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 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
☐ 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 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 provided 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: 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 as:

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

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
- ☐ 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 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 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: 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 provided for participants as:

☐ An agency-based transportation program
☐ A transportation business

Required attachments Review the SDS certification website 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
☐ 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 transportation services regulations, 7 AAC 130.290, the Transportation 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: Meal Services

Name of Provider Agency _____

Director for Meal Services

Name _____

Telephone Number _____ FAX Number _____

Cell Number _____ Email _____

Dietary Consultant

Name _____ Alaska License Number _____

Telephone Number _____ FAX Number _____

Cell Number _____ Email _____

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

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

Required attachments Review the SDS certification website 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
- ☐ 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
- ☐ Termination of Provider Services policy & procedure
- ☐ Training policy & procedure

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 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: 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 provided for participants as:

☐ An agency-based environmental modifications program

☐ A contractor business

Required attachments Review the SDS certification 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

I affirm that the provider will comply with the Environmental Modifications Services regulations, 7 AAC 130.300, 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

Care Coordinator Certification
Disclosure of Business and Familial Relationships

Name of care coordinator _____ **Provider number** _____

Name of provider agency employer _____

Table 1 *List provider agencies in which you have an ownership, partnership, or equity interest equal to or greater than 5%.*		
Name of provider agency	Address	Telephone

Table 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%.*		
Name of business/commercial activity	Name of other agency/owner or administrator	Address

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.*		
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.

_____ _____

Care coordinator signature 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

Supported-Living Habilitation Site Information/Change of Status Report

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

Instructions: *For each site, attach 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.*

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.

_____ _____

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

Care Coordinator Certification Renewal Application

Applicant name _____

Current 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 to be offered for the following waivers:

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

Provider agency name _____ Provider number _____

Business physical address/City/Zip _____

Name of back-up care coordinator _____

Telephone number _____ Provider number _____

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

- ☐ Certificate of completion of care coordination training within current certification period
- ☐ *Disclosure of Business and Familial Relationships* form (Cert-20)

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 offer 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 Renewal 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 have been up-dated, changed or revised since the date of the agency's last certification; copies are enclosed for recertification.

- ☐ 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 Renewal Application
Service Declaration: Care Coordination Services

Name of provider agency _____

Program administrator for Care Coordination Services

Name _____

Telephone number _____ FAX number _____

Cell number _____ Email _____

Service 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.

The following policies and procedures have been up-dated, changed or revised since the date of the agency's last certification; copies are enclosed for recertification.

Required for sole proprietors and agency providers

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

Required for 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 Renewal 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.

The following policies and procedures have been up-dated, changed or revised since the date of the agency's last certification; copies are enclosed for recertification.

- ☐ 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 Renewal 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.

The following policies and procedures have been up-dated, changed or revised since the date of the agency's last certification; copies are enclosed for recertification.

- ☐ 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 Renewal 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.

☐ Assisted living home license

The following policies and procedures have been up-dated, changed or revised since the date of the agency's last certification; copies are enclosed for recertification.

☐ 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 Renewal 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.

The following policies and procedures have been up-dated, changed or revised since the date of the agency's last certification; copies are enclosed for recertification.

☐ 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 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 Renewal 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.

- ☐ 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 have been up-dated, changed or revised since the date of the agency's last certification; copies are enclosed for recertification.

- ☐ 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 Renewal 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.

The following policies and procedures have been up-dated, changed or revised since the date of the agency's last certification; copies are enclosed for recertification.

- ☐ Admissions
- ☐ Background check
- ☐ Complaint management
- ☐ Confidentiality
- ☐ Conflicts of interest
- ☐ Critical incident reporting
- ☐ Emergency response
- ☐ Financial accountability
- ☐ Evaluation of employees
- ☐ Medication administrations
- ☐ 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 Renewal Application
Service Declaration: Intensive Active Treatment Services

Name of provider _____

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 that have been up-dated, changed or revised since the date of the agency's last certification are enclosed for recertification.

- ☐ Admissions
- ☐ Background check
- ☐ Complaint management
- ☐ Confidentiality
- ☐ Conflicts of interest
- ☐ Critical incident reporting
- ☐ Emergency response
- ☐ Evaluation of employees
- ☐ Financial accountability
- ☐ Medication administrations
- ☐ 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 Renewal 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 as:

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

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

The following policies and procedures have been up-dated, changed or revised since the date of the agency's last certification; copies are enclosed for recertification.

☐ 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 Renewal 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-owner or –leased vehicle registrations

The following policies and procedures have been up-dated, changed or revised since the date of the agency's last certification; copies are enclosed for recertification.

- ☐ 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 130.290; 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 Renewal 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 will be offered 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 have been up-dated, changed or revised since the date of the agency's last certification; copies are enclosed for recertification.

- ☐ 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 130.29; 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 Renewal 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 for recipients as

☐ Agency-based environmental modifications services

☐ Contractor business services: General Contractor license # _____

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

The following policies and procedures have been up-dated, changed or revised since the date of the agency's last certification; copies are enclosed for recertification.

☐ 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*

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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 _____ FAX number _____

Cell number _____ Email _____

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	////	////	////	////
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

Required attachments Review the SDS certification website 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 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*

Check box below for the policies and procedures, submitted for certification on/after July 1, 2013, that will control operations in the new location; copies of policies and procedures unique to the new location or not submitted before that date are attached to this application.

- ☐ 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 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 _____

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
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	////	////	////	////
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

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

The following attachments are required:

- ☐ *Service Declaration* for the 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 _____ Email _____

☐ **New mailing address or contact information** (*Required 10 Days prior to change*).

Mailing address/City/Zip _____

Telephone number _____ FAX number _____

Cell number _____ Email _____

☐ **New license for facility currently licensed under AS 47.32.** (*Required upon issuance*)

Attach copy of license showing changes regarding facility.

☐ **New agency name or physical location** (*Required 60 days prior to change*).
For name change, attach new business license and if applicable, other licenses; new Certificate of Insurance *showing name change; and any other documents, required for certification, that have been changed as result of the name change.*

☐ Services provided at this location ☐ Services not provided at this location

Name of provider agency _____

Physical address _____

City _____ Zip _____

☐ **New form of business organization** (*Required 60 days prior to change*).

Attach new business license, and specify EIN/Tax number

☐ Sole proprietorship ☐ For-profit corporation
☐ General partnership ☐ Non-profit corporation
☐ Limited liability company ☐ Limited partnership

☐ **Agency sale/Change of ownership** (*Required 60 days prior to change*

Purchaser/New owner name _____

Date of sale or change of ownership _____

☐ **Agency closure** (*Required 60 days prior to change*).

Date of closure _____

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 _____ Email _____

☐ **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 change.*

Former name of care coordinator _____

Name changed to _____