AGENCY QSP ENROLLMENT
FORM PACKET

This packet contains <u>only</u> the necessary forms to enroll as an Agency QSP. You are required to submit further information with these forms. Please read through the Agency Handbook for further required information.

The following forms are <u>required</u>:

- ✓ SFN 1606 –Agency Request to be a Qualified Service Provider
- ✓ SFN 1168 – Ownership/Controlling Interest and Conviction Information
- ✓ SFN 433 – Child Abuse & Neglect Background Inquiry
  (For agency employees with direct client contact)
- ✓ 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 HCBS. If we receive outdated forms, they will be returned to you**,** <u>delaying your enrollment</u>.

Please check our website (http://www.nd.gov/eforms/) to make sure you have the most recent version of forms. The form number and the date each form was revised can be found at the top left of the form (shown below).


INDIVIDUAL REQUEST TO BE A QUALIFIED SERVICE PROVIDER

If you have questions,
Please call the HCBS Office

1-800-755-2604 or 701-328-4602
(Option 1)

The forms must be **completed with a pen or typed**. Signatures are required. You can email, fax or mail your complete packet to:

Email: DHSHCBS@ND.GOV
Fax: 701-328-4875

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

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AGENCY REQUEST TO BE A QUALIFIED SERVICE PROVIDER

NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES
MEDICAL SERVICES DIVISION
SFN 1606 (12-2018)

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

This application is for a group or a sole proprietorship with an Employer Identification Number (EIN). If you are an individual or a sole proprietorship that does not have an Employer Identification Number, then you must complete the Individual Enrollment Application form.

IDENTIFYING INFORMATION

Group Information

Group Organization Name (DBA)	Years Doing Business Under This Name
Have you ever used a different Doing Business As (DBA) name?	Former DBA Name

IMPORTANT: Your EIN will be linked to your ND provider number. All claims paid to your ND provider number will be submitted as income under your EIN to the Internal Revenue Service (IRS).The EIN must be for the group whose information was given.
NOTE: If the EIN ever changes, you must reapply for a ND provider number.

Is this application due to a change of ownership (CHOW)? ☐ Yes ☐ No	Previous Owner's Provider Number

Tax Reporting Information

Legal Name	EIN	Begin Date	End Date

Current/Previous ND Provider Number

Current and/or Previous Provider Number

Managing Owner/Owners or Managing Employee

1. Have the managing owner/owners or managing employee used any previous names (maiden, aliases) in the past 7 years?
☐ Yes ☐ No If yes, provide previous names below

* Attach additional sheets if necessary.

2. Are there any additional owners, directors, officers, agents, or managing individuals who have been convicted of a misdemeanor, felony, or who are currently on probation? ☐ Yes ☐ No If yes, complete the following:

NAME OF INDIVIDUAL	DATE	LIST OFFENSE/S

* Attach additional sheets if necessary.
Send the court papers for for all felony convictions and any misdemeanors in the past seven years.

3. Are there any owners, directors, officers, agents or managing individuals that are currently on probation? ☐ Yes ☐ No

If you answered yes, you are required to submit evidence of rehabilitation with your application. If this information is not provided, your application cannot be considered.

You are required to notify the Department of any changes to conviction history for any owners, directors, officers, agents or managing indiviudals within your company or organization.

Non-Profit Organization Section

Is the business listed under tax-exempt status? ☐ Yes ☐ No
If yes, please send a copy of your IRS issued exemption.

SERVICE LOCATION, BILLING, AND MAILING INFORMATION

Service Location Information

Physical Address (P.O. Box not accepted)		
Building, Suite Number, etc.	County	
City	State	ZIP Code
Telephone Number and Extension	Fax Number	

Service Location Contact Person

Last Name, First Name, MI	Telephone Number and Extension (include area code)
Position	Cell Phone Number
Email Address	Fax Number

Billing Address (This address is equivalent to your pay to address where your checks will be mailed.)

Is this address the same as the Service Location? ☐ Yes ☐ No **If yes**, skip to the next question; if no, please fill out the billing address information. Is this address the same as the Mailing Address? ☐ Yes ☐ No **If yes**, skip to the next question; if no, please fill out the billing address information.			
Payee Name			
Building, Suite Number, etc.	PO Box / Street Address		
City	State	County	ZIP Code

Billing Location Contact Person

Last Name, First Name, MI	
Position	Fax Number
Email Address	Telephone Number and Extension

Mailing Address (This is the address where bulletins, manuals, reports, updates, etc. will be sent)

Is this mailing address the same as service location? ☐ Yes ☐ No **If yes**, skip to the next question.			
Building, Suite Number, etc.	PO Box / Street Address		
City	State	County	ZIP Code

Mailing Location Contact Person

Last Name, First Name, MI	
Position	Fax Number
Email Address	Telephone Number and Extension

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. Attach copies

Provider Type: Qualified Service Provider

License Information

	License Number	Licensing Agency	Effective Date	Expiration Date	State
A					
B					
C					
D					

Certification Information

	License Number	Licensing Agency	Effective Date	Expiration Date	State
A					
B					
C					
D					

Provider Specialty Information

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

- ☐ Adult Day Care
- ☐ Adult Residential Care
- ☐ Assisted Living Personal Care
- ☐ Attendant Care
- ☐ Case Management
- ☐ Chore (check Chart A in handbook for requirements)
- ☐ Community Transition Service
- ☐ Emergency Response
- ☐ Environmental Modification
- ☐ Extended Personal Care SFN 576
- ☐ Homemaker
- ☐ Home Delivered Meals
- ☐ Non-Medical Transportation - Driver with Vehicle (check Chart A in handbook for requirements)
- ☐ Non-Medical Transportation Escort
- ☐ Nurse Assessment
- ☐ Nurse Education SFN 577
- ☐ Nurse Management
- ☐ Personal Care Unit Rate
- ☐ Respite Care
- ☐ Respite in AFC
- ☐ Snow Removal (check Chart A in handbook for requirements)
- ☐ Specialized Equipment
- ☐ Supervision
- ☐ Supported Employment
- ☐ Transitional Living

If providing **Driver with Vehicle Services**, I, the undersigned QSP Agency, affirm that the vehicle(s) used to provide transportation is/are in good operating order, including the brakes, lights, tires and seatbelts. I understand and agree that the State of North Dakota shall not be liable for any damages which may arise out of or result from the operation of the vehicle.

If employees are providing their own vehicle to transport clients, I agree to maintain a current, signed statement in the employee file attesting to the condition of their vehicle. If an employee will be driving the client's vehicle, the Agency will maintain a signed statement from the client agreeing to the use of their vehicle.

All Agency representatives and employees providing this service are required to maintain a current drivers license and verify with their insurance carrier to ensure current and appropriate coverage for this service. Agencies are <u>not required</u> to submit insurance information to the Department.

I agree to notify the Department if our agency no longer meets the standards for this service.

Provider Signature	Date

SERVICE

Provider Website	Gender Served ☐ Male ☐ Female ☐ Both

Age Served
☐ All ☐ 0-5 years ☐ 6-12 years ☐ 13-17 years ☐ 18-21 years ☐ 22-59 years ☐ 60+ years

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 _____

Service Area

Define your service area by counties served, or by distance from your location:

☐ Adams	☐ Dickey	☐ Hettinger	☐ Mountrail	☐ Sargent	☐ Ward
☐ Barnes	☐ Divide	☐ Kidder	☐ Nelson	☐ Sheridan	☐ Wells
☐ Benson	☐ Dunn	☐ LaMoure	☐ Oliver	☐ Sioux	☐ Williams
☐ Billings	☐ Eddy	☐ Logan	☐ Pembina	☐ Slope	☐ Out-of State
☐ Bottineau	☐ Emmons	☐ McHenry	☐ Pierce	☐ Stark	☐ Within 10 Miles
☐ Bowman	☐ Foster	☐ McIntosh	☐ Ramsey	☐ Steele	☐ Within 25 Miles
☐ Burke	☐ Golden Valley	☐ McKenzie	☐ Ransom	☐ Stutsman	☐ Within 50 Miles
☐ Burleigh	☐ Grand Forks	☐ McLean	☐ Renville	☐ Towner	☐ Within 100 Miles
☐ Cass	☐ Grant	☐ Mercer	☐ Richland	☐ Trail	☐ Within 500 Miles
☐ Cavalier	☐ Griggs	☐ Morton	☐ Rolette	☐ Walsh	☐ Within 999 Miles

Is this location wheelchair accessible?	☐ Yes	☐ No	
Is this location TDD/TTY equipped? If yes, enter number.	☐ Yes	☐ No	TDD/TTY Telephone Number
Does this location provide after-hours services? If yes, enter number.	☐ Yes	☐ No	After-Hours Contact Telephone Number
Do you wish to be excluded from public Provider searches?	☐ Yes	☐ No	

ELECTRONIC FUNDS TRANSFER

Do you wish to participate in Electronic Funds Transfer Payments?
☐ Yes ☐ No If yes, please fill out the EFT information below; if no, your check will be mailed to the billing address listed.

Bank Name		Bank Telephone Number	
Bank Address			
City		State	ZIP Code
Bank Routing Transit Number	Bank Account Number	Account Type ☐ Checking ☐ Savings	
Account Holders Name		Payee Provider's Name	

Submit a voided check or documentation from your financial institution. Include the 09 or 29 digit financial routing number.

CLAIMS SUBMISSION

Indicate which of the following will be used to submit claims: ☐ North Dakota Health Enterprise Portal ☐ Paper

GLOBAL ENDORSEMENT

Indicate category(s) in which Global Endorsement is sought:

☐ Catheter (CA)	☐ Hoyer Lift/Mechanized Bath Chair (Ho)	☐ Suppository (non-prescription) (Su)
☐ Cognitive/Supervision (Co)	☐ Medical gases (oxygen only) (Me)	☐ Ted Stockings (Ts)
☐ Exercise (Ex)	☐ Prosthesis/Orthotics/Adaptive Devices (Pr)	☐ Temperature/Blood Pressure/Respiration Rate/Pulse (Te)

Initial each of the following to indicate your understanding and agreement

_____ The agency will notify the client's case manager or the County Social Service Office when any of the following occur:

1. Client is not home at the scheduled time for service:
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 case manager for specific client(s).

_____ The Agency will adhere to applicable federal and state laws.

_____ The Agency will provide care at a level acceptable to the client and the Department of Human Services.

_____ The Agency cannot be compensated for services provided to a client by the direct care person who is the spouse, parent of child (client) under 18 years of age, or has been ordered by the court to provide such care.

_____ 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 will keep records for each client visit that includes all infromation required by the Department, as outlined in the Qualfied Service Provider Handbook.The Department will request a refund or process adjustments to take back payment made to a provider if the provider does not provide the requested records or keep appropriate records.

_____ The Agency will assure that all employees providing non-medical transportation services meet all the non-medical transportation standards listed in the In-Home Services Qualified Service Providers Handbook.

_____ The Agency will not assign an employee to deliver the service until a completed SFN 433 Abuse form is on file that and states no services required. If a form is returned by the state showing a "services required", I agree to notify the Department immediately and withhold the employee from providing services to our clients. I agree to update the SFN 433 every two years and have a current copy on file.

_____ The Agency will not assign an employee to deliver the service until it is documented and on file that he/she meets all the required standards, printed in the Qualified Service Provider handbook, including any endorsements that may be required for the service. These will be updated every two years and kept in agency personnel files.

_____ The Agency will not assign an employee to provide services in an Adult Foster Care Home until a background check has been completed by the Department.

_____ The Agency will check websites listed in the handbook every two years. Notify HCBS of positive findings, misdemeanors or felonies.

_____ The Agency will assure an infections/contagious self declaration form is on file and updated every two years for staff who provide services to public pay clients.

_____ Agency staff will review the Working Together for Home Fire Safety and Exposing an Invisible Killer Fact Sheet enclosed in the handbook.

_____ The Agency assures that employees who provide services to public pay clients are age 18 and over.

_____ The Agency verifies that they have procedures in place to accurately document the provision of furnished services for public pay clients and that they have trained the individuals furnishing services in their responsibility to report furnished services properly and accurately.

_____ The Agency will maintain records for each client that includes the: (1) name of the client, (2) name of the provider (and employee who performed the task), (3) date of the service, (4) start time and end time (including a.m. and p.m.), (5) units of service, and (6) tasks performed.

_____ The Agency will not assign an employee to provide services to public pay clients if the employee has been found guilty of, pled guilty to, or pled no contest to an offense described in N.D. Administrative Code 75-03-23-07(2)(b)(1).

_____ The Agency will not assign an employee to provide services to public pay clients if the employee has been found guilty of, pled guilty to, or pled no contest to an offense, if the Department has not determined that the individual has been sufficiently rehabilitated as outlined in N. D. Administrative Code 75-03-23-07(2)(b)(2). The Agency must contact the Department for the determination.

continued next page

Initial each of the following to indicate your understanding and agreement (continued)

_____ Agency staff will assist the Department of Human Services in compliance investigations and will provide information in writing upon request.

_____ The Agency assures that staff will no accept gifts of money from the client and will not smoke, consume alcoholic beverages, report to work under the influence of drugs or alcohol, consume the client;s food, conduct personal business in the client's home or use the client's property for personal use.

_____ The Agency assures that staff will not provide services in the client's home unless the client is at home.

_____ I agree to notify the Department of Human Services within 14 days when the agency's physical 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.

SIGNATURE

Printed Name	Title	Date
Signature		

OWNERSHIP/CONTROLLING INTEREST AND CONVICTION INFORMATION

DEPARTMENT OF HUMAN SERVICES
MEDICAL SERVICES DIVISION
SFN 1168 (8-2020)

The Privacy Act of 1974 requires the following information be provided when individuals are requested to disclose their social security numbers. Disclosure of the social security number is mandatory for participation in this program by the Centers for Medicare and Medicaid Services, Department of Health and Human Services. (Citation: 42 CFR 455.104, 455.105, and 455.106) [to participate in the North Dakota Medical Assistance Program (Medicaid) as mandated.] Failure to provide the social security number may result in a delay in processing the application. Disclosure must be made at the time of enrollment or contracting with the Department at time of survey, or within 35 days of a written request from the Department. Any change in ownership shall be reported within 35 days after any change.

I. Identifying Information

The address for corporate entities must include, as applicable, primary business address, every business location, and PO Box address.

Legal Name (Must Match Line 1 of W-9)		Doing Business As (Must match Line 2 of W-9)	
Service Address (required)	City	State	ZIP Code
Mailing Address (required)	City	State	ZIP Code
Billing Address	City	State	ZIP Code
List any PO boxes and corresponding address information associated with this facility			Facility Telephone Number (required)
FAX Number	ND Medicaid Provider Number	NPI Number	E-Mail Address (required)

II. Direct/Indirect Ownership Information - All Owners with 5% or more Ownership - Per CFR 42 CFR 455.436

Any Owner (Individual or Company) with 5% or more Ownership must be listed:
- -Individual as an Owner - List your Social Security Number (SSN) and birth date
- -Company as an Owner - List the Tax Identification Number (TIN) of the company that is an owner
- -No Ownership: The group that is enrolling/enrolled would be considered its own owner and that information should be listed here.
- -For providers enrolled with Medicare and Medicaid, any discrepancies noted in 5% or more ownership will be reported to Medicare.

Name	% Ownership	Relationship	SSN/TIN (required)	Date of Birth (required for individual)
Physical Address (required)		City	State	ZIP Code
Billing Address		City	State	ZIP Code
List Any PO Box Information		City	State	ZIP Code
Name	% Ownership	Relationship	SSN/TIN (required)	Date of Birth (required for individual)
Physical Address (required)		City	State	ZIP Code
Billing Address		City	State	ZIP Code
List Any PO Box Information		City	State	ZIP Code
Name	% Ownership	Relationship	SSN/TIN (required)	Date of Birth (required for individual)
Physical Address (required)		City	State	ZIP Code
Billing Address		City	State	ZIP Code
List Any PO Box Information		City	State	ZIP Code

Additional ownsers attached? ☐ Yes ☐ No

III. Managing Employee/Control Interest - Per CFR 42 CFR 455.436

The following individuals are to be listed here:
- Managing Employees (CFE, CIO, CEO, office manager, PIC, DON, etc.
- Board of Directors Board members are required for corporate entities only)
- Trustee Members
- Personnel Authorized to sign on behalf of the organziation

-Individuals who have signed any legal documents for this application

Name	Title	DOB (required)	SSN (required)	Address	Work Telephone Number

Additional managing employees/persons with controlling interest attached? ☐ Yes ☐ No

IV. Ownership/Controlling Interest Information

A BOX MUST BE CHECKED

Does any person, business or organization with an ownership or controlling interest in the provider listed in Section I have an ownership or controlling interest of five percent (5%) or more in any other Medicaid provider? ☐ Yes ☐ No

Whether the person (individual or corporation) with an ownership or control interest in the disclosing entity (or fiscal agent or managed care entity) is related to another person with ownership or control interest in the disclosing entity as a spouse, parent, child, or sibling; or whether the person (individual or corporation) with an ownership or control interest in any subcontractor in which the disclosing entity (or fiscal agent or managed care entity) has a 5% or more interest in any other disclosing entity, fiscal agent (FA), or managed care entity (MCE).

If yes, indicate the name(s) that have the ownership or controlling interest and include the contact information for the other Provider(s). If additional space is needed, attach a separate document.

Name of Other Disclosing Entity, FA, or MCE	North Dakota Medicaid Provider Number (if applicable)		
Relationship	SSN/TIN (required)	Date of Birth (required for individual)	
Physical Address (required)	City	State	ZIP Code
Billing Address	City	State	ZIP Code
List Any PO Box Information	City	State	ZIP Code

Additional Ownership/Controlling Interest information attached? ☐ Yes ☐ No

V. Conviction Information

Are there any directors, officers, agents, managing employees, or subcontractors of the institution, agency, or organization who have been convicted of or plead guilty to a criminal offense related to programs under Medicare, Medicaid, or Title XX Services Program?

☐ Yes ☐ No **A BOX MUST BE CHECKED**

List the identity of any person who has ownership, controlling interest or is an agent or managing employee in the provider listed Section I and has been convicted of a criminal offense related to that persons involvement in any program under Medicare, Medicaid, or the title XX services program since the inception of those programs.

Name	SSN/TIN (required)	Date of Birth (required for individual)	
Physical Address (required)	City	State	ZIP Code
Billing Address	City	State	ZIP Code
List Any PO Box Information	City	State	ZIP Code

Additional conviction information attached? ☐ Yes ☐ No

VI. Signature

Whoever knowingly and willfully makes or causes to be made a false statement or representation of this statement, may be prosecuted under applicable federal or state laws. In addition, knowingly and willfully failing to fully and accurately disclose the information requested may result in denial of a request to participate or where the entity already participates, a termination of its agreement or contract with the state agency as appropriate. It is the provider's responsibility to ensure all information is accurate and to report any changes as required by law by completing a new SFN 1168 Ownership/Controlling Interest and Conviction Information form.

Name of Authorized Representative (Please Print)	Date of Birth (required)	Social Security Number (required)
Title		
Signature		Date

INSTRUCTIONS FOR COMPLETING DISCLOSURE OF OWNERSHIP/CONTROLLING INTEREST FORM

Completion and submission of this form is a condition of participation, certification, or decertification under any of the programs established by titles XIX, XX, and XXI, or as a condition of approval or renewal of a contractor agreement between the disclosing entity and North Dakota Medicaid. A full and accurate disclosure of ownership and financial interest is required. Failure to submit requested information may result in termination of existing agreements.

General Instructions

For definitions, procedures and requirements, refer to the appropriate 42 Code of Federal Regulations, Subpart B, 455.100 - 455.106:
Title XIX - 42 CFR 455.106
Title XXI - 42 CFR 457.900

Please answer all questions as of the current date. If the yes block for any item is checked, list requested additional information. If additional space is needed, attach an additional sheet. Return the original, and retain a copy for your files.

This form is to be completed when changes occur that alter what is reported on this form or when the provider is required to re-enroll.

Detailed Instructions

These instructions are designed to clarify certain questions on the form. Instructions are listed in question order for easy reference. No instructions have been given for questions considered self-explanatory.

Item I: Identifying Information

Specify in what capacity the entity is doing business as, example, name of the facility or practice. Be sure to list any PO boxes and corresponding address information associated with this facility. Include a separate document if needed.

Item II: Direct/Indirect Ownership Information and Item IV Managing Employee Information

Definitions follow:

Agent means any person who has been delegated the authority to obligate or act on behalf of a provider.

Disclosing entity means a Medicaid provider (other than an individual practitioner or group of practitioners), or a fiscal agent.

Other disclosing entity means any other Medicaid disclosing entity and any entity that does not participate in Medicaid, but is required to disclose certain ownership and control information because of participation in any of the programs established under title V, XVIII, or XX of the Act. This includes: (a) Any hospital, skilled nursing facility, home health agency, independent clinical laboratory, renal disease facility, rural health clinic, or health maintenance organization that participates in Medicare (title XVIII); (b) Any Medicare intermediary or carrier; and (c) Any entity (other than an individual practitioner or group of practitioners) that furnishes, or arranges for the furnishing of, health-related services for which it claims payment under any plan or program established under title V or title XX of the Act.

Fiscal agent means a contractor that processes or pays vendor claims on behalf of the Medicaid agency.

Group of practitioners means two or more health care practitioners who practice their profession at a common location (whether or not they share common facilities, common supporting staff, or common equipment).

Health insuring organization *(HIO)*) means a county operated entity, that in exchange for capitation payments, covers services for beneficiaries (1) Through payments to, or arrangements with, providers; (2) Under a comprehensive risk contract with the State; and (3) Meets the following criteria (i) First became operational prior to January 1, 1986; or (ii) Is described in section 9517(e)(3) of the Omnibus Budget Reconciliation Act of 1985 (as amended by section 4734 of the Omnibus Budget Reconciliation Act of 1990).

Indirect ownership interest means an ownership interest in an entity that has an ownership interest in the disclosing entity. This term includes an ownership interest in any entity that has an indirect ownership interest in the disclosing entity.

Managed care entity *(MCE)* means managed care organizations (MCOs), PIHPs, PAHPs, PCCMs, and HIOs.

Managing employee means a general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operation of an institution, organization, or agency.

Ownership interest means the possession of equity in the capital, the stock, or the profits of the disclosing entity. *Person with an* ***ownership or control interest*** means a person or corporation that(a) Has an ownership interest totaling 5 percent or more in a disclosing entity; (b) Has an indirect ownership interest equal to 5 percent or more in a disclosing entity; (c) Has a combination of direct and indirect ownership interests equal to 5 percent or more in a disclosing entity; (d) Owns an interest of 5 percent or more in any mortgage, deed of trust, note, or other obligation secured by the disclosing entity if that interest equals at least 5 percent of the value of the property or assets of the disclosing entity; (e) Is an officer or director of a disclosing entity that is organized as a corporation; or (f) Is a partner in a disclosing entity that is organized as a partnership. This includes **Board of Directors** and Trustees of Nonprofit and For profit **corporations**, Members of LLC and partners of partnerships and Joint Ventures.

Item III: Managing Employee/Control Interest

Reference the definitions provided in Item III.

Item IV: Ownership/Controlling Interest Information

Ownership interest means the possession of equity in the capital, the stock, or the profits of the disclosing entity. *Person with an* ***ownership or control interest*** means a person or corporation that (a) Has an ownership interest totaling 5 percent or more in a disclosing entity; (b) Has an indirect ownership interest equal to 5 percent or more in a disclosing entity; (c) Has a combination of direct and indirect ownership interests equal to 5 percent or more in a disclosing entity; (d) Owns an interest of 5 percent or more in any mortgage, deed of trust, note, or other obligation secured by the disclosing entity if that interest equals at least 5 percent of the value of the property or assets of the disclosing entity; (e) Is an officer or director of a disclosing entity that is organized as a corporation; or (f) Is a partner in a disclosing entity that is organized as a partnership. This includes **Board of Directors** and Trustees of Nonprofit and For profit **corporations**, Members of LLC and partners of partnerships and Joint Ventures.

Item V: Conviction Information
This section is for exclusion and/or sanction information. Please provide accurate information regarding previous and current exclusions and sanctions. All YES answers require additional documentation in the space provided.

In order for providers to ensure that persons with ownership or control interest in the provider or an agent or managing employee of the provider have not been convicted of a criminal offense specific to the areas cited under VI, they must perform the same screening functions that State Medicaid Agencies are required to perform. Per 42 CFR 455.436- The State Medicaid Agency must do all of the following: (a) confirm the identity and determine the exclusion status of providers and any person with an ownership or control interest or who is an agent or managing employee of the provider through routine checks of Federal databases (b) Check the Social Security Administration's Death Master File, the National Plan and Provider Enumeration System (NPPES), the List of Excluded Individuals/Entities (LEIE), the Excluded Parties List System (EPLS), and any such other databases as the Secretary may prescribe. (c)(1) Consult appropriate databases to confirm identity upon enrollment and reenrollment; and (2) Check the LEIE and EPLS (now known as SAM) no less frequently than monthly.

Item VI: Signature
This section must be signed by an authorized agent of the disclosing entity.

Title 42: Public Health
§455.104 Disclosure by Medicaid providers and fiscal agents: Information on ownership and control.

(a) *Who must provide disclosures.* The Medicaid agency must obtain disclosures from disclosing entities, fiscal agents, and managed care entities.

(b) *What disclosures must be provided.* The Medicaid agency must require that disclosing entities, fiscal agents, and managed care entities provide the following disclosures:(1)(i) The name and address of any person (individual or corporation) with an ownership or control interest in the disclosing entity, fiscal agent, or managed care entity. The address for corporate entities must include as applicable primary business address, every business location, and P.O. Box address.

(ii) Date of birth and Social Security Number (in the case of an individual).

(iii) Other tax identification number (in the case of a corporation) with an ownership or control interest in the disclosing entity (or fiscal agent or managed care entity) or in any subcontractor in which the disclosing entity (or fiscal agent or managed care entity) has a 5 percent or more interest.

(2) Whether the person (individual or corporation) with an ownership or control interest in the disclosing entity (or fiscal agent or managed care entity) is related to another person with ownership or control interest in the disclosing entity as a spouse, parent, child, or sibling; or whether the person (individual or corporation) with an ownership or control interest in any subcontractor in which the disclosing entity (or fiscal agent or managed care entity) has a 5 percent or more interest is related to another person with ownership or control interest in the disclosing entity as a spouse, parent, child, or sibling.

(3) The name of any other disclosing entity (or fiscal agent or managed care entity) in which an owner of the disclosing entity (or fiscal agent or managed care entity) has an ownership or control interest.

(4) The name, address, date of birth, and Social Security Number of any managing employee of the disclosing entity (or fiscal agent or managed care entity).

(c) *When the disclosures must be provided.*

(1) *Disclosures from providers or disclosing entities.* Disclosure from any provider or disclosing entity is due at any of the following times:

(i) Upon the provider or disclosing entity submitting the provider application.

(ii) Upon the provider or disclosing entity executing the provider agreement.

(iii) Upon request of the Medicaid agency during the re-validation of enrollment process under §455.414.

(iv) Within 35 days after any change in ownership of the disclosing entity.

(2) *Disclosures from fiscal agents.* Disclosures from fiscal agents are due at any of the following times:

(i) Upon the fiscal agent submitting the proposal in accordance with the State's procurement process.

(ii) Upon the fiscal agent executing the contract with the State.

(iii) Upon renewal or extension of the contract.

INSTRUCTIONS TO COMPLETE
SFN 433 Child Abuse and Neglect Inquiry Form

This form is required for any employees that will be in direct contact with any HCBS Clients at the time of hire and every two years following.
You are required to submit this form to Children and Family Services (CFS) before you send it to HCBS. This form will not be accepted until it has been completed by CFS.
The form should only be submitted to HCBS once it has been returned to you, signed and dated from CFS.

Part I: Agency/Organization Information

- Agency/Organization Name should NOT contain "HCBS" as the name.
- Agency/Organization Name should contain your agency name.
- The Contact Person & Phone # should be whomever is completing the paperwork at your Agency.
- The address should be your Agency address.
- If you want to receive this form back by email instead of through the US mail, include an email address in this section along with your actual mailing address.

Part II: Authorization for Release of Information

- Employee must check both boxes and **initial** both lines
- Check "other" for "This information is being requested for" After other, write QSP.
- When writing employee name, include FULL LEGAL NAME including the FULL MIDDLE NAME.
- If no middle name, Check the box indicating "None"
- If no former last name within the last 10 years, please make sure to check the box indicating none. This is for males and females.
- Complete all other boxes with employee physical addresses.
- Employee Sign and Date.

- Fax all forms **DIRECTLY TO CFS** @ the fax/email on the bottom of the form. This form **SHOULD NOT** be sent to HCBS until CFS has signed off on it.
- Once you receive the completed, approved form from CFS, forward to HCBS
-
- If this form is returned by CFS and shows a Services Required finding – at any time, you are **REQUIRED** to submit the form to HCBS. HCBS will collect information and determine if the employee can provide services to HCBS Clients. The agency cannot make the determination on their own. If a determination is made without HCBS approval, your agency could be required to pay back any funds paid out that the employee provided. Until a determination is made by HCBS, the employee cannot provide any services to HCBS clients.

Failure to follow the above instructions may result in a delay in your application.

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

☐ Employment with NDDHS ☐ Employment in a NDDHS licensed or contracted agency ☐ Childcare/In-home provider

☐ Adoption study ☐ Foster parent licensing ☐ Private agency employment/volunteer

☒ Other (List): QSP Enrollment

LAST Name	FIRST Name	FULL MIDDLE Name ☐ None ☐ Intial Only	Social Security Number*	Date of Birth

Birth Name, Alias, or Other Married Names You Have Gone by in the Last Ten Years **OR** ☐ 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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Form **W-9**
(Rev. October 2018)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

▶ **Go to *www.irs.gov/FormW9* for instructions and the latest information.**

Give Form to the requester. Do not send to the IRS.

Print or type. See **Specific Instructions** on page 3.

1 Name (as shown on your income tax return). Name is required on this line; do not leave this line blank.

2 Business name/disregarded entity name, if different from above

3 Check appropriate box for federal tax classification of the person whose name is entered on line 1. Check only **one** of the following seven boxes.

☐ Individual/sole proprietor or single-member LLC ☐ C Corporation ☐ S Corporation ☐ Partnership ☐ Trust/estate

☐ Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=Partnership) ▶ _____

Note: Check the appropriate box in the line above for the tax classification of the single-member owner. Do not check LLC if the LLC is classified as a single-member LLC that is disregarded from the owner unless the owner of the LLC is another LLC that is **not** disregarded from the owner for U.S. federal tax purposes. Otherwise, a single-member LLC that is disregarded from the owner should check the appropriate box for the tax classification of its owner.

☐ Other (see instructions) ▶

4 Exemptions (codes apply only to certain entities, not individuals; see instructions on page 3):

Exempt payee code (if any) _____

Exemption from FATCA reporting code (if any) _____

(Applies to accounts maintained outside the U.S.)

5 Address (number, street, and apt. or suite no.) See instructions.

Requester's name and address (optional)

6 City, state, and ZIP code

7 List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on line 1 to avoid backup withholding. For individuals, this is generally your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the instructions for Part I, later. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN,* later.

Note: If the account is in more than one name, see the instructions for line 1. Also see *What Name and Number To Give the Requester* for guidelines on whose number to enter.

Social security number

			–			–				

or

Employer identification number

		–							

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me); and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding; and
3. I am a U.S. citizen or other U.S. person (defined below); and
4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions for Part II, later.

Sign Here **Signature of U.S. person** ▶ **Date** ▶

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Future developments. For the latest information about developments related to Form W-9 and its instructions, such as legislation enacted after they were published, go to *www.irs.gov/FormW9.*

Purpose of Form

An individual or entity (Form W-9 requester) who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) which may be your social security number (SSN), individual taxpayer identification number (ITIN), adoption taxpayer identification number (ATIN), or employer identification number (EIN), to report on an information return the amount paid to you, or other amount reportable on an information return. Examples of information returns include, but are not limited to, the following.

- Form 1099-INT (interest earned or paid)
- Form 1099-DIV (dividends, including those from stocks or mutual funds)
- Form 1099-MISC (various types of income, prizes, awards, or gross proceeds)
- Form 1099-B (stock or mutual fund sales and certain other transactions by brokers)
- Form 1099-S (proceeds from real estate transactions)
- Form 1099-K (merchant card and third party network transactions)
- Form 1098 (home mortgage interest), 1098-E (student loan interest), 1098-T (tuition)
- Form 1099-C (canceled debt)
- Form 1099-A (acquisition or abandonment of secured property)

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN.

If you do not return Form W-9 to the requester with a TIN, you might be subject to backup withholding. See What is backup withholding, *later.*

By signing the filled-out form, you:

1. Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),

2. Certify that you are not subject to backup withholding, or

3. Claim exemption from backup withholding if you are a U.S. exempt payee. If applicable, you are also certifying that as a U.S. person, your allocable share of any partnership income from a U.S. trade or business is not subject to the withholding tax on foreign partners' share of effectively connected income, and

4. Certify that FATCA code(s) entered on this form (if any) indicating that you are exempt from the FATCA reporting, is correct. See *What is FATCA reporting,* later, for further information.

Note: If you are a U.S. person and a requester gives you a form other than Form W-9 to request your TIN, you must use the requester's form if it is substantially similar to this Form W-9.

Definition of a U.S. person. For federal tax purposes, you are considered a U.S. person if you are:

- An individual who is a U.S. citizen or U.S. resident alien;
- A partnership, corporation, company, or association created or organized in the United States or under the laws of the United States;
- An estate (other than a foreign estate); or
- A domestic trust (as defined in Regulations section 301.7701-7).

Special rules for partnerships. Partnerships that conduct a trade or business in the United States are generally required to pay a withholding tax under section 1446 on any foreign partners' share of effectively connected taxable income from such business. Further, in certain cases where a Form W-9 has not been received, the rules under section 1446 require a partnership to presume that a partner is a foreign person, and pay the section 1446 withholding tax. Therefore, if you are a U.S. person that is a partner in a partnership conducting a trade or business in the United States, provide Form W-9 to the partnership to establish your U.S. status and avoid section 1446 withholding on your share of partnership income.

