

Commonwealth of Kentucky
Cabinet for Health and Family Services
Department for Medicaid Services

DECEMBER 2003
MAP-576 NURSE AIDE TRAINING EXPENSE REPORT AND AUTHORIZATION
FOR PAYMENT

Does your facility have a Medicaid approved Nurse Aide Training Program? _____

If not, please enter the name and address of the entity providing Nurse Aide training for your employees.

Name _____

Address _____

Phone Number _____

Nurse Aide Training Number _____

Provider Number _____

If necessary, additional pages may be completed so that all students completing training can be listed. However, only one nursing facility student to total student ratio should be calculated for all sheets and carried forward to page 1, Line B.

Ratio of Nursing Facility Student to Total Students

Line 1 Enter Number of Employee Students from Column 2 _____

Line 2 Enter Total Number of Students from Column 1 _____

Line 3 % of Students employed by the nursing facility _____

(line 1 divided by line 2)