



## **DOULA ATTESTATION FORM\***

*(For enrollment as a New York State Medicaid Perinatal Doula Services Provider)*

**\* REQUIRED FOR ALL Perinatal Doula Services Provider APPLICANTS**

### **NYS DEPARTMENT OF HEALTH ENROLLMENT FORM INSTRUCTIONS:**

- Applicants are required to use the NYS Department of Health enrollment forms.
- Enrollment forms can be completed electronically except for initials and signatures. Initials and signatures must be in ink. Electronic initials and signatures will not be accepted.

### **ALL APPLICANTS MUST MEET THE FOLLOWING REQUIREMENTS:**

- Possess a National Provider Identification Number (NPI)
- Be age 18 or older
- Possess current Adult and Infant CPR certification
- Possess current doula-specific liability insurance coverage
- Complete the New York State Medicaid Fee-for-Service Doula Directory Form. The form can be found here:
  - <https://forms.office.com/g/Qupri80Zin>
- Become familiar with the Health Insurance Portability and Accountability Act (HIPAA). HIPAA is a federal law that created national standards to protect sensitive patient health information from being shared without the patient's consent or knowledge. All NYS Medicaid-enrolled providers must comply with current HIPAA requirements and standards. For more information, applicants can review HIPAA information on eMedNY.org:
  - [https://www.emedny.org/hipaa/5010/online\\_resources.aspx](https://www.emedny.org/hipaa/5010/online_resources.aspx)
- Qualify for enrollment under the Training Pathway or Work Experience Pathway
- Complete the Doula Attestation Form and all other required forms

### **LOCATE DOULA ATTESTATION FORM INSTRUCTIONS ON FOLLOWING PAGE**



## **DOULA ATTESTATION FORM INSTRUCTIONS:**

- **All** doula applicants must complete Part A of this form
  
- **Training Pathway** applicants must:
  1. Meet all the Training Pathway requirements,
  2. Complete Part B of this form,
  3. Complete Part B Addendum on this form only if additional training was completed to meet the minimum of 24 hours of training and/or the required competencies, and
  4. Submit a copy of all completed doula training certificate(s). If the doula training organization that provided doula training does not provide a certificate of completion, a signed and dated letter on the doula training organization's letterhead stating the doula has completed a doula training course can be substituted for a certificate.
  
- **Work Experience Pathway** applicants must:
  1. Meet all the Work Experience Pathway requirements,
  2. Complete Part C on this form, and
  3. Submit three different completed Client and/or Professional Recommendation Forms.



**PART A**

**REQUIRED FOR ALL DOULA APPLICANTS**

I, , (first and last name), attest that I have fulfilled the following requirements to enroll as a New York State Medicaid doula services provider. I am providing my initials on each line in ink below to indicate I meet the following requirements:

\_\_\_\_\_ Age 18 or older  
(initial here in ink)

\_\_\_\_\_ Possess current CPR certification for Adults and Infants  
(initial here in ink)

\_\_\_\_\_ Possess current doula-specific liability coverage policy  
(initial here in ink)

I, , (first and last name), attest that I have completed the New York State Medicaid Fee-for-Service Doula Directory Form to be added to the New York State Medicaid Fee-for-Service Doula Directory. The information I provided is accurate and up-to-date. I acknowledge that the information I shared will be posted publicly to the NYS DOH website once I am enrolled as a NYS Medicaid Doula Services Provider. I will update the Directory Form each time my information changes.

I, , (first and last name), attest that I am aware of HIPAA regulations and that as a NYS Medicaid-enrolled provider, I am a covered entity and must comply with these regulations.

First and Last Name of Doula Services Applicant:

NPI:

\_\_\_\_\_  
Signature of Doula Services Applicant (in ink)

Date:



**PART B**

**REQUIRED FOR TRAINING PATHWAY ONLY**

I, , hereby attest to having provided doula support at a  
(first and last name)

minimum of three births and completing a minimum of 24 hours of training in the following required doula competencies:

Twenty hours of training on the following core competencies:

- Foundations on anatomy of pregnancy and childbirth;
- Labor support techniques and nonmedical comfort measures;
- Common medical interventions: risks, benefits, and decision-making;
- Prenatal and postpartum education and support;
- Lactation support, education and infant feeding; and
- Scope of practice;

Four hours of training on the following broader competencies:

- Cultural awareness/humility and cross-cultural communication;
- Health equity in medical field, especially reproductive health;
- Person-centered and trauma-informed care; and
- Community-based knowledge and facilitating connection to resources;

Name of Doula Training Organization:

Address of Doula Training Organization:

Phone Number of Doula Training Organization:

Date of Completion of Doula Training:

**I attest that I am including a copy of the training certificate or, if not available, a letter from the doula organization noting completion. I certify that the information on this form is accurate to the best of my knowledge.**

**First and Last Name of Doula Services Applicant:**

**Signature of Doula Services Applicant (in ink)** \_\_\_\_\_

**Date:**



**PART B ADDENDUM**

**REQUIRED FOR TRAINING PATHWAY ONLY IF ADDITIONAL TRAINING  
COMPLETED TO MEET TRAINING PATHWAY REQUIREMENTS**

I, , hereby attest to taking additional doula training to  
(first and last name)

meet the minimum of 24 hours of training and/or the required doula competencies.

Name of Doula Training Organization:

Address of Doula Training Organization:

Phone Number of Doula Training Organization:

Date of Completion of Doula Training:

**I attest that I am including a copy of each training I completed to meet the training pathway requirements or, if not available, a letter(s) from the doula organization noting completion. I certify that the information on this form is accurate to the best of my knowledge.**

**First and Last Name of Doula Services Applicant:**

\_\_\_\_\_  
**Signature of Doula Services Applicant (in ink)**

**Date:**



**PART C**

**REQUIRED FOR WORK EXPERIENCE PATHWAY ONLY**

I, , hereby attest to having provided doula support at a  
(first and last name)  
minimum of 30 births or 1,000 hours of doula experience in either a volunteer or paid  
capacity within the last ten years, and to possessing skills in prenatal, labor, and postpartum  
care.

**I attest that I am providing copies of three different client and/or professional  
recommendations. These recommendations have been completed using the form  
provided by the NYS Department of Health and were signed within one year of this  
application. I certify that the information on this form is accurate to the best of my  
knowledge.**

**First and Last Name of Doula Services Applicant:**

**Signature of Doula Services Applicant (in ink)**

**Date:**