In the cases below, the following person must give Form W-9 to the partnership for purposes of establishing its U.S. status and avoiding withholding on its allocable share of net income from the partnership conducting a trade or business in the United States.

- In the case of a disregarded entity with a U.S. owner, the U.S. owner of the disregarded entity and not the entity;
- In the case of a grantor trust with a U.S. grantor or other U.S. owner, generally, the U.S. grantor or other U.S. owner of the grantor trust and not the trust; and
- In the case of a U.S. trust (other than a grantor trust), the U.S. trust (other than a grantor trust) and not the beneficiaries of the trust.

Foreign person. If you are a foreign person or the U.S. branch of a foreign bank that has elected to be treated as a U.S. person, do not use Form W-9. Instead, use the appropriate Form W-8 or Form 8233 (see Pub. 515, Withholding of Tax on Nonresident Aliens and Foreign Entities).

Nonresident alien who becomes a resident alien. Generally, only a nonresident alien individual may use the terms of a tax treaty to reduce or eliminate U.S. tax on certain types of income. However, most tax treaties contain a provision known as a "saving clause." Exceptions specified in the saving clause may permit an exemption from tax to continue for certain types of income even after the payee has otherwise become a U.S. resident alien for tax purposes.

If you are a U.S. resident alien who is relying on an exception contained in the saving clause of a tax treaty to claim an exemption from U.S. tax on certain types of income, you must attach a statement to Form W-9 that specifies the following five items.

1. The treaty country. Generally, this must be the same treaty under which you claimed exemption from tax as a nonresident alien.

2. The treaty article addressing the income.

3. The article number (or location) in the tax treaty that contains the saving clause and its exceptions.

4. The type and amount of income that qualifies for the exemption from tax.

5. Sufficient facts to justify the exemption from tax under the terms of the treaty article.

Example. Article 20 of the U.S.-China income tax treaty allows an exemption from tax for scholarship income received by a Chinese student temporarily present in the United States. Under U.S. law, this student will become a resident alien for tax purposes if his or her stay in the United States exceeds 5 calendar years. However, paragraph 2 of the first Protocol to the U.S.-China treaty (dated April 30, 1984) allows the provisions of Article 20 to continue to apply even after the Chinese student becomes a resident alien of the United States. A Chinese student who qualifies for this exception (under paragraph 2 of the first protocol) and is relying on this exception to claim an exemption from tax on his or her scholarship or fellowship income would attach to Form W-9 a statement that includes the information described above to support that exemption.

If you are a nonresident alien or a foreign entity, give the requester the appropriate completed Form W-8 or Form 8233.

Backup Withholding

What is backup withholding? Persons making certain payments to you must under certain conditions withhold and pay to the IRS 24% of such payments. This is called "backup withholding." Payments that may be subject to backup withholding include interest, tax-exempt interest, dividends, broker and barter exchange transactions, rents, royalties, nonemployee pay, payments made in settlement of payment card and third party network transactions, and certain payments from fishing boat operators. Real estate transactions are not subject to backup withholding.

You will not be subject to backup withholding on payments you receive if you give the requester your correct TIN, make the proper certifications, and report all your taxable interest and dividends on your tax return.

Payments you receive will be subject to backup withholding if:

1. You do not furnish your TIN to the requester,

2. You do not certify your TIN when required (see the instructions for Part II for details),

3. The IRS tells the requester that you furnished an incorrect TIN,

4. The IRS tells you that you are subject to backup withholding because you did not report all your interest and dividends on your tax return (for reportable interest and dividends only), or

5. You do not certify to the requester that you are not subject to backup withholding under 4 above (for reportable interest and dividend accounts opened after 1983 only).

Certain payees and payments are exempt from backup withholding. See *Exempt payee code,* later, and the separate Instructions for the Requester of Form W-9 for more information.

Also see *Special rules for partnerships,* earlier.

What is FATCA Reporting?

The Foreign Account Tax Compliance Act (FATCA) requires a participating foreign financial institution to report all United States account holders that are specified United States persons. Certain payees are exempt from FATCA reporting. See *Exemption from FATCA reporting code,* later, and the Instructions for the Requester of Form W-9 for more information.

Updating Your Information

You must provide updated information to any person to whom you claimed to be an exempt payee if you are no longer an exempt payee and anticipate receiving reportable payments in the future from this person. For example, you may need to provide updated information if you are a C corporation that elects to be an S corporation, or if you no longer are tax exempt. In addition, you must furnish a new Form W-9 if the name or TIN changes for the account; for example, if the grantor of a grantor trust dies.

Penalties

Failure to furnish TIN. If you fail to furnish your correct TIN to a requester, you are subject to a penalty of $50 for each such failure unless your failure is due to reasonable cause and not to willful neglect.

Civil penalty for false information with respect to withholding. If you make a false statement with no reasonable basis that results in no backup withholding, you are subject to a $500 penalty.

Criminal penalty for falsifying information. Willfully falsifying certifications or affirmations may subject you to criminal penalties including fines and/or imprisonment.

Misuse of TINs. If the requester discloses or uses TINs in violation of federal law, the requester may be subject to civil and criminal penalties.

Specific Instructions

Line 1

You must enter one of the following on this line; **do not** leave this line blank. The name should match the name on your tax return.

If this Form W-9 is for a joint account (other than an account maintained by a foreign financial institution (FFI)), list first, and then circle, the name of the person or entity whose number you entered in Part I of Form W-9. If you are providing Form W-9 to an FFI to document a joint account, each holder of the account that is a U.S. person must provide a Form W-9.

a. **Individual.** Generally, enter the name shown on your tax return. If you have changed your last name without informing the Social Security Administration (SSA) of the name change, enter your first name, the last name as shown on your social security card, and your new last name.

Note: ITIN applicant: Enter your individual name as it was entered on your Form W-7 application, line 1a. This should also be the same as the name you entered on the Form 1040/1040A/1040EZ you filed with your application.

b. **Sole proprietor or single-member LLC.** Enter your individual name as shown on your 1040/1040A/1040EZ on line 1. You may enter your business, trade, or "doing business as" (DBA) name on line 2.

c. **Partnership, LLC that is not a single-member LLC, C corporation, or S corporation.** Enter the entity's name as shown on the entity's tax return on line 1 and any business, trade, or DBA name on line 2.

d. **Other entities.** Enter your name as shown on required U.S. federal tax documents on line 1. This name should match the name shown on the charter or other legal document creating the entity. You may enter any business, trade, or DBA name on line 2.

e. **Disregarded entity.** For U.S. federal tax purposes, an entity that is disregarded as an entity separate from its owner is treated as a "disregarded entity." See Regulations section 301.7701-2(c)(2)(iii). Enter the owner's name on line 1. The name of the entity entered on line 1 should never be a disregarded entity. The name on line 1 should be the name shown on the income tax return on which the income should be reported. For example, if a foreign LLC that is treated as a disregarded entity for U.S. federal tax purposes has a single owner that is a U.S. person, the U.S. owner's name is required to be provided on line 1. If the direct owner of the entity is also a disregarded entity, enter the first owner that is not disregarded for federal tax purposes. Enter the disregarded entity's name on line 2, "Business name/disregarded entity name." If the owner of the disregarded entity is a foreign person, the owner must complete an appropriate Form W-8 instead of a Form W-9. This is the case even if the foreign person has a U.S. TIN.

Line 2

If you have a business name, trade name, DBA name, or disregarded entity name, you may enter it on line 2.

Line 3

Check the appropriate box on line 3 for the U.S. federal tax classification of the person whose name is entered on line 1. Check only one box on line 3.

IF the entity/person on line 1 is a(n) . . .	THEN check the box for . . .
• Corporation	Corporation
• Individual • Sole proprietorship, or • Single-member limited liability company (LLC) owned by an individual and disregarded for U.S. federal tax purposes.	Individual/sole proprietor or single-member LLC
• LLC treated as a partnership for U.S. federal tax purposes, • LLC that has filed Form 8832 or 2553 to be taxed as a corporation, or • LLC that is disregarded as an entity separate from its owner but the owner is another LLC that is not disregarded for U.S. federal tax purposes.	Limited liability company and enter the appropriate tax classification. (P= Partnership; C= C corporation; or S= S corporation)
• Partnership	Partnership
• Trust/estate	Trust/estate

Line 4, Exemptions

If you are exempt from backup withholding and/or FATCA reporting, enter in the appropriate space on line 4 any code(s) that may apply to you.

Exempt payee code.

