Health Plan of San Joaquin | Mountain Valley Health Plan

ANNUAL THIRD-PARTY TRAINING ACKNOWLEDGMENT & ATTESTATION

San Joaquin County Health Commission, doing business as Health Plan of San Joaquin/Mountain Valley Health Plan ("HEALTH PLAN") establishes mandatory trainings that select THIRD PARTIES must complete annually. HEALTH PLAN utilizes this form to capture the applicable THIRD-PARTY attestations for completion of one or more mandatory trainings.

For the identified training areas, select THIRD PARTIES and their employees are required to either:

(A) Complete trainings offered on the HEALTH PLAN website, or

(B) Complete an "alternative equivalent training" for the specific training area and provide proof of training.

For "alternative equivalent training," proof can be a certificate of completion, training program outline, or web link to the training. Additionally, the HEALTH PLAN must determine if the "alternative equivalent training" meets HEALTH PLAN interpreted requirements for satisfying the training, if it does not the delegate and their employees will be required to complete the HEALTH PLAN provided training.

After choosing one of the training options, authorized THIRD-PARTY representative must attest below for themselves and all entity employees who completed the training.

An Authorized Person can complete the training attestation on behalf of your entity for all employees.

Name of THIRD-PARTY Entity:
Business Address:
Tax Identification Number:
Lines of Business Associated:

THIRD-PARTY Entity **attests that it utilized HEALTH PLAN-provided training** one or more of the following training areas that your organization is submitting this attestation to satisfy:

Selected	Training	Training Date
☐	Not Applicable	
☐	Medicare Dual Eligible Special Needs Plan's (D-SNP) Model of Care (MOC) MOC	
☐	Cultural Competency	
☐	Diversity/Inclusion	
☐	Identifying a grievance, appeal, coverage determination, or organization determination request	

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Selected	Training	Training Date
☐	Annual Product Training	
☐	Emergency Preparedness	
☐	Hierarchical Condition Category (HCC)	
☐	Medical Star Ratings	
☐	Job-specific, specify training area:	

THIRD-PARTY Entity **attests that it utilized an "alternative equivalent training"** for one or more of the following training areas and is requesting HEALTH PLAN approval to satisfy the training area requirement:

Selected	Training	Training Date
☐	Not Applicable	
☐	Medicare Dual Eligible Special Needs Plan's (D-SNP) Model of Care (MOC) MOC	
☐	Cultural Competency	
☐	Diversity/Inclusion	
☐	Identifying a grievance, appeal, coverage determination, or organization determination request	
☐	Annual Product Training	
☐	Emergency Preparedness	
☐	Hierarchical Condition Category (HCC)	
☐	Medical Star Ratings	
☐	Job-specific, specify training area:	

I hereby attest to myself and all individuals on the attached list have received the annually required training(s) selected above. *Please sign and date below.*

Name:		**Signature:**	
Title:			
Subcontractor/Organization/Name:			
Address:			
City:		**State:**	**Zip Code:**
Phone:	**Email:**		**Date:**

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If not submitting this form via HEALTH PLAN website (**www.hpsj.com/vendor-trainings**), send this completed form and if applicable proof of "alternative equivalent training," completion to HEALTH PLAN at **procurement@hpsj.com** or fax **209-942-6354**. This training is required for all contracted THIRD-PARTY entities assigned by HEALTH PLAN. Please ensure support documentation is maintained fo r the attestation submitted for all THIRD-PARTY entity staff who completed the training. You can upload a roster of your staff names and titles, that completed the training in lieu of completing the attestation below.

THIRD-PARTY TRAINING ROSTER

Third-Party Name:	
Training Title:	**Training Date:**
Third-Party Contact Name:	
Third-Party Contact Phone:	
Third-Party Contact Email:	

THIRD-PARTY Entity Employee Names Below **WHO COMPLETED TRAINING**:

Employee Name (Last Name, First Name):	Title:

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THIRD-PARTY Entity Employee Names Below **WHO DID NOT COMPLETE TRAINING, BUT WILL DO SO WITHIN NEXT 90 DAYS**:

Employee Name (Last Name, First Name):	Title: