

Optimal Care for Every Community Training Subcontractor Attestation

Subcontractor Name: [REDACTED]

Lines of Business Associated: [REDACTED]

I hereby attest to the following:

I. Optimal Care for Every Community Training Program

We/I attest that staff serving members and Downstream Subcontractors completed the Optimal Care for Every Community Training by December 31, 2026. I attest that staff serving members and Downstream Subcontractors will complete the training on an ongoing basis, within 90-days of start date and during times of re-credentialing or contract renewals. I attest that certificates or documentation of training completion, such as certificates of completion, training logs, system-generated reports, spreadsheets, and other training records (including the following details: employee names, dates, attendance, topic, and test scores, if any) are maintained for a period of ten years. I hereby attest that my organization has fulfilled the requirement below to ensure satisfaction with Optimal Care for Every Community Training requirement:

- a. Completion of the web-based Optimal Care for Every Community Training located on the IEHP Providers website: <https://www.providerservices.iehp.org/en/resources/provider-manuals-and-training/optimal-care-for-every-community-training>

II. Records Management

We/I attest that all records related to the administration or delivery of benefits to IEHP Members and delegated activities are maintained for a period of no less than 10 years.

III. Required Optimal Care for Every Community Remediation Training

We/I attest to meet IEHP's Optimal Care for Every Community Training Program requirements and furthermore, understand that any discrimination grievances and noncompliance may result in a Corrective Action Plan (CAP) and subsequent disciplinary actions.

Unless otherwise noted in the space immediately above, We/I am not aware of any possible violations of any laws and regulations at this time.

We/I attest and agree to the above and that documentation to support compliance with this attestation will be made available to IEHP or Federal and/or State regulatory agencies upon request.

Name (Print): _____

Title: _____

Subcontractor/Organization/ Name: _____

Signature: _____

Address: _____

City, State, Zip: _____

Phone: _____ E-Mail: _____

Date: _____

Attestation Form Submission Instructions

This Attestation Form must be signed by an individual with the authority to sign on behalf of the Subcontractor and to attest to the accuracy and completeness of the information provided. Timely submission is a condition of continued contracting. Please submit the completed Attestation Form within 10 days of training completion or using **any one of the following methods**:

1. **Email:** Scan and email the signed Attestation Form to IEHP Health Equity Operations Department at: OptimalCareTraining@iehp.org.
2. **Mail To:**
Attn: IEHP Health Equity Operations
Department
Inland Empire Health Plan
PO Box 1800
Rancho Cucamonga, Ca 91729
3. **Fax To:** 909-477-8536