Washington State Department of Social & Health Services
ALTSA Aging and Long-Term Support Administration

OFFICE OF RATES MANAGEMENT
DELIVERIES AND OVERNIGHT: 4500 10TH AVENUE SE, LACEY, WA 98503
MAILING: PO BOX 45600, OLYMPIA, WA 98504-5600

Nursing Assistant Training and Testing Reimbursement

Provider completes and submits form quarterly. **Reimbursement request must be received 30 days after the end of the quarter.**

**** Shaded area for DSHS use only**

A. PROVIDER INFORMATION

1. PROVIDER NAME	2. MEDICAID REIMBURSEMENT PERCENTAGE	3. SSPS NUMBER
4. CONTACT PERSON	5. TELEPHONE NUMBER	6. VENDOR NUMBER
7. CONTACT PERSON'S FAX NUMBER	8. CONTACT PERSON'S E-MAIL ADDRESS	
9. REIMBURSEMENT PERIOD FOR THREE MONTH PERIOD ENDING: ☐ March 31 ☐ June 30 ☐ September 30 ☐ December 31		YEAR

B. DIRECT CARE COSTS

	REQUESTED CURRENT COSTS	ALLOWABLE CURRENT COSTS
1. Cost of staff conducting training:		
a. Salaries		
b. Benefits		
c. Payroll Taxes		
2. Less amount charged to other facilities or individuals for training		

C. OPERATIONS COSTS

1. Books, materials and supplies provided to nursing assistants for training		
2. Fees paid to other institution for training/CPR.		
3. Fees reimbursed to employees for prior testing and training		
4. Fees paid for testing nursing assistants		
5. Less amount charged to other facilities or individuals for training		

D. TOTAL COSTS AND REIMBURSEMENT REQUEST

	CURRENT COSTS	ALLOWABLE COSTS
1. Total Direct Care costs		
2. Total Operations costs		
3. Total D1. and D2.		
4. Request for reimbursement of Medicaid share of costs:		**PAY THIS AMOUNT**
_____ = (round to whole percentage)		

E. PROVIDER AUTHORIZATION

I certify under penalty of perjury the items and totals listed are proper charges for materials and services furnished to the nursing assistants, and I have properly accounted for the proceeds received from individuals and other facilities. I have furnished the materials and services without discrimination on the grounds of race, creed, color, national origin, sex or age.

ADMINISTRATOR'S SIGNATURE	DATE

F. DEPARTMENT OF SOCIAL AND HEALTH SERVICES (DSHS) AUTHORIZATION

DSHS AUTHORIZING SIGNATURE	DATE

NURSING ASSISTANT TRAINING AND TESTINGREIMBURSEMENT INSTRUCTIONS

PLEASE READ

Use the enclosed forms to request reimbursement for nursing assistant training and testing costs. You should submit these forms with supporting documents at the end of the quarter in which you had training and/or testing.

You have up to thirty (30) days from the end of the quarter to submit a reimbursement request, and thirty (30) days from the date of our *initial reimbursement summary allowed form* to submit a corrected request for the same quarter.

A. **Provider Information**

1. Enter the name of your facility. If you have had a name change within the last two years, enter that name too.
2. Medicaid Reimbursement percentage. **NOTE: The reimbursement percentage is calculated by taking the number of Medicaid patients days reported on your cost report Schedule N divided by the total patient days on the same schedule. The reimbursement percentage is updated July each year.**
3. Enter your six digit SSPS provider number.
4. Enter the name of the person we should contact for questions concerning this form.
5. Enter the telephone number of the contact person.
6. Enter your seven digit Medicaid Vendor Number.
7. Enter the fax number of the contact person.
8. Enter the e-mail address of the contact person.
9. Check the appropriate box for the quarter for which you are requesting reimbursement and enter the year.

B. **Direct Care Costs**

1. & 2. Follow instructions on the *Instructor Information Sheet.* Transfer totals to the *Reimbursement Request form.*

C. **Operations Costs**

1. through 5. Follow instructions on the *Supplies, Student, and Instructor Information sheets.* Transfer totals to the *Reimbursement Request form.*

D. **Total Costs and Reimbursement Request**

1. Enter the total amount for Section B, items 1. and 2.
2. Enter the total amount for Section C, items 1. through 5.
3. Enter the total amount for D, 1. and 2.
4. Compute your Reimbursement amount by entering your Medicaid percentage on the line provided and multiply the total amount entered on line 3 by this percentage.

E. **Provider Authorization**

The Nursing Home Administrator must sign and date this form. Submit originals signed in **ink**.

QUESTIONS?

Contact the Office of Rates Management
Phone: (360) 725-2439
Email: BenWang@dshs.wa.gov