

**Arkansas Department of Health and Human Services
 Division of Medical Services
 Office of Long Term Care
 P.O. Box 8059, Mail Slot S405
 Little Rock, AR 72203-8059**

**NURSING ASSISTANT TRAINING COST
 REIMBURSEMENT CLAIM FORM**

FOR THE MONTH OF: _____, _____

AASIS Vendor Number:

Name of Facility:

Address:

Number of Residents: _____ Medicaid _____ Private _____ Medicare _____ Other _____

Number of Students that Completed Training: _____

Attach the following documents for each student being claimed:
1. State Criminal Background Determination Letter from OLTC
2. Completion of Training Certificate

	EXPENSE		TRAINING COST
1.	NA Transportation Expense	\$	_____
2.	Books	\$	_____
3.	Instructional Equipment	\$	_____
4.	Instructional Videos	\$	_____
5.	Other Training Materials	\$	_____
6.	Training Space	\$	_____
7.	NA Instructor Wages	\$	_____
8.	NA Instructor Fringe Benefits	\$	_____
9.	Nursing Assistant Consultant Fees	\$	_____
10.	Consultant Reimbursable Expenses	\$	_____
11.	Instructor Workshop Fees	\$	_____
12.	Instructor Workshop Travel	\$	_____
13.	Nursing Assistant Tuition (Amount paid to "outside" training course)	\$	_____
	Training Site(s): _____ _____		
	TOTAL TRAINING EXPENSE	\$	_____
	Administrator Signature _____		
	Date of Signature _____		

FOR OFFICE USE ONLY:

of Students _____

Multiplied by Cap Amount:

Total Approved Cost:

Percent Ratio: _____

Amount to be Reimbursed:

Pay: _____

Invoice Reference#
_____ NATP _____

Date: _____

Approved by:

**Nursing Assistant Training Costs
Reimbursement Claim Form**

PURPOSE OF FORM

The Nursing Assistant Training Costs Reimbursement Claim Form is used by nursing facilities to claim reimbursement for allowable nursing assistant training costs.

COMPLETION OF FORM

Month and Year Section:

Complete the applicable month and year in which expenses are being claimed.

Name and Address of Facility Section:

Contact this office if the facility name or address has changed.

Number of Residents Section:

1. Provide the total number of residents on the last day of the month.
2. Provide the number of residents covered by or eligible for Medicaid (or pending Medicaid) as of the last day of the month.
3. Provide the number of residents whose care was paid for privately or by private insurance, etc. as of the last day of the month.
4. Provide the number of residents whose care was paid for by Medicare as of the last day of the month.
(Medicare certified facilities only).
5. Provide the number of residents that do not fall into the previous categories as of the last day of the month.

Number of Students that Completed Training Section:

Provide the number of students that completed the nursing assistant training course. Do not include any students that failed to pass or complete the training.

You must provide a copy of the State Criminal Background Determination letter from OLTC and a copy of the Completion of Training Certificate for each student being claimed.

Expense and Training Cost Section:

Complete by line the dollar and cent amount of cost for each expense category. Complete the Total Training Expense.

For item #13, list the non-facility training program that provide training during the month and the tuition costs paid on behalf of the new trainees. If more than one approved non-facility training program was used by the facility, list all programs.

Refer to the Nursing Assistant Training Cost Reimbursement policy, Section X of the Rules and Regulations for the Arkansas Long Term Care Nursing Assistant Training Program for details concerning allowable cost items.

Administrator Signature and Date of Signature Section:

The reimbursement claim for monthly nursing assistant training program costs must be signed by the Nursing Facility Administrator for the facility. The date of the signature is the date the claim form is signed (claims may not be submitted earlier than the first day of the month following the expense month).

Leave the For Office Use Only Section blank.

Submit original form and signature. Copies are not acceptable. Route completed forms to:

**Department of Health and Human Services
Office of Long Term Care
P.O. Box 8059, Mail Slot S405
Little Rock, Arkansas 72203-8059**

**ARKANSAS DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF MEDICAL SERVICES
OFFICE OF LONG TERM CARE
NURSING ASSISTANT TRAINING PROGRAM
SLOT S405
P. O. BOX 8059**

LITTLE ROCK, AR 72203-8059
Telephone: 501-682-6172 Fax: 501-682-8551 TDD: 501-682-6789
Website: <http://www.medicaid.state.ar.us/internetsolution/general/units/oltc/index.aspx>

NURSING ASSISTANT TRAINING PROGRAM (NATP)

