

# FAMILY HOME CARE (FHC) QSP ENROLLMENT

## FORM PACKET

This packet contains all necessary forms for you to enroll as a QSP.  
The following forms are required for you to enroll:



- ✓ SFN 1604 – Request to be a Qualified Service Provider For Family Home Care (Include a copy of a form of ID, ex: driver's license or social security card)
- ✓ SFN 1168 – Ownership/Controlling Interest and Conviction Information
- ✓ SFN 433 – Child Abuse & Neglect Background Inquiry
- ✓ SFN 615 – Medicaid Program Provider Agreement
- ✓ W9 – Request for Taxpayer Identification Number & Certification

It is important that you always send the most updated version of these forms to the QSP Enrollment Office. If we receive outdated forms, they will be returned to you, which will delay your enrollment.

Please check our website (<http://www.nd.gov/eforms/>) to make sure you have the most recent version of forms or call our office at 701-328-4602 with any questions on how to complete the forms. The form number and the date each form was revised can be found at the top left of the form (shown below).

**If you have any questions,  
please call the QSP Office  
1-800-755-2604 or 701-328-4602.**

The forms must be **completed with a pen or typed.** Signatures are required.

You can email, fax or mail your complete packet to:

Email: [DSHCBS@ND.GOV](mailto:DSHCBS@ND.GOV)

Fax: 701-328-4875

Mail: Medical Services / QSP  
600 E Boulevard Ave Dept. 325  
Bismarck ND 58505-0250

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**INSTRUCTIONS TO COMPLETE –  
SFN 1604 – Request to be a Qualified Service Provider for Family Home Care**

- List your Last Name, First Name; Gender; Date of Birth and Social Security Number
- If you are currently enrolled as a QSP or have been enrolled as a QSP in the past, write your Provider #.
- List any previous names you have ever used in the past.
- Home location information
  - Your complete physical or 911 address including county.
  - A PO Box cannot be accepted in this space.
- Mailing/Billing Address information
  - The address where you receive mail and where you want your checks sent.
  - A PO Box is acceptable here.
- If you have not lived in North Dakota in the past 7 years, what were your previous addresses?
  - If there is more than one address, please attach an additional sheet.
- **Provider Specialty Information:**
  - Your client's name, relationship to you and the county the client lives in.
- **Languages Supported:**
  - Check any languages that you can speak, read, write, and understand.
- **Service Area:**
  - Check the county the service will be provided in.
- **Electronic Funds Transfer (Direct Deposit)**
  - Check yes if you want your payments direct deposited into your bank account and complete the account information.
  - Attach a voided check or documentation from your financial institution which has the financial routing number.
  - **If this is not included, you will not be set up for direct deposit.**
- **Claims Submission**
  - Check if you will use online billing via North Dakota Health Enterprise Portal by internet or paper billing by mailing or delivering your billing form.

## QUESTIONS:

- **#1** Check the last grade of school you completed.
- **#2a Do** you have the basic ability to read, write and verbally communicate in English?
- **#2b Do** you need someone to help you read, write and verbally communicate in English?
  - **If unable to read and write, and verbally communicate in English, contact the QSP Office for additional forms. (701-328-4602)**
- **# 3** Have you ever been convicted of a misdemeanor offense?
  - **If yes, include official reports or a written explanation of offense.**
  - **Are you currently on probation?**
  - **If Yes, check the box and read and initial the following question.**
- **# 4** Have you ever been convicted of a felony offense?
  - **If yes, include official reports or a written explanation of offense.**
  - **Are you currently on probation?**
  - **If Yes, check the box and read and initial the following question.**
- 
- **#5 - #12** - Answer Yes or No.
- **#7 is often answered incorrectly, please double-check your answer**
- **Initial (Not Checkmark)** each of the following to indicate your understanding and agreement
  - Listed are assurances that you must make to enroll as a QSP. Read each statement carefully and then initial. All must be initialed, not checked. Agreement to all statements is required.
  - If you have questions about the assurances, contact the QSP Enrollment Office at 701-328-4602.
- **SIGNATURE:**
  - **Print your name, sign, and then date.**
  - Your signature verifies that the information being sent is true and correct to the best of your knowledge, and that you are aware this is a public document. Providing false information may be reason for the Department to deny or cancel any qualified service provider agreements.

**NOTE: A COPY OF A FORM OF AN OFFICIAL IDENTITY DOCUMENT MUST BE SENT TO THE DEPARTMENT; example: driver's license, tribal ID card etc.**





**REQUEST TO BE A QUALIFIED SERVICE PROVIDER FOR FAMILY HOME CARE**  
 DEPARTMENT OF HUMAN SERVICES  
 MEDICAL SERVICES DIVISION  
 SFN 1604 (12-2018)

FOR OFFICE USE ONLY	
Date Approved	Approved By
<input type="checkbox"/> Change/Add <input type="checkbox"/> New <input type="checkbox"/> Renew <input type="checkbox"/> Reapply	
ID	Date Closed

**IDENTIFYING INFORMATION - Provide a copy of a form of official identity.**

Last Name, First Name, MI, Suffix	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth
Can information about date of birth and gender be available to clients? <input type="checkbox"/> Yes <input type="checkbox"/> No	Social Security Number	

**NOTE: Your SSN will be linked to your ND Provider number. All claims paid to your ND Provider number will be submitted as income under your SSN to the IRS.**

**Disclosure of the social security number is required pursuant to 26 CFR 301.6109-1 and is requested for the purpose of reporting tax information. Failure to disclose this information results in \$50 penalty under 26 CFR 301.6723-1 unless it is due to reasonable cause and not willful neglect.**

**Current/Previous ND Provider Number**

Enter your current and/or previous provider number
--

**List all names you have used in the past, at any time.**

First Name, Last Name	First Name, Last Name
First Name, Last Name	First Name, Last Name

**Home Location Information (911 Address)**

Physical Address	Building, Suite Number, etc.	
City, State, ZIP Code	County	
Telephone Number	Cell Phone Number	Email Address
Mailing/Billing Address	Building, Suite Number, etc.	
City, State, ZIP Code	County	

**If you have not lived in North Dakota in the past 7 years, what was your previous address**

Physical Address	Building, Suite Number, etc.
City, State, ZIP Code	County

**PROVIDER TYPE/SPECIALTY**

<b>Provider Type:</b> Qualified Service Provider		<b>Provider Specialty:</b> Family Home Care	
Client's First Name	Client's Last Name	Client's Relationship to You	County

**Service**

**What languages can you speak, read and write? (Check all that may apply)**

<input type="checkbox"/> Albanian	<input type="checkbox"/> Czech	<input type="checkbox"/> Hindi	<input type="checkbox"/> Portuguese	<input type="checkbox"/> Swahili
<input type="checkbox"/> Arabic	<input type="checkbox"/> English	<input type="checkbox"/> Indian	<input type="checkbox"/> Romanian	<input type="checkbox"/> Syrian
<input type="checkbox"/> Bangla	<input type="checkbox"/> Farsi	<input type="checkbox"/> Italian	<input type="checkbox"/> Russian	<input type="checkbox"/> Tagalog
<input type="checkbox"/> Bosnian	<input type="checkbox"/> Filipino	<input type="checkbox"/> Japanese	<input type="checkbox"/> Stavic	<input type="checkbox"/> Turkish
<input type="checkbox"/> Cambodian/Kampuchean	<input type="checkbox"/> French	<input type="checkbox"/> Korean	<input type="checkbox"/> Sign Language	<input type="checkbox"/> Ukrainian
<input type="checkbox"/> Chinese (Mandarin)	<input type="checkbox"/> German	<input type="checkbox"/> Laotian	<input type="checkbox"/> Spanish	<input type="checkbox"/> Vietnamese
<input type="checkbox"/> Cantonese	<input type="checkbox"/> Greek	<input type="checkbox"/> Navajo	<input type="checkbox"/> Taiwanese	<input type="checkbox"/> Other _____

**Check the county the service will be provided in:**

- |                                    |  |                                    |                                    |                                   |                                   |
|------------------------------------|--|------------------------------------|------------------------------------|-----------------------------------|-----------------------------------|
| <input type="checkbox"/> Adams     | <input type="checkbox"/> Cavalier      | <input type="checkbox"/> Grant     | <input type="checkbox"/> McLean    | <input type="checkbox"/> Ransom   | <input type="checkbox"/> Steele   |
| <input type="checkbox"/> Barnes    | <input type="checkbox"/> Dickey        | <input type="checkbox"/> Griggs    | <input type="checkbox"/> Mercer    | <input type="checkbox"/> Renville | <input type="checkbox"/> Stutsman |
| <input type="checkbox"/> Benson    | <input type="checkbox"/> Divide        | <input type="checkbox"/> Hettinger | <input type="checkbox"/> Morton    | <input type="checkbox"/> Richland | <input type="checkbox"/> Towner   |
| <input type="checkbox"/> Billings  | <input type="checkbox"/> Dunn          | <input type="checkbox"/> Kidder    | <input type="checkbox"/> Mountrail | <input type="checkbox"/> Rolette  | <input type="checkbox"/> Trail    |
| <input type="checkbox"/> Bottineau | <input type="checkbox"/> Eddy          | <input type="checkbox"/> LaMoure   | <input type="checkbox"/> Nelson    | <input type="checkbox"/> Sargent  | <input type="checkbox"/> Walsh    |
| <input type="checkbox"/> Bowman    | <input type="checkbox"/> Emmons        | <input type="checkbox"/> Logan     | <input type="checkbox"/> Oliver    | <input type="checkbox"/> Sheridan | <input type="checkbox"/> Ward     |
| <input type="checkbox"/> Burke     | <input type="checkbox"/> Foster        | <input type="checkbox"/> McHenry   | <input type="checkbox"/> Pembina   | <input type="checkbox"/> Sioux    | <input type="checkbox"/> Wells    |
| <input type="checkbox"/> Burleigh  | <input type="checkbox"/> Golden Valley | <input type="checkbox"/> McIntosh  | <input type="checkbox"/> Pierce    | <input type="checkbox"/> Slope    | <input type="checkbox"/> Williams |
| <input type="checkbox"/> Cass      | <input type="checkbox"/> Grand Forks   | <input type="checkbox"/> McKenzie  | <input type="checkbox"/> Ramsey    | <input type="checkbox"/> Stark    |                                   |

**ELECTRONIC FUNDS TRANSFER**

- Do you want your payments direct deposited into your bank/credit union?  
 Yes - Complete information below and **send a voided check or documentation from your financial institution.**  
 No - Your check will be mailed to your billing address

I authorize the NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES and the financial institution named below to initiate deposits to the checking account listed. This authority will remain in effect until I notify the Department in writing to cancel this authority and allow the financial institution a reasonable amount of time to act upon the cancellation.

Name of Financial Institution (Bank/Credit Union)		Bank Telephone Number	
Address of Financial Institution			
City		State	ZIP Code
Bank Routing Transit Number	Bank Account Number	Account Type <input type="checkbox"/> Checking <input type="checkbox"/> Savings	
Account Holder's Name			

**CLAIMS SUBMISSION**

Do you want to bill     Online     Paper

**QUESTIONS**

1. Check last grade completed  
 1     2     3     4     5     6     7     8     9     10     11     12     12+     GED
- 2a. Do you have the basic ability to read, write, and verbally communicate in English?     Yes     No    **NOTE: If yes, additional requirements needed.**  
 2b. Do you need someone to help you read, write, and verbally communicate in English?     Yes     No

3. Have you EVER been convicted of a misdemeanor?     Yes     No  
 If yes, complete the following. **Send the court papers for all North Dakota misdemeanor convictions over the past seven years an all out-of-state convictions.**

Date	Offense

\* Attach additional sheets if necessary.

Are you on probation?     Yes     No    **If you answered yes, you are required to read the following statement and initial.**

I understand that if I am currently on probation, the Department is unable to consider my application unless evidence of rehabilitation is submitted with my application.

\_\_\_\_\_  
(initials required)

4. Have you EVER been convicted of a felony?  Yes  No

If yes, complete the following. **Send all papers for all felony convictions.**

Date	Offense

\* Attach additional sheets if necessary.

Are you on probation?  Yes  No **If you answered yes, you are required to read the following statement and initial.**

I understand that if I am currently on probation, the Department is unable to consider \_\_\_\_\_  
my application unless evidence of rehabilitation is submitted with my application. (initials required)

**You are required to notify the Department of any changes to your conviction history.**

5. Have you ever been found guilty of abuse or neglect or had services required as a result of a child abuse/neglect report or assessment?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, explain.
6. Have you ever stolen or taken property without permission?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, explain.
7. Do you have a contagious/infectious disease?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, explain.
8. Are you physically/mentally able to provide services yourself?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If no, explain.
9. Have you ever been disciplined or terminated from an agency that is enrolled as a qualified service provider?		<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, attach explanation.
10. If employed as staff member of an agency enrolled as qualified service provider have you ever submitted inaccurate service records, billing information or documentation?		<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, attach explanation.
11. Have you ever had your qualified service provider status or license (AFC, early childhood program license, self-declaration document, etc) issued by the Department of Human Services denied, revoked, suspended, restricted or terminated?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, explain.
12. Have you ever had your LPN/RN/CNA/PT/OT, etc. license denied, revoked, suspended, restricted, terminated or surrendered? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please provide an explanation.		

