INDIVIDUAL REQUEST TO BE A QUALIFIED SERVICE PROVIDER / AFC PROVIDER

DEPARTMENT OF HUMAN SERVICES
MEDICAL SERVICES DIVISION / AGING SERVICES
SFN 1605 (12-2021)

FOR OFFICE USE ONLY	
Date Approved	Approved By
☐ Change/Add ☐ New ☐ Renew ☐ Reapply	
ID	Date Closed

Clear Fields

NAME AS ON SOCIAL SECURITY CARD.

Last Name, First Name, MI, Suffix		
Social Security Number	Gender ☐ Male ☐ Female	Date of Birth

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 Qualified Service Provider Number

Current/Previous Provider Number	NPI

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

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

Note: A copy of Government issued identification must be submitted with this form.

Home Location Information (911 Address) - You must inform Medical Services within 14 days of any address changes.

Physical Address			Apartment/Building Number
City	State	ZIP Code	County
Telephone Number	Cell Phone Number		Email Address
Mailing/Billing Address			Apartment/Building Number
City	State	ZIP Code	County

LICENSURE/CERTIFICATION

NOTE: Enter information pertaining to your current licensure and/or certification. The license must be for the state in which services are rendered.

License Number	Licensing Agency	Effective Date	Expiration Date	State
A				
B				

☐ Yes ☐ No Have you ever had your LPN/RN/CNA/PT/OT, etc. license denied, revoked, suspended, restricted, terminated or surrendered? If yes, please provide an explanation.

PROVIDER SPECIALTY INFORMATION

Note: Your specialty is the Service you want to provide.

☐ AFC - Adult Foster Care ☐ AFC - Respite Care ☐ AFC-Extended Personal Care - SFN 576

Do you want to be included on the county's list of available Qualified Service Providers? ☐ Yes ☐ No

Type of Client Served:

☐ Private Pay ☐ Public Pay

Languages Supported (Check all that may apply)

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

Please define your services area by counties served:

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

ELECTRONIC FUNDS TRANSFER/Direct Deposit

This is required if providing for public pay clients. Complete information below and send a voided check or documentation from your financial institution.

I authorize the NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES and the financial institution names 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 ☐ Checking ☐ Savings	
Account Holder's Name			

CLAIMS SUBMISSION

Indicate which of the following will be used to submit claims.

☐ Therap ☐ North Dakota Health Enterprise Portal (on-line billing-MMIS)

QUESTIONS

1. Check last grade completed (check only one)
☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ 11 ☐ 12 ☐ GED ☐ 12+

2. Have you EVER been convicted of a misdemeanor? ☐ Yes ☐ No

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

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

Date	Offense

* Attach additional sheets if necessary.

4. 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. Are you physically/mentally able to provide QSP services yourself?	☐ Yes ☐ No	If no, explain.
6. 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?	☐ Yes ☐ No	If yes, explain.
7. Have you ever stolen or taken property without permission?	☐ Yes ☐ No	If yes, explain.
8. Do you have a contagious/infectious disease?	☐ Yes ☐ No	If yes, explain.

9. Do you take care of anyone over the age of 18 who pays you with their own money or whose family pays for their care? ☐ Yes ☐ No

If yes, how much are you paid for providing this care? _____ Rate ☐ Hour ☐ Day

10. Do you have the basic ability to read, write, and verbally communicate in English? ☐ Yes ☐ No

11. Do you need someone to help you read, write, and verbally communicate in English? ☐ Yes ☐ No NOTE: If yes, additional requirements needed.

12. Are you planning to provide respite care in an Adult Foster Care Facility?	☐ Yes ☐ No	If Yes, what is the name of the foster care facility?
13. 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?	☐ Yes ☐ No	If Yes, explain.
14. Have you ever been disciplined or terminated from an agency that is enrolled as a Qualified Service Provider?	☐ Yes ☐ No ☐ NA	If Yes, explain.
15. If employed as a staff member of an agency enrolled as a Qualified Service Provider, have you ever submitted inaccurate service records, billing information, or documentation?	☐ Yes ☐ No ☐ NA	If Yes, explain.

A YES response will not necessarily restrict you from enrollment as a Qualified Service Provider. Your age, the time of the offense, seriousness and nature of the violation, as well as rehabilitation will be taken into consideration. Please provide an explanation so that we have enough information to make a determination.

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

_____ I agree to study the Fire Safety Fact Sheet, the Carbon Monoxide Fact Sheet, Guidelines for Universal Precautions and Why We Wear Masks that is included in the provider handbook.

_____ I will notify the member/client's case manager or Home and Community Based Services (HCBS) when any of the following occur:

1. Client is not home at the scheduled time for service without notice;
2. Observed change in client's physical, cognitive, emotional, and/or environmental condition;
3. Change in the amount or type of services that may be needed by the client;
4. Possible abuse or exploitation of client; and
5. Other circumstances as agreed upon with HCBS 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 HCBS in compliance investigations/reviews and will provide information in writing upon request.

_____ I will not accept or solicit gifts or money from the client.

_____ I cannot be compensated for services provided to a client who is my child (client) under 18 years of age, or if I have been ordered by the court to provide such care (e.g. guardianship).

_____ I will obey all applicable federal and state laws.

_____ 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 apropriate records.

_____ I have read the "AFC Provider Handbook" and will keep a keep a current copy for my records.

_____ I understand I am a self-employed person, and that I am responsible to pay 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 as these are my responsibility as a self-employed individual.

_____ I agree to not discuss any information, including personal health information, relating to clients with anyone NOT directly associated with the service delivery. I will NOT reveal personal information except as necessary to comply with the law and to deliver services. I understand this includes when others assist with my billing.

_____ I give the North Dakota Department of Human Services permission to check for my name in the Human Service Zone 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 do the work, service, and/or care myself.

_____ I will not charge the Department (HCBS clients) more than I charge my private pay clients.

_____ In the event that I am found guilty of a crime against children, am convicted of a felony or a misdemeanor; or if a child abuse and neglect decision of "services required" has been made, I will immediately notify the Department.

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

_____ I agree to notify the Department of Human Services within 14 days when my physical or mailing address changes.

_____ I will not provide care to any client while under the influence of drugs or alcohol.

_____ I will keep records for each client visit that includes all infromation required by the Department, as outlined in the Qualfied Service Provider Handbook.

_____ **Respite Services Only:** I will not smoke, consume the client's food, or conduct personal business in the AFC home. Use of the client's property is only with the written agreement of the client.

_____ **Respite Services Only:** I will make arrangements for client care when I am unable to provide services as scheduled.

Attached is the required evidence that I meet the standards for Qualified Service Provider and for the Endorsement(s) I seek. The information above is true 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.

A COPY OF A FORM OF OFFICIAL IDENTITY MUST BE SENT WITH THIS FORM.

SIGNATURE

Printed Name	Signature	Date