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

# Service Declaration: Intensive Active Treatment Services

## Agency

Name of provider agency: _______________________________________________Medicaid Provider #: ________________

## Program Administrator for Intensive Active Treatment Services

Name: ____________________________________________________________________________________________

Telephone #: _______________________ Fax #: ______________________

Cell #: _____________________________ E-mail: _________________________________________________________

Professional service providers

| Name | Profession/Job title | License number |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

## Programs and Services

The intensive active treatment services described in 7 AAC 130.275 will be offered to recipients.

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

APDD: Adults with Physical and Developmental Disabilities

CCMC: Children with Complex Medical Conditions

IDD: Individuals with Intellectual and Developmental Disabilities

ISW: Individualized Supports Waiver

## Required Attachments: Provider Operations (Agency-based providers only)

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

Initial Applications: All of the following policies and procedures must be enclosed.

Renewal Applications: Submit only Policies and Procedures if they have been updated since the last certification or due to a change in regulation

Operations Manual: The following policies and procedures required for certification are enclosed:

- Policy Assurances Form (Cert-37)
- Background Check
- Critical Incident Report
- Financial Accountability
- Medication Management
- Person-Centered Practice
- Quality Improvement
- Restrictive Intervention
- Termination of Provider Services
- Training

## Census area to be served

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

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

## Provider Assurances

*I affirm that the provider agency will comply with the intensive active treatment services regulations, 7AAC 130.275, 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*

________________________________________
*Print Name*

________________________________________
Title

________________________________________
Date