NORTH Dakota Be Legendary.

Health & Human Services

Group Provider Attestation

Targeted Case Management for Behavioral Health

Provider Name (printed) _____ **NPI** _____

Please fill out this form to confirm required training or background requirements for enrollment as a Targeted Case Management provider. Requirements are per Medical Services Division or Medicaid State Plan requirements.

This group provider meets all the following requirements (# 5 is needed if the group provider is a North Dakota federally recognized Indian Tribe or Indian Tribal Organization). **CHECK ALL THAT APPLY**

For dates of service on or after May 1, 2020, an agency must meet all the following criteria:

☐ 1. Demonstrate the ability to be available 24 hours, 7 days a week to individuals who need emergency targeted case management services.

☐ 2. Ensure supervisors of targeted case management staff have a minimum of a bachelor's degree and experience with case management.

☐ 3. Attest that individuals providing targeted case management have reviewed the competencies or standards of practice in one of the following:

   a. The Substance Abuse and Mental Health Services Administration (SAMHSA) Core Competencies for Integrated Behavioral Health and Primary Care; or

   b. The Case Management Society of America Standards of Practice.

☐ 4. Attest that individuals providing targeted case management have general knowledge, training and/or experience working with individuals with behavioral health conditions.

☐ 5. For North Dakota federally recognized Indian Tribes or Indian Tribal Organizations, attest that individual case managers enrolled with ND Medicaid possess the necessary cultural sensitivity and background knowledge to provide appropriate services to the Native American population served.

NORTH Dakota Be Legendary.

Health & Human Services

Group Provider Attestation

Targeted Case Management Services

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**

_____

Printed Name of Authorized Representative

Please sign and return by email to NDMedicaidEnrolllment@Noridian.com