NORTH DAKOTA DEVELOPMENTAL DISABILITY PROVIDER APPLICATION

NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES
DEVELOPMENTAL DISABILITIES DIVISION
SFN 1794 (8-2018)

Clear Fields

The North Dakota Department of Human Services requires that services and settings be provided according to applicable regulations, policies, state and federal laws. Failure to abide by these may result in adverse actions including, but not limited to the denial or termination of a license.

To ensure timely processing of your application, please attach and submit the following required documents by mail or email to:

DD Division
Attn: Licensing Unit
1237 W Divide Ave, Suite 1A
Bismarck, ND 58501-1208
OR
dhsddreq@nd.gov

- ☐ Copy of Invitation to Submit Application following successfully completed Letter of Intent
- ☐ Completed and signed Individual Provider Application (SFN 1794)
- ☐ Copy of verification of completion of New Developmental Disabilities (DD) Provider Orientation
- ☐ Copy of verification of Council of Quality Leadership (CQL) Systems Accreditation
- ☐ Copy of verification of training through Minot State University
- ☐ Copy of verification of completion of Abuse and Neglect Training
- ☐ Copy of staff qualifications
- ☐ Health Enterprise MMIS Application
- ☐ W-9
- ☐ Lease Agreement
- ☐ Medicaid Program Provider Agreement (SFN 615)*
- ☐ Governance Statement (SFN 1549)*
- ☐ Financial Disclosure Statements (SFN 236)*
- ☐ Criminal Conviction Statements (235)*
- ☐ Proof of Insurance (SFN 234)*
- ☐ Blueprints
- ☐ Policies/Procedures Checklist (SFN 1544)*
- ☐ Subminimum Wage Certificate*
- ☐ For facility-based locations, include Fire and Sanitation inspections for each location (SFN 223 and SFN 1545)*
- ☐ Initial Home & Community Based Services (HCBS) Setting Review for new waiver settings
- ☐ Provider Assurance to the Federal Home and Community Based Services (HCBS Regulations) (SFN 1010)*

* Needed upon license renewal

Provider Information	☐ Initial	☐ Renewal	☐ Change

A. Demographic Information

Provider Agency Name			
Address	City	State	ZIP Code
Telephone Number / Fax Number	Email Address		
Website (if applicable)	Organizational Status ☐ Government ☐ For Profit ☐ Non- Profit		

B. Service Location Information - complete one form for each service and individual location

Service Name

- ☐ Residential Habilitation
- ☐ Independent Habilitation
- ☐ Intermediate Care Facility (ICF/IID)
- ☐ Infant Development
- ☐ Day Habilitation
- ☐ Prevocational Services

Family Support Services (FSS)

- ☐ In-Home Supports
- ☐ Parenting Supports
- ☐ Extended Home Health Care
- ☐ Family Care Option

Employment Supports

- ☐ Individual Employment Supports
- ☐ Small Group Employment Supports

Physical Address	City	State	ZIP Code

Property Ownership	Provider Owned
☐ Own ☐ Lease ☐ Rent ☐ Other	☐ Yes ☐ No
Type of Setting	**Client Number**
☐ Facility Based ☐ Non-facility Based	

Region(s) of Operation - write in the Roman Numeral from the list below

County Served within Each Region (fill in from the list below)

Region(s) of Operation	County Served within Each Region
I	Divide, McKenzie, Williams
II	Bottineau, Burke, McHenry, Mountrail, Pierce, Renville, Ward
III	Benson, Cavalier, Eddy, Rolette, Towner, Ramsey
IV	Grand Forks, Nelson, Pembina, Walsh
V	Cass, Ransom, Richland, Sargent, Steele, Traill
VI	Barnes, Dickey, Foster, Griggs, LaMoure, Logan, McIntosh, Stutsman, Wells
VII	Burleigh, Emmons, Grant, Kidder, McLean, Mercer, Morton, Oliver, Sheridan, Sioux
VIII	Adams, Billings, Bowman, Dunn, Golden Valley, Hettinger, Slope, Stark

By signing below, I certify that the information provided is accurate, complete and compliant with the rules and standards of the Department. I further agree to release such information as the Department deems necessary to make a determination of the applicant's capacity to serve individuals.

Signature	Title	Date
Signature	Title	Date

Accreditation/Certification

Body	Date	Expiration Date
Body	Date	Expiration Date