Attestation of Training Completion

The undersigned Organization/Person ("Organization/Person") certifies and attests that as a first tier entity, downstream entity or related entity (as such terms are defined by Centers for Medicare and Medicaid Services (CMS)), 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 to serve HealthChoice Ilinois enrollees.

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: (Health Plan Name)*
☐	New Provider Orientation		N/A – must complete CountyCare module
☐	Health, Safety, Welfare and Reporting of Incidents ("Critical Incidents")		
☐	Cultural Competency and Humility		
☐	Fraud, Waste, and Abuse (FWA)		
☐	Social Determinants of Heath (SDOH)		

**Illinois Department of Aging (IDoA) Home and Community Based Services (HCBS) Waiver Providers only: Homecare Service Providers may attest to the completion of comparable training in accordance with requirements of 89 Ill. Admin. Code 240.1535.*

In addition, the Organization/Person certifies and attests that it has required its 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 Person

NPI

Name of Organization

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.

CountyCare Attestation of Training Completion

Please list individuals in your organization that have completed the training noted on page 1 of this form (or include excel file with same information as below if submitted electronically).

NOTE: THESE FIELDS ARE REQUIRED – if a field is incomplete, attestation will not be recorded. A separate Excel file with required fields including NPI, Last Name, First Name, and Delegate Name (if applicable) may be included as a separate attachment.

NPI	Last Name	First Name	Delegate Name (if applicable)

Please return this completed form to:

CountyCare Provider Services – Provider Training Attestation
Email: countycareproviderservices@cookcountyhhs.org
Contact CountyCare Provider Services at 312-864-8200, option 3 with questions regarding training or this attestation.