



# STATE OF ALASKA

Department of Health and Social Services  
Division of Senior and Disabilities Services

## Home and Community Based Waiver Services Certification Application Packet

for

Children with Complex Medical Conditions (CCMC)  
People with Mental Retardation and Developmental Disabilities (MRDD)  
Adults with Physical Disabilities (APD)  
Older Alaskans (OA)

February 12, 2004  
Second Edition

Name of Agency \_\_\_\_\_

Physical Address/City/Zip \_\_\_\_\_

Mailing Address/City/Zip \_\_\_\_\_

State of Alaska Business License Number \_\_\_\_\_

Agency Billing Numbers \_\_\_\_\_

Telephone Number \_\_\_\_\_ FAX Number \_\_\_\_\_

Cell Number \_\_\_\_\_ Email \_\_\_\_\_

Person Completing Packet \_\_\_\_\_

Telephone Number \_\_\_\_\_ Email \_\_\_\_\_

Mail Certification Application Packet to:

State of Alaska  
Department of Health and Social Services  
Division of Senior and Disabilities  
3601 C Street, Suite 310  
Anchorage, AK 99503

## Section 2 - Agency Certification Application

Name of Agency: \_\_\_\_\_

Name of Owner(s), if applicable: \_\_\_\_\_

Name of Program Administrator: \_\_\_\_\_

Telephone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

Cell Number: \_\_\_\_\_ Email: \_\_\_\_\_

Community to be served: \_\_\_\_\_

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All applying agencies must complete Section 2 and the Sections applicable to the Home and Community Based (HCB) Waiver Services which the agency plans to provide:

- Section 4 - Care Coordination Services
- Section 5 - Residential Habilitation Services
- Section 5 - Day Habilitation Services
- Section 5 - Supported Employment Habilitation Services
- Section 6 - Adult Day Services
- Section 7 - Residential Supported Living Services
- Section 8 - Respite Services
- Section 9 - Intensive Active Treatment Services
- Section 10 - Environmental Modification Services
- Section 11 - Chore Services
- Section 12 - Transportation Services
- Section 13 - Meal Services

## TABLE of AVAILABLE SERVICES

Please check the service(s) the agency plans to provide to HCB Waiver recipients.

Services	HCB Waiver Services Programs			
	Older Alaskans	Adults with Physical Disabilities	Children with Complex Medical Conditions	Persons with Mental Retardation & Developmental Disabilities
Care Coordination				
Residential Habilitation	Not Available			
Day Habilitation	Not Available			
Supported Employment Habilitation	Not Available			
Adult Day Services			Not Available	Not Available
Residential Supported Living Services			Not Available	Not Available
Respite Services				
Intensive Active Treatment Services	Not Available			
Environmental Modification Services				
Chore Services				
Transportation Services				
Meals Services				

## REQUIRED ATTACHMENTS

Review the Description of Attachments. Provide the materials listed for **Initial Application**, if not previously certified, or **Recertification**; label, tab or index in the order designated. (Materials will be placed in DSDS file folders so do not send in binders or page protectors.)

### Initial Application

1. State of Alaska Business License.
2. Certificate of Insurance.
3. Documentation of authority to conduct business.
4. Organization chart.
5. Employee handbook or orientation materials.
6. Fiscal and accounting process description.
7. Agency values, philosophy and mission.
8. Emergency response and recovery plan.
9. Confidentiality policy and Notice of Privacy Practices.
10. Policy for handling consumer complaints.
11. Annual assessment and written report plan, and sample consumer satisfaction survey form.

### Recertification

1. State of Alaska Business License.
2. Certificate of Insurance.
3. Organization chart.
4. Annual assessment report.
5. Documents showing changes, if any, in personnel or to prior certification materials.

### DESCRIPTION OF ATTACHMENTS

1. A copy of your current **business license** in the name of the organization you wish to have certified. (Licensure is required throughout the certification period.)
2. A copy of your **Certificate of Insurance** indicating worker's compensation, comprehensive general liability, commercial automotive liability, and/or professional liability coverage appropriate to the HCB Waiver Services the agency is seeking to provide, and naming the Division of Senior and Disabilities Services, Provider Certification, (P.O. Box 110680, Juneau, Alaska 99802-0680) as a certificate holder. (All coverage must meet the minimum levels required by law.)
3. A copy of the articles of organization or incorporation, partnership agreement, bylaws or other documentation showing your **authority to conduct business**. (All agencies with boards of directors must have a procedure which addresses board member conflicts of interest and which documents disclosure and removal of a conflict or a determination that a conflict is not material; if applicable, identify this procedure in the materials submitted.)
4. An agency **organization chart** showing all paid staff and volunteer positions involved in providing HCB Waiver Services, lines of supervisory authority, and the names of the people holding these positions. (If the agency has an advisory board, include the names of all board members, and indicate how the board relates to the agency.)

5. A description of the agency **fiscal and accounting process** which is used to ensure correct billing and which incorporates generally-accepted accounting principles and the requirements of 7 AAC § 43.030.
6. A copy of the agency **employee handbook or orientation materials** addressing the agency code of ethics; non-discrimination policy; safety and health policies; background check policy; employee rights, including a grievance procedure; performance measures; training requirements and schedules for licensed and unlicensed staff; and procedures for confirmation of currency of mandatory licensure.
7. A description of agency **values, philosophy, and mission**.
8. A copy of the agency **emergency response and recovery plan** which provides for safe evacuation, housing, and continuing services in the event of flood, fire, earthquake, severe weather, prolonged loss of utilities, failure of a scheduled provider to arrive, or other emergency which could present a threat to the health, life or safety of clients.
9. A copy of the agency **confidentiality policy** which incorporates HIPAA (Health Insurance Portability and Accountability Act of 1996) and other federal and state requirements, and a copy of the agency **Notice of Privacy Practices** provided to recipients.
10. A copy of the agency **policy for handling consumer complaints**, including written and oral grievances, and the methods used for resolution.
11. A copy of the agency procedure for an **annual assessment and written report**, for each HCB Waiver Service provided, which includes the following elements:
  - A. Involvement of staff, program administrator, recipients, families, caregivers, advisory board, governing board, and other relevant agencies, organizations, and businesses;
  - B. Evaluation of recipient, family, and caregiver satisfaction with services, based on distribution and analysis of **consumer satisfaction survey** forms which allow for a range of answers, and on oral and written complaints or grievances;
  - C. Assessment, based on analysis of expected and actual outcomes, of how well the agency assisted recipients, families, and caregivers; and
  - D. Recommendations for improvement, corrective action for problem areas, and future program/business directions brought to light by the evaluation process.

## **GENERAL ASSURANCES**

1. The agency will comply with the background check requirements, mandated by AS § 47.05.017 and AS §§ 47.05.300 –.05.390, by following the Background Check Unit procedures posted on the website: <http://hss.state.ak.us/dph/CL/bgcheck>. An initial background check will be conducted for both paid staff and volunteers who have direct contact with HCB Waiver recipients, with a follow-up check every two years thereafter.

2. The agency will notify DSDS, in writing within 24 hours or by the next business day, of a criminal or civil charge against, or conviction (including restraining orders) of, any paid staff or volunteer.
3. The agency will notify DSDS, in writing within one week, of a change in agency name, agency location, or ownership, or of program administrator for any HCB Waiver Service.
4. Fees for services provided to HCB Waiver recipients will not exceed the fees for comparable services provided to private pay clients in compliance with 7 AAC § 43.040.
5. Copies of current driver's licenses (appropriate for the vehicle driven) for all individuals who transport HCB Waiver recipients and copies of current CPR and First Aid cards for all individuals who provide direct services will be kept on file and provided when requested.
6. The agency will comply with the Civil Rights Act of 1964, (42 U.S.C. § 2000d); the Americans with Disabilities Act (42 U.S.C. §§ 12101-12213); the Drug-Free Workplace Act of 1988 (41 U.S.C. §§ 701-707); OSHA regulations related to health, safety, sanitation, and protection of employees from blood borne pathogens; AS § 18.80.220 and other federal and state laws and regulations barring discriminatory employment practices; AS § 47.17.010 Child Protection and AS § 47.24.010 Reports of Harm.

**AGENCY AGREEMENT**

Your signature indicates your agency has agreed to fulfill all of the requirements pertaining to Home and Community Based Waiver Services, and that all agency personnel meet the qualifications identified in this certification application packet and in regulations.

