REQUEST TO BE A QUALIFIED SERVICE PROVIDER FOR FAMILY HOME CARE

DEPARTMENT OF HEALTH AND HUMAN SERVICES
MEDICAL SERVICES DIVISION
SFN 1604 (5-2023)

Clear Fields

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

Do not complete this application unless you are already in contact with a Case Manager or your family member has already been approved for this service.

IDENTIFYING INFORMATION - Provide a copy of government issued identification.

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	Gender ☐ Male ☐ Female	Date of Birth
Social Security Number	Current and/or Previous Provider number	

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 (if different)			Building, Suite Number, etc.
City	State	ZIP Code	County

FAMILY MEMBER INFORMATION

Family Member's First Name	Family Member's Last Name	Family Member's Relationship to You	County

Languages You Can Speak, Read, and Write? (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	_____

Check the Counties That Services 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

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 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	
Bank Address	City	State	ZIP Code
Bank Routing Transit Number	Bank Account Number	Account Type ☐ Checking ☐ Savings	
Account Holder's Name			

Submit a voided check or documentation from your financial institution.

CLAIMS SUBMISSION

Do you want to bill
☐ Online ☐ Paper

QUESTIONS

1. 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

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 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 immediately notify the Department of any changes to your conviction history.

6. I am physically and mentally able to provide QSP services.	☐ 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 Health and 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?	☐ 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 family member, the family 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 Fire Safety Checklist and The Invisible Killer Carbon Monoxide Fact Sheet, found in the FHC Handbook.

_____ I will notify the family member's HCBS case manager when the following occur:
1. Observed change in family member's physical, cognitive, emotional, and/or environmental condition;
2. Change in the amount or type of services that may be needed by the family member;
3. Possible abuse or exploitation of family member;
4. Other circumstances as agreed upon with case manager for specific family members.

_____ I will provide care at a level acceptable to the family member and the Department.

_____ I agree to assist the Department 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 or if a family member passes away. 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 family member visit that includes all information required by the Department, as outlined in the applicable Qualified Services Provider Handbook, QSP's who fail to keep records may be subject to criminal and monetary penalties.

_____ 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.

_____ Once approved as a QSP, if I am found guilty or plead guilty to any type of misdemeanor or felony, I will notify the Department within 14 days.

_____ I will not abuse, neglect, exploit, or assert undue influence on anyone under my care.

_____ I confirm I have not been found guilty or pled guilty to a crime against children. Once approved as a QSP, if I am found guilty or plead guilty to a crime against children, I will notify the Department within 14 days.

_____ I agree to notify the Department 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 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.

Printed Name	Signature	Date