MAP-576
(Rev. 07/22)

COMMONWEALTH OF KENTUCKY
CABINET FOR HEALTH AND FAMILY SERVICES
DEPARTMENT FOR MEDICAID SERVICES
NURSE AIDE TRAINING EXPENSE REPORT AND AUTHORIZATION FOR PAYMENT

Provider Name and Address:

_____

_____

_____

Expenses incurred are reimbursed subject to provisions of Medicaid Provider Agreement (Map – 343):
#_____
(Medicaid Provider Number)

Billing for the month of_____20____.

KY Vendor #_____

PLEASE TYPE OR PRINT ALL INFORMATION AS ILLEGIBLE REQUESTS CAN NOT BE PROCESSED

Reference #	Item Description	Units	Cost per Unit	Cost

Line A **Total Cost** _____

Line B **Enter % page 2, Line 3 (% of students employed by facility)** _____

Line C **Enter product of Line A *Line B (portion of costs related to employees)** _____

Line D **Total Medicaid Days from most recent cost report** _____

Line E **Total CNF Days from most recent cost report** _____

Line F **Line D divided by Line E (Medicaid %)** _____

Line G **Enter product of Line C *Line F (Medicaid's portion of total costs)** _____

Before Payment can be processed this certification section must be completed.

I certify that the above items represent actual costs incurred to Nurse Aide Training requirements for employees of this facility and are reimbursable under guidelines established by the Department for Medicaid Services, specifically 907 KAR 1:450. By signing and submitting this form, you are certifying you have read and agreed to the complete terms of the latest version of the **KNAT** Reimbursement contract located at https://chfs.ky.gov/agencies/dms/dpo/bpb/Pages/nursing-facilities.aspx

Date: _____

Signed: _____ (officer of administrator of facility)

Phone #

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For Department for Medicaid Services Use Only

This payment report has been received and verified by: _____

Title:

This payment report is approved for payment by: _____

Title:

Column 1 Student Name	**Column 2** Facility employee? Yes or No	**Column 3** If Col. 2 is yes, enter hire date	**Column 4** Completion date of training	**Column 5** Completion date of testing

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Does your facility have a Medicaid approved Nurse Aide Training Program? _____

If not, please enter the name and address of the entity providing Nurse Aide training for your employees.

Name _____

Address _____

_____

Phone Number _____

Nurse Aide Training Number _____

Provider Number _____

If necessary, additional pages may be completed so that all students completing training can be listed. However, only one nursing facility student to total student ratio should be calculated for all sheets and carried forward to page 1, Line B.

Ratio of Nursing Facility Student to Total Students

Line 1	**Enter Number of Employee Students from Column 2**	_____
Line 2	**Enter Total Number of Students from Column 1**	_____
Line 3	**% of Students employed by the nursing facility**	_____
	(Line 1 divided by line 2)	