HOME AND COMMUNITY-BASED SERVICES (HCBS) AUTHORIZING SIGNATURES

DEPARTMENT OF HEALTH AND HUMAN SERVICES
AGING AND DEVELOPMENTAL DISABILITIES (DD)
SFN 1123 (1-2024)

Clear Fields

Meeting Details **Authorization Span** *(enter date span of authorized services)*

Date of Meeting/Service Change Request	From:	To:
Individual Name	ND Number	Name of Case Manager

Plans

Select the plan(s) that this signature sheet represents

- ☐ Person Centered Plan of Care
- ☐ Risk Assessment and Health and Safety Plan
- ☐ Referral for Long-Term Services and Supports Options Counseling
- ☐ Single Event Targeted Case Management

Assurances

Check all that apply

- ☐ I wish to receive the services described in this person-centered plan of care rather than receiving care in a nursing facility.
- ☐ I am aware that I may have a recipient liability and/or service fee.
- ☐ I am aware that the services and estimated cost is subject to change based on legislative action.
- ☐ I have been made aware of services, funding caps, and limits.
- ☐ I selected the services listed in the person-centered plan of care
- ☐ I selected the providers listed in the person-centered plan of care.
- ☐ I am aware that if my Medicaid eligibility terminates, I will no longer be eligible for services funded by ExSPED, MSP-PC, or Medicaid Waiver.
- ☐ I am aware that Case Management, as well as personal care services, will be billed to Medicaid and may be subject to a recipient liability if Medicaid is active, even if it has been determined that I have a 0% SPED fee.
- ☐ I am aware of my right to appeal by writing to:

  Appeals Supervisor, Legal Division
  Department of Health and Human Services
  600 E Boulevard Ave. Dept. 325
  Bismarck, ND 58505-0250

*By typing my name, I am signing this application form electronically. I agree that my electronic signature is the legal equivalent of my handwritten signature. I attest, subject to the penalties of perjury, that I am the individual completing this application and that I have provided accurate information to the best of my knowledge. NDCC 9-16

I approve the plan and/or changes in the plan as it was discussed/requested. *

Individual/Legal Representative Signature	Date
Family Home Care/Family Personal Care Provider Signature (if applicable)	Date
Case Manager Signature	Date

My signature indicates that I have participated in the team meeting and development of the service plan.*

Signature	Relationship/Title	Provider Agency (if applicable)