

## Attestation of Provider Training

By signing below, I attest that I have received materials and training on the following subjects as they relate to Community Health Center Network and its contracted health plan partner, Alameda Alliance for Health.

- Access to Care Appointment Standards
- Care Neighborhood
- Cultural Humility
- Electronic Consult Program
- Fraud, Waste and Abuse
- Getting to the Heart
- Member Grievances
- Member Rights and Responsibilities
- Quality Management and HEDIS Measures
- Interpretive Services
- Transportation Services
- Utilization Management

**Date:** \_\_\_\_\_

**Signature:** \_\_\_\_\_

**Provider Name:** \_\_\_\_\_

**Provider Group Name:** \_\_\_\_\_

**Practice Address:** \_\_\_\_\_

**City:** \_\_\_\_\_

**State:** CA

**Zip:** \_\_\_\_\_