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DHS
Oregon Department of Human Services
Seniors and People with Disabilities

Nurse Aide Training and Competency Evaluation Program
Reimbursement - Nurse Aide Training

Please present this form with receipts to nursing facility employer for reimbursement.

NA information (to be completed by NA)		
Last name:	First name:	Middle name:
Social Security Number (last 4 digits):	Birth date:	Drivers license/identification:
Training: (attach receipts)		
Approved program name:		Location:
Amount paid: $		Date of payment:
Completion date of training:		

Please affirm by signature		
☐ I have not received any payment for any of this expense from another source such as another nursing facility or training program.		
☐ I personally incurred these training costs: $		
☐ I have received payment from another source in the amount of: $		
☐ I understand that the information that I have provided is true and accurate and understand the information may be audited.		
NA signature:		Date:

Criteria for reimbursement:

- NA Personally incurred the training costs
- Employed by a nursing facility enrolled in Medicare and/or Medicaid
- Employed by a nursing facility within 12 months of completion of the nurse aide training program
- Receipts of payments for training, textbooks, other required course materials and certification fees
- Training program Certificate of Completion

Note: This reimbursement can only be paid one time and it is not available when employed in other patient or residential care settings. The reimbursement may be prorated if the NA has not been employed by the first nursing facility employer for the full 12 months following the completion of training [OAR 411-070-0470(3)].

Nursing facility documentation: (To be completed by facility and please submit copy with SDS 0451.)	
Facility name:	Authorizing signature:
Provider NPI number:	Oregon license number:
Amount paid to NA: $	Date paid: