State of Alaska • Department of Health and Social Services • Senior and Disabilities Services
Home and Community-based Waiver Services

Adults with Physical and Developmental Disabilities • Alaskans Living Independently
Children with Complex Medical Conditions • Individuals with Intellectual and Developmental Disabilities

Provider Certification Application

Owner name (as reported on W-9) _____

Business name (DBA) _____

Administrator _____

Business physical address/City/Zip _____

Business mailing address/City/Zip _____

Telephone number _____ FAX number _____

Cell number _____ Email _____

Table of Services *Check box for each service the provider plans to offer to recipient. (NA indicates services unavailable for the waiver specified in that column.)*

Waiver service	APDD	ALI	CCMC	IDD
Nursing oversight and care management	NA	NA		
Care coordination				
Chore				
Adult day			NA	NA
Residential supported living			NA	NA
Day habilitation		NA		
Residential habilitation	////	////	////	////
Family home habilitation		NA		
Supported-living habilitation		NA		
Group-home habilitation		NA		
In-home support habilitation		NA		
Supported-employment		NA		
Intensive active treatment		NA		
Respite care				
Family-directed respite care	NA	NA		
Transportation				
Meal	////	////	////	////
Congregate meals				
Home-delivered meals				
Environmental modification				

Geographical area to be served *Check box for each location at which services will be offered.*

- ☐ Anchorage
- ☐ Interior
- ☐ Northwest
- ☐ Southcentral
- ☐ Southeast
- ☐ Southwest
- ☐ Statewide

Business information

Location of recipient records _____

Form of organization

- ☐ Sole proprietorship
- ☐ General partnership
- ☐ Limited liability company
- ☐ Government/Public agency
- ☐ For-profit corporation
- ☐ Non-profit corporation
- ☐ Limited partnership
- ☐ Tribal health organization

EIN/Tax ID number _____

Billing agent ☐ Agency employee ☐ Contractor

Name of billing agent _____

"Pay-to" name (business or individual) _____

"Pay-to" address _____

Required attachments: Review the SDS certification website for instruction and content requirements. Note: send only one copy of the following attachments if the provider offers multiple services.

All providers must submit the following documents:

- ☐ State of Alaska business license
- ☐ Certificate of Insurance
- ☐ Organization chart
- ☐ Personnel list (if applicable)
- ☐ Critical Incident Reporting training certificate

For each waiver service checked on the *Table of Services*, submit the following:

- ☐ *Provider Certification Application Service Declaration* for that service
- ☐ Attachments specified on the *Service Declaration*

Providers that will operate without employees must submit the following form:

- ☐ *Provider Certification Application Worker Assurances*

Provider Assurances

I affirm to that the provider will comply with the Medicaid Home and Community-Based Waiver Services regulation, including the Provider Conditions of Participation; *7 AAC 130.200 – 7AAC 130.319; and all applicable federal, state, and local laws and regulations. I certify that the information provided in the attachments required for certification is true, accurate, and complete.*

_____ _____

Owner/Administrator/Director signature *Print name*

_____ _____

Title *Date*

Name of person completing application: _____

Telephone/Cell number _____ Email _____

State of Alaska • Department of Health and Social Services • Senior and Disabilities Services
Home and Community-based Waiver Services

Adults with Physical and Developmental Disabilities • Alaskans Living Independently
Children with Complex Medical Conditions • Individuals with Intellectual and Developmental Disabilities

Care Coordinator Certification Application

Applicant name _____

Provider agency _____ Provider number _____

Business physical address/City/Zip _____

Business mailing address/City/Zip _____

Telephone number _____ FAX number _____

Cell number _____ Email _____

Services I am qualified to provide and plan to offer care coordination services for the following waivers:

- ☐ Adults with Physical and Developmental Disabilities
- ☐ Alaskans Living Independently
- ☐ Children with Complex Medical Conditions
- ☐ Individuals with Intellectual and Developmental Disabilities

Required attachments Review the SDS certification website for instruction and content requirements.

- ☐ Applicant's resume
- ☐ Documentation showing applicant's educational qualifications
- ☐ Certificate of completion of care coordination training within the prior 12 months
- ☐ *Disclosure of Business and Familial Relationships* form (CERT-20)

Name of back-up care coordinator _____

Telephone number _____ Provider number _____

Care Coordinator Assurances

I affirm that I will comply with the care coordination services regulations, 7 AAC 130.211 – 7 AAC 130.215 and 7 AAC 130.240; the Care Coordination Services Conditions of Participation*; and all applicable federal, state, and local laws and regulations. I certify that the information offered in the attachments required for certification is true and complete.*

_____

Applicant signature

_____ _____

Print name *Date*

Provider Assurances

I certify that the applicant meets and complies with the requirements of the Care Coordination Services Conditions of Participation, *is employed by named provider agency, and meets the provider's employment and certification standards to provide care coordination services.*

_____

Care coordinator program administrator signature

_____ _____

Print name *Date*

State of Alaska • Department of Health and Social Services • Senior and Disabilities Services
Home and Community-based Waiver Services

Adults with Physical and Developmental Disabilities • Alaskans Living Independently
Children with Complex Medical Conditions • Individuals with Intellectual and Developmental Disabilities

Provider Certification Application
Service Declaration: Nursing Oversight and Care Management Services

Name of provider agency _____

Manager/Coordinator for Nursing Oversight and Care Management Services

Name _____

Telephone number _____ FAX number _____

Cell number _____ Email _____

Registered Nurse service providers

Name	License number

Services The nursing oversight and care management services described in 7 AAC 130.235 will be offered to recipients.

