



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

**Individual Care Coordinator  
Conflict of Interest Assurance**

Name of Care Coordinator \_\_\_\_\_ Provider Number \_\_\_\_\_

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

Name of Recipient \_\_\_\_\_ Medicaid ID Number \_\_\_\_\_

This document must be completed with every recipient’s waiver Plan of Care and stored in the recipient’s file at the care coordination agency. Failure to have the form on file when audited may result in sanctions.

Assurances	Initial
I assure that I do not work for an agency providing Home and Community Based (HCB) services (waiver or personal care services), or if I do, that the agency has applied for or been approved for an exception to conflict-free care coordination requirements.	
I assure that I am not an owner or board member of an agency that provides home and community-based services to the recipient.	
I assure that I do not provide any HCB services for compensation (regardless of employer).	
I assure that I am not financially responsible for or have a fiduciary relationship with the recipient (i.e. Guardianship, Conservatorship, Power of Attorney).	

***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.***

\_\_\_\_\_  
Care Coordinator Signature Date