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_____.

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

<table>
<thead>
<tr>
<th>Reference #</th>
<th>Item Description</th>
<th>Units</th>
<th>Cost per Unit</th>
<th>Cost</th>
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</thead>
<tbody>
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</table>

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 #
### Nurse Aide Training Expense Report and Authorization for Payment

For Department for Medicaid Services Use Only

<table>
<thead>
<tr>
<th>Column 1</th>
<th>Column 2</th>
<th>Column 3</th>
<th>Column 4</th>
<th>Column 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Student Name</td>
<td>Is the student a facility employee?</td>
<td>If Col. 2 is yes, enter hire date</td>
<td>If Col. 2 is no, enter students payer</td>
<td>Completion date of training</td>
</tr>
</tbody>
</table>

Program Code: WCCN Account #: 01-49-746-WCCN-E466 and 12-49-746-WCCN-E466

This payment report has been received and verified by:  
Title: ____________________________

This payment report is approved for payment by:  
Title: ____________________________

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