Required attachments Review the SDS certification website for instruction and content requirements.

The following policies and procedures required for certification are enclosed:

- ☐ Admissions
- ☐ Background check
- ☐ Complaint management
- ☐ Confidentiality
- ☐ Conflicts of interest
- ☐ Critical incident reporting
- ☐ Emergency response
- ☐ Evaluation of employees
- ☐ Financial accountability
- ☐ Quality improvement
- ☐ Restrictive intervention
- ☐ Termination of provider services
- ☐ Training

Provider Assurances

I affirm that the provider will comply with the nursing oversight and care management services regulations, 7 AAC 130.235, and all applicable federal, state, and local laws and regulations. I certify that the information offered in the attachments required for certification is true, accurate, and complete.

_____ _____

Owner/Administrator/Director signature *Print name*

_____ _____

Title *Date*

State of Alaska • Department of Health and Social Services • Senior and Disabilities Services
Home and Community-based Waiver Services

Adults with Physical and Developmental Disabilities • Alaskans Living Independently
Children with Complex Medical Conditions • Individuals with Intellectual and Developmental Disabilities

Provider Certification Application
Service Declaration: Care Coordination Services

Name of provider agency _____

Program administrator for Care Coordination Services

Name _____

Telephone number _____ FAX number _____

Cell number _____ Email _____

Services The care coordination services described in 7 AAC 130.211 –7 AAC 130.215 and 7 AAC 130.240 will be offered to recipients.

Required attachments Review the SDS certification website for instruction and content requirements.

- ☐ *Notice of Appointment or Change of Program Administrator* (CERT-04)
- ☐ Program administrator's resume
- ☐ Documentation of program administrator's educational qualifications

The following policies and procedures are enclosed:

Required for certification of sole proprietors and agency providers

- ☐ Admissions
- ☐ Confidentiality
- ☐ Conflicts of interest
- ☐ Financial accountability
- ☐ Quality improvement
- ☐ Termination of provider services

Required for certification of agency providers, in addition to the above policies and procedures

- ☐ Background check
- ☐ Complaint management
- ☐ Critical incident reporting
- ☐ Emergency response
- ☐ Evaluation of employees
- ☐ Training

Provider assurances

I affirm that the provider will comply with the care coordination services regulations, 7 AAC 130.211 – 7 AAC 130.215 and 7 AAC 130.240; the Care Coordination Services Conditions of Participation; *and all applicable federal, state, and local laws and regulations. I certify that the information offered in the attachments required for certification is true, accurate, and complete.*

_____ _____

Owner/Administrator/Director signature *Print name*

_____ _____

Title *Date*

State of Alaska • Department of Health and Social Services • Senior and Disabilities Services
Home and Community-based Waiver Services

Adults with Physical and Developmental Disabilities • Alaskans Living Independently
Children with Complex Medical Conditions • Individuals with Intellectual and Developmental Disabilities

Provider Certification Application
Service Declaration: Chore Services

Name of provider agency _____

Program administrator for Chore Services

Name _____

Telephone number _____ FAX number _____

Cell number _____ Email _____

Services The chore services described in 7 AAC 130.245 will be offered to recipients.

Required attachments Review the SDS certification website for instruction and content requirements.

- ☐ *Notice of Appointment or Change of Program Administrator* (CERT-04)
- ☐ Program administrator's resume
- ☐ Documentation of program administrator's educational qualifications

The following policies and procedures required for certification are enclosed:

- ☐ Admissions
- ☐ Background check
- ☐ Complaint management
- ☐ Confidentiality
- ☐ Conflicts of interest
- ☐ Critical incident reporting
- ☐ Emergency response
- ☐ Evaluation of employees
- ☐ Financial accountability
- ☐ Quality improvement
- ☐ Restrictive intervention
- ☐ Termination of provider services
- ☐ Training

Provider Assurances

I affirm that the provider will comply with the chore services regulations, 7 AAC 130.245; the Chore Services Conditions of Participation; *and all applicable federal, state, and local laws and regulations. I certify that the information offered in the attachments required for certification is true, accurate, and complete.*

_____ _____

Owner/Administrator/Director signature *Print name*

_____ _____

Title *Date*

State of Alaska • Department of Health and Social Services • Senior and Disabilities Services
Home and Community-based Waiver Services

Adults with Physical and Developmental Disabilities • Alaskans Living Independently
Children with Complex Medical Conditions • Individuals with Intellectual and Developmental Disabilities

Provider Certification Application
Service Declaration: Adult Day Services

Name of provider agency _____

Program administrator for Adult Day Services

Name _____

Telephone number _____ FAX number _____

Cell number _____ Email _____

Name of activity coordinator _____

Services The adult day services described in 7 AAC 130.250 will be offered to recipients.

Required attachments Review the SDS certification website for instruction and content requirements.

