STATE OF ALASKA

Department of Health and Social Services
Division of Senior and Disabilities Services

Home and Community Based Waiver Services Certification Application Packet

for
Children with Complex Medical Conditions (CCMC)
People with Mental Retardation and Developmental Disabilities (MRDD)
Adults with Physical Disabilities (APD)
Older Alaskans (OA)

February 12, 2004
Third Edition

Name of Agency_____

Physical Address/City/Zip_____

Mailing Address/City/Zip_____

State of Alaska Business License Number_____

Agency Billing Numbers_____

Telephone Number _____**FAX Number**_____

Cell Number_____**Email**_____

Person Completing Packet_____

Telephone Number_____**Email**_____

Mail Certification Application Packet to:

State of Alaska
Department of Health and Social Services
Division of Senior and Disabilities Services
550 West 8th Ave, Anchorage, AK 99501

Table of Contents
for
Home and Community Based Waiver Services
Certification Application Packet

Section 1 - Overview of Home and Community Based (HCB) Waiver Services

Your agency is required to be certified by DSDS and enrolled with Affiliated Computer Services (ACS) to provide services and to bill Medicaid for recipients served under these HCB Waiver Services programs:

- Children with Complex Medical Conditions (CCMC)
- People with Mental Retardation and Developmental Disabilities (MRDD)
- Adults with Physical Disabilities (APD)
- Older Alaskans (OA)

Please read the regulations which pertain to HCB Waiver Services, 7 AAC 105.100-160.990 to understand the requirements and the standards to which your agency will be held.

To be certified, your agency must submit a complete Certification Application Packet which includes: a) Cover Sheet, b) Section 2 - Agency Certification Application, c) (Section 3, if your agency is a private nonprofit agency or governmental agency), d) the Section for the HCB Waiver Services you plan to provide, and e) all required attachments listed in the Sections. An agency planning to operate multiple office locations must submit a complete Certification Application Packet for each office location.

Care Coordination Services

Care Coordination Agency and Independent Care Coordinator

- Cover Sheet
- Section 2 - Agency Certification Application
- Section 4 - Care Coordination Services

Care Coordinator Employed After Agency Certification/Recertification

- Cover Sheet
- Table of Available Services (page 7)
- Section 4 - Care Coordination Services

If certified, your agency will receive a billing number with a CMG prefix (e.g., CMG999) which may be used to bill for care coordination agency services only; CMG agencies may not provide or bill for any other HCB Waiver Services. Care coordinators will receive a number with a CM prefix (e.g., CM9999) which must be used to identify the individual who provides a service.

Habilitation Services (Residential, Day, and Supported Employment).

- Cover Sheet
- Section 2 - Agency Certification Application
- Section 5 - Habilitation Services

If certified, you will receive a billing number from Affiliated Computer Services (ACS) with an HC prefix (e.g., HC9999) to provide these services.

Adult Day Services

- Cover Sheet
- Section 2 - Agency Certification Application
- Section 6 - Adult Day Services

If certified, you will receive a billing number from Affiliated Computer Services (ACS) with an HC prefix (e.g., HC9999) to provide these services.

Residential Supported Living Services

- Cover Sheet
- Section 2 - Agency Certification Application
- Section 7 - Residential Supported Living Services

If certified, you will receive a billing number from Affiliated Computer Services (ACS) with an RL prefix (e.g., RL9999) to provide these services.

Respite Services

- Cover Sheet
- Section 2 - Agency Certification Application
- Section 8 - Respite Services

If certified, you will receive a billing number from Affiliated Computer Services (ACS) with an HC prefix (e.g., HC9999) to provide these services.

Intensive Active Treatment

- Cover Sheet
- Section 2 - Agency Certification Application
- Section 9 - Intensive Active Treatment Services

If certified, you will receive a billing number from Affiliated Computer Services (ACS) with an HC prefix (e.g., HC9999) to provide these services.

Environmental Modification Services

Agency Administered Services and Contractor Services

- Cover Sheet
- Section 2 - Agency Certification Application
- Section 10 - Environmental Modifications

Contractor Seeking Enrollment Under 7 AAC § 130.220

- Cover Sheet
- Section 2 - Agency Certification Application (Note: Only Attachment 1 required)
- Section 10 - Environmental Modifications

If certified, you will receive a billing number from Affiliated Computer Services (ACS) with an EM prefix (e.g., EM9999) to provide these services.

Chore Services

- Cover Sheet
- Section 2 - Agency Certification Application
- Section 11 - Chore Services

If certified, you will receive a billing number from Affiliated Computer Services (ACS) with an HC prefix (e.g., HC9999) to provide these services.

Transportation Services

Agency Services and Transportation Agency

- Cover Sheet
- Section 2 - Agency Certification Application
- Section 12 - Transportation Services

Transportation Provider Seeking Enrollment Under 7 AAC § 130.220

- Cover Sheet
- Section 2 - Agency Certification Application (Note: Only Attachment 1 required.)
- Section 12 - Transportation Services

If certified, you will receive a billing number from Affiliated Computer Services (ACS) with an HC prefix (e.g., HC9999) to provide these services.

Meals Services

- Cover Sheet
- Section 2 - Agency Certification Application
- Section 13 - Meals Services

If certified, you will receive a billing number from Affiliated Computer Services (ACS) with an HC prefix (e.g., HC9999) to provide these services.

Add HCB Waiver Services to Current Agency Certification

- Cover Sheet
- Table of Available Services (page 7)
- Section for the services to be added

If certified, you will receive a billing number from Affiliated Computer Services (ACS) with the appropriate prefix (HC, CMG, RL or EM) to provide these services if the agency does not have a current billing number which includes the requested services.

AFFILIATED COMPUTER SERVICES (ACS) ENROLLMENT

After your agency is certified by DSDS, you must complete a Standard Enrollment Application which can be downloaded from http://www.medicaidalaska.com/providers/Enrollment.shtml, the Affiliated Computer Services (ACS) web site. You must submit a copy of your DSDS Provider Certification form (which will be sent to you after review and approval of your certification application materials) with your enrollment application to ACS.

Section 2 - Agency Certification Application

Name of Agency: _____

Name of Owner(s), if applicable: _____

Name of Program Administrator: _____

Telephone Number: _____Fax Number:_____

Cell Number: _____Email: _____

Community to be served: _____

All applying agencies must complete Section 2 and the Sections applicable to the Home and Community Based (HCB) Waiver Services which the agency plans to provide:

- Section 4 - Care Coordination Services
- Section 5 - Residential Habilitation Services
- Section 5 - Day Habilitation Services
- Section 5 - Supported Employment Habilitation Services
- Section 6 - Adult Day Services
- Section 7 - Residential Supported Living Services
- Section 8 - Respite Services
- Section 9 - Intensive Active Treatment Services
- Section 10 - Environmental Modification Services
- Section 11 - Chore Services
- Section 12 - Transportation Services
- Section 13 - Meal Services

TABLE of AVAILABLE SERVICES

Please check the service(s) the agency plans to provide to HCB Waiver recipients.

