



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

Provider Certification Application for Additional Location

Owner name (as reported on W-9) _____

Business legal name _____

Business name (DBA) _____

Administrator _____

Business physical address/City/Zip _____

Business mailing address/City/Zip _____

Telephone number _____ FAX number _____

Cell number _____ Email _____

Additional location

Contact _____

Business physical address/City/Zip _____

Business mailing address/City/Zip _____

Telephone number _____ FAX number _____

Cell number _____ Email _____

Table of Services Check box for each service the provider plans to offer to recipients. (NA indicates services unavailable for the waiver specified in that column.)

Waiver service	APDD	ALI	CCMC	IDD
Nursing oversight and care management	NA	NA		
Care coordination				
Chore				
Adult day			NA	NA
Residential supported living			NA	NA
Day habilitation	////	////	////	////
Site-based		NA		
Community-based		NA		
Residential habilitation	////	////	////	////
Family home habilitation		NA		
Supported-living habilitation		NA		
Group-home habilitation		NA		
In-home support habilitation	NA	NA		
Supported-employment		NA		
Intensive active treatment		NA		
Respite care				
Family-directed respite care	NA	NA		
Transportation				
Meal	////	////	////	////
Congregate meals				
Home-delivered meals				
Environmental modification				

Required attachments Review the SDS certification website for instruction and content requirements.

- State of Alaska business license
- Certificate of Insurance
- Organization chart
- Personnel list (if applicable)
- Critical Incident Reporting training certificate

For each waiver service checked on the *Table of Services*, submit the following:

- Provider Certification Application Service Declaration* for that service
- Attachments specified on the *Service Declaration*

Providers that will operate without employees must submit the following form:

- Provider Certification Application Worker Assurances*

Check box below for the policies and procedures, submitted for certification on/after July 1, 2013, that will control operations in the new location; copies of policies and procedures unique to the new location or not submitted before that date are attached to this application.

- | | | |
|--|--|---|
| <input type="checkbox"/> Admissions | <input type="checkbox"/> Critical incident reporting | <input type="checkbox"/> Quality improvement |
| <input type="checkbox"/> Background check | <input type="checkbox"/> Emergency response | <input type="checkbox"/> Restrictive intervention |
| <input type="checkbox"/> Complaint management | <input type="checkbox"/> Evaluation of employees | <input type="checkbox"/> Termination of provider services |
| <input type="checkbox"/> Confidentiality | <input type="checkbox"/> Financial accountability | <input type="checkbox"/> Training |
| <input type="checkbox"/> Conflicts of interest | <input type="checkbox"/> Medication administration | |

Provider Assurances

I affirm to that the provider will comply with the Medicaid Home and Community-Based Waiver Services regulations, including the Provider Conditions of Participation; 7 AAC 130.200 – 7AAC 130.319; and all applicable federal, state, and local laws and regulations. I certify that the information provided in the attachments required for recertification is true, accurate, and complete.

Owner/Administrator/Director signature _____ *Print name* _____

Title _____ *Date* _____

Name of person completing application _____

Telephone/Cell number _____ Email _____