- ☐ *Notice of Appointment or Change of Program Administrator* (CERT-04)
- ☐ Program administrator's resume
- ☐ Documentation of program administrator's educational qualifications

The following policies and procedures required for certification are enclosed:

- ☐ Admissions
- ☐ Background check
- ☐ Complaint management
- ☐ Confidentiality
- ☐ Conflicts of interest
- ☐ Critical incident reporting
- ☐ Emergency response
- ☐ Evaluation of employees
- ☐ Financial accountability
- ☐ Medication administration
- ☐ Quality improvement
- ☐ Restrictive intervention
- ☐ Termination of provider services
- ☐ Training

Provider Assurances

I affirm that the provider will comply with the adult day services regulations, 7 AAC 130.250, the Adult Day Services Conditions of Participation, *and all applicable federal, state, and local laws and regulations. I certify that the information offered in the attachments required for certification is true, accurate, and complete.*

_____ _____

Owner/Administrator/Director signature *Print name*

_____ _____

Title *Date*

State of Alaska • Department of Health and Social Services • Senior and Disabilities Services
Home and Community-based Waiver Services

Adults with Physical and Developmental Disabilities • Alaskans Living Independently
Children with Complex Medical Conditions • Individuals with Intellectual and Developmental Disabilities

Provider Certification Application
Service Declaration: Residential Supported-Living Services

Name of provider agency _____

Program administrator for Residential Supported-Living Services

Name _____

Telephone number _____ FAX number _____

Cell number _____ Email _____

Administrator designee

Name _____

Telephone number _____ FAX number _____

Cell number _____ Email _____

Services The residential supported-living services described in 7 AAC 130.255 will be offered to recipients.

Required attachments Review the SDS certification website for instruction and content requirements.

- ☐ *Notice of Appointment or Change of Program Administrator* (CERT-04)
- ☐ Program administrator's resume
- ☐ Documentation of program administrator's educational qualifications
- ☐ Assisted living home license

The following policies and procedures required for certification are enclosed:

- ☐ Admissions
- ☐ Background check
- ☐ Complaint management
- ☐ Confidentiality
- ☐ Conflicts of interest
- ☐ Critical incident reporting
- ☐ Emergency response
- ☐ Evaluation of employees
- ☐ Financial accountability
- ☐ Quality improvement
- ☐ Restrictive intervention
- ☐ Termination of provider services
- ☐ Training

Provider Assurances

I affirm that the provider will comply with the residential supported living services regulations, 7 AAC 130.255; the Residential Supported-Living Services Conditions of Participation; *and all applicable federal, state, and local laws and regulations. I certify that the information offered in the attachments required for certification is true, accurate, and complete.*

_____ _____

Owner/Administrator/Director signature *Print name*

_____ _____

Title *Date*

State of Alaska • Department of Health and Social Services • Senior and Disabilities Services
Home and Community-based Waiver Services

Adults with Physical and Developmental Disabilities • Alaskans Living Independently
Children with Complex Medical Conditions • Individuals with Intellectual and Developmental Disabilities

Provider Certification Application
Service Declaration: Day Habilitation Services

Name of provider agency _____

Program administrator for Day Habilitation Services

Name _____

Telephone number _____ FAX number _____

Cell number _____ Email _____

Services The day habilitation services described in 7 AAC 130.260 will be offered to recipients as:

☐ Site-based services ☐ Community-based services

Required attachments Review the SDS certification website for instruction and content requirements.

☐ *Notice of Appointment or Change of Program Administrator* (CERT-04)
☐ Program administrator's resume
☐ Documentation of program administrator's educational qualifications

The following policies and procedures required for certification are enclosed:

☐ Admissions
☐ Background check
☐ Complaint management
☐ Confidentiality
☐ Conflicts of interest
☐ Critical incident reporting
☐ Emergency response
☐ Evaluation of employees
☐ Financial accountability
☐ Medication administration
☐ Quality improvement
☐ Restrictive intervention
☐ Termination of provider services
☐ Training

Site-based services only:

☐ Physical address _____
☐ Building or use permit

Provider Assurances

I affirm that the provider will comply with the day habilitation services regulations, 7 AAC 130.260; the Day Habilitation Services Conditions of Participation*; and all applicable federal, state, and local laws and regulations. I certify that the information offered in the attachments required for certification is true, accurate, and complete.*

_____ _____
Owner/Administrator/Director signature *Print name*

_____ _____
Title *Date*

State of Alaska • Department of Health and Social Services • Senior and Disabilities Services
Home and Community-based Waiver Services

Adults with Physical and Developmental Disabilities • Alaskans Living Independently
Children with Complex Medical Conditions • Individuals with Intellectual and Developmental Disabilities

Provider Certification Application
Service Declaration: Residential Habilitation Services

Name of Provider Agency _____

Program Administrator for Residential Habilitation Services

Name _____

Telephone Number _____ FAX Number _____

Cell Number _____ Email _____

Services The residential habilitation services described in 7 AAC 130.265 will be offered to recipients as:

- ☐ Family home habilitation
- ☐ Group-home habilitation
- ☐ Supported-living habilitation
- ☐ In-home support habilitation

Required attachments Review the SDS certification website for instruction and content requirements.

- ☐ *Notice of Appointment or Change of Program Administrator* (CERT-04)
- ☐ Program administrator's resume
- ☐ Documentation of program administrator's educational qualifications
- ☐ Copies of assisted living home licenses and foster home licenses
- ☐ *Group-home Habilitation Site Information* form (CERT-12)
- ☐ *Family Home Habilitation Site Information* form (CERT-13)

The following policies and procedures required for certification are enclosed:

- ☐ Admissions
- ☐ Background check
- ☐ Complaint management
- ☐ Confidentiality
- ☐ Conflicts of interest
- ☐ Critical incident reporting
- ☐ Emergency response
- ☐ Evaluation of employees
- ☐ Financial accountability
- ☐ Medication administration (*required of providers of supported-living or in-home support habilitation only*)
- ☐ Quality improvement
- ☐ Restrictive intervention
- ☐ Termination of provider services
- ☐ Training

Provider Assurances

I affirm that the provider will comply with the residential habilitation services regulations, 7 AAC 130.265; the Residential Habilitation Services Conditions of Participation*; and all applicable federal, state, and local laws and regulations. I certify that the information offered in the attachments required for certification is true, accurate, and complete.*

_____ _____

Owner/Administrator/Director Signature *Print name*

_____ _____

Title *Date*

State of Alaska • Department of Health and Social Services • Senior and Disabilities Services
Home and Community-based Waiver Services

Adults with Physical and Developmental Disabilities • Alaskans Living Independently
Children with Complex Medical Conditions • Individuals with Intellectual and Developmental Disabilities

Provider Certification Application
Service Declaration: Supported Employment Services

Name of provider agency _____

Program administrator for Supported Employment Services

Name _____

Telephone number _____ FAX number _____

Cell number _____ Email _____

Services The supported employment services described in 7 AAC 130.270 will be offered to recipients.

