

AFFIRMATION OF COMPLETION OF
CORE COMPETENCY TRAINING

I, _____, am a Medicaid Waiver Service
(print name)

Provider, _____, and affirm that:
(provider number)

1. In compliance with the *Developmental Disabilities Medicaid Waiver Services and Limitation Handbook* (Appendix C, page C-8, 2.1 Item #7), which requires all direct service providers to complete the Agency's "Direct Care Core Competencies Training":

I have completed the required training; or

I am the _____ of the _____, and the
(position title) (name of service agency)

following individuals on the attached list, who are direct service providers at the agency named above and providing services to Medicaid recipients receiving services through the Developmental Disabilities Home and Community-Based Waiver, have completed the required training. *[If you are also a direct service provider at the service agency and have completed the required training include your name on the list.]*

2. I understand and acknowledge that if I knowingly provide false information in this affirmation, I will have breached the Medicaid Waiver Services Agreement between the Agency for Persons with Disabilities and myself, and will be subject to fines and penalties as provided in the Agreement.

(signature)

(date)