State of Alaska • Department of Health and Social Services • Senior and Disabilities Services

Home and Community-based Waiver Services

Provider Certification Application and Renewal Application

ALL FIELDS ARE REQUIRED

Application Type: ◯ Initial Application ◯ Renewal Application Medicaid Provider #_____

Agency Information

Business Name (DBA):_____ EIN/Tax ID #_____

Legal Name (as reported on business income tax return):_____

Business physical address/City/Zip:_____

Business mailing address/City/Zip:_____

Physical address of Recipient Records/City/Zip:_____

Business phone #_____ Fax #_____

Business e-mail:_____ Business web site:_____

Form of Organization

◯ Sole proprietorship ◯ Government/Public agency ◯ Limited partnership

◯ General partnership ◯ For-profit corporation ◯ Tribal health organization

◯ Limited liability company ◯ Non-profit corporation

Agency Contacts

Program Administrator: _____

Contact number: _____ Contact e-mail: _____

Medicaid Billing Agent: ◯ Agency Employee ◯ Contractor Name: _____

Name of Individual Medicaid Billing Agent: _____

Table of Services

Check the box <u>for each service</u> the provider plans to offer to recipient. A corresponding Service Declaration form MUST be included with this application for each service selected.

Waiver Service	Service Declaration	Waiver Service	Service Declaration
☐ Adult Day	Cert-08	☐ Residential Habilitation-Family Home	Cert-11
☐ Care Coordination	Cert-06	☐ Residential Habilitation-Group Home	Cert-11
☐ Chore	Cert-07	☐ Residential Habilitation-In-Home Support	Cert-11
☐ Day Habilitation	Cert-10	☐ Residential Habilitation-Supported Living	Cert-11

☐ Intensive Active Treatment	Cert-15	☐ Residential Supported Living	Cert-09
☐ Environmental Modification	Cert-19	☐ Respite	Cert-16
☐ Meals	Cert-18	☐ Supported Employment	Cert-14
☐ Nursing Oversight/Care Management	Cert-05	☐ Transportation	Cert-17

Required Attachments

IMPORTANT: Review the SDS certification website for application guidance and content requirements at: http://dhss.alaska.gov/dsds/Documents/docs/WaiverCertAppGuidance.pdf

Applications will not be reviewed without all completed forms and attachments. If an application is determined incomplete, the provider will be notified by e-mail that re-applying is necessary. Incomplete applications are not returned to providers

Provider Core Requirements:

☐ State of Alaska Business License
☐ Critical Incident Report Training Completion Certificate (SDS Course)
☐ Certificates of Insurance *(Workers Comp, Vehicle, General Liability, etc. See guidance for details.)*
☐ Organizational Chart
☐ Personnel List (if applicable)
☐ *Renewal applications only:* Quality Improvement Report for the previous certification period

Provider Operations

For each waiver service checked on the *Table of Services*, submit the following:

☐ Provider Certification Service Declarations(s)
☐ Policies and Procedures listed on Service Declaration(s)
☐ Additional attachments listed on Service Declaration(s)

Important Note:

- *Send only one copy if the provider offers multiple services.*
- *For renewals, only submit Policies and Procedures if they have been updated since the last certification or due to a change in regulation.*

Provider Assurances

I affirm that the provider agency will comply with the Medicaid Home and Community-Based Waiver Services regulations, including the Provider Conditions of Participation; 7AAC 130.200-7AAC 130.319; and all applicable federal, state, and local laws and regulations. I certify that the information provided in the attachments required for certification is true, accurate, and complete.

_____ Print Name: _____

Owner/Administrator/Director signature

Title: _____ Date: _____

Telephone/Cell #: _____ E-mail: _____

Name of person completing application: _____