AGENCY REQUEST TO BE A QUALIFIED SERVICE PROVIDER

DEPARTMENT OF HEALTH AND HUMAN SERVICES
MEDICAL SERVICES DIVISION
SFN 1606 (3-2023)

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

This application is for a group or a sole proprietorship with an Employer Identification Number (EIN). If you are an individual or a sole proprietorship that does not have an Employer Identification Number, then you must complete the Individual Enrollment Application form.

IDENTIFYING INFORMATION

Clear Fields

Group Information

Group Organization Name (DBA) (Must match line 2 of W-9)	Years Doing Business Under This Name
Have you ever used a different Doing Business As (DBA) name? ☐ Yes ☐ No	Former DBA Name

IMPORTANT: Your EIN will be linked to your ND provider number. All claims paid to your ND provider number will be submitted as income under your EIN to the Internal Revenue Service (IRS).The EIN must be for the group whose information was given.
NOTE: If the EIN ever changes, you must reapply for a ND provider number.

Is this application due to a change of ownership (CHOW)? ☐ Yes ☐ No	Previous Owner's Provider Number

Tax Reporting Information

Legal Name (Must match line 1 of W-9)	EIN	Begin Date	End Date

Primary Contact Person for QSP Enrollment

Last Name	First Name	Email Address

Current/Previous ND Provider Number

Current and/or Previous Provider Number	NPI

Non-Profit Organization Section

Is the business listed under tax-exempt status? ☐ Yes ☐ No
If yes, please send a copy of your IRS issued exemption.

Managing Owner/Owners or Managing Employee

1. Have the managing owner/owners or managing employee used any previous names (maiden, aliases) in the past 7 years?
☐ Yes ☐ No If yes, provide previous names below

* Attach additional sheets if necessary.

2. Are there any additional owners, directors, officers, agents, or managing individuals who have been convicted of a misdemeanor, felony, or who are currently on probation? ☐ Yes ☐ No If yes, complete the following:

NAME OF INDIVIDUAL	DATE	LIST OFFENSE/S

* Attach additional sheets if necessary.
Send the court papers for for all felony convictions and any misdemeanors in the past seven years.

3. Are there any owners, directors, officers, agents or managing individuals that are currently on probation? ☐ Yes ☐ No

If you answered yes, you are required to submit evidence of rehabilitation with your application. If this information is not provided, your application cannot be considered.

You are required to notify the Department of any changes to conviction history for any owners, directors, officers, agents or managing indiviudals within your company or organization.

SERVICE LOCATION, BILLING, AND MAILING INFORMATION

Service Location Information

Physical Address (P.O. Box not accepted)		
Building, Suite Number, etc.	County	
City	State	ZIP Code
Telephone Number and Extension	Fax Number	

Service Location Contact Person

Last Name, First Name, MI	Telephone Number and Extension (include area code)
Position	Cell Phone Number
Email Address	Fax Number

Billing Address (This address is equivalent to your pay to address where your checks will be mailed.)

Is this address the same as the Service Location? ☐ Yes ☐ No **If yes**, skip to the next question; if no, please fill out the billing address information. Is this address the same as the Mailing Address? ☐ Yes ☐ No **If yes**, skip to the next question; if no, please fill out the billing address information.			
Payee Name			
Building, Suite Number, etc.	PO Box / Street Address		
City	State	County	ZIP Code

Billing Location Contact Person

Last Name, First Name, MI	
Position	Fax Number
Email Address	Telephone Number and Extension

Mailing Address (This is the address where bulletins, manuals, reports, updates, etc. will be sent)

Is this mailing address the same as service location? ☐ Yes ☐ No **If yes**, skip to the next question.			
Building, Suite Number, etc.	PO Box / Street Address		
City	State	County	ZIP Code

Mailing Location Contact Person

Last Name, First Name, MI	
Position	Fax Number
Email Address	Telephone Number and Extension

LICENSURE / CERTIFICATION

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

License/Certification Information

License Number	Licensing Agency	Effective Date	Expiration Date	State
A				
B				
C				
D				

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 sufficient proof of employee competencies, you will **automatically be enrolled in the following specialties**: **Homemaker, Personal Care, 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)

Note: By checking the box above and providing sufficient proof of employee competency in the cognitive global endorsement (see handbook), you will **automatically be enrolled in the following specialties**: **Companionship, Respite Care, Supervision**.

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, some of these require additional documentation for enrollment consult the Handbook for requirements for each service.)

☐ Adult Day Care
☐ Adult Residential Care
☐ Assisted Living Facility - Personal Care
☐ Case Management
☐ Community Support
☐ Emergency Response Systems
☐ Environmental Modification
☐ Home Delivered Meals
☐ Nurse Education
☐ Nursing Assessment
☐ Residential Habilitation
☐ Respite Care - Institutional
☐ Respite in Adult Foster Care
☐ Specialized Equipment
☐ Supported Employment
☐ Transition Coordination
☐ Transitional Living

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

Note: By selecting this service you acknowledge you have read, understand, and will maintain current education to a minimum of two employees on the following:

- The generally accepted procedure for seasonal cleaning or unusual/heavy cleaning.
- Following manufacturers instructions for supplies used and equipment needed to complete specific chore tasks.
- Understanding of proper mixing and disposal of chemicals used in cleaning.
- The ability to operate snow removal equipment.
- The ability to operate mowing equipment.

☐ Chore Service - **Pest Extermination Services Only** (Check box to enroll in this service)

By selecting this service, you acknowledge you have read, understand and will maintain current education to all employees providing the services of the generally accepted procedures for **pest extermination**.

Check the box below to select the appropriate service and to enroll for this service.

☐ **Extended Personal Care**

☐ **Extended Personal Care** - **Nurse** (Staff must have proper license to enroll in this service)

Note: By selecting this service(s) I acknowledge I have read, understand, and agree to comply with the following requirements: Each employee providing this service will read, sign and date an SFN 576 Extended Personal Care Service Provider Agreement form, to be kept in their employee personnel file. You are not required to submit this form, unless requested by the Department.

Without a current signed and dated SFN 576 on file, employees are not eligible to provide this service.

Check the box below to select the appropriate service and to enroll for this service.

☐ **Nurse Education** (Staff must have a proper license to enroll in this service)

Note: By selecting this service(s) I acknowledge I have read, understand, and agree to comply with the following requirements: Each employee providing this service will read, sign and date an SFN 577 Nurse Educator Nursing Plan of Care (NPOC) Agreement form, **completed by a current RN only**, to be kept in their employee personnel file. You are not required to submit this form, unless requested by the Department.

Without a current signed and dated SFN 577 on file, employees are not eligible to provide this service.

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

Note: By selecting this service you acknowledge that you have read, understand, and agree you will maintain current education to a minimum of two employees on the following:

- If providing Driver with Vehicle Services, I, the undersigned QSP Agency, affirm that the vehicle(S) used to provide transportation is/are 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 which may arise out of or result from the operation of the vehicle.
- If employees are providing their own vehicle to transport clients, I agree to maintain a current, signed statement in the employee file attesting to the condition of their vehicle. If an employee will be driving the client's vehicle, the Agency will maintain a signed statement from the client agreeing to the use of their vehicle.
- **All agency representatives and employees providing this services are required to maintain a current driver's license and verify with their insurance carrier to ensure current and appropriate coverage for this service. Agencies are not required to submit insurance information to the Department.**
- **I agree to notify the Department if our agency no longer meets the standards for this service.** I agree to notify the Department if my (or an employee) driving record changes and I no longer meet the standards for this service.

Medication Error Agreement

Enrollment in the following services requires you to acknowledge you have read, understand and agree to the following statement.

Adult Day Care	***Community Support***	***Residential Habilitation***
Adult Residential Care	***Institutional Respite Care***	***Transitional Living***

☐ **By checking this box, you agree to the following statements:**

QSPs enrolling for these services provided under the North Dakota HCBS Medicaid Waiver are required by the Centers for Medicare and Medicaid (CMS) to ensure the following health, welfare, and safety quality measures are met:

1. A report will be filed with ND Medicaid describing a medication error or omission, which resulted in one of the following:
   - Imminent danger to the health, safety or security of the waiver recipient;
   - Potential for jeopardizing the waiver recipients health safety or security if left uncorrected;
   - Hospitalization of the recipient;
   - Sentinel event i.e. death of a waiver recipient.
2. The report must be filed within 5 days of the incident.
3. A written plan will be provided to abate or eliminate immediately, or within a fixed period of time as outlined by the basic care, swing bed or nursing home facility licensing requirements, the practices or conditions that resulted in the incident.
4. Critical Incident Reporting is required. 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 waiver participant. Reportable incidents include:
   - **Abuse, Neglect, or Exploitation** events.
   - **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.

