

**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.



Health & Human Services

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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 \_\_\_\_\_.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Provider Facility/Organization Name  
Street Address  
City, State, Zip Code

\_\_\_\_\_  
Signature of Authorized Representative

\_\_\_\_\_  
Date

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