Barry County Community Mental Health Authority

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 Barry County Mental Health Authority.

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 BCCMHA

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