



Home and Community-based Waiver Services

Provider Certification Application and Renewal Application

\*ALL FIELDS ARE REQUIRED\*

Application Type: Initial Application Renewal Application Medicaid Provider # \_\_\_\_\_

Agency Information

Business Name (DBA): \_\_\_\_\_ EIN/Tax ID # \_\_\_\_\_

Legal Name (as reported on business income tax return): \_\_\_\_\_

Business physical address/City/Zip: \_\_\_\_\_

Business mailing address/City/Zip: \_\_\_\_\_

Physical address of Recipient Records/City/Zip: \_\_\_\_\_

Business phone # \_\_\_\_\_ Fax # \_\_\_\_\_

Business e-mail: \_\_\_\_\_ Business web site: \_\_\_\_\_

Form of Organization

- Sole proprietorship Government/Public agency Limited partnership
General partnership For-profit corporation Tribal health organization
Limited liability company Non-profit corporation

Agency Contacts

Program Administrator: \_\_\_\_\_

Contact number: \_\_\_\_\_ Contact e-mail: \_\_\_\_\_

Medicaid Billing Agent: Agency Employee Contractor Name: \_\_\_\_\_

Name of Individual Medicaid Billing Agent: \_\_\_\_\_

Table of Services

Check the box for each service the provider plans to offer to recipient. A corresponding Service Declaration form MUST be included with this application for each service selected.

Table with 4 columns: Waiver Service, Service Declaration, Waiver Service, Service Declaration. Rows include Adult Day, Care Coordination, Chore, Day Habilitation, Residential Habilitation-Family Home, Residential Habilitation-Group Home, Residential Habilitation-In-Home Support, Residential Habilitation-Supported Living.

Intensive Active Treatment	Cert-15	Residential Supported Living	Cert-09
Environmental Modification	Cert-19	Respite	Cert-16
Meals	Cert-18	Supported Employment	Cert-14
Nursing Oversight/Care Management	Cert-05	Transportation	Cert-17

**Required Attachments**

**IMPORTANT:** Review the SDS certification website for application guidance and content requirements at: <http://dhss.alaska.gov/dsds/Documents/docs/WaiverCertAppGuidance.pdf>

**Applications will not be reviewed without all completed forms and attachments.** If an application is determined incomplete, the provider will be notified by e-mail that re-applying is necessary. Incomplete applications are not returned to providers

**Provider Core Requirements:**

State of Alaska Business License  
 Critical Incident Report Training  
 Completion Certificate (SDS Course)  
 Certificates of Insurance (*Workers Comp, Vehicle, General Liability, etc. See guidance for details.*)

Organizational Chart  
 Personnel List (if applicable)

*Renewal applications only:*  
 Quality Improvement Report for the previous certification period

**Provider Operations**

For each waiver service checked on the *Table of Services*, submit the following:

Provider Certification Service Declarations(s)                      Additional attachments listed on Service Declaration(s)  
 Policies and Procedures listed on Service Declaration(s)

***Important Note:***

- o *Send only one copy if the provider offers multiple services.*
- o *For renewals, only submit Policies and Procedures if they have been updated since the last certification or due to a change in regulation.*

**Provider Assurances**

*I affirm that the provider agency will comply with the Medicaid Home and Community-Based Waiver Services regulations, including the Provider Conditions of Participation; 7AAC 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.*

\_\_\_\_\_ Print Name: \_\_\_\_\_

*Owner/Administrator/Director signature*

Title: \_\_\_\_\_ Date: \_\_\_\_\_

Telephone/Cell #: \_\_\_\_\_ E-mail: \_\_\_\_\_

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