LIFESPAN RESPITE CARE GRANT RESPITE PROVIDER AGREEMENT

DEPARTMENT OF HEALTH AND HUMAN SERVICES
AGING SERVICES
SFN 559 (1-2023)

Clear Fields

SECTION 1. PROVIDER/AGENCY INFORMATION

Individual/Agency Legal Name		Start Date	End Date
Agency Contact Person			
Address	City	State	ZIP Code
Email Address	Telephone Number	Cell Phone Number	

SECTION 2. LIFESPAN/RESPITE CARE GRANT SERVICE AND REIMBURSEMENT RATE

☐ Respite Care-Hourly Rate	$
☐ Respite Care - Daily Rate (Maximum payment for overnight/24-hour care cannot exceed the current swingbed rate.)	$

SECTION 3. BILLING PROCEDURES

- Submit a completed "Substitute IRS Form W-9" (SFN 53656) to the Department of Health and Human Services Aging Services. A Substitute IRS Form only needs to be submitted once.
- Submit a completed Lifespan Respite Care Grant Provider Service Log (SFN 546) for each caregiver/care recipient you serve during the billing period to the Department of Health and Human Services Aging Services for payment.
- **Provider Service Logs must be submitted for payment within 60 days from the first day of service.**
- Provider Service Logs submitted more than 60 days following the expiration of this agreement will not be reimbursed.

SECTION 4. INITIAL EACH OF THE FOLLOWING TO INDICATE UNDERSTANDING AND AGREEMENT

_____ I will notify the Program Administrator 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 an individual provider, 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 of Health and Human Services more than I charge my private pay clients.

_____ I understand that the Department of Health and Human Services may require an individual/agency to pay back Lifespan Respite Care Grant 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 Health and Human Services in compliance investigations/reviews and will provide information in writing upon request.

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

_____ I will provide records to the Department of Health and 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.

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SECTION 4. INITIAL EACH OF THE FOLLOWING TO INDICATE UNDERSTANDING AND AGREEMENT (cont)

_____ I agree to not discuss any information, including personal health information, relating to caregivers/care recipients 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 the Program Administrator has approved this agreement and a copy has been returned to me.

_____ I have read and understand the Lifespan Respite Care Grant Service Standards.

SECTION 5. SIGNATURES

PROVIDER

By signing below, whether electronically or manually, I certify that I have read and understand the Lifespan Respite Care Grant Service Standards. I hereby affirm that all information I have provided within this Agreement is accurate and precise. I acknowledge that any attempt to provide inaccurate or untruthful documentation may disqualify me from receiving funding from the Lifespan Respite Care Grant now or in the future.

☐ **By checking this box and typing my name below, I am signing this Agreement electronically. I agree that my electronic signature is the legal equivalent of my manual/handwritten signature. I agree that the electronic signatures appearing on this Agreement have the same validity and enforceability as handwritten signatures. I further agree to receive, obtain, and/ or submit documents and information relating to the Lifespan Respite Care Grant Service electronically. I understand I may request a paper version of this and other documents and I have the right to withdraw my consent to electronic delivery.**

Signature of Provider	Date

PROGRAM ADMINISTRATOR

☐ **By checking this box and typing my name below, I am signing this Agreement electronically. I agree that my electronic signature is the legal equivalent of my manual/handwritten signature. I agree that the electronic signatures appearing on this Agreement have the same validity and enforceability as handwritten signatures. I further agree to receive, obtain, and/ or submit documents and information relating to the Lifespan Respite Care Grant Service electronically. I understand I may request a paper version of this and other documents and I have the right to withdraw my consent to electronic delivery.**

Signature of Program Administrator	Date

SUBMIT COMPLETED FORM BY CLICKING ON BUTTON BELOW:

Email Completed Form Here
(by clicking this button, the form is emailed to carechoice@nd.gov)

For questions please contact:
Telephone: (855) 462-5465
carechoice@nd.gov

Department of Health and Human Services
Aging Services
1237 W Divide Avenue Suite 6
Bismarck, ND 58501
FAX Number: (701) 328-8744

DISTRIBUTION: **Original** - Aging Services **Copy** - Provider