

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

KY Medicaid Man	aged Care Contract Num	ber			
As a duly authoriz	ed representative of the	below named Organiza	tion, I hereby acknow	ledge and agree that the (	Organization:
• Has been	Adopts and trains its curr	ent applicable employed (Y Medicaid contracted)	es, and downstream en	Care Contract training; and tities (including contracted ore, using the KY Medicaid N	providers), whether
0	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 Medicaid Medicaid Managed Care Contract training, within 30 days of contract or hire				
Choose o	ne:				
Accept – My o		ne KY Medicaid Manage		edicaid Managed Care Cont	_
Agreed:					
Organization Nan	ne				
Signature		Printed Name		Title	_
Date					