IAMHP
ILLINOIS ASSOCIATION OF MEDICAID HEALTH PLANS

Attestation of Training Completion for HealthChoice Illinois and/or FIDE SNP 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 Advantage Fully Integrated Dual Eligible Special Needs Plans or with the Department on Aging.

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 or The Department on Aging)
☐	Cultural Competency ☐ FIDE SNP plans training must include American with Disabilities (ADA) compliance, accessibility, and accommodation training.		
☐	Fraud, Waste and Abuse (FWA)		
☐	HCBS Waiver Homecare Service Provider		
☐	Health, Safety and Welfare (Abuse, Neglect, Exploitation and Critical Incidents)		

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.

Attestation of Training Completion

Please list individuals in your organization that have completed each of the trainings noted on page 1 of this form. Use multiple forms for each training if necessary.

Training Type/Name: **Date/Time Delivered:**		
NPI (if applicable)	**Name – Please Print** (Last, First)	**Position**

Please return this form to: