

## INDIVIDUAL 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 1603 – Individual Request to be a Qualified Service Provider
- ☐ NPI Number (Not applicable for Family Personal Care)
  - *This is a one-time process to obtain the NPI Number. Instructions are on Page 5.*
- ☐ SFN 750 – Documentation of Competency OR Copy of License/Certification
  - *This form is required unless you are registered as an RN, LPN, PT, OT or CNA*
- ☐ 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
- ☐ SFN 583 – North Dakota Medicaid Electronic Remittance Advice (835) Enrollment
  - *See instructions on Page 22 for further information.*

**It is important that you always send the most updated version of these forms to HCBS.** If we receive outdated forms, they will be returned to you, which will delay your enrollment.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

**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: [DHS HCBS@ND.GOV](mailto:DHS HCBS@ND.GOV)

Fax: 701-328-4875

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

The image shows a thumbnail of the SFN 1603 form, titled 'INDIVIDUAL REQUEST TO BE A QUALIFIED SERVICE PROVIDER'. It includes sections for 'PERSONAL INFORMATION', 'PROFESSIONAL INFORMATION', 'OWNERSHIP/CONTROLLING INTEREST', 'CHILD ABUSE AND NEGLECT', 'MEDICAID PROGRAM PROVIDER AGREEMENT', 'W-9', 'FWA TRAINING', and 'SFN 583'. There are checkboxes for 'New Provider' and 'Renewing Provider', and a signature line at the bottom.

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# INDIVIDUAL QSP ENROLLMENT CHECKLIST (CONTINUED)

**Additional documentation is required to enroll in the specific services listed below:**

- ☐ Adult Day Care
  - SFN 1703 – Compliance Checklist
  - SFN 55 – Cost Report
- ☐ Adult Foster Care
  - STOP – DO NOT USE THIS FORM PACKET. Please see AFC Handbook and AFC Form Packet
- ☐ Case Management
  - Must be a Licensed Social Worker
- ☐ Chore Services
  - Complete included Chore Services Agreement
- ☐ Extended Personal Care
  - SFN 576 – Extended Personal Care Service Provider Agreement
- ☐ Nurse Educator
  - SFN 577 – Nurse Educator Nursing Plan of Care
- ☐ Non-Medical Transportation
  - Copy of Current Valid Driver's License
  - Signed Statement on SFN 1603 Page 2
- ☐ Respite Home Care
  - SFN 659 – Home Evaluation (to be completed by HCBS Case Manager)
- ☐ Respite Care in Adult Foster Care
  - SFN 466 – Background Check Address Disclosure
  - SFN 467 – Personal Authorization for Criminal Record Inquiry

**QSP's are required to have a current copy of the Handbook on file**, which can be found on the nd.gov website:

<http://www.nd.gov/dhs/info/pubs/docs/medicaid/qsp-handbook-individual-provider.pdf>

QSP's are also required to review the following fact sheets located in the Handbook:

Working Together for Home Fire Safety Fact Sheet  
Dangers of Exposing an Invisible Killer - Carbon Monoxide Fact Sheet

# 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 1603

## INDIVIDUAL REQUEST TO BE A QUALIFIED SERVICE PROVIDER

### Identifying Information:

- Enter your **Last Name, First Name; Gender; Date of Birth and Social Security Number**
- **Check the box** to indicate whether you want your date of birth and gender to be shared with clients.
- **Enter your Provider ID#** if you are currently enrolled or have previously been enrolled as a QSP in the past.
- **List any previous names** you have ever used in the past.

### NPI Number (Not Applicable to Family Personal Care services only)

- If you do not have an NPI number, please apply online (preferred method)
  - <https://nppes.cms.hhs.gov/#/>
- You will need a **Taxonomy Code** to obtain an NPI number
  - The Department of Human Services (DHS) recommends that you use taxonomy code **3747P1801X** for enrolling in personal care services, even if you provide other types of services as well. If you are **ONLY** going to be providing Homemaker services, use taxonomy code **376J00000X**. If you are **ONLY** going to be providing Chore services, use taxonomy code **372500000X**.

### 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.

### Licensure/Certification (if applicable)

- List any current certificate or license (i.e. CNA, RN, LPN, PT, OT)
- Check the appropriate box

### Provider Specialty Information

- Check the services you want to provide as a QSP.
- Please view the definitions of each service on pages 8-9 of your QSP handbook.
- **Enrollment for a service will be considered only when the required forms for that service are submitted.** You will not be enrolled for services that require additional forms if all required information is not sent.

