## MEDICAID-3085 SESSION LAW 2013-306 PCS TRAINING ATTESTATION FORM

Send completed form, and supporting documentation, to NC Medicaid at  $\underline{\text{Medicaid.PCSTraining@dhhs.nc.gov.}}$  For questions, contact 919-855-4360, or send an email to  $\underline{\text{Medicaid\_Program\_Questions@dhhs.nc.gov.}}$ 

PROVIDER TYPE (select one)		DATE OF S	DATE OF SUBMISSION:	
☐ Home Care Agency	☐ Family Care Home ☐ Adult	Care Home ☐ Adu	It Care Bed in Nursing Facility	☐ SLF-5600a
☐ SLF-5600c	☐ Special Care Unit (stand-alone Speci	ial Care Unit or SCU bed)	☐ Non-Provider:	
ART I: SUBMITTER INFO	DRMATION			
ARTI: SUBMITTER INFO	RMATION			
ational Provider Identifier	(NPI#):			
rovider Name:				
ubmitter Name: First:				M.I:
ddress:		City:		
ounty:	Zip:	zip code + 4 digit extension) Phone:		
uite:	Email:	Fax (If Applicable):		
PART II: TRAINER QUA	LIFICATIONS			
Check the box t	o the left if you have attached addit	tional documentation t	or this section.	
List Trainer Qualifications.				
*				
PART III: CURRICULUM	OUTLINE			
Check the box t	o the left if you have attached addit	tional documentation f	or this section	
	ning methodology. Include goals, core cor			
Junio the structure and train	ing memodology. Include goals, core col	inpeterioles, and skills valle	idion.	
BMITTER SIGNATUR	E:		DATE: (mm/dd/yyyy)	
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