1915(i) INDIVIDUAL RIGHTS & RESPONSIBILITIES
North Dakota Department of Health and Human Services
Medical Services Division
1915(i) Form 3 (12/2022)

Instructions: *This form is reviewed with the 1915(i) individual with the Care Coordinator at their initial meeting. The individual and Care Coordinator will sign the form as acknowledgement of the review and understanding of the information. A copy is provided to the individual, and the Care Coordinator maintains the original in the individual's file.*

As a Member and/or Legal Decision Maker, it is Your Responsibility to:

- Contact the Care Coordinator if you move to a new location or change your phone number
- Contact the Care Coordinator if your service needs to be increased or decreased
- Contact the Care Coordinator if you want to change providers
- Be available for scheduled visits with providers
- Participate in all plan of care meetings with the Care Coordinator
- Contact the Care Coordinator to discuss any problems and concerns with 1915(i) services you may have

1915(i) Individuals have the Right to:

- Confidentiality
- Receive the services you need if you are eligible
- Timely notice of eligibility decisions
- Notification if services are denied, reduced, or terminated
- Direct your plan of care, within guidelines
- Choose who is involved in your person-centered team
- Choose the times and location of meetings
- Choose your service providers
- Privacy, dignity, and respect
- Be free from discrimination
- Be free from abuse, neglect, and exploitation
- Have your property treated with care
- Be free from coercion
- Be free from restraints
- Voice complaints and concerns
- Right to request a fair hearing

Appeals:

Medicaid applicants and individuals who are dissatisfied with a decision made by the Human Service Zone or the North Dakota Department of Health and Human Services, or who have not had their application acted on with reasonable promptness, may appeal to the North Dakota Department of Health and Human Services.

To File an Appeal:
An appeal can be filed verbally over the phone or in written format by email, fax, or mail. A request to appeal must be filed no later than 30 days from the date the notice of action is mailed.

You can use SFN 162: Request for Hearing to file the appeal, but it is not required. You are not required to sign SFN 162: Request for Hearing to submit the appeal request. SFN 162: Request for Hearing can be accessed at https://www.nd.gov/eforms/Doc/sfn00162.pdf.

If you do not use SFN 162: Request for Hearing, please provide your name, contact information, program decision or error that you are appealing, and reason for disagreement with the decision.

Contact information:
Appeals Supervisor, Legal Advisory Unit
N.D. Department of Health and Human Services
600 E Boulevard Avenue, Dept. 325
Bismarck, ND 58505-0250
Phone: (701) 328-2311
Toll Free: (800) 472-2622
711 (TTY)
Fax: (701) 328-2173
Email: dhslau@nd.gov
Website: www.nd.gov/dhs/services/medicalserv/medicaid/appeal.html

Language Assistance and Auxiliary Aids and Services are available at no cost.

It is Your Care Coordinator's Responsibility to:
- Respond to requests for information in a timely manner
- Allow the individual to direct his/her care plan, within program guidelines
- Allow the individual to choose their service providers
- Report any suspected fraud, concealment, or misrepresentation of information provided by the individual or legal representative as it relates to eligibility for 1915(i)
- Treat individuals with dignity and respect
- Respect the privacy of confidential information
- Assist you with addressing complaints or concerns with services you may have

If You Suspect Fraud or Abuse, Report it to ND Medicaid:
A fraud or abuse report may be filed verbally over the phone or in written format by email, fax, or mail. You can use SFN 20: Suspected Fraud Referral to report suspected fraud or abuse, but it is not required. SFN 20: Suspected Fraud Referral can be accessed at https://www.nd.gov/eforms/Doc/sfn00020.pdf.

If you do not use SFN 20: Suspected Fraud Referral, please provide your name, contact information, and narrative of suspected fraud or abuse.

<u>Contact information</u>:
Surveillance Utilization Review Administrator
N.D. Department of Health and Human Services
c/o Medical Services Division
600 E Boulevard Avenue, Dept. 325
Bismarck, ND 58505-0250
Phone: (701) 328-4024
Toll Free: (800) 755-2604
711 (TTY)
Fax: (701) 328-1544
Email: medicaidfraud@nd.gov

If you are uncomfortable reporting any problems/concerns to your Care Coordinator, NDDHHS Medical Services Division is available at (701) 328-2330 to assist you in addressing your problems/concerns.

My signature acknowledges that the information contained in this form was reviewed with me, and I understand my rights and responsibilities or have been informed of who I can go to with any questions I may have.

Individual Signature	Date
Parent/Legal Guardian Signature	Date
Care Coordinator Signature	Date