ALASKA HOSPITAL & HEALTHCARE ASSOCIATION

CNA Earn and Learn Program
Expense Reimbursement Request Form

This form is to request reimbursement for expenses associated with training and certification for an individual CNA trainee. