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: $ _____

Registration Document Renewal Date: _____ Amount: $ _____

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 - BCHS License Number:_____

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