Santa Clara Family Health Plan

Access to Care Training Attestation

Date: _____ Group/Clinic Name: _____

Provider Name: _____ NPI: _____

Address: _____ City: _____ State: _____ Zip: _____

Office Phone: _____ Office Fax: _____

Office Manager Email: _____

Training Completed as a Result of:

☐ New Provider Orientation
☐ Corrective Action Notice/Letter
☐ Other: _____

I, _____ hereby attest that my staff and I have completed the following Santa Clara Family Health Plan (SCFHP) Training:

☐ Timely Appointment Access and Availability
☐ Telephone Triage and Screening
☐ In-office Wait Times
☐ After-Hours Access
☐ Language Assistance
☐ Other: _____

Furthermore, my staff and I agree to follow all access to care regulations and standards including those related to timely appointment access, after-hours access, and language assistance.

_____ Provider's Name

_____ Title

_____ Signature

_____ Date

_____ Phone

_____ Email

Please send a copy of this signed attestation to:
SCFHP Provider Network Management Attn: Carmen Switzer
PO Box 18880
San Jose, CA 95158
carmens@scfhp.com
Fax: 408-362-9817