NORTH DAKOTA BEHAVIOR MODIFICATION, BEHAVIOR ANALYST AND PROVIDER CONSULTATION SERVICES

DEPARTMENT OF HEALTH AND HUMAN SERVICES
ADULT AND AGING SERVICES
SFN 1692 (1-2025)

Agreement between the Department of Health and Human Services, hereinafter referred to as "the Department" and: hereinafter referred to as "Provider".

SECTION 1: CONTACT INFORMATION (Indicate the type of provider)

Agency Legal Name	Agency Contact Person		
Address	City	State	ZIP Code
Email Address	Telephone Number	Cell Phone Number	

SECTION 2: SERVICE

I wish to provide the following service:

☐ Behavior Modification Services ☐ Behavioral Analysts Services

This service includes providing behavioral modification or behavioral analyst services which may include provider consultation and education.

SECTION 3: LIST OF ELIGIBLE PROVIDERS

Do you want to be on a list of available providers that is given to applicants? ☐ Yes ☐ No

List the counties where you are willing to provide care (list all counties that apply):

Provider names will remain on the list through the effective dates of this Agreement.

SECTION 4: BILLING PROCEDURES

As a condition of participation in the behavior modification, behavior analyst and provider consultation service, the provider agrees to submit true, accurate and complete claims for payment in the manner prescribed by the Department. The Department agrees to pay the Provider for authorized services rendered to persons who are eligible for such services under this program with payment to be in accordance with the providers usual and customary rate paid for similar services (behavior modification, behavior analysts services) paid by the Department. Allowable service costs will be paid in the amount authorized by the Department once the provider submits the following documents.

- Submit a completed "Substitute IRS Form W-9" (SFN53656) to the Department of Health and Human Services. A Substitute IRS Form only needs to be submitted once.
- Submit a Behavior Modification, Behavioral analyst and Provider Consultation billable hours form to receive reimbursement of all authorized and billable hours provided to an eligible individual. Submit the form within 60 days of the last date of service to the -Info-HHS MFP Billing mfpbilling@nd.gov email address.
- Providers must maintain documentation that includes the date of service, eligible individual or provider receiving the services name, the analysts name and a description of services rendered.

SECTION 5: PROGRAM PARTICIPANTS REQUIREMENTS

I agree to follow the Behavioral Modification, Behavioral Analyst and Provider Consultation Services Policy and Procedures.

I agree to ensure that Agency employees providing behavior modification and behavior analysts services hold the appropriate credentials for providing this service in the State of North Dakota.

I will notify the Aging Services staff, when possible, of any suspected abuse or exploitation of the eligible individual that occurs.

I understand that the Department will not withhold or pay any social security, federal, or state income tax, unemployment insurance, or worker's compensation insurance premiums from the payments the agency receives.

These are the responsibility of the individual or agency independent contractor.

I understand that the Department may require an individual/agency to pay back funds that were received by the provider as the result of an overpayment, false claim, or any other manner of inappropriate billing including provider error or omission.

I agree to assist the Department in compliance investigations/reviews and will provide information in writing upon request.

SECTION 5: PROGRAM PARTICIPANTS REQUIREMENTS (continued)

I will provide records and documentation to the Department upon request. The Department can request a refund to take back payment made to the provider if the provider does not provide the requested records or keep appropriate records, The records must be retained for a period of 75 months.

I will obey all applicable federal and state laws.

I agree to complete the required employee screening outlined in the program handbook.

I agree to maintain the confidentiality of all records of program participants and not discuss and information, including personal health information, relating to clients with anyone not directly associated with the service delivery. I will not reveal personal information excepts as necessary to comply with the law and to deliver services. I understand this includes when others assist with billing for services rendered.

The parties stipulate that this agreement may be terminated at any time upon giving written notice to the other party.

I understand services cannot be provided until Aging Services staff have approved this agreement and returned a copy to the provider.

I understand this service is a temporary service that will be paid with federal American Rescue Plan 9817 funds according to the CMS approved spending plan which expires on December 31, 2025. The last date that authorized, documented and reimbursable services can be provided is September 30, 2025.

SECTION 6: SIGNATURES

By signing this Agreement, the Provider certifies that neither the Provider nor its principles are presently debarred, declared ineligible, or voluntarily excluded from participation in transactions with the State or Federal Government by any Department Agency of the Federal Government or the State of North Dakota.

This Agreement shall remain in effect until the end of the program funding on December 31, 2025. In the event of termination by the Department, the Department's sole obligation shall be to pay for services provided prior to the effective date of termination. This agreement may be terminated by either party without cause by giving a thirty (30) day notice in writing to the other party.

The Department may immediately terminate this Agreement in writing when the Provider fails to comply with any applicable statute, rule, regulation, term or provision of this Agreement. The Provider also understands and agrees that its conduct may be subject to additional penalties or sanctions. The Provider further understands that there are federal penalties for false reporting and fraudulent acts committed during the course and scope of this Agreement.

Please sign or type your name below. By typing my name below, I am signing this application form electronically. I agree that my electronic signature is the legal equivalent of my handwritten signature.

I have read this Agreement, understand it, and agree to abide by its terms and conditions. I also agree that violation of any of the terms or conditions of this agreement constitute sufficient grounds for termination of this agreement and may be grounds for other action.

Provider Name/Printed Name	Title
Provider Signature	Date

Department Approval

Start Date of Agreement	End Date of Agreement
Aging Service Staff Name/Printed Name	Title
Aging Services Staff Signature	Date