

## FAMILY HOME CARE (FHC) QSP ENROLLMENT CHECKLIST

**All documentation listed below is required for enrollment and renewal:**  
*Please refer to the Handbook for more information.*

- ☐ Copy of Government Issued Identification (i.e. driver's license, tribal ID, etc.)
- ☐ SFN 1604 – Individual Request to be a Qualified Service Provider
- ☐ SFN 1168 – Ownership/Controlling Interest and Conviction Information
- ☐ SFN 433 – Child Abuse and Neglect Background Inquiry
- ☐ SFN 615 – Medicaid Program Provider Agreement
- ☐ W-9 – Request for Taxpayer Identification Number and Certification
- ☐ Fraud, Waste and Abuse (FWA) Training Certificate of Completion

**It is important that you always send the most updated version of these forms to HCBS.** If we receive outdated forms, they will be returned to you, which will delay your enrollment.

Please check our website (<http://www.nd.gov/eforms/>) to make sure you have the most recent version of forms. The form number and the date each form was revised can be found at the top left of the form (shown below).

**If you have any questions, please call:  
1-800-755-2604 or 701-328-4602.**

**The forms must be completed with a pen or typed.  
Signatures are required.**

You can email, fax or mail your complete packet to:

Email: [DSHHCBS@ND.GOV](mailto:DSHHCBS@ND.GOV)

Fax: 701-328-4875

Mail: Medical Services/HCBS Division  
600 E Boulevard Ave Dept. 325  
Bismarck ND 58505-0250



# GOVERNMENT ISSUED IDENTIFICATION

**A legible photocopy of ONE official government issued form of identification must be sent to the department.**

Examples:

Driver's License

Non-Driver Identification

Tribal Identification

Military Identification

Passport

Social Security Card

Your application will NOT be processed without one of these submitted. If the photocopy cannot be read, it will be returned to you and a new copy will be requested.

# INSTRUCTIONS TO COMPLETE SFN 1604

## INDIVIDUAL REQUEST TO BE A QUALIFIED SERVICE PROVIDER FOR FAMILY HOME CARE

### Identifying Information:

- List your Last Name, First Name; Gender; Date of Birth and Social Security Number
- If you are currently enrolled as a QSP or have been enrolled as a QSP in the past, write your Provider #.
- List any previous names you have ever used in the past.

### Home Location Information (911 Address)

- Enter your complete physical or 911 address, including county.
- A PO Box is NOT accepted in this space.
- Enter your mailing/billing address, which is the address where you receive mail and where you want your checks sent.
- A PO Box is acceptable here.

### Enter your previous out-of-state addresses in the past 7 years

- If there is more than one address, please attach an additional sheet.

### Provider Specialty Information:

- Your client's name, relationship to you and the county the client lives in.

### Languages Supported:

- Check any languages that you can speak, read, write, and understand.

### Service Area:

- Check the county the service will be provided in.

### Electronic Funds Transfer (Direct Deposit)

- Check yes if you want your payments direct deposited into your bank account and complete the account information.
- Attach a voided check or documentation from your financial institution which has the financial routing number.
- **If this is not included, you will not be set up for direct deposit.**

### Claims Submission

- Check if you will use online billing via North Dakota Health Enterprise Portal by internet or paper billing by mailing or delivering your billing form.

### QUESTIONS:

- **#1** - Check the last grade of school you completed.
- **#2a** - Do you have the basic ability to read, write and verbally communicate in English?
- **#2b** - Do you need someone to help you read, write and verbally communicate in English?
  - If you are unable to read, write or verbally communicate in English, contact QSP Enrollment (contact information is on Page 1 of this packet).

- **# 3** - Have you ever been convicted of a misdemeanor offense?
  - **If yes, include official reports or a written explanation of offense.**
  - **Are you currently on probation?**
  - **If Yes, check the box and read and initial the following question.**
- **# 4** - Have you ever been convicted of a felony offense?
  - **If yes, include official reports or a written explanation of offense.**
  - **Are you currently on probation?**
  - **If Yes, check the box and read and initial the following question.**
- **#5 - #12** - Answer Yes or No.
  - Please read Question #8 carefully! This question is frequently misread.

## **STATEMENTS**

- Listed are assurances that you must make to enroll as a QSP to indicate your understanding and agreement.
- Read each statement carefully and then initial. All statements must be initialed, not checked.
- Agreement to all statements is required.

## **SIGNATURE:**

- **Print your name, sign, and then date.**
- Your signature verifies that the information being sent is true and correct to the best of your knowledge, and that you are aware this is a public document. Providing false information may be reason for the Department to deny or cancel any qualified service provider agreements.











**INSTRUCTIONS TO COMPLETE  
SFN 1168 Ownership/Controlling Interest and Conviction Information**

The following instructions apply only to **Individual QSPs**.

Section	Instructions for each section
<b>I</b>	<b>Identifying Information:</b> <ul style="list-style-type: none"> <li>➤ Only include the following: <ul style="list-style-type: none"> <li>➤ Your Name</li> <li>➤ Your Address</li> <li>➤ Your Phone Number</li> <li>➤ Your Email Address (If you have one)</li> </ul> </li> </ul>
<b>II</b>	<b>Direct/Indirect Ownership:</b> <ul style="list-style-type: none"> <li>➤ SKIP THIS SECTION</li> <li>➤ You do <u>not</u> need to fill in any information here</li> </ul>
<b>III</b>	<b>Managing Employee/Control Interest:</b> <ul style="list-style-type: none"> <li>➤ SKIP THIS SECTION</li> <li>➤ You do <u>not</u> need to fill in any information here</li> </ul>
<b>IV</b>	<b>Ownership/Controlling Interest:</b> <ul style="list-style-type: none"> <li>➤ SKIP THIS SECTION</li> <li>➤ You do <u>not</u> need to fill in any information here</li> </ul>
<b>V</b>	<b>Conviction Information:</b> <ul style="list-style-type: none"> <li>➤ Read the question, then: <ul style="list-style-type: none"> <li>➤ Check “yes” if you have been convicted or pled guilty to an offense listed in the question.</li> <li>➤ Check “no” if you have <u>not</u> been convicted or pled guilty to this type of offense.</li> </ul> </li> </ul>
<b>VI</b>	<b>Signature:</b> <ul style="list-style-type: none"> <li>➤ YOU are the authorized representative.</li> <li>➤ Provide your Name, Date of Birth, Social Security #</li> <li>➤ Sign and date the form.</li> </ul>

















**INSTRUCTIONS TO COMPLETE  
SFN 433  
CHILD ABUSE AND NEGLECT BACKGROUND INQUIRY**

**Part I: Agency/Organization Information** If not prefilled, write in:

- Agency/Organization: QSP Enrollment
- Contact Person: [DHSNCBS@ND.GOV](mailto:DHSNCBS@ND.GOV)
- Telephone Number: 701-328-4602
- Address: 600 E Boulevard Avenue, Bismarck ND 58505

**Part II: Authorization for Release of Information**

- Check both boxes and **initial both lines**
- Check “other for “This information is being requested for” After other, write QSP Enrollment.
- Last Name, First Name, and Middle Name are REQUIRED.
- When writing your name, you must include your FULL LEGAL NAME including your FULL MIDDLE NAME.
- If no middle name, check the box None.
- If you only have an initial instead of a full middle name, write the initial and check the box Initial Only.
- Social Security Number and Date of Birth is REQUIRED.
- If you have no former last name within the last 10 years, please make sure to check the box indicating none. This is for males and females and is REQUIRED.
- Complete all other boxes with your addresses.
- Sign and Date

**Part III: Do Not Write Below – State Office Use Only**

- Leave Blank

**Note: If you cross out any information, please initial your changes.**

**Failure to follow the above instructions will delay your application. The form will be returned to you to correct any missing/incomplete information.**





## CHILD ABUSE AND NEGLECT BACKGROUND INQUIRY

NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES

CHILD ABUSE AND NEGLECT PROGRAM

SFN 433 (1-2021)

### Part I: Agency/Organization Information

Agency/Organization Home & Community Based Services	Contact Person QSP Enrollment	Telephone Number (701) 328-4602	
Address 600 E BOULEVARD AVE	City BISMARCK	State ND	ZIP Code 58505
Email Address and/or Fax Number DHSCHBS@ND.GOV (701) 328-4875			

### Part II: Authorization for Release of Information (to be completed by the person giving consent/authorization)

- ☐ \_\_\_\_\_ (Initials) I give North Dakota Department of Human Services (NDDHS) and its' authorized agents (Human Service Zone agencies) permission to check the Child Abuse/Neglect Information Index for my name.
- ☐ \_\_\_\_\_ (Initials) I further give permission to NDDHS and its' authorized agents to release child abuse and neglect records pertaining ONLY to the services required decisions indicated below to the above-named agency/organization.  
(NOTE: If this statement is not *checked and initialed*, and if child abuse and neglect records contain any medical, drug, alcohol, or mental health treatment information, an Authorization to Disclose Information Form (SFN 1059) will be required.)

