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 Employmen	t Services
Name	
	FAX Number
Cell Number	Email
Services: The supported employment services describe	ed in 7 AAC 130.270 will be provided for participants.
Required attachments Review the SDS certification v	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	Evaluation of Employees policy & procedure
☐ Background Check policy & procedure	Financial Accountability policy & procedure
Complaint Management policy & procedure	☐ Medication Administration policy & procedure
Confidentiality policy & procedure	Quality Improvement policy & procedure
Conflict of Interest policy & procedure	Restrictive Intervention policy & procedure
☐ Critical Incident Reporting policy & procedure	☐ Termination of Provider Services policy & procedure
☐ Emergency Response policy & procedure	☐ Training policy & procedure
Provider Assurances	
그리다 가게 하는 것이 하는 것이 하는 것이 되었다면 하는 것이라고 하는 것이 없는 것이 되어 가게 하는 것이다. 그리고 있다면 없는 것이라고 있다면 하는 것이라고 있다면 하는 것이다.	ed employment services regulations, 7 AAC 130.270, the Supported lall applicable federal, state, and local laws and regulations. Its required for certification is true and complete.
Owner/Administrator/Director Signature	Print name
Title	Date

CERT-14 (Rev. 12-13-13)

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	
Services: The Respite Care Services described in 7 AA	
Agency respite care services	
☐ Family-directed respite care services	
Required attachments Review the SDS certification w	vebsite 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	Financial Accountability policy & procedure
☐ Background Check policy & procedure	Evaluation of Employees policy & procedure
Complaint Management policy & procedure	☐ Medication Administration policy & procedure
Confidentiality policy & procedure	Quality Improvement policy & procedure
Conflict of Interest policy & procedure	Restrictive Intervention policy & procedure
Critical Incident Reporting policy & procedure	Termination of Provider Services policy & procedure
☐ Emergency Response policy & procedure	Training policy & procedure
Provider Assurances	
	are services regulations, 7 AAC 130.280, the Respite Care Services state, and local laws and regulations. I certify that the information s true, accurate, and complete.
Owner/Administrator/Director Signature	Print name
Title	Date

CERT-16 (Rev. 12-13-13)

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	
	1
Name	
	FAX Number
Cell Number	Email
Services: The Transportation Services described in 7 A	
☐ An agency-based transportation pro☐ A transportation business	gram
Required attachments Review the SDS certification v	vebsite for Instructions and Application Guidance.
The following attachments must be submitted:	
Service Requirements Copies of local permits (if applicable)	
Agency-based additional information Copies of vehicle registrations	
Operations Manual	
☐ Background Check policy & procedure	Evaluation of Employees policy & procedure
Complaint Management policy & procedure	Financial Accountability policy & procedure
Confidentiality policy & procedure	Quality Improvement policy & procedure
Conflict of Interest policy & procedure	Restrictive Intervention policy & procedure
☐ Critical Incident Reporting policy & procedure	☐ Termination of Provider Services policy & procedure
☐ Emergency Response policy & procedure	☐ Training policy & procedure
Provider Assurances	
	rtation services regulations, 7 AAC 130.290, the Transportation le federal, state, and local laws and regulations. I certify that the ertification is true, accurate, and complete.
Owner/Administrator/Director Signature	Print name
Title	Date

CERT-17 (Rev. 12-13-13)

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	
Cell Number	
Dietary Consultant	
Name	Alaska License Number
Telephone Number	FAX Number
Cell Number	
Services: The meal services described in 7 AAC 130.29	95 will be will be offered as
Congregate meal services	3
☐ Home-delivered meal ser	vices
Required attachments Review the SDS certification w	rebsite for Instructions and Application Guidance.
The following attachments must be submitted:	
Service Requirements	
Food service permit	Sample five-week cycle menu
Operations Manual	
Admissions policy & procedure	☐ Emergency Response policy & procedure
☐ Background Check policy & procedure	☐ Evaluation of Employees policy & procedure
Complaint Management policy & procedure	Financial Accountability policy & procedure
Confidentiality policy & procedure	Quality Improvement policy & procedure
Conflict of Interest policy & procedure	☐ Termination of Provider Services policy & procedure
Critical Incident Reporting policy & procedure	Training policy & procedure
Provider Assurances	
	vices regulations, 7 AAC 130.295, the Meal Services Conditions of al laws and regulations. I certify that the information provided in eate, and complete.
Owner/Administrator/Director Signature	Print name
Title	Date

CERT-18 (Rev. 12-13-13)

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	e e e e e e e e e e e e e e e e e e e
Manager/Coordinator for Environmental Modifi	
Name	
	FAX Number
	Email
Services: The Environmental Modification Services	described in 7 AAC 130.300 will be provided for participants as:
An agency-based environmental modified	fications program
A contractor business	
Required attachments Review the SDS certification	n website for Instructions and Application Guidance.
The following attachments must be submitted: Service Requirements Contractor Based Additional	
Proof of General Contractor's License	
Proof of contractor's insurance and bonding	
Provider Assurances	
	conmental Modifications Services regulations, 7 AAC 130.300, and all tions. I certify that the information provided in the attachments plete.
Owner/Administrator/Director Signature	Print name
Title	Date

CERT-19 (Rev. 12-13-13)



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

Care Coordinator Certification Disclosure of Business and Familial Relationships

Name of care coordinator	Pt	Provider number
Name of provider agency employer		
Table 1 List provider agencies in which you have	e an ownership, partnership, or equity interest equal to or greater than 5%.	o or greater than 5%.
Name of provider agency	Address	Telephone
T. L. A. T. A. A. L. C.	y no worker and proposed on we will an invited	Idministrator onch bana an amorebin
Lable 2 List other businesses or commercial activities, in we partnership, or equity interest equal to or greater than 5%.	Lable 2 List other businesses or commercial activities, in which you and another provider, owner, or administrator each have an ownership, partnership, or equity interest equal to or greater than 5%.	dammish dior each nave an ownership,
Name of business/commercial activity	Name of other agency/owner or administrator	Address
Table 3 List any individual who is an owner, admi spouse, parent, sibling or child, or the spouse of a	Table 3 List any individual who is an owner, administrator, or employee of a provider agency or of a business/commercial activity who is your spouse, parent, sibling or child, or the spouse of a parent, sibling, or child.	business/commercial activity who is your
Name of agency/business/commercial activity	Name of relative	Relationship

Care coordinator assurances

I certify that the information provided regarding my business and familial relationships is true, accurate, and complete.

Date

41110			
Contractor of the contractor		0	
and to a			
Social in the		1	
0000	L		



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

Provider Certification Application Service Declaration: Residential Habilitation Services

Supported-Living Habilitation Site Information/Change of Status Report

Provider number

Name of provider agency

Instructions: For each site, attach a copy of the	Instructions: For each site, attach a copy of the contractual agreement between the agency and the recipient; use additional forms as needed.	d the recipient; use additional	forms as needed.
Change of status notification required 10 days prior to change.	quired 10 days prior to change.		
Supported living service sites			
Name of home	Primary contact	Telephone number	Add/remove

Provider Assurances

I certify that the information, regarding supported-living sites in which residential habilitation services are provided, is true, accurate, and complete.

Date
Title

Print name

Owner/Administrator/Director signature

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

Care Coordinator Certification Renewal Application

Applicant name	
Current provider number	
Business physical address/City/Zip	
	FAX number
	Email
☐ Adul ☐ Alasl ☐ Child ☐ Indiv	and plan to offer care coordination services to be offered for the following waivers: Its with Physical and Developmental Disabilities
	Provider number
Business physical address/City/Zip	
Name of back-up care coordinator	
	Provider number
Required attachments Review the	SDS certification website for instruction and content requirements.
	pletion of care coordination training within current certification period iness and Familial Relationships form (Cert-20)
Care Coordinator Assurances	ness and I amutal Retationships form (CC1-20)
I affirm that I will comply with the constraint 130.240; the Care Coordination Services	are coordination services regulations, 7 AAC 130.211 – 7 AAC 130.215 and 7 AAC vices Conditions of Participation; and all applicable federal, state, and local laws and ation offered in the attachments required for certification is true and complete.
Applicant signature	
Print name	Date
Provider Assurances	
	d complies with the requirements of the Care Coordination Services Conditions of I provider agency, and meets the provider's employment and certification standards to
Care coordinator program administ	rator signature
Print name	Date

