

**FORWARDHEALTH
 NURSE AIDE TRAINING AND COMPETENCY TEST REIMBURSEMENT REQUEST**

The information on this reimbursement request is required for the reimbursement of Medicaid-certified long term care facilities, nursing facilities (NFs), for a certified nursing assistant's (CNA's) training and/or testing. This reimbursement is only available for CNAs who are employed by an NF.

Submit this completed form by mail to ForwardHealth, 6406 Bridge Road, Madison, WI 53784-0002.

Instructions: Type or print clearly. Before completing this form, read the Nurse Aide Training and Competency Test Reimbursement Request Completion Instructions, F-1013A. **The use of this form is mandatory; use an exact copy of this form.**

Reference the Wisconsin Nurse Aide Registry Web site prior to submitting this reimbursement request to obtain/verify certification information. To access the Wisconsin Nurse Aide Registry Web site, go to www.dhs.wisconsin.gov/caregiver/. Click on the "Nurse Aide Training and Registry" link, and then click on "Search Nurse Aide Registry." Perform a "Search by Number," Social Security number (SSN), to verify the CNA's SSN and competency test date. Inclusion Date is the competency test date for newly certified CNAs. A reimbursement request will deny if either the SSN or the competency test date on the request do not match what is on the Registry.

Per 42 CFR Part 431 and s. 483.152(c), NFs are eligible to seek reimbursement when they have incurred training and/or testing costs for an employee or when they have hired a CNA who incurred training and testing costs within 365 days of their employment by the NF. Wisconsin Medicaid has established a maximum amount that CNAs have to be reimbursed. Nursing facilities receive a percentage of that maximum amount based on their Medicaid utilization, number of Medicaid patient days divided by their total patient days. Wisconsin Medicaid implemented this reimbursement methodology on October 1, 1997. It ensures that CNA training and testing costs are properly allocated between Wisconsin Medicaid, Medicare, and private pay residents.

Name — NF (Physical Name, not Corporate Name)		POP ID (Required)	National Provider Identifier — NF
Last Name — CNA		First Name — CNA	
SSN — CNA	Registration Number — CNA	Date of Hire (Required) / /	
Training Completion Date* / /	Competency Test Date** / /	Inclusion Date / /	

Training and Testing Questions — Check the box for the applicable answer for questions 1-3.

1. Who incurred the training cost? CNA NF
2. Who incurred the testing cost? CNA NF
3. Is this a recertification? Yes No

CERTIFICATION

This is to certify that the foregoing information is true, accurate, and complete. I understand that payment and satisfaction of this reimbursement request is from federal and state funds, and any false claims, statements, documents, or concealment of material fact may be prosecuted under applicable federal or state laws.

Name and Telephone Number — NF Contact

SIGNATURE — Provider	Date Signed — Provider
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* Leave the Training Completion Date element of this form blank if neither the CNA nor the NF incurred training costs.

** To obtain reimbursement for both training and testing, enter the appropriate date in the Training Completion Date and the Competency Test Date elements of this form.

