



## Attestation of Training Completion for HealthChoice and/or MMAI Participating Providers

The undersigned Organization/Person (“Organization/Person”) certifies and attests that as a provider or provider entity (e.g., hospital, clinic, etc.) or as a subcontractor or affiliate (as such terms are defined by the Department of Healthcare and Family Services (HFS)), it has obtained and/or conducted required training for it and for all of its personnel and employees, as applicable, (including the Chief Executive, senior administrators or managers, and governing body members), as required for the provision of services under the contracts with the managed care organizations operating Medicaid plans for HealthChoice Illinois and/or through the Medicare–Medicaid Alignment Initiative (MMAI).

**Please mark the method(s) of training and education that you or your organization chose to comply with this requirement, as well as the date this training was completed:**

	Training Type	Date Completed	Training completed with/by: (Health Plan Name)
<input type="checkbox"/>	Cultural Competency <ul style="list-style-type: none"> <li>• MMAI plans training must include American with Disabilities (ADA) compliance, accessibility, and accommodation training.</li> </ul>		
<input type="checkbox"/>	FWA		
<input type="checkbox"/>	Health, Safety and Welfare (Abuse, Neglect Exploitation and Critical Incidents)		
<input type="checkbox"/>	Integrated Health Homes (IHH)/Medical Home		

In addition, the Organization/Person certifies and attests that it has required its subcontractors and/or affiliates and downstream entities to certify and attest that they have obtained and conducted, as applicable, the required training for all personnel and employees, as applicable. Upon request by the State of Illinois or CMS, the Organization/Person will furnish training logs, as well as certifications or attestations it obtains from its downstream entities to validate that the required training was completed.

\_\_\_\_\_  
Name of Organization/Person

\_\_\_\_\_  
NPI or Tax ID

\_\_\_\_\_  
Name of Organization Representative

\_\_\_\_\_  
Representative Title

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
Date Signed

\_\_\_\_\_  
City, State, ZIP Code

If more than one individual in your organization completed the training listed above, please complete page 2 of this form.

