LIFESPAN RESPITE GRANT RESPITE PROVIDER AGREEMENT

DEPARTMENT OF HEALTH AND HUMAN SERVICES
ADULT AND AGING SERVICES
SFN 559 (6-2026)

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SECTION 1: PROVIDER OR AGENCY INFORMATION

Individual or 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 OR RESPITE CARE GRANT SERVICE AND REIMBURSEMENT RATE

☐ Respite Care - Hourly Rate	Rate
☐ Respite Care - Daily Rate: Maximum payment for overnight or 24-hour care cannot exceed the current swingbed rate.	Rate

SECTION 3: BILLING PROCEDURES

- Submit a completed Substitute IRS Form W-9, SFN 53656, to the Department of Health and Human Services Adult and 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 or care recipient you serve during the billing period to the Department of Health and Human Services Adult and Aging Services for payment.
- Provider Service Logs must be submitted within sixty (60) days from the last service date of a given month, or the claim will be denied.

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

Statement	Initials
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 or 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.	

Statement	Initials
I agree to assist the Department of Health and Human Services in compliance investigations or 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 or 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 following the closure of a caregiver client.	
I will obey all applicable federal and state laws.	
I will notify Department of Health and Human Services Staff immediately of any changes to my vendor registry information, and I acknowledge that failure to do so may cause significant delays or failures in payment.	
I am aware of approved activities while providing respite care that are within my licensing capacity and/or as indicated in the Lifespan Respite Care Grant Respite Care Service Standards.	
I agree to not discuss any information, including personal health information, relating to caregivers or 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 this form, 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, I am signing this Agreement electronically. I agree that my electronic signature is the legal equivalent of my manual or 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, 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, I am signing this Agreement electronically. I agree that my electronic signature is the legal equivalent of my manual or 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, 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:

Email the completed form 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
Adult and Aging Services
1237 W Divide Avenue Suite 6
Bismarck, ND 58501
FAX Number: (701) 328-8744

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