INDIVIDUAL REQUEST TO BE A QUALIFIED SERVICE PROVIDER

DEPARTMENT OF HEALTH AND HUMAN SERVICES
MEDICAL SERVICES DIVISION
SFN 1603 (5-2023)

FOR OFFICE USE ONLY	
Date Approved	Approved By
☐ Change/Add ☐ New ☐ Reval ☐ Reapply	
ID	Date Closed

NAME AS ON SOCIAL SECURITY CARD

NOTE: Your Social Security number will be linked to your North Dakota provider number. All claims paid to your North Dakota provider number will be submitted as income under your Social Security number to the IRS.

Disclosure of the Social Security number is required pursuant to 26 CFR 301.6109-1 and is requested for the purpose of reporting tax information. Failure to disclose this information results in $50 penalty under 26 CFR 301.6723-1 unless it is due to reasonable cause and not willful neglect

Last Name, First Name, MI, Suffix	Social Security Number	QSP Gender ☐ Male ☐ Female	Date of Birth

Current/Previous Provider Number

Current/Previous Provider Number (if applicable)	NPI (Required)

List all names you have used in the past, at any time.

Last Name, First Name	Last Name, First Name
Last Name, First Name	Last Name, First Name

Note: A copy of Government issued identification must be submitted with this form.

Home Location Information (911 Address) - You must inform Medical Services within 14 days of any address changes.

Physical Address			Apartment/Building Number
City	State	ZIP Code	County
Telephone Number	Cell Phone Number	Email Address	
Billing Address (if different)			Apartment/Building Number
City	State	ZIP Code	County

LICENSURE/CERTIFICATION

NOTE: Enter information pertaining to your current licensure and/or certification. The license must be for the state in which services are provided.

License Information

License Number	Licensing Agency	Effective Date	Expiration Date	State

Have you ever had your LPN/RN/CNA/PT/OT, etc. license denied, revoked, suspended, restricted, terminated or surrendered?
☐ No ☐ Yes - provide an explanation:

Do you want to be on the DHHS list of available Qualified Service Providers? ☐ Yes ☐ No

Languages Supported (check all that may apply)

☐ English	☐ Chinese (Mandarin)	☐ German	☐ Korean	☐ Stavic	☐ Tagalog
☐ Albanian	☐ Cantonese	☐ Greek	☐ Laotian	☐ Sign Language	☐ Turkish
☐ Arabic	☐ Czech	☐ Hindi	☐ Navajo	☐ Spanish	☐ Ukrainian
☐ Bangla	☐ Farsi	☐ Indian	☐ Portuguese	☐ Taiwanese	☐ Vietnamese
☐ Bosnian	☐ Filipino	☐ Italian	☐ Romanian	☐ Swahili	☐ Other (specify):
☐ Cambodian/Kampuchean	☐ French	☐ Japanese	☐ Russian	☐ Syrian	________

Define Your Service Area by Counties Served

Note: Only select counties where you live or are willing to travel to provide service.

☐ Adams	☐ Cavalier	☐ Grant	☐ McLean	☐ Ransom	☐ Steele
☐ Barnes	☐ Dickey	☐ Griggs	☐ Mercer	☐ Renville	☐ Stutsman
☐ Benson	☐ Divide	☐ Hettinger	☐ Morton	☐ Richland	☐ Towner
☐ Billings	☐ Dunn	☐ Kidder	☐ Mountrail	☐ Rolette	☐ Trail
☐ Bottineau	☐ Eddy	☐ LaMoure	☐ Nelson	☐ Sargent	☐ Walsh
☐ Bowman	☐ Emmons	☐ Logan	☐ Oliver	☐ Sheridan	☐ Ward
☐ Burke	☐ Foster	☐ McHenry	☐ Pembina	☐ Sioux	☐ Wells
☐ Burleigh	☐ Golden Valley	☐ McIntosh	☐ Pierce	☐ Slope	☐ Williams
☐ Cass	☐ Grand Forks	☐ McKenzie	☐ Ramsey	☐ Stark	

Service Enrollment

Note: Definitions of the services can be found in the handbook.

