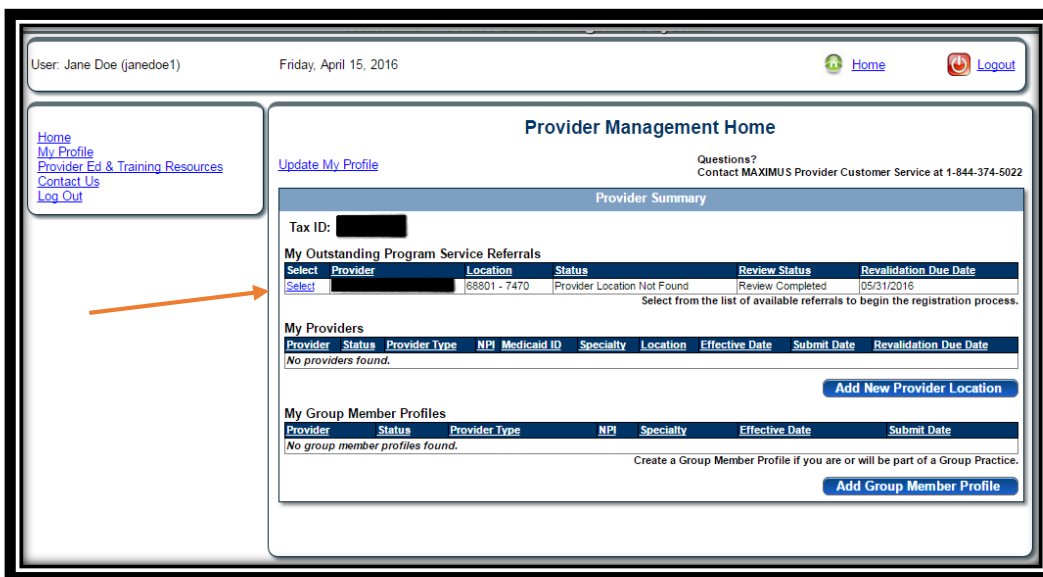
The steps below will guide you through filling out or updating an application for HCBS providers. All application must be submitted for review when completed.

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

Symbols to watch for:

	Edit		Required		Add
	Key Provider Identifier		Delete		

1. Click on **Select** under “My Outstanding Program Service Referrals”.
 - If **Select** is not available, contact your Resource Development Worker.
 - If you have already clicked on **Select** and are returning to the portal to continue filling out the application, the select 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 direction.



User: Jane Doe (janedoe1) Friday, April 15, 2016 Home Logout

Provider Management Home

Update My Profile Questions? Contact MAXIMUS Provider Customer Service at 1-844-374-5022

Provider Summary

Tax ID: [REDACTED]

My Outstanding Program Service Referrals

Select	Provider	Location	Status	Review Status	Revalidation Due Date
Select	[REDACTED]	68801 - 7470	Provider Location Not Found	Review Completed	05/31/2016

Select from the list of available referrals to begin the registration process.

My Providers

Provider	Status	Provider Type	NPI	Medicaid ID	Specialty	Location	Effective Date	Submit Date	Revalidation Due Date
No providers found.									

Add New Provider Location

My Group Member Profiles

Provider	Status	Provider Type	NPI	Specialty	Effective Date	Submit Date
No group member profiles found.						

Create a Group Member Profile if you are or will be part of a Group Practice.

Add Group Member Profile

2. Complete All Required Fields.

- New Provider must select Individual or Organization. Providers using a SSN are generally Individuals. Providers using an EIN are generally Organizations.
- Enter the NFOCUS Referral number exactly as it appears in your email notification.
 - Examples: NFOCUS-8120 or NFOCUS12248

The screenshot shows a web form titled "Revalidate Registration". At the top right, there is a note: "* Designates a required field". The form contains 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*: NFOCUS [Redacted]

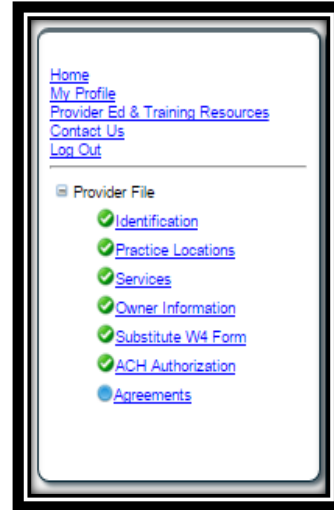
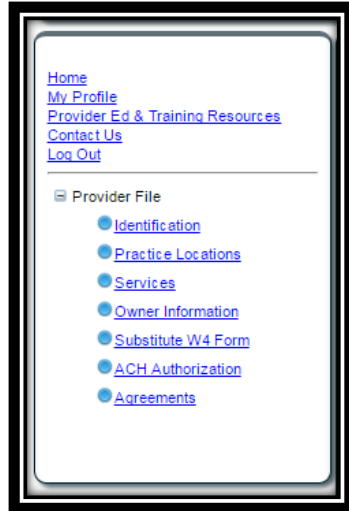
At the bottom right of the form, there are two buttons: "Save" and "Cancel".