Services	HCB Waiver Services Programs			
	Older Alaskans	**Adults with Physical Disabilities**	**Children with Complex Medical Conditions**	**Persons with Mental Retardation & Developmental Disabilities**
Care Coordination				
Residential Habilitation	Not Available			
Day Habilitation	Not Available			
Supported Employment Habilitation	Not Available			
Adult Day Services			Not Available	Not Available
Residential Supported Living Services			Not Available	Not Available
Respite Services				
Intensive Active Treatment Services	Not Available			
Environmental Modification Services				
Chore Services				
Transportation Services				
Meals Services				

REQUIRED ATTACHMENTS

Review the Description of Attachments. Provide the materials listed for **Initial Application,** if not previously certified**,** or **Recertification**; label, tab or index in the order designated. (Materials will be placed in DSDS file folders so do not send in binders or page protectors.)

Initial Application

1. State of Alaska Business License.
2. Certificate of Insurance.
3. Documentation of authority to conduct business.
4. Organization chart.
5. Employee handbook or orientation materials.
6. Fiscal and accounting process description.
7. Agency values, philosophy and mission.
8. Emergency response and recovery plan.
9. Confidentiality policy and Notice of Privacy Practices.
10. Policy for handling consumer complaints.
11. Annual assessment and written report plan, and sample consumer satisfaction survey form.

Recertification

1. State of Alaska Business License.
2. Certificate of Insurance.
3. Organization chart.
4. Annual assessment report.
5. Documents showing changes, if any, in personnel or to prior certification materials.

DESCRIPTION OF ATTACHMENTS

1. A copy of your current **business license** in the name of the organization you wish to have certified. (Licensure is required throughout the certification period.)

2. A copy of your **Certificate of Insurance** indicating worker's compensation, comprehensive general liability, commercial automotive liability, and/or professional liability coverage appropriate to the HCB Waiver Services the agency is seeking to provide, and naming the Division of Senior and Disabilities Services, Provider Certification, 550 W. 8th Ave, Anchorage, Ak 99501 as a certificate holder. (All coverage must meet the minimum levels required by law.)

3. A copy of the articles of organization or incorporation, partnership agreement, bylaws or other documentation showing your **authority to conduct business**. (All agencies with boards of directors must have a procedure which addresses board member conflicts of interest and which documents disclosure and removal of a conflict or a determination that a conflict is not material; if applicable, identify this procedure in the materials submitted.)

4. An agency **organization chart** showing all paid staff and volunteer positions involved in providing HCB Waiver Services, lines of supervisory authority, and the names of the people holding these positions. (If the agency has an advisory board, include the names of all board members, and indicate how the board relates to the agency.)

5. A description of the agency **fiscal and accounting process** which is used to ensure correct billing and which incorporates generally-accepted accounting principles and the requirements of 7 AAC § 105.230.

6. A copy of the agency **employee handbook or orientation materials** addressing the agency code of ethics; non-discrimination policy; safety and health policies; background check policy; employee rights, including a grievance procedure; performance measures; training requirements and schedules for licensed and unlicensed staff; and procedures for confirmation of currency of mandatory licensure.

7. A description of agency **values, philosophy, and mission**.

8. A copy of the agency **emergency response and recovery plan** which provides for safe evacuation, housing, and continuing services in the event of flood, fire, earthquake, severe weather, prolonged loss of utilities, failure of a scheduled provider to arrive, or other emergency which could present a threat to the health, life or safety of clients.

9. A copy of the agency **confidentiality policy** which incorporates HIPAA (Health Insurance Portability and Accountability Act of 1996) and other federal and state requirements, and a copy of the agency **Notice of Privacy Practices** provided to recipients.

10. A copy of the agency **policy for handling consumer complaints**, including written and oral grievances, and the methods used for resolution.

11. A copy of the agency procedure for an **annual assessment and written report,** for each HCB Waiver Service provided, which includes the following elements:

    A. Involvement of staff, program administrator, recipients, families, caregivers, advisory board, governing board, and other relevant agencies, organizations, and businesses;

    B. Evaluation of recipient, family, and caregiver satisfaction with services, based on distribution and analysis of **consumer satisfaction survey** forms which allow for a range of answers, and on oral and written complaints or grievances;

    C. Assessment, based on analysis of expected and actual outcomes, of how well the agency assisted recipients, families, and caregivers; and

    D. Recommendations for improvement, corrective action for problem areas, and future program/business directions brought to light by the evaluation process.

GENERAL ASSURANCES

1. The agency will comply with the background check requirements, mandated by AS 47.05.300 –.05.390, and 7 AAC 10.010-.990.

2. The agency will notify DSDS Provider Certification and the DPA Background Check Unit within 24 hours as mandated by 7 AAC 10.925 (a) through 7 AAC 10.925 (b)(1) and within 14 days as mandated by 7 AAC 10.925 (b)(2).

3. The agency will notify DSDS, in writing within one week, of a change in agency name, agency location, or ownership, or of program administrator for any HCB Waiver Service.

4. Fees for services provided to HCB Waiver recipients will not exceed the fees for comparable services provided to private pay clients in compliance with 7 AAC §145.020.

5. Copies of current driver's licenses (appropriate for the vehicle driven) for all individuals who transport HCB Waiver recipients and copies of current CPR and First Aid cards for all individuals who provide direct services will be kept on file and provided when requested.

6. The agency will comply with the Civil Rights Act of 1964, (42 U.S.C. § 2000d); the Americans with Disabilities Act (42 U.S.C. §§ 12101-12213); the Drug-Free Workplace Act of 1988 (41 U.S.C. §§ 701-707); OSHA regulations related to health, safety, sanitation, and protection of employees from blood borne pathogens; AS § 18.80.220 and other federal and state laws and regulations barring discriminatory employment practices; AS § 47.17.010 Child Protection and AS § 47.24.010 Reports of Harm.

AGENCY AGREEMENT

Your signature indicates your agency has agreed to fulfill all of the requirements pertaining to Home and Community Based Waiver Services, and that all agency personnel meet the qualifications identified in this certification application packet and in regulations.

Your signature indicates that the State of Alaska, its officers, agents and employees shall be indemnified, held harmless and defended from all liability, including cost and expenses, for all actions and claims resulting from injuries or damages sustained by any person or property arising directly or indirectly as a result of any error, omission, or negligent act of the applying agency, agency subcontractors, or anyone directly or indirectly employed by the agency, in the performance of HCB Waiver Services.

Your signature indicates acceptance of this agreement as notice that failure to comply with the General Assurances and Medicaid regulations, including maintaining and providing upon request to DSDS accurate and up-to-date certification records (financial, clinical, and other records relating to the provision of goods or services on behalf of a recipient), can be cause for revoking certification and potentially lead to Medicaid sanctions, including recoupment of Medicaid payments for services, 7 AAC §§105.400.

As an authorized agent of the applying agency, I affirm that I have read and will adhere to conditions and requirements of 7 AAC §§ 105.100-160.990 inclusive; that all agency staff meet the required levels of experience, education and training to provide HCB Waiver Services; and that the information in this application is true and correct.

_____

Signature of authorized agent Title

_____

Printed Name Date

Section 3 - Government and Nonprofit Agency Assurances

Name of Agency: _____

GENERAL ASSURANCES

1. A formal governing body has full legal authority and responsibility for operation of the agency.

2. Board meetings are open to the public.

3. Tribal Health Program applicants consent to be sued by the State of Alaska for claims arising from activities related to Home and Community Based Waiver Services programs.

REQUIRED ATTACHMENTS

1. A copy of the IRS letter granting non-profit status to the agency.
2. The name, address, and length of term of each member of the board of directors.

_____

Signature of authorized agent Title

_____

Printed Name Date

Section 4 - Care Coordination Services

Name of Agency: _____

If previously certified, agency CMG #:_____

Program Administrator for Care Coordination: _____

Telephone Number: _____Fax Number:_____

Cell Number: _____Email: _____

Community to be served: _____

This section must be completed by agencies seeking certification to provide Care Coordination Services under the HCB Waiver Services programs. Care Coordination Services are defined in 7AAC §130.240; please read carefully. Care Coordination Services providers must meet the requirements of this section, in addition to those of Section 2.

CARE COORDINATION SERVICES PROGRAM ADMINISTRATOR STANDARDS

The Program Administrator for this service must meet the following requirements.

1. Education and Experience:

   A. One year of full-time, paid experience working with human services clients and their families, DSDS services, and service providers; **and** one year (which may be concurrent) of full-time, paid experience as a supervisor of two or more staff (working full-time in a human services field or setting) in a position with responsibility for planning, development, management or operation of programs and service delivery, fiscal management, needs assessment, program evaluation, and similar tasks.

   B. In addition to the experience specified above, education and/or experience as follows:

      1) BA or BS Degree in social work, psychology, rehabilitation, nursing or a closely related human services field, from an accredited college or university; **or**

      2) AA Degree in psychology, social work, rehabilitation, nursing or a closely related human services field, from an accredited college or university, **and** two years of full-time, paid work experience in a human services field or setting; **or**

      3) Four years of full-time, paid work experience in psychology, social work, rehabilitation, nursing or a closely related human services field or setting; **or**

      4) Certification as a rural community health aide or practitioner **and** one year of full-time, paid work experience providing home care or similar services.

Distinguishing Characteristics:

A. Knowledge of the medical, behavioral, habilitative and rehabilitative conditions and requirements of the HCB Waiver Services programs population.

B. Knowledge of laws, rules, regulations, and precedents, including the Individuals with Disabilities Education Act (IDEA) and the Americans with Disabilities Act (ADA); terminology used in the work; requirements for HCB Waiver Services Care Coordination Services and the care coordination process, and for family-centered services; and knowledge of available local and statewide resources.

C. Ability to assess treatment needs of individuals who experience physical and/or intellectual disabilities.

D. Ability to establish program or service procedures, policies and guidelines, and relate them to objectives.

E. Ability to organize, evaluate and present information effectively, both orally and in writing.

F. Ability to supervise professional and support staff.

CARE COORDINATOR STANDARDS

Care coordinators must meet the following requirements.

1. Education and/or Experience:

   A. BA, BS or AA degree in psychology, social work, rehabilitation, nursing or a closely related human services field, from an accredited college or university, **and** one year of full time, paid work experience with human services recipients and providers; **or**

   B. Two years of college credit in psychology, social work, rehabilitation, nursing or a closely related human services field, from an accredited college or university, **and** one year of full time, paid work experience with human services recipients and providers; **or**

   C. Three years of paid full-time, paid work experience with a minimum of one year (of the three) of full-time, paid work experience with human services recipients and providers; **or**

   D. Certification as a rural community health aide or practitioner, **and** one year of full-time, paid work experience providing home care or similar services.

2. Distinguishing Characteristics:

   A. Knowledge of the medical, behavioral, habilitative and rehabilitative conditions and requirements of the HCB Waiver Services programs population.

   B. Knowledge of laws, rules, regulations, and precedents, including the Individuals with Disabilities Education Act (IDEA) and the Americans with Disabilities Act (ADA); terminology used in the work; requirements for HCB Waiver Services Care

Coordination Services and the care coordination process, and for family-centered services; and knowledge of available local and statewide resources.

C. Ability to assess treatment needs of individuals who experience physical and/or intellectual disabilities.

D. Ability to organize, evaluate and present information effectively, both orally and in writing.

E. Ability to work with professional and support staff.

REQUIRED ATTACHMENTS

Initial Application

All items in the Description of Attachments.

Recertification

1. List of all certified care coordinators and applicants with information described.
2. Documentation showing the program administrator, care coordinators and applicants have had care coordination training within the last 24 month.
3. Documentation (resume, degree or transcript, training and letters of reference) which substantiates applicants and care coordinators not associated with the agency in connection with the prior agency certification period (even though previously certified as care coordinators when employed by another agency) meet the requirements.
4. Documents showing changes, if any, in personnel or to prior certification materials.

DESCRIPTION OF ATTACHMENTS

1. A **list of all certified care coordinators** with CM numbers; physical and mailing addresses (if different from the agency); telephone numbers, including cell numbers if available; email addresses; program specialization (OA, APD, CCMC or MRDD); dates of employment with the agency; and dates of most current DSDS Care Coordination Training.

2. **Documentation which substantiates** that the program administrator and each care coordinator or applicant meets the required level of experience and education, and the distinguishing characteristics.

   A. An up-dated **resume** listing positions and employers; dates (specifying month and year) of experience in the positions; and the responsibilities and accomplishments of each position pertinent to, and demonstrating development of, the distinguishing characteristics.

   B. Confirmation in the form of a copy of a **degree or transcript** for the required level of education.

   C. Proof of successful completion, by the administrator and each care coordinator or applicant, of DSDS **care coordinator training** within the previous 24 month period.

D. **Letters of reference** (written within the past five years, and from sources other than employees of the State of Alaska and employees of the applying agency): three letters for the program administrator and two letters for each care coordinator and applicant.

3. **Position descriptions** for Care Coordination Program Administrator and for Care Coordinator, incorporating DSDS standards for education, experience and distinguishing characteristics.