- Generally, individuals (including sole proprietors) are not exempt from backup withholding.
- Except as provided below, corporations are exempt from backup withholding for certain payments, including interest and dividends.
- Corporations are not exempt from backup withholding for payments made in settlement of payment card or third party network transactions.
- Corporations are not exempt from backup withholding with respect to attorneys' fees or gross proceeds paid to attorneys, and corporations that provide medical or health care services are not exempt with respect to payments reportable on Form 1099-MISC.

The following codes identify payees that are exempt from backup withholding. Enter the appropriate code in the space in line 4.

1—An organization exempt from tax under section 501(a), any IRA, or a custodial account under section 403(b)(7) if the account satisfies the requirements of section 401(f)(2)

2—The United States or any of its agencies or instrumentalities

3—A state, the District of Columbia, a U.S. commonwealth or possession, or any of their political subdivisions or instrumentalities

4—A foreign government or any of its political subdivisions, agencies, or instrumentalities

5—A corporation

6—A dealer in securities or commodities required to register in the United States, the District of Columbia, or a U.S. commonwealth or possession

7—A futures commission merchant registered with the Commodity Futures Trading Commission

8—A real estate investment trust

9—An entity registered at all times during the tax year under the Investment Company Act of 1940

10—A common trust fund operated by a bank under section 584(a)

11—A financial institution

12—A middleman known in the investment community as a nominee or custodian

13—A trust exempt from tax under section 664 or described in section 4947

The following chart shows types of payments that may be exempt from backup withholding. The chart applies to the exempt payees listed above, 1 through 13.

IF the payment is for . . .	THEN the payment is exempt for . . .
Interest and dividend payments	All exempt payees except for 7
Broker transactions	Exempt payees 1 through 4 and 6 through 11 and all C corporations. S corporations must not enter an exempt payee code because they are exempt only for sales of noncovered securities acquired prior to 2012.
Barter exchange transactions and patronage dividends	Exempt payees 1 through 4
Payments over $600 required to be reported and direct sales over $5,000[1]	Generally, exempt payees 1 through 5[2]
Payments made in settlement of payment card or third party network transactions	Exempt payees 1 through 4

[1] See Form 1099-MISC, Miscellaneous Income, and its instructions.

[2] However, the following payments made to a corporation and reportable on Form 1099-MISC are not exempt from backup withholding: medical and health care payments, attorneys' fees, gross proceeds paid to an attorney reportable under section 6045(f), and payments for services paid by a federal executive agency.

Exemption from FATCA reporting code. The following codes identify payees that are exempt from reporting under FATCA. These codes apply to persons submitting this form for accounts maintained outside of the United States by certain foreign financial institutions. Therefore, if you are only submitting this form for an account you hold in the United States, you may leave this field blank. Consult with the person requesting this form if you are uncertain if the financial institution is subject to these requirements. A requester may indicate that a code is not required by providing you with a Form W-9 with "Not Applicable" (or any similar indication) written or printed on the line for a FATCA exemption code.

A—An organization exempt from tax under section 501(a) or any individual retirement plan as defined in section 7701(a)(37)

B—The United States or any of its agencies or instrumentalities

C—A state, the District of Columbia, a U.S. commonwealth or possession, or any of their political subdivisions or instrumentalities

D—A corporation the stock of which is regularly traded on one or more established securities markets, as described in Regulations section 1.1472-1(c)(1)(i)

E—A corporation that is a member of the same expanded affiliated group as a corporation described in Regulations section 1.1472-1(c)(1)(i)

F—A dealer in securities, commodities, or derivative financial instruments (including notional principal contracts, futures, forwards, and options) that is registered as such under the laws of the United States or any state

G—A real estate investment trust

H—A regulated investment company as defined in section 851 or an entity registered at all times during the tax year under the Investment Company Act of 1940

I—A common trust fund as defined in section 584(a)

J—A bank as defined in section 581

K—A broker

L—A trust exempt from tax under section 664 or described in section 4947(a)(1)

M—A tax exempt trust under a section 403(b) plan or section 457(g) plan

Note: You may wish to consult with the financial institution requesting this form to determine whether the FATCA code and/or exempt payee code should be completed.

Line 5

Enter your address (number, street, and apartment or suite number). This is where the requester of this Form W-9 will mail your information returns. If this address differs from the one the requester already has on file, write NEW at the top. If a new address is provided, there is still a chance the old address will be used until the payor changes your address in their records.

Line 6

Enter your city, state, and ZIP code.

Part I. Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. If you are a resident alien and you do not have and are not eligible to get an SSN, your TIN is your IRS individual taxpayer identification number (ITIN). Enter it in the social security number box. If you do not have an ITIN, see *How to get a TIN* below.

If you are a sole proprietor and you have an EIN, you may enter either your SSN or EIN.

If you are a single-member LLC that is disregarded as an entity separate from its owner, enter the owner's SSN (or EIN, if the owner has one). Do not enter the disregarded entity's EIN. If the LLC is classified as a corporation or partnership, enter the entity's EIN.

Note: See *What Name and Number To Give the Requester,* later, for further clarification of name and TIN combinations.

How to get a TIN. If you do not have a TIN, apply for one immediately. To apply for an SSN, get Form SS-5, Application for a Social Security Card, from your local SSA office or get this form online at *www.SSA.gov*. You may also get this form by calling 1-800-772-1213. Use Form W-7, Application for IRS Individual Taxpayer Identification Number, to apply for an ITIN, or Form SS-4, Application for Employer Identification Number, to apply for an EIN. You can apply for an EIN online by accessing the IRS website at *www.irs.gov/Businesses* and clicking on Employer Identification Number (EIN) under Starting a Business. Go to *www.irs.gov/Forms* to view, download, or print Form W-7 and/or Form SS-4. Or, you can go to *www.irs.gov/OrderForms* to place an order and have Form W-7 and/or SS-4 mailed to you within 10 business days.

If you are asked to complete Form W-9 but do not have a TIN, apply for a TIN and write "Applied For" in the space for the TIN, sign and date the form, and give it to the requester. For interest and dividend payments, and certain payments made with respect to readily tradable instruments, generally you will have 60 days to get a TIN and give it to the requester before you are subject to backup withholding on payments. The 60-day rule does not apply to other types of payments. You will be subject to backup withholding on all such payments until you provide your TIN to the requester.

Note: Entering "Applied For" means that you have already applied for a TIN or that you intend to apply for one soon.

Caution: A disregarded U.S. entity that has a foreign owner must use the appropriate Form W-8.

Part II. Certification

To establish to the withholding agent that you are a U.S. person, or resident alien, sign Form W-9. You may be requested to sign by the withholding agent even if item 1, 4, or 5 below indicates otherwise.

For a joint account, only the person whose TIN is shown in Part I should sign (when required). In the case of a disregarded entity, the person identified on line 1 must sign. Exempt payees, see *Exempt payee code,* earlier.

Signature requirements. Complete the certification as indicated in items 1 through 5 below.

1. Interest, dividend, and barter exchange accounts opened before 1984 and broker accounts considered active during 1983. You must give your correct TIN, but you do not have to sign the certification.

2. Interest, dividend, broker, and barter exchange accounts opened after 1983 and broker accounts considered inactive during 1983. You must sign the certification or backup withholding will apply. If you are subject to backup withholding and you are merely providing your correct TIN to the requester, you must cross out item 2 in the certification before signing the form.

3. Real estate transactions. You must sign the certification. You may cross out item 2 of the certification.

4. Other payments. You must give your correct TIN, but you do not have to sign the certification unless you have been notified that you have previously given an incorrect TIN. "Other payments" include payments made in the course of the requester's trade or business for rents, royalties, goods (other than bills for merchandise), medical and health care services (including payments to corporations), payments to a nonemployee for services, payments made in settlement of payment card and third party network transactions, payments to certain fishing boat crew members and fishermen, and gross proceeds paid to attorneys (including payments to corporations).

5. Mortgage interest paid by you, acquisition or abandonment of secured property, cancellation of debt, qualified tuition program payments (under section 529), ABLE accounts (under section 529A), IRA, Coverdell ESA, Archer MSA or HSA contributions or distributions, and pension distributions. You must give your correct TIN, but you do not have to sign the certification.

