REQUEST FOR ATTENDANT CARE SERVICES

NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES
AGING SERVICES DIVISION/HOME AND COMMUNITY BASED SERVICES
SFN 944 (10-2016)

Clear Fields

DEMOGRAPHIC INFORMATION

Name		Telephone Number	
Mailing Address	City	State	Zip Code
Residential Address ☐ Check box if same as mailing address	City	State	Zip Code
E-mail Address (optional)	Medicaid Number	Date of Birth	

APPLICANT CERTIFICATIONS

☐ I certify that I have an informal caregiver support system to provide contingency (back-up) care when my regular care providers are unavailable.

☐ I state that the information I give on the application is true and correct. I understand if I give information that is not true or if I don not give information that I am supposed to, I may get health benefits that I should not get. If that happens, I can be punished by law. Also, I may have to pay money back to Medicaid for the bills it paid that it should not have. [Medicaid applications must be signed under penalty of perjury. 42 CFR 435.907(b)]

Applicant's (or Authorized Representative's) Signature	Date

Witness to mark if applicant is unable to provide signature:

Print Name	Signature

PRIMARY CARE PHYSICIAN CERTIFICATIONS

I verify that this applicant is:

☐ Dependent on a ventilator for at least 20 hours per day

☐ Medically stable, which is defined as: A medical condition that is not worsening and where life-threatening injury or disease has been brought under control so that it does not cause immediate acute risk to the individual and the individual does not require intensive medical interventions.

Additional Physician Comments

☐ Competent to participate in the development and oversight of his/her plan of care and care providers in a home environment

Physician's Signature	NPI	Date

PROVIDERS

Primary Care Physician's Name	Health Care Facility
HCBS Case Manager's Name	

NURSE MANAGEMENT

Name of Qualified Service Provider for Nurse Management
Name of Qualified Service Provider for Nurse Management
Name of Qualified Service Provider for Nurse Management

ATTENDANT CARE PROVIDERS (must include an ACS provider for contingency planning)

Name of Qualified Service Provider for Attendant Care Services
Name of Qualified Service Provider for Attendant Care Services
Name of Qualified Service Provider for Attendant Care Services
Name of Qualified Service Provider for Attendant Care Services
Name of Qualified Service Provider for Attendant Care Services
Name of Qualified Service Provider for Attendant Care Services

CONTINGENCY (BACK-UP) CARE PROVIDERS

Name		Telephone Number	
Relationship			
Address	City	State	Zip Code

Name		Telephone Number	
Relationship			
Address	City	State	Zip Code

Name		Telephone Number	
Relationship			
Address	City	State	Zip Code