**Initial each of the following to indicate your understanding and agreement:**

_____	I am aware that in order to provide Family Home Care Services, I must live with the client/member and understand that if my living situation changes I am required to notify the Department and the case manager immediately.
_____	I am physically able to provide services.
_____	I agree to study the enclosed Working Together for Home Fire Safety Fact Sheet and Exposing Invisible Killer Carbon Monoxide Fact Sheet.
_____	I will notify the client's case manager at the county social service office when the following occur: 1. Observed change in client's physical, cognitive, emotional, and/or environmental condition; 2. Change in the amount or type of services that may be needed by the client; 3. Possible abuse or exploitation of client; 4. Other circumstances as agreed upon with case manager for specific client(s).
_____	I will provide care at a level acceptable to the client and the Department of Human Services.
_____	I agree to assist the Department of Human Services and/or county agency in compliance investigations and will provide information in writing upon request.
_____	I agree not to discuss any information, including personal health information, pertaining to clients with anyone NOT directly associated with the service delivery. I will NOT reveal personal information, except as necessary to comply with law and to deliver services.
_____	I will adhere to applicable federal and state laws.
_____	I will not provide service while under the influence of drugs or alcohol.

\_\_\_\_\_ I will keep service records and authorizations for a period of 42 months from the close of the Federal Fiscal Year (October 1 - September 30) in which the services are delivered. I acknowledge that I am required to keep these records even if I am no longer a provider. I agree to provide records to the Department upon request and understand that the Department will request a refund or process adjustments to take back payment made to a provider if the provider does not submit the requested records or keep appropriate records.

\_\_\_\_\_ I will keep records for each client visit that includes all information required by the Department, as outlined in the Qualified Service Provider Handbook.

\_\_\_\_\_ I have read the Family Home Care Handbook and will retain a current copy for my records.

\_\_\_\_\_ As a self-employed person, I understand that I am responsible for self-employment taxes and estimated tax on qualified service provider (QSP) payments. I understand that the Department will not withhold or pay any social security, federal, or state income tax, unemployment insurance, or worker's compensation insurance premiums from the payments I receive as a QSP. Withholding and paying taxes on QSP payments is the responsibility of the self-employed individual.

\_\_\_\_\_ I agree to perform the work, service, and/or care myself.

\_\_\_\_\_ I assure that I have not been guilty of a crime against children or been convicted of a felony or misdemeanor. In the event that I am found guilty of a crime against children, been convicted of a felony or misdemeanor, or if a child abuse and neglect decision of "services required" is made, I will immediately notify the Department.

\_\_\_\_\_ I will not abuse, neglect, exploit, or assert undue influence on anyone under my care.

\_\_\_\_\_ I give the North Dakota Department of Human Services permission to check for my name in the county child abuse neglect files and the North Dakota Child Abuse and Neglect Information Index. I further consent that the information on the North Dakota Child Abuse and Neglect Information Index can be shared with the Home and Community Based Services (HCBS) Department Staff.

\_\_\_\_\_ I agree to notify the Department of Human Services within 14 days if my physical (911) address changes.

**The information above is true and correct to the best of my knowledge.**

**Providing false information may be the basis for the North Dakota Department of Human Services refusing or revoking any Qualified Service Provider agreements.**

**THIS IS A PUBLIC DOCUMENT AND WILL BE MADE AVAILABLE TO THE PUBLIC UPON REQUEST, WITH THE EXCEPTION OF ANY INFORMATION THAT IS CONSIDERED CONFIDENTIAL.**

**SIGNATURE**

Printed Name	Signature	Date
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**INSTRUCTIONS TO COMPLETE  
SFN 1168 Ownership/Controlling Interest and Conviction Information**

The following instructions apply only to **Individual QSPs**.