☐ **Basic Provider Specialties** (check box to select enrollment in these services)

Note: By checking the box above and providing either a Documentation of Competency SFN 750 or a current CNA/RN/LPN you will **automatically be enrolled in the following specialties**: **Personal Care, Homemaker, Non-Medical Transportation - Escort**.
If you **choose not** to perform one or more of the services, please list them below:

☐ **Cognitive Global Endorsement Specialties** (check box to select enrollment in these services)

By checking the box above and having a cognitive global endorsement on your completed Documentation of Competency SFN 750 (Letter E) you will **automatically be enrolled in the following specialties**: **Companionship, Supervision, Respite Care**.
If you **choose not** to perform one or more of the services, please list them below

Additional Service Specialties (check the box for each service below for which you choose to enroll)

☐ Adult Day Care (Provided in QSP's home) (Requires home evaluation and SFN 55 Cost Report)

☐ Case Management (Requires Master's Degree in Social Work and must be a ND Licensed Social Worker)

☐ Respite in Adult Foster Care (Requires criminal background check; SFN 466, SFN 467, and SFN 60688)

☐ **Chore Service** (check box to select enrollment in this service)

Note: By selecting this service you acknowledge that you have read, understand, and agree to the following:

I assure I understand the following:
- Know generally accepted procedure for seasonal cleaning or unusual/heavy cleaning.
- Ability to follow manufacturer's instructions for supplies used and equipment needed to complete specific chore tasks.
- Understanding of proper mixing and disposal of chemicals used in cleaning.
- Ability to operate snow removal equipment.
- Ability to operate mowing equipment.

☐ **Non-Medical Transportation - Driver** (check box to select enrollment in this service)

Note: By selecting this service you acknowledge that you have read, understand, and agree to the following:

I affirm that the vehicle used to provide transportation is in good operating order, including the brakes, lights, tires and seatbelts. I understand and agree that the State of North Dakota shall not be liable for any damages that may arise out of or resulting from operating my vehicle.

I will verify with my insurance carrier that my insurance coverage is current and appropriate for the services I am providing. I am **not required** to submit proof of insurance to the Department.

I will maintain a current drivers license. I understand that if this information is not current, I may not be paid for providing this service to clients.

I agree to notify the Department if my driving record changes and I no longer meet the standards for this service.

Check the box to select enrollment in this service)

☐ **Extended Personal Care – Nurse** (Must have a current valid ND LPN/RN license) ☐ **Extended Personal Care – Non-Nurse**

Note: By selecting this service I acknowledge that I have read, understand, and agree to comply with the following requirements:

The purpose of extended personal care services (EPCS) is to complete tasks that are nursing or medical in nature and specific to the needs of an eligible individual. Approval to complete these tasks is provided by the nurse educator who has provided training to the EPCS provider and is enrolled with the Department of Health and Human Services (Department) to provide nurse education. Or, if a necessary medical task is too complex to be taught to an unlicensed provider, the nurse may provide the service directly to the client.

This service may include medical or nursing care to the extent permitted by state law that will maintain the health and well-being of the individual and will allow the individual to remain in the community. These are services that an individual without a functional disability would customarily and personally perform without the assistance of a licensed health care provider, such as catheter irrigation, administration of medications, wound care or other tasks as approved by the state program administrator. Activities of daily living such as bathing, dressing, routine skin care, toileting, transferring/positioning, mobility, and instrumental activities of daily living such as housework, laundry, or meal prep are not part of this service. EPCS does not include tasks for monitoring healthy habits, encouraging healthy eating, monitoring falls or tasks covered under the global endorsements or education for these tasks.

Providers must immediately report all critical incidents.

A critical incident is any actual or alleged event or situation that creates a significant risk or substantial or serious harm to the physical or mental health, safety or well-being of a client receiving HCBS services.

