Andy Beshear
GOVERNOR

CABINET FOR HEALTH AND FAMILY SERVICES
DEPARTMENT FOR MEDICAID SERVICES
275 East Main Street, 6-WA
Frankfort, Kentucky 406 21
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Eric Friedlander
SECRETARY

Lisa Lee
COMMISSIONER

KY CCBHC COST REPORT TRAINING ATTESTATION

TO: KY Department for Medicaid Services
CCBHC Project Manager

Please provide the following agency information:

Agency Name	
Agency NPI	
Authorized Signer Name	
Primary CCBHC Contact Name	
Primary CCBHC Contact Email	

KY DMS requires completion of the KY CCBHC Cost Report training by appropriate agency staff prior to agency application for the KY DMS CCBHC Section 223 Demonstration.

This attestation is provided as confirmation that appropriate staff within this agency have completed the required CCBHC Cost Report training. Appropriate staff includes agency leadership, management staff and/or any agency staff authorized for financial reporting.

Please provide names and agency roles of all leadership, management or authorized staff who completed the KY CCBHC Cost Report training.

Staff Name(s)	Agency Role/Title

As authorized signer for the above-named agency, I attest that the information provided above confirming completion of the KY CCBHC Cost Report Training is accurate and true.

_____ _____
Authorized Signer Signature Date