GROUP PROVIDER ATTESTATION

TARGETED CASE MANAGEMENT SERVICES

CHILD WELFARE

______________________ ___________________

Provider Name (printed) NPI

Please note that you have requested enrolling as a Case Management provider; however, Medical Services needs confirmation that you have the appropriate training or background as required by the Medical Services Division policies or Medicaid State Plan requirements.

This group provider has met all the following requirements:

(CHECK ALL THAT APPLY):

1. ______ Has in place a training process that will ensure that staff have adequate knowledge relating to children involved in unsafe, crisis, and/or unstable situations.
2. ______ Has the ability to be available 24 hours, 7 days a week to eligible clients who are in need of emergency case management services.
3. ______ All Supervisors of case management staff have a minimum of a bachelor's degree in social work, psychology, sociology, counseling, human development, elementary education, early childhood education, special education, child development and family science, human resource management (human service track), or criminal justice.
4. ______ All Supervisors of case management staff have successfully completed the Department of Human Services approved Wraparound Certification training, or are in "Provisionally Certified" status of successfully completing Wraparound Certification training within twelve months of beginning to provide case management.
5. ______ All Supervisors of case management staff shall maintain Wraparound Certification status through attending a Department of Human Services approved Wraparound Recertification training at least once every two years.

I attest that this provider met the above requirements on ________________ (Month/Day/Year).

______________________________Provider Facility/Organization Name
______________________________Street Address
______________________________City, State, Zip Code

____

Signature of Authorized Representative

____

Date

____

Printed Name of Authorized Representative

Please sign and return by Email to NDMedicaidEnrollment@noridian.com or by fax to 701-433-5956, ATT: NDM Provider Enrollment

Revision 9/6/2024