INDIVIDUAL REQUEST TO BE A QUALIFIED SERVICE PROVIDER/ ADULT FAMILY FOSTER CARE (AFFC) PROVIDER

ND DEPARTMENT OF HUMAN SERVICES
AGING SERVICES
SFN 980 (10-2012)

Clear Fields

FOR OFFICE USE ONLY	
Date Approved:	By:
☐ New ☐ Renew ☐ Reapply	
ID:	Date Closed:

(A) Individual's Legal Name (as on income tax forms):	Date of Birth:	Other Names Used:	
Mailing Address:	City:	State:	ZIP Code:
Street Address:	City:	State:	ZIP Code:
E-Mail Address:	Social Security Number:	Gender: ☐ Male ☐ Female	Telephone Number:

Disclosure of the social security number is required pursuant to 26 CFR 301.6109-1 and is requested for the purpose of reporting tax information. Failure to disclose this information results in $50 penalty under 26 CFR 301.6723-1 unless it is due to reasonable cause and not willful neglect.

(B) Check the services you seek to provide in Column 1. List respective county in Column 2. Identify rate in Column 3.

(1) SERVICE	(2) County(s) in Which You Will Provide Service (Respite Services Only)	(3) Hourly Rate Requested (Respite Services Only)
☐ AFFC - Adult Family Foster Care		
☐ AFFC - Respite Services		

(C) Do you want to be on the county's list of available Qualified Service Providers? ☐ Yes ☐ No

(D) Indicate category(ies) in which Global Endorsement is sought:

- ☐ Catheter (CA)
- ☐ Cognitive/Supervision (Co)
- ☐ Exercise (Ex)
- ☐ Hoyer Lift/Mechanized Bath Chair (Ho)
- ☐ Medical Gases (oxygen only) (Me)
- ☐ Prosthesis/Orthotics/Adaptive Devices (Pr)
- ☐ Suppository (non-prescription) (Su)
- ☐ Ted Stockings (Ts)
- ☐ Temperature/Blood Pressure/Respiration Rate/Pulse (Te)

(E) List Licenses/Certificates/Accreditations that you hold (attach copy):

L/C/A	License/Certificate or Accreditation	Number	Expiration Date	Issued By

(F) Information for Standards Numbers 1, 2 and 3 from QSP Handbook, Section C:

1. Check last grade completed: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ 11 ☐ 12 ☐ 12+ ☐ GED
   a. Do you have the basic ability to read, write, and verbally communicate in English? ☐ Yes ☐ No
   b. If No, in what language are you able to read, write, and verbally communicate? _____

2. (a) Have you been convicted of a felony or misdemeanor offense? ☐ Yes ☐ No
   If Yes, explain; and attach official court report.

   (b) Have you ever, or been accused of, physically, verbally, mentally, or sexually abused or neglected someone or have you ever received services required as a result of child abuse or neglect report or assessment? ☐ Yes ☐ No
   If yes, explain:

   (c) Have you ever had your Qualified Service Provider status or a license (AFFC, early childhood program license, self-declaration document, etc.) issued by the Department of Human Services denied, revoked, suspended, restricted or terminated? If yes, explain: ☐ Yes ☐ No

   (d) Have you ever stolen or taken property without permission from someone? ☐ Yes ☐ No If Yes, explain:

   (e) I assure that I ☐ have ☐ have not been found to have abused or neglected a child and I give the North Dakota Department of Human Services permission to check my name in the county child abuse and neglect files and the ND Child and Abuse and Neglect Index can be shared with the Department Staff.

A YES response will not necessarily restrict you from enrollment as a Qualified Service Provider. Your age, the time of the offense, seriousness and nature of the violation, as well as rehabilitation will be taken into consideration. Please provide an explanation (use a seaprate sheet) so that we have enough information to make a determination.