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

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

Name of provider agency		
Manager/Coordinator for Nursing Oversight a	and Care Management Services	
Name		
elephone number FAX number		
Cell number	er Email	
Registered Nurse service providers		
Name	License number	
	ement services described in 7 AAC 130.235 will be offered to recipients.	
	ation website for instruction and content requirements. up-dated, changed or revised since the date of the agency's last on.	
Admissions	Evaluation of employees	
☐ Background check	Financial accountability	
Complaint management	Quality improvement	
Confidentiality	Restrictive intervention	
Conflicts of interest	☐ Termination of provider services	
☐ Critical incident reporting ☐ Emergency response	Training	
Provider Assurances		
I affirm that the provider will comply with the nu	rsing oversight and care management services regulations, 7 AAC cal laws and regulations. I certify that the information offered in the curate, and complete.	
Owner/Administrator/Director signature	Print name	
Title	Date	

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

Provider Certification Renewal Application Service Declaration: Care Coordination Services

Name of provider agency	
Program administrator for Care Coordination Service	ces
Name	
Telephone number	FAX number
Cell number	Email
Service The care coordination services described in 7 A offered to recipients.	AAC 130.211 –7 AAC 130.215 and 7 AAC 130.240 will be
Required attachments Review the SDS certification w	vebsite for instruction and content requirements.
The following policies and procedures have been up-dat certification; copies are enclosed for recertification.	red, changed or revised since the date of the agency's last
Required for sole proprietors and agency provid	<u>lers</u>
Admissions	Financial accountability
Confidentiality	Quality improvement
Conflicts of interest	☐ Termination of provider services
Required for agency providers, in addition to the	e above policies and procedures
Background check	☐ Emergency response
Complaint management	Evaluation of employees
Critical incident reporting	☐ Training
D 11 1	
Provider Assurances	
and 7 AAC 130.240; the Care Coordination Services Co	rdination services regulations, 7 AAC 130.211 – 7 AAC 130.215 and itions of Participation; and all applicable federal, state, and
accurate, and complete.	n offered in the attachments required for certification is true,
Owner/Administrator/Director signature	Print name
Title	Date

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

Provider Certification Renewal Application Service Declaration: Chore Services

Name of provider agency			
Program administrator for Chore	Services		
Name			
Telephone number			
Cell number			
Services The chore services describ	ed in 7 AAC 130	0.245 will be offered to recipients.	
Required attachments Review the	SDS certification	n website for instruction and content requirements.	
The following policies and procedure certification; copies are enclosed for	es have been up-or recertification.	dated, changed or revised since the date of the agency's last	
☐ Admissions		☐ Evaluation of employees	
☐ Background of	check	Financial accountability	
Complaint ma	anagement	Quality improvement	
Confidentiali	ty	Restrictive intervention	
Conflicts of in	nterest	Termination of provider services	
Critical incide	ent reporting	Training	
Emergency re			
Provider Assurances			
I affirm that the provider will comply	y with the chore s	services regulations, 7 AAC 130.245; the Chore Services Conditions	
		l local laws and regulations. I certify that the information offered in	
the attachments required for certific	ation is true, acci	urate, and complete.	
Owner/Administrator/Director signa	ıture	Print name	
Title		Date	

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

Provider Certification Renewal Application Service Declaration: Adult Day Services

Name of provider agency	
Program administrator for Adult Day Services	
Name	
	FAX 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.
The following policies and procedures have been up-detertification; copies are enclosed for recertification.	lated, changed or revised since the date of the agency's last
Admissions	☐ Evaluation of employees
Background check	Financial accountability
Complaint management	Medication administration
Confidentiality	Quality improvement
Conflicts of interest	Restrictive intervention
Critical incident reporting	☐ Termination of provider services
Emergency response	☐ Training
Provider Assurances	
I affirm that the provider will comply with the adult do	ay services regulations, 7 AAC 130.250; the Adult Day Services
Conditions of Participation; and all applicable federal	l, 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

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

Provider Certification Renewal Application Service Declaration: Residential Supported-Living Services

Name of provider agency	
Program administrator for Residential Supp	orted-Living Services
Name	
Telephone number	FAX number
Cell number	
Administrator designee	
Name	
	FAX number
	Email
	ices described in 7 AAC 130.255 will be offered to recipients.
Required attachments Review the SDS certif	ication website for instruction and content requirements.
Assisted living home lic	ense
The following policies and procedures have bee certification; copies are enclosed for recertification	en up-dated, changed or revised since the date of the agency's last tion.
☐ Admissions ☐ Background check ☐ Complaint management	
☐ Confidentiality ☐ Conflicts of interest	Restrictive intervention
Critical incident reporting Emergency response	☐ Termination of provider services ☐ Training
Provider Assurances	
Residential Supported-Living Services Condition	residential supported living services regulations, 7 AAC 130.255; the ons of Participation; and all applicable federal, state, and local laws and ed in the attachments required for certification is true, accurate, and
Owner/Administrator/Director signature	Print name
Title	Date

