Health Plan of San Joaquin

Cultural Competency Training Acknowledgement

Option 1: Training provided by HPSJ

Date of HPSJ training: ....

Name of HPSJ contracted entity or provider: ....
(Name)

I attest to have received **HPSJ training resources for cultural competency** and confirm that .... network provider for the Medicaid program has completed the training.
(Name)

Option 2: Cultural competency training provided by another organization or health plan

Date of cultural competency training:...

Name of HPSJ contracted Entity or Provider: ....
(Name)

I attest to having received **Cultural competency training** on behalf of ....
(Organization/Health Plan)
training resources for cultural competency and confirm that ....
(Name)
network provider for the Medicaid Program have completed the trainings.

I attest to receiving and reviewing Cultural Competency training provided to me. Please sign and date below.

....	....
Print Name	**Title**
....	....
Signature	**Date**

Please fax this signed form to Provider Services at 209.461.2565, thank you!

LAST REVISED: OCTOBER, 2017