NORTH Dakota | Human Services

Be Legendary.™

1915(i): I’m enrolled… now what??

Care Coordination

Provider	Area(s) Served	Ages Served	Address	City	State	Zip Code	Email Contact	Phone
Community Options	Cass, Trail, Steele, Ransom, Richalnd, Sargent	All	2701 9th Ave S. Ste E	Fargo	ND	58301	referral@coresinc.org	701-955-8502 ext 115
Community Options	Stutsman, Wells, Foster, Griggs, Barnes, Logan, LaMoure, Mcintosh, Dickey	All	420 20th St SW	Jamestown	ND	58401	referral@coresinc.org	701-955-8502 ext 115
Community Options	Burleigh, Morton, McLean, Sheridan, Mercer, Oliver, Kidder, Grant, Sioux, Emmons	All	4909 Shelburne St	Bismarck	ND	58503	referral@coresinc.org	701-955-8502 ext 115
Community Options	Burleigh, Morton, McLean, Sheridan, Mercer, Oliver, Kidder, Grant, Sioux, Emmons	All	100 Standing Rock Ave	Fort Yates	ND	58538	referral@coresinc.org	701-955-8502 ext 115
Community Options	Stark, Dunn, Billings, Golden Valley, Slope, Hettinger, Bowman, Adams	All	193 24th St E. Ste 103	Dickinson	ND	58601	referral@coresinc.org	701-955-8502 ext 115
Community Options	McKenzie, Divide, Williams	All	309 Washington Ave Ste 402	Williston	ND	58801	referral@coresinc.org	701-955-8502 ext 115
Community Options	Ward, Burke, Renville, Bottineau, Mountrail, McHenry, Pierce	All	300 3rd Ave SW Ste D	Minot	ND	58701	referral@coresinc.org	701-955-8502 ext 115
Community Options	Ramsey, Rolette, Towner, Cavalier, Benson, Eddy	All	425 S. College Dr. Ste 8	Devils Lake	ND	58301	referral@coresinc.org	701-955-8502 ext 115
Community Options	Grand Forks, Pembina, Walsh, Nelson	All	1405 Library Circle	Grand Forks	ND	58201	referral@coresinc.org	701-955-8502 ext 115
Poppy's Promise	Burleigh, Morton, Kidder, McLean, Oliver, Mercer	0-26	1221 West Divide Avenue, Ste 2	Bismarck	ND	58501	aclemons@poppyspromise.com	701-204-7870
Lighthouse Church	Cass	All	111 9th St S	Fargo	ND	58103	melinda.schnase@lhcfargo.org	701-212-8626
Northeast Human Service Center	Pembina, Walsh, Nelson, Grand Forks	All	151 S 4th St Ste 401	Grand Forks	ND	58201	labingham@nd.gov	701-795-3131
Amachi Mentoring	Devils Lake	All	315 4th Ave NE	Devils Lake	ND	58301	aliciaamachi@yahoo.com	701-662-6767

Training & Support for Caregivers

Provider	Location	Ages Served	Address	City	State	Zip Code	Email Contact	Phone
No enrolled providers at this time.								

Community Transition Services

Provider	Location	Ages Served	Address	City	State	Zip Code	Email Contact	Phone
Veridian	All						www.veridianfiscalsolutions.org/1915i/default.aspx	

Benefits Planning

Provider	Location	Ages Served	Address	City	State	Zip Code	Email Contact	Phone
Community Options	Burleigh, Morton, McLean, Sheridan, Mercer, Oliver, Kidder, Grant, Sioux, Emmons	All	4909 Shelburne St	Bismarck	ND	58503	referral@coresinc.org	701-955-8502 ext 115

Non-Medical Transportation

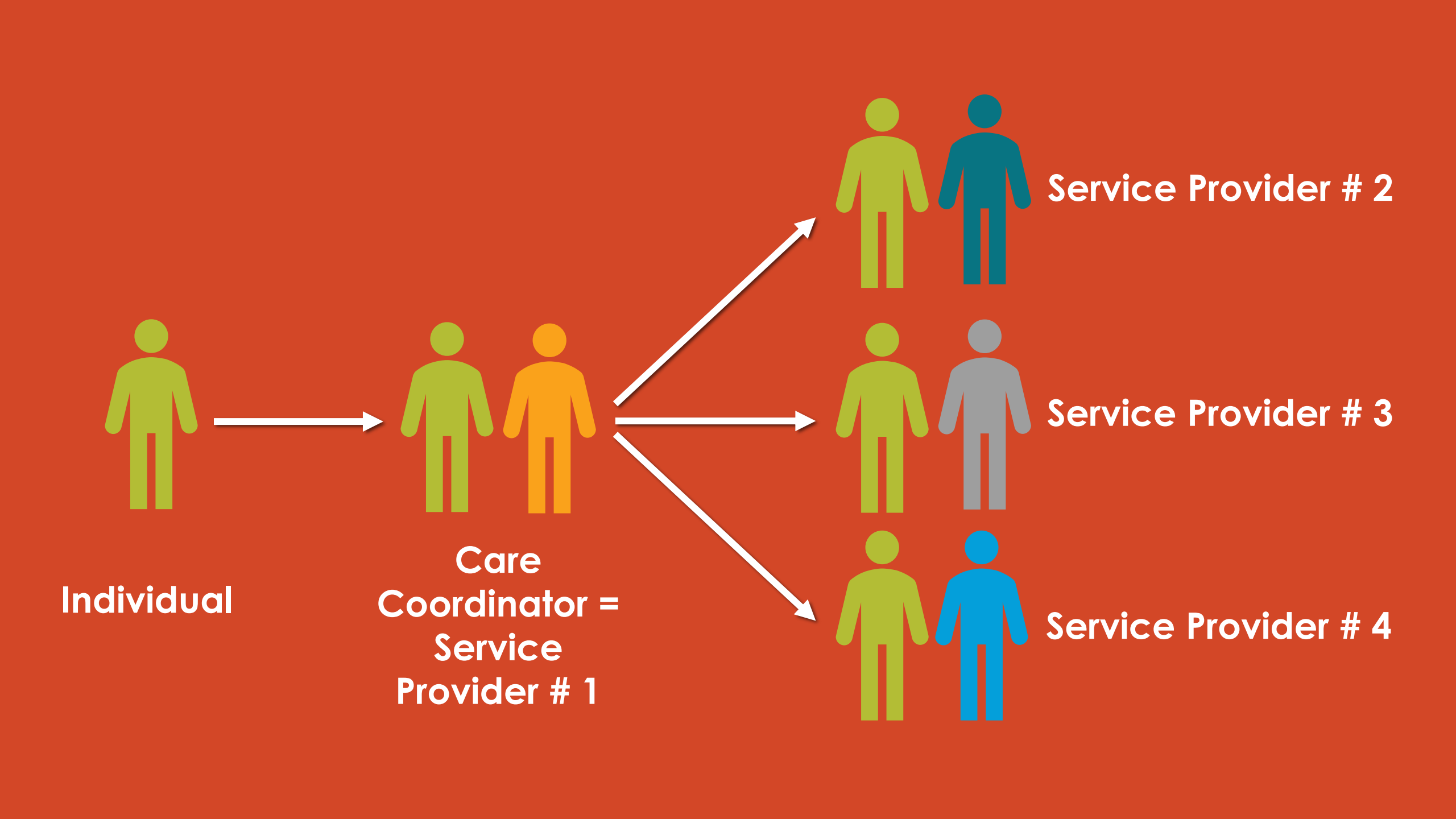
Provider	Location	Ages Served	Address	City	State	Zip Code	Email Contact	Phone
Community Options	Cass, Trail, Steele, Ransom, Richalnd, Sargent	All	2701 9th Ave S. Ste E	Fargo	ND	58301	referral@coresinc.org	701-955-8502 ext 115
Community Options	Stutsman, Wells, Foster, Griggs, Barnes, Logan, LaMoure, Mcintosh, Dickey	All	420 20th St SW	Jamestown	ND	58401	referral@coresinc.org	701-955-8502 ext 115
Community Options	Burleigh, Morton, McLean, Sheridan, Mercer, Oliver, Kidder, Grant, Sioux, Emmons	All	4909 Shelburne St	Bismarck	ND	58503	referral@coresinc.org	701-955-8502 ext 115
Community Options	Burleigh, Morton, McLean, Sheridan, Mercer, Oliver, Kidder, Grant, Sioux, Emmons	All	100 Standing Rock Ave	Fort Yates	ND	58538	referral@coresinc.org	701-955-8502 ext 115
Community Options	McKenzie, Divide, Williams	All	309 Washington Ave Ste 402	Williston	ND	58801	referral@coresinc.org	701-955-8502 ext 115
Community Options	Ward, Burke, Renville, Bottineau, Mountrail, McHenry, Pierce	All	300 3rd Ave SW Ste D	Minot	ND	58701	referral@coresinc.org	701-955-8502 ext 115
Community Options	Ramsey, Rolette, Towner, Cavalier, Benson, Eddy	All	425 S. College Dr. Ste 8	Devils Lake	ND	58301	referral@coresinc.org	701-955-8502 ext 115
Community Options	Grand Forks, Pembina, Walsh, Nelson	All	1405 Library Circle	Grand Forks	ND	58201	referral@coresinc.org	701-955-8502 ext 115
Lighthouse Church	Cass	All	111 9th St S	Fargo	ND	58103	melinda.schnase@lhcfargo.org	701-212-8626