Reportable incidents include:

1. **Abuse (physical, emotional, sexual), neglect, or exploitation**. Will need to also fill out a VAPS referral.
2. **Rights violations** through omission or commission, the failure to comply with the rights to which an individual is entitled as established by law, rule, regulation or policy.
3. **Serious Injury or medical emergency** which would not be routinely provided by a primary care provider.
4. **Wandering or elopement.**
5. **Restrain violations** (Use of restraints not documented in care planning.)
6. **Death** of a client and cause (including death by suicide).
7. Report of all **medication errors** or omissions.
8. Any event that has the potential to jeopardize the client's **health, safety or security** if left uncorrected.
9. **Changes in health or behavior** that may jeopardize continued services.
10. **Illnesses or injuries** that resulted from **unsafe or unsanitary** conditions.

Complete a General Event Report (GER) within Therap. Or use the GER offline forms if the QSP does not have access to Therap. Submit the GER within 24 hours of the incident and notify the case manager." Notify the nurse educator immediately.

EPCS provider must notify the HCBS case manager and nurse educator if the client is not home at the scheduled time for service, If there is an observed change in the clients physical, cognitive, emotional or environmental condition, or there is a change in the amount or type of service that may be needed by the client.

Education is provided to the EPCS provider in the presence of a client who is competent to make their own decisions or in the presence of their legal representative.

EPCS is provided by an individual enrolled with the Department as a qualified service provider (QSP) to provide EPCS. Both agency and individual QSPs are required to identify a backup plan or provider in the event they are not able to provide services.

EPCS is provided in accordance with the Person-Centered Plan developed by the client and home and community based services (HCBS) case manager. The Nursing Plan of Care (NPOC) is developed by the client and a nurse educator. The EPCS provider must contact the nurse educator for training prior to administering new medication or treatments for which training has not been provided. The nurse educator will send training documentation to the case manager and state nurse administrator. The training documentation must be signed by the nurse educator and the extended personal care provider(s).

The EPCS provider is given an Authorization to Provide Services document by the HCBS case manager in which the reimbursable tasks and the time allowed for the provision of each task is described.
Documentation with training is provided by the nurse educator to the EPCS provider approving identified nursing tasks. The nurse educator must provide documentation to the EPCS provider which describes the nursing tasks approved. Payment is limited to the services described in the Authorization to Provide Services.

The EPCS provider is required to maintain records related to: (1) the written instructions for completing the authorized tasks provided by the nurse educator; and (2) incidents that result in client injury or require medical care.

Documentation must include:
- EPCS provider's name
- Client's name
- Date service provided
- Start and end time of the tasks performed including AM and PM
- Tasks performed (i.e. medication administration, wound care or eye drops)

Sample documentation forms are provided in the QSP packet and may be used at your discretion.

☐ **Nurse Educator** (check box to select enrollment in this service) (Must have a current valid ND RN license)

Note: By selecting this service I acknowledge that I have read, understand, and agree to comply with the following requirements:

The purpose of a nurse educator is to provide nursing assessment, care planning, training, and periodic review of client care needs. The licensed nurse is required to participate in the development of a plan of care for clients who require assistance with maintenance of routine medical or nursing tasks.

This service may include medical or nursing care to the extent permitted by state law that will maintain the health and well- being of the individual and will allow the individual to remain in the community. These are services that an individual without a functional disability would customarily and personally perform without the assistance of a licensed health care provider, such as catheter irrigation, administration of medications, or wound care, or other tasks as approved by the HCBS nurse administrator with Aging Services. Activities of daily living such as bathing dressing, routine skin care, toileting, transferring/positioning, mobility, and instrumental activities of daily living such as housework, laundry, or meal prep are not part of this service. Extended personal care service (EPCS) does not include tasks for monitoring healthy habits, encouraging healthy eating, monitoring falls, or tasks covered under the global endorsements or education for these tasks.