### The following services have additional requirements:

- **Adult Day Care** – SFN 1703 – Compliance Checklist & SFN 55 – Cost Report
- **Adult Foster Care** – See AFC Handbook and AFC Form Packet

- **Case Management** – Must provide Licensed Social Worker documentation
- **Chore Services** - Complete included Chore Services Agreement
- **Extended Personal Care** – SFN 576 – Extended Personal Care Service Provider Agreement
- **Nurse Educator** – SFN 577 – Nurse Educator Nursing Plan of Care
- **Non-Medical Transportation** – Copy of Current Valid Driver's License & Signed Statement on SFN 1603 Page 2
- **Respite Home Care** – SFN 659 – Home Evaluation (to be completed by HCBS Case Manager)
- **Respite Care in Adult Foster Care** – SFN 466 – Background Check Address Disclosure & SFN 467 – Personal Authorization for Criminal Record Inquiry

**Check the box** to indicate if you want to be on the Public list of available QSP's.

- This list is used by clients to choose their provider. If you want clients to know you are a QSP, check YES. However, if you plan to care for one specific client and do not want to add other clients, check NO.
- **If you plan to work for private pay clients only, you do not have to enroll as a Qualified Service Provider.**

### **Languages Supported**

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

### **Service Areas**

- Check all counties where you can provide service to clients.

### **Driving with Vehicle Statement**

- This statement must be signed and dated if you plan to provide Driver with Vehicle services. If you will not be enrolling for this service, skip this section.

### **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.**

### **QUESTIONS**

- #1 - Check the last grade of school completed.
- #2 & #3 – Conviction Information (Check Yes or No)
  - **List ALL convictions in the box** and include date and name of offense
    - This includes both misdemeanor and felony offenses for both in-state and out-of-state, even if over seven years old.
    - Please attach additional pages, if necessary.
    - This is not required for traffic offenses.
  - **Provide court records** for any convictions listed that happened **within the past seven years.**
- #4 – Probation Information (Check Yes or No)
  - If Yes, read and initial the statement

- 5 - #8 – Answer Yes or No
  - Please read Question #8 carefully! This question is frequently misread.
- #9 Answer Yes or No
  - If Yes, enter the dollar amount below and check the box indicating which rate
    - If you have private pay clients that you charge less than the QSP rate, the Department must also pay the lower (private pay) rate.
    - If you change your private pay rate, the Department must be told of the change before the rate paid by the Department will be adjusted.
    - You may not charge the Department more than you charge private pay clients.
- #10 & #11 – Answer Yes or No
  - If you are unable to read, write or verbally communicate in English, contact QSP Enrollment (contact information is on Page 1 of this packet).
- #12 – Answer Yes or No
  - If Yes, provide name of the Adult Foster Care Home and provide additional forms SFN 466 and SFN 467 if this is a new application or reenrollment.
- #13 - #15 – Answer Yes or No
  - If Yes, provide detailed explanation. Attach additional pages if necessary. Please be specific and provide dates, names, etc.

#### **CLAIMS SUBMISSION (Family Personal Care Only)**

- 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.

#### **ELECTRONIC VISIT VERIFICATION**

- Check Therap if you are planning on using the state provided EVV system
- If you wish to use another EVV system, check Other and provide the name
- Check Yes if you are planning to submit your claims through an EVV system
- Check No if you are planning to submit your own professional claim

#### **GLOBAL ENDORSEMENT**

- Global endorsements are explained on page 23 of the QSP Handbook. You will only be enrolled for the endorsements that you have been found competent in.

#### **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 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.

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# INSTRUCTIONS TO COMPLETE SFN 750

## DOCUMENT OF COMPETENCY

**If you have one of the following current licenses or certifications, DO NOT COMPLETE this form.** Your license or certification meets or exceeds the Department of Human Services competency standards.

Registered Nurse  
Licensed Practical Nurse  
Registered Physical Therapist  
Registered Occupational Therapist  
Certified Nurse Assistant

A copy of the current license/certificate or the license/certificate number must be sent with your enrollment forms.

Certificates or other proof of completion of a training or education program focused on in-home care will be considered, if proof is provided that standards 5 through 25 on SFN 750 are included in the curriculum, and the training program is provided by a licensed healthcare professional. The program must have a renewal process every two years.