Required attachments Review the SDS certification website for instruction and content requirements.

- ☐ *Notice of Appointment or Change of Program Administrator* (CERT-04)
- ☐ Program administrator's resume
- ☐ Documentation of program administrator's educational qualifications

The following policies and procedures required for certification are enclosed:

- ☐ Admissions
- ☐ Background check
- ☐ Complaint management
- ☐ Confidentiality
- ☐ Conflicts of interest
- ☐ Critical incident reporting
- ☐ Emergency response
- ☐ Evaluation of employees
- ☐ Financial accountability
- ☐ Medication administration
- ☐ Quality improvement
- ☐ Restrictive intervention
- ☐ Termination of provider services
- ☐ Training

Provider Assurances

I affirm that the provider will comply with the supported employment services regulations, 7 AAC 130.270; the Supported Employment Services Conditions of Participation*; and all applicable federal, state, and local laws and regulations. I certify that the information offered in the attachments required for certification is true and complete.*

_____ _____

Owner/Administrator/Director signature *Print name*

_____ _____

Title *Date*

State of Alaska • Department of Health and Social Services • Senior and Disabilities Services
Home and Community-based Waiver Services

Adults with Physical and Developmental Disabilities • Alaskans Living Independently
Children with Complex Medical Conditions • Individuals with Intellectual and Developmental Disabilities

Provider Certification Application
Service Declaration: Intensive Active Treatment Services

Name of provider/provider agency _____

Manager/Coordinator for Intensive Active Treatment Services

Name _____

Telephone number _____ FAX number _____

Cell number _____ Email _____

Professional service providers

Name	Profession/Job title	License number

Services The intensive active treatment services described in 7 AAC 130.275 will be offered to recipients.

Required attachments (Agency-based providers only) Review the SDS certification website for instruction and content requirements.

The following policies and procedures required for certification are enclosed:

- ☐ Admissions
- ☐ Background check
- ☐ Complaint management
- ☐ Confidentiality
- ☐ Conflicts of interest
- ☐ Critical incident reporting
- ☐ Emergency response
- ☐ Evaluation of employees
- ☐ Financial accountability
- ☐ Medication administration
- ☐ Quality improvement
- ☐ Restrictive intervention
- ☐ Termination of provider services
- ☐ Training

Provider Assurances

I affirm that the provider will comply with the intensive active treatment services regulations, 7 AAC 130.275, and all applicable federal, state, and local laws and regulations. I certify that the information offered in the attachments required for certification is true, accurate, and complete.

_____ _____

Owner/Administrator/Director signature *Print name*

_____ _____

Title *Date*

State of Alaska • Department of Health and Social Services • Senior and Disabilities Services
Home and Community-based Waiver Services

Adults with Physical and Developmental Disabilities • Alaskans Living Independently
Children with Complex Medical Conditions • Individuals with Intellectual and Developmental Disabilities

Provider Certification Application
Service Declaration: Respite Care Services

Name of provider agency _____

Program administrator for Respite Care Services

Name _____

Telephone number _____ FAX number _____

Cell number _____ Email _____

Services The respite care services described in 7 AAC 130.280 will be offered to recipients as:

☐ Agency respite care services ☐ Family-directed respite care services

Required attachments Review the SDS certification website for instruction and content requirements

☐ *Notice of Appointment or Change of Program Administrator* (CERT-04)
☐ Program administrator's resume
☐ Documentation of program administrator's educational qualifications

The following policies and procedures required for certification are enclosed:

☐ Admissions
☐ Background check
☐ Complaint management
☐ Confidentiality
☐ Conflicts of interest
☐ Critical incident reporting
☐ Emergency response
☐ Evaluation of employees
☐ Financial accountability
☐ Medication administration
☐ Quality improvement
☐ Restrictive intervention
☐ Termination of provider services
☐ Training

Provider Assurances

I affirm that the provider will comply with the respite care services regulations, 7 AAC 130.280; the Respite Care Services Conditions of Participation; *and all applicable federal, state, and local laws and regulations. I certify that the information offered in the attachments required for certification is true, accurate, and complete.*

_____ _____
Owner/Administrator/Director signature *Print name*

_____ _____
Title *Date*

State of Alaska • Department of Health and Social Services • Senior and Disabilities Services
Home and Community-based Waiver Services

Adults with Physical and Developmental Disabilities • Alaskans Living Independently
Children with Complex Medical Conditions • Individuals with Intellectual and Developmental Disabilities

Provider Certification Application
Service Declaration: Transportation Services

Name of provider agency/business _____

Manager/Coordinator for Transportation Services _____

Name _____

Telephone number _____ FAX number _____

Cell number _____ Email _____

Services The transportation services described in 7 AAC 130.290 will be offered to recipients as:

- ☐ Agency-based transportation services
- ☐ Transportation business services

Required attachments Review the SDS certification website for instruction and content requirements.