What Name and Number To Give the Requester

For this type of account:	Give name and SSN of:
1. Individual	The individual
2. Two or more individuals (joint account) other than an account maintained by an FFI	The actual owner of the account or, if combined funds, the first individual on the account[1]
3. Two or more U.S. persons (joint account maintained by an FFI)	Each holder of the account
4. Custodial account of a minor (Uniform Gift to Minors Act)	The minor[2]
5. a. The usual revocable savings trust (grantor is also trustee)	The grantor-trustee[1]
b. So-called trust account that is not a legal or valid trust under state law	The actual owner[1]
6. Sole proprietorship or disregarded entity owned by an individual	The owner[3]
7. Grantor trust filing under Optional Form 1099 Filing Method 1 (see Regulations section 1.671-4(b)(2)(i)(A))	The grantor*
For this type of account:	**Give name and EIN of:**
8. Disregarded entity not owned by an individual	The owner
9. A valid trust, estate, or pension trust	Legal entity[4]
10. Corporation or LLC electing corporate status on Form 8832 or Form 2553	The corporation
11. Association, club, religious, charitable, educational, or other tax-exempt organization	The organization
12. Partnership or multi-member LLC	The partnership
13. A broker or registered nominee	The broker or nominee
14. Account with the Department of Agriculture in the name of a public entity (such as a state or local government, school district, or prison) that receives agricultural program payments	The public entity
15. Grantor trust filing under the Form 1041 Filing Method or the Optional Form 1099 Filing Method 2 (see Regulations section 1.671-4(b)(2)(i)(B))	The trust

[1] List first and circle the name of the person whose number you furnish. If only one person on a joint account has an SSN, that person's number must be furnished.

[2] Circle the minor's name and furnish the minor's SSN.

[3] You must show your individual name and you may also enter your business or DBA name on the "Business name/disregarded entity" name line. You may use either your SSN or EIN (if you have one), but the IRS encourages you to use your SSN.

[4] List first and circle the name of the trust, estate, or pension trust. (Do not furnish the TIN of the personal representative or trustee unless the legal entity itself is not designated in the account title.) Also see *Special rules for partnerships,* earlier.

***Note:** The grantor also must provide a Form W-9 to trustee of trust.

Note: If no name is circled when more than one name is listed, the number will be considered to be that of the first name listed.

Secure Your Tax Records From Identity Theft

Identity theft occurs when someone uses your personal information such as your name, SSN, or other identifying information, without your permission, to commit fraud or other crimes. An identity thief may use your SSN to get a job or may file a tax return using your SSN to receive a refund.

To reduce your risk:

- Protect your SSN,
- Ensure your employer is protecting your SSN, and
- Be careful when choosing a tax preparer.

If your tax records are affected by identity theft and you receive a notice from the IRS, respond right away to the name and phone number printed on the IRS notice or letter.

If your tax records are not currently affected by identity theft but you think you are at risk due to a lost or stolen purse or wallet, questionable credit card activity or credit report, contact the IRS Identity Theft Hotline at 1-800-908-4490 or submit Form 14039.

For more information, see Pub. 5027, Identity Theft Information for Taxpayers.

Victims of identity theft who are experiencing economic harm or a systemic problem, or are seeking help in resolving tax problems that have not been resolved through normal channels, may be eligible for Taxpayer Advocate Service (TAS) assistance. You can reach TAS by calling the TAS toll-free case intake line at 1-877-777-4778 or TTY/TDD 1-800-829-4059.

Protect yourself from suspicious emails or phishing schemes. Phishing is the creation and use of email and websites designed to mimic legitimate business emails and websites. The most common act is sending an email to a user falsely claiming to be an established legitimate enterprise in an attempt to scam the user into surrendering private information that will be used for identity theft.

The IRS does not initiate contacts with taxpayers via emails. Also, the IRS does not request personal detailed information through email or ask taxpayers for the PIN numbers, passwords, or similar secret access information for their credit card, bank, or other financial accounts.

If you receive an unsolicited email claiming to be from the IRS, forward this message to *phishing@irs.gov.* You may also report misuse of the IRS name, logo, or other IRS property to the Treasury Inspector General for Tax Administration (TIGTA) at 1-800-366-4484. You can forward suspicious emails to the Federal Trade Commission at *spam@uce.gov* or report them at *www.ftc.gov/complaint.* You can contact the FTC at *www.ftc.gov/idtheft* or 877-IDTHEFT (877-438-4338). If you have been the victim of identity theft, see *www.IdentityTheft.gov* and Pub. 5027.

Visit *www.irs.gov/IdentityTheft* to learn more about identity theft and how to reduce your risk.

Privacy Act Notice

Section 6109 of the Internal Revenue Code requires you to provide your correct TIN to persons (including federal agencies) who are required to file information returns with the IRS to report interest, dividends, or certain other income paid to you; mortgage interest you paid; the acquisition or abandonment of secured property; the cancellation of debt; or contributions you made to an IRA, Archer MSA, or HSA. The person collecting this form uses the information on the form to file information returns with the IRS, reporting the above information. Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation and to cities, states, the District of Columbia, and U.S. commonwealths and possessions for use in administering their laws. The information also may be disclosed to other countries under a treaty, to federal and state agencies to enforce civil and criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism. You must provide your TIN whether or not you are required to file a tax return. Under section 3406, payers must generally withhold a percentage of taxable interest, dividend, and certain other payments to a payee who does not give a TIN to the payer. Certain penalties may also apply for providing false or fraudulent information.

INSTRUCTIONS TO COMPLETE

SFN 615 – Medicaid Program Provider Agreement

On Page 1:

- Provider – Your agency 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 first and last name
- Title – Your title within agency
- Date – Today's Date
- Provider Signature – Your Signature

****PLEASE SEND ALL FOUR PAGES WITH YOUR APPLICATION.****

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MEDICAID PROGRAM PROVIDER AGREEMENT

NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES
MEDICAL SERVICES DIVISION
SFN 615 (Rev. 6-2020)

Agreement between the North Dakota Department of Human Services, hereinafter referred to as "the Department" and:

Provider:	NPI:	Medicaid Provider Number	
Mailing Address:	City:	State:	ZIP Code:

hereinafter referred to as "Provider".

1. Participation. As a condition to participation in the North Dakota Medicaid Program, the Provider agrees to submit true, accurate and complete claims for payment in the manner prescribed by the Department. The Department agrees to pay the Provider for services rendered to persons who are eligible for such services under the rules and regulations for the North Dakota Medicaid Program with payment to be in accordance with the payment structure established by the Department and other programs for which payments are made through the same system.

I wish to participate in (check all that apply):

☐ Medicaid Fee For Service ☐ PACE ☐ Medicaid Expansion MCO (Sanford Health Plan)

Selecting any of the above managed care organization (MCO) boxes (PACE or Sanford Health Plan) does not automatically enroll a provider to render or bill services for the MCO. As all benefits and claims are administrated by the MCO, in order to provide and bill these MCO services, all providers must be contracted directly with the applicable MCO.

2. Compliance. As a condition to participation in the North Dakota Medicaid Program, the Provider agrees that it will comply with all applicable provisions of statute, rules, and federal regulations governing the providing of healthcare and reimbursement of services and items under Medicaid in North Dakota, including the current applicable Medicaid Provider Handbook and any instructions contained in provider information releases or other program notices. The Provider specifically agrees that it is required to comply with:

Title VI of the Civil Rights Act of 1964 (P.L. 88-352) and all requirements imposed thereunder by regulation of the Department of Health and Human Services (45 CFR Part 80) to the end that no person shall on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the provider receives federal financial participation from the state agency; and hereby gives assurance that it will immediately take any measures necessary to effectuate this agreement;

The Health Insurance Portability and Accountability Act of 1996, 45 CFR parts 160 and 164;
The Age Discrimination Act of 1975, 45 CFR parts 90 and 91;
The Americans with Disabilities Act of 1990, 42 USC section 1201 et. seq.;
The North Dakota Human Rights Act of 1983, NDCC Chapter 14-02.4;
The Social Security Act, section 1902(a)68);

Section 504 of the Rehabilitation Act of 1973 as amended, to the end that no otherwise qualified disabled individual shall, solely by reason of his or her disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal financial participation; and

Sections 3, 8, 9, and 15 of the Medicare-Medicaid Anti-Fraud and Abuse Amendments of 1977 (P.L. 95-142) and all requirements imposed there under by regulations of the Department of Health and Human Services (42 CFR Parts 431 and 455) including but not limited to, the maintenance and disclosure of records identifying those persons holding an ownership or control interest in the provider.

3. Contact. The Provider must advise the Department of its current address or change in ownership. The address must include a physical street address. If a P.O. Box is used, the owner's home address and phone number must be included. All Medicaid correspondence shall be sent to the mailing address on file with the Department and shall be deemed to be received by the Provider.

4. Professionalism. The Provider agrees to be licensed, certified, or registered with the appropriate State authority and to provide items and services in accordance with statute, rules, and professionally recognized standards by qualified staff or professionally-supervised paraprofessionals where their use is authorized. The Provider agrees to screen all employees and contractors to determine whether any of them have been excluded. Compliance with this obligation is a condition of enrollment. The Provider needs to immediately report any exclusion information discovered to the Department.