AGENCY AGREEMENT

Your signature indicates your agency has agreed to fulfill all of the requirements pertaining to Care Coordination Services, and that all personnel providing Care Coordination Services meet the qualifications specified in this certification application packet and in regulations.
Your signature indicates acceptance of this agreement as notice that failure to comply with the General Assurances and Medicaid regulations, including maintaining and providing upon request to DSDS accurate and up-to-date certification records (financial, clinical, and other records relating to the provision of goods or services on behalf of a recipient), can be cause for revoking certification and potentially lead to Medicaid sanctions, including recoupment of Medicaid payments for services, 7 AAC §§105.400.

As an authorized agent of the applying agency, I affirm that I have read and will adhere to conditions and requirements of 7 AAC §§ 105.100-160.990 inclusive; that all agency staff meet the required levels of experience, education and training to provide HCB Waiver Services; and that the information in this application is true.

_____

Signature of authorized agent Title

_____

Printed Name Date

Section 5 – Habilitation Services
Day, Residential and Supported Employment

Name of Agency: _____

Program Administrator for Habilitation Services: _____

Telephone Number: _____Fax Number:_____

Cell Number: _____ Email: _____

Community to be served: _____

This section must be completed by agencies seeking certification to provide Habilitation Services under the HCB Waiver Services programs. Habilitation Services are defined in 7 AAC §130.260, 7AAC § 130.265 and 7 AAC§ 130.270; please read carefully. Habilitation Services providers must meet the requirements of this section, in addition to those of Section 2.

HABILITATION SERVICES PROGRAM ADMINISTRATOR STANDARDS

The Program Administrator for this service must meet the following requirements.

1. Education and Experience:

   A. One year of full-time, paid experience working with human services clients and their families, DSDS services, and service providers; **and** one year (which may be concurrent) of full-time paid experience as a supervisor of two or more staff (working full-time in a human services field or setting) in a position with responsibility for planning, development, management or operation of programs and service delivery, fiscal management, needs assessment, program evaluation, and similar tasks.

   B. In addition to the experience specified above, education and/or experience as follows:

      1) BS or BA Degree in psychology, social work, rehabilitation, nursing or a closely related human services field, from an accredited college or university; **or**

      2) AA Degree in psychology, social work, rehabilitation, nursing or a closely related human services field from an accredited college or university **and** two additional years of full-time work experience in a human services field or setting; **or**

      3) Four years of full-time, paid work experience in psychology, social work, rehabilitation, nursing or a closely related human services field or setting; **or**

      4) Certification as a rural community health aide or practitioner, **and** one year of full-time, paid work experience providing home care or similar services.

2. Distinguishing Characteristics

   A. Knowledge of the medical, behavioral, habilitative and rehabilitative conditions and requirements of the HCB Waiver Services programs population.

   B. Knowledge of laws, rules, regulations, and precedents, including the Individuals with Disabilities Education Act (IDEA) and the Americans with Disabilities Act (ADA); terminology used in the work; and requirements for HCB Waiver Services Habilitation Services.

   C. Ability to assess treatment needs of individuals who experience physical and/or intellectual disabilities.

   D. Ability of establish program or service procedures, policies, or guidelines and relate them to objectives.

   E. Ability to organize, evaluate and present information effectively, both orally and in writing.

   F. Ability to supervise professional and support staff.

HABILITATION SERVICES PROVIDER STANDARDS

All individuals providing Habilitation Services must

1. Be at least 18 years old, **and**

2. Have a high school diploma **or** a GED **or** pass a test administered by the agency to confirm ability to read written instructions and make appropriate chart notes; **and**

3. Have six months of experience (full-time, paid or unpaid) **or** six months of training providing direct care to human services recipients (e.g., providing assistance to individuals or groups with problems caused by substance abuse, aging, physical or intellectual disabilities, or juvenile delinquency).

REQUIRED ATTACHMENTS

Initial Application

All items in the Description of Attachments.

Recertification

1. List of assisted living homes and current licenses.
2. List of shared care and family habilitation homes and current licenses.
3. Documents showing changes, if any, in personnel or to prior certification materials.

DESCRIPTION OF ATTACHMENTS

1. **Documentation which substantiates** that the Habilitation Services Program Administrator meets the required level of experience and education, and the distinguishing characteristics.

A. An up-dated **resume** listing positions and employers; dates (specifying month and year) of experience in the positions; and the responsibilities and accomplishments of each position pertinent to, and demonstrating development of, the distinguishing characteristics.

B. Confirmation in the form of a copy of a **degree or transcript** for the required level of education.

C. Three **letters of reference** (written within the past five years and from sources other than employees of the State of Alaska and employees of the applying agency).

2. **Position descriptions** for Habilitation Services Program Administrator and for Habilitation Services Provider incorporating DSDS standards for education, experience and distinguishing characteristics.

3. List **assisted living homes** utilized for out-of-home placements, and provide copies of the assisted living home licenses.

Name of Home	Address	Number of Licensed Beds	License No.

4. List **shared care homes and family habilitation homes** utilized for out-of-home placements, and provide a copy of the license for each home.

Name of Home	Address	Number of Licensed Beds	License No.

GENERAL ASSURANCE

The Habilitation Services Program Administrator will maintain on file a resume and two letters of reference (written within the past five years and from sources other than employees of the State of Alaska and employees of the applying agency) for each Habilitation Services Provider.

AGENCY AGREEMENT

Your signature indicates your agency has agreed to fulfill all of the requirements pertaining to Habilitation Services (Day Habilitation, Residential Habilitation, and Supported Employment Habilitation), and that all personnel providing Habilitation Services meet the qualifications specified in this certification application packet and in regulations.

Your signature indicates acceptance of this agreement as notice that failure to comply with the General Assurances and Medicaid regulations, including maintaining and providing upon request to DSDS accurate and up-to-date certification records (financial, clinical, and other records relating to the provision of goods or services on behalf of a recipient), can be cause for revoking certification and potentially lead to Medicaid sanctions, including recoupment of Medicaid payments for services, 7 AAC §§105.400-105.410.

As an authorized agent of the applying agency, I affirm that I have read and will adhere to conditions and requirements of 7 AAC §§105.100-160.990 inclusive; that all agency staff meet the required levels of experience, education and training to provide HCB Waiver Services; and that the information in this application is true.

_____

Signature of authorized agent Title

_____

Printed Name Date

Section 6 – Adult Day Services

Name of Agency: _____

Program Administrator for Adult Day Services: _____

Telephone Number: _____Fax Number: _____

Cellular Number: _____ Email: _____

Community to be served: _____

This section must be completed by agencies seeking certification to provide Adult Day Services under the HCB Waiver Services programs. Adult Day Services are defined in 7 AAC §130.250; please read carefully. Adult Day Services providers must meet the requirements of this section, in addition to those of Section 2.

ADULT DAY SERVICES PROGRAM ADMINISTRATOR STANDARDS

The Program Administrator for this service must

1. Be at least 21 years of age; **and**

2. Meet one of the following:

   A. BA or BS Degree in psychology, social work, rehabilitation, nursing or a closely related human services field from an accredited college or university; **or**

   B. AA Degree in psychology, social work, rehabilitation, nursing or a closely related human services field from an accredited college or university **and** two years of full-time, paid work experience in a human services field or setting; **or**

   C. Four years of full-time, paid work experience in psychology, social work, rehabilitation, nursing or a closely related human services field or setting; **or**

   D. Certification as a rural community health aide or practitioner **and** one year of full-time, paid work experience providing home care or similar services; **and**

3. Have skills in administration, planning, coordination, supervision, counseling, and the delivery of Adult Day Services or other services to HCB Waiver recipients.

ADULT DAY SERVICES ACTIVITY COORDINATOR AND ADULT DAY SERVICES PROVIDER STANDARDS

All individuals providing Adult Day Services must

1. Be at least 18 years old, **and**

2. Have sufficient skills, education and experience to provide services to HCB Waiver recipients; **and**

3. Have the ability to follow directions and keep records of tasks performed.

REQUIRED ATTACHMENTS

Initial Application

All items in the Description of Attachments.

Recertification

Documents showing changes, if any, in personnel or to prior certification materials.

DESCRIPTION OF ATTACHMENTS

1. **Documentation which substantiates** that the Adult Day Services Program Administrator and the Adult Day Services Activity Coordinator meets the required level of experience and education, and the distinguishing characteristics.

    A. An up-dated **resume** listing positions and employers; dates (specifying month and year) of experience in the positions; and the responsibilities and accomplishments of each position pertinent to, and demonstrating development of, the distinguishing characteristics.

    B. Confirmation in the form of a copy of a **degree or transcript** for the required level of education.

    C. Two **letters of reference** (written within the past five years and from sources other than employees of the State of Alaska and employees of the applying agency) for the Program Administrator and for the Activity Coordinator.

2. **Position descriptions** for Adult Day Services Program Administrator, Adult Day Activity Coordinator and Adult Day Services Provider incorporating DSDS standards for age, education and experience.

3. **Brochure** and/or a client handbook.

4. **Hours of operation**; include agency policy for closing during inclement weather and designated holidays.

5. **Plans for individual and group activities** suitable for the needs and abilities of recipients; include a description of who is involved in planning activities.

6. **Plan for transportation** of recipients for recreational outings.

7. **Program size**, maximum number of participants, and staff-to-participant ratio.

8. Entire **floor plan** of the area used by the Adult Day Services program, with square footage of each room indicated and with bathrooms labeled.

9. Policy and procedure for **administration of medications**.

GENERAL ASSURANCES

1. The Program Administrator will maintain on file a resume and two letters of reference (written within the past five years and from sources other than employees of the State of Alaska and employees of the applying agency) for each Adult Day Services Provider.

2. All meals will be provided by an agency certified by DSDS.

3. The Adult Day Services program will comply with the Adult Day Services Standards adopted by the Alaska Commission on Aging on February 20, 2003.

4. Written procedures for handling emergencies will be posted in the facility and in program vehicles.

AGENCY AGREEMENT

Your signature indicates your agency has agreed to fulfill all of the requirements pertaining to Adult Day Services, and that all personnel providing Adult Day Services meet the qualifications specified in this certification application packet and in regulations.

Your signature indicates acceptance of this agreement as notice that failure to comply with the General Assurances and Medicaid regulations, including maintaining and providing upon request to DSDS accurate and up-to-date certification records (financial, clinical, and other records relating to the provision of goods or services on behalf of a recipient), can be cause for revoking certification and potentially lead to Medicaid sanctions, including recoupment of Medicaid payments for services, 7 AAC §§105.400-105.410.

As an authorized agent of the applying agency, I affirm that I have read and will adhere to conditions and requirements of 7 AAC §§105.400-105.410 inclusive; that all agency staff meet the required levels of experience, education and training to provide HCB Waiver Services; and that the information in this application is true and correct.

_____

Signature of authorized agent Title

_____

Printed Name Date

Section 7 – Residential Supported Living Services

Name of Agency: _____

Program Administrator for Residential Supported Living: _____

Telephone Number: _____ Fax Number: _____

Cell Number: _____ Email: _____

Community to be served: _____

To be certified by the Division of Senior and Disabilities Services and to enroll with Medicaid as a Residential Supported Living Services provider under the HCB Waiver Services programs, an agency must be currently licensed by the State of Alaska as an assisted living home (Adult Foster Care, or Adult Residential Care I or II). Residential Supported Living Services are defined in 7 AAC §130.255; please read carefully. Residential Supported Living Services providers must meet the requirements of this section, in addition to those of Section 2.

REQUIRED ATTACHMENTS

Initial Application

All items in the Description of Attachments.

Recertification

1. Current assisted living home license.
2. If issued, a copy of the Order for Correction and corrective action plan.
3. Documents showing changes, if any, in personnel or to prior certification materials.

DESCRIPTION OF ATTACHMENTS

1. Copy of the current **assisted living home license**.

2. If deficiencies were cited during the most recent Department of Public Health inspection, include a copy of the **Order for Correction** and your **corrective action plan**.

3. If your assisted living facility license has ever been suspended, describe the **reason(s) for suspension and corrective actions** that were taken for reinstatement.

4. Copy of your **admission policy, house rules, and resident contract**. If these materials do not address all the services provided, include policy/guidelines for the additional services.

AGENCY AGREEMENT

Your signature indicates your agency has agreed to fulfill all of the requirements pertaining to Residential Supported Living Services and that all personnel providing Residential Supported Living Services meet the qualifications specified in this certification application packet and in regulations, and in state Assisted Living Home licensing requirements.

Your signature indicates acceptance of this agreement as notice that failure to comply with the General Assurances and Medicaid regulations, including maintaining and providing upon request to DSDS accurate and up-to-date certification records (financial, clinical, and other records relating to the provision of goods or services on behalf of a recipient), can be cause for revoking certification and potentially lead to Medicaid sanctions, including recoupment of Medicaid payments for services, 7 AAC §§105.400-105.410.

As an authorized agent of the applying agency, I affirm that I have read and will adhere to conditions and requirements of 7 AAC §§ 105.100-160.990 inclusive; that all agency staff meet the required levels of experience, education and training to provide HCB Waiver Services; and that the information in this application is true and correct.

_____

Signature of authorized agent Title

_____

Printed Name Date

Section 8 - Respite Services

Name of Agency: _____

Program Administrator for Respite: _____

Telephone Number: _____Fax Number: _____

Cell Number: _____ Email: _____

Community to be served: _____

This section must be completed by agencies seeking certification to provide Respite Services under the HCB Waiver Services programs. Respite Services are defined in 7 AAC §130.280; please read carefully. Respite Services providers must meet the requirements of this section, in addition to those of Section 2.

