



Alaska • Department of Health and Social Services • Senior and Disabilities Services
 Home and Community-based Waiver Services
Care Coordinator Certification Application and Renewal Application

Application Type: Initial Application Renewal Application Medicaid Provider # _____

Applicant name: _____

Provider agency: _____

Business physical address/City/Zip: _____

Business mailing address/City/Zip: _____

Telephone #: _____

Fax #: _____

Cell #: _____

E-mail: _____

Waiver Programs

I plan to offer care coordination services for the following waiver programs:

- Adults with Physical and Developmental Disabilities (APDD)
- Alaskans Living Independently (ALI)
- Children with Complex Medical Conditions (CCMC)
- Individuals with Intellectual and Developmental Disabilities (IDD)
- Individualized Supports Waiver (ISW)
- Tax Equity and Fiscal Responsibility Act (TEFRA)

Required Attachments

Review the SDS certification website for instructions and content requirements:

<http://dhss.alaska.gov/dsds/Documents/docs/WaiverCertAppGuidance.pdf>

Applicant’s resume

Documentation showing applicant’s educational qualifications

Certificate of completion of SDS care coordination training within the prior 12 months

Disclosure of business and Familial Relationships form (Cert-20)

Renewal Applications:

Certificate of completion of SDS care coordination training within the current certification period

Documentation showing the completion of required continuing education hours (CEH). *See Waiver Provider Certification Application Guidance in the Service Specific Requirements for information on meeting CEH requirement:* <http://dhss.alaska.gov/dsds/Pages/provider/default.aspx>

Disclosure of business and Familial Relationships form (Cert-20)

Back-up Care Coordinator

Name of back-up Care Coordinator: _____

Telephone/cell #: _____ Medicaid Provider #: _____

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

Date

Print Name: _____

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 provide care coordination services.

Care Coordinator Program Administrator signature

Date

Print Name: _____