State of Alaska • Department of Health & Social Services
Division of Senior & Disabilities Services
Provider Certification & Compliance Unit

Individual Care Coordinator Conflict of Interest Assurance

This document must be completed with every recipient's waiver Support Plan and stored in the recipient's file at the care coordination agency. Failure to have the form on file when audited may result in sanctions.

Demographics:

Name of Care Coordinator: _____

Care Coordinator Provider number: _____

Name of Agency: _____

Agency Provider number: _____

Name of Recipient: _____

Recipient Medicaid ID number: _____

Assurances:

I assure that I do not work for an agency providing Home and Community Based (HCB) services (waiver or personal care services), or if I do, that the agency has applied for or been approved for an exception to conflict-free care coordination requirements.
Care Coordinator Initials: _____

I assure that I am not an owner or board member of an agency that provides home and community-based services to the recipient.
Care Coordinator Initials: _____

I assure that I do not provide any HCB services for compensation (regardless of the employer).
Care Coordinator Initials: _____

I assure that I am not financially responsible for or have a fiduciary relationship with the recipient (i.e. Guardianship, Conservatorship, Power of Attorney).
Care Coordinator Initials: _____

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.

Care Coordinator Signature: _____

Date: _____