

Michigan Department of Health and Human Services
Nurse Aide Training and Competency Evaluation Program
Certified Nurse Aide Training Reimbursement

PURPOSE: The Certified Nurse Aide (CNA) must present this information to his/her Medicaid and/or Medicare certified nursing facility employer to apply for reimbursement of eligible CNA training and testing costs. Reimbursement is not available to CNAs working in other residential or patient care settings.

CNA:

Last Name	First Name	Middle Initial
Social Security Number	Birthdate	Driver License/Identification

I incurred the following expenses to become a CNA (Certified Nurse Aide).

TRAINING: *(Attach receipts)*

Approved Program Name: _____	Amount: \$ _____
Location: _____	Date of Payment: _____
Completion Date of Training: _____	

COMPETENCY EVALUATION: *(Attach receipts)*

Clinical Skills Test

Site: _____	Date: _____	Amount: \$ _____
Site: _____	Date: _____	Amount: \$ _____
Site: _____	Date: _____	Amount: \$ _____

Knowledge Test

Site: _____	Date: _____	Amount: \$ _____
Site: _____	Date: _____	Amount: \$ _____
Site: _____	Date: _____	Amount: \$ _____

Rescheduling Fee (No-Show)

Date: _____	Amount: \$ _____
Date: _____	Amount: \$ _____
Date: _____	Amount: \$ _____

Initial Registration Fee

Date: _____	Amount: \$ _____
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Registration Document Renewal

Date: _____	Amount: \$ _____
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Check appropriate box, sign and date:

- I have not received any payment for any of these expenses from another source, such as another nursing home, a vocational training program, etc.
- I have received payment from another source for the listed expenses:

Amount: \$ _____	Date: _____	Source: _____
Amount: \$ _____	Date: _____	Source: _____
Amount: \$ _____	Date: _____	Source: _____

I understand that the information I have provided may be audited.

CNA Signature: _____ Date: _____

NURSING FACILITY: (Retain this information for documentation of NATCEP costs.)

Facility Name: _____

Provider NPI Number: _____ LARA - BCCHS License Number: _____