



### Worker Assurances

#### Agency Information

Doing Business As (DBA) Name: Medicaid ID #:

Legal Business Name:

Program Administrator:

Business Physical Address/City/Zip:

Business Mailing Address/City/Zip:

Business Phone #: Contact Phone #:

Fax #: Business E-mail:

#### Provider Assurances

I have reviewed the requirements for workers' compensation insurance and have determined that I do not require coverage at this time because I am applying for certification of a provider agency that will have no employees or volunteers. The provider agency will operate with the owner(s) providing all services.

I understand the State of Alaska Workers' Compensation Act requires that I obtain workers' compensation insurance if I have one or more employees or volunteers. I understand that if I alter my business operations by hiring one or more employees or utilizing volunteers, I must:

1. Submit a copy of my workers' compensation certificate of insurance; and
2. Name Senior and Disabilities Services, Provider Certification Unit, 1835 Bragaw Street Suite 350, Anchorage, AK 99508, as a certificate holder for that insurance.

I understand that I am not required to submit documents related to operating a provider agency with employees or volunteers because I have no employees or volunteers; and that, if I plan to hire employees or volunteers, I must submit policies and procedures addressing employee/volunteer training and background check requirements.

*I affirm that, when I plan to hire employees or use volunteers, I will submit proof of workers' compensation insurance coverage and all materials related to operating a provider agency with employees/volunteers, as required by the Medicaid Home and Community-Based Waiver Services regulations and the Conditions of Participation applicable to providers and to the waiver services I offer to recipients. I understand that failure to do so will cause the provider agency to be out of compliance with 7 AAC 130.220, and to be subject to decertification.*

Owner/Administrator/Director Signature Title

Print Name Date