This information is being requested for: <b>(Check Only One)</b>				
<input type="checkbox"/> Employment with NDDHS	<input type="checkbox"/> Employment in a NDDHS Licensed or Contracted Agency	<input type="checkbox"/> Childcare/In-home Provider		
<input type="checkbox"/> Adoption Study	<input type="checkbox"/> Private Agency Employment/Volunteer	<input type="checkbox"/> Foster Parent Licensing		
<input checked="" type="checkbox"/> Other (List): QSP Enrollment				
LAST Name	FIRST Name	FULL MIDDLE Name <input type="checkbox"/> None <input type="checkbox"/> Initial Only	Social Security Number*	Date of Birth
Birth Name, Alias, or Other Married Names You Have Gone by in the Last Ten Years			<b>OR</b> <input type="checkbox"/> Check this box if you have no additional names	
Current Physical Address	City	State	ZIP Code	
Last North Dakota Address	City	State	ZIP Code	
Signature			Date	

\* The Privacy Act of 1974 (P.L. 93-579, Section 7) requires the following information be provided when individuals are requested to disclose their social security number. Disclosure of the social security number is voluntary and is requested for identification purposes. Failure to disclose this information may result in a delay in reporting results.

This authorization remains in effect for 60-days from the date of signature unless specifically revoked by written notice to the agency/organization contact person. Any disclosure prior to a written revocation of this authorization shall not be a breach of confidentiality. A photocopy of this authorization is as effective as the original.

### Part III: Do Not Write Below - State Office Use Only

(NOTE: Results only include a search of the ND Child Abuse/Neglect Information Index. No tribal agency registry information is available through the state Index.)

- ☐ The above-named individual is not listed on the ND Child Abuse/Neglect Information Index.
- ☐ An assessment decision of Services Required was found on the ND Child Abuse/Neglect Information Index.
- ☐ For further details, please contact the Human Service Zone listed below.

Human Service Zone	Telephone Number	Email Address	Decision Date
Signature of Person Completing CA/N Information Index Inquiry		Submit the completed form to: Children and Family Services 600 East Boulevard Avenue, Dept. 325 Bismarck, ND 58505 (701) 328-2316 E-mail: dhscfs_cani@nd.gov Fax: (701) 328-3538	
Date Completed			



**INSTRUCTIONS TO COMPLETE  
SFN 615  
MEDICAID PROGRAM PROVIDER AGREEMENT**

**On Page 1:**

- Provider – Your Name
- NPI – Leave BLANK
- Medicaid Provider Number –
  - If you are a new provider - Leave BLANK
  - If you are a renewing provider – provide your 7-digit provider number
- Address – Your Street Address, City, State and Zip Code
- **I wish to participate in (check all that apply):**
  - **Check the box for – Medicaid Fee For Service**

**On Page 4,**

- Provider – Your Name
- Title – QSP
- Date – Today's Date
- Provider Signature – Your Signature













**INSTRUCTIONS TO COMPLETE  
W-9  
REQUEST FOR TAXPAYER IDENTIFICATION NUMBER AND CERTIFICATION**

TOP Section:

- Line 1 - Name - Your Name
- Line 2 – SKIP
- Line 3 – Check the “Individual/Sole Proprietor box
- Line 4 – SKIP
- Lines 5 & 6 - Your Street Address, City, State and Zip Code
- Line 7 – SKIP

PART I – Taxpayer Identification Number

- Social Security Number – Include your Social Security Number

Part II – Certification

- Signature of US Person – Sign your Name here
- Date – Write today’s date



# Request for Taxpayer Identification Number and Certification

Give Form to the  
requester. Do not  
send to the IRS.

► Go to [www.irs.gov/FormW9](http://www.irs.gov/FormW9) for instructions and the latest information.

