



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**

Owner name (as reported on W-9) \_\_\_\_\_

Business legal name \_\_\_\_\_

Business name (DBA) \_\_\_\_\_

Provider Number \_\_\_\_\_

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	////	////	////	////
Site-based		NA		
Community-based		NA		
Residential habilitation	////	////	////	////
Family home habilitation		NA		
Supported-living habilitation		NA		
Group-home habilitation		NA		
In-home support habilitation	NA	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				

**Business information**

Location of recipient records \_\_\_\_\_

Form of organization  Sole proprietorship  For-profit corporation  
 General partnership  Non-profit corporation  
 Limited liability company  Limited partnership  
 Government/Public agency  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
- Organizational chart
- Personnel list (if applicable)
- Quality Improvement report

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 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 certification is true, accurate, and complete.*

\_\_\_\_\_  
*Owner/Administrator/Director signature*

\_\_\_\_\_  
*Print name*

\_\_\_\_\_  
*Title*

\_\_\_\_\_  
*Date*

Name of person completing application: \_\_\_\_\_

Telephone/Cell number \_\_\_\_\_ Email \_\_\_\_\_