North Carolina Department of Health and Human Services-NC Medicaid

SESSION LAW 2013-306
PCS TRAINING ATTESTATION FORM

Send completed form, and supporting documentation, to NC Medicaid at Medicaid.PCSTraining@dhhs.nc.gov. For questions, contact 919-855-4360, or send an email to PCS_Program_Questions@dhhs.nc.gov.

PROVIDER TYPE (select one): **DATE OF SUBMISSION:** _____(mm/dd/yyyy)

☐ Home Care Agency ☐ Family Care Home ☐ Adult Care Home ☐ Adult Care Bed in Nursing Facility ☐ SLF-5600a

☐ SLF-5600c ☐ Special Care Unit (stand-alone SCU or SCU bed) ☐ Non-Provider: _____

PART I: SUBMITTER INFORMATION

National Provider Identifier (NPI#): _____

Provider Name: _____

Submitter Name: First:_____ **Last:**_____ **M.I:**_____

Address: _____ **City:** _____

County: _____**Zip:** _____(zip code + 4 digit extension) **Phone:** _____

Suite: _____ **Email:** _____ **Fax** (If Applicable)**:**_____

PART II: TRAINER QUALIFICATIONS

☐ **Check the box to the left if you have attached additional documentation for this section.**

List Trainer Qualifications.

_____
_____
_____
_____
_____
_____
_____
_____
_____

PART III: CURRICULUM OUTLINE

☐ **Check the box to the left if you have attached additional documentation for this section.**

Outline the structure and training methodology. Include goals, core competencies, and skills validation.

_____
_____
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_____

SUBMITTER SIGNATURE: **DATE:** (mm/dd/yyyy)

_____ (_____/_____/_____)