



**Service Declaration: Residential Habilitation Services**

**Agency**

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

**Program Administrator for Residential Habilitation Services**

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

Telephone #: \_\_\_\_\_ Fax #: \_\_\_\_\_

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

**Programs and Services**

The residential habilitation services described in 7 AAC 130.265 will be offered to recipients as.

- |                               |                               |
|-------------------------------|-------------------------------|
| Family home habilitation      | Group-home habilitation       |
| Supported-living habilitation | In-home supports habilitation |

Waiver Programs: Select each waiver program the agency intends to serve:

- APDD: Adults with Physical and Developmental Disabilities
- CCMC: Children with Complex Medical Conditions
- IDD: Individuals with Intellectual and Developmental Disabilities
- ISW: Individualized Supports Waiver

**Required Attachments: Provider Operations**

Review the SDS certification website for instruction and content requirements.

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

Initial Applications: All of the following policies and procedures must be enclosed.

Renewal Applications: Submit only Policies and Procedures if they have been updated since the last certification or due to a change in regulation

Operations Manual: The following policies and procedures required for certification are enclosed:

- |                                  |                                  |
|----------------------------------|----------------------------------|
| Policy Assurances Form (Cert-37) | Person-Centered Practice         |
| Background Check                 | Quality Improvement              |
| Critical incident report         | Restrictive Intervention         |
| Financial Accountability         | Termination of Provider Services |

Independence and Inclusion

Training

Medication Management (*not required for Family Habilitation or Group Home*)

\*Note: A Policy on Medication management is NOT required for Family Residential Habilitation and Group Home Residential Habilitation services.

The following required forms are enclosed:

*Notice of appointment or Change of Program Administrator (Cert-04) (initial or change only)*

**For Family Home or and Group Home Services as applicable:**

Assisted Living Home License or Community Care License (foster home) for each facility to be certified

*Group Home Habilitation Site Information form (Cert-12)*

*Family Home Habilitation Site Information form (Cert-13)*

**Census area to be served**

*Check box for each location in which services will be offered.*

Aleutians East	Haines	Mat-Su	Southeast Fairbanks
Aleutians West	Hoonah/Angoon	Nome	Valdez/Cordova
Anchorage	Juneau	North Slope	Wrangell
Bethel	Kenai	Northwest Arctic	Yakutat
Bristol Bay	Ketchikan Gateway	Petersburg	Yukon-Koyukuk
Denali	Kodiak Island	Prince of Wales/Hyder	
Dillingham	Kusilivak	Sitka	
Fairbanks North Star	Lake and Peninsula	Skagway	

**Provider Assurances**

*I affirm that the provider agency will comply with the residential habilitation services regulations, 7AAC 130.265, and the Residential Habilitation 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, accurate, and complete.*

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

\_\_\_\_\_  
*Print Name*

\_\_\_\_\_  
Title

\_\_\_\_\_  
Date