Transportation business service only

- ☐ Copies of local permits (if applicable)

Agency-based transportation service

- ☐ Copies of local permits (if applicable)
- ☐ Copies of agency-owned/leased vehicle registrations

The following policies and procedures required for certification are enclosed:

- ☐ Background check
- ☐ Complaint management
- ☐ Confidentiality
- ☐ Conflicts of interest
- ☐ Critical incident reporting
- ☐ Emergency response
- ☐ Evaluation of employees
- ☐ Financial accountability
- ☐ Quality improvement
- ☐ Restrictive intervention
- ☐ Termination of provider services
- ☐ Training

Provider Assurances

I affirm that the provider will comply with the transportation services regulations, 7 AAC 130.29; the Transportation Services Conditions of Participation; *and all applicable federal, state, and local laws and regulations. I certify that the information offered in the attachments required for certification is true, accurate, and complete.*

_____ _____

Owner/Administrator/Director signature *Print name*

_____ _____

Title *Date*

State of Alaska • Department of Health and Social Services • Senior and Disabilities Services
Home and Community-based Waiver Services

Adults with Physical and Developmental Disabilities • Alaskans Living Independently
Children with Complex Medical Conditions • Individuals with Intellectual and Developmental Disabilities

Provider Certification Application
Service Declaration: Meal Services

Name of provider agency _____

Director for Meal Services

Name _____

Telephone number _____ FAX number _____

Cell number _____ Email _____

Dietary consultant

Name _____ License number _____

Telephone number _____ FAX number _____

Cell number _____ Email _____

Services The meal services described in 7 AAC 130.295 will be offered to recipients as:

- ☐ Congregate meal services
- ☐ Home-delivered meal services

Required attachments Review the SDS certification website for instruction and content requirements.

- ☐ Food service permit
- ☐ Sample five-week cycle menu

The following policies and procedures required for certification are enclosed:

- ☐ Admissions
- ☐ Background check
- ☐ Complaint management
- ☐ Confidentiality
- ☐ Conflicts of interest
- ☐ Critical incident reporting
- ☐ Emergency response
- ☐ Evaluation of employees
- ☐ Financial accountability
- ☐ Quality improvement
- ☐ Termination of provider services
- ☐ Training

Provider Assurances

I affirm that the provider will comply with the meal services regulations, 7 AAC 130.295; the Meal Services Conditions of Participation; *and all applicable federal, state, and local laws and regulations. I certify that the information offered in the attachments required for certification is true, accurate, and complete.*

_____ _____

Owner/Administrator/Director signature *Print name*

_____ _____

Title *Date*

State of Alaska • Department of Health and Social Services • Senior and Disabilities Services
Home and Community-based Waiver Services

Adults with Physical and Developmental Disabilities • Alaskans Living Independently
Children with Complex Medical Conditions • Individuals with Intellectual and Developmental Disabilities

Provider Certification Application
Service Declaration: Environmental Modifications Services

Name of provider agency/business _____

Manager/Coordinator for Environmental Modifications Services

Name _____

Telephone number _____ FAX number _____

Cell number _____ Email _____

Services: The environmental modification services described in 7 AAC 130.300 will be offered to recipients as:

☐ Agency-based environmental modifications services
☐ Contractor business services: General Contractor license # _____

Required attachment (Agency-based providers only) Review the SDS certification website for instruction and content requirements.

The following policies and procedures required for certification are enclosed:

☐ Admissions
☐ Background check
☐ Complaint management
☐ Confidentiality
☐ Conflicts of interest
☐ Critical incident reporting
☐ Emergency response
☐ Evaluation of employees
☐ Financial accountability
☐ Quality improvement
☐ Termination of provider services
☐ Training

Provider Assurances

I affirm that the provider will comply with the environmental modifications services regulations, 7 AAC 130.300; the Environmental Modifications Conditions of Participation; *and all applicable federal, state, and local laws and regulations. I certify that the information offered in the attachments required for certification is true, accurate, and complete.*

_____ _____
Owner/Administrator/Director signature *Print name*

_____ _____
Title *Date*

State of Alaska • Department of Health and Social Services • Senior and Disabilities Services
Home and Community-based Waiver Services

Adults with Physical and Developmental Disabilities • Alaskans Living Independently
Children with Complex Medical Conditions • Individuals with Intellectual and Developmental Disabilities

Provider Certification Application
Worker Assurances

Owner name (as reported on W-9) _____

Business name (DBA) _____

Administrator _____

Current provider numbers _____

Business physical address/City/Zip _____

Business mailing address/City/Zip _____

Telephone number _____ FAX number _____

Cell number _____ Email _____

I have reviewed the requirements for workers' compensation insurance, and have determined that I do not require coverage at this time because I am applying for certification of a provider agency that will have no employees. The provider agency will operate with the owner or owners providing all services.

I understand the State of Alaska Workers' Compensation Act requires that I obtain workers' compensation insurance if I have one or more employees. I understand that if I alter my business operations by hiring one or more employees, I must

1. submit a copy of my Certificate of Insurance, or a similar document showing insurance coverage, to Senior and Disabilities Services; and
2. name Senior and Disabilities Services, Provider Certification Unit, 550 8th Ave., Anchorage, AK 99501, as a certificate holder for that insurance.

I understand that I am not required to submit documents related to operating a provider agency with employees because I have no employees; and that, if I plan to hire employees, I must submit policies and procedures addressing employee training, employee evaluation, and background checks.

I affirm that, when I plan to hire employees, I will submit proof of workers' compensation insurance coverage and all materials related to operating a provider agency with employees, as required by the Medicaid Home and Community-Based Waiver Services regulations and the Conditions of Participation applicable to providers and to the waiver services I offer to recipients. I understand that failure to do so will cause the provider agency to be out of compliance with 7 AAC 130.220, and to be subject to decertification.

