Attestation for L.A. Care Health Plan Trainings

As a contracted entity with L.A. Care Health Plan, you and your staff must participate in the New Provider Training as part of the onboarding process, and when Ad hoc trainings or updates are required. You must have all required staff in attendance of training(s), legibly complete the sign-in sheet (All Fields), and the facilitator or Office Manager must attest below that the staff listed on the corresponding sign-in sheet were in attendance for the entire presentation. **Signing this attestation confirms that you and your staff have completed the required training and have received and reviewed "The New Provider Orientation Handbook, provided by L.A. Care Health Plan."** As part of L.A. Care Health Plan's oversight and monitoring activities, L.A. Care Health Plan will review sign-in sheets, attestations, and any other corresponding materials to ensure they are complete, accurate, true, and meet any required deadlines.

Please indicate which training has been completed by you and your staff.

L.A. Care Health (Training Title entered by Facilitator) _____Date Completed:_____

L.A Care Health New Provider Onboarding Training (NPOT)_____Date Completed:_____

L.A. Care Health Model of Care Training (MOC)_____Date Completed:_____

L.A. Care Health General Annual Compliance Training (GACT) _____Date Completed:_____
(MOC, Fraud, Waste and Abuse, General Compliance Training, False Claims Act) Distribution of Policies/Procedures and or Standard of Conducts).

L.A. Care Health Early Periodic Screening Diagnosis and Treatment Training (EPSDT)_____Date Completed:_____

Other (please print title)_____Date Completed:_____

By signing below, I attest that staff listed on the corresponding sign-in sheet representing my organization,_____

a contracted entity with L.A. Care Health Plan, have completed and/or received and reviewed the training listed above.
I attest that my organization will furnish copies of sign-in sheets, attestations, and any other related material at the request of L.A. Care Health Plan.

Name of office manager/individual provider: _____

Title: _____

Signature:_____ Date:_____

Email:_____ Phone: _____

*LA CARE FORMS AND THE LANGUAGE CONTAINED HEREIN ARE NOT TO BE ALTERED