Appendix F –
Checklist for Alaska Breast & Cervical Screening Assistance Consultant/Resource Provider Agreement

(To be completed by Provider)	Completed	Not Applicable
1. Provider Agreement:	☐	
a. The clinic/organization name inserted on page 1 of the Provider Agreement matches the clinic/organization name on the current State of Alaska Business License and on the proof of Federal Tax Identification/Employer Identification Number (EIN).	☐	
b. The Provider Agreement is signed by an individual authorized to enter into agreements on behalf of the clinic/organization.	☐	
c. Printed name of the Provider Representative is included on page 9.	☐	
d. Contact information (phone/fax number and mailing/email address) is included on page 9.	☐	
e. Entity type is identified on page 9.	☐	
i. If an agency is applying as an Alaska Native Entity, a signed Waiver of Sovereign Immunity (Appendix D) is attached.	☐	☐
2. Provider Profile (Appendix B)	☐	
3. Federal Assurances & Certifications (Appendix E1)	☐	
4. Proof of Federal Tax Identification/Employer Identification Number (EIN)	☐	
5. Current State of Alaska Business License	☐	
6. Proof of Application Certificates of Insurance identified in Section IX (B)	☐	

Note: Please email this all completed Checklist, Provider Agreement and supporting eligibility documentation to the following email address: HSS.FMS.Grants.Provider.Agreements@alaska.gov.