_____ _____

Owner/Administrator/Director signature *Print name*

_____ _____

Title *Date*

State of Alaska • Department of Health and Social Services • Senior and Disabilities Services
Home and Community-based Waiver Services

Adults with Physical and Developmental Disabilities • Alaskans Living Independently
Children with Complex Medical Conditions • Individuals with Intellectual and Developmental Disabilities

Provider Certification Application
Notice of Appointment or Change of Program Administrator

Send completed form and attachments to DSDSCertification@alaska.gov, *or Fax to* 907-754-3475, Attention: Provider Certification

Provider agency

Name of provider agency _____

Provider number _____

☐ **Notice of appointment**

Name of program administrator _____

☐ **Change of program administrator**

Name of new program administrator _____

Services The program administrator will manage the following waiver service:

☐ Adult Day	☐ Residential Habilitation
☐ Care Coordination	☐ Respite
☐ Chore	☐ Supported Employment
☐ Day Habilitation	☐ Residential Supported Living

Required attachments Although the following are listed on each Service Declaration, send only one copy for a notice of change or for a program administrator that will manage more than one waiver service.

☐ Program administrator's resume
☐ Documentation of program administrator's educational qualifications

References The work experience of the program administrator may be verified by contacting the following individuals:

Reference name: _____

Telephone: _____ Email: _____

Reference name: _____

Telephone: _____ Email: _____

Reference name: _____

Telephone: _____ Email: _____

Provider Assurances

I certify that the named program administrator meets the requirements for education and experience and possesses the required knowledge base and skills specified in the Conditions of Participations for the indicated waiver service.

_____ _____
Owner/Administrator/Director signature *Print name*

_____ _____
Title *Date*

State of Alaska • Department of Health and Social Services • Senior and Disabilities Services

Home and Community-based Waiver Services

Adults with Physical and Developmental Disabilities • Alaskans Living Independently
Children with Complex Medical Conditions • Individuals with Intellectual and Developmental Disabilities

Provider Certification Application
Service Declaration: Nursing Oversight and Care Management Services

Name of Provider Agency _____

Manager/Coordinator for Nursing Oversight and Care Management Services

Name _____

Telephone Number _____ FAX Number _____

Cell Number _____ Email _____

Registered Nurse Service Providers

Name	License Number

Services: The nursing oversight and care management services described in 7 AAC 130.235 will be provided for participants.

Required attachments Review the SDS certification website for *Instructions and Application Guidance.*

Operations Manual

- ☐ Admissions policy & procedure
- ☐ Background Check policy & procedure
- ☐ Complaint Management policy & procedure
- ☐ Confidentiality policy & procedure
- ☐ Conflict of Interest policy & procedure
- ☐ Critical Incident Reporting policy & procedure
- ☐ Emergency Response policy & procedure
- ☐ Evaluation of Employees policy & procedure
- ☐ Financial Accountability policy & procedure
- ☐ Quality Improvement policy & procedure
- ☐ Restrictive Intervention policy & procedure
- ☐ Termination of Provider Services policy & procedure
- ☐ Training policy & procedure

Provider Assurances

I affirm that the provider will comply with the nursing oversight and care management services regulations, 7 AAC 130.235, and all applicable federal, state, and local laws and regulations. I certify that the information provided in the attachments required for certification is true, accurate, and complete.

_____ _____

Owner/Administrator/Director Signature *Print name*

_____ _____

Title *Date*

State of Alaska • Department of Health and Social Services • Senior and Disabilities Services

Home and Community-based Waiver Services

Adults with Physical and Developmental Disabilities • Alaskans Living Independently
Children with Complex Medical Conditions • Individuals with Intellectual and Developmental Disabilities

Provider Certification Application
Service Declaration: Care Coordination Services

Name of Provider Agency _____

Program Administrator for Care Coordination Services

Name _____

Telephone Number _____ FAX Number _____

Cell Number _____ Email _____

Services: The care coordination services described in 7 AAC 130.211 –7 AAC 130.215 and 7 AAC 130.240 will be provided for participants.

Required attachments Review the SDS certification website for *Instructions and Application Guidance.*

The following attachments must be submitted:

Service Requirements

☐ *Notice of New Appointment or Change of Program Administrator* (CERT-04) and attachments

Operations Manual

☐ Admissions policy & procedure
☐ Background Check policy & procedure
☐ Complaint Management policy & procedure
☐ Confidentiality policy & procedure
☐ Conflict of Interest policy & procedure
☐ Critical Incident Reporting policy & procedure
☐ Emergency Response policy & procedure
☐ Financial Accountability policy & procedure
☐ Evaluation of Employees policy & procedure
☐ Quality Improvement policy & procedure
☐ Restrictive Intervention policy & procedure
☐ Termination of Provider Services policy & procedure
☐ Training policy & procedure

Provider Assurances

I affirm that the provider will comply with the care coordination services regulations, 7 AAC 130.211 – 7 AAC 130.215 and 7 AAC 130.240, the Care Coordination Services Conditions of Participation, and all applicable federal, state, and local laws and regulations. I certify that the information provided in the attachments required for certification is true, accurate, and complete.

_____ _____

Owner/Administrator/Director Signature *Print name*

_____ _____

Title *Date*

State of Alaska • Department of Health and Social Services • Senior and Disabilities Services

Home and Community-based Waiver Services

Adults with Physical and Developmental Disabilities • Alaskans Living Independently
Children with Complex Medical Conditions • Individuals with Intellectual and Developmental Disabilities

Provider Certification Application
Service Declaration: Chore Services

Name of Provider Agency _____

Program Administrator for Chore Services

Name _____

Telephone Number _____ FAX Number _____

Cell Number _____ Email _____

Services: The chore services described in 7 AAC 130.245 will be provided for participants.

