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

NEW PROVIDER APPLICATION

Mailing address: 3601 C Street, Suite 878, Anchorage, AK 99503
Fax 907-269-3623

1.	Agency Name:		Date:
2	Insert the physical location i.e. street address for the location the agency will be operating at [7AAC 70.030(b)(3)]:		
3	Insert the mailing address for the agency:		Same as above ☐
4	Insert the headquarter location:		Same as above ☐
5	Who will be the point of contact? Name:	Phone:	E-mail:
6	What is the target date to begin services at this location:		
7	Please indicate the service area the location will be located within [7AAC 70.030(b)(2)]:		
8	The agency will provide services to which population (check all that apply): ☐ Adults w/ MH ☐ Adults w/ SUD ☐ Youth w/ MH ☐ Youth w/ SUD		
9	Are you seeking DBH Department Approval (DA) for the purposes of billing Medicaid? ☐ Yes ☐ No		
10	Projected number of recipients annually who will receive services: ☐ 0-100 ☐ 101-500 ☐ 501-1000 ☐ 1001-2000 ☐ 2001+		
11	Indicate the service category(s) that will be delivered [7AAC 70.030(a)(1)(A)]: ☐ Clinic ☐ Rehab ☐ Detox (ASAM Level) ☐ Residential SUD (ASAM Level) ☐ Detox & Residential SUD (ASAM Level)		
12	I understand that the agency must be Nationally Accredited within two years from the date the department issued the provisional approval. If department approval is awarded [7AAC 70.150], what National Accreditation Agency will accredit the location & services? ☐ The Joint Commission ☐ The Commission on Accreditation of Rehabilitation Facilities (CARF) ☐ The Council on Accreditation (COA)		
13	Do you understand that your agency must collect and report the statistics, service data, and other information requested by the department [7AAC 70.100(a)(4)] ☐ Yes ☐ No		
14	Provide completed DBH/Facility Account Form (Background Check form) and proof of emailed/faxed to the Background Check Unit (BCU)		
15	Provide copy of letter received from the Background Check Unit that the background check process has begun.		
16	List of all employees and positions (no resumes)		
17	Completed Provider Attestation Form		
18	Completed Self-Evaluation Form		
19	If providing behavioral health clinic services, such as psychotherapy, psych. testing, med. management, etc. please attach the documented formal agreement with the physician for the purpose of providing general direction and direct clinical services [7AAC 70.100(a)(3)]. ☐ Yes I have attached the agreement ☐ No I do not have an agreement with a physician ☐ Not applicable		

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 staff upon on-site evaluations.

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

Date: _

DIVISION OF BEHAVIORAL HEALTH USE ONLY
Follow-up Required: