INDIVIDUAL REQUEST TO BE A QUALIFIED SERVICE PROVIDER FOR RESPITE SERVICES

DEPARTMENT OF HEALTH AND HUMAN SERVICES
ADULT AND AGING SERVICES/NDFCSP
SFN 175 (7-2024)

Clear Fields

FOR OFFICE USE ONLY	
Date Approved	Approved By
☐ New ☐ Renew	Provider Number
Date Closed	Region

*** Disclosure of the Social Security number is required pursuant to 26 CFR 301.6109-1 and is requested for the purpose of reporting tax information. Failure to disclose this information results in $50 penalty under 26 CFR 301.6723-1 unless it is due to reasonable cause and not willful neglect**

NAME AS ON SOCIAL SECURITY CARD

Last Name, First Name, MI, Suffix	Gender ☐ Male ☐ Female	Date of Birth
Can information about date-of-birth and gender be available to clients? ☐ Yes ☐ No	* Social Security Number	

NOTE: Your Social Security number will be linked to your North Dakota provider number. All claims paid to your North Dakota provider number will be submitted as income under your Social Security number to the IRS.

Current/Previous Provider Number (if applicable)

Current Provider Number

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

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

Note: A copy of a form of official identity must be sent to the Department.

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

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

If you have not lived in ND in the past 7 years, list all previous addresses for the past 7 years. Attach extra sheets as needed.

Physical Address			Apartment/Building Number
City	State	ZIP Code	County

LICENSURE / CERTIFICATION

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

License Information

License Number	Licensing Agency	Effective Date	Expiration Date	State
A				
A				

Have you ever had your LPN/RN/CNA/PT/OT, etc., license denied, revoked, suspended, restricted, terminated or surrendered?
☐ Yes-Explain below: ☐ No

Provider Specialty Information

Respite Care - Requires Cognitive Endorsement

☐ Respite Care

Additional forms are required for the following services, call 1-855-462-5465. You will NOT be enrolled for these services unless the required documentation is sent.

☐ Respite Home ☐ Respite in Adult Foster Care

Do you want to be on the NDFCSP regional list of available Qualified Service Providers? ☐ Yes ☐ No

Languages Supported (check all that may apply)

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

Define your service area by counties served

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

GLOBAL ENDORSEMENT

Indicate category(ies) in which Global Endorsement is sought: (Cognitive/Supervision required for NDFCSP)

☐ 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)

QUESTIONS

1. Last Grade Completed (check only one)

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ 11 ☐ 12 ☐ 12+ ☐ GED

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

If yes, complete the following. **Send the court papers for all ND misdemeanor convictions over the past seven years and all out-of-state convictions.**

Date	Offense

** Attach additional sheets if necessary.*

Are you on probation? ☐ Yes ☐ No **If you answered yes, you are required to read the following statement and initial.**

I understand that if I am currently on probation, the Department is unable to consider my application unless evidence of rehabilitation is submitted with my application. _____ *(Initials Required)*

You are required to notify the Department of any changes to your conviction history.

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

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

Date	Offense

** Attach additional sheets if necessary.*

Are you on probation? ☐ Yes ☐ No **If you answered yes, you are required to read the following statement and initial.**

I understand that if I am currently on probation, the Department is unable to consider my application unless evidence of rehabilitation is submitted with my application. _____ *(Initials Required)*

You are required to notify the Department of any changes to your conviction history.

4. Have you ever been found guilty of abuse or neglect or had services required as a result of a child abuse/neglect report or assessment? ☐ Yes ☐ No	If Yes, Explain
5. Have you ever stolen or taken property without permission? ☐ Yes ☐ No	If Yes, Explain
6. Do you have a contagious/infectious disease? ☐ Yes ☐ No	If Yes, Explain
7. I am physically and mentally able to provide QSP services. ☐ Yes ☐ No	If No, Explain

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

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

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

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

11. Are you planning to provide respite care in an adult foster care home? ☐ Yes ☐ No	If Yes, Name of Foster Care Home
12. Have you ever had your qualified service provider status or license (AFC, early childhood program license, self-declaration document, etc.) issued by the Department denied, revoked, suspended, restricted, or terminated? ☐ Yes ☐ No	If Yes, Explain
13. Have you ever been disciplined or terminated from an agency that is enrolled as a Qualified Service Provider? ☐ Yes ☐ No ☐ NA	If Yes, Explain
14. If employed as a staff member of an agency enrolled as a Qualified Service Provider, have you ever submitted inaccurate service records, billing information, or documentation? ☐ Yes ☐ No ☐ NA	If Yes, Explain

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

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

_____ I will notify the Regional Aging Services Program Administrator (RASPA) 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 RASPA for specific client(s).

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

_____ I will provide care at a level acceptable to the family member and the Department.

_____ I will make arrangements with the client for care when I am unable to provide services as scheduled.

_____ I agree to assist the Department in compliance investigations and will provide information in writing upon request.

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

_____ I will not take children or other family members into the member/client's home.

_____ I will not smoke, consume alcoholic beverages, report for work under the influence of drugs or alcohol, consume the client's food, or conduct personal business in the client's home. Use of the client's property which is not for the benefit of the client is only with a written agreement from the client.

_____ I will obey all applicable federal and state laws.

_____ I will keep provider journals for a period of 75 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 appropriate records.

_____ I have read the "North Dakota Family Caregiver Support Program Provider Handbook" and will keep a current copy for my records.

_____ I will keep records for each client visit that show the name of the client, name of the provider, start time and end time (including a.m. and p.m.), the date of service, and tasks performed during that time.

_____ I understand I am a self-employed person, and that I am responsible to pay self-employment taxes and estimated tax on Qualified Service Provider (QSP) payments. I understand that the Department will not withhold or pay any social security, federal, or state income tax, unemployment insurance, or worker's compensation insurance premiums from the payments I receive as a QSP as these are my responsibility as a self-employed individual.

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

_____ I give the North Dakota Department of Health and Human Services permission to check for my name in the county child abuse and neglect files and the North Dakota Child Abuse and Neglect Information Index. I further consent that the information on the North Dakota Child Abuse and Neglect Information Index can be shared with the Adult and Aging Services Staff.

_____ I agree to perform the work, service, and/or care myself.

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

_____ I will not provide services in the client's home unless the client is home.

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

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

_____ I agree to notify the Department within 14 days when my physical address changes.

Attached is the required evidence that I meet the standards for Qualified Service Provider and for the Endorsement(s) I seek. The information above is true and correct to the best of my knowledge. Providing false information may be the basis for the North Dakota Department of Health and Human Services refusing or revoking any qualified service provider agreements.

THIS IS A PUBLIC DOCUMENT AND WILL BE MADE AVAILABLE TO THE PUBLIC UPON REQUEST WITH THE EXCEPTION OF ANY INFORMATION THAT IS CONSIDERED CONFIDENTIAL.

SIGNATURE

Printed Name	Signature	Date

A COPY OF A FORM OF OFFICIAL IDENTITY MUST BE INCLUDED WITH THIS FORM TO BE APPROVED.