**CNA TRAINING/TESTING COSTS**

**-THIRD-PARTY PAYOR REIMBURSEMENT FORM-**

(Please Print)

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **STUDENT** NAME: | |  | | | Telephone |  |  | DOB: | |
| **CNA Training Provider** Name/Contact Information: | |  | | | Address: |  |  | Telephone: | |
|  | |  | | |  |  |  |  | |
| **CNA EXPENSES:\*** | | |  | |  |  |  |  | |
| Expense Type: | Amount ($) | | | Date Completed: | | Notes: |  | *Cumulative* Total $ | |
| Tuition |  | | |  | |  |  |  | |
| Books |  | | |  | |  |  |  | |
| Fees |  | | |  | |  |  |  | |
| Required Supplies |  | | |  | |  |  |  | |
| Competency Evaluation Fee |  | | |  | |  |  |  | |
| Transportation**\*\*** |  | | |  | |  |  |  | |
| Other (please explain below): |  | | |  | |  |  |  | |
|  |  | | |  | |  | **(1) GRAND TOTAL :** |  | |
| I attest to the fact that the information provided is true/accurate and these amounts reflect actual expenses incurred while completing my CNA training/testing. ***Student Signature***: **Date:** | | | | | | | | |
| **THIRD-PARTY INFORMATION:** | | |  | |  |  |  |  | |
| Third-Party Payor Name/Contact: |  | | | Address: | |  |  | Telephone: | |
|  |  | | |  | |  |  |  | |
|  |  | | |  | |  |  |  | |
| I certify we are a third-party payor as defined under M.S. 144A.611, that the information provided accurately reflects actual costs incurred by the student named above for CNA training and/or testing - and that our organization paid these costs on behalf of this student.  ***Third-Party Payor Signature***:  **Date**: | | | | | | | | |

**\***Attach Proof of CNA Expenses / **\*\***For Transportation Costs-Attach Transportation Log

INSTRUCTIONS

**THIRD-PARTY PAYOR** (NOTE: Reimbursement is provided only for eligible third-party organizations, as defined in M.S. 144A.611):

1. Complete the student information.
2. Complete the information on the CNA training provider.
3. Complete the information regarding qualified CNA expenses (***include only*** *those expenses your organization paid on behalf of the student).* If you have *any* questions on what is a qualified/allowable expense, please contact the Department (see contact information on the bottom of this form) (NOTE: *only* allowable expenses are eligible for reimbursement).
4. Have the student sign and date the form.
5. Complete the information on your organization (the third-party paying the CNA expenses).
6. Sign and date the form.
7. Make a photocopy of the form and all associated documentation - for your records.
8. Attach proof of all expenses (receipts, etc.). For transportation expenses, only “reasonable” transportation costs are allowable and the individual must complete and you must attach a *Transportation Log* (see form).
9. Send the original completed, signed and dated form (along with proof of CNA training and testing expenses incurred by the student (receipts, transportation log, etc.), to the Facility where the individual is employed as a Nursing Assistant. (Make sure the form is complete and all required documents are present. Incomplete or unsigned forms may delay processing).
10. Wait for reimbursement from the facility.

**FACILITY:**

1. Receive the form and supporting documentation from the third-party payor.
2. Verify the individual is employed by the facility (as a nursing assistant). [If the individual is not employed by your facility, request additional identifying information from the third-party payor *or* return the original form & documents to the third-party payor (explaining the denial of payment).]
3. Check the form to ensure it is complete, signed, dated and supporting documentation is provided. Contact the third-party payor to resolve issues if anything is missing or incomplete.
4. Keep the signed originals and all documentation of expenses - for your facility records (in case of audit).
5. When the individual has been employed as a CNA for 90 days, *immediately* process payment for eligible expenses paid on behalf of the student *directly* to the third-party payor. Send payment to the third-party *along with* a *photocopy* of the Reimbursement Form.
6. If the employee quits or leaves employment prior to 90 days, return the original form/documents to the third-party payor (along with an explanation for the denial of payment).

NOTE: This process and form apply *only* to situations where qualified third-party organizations pay eligible CNA training and/or testing costs on behalf of an individual that is subsequently employed for 90 days at a MN nursing facility (as a CNA).

*Different reimbursement rules apply* when an individual pays their own CNA training and/or testing costs *or* when a facility first hires an individual (or offers to hire that individual) and subsequently sends the individual to CNA training *or* the individual attends training on their own after a promise of employment or actual employment by the facility. For more information and guidance, please contact the Department (see contact information below).

***Questions?***

MN Department of Human Services (DHS)

Munna Yasiri

[munna.yasiri@state.mn.us](mailto:munna.yasiri@state.mn.us)

9/7/17

**CNA TRAINING/TESTING COSTS**

**-SAMPLE THIRD-PARTY PAYOR REIMBURSEMENT FORM-**

(Please Print)

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **STUDENT** NAME: MARY | | K. LONG | | | Telephone (545)123-2434 |  |  | DOB: 12/1/1984 | |
| **CNA Training Provider** Name/Contact Information: | | AMERICAN RED CROSS | | | Address: | 123 MAIN ST |  | Telephone: | |
|  | | KATHY GREYSTONE | | |  | CROSSHAIRS, MN 65777 |  | (545)233-1756 | |
| **CNA EXPENSES:\*** | | |  | |  |  |  |  | |
| Expense Type: | Amount ($) | | | Date Completed: | | Notes: |  | *Cumulative* Total $ | |
| Tuition | 550.00 | | | 10/1/17 | |  |  | 550.00 | |
| Books | 50.00 | | | 10/1/17 | |  |  | 600.00 | |
| Fees | 10.00 | | | 10/15/17 | |  |  | 610.00 | |
| Required Supplies | 20.00 | | | 10/15/17 | | Not allowed-no proof |  | --- | |
| Competency Evaluation Fee | 50.00 | | | 11/30/17 | |  |  | 660.00 | |
| Transportation**\*\*** | --- | | | --- | |  |  | --- | |
| Other (please explain below): | --- | | | --- | |  |  |  | |
|  |  | | |  | |  | **(1) GRAND TOTAL :** | 660.00 | |
| I attest to the fact that the information provided is true/accurate and these amounts reflect actual expenses incurred while completing my CNA training/testing. ***Student Signature***: (signed) Mary Long **Date:** 3/1/18 | | | | | | | | |
| **THIRD-PARTY INFORMATION:** | | |  | |  |  |  |  | |
| Third-Party Payor Name/Contact: | HELPING ABE CENTER | | | Address: | | 55 MAIN ST |  | Telephone: | |
| HANNA MCLEAN |  | | |  | | CROSSHAIRS,MN 65777 |  | (545)747-3488 | |
| I certify we are a third-party payor as defined under M.S. 144A.611, that the information provided accurately reflects actual costs incurred by the student named above for CNA training and/or testing - and that our organization paid these costs on behalf of this student.  ***Third-Party Payor Signature***: (signed) HANNA MCLEAN **Date:** 3/1/18 | | | | | | | | |

**\***Attach Proof of CNA Expenses / **\*\***For Transportation Costs-Attach Transportation Log