471-000-94 Instructions for Completing Form MC-84, "Personal Assistance Provider Check List"

Use: Local office staff begins completing Form MC-84 at the start of enrollment and continue completing the form throughout the enrollment process.

Number Prepared: Two copies of Form MC-84 are completed.

Completion: Local office staff completes Form MC-84 as follows:

Enter the personal assistant's name and the date that the enrollment process is initiated.

Check the appropriate requirements during the interview and enrollment process.

General Requirements are verified at the initial interview.

Personal Assistance Provider Requirements are checked during the interview as the services required are discussed with the potential provider.

Forms Completion is checked as each item is completed.

Signature: The provider and the local office worker signs Form MC-84.

Distribution: After completion, the worker files the white copy in the provider's file and gives the yellow copy to the provider.

Nebraska Department of Health and Human Services
PERSONAL ASSISTANCE PROVIDER CHECK LIST

NEBRASKA HEALTH AND HUMAN SERVICES SYSTEM

Provider Name	Date

GENERAL REQUIREMENTS:

_____ Is age 19 or over.
_____ Is not financially responsible for the client.
_____ Is physically healthy and capable.
_____ Evidences maturity.
_____ Understands and agrees to comply with right of client to confidentiality and privacy.
_____ Evidences ability to work with Nebraska Department of Health & Human Services.
_____ Has appropriate experience or training.
_____ Has general understanding of Personal Assistance Provider functions.
_____ Has clear record with child/adult abuse/neglect registry.

BASIC PROVIDER QUALIFICATIONS

_____ Understands and accepts provider functions, rates, and limitations.
_____ Understands and agrees with prior authorization of service.
_____ Understands and agrees to complete and file billing forms within 90 days.
_____ Agrees to accept payments as payment in full.
_____ Agrees to sign provider agreement.
_____ Agrees to provide necessary information/documentation and to retain documents four (4) years from date of service.
_____ Agrees to notify client when unable to provide service.
_____ Agrees to notify the Department when unable to provide service.
_____ Agrees to notify the Department if terminating provider status.

FORMS COMPLETION

_____ Provider Agreement (MILTC-9) has been signed and submitted to Local Office.
_____ Copy of License/Certificate of Completion of a Basic Aide Training Course approved by Nebraska Department of Health and Human Services, or declaration of experience submitted to Local Office.
_____ Physician's/RN's statement for health maintenance activities has been obtained and placed in client's case record. (MILTC-4D).
_____ Service Needs Assessment Plan has been explained to the provider.
_____ Manual material has been explained and given to the provider.
_____ Provider Packet and Service Provider Time Sheet (Form MC-37 E/S) have been explained and given to the provider.
_____ N–FOCUS Health and Human Services Billing Document (HHS-5N) and Provider Authorization have been explained to the provider.

Provider Signature

Local Office Staff

Distribution: WHITE COPY—Client Case Record YELLOW COPY—Provider

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MC-84 11/06 (62023)
Do not use previous version (11/04)