State of Illinois
Department of Human Services

Staff Training Reimbursement Request for SNF/PED Facilities

1. SNF/PED PROVIDER NAME: _____ 2. SNF/PED MEDICAID PROVIDER NO: _____ (12 DIGITS) 3. SNF/PED FACILITY NO: _____ (7 DIGITS)

4. SNF/PED PAYEE NAME: _____ 5. SNF/PED FEIN NO: _____ (9 DIGITS)

6. Training Site No. Class/OJT		7. Training Type	8. Social Security No.	9. Name (Last, First)	10. Training Hire Date	11. Training Begin Date	12. Training End Date	13. Hourly Salary	14. Total Hrs. of Training	15. Instruction	16. Instr. Materials	17. Comp. Eval. Test	18. TABE Type

TRAINING TYPE:

D	=	DIRECT SUPPORT PERSON
DR	=	DIRECT SUPPORT PERSON RETRAINING
A	=	DEVELOPMENTAL DISABILITIES AIDE & HABILITATION AIDE
AR	=	DEVELOPMENTAL DISABILITES AIDE & HABILITATION AIDE RETRAINING
N	=	NURSING ASSISTANT/AIDE (CNA)
NC	=	NURSING ASSISTANT/AIDE (CNA) COMPETENCY BASED
NR	=	NURSING ASSISTANT/AIDE (CNA) RETRAINING
QT	=	QSP TRAIN-THE-TRAINER
Q	=	QSP TRAINING
QE	=	QSP CONTINUING EDUCATION
R	=	RESIDENTIAL DIRECTOR CORE TRAINING
MT	=	MEDICATION ADMINISTRATION TRAIN - THE - TRAINER (RN) TRAINING
M	=	MEDICATION ADMINISTRATION TRAINING (AIDE)

TABE TYPE:

S	=	SURVEY
C	=	COMPLETE BATTERY
OA	=	ABLE
OC	=	CASAS
O	=	OTHER (PLEASE INDICATE DHS APPROVED TEST)

I certify that all entries on this claim are true, accurate, and complete. I agree to keep and make available to State and Federal officials such records as are necessary to establish compliance with Department regulations and to support this claim. Records will be maintained for not less than five(5) years. I understand that payment will be made from State and Federal funds and that any false claims, statements or documents, or concealment of material facts may be cause for prosecution or other appropriate legal action. I further certify that the facility, in compliance with the Civil Rights Act of 1964 or the Rehabilitation Act of 1973, has not discriminated on the gournds of race, color, religion, sex, national origin, or disability.

Authorized signature testifies that this request for reimbursement was performed at a certified training site and/or by a certified trainer. The person signing this reimbursement request and the facility/agency may be held liable if information has been falsified.

19. AUTHORIZED SIGNATURE: _____ DATE: _____

20. CONTACT PERSON: _____ PHONE NO: _____

21. FOR DHS USE ONLY

State of Illinois
Department of Human Services

Staff Training Reimbursement Request for SNF/PED Facilities

INSTRUCTIONS FOR COMPLETION OF IL462-1209A
STAFF TRAINING REIMBURSEMENT REQUEST FOR SNF/PED FACILITIES
(Please Type or Print Legibly)

1. Enter the SNF/PED provider's name.

2. Enter the SNF/PED Medicaid provider number (FEIN - Federal Employer's Identification Number nine digits plus three digits) assigned by the Department of Healthcare and Family Services to enrolled facilities.

3. Enter the SNF/PED Facility number (7 digits) (e.g. 6000000) assigned by the Department of Public Health to enrolled facilities.

4. Enter the SNF/PED Payee Name.

5. Enter the SNF/PED 9-digit FEIN (Federal Employer's Identification Number).

6. Enter the approved Department of Public Health training site number for Direct Support Person, Developmental Disabilities Aide & Habilitation Aide or Nursing Assistant/Aide (CNA) that the individual was trained for classroom and on-the-job (OJT).

7. Enter the training type code for the type of training provided for each individual who has satisfactorily completed the course; the training type codes are listed on the IL462-1209A form.

8. Enter the Social Security Number of each individual who has satisfactorily completed the course.

9. Enter the individual's full name, using the last name, first name format.

10. Enter the individual's date of hire using MM/DD/YYYY format for Direct Support Person, Developmental Disabilities Aide & Habilitation Aide or Nursing Assistant/Aide (CNA).

11. Enter the date the training began using the MM/DD/YYYY format for Direct Support Person, Developmental Disabilities Aide & Habilitation Aide or Nursing Assistant/Aide (CNA).

12. Enter the date the training was satisfactorily completed using the MM/DD/YYYY format for all training type codes.

13. Enter the hourly salary, including fringe benefits, **actually paid to the trainee and incurred by the facility** during the training course. Do not enter the DHS maximum unless this is your incurred amount.

14. Enter the total number of training hours completed by each individual (in whole hours).

15. Enter the **actual** instruction (trainer) costs incurred **by the facility.** Do not enter the DHS maximum unless this is your actual incurred amount.

16. Enter the **actual** cost of instruction materials incurred **by the facility.** Do not enter the DHS maximum unless this is your actual incurred amount.

17. Enter the cost of IDPH competency evaluation test.

18. Enter the TABE type (Test of Adult Basic Education) code (i.e.; "S" = Survey, "C" = Complete, "OA" = ABLE, "OC" = CASAS or "O" = Other) using the type codes listed on the IL462-1209A form if the TABE or another DHS-approved test was administered.

19. After reading the certification statement, the administrator or authorized representative of the facility must sign and date the billing form. Stamped signatures are not acceptable. Only legally authorized representatives of the facility may sign this form, and only original signatures are acceptable (no faxes).

20. Please enter a contact person's name and phone number to contact in case of billing questions regarding the IL462-1209A form submitted for training reimbursement.

21. This area is "FOR DHS USE ONLY" to enter Reimbursement Request computer-assigned number.