GROUP PROVIDER ATTESTATION

TARGETED CASE MANAGEMENT SERVICES
HIGH RISK PREGNANT WOMEN AND INFANTS

______________________________ ______________________
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 has met all the following requirements:

(CHECK ALL THAT APPLY):

1. ______ Has at least six months experience in delivering services in a community or home setting.
2. ______ Has the ability to coordinate prenatal care services for individuals, develop relationships with health care and other area agencies in the particular geographical area they are serving, demonstrate experience in assessing the needs of pregnant women and developing case management plans based on the needs of clients and must demonstrate the ability to evaluate an at risk pregnant woman's progress in obtaining appropriate medical care and other needed services.
3. ______ All case management staff supervisors have a minimum of a degree in social work, nursing, education, and have at least three years experience in service delivery and supervision.
4. ______ Has in place a training process that will ensure that staff have adequate knowledge relating to high-risk pregnancy, parenting and other important issues.
5. _______ Has the ability to provide 24 hour, 7 day a week crisis services to eligible women who are in need of emergency case management services.
6. _______ Has at least one practitioner who possesses the appropriate training or background as required by the Targeted Case Management State Plan.

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

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