



# CHILDREN WITH MEDICALLY FRAGILE NEEDS APPLICATION

DEPARTMENT OF HEALTH AND HUMAN SERVICES

MEDICAL SERVICES DIVISION

SFN 394 (2-2025)

Name of Child		Child's Date of Birth		Telephone Number	
Address		City		State	ZIP Code
<b>Green Card:</b>	Green Card Number	Year Issued		<input type="checkbox"/> N/A	
Is child on ND Medicaid? <input type="checkbox"/> No <input type="checkbox"/> Yes-Effective Date:		Primary Physician			
Diagnosis					
Durable Medical Equipment Needed					
Mother's Name		Telephone Number		Work Phone Number	
Address		City		State	ZIP Code
Father's Name		Telephone Number		Work Phone Number	
Address		City		State	ZIP Code

Return Completed Form To:

Children with Medically Fragile Needs  
Dept of Health and Human Services  
600 East Boulevard Ave Dept 325  
Bismarck ND 58505-0250

Toll Free: 1-800-755-2604  
FAX: 1-701-328-1544

**By typing my name below, I am signing this application form electronically. I agree that my electronic signature is the legal equivalent of my handwritten signature. I attest, subject to the penalties of perjury that I am the individual completing this application and that I have provided accurate information.**

Parent/Legal Caretaker Signature	Case Manager of Choice
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**Case Management** is a service within the waiver. Families have the choice as to who they want to complete this service. The following are some examples/possibilities families can look into to complete this service, this is NOT an all-inclusive list. Developmental Disability Program Manager/Human Service Zone Offices/Lutheran Social Services/Medical Home case managers/Easter Seals/anyone who work closely with the family and meets the minimum requirements of the services (for more information and assistance please contact the Program Manager). Providers of this services must be enrolled as a Provider with North Dakota Medicaid.