5. Recordkeeping. The Provider agrees to document each item or service for which Medicaid reimbursement is claimed, at the time it is provided, in compliance with documentation requirements of the Department, applicable rules, and this agreement.

(Continued next page...)

Such records shall be maintained according to the Medical Services Division Media Formats policy for at least seven years after the date of service or as required by rule. Upon reasonable request, the Department, the U.S. Department of Health and Human Services (DHHS) or their agencies, shall be given immediate access to, and permitted to review and copy all records relied on by the Provider in support of services billed to Medicaid. Copies will be furnished at the Provider's expense. The Provider agrees to follow all applicable state and federal laws and regulations related to maintaining confidentiality of records.

6. Accurate Billing. The Provider agrees to certify by the signature of the Provider or designee, including electronic signatures on a claim form or transmittal document, that the items or services claimed were actually provided and medically necessary, were documented at the time they were provided, were provided in accordance with professionally recognized standards of healthcare, applicable Department rules, this agreement, and are not billed in excess of the Provider's usual and customary fees. The Provider shall be solely responsible for the accuracy of claims submitted, and shall immediately repay the Department for any items or services the Department, the federal government, duly authorized representatives or the provider determines were not properly provided, documented, or claimed. The Provider must assure it is not submitting a duplicate claim under another program or provider type.

The Provider agrees that all original claims for service must be received by the Department within twelve months from the date the service was provided. The Provider agrees that all requests for adjustments of an adjudicated claim must be received by the Department within 12 months of the remittance advice date of the adjudicated claim. The Provider agrees that claims not submitted for payment within these timeframes may not be billed to the client.

7. Overpayment. The Provider agrees that in any event it receives payment for services or goods in an amount in excess of payment permitted by the Department, that such overpayments may be deducted from future payments otherwise payable to the Provider. The Provider acknowledges that such remedy is not the only or exclusive remedy available to the Department. It is the Provider's responsibility to inform the Department of any Medicaid overpayments discovered.

8. Secondary Payer. The Provider acknowledges that Medicaid is a secondary payer and agrees to first seek payment from other sources as required by statute, rule, or regulation.

9. Full Payment. The Provider agrees to accept Medicaid payment for any item or service as payment in full and agrees to make no additional charge. The Provider further agrees:

If Medicaid requires a prior authorization, screening, or an assessment before the item or service is provided, the Provider may not bill Medicaid or the client when any of the before mentioned items were not submitted in a timely manner;

Not to bill the client unless the item or service is not covered or approved for payment by the Department and the client has agreed to be responsible for payment prior to receiving the item or service.

If a third party pays the client, the client may be billed for that amount, and Medicaid may not be billed. The Provider agrees not to bill Medicaid or the client if a third party payment is made to the provider unless the third party payment is less than the amount Medicaid would pay. The Provider shall not refuse to furnish services on account of a third party's potential liability for the services. (42 CFR § 447.20)

To sign up for and receive electronic funds transfers from the Department for their Medicaid payments. Any provider exempt from this requirement will have it noted on their provider checklists.

10. Ownership. The Provider agrees to comply with the disclosure of ownership requirements of 42 CFR Part 455, Subpart B and to notify the Department thirty (30) days prior to any change of ownership. This Provider agreement is nontransferrable. The Provider agrees to provide the Department with the information described below:

a. The name and address of each person directly or indirectly owning a five percent or more interest in theProvider's business;
b. Whether any of the persons identified in are related as spouse, parent, child, or sibling; and
c. The name of any other Medicaid provider entity in which a person identified in has indirect or direct ownership of five percent or more.

The provider agrees to furnish to the Department, or the US Dept of Health & Human Services or their agencies on request, disclosure by providers of 42 CFR § 455.105 information related to business transactions in accordance with paragraph (b) of the section below.

"(b) *Information that must be submitted.* A provider must submit, within 35 days of the date on a request by the Secretary or the Medicaid agency, full and complete information about:

(1) The ownership of any subcontractor with whom the provider has had business transactions totaling more than $25,000 during the 12-month period ending on the date of the request; and
(2) Any significant business transactions between the provider and any wholly owned supplier, or between the provider and any subcontractor, during the 5-year period ending on the date of the request.

11. Advance Directives. The Provider agrees to maintain written policies and procedures with respect to all adult individuals receiving care; to provide written information to each such individual regarding the individuals rights to make decisions concerning such care, including the right to accept or refuse medical or surgical treatment, the individuals right to formulate

(Continued next page...)

advance directives, and the Provider's written policies respecting the implementation of those rights; to document in the individuals medical record whether or not the individual has executed an advance directive; not to condition the provision of care or otherwise discriminate against an individual based on whether or not the individual has executed an advance directive; to ensure compliance with state law respecting advance directives; and to provide for education for staff and the community on issues concerning advance directives. "Advance directive" means a written instruction, such as a living will prepared in accordance with N.D.C.C. Chapter 23-06.4 or a durable power of attorney for health care prepared in accordance with N.D.C. C. Chapter 23-06.5, relating to the provision of such care when the individual is incapacitated. The written information must be provided at the time of the individual's admission to a hospital; in advance of the individual coming under the care of the Provider, in the case of home health care; at the time of initial receipt of hospice care by the individual from the program if a hospice program and; at the time of enrollment of the individual with the organization if a health maintenance organization.

12. Provider Screening. Provider screening. All current providers and providers applying to participate in the Medicaid program agree to screen their employees and contractors per Federal Regulations under 42 CFR 455.436. To ensure that employees and contractors meet program standards and are not excluded as an individual or an entity, the provider will:

- Upon hire:
  - Confirm the identity of the employee or contractor and determine their exclusion status
  - Search the HHS-OIG website by names of any individual or entity
  - Immediately report an exclusion information discovered to the Department
- Ongoing:
  - Continue to screen employees/contractors on a routine basis and immediately report any findings to the Department.

Civil monetary penalties may be imposed against Medicaid providers and managed care entities (MCEs) who employ or enter into contracts with excluded individuals or entities to provide items or services to Medicaid recipients. (Section 1128A(a)(6) of the Act; and 42 CFR section 1003.102(a)(2)).

13. Enrollment. The Provider agrees that each individual provider performing services (except those services performed under the direct or general supervision of an enrolled provider) must be individually enrolled as a provider and that if individual providers within a group fail to enroll separately, payment to the group for services rendered to a Medicaid recipient by the non-enrolled provider will be denied or, if paid in error, recovered.

As a condition of enrollment, the provider must consent to a criminal background check including fingerprinting when required to do so under State law or by the level of screening based on risk of fraud, waste or abuse as determined for that category of provider.

The Provider agrees that if the enrollment date precedes the effective date of this agreement that all terms and conditions of this agreement apply to the period between the enrollment date and the effective date.

14. Duration and Termination of Agreement. This Agreement shall remain in effect until terminated in writing except the Department may terminate this agreement without notice if no service has been rendered by the Provider within two (2) calendar years. In the event of termination by the Department, the Departments sole obligation shall be to pay for services provided prior to the effective date of termination. This agreement may be terminated by either party without cause by giving thirty (30) days notice in writing to the other party.

This Agreement shall be terminated immediately and without notice if the Provider's license or certification required by law is suspended, not renewed, denied, or is otherwise not in effect at the time service is provided.

The Department may immediately terminate this Agreement in writing when the Provider fails to comply with any applicable statute, rule, regulation, term or provision of this Agreement. The Provider also understands and agrees that its conduct may be subject to additional penalties or sanctions. The Provider further understands that there are federal penalties for false reporting and fraudulent acts committed during the course and scope of this Agreement.

15. Certification. By signing this Agreement, the Provider certifies that neither the Provider nor its principles, are presently debarred, declared ineligible, or voluntarily excluded from participation in transactions with the State or Federal Government by any Department Agency of the Federal Government or the State of North Dakota.

16. Effective Date of Agreement. This Agreement is effective when signed by both the Provider and the Department. It supersedes all prior agreements. Any variation to the effective date must be approved by the Department.

I have read this Agreement, understand it, and agree to abide by its terms and conditions. I also agree that violation of any of the terms or conditions of this agreement constitute sufficient grounds for termination of this agreement and may be grounds for other action.

Provider Name	Title	Date
Provider Signature		

STATE OFFICE USE ONLY

Medical Services Director or Designee	Date

Forms can be found on the website nd.gov

- SFN **1606** - Agency Request to be a Qualified Service Provider
  https://apps.nd.gov/itd/recmgmt/rm/stFrm/eforms/Doc/sfn01606.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.

Agency Qualified Service Provider Handbook link:
http://www.nd.gov/dhs/services/adultsaging/providers.html