AUTHORIZATION TO PROVIDE DEVELOPMENTAL DISABILITY SERVICES

NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES
DEVELOPMENTAL DISABILITIES/HOME AND COMMUNITY BASED SERVICES
SFN 1810 (8-2018)

Clear Fields

SECTION I

By accepting this Authorization to Provide Services the Provider agrees to provide the services in accordance with standards and conditions agreed to in signing the Medical Assistance Program Provider Agreement as a designated Qualified Service Provider. If an authorization is for multiple providers the monthly total authorized dollar(s)/units for a client may not be exceeded by the combined providers. **This authorization is not a guarantee of payment for service. Providers can verify client eligibility for Medicaid by contacting VERIFY at 1-800-428-4140 or 701-328-7098. Clients may be responsible for a recipient liability or service fee that is payable to the Qualified Service Provider.**

Qualified Service Provider(s) Name (Last, First)	QSP Number	Client Name (Last. First)	
QSP Physical Address		Medicaid ID Number	
Is approximate mileage for Rural Differential (RD) over 21 miles? ☐ Yes - Choose RD Tier (choose one): ☐ RD1 ☐ RD2 ☐ RD3 ☐ No	RD Removed Date	Address City	Telephone Number State / ZIP Code
Authorization Period **From To** **Six Month Review Authorization Period** **From To**	Authorization Not to Exceed Intermittent Unit Rate $ _____ Per/**month**	☐ AFC or ☐ AFC-RC Authorization Not to Exceed **Daily** Rate of $	

SECTION II

Service(s) Authorized: Please [X] service, units authorized, and record dollar amount for the service.

Service	Procedure Code	Unit Rate	Units Per Month	Cost/Month
☐ Adult Foster Care (AFC)	00026			
☐ Homemaker (HM)	00010			
☐ AFC-Respite Care Service (AFC-RC)	00012			

SECTION III

Task(s) Authorized: Please [X] all authorized tasks. (An explanation of the tasks is printed on the back of this form.)

☐ Bathing (NA for HM)	☐ Incontinence (NA for HM)	☐ Nail (Finger) Care (NA for HM)
☐ Communication (NA for HM)	☐ Laundry	☐ Shopping (NA for AFC-RC)
☐ Dress/Undress (NA for HM)	☐ Meal Preparation (NA for AFC)	☐ Skin Care (NA for HM)
☐ Eye Care (NA for HM)	☐ Medication Assistance (NA for HM)	☐ Teeth, Mouth, Denture Care (NA for HM)
☐ Feeding (NA for HM)	☐ Mobility - Inside (NA for HM)	☐ Toileting (NA for HM)
☐ Hair Care/Shaving (NA for HM)	☐ Mobility - Outside (NA for HM)	☐ Transferring/Turning/Positioning (NA for HM)
☐ Housework	☐ Money Management (NA for AFC-RC)	☐ Transportation (NA for HM/AFC-RC)

GLOBAL ENDORSEMENTS: Only a provider who carries a global endorsement may provide these activities and tasks. Refer to the QSP list to determine which global endorsements the provider is approved to provide. (NA for HM)

☐ Cognitive/Supervision	☐ Hoyer Lift	☐ Medical Gases	☐ Suppository	☐ Temp/Pulse/Respiration/ Blood Pressure (Individual to be contacted for readings)
☐ Exercises	☐ Indwelling Bladder Catheter	☐ Prosthesis/Orthotics	☐ Ted Socks	_____

CLIENT SPECIFIC ENDORSEMENTS: Documentation by a health care provider required verifying client specific instructions. (NA for HM)

☐ Apnea Monitor	☐ Jobst Stockings	☐ Ostomy Care	☐ Postural/Bronchial Drainage	☐ Rik Bed Care

Annual/Initial Authorization (DDPM's Signature/Date)	**Six Month Review:** If no change in SECTION II or III is needed, authorization to provide service continues as agreed upon.
Authorization Canceled (DDPM's Signature/Date)	DDPM's Signature/Date

Distribution: Original - Qualified Service Provider Copy - Client's File Copy - Client Copy - DD/HCBS

AUTHORIZED SERVICE ACTIVITIES

BATHING assisting a client with tub/shower/bed bath, dressing after the bath, and bathroom cleanup.
COMMUNICATION limited to assisting the client in using the telephone, and client directed reading of mail and sending mail related to obtaining and managing essential services.
DRESS/UNDRESS assisting a client in getting dressed and undressed.
EYE CARE limited to routine regimen of eye drops, ointment, eye pad. **Does not include prescription eye drops or prescription ointment.**
FEEDING assisting a client to eat who is unable to eat without assistance. **Does not include tube feedings.**
HAIR CARE assisting a client with wash/comb hair and shaving. Does not include cutting hair.
HOUSEWORK routine light cleaning that includes dusting, vacuuming, floor care, garbage removal, changing linens, dishwashing, and other similar tasks in rooms occupied or used by the client. **Must be done when the client is at home**.
INCONTINENCE assisting the client with routine care associated with incontinence.
LAUNDRY includes washing, drying, folding, putting away, ironing, mending and other similar tasks. **Must be done in the client home or a laundromat. Client must be home when the service is provided.**
MEAL PREPARATION includes planning, preparing and serving the meal(s). **Does not include canning of produce or baking of such items as cookies, cakes, bread. Meals must be prepared in the client's home.**
MEDICATION ASSISTANCE limited to assisting with client self administration of routine oral medications by doing the following opening container, assisting the client with proper position for taking medication; assist with giving client drinking fluid to swallow medication; recap the container.
MOBILITY assisting the client to walk, use wheelchair, walker, crutches or cane.
MONEY MANAGEMENT limited to assistance with monthly budgeting or bill paying.
NAIL CARE limited to routine fingernail care to persons who do **NOT** have diabetes, heart disease, fungus, or circulatory disease problems. **Cutting of toenails is not allowed.**
SHOPPING limited to purchasing items for clients.
SKIN CARE limited to prophylactic (preventative) and palliative (relief or relieving) skin care, including application of creams or lotions for minor skin problems. **Does not include prescription ointment, prescription lotion or other prescription topicals, or wound care or care of skin lesions.**
TEETH, MOUTH, DENTURE CARE assisting a client with oral hygiene, brushing teeth, and cleaning dentures.
TOILETING assisting the client with all aspects of routine regime for toileting.
TRANSFERRING/TURNING/POSITIONING assisting the client with routine sitting up or positioning on back while in bed, transferring needs, using transfer belt, standard sit, bed to wheelchair, etc.
TRANSPORTATION limited to AFC.

GLOBAL ENDORSEMENTS (Only a provider who carries a global endorsement may provide these activities and tasks.)
COGNITIVE/SUPERVISION assisting a client who needs supervision continuously, except for brief periods of time, for health/safety, cognitive and/or behavioral reasons.
EXERCISES limited to assisting with routine exercises, which have been recommended in writing by a therapist for a client, to maintain or improve physical functioning that was lost or decreased due to an injury or a chronic disabling condition (i.e., multiple sclerosis, Parkinson's, stroke, etc.). Exercise does not include physical activity that generally should be an aspect of a wellness program for any individual (i.e., walking for weight control, general wellness, etc.)
HOYER LIFT/MECHANIZED BATH CHAIRS assistance with routine use of mechanized bath chair or hoyer lift used by client.
INDWELLING BLADDER CATHETER limited to general maintenance care after a well-established routine of care has been established for the client. **No catheterization of client allowed.**
MEDICAL GASES limited to routine assistance with medical gases after a regimen of therapy has been established. Limited to oxygen use only.
PROSTHESIS/ORTHOTICS/ADAPTIVE DEVICES assist to apply and remove.
SUPPOSITORY limited to assisting with suppository only to maintain bowel program. **Does not include prescription suppositories.**
TED SOCKS apply ted socks according to manufacturer instructions. Limited to routine care for chronic conditions, ted socks only.
TEMPERATURE/BLOOD PRESSURE/PULSE/RESPIRATION RATE limited to taking the routine measurements. Vital signs, including temp/ pulse/respiration/blood pressure, can be authorized upon the written recommendation of a health care provider which outlines the requirements for monitoring, reason vital signs should be monitored, and the frequency. When the tasks of temp/pulse/ respiration/blood pressure are authorized, the individual to be contacted for readings must be listed on the SFN 1810.

CLIENT SPECIFIC ENDORSEMENTS (These activities and tasks may be provided only by a personal, respite, or AFC service provider who has demonstrated competency.)
APNEA MONITOR limited to routine assistance with apnea monitoring. Evidence of having training equivalent to what a primary caregiver has received for this specific client.
JOBST STOCKINGS routine care for chronic conditions. Evidence of having training equivalent to what a primary caregiver has received for this specific client.
OSTOMY CARE limited to general maintenance care after a well established routine of care has been set forth for the client. Evidence of having training equivalent to what a primary caregiver has received for this specific client.
POSTURAL/BRONCHIAL DRAINAGE limited to routine procedure established for client. Must have received specific training from a therapist who specializes in this procedure.
RIK/SPECIALTY BED CARE limited to client specific requirements. Evidence of having training equivalent to what a primary caregiver has received for this specific client.