STATE OF
HAWAII
Department of
Health

DEVELOPMENTAL DISABILITIES DIVISION
Community Resources Branch

ATTESTATION FORM

(Use for verifying completed checks of Med-QUEST Excluded Individuals list)

Source: HI Waiver Provider Standards Manual (July 2026) 3.5.E(2) Med-QUEST Exclusion List Requirement (p.91).

Complete and submit this attestation form and upload it to the Provider Portal.

Provider Agency Name: _____

☐ I attest that my agency, as a Medicaid-funded provider, has searched Hawaii's excluded provider list to determine if any existing employee or contractor has been excluded from participating in the Medicaid program, **prior to hire and monthly.**

By signing, I attest I am authorized to sign on the provider agency's behalf and the information in this document is true and accurate.

_____ _____

Print Name of Person Completing Form | Title

_____ _____

Signature | Date

This form can be signed electronically ("E-sign") or printed and signed. An E-sign is accepted as an original signature.