CAREGIVER OPTION PLAN-FAMILY CAREGIVER SUPPORT PROGRAM (FCSP)

NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES
AGING SERVICES DIVISION
SFN 165 (11-2017)

Clear Fields

Name		Start Date	End Date
Residential Address		County	Region
City		Cell Phone Number	
ZIP Code	Telephone Number	Email Address	

SECTION 1: AUTHORIZED PROVIDERS

SERVICE	SERVICE PROVIDER	RATE
1. Respite Care Providers		$
		$
		$
		$
		$
		$
2. Training		$
3. Counseling		$

SECTION 2: AUTHORIZED SERVICES

TIME FRAME AUTHORIZED	RESPITE CARE	SUPPLEMENTAL	TRAINING/COUNSELING
Initial Authorization			
From/To			
First Review-Authorized By			
From/To			
Second Review-Authorized By			
From/To			
Third Review-Authorized By			
From/To			
Expected Outcome			

SECTION 3: INITIAL EACH OF THE FOLLOWING TO INDICATE UNDERSTANDING AND AGREEMENT

_____ I have made an independent choice of service provider(s). I understand that services provided by unauthorized service providers will not be reimbursed by Aging Services.

_____ I understand that any unauthorized expenditures for services will not be reimbursed by Aging Services.

_____ I understand the Caregiver Option Plan is reviewed at least quarterly and authorized funding may be increased or reduced based on my use of services and on FCSP funds available.

_____ I understand that any service dollars not used within the quarter will not carry forward to the next quarter; a new allocation will be established based on usage.

_____ I understand the Caregiver Option Plan may be terminated if I have not used any program services during the review period and I would need to reapply for services.

_____ I understand that I am not eligible to receive services through the FCSP if I or the person I am caring for is eligible to receive services from a State or Federal Home and Community Based Services program, or if I am being paid privately to provide care.

_____ I understand that Aging Services must be notified of any change in my caregiving circumstance to avoid the possibility of recoupment of funds by Aging Services.

_____ I understand that in the event the FCSP paid for services during a time when I was not eligible to be enrolled in the program, I will be required to pay back the amount of services I received when I was considered eligible.

_____ I am aware that all Older American Act clients are provided the opportunity to contribute toward the cost of services received. I have been provided with a self-addressed envelope in which to make a confidential contribution. I understand that no client is denied service due to his or her inability or unwillingness to contribute.

_____ I am in agreement with the services listed above. I am aware of my right to file a grievance by writing to:
Director, Aging Services Division
1237 West Divide Avenue, Suite 6
Bismarck, ND 58501

Caregiver Signature	Date
Aging Services Division Signature	Date

DISTRIBUTION: **Original** - FCSP File **Copy**- Caregiver