Refer to CHART B in your handbook for the global endorsements each health care professional will automatically be given.

**If you do not have one of the above, this form must be completed by a licensed healthcare provider to meet QSP requirements. You cannot fill out this form yourself.**

Physician  
Physician Assistant  
Chiropractor  
Nurse Practitioner  
Registered Nurse  
Licensed Practical Nurse  
Registered Occupational Therapist  
Registered Physical Therapist

### TO COMPLETE THE FORM:

- **Applicant / Provider Name:** Write the name of the person enrolling as a QSP
- **Standards 5 - 25:** A health care professional must complete columns (3) and (4) to show the standards for which competency has been confirmed. **CHART A in your handbook lists the requirements to meet each competency.**
  - If enrolling for personal care services, you must show you know the generally accepted practices for **ALL** standards #5 through #25 even if you do not plan to provide one of the services listed. Failure to have all standards checked will result in denial of your application.
  - If enrolling only for the Homemaker service, you must show competency in standards # 5-11 on SFN 750
- **Global Endorsements:** Refer to Page 23 of the QSP handbook for further information.

- The health care professional must complete columns (3) and (4) to show if competency is confirmed for each endorsement.
- You will not be enrolled for the endorsement if the line is incomplete.
- **Professional Health Care Providers verification of competency**
  - A Health Care Professional's signature and license number is required (instructions for the Health Care Professional are located on the back side of the SFN 750).
  - CHART B in your handbook shows which global endorsements certain health care professionals can authorize.

If you are unable to find a health care professional to complete the SFN 750, contact the Enrollment Administrator for a referral to Train ND. 1-800-755-2604 or 701-328-4602.





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## INSTRUCTIONS TO COMPLETE

### SFN 1168 Ownership/Controlling Interest and Conviction Information

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

Section	Instructions for each section
I	<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>
II	<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>
III	<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>
IV	<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>
V	<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>
VI	<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>

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**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: [DSHCBS@ND.GOV](mailto:DSHCBS@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			

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

**On Page 1:**

- Provider – Your Name
- NPI Number – REQUIRED (except for Family Personal Care services only)
- 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 the box for – Medicaid Fee For Service**

**On Page 4:**

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

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# **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

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# 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.*

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# **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.



# **INSTRUCTIONS TO COMPLETE SFN 583**

## **NORTH DAKOTA MEDICAID ELECTRONIC REMITTANCE ADVICE (835) ENROLLMENT**

If you choose to use Therap for billing, you are required to submit this form. If you are using another EVV System, you will need to contact them to determine if this form is required and for information needed to complete this form. If you are submitting your own professional claims, this form is not required.

This is a one time process required only once upon initial enrollment, or if your EVV provider changes.

**This form must be submitted electronically. It will not be included in this packet.**

Go to <https://www.nd.gov/eforms/Doc/sfn00583.pdf> to submit this form.

You only need to complete the following information on this form:

### **Provider Information**

- Provider name - Enter your first and last name
- Street address – Enter physical address
- Enter City
- Enter State
- Enter Zip Code

### **Provider Identifier Information**

- National Provider Identifier - Enter your NPI number
- Trading Partner ID – If using Therap, Enter “ND QSP”.

### **Electronic Remittance Advice Clearing House Information**

- Clearing House Name – Enter “Therap Services LLC”

### **Authorized Signature**

- Print name of Person Submitting Enrollment - Enter Your Name
- Submission Date - Enter 4 digit year, month, day in this format: (CCYYMMDD)
- On the next page, read the statements and mark an “X” in the box to confirm.

**Submit by clicking on “Click Here to E-mail Form” box**

**Include a statement with your application materials confirming you have submitted this form.**

**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 1603** - INDIVIDUAL REQUEST TO BE A QUALIFIED SERVICE PROVIDER  
<http://www.nd.gov/eforms/Doc/sfn01603.pdf>
- **SFN 750** - DOCUMENTATION OF COMPETENCY  
<http://www.nd.gov/eforms/Doc/sfn00750.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>
- **SFN 661** - ELECTRONIC FUNDS TRANSFER (EFT) FORM – For Direct Deposit  
<http://www.nd.gov/eforms/Doc/sfn00661.pdf>

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

QSP Individual Handbook link:

<http://www.nd.gov/dhs/info/pubs/docs/medicaid/qsp-handbook-individual-provider.pdf> .

This link will always have the most current handbook.