Respite

Provider	Location	Ages Served	Address	City	State	Zip Code	Email Contact	Phone
Poppy's Promise	Burleigh, Morton, Kidder, McLean, Oliver, Mercer	0-26	1221 West Divide Avenue, Ste 2	Bismarck	ND	58501	aclemons@poppyspromise.com	701-204-7870

Pre-vocational

Provider	Location	Ages Served	Address	City	State	Zip Code	Email Contact	Phone
Community Options	Cass, Trail, Steele, Ransom, Richalnd, Sargent	All	2701 9th Ave S. Ste E	Fargo	ND	58301	referral@coresinc.org	701-955-8502 ext 115
Community Options	Stutsman, Wells, Foster, Griggs, Barnes, Logan, LaMoure, Mcintosh, Dickey	All	420 20th St SW	Jamestown	ND	58401	referral@coresinc.org	701-955-8502 ext 115
Community Options	Burleigh, Morton, McLean, Sheridan, Mercer, Oliver, Kidder, Grant, Sioux, Emmons	All	4909 Shelburne St	Bismarck	ND	58503	referral@coresinc.org	701-955-8502 ext 115


Service Provider # 2
Service Provider # 3
Service Provider # 4
Individual
Care Coordinator = Service Provider # 1

Individual Enrollment ➡ Fully Served

- Individual is determined eligible at the Zone
- Zone Eligibility Worker sends approval letter and provider list
- Individual chooses and contacts Care Coordinator provider agency
- If no Care Coordination Service Authorization has been entered within 2 weeks of approval, Navigator assists individual with connection

Individual Enrollment ➡ Fully Served (cont.)

- First 30 days are Care Coordinator services (Plan of Care development)
- Care Coordinator assists the individual to request additional service providers of their choice using SFN 1505- Request for Service Provider
- Additional Providers enter their Service Authorizations and begin to provide services upon approval

1915(I) REQUEST FOR SERVICE PROVIDER

NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES
MEDICAL SERVICES DIVISION
SFN 1505 (6-2021)

Clear Form

SUBMIT FORM VIA EMAIL TO:
Selected Service Provider

This form is utilized by the care coordinator to request service providers as identified by the member. The information contained in this request is identified in the plan of care. Please attach the 1915(i) Comprehensive Person-Centered Plan of Care to this form and send to each provider identified in the plan of care. Submit one Request for Service Provider form for each service requested.

The selected service provider must respond within two (2) business days to the care coordinator with an acceptance or denial of this request.

Client Information

Client Name (Last, First, MI)	ND Medicaid ID Number

Service Requested

- ☐ Care Coordination
- ☐ Benefits Planning Services
- ☐ Family Peer Support
- ☐ Housing Supports (Pre-tenancy)
- ☐ Housing Support (Tenancy)
- ☐ Non-Medical Transportation
- ☐ Peer Support
- ☐ Pre-Vocational Training
- ☐ Respite Care
- ☐ Supported Education
- ☐ Supported Employment
- ☐ Training and Supports for Unpaid Caregivers*
  - ☐ H0039 code/15 minutes and/or ☐ T2025 code/per service

*If both 15 minute and per service are selected, please identify units/dollar amount, frequency, and duration for each

Units or Dollar Amount Requested:	Frequency Limit Requested:	Duration Limit Requested:

Care Coordinator

Care Coordinator	Telephone Number	Email Address

Signature	Date Request Sent

Service Provider

1st Choice of Provider

Provider	
Telephone Number	Email Address
☐ I accept this request. ☐ I deny this request.	
Reason(s) for Denial	
Signature of Provider	Date

2nd Choice of Provider

Provider	
Telephone Number	Email Address
☐ I accept this request. ☐ I deny this request.	
Reason(s) for Denial	
Signature of Provider	Date

3rd Choice of Provider

Provider	
Telephone Number	Email Address
☐ I accept this request. ☐ I deny this request.	
Reason(s) for Denial	
Signature of Provider	Date

Return form to care coordinator via email.

AUTHORIZATION TO DISCLOSE INFORMATION

NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES
LEGAL SERVICES
SFN 1059 (9-2019)

Clear Fields

PRIVACY STATEMENT: Disclosure of the social security number is voluntary and is requested for the purpose of accurate identification. Failure to disclose a social security number will not affect the disclosure of other information. The Department will not condition treatment on your agreement to authorize disclosure of your health information. The Department may, however, require that you authorize disclosure of your health information if needed to make a determination about your eligibility for benefits or enrollment in a Department health plan.

Name of Client (Last, First, Middle Initial)	Social Security Number		Date of Birth
Previous Names Used			
Street Address	City	State	ZIP Code

CLIENT RELEASE AND SIGNATURE

1. I Hereby Authorize:

Name of Person/Agency	Email Address (complete ONLY if email delivery is requested)		
Street Address	City	State	ZIP Code

2. Permission To: ☐ Disclose To ☐ Obtain From ☐ Mutually Exchange With

Name of Person/Agency	Email Address (complete ONLY if email delivery is requested)		
Street Address	City	State	ZIP Code

3. Provide a detailed description of the information to be disclosed, including how much and what kind of information. (See instructions)

4. The information identified above will be used for: (Select all that apply)

☐ Coordination of Care/Treatment/Discharge Planning ☐ Legal ☐ At the Request of the Individual
☐ Billing/Payment ☐ Eligibility Determination ☐ Collateral
☐ Other (must specify to be valid): _____

5. Authorization remains in effect for one year from date signed unless a different expiration date is entered here (MM/DD/YYYY):

CLIENT CONSENT

This authorization is voluntary and remains in effect until the expiration date unless specifically revoked. This authorization may be revoked by written notice, at any time except to the extent that action has been taken in reliance on it. Refer to the Department's Notice of Privacy Practices for further description of revocation rights. Unless otherwise agreed in writing, information may be disclosed under this authorization in any form or medium, including verbal, written or electronic transmission. A photo copy of this authorization is as effective as the original.

Except for information protected under the federal regulations governing Confidentiality of Substance Use Disorder Patient Records, 42 C.F.R. Part 2, there is a potential for information disclosed pursuant to this authorization to be subject to re-disclosure by the recipient and no longer protected by state or federal privacy laws.

SUBSTANCE USE DISORDER INFORMATION is protected under the federal regulations governing Confidentiality of Substance Use Disorder Patient Records, 42 C.F.R. Part 2, and cannot be disclosed without written consent unless otherwise provided for in the regulations. In accordance with North Dakota law, the signature of a minor 14 years of age or older is required to disclose substance use disorder information. Both the signature of a minor 13 years of age or younger and the signature of the minor's legal representative is required to authorize the disclosure of substance use disorder information.

Signature of Client		Date
Signature of Parent/Guardian or Custodian (if needed)	Relationship	Date
Signature of Witness (if needed)		Date

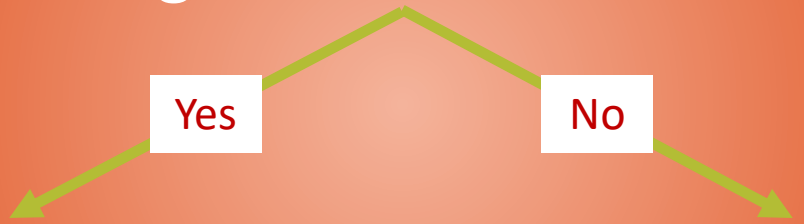
☐ **CHECK IF APPLICABLE - NOTICE TO WHOMEVER DISCLOSURE IS MADE CONCERNING SUBSTANCE USE DISORDER PATIENT RECORDS:** 42 CFR Part 2 prohibits unauthorized disclosure of these records.

