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

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
- ☐ Children with Complex Medical Conditions
- ☐ Alaskans Living Independently
- ☐ 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*

_____ _____
Title *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*