ACKNOWLEDGEMENT OF COMPLETION OF TRAINING ON MEDICAID FRAUD, WASTE AND ABUSE

I ________________________________ have been trained and provided information on quality documentation standards and DCHS's zero tolerance for Medicaid fraud, waste, and abuse. I understand that:

1. I must document my efforts to provide intervention and support to consumers timely and accurately, as the encounter occurred. I understand that notes will be reviewed to ensure documentation meets quality and compliance standards.

2. DCHS has zero tolerance for fraud, waste, and abuse. I understand that there are serious consequences to staff, the agency and consumers and families when fraud occurs. I understand that my contract or employment with DCHS will be terminated, and I may face legal consequences/actions if I engage in Medicaid fraud, waste, and abuse.

_________________________________ ____________________

Staff Name **Date**

____

Staff Signature

HR:_____________________________ **Date:**__________________

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