



State of Alaska • Department of Health and Social Services • Senior and Disabilities Services  
Home and Community-based Services

Adults with Physical and Developmental Disabilities • Alaskans Living Independently  
Children with Complex Medical Conditions • Individuals with Intellectual and Developmental Disabilities  
Personal Care Services

**Care Coordination Agency Certification  
Conflict of Interest Attestation**

Name of Agency \_\_\_\_\_ Provider Number \_\_\_\_\_

This document is to be completed by the approved Program Administrator for care coordination services and is a required document for certification of the provider agency as per 7 AAC 130.220.

**Reminder: Per 7 AAC 130.240 and the care coordination Conditions of Participation, a care coordination agency and care coordinators employed by a care coordination agency must not have a conflict of interest in the provision of care coordination.**

Does the agency provide HCB services (other than care coordination) including 1915 (c) waiver, or state plan personal care services?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If the response to the above question is Yes, has the agency applied for or been approved for an exception to conflict-free care coordination?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Does the agency financially benefit from other services a participant may receive?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Does the agency have a shared executive director/CEO, Board of Directors, or any financial interest in any entity providing service delivery in home and community based services including 1915 (c) waiver, or state plan personal care services?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
I affirm by checking “Yes” that the agency does not employ any care coordinators with a conflict of interest, as evidenced by the “Individual Care Coordinator Conflict of Interest Assurance” form maintained in each recipient file.	<input type="checkbox"/> Yes	<input type="checkbox"/> No

*I understand that any false statement, misrepresentation, omission, or concealment in this document may subject me to criminal, civil, or administrative penalties. Under penalty of perjury, I certify that the information I have provided is true, accurate, and complete to the best of my knowledge.*

\_\_\_\_\_  
Signature of Program Administrator for Care Coordination Service

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name