Commonwealth of Kentucky
Cabinet for Health and Family Services
Department for Medicaid Services

REVISED MARCH 2005 MAP-414 APPENDIX I

Department for Medicaid Services
Application for Approval of Nurse Aide Training Program

1. Date of application _____

2. Name of training program provider/facility _____

3. Administrator _____

4. Address _____

5. Telephone number area code ( ) _____

6. Federal I.D. number _____ County: _____

7. Type of nurse aide training provider (Please check)

_____ Office of Career and Technical Education, Department of Workforce Investment, Education Cabinet and/or KCTCS

_____ Nursing Facility

_____ Community College or University

_____ Proprietary Education _____ License Number

_____ Other licensed health care facility offering nurse aides training to its' own employees.

_____ Non-Profit, church related or tax supported program not identified in above categories.

8. Ownership and type of organization (i.e. corporation. pubic, private, sole proprietorship, etc.) _____

9. Classroom/laboratory facility address _____

10. Description of classroom/ lab facilities _____

11. List equipment and supplies for classroom instruction_____

12. Name and address of facility to be used for clinical practice. (Please enclose letter of agreement.)_____

13. Attach lesson plan schedule (syllabus - days and times allowed for a whole unit to be completed with each session) to comply with the 75 hour curriculum including a minimum of 16 hours of supervised practical training.

14. Name and title of program supervisor _____
Active/current Kentucky R.N. licensure number: _____
(Attach a copy of License)

The Director of Nursing may be the program supervisor, but may not instruct any portion of the course.

15. Work experience that will qualify the RN as the supervisor (minimum of two (2) years experience in nursing at least one of which is in the provision of long-term care services). _____

16. Methods of Instruction (M.O.I.) program, location/ date attended by the supervisor:
(Attach copy of M.O.I. Certificate): _____

17. Name and title of second instructor if different from above (see No. 14)_____

18. Active/ current Kentucky RN or LPN License: _____
(Attach copy of License)

19. Work experience that will qualify the second instructor to teach the training._____

20. Methods of Instruction program, location/ date attended by the second instructor:
(Attach a copy of M.O.I. Certificate):_____

21. The undersigned provider:

A. Agrees to comply with and abide by all applicable federal and state laws and regulation, with Kentucky Medicaid Program's policies and procedures governing Title XIX approved nurse aide training programs.

B. Certifies that the above provider applicant is licensed by the state of Kentucky (applicable only to proprietary agencies).

C. Agrees to comply with the civil rights requirements set forth in 45 CFR Parts 80, 84, 90. (The Cabinet for Health and Family Services shall make no payment to providers of services who discriminate on the basis of race, color, national origin, sex, handicap, religion, or age in the provision of services.)

D. Agrees to maintain records of the training and competency performance of nurse aide who have successfully completed the program for a period of five (5) years. These records will be made available to the Department for Medicaid Services or its designee, upon request.

E. Assures that he or she is aware of KRS 194.500 to 194.990 and KRS 205.845 to 205.855 and 205.855 to 205.990 relating to medical assistance fraud.

F. Agrees to inform the Cabinet for Health and Family Services, Department for Medicaid Services, within 30 days of any changes in the following:

(a) name;
(b) ownership;
(c) licensure (for proprietary agency);
(d) primary instructor; or
(e) address
(f) clinical site

G. Agrees that all information provided in this application is accurate and in accordance with the Kentucky Department for Medicaid Services policies and procedures for Nurse Aide Training and Competency Evaluation Program.

Authorized Signature: _____

Title: _____ Date: _____

My facility is applying for approval to teach a Nurse Aide Training program. I verify that, my facility within the previous two (2) years:

1. In the case of a Medicaid SNF, has not operated under a nurse staffing waiver.

2. In the case of a Medicaid NF, has not operated under a nurse staffing waiver which allows waiver of more than forty-eight (48) hours of nursing staffing per week.

3. Has not been subject to an extended or partial extended survey.

4. Has not been assessed a civil money penalty described in section 1819 (h) (2) (B) (ii) or 1919 (h) (2) (B) (ii) of the Social Security Act of not less than $5,000.00.

5. Has not been subject to a remedy described in sections 1819 (h) (2) (B) (i) or (iii), 1819 (h) (4), 1919 (h) (1) (B) (I), or 1919 (h) (2) (A) (i) (iii) or (iv). These sections describe temporary management, denial of payment for admissions, termination, emergency, transfer, and closure.

6. Has not had its participation in Medicare or Medicaid terminated.

7. Was not subject to a denial of payment under Medicare of Medicaid.

8. Was not assessed a civil money penalty of not less than $5000.00 for deficiencies in facility standards.

9. Has not operated under temporary management.

10. Was never closed or had its residents transferred pursuant to state action.

_____

ADMINISTRATOR

_____

DATE

Approval of Nurse Aide Training Program by the Department for Medicaid Services

_____

Signature of Authorized Medicaid Representative

_____

Approval Number

_____

Date