COLORADO
Department of Health Care Policy & Financing

Doula Provider Attestation

Health First Colorado (Colorado's Medicaid program) and Child Health Plan *Plus* (CHP+)

Provider Request

Important: Please read carefully before completing this form.

- Complete only one pathway section — Certification or Experience—not both.
- Attach all required documents with the application submission.
- Verify that all dates (e.g., CPR, Code of Conduct, Attestation) match across every document
  listed in the application 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 certificate from an approved doula training organization listed on the Doulas web page.

Provider Name: _____

National Provider Identifier (NPI): _____

Provider Email for Attestation Follow Up: _____

I attest that I have licensing, 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 the form.*

Certification Pathway

Complete all four (4) attestations and upload required documentation.

(1) **Doula Certification:** I attest that I have received training as a Doula from one of the Department-approved Training Organizations. Attach a copy of the certification.

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. Ony include dates of birth and client initials – do not include name or additional identifiers.

Dates of Birth	Client Initials
Date of Birth 1:	
Date of Birth 2:	
Date of Birth 3:	

(3) **Cardiopulmonary Resuscitation (CPR) Training:** I attest that I have current CPR Training Credentials. Attach a copy of card.

Date Completed: _____

(4) **Code of Conduct:** I attest to follow the Doula Code of Conduct
Date Completed: _____

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

Experience Pathway:

Complete all five (5) 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 been in the past two (2) years.

Dates of Birth	Client Initials
Date of Birth 1:	
Date of Birth 2:	
Date of Birth 3:	
Date of Birth 4:	
Date of Birth 5:	
Date of Birth 6:	
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 provider 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) **Cardiopulmonary Resuscitation Training:** I attest that I have current CPR training. Attach a copy of the CPR card.

Date Completed: _____

(4) **Code of Conduct:** I attest that I will follow the Doula Code of Conduct.

Date Completed: _____

(5) **Knowledge and Competency:** I attest to having knowledge and competency in the following areas:

Initial to indicate competency:

Area of Competency	**Initials**
Pregnancy/Perinatal Support	
Childbirth Education	
Anatomy of Pregnancy, Childbirth and Postpartum	
Non-medical Comfort Measures	
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)	

I hereby 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 be cause for denial of my application or removal from the Colorado Medicaid Doula Benefit. I understand that it is my responsibility to provide appropriate documentation to meet the requirements.

Provider Name: _____

Provider Signature: _____

Date: _____

Revised February 2026