



COLORADO

Department of Health Care
Policy & Financing

Health First Colorado Doula Provider Attestation

Colorado's Medicaid Program and Child Health Plan Plus (CHP+)

Important: Please read carefully before completing this form.

- Complete only **one** pathway section – **Certification or Experience**—not both.
- Attach all required documents with your application submission.
- Verify that all dates (e.g., CPR, Code of Conduct, Attestation) match across every document you list and this attestation form.
- Include only initials and dates of births – do **not** use full names or other personal identifiers for clients births attended.
- Certificate pathway applicants – attach your **certificate from an approved doula training organization** listed on the [department's webpage](#).

Provider Request

Provider Name	
National Provider Identifier (NPI)	
Provider Email	

I attest that I have the credentials, experience and/or training as indicated below. I am pursuing enrollment through the (check one):

Certification Pathway

Experience Pathway

Note: Complete all attestations in the pathway section that was checked, and then sign under the statement of attestation at the end of this form.

Certification Pathway

Complete all four attestations and upload required documents.

1. Doula Certification

I attest that I have received training as a doula from one of the Department approved training organizations.



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Attach: Copy of your *doula certificate*.

Certifying Organization: _____

Date Completed: _____ # of Training Hours Completed: _____

2. Birth Attendance

I attest that I have attended at least three (3) births (not including my own) within the last five (5) years.

Only include dates of birth and clients initials—do not include names or additional identifiers.

- Date of Birth 1: _____
- Date of Birth 2: _____
- Date of Birth 3: _____

3. CPR Training

I attest that I have current CPR Certification. **Attach:** Copy of your CPR card.

Date Completed: _____

4. Code of Conduct

I attest that I will follow the Doula Code of Conduct.

Date Completed: _____

Skip the next section and continue to the Statement of Attestation to sign and date this form.

Experience Pathway

Complete all five attestations and upload required documents.

1. Birth Attendance

I attest that I have attended at least ten (10) births in my role as a doula and at least five (5) of those births have occurred in the past two (2) years.

Only include dates of birth and clients initials—do not include names or additional identifiers.

(Use additional rows if needed)

- Date of Birth 1: _____
- Date of Birth 2: _____
- Date of Birth 3: _____
- Date of Birth 4: _____
- Date of Birth 5: _____
- Date of Birth 6: _____



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- Date of Birth 7: _____
- Date of Birth 8: _____
- Date of Birth 9: _____
- Date of Birth 10: _____

2. Letters of Recommendation

I attest that I have attached four (4) letters of recommendation:

- Two (2) from providers of a birth team (e.g., doula, nurse, midwife, obstetrician)
- Two (2) from previous clients
- Birth Team Letter #1 - Name: _____ Date of Birth Attended: _____
- Birth Team Letter #2 - Name: _____ Date of Birth Attended: _____
- Client Letter #1 -Name: _____ Date of Birth Attended: _____
- Client Letter #2 - Name _____ Date of Birth Attended: _____

3. CPR Training

I attest that I have current CPR Certification. **Attach:** Copy of your CPR card.

Date Completed: _____

4. Code of Conduct

I attest that I will follow the Doula Code of Conduct.

Date Completed: _____

5. Knowledge & Competency

I attest to having knowledge and competency in the following areas:

Please initial each item.

	Pregnancy/Perinatal Support
	Childbirth Education
	Anatomy of Pregnancy, Childbirth and Postpartum
	Non-medical Comfort Measures



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	Labor Support Techniques
	Newborn/Infant Care
	Feeding/Lactation Support
	Postpartum/Recovery Support
	Family/Partner Support
	Developing a Community Resource List
	Trauma-Informed Care
	Diversity, Equity and Inclusion (Cultural Sensitivity)

Statement of Attestation

I affirm that the information contained herein and any attachments are true, current, and complete and are furnished in good faith. I understand that omissions or misrepresentations may result in denial of my application or removal from the Health First Colorado Medicaid Doula Benefit. I understand that it is my responsibility to provide and maintain appropriate documentation to meet the requirements.

Provider Name: _____

Provider Signature: _____

Date: _____