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

Specialized Residential Habilitation Services Provider Certification and Compliance Attestation

Name of Agency: _____ Medicaid Provider #: _____

This document is to be completed by the approved Program Administrator of Residential Habilitation services and is a required document for certification of specialized services. By initiating each item below, the agency's Program Administrator assures this agency will provide Specialized Residential Habilitation services in compliance with 7 AAC 130.220, 7 AAC 130.265, and applicable Conditions of Participation.

INITIALS:

_____ Our agency has read and understands the State of Alaska Home and Community-Based Waiver services regulations and Conditions of Participation for Residential Habilitation and agrees we will maintain compliance and provide services accordingly.

_____ Our agency understands and agrees that *only* Specialized Residential Habilitation services can be provided in the home to protect the health, safety, and well-being of all staff and recipients.

_____ Our agency understands and agrees that a Registered Nurse actively licensed under AS 08.68 will be employed or contracted at all times at the agency level to provide consultation and training to staff on an ongoing basis and as needed. The Registered Nurse must maintain compliance with State of Alaska Nursing Statutes and Regulations.

_____ Our agency understands and agrees that a Psychologist or Medical Professional who has expertise and training in psychiatric, behavioral health, or mental health treatment, and is actively licensed under AS 08.64, AS 08.68, and AS 08.86 will be employed or contracted at all times at the agency level to provide consultation and training to staff on an ongoing basis and as needed.

_____ Our agency understands and agrees to maintain staffing levels appropriate to the services approved for each of the recipients served and ensures staff will be trained on targeted behavioral health techniques specific to recipients' needs.

_____ Our agency understands and agrees that we will not accept private pay residents while certified as a Specialized Residential Habilitation home under 7 AAC 130.220.

_____ Our agency understands and agrees that we have been certified as a licensed residential habilitation provider for 10 consecutive years, at a minimum, or are currently accredited through the Commission on Accreditation of Rehabilitation Facilities (CARF) or the Council on Accreditation (COA).

_____ Our agency understands and agrees to maintain compliance with the recipient capacity and home composition requirements for Specialized Family Home and Specialized Group Home.

Provider Assurances

I affirm that the provider agency will comply with the residential habilitation services regulations, 7AAC 130.265, and the Residential Habilitation Services 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, accurate, and complete.

_____ _____

Owner/Administrator/Director (Responsible Agent) Signature Title

_____ _____

Print Name Date

_____ _____

Contact E-mail Contact Phone