# 2022 Special Needs Plan (SNP) -

**Model of Care (MOC) Training Attestation**

I attest that the employees listed on the attached roster have completed the annual Special Needs Plan Model of Care training. I also attest that the employees understand that they are responsible for knowing and adhering to the information provided herein.

|  |  |  |
| --- | --- | --- |
| Signature |  | Date Completed |
| Name (Print) |  |  |
| Organization |  | Tax ID |

Please print below the names of all additional employees covered under this attestation:

|  |  |
| --- | --- |
| **Employee Name** | **Training Completion Date** |