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

Care Coordinator Certification Application and Renewal Application

Application Type: Initial Application Renewal Application Medicaid Provider #____________

Applicant name: ____

Provider agency: ___________________________________

Business physical address/City/Zip: ____

Business mailing address/City/Zip: ____

Telephone #: ____________ Fax #: _____________

Cell #: _________________ E-mail: ____

Waiver Programs

I plan to offer care coordination services for the following waiver programs:

- Adults with Physical and Developmental Disabilities (APDD)
- Alaskans Living Independently (ALI)
- Children with Complex Medical Conditions (CCMC)
- Individuals with Intellectual and Developmental Disabilities (IDD)
- Individualized Supports Waiver (ISW)
- Tax Equity and Fiscal Responsibility Act (TEFRA)

Required Attachments

Review the SDS certification website for instructions and content requirements:
http://dhss.alaska.gov/dsds/Documents/docs/WaiverCertAppGuidance.pdf

- Applicant's resume
- Documentation showing applicant's educational qualifications
- Certificate of completion of SDS care coordination training within the prior 12 months
- *Disclosure of business and Familial Relationships* form (Cert-20)

Renewal Applications:

- Certificate of completion of SDS care coordination training within the current certification period
- Documentation showing the completion of required continuing education hours (CEH). *See Waiver Provider Certification Application Guidance in the Service Specific Requirements for information on meeting CEH requirement:* http://dhss.alaska.gov/dsds/Pages/provider/default.aspx
- *Disclosure of business and Familial Relationships* form (Cert-20)

Back-up Care Coordinator

Name of back-up Care Coordinator: ____

Telephone/cell #: _____________ Medicaid Provider #: ______________

Care Coordinator Assurances

I affirm that I will comply with the care coordination services regulations, 7 AAC 130.211 – 7 AAC 130.215 and 7 AAC 130.240; the Care Coordination Services Conditions of Participation*; and all applicable federal, state, and local laws and regulations. I certify that the information offered in the attachments required for certification is true and complete.*

____ ________________________

Applicant signature *Date*

Print Name: ____

Provider Assurances

I certify that the applicant meets and complies with the requirements of the Care Coordination Services Conditions of Participation, *is employed by named provider agency, and meets the provider's employment and certification standards to provide care coordination services.*

____ ________________________

Care Coordinator Program Administrator signature *Date*

Print Name: ____