CERT-27 (Rev. 4-4-14)

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

Provider Certification Renewal Application Service Declaration: Day Habilitation Services

Name of provider agency	
Program administrator for Day Habilitation Serv	vices
Name	
Telephone number	FAX number
Cell number	Email
Services The day habilitation services described in 7	
☐ Site-based services	Community-based services
Required attachments Review the SDS certification	on website for instruction and content requirements.
The following policies and procedures have been up certification; copies are enclosed for recertification.	-dated, changed or revised since the date of the agency's last
☐ 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	
	abilitation services regulations, 7 AAC 130.260; the Day Habilitation able federal, state, and local laws and regulations. I certify that the certification is true, accurate, and complete.
Owner/Administrator/Director signature	Print name
Title	Date

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

Provider Certification Renewal Application Service Declaration: Residential Habilitation Services

Name of Provide	r Agency	
etoteks U	strator for Residential Habilitation	Services
Name		
Telephone Number	er	FAX Number
Cell Number		Email
Services The re	sidential habilitation services descri	ribed in 7 AAC 130.265 will be offered to recipients as
D	☐ Family home habilitation ☐ Supported-living habilitation	☐ Group-home habilitation ☐ In-home support habilitation
Required attachr	nents Review the SDS certification v	website for instruction and content requirements.
	☐ Copies of assisted living home li ☐ Group-home Habilitation Site In ☐ Family Home Habilitation Site I	nformation form (CERT-12)
	icies and procedures have been up-dates are enclosed for recertification.	ted, changed or revised since the date of the agency's last
	☐ 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
Residential Habili regulations. I cert	rovider will comply with the residenti tation Services Conditions of Particip	al habilitation services regulations, 7 AAC 130.265; the pation; and all applicable federal, state, and local laws and attachments required for certification is true, accurate, and
complete. Owner/Administra	ator/Director signature	Print name
Title		Date

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

Provider Certification Renewal Application Service Declaration: Supported Employment Services

Name of provider agency	
Program administrator for Supported Employment	t Services
Name	
Telephone number	FAX number
Cell number	
Services The supported employment services describe	
Required attachments Review the SDS certification	n website for instruction and content requirements.
The following policies and procedures have been up-decertification; copies are enclosed for recertification.	ated, changed or revised since the date of the agency's last
Admissions	Financial accountability
☐ Background check	Evaluation of employees
Complaint management	☐ Medication administrations
Confidentiality	Quality improvement
Conflicts of interest	Restrictive intervention
Critical incident reporting	☐ Termination of provider services
☐ Emergency response	☐ Training
Provider Assurances	
	ted employment services regulations, 7 AAC 130.270; the Supported dall applicable federal, state, and local laws and regulations. I required for certification is true and complete.
Owner/Administrator/Director signature	Print name
Title	Date

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

Provider Certification Renewal Application Service Declaration: Intensive Active Treatment Services

Name of provider			
Manager/Coordin	ator for Intensive Active Treatm	ent Services	
Name			
Professional servi	ce providers		
	Name	Profession/Job title	License number
		· · · · · · · · · · · · · · · · · · ·	
Services The inter	asive active treatment services desc	ribed in 7 AAC 130.275 will be offe	ered to recipients.
Required attachm requirements.	nents (Agency-based providers onl	y.) Review the SDS certification w	ebsite for instruction and content
The following policertification are en	cies and procedures that have been closed for recertification.	up-dated, changed or revised since	the date of the agency's last
	Admissions	☐ Evaluation of employees	
	Background check	☐ Financial accountability	
	Complaint management	☐ Medication administrations	
	Confidentiality	Quality improvement	
Conflicts of interest		Restrictive intervention	
	Critical incident reporting	☐ Termination of provider serv	ices
	Emergency response	☐ Training	
Provider Assuran	ces		
		e active treatment services regulati	
		ns. I certify that the information off	ered in the attachments required
for certification is	true, accurate, and complete.		
Owner/Administra	tor/Director signature	Print name	
Title		Date	

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

Provider Certification Renewal Application Service Declaration: Respite Care Services

Name of provider age	ncy		
Program administrat	or for Respite Care Services		
Name			
	FAX number		
Cell number	Email		
Services The respite of	are services described in 7 AAC	130.280 will be offered as:	
	Agency respite care services	☐ Family-directed respite care services	
Required attachment	s Review the SDS certification	website for instruction and content requirements.	
The following policies certification; copies are	and procedures have been up-date enclosed for recertification.	ated, changed or revised since the date of the agency's last	
	Admissions	☐ Evaluation of employees	
	Background check	Financial accountability	
	Complaint management	☐ Medication administration	
] Confidentiality	Quality improvement	
	Conflicts of interest	Restrictive intervention	
	Critical incident reporting	☐ Termination of provider services	
	Emergency response	Training	
Provider Assurances			
Conditions of Participa		are services regulations, 7 AAC 130.280; the Respite Care Services state, and local laws and regulations. I certify that the information true, accurate, and complete.	
Owner/Administrator/	Director signature	Print name	
Title		Date	

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

Provider Certification Renewal Application Service Declaration: Transportation Services

Name of provider agency/busine	ess		
Manager/Coordinator for Trans	sportation Services		
Name			
Telephone number		FAX number	
Cell number			
Services The Transportation Serv	vices described in 7 A	AAC 130.290 will be offered to recipients as:	
	Agency-based	transportation services	
	☐ Transportation	business services	
Required attachments Review to	he SDS certification	website for instruction and content requirements.	
Transportation business service or	ıly:		
Copies of l	ocal permits (if appli	icable)	
Agency-based transportation servi	ice		
Copies of 1	ocal permits (if appli	icable)	
Copies of a	agency-owner or –lea	ased vehicle registrations	
The following policies and agency's last certification:		en up-dated, changed or revised since the date of the for recertification.	
Backgroun	d check	Evaluation of employees	
Complaint	management	Financial accountability	
☐ Confidenti	ality	Quality improvement	
Conflicts of	of interest	Restrictive intervention	
Critical inc	cident reporting	☐ Termination of provider services	
☐ Emergency	response /	☐ Training	
Provider Assurances			
I affirm that the provider will com	iply with the transpor	rtation services regulations, 7 AAC 130.290; the Transportation	
Services Conditions of Participati	on; and all applicabl	le federal, state, and local laws and regulations. I certify that the	
information offered in the attachn	ients required for cer	rtification is true, accurate, and complete.	
Owner/Administrator/Director sig	znature	Print name	
Title			

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

Provider Certification Renewal Application Service Declaration: Meal Services

Name of provider agency	
Director for Meal Services	
Name	
Telephone number	
Cell number	
Dietary consultant	
Name	License number
Telephone number	
Cell number	
Services The meal services described in 7 AA	
☐ Food service permit ☐ Sample five-week cyc	fication website for instruction and content requirements. cle menu een up-dated, changed or revised since the date of the agency's last ation. Emergency response Evaluation of employees Tinancial accountability Quality improvement Termination of provider services
Provider Assurances	
	meal services regulations, 7 AAC 130.29; the Meal Services Conditions of
Participation; and all applicable federal, state, attachments required for certification is true, a	and local laws and regulations. I certify that the information offered in the accurate, and complete.
Owner/Administrator/Director signature	Print name
Title	Date

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

Provider Certification Renewal Application Service Declaration: Environmental Modifications Services

Name of provider agency/business	
Manager/Coordinator for Environmental Mod	ifications Services
Name	
Telephone number	FAX number
Cell number	Email
Services: The environmental modification service	es described in 7 AAC 130.300 will be offered for recipients as
Agency-based environmental modification	ons services
Contractor business services: General Co	ontractor license #
Required attachments (<u>Agency-based providers</u> requirements.	s only.) Review the SDS certification website for instruction and content
The following policies and procedures have been certification; copies are enclosed for recertification	up-dated, changed or revised since the date of the agency's last n.
Admissions	Emergency response
Background check	Evaluation of employees
Complaint management	Financial accountability
Confidentiality	Quality improvement
Conflicts of interest	Termination of provider services
Critical incident reporting	Training
Provider Assurances	
Environmental Modifications Conditions of Partic	rironmental modifications services regulations, 7 AAC 130.300; the cipation; and all applicable federal, state, and local laws and in the attachments required for certification is true, accurate, and
Owner/Administrator/Director signature	Print name
Title	Date

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

Provider Certification Application Additional Location

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	
Cell number	
Additional location	
Contact	
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 recipients. (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	1/1/	1///	////	////
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	1111	1111	1111	////
Congregate meals				
Home-delivered meals				
Environmental modification				

Geographical area to be served Check box for each local	ation at which services will be offered.
Anchorage Interior Northwest Southcentral	Southeast Southwest Statewide
Required attachments Review the SDS certification well	osite for instruction and content requirements.
 ☐ 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 Declar ☐ Attachments specified on the Service Declaration Providers that will operate without employees must submit ☐ Provider Certification Application Worker Assure	it the following form:
Check box below for the policies and procedures, submitt control operations in the new location; copies of policies a submitted before that date are attached to this application.	
□ Background check □ Financial □ Complaint management □ Medication □ Confidentiality □ Quality in the conflicts of interest □ Conflicts of interest □ Restrictive	n of employees accountability on administration nprovement e intervention on of provider services
Provider Assurances	
I affirm to that the provider will comply with the Medicaid regulations, including the Provider Conditions of Particip applicable federal, state, and local laws and regulations. attachments required for recertification is true, accurate,	ation; 7 AAC 130.200 – 7AAC 130.319; and all I certify that the information provided in the
Owner/Administrator/Director signature	Print name
Title	Date
Name of person completing application	
Telephone/Cell number E	mail

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

Provider Certification Application Additional Service

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

Table of Services Check box for each service the provider plans to offer to recipients. (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	1///	1111	////	////
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	1111	////	////	////
Congregate meals				
Home-delivered meals				
Environmental modification				

Geographical area to be served: Check box for each	ch location at which services will be offered.			
☐ Anchorage ☐ Interior ☐ Northwest ☐ Southcentral	Southeast Southwest Statewide			
Required attachments Review the SDS certification	on website for instruction and content requirements.			
The following attachments are required:				
Service Declaration for t	he additional service			
Attachments specified on the Service Declaration				
Provider Assurances				
I affirm to that the provider will comply with the Medicaid Home and Community-Based Waiver Services regulations, 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 recertification is true, accurate, and complete.				
Owner/Administrator/Director				
Signature	Print name			
Title	Date			
Name of person completing application				
Telephone/Cell number	Email			

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Change of Status: Provider Agency

Instructions Check box for type of change, and provide required information. For all changes, attach a copy of completed Xerox Change of Provider Information form, submitted separately to Xerox. Send completed form and attachment to DSDSCertification@alaska.gov, or Fax to 907-754-3475, Attention: Provider Certification.

Name of provider agency	
Provider number	
Person to contact regarding change	
Telephone number	
New mailing address or contact information (Required 10 Days prior to change).
Mailing address/City/Zip	
	FAX number
	Email
New license for facility currently licensed und	er AS 47.32. (Required upon issuance)
Attach copy of license showing changes regarding for	acility.
	f applicable, other licenses; new Certificate of numents, required for certification, that have been Services not provided at this location
Name of provider agency	
Physical address	7:
	Zip
□ New form of business organization (Required 6	
Attach new business license, and specify EIN/Tax nu	
	☐ For-profit corporation☐ Non-profit corporation
Limited liability company	Limited partnership
Agency sale/Change of ownership (Required 6)	
Purchaser/New owner name	o days prior to change
Date of sale or change of ownership	
Agency closure (Required 60 days prior to char	rage)
D-tf-1	<u> </u>
Location of records/physical address	
City	Zip

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Change of Status: Care Coordinator

Instructions Check box for type of reported change and provide required information. Send completed form and attachments to DSDSCertification@alaska.gov, or Fax to 907-754-3475, Attention: Provider Certification. Notification required 10 days prior to a planned change or within one business day of an unplanned change.

Care coordinator		
Name of care coordinator		
Care coordinator provider number		
Person to contact regarding change		
Telephone number Em		
☐ End of agency affiliation		
Name of agency	Provider number	
End date of employment		
☐ Change of agency affiliation		
Name of agency	Provider number	
End date of employment		
Name of new employer	Provider number	
Beginning date of employment		
New Email address		
☐ Name change Attach legal document showing name chan		
Former name of care coordinator		
Name changed to		