- **Serious Injury or Medical Emergency** which would not be routinely provided by a primary care provider.
- **Wandering or Elopement** from the agency.
- **Restrain Violations** (Use of restraints not documented in care planning.)
- **Death** of a waiver recipient and cause.
- Report of all **Medication Errors** or omissions.
- Any event that has the potential to jeopardize the waiver recipients health, safety or security if left uncorrected.
- Changes in health or behavior that may jeopardize continued services.
- Illnesses or injuries that resulted from unsafe or unsanitary conditions.

All reports must be filed within 24 hours of the incident to the case manager.
An incident report must be completed using the General Event Reports (GER) form:
https://help.therapservices.net/app/answers/detail/a_id/2039/kw/offline%20forms#OfflineForms-GER

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 _____
☐ Cambodian/Kampuchean	☐ French	☐ Japanese	☐ Russian	☐ Syrian	

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

Service Area

ONLY Check counties in which you have adequate staffing to provide services.

Define your service area by counties served, or by distance from your location:

☐ Adams	☐ Dickey	☐ Hettinger	☐ Mountrail	☐ Sargent	☐ Ward
☐ Barnes	☐ Divide	☐ Kidder	☐ Nelson	☐ Sheridan	☐ Wells
☐ Benson	☐ Dunn	☐ LaMoure	☐ Oliver	☐ Sioux	☐ Williams
☐ Billings	☐ Eddy	☐ Logan	☐ Pembina	☐ Slope	☐ Out-of State
☐ Bottineau	☐ Emmons	☐ McHenry	☐ Pierce	☐ Stark	☐ Within 10 Miles
☐ Bowman	☐ Foster	☐ McIntosh	☐ Ramsey	☐ Steele	☐ Within 25 Miles
☐ Burke	☐ Golden Valley	☐ McKenzie	☐ Ransom	☐ Stutsman	☐ Within 50 Miles
☐ Burleigh	☐ Grand Forks	☐ McLean	☐ Renville	☐ Towner	☐ Within 100 Miles
☐ Cass	☐ Grant	☐ Mercer	☐ Richland	☐ Trail	☐ Within 500 Miles
☐ Cavalier	☐ Griggs	☐ Morton	☐ Rolette	☐ Walsh	☐ Within 999 Miles

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 names 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	
Bank Address			
City		State	ZIP Code
Bank Routing Transit Number	Bank Account Number	Account Type ☐ Check ☐ Savings	
Account Holders Name			

Submit a voided check or documentation from your financial institution.

ELECTRONIC VISIT VERIFICATION (EVV)
Please refer to Agency Handbook for more information on which services require EVV.

Please indicate which EVV system you will be using:

☐ Therap (State Contracted System) ☐ Other (If other, please provide name): _____

(You are responsible for all costs and set up associated with using a non-state contracted EVV system and Aggregator. There is no charge for utilizing the state contracted EVV system).

CLAIMS SUBMISSION

Method of Submission
☐ North Dakota Health Enterprise Portal (MMIS) ☐ Therap ☐ Other (if other, please provide name)

Carefully read each of the statements below and initial at the bottom of this section.

- The agency will notify the client's case manager or the Human Service Zone when any of the following occur:

  1. Client is not home at the scheduled time 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 case manager for specific client(s).

