



State of Alaska • Department of Health and Social Services • Senior and Disabilities Services
 Home and Community-based Waiver Services
 Adults with Physical and Developmental Disabilities • Alaskans Living Independently
 Children with Complex Medical Conditions • Individuals with Intellectual and Developmental Disabilities

Care Coordinator Certification
Disclosure of Business and Familial Relationships

Name of care coordinator _____ Provider number _____

Name of provider agency employer _____

Table 1 List provider agencies in which you have an ownership, partnership, or equity interest equal to or greater than 5%.

Name of provider agency	Address	Telephone

Table 2 List other businesses or commercial activities, in which you and another provider, owner, or administrator each have an ownership, partnership, or equity interest equal to or greater than 5%.

Name of business/commercial activity	Name of other agency/owner or administrator	Address

Table 3 List any individual who is an owner, administrator, or employee of a provider agency or of a business/commercial activity who is your spouse, parent, sibling or child, or the spouse of a parent, sibling, or child.

Name of agency/business/commercial activity	Name of relative	Relationship

Care coordinator assurances

I certify that the information provided regarding my business and familial relationships is true, accurate, and complete.

 Care coordinator signature

 Date