State of Alaska • Department of Health • Division of Senior and Disabilities Services
Home and Community-Based Waiver Services

Service Declaration: Nursing Oversight and Care Management Services

Agency

Name of Provider Agency: _____ Medicaid Provider #: _____

Program Administrator for Nursing Oversight and Care Management Services

Name: _____

Telephone #: _____ Fax #: _____

E-mail: _____ Cell #: _____

Registered Nurse service providers:

Name:	License Number:

Programs and Services

The Nursing Oversight and Care Management services described in 7 AAC 130.235 will be offered to recipients.

Waiver Programs: Select each waiver program the agency intends to serve:

- ☐ CCMC: Children with Complex Medical Conditions
- ☐ IDD: Individuals with Intellectual and Developmental Disabilities

Required Attachments and Provider Operations

Review the SDS certification website for instruction and content requirements.
https://health.alaska.gov/dsds/Pages/provider/default.aspx

Initial Applications:

The following required forms must be enclosed:

- ☐ Notice of Appointment or Change of Program Administrator (Cert-04)
- ☐ Policy Assurances Form (Cert-37)

The following policies and procedures must be enclosed:

- ☐ Background Checks
- ☐ Critical Incident Reporting
- ☐ Financial Accountability
- ☐ Person-Centered Practice
- ☐ Quality Improvement
- ☐ Restrictive Intervention
- ☐ Termination of Provider Services
- ☐ Training

Renewal Applications:

The following required forms must be enclosed:

- ☐ Notice of Appointment or Change of Program Administrator (Cert-04) (*change only*)
- ☐ Policy Assurances Form (Cert-37)

Submit only policies and procedures if they have been updated since the last certification or due to a change in regulation.

Census Area to be Served

Check box for each location in which services will be offered.

☐ Aleutians East	☐ Dillingham	☐ Kusilivak	☐ Sitka
☐ Aleutians West	☐ Fairbanks North Star	☐ Lake and Peninsula	☐ Skagway
☐ Anchorage	☐ Haines	☐ Mat-Su	☐ Southeast Fairbanks
☐ Bethel	☐ Hoonah/Angoon	☐ Nome	☐ Wrangell
☐ Bristol Bay	☐ Juneau	☐ North Slope	☐ Yakutat
☐ Chugach	☐ Kenai	☐ Northwest Arctic	☐ Yukon-Koyukuk
☐ Copper River	☐ Ketchikan Gateway	☐ Petersburg	
☐ Denali	☐ Kodiak Island	☐ Prince of Wales/Hyder	

Provider Assurances

I affirm that the provider agency will comply with the Nursing Oversight and Care Management services regulations, 7 AAC 130.235, *the* Nursing Oversight and Care Management Services Conditions of Participation, *and all applicable federal, state, and local laws and regulations. I certify that the information offered in the attachments required for certification is true, accurate, and complete.*

_____ _____

Owner/Administrator/Director Signature Title

_____ _____

Print Name Date