



Care Coordinator Certification Application and Renewal Application

ALL FIELDS ARE REQUIRED

Application Type: Initial Application Renewal Application Medicaid Provider #:

Care Coordinator Information

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 application guidance under “Related Resources” on the SDS Provider Certification and Compliance website for application content requirements: <https://health.alaska.gov/en/senior-and-disabilities-services/provider-certification-and-compliance/>

Initial Applications:

Applicant’s resume

Documentation showing applicant’s educational qualifications

Certificate of completion of SDS Beginning Care Coordination training taken 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 Renewal Care Coordinator Application Guidance at link above for information on CEH requirements.*

Disclosure of Business and Familial Relationships form (Cert-20)

Backup Care Coordinator

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.

Name of Backup Care Coordinator:

Telephone/Cell #:

Medicaid Provider #:

Backup Care Coordinator Signature

Date

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 Agency Program Administrator Signature

Date

Print Name