Your signature indicates that the State of Alaska, its officers, agents and employees shall be indemnified, held harmless and defended from all liability, including cost and expenses, for all actions and claims resulting from injuries or damages sustained by any person or property arising directly or indirectly as a result of any error, omission, or negligent act of the applying agency, agency subcontractors, or anyone directly or indirectly employed by the agency, in the performance of HCB Waiver Services.

Your signature indicates acceptance of this agreement as notice that failure to comply with the General Assurances and Medicaid regulations, including maintaining and providing upon request to DSDS accurate and up-to-date certification records (financial, clinical, and other records relating to the provision of goods or services on behalf of a recipient), can be cause for revoking certification and potentially lead to Medicaid sanctions, including recoupment of Medicaid payments for services, 7 AAC §§ 43.950 - 43.955.

As an authorized agent of the applying agency, I affirm that I have read and will adhere to conditions and requirements of 7 AAC §§ 43.005 – 43.1990 inclusive; that all agency staff meet the required levels of experience, education and training to provide HCB Waiver Services; and that the information in this application is true and correct.

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Signature of authorized agent Title

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Printed Name Date

## Section 10 - Environmental Modification Services

Name of Agency: \_\_\_\_\_

Person who completed this section: \_\_\_\_\_

Telephone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

Cell Number: \_\_\_\_\_ Email: \_\_\_\_\_

Community to be served: \_\_\_\_\_

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This section must be completed by agencies and contractors seeking certification, and by contractors seeking enrollment under 7 AAC § 43.1090 (c) (1), to provide Environmental Modification Services under the HCB Waiver Services programs. Environmental Modification Services are defined in 7 AAC § 43.1054; please read carefully. Environmental Modification Services providers must meet the requirements of this section, in addition to those of Section 2.

### **CONTRACTOR ENVIRONMENTAL MODIFICATION SERVICES**

#### **REQUIRED ATTACHMENTS**

##### **Initial Application**

1. Current State of Alaska General Contractor's License.
2. Current contractor's insurance and bonding eligibility.

##### **Recertification**

1. Current State of Alaska General Contractor's License.
2. Current contractor's insurance and bonding eligibility.

### **CONTRACTOR ENVIRONMENTAL MODIFICATION SERVICES GENERAL ASSURANCES**

1. The contractor agrees that all work will be completed in a timely manner, consistent with the estimated start and completion dates, and that no substitutions of materials of a quality lower than that specified on the cost estimate sheet will be used.
2. The contractor will install all equipment following the manufacturer's recommendations and/or applicable code requirements and guidelines.
3. The contractor agrees to perform no work for which the Department of Labor has issued a cease and desist work order.

4. The contractor agrees to notify DSDS in writing, within 24 hours or the next business day, of the loss of his/her contractor's license, or a claim against or loss of his/her bond.

**AGENCY ADMINISTERED ENVIRONMENTAL MODIFICATION SERVICES  
GENERAL ASSURANCES**

1. The agency will engage only licensed electricians, mechanical contractors, or plumbers, with appropriate Certificates of Fitness issued under AS § 18.62.010, to perform all work subject to the Uniform Code adopted by the State for electrical or plumbing installations or modifications, AS § 18.60.580 and AS § 18.60.705.
2. The agency will monitor contractor performance to ensure that all work is completed in a timely manner, consistent with the estimated start and completion dates, and that no substitutions of materials of a quality lower than that specified on the cost estimate sheet are used.
3. The agency will ensure that no work for which the Department of Labor has issued a cease and desist work order is performed.

**AGENCY AGREEMENT**

Your signature indicates your agency has agreed to fulfill all of the requirements pertaining to Environmental Modification Services, and that all personnel providing Environmental Modification Services meet the qualifications specified in this certification application packet and in regulations.

Your signature indicates acceptance of this agreement as notice that failure to comply with the General Assurances and Medicaid regulations, including maintaining and providing upon request to DSDS accurate and up-to-date certification records (financial, clinical, and other records relating to the provision of goods or services on behalf of a recipient), can be cause for revoking certification and potentially lead to Medicaid sanctions, including recoupment of Medicaid payments for services, 7 AAC §§ 43.950 - 43.955.

As an authorized agent of the applying agency, I affirm that I have read and will adhere to conditions and requirements of 7 AAC §§ 43.005 - 43.1990 inclusive; that all agency staff meet the required levels of experience, education and training to provide HCB Waiver Services; and that the information in this application is true and correct.

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Signature authorized agent

Title

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Printed Name

Date