2020 Attestation Form
for
Humana KY Medicaid Subcontractors
on
KY Department for Mediciad Services (KDMS) Medicaid Contract

KY Medicaid Managed Care Contract Number_____

As a duly authorized representative of the below named Organization, I hereby acknowledge and agree that the Organization:

- Has been provided, read, understands and will comply with KY Medicaid Managed Care Contract training; and
    - Adopts and trains its current applicable employees, and downstream entities (including contracted providers), whether supporting the Humana KY Medicaid contracted work onshore or offshore, using the KY Medicaid Managed Care Contract training, within 30 days of this notification
    - Agrees to provide the training to the applicable new employees, providers and downstream entities, whether supporting the Humana KY Medicaid contracted work onshore or offshore, using the KY Mediciad Medicaid Managed Care Contract training, within 30 days of contract or hire

Choose one:

☐ Accept – My organization trains its employees and downstream entities using the KY Medicaid Managed Care Contract training content.

☐ Accept – My organization has reviewed the KY Medicaid Managed Care Contract training content provided and trains its employees and downstream entities on materially similar content.

Agreed:

_____

Organization Name

_____ _____ _____

Signature Printed Name Title

_____

Date