NORTH DAKOTA FAMILY CAREGIVER SUPPORT PROGRAM (FCSP) PROVIDER AGREEMENT

DEPARTMENT OF HEALTH AND HUMAN SERVICES
AGING SERVICES
SFN 128 (3-2023)

Clear Fields

SECTION 1. CONTACT INFORMATION (Indicate the type of provider)

☐ Family Member ☐ Qualified Service Provider (QSP) ☐ Agency	QSP Number (if applicable)	Start Date	End Date
Individual/Agency Legal Name	Agency Contact Person		
Address	City	State	ZIP Code
Email Address	Telephone Number	Cell Phone Number	

SECTION 2. SERVICE AND REIMBURSEMENT RATE (Indicate service(s) to be provided and hourly/daily rate)

☐ Respite Care-Hourly Rate	(Maximum payment per hour cannot exceed the current maximum Medicaid Qualified Service Provider rate.)	$
☐ Respite Care - Daily Rate	(Maximum payment for overnight/24-hour care cannot exceed the current swingbed rate.)	$
☐ Individual Caregiver Training		$
☐ Individual/Family Counseling		$

SECTION 3. LIST OF ELIGIBLE PROVIDERS

Do you want to be on the regional list of available FCSP providers that is given to clients? Provider names will remain on the list through the effective dates of this Agreement. ☐ Yes ☐ No

SECTION 4. BILLING PROCEDURES

- Submit a completed "Substitute IRS Form W-9" (SFN 53656) to the Department of Human Services Regional Human Service Center. A Substitute IRS Form only needs to be submitted once.
- Submit a completed North Dakota Family Caregiver Support Program (FCSP) Provider Service Log (SFN 135 or SFN 492) for each FCSP client you serve during the billing period to the Department of Human Services Regional Human Service Center for payment.
- **Provider Service Logs must be submitted for payment by the 5th day of the month following the month services were provided.**
- Provider Service Logs submitted more than ninety days following the expiration of this agreement will not be reimbursed.

SECTION 5. PROGRAM PARTICIPANTS REQUIREMENTS

I will notify Aging Services Staff when possible abuse or exploitation of the client occurs.

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

I understand that I am a self-employed person and that I am responsible to pay self-employment taxes and estimated tax on payments received. I understand that the Department will not withhold or pay any social security, federal, or state income tax, unemployment insurance, or worker's compensation insurance premiums from the payments I receive. These are my responsibilities as a self-employed individual.

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

I understand that the Department of Human Services may require an individual/agency to pay back FCSP funds that were received by the provider as the result of an overpayment, false claim or any other manner of inappropriate billing.

I agree to assist the Department of Human Services in compliance investigations/reviews and will provide information in writing upon request.

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SECTION 5. PROGRAM PARTICIPANTS REQUIREMENTS (cont)

I will keep records for each client visit that show the provider name, caregiver name, date of service, start time and end time, and tasks performed during that time.

I will provide records to the Department of Human Services upon request. The Department can request a refund to take back payment made to a provider if the provider does not provide the requested records or keep appropriate records. The records must be retained for a period of 75 months.

I will obey all applicable federal and state laws.

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

I will not smoke, consume alcoholic beverages or report for work under the influence of drugs or alcohol.

The parties stipulate that this agreement may be terminated at any time upon the giving of written notice to the other party.

I understand services cannot be provided until Aging Services Staff have approved this agreement and returned a copy to me.

Type Initial Here

_____ I understand and agree with the above requirements for participation in the FCSP.

Please sign or type your name below. By typing my name below, I am signing this application form electronically. I agree that my electronic signature is the legal equivalent of my handwritten signature.

SECTION 6. SIGNATURES

Signature	Date
Approved	Date

SECTION 7. NON MEDICAL TRANSPORTATION (qualified family members and FSCP only QSP's)

Qualified family members or QSP's enrolled to provide services **ONLY** to FCSP caregivers willing to provide non-medical transportation must sign below.

If providing Non-Medical Transportation - Driver with Vehicle Services, I, the undersigned applicant (driver/QSP), affirm that the vehicle used to provide transportation is in good operating order, including the brakes, lights, tires and seat belts. I understand and agree that the State of North Dakota shall not be liable for any damages that may arise out of or resulting from operating my vehicle.

I will verify with my insurance carrier that my insurance coverage is current and appropriate for the services I am providing. I am not required to submit proof of insurance to the Department.

I will maintain a current drivers license with the ND Department of Transportation. I understand that if this information is not current, I may not be paid for providing this service to clients.

I agree to notify the Department if my driving record changes and I no longer meet the standards for this service.

Please sign or type your name below. By typing my name below, I am signing this application form electronically. I agree that my electronic signature is the legal equivalent of my handwritten signature.

Provider Signature	Date

DISTRIBUTION: **Original** - Human Service Center **Copy** - Provider