L.A. Care HEALTH PLAN®
For All of L.A.

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 and Universal Provider Manual to include but is not limited to distribution of member rights and responsibilities statement to the new practitioner 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.

New Provider Onboarding Training (NPOT) Date Completed: _____

L.A. Care Health Diversity, Equity, and Inclusion (DEI) Training Date Completed: _____

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

General Annual Compliance Training (GACT) Date Completed: _____
(Fraud, Waste and Abuse, General Compliance Training, False Claims Act) Distribution of Policies/Procedures and or Standard of Conducts).

Medi-Cal for Kids and Teens Provider Training Date Completed: _____

Other _____ Date Completed: _____

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

Name and Title: _____

Signature: _____ Date: _____

Email: _____ Phone: _____

*L.A. CARE FORMS AND THE LANGUAGE CONTAINED HEREIN ARE NOT TO BE ALTERED