North Carolina Department of Health and Human Services-NC Medicaid

SESSION LAW 2013-306
PCS TRAINING ATTESTATION FORM

Completed forms and any supporting documentation are required to be uploaded to QiReport. For questions, call 919-855-4360 or send an email to PCS_Program_Questions@dhhs.nc.gov.

PROVIDER TYPE (select one): **DATE OF SUBMISSION:** _____(mm/dd/yyyy)

☐ Home Care Agency ☐ Family Care Home ☐ Adult Care Home ☐ Adult Care Bed in Nursing Facility ☐ SLF-5600a

☐ SLF-5600c ☐ Special Care Unit (stand-alone SCU or SCU bed) ☐ 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)

_____ (_____/_____/_____)