North Dakota Department of Human Services Targeted Case Management Application Checklists & Attestations

Contents

TCM Child Welfare
Individual Application Checklist

Application Tracking #	
Provider Name	

Contact Person	
Phone	
Email	

Check List						**Check**
Degree*	**Field**		**Issued:**			
Wraparound Certificate**	**Issued:**		**Expires:**			
Individual NPI		**Enumeration Date:**				
SFN 615 (11-2017)		Signed by the Individual Provider who is applying				

PROVIDER TYPE	017-Other Service Providers
SPECIALTY	335-Case Manager/Care Coordinator
TAXONOMY	171M00000X

ND Medicaid Individual Taxonomy List

https://www.nd.gov/dhs/info/mmis/docs/mmis-individual-provider-code-taxonomy.pdf

***Degree must be Bachelor's or above and be in one of the following fields:**		
1. Social Work	5. Human Development	9. Child Development and Family Science
2. Psychology	6. Elementary Education	10. Human Resource Mangement (human-service track)
3. Sociology	7. Early Childhood Education	
4. Counseling	8. Special Education	11. Criminal Justice

****If enrolling before Wraparound Certificate is issued, Wraparound Certificate must be obtained and submitted within 12 months.**

Please coordinate with your billing department and any other applicable area to determine the correct enrollment effective date.**The Department will not make changes to that date once the application is approved** and any claims submitted with a date of service prior to the enrollment effective date will deny. A retroactive enrollment effective date is limited to no more than ninety (90) days*** prior to the date a **complete** application packet is received by the Department. If the date requested is outside the 90 day timeframe, the enrollment effective date assigned will be 90 days from the date the complete application packet was received.

****If this application is associated with an emergency service, the Department may consider a date more than 90 days prior to the date a complete application packet is received. You must include a copy of the claim and medical records with your application documents.**

☐ **This application is associated with an emergency service. We are requesting the date of _____. Refer to the *** above.**

Enrollment Effective Date			
Printed Name (Requester)		**Date**	

Revision 1/10/2019 JS

TCM Long Term Care
Individual Application Checklist

Application Tracking #	
Provider Name	

Contact Person	
Phone	
Email	

Check List						**Check**
Attestation	**Requirements Completed On:**					
Social Work License*	**Issued:**		**Expires:**			
Individual NPI		**Enumeration Date:**				
SFN 615 (11-2017)		Signed by the Individual Provider who is applying				

PROVIDER TYPE 017-Other Service Providers

SPECIALTY 335-Case Manager/Care Coordinator

TAXONOMY 171M00000X

ND Medicaid Individual Taxonomy List

https://www.nd.gov/dhs/info/mmis/docs/mmis-individual-provider-code-taxonomy.pdf

***Social Work License is not required if provider can attest to the requirements on the TCM Long Term Care Practitoner's Attestation and submits the completed Attestation.**

***Socal Work License submitted must be current as of the date the application is approved.**

Please coordinate with your billing department and any other applicable area to determine the correct enrollment effective date.**The Department will not make changes to that date once the application is approved** and any claims submitted with a date of service prior to the enrollment effective date will deny. A retroactive enrollment effective date is limited to no more than ninety (90) days* prior to the date a **complete** application packet is received by the Department. If the date requested is outside the 90 day timeframe, the enrollment effective date assigned will be 90 days from the date the complete application packet was received.

***If this application is associated with an emergency service, the Department may consider a date more than 90 days prior to the date a complete application packet is received. You must include a copy of the claim and medical records with your application documents.**

☐ **This application is associated with an emergency service. We are requesting the date of _____. Refer to the * above.**

Enrollment Effective Date			
Printed Name (Requester)		**Date**	

Revision 1/10/2019 JS

TCM High Risk Pregnant Women & Infants
Individual Application Checklist

Application Tracking #	
Provider Name	

Contact Person	
Phone	
Email	

Check List						**Check**
Degree*	**Field:**		**Issued:**			
Attestation*	**Requirements Completed On:**					
License*	**Issued:**		**Expires:**			
Individual NPI		**Enumeration Date:**				
SFN 615 (11-2017)		Signed by the Individual Provider who is applying				

PROVIDER TYPE 017-Other Service Providers

SPECIALTY 335-Case Manager/Care Coordinator

TAXONOMY 171M00000X

ND Medicaid Individual Taxonomy List

https://www.nd.gov/dhs/info/mmis/docs/mmis-individual-provider-code-taxonomy.pdf

***May Enroll under any of the criteria below.**

Enrollment Criteria
1. Social Work Master's Degree
2. Social Work License + Attestation (Option #1 checked)
3. RN License
4. LPN License + Attestation (Option #1 checked)
5. Bachelor's Degree + Attestation (Option # 2 checked - health educator)
6. Licensed Registered Dietician License or Licensed Nutritionist License

Please coordinate with your billing department and any other applicable area to determine the correct enrollment effective date.**The Department will not make changes to that date once the application is approved** and any claims submitted with a date of service prior to the enrollment effective date will deny. A retroactive enrollment effective date is limited to no more than ninety (90) days** prior to the date a **complete** application packet is received by the Department. If the date requested is outside the 90 day timeframe, the enrollment effective date assigned will be 90 days from the date the complete application packet was received.

****If this application is associated with an emergency service, the Department may consider a date more than 90 days prior to the date a complete application packet is received. You must include a copy of the claim and medical records with your application documents.**

☐ **This application is associated with an emergency service. We are requesting the date of _____. Refer to the ** above.**

Enrollment Effective Date			
Printed Name (Requester)		**Date**	

Revision 1/10/2019 JS

TCM For High Risk Pregnant Native American Women & Infants

Individual Application Checklist

Application Tracking #	
Provider Name	

Contact Person	
Phone	
Email	

Check List						**Check**
Degree*	**Field:**		**Issued:**			
Attestation*	**Requirements Completed On:**					
License*	**Issued:**		**Expires:**			
Individual NPI		**Enumeration Date:**				
SFN 615 (11-2017)		Signed by the Individual Provider who is applying				

PROVIDER TYPE	017-Other Service Providers
SPECIALTY	335-Case Manager/Care Coordinator
TAXONOMY	171M00000X

ND Medicaid Individual Taxonomy List

https://www.nd.gov/dhs/info/mmis/docs/mmis-individual-provider-code-taxonomy.pdf

***May Enroll under any of the criteria below.**

Enrollment Criteria
1. Social Work Master's Degree
2. Social Work License + Social Work Bachelor's Degree + Attestation (Option #1 checked)
3. RN License
4. LPN License + Attestation (Option #1 checked)
5. Bachelor's Degree + Attestation (Option #2 checked - Health Educator)
6. High School Diploma + Attestation (Option #3 checked - Case Management Implementer)
7. License Registered Dietician License or Licensed Nutritionist License

Please coordinate with your billing department and any other applicable area to determine the correct enrollment effective date.**The Department will not make changes to that date once the application is approved** and any claims submitted with a date of service prior to the enrollment effective date will deny. A retroactive enrollment effective date is limited to no more than ninety (90) days** prior to the date a **complete** application packet is received by the Department. If the date requested is outside the 90 day timeframe, the enrollment effective date assigned will be 90 days from the date the complete application packet was received.

****If this application is associated with an emergency service, the Department may consider a date more than 90 days prior to the date a complete application packet is received. You must include a copy of the claim and medical records with your application documents.**

☐ **This application is associated with an emergency service. We are requesting the date of _____. Refer to the ** above.**

Enrollment Effective Date			
Printed Name (Requester)		**Date**	

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TCM SMI at Human Service Centers
Individual Application Checklist

Application Tracking #	
Provider Name	

Contact Person	
Phone	
Email	

Check List						**Check**
Attestation*	**Requirements Completed On:**					
Individual NPI		**Enumeration Date:**				
SFN 615 (11-2017)		Signed by the Individual Provider who is applying				

PROVIDER TYPE 017-Other Service Providers

SPECIALTY 335-Case Manager/Care Coordinator

TAXONOMY 171M00000X

ND Medicaid Individual Taxonomy List

https://www.nd.gov/dhs/info/mmis/docs/mmis-individual-provider-code-taxonomy.pdf

***May Enroll under one of the below options. If enrolling before the e-learning modules have been completed, an Attestation showing they have been completed must be submitted within 6 months.**

Enrollment Requires
1. SMI Attestation
OR
2. Submit Attestation within 6 months

Please coordinate with your billing department and any other applicable area to determine the correct enrollment effective date. **The Department will not make changes to that date once the application is approved** and any claims submitted with a date of service prior to the enrollment effective date will deny. A retroactive enrollment effective date is limited to no more than ninety (90) days** prior to the date a **complete** application packet is received by the Department. If the date requested is outside the 90 day timeframe, the enrollment effective date assigned will be 90 days from the date the complete application packet was received.

****If this application is associated with an emergency service, the Department may consider a date more than 90 days prior to the date a complete application packet is received. You must include a copy of the claim and medical records with your application documents.**

☐ **This application is associated with an emergency service. We are requesting the date of _____. Refer to the ** above.**

Enrollment Effective Date			
Printed Name (Requester)		**Date**	

Revision 1/10/2019 JS

TCM SED at Human Service Centers
Individual Application Checklist

Application Tracking #	
Provider Name	

Contact Person	
Phone	
Email	

Check List						**Check**
Wraparound Certificate*	**Issued:**		**Expires:**			
Individual NPI		**Enumeration Date:**				
SFN 615 (11-2017)		Signed by the Individual Provider who is applying				

PROVIDER TYPE	017-Other Service Providers
SPECIALTY	335-Case Manager/Care Coordinator
TAXONOMY	171M00000X

ND Medicaid Individual Taxonomy List

https://www.nd.gov/dhs/info/mmis/docs/mmis-individual-provider-code-taxonomy.pdf

***May Enroll under one of the below options. If enrolling before Wraparound Certificate is issued, Wraparound Certificate must be obtained and submitted within 9 months.**

Enrollment Requires
1. Wraparound Certificate
OR
2. Wraparound Certificate within 9 months

Please coordinate with your billing department and any other applicable area to determine the correct enrollment effective date. **The Department will not make changes to that date once the application is approved** and any claims submitted with a date of service prior to the enrollment effective date will deny. A retroactive enrollment effective date is limited to no more than ninety (90) days** prior to the date a **complete** application packet is received by the Department. If the date requested is outside the 90 day timeframe, the enrollment effective date assigned will be 90 days from the date the complete application packet was received.

****If this application is associated with an emergency service, the Department may consider a date more than 90 days prior to the date a complete application packet is received. You must include a copy of the claim and medical records with your application documents.**

☐ **This application is associated with an emergency service. We are requesting the date of _____. Refer to the* * above.**

Enrollment Effective Date			
Printed Name (Requester)		**Date**	

Revision 1/10/2019 JS

Group Application Checklist
025- Targeted Case Management Group
Type of TCM Services provided (Check all you are enrolling to provide):

☐ Child Welfare ☐Long Term Care ☐ High Risk Pregnant Women & Infants

Application Tracking #	
Provider Name	
Service Location	

Are you enrolling any other service locations at this time? ☐ YES ☐ NO

If yes, please attach a list with the addresses of all service locations being enrolled (must have the same Provider Type, NPI, EIN, and billing address)

Contact Person	
Phone	
Email	

Check List									Check
W-9 (10-2018)	Signed By:								
CP 575/147C*									
Tax Exempt Letter		Required only if group provider is tax exempt							
Attestation**		Issued:		Expires:					
Organizational NPI		Enumeration Date:							
SFN 661 (6-2010)	Signed By:								
Bank Letter/Voided Check									
SFN 509 (10-2018)		Required for Out of State Fee For Service Providers Only - Date of Service must match Claim Submission Effective Date							
Medical Notes		Required for Out of State Fee For Service Providers Only - Date of Service must match Claim Submission Effective Date							
SFN 1168 (6-2018)	Signed By:			Instructions for the SFN 1168					
Do you have any Managing Employees (authorized to sign on behalf of the business) not showing on the SFN 1168?				☐ YES	☐ NO				
List of Board Members/Trustees with dates of birth and SSNs		Required if group is a corporation or non-profit corporation							
SFN 615 (11-2017)	Signed By:								

PROVIDER TYPE	025-Agencies
SPECIALTY	035-Case Management
TAXONOMY	251B00000X

ND Medicaid Group Taxonomy List

http://www.nd.gov/dhs/info/mmis/docs/mmis-group-provider-code-taxonomy.pdf

***The IRS Form CP 575 is an Internal Revenue Service (IRS) generated letter providers receive from the IRS granting their Employer Identification Number (EIN). A copy of your CP 575 is required to verify the provider or supplier's legal business name and EIN. If you are not able to locate the first EIN letter, you can get a 147C letter from the IRS. This is a different type of EIN verification. Call the IRS at 1-800-829-0115 between the hours of 7 a.m. and 7 p.m. in your local time zone. Request a 147C letter when the IRS agent takes your call.**

****Attestation submitted must match the TCM services checked at the top of this checklist. If enrolling to provide more than one type of service, please submit the attestation for each service.**

*****If this application is associated with an emergency service, the Department may consider a date up to 90 days prior to the date a complete application packet is received.**

Please coordinate with your billing department and any other applicable area to determine the correct enrollment effective date. **The Department will not make changes to that date once the application is approved** and any claims submitted with a date of service prior to the enrollment effective date will deny. A retroactive enrollment effective date is limited to no more than ninety (90) days******** prior to the date a **complete** application packet is received by the Department. If the date requested is outside the 90 day timeframe, the enrollment effective date assigned will be 90 days from the date the complete application packet was received.

******If this application is associated with an emergency service, the Department may consider a date more than 90 days prior to the date a complete application packet is received. You must include a copy of the claim and medical records with your application documents.**

☐ **This application is associated with an emergency service. We are requesting the date of _____. Refer to the **** above.**

Enrollment Effective Date			
Printed Name (Requester)		Date	

Revision 1/10/2019 JS

ATTESTATION FOR LONG TERM CARE TARGETED CASE MANAGEMENT SERVICES

_____ _____

Practitioner Name (printed) NPI

Please note that you have requested enrolling as a Case Management individual provider (practitioner); however, Medical Services needs confirmation that you have the appropriate training or background as required by the Medical Services Division policies or Medicaid State Plan requirements.

I have met the following requirements:

(CHECK ALL THAT APPLY):

1. _____ I am a Developmental Disabilities program manager

AND

a. _____ I am a Qualified Intellectual Disabilities Professional (QIDP)

OR

b. _____ I have at least 1 year of experience as a Developmental Disabilities Case Manger in the North Dakota Department of Human Services.

I attest that I met the above requirements on _____ (Month/Day/Year).

_____ _____

Signature of Enrolling Practitioner Date

Provider Facility/Organization to complete:

I attest that the practitioner mentioned above has met the established criteria as indicated above.

_____Provider Facility/Organization Name
_____Street Address
_____City, State, Zip Code

_____ _____

Supervisor Signature Date

_____

Printed Name of Supervisor

Please sign and return by Email to dhsenrollment@nd.gov or by fax to 701-328-1544, Attention: Provider Enrollment

Revision Date 10/19/2018 JAS

ATTESTATION FOR TARGETED CASE MANAGEMENT SERVICES TO HIGH RISK PREGNANT WOMEN AND INFANTS

_____ _____

Practitioner Name (printed) NPI

Please note that you have requested enrolling as a Case Management individual provider (practitioner); however, Medical Services needs confirmation that you have the appropriate training or background as required by the Medical Services Division policies or Medicaid State Plan requirements.

I have met the following requirement:

(CHECK ALL THAT APPLY):

1. _____ I have at least six months of case management experience.

OR

2. _____ I am qualified to practice as a Health Educator and have at least six months of case management experience.

I attest that I met the above requirement on _____(Month/Day/Year).

_____ _____

Signature of Enrolling Practitioner Date

Provider Facility/Organization to complete:

I attest that the practitioner mentioned above has met the established criteria as indicated above.

_____Provider Facility/Organization Name
_____Street Address
_____City, State, Zip Code

_____ _____

Supervisor Signature Date

_____

Printed Name of Supervisor

Please sign and return by Email to dhsenrollment@nd.gov or by fax to 701-328-1544, Attention: Provider Enrollment

Revision Date 10/19/2018 JAS

ATTESTATION FOR TARGETED CASE MANAGEMENT SERVICES FOR HIGH RISK PREGNANT NATIVE AMERICAN WOMEN AND INFANTS

_____ _____

Practitioner Name (printed) NPI

Please note that you have requested enrolling as a Case Management individual provider (practitioner); however, Medical Services needs confirmation that you have the appropriate training or background as required by the Medical Services Division policies or Medicaid State Plan requirements.

I have met the following requirement:

(CHECK ALL THAT APPLY):

1. _____ I have at least six months of case management experience.

OR

2. _____ I am qualified to practice as a Health Educator and have at least six months of case management experience.

OR

3. _____ I am qualified to practice as a Case Management Implementer and have at least six months of case management experience.

I attest that I met the above requirement on _____ (Month/Day/Year).

_____ _____

Signature of Enrolling Practitioner Date

Provider Facility/Organization to complete:

I attest that the practitioner mentioned above has met the established criteria as indicated above.

_____ Provider Facility/Organization Name
_____ Street Address
_____ City, State, Zip Code

_____ _____

Supervisor Signature Date

_____

Printed Name of Supervisor

Please sign and return by Email to dhsenrollment@nd.gov or by fax to 701-328-1544, Attention: Provider Enrollment

Revision Date 10/19/2018 JAS

ATTESTATION FOR TARGETED CASE MANAGEMENT SERVICES TO ADULTS WITH SERIOUS MENTAL ILLNESS

_____ _____

Practitioner Name (printed) NPI

Please note that you have requested enrolling as a Case Management individual provider (practitioner); however, Medical Services needs confirmation that you have the appropriate training or background as required by the Medical Services Division policies or Medicaid State Plan requirements.

I have met the following requirement:

1. _____ I completed the North Dakota Department of Human Services current approved e-learning modules on _____(Month/Day/Year).

I attest that I met the above requirement on _____(Month/Day/Year).

_____ _____

Signature of Enrolling Practitioner Date

Provider Facility/Organization to complete:

I attest that the practitioner mentioned above has met the established criteria as indicated above.

_____Provider Facility/Organization Name
_____Street Address
_____City, State, Zip Code

_____ _____

Supervisor Signature Date

_____

Printed Name of Supervisor

Please sign and return by Email to dhsenrollment@nd.gov or by fax to 701-328-1544, Attention: Provider Enrollment

GROUP PROVIDER ATTESTATION FOR CHILD WELFARE TARGETED CASE MANAGEMENT SERVICES

_____ _____

Provider Name (printed) NPI

Please note that you have requested enrolling as a Case Management provider; however, Medical Services needs confirmation that you have the appropriate training or background as required by the Medical Services Division policies or Medicaid State Plan requirements.

This group provider has met all the following requirements:

(CHECK ALL THAT APPLY):

1. _____ Has in place a training process that will ensure that staff have adequate knowledge relating to children involved in unsafe, crisis, and/or unstable situations.
2. _____ Has the ability to be available 24 hours, 7 days a week to eligible clients who are in need of emergency case management services.
3. _____ All Supervisors of case management staff have a minimum of a bachelor's degree in social work, psychology, sociology, counseling, human development, elementary education, early childhood education, special education, child development and family science, human resource management (human service track), or criminal justice.
4. _____ All Supervisors of case management staff have successfully completed the Department of Human Services approved Wraparound Certification training, or are in "Provisionally Certified" status of successfully completing Wraparound Certification training within twelve months of beginning to provide case management.
5. _____ All Supervisors of case management staff shall maintain Wraparound Certification status through attending a Department of Human Services approved Wraparound Recertification training at least once every two years.

I attest that this provider met the above requirements on _____ (Month/Day/Year).

_____Provider Facility/Organization Name
_____Street Address
_____City, State, Zip Code

_____ _____

Signature of Authorized Representative Date

_____

Printed Name of Authorized Representative

Please sign and return by Email to dhsenrollment@nd.gov or by fax to 701-328-1544, Attention: Provider Enrollment

GROUP PROVIDER ATTESTATION FOR LONG TERM CARE TARGETED CASE MANAGEMENT SERVICES

_____ _____

Provider Name (printed) NPI

Please note that you have requested enrolling as a Case Management provider; however, Medical Services needs confirmation that you have the appropriate training or background as required by the Medical Services Division policies or Medicaid State Plan requirements.

This group provider has met the following requirement:

1. _____ Has sufficient knowledge and experience relating to the availability of alternative long term care services for elderly and disabled persons.

I attest that this provider met the above requirement on _____ (Month/Day/Year).

_____Provider Facility/Organization Name
_____Street Address
_____City, State, Zip Code

_____ _____

Signature of Authorized Representative Date

_____

Printed Name of Authorized Representative

Please sign and return by Email to dhsenrollment@nd.gov or by fax to 701-328-1544, Attention: Provider Enrollment

GROUP PROVIDER ATTESTATION FOR TARGETED CASE MANAGEMENT SERVICES FOR HIGH RISK PREGNANT WOMEN AND INFANTS

_____ _____

Provider Name (printed) NPI

Please note that you have requested enrolling as a Case Management provider; however, Medical Services needs confirmation that you have the appropriate training or background as required by the Medical Services Division policies or Medicaid State Plan requirements.

This group has met all the following requirements:

(CHECK ALL THAT APPLY):

1. _____ This Has at least six months experience in delivering services in a community or home setting.
2. _____ Has the ability to coordinate prenatal care services for clients, develop relationships with health care and other area agencies in the particular geographical area served, experience in assessing the needs of pregnant women and developing case management plans based on the needs of clients and the ability to evaluate an at risk pregnant woman's progress in obtaining appropriate medical care and other needed services.
3. _____ All case management staff supervisors have a minimum of a degree in social work, nursing, education, and have at least three years experience in service delivery and supervision.
4. _____ Has in place a training process that will ensure that staff have adequate knowledge relating to high-risk pregnancy, parenting and other important issues.
5. _____ Has the ability to provide 24 hour, 7 day a week crisis services to eligible clients who are in need of emergency case management services.

I attest that this provider met the above requirements on _____ (Month/Day/Year).

_____Provider Facility/Organization Name
_____Street Address
_____City, State, Zip Code

_____ _____

Signature of Authorized Representative Date

_____

Printed Name of Authorized Representative

Please sign and return by Email to dhsenrollment@nd.gov or by fax to 701-328-1544, Attention: Provider Enrollment

Revision Date 10/19/2018 JAS

GROUP PROVIDER ATTESTATION FOR TARGETED CASE MANAGEMENT SERVICES FOR HIGH RISK PREGNANT NATIVE AMERICAN WOMEN AND INFANTS

_____ _____

Provider Name (printed) NPI

Please note that you have requested enrolling as a Case Management provider; however, Medical Services needs confirmation that you have the appropriate training or background as required by the Medical Services Division policies or Medicaid State Plan requirements.

This group has met all the following requirements:

(CHECK ALL THAT APPLY):

1. _____ Has appropriate staff and programs to meet the cultural needs of Native American at risk pregnant women.
2. _____ Possesses the necessary cultural sensitivity and background knowledge that is specific to the particular geographic area proposed by the provider.
3. _____ Has at least six months experience in delivering services in a community or home setting to high risk pregnant women.
4. _____ Has the ability to coordinate prenatal care services for clients, develop relationships with health care and other area agencies in the particular geographical area served, experience in assessing the needs of pregnant women and developing case management plans based on the needs of clients and the ability to evaluate an at risk pregnant woman's progress in obtaining appropriate medical care and other needed services.
5. _____ All case management staff supervisors have a minimum of a bachelor's degree in social work, nursing, education, and have at least three years experience in service delivery and supervision.
6. _____ Has in place a training process that will ensure that staff have adequate knowledge relating to high-risk pregnancy, parenting, and other important issues.
7. _____ Has the ability to provide 24 hour, 7 day a week crisis services to eligible clients who are in need of emergency case management services.

I attest that this provider met the above requirements on _____ (Month/Day/Year).

_____Provider Facility/Organization Name
_____Street Address
_____City, State, Zip Code

_____ _____

Signature of Authorized Representative Date

_____

Printed Name of Authorized Representative

Please sign and return by Email to dhsenrollment@nd.gov or by fax to 701-328-1544, Attention: Provider Enrollment

Revision Date 10/19/2018 JAS