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| **Department of Health Services**  Division of Quality Assurance  F-62588 (03/2025) | | | | **State of Wisconsin**  42 CFR 483.160 and DHS 129.11 - 129.18  Page 1 of 3 | | |
| **Feeding Assistant Training Program Application** | | | | | | |
| **Introduction** | | | | | | |
| The Department of Health and Human Services (DHS), The Centers for Medicare & Medicaid Services (CMS) authorizes the State of Wisconsin to review and determine eligibility for feeding assistant training programs under the requirements of the Medicare and Medicaid programs. This application form meets federal and state requirements for feeding assistant training program eligibility determination. All entities must submit an application to the department for review and approval determination.  **Application completion**   * Direct questions regarding completion of the application to: [dhsdqafeedingassistantprogram@dhs.wisconsin.gov](mailto:dhsdqafeedingassistantprogram@dhs.wisconsin.gov) * Submit the completed application to: [dhsdqafeedingassistantprogram@dhs.wisconsin.gov](mailto:dhsdqafeedingassistantprogram@dhs.wisconsin.gov). The department will approve or deny the application in writing within 45 days of receiving the **completed** application.   \*Note – Upon program approval the program designee will be issued the Wisconsin Caregiver Program material, standardized competency evaluation materials, certificate template, and a feeding assistant roster. | | | | | | |
| **I.** | **General information** | | | | | |
| **A.** | **Program information** | | | | | |
| Facility name | | | | | | |
| Current address *(Street/PO Box)* | | | City | | State | ZIP code |
| Phone number | | | | | | |
| Name – Program designee *(Last, First, MI)* | | | | | | |
| Phone number | | Email address | | | | |
| **II..** | **Instructor qualifications** | | | | | |
| **A.** | **Instructor** | | | | | |
| *Complete the Feeding Assistant Training Program Instructor Application (*[*DQA form F-62692*](https://www.dhs.wisconsin.gov/forms/index.htm?combine=f-62692&field_division_office_owner_target_id=All&field_language_target_id=All)*) for each instructor and submit electronically with the application.* | | | | | | |
| Name of instructor(s) | | | | | | |

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| **III.** | | | | **Program material** | | | | | | | |
| **A.** | **Curriculum options** | | | | | | | | | | |
| Please choose from below:  Textbook (Name and edition) or Online (URL link): ­­­­­­­­­­­­­­­­­­­­­­­  *\*Two programs have been pre-approved by DHS and ready for use as an option, but not required. (How to Be a Feeding Assistant, AHCA and Assisting with Nutrition and Hydration in Long-Term Care, Hartman Publishing)*  Facility created (If creating your own, the syllabus, course calendar, assignments, or any other pertinent information are to be submitted for review/approval.) | | | | | | | | | | | |
| **B.** | | **Mandatory training areas** | | | | | | | | | |
| The feeding assistant training program must include the following federally and state mandated topics, to be covered during a minimum of 8 hours of instruction. Record the time for instruction being provided for each training area. | | | | | | | | | | | |
|  | | | **Mandatory training areas** | | | | | **Time required for instruction** | | |  |
|  | | | 1. Feeding techniques **[DHS 129.11(1)(a)]** | | | | |  | | |  |
|  | | | 1. Assistance with feeding and hydration **[DHS 129.11(1)(b)]** | | | | |  | | |  |
|  | | | 1. Communications and interpersonal skills **[DHS 129.11(1)(c)]** | | | | |  | | |  |
|  | | | 1. Appropriate responses to resident behavior **[DHS 129.11(1)(d)]** | | | | |  | | |  |
|  | | | 1. Safety and emergency procedures, such as the Heimlich maneuver **[DHS 129.11(1)(e)]** | | | | |  | | |  |
|  | | | 1. Infection control **[DHS 129.11(1)(f)]** | | | | |  | | |  |
|  | | | 1. Resident Rights **[DHS 129.11(1)(g)]** | | | | |  | | |  |
|  | | | 1. Recognizing changes in residents inconsistent with the norm and the importance of reporting changes to the nurses **[DHS 129.11(1)(h)]** | | | | |  | | |  |
|  | | | **Time sub-total**  ***Must be at least 8 hours*** | | | | |  | | |  |
|  | | | 1. Wisconsin Caregiver Program **[DHS 129.11(2)(a)]** | | | | |  | | |  |
|  | | | 1. Selected Resident Population **[DHS 129.11(2)(b)]** | | | | |  | | |  |
|  | | | **Total time** | | | | |  | | |  |
|  | | | | |  | |  | | |  | |
| **C.** | **Policy and procedures** | | | | | | | | | | |
| * Submit a copy of the policy/procedure that will describe how the program will administer the state competency evaluation examination, procedure to ensure accurate test scoring, and provisions to ensure the security for the examination and certificate templates per DHS 129.13. * Submit a copy of the policy/procedure on record retention per DHS 129.18. | | | | | | | | | | | |
| **IV. Attestation** | | | | | | | | | | | |
| **The approved program is responsible for notifying the Division of Quality Assurance, in writing,**  **of any changes in the information provided on this application.** | | | | | | | | | | | |
| I understand, under penalty of law, that the information provided above is truthful and accurate to the best of my knowledge and that knowingly providing false information or omitting information may result in a fine of up to $10,000 or imprisonment not to exceed six years, or both (per Wis. Stat. § 946.32). | | | | | | | | | | | |
| **Signature** – Applicant/Program designee | | | | | | | | | Date signed | | |
| Name – Applicant *(Print or type)* | | | | | | Title | | | | | |

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| **DHS USE ONLY** | | | | | |
| Approved/Acknowledged | | | Entered database | Date: | |
| Denied | Reason for denial: | | | | |
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| Name – Reviewer | | Title | | | Date reviewed |