REQUEST TO BE A QUALIFIED SERVICE PROVIDER/AGENCY FOSTER HOME FOR ADULTS/AFHA

NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES
MEDICAL SERVICES DIVISION
SFN 1619 (4-2020)

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

Clear Fields

IDENTIFYING INFORMATION

Group Information

Group Organization Name (DBA)	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	EIN	Begin Date	End Date

Current/Previous ND Provider Number

Current and/or Previous Provider Number

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 within ten days of any changes to conviction history for any owners, directors, officers, agents or managing indiviudals within your company or organization.

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.

SERVICE LOCATION, BILLING, AND MAILING INFORMATION

Service Location Information

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

Service Location Contact Person

Name (Last, First, 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			
PO Box / Street Address	Building (Suite/Apartment number etc.)		
City	State	County	ZIP Code

Billing Location Contact Person

Name (Last, First, 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.

PO Box / Street Address	Building (Suite/Apartment number etc.).		
City	State	County	ZIP Code

Mailing Location Contact Person

Name (Last, First, 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

Provider Type: Qualified Service Provider

License Information

License Number	Licensing Agency	Effective Date	Expiration Date	State
A				
B				

Certification Information

License Number	Licensing Agency	Effective Date	Expiration Date	State
A				
B				

Provider Specialty Information

Note: Your specialty is the Service you seek to provide.

☐ Community Supports ☐ Residentional Rehabilitation

While 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 service are required to maintain a current drivers 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.

Provider Signature	Date

GLOBAL ENDORSEMENT

Indicate category(s) in which Global Endorsement is sought:

☐ Catheter (CA) ☐ Hoyer Lift/Mechanized Bath Chair (Ho) ☐ Suppository (non-prescription) (Su)

☐ Cognitive/Supervision (Co) ☐ Medical gases (oxygen only) (Me) ☐ Ted Stockings (Ts)

☐ Exercise (Ex) ☐ Prosthesis/Orthotics/Adaptive Devices (Pr) ☐ Temperature/Blood Pressure/Respiration Rate/Pulse (Te)

SERVICE

Provider Website	Gender Served ☐ Male ☐ Female ☐ Both

Age Served
☐ All ☐ 0-5 years ☐ 6-12 years ☐ 13-17 years ☐ 18-21 years ☐ 22-59 years ☐ 60+ years

Languages Supported (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 _____

Service Area

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

Is this location wheelchair accessible?	☐ Yes ☐ No		
Is this location TDD/TTY equipped? If yes, enter number.	☐ Yes ☐ No	TDD/TTY Telephone Number	
Does this location provide after-hours services? If yes, enter number.	☐ Yes ☐ No	After-Hours Contact Telephone Number	
Do you wish to be excluded from public Provider searches?	☐ Yes ☐ No		

ELECTRONIC FUNDS TRANSFER

Direct deposit is required for Agency QSPs. please fill out the EFT information below.

Bank Name		Bank Telephone Number	
Bank Address			
City		State	ZIP Code
Bank Routing Transit Number	Bank Account Number	Account Type ☐ Checking ☐ Savings	
Account Holders Name		Payee Provider's Name	

Submit a voided check or documentation from your financial institution.

Initial each of the following to indicate your understanding and agreement

The agency will notify the client's case manager or the County Human Zone when any of 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; and
4. 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 the Department of 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.

_____ Agency will keep client authorizations and service records for each client visit that include all required information as indicated in the AFHA Handbook. Records must be kept 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 understand that records must be kept even if the Agency closes and agree to provide records to the Department upon request. I understand that the Department will request a refund or process adjustments to take back payments made if the agency does not submit the requested records or keep appropriate records.

_____ The Agency verifies that they have procedures in place to accurately document the provision of furnished services for public pay clients and that they have trained employees in their responsibility to accurately document for provided services.

_____ 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, printed in the Qualified Service Provider handbook, including any endorsements that may be required for the service. These will be updated every two years and kept in agency personnel files.

_____ The Agency will not assign an employee to provide services in an Adult Foster Care Home for Adults (AFHA) until a background check has been completed by the Department.

_____ The Agency will ensure all employees meet standards at all times. 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)(2) or if the Department has not determined that the individual has been sufficiently rehabilitated. The agency must contact the Department for approval. Notify the QSP Enrollment office of any positive findings, misdemeanors or felonies within 10 days for any employees or owners.

_____ Agency staff will review the Working Together for Home Fire Safety and Exposing an Invisible Killer Fact Sheet enclosed in the handbook.

_____ Agency staff will assist the Department of Human Services in compliance investigations and will provide information in writing upon request.

_____ I agree to notify the Department of Human Services within 14 days when the agency's physical 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.

SIGNATURE

Printed Name	Title	Date
Signature		