



**LIFESPAN RESPITE CARE GRANT
 PLANNED, UNPLANNED AND EMERGENCY RESPITE PROVIDER AGREEMENT**
 NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES
 AGING SERVICES DIVISION
 SFN 559 (9-2021)

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

<input type="checkbox"/> Respite Care-Hourly Rate	\$
<input type="checkbox"/> 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 Human Services Aging Services Division. 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 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 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 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 Human Services more than I charge my private pay clients.
- _____ I understand that the Department of 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 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 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.

(continued next page)

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 Aging Services Staff have 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
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AGING SERVICES DIVISION 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 Aging Services Division Program Administrator	Date
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SUBMIT COMPLETED FORM BY CLICKING ON BUTTON BELOW:

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

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

DISTRIBUTION: Original - Aging Services Division Copy - Provider