3. Do you have a contagious/infectious disease? ☐ Yes ☐ No If Yes, explain:

4. Are you physically able to provide services? ☐ Yes ☐ No If No, explain:

Continue on other side

(G) The following questioned must be answered:

1. **Respite Care Providers Only:**
   Do you take care of anyone over the age of 18 who pays you with their own money or whose family pays for the care? ☐ Yes ☐ No
   How much do you charge for providing the care? _____ Check One: ☐ Hour ☐ Day ☐ Month
2. Are you planning to provide respite care in an Adult Family Foster Care Home. ☐ Yes ☐ No
   If Yes, what is the name of the foster home? _____

(H) Initial each of the following to indicate your understanding and agreement:

_____ I agree to perform the work, service, and/or care myself.

_____ I agree to study the **Home Fire Prevention Checklist** that is included in the provider application.

_____ I will notify the case manager at the County Social Service Office when the following occur:
1. Client or resident is not home at the time scheduled for service;
2. Observed change in client's or resident's physical, cognitive, emotional, and/or environmental condition;
3. Change in the amount or type of service that may be needed by the client or resident;
4. Possible abuse or exploitation of client or resident; and
5. Other circumstances as agreed upon with case manager for specific client(s) or resident(s).

_____ I will provide care at a level acceptable to the client or resident and the Department of Human Services (Department).

_____ I agree to assist the Department and/or County Agency or both in compliance investigations and will provide information in writing upon request.

_____ I will not accept or solicit gifts or money from the client/resident.

_____ I cannot be compensated for services provided to a client or resident who is my spouse, child (client) under 18 years of age, or if I have been ordered by the court to provide such care.

_____ I will adhere to applicable federal and state laws.

_____ I will retain records for a period of 42 months from the close of the Federal Fiscal Year (Oct 1 - Sept 30) in which the services are delivered and I will provide records to the Department upon request. The Department can request a refund or process adjustments to take back payments made to a provider if the provider does not provide the requested records or keep appropriate records.

_____ I have read the "AFFC Provider/Qualified Service Provider Handbook" and will retain a copy for my records.

_____ As a self-employed person, I understand I am responsible to pay self-employment taxes (social security and Medicare) and estimated tax on my Qualified Service Provider (QSP) payments. I understand that the Department will not withhold or pay an social security, federal or state income tax, unemployment insurance, or workers' compensation insurance premiums from the payments I receive as a QSP. Withholding any paying taxes on QSP payments is the responsibility of the self-employed individual.

_____ I agree to refrain from discussing any information, including personal health information, pertaining to clients or residents with anyone NOT directly associated with the service delivery. I will NOT reveal personal information except as necessary to comply with the law and to deliver services.

_____ I assure that I have not been guilty of a crime against children or been convicted of a felony. In the event I am found guilty of a crime against children, been convicted of a felony or a child abuse and neglect decision of the "services required" have been made, I will immediately notify the Department.

_____ I will not charge the Department more than I charge for private pay clients or residents.

_____ I will not abuse, neglect, exploit, or assert undue influence on anyone under my care.

_____ **AFFC Provider Only**: I will not provide care to any client or resident while under the influence of drugs or alcohol.

_____ **AFFC Provider Only**: I will maintain records for each client or resident that show the date of service, amount of time spent providing care and tasks performed during that time.

_____ **Respite Services Only:** I will maintain records for each client or resident visit that show the date of service, amount of time spent in the AFFC (units of service) and tasks performed during that time.

_____ **Respite Services Only:** I will not smoke, consume alcoholic beverages, report for work under the influence of drugs or alcohol, consume the client's or resident's food, or conduct personal business in the AFFC home. Use of the client's or resident's property (which is not for the benefit of the client or resident) is only with a written agreement from the client or resident.

_____ **Respite Services Only:** I will make arrangements for client/resident/customer/consumer care when I am unable to provide services as scheduled.

(I) Attached is the required evidence that I meet the standards for Qualified Service Provider and for the Endorsement(s) I seek. The information above is true and correct to the best of my knowledge. Providing false information may be the basis for the North Dakota Department of Human Services refusing or revoking any qualified service provider agreements.

THIS IS A PUBLIC DOCUMENT AND WILL BE MADE AVAILABLE TO THE PUBLIC UPON REQUEST WITH THE EXCEPTION OF ANY INFORMATION THAT IS CONSIDERED CONFIDENTIAL.

Print Name:	Date:
Signature:	