Required attachments Review the SDS certification website for *Instructions and Application Guidance.*

The following attachments must be submitted:

Service Requirements

☐ *Notice of New Appointment or Change of Program Administrator* (CERT-04) and attachments

Operations Manual

☐ Admissions policy & procedure
☐ Background Check policy & procedure
☐ Complaint Management policy & procedure
☐ Confidentiality policy & procedure
☐ Conflict of Interest policy & procedure
☐ Critical Incident Reporting policy & procedure
☐ Emergency Response policy & procedure
☐ Evaluation of Employees policy & procedure
☐ Financial Accountability policy & procedure
☐ Quality Improvement policy & procedure
☐ Restrictive Intervention policy & procedure
☐ Termination of Provider Services policy & procedure
☐ Training policy & procedure

Provider Assurances

I affirm that the provider will comply with the chore services regulations, 7 AAC 130.245, the Chore Services Conditions of Participation, and all applicable federal, state, and local laws and regulations. I certify that the information provided in the attachments required for certification is true, accurate, and complete.

_____ _____

Owner/Administrator/Director Signature *Print name*

_____ _____

Title *Date*

State of Alaska • Department of Health and Social Services • Senior and Disabilities Services

Home and Community-based Waiver Services

Adults with Physical and Developmental Disabilities • Alaskans Living Independently
Children with Complex Medical Conditions • Individuals with Intellectual and Developmental Disabilities

Provider Certification Application
Service Declaration: Adult Day Services

Name of Provider Agency _____

Program Administrator for Adult Day Services

Name _____

Telephone Number _____ FAX Number _____

Cell Number _____ Email _____

Name of Activity Coordinator _____

Services: The Adult Day Services described in 7 AAC 130.250 will be provided for participants.

Required attachments Review the SDS certification website for *Instructions and Application Guidance.*

The following attachments must be submitted:

Service Requirements

☐ *Notice of New Appointment or Change of Program Administrator* (CERT-04) and attachments

☐ Building or use permit

Operations Manual

☐ Admissions policy & procedure
☐ Background Check policy & procedure
☐ Complaint Management policy & procedure
☐ Confidentiality policy & procedure
☐ Conflict of Interest policy & procedure
☐ Critical Incident Reporting policy & procedure
☐ Emergency Response policy & procedure
☐ Evaluation of Employees policy & procedure
☐ Financial Accountability policy & procedure
☐ Medication Administration policy & procedure
☐ Quality Improvement policy & procedure
☐ Restrictive Intervention policy & procedure
☐ Termination of Provider Services policy & procedure
☐ Training policy & procedure

Provider Assurances

I affirm that the provider will comply with the adult day services regulations, 7 AAC 130.250, the Adult Day Services Conditions of Participation, and all applicable federal, state, and local laws and regulations. I certify that the information provided in the attachments required for certification is true, accurate, and complete.

_____ _____

Owner/Administrator/Director Signature *Print name*

_____ _____

Title *Date*

State of Alaska • Department of Health and Social Services • Senior and Disabilities Services

Home and Community-based Waiver Services

Adults with Physical and Developmental Disabilities • Alaskans Living Independently
Children with Complex Medical Conditions • Individuals with Intellectual and Developmental Disabilities

Provider Certification Application
Service Declaration: Residential Supported-Living Services

Name of Provider Agency _____

Program Administrator for Residential Supported-Living Services

Name _____

Telephone Number _____ FAX Number _____

Cell Number _____ Email _____

Administrator Designee

Name _____

Telephone Number _____ FAX Number _____

Cell Number _____ Email _____

Services: The Residential Supported-Living Services described in 7 AAC 130.255 will be provided for participants.

Required attachments Review the SDS certification website for *Instructions and Application Guidance.*
The following attachments must be submitted:

Service Requirements

☐ *Notice of New Appointment or Change of Program Administrator* (CERT-04) and attachments

☐ Assisted Living Home License

Operations Manual

☐ Admissions policy & procedure
☐ Background Check policy & procedure
☐ Complaint Management policy & procedure
☐ Confidentiality policy & procedure
☐ Conflict of Interest policy & procedure
☐ Critical Incident Reporting policy & procedure
☐ Emergency Response policy & procedure
☐ Evaluation of Employees policy & procedure
☐ Financial Accountability policy & procedure
☐ Quality Improvement policy & procedure
☐ Restrictive Intervention policy & procedure
☐ Termination of Provider Services policy & procedure
☐ Training policy & procedure

Provider Assurances

I affirm that the provider will comply with the residential supported living services regulations, 7 AAC 130.255, the Residential Supported-Living Services Conditions of Participation, and all applicable federal, state, and local laws and regulations. I certify that the information provided in the attachments required for certification is true, accurate, and complete.