Nurse instruction is provided by a licensed nurse enrolled with the Department as a qualified service provider (QSP) to provide nurse education. Both Agency and individual nurse educator QSPs are required to identify a backup plan or provider in the event they are not able to provide services.

The nurse educator must complete a nursing plan of care (NPOC) and the NPOC must be completed every six months. Nurse educator activities must be delivered in accordance with this NPOC. The completed NPOC must be provided to the home and community based services (HCBS) case manager. The NPOC and the Person-Centered Plan completed by the HCBS case manager must be approved by the nurse administrator for extended personal care services prior to the implementation or continuation of services. The HCBS case manager provides the nurse educator with an Authorization to Provide Services. This document authorizes the provision of nurse educator services and authorizes units for the provision of that service.

Nursing education is provided to the EPCS provider (QSP) who is enrolled with the department to provide EPCS and must be provided in the presence of a client who is competent to make their own decisions, or their legal guardian.

Other requirements include following established protocol for reporting critical incidents to the Department.
A “critical incident” is any actual or alleged event or situation that creates a significant risk of substantial or serious harm to the physical or mental health, safety or well-being of a client receiving HCBS services.

Reportable incidents include:

1. **Abuse (physical, emotional, sexual), neglect, or exploitation**. Will need to also fill out a VAPS referral.
2. **Rights violations** through omission or commission, the failure to comply with the rights to which an individual is entitled as established by law, rule, regulation or policy.
3. **Serious Injury or medical emergency** which would not be routinely provided by a primary care provider.
4. **Wandering or elopement.**
5. **Restrain violations**
6. **Death** of a client and cause (including death by suicide).
7. Report of all **medication errors** or omissions.
8. Any event that has the potential to jeopardize the client's **health, safety or security** if left uncorrected.
9. **Changes in health or behavior** that may jeopardize continued services.
10. **Illnesses or injuries** that resulted from **unsafe or unsanitary** conditions.

Complete a General Event Report (GER) within Therap. Or use the GER offline forms if the QSP does not have access to Therap. Submit the GER within 24 hours of the incident and notify the case manager.

Nursing education is provided to the EPCS provider (QSP) and must be provided in the presence of a client who is competent to make their own decisions, or their legal representative.
The nurse educator is responsible for ongoing monitoring of medication or specific treatment regimens by reviewing if any changes occur or with the NPOC completed every six months.

The nurse educator will review and identify any potentially harmful practices (e.g., the concurrent use of contraindicated medications) and the method (s) for following up on potentially harmful practices. Any potentially harmful practices will be reported to ND Department of Health and Human Services HCBS. HCBS will be responsible for follow- up and oversight.

The nurse educator is required to maintain records related to:
(1) the instruction for the trained and delegated tasks
(2) monitoring and supervision of trained/delegated tasks
(3) instructions for the EPCS provider on how to contact the nurse educator for additional training prior to administering any new medication or treatment
(4) critical incidents according to the critical incident policy
(5) the results of the monitoring and reassessment contacts with the client

The nurse educator will send training documentation to the case manager and state nurse administrator. The training documentation must be signed by the nurse educator and the extended personal care providers who are providing the care/tasks.

The nurse educator must provide written documentation to the Department that shows he or she has provided instructions to the EPCS provider that outlines the types of situations that are considered reportable incidents. The SFN 968 Reportable Incidents for Extended Personal Care Service must be updated annually, and a copy sent to the clients HCBS case manager. EPCS providers must report incidents to the HCBS case manager and nurse educator within 24 hours of receiving the report, or one business day per Critical Incident Reporting Policy 535-05-37 requirements.

The nurse educator must notify the HCBS case manager if the client is not home at the scheduled time for service; there is an observed change in the clients physical, cognitive, emotional, or environmental condition; there is a change in the amount or type of service that may be needed by the client, or if the client appears to be the victim of abuse or exploitation.

