QUALIFIED SERVICE PROVIDER (QSP) ACKNOWLEDGMENT

DEPARTMENT OF HEALTH AND HUMAN SERVICES
ADULT AND AGING SERVICES
SFN 1702 (3-2025)

Clear Fields

Thank you for accepting this referral to provide home and community-based services (HCBS). To best serve the individual please fill out this form and return it to the QSP Navigator. Once this form as been received it will be reviewed by Adult and Aging Services for final approval before additional details of the client will be released.

QSP Individual and/or Agency Name		QSP Provider Number
QSP Contact Person Name	QSP Contact Telephone Number	QSP Contact Email Address

Are you able to start right away?

- ☐ Yes - When can you start? _____
- ☐ No - When could you start? _____

Do you have staff located in the community of the individual to provide care?

- ☐ Yes
- ☐ No - Do you need to hire staff before you could begin providing care to the individual?
  - ☐ Yes
  - ☐ No
  - ☐ Other (specify): _____

Will you be seeking a rural differential rate for this employee?

- ☐ Yes - Answer Below:
- ☐ No

Employee Name			
Address	City	State	ZIP Code

Additional information you would like to make Adult and Aging Services aware of:

Signature	Date