

**SESSION LAW 2013-306
PCS TRAINING ATTESTATION FORM**

Send completed form, and supporting documentation, to NC Medicaid at Medicaid.PCSTraining@lists.ncmail.net. 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)
<input type="checkbox"/> Home Care Agency <input type="checkbox"/> Family Care Home <input type="checkbox"/> Adult Care Home <input type="checkbox"/> Adult Care Bed in Nursing Facility <input type="checkbox"/> SLF-5600a	
<input type="checkbox"/> SLF-5600c <input type="checkbox"/> Special Care Unit (stand-alone SCU or SCU bed) <input type="checkbox"/> 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.

SUBMITTER SIGNATURE:

DATE: (mm/dd/yyyy)
(_____ / _____ / _____)