State of Alaska • Department of Health and Social Services • Senior and Disabilities Services
Home and Community-based Waiver Services

Care Coordinator Certification
Disclosure of Business and Familial Relationships

Name of Care Coordinator		Medicaid Provider #	
Name of provider agency employer			

Table 1 *List provider agencies in which you have an ownership, partnership, or equity interest equal to or greater than 5%.*

Name of provider agency	Address	Telephone

Table 2 *List other businesses or commercial activities, in which you and another provider, owner, or administrator each have an ownership, partnership, or equity interest equal to or greater than 5%.*

Name of business/commercial activity	Name of other agency/owner or administrator	Address

Table 3 *List any individual who is an owner, administrator, or employee of a provider agency or of a business/commercial activity who is your spouse, parent, sibling or child, or the spouse of a parent, sibling, or child.*

Name of agency/business/commercial activity	Name of relative	Relationship

Care coordinator assurances

I certify that the information provided regarding my business and familial relationships is true, accurate, and complete.

_____ _____

Owner/Administrator/Director signature *Print Name*

_____ _____

Title Date