EL DORADO COUNTY
HEALTH AND HUMAN SERVICES AGENCY

Substance Use Disorder Services DMC-ODS
Network Provider Attestation

Rendering Provider Full Name: Agency Name:

I have reviewed the El Dorado County Substance Use Disorder Services (SUDS) Credentialing Policy. As a service provider for SUDS, I understand that SUDS Policy requires me to be able to provide services for which Medicare and Medi-Cal will pay directly or indirectly, including services which are clinical or administrative/managerial in nature, including support services and I attest to the following:

I am able to provide services under federally funded health care programs. Specifically:

a. ☐I have* ☐ I have not (*please check one*) been convicted of a felony offense related to health care, or have a history of loss of license.
b. ☐I have* ☐ I have not (*please check one*) been debarred, excluded or otherwise made in-eligible to provide services under federally funded health care programs, by a State or a federal agency.
c. ☐I have* ☐ I do not have (*please check one*) a history of loss or limitation of privileges or disciplinary activity;
d. ☐I do ☐ I do not (please check one) have limitations or inabilities that affect the provider's ability to perform any of the position's essential functions, with or without accommodation
e. ☐ I am ☐ I am not (please check one) using illegal drugs.

**A felony conviction does not automatically exclude a provider from participation in the Plan's network. However, in accordance with 42 C.F.R. §§ 438.214(d), 438.610(a) and (b), and 438.808(b), Plans may not employ or contract with individuals excluded from participation in Federal health care programs under either Section 1128 or Section 1128A of the Social Security Act. If you have been convicted of a felony offence related to health care, have been debarred, excluded or are otherwise ineligible, or have a history of loss or limitation of privileges or disciplinary action please provide a detailed explanation on the back of this form.*

I understand that it is my responsibility to notify my immediate Supervisor or higher-level manager of any change in my ability to provide services under federally funded health care programs, including suspension or exclusion. Further, I understand that El Dorado County will verify my ability to participate in federally funded health care programs on not less than a tri-annual basis.

BY SIGNING, I CERTIFY THAT I HAVE COMPLETED THIS ATTESTATION ACCURATELY AND COMPLETELY AND THAT TO THE BEST OF MY KNOWLEDGE AND BELIEF, SERVICES RENDERED BY ME AS A PROVIDER OF EL DORADO COUNTY SUDS DMC-ODS NETWORK OF CARE MAY BE BILLED TO MEDI-CAL AND MEDICARE AS APPROPRIATE.

Date	Provider Name	Provider Signature
Date	Supervisor Name	Supervisor Signature