PROVIDER ATTESTATION

This attestation serves as a confirmation that the agency identified below is in compliance with 7AAC 70, 7AAC 78, 7 AAC 105, 7AAC 110, 7AAC 135, 7 AAC 139, 7 AAC 160, AS 47 and all other applicable Alaska codes and statutes.

Agency Name:
Person Completing Form:
Address:
Date:
Phone:
Fax:
National Accreditation Agency: ☐ Joint Commission ☐ CARF ☐ COA ☐None

				Please indicate Yes, No or N/A for each requirement:
#	**Yes**	**No**	**N/A**	**STAFFING**
1.				The agency complies with background check requirements as established in AS 47.05.300-390.
2.				The staffing levels are adequate to deliver each proposed service type.
3.				As identified in staff resumes the staff qualifications, training, experience and credentials are consistent with the agency's identification as a co-occurring diagnosis capable or co-occurring diagnosis enhanced program.
4.				Staff is trained in HIV risk assessment, risk reduction, and intervention (for substance use programs only).
5.				The agency implements organized and regular staff supervision.
6.				All personnel records have individual professional development plans.

#	Yes	No	CONFIDENTIALITY PRACTICE
7.			The agency and subcontractors comply with 42CFR, Part 2 confidentiality regulations.
8			The agency and subcontractors comply with HIPAA 45 CFR 164.502 (information secure, escorted non-employees, confidentiality agreements, business agreements).
9.			The agency's policies, procedures and practices demonstrate appropriate management of confidential information.

#	Yes	No	PROGRAMMATIC
11.			The agency posts notice that it complies with federal & state laws prohibiting discriminatory practices.
12.			Grievance procedures are posted on-site.
13.			Emergency evacuation plan is posted on-site.
14.			The agency has an emergency response and recovery plan.
15.			The agency has a safety plan to address clients who are dangerous to self or others.
17.			The agency has an active quality assurance plan and demonstrates implementation of such plan.

#	Yes	No	N/A	PLEASE INDICATE ALL THAT APPLY:
18	The agency has emergency services policies and procedures in place for: *(indicate N/A, if appropriate)*			
				Psychiatric emergencies
				Access to alcohol and other drugs related Withdrawal Management
				24/7 availability
				Follow-up care
				Current Clients
19	Programming addresses priority populations for mental health treatment: (*indicate N/A, if appropriate*)			
				Individuals needing psychiatric emergency services
				Adults with serious mental illness
				Seriously emotionally disturbed youth
				Individuals with co-occurring substance use disorder
20	The agency addresses priority populations for substance use treatment and there are policies and procedures implemented for prioritizing the following populations:			
				Pregnant injection drug users
				Pregnant women
				Injection drug users
				Women with dependent children
				Persons and families whose presenting problem is addiction
				Individuals with co-occurring mental health disorders
21	Program waitlist policies and procedures are in place and address the following priority populations:			
				Unique identifiers assigned for injection drug users
				Pregnant women and injection drug users are provided interim services within 48 hours.
				Injection drug users must be admitted no later than 14 days/ no later than 120 days if no slot is available.

Please include the following documentation with the signed Attestation Form:

A. Organizational chart.
B. Program schedule of services offered.
C. Program flyers & brochures.
D. Policies' & Procedures that support attestation (i.e., staffing, supervision, emergency procedures, waitlist, clinical record management/maintenance, confidentiality, etc.).
E. Quality assurance plan and subsequent reports and.
F. Other documentation that supports attestation.

Certification Statement:

I certify that the responses in this attestation and the information in the documents are accurate, complete, and current. I understand that this attestation may be verified by Division of Behavioral Health staff upon on-site evaluations. This attestation confirms the agency's commitment and responsibility to maintain and manage the above standards over time.

Date: _____

Printed Name: _____ Title: _____

Signature: _____
(Administrator or Authorized Person)