



**Service Declaration: Care Coordination Services**

**Agency**

Name of Provider Agency:

Medicaid Provider #:

**Program Administrator for Care Coordination Services**

Name:

Telephone #:

Fax #:

E-mail:

Cell #:

**Program and Services**

The Care Coordination services described in 7 AAC 127; 7 AAC 130.211-7AAC 130.218, and 7 AAC 130.240 will be offered to recipients.

Waiver Programs: Select each waiver program the agency intends to serve:

ALI: Adults Living Independently

APDD: Adults with Physical and Developmental Disabilities

CCMC: Children with Complex Medical Conditions

IDD: Individuals with Intellectual and Developmental Disabilities

ISW: Individualized Supports Waiver

TEFRA: Tax Equity and Fiscal Responsibility Act; Division of Public Assistance program

**Required Attachments and Provider Operations**

Review the SDS certification website for instruction and content requirements.

<https://health.alaska.gov/dsds/Pages/provider/default.aspx>

**Initial Applications:**

The following required forms must be enclosed:

Notice of Appointment or Change of Program Administrator (Cert-04)

Policy Assurances Form (Cert-37)

Care Coordination Agency Certification Conflict of Interest Attestation (Cert-46)

The following policies and procedures must be enclosed:

Background Checks\*

Person-Centered Practice

Critical Incident Reporting

Quality Improvement

Financial Accountability

Termination of Provider Services

Independence and Inclusion

Training\*

\*Note: Policies on Background Checks and Training are NOT required for agencies operated by a sole owner with no employees or volunteers.

**Renewal Applications:**

The following required forms must be enclosed:

Notice of Appointment or Change of Program Administrator (Cert-04) (*change only*)

Policy Assurances Form (Cert-37)

Care Coordination Agency Certification Conflict of Interest Attestation (Cert-46)

Submit only policies and procedures if they have been updated since the last certification or due to a change in regulation.

**Census Area to be Served**

*Check box for each location in which services will be offered.*

Aleutians East	Dillingham	Kusilivak	Sitka
Aleutians West	Fairbanks North Star	Lake and Peninsula	Skagway
Anchorage	Haines	Mat-Su	Southeast Fairbanks
Bethel	Hoonah/Angoon	Nome	Wrangell
Bristol Bay	Juneau	North Slope	Yakutat
Chugach	Kenai	Northwest Arctic	Yukon-Koyukuk
Copper River	Ketchikan Gateway	Petersburg	
Denali	Kodiak Island	Prince of Wales/Hyder	

**Provider Assurances**

*I affirm that the provider agency will comply with the Care Coordination services regulations, 7 AAC 130.211-7 AAC 130.218, and 7 AAC 130.240, the Care Coordination Services and Long-Term Services and Supports Targeted Case Management 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, accurate, and complete.*

Owner/Administrator/Director Signature

Title

Print Name

Date