

FORWARDHEALTH
NURSE AIDE TRAINING AND COMPETENCY TEST REIMBURSEMENT REQUEST

The information on this request is required for the reimbursement of Medicaid-certified long-term care nursing facilities (NFs) for certified nursing assistant (CNA) 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, Claims and Adjustments, 313 Blettner Boulevard, Madison, WI 53784.

Instructions: Type or print clearly. Before completing this form, read the Nurse Aide Training and Competency Test Reimbursement Request Completion Instructions, F-01013A. **The use of this form is mandatory; use an exact copy of this form.**

Reference the Wisconsin Nurse Aide Registry website prior to submitting this reimbursement request to obtain or verify certification information. To access the Wisconsin Nurse Aide Registry website, 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 does not match what is on the Registry.

Per 42 C.F.R. pt. 431 and § 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. NFs receive a percentage of that maximum amount based on their Medicaid utilization (number of Medicaid patient days divided by their total patient days).

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.

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|------------------------------------|------------------------------|-----------------------------|
| 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 Email – NF Contact

SIGNATURE – Provider	Date Signed
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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.



F-01013