Provider/Delegate Representative Attestation

Special Needs Plans (SNP) Model of Care Training Attestation 2024

I, _____, hereby attest that the attached listed Providers have completed the **Special Needs Plan (SNP) Model of Care Training** (for CA Providers: includes Dementia Training).

The listed Providers understand the Model of Care and the role in improving health outcomes for the most vulnerable population.

It is understood that the training is mandatory for all Providers that care for SNP Members and is required by the Centers for Medicare and Medicaid Services (CMS).

Training Type **(Circle one): ANNUAL or ONBOARDING/NEWLY CONTRACTED**

State:_____ County:_____

Provider/Representative Name:_____ Date:_____

Title:_____ Signature: _____

Medical Group/IPA/Provider Name: _____

TIN#:_____

Please return completed attestation and Provider Roster list to:

Alignment Quality Management Department

Email to qi@ahcusa.com

or send via fax 562-207-4617

PROVIDER ROSTER

Purpose: Special Needs (SNP) Model of Care (MOC) annual training is mandatory and is required by the Centers for Medicare and Medicaid Services (CMS) for all Medicare Advantage Special Needs Plan Providers.

Instructions: Upon review of training, please provide your first and last name, associated Medical group (MG) or IPA name and training completion date. Submit this Provider roster of those who participated in the training along with the attestation.

First and Last Name	MG or IPA Name	Training Completion Date