DISTRIBUTION: ☐ To agency/person from whom information is sought ☐ Client ☐ Other
☐ Requesting Agency ☐ Client refused copy

Service Authorizations

A Service Authorization must be approved by the State prior to any 1915(i) services being rendered

Are you providing Care Coordination Services?



You will learn specifics on timing your Service Authorization submission during your 1:1 Care Coordination training

You will learn how to submit your Service Authorization during our Service Authorization Training/TA session

Collaboration/Information Sharing

- Initial- when services are being requested for the individual
- Monthly- information on individual goals/objectives/progress is shared
- Annually- input for annual POC review is shared

Collaboration/Information Sharing (cont.)

- Any time- when there is information to share about changes to the individual's health, concerns about their safety, changes to their living situation or other things that may impact their eligibility
- Information containing protected health information (PHI) must be shared in a secure way
- There must be an ROI in place between all agencies and individuals sharing information

MULTI-AGENCY AUTHORIZATION TO DISCLOSE INFORMATION

ND DEPARTMENT OF HUMAN SERVICES
SFN 970 (Rev. 05-2003)

Initial:	Date:

PRIVACY STATEMENT: Disclosure of the social security number is voluntary and is requested for the purpose of accurate identification. Failure to disclose the social security number will not affect the disclosure of other information. The Department will not condition treatment on your agreement to authorize disclosure of your health information. The department may, however, require that you authorize disclosure of your health information if needed to make a determination about your eligibility for benefits or enrollment in a Department health plan.
INSTRUCTIONS: Provide information as it existed when the service was provided.

Name of Client: (Last, First, Middle Initial)	Social Security Number:	Date of Birth:	
Street Address:	City:	State:	Zip Code:

CLIENT RELEASE AND SIGNATURE

I hereby authorize the following agencies/individuals to disclose information to and exchange the indicated information with: (Please place your initials in the boxes to the left indicating your authorization)

Name of Person/Organization:

Street Address:	City:	State:	Zip Code:

To Disclose and Exchange the Following Information:

☐ Verification of Treatment	☐ Progress Reports
☐ Assessment Results	☐ Testing Results
☐ Educational/Vocational Information	☐ Child Abuse/Neglect Assessment/Results
☐ Psychological Eval/Recommendations	☐ Other______
☐ Legal Status/Court Order	☐ Other______
☐ Psychiatric Eval/Recommendations	☐ Other______
☐ Medical Information	☐ Other______
☐ Addiction Eval/Recommendations	☐ Other______

Name of Person/Organization:

Street Address:	City:	State:	Zip Code:

To Disclose and Exchange the Following Information:

☐ Verification of Treatment	☐ Progress Reports
☐ Assessment Results	☐ Testing Results
☐ Educational/Vocational Information	☐ Child Abuse/Neglect Assessment/Results
☐ Psychological Eval/Recommendations	☐ Other______
☐ Legal Status/Court Order	☐ Other______
☐ Psychiatric Eval/Recommendations	☐ Other______
☐ Medical Information	☐ Other______
☐ Addiction Eval/Recommendations	☐ Other______

Name of Person/Organization:

Street Address:	City:	State:	Zip Code:

To Disclose and Exchange the Following Information:

☐ Verification of Treatment	☐ Progress Reports
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☐ Educational/Vocational Information	☐ Child Abuse/Neglect Assessment/Results
☐ Psychological Eval/Recommendations	☐ Other______
☐ Legal Status/Court Order	☐ Other______
☐ Psychiatric Eval/Recommendations	☐ Other______
☐ Medical Information	☐ Other______
☐ Addiction Eval/Recommendations	☐ Other______

Name of Person/Organization:

Street Address:	City:	State:	Zip Code:

To Disclose and Exchange the Following Information:

