NORTH Dakota Be Legendary.
Health & Human Services

1915(i) CARE COORDINATION REQUEST REPORT
Rev (11/2024)

Immediately upon completion, submit form via email to:
nd1915i@nd.gov

Care coordination agencies: fill out this form to inform 1915(i) staff that you are accepting a member for care coordination services. Report the date the member made initial contact with you regarding 1915(i) Care Coordination services. This means contact made independently by the member or a parent/legal guardian and the care coordination agency. Upon receipt of this form, 1915(i) staff will provide the Care Coordinator with the 1915(i) and Medicaid eligibility information necessary for Plan of Care development. DO NOT use this form to transfer care coordination services between provider agencies.

Care coordination agencies must respond to the member within five (5) business days of the first call or contact by the member or a parent/legal guardian.

Provider Agency Information	
Agency Name:	Agency Phone:
Care Coordinator Name:	Care Coordinator E-mail:
Member Information	
Name:	Phone:
Parent/Guardian Name (if applicable):	Parent/Guardian Phone (if applicable):
Contact Record	
Date member first contacted provider agency:	
Date provider agency attempted initial follow-up:	
Date(s) provider agency attempted additional follow-up:	
Result of Contact/Provider Agency Decision	
☐ Not able to contact member within 5 days of initial contact ☐ Provider agency has notified member of request being approved Date of notification: _____ Method of notification: _____ ☐ Provider agency has notified member of request being denied Date of notification: _____ Method of notification: _____ Reason for denial:	
Signature of provider agency representative:	Date: