

CNA TRAINING PROGRAM

REQUEST FOR BUDGET APPROVAL

Facility Name: _____ Contact: _____

Address: _____

Phone: _____ Fax: _____ Email: _____

Facility Fiscal Year: _____ Provider ID Number: _____

Total number of students in program: _____

Number of facility employees in program: _____

(Or those individuals signing letters of intent)

Is this program offered in conjunction with other nursing homes? Yes ___ No ___

Other facilities participating in program (If applicable):

Program beginning date: _____ Ending date: _____

Percentage of Medicaid residents in facility when program is offered: _____%.

ITEMIZED BUDGET

INSTRUCTOR TIME FOR INSTRUCTION _____ * \$ _____ = \$ _____ (1)
(Limited to 150 Hours) Hours Rate

PREPARATION TIME FOR INSTRUCTOR _____ * \$ _____ = \$ _____ (2)
(Limited to 15 Hours) Hours Rate

IF THE NUMBER OF STUDENTS EXCEED TEN - ADDITIONAL
INSTRUCTOR TIME FOR INSTRUCTION: _____ * \$ _____ = \$ _____ (3)
(Prorated) Hours Rate

TRAINING MATERIALS:

Books \$ _____

Supplies \$ _____

Competency exams \$ _____

Other (Please specify below) \$ _____

TOTAL = \$ _____ (4)

Liability insurance: = \$ _____ (5)

