Department of Health & Human Services
DHHS
NEBRASKA

Division of Medicaid and Long-Term Care

Nebraska Service Provider Agreement
Chore/PAS Provider Addendum

Provider Identification

Check all that apply: ☐ Aged & Disabled/Waiver ☐ Personal Assistance Services ☐ SSAD

Provider Name	Date of Birth	Social Security Number	FTIN Number

- ☐ Bill paying (A.D. Waiver)
- ☐ Essential Shopping (A.D. Waiver & SSAD)
- ☐ Food Preparation (A.D. Waiver & SSAD)
- ☐ Full Time/Live-in Housekeeper (A.D. Waiver & SSAD)
- ☐ Housekeeping (A.D. Waiver & SSAD)
- ☐ Laundry (A.D. Waiver & SSAD)
- ☐ Personal Assistance Services (PAS)
- ☐ Personal Care (A.D. Waiver)
- ☐ Supervision (A.D. Waiver)
- ☐ Simple Home Repair (A.D. Waiver)
- ☐ Yard Maintenance/Snow Removal (A.D. Waiver)

Provider Certification

- ☐ I am free of a communicable disease
- ☐ I am physically capable of providing services and willing to provide a physician's verification statement if requested by staff
- ☐ I have knowledge of basic first aid skills and available emergency medical resources.
- ☐ I will exercise reasonable caution and care in use and storage of client's equipment, appliances, tools and supplies
- ☐ I will provide any tools and equipment necessary to perform authorized tasks or duties if the client does not provide them
- ☐ I am able to recognize distress or signs of illness in clients
- ☐ I am willing to talk with family/client about emergency procedures in their home
- ☐ I will bill only for chore/PAS services actually provided. I understand that chore/PAS services may be provided only when a client is physically present (e.g. not hospitalized or in a nursing facility)

Requirements for Minors - Complete if age 18 or younger (A.D. Waiver and SSAD only)

- ☐ I will provide two references from adults (not relatives), if requested, as to my responsibility and/or reliability to provide chore services
- ☐ I have parental permission and will have my parent or legal guardian sign the Service Provider Agreement along with me

Comments

Billing Agreement

As part of my PAS/A.D. Waiver chore provider agreement, I understand that I cannot submit billing for days that I or my client spends in a hospital, nursing facility, rehabilitation, or correctional facility. I understand that I am not to bill for time that I did not work with or for the client. Any such attempt to bill for payment may be considered fraud and is subject to prosecution and/or civil monetary damages.

Initials: _____

I understand that my documentation of services provided must include the actual in and out times on the actual dates the services were provided.

Initials: _____

I understand that I am authorized to bill using the following units and must work at least the minimum time within each range in order to bill using those units:

- ☐ Quarter Hour: billed in 15 minute increments (PAS)
- ☐ Hourly: Minimum 1 hour worked but less than 5 hours worked in a 24 hour period (Chore)
- ☐ Partial Day: Minimum 5 hours worked but less than 13 hours worked in a 24 hour period (Chore)
- ☐ Full Day: Minimum of 13 hours worked in a 24 hour period (Chore)

Initials: _____

Signatures and Date

I have read and understand the above standards as explained by the DHHS representative. I certify that I will meet the above standards while providing chore/PAS services(s). If I represent an agency, I certify that agency employees will meet these standards while providing chore service(s).

Provider/Agency Representative Signature _____ Date _____

Parent or Legal Guardian Signature (If required) _____ Date _____

I have explained the above standards to this provider and she/he or the agency meet all the standards to provide chore/PAS services.

Signature of Authorized Representative - Nebraska Department of Health and Human Services _____ Date _____

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(Previously MILTC-0151 & MILTC-8: Forms now combined)