



## Practitioner Orientation Attestation Form

By signing below, I \_\_\_\_\_ attest that I have received materials and training on the following subjects:

- About to SFHP Provider Network
- Key Contacts
- SFHP Programs
- Eligibility
- Access to Care
- Referrals, Prior Authorization, and Appeal to UM Decisions
- Member Complaints and Grievances
- Medi-Cal Benefits
- Sensitive Services
- Initial Health Assessment (IHA)
- Staying Healthy Assessment (SHA)
- Coordination of Care for Medi-Cal Members
- DHCS Waiver Programs
- Health Education
- Cultural and Linguistics Training

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Signature

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Date

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Print Name

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Address, City, St, Zip