RESPITE SERVICES PROGRAM ADMINISTRATOR STANDARDS

The Program Administrator for this service must meet the following requirements.

1. Education and Experience:

   A. One year of full-time, paid experience working with human services clients and their families, DSDS services, and service providers; **and** one year (which may be concurrent) of full-time, paid experience as a supervisor of two or more staff (working full time in a human services field or setting) in a position with responsibility for planning, development, management or operation of programs and service delivery, fiscal management, needs assessment, program evaluation and similar tasks.

   B. In addition to the experience specified above, education and/or experience as follows:

      1) BA or BS Degree in psychology, social work, rehabilitation, nursing or a closely related human services field from an accredited college or university; **or**

      2) AA Degree in psychology, social work, rehabilitation, nursing or a closely related human services field from an accredited college or university **and** two years of full-time, paid work experience in a human services field or setting; **or**

      3) Four years of full-time, paid work experience in psychology, social work, rehabilitation, nursing or a closely related human services field or setting; **or**

      4) Certification as a rural community health aide or practitioner **and** one year of full-time, paid work experience providing home care or similar services.

2. Distinguishing Characteristics:

    A. Knowledge of the medical, behavioral, habilitative and rehabilitative conditions and requirements of the HCB Waiver Services programs population.

    B. Knowledge of laws, rules, regulations, and precedents, including the Individuals with Disabilities Education Act (IDEA) and the Americans with Disabilities Act (ADA); terminology used in the work; and requirements for HCB Waiver Respite Services.

    C. Ability to assess treatment needs of individuals who experience physical and/or intellectual disabilities.

    D. Ability of establish program or service procedures, policies, or guidelines and relate them to objectives.

    E. Ability to organize, evaluate and present information effectively, both orally and in writing.

    F. Ability to supervise professional and support staff.

RESPITE SERVICES PROVIDER STANDARDS

All individuals providing Respite Services must

1. Be at least 18 years old; **and**

2. Have a high school diploma **or** a GED **or** pass a test administered by the agency to confirm ability to read written instructions and make appropriate chart notes, **and**

3. Have the ability to communicate with HCB Waiver recipients and with his/her supervisor.

REQUIRED ATTACHMENTS

Initial Application

All items in the Description of Attachments.

Recertification

1. If providing family-directed respite services, a copy of the current Letter of Agreement.
2. Documents showing changes, if any, in personnel or to prior certification materials.

DESCRIPTION OF ATTACHMENTS

1. **Documentation which substantiates** that the Respite Program Administrator meets the required level of experience and education, and the distinguishing characteristics.

    A. An up-dated **resume** listing positions and employers; dates (specifying month and year) of experience in the positions; and the responsibilities and accomplishments of each position pertinent to, and demonstrating development of, the distinguishing characteristics.

B. Confirmation in the form of a copy **degree or transcript** for the required level of education.

C. Three **letters of reference** (written within the past five years and from sources other than employees of the State of Alaska and employees of the applying agency).

2. **Position descriptions** for Respite Services Program Administrator and for Respite Services Provider incorporating DSDS standards for education, experience and distinguishing characteristics.

3. Description of **previous agency experience** providing respite or similar services.

4. Description of **training** provided to Respite Services Providers for handling emergency situations.

5. If the agency is providing family-directed respite care services under 7 AAC § 130.280(e) a **description of how the agency will involve family members** in the selection and training of Respite Services Providers, and a copy of the current **Letter of Agreement** regarding these services.

GENERAL ASSURANCE

The Respite Services Program Administrator will maintain on file a resume and two letters of reference (written within the past five years and from sources other an employees of the State of Alaska and employees of the applying agency) for each Respite Services Provider.

AGENCY AGREEMENT

Your signature indicates your agency has agreed to fulfill all of the requirements pertaining to Respite Services, and that all personnel providing Respite Services meet the qualifications specified in this certification application packet and in regulations.

Your signature indicates acceptance of this agreement as notice that failure to comply with the General Assurances and Medicaid regulations, including maintaining and providing upon request to DSDS accurate and up-to-date certification records (financial, clinical, and other records relating to the provision of goods or services on behalf of a recipient), can be cause for revoking certification and potentially lead to Medicaid sanctions, including recoupment of Medicaid payments for services, 7 AAC §§105.400-105.410.

As an authorized agent of the applying agency, I affirm that I have read and will adhere to conditions and requirements of 7 AAC §§105.100-160.990 inclusive; that all agency staff meet the required levels of experience, education and training to provide HCB Waiver Services; and that the information in this application is true.

_____

Signature of authorized agent Title

_____

Printed Name Date

Section 9 - Intensive Active Treatment Services

Name of Agency:_____

Program Administrator for Intensive Active Treatment:_____

Telephone Number: _____Fax Number: _____

Cell Number: _____ Email: _____

Community to be served: _____

This section must be completed by agencies seeking certification to provide Intensive Active Treatment (IAT) services to HCB Waiver recipients. IAT services are defined in 7AAC §130.275; please read carefully. IAT Services providers must meet the requirements of this section, in addition of those of Section 2.

INTENSIVE ACTIVE TREATMENT PROVIDER STANDARDS

All individuals providing Intensive Active Treatment must

1. Be at least 18 years old, **and**

2. Be a professional (licensed by the State of Alaska under AS § 08) with expertise specific to the diagnosed condition of the individual who will be receiving services and appropriate to delivery of treatment specified in an approved Plan of Care, **or** a paraprofessional (licensed by the State of Alaska under AS § 08, if required, and working under the supervision of a qualified professional) with expertise specific to the diagnosed condition of the individual who will be receiving services and appropriate to delivery of treatment specified in an approved Plan of Care; **and**

3. Have one year full-time, paid work experience in delivery of the treatment (e.g., one year providing substance or alcohol abuse treatment) which will be provided as specified in an approved Plan of Care.

REQUIRED ATTACHMENTS

Initial Application

Current State of Alaska license or certification.

Recertification

Current State of Alaska license or certification.

AGENCY AGREEMENT

Your signature indicates your agency has agreed to fulfill all of the requirements pertaining to Intensive Active Treatment Services, and that all personnel providing Intensive Active Treatment Services meet the qualifications identified in this certification application packet and in regulations.

Your signature indicates acceptance of this agreement as notice that failure to comply with the General Assurances and Medicaid regulations, including maintaining and providing upon request to DSDS accurate and up-to-date certification records (financial, clinical, and other records relating to the provision of goods or services on behalf of a recipient), can be cause for revoking certification and potentially lead to Medicaid sanctions, including recoupment of Medicaid payments for services, 7 AAC §§105.400-105.410.

As an authorized agent of the applying agency, I affirm that I have read and will adhere to conditions and requirements of 7 AAC §§105.100-160.990inclusive; that all agency staff meet the required levels of experience, education and training to provide HCB Waiver Services; and that the information in this application is true.

_____

Signature of authorized agent Title

_____

Printed Name Date

Section 10 - Environmental Modification Services

Name of Agency: _____

Person who completed this section: _____

Telephone Number: _____Fax Number: _____

Cell Number: _____ Email: _____

Community to be served: _____

This section must be completed by agencies and contractors seeking certification, and by contractors seeking enrollment under 7 AAC § 130.220 to provide Environmental Modification Services under the HCB Waiver Services programs. Environmental Modification Services are defined in 7 AAC §130.300; please read carefully. Environmental Modification Services providers must meet the requirements of this section, in addition to those of Section 2.

CONTRACTOR ENVIRONMENTAL MODIFICATION SERVICES

REQUIRED ATTACHMENTS

Initial Application

1. Current State of Alaska General Contractor's License.
2. Current contractor's insurance and bonding eligibility.

Recertification

1. Current State of Alaska General Contractor's License.
2. Current contractor's insurance and bonding eligibility.

CONTRACTOR ENVIRONMENTAL MODIFICATION SERVICES
GENERAL ASSURANCES

1. The contractor agrees that all work will be completed in a timely manner, consistent with the estimated start and completion dates, and that no substitutions of materials of a quality lower than that specified on the cost estimate sheet will be used.

2. The contractor will install all equipment following the manufacturer's recommendations and/or applicable code requirements and guidelines.

3. The contractor agrees to perform no work for which the Department of Labor has issued a cease and desist work order.

4. The contractor agrees to notify DSDS in writing, within 24 hours or the next business day, of the loss of his/her contractor's license, or a claim against or loss of his/her bond.

AGENCY ADMINISTERED ENVIRONMENTAL MODIFICATION SERVICES GENERAL ASSURANCES

1. The agency will engage only licensed electricians, mechanical contractors, or plumbers, with appropriate Certificates of Fitness issued under AS § 18.62.010, to perform all work subject to the Uniform Code adopted by the State for electrical or plumbing installations or modifications, AS § 18.60.580 and AS § 18.60.705.

2. The agency will monitor contractor performance to ensure that all work is completed in a timely manner, consistent with the estimated start and completion dates, and that no substitutions of materials of a quality lower than that specified on the cost estimate sheet are used.

3. The agency will ensure that no work for which the Department of Labor has issued a cease and desist work order is performed.

AGENCY AGREEMENT

Your signature indicates your agency has agreed to fulfill all of the requirements pertaining to Environmental Modification Services, and that all personnel providing Environmental Modification Services meet the qualifications specified in this certification application packet and in regulations.

Your signature indicates acceptance of this agreement as notice that failure to comply with the General Assurances and Medicaid regulations, including maintaining and providing upon request to DSDS accurate and up-to-date certification records (financial, clinical, and other records relating to the provision of goods or services on behalf of a recipient), can be cause for revoking certification and potentially lead to Medicaid sanctions, including recoupment of Medicaid payments for services, 7 AAC §§105.400-105.410.

As an authorized agent of the applying agency, I affirm that I have read and will adhere to conditions and requirements of 7 AAC §§ 105.100-160.990 inclusive; that all agency staff meet the required levels of experience, education and training to provide HCB Waiver Services; and that the information in this application is true and correct.

_____

Signature authorized agent Title

_____

Printed Name Date

Section 11 - Chore Services

Name of Agency: _____

Program Administrator for Chore Services: _____

Telephone Number: _____Fax Number:_____

Cell Number: _____ Email: _____

Community to be served: _____

This section must be completed by agencies seeking certification to provide Chore Services under the HCB Waiver Services programs. Chore Services are defined in 7AAC §130.245. Chore Services providers must meet the requirements of this section, in addition to those of Section 2.

CHORE SERVICES PROGRAM ADMINISTRATOR STANDARDS

The Program Administrator for this service must meet the following requirements.

1. Education and Experience:

   A. One year of full-time, paid experience working with human services clients and their families, DSDS services, and service providers; **and** one year (which may be concurrent) of full-time, paid experience as a supervisor of two or more staff (working full-time in a human services field or setting) in a position with responsibility for planning, development, management or operation of programs and service delivery, fiscal management, needs assessment, program evaluation and similar tasks.

   B. High school diploma or GED.

2. Distinguishing Characteristics:

   A. Knowledge of laws, rules, regulations, and precedents, including the Individuals with Disabilities Education Act (IDEA) and the Americans with Disabilities Act (ADA); terminology used in the work; and requirements for HCB Waiver Chore Services.

   B. Ability to establish program or service procedures, policies or guidelines and relate them to objectives.

   C. Ability to organize, evaluate and present information effectively, both orally and in writing.

   D. Ability to supervise and support staff.

CHORE SERVICES PROVIDER STANDARDS

All individuals providing Chore Service must:

1. Be at least 18 years old; **and**

2. Have a High school diploma **or** a GED **or** pass a test administered by the agency to confirm ability to read written instructions and to make appropriate chart notes; **and**

3. Have the ability to communicate with the recipient, and with his/ her supervisor.

REQUIRED ATTACHMENTS

Initial Application

All items in the Description of Attachments.

Recertification

Documents showing changes, if any, in personnel or to prior certification materials.

DESCRIPTION OF ATTACHMENTS

1. **Documentation which substantiates** that the Chore Services Program Administrator meets the required level of experience and education, and the distinguishing characteristics.

   A. An up-dated **resume** listing positions and employers; dates (specifying month and year) of experience in the positions; and the responsibilities and accomplishments of each position pertinent to, and demonstrating development of, the distinguishing characteristics.

   B. Confirmation in the form of a copy **degree or transcript** for the required level of education.

   C. Three **letters of reference** (written within the past five years and from sources other than employees of the State of Alaska and employees of the applying agency).

2. **Position descriptions** for Chore Services Program Administrator and for Chore Services Provider incorporating DSDS standards for education, experience and distinguishing characteristics.

3. Description of **previous agency experience** providing chore or similar services.

4. Description of **training** provided to Chore Services Providers for handling emergencies.

GENERAL ASSURANCES

The Program Administrator will maintain on file a resume and two letters of reference (written within the past five years and from sources other than employees of the State of Alaska and employees of the applying agency) for each Chore Services Provider.

AGENCY AGREEMENT

Your signature below indicates your agency has agreed to fulfill all of the requirements pertaining to Chore Services, and that all personnel providing Chore Services meet the qualifications specified in this certification application packet and in regulations.

Your signature indicates acceptance of this agreement as notice that failure to comply with the General Assurances and Medicaid regulations, including maintaining and providing upon request to DSDS accurate and up-to-date certification records (financial, clinical, and other records relating to the provision of goods or services on behalf of a recipient), can be cause for revoking certification and potentially lead to Medicaid sanctions, including recoupment of Medicaid payments for services, 7 AAC §§105.400-105.410.

As an authorized agent of the applying agency, I affirm that I have read and will adhere to conditions and requirements of 7 AAC §§105.100-160.990 inclusive; that all agency staff meet the required levels of experience, education and training to provide HCB Waiver Services; and that the information in this application is true.

_____

Signature of authorized agent Title

_____

Printed Name Date

Section 12 - Transportation Services

Name of Agency: _____

Program Administrator for Transportation: _____

Telephone Number: _____ Fax Number: _____

Cell Number: _____ Email: _____

Community to be served: _____

This section must be completed by agencies and transportation providers seeking certification, and by transportation providers seeking enrollment under 7 AAC § 130.220 to provide Transportation Services under the HCB Waiver Services programs. Transportation Services are defined in 7AAC §130.290. Transportation Services providers must meet the requirements of this section, in addition to those of Section 2.

TRANSPORTATION SERVICES PROGRAM ADMINISTRATOR AND TRANSPORTATION SERVICES PROVIDER STANDARDS

All individuals providing transportation services must

1. Be at least 18 years old, **and**

2. Have a current Alaska Driver License with class designation appropriate to the type of vehicle he/she will operate; **and**

3. Have sufficient education and experience to provide Transportation Services for HCB Waiver recipients.

REQUIRED ATTACHMENTS

Initial Application

1. Current Alaska Driver License for the Transportation Services Program Administrator.
2. Current vehicle registration for all vehicles used to transport HCB Waiver recipients.
3. Copy of the notice of grant award if your agency is receiving grant funding for an established transportation program through the DSDS Nutrition, Transportation and Support Services Program, and agency staff are providing the transportation services.

Recertification

1. Current Alaska Driver License for the Transportation Services Program Administrator.
2. Current vehicle registration for all vehicles used to transport HCB Waiver recipients.
3. Copy of the notice of grant award if your agency is receiving grant funding for an established transportation program through the DSDS Nutrition, Transportation and Support Services Program, and agency staff are providing the transportation services.

GENERAL ASSURANCES

The Program Administrator will maintain on file copies of current Alaska Driver Licenses and driving records (completed within the past 12 months) for all Transportation Services Providers, and will verify the license class designation of each driver is appropriate for the type of vehicle operated.

AGENCY AGREEMENT

Your signature indicates your agency has agreed to fulfill all of the requirements pertaining to Transportation Services, and that all personnel providing Transportation Services meet the qualifications specified in this certification application packet and in regulations.

Your signature indicates acceptance of this agreement as notice that failure to comply with the General Assurances and Medicaid regulations, including maintaining and providing upon request to DSDS accurate and up-to-date certification records (financial, clinical, and other records relating to the provision of goods or services on behalf of a recipient), can be cause for revoking certification and potentially lead to Medicaid sanctions, including recoupment of Medicaid payments for services, 7 AAC §§105.400-105.410.

As an authorized agent of the applying agency, I affirm that I have read and will adhere to conditions and requirements of 7 AAC §§105.100-160.990 inclusive; that all agency staff meet the required levels of experience, education and training to provide HCB Waiver Services; and that the information in this application is true.

_____

Signature of authorized agent Title

_____

Printed Name Date

Section 13 - Meals Services
(Congregate or Home Delivered)

Name of Agency: _____

Program Administrator for Meal Services:_____

Telephone Number: _____Fax Number: _____

Cell Number: _____ Email: _____

Meal Preparation Location(s): _____

Check type(s) of meal services agency will provide: ☐ Congregate ☐ Home Delivered

This section must be completed by agencies seeking certification to provide Meals Services under the HCB Waiver Services programs. Meals Services are defined in 7 AAC §130.295; please read carefully. Meals Services providers must meet the requirements of this section, in addition to those of Section 2.

MEALS SERVICES PROGRAM ADMINISTRATOR AND
MEALS SERVICES PROVIDER STANDARDS

All individuals providing Meals Services must

1. Be at least 18 years old, **and**

2. Have education and experience sufficient to provide Meals Services to HCB Waiver recipients.

REQUIRED ATTACHMENTS

Initial Application:

All items in the Description of Attachments.

Recertification

1. A copy of the current food service permit.
2. Sample five-week menu cycle.
3. A copy of the current notice of grant award.
4. Documents showing changes, if any, in personnel or to prior certification materials.

DESCRIPTION OF ATTACHMENTS

1. **Position description** for Meals Services Program Administrator and Meal Services Provider incorporating DSDS standards for age and experience.

2. Documentation of successful completion of **food safety training** by the individual supervising Meals Services Providers.

3. A copy of the current **food service permit (**unless agency exempt by regulation) issued by the Department of Environmental Conservation (DEC), Division of Environmental Health, or by the municipality with delegated authority to implement the requirements of 18 AAC §§ 31.010 –31.990.

4. Description of the **methods used** by the agency to ensure food preparation safety, sanitation, and safe delivery of prepared meals.

5. A sample five-week **menu cycle** approved by a registered dietician or licensed nutritionist.

6 A copy of the **notice of grant award** if your agency is receiving grant funding for an established Meal Services program through the DSDS Nutrition, Transportation and Support Services Program and agency staff are providing the Meal Services, or through an established Department of Education School Lunch Program.

GENERAL ASSURANCES

1. The agency agrees to comply with the DEC Food Service Regulations, 18 AAC § 31, and with the requirements of the Alaska Commission on Aging, Nutrition, Transportation, and Support Services Standards, February 2003.

2. If subsistence foods are used, the agency agrees to meet DEC standards of quality, sanitation and safety, 18 AAC § 31.

AGENCY AGREEMENT

Your signature indicates your agency has agreed to fulfill all of the requirements pertaining to Meals Services, and that all personnel providing Meals Services meet the qualifications specified in this certification application packet and in regulations.

Your signature indicates acceptance of this agreement as notice that failure to comply with the General Assurances and Medicaid regulations, including maintaining and providing upon request to DSDS accurate and up-to-date certification records (financial, clinical, and other records relating to the provision of goods or services on behalf of a recipient), can be cause for revoking certification and potentially lead to Medicaid sanctions, including recoupment of Medicaid payments for services, 7 AAC §§105.400-105.410.

As an authorized agent of the applying agency, I affirm that I have read and will adhere to conditions and requirements of 7 AAC §§105.100-160.990 inclusive; that all agency staff meet the required levels of experience, education and training to provide HCB Waiver Services; and that the information in this application is true.

_____

Signature of authorized agent Title

_____

Printed Name Date