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

Care Coordinator Certification Disclosure of Business and Familial Relationships

Instructions: Provide information about any business in which you or your immediate family have ownership interest. **Do not** submit a blank form. "None" or "N/A" **must** be included under each section if it does not apply.

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.

_____ _____
Care Coordinator Signature Title

_____ _____
Print Name Date