3. Click **Save**.

- This will take you to the application.

If at any time you want to return to the home page, 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 of the pages you need to complete. Each blue bullet point will change to a green checkmark when it is completed.



2. Identification:

Identification Save Next

Provider Information

ProviderName	Tax ID	Provider Type	Effective Date
		HCBS	

Primary Contact Information

No primary contact information found.

Uploaded Documents

No uploaded documents found.

Browse... No file selected.

Name
Description

Upload file

Identification (73642) Save Next

Three orange arrows point to the Effective Date column header, the Primary Contact Information section, and the Upload file button.

1. 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* 06/14/2010

Revalidation Date 05/31/2016

Enrollment Status Not Set Yet

Save **Cancel**

2. Select the appropriate citizen status, complete all required fields, and ensure all the information is correct and select **Save**.
 - If you are a qualified alien under the Federal Immigration and Nationality Act, select the applicable immigration Status and provide your alien number.
 - See the HCBS Provider Management Home Resource if a Key Provider Identifier is incorrect.
3. Primary Contact Information. On the Identification page, select Add. The following box will open:

Primary Contact Information

Provider

Name* [Redacted]

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

Street Address* 1234 W Main Street

City* Lincoln

State* Nebraska

Zip* 68522

Ext Zip* 1037

Phone Number* (402) 555-5555

Phone Extension

Fax Number

Email Address* provider@test.com

Save **Cancel**

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

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

5. Click **Next** to proceed to the next page.
3. Practice Locations:

Practice Locations Save Previous Next

Provider Physical Address

Address 1	Address 2	Address 3	City	State	Zip	Zip Ext	
1234 W Main Street			Lincoln	NE	68801	7470	

Billing / Payment Contact Information

Address 1	Address 2	Address 3	City	State	Zip	Zip Ext	

Correspondence Information

Address 1	Address 2	Address 3	City	State	Zip	Zip Ext	Phone Number	

Uploaded Documents

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

Choose File No file chosen

Name

Description

Upload file

Practice Locations (43127) Save Previous Next

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

Note: If you provide services in a client's home **do not enter the client's address**. Enter the address of your primary residence.

1. Provider Physical Address:
 - Click the edit symbol.
 - The following box will open:

Edit Provider Physical Address

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 () -

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.

2. Billing / Payment Contact Information:

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

Edit Billing / Payment Contact Information

Same as Practice Location

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

Save Cancel

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

3. Correspondence Information:

- Click the add symbol.
- The following box will open:

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

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

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

2. Select **Next**.

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

5. Household Members: NOT ALL PROVIDERS WILL HAVE THIS PAGE.
 1. Some HCBS providers are required to list Household Members living in their home. You do not have to list the provider or the client. List ALL other people that live at the Provider's Physical Address by selecting **ADD**.

Household Members Save Previous **Next**

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

- Instructions

I understand that the Nebraska Department of Health and Human Services requires the following background information on me. History may be requested from law enforcement or criminal justice agencies, including but not limited to:

- State of Nebraska Adult/ Child Abuse and Neglect Central Registry/er
- Law Enforcement Records
- The State of Nebraska Sex Offender's Registry
- The Nebraska Department of Motor Vehicles Nebraska Driver License Information System
- License Information System
- GSA website <http://epjs.gov> for debarment actions by federal agencies and exclusion actions from Medicare, Medicaid or other federal programs through the Office of Inspector General at www.oig.hhs.gov/fraud/exclusions.asp.

Based on the services you are providing, you will be providing services in your home. The Department requires background information on all members of that household including full names, previous names, birthdates and Social Security numbers on all persons living in that residence and any criminal background information. This information is required in determining your approval as a service provider.

Please complete this information in the section below.

Household Members

Name	Date of Birth	Household Status	Sex
No household members found.			

2. When all Household Members have been entered click **Next**.

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

6. Ownership/Controlling Interest and Conviction Disclosure:

1. Expand the "Owner Information" section by clicking on the small white plus.

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 455.108. 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

+ Additional Addresses

+ Questions

Uploaded Documents

No uploaded documents found.

Choose File No file chosen

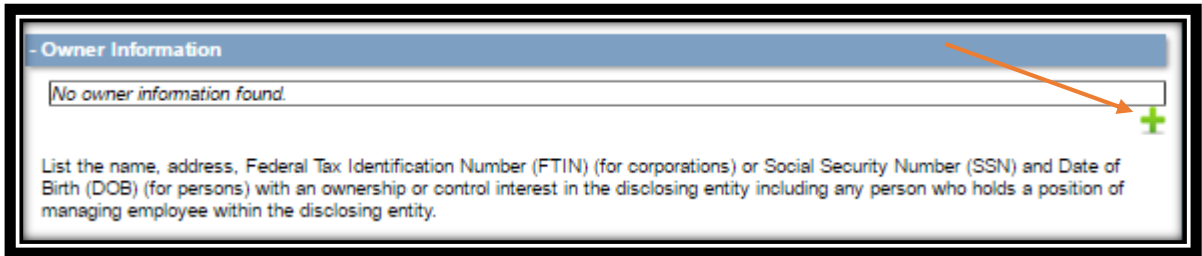
Name	Description
<input type="text"/>	<input type="text"/>

Upload file

Ownership/Controlling Interest Info (43127) Save Previous **Next**

2. Complete the Ownership Information by selecting **Add**.

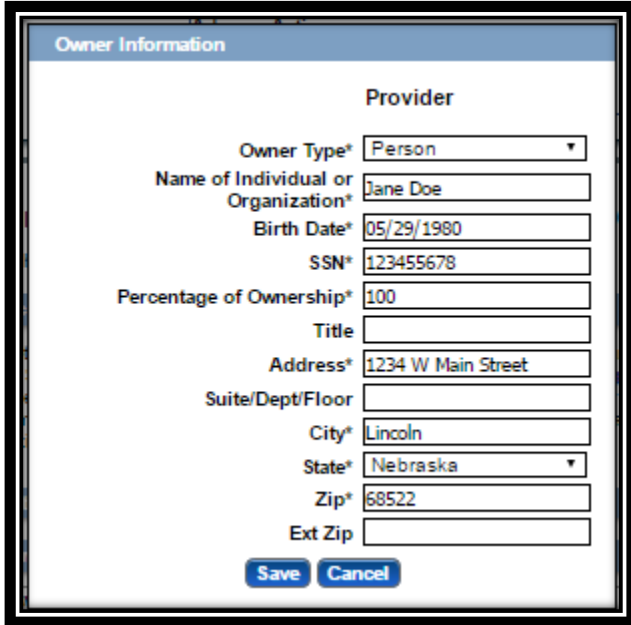
Notes: Most HCBS will list themselves as the owner at 100%.



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 including any person who holds a position of managing employee within the disclosing entity.



Owner Information

Provider

Owner Type* Person

Name of Individual or Organization* Jane Doe

Birth Date* 05/29/1980

SSN* 123455678

Percentage of Ownership* 100

Title

Address* 1234 W Main Street

Suite/Dept/Floor

City* Lincoln

State* Nebraska

Zip* 68522

Ext Zip

Save Cancel

3. Select **Save**.
4. Complete the Additional Addresses section if necessary.



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

Uploaded Documents

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

Choose File No file chosen

Name
Description

Upload file

Ownership/Controlling Interest Info (43127)

Save Previous **Next**

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

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

You will not be required to upload any documents on the Ownership and Controlling Interest page.

7. Substitute W4 Form or W9 Form:

1. Individuals will have a Substitute W4 Form.

- Fill out all Applicable fields. Marital Status and Allowances are required.
- 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 Married
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 2

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

2. Organizations 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.

8. ACH Authorization:
 1. Select your payment method.

ACH Authorization Save Previous Next

Please mark you choice:

- Direct Deposit
- ReliaCard

Uploaded Documents

No uploaded documents found.

No file chosen

Name

Description

ACH Authorization (43127) Save Previous Next

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

ACH Authorization Save Previous Next

Please mark your choice:

Direct Deposit
 ReliaCard

Instructions

READ INSTRUCTIONS BEFORE COMPLETING

- Electronic Fund Transfer (EFT) enrollment is required for a provider to enroll with Nebraska Medicaid.
- Medicaid providers must submit this form to receive payment via EFT (Electronic Fund Transfer). It is also the responsibility of the Medicaid provider to ensure this information is updated, as necessary.
- Nebraska Medicaid transmits the EFT via the NACHA standard CCD + format.
- It is the responsibility of the Provider to contact their financial institution to request the receipt of all data contained within the ACH information field (including the RTN Reassociation Trace Number) of the CCD + Addenda Record. This Trace Number uniquely identifies the transaction set and aids in reassociating payments and remittance advices.

