Special Needs Plan Attestation Form

Path to the Special Needs Training

CarePlus Website: https://www.careplushealthplans.com/careplus-providers/snp

- Locate the "Required Annual Training" section and click on the link provided to view the presentation.

SNP Training: ☐ **INITIAL** ☐ **ANNUAL**

Vendor # _____ **Date:** _____ **PSE:** _____ **County:** _____

Vendor / Network Name _____

Tax Identification Number(s): _____

Physician Address: _____

Other Location: _____

Name of person(s) who received the training	**Title**

Name(s) of Providers in office **(Please use the back or attach a roster if necessary)**	**Provider #**

Signature below indicates confirmation from the provider's office that they have received training and/or training materials from CarePlus for the Special Needs Plans Model of Care Training. It is the responsibility of the undersigned to disseminate and review this information with its existing physician(s) and any newly added providers added thereafter. In addition, you must have a process in place for maintenance of all training documentation including rosters, sign in sheets, etc.

Signature	**Title**
Print Name	**Date**