NORTH DAKOTA MEDICAL ACUITY TIER RATE ADD-ON PROVIDER SUBMISSION

DEPARTMENT OF HEALTH AND HUMAN SERVICES
DEVELOPMENTAL DISABILITIES
SFN 1410 (2-2023)

Clear Fields

Individual Name (Last, First, MI)			Date of Request
Date of Birth	Age	Medicaid Number	Date of Most Recent SIS
Service for this Tier Request			
Most Recent SIS Exceptional Medical Support Needs Total Score		Developmental Disabilities (DD) Provider Agency Requesting Tier	
Human Service Center		Developmental Disabilities Program Manager	
Does this individual have a current, approved, medical acuity tier with another Developmental Disabilities Provider Agency? ☐ Yes ☐ No			
If Yes, List the Agency			

Required Documents to submit to DD State Office: (all must be included for this request to be considered)

Completed Medical Assessment (SFN 1415)	☐ Yes	☐ No
Nursing Care Plan	☐ Yes	☐ No
Nursing Assessment (physical assessment and documentation)	☐ Yes	☐ No

This section for DD Central Office use only

Date Request Received by Regional DD Program Administrator	Date Request Received by DD
Level of Medical Acuity Tier Determination ☐ Tier 1 ☐ Tier 2 ☐ Tier 3 ☐ Request Denied	Effective Date of Approved Medical Acuity Tier Rate Add-On
Length of Approval (or End Date of Add-On Approval)	Service for Tier Approval
If Denied, Explain Reason	

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 attest, subject to the penalties of perjury that I am the individual completing this application and that I have provided accurate information.

State Office Signature	Date

DD Provider Agency Decision: (mark one of the following)

☐ Yes	The DD Provider Agency listed below agrees to provide the level of support that has been approved by DD as described within the Medical Acuity Tier Rate Add-On Policy.
☐ No	The DD Provider Agency listed below will not provide the level of support as described within the Medical Acuity Tier Rate Add-On Policy. The individual's team has reviewed the determination and agrees that the DD Provider Agency will provide support at a lower Medical Acuity Tier. Which Tier Will be Utilized: ☐ Tier 1 ☐ Tier 2
☐ No	The DD Provider Agency listed below will not provide the level of support listed within the Medical Acuity Tier Rate Add-On Policy and the Medical Acuity Tiers will not be utilized.

By signing this form, the undersigned agree to and understand the determination marked above by the DD Provider Agency listed here.

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 attest, subject to the penalties of perjury that I am the individual completing this application and that I have provided accurate information.

Developmental Disabilities Provider Agency	
Developmental Disabilities Provider Agency Representative Signature	Date
Developmental Disabilities Program Manager Signature	Date
Individual or Legal Guardian Signature	Date

All signatures must be obtained and returned to DD with the Provider Agency decision within 15 business days of determination of Medical Acuity Tier Rate Add-On. This completed form, with all signatures obtained, as well as the required documents must be attached to the service plan.

Should your organization wish to request an appeal of this determination, you must do so pursuant to the timelines outlined in North Dakota Century Code 50-24.1-24.