Alignment Healthcare

PROVIDER/DELEGATE REPRESENTATIVE ATTESTATION

Special Needs Plans (SNP) Model of Care Training Attestation

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 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 **(select one):** ☐ ANNUAL ☐ ONBOARDING/NEWLY CONTRACTED

State: _____ County: _____

Provider/Representative Name: _____ Date: _____

Medical Group/IPA/Provider Name: _____

TIN: _____ Title: _____

Signature: _____

Please return the completed attestation and Provider Roster list to:

Alignment Quality Management Department

Email to qi@ahcusa.com

FAX to 562-207-4617

Alignment Healthcare

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

The following providers completed the annual SNP MOC Training

TIN #	NPI #	Provider Name	IPA/ MG

*** If there are more than 25 providers, please attach additional pages or a complete provider roster*