State of Alaska • Department of Health & Social Services •
Division of Senior & Disabilities Services

Conflict of Interest Exception Application

Name of Agency:

Provider Number:

To be considered for an exception to conflict-free requirements, the owner/administrator/director of the certified service agency must complete this application for approval to provide care coordination in addition to other home and community-based (HCB) services (including both 1915 (c) waiver services, and state plan personal care services). This is a required document per 7 AAC 130.220(j).

Applications for conflict-free exceptions **must be submitted to SDS by close of business June 17, 2022, via email** to **HSS.DSDS.Policy@alaska.gov.**

1. Please check the boxes below to indicate the areas of conflict.

   ☐ Does the agency provide HCB services (other than care coordination) including 1915 (c) waiver, or state plan CFC and personal care services?

   ☐ Does the agency financially benefit from other services a participant may receive?

   ☐ Does the agency have a shared executive director/CEO, Board of Directors, or any financial interest in any entity providing service delivery in home and community-based services including 1915 (c), or state plan CFC and personal care services?

   ☐ Do all care coordinators employed by the agency meet the conditions contained on the "Individual Care Coordinator Conflict of Interest Assurances" form.

2. In the space below, describe how your agency will ensure administrative separation of HCB services from care coordination. Your description must:
   a. Include a basic description of the duties of the HCB services supervisor(s) and the care coordination supervisor(s).
   b. Explain how recipients are given choice of care coordinator.
   c. Explain how recipients are given choice of HCB services and other natural supports or services offered in the community.
   d. Explain how the agency ensures that the care coordinator is free from influence of direct service providers regarding recipient care plans.

Attach a separate document if you need more room.

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3. Attach an organizational chart that includes position titles and names of staff (use "vacant" if position not filled), and that clearly demonstrates two separate supervisors (one supervisor of for care coordination and one supervisor of HCB services).
4. Attestations:

    1. I attest that the agency has and uses a plan/policy/procedure to ensure administrative separation of HCB services from care coordination. This plan/policy/procedure ensures that:
        a. The agency has administrative separation of supervision of care coordination and HCB services.
        b. The attached organization chart shows two separate supervisors, one for care coordination and one for HCB services.
        c. Care coordination recipients are offered choice for HCB services between and among available service providers.
        d. Care coordination recipients are not limited to HCB services provided only by this agency.
        e. Care coordination recipients are given choice of care coordinators within the agency.
        f. Disputes between care coordination and HCB services units are resolved.

    2. I attest that the agency has and uses a plan/policy/procedure to implement dispute resolution. This plan/policy/procedure ensures that:
        a. Recipients are free to choose or deny HCB services without influence from the internal agency care coordinator and HCB service staff.
        b. Recipients choose how, when, and where to receive their approved HCB services.
        c. Recipients are free to communicate grievance(s) regarding care coordination and/or HCB services delivered by the agency.
        d. The grievance/complaint procedure is clear and understood by recipients and legal representatives.
        e. Grievances/complaints are resolved in a timely manner.

    3. I attest that outcomes/evidence of the above methods are or will be made available by report to Senior and Disabilities Services upon request.

    4. I attest and understand that the agency must have each individual care coordinator complete a Conflict-of-Interest Assurance form for each recipient and maintain this form in the recipient's file.

    5. I attest and understand that each individual care coordinator may not have any conflict of interest with recipients they serve.

6. I attest and understand that my agency may not submit claims to Medicaid for care coordination services provided by an individual care coordinator that has a conflict of interest with recipients they serve.

7. I attest and understand that failure to mitigate conflict by implementing the requirements herein may result in a revocation of the exception to conflict-free requirements at any time.

I understand that any false statement, misrepresentation, omission, or concealment in this document may subject me to criminal, civil, or administrative penalties. Under penalty of perjury, I certify that the information I have provided is true, accurate, and complete to the best of my knowledge.

Owner/Administrator/Director Signature:

Printed Name:

Title:

Date: