



State of Alaska • Department of Health and Social Services •
Senior and Disabilities Services

**Personal Care Services
Provider Certification Application**

Send completed form and attachments to DSDSCertification@alaska.gov, or fax to 907-754-3475, or mail/drop off at 550 W. 8th Ave., Anchorage, AK 99501 Attention: Provider Certification

ALL Fields Are Required

Choose Application Type: Initial Application Renewal Application

Medicaid Provider Number: _____

Choose One or Both: Agency Based Services Consumer Directed Services

Agency Information

Business Name (DBA): _____

Legal Name (as reported on business income tax return): _____

EIN/Tax ID Number: _____

Business Physical Address/City/Zip: _____

Business Mailing Address/City/Zip: _____

Telephone Number: _____ Fax Number: _____

Business Email: _____

Physical Address of Recipient Records: _____

Form of Organization:

For-Profit Corporation

Limited Partnership

General Partnership

Non-Profit Corporation

Government/Public Agency

Sole Proprietorship

Limited Liability Company

Tribal Health Organization

Agency Contacts

Program Administrator: _____

Contact Number: _____

Contact Email: _____

Supervising Nurse: _____

License Number: _____

Medicaid Billing Agent: Agency Employee

Contractor Name: _____

Name of Individual Medicaid Billing Agent: _____

Required attachments. Applications cannot be processed without all forms and attachments.
Review the SDS Provider Certification & Compliance website for instructions and content requirements.

Provider Core Requirements: Required for All Applications

- Business License
- Certificate of Insurance
- Critical Incident Report Training Completion Certificate (SDS Course)
- Organizational Chart
- PCS Program Administrator Notice of Appointment (Cert-04)
- Personnel List (if applicable)

Policies, Procedures, and Assurances Required

Initial Application: ALL

Renewal Application: Only if modifications were made to policies since last certification or due to a regulation change.

Admissions

Assurances form (Cert-37)

Assistance with Self Administration of Medication (ASAM)

Cert-37 covers the following policies:

Background Check

√ Complaint Management

Backup Plans for PCAs (Consumer-Direct agencies only)

√ Confidentiality

Critical Incident Reporting

√ Notice of Privacy Practices

Financial Accountability

√ Conflict of Interest

Quality Improvement

√ Emergency Response

Restrictive Interventions

√ Evaluation of Employees

Termination and Transfer of Provider Services

Training

Required for All Renewal Applications

Quality Improvement Report

Provider Assurances

I affirm that the provider will comply with the Personal Care Services regulations, including the Personal Care Services Conditions of Participation; 7 AAC 125.010-7AAC 125.199; and all applicable federal, state, and local laws and regulations. I certify that the information provided in the attachments required for certification is true, accurate, and complete.

Owner/Administrator/Director Signature

Print Name

Title

Date

Name of Person Completing Application: _____

Telephone Number: _____

Email: _____