State of Alaska • Department of Health • Division of Senior and Disabilities Services
Home and Community-Based Waiver Services

Care Coordinator Certification Application and Renewal Application

ALL FIELDS ARE REQUIRED

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 #: _____ Email: _____

Waiver Programs

I plan to offer Care Coordination services for the following waiver programs:

- ☐ ALI: Alaskans 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

Required Attachments

IMPORTANT: Review the SDS certification website for application guidance and content requirements at: https://health.alaska.gov/dsds/Pages/provider/default.aspx

Initial Applications:

- ☐ Applicant's resume
- ☐ Documentation showing applicant's educational qualifications
- ☐ Certificate of completion of SDS Beginning 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 Individual Care Coordinator Renewal Certification Application Guidance for information on CEH requirements:* https://health.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 127; 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 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 and Long-Term Services and Supports Targeted Case Management Conditions of Participation, *is employed by named provider agency, and meets the provider's employment and certification standards to provide Care Coordination services.*

_____ _____

Care Coordination Program Administrator Signature Date

_____

Print Name