OFFICE OF RATES MANAGEMENT
OVERNIGHT DELIVERIES: 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 forms 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. PROVIDERONE 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. Online Training Module Cost (must be preapproved) Monthly Cost by quarter or per student cost.	$		

C. Operation 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	$		

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

Reimbursement Instructions

Use the forms found on our website to request reimbursement for nursing assistant training and testing costs. You should submit these forms with the NAC worksheets and 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. Must be postmarked by the last day of the following month of the reimbursement 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 and posted on the website.**
3. Enter your provider one 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 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?

Telephone numbers: Katy Hartman – 360-725-2475

E-mail Addresses: Katy Hartman – katy.hartman@dshs.wa.gov

ALTSA Website: https://www.dshs.wa.gov/altsa/management-services-division/nursing-assistant-certifieds-reimbursement-forms

Mailing Address: ALTSA, Office of Rates Management, Attention Katy Hartman, PO Box 45600, Olympia, WA 98504-5600

Overnight Address: (FEDEX, UPS) ALTSA, Office of Rates Management, Attention Katy Hartman, Blake West 4450 10th Ave SE, Lacey, WA 98503

Fax: (360) 725-2641