Documentation Requirements:

- NPOC must be approved initially and every 6 months by the Department.
- SFN 968 Reportable Incidents for Extended Personal Care Service must be approved initially and annually by the Department.
- Copies of all other documentation must be provided by the HCBS Case Manager

Sample documentation forms are provided in the QSP packet and may be used at your discretion.

The nurse educator will act in accordance with North Dakota Century Code Chapter 43.12.1, *Nurse Practices Act*, and associated administrative rules, Title 54 of North Dakota Administrative Code.

QUESTIONS

1. Last Grade Completed
☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ 11 ☐ 12 ☐ 12+ ☐ GED

2. Have you EVER been convicted of a misdemeanor? ☐ Yes ☐ No

3. Have you EVER been convicted of a felony? ☐ Yes ☐ No

Prior convictions will not automatically disqualify you from enrollment, all information will be reviewed to determine if enrollment is appropriate.

If yes, complete the following. **Send the court papers for all misdemeanor and felony convictions.**

Date	Offense

* Attach additional sheets if necessary.

4. Are you on probation? ☐ Yes ☐ No **If you answered yes, you are required to read the following statement and initial.**

I understand that if I am currently on probation, the Department is unable to consider my application unless evidence of rehabilitation is submitted with my application.

____
(Initials Required)

You are required to notify the Department of any changes to your conviction history.

Question		
5. I am physically and mentally able to provide QSP services.	☐ Yes ☐ No	If No, Explain
6. Have you ever been found guilty of abuse or neglect or had services required as a result of a child abuse/neglect report or assessment?	☐ Yes ☐ No	If Yes, Explain
7. Have you ever stolen or taken property without permission?	☐ Yes ☐ No	If Yes, Explain
8. Do you have a contagious/infectious disease?	☐ Yes ☐ No	If Yes, Explain

9. Do you take care of anyone over the age of 18 who pays you with their own money or whose family pays for their care? ☐ Yes ☐ No

If yes, how much are you paid for providing this care?	Rate ☐ Hourly ☐ Daily

Question	Response	Details
10. Do you have the basic ability to read, write, and verbally communicate in English?	☐ Yes ☐ No	
11. Do you need someone to help you read, write, and verbally communicate in English?	☐ Yes ☐ No	NOTE: If yes, additional requirements needed
12. Are you planning to provide respite care in an adult foster care home?	☐ Yes ☐ No	If Yes, Name of Foster Care Home
13. Have you ever had your qualified service provider status or license (AFC, early childhood program license, self-declaration document, etc.) issued by the Department of Health and Human Services denied, revoked, suspended, restricted, or terminated?	☐ Yes ☐ No	If Yes, Explain
14. Have you ever been disciplined or terminated from an agency that is enrolled as a Qualified Service Provider?	☐ Yes ☐ No ☐ N/A	If Yes, Explain
15. If employed as a staff member of an agency enrolled as a Qualified Service Provider, have you ever submitted inaccurate service records, billing information or documentation?	☐ Yes ☐ No ☐ N/A	If Yes, Explain

A Yes response will not necessarily restrict you from enrollment as a Qualified Service Provider. Your age, the time of the offense, seriousness, and nature of the violation as well as rehabilitation will be taken into consideration. Please provide an explanation so that we have enough information to make a determination.

ELECTRONIC VISIT VERIFICATION (EVV) (Required for QSP services)

Indicate which EVV system you will be using:

☐ Therap (State Contracted System) ☐ Other - Specify Name: ______________________________

(You will be responsible for all costs and set up associated with using a non-state contracted EVV System. Individuals who use an alternate EVV vendor are responsible to work directly with the state's aggregator system to submit required EVV data. There will be no charge for utilizing the state contracted EVV system).

