ATTESTATION OF TRAINING COMPLETION

The undersigned Organization/Person ("Organization/Person") certifies and attests 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 the required training listed below 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 for the Integrated Care Program, (ICP), Medicare–Medicaid Alignment Initiative (MMAI), and/or Family Health Plan Program (FHP).

Health Alliance has provided the training or information where to obtain the training in the provider manual located on our provider web portal. The Organization/Person may complete training from any of the Managed Care Entities.

Training Type	Date Completed	Training completed with: (Health Plan/Organization Name)
☐ Abuse, Neglect and Exploitation		
☐ Critical Incidents		
☐ Cultural Competency		
☐ Americans with Disabilities Act		
☐ Fraud, Waste and Abuse		
☐ Medical Home		

The Organization/Person also certifies and attests all downstream entities have conducted the required training for all personnel and employees, as applicable.

Upon request by the State of Illinois or CMS, the Organization/Person must furnish the training documents if different than Health Alliances' (i.e. their organization or another Medicaid Health Plan), the training logs, as well as downstream entity certifications or attestations to validate the required training was completed by all applicable staff..

The Organization/Person understands to maintain records (e.g. attendance logs, certification or attestations) for a period of 10 years. CMS and/or Health Alliance may request this documentation during an audit.

By typing the name in the signature line will constitute an electronic signature. Please return this page to your Provider Relations Specialist via email and/or you can mail it to your Provider Relations Specialist at Health Alliance Medical Plans, Attn: Provider Relations, 301 S. Vine St., Urbana, IL 61801. If you have any questions, please contact your Provider Relations Specialist.

Names of Organization/Person	NPI or Tax ID
Name of Organization Representative	Representative Title
Signature	Street Address
Date Signed	City, State, Zip Code