Section	Instructions for each section
<b>I</b>	<b>Identifying Information:</b> <ul style="list-style-type: none"><li>➤ Only include the following:<ul style="list-style-type: none"><li>➤ Your Name</li><li>➤ Your Address</li><li>➤ Your Phone Number</li><li>➤ Your Email Address (If you have one)</li></ul></li></ul>
<b>II</b>	<b>Direct/Indirect Ownership:</b> <ul style="list-style-type: none"><li>➤ SKIP THIS SECTION</li><li>➤ You do <u>not</u> need to fill in any information here</li></ul>
<b>III</b>	<b>Managing Employee/Control Interest:</b> <ul style="list-style-type: none"><li>➤ SKIP THIS SECTION</li><li>➤ You do <u>not</u> need to fill in any information here</li></ul>
<b>IV</b>	<b>Ownership/Controlling Interest:</b> <ul style="list-style-type: none"><li>➤ SKIP THIS SECTION</li><li>➤ You do <u>not</u> need to fill in any information here</li></ul>
<b>V</b>	<b>Conviction Information:</b> <ul style="list-style-type: none"><li>➤ Read the question, then:<ul style="list-style-type: none"><li>➤ Check “yes” if you have been convicted or pled guilty to an offense listed in the question.</li><li>➤ Check “no” if you have <u>not</u> been convicted or pled guilty to this type of offense.</li></ul></li></ul>
<b>VI</b>	<b>Signature:</b> <ul style="list-style-type: none"><li>➤ YOU are the authorized representative.</li><li>➤ Provide your Name, Date of Birth, Social Security #</li><li>➤ Sign and date the form.</li></ul>

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**INSTRUCTIONS TO COMPLETE - SFN 433 Child Abuse and Neglect Inquiry Form**  
Individual Qualified Service Providers (QSPs)

**Part I: Agency/Organization Information** If not prefilled, write in:

- Agency/Organization: QSP Enrollment
- Contact Person: [DSHCBS@ND.GOV](mailto:DSHCBS@ND.GOV)
- Telephone Number: 701-328-4602
- Address: 600 E Boulevard Avenue, Bismarck ND 58505

**Part II: Authorization for Release of Information**

- Check both boxes (if not already checked)
- Initial both lines
- This information is being requested for:
  - Check “other”
  - On the line after “other”, write ‘QSP Enrollment’
- When writing your name, you must include:
  - Full, legal, First and Last names,
  - Include your FULL middle name, not just your middle initial.
    - If your legal middle name is only an initial, check the box “Initial Only”
- Your Social Security Number and Date of Birth are required.
- Write in any other names you have used in the last ten years.
  - If you have no former FIRST or LAST name within the past 10 years, please make sure to check the box to indicate this.
  - This is required for both males & females.
- The address you provide cannot be a PO Box.
- Remember to sign your name and date the form.
- Incomplete forms will be returned to you.
- **\*\*IMPORTANT\*\*** If you cross or scribble out any information, **you must initial next to those changes.** If you do not do this, your form will be returned to you as incomplete.

**Part III: Do Not Write Below – State Office Use Only**

- Leave Blank

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# CHILD ABUSE AND NEGLECT BACKGROUND INQUIRY

NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES

CHILD ABUSE AND NEGLECT PROGRAM

SFN 433 (3-2020)

## Part I: Agency/Organization Information

Agency/Organization Home & Community Based Services / QSP Enrollment	Contact Person DHSHCBS@ND.GOV	Telephone Number (701) 328-4602	
Address 600 E BOULEVARD AVE	City BISMARCK	State ND	ZIP Code 58505

## Part II: Authorization for Release of Information (to be completed by the person giving consent/authorization)

\_\_\_\_\_ (Initials) I give North Dakota Department of Human Services (NDDHS) and its' authorized agents (county social service agencies) permission to check the Child Abuse/Neglect Information Index for my name.

\_\_\_\_\_ (Initials) I further give permission to NDDHS to release child abuse and neglect records pertaining ONLY to the services required decisions indicated below to the above-named agency/organization. (**NOTE:** If this statement is not *checked and initialed*, and if child abuse and neglect records contain any medical, drug, alcohol, or mental health treatment information, an Authorization to Disclose Information Form (SFN 1059) will be required.)

This information is being requested for: (Check Only One)				
<input type="checkbox"/> Employment with NDDHS	<input type="checkbox"/> Employment in a NDDHS licensed or contracted agency	<input type="checkbox"/> Childcare/In-home provider		
<input type="checkbox"/> Adoption study	<input type="checkbox"/> Foster parent licensing	<input type="checkbox"/> Private agency employment/volunteer		
<input checked="" type="checkbox"/> Other (List): <u>QSP Enrollment</u>				
LAST Name	FIRST Name	FULL MIDDLE Name <input type="checkbox"/> None <input type="checkbox"/> Initial Only	Social Security Number*	Date of Birth
Birth Name, Alias, or Other Married Names You Have Gone by in the Last Ten Years		<b>OR</b> <input type="checkbox"/> Check this box if you have no additional names		
Current Physical Address	City	State	ZIP Code	
Last North Dakota Address	City	State	ZIP Code	
Signature			Date	

\* The Privacy Act of 1974 (P.L. 93-579, Section 7) requires the following information be provided when individuals are requested to disclose their social security number. Disclosure of the social security number is voluntary and is requested for identification purposes. Failure to disclose this information may result in a delay in reporting results.

This authorization remains in effect for 60-days from the date of signature unless specifically revoked by written notice to the agency/organization contact person. Any disclosure prior to a written revocation of this authorization shall not be a breach of confidentiality. A photocopy of this authorization is as effective as the original.

## Part III: Do Not Write Below - State Office Use Only

(NOTE: Results only include a search of the ND Child Abuse/Neglect Information Index. No tribal agency registry information is available through the state Index.)

- The above-named individual is not listed on the ND Child Abuse/Neglect Information Index.
- An assessment decision of Services Required was found on the ND Child Abuse/Neglect Information Index. For further details, please contact NDDHS, Children and Family Services.

If there are any questions about this form, or if you feel the conclusion was reached in error, please contact the agency which performed the inquiry, or contact

**Children and Family Services**  
**600 East Boulevard Avenue, Dept. 325**  
**Bismarck, ND 58505**  
**(701) 328-2316**  
**E-mail: dhscfs\_cani@nd.gov**  
**Fax: (701) 328-3538**

County	Decision Date
Signature of Person Completing CA/N Information Index Inquiry and Date Completed	

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## **INSTRUCTIONS TO COMPLETE**

### **SFN 615 – Medicaid Program Provider Agreement**

#### **On Page 1:**

- Provider – Your Name
- NPI – Leave BLANK
- Medicaid Provider Number –
  - If you are a new provider - Leave BLANK
  - If you are a renewing provider – provide your 7-digit provider number
- Address – Your Street Address, City, State and Zip Code
- **I wish to participate in (check all that apply):**
  - **Check the box for – Medicaid Fee For Service**

#### **On Page 4,**

- Provider – Your Name
- Title – QSP
- Date – Today's Date
- Provider Signature – Your Signature

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## **INSTRUCTIONS TO COMPLETE**

### **W9 – Request for Taxpayer Identification Number & Certification**

TOP Section:

- Line 1 - Name - Your Name
- Line 2 – SKIP
- Line 3 – Check the “Individual/Sole Proprietor box
- Line 4 – SKIP
- Lines 5 & 6 - Your Street Address, City, State and Zip Code
- Line 7 – SKIP

PART I – Taxpayer Identification Number

- Social Security Number – Include your Social Security Number

Part II – Certification

- Signature of US Person – Sign your Name here
- Date – Write today’s date

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**Check your Application paperwork to make sure everything is complete.**

**These forms can be found on the website nd.gov**

- **SFN 1604** Request to be a Qualified Service Provider for Family Home Care  
<http://www.nd.gov/eforms/Doc/sfn01604.pdf>
- **SFN 433** CHILD ABUSE AND NEGLECT BACKGROUND INQUIRY  
<http://www.nd.gov/eforms/Doc/sfn00433.pdf>
- **SFN 615** MEDICAID PROGRAM PROVIDER AGREEMENT  
<http://www.nd.gov/eforms/Doc/sfn00615.pdf>
- **W-9** REQUEST FOR TAXPAYER IDENTIFICATION NUMBER AND CERTIFICATION  
<http://www.irs.gov/pub/irs-pdf/fw9.pdf>
- **SFN 1168** OWNERSHIP/CONTROLLING INTEREST AND CONVICTION INFORMATION  
<http://www.nd.gov/eforms/Doc/sfn01168.pdf>

**Always Keep A Copy Of The Most Current Handbook.**

Qualified Service Family Home Care Handbook link:

<http://www.nd.gov/dhs/info/pubs/docs/medicaid/qsp-handbook-family-home-care.pdf>. This link will always have the most current handbook.