☐ Verification of Treatment	☐ Progress Reports
☐ Assessment Results	☐ Testing Results
☐ Educational/Vocational Information	☐ Child Abuse/Neglect Assessment/Results
☐ Psychological Eval/Recommendations	☐ Other______
☐ Legal Status/Court Order	☐ Other______
☐ Psychiatric Eval/Recommendations	☐ Other______
☐ Medical Information	☐ Other______
☐ Addiction Eval/Recommendations	☐ Other______

Name of Client:	Initial:	Date:

Name of Person/Organization:

Street Address:	City:	State:	Zip Code:

To Disclose and Exchange the Following Information:

☐ Verification of Treatment	☐ Progress Reports
☐ Assessment Results	☐ Testing Results
☐ Educational/Vocational Information	☐ Child Abuse/Neglect Assessment/Results
☐ Psychological Eval/Recommendations	☐ Other______
☐ Legal Status/Court Order	☐ Other______
☐ Psychiatric Eval/Recommendations	☐ Other______
☐ Medical Information	☐ Other______
☐ Addiction Eval/Recommendations	☐ Other______

Name of Person/Organization:

Street Address:	City:	State:	Zip Code:

To Disclose and Exchange the Following Information:

☐ Verification of Treatment	☐ Progress Reports
☐ Assessment Results	☐ Testing Results
☐ Educational/Vocational Information	☐ Child Abuse/Neglect Assessment/Results
☐ Psychological Eval/Recommendations	☐ Other______
☐ Legal Status/Court Order	☐ Other______
☐ Psychiatric Eval/Recommendations	☐ Other______
☐ Medical Information	☐ Other______
☐ Addiction Eval/Recommendations	☐ Other______

The Information Identified Above will be Used For:

This Authorization to Disclose Information Remains in Effect Until: (Date) ______________ OR: (Specific Event Terminating Operation of the Release) ______________

CLIENT CONSENT:

This authorization is voluntary and remains in effect until the above date or event, unless specifically revoked by written notice to the agency or person. Refer to the notice of Privacy Practices for further description of revocation rights. Any information disclosed prior to written revocation of this authorization shall not be a breach of confidentiality. A photocopy of this authorization is as effective as the original. Unless otherwise agreed in writing, information may be disclosed under this authorization in any form or medium, including oral, written, or electronic transmission.

Signature of Client:	Date:
Signature of Parent/Guardian or Custodian: (If Needed and Relationship)	Date:
Signature of Witness: (If Needed)	Date:

NOTICE: Except for information subject to 42 CFR Part 2, information disclosed to another entity may potentially be redisclosed, in which case it may not be protected by State or Federal Law.

☐ Check If Applicable: **NOTICE TO WHOMEVER DISCLOSURE IS MADE CONCERNING ADDICTION RECORDS.** This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

DISTRIBUTION: Original - To Agency/Person Completing Form
Copies - To Person/Organizations and Client

Providing Services

- Individual, Care Coordinator, and other team members will determine what is important TO them, and what is important FOR them, and that will guide the services they receive. A provider may help work on specific objectives, or they may provide more overall, general support, based on what service they are providing and what the individual wants and needs.

Providing Services (cont.)

- Service providers are responsible to verify the individual's 1915(i) eligibility status prior to providing services- the recommendation is daily, as Medicaid will not pay claims billed for ineligible individuals.

For Individuals Enrolled in Traditional Medicaid: call AVRS at 1-877-328-7098

For Individuals Enrolled in Medicaid Expansion: log on to the BCBS site, Availity here

Providing Services (cont.)

- Individuals may change to Expansion from Traditional, or from Traditional to Expansion. In the event their eligibility status cannot be verified in the system typically used, check the other. If their status cannot be verified in either, inform the Care Coordinator who will work with the 1915(i) team to determine what occurred.

Providing Services (cont.)

- DHS is currently working with Therap to develop a Case Management and documentation system for 1915(i), which will be rolled out when development is complete. This will assist with information sharing. Until this system is introduced, Care Coordinators and additional service providers should work together to establish documentation standards on a case-by-case basis.
- At a minimum, providers will want to keep detailed records of all interactions with individuals with dates and start/end times. These records will be shared with the Care Coordinator monthly.

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mohaugen@nd.gov

nd1915i@nd.gov

behavioralhealth.nd.gov/1915i