Please carefully read each of the statements below, and initial at the bottom of this section:

- I agree to study the Fire Safety Fact Sheet, the Carbon Monoxide Fact Sheet, and Guidelines for Universal Precautions that is included in the provider handbook.
- I will notify the member/client's case manager or Home and Community Based Services (HCBS) when any of the following occur:
  1. Client is not home at the time scheduled for service;
  2. Observed change in client's physical, cognitive, emotional, and/or environmental condition;
  3. Change in the amount or type of services that may be needed by the client;
  4. Possible abuse or exploitation of client; and
  5. Other circumstances as agreed upon with HCBS case manager for specific client(s).
- I will provide care at a level acceptable to the client and the Department of Health and Human Services.
- I will make arrangements for client/customer/consumer care when I am unable to provide services as scheduled.
- I agree to assist the Department of Health and Human Services and/or HCBS in compliance investigations and will provide information in writing upon request.
- I will not accept or solicit gifts or money from the client.
- I will not take children or other family members in the member/client's home.
- I will not smoke, consume alcoholic beverages, report for work under the influence of drugs or alcohol, consume the client's food, or conduct personal business in the client's home. Use of the member/ client's property which is not for the benefit of the client is only with a written agreement from the client.
- I cannot be compensated for services provided to a client who is my child (client) under 18 years of age, or if I have been ordered by the court to provide such care (e.g. guardianship).
- I cannot be compensated for services provided to a client who is my spouse.
- I will obey all applicable Federal and State laws.
- I will keep service records and authorizations for a period of 42 months from the close of the Federal Fiscal Year (October 1 - September 30) in which the services are delivered. I acknowledge that I am required to keep these records even if I am no longer a provider. I agree to provide records to the Department upon request and understand that the Department will request a refund or process adjustments to take back payment made to a provider if the provider does not submit the requested records or keep appropriate records.
- I will keep records for each client visit that includes all information required by the Department. I understand that if I do not keep records as outlined in the Provider Handbook, I may be subject to legal and monetary penalties.
- I have read the Individual Provider Handbook and will keep a current copy for my records.
- I understand I am a self-employed person, and that I am responsible to pay self-employment taxes and estimated tax on qualified service provider (QSP) payments. 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 as a QSP as these are my responsibility as a self-employed individual.
- I agree to not discuss any information, including personal health information, pertaining 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.
- I agree to perform the work, service, and/or care myself.
- I will not charge the Department (HCBS clients) more than I charge my private pay clients.
- I will not provide services in the client's home unless the client is home.
- In the event that I am found guilty or have been convicted of a criminal charge, or if a child abuse and neglect decision of "services required" has been made, **I will immediately notify the Department.**
- I will not abuse, neglect, exploit, or assert undue influence on anyone under my care.
- I agree to notify the Department of Health and Human Services within 14 days if my physical or mailing address changes.

________ **By initialing I acknowledge that I have read, understand, and agree to the above statements.**

ELECTRONIC FUNDS TRANSFER/Direct Deposit

This is required. Complete information below and send a voided check or documentation from your financial institution.

I authorize the DEPARTMENT OF HEALTH AND HUMAN SERVICES and the financial institution named below to initiate deposits to the checking account listed. This authority will remain in effect until I notify the department in writing to cancel this authority and allow the financial institution a reasonable amount of time to act upon the cancellation.

Name of Financial Institution (Bank/Credit Union)		Bank Telephone Number	
Address of Financial Institution	City	State	ZIP Code
Bank Routing Transit Number	Bank Account Number	Account Type ☐ Checking ☐ Savings	

Attached is the required evidence that I meet the standards for qualified service provider and for the endorsement(s) I seek. The information above is true and correct to the best of my knowledge. Providing false information may be the basis for the North Dakota Department of Health and Human Services refusing or revoking any Qualified Service Provider agreements.

THIS IS A PUBLIC DOCUMENT AND WILL BE MADE AVAILABLE TO THE PUBLIC UPON REQUEST WITH THE EXCEPTION OF ANY INFORMATION THAT IS CONSIDERED CONFIDENTIAL.

SIGNATURE

Signatures must be handwritten in pen or a digital signature that includes an automatically populated date and time.

Name	Signature	Date