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 for Additional Location

Owner name (as reported on W-9) _____

Business legal name _____

Business name (DBA) _____

Administrator _____

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

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	☐ Critical incident reporting	☐ Quality improvement
☐ Background check	☐ Emergency response	☐ Restrictive intervention
☐ Complaint management	☐ Evaluation of employees	☐ Termination of provider services
☐ Confidentiality	☐ Financial accountability	☐ Training
☐ Conflicts of interest	☐ Medication administration	

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 _____