SOLIS
HEALTH PLANS

2026 SNP Model of Care
Training Attestation

Once completed, please email this form to providerrelations@solishealthplans.com.

I attest that I have completed and understand the Solis Health Plans Special Needs Plan (SNP) Model of Care training. I further attest that this information will be communicated and applied, as appropriate, within my organization.

If signing as a Primary Care Provider or individual clinician:
My signature confirms that I personally completed the SNP Model of Care training.

If signing as a Chief Executive Officer, Medical Director, or authorized organizational representative:
My signature confirms that all applicable providers and staff within my organization who serve Solis SNP members have completed the required SNP Model of Care training.

Name:	
Title: Choose one of the options below. ☐ Chief Executive Officer ☐ Primary Care Provider ☐ Medical Director ☐ Other: _____	
Provider Tax Identification Number (TIN):	
Organization Name:	
Signature:	**Date:**