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 DMS CCBHC NEW PROVIDER 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 all KY DMS CCBHC New Provider training by appropriate agency staff prior to agency participation in the KY DMS CCBHC Section 223 Demonstration certification process. This attestation is provided as confirmation that appropriate staff within this agency have completed the required trainings as listed below. Appropriate staff should include agency leadership staff and/or those staff who have a leadership or supervisory role, including CCBHC program managers and clinical supervisors or leads.

The following trainings must be completed by appropriate agency staff:

1. CCBHC Community Needs Assessment Training
2. CCBHC Program Criteria 1 & 2 Training
3. CCBHC Program Criteria 3 and Designated Collaborating Organization (DCO) Agreements
4. CCBHC Program Criteria 4 Training
5. CCBHC Program Criteria 5 & 6 Training

Please provide names and agency roles of all leadership/management/supervisory staff who completed these trainings, You may add additional lines if needed.

Staff Name(s)	Agency Role/Title

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

_____ _____

Authorized Signer Signature Date