Option 1: Training provided by HPSJ

Date of HPSJ training: ........................................................................................................

Name of HPSJ contracted entity or provider: ................................................................. (Name)

I attest to have received HPSJ training resources for cultural competency and confirm that............................................................................. network provider for the Medicaid program has completed the training.

Option 2: Cultural competency training provided by another organization or health plan

Date of cultural competency training: .................................................................................

Name of HPSJ contracted Entity or Provider: ................................................................. (Name)

I attest to having received Cultural competency training on behalf of ................................ (Organization/Health Plan) training resources for cultural competency and confirm that ................................................................. (Name) network provider for the Medicaid Program have completed the trainings.

I attest to receiving and reviewing Cultural Competency training provided to me. Please sign and date below.

.................................................................................................................................

Print Name

.................................................................................................................................

Title

.................................................................................................................................

Signature

.................................................................................................................................

Date

Please fax this signed form to Provider Services at 209.461.2565, thank you!

LAST REVISED: OCTOBER, 2017