APPLICATION INSTRUCTIONS

1. Review Rules and Regulations for the Arkansas Long Term Care Facility Nursing Assistant Training Program. Pay special attention to Section IV. B. Implementation Requirements, C. Nursing Assistant Trainee Activities, and Section V.
2. Respond to all application items in compliance with the standards (above) and as required within instructions for each item.
3. Obtain agreements from any and all nursing facilities that will be used as clinical training or testing sites and attach a copy of each agreement. Agreements must either (a) be current, i.e. signed by facility authority within the past six months, or (b) specify the time period for which the agreement is valid. Facility authority is the facility administrator or corporate officer who is a designated authority.
4. Mail application with original notarized signatures along with attachments to:

Arkansas Department of Health and Human Services
Division of Medical Services
Office of Long Term Care
Nursing Assistant Training Program
Slot S405
P.O. Box 8059
Little Rock, AR 72203-8059

You Need to Know:

- Incomplete applications will be returned, which will delay the approval of your program
 - If the application contains errors or discrepancies, you will be notified within 15 days of Department's receipt of the application and you will be given an opportunity to make corrections. This may delay the date of approval of your program.
 - You should allow AT LEAST 20 DAYS from the date you mail your application before inquiring about the status of the application.
 - Training shall not be conducted until approval for instructors, classrooms and/or clinical sites has been received by the training program.
 - Programs offered in or by nursing facilities that have been subject to one or more of the following actions will not be approved as per Arkansas Code 20-70-01 et seq.:
 - (1) Waiver for nurse staffing requirements in excess of 48 hours during the week;
 - (2) Extended or partial extended survey*;
 - (3) Assessment of civil money penalty in excess of \$5000;
 - (4) Denial of payment for new admissions for Medicare/Medicaid;
 - (5) Appointment of temporary management;
 - (6) Transfer of residents;
 - (7) Termination from Medicare/Medicaid;
 - (8) Closure of facility.
- * Extended survey is defined for this provision as a survey that includes a review of facility policy and procedures pertinent to Level A deficiencies in Resident Rights, Resident Behavior and Facility Practices, Quality of Life, or Quality of Care. Partial extended survey is defined as a survey conducted as a result of a deficiency in Level A requirements other than those listed above in the extended survey definition.
- Nursing facilities that are prohibited due to one of the actions above will not be approved as a clinical training or testing site for any nursing assistant training program. Sanctioned nursing facilities may apply for a training waiver by submitting a written request to this office.
 - Public training programs MUST contact the Arkansas State Board of Private Career Education, 612 Summit, Suite 102, Little Rock, AR 72201, 501-682-2565, to apply for a license to operate a proprietary educational program in Arkansas.

ARKANSAS DEPARTMENT OF HEALTH AND HUMAN SERVICES
 DIVISION OF MEDICAL SERVICES
 OFFICE OF LONG TERM CARE
NURSING ASSISTANT TRAINING PROGRAM
 SLOT S405

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APPLICATION FOR NURSING ASSISTANT TRAINING PROGRAM

1.	Enter Nursing Assistant Training Program Name:
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	If the name of the Nursing Assistant Training Program has changed, enter the new name here:
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2.	Check application type:	
	NEW	Check NEW for initial application or if program is not currently approved.
	RENEWAL NATP Code #	Check RENEWAL if program is currently approved and you have received ADHS Renewal notice.
	CHANGE NATP Code #	Check CHANGE if program is currently approved and you are requesting approval for program changes. Complete entries for all items that have changed & certify changes by signature in Block #12 of this application.

3.	Check Program Category:
	Non-facility based program (not offered in or by a facility)
	Facility-based program (offered in and by a facility)
	<i>Note: Applications under Arkansas Code 20-10-701 et seq. may not be completed by the facility that has been prohibited from training. The Department shall not approve a program offered by or in a nursing facility which, in the previous two years: a) has operated under a waiver of the nurse staffing requirements in excess of 48 hours during the week; b) has been subject to an extended (or partial extended) survey; or c) has been subject to a civil money penalty of not less than \$5,000, denial of payment, appointment of temporary management, closure, or transfer of residents.</i>

4.	Primary Instructor Name:	E-Mail Address:
	Arkansas R.N. License Number:	Social Security Number:

Yes	No	Check responses to the following questions about the Primary Instructor:
		a. Does the Primary Instructor have at least two (2) years of nursing experience?
		b. Is at least one (1) year of the required nursing experience in the provision of long term care facility services in a nursing facility or skilled nursing facility?
		c. Has the Primary Instructor completed a course in teaching adults or have experience in teaching adults or supervising Nursing Assistants?

