blue california
Promise Health Plan

2025 Americans with Disabilities Act provider training attestation

Instructions: Complete either the individual or group attestation.

Individual attestation

☒ I am an individual who has completed the training. By submitting this form, I acknowledge that I have completed the Americans with Disabilities Act course to meet the 2025 Long-Term Services and Supports provider training requirement.

Group/Provider Name: _____

Provider Specialty Type (CBAS, SNF/LTC, ILC, Home Delivered Meals, Home Adaptation, etc.):_____

First Name:_____Last Name: _____

Email: _____

NPI: _____

End of Individual attestation. If you are completing the group attestation, see next page.

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Group attestation: Complete information about yourself, then list the providers in your group who have completed the training.

☐ I am submitting this form for a group who has completed the training. By submitting this form, I acknowledge that the staff listed on the following page(s) have completed the Americans with Disabilities Act course to meet the 2025 Long-Term Services and Supports provider training requirement.

Group/Provider Name: _____

Provider Specialty Type (CBAS, SNF/LTC, ILC, Home Delivered Meals, Home Adaptation, etc.): _____

Your First Name: _____ Your Last Name: _____

Your Title: _____

Your Email: _____

Your NPI: _____

List the staff in your group who have completed the training on the next page(s).

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List the staff in your group who have completed the training. You may add more pages if needed.

First name	Last name	Job Title	Hire Date	Provider/group name and NPI