Michigan Department of Community Health

Nurse Aide Training and Competency Evaluation Program

Certified Nurse Assistant Training Reimbursement

PURPOSE: The Certified Nurse Assistant (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 Assistant).

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: ____ MDCH License Number: ____

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