REQUEST TO BE A QUALIFIED SERVICE PROVIDER FOR FAMILY HOME CARE

DEPARTMENT OF HUMAN SERVICES
MEDICAL SERVICES DIVISION
SFN 1604 (11-2021)

Clear Fields

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

IDENTIFYING INFORMATION - Provide a copy of government issued identification.

Last Name, First Name, MI, Suffix	Gender ☐ Male ☐ Female	Date of Birth
Social Security Number	Enter your current and/or previous provider number	

NOTE: Your SSN will be linked to your ND Provider number. All claims paid to your ND Provider number will be submitted as income under your SSN 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.

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

Home Location Information (911 Address)

Physical Address		Building, Suite Number, etc.
City, State, ZIP Code		County
Telephone Number	Cell Phone Number	Email Address
Mailing/Billing Address		Building, Suite Number, etc.
City, State, ZIP Code		County

CLIENT INFORMATION

Client's First Name	Client's Last Name	Client's Relationship to You	County

Service

What languages can you speak, read and write? (Check all that may apply)

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

Check th county the service will be provided in:

☐ 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	

ELECTRONIC FUNDS TRANSFER/DIRECT DEPOSIT

☐ Do you wish to participate in electronic funds transfer payments? In the near future this will be required, so it is recommended that you enroll in direct deposit.

☐ Yes - Complete information below and **send a voided check or doucmentation from your financial institution**.

☐ No - Your check will be mailed to your billing address

I authorize the NORTH DAKOTA DEPARTMENT OF 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	
Account Holder's Name			

CLAIMS SUBMISSION

Do you want to bill ☐ Online ☐ Paper

QUESTIONS

1. Check last grade completed

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ 11 ☐ 12 ☐ 12+ ☐ GED

2a. Do you have the basic ability to read, write, and verbally communicate in English? ☐ Yes ☐ No

2b. Do you need someone to help you read, write, and verbally communicate in English? ☐ Yes ☐ No

NOTE (2b): If yes, additional requirements needed. Contact QSP enrollment for form.

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

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

If yes, complete the following. **Send the court papers for all North Dakota and out of state misdemeanor and felony convictions.**

Date	Offense

* Attach additional sheets if necessary.

5. 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.

6. Are you physically/mentally able to provide services yourself?	☐ Yes ☐ No	If no, explain.
7. 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.
8. Have you ever stolen or taken property without permission?	☐ Yes ☐ No	If yes, explain.
9. Do you have a contagious/infectious disease?	☐ Yes ☐ No	If yes, explain.

10. Have you ever been disciplined or terminated from an agency that is enrolled as a qualified service provider?	☐ Yes ☐ No If yes, attach explanation.
11. If employed as staff member of an agency enrolled as qualified service provider have you ever submitted inaccurate service records, billing information or documentation?	☐ Yes ☐ No If yes, attach explanation.
12. 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 Human Services denied, revoked,suspended, restricted or terminated?	☐ Yes ☐ No If yes, attach explanation.
13. Have you ever had your LPN/RN/CNA/PT/OT, etc. license denied, revoked, suspended, restricted, terminated or surrendered? If yes, please provide an explanation.	☐ Yes ☐ No If yes, attach explanation.

Initial each of the following to indicate your understanding and agreement:

_____ I am aware that in order to provide Family Home Care Services, I must live with the client/member, the client/member must be a relative, and understand that if my living situation changes I am required to notify the Department and the case manager immediately.

_____ I am physically able to provide services.

_____ I agree to read the enclosed Working Together for Home Fire Safety Fact Sheet and Exposing Invisible Killer Carbon Monoxide Fact Sheet.

_____ I will notify the member/client's HCBS case manager when the following occur:

1. Observed change in client's physical, cognitive, emotional, and/or environmental condition;
2. Change in the amount or type of services that may be needed by the client;
3. Possible abuse or exploitation of client;
4. Other circumstances as agreed upon with case manager for specific client(s).

_____ I will provide care at a level acceptable to the client and the Department of Human Services.

_____ I agree to assist the Department of Human Services in compliance investigations and will provide information in writing upon request.

_____ I agree not to 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 law and to deliver services.

_____ I will adhere to applicable federal and state laws.

_____ I will not provide service while under the influence of drugs or alcohol.

_____ 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 apropriate recrods.

_____ I will keep records for each client visit that includes all information required by the Department, as outlined in the Qualfied Service Provider Handbook.

_____ I have read the Family Home Care Handbook and will retain a current copy for my records.

_____ As a self-employed person, I understand that I am responsible for 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. Withholding and paying taxes on QSP payments is the responsibility of the self-employed individual.

_____	I agree to perform the work, service, and/or care myself.
_____	I assure that I have not been guilty of a crime against children or been convicted of a felony or misdemeanor. In the event that I am found guilty of a crime against children, been convicted of a felony or misdemeanor, or if a child abuse and neglect decision of "services required" is made, I will immediately notify the Department.
_____	I will not abuse, neglect, exploit, or assert undue influence on anyone under my care.
_____	I give the North Dakota Department of Human Services permission to check for my name in the North Dakota Child Abuse and Neglect Information Index and the Human Serv ice Zone Child Abuse and Neglect Files. I further consent that the information on the North Dakota Child Abuse and Neglect Information Index can be shared with the Home and Community Based Services (HCBS) Department Staff.
_____	I agree to notify the Department of Human Services within 14 days if my physical (911) address, legal name, primary phone number, or e-mail address changes.

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 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

Printed Name	Signature	Date