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

**Personal Care Services**
**Provider Certification Application**

*Send completed form and attachments to DSDSCertification@alaska.gov, or fax to 907-754-3475, or mail/drop off at 1835 Bragaw Street, Suite 350 Anchorage, AK 99508*
*Attention: Provider Certification* ***ALL Fields Are Required***

**Choose Application Type:** ☐ Initial Application ☐ Renewal Application

Medicaid Provider Number: _____

**Choose One or Both:** ☐ Agency Based Services ☐ Consumer Directed Services

## Agency Information

Business Name (DBA): _____

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

EIN/Tax ID Number: _____

Business Physical Address/City/Zip: _____

Business Mailing Address/City/Zip: _____

Telephone Number: _____ Fax Number: _____

Business Email: _____

Physical Address of Recipient Records: _____

Form of Organization:

☐ For-Profit Corporation ☐ Limited Partnership
☐ General Partnership ☐ Non-Profit Corporation
☐ Government/Public Agency ☐ Sole Proprietorship
☐ Limited Liability Company ☐ Tribal Health Organization

## Agency Contacts

Program Administrator: _____

Contact Number: _____ Contact Email: _____

Supervising Nurse: _____ License Number: _____

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

Name of Individual Medicaid Billing Agent: _____

**Required attachments. Applications cannot be processed without all forms and attachments.**
Review the SDS Provider Certification & Compliance website for instructions and content requirements.

**Provider Core Requirements: Required for All Applications**

- ☐ Business License
- ☐ Certificate of Insurance
- ☐ Critical Incident Report Training Completion Certificate (SDS Course)
- ☐ Organizational Chart
- ☐ PCS Program Administrator Notice of Appointment (Cert-04)
- ☐ Personnel List (if applicable)

**Policies, Procedures, and Assurances Required**

*Initial Application:* ALL
*Renewal Application:* Only if modifications were made to policies since last certification or due to a regulation change.

- ☐ Admissions
- ☐ Assistance with Self Administration of Medication (ASAM)
- ☐ Background Check
- ☐ Backup Plans for PCAs (Consumer-Direct agencies only)
- ☐ Critical Incident Reporting
- ☐ Financial Accountability
- ☐ Quality Improvement
- ☐ Restrictive Interventions
- ☐ Termination and Transfer of Provider Services
- ☐ Training

- ☐ Assurances form (Cert-37)

Cert-37 covers the following policies:

- √ Complaint Management
- √ Confidentiality
- √ Notice of Privacy Practices
- √ Conflict of Interest
- √ Emergency Response
- √ Evaluation of Employees

**Required for All Renewal Applications**

- ☐ Quality Improvement Report

**Provider Assurances**

*I affirm that the provider will comply with the Personal Care Services regulations, including the Personal Care Services Conditions of Participation; 7 AAC 125.010-7AAC 125.199; 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.*

_____ ☐
*Owner/Administrator/Director Signature* *Print Name*

☐ ☐
*Title* *Date*

Name of Person Completing Application: ☐

Telephone Number: ☐ Email: ☐