Print or type. See Specific Instructions on page 3.	1 Name (as shown on your income tax return). Name is required on this line; do not leave this line blank.	
	2 Business name/disregarded entity name, if different from above	
	3 Check appropriate box for federal tax classification of the person whose name is entered on line 1. Check only <b>one</b> of the following seven boxes.  <input type="checkbox"/> Individual/sole proprietor or single-member LLC <input type="checkbox"/> Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=Partnership) ► _____ <b>Note:</b> Check the appropriate box in the line above for the tax classification of the single-member owner. Do not check LLC if the LLC is classified as a single-member LLC that is disregarded from the owner unless the owner of the LLC is another LLC that is <b>not</b> disregarded from the owner for U.S. federal tax purposes. Otherwise, a single-member LLC that is disregarded from the owner should check the appropriate box for the tax classification of its owner. <input type="checkbox"/> Other (see instructions) ► _____	4 Exemptions (codes apply only to certain entities, not individuals; see instructions on page 3):  Exempt payee code (if any) _____  Exemption from FATCA reporting code (if any) _____  <i>(Applies to accounts maintained outside the U.S.)</i>
	5 Address (number, street, and apt. or suite no.) See instructions.	Requester's name and address (optional)
	6 City, state, and ZIP code	
	7 List account number(s) here (optional)	

## Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on line 1 to avoid backup withholding. For individuals, this is generally your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the instructions for Part I, later. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN*, later.

**Note:** If the account is in more than one name, see the instructions for line 1. Also see *What Name and Number To Give the Requester* for guidelines on whose number to enter.

Social security number									
				-				-	
or									
Employer identification number									
				-					

## Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me); and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding; and
3. I am a U.S. citizen or other U.S. person (defined below); and
4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

**Certification instructions.** You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions for Part II, later.

Sign Here	Signature of U.S. person ►	Date ►
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## General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

**Future developments.** For the latest information about developments related to Form W-9 and its instructions, such as legislation enacted after they were published, go to [www.irs.gov/FormW9](http://www.irs.gov/FormW9).

## Purpose of Form

An individual or entity (Form W-9 requester) who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) which may be your social security number (SSN), individual taxpayer identification number (ITIN), adoption taxpayer identification number (ATIN), or employer identification number (EIN), to report on an information return the amount paid to you, or other amount reportable on an information return. Examples of information returns include, but are not limited to, the following.

- Form 1099-INT (interest earned or paid)

- Form 1099-DIV (dividends, including those from stocks or mutual funds)
- Form 1099-MISC (various types of income, prizes, awards, or gross proceeds)
- Form 1099-B (stock or mutual fund sales and certain other transactions by brokers)
- Form 1099-S (proceeds from real estate transactions)
- Form 1099-K (merchant card and third party network transactions)
- Form 1098 (home mortgage interest), 1098-E (student loan interest), 1098-T (tuition)
- Form 1099-C (canceled debt)
- Form 1099-A (acquisition or abandonment of secured property)

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN.

*If you do not return Form W-9 to the requester with a TIN, you might be subject to backup withholding. See What is backup withholding, later.*



# INSTRUCTIONS TO COMPLETE FRAUD, WASTE AND ABUSE (FWA) TRAINING

The online training is available at DHS QSP site. See instructions below to access the training:

- Use the following link to access the training on our website:
  - <http://www.nd.gov/dhs/services/adultsaging/providers.html>
- Scroll down the page to the RESOURCES heading
- Click on ONLINE TRAINING – Fraud, Waste and Abuse
  - Once you've completed the training, enter your name in the required field.
  - A certificate of completion will be generated.

A copy of this certificate should be included your enrollment documents.

**Check your Application paperwork to make sure everything is complete.**

**These forms can be found on the website [www.nd.gov](http://www.nd.gov)**

- SFN **1604** Request to be a Qualified Service Provider for Family Home Care  
<http://www.nd.gov/eforms/Doc/sfn01604.pdf>
- SFN **433** CHILD ABUSE AND NEGLECT BACKGROUND INQUIRY  
<http://www.nd.gov/eforms/Doc/sfn00433.pdf>
- SFN **615** MEDICAID PROGRAM PROVIDER AGREEMENT  
<http://www.nd.gov/eforms/Doc/sfn00615.pdf>
- **W-9** REQUEST FOR TAXPAYER IDENTIFICATION NUMBER AND CERTIFICATION  
<http://www.irs.gov/pub/irs-pdf/fw9.pdf>
- SFN **1168** OWNERSHIP/CONTROLLING INTEREST AND CONVICTION INFORMATION  
<http://www.nd.gov/eforms/Doc/sfn01168.pdf>

**Always Keep A Copy Of The Most Current Handbook.**

Qualified Service Family Home Care Handbook link:

<http://www.nd.gov/dhs/info/pubs/docs/medicaid/gsp-handbook-family-home-care.pdf>.

This link will always have the most current handbook.