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.

Please enter your banking information below:

Banking Information

No banking information found. +

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.

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

Banking Information

Provider

Trading Partner ID

Financial Institution Name*

Street*

City*

State*

Zip Code/Postal Code

Zip Code Extension

Financial Institution Phone Number* () -

Financial Institution Extension

Financial Institution Routing Number*

Confirm Financial Institution Routing Number*

Account Number*

Confirm Account Number*

Account Type* Checking Savings

Account Type Entity* 1 - Individual

Name as it Appears on Account*

Save Cancel

2. If you select ReliaCard:
 - Click Add to enter the ReliaCard Authorization information.
 - Complete all required fields and click **Save**.

ReliaCard Authorization

Provider

First Name* Jane

Middle Initial

Last Name* Doe

Street* 1234 W Main Street

City* Lincoln

State* Nebraska

Zip Code/Postal Code* 68522

Save Cancel

3. 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.				

Choose File No file chosen

Name Jane Doe

Description

Upload file

ACH Authorization (43127)

Save Previous Next

9. Agreements:

1. Click on each “Click here to view the entire agreement”. A separate tab will show on your web browser that contains each agreement.
2. Place a checkmark in the “I agree’ or “I attest” box.
Note: The check box is only accessible after clicking the web link.
3. If you agree with the contents of the agreement, place a checkmark in the Provider Release of Information section.

Agreements Save Previous

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.

4. Answer all of 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



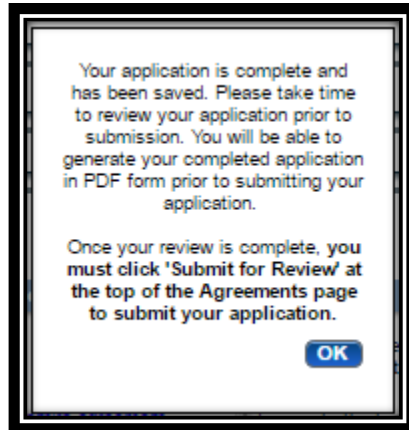
Please enter the characters in the image above:

Enter password:

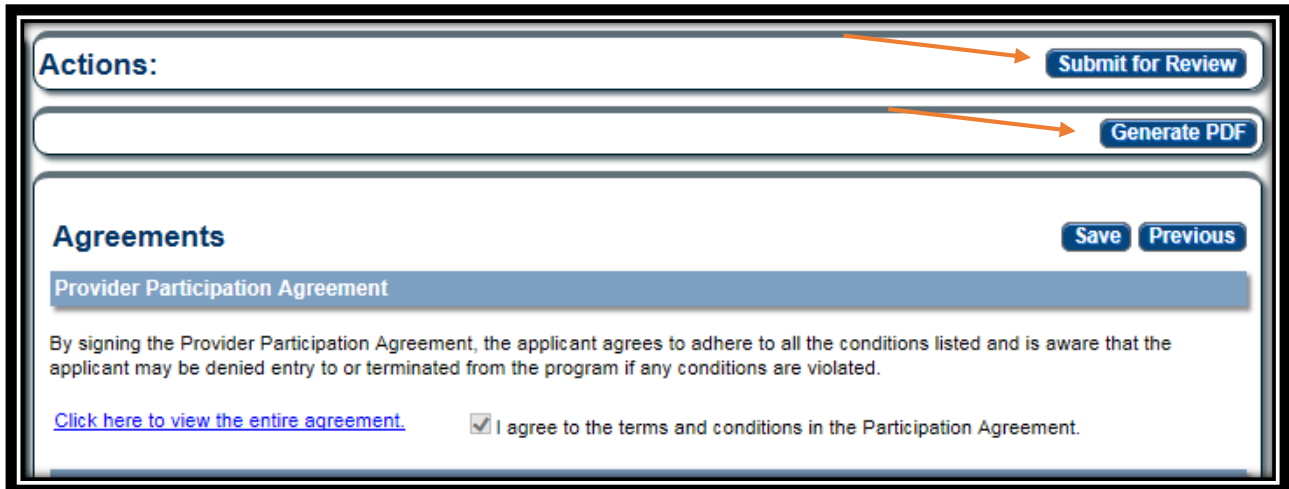
The password requested is your user login password.

5. In the Signature section, enter the characters in the image
Note: characters are not case sensitive.
6. Enter the password used to log into the portal and click **Save**.

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



8. Click **OK**.
10. Click **"Generate a PDF"** if you wish to save or print a PDF of the application.
11. You MUST hit **"Submit for Review"** to successfully complete the application process.



12. When finished the following screen will be displayed:

