NORTH DAKOTA TRANSITION AND DIVERSION SERVICES PILOT PROJECT PROVIDER AGREEMENT

DEPARTMENT OF HEALTH AND HUMAN SERVICES
ADULT AND AGING SERVICES
SFN 664 (7-2024)

Clear Fields

Agreement between the Department of Health and Human Services, hereinafter referred to as "the Department" and: hereinafter referred to as "Provider".

SECTION 1: CONTACT INFORMATION (Indicate the type of provider)

Agency Legal Name	Agency Contact Person		
Address	City	State	ZIP Code
Email Address	Telephone Number	Cell Phone Number	

SECTION 2: SERVICE

I wish to provide the following service:

☐ ND Transition and Diversion Services Pilot Project

This service includes providing both Transition Coordination Housing Facilitation and Transition or Diversion Costs Spending Assistance.

SECTION 3: LIST OF ELIGIBLE PROVIDERS

Do you want to be on the regional list of available Transition and Diversion Services Pilot Projcect providers that is given to approved applicants? ☐ Yes ☐ No

Provider names will remain on the list through the effective dates of this Agreement.

SECTION 4: BILLING PROCEDURES

As a condition of participation in the ND Transition and Diversion Service Pilot Project, the Provider agrees to submit true, accurate and complete claims for payment in the manner prescribed by the Department. The Department agrees to pay the Provider for services rendered to persons who are eligible for such services under the policy for North Dakota Transition and Diversion Service Pilot Project with payment to be in accordance with the payment structure established by the Department. Transition Coordination and Housing Facilitation services will be paid at the most current unit rate established for 1915(i) State Plan Amendment Services. Transition/Diversion costs will be made for the amounts approved, spent, and supported by proof of purchase/receipts.

- Submit a completed "Substitute IRS Form W-9" (SFN 53656) to the Department of Health and Human Services. A Substitute IRS Form only needs to be submitted once.
- Submit a ND Transition and Diversion Service Pilot Project Billable Hours form for reimbursement of all Transition Coordination/ Housing Facilitation services provided. This is to be submitted to Aging Services monthly using the -Info-HHS MFP Billing mfpbilling@nd.gov email address.
- Providers will submit a completed ND Transition and Diversion Service Pilot Project Services Payment Request and corresponding receipts for reimbursement of all spending for approved moving and diversion costs monthly to the Info-HHS MFP Billing mfpbilling@nd.gov email address.

SECTION 5: PROGRAM PARTICIPANTS REQUIREMENTS

I agree to follow the ND Transition and Diversion Service Pilot Project policy and procedures provided by the Department of Health and Human Services. This includes the utilization of the Therap Case Management System, program forms, checklists, and billing forms.

I agree to make staff available to provide the transition coordination and assistance with the purchase of the transition or diversion related costs.

I agree to provide transition coordination staff with access to a computer with Web access so that required Therap system documentation can be completed.

I agree to provide all staff involved with the ND Transition and Diversion Service Pilot Project access to Therap system to complete the required documentation.

I agree to allow all staff to participant in training on how to utilize the Therap System and related program process and documentation requirements provided by DHHS staff.

I will notify Aging Services Staff, when possible, of any abuse or exploitation of the client that occurs.

SECTION 5: PROGRAM PARTICIPANTS REQUIREMENTS (continued)

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 the agency receives. These are my responsibilities as an agency.

I understand that the Department of Health and Human Services may require an individual/agency to pay back 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 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.

I agree to complete required employee screening outlined in the ND Transition and Diversion Service Pilot Project Handbook.

I agree to maintain the confidentiality of all records of program participants and not discuss any information, including personal health information, relating 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.

The parties stipulate that this agreement may be terminated at any time upon giving a written notice to the other party.

I understand services cannot be provided until Aging Services Staff have approved this agreement and returned a copy.

SECTION 6: SIGNATURES

By signing this Agreement, the Provider certifies that neither the Provider nor its principles are presently debarred, declared ineligible, or voluntarily excluded from participation in transactions with the State or Federal Government by any Department Agency of the Federal Government or the State of North Dakota.

This Agreement shall remain in effect until the end of the program funding on December 31, 2025. In the event of termination by the Department, the Department's sole obligation shall be to pay for services provided prior to the effective date of termination. This agreement may be terminated by either party without cause by giving a thirty (30) day notice in writing to the other party.

The Department may immediately terminate this Agreement in writing when the Provider fails to comply with any applicable statute, rule, regulation, term or provision of this Agreement. The Provider also understands and agrees that its conduct may be subject to additional penalties or sanctions. The Provider further understands that there are federal penalties for false reporting and fraudulent acts committed during the course and scope of this Agreement.

Please sign or type your name below. By typing my name below, I am signing this application form electronically. I agree that my electronic signature is the legal equivalent of my handwritten signature.

I have read this Agreement, understand it, and agree to abide by its terms and conditions. I also agree that violation of any of the terms or conditions of this agreement constitute sufficient grounds for termination of this agreement and may be grounds for other action.

Provider Name/Printed Name	Title
Provider Signature	Date

Department Approval

Start Date of Agreement	End Date of Agreement
Aging Service Staff Name/Printed Name	Title
Aging Services Staff Signature	Date