



State of Alaska • Department of Health and Social Services • Senior and Disabilities Services
Home and Community-based Waiver Services

Worker Assurances

Owner name (as reported on W-9)

Business name (DBA)

Administrator

Current provider numbers

Business physical address/City/Zip

Business mailing address/City/Zip

Telephone number

FAX number

Cell number

Email

I have reviewed the requirements for workers' compensation insurance, and have determined that I do not require coverage at this time because I am applying for certification of a provider agency that will have no employees. The provider agency will operate with the owner or owners providing all services.

I understand the State of Alaska Workers' Compensation Act requires that I obtain workers' compensation insurance if I have one or more employees. I understand that if I alter my business operations by hiring one or more employees, I must:

1. submit a copy of my Certificate of Insurance, or a similar document showing insurance coverage, to Senior and Disabilities Services; and
2. name Senior and Disabilities Services, Provider Certification Unit, 550 8th Ave., Anchorage, AK 99501, as a certificate holder for that insurance.

I understand that I am not required to submit documents related to operating a provider agency with employees because I have no employees; and that, if I plan to hire employees, I must submit policies and procedures addressing employee training, employee evaluation, and background checks.

I affirm that, when I plan to hire employees, I will submit proof of workers' compensation insurance coverage and all materials related to operating a provider agency with employees, as required by the Medicaid Home and Community-Based Waiver Services regulations and the Conditions of Participation applicable to providers and to the waiver services I offer to recipients. I understand that failure to do so will cause the provider agency to be out of compliance with 7 AAC 130.220, and to be subject to decertification.

Owner/Administrator/Director signature

Print name

Title

Date