_____ _____
Owner/Administrator/Director Signature *Print name*

_____ _____
Title *Date*

State of Alaska • Department of Health and Social Services • Senior and Disabilities Services

Home and Community-based Waiver Services

Adults with Physical and Developmental Disabilities • Alaskans Living Independently
Children with Complex Medical Conditions • Individuals with Intellectual and Developmental Disabilities

Provider Certification Application
Service Declaration: Day Habilitation Services

Name of Provider Agency _____

Program Administrator for Day Habilitation Services

Name _____

Telephone Number _____ FAX Number _____

Cell Number _____ Email _____

Services: The Day Habilitation Services described in 7 AAC 130.260 will be offered as

☐ Site-based services
☐ Community-based services

Required attachments Review the SDS certification website for *Instructions and Application Guidance.*

The following attachments must be submitted:

Service Requirements

☐ *Notice of New Appointment or Change of Program Administrator* (CERT-04) and attachments

Site-based additional ☐ Physical address _____
☐ Building or use permit

Operations Manual

☐ Admissions policy & procedure
☐ Background Check policy & procedure
☐ Complaint Management policy & procedure
☐ Confidentiality policy & procedure
☐ Conflict of Interest policy & procedure
☐ Critical Incident Reporting policy & procedure
☐ Emergency Response policy & procedure
☐ Evaluation of Employees policy & procedure
☐ Financial Accountability policy & procedure
☐ Medication Administration policy & procedure
☐ Quality Improvement policy & procedure
☐ Restrictive Intervention policy & procedure
☐ Termination of Provider Services policy & procedure
☐ Training policy & procedure

Provider Assurances

I affirm that the provider will comply with the day habilitation services regulations, 7 AAC 130.260, the Day Habilitation Services Conditions of Participation, and all applicable federal, state, and local laws and regulations. I certify that the information provided in the attachments required for certification is true, accurate, and complete.

_____ _____
Owner/Administrator/Director Signature *Print name*

_____ _____
Title *Date*

State of Alaska • Department of Health and Social Services • Senior and Disabilities Services

Home and Community-based Waiver Services

Adults with Physical and Developmental Disabilities • Alaskans Living Independently
Children with Complex Medical Conditions • Individuals with Intellectual and Developmental Disabilities

Provider Certification Application
Service Declaration: Residential Habilitation Services

Name of Provider Agency _____

Program Administrator for Residential Habilitation Services

Name _____

Telephone Number _____ FAX Number _____

Cell Number _____ Email _____

Services: The following services described in 7 AAC 130.265 will be provided for participants.

- ☐ Family home habilitation services (licensed)
- ☐ Supported-living habilitation services (unlicensed)
- ☐ Group-home habilitation services (licensed)
- ☐ In-home support habilitation services (unlicensed)

Required attachments Review the SDS certification website for *Instructions and Application Guidance.* The following attachments must be submitted:

Service Requirements

- ☐ *Notice of New Appointment or Change of Program Administrator* (CERT-04) and attachments
- ☐ Copies of Assisted Living Home License or Community Care License
- ☐ *Group-home Habilitation Site Information* form (CERT-12)
- ☐ *Family Home Habilitation Site Information* form (CERT-13)

Operations Manual

- ☐ Admissions policy & procedure
- ☐ Background Check policy & procedure
- ☐ Complaint Management policy & procedure
- ☐ Confidentiality policy & procedure
- ☐ Conflict of Interest policy & procedure
- ☐ Critical Incident Reporting policy & procedure
- ☐ Emergency Response policy & procedure
- ☐ Evaluation of Employees policy & procedure
- ☐ Financial Accountability policy & procedure
- ☐ Medication Administration policy & procedure
- ☐ Quality Improvement policy & procedure
- ☐ Restrictive Intervention policy & procedure
- ☐ Termination of Provider Services policy & procedure
- ☐ Training policy & procedure

Provider Assurances

I affirm that the provider will comply with the residential habilitation services regulations, 7 AAC 130.265, the Residential Habilitation Services Conditions of Participation, and all applicable federal, state, and local laws and regulations. I certify that the information provided in the attachments required for certification is true, accurate, and complete.

_____ _____

Owner/Administrator/Director Signature *Print name*

_____ _____

Title *Date*

State of Alaska • Department of Health and Social Services • Senior and Disabilities Services
Home and Community-based Waiver Services

Adults with Physical and Developmental Disabilities • Alaskans Living Independently
Children with Complex Medical Conditions • Individuals with Intellectual and Developmental Disabilities

Provider Certification Application
Service Declaration: Residential Habilitation Services

Group-Home Habilitation Site Information/Change of Status Report

Name of provider agency _____ **Provider number** _____

Instructions: *For each home, attach a copy of the assisted living home license and a copy of the contractual agreement between the agency and the recipient; use additional forms as needed. Change of status notification required 10 days prior to change.*

Group home service sites				
Name of home	Primary contact	Telephone number	License number	Add/Remove

Provider Assurances

I certify that the information, regarding group homes in which residential habilitation services are provided, is true, accurate, and complete.

_____ _____

Owner/Administrator/Director signature *Print name*

_____ _____

Title *Date*

CERT-12 (Rev 4-14-14)

State of Alaska • Department of Health and Social Services • Senior and Disabilities Services
Home and Community-based Waiver Services

Adults with Physical and Developmental Disabilities • Alaskans Living Independently
Children with Complex Medical Conditions • Individuals with Intellectual and Developmental Disabilities

Provider Certification Application
Service Declaration: Residential Habilitation Services

Family Home Habilitation Site Information/Change of Status Report

Name of provider agency _____ **Provider number** _____

Instructions: *For each home, attach a copy of assisted living home license or foster home license, and a copy of the contractual agreement between the agency and the recipient for all provider-owned or -controlled sites; use additional forms as needed. Change of status notification required 10 days prior to change.*

Adult service sites				
Name of home	Primary contact	Telephone number	License number	Add/Remove

Child service sites				
Name of home	Primary contact	Telephone number	License numbers	Add/Remove

Provider Assurances

I certify that the information, regarding family homes in which residential habilitation services are provided, is true, accurate, and complete.

_____ _____

Owner/Administrator/Director signature *Print name*

_____ _____

Title *Date*