- The Agency will adhere to applicable federal and state laws.
- The Agency will provide care at a level acceptable to the client and Health and Human Services.
- The Agency cannot be compensated for services provided to a client by the direct care person who is the spouse, parent of child (client) under 18 years of age, or has been ordered by the court to provide such care.
- 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 records.
- I will keep records for each client visit that includes all infromation required by the Department, as outlined in the Qualfied Service Provider Handbook.The Department will request a refund or process adjustments to take back payment made to a provider if the provider does not provide the requested records or keep appropriate records.
- The Agency will assure that all employees providing non-medical transportation services meet all the non-medical transportation standards listed in the Agency Qualified Service Providers Handbook.
- The Agency will not assign an employee to deliver the service until it is documented and on file that he/she meets all the required standards, according to the current handbook guidelines, including any endorsements that may be required for the service. These will be updated according to the current handbook guidelines, and kept in agency personnel files.
- The Agency will not assign an employee to provide services in an Agency Foster Home for Adults until a background check has been completed by the Department.
- The Agency will check websites listed in the handbook on a regular basis to ensure employees continue to meet standards. Notify HCBS of positive findings, misdemeanors or felonies.
- The Agency will assure an infections/contagious self declaration form is on file and updated every two years for staff who provide services to public pay clients.
- Agency staff will review the Fire Safety Fact Sheet, Carbon Monoxide Fact Sheet, and universal precautions enclosed in the handbook.
- The Agency assures that employees who provide services to public pay clients are age 18 and over.
- The Agency verifies that they have procedures in place to accurately document the provision services for public pay clients and that they have trained the individuals providing services in their responsibility to report services properly and accurately.
- The Agency will maintain records for each client that includes the: (1) name of the client and ID, (2) name of the provider and ID (and employee who performed the task), (3) date, and location of the service, (4) start time and end time (including a.m. and p.m.), (5) units of service, and (6) tasks performed.
- The Agency will not assign an employee to provide services to public pay clients if the employee has been found guilty of, pled guilty to, or pled no contest to an offense described in N.D. Administrative Code 75-03-23-07(2)(b)(1).
- The Agency will not assign an employee to provide services to public pay clients if the employee has been found guilty of, pled guilty to, or pled no contest to an offense, if the Department has not determined that the individual has been sufficiently rehabilitated as outlined in N.D. Administrative Code 75-03-23-07(2)(b)(2). The Agency must contact the Department for the determination.
- Agency staff will assist the Health and Human Services in compliance investigations and will provide information in writing upon request.
- The Agency assures that staff will not accept gifts of money from the client and will not smoke, consume alcoholic beverages, report to work under the influence of drugs or alcohol, consume the client's food, conduct personal business in the client's home or use the client's property for personal use.

- The Agency has a Quality Improvement Program that meets the standards set forth by the Department. If accredited by the Council on Quality and Leadership (CQL), the Agency meets these standards.
- The Agency assures that staff will not provide services in the client's home unless the client is at home.
- I agree to notify the Department within 14 days when the agency's physical address changes.
- The Agency assures current contracts will be reviewed to ensure there are no conflicts prohibiting QSP services (Example: a current contract stating the facility will not seek additional federal funding of beds).
- If providing Home Delivered Meals (HDM), I acknowledge compliance with all local, state and federal laws and regulations: NDAC 33-33-04.

Policies and Procedures

Initial each of the following to acknowledge your agency has established each policy in writing. The Department requires each policy is reviewed and revised by Agency staff as needed upon initial enrollment and before each renewal. These policies do not need to be submitted to the Department; however, they must be available upon request at any time.

Initials		Date Reviewed/Revised
_____	Agency Compliance Program	_____
_____	Process of reporting suspected Fraud, Waste, and Abuse	_____

If your agency is only providing Emergency Response Services, Home Delivered Meals, Environmental Modification or Specialized Equipment, the below policies are not required and do not need to be initialed.

_____	Process of Reporting Critical incidents to the Department	_____
_____	Employee screening: initial, routine, and ongoing	_____
_____	Plan of staff training to accurately document time and tasks	_____
_____	Supervision of employee including job title, method and frequency of supervision	_____
_____	Smoking to include e-cigarettes/vaping, consuming alcoholic beverages and/or illegal drugs	_____
_____	Soliciting or accepting gifts and money from the client	_____
_____	Conducting personal business in the client's home	_____
_____	Consuming the client's food, using the client's property, and/or handling the client's money	_____
_____	Timeliness of service delivery upon receipt of referral, including routine and emergency referrals	_____
_____	Plan to meet the requirement for seven (7) day per week service coverage (if applicable)	_____
_____	Procedure for coverage for clients during employee absence	_____
_____	Confidentiality of client information	_____
_____	How client complaints are handled	_____

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.

SIGNATURE

Printed Name	Title	Date
Signature		