



State of Alaska • Department of Health and Social Services • Senior and Disabilities Services  
Home and Community-Based Waiver Services and Personal Care Services

**Notice of Appointment or Change of Program Administrator**

Send completed form and attachments to [DSDSCertification@alaska.gov](mailto:DSDSCertification@alaska.gov) or Fax to 907-754-3475  
Attention: Provider Certification

**Provider agency**

Name of provider agency \_\_\_\_\_ Medicaid Provider #: \_\_\_\_\_

**Notice of Appointment**

**Change of Program Administrator**

Name of new Program Administrator \_\_\_\_\_

Telephone \_\_\_\_\_ Email \_\_\_\_\_

**Services**

The Program Administrator will manage the following service(s):

- |                        |                              |
|------------------------|------------------------------|
| Adult Day              | Residential Habilitation     |
| Care Coordination      | Residential Supported Living |
| Chore                  | Respite                      |
| Day Habilitation       | Supported Employment         |
| Personal Care Services |                              |

**Required attachments**

Although the following are listed on each Service Declaration, send only one copy for a notice of change or for a program administrator that will manage more than one waiver service. Note that there are no Service Declarations for Personal Care Services but the following are required.

- Program Administrator's resume
- Documentation of Program Administrator's educational qualifications

**References**

The work experience of the Program Administrator may be verified by contacting the following individuals:

Reference Name \_\_\_\_\_

Telephone \_\_\_\_\_ Email \_\_\_\_\_

Reference Name \_\_\_\_\_

Telephone \_\_\_\_\_ Email \_\_\_\_\_

Reference Name \_\_\_\_\_

Telephone \_\_\_\_\_ Email \_\_\_\_\_

**Provider Assurances**

*I certify that the named program administrator meets the requirements for education and experience and possesses the required knowledge base and skills specified in the Conditions of Participation for Personal care Services or the indicated waiver service(s)*

\_\_\_\_\_  
*Owner/Administrator/Director signature*

\_\_\_\_\_  
*Print name*

\_\_\_\_\_  
*Title*

\_\_\_\_\_  
*Date*