



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 _____ Provider Number _____

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.

- | | | |
|--|--|---|
| <input type="checkbox"/> Admissions | <input type="checkbox"/> Critical incident reporting | <input type="checkbox"/> Restrictive intervention |
| <input type="checkbox"/> Background check | <input type="checkbox"/> Emergency response | <input type="checkbox"/> Termination of provider services |
| <input type="checkbox"/> Complaint management | <input type="checkbox"/> Evaluation of employees | <input type="checkbox"/> Training |
| <input type="checkbox"/> Confidentiality | <input type="checkbox"/> Financial accountability | |
| <input type="checkbox"/> Conflicts of interest | <input type="checkbox"/> Quality improvement | |

Census area to be served: Check box for each location at which services will be offered.

- | | | | | |
|---|---|---|--|--|
| <input type="checkbox"/> Aleutians East | <input type="checkbox"/> Dillingham | <input type="checkbox"/> Ketchikan Gateway | <input type="checkbox"/> North Slope | <input type="checkbox"/> Southeast Fairbanks |
| <input type="checkbox"/> Aleutians West | <input type="checkbox"/> Fairbanks North Star | <input type="checkbox"/> Kodiak Island | <input type="checkbox"/> Northwest Arctic | <input type="checkbox"/> Valdez/Cordova |
| <input type="checkbox"/> Anchorage | <input type="checkbox"/> Haines | <input type="checkbox"/> Kusilivak | <input type="checkbox"/> Petersburg | <input type="checkbox"/> Wrangell |
| <input type="checkbox"/> Bethel | <input type="checkbox"/> Hoonah/Angoon | <input type="checkbox"/> Lake and Peninsula | <input type="checkbox"/> Prince of Wales/Outer Ketchikan | <input type="checkbox"/> Yakutat |
| <input type="checkbox"/> Bristol Bay | <input type="checkbox"/> Juneau | <input type="checkbox"/> Mat-Su | <input type="checkbox"/> Sitka | <input type="checkbox"/> Yukon-Koyukuk |
| <input type="checkbox"/> Denali | <input type="checkbox"/> Kenai | <input type="checkbox"/> Nome | <input type="checkbox"/> Skagway | |

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