

Community Mental Health and Substance Abuse Services of St. Joseph County

Corporate Compliance Training

I, _____, acknowledge that I have received and read the required Corporate Compliance training. I can recognize my role in detecting and preventing Medicaid fraud, abuse, and waste. I acknowledge that I must report any fraud, abuse, or waste to the appropriate person at Community Mental Health and Substance Abuse Services of St. Joseph County.

As of today, I am not aware of any compliance issues that must be reported. Should I become aware of any potential violations of the False Claims Act or any other reportable occurrences, I will report them immediately as specified in the Corporate Compliance Training.

Signature

Date

Employer other than CMHSAS of SJC

Please note it is your responsibility to retain documentation proof of your trainings.