5.	Contact/Mailing Address: Enter a single, physical address and telephone number for the training program. All correspondence from the Office of Long Term Care will be sent to this address and all on-site NATP surveys will be conducted at this address.		
	Street		
	City	ST	Phone ()

6. Additional Instructor(s): List the name(s) and requested information below for individuals who will conduct the actual NATP training. Attach a copy of each instructors current Arkansas nursing license.				
Name:	Discipline:		Does Instructor have at least one (1) year of nursing experience in a long term care facility?	
	RN	LPN	Yes	No

7. Classroom Location: Enter a single classroom name and location. Attach additional sheets as needed.				
Name				
Street				
City	ST	Zip Code	Phone ()	

8. Please check responses to the following questions:		
Yes	No	
		a. Does this program teach the Arkansas Curriculum for Nursing Assistants in Long Term Care Facilities?
		b. Does this program exceed both the curriculum content and minimum hours indicated above? If Yes, enter the number of hours offered: Classroom: Clinical:
		c. Does this program have adequate textbooks, audio-visual materials and other supplies and equipment necessary for training?
		d. Do the classroom and skills training rooms provide for adequate space, cleanliness, safety, lighting and temperature controls to promote safe and effective learning?

9. Clinical Training Site(s): In the space(s) provided below, list all certified nursing facilities that will be used for the required clinical training for the NATP. (Additional sites may be listed on a separate sheet).				
a. Facility Name				
Street				
City	ST	Zip Code	Phone ()	
b. Facility Name				
Street				
City	ST	Zip Code	Phone ()	

<p>10. I certify that the information submitted in this application and attachments is true and correct. I agree to provide prior notification to the Office of Long Term Care of any change in information presented in this application by submitting a Program Change Application as required. I acknowledge that failure to comply with Arkansas DHHS Rules and Regulations for the Arkansas Long Term Care Facility Nursing Assistant Training Program may result in withdrawal of NATP approval.</p>	
<p>Signature of Primary Instructor (MUST be signed before a notary).</p> <p>_____</p> <p>Sworn and subscribed before me on this _____ day</p> <p>of _____, 20_____</p> <p>In _____ County, in the State of _____</p> <p>Notary Signature: _____</p>	<p>(Notary Stamp/Seal):</p>

**ARKANSAS DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF MEDICAL SERVICES
OFFICE OF LONG TERM CARE
NURSING ASSISTANT REGISTRY
SLOT S405**

**P. O. BOX 8059
LITTLE ROCK, AR 72203-8059**
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INTER-STATE TRANSFER FORM

SECTION A		TO BE COMPLETED BY THE NURSING ASSISTANT	
<p>Name: _____ (Last) (First) (Initial) (Maiden)</p> <p>Address: _____ (Street Address or PO Box) (Apt Number)</p> <p>_____ (City) (State) (Zip Code)</p> <p>_____ (Telephone) (Email Address)</p> <p>_____ (Social Security Number) (Date of Birth)</p> <p align="center">Attach a copy of your Drivers License or State-issued ID</p> <p>Attach a copy of your Social Security Card</p> <p>Attach a copy of your Nursing Assistant Certificate</p> <p>FAILURE TO ATTACH THE ABOVE DOCUMENTS WILL RESULT IN PROCESSING DELAYS AND/OR DENIAL OF TRANSFER INTO THE STATE OF ARKANSAS</p>			

STOP! DO NOT COMPLETE SECTION B OR THE APPLICATION WILL BE RETURNED TO YOU!

SECTION B		TO BE COMPLETED BY THE STATE OF ARKANSAS ONLY	
<p>Transferring from _____</p> <p>Date originally certified and placed on the Registry _____ Expiration Date (If Any) _____</p> <p>Did Training Program meet OBRA 1987 Requirements? Yes ___ No ___ Number of Hrs in Training _____</p>			
<p>Method of Certification</p> <p>___ Passed State Competency Examination? Date _____</p> <p>___ Transferred from another state? List state _____</p> <p>___ Exemption to Training? List exemption _____</p> <p>___ Not Certified</p>	<p align="center">Status of Certificate</p> <p>___ Active</p> <p>___ Inactive</p> <p>Date checked _____</p> <p>Online ___ Phone ___</p> <p>Attach copy of online registry check</p>		
<p>Disciplinary Action</p> <p>Are there any findings of abuse, neglect, or misappropriation? Yes ___ No ___</p> <p>Is the individual disqualified due to criminal record check? Yes ___ No ___</p>	<p align="center">Arkansas Registry Status</p> <p>___ Not found on the NAR</p> <p>___ On the NAR, current</p> <p>___ On the NAR, expired</p> <p>___ On the NAR, disqualified</p> <p>Attach copy of AR certification</p>		
<p>AR NAR Signature/Title _____ Date _____</p>	<p>AR NAR Decision</p> <p>___ Accepted Transfer</p> <p>___ Denied AR Certification</p> <p>Reason: _____</p> <p>Attach copy of AR certification & letter of approval</p>		