

ADVERSE BENEFIT DETERMINATION NOTICE

Training Attestation & Self-Study Answer Sheet

Name (please print): _____ Score: _____

Agency/Program: _____

My signature below indicates, I am attesting that:

- I have completed the training titled *Medicaid & Non-Medicaid Adverse Benefit Determination and Negative ABD Process*.
- I understand the material presented and that I can ask for additional guidance from the Support Services Director and/or the Corporate Compliance Officer.
- I understand the importance of ensuring that individuals served receive clinically appropriate, humane, and compassionate services of the same quality that one would expect for their own loved ones.
- I understand that any decisions I make that result in adverse benefit determinations or negative adverse benefit determinations are based only on the appropriateness of care and service and the existence of coverage.
- I understand that St. Clair County Community Mental Health does not reward anyone, financially or otherwise, for denying, limiting, suspending, or discontinuing medically necessary services to any individual served.
- I understand that if I have a concern about an apparent reward or incentive related to denying, limiting, suspending, or discontinuing medically necessary services to any individual served, I must report my concern to my supervisor or to the Corporate Compliance Officer of St. Clair County Community Mental Health.

Signature: _____ Date: _____

Trainer and/or Grader Name (please print): _____

Trainer and/or Grader Signature: _____ Date: _____

Upon completion, please forward this training attestation and answer sheet to your organization's human resources/training representative.



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