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

Out-of-State Provider Agency
Home and Community-based Services Certification
Policies, Procedures and Compliance Attestation

Name of Agency: _____ Provider Number: _____

This document is to be completed by the approved Program Administrator of Home and Community-based Services (HCBS) and is required for certification of the out-of-state provider agency.

Our agency has read and understands the State of Alaska HCBS Waiver Regulations and Conditions of Participation (7 AAC 130.200-7 AAC 130.319) for applicable services and agrees to provide services accordingly.

☐ Yes ☐ No

Our agency is currently certified to offer the same service in a location outside of Alaska that the agency is seeking to provide for the State of Alaska.

☐ Yes ☐ No

Our agency is providing all Medicaid HCBS services to recipients in settings that meet the CMS Settings Final Rule.

☐ Yes ☐ No

Our agency will submit critical incidents involving Alaska recipients to the State of Alaska in accordance with 7 AAC 130.224.

☐ Yes ☐ No

Individuals that have been barred are not permitted to have contact with recipients and/or their PHI without an approved state background check variance.

☐ Yes ☐ No

The Office of Inspector General (OIG) has been checked to ensure that all board members and owners are not on the Federal Exclusions List.

☐ Yes ☐ No

Our agency agrees to ensure documentation requirements for services provided to Alaska recipients is maintained in accordance with 7 AAC 105.230.

☐ Yes ☐ No

State Certification and/or Licensing contact number: _____

State Medicaid Office Enrollment contact number: _____ NPI#: _____

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.

_____ _____

Signature of Program Administrator Date

_____

Print Name of Program Administrator