

State of Alaska Department of Health and Social Services
Division of Behavioral Health

**1115 Behavioral Health Waiver Facility
Application Form**

1	Agency Name:	Date:
2	Physical address: (Location of this facility where services are provided)	
3	Mailing address:	
4	Program Administrator:	Phone: E-Mail:
5	Indicate what 1115 Waiver Services the facility will be providing at this location (check all that apply): <input type="checkbox"/> 23-Hour Crisis Observation and Stabilization (COS) <input type="checkbox"/> Adult Mental Health Residential <input type="checkbox"/> Level I <input type="checkbox"/> Level II <input type="checkbox"/> Children's Mental Health Residential <input type="checkbox"/> Level I <input type="checkbox"/> Level II <input type="checkbox"/> Assertive Community Treatment (ACT) Services <input type="checkbox"/> Community Recovery Support Services (CRSS) <input type="checkbox"/> Crisis Residential and Stabilization Services (CSS) <input type="checkbox"/> Home-Based Family Treatment Services <input type="checkbox"/> Level I <input type="checkbox"/> Level II <input type="checkbox"/> Level III <input type="checkbox"/> Intensive Case Management Services (ICM) <input type="checkbox"/> Intensive Outpatient 2.1 <input type="checkbox"/> Mobile Outreach and Crisis Response Services (MOCR) <input type="checkbox"/> Partial Hospitalization Program <input type="checkbox"/> Peer-Based Crisis Services <input type="checkbox"/> Therapeutic Treatment Home Services <input type="checkbox"/> Treatment Plan Development/Review	
6	What is the target date to begin services at this location? Note: Medicaid enrollment after Department approval requires up to four weeks when processing new applications and backdating enrollment files is prohibited.	
7	Would Medicaid be billed for eligible recipients who receive services at this facility location? <input type="checkbox"/> Yes <input type="checkbox"/> No	
8	Choose the National Accreditation Agency that will accredit the location & services: <input type="checkbox"/> CARF <input type="checkbox"/> Joint Commission <input type="checkbox"/> COA <input type="checkbox"/> Alternative Accreditation <input type="checkbox"/> Unknown	
9	I understand that for this location, our agency must collect and report the statistics, service data, and other information requested by the department: <input type="checkbox"/> Yes <input type="checkbox"/> No	

Certification Statement:

I certify that the responses in this request and the information in the attached documents are accurate, complete, and current. I understand the information may be verified by Division of Behavioral Health (Division) staff upon on-site evaluations. I understand the Division has the authority and discretion to grant this approval in the absence of an updated Community Action Plan if it will enhance the continuum of services for the service area.

Name (print): _____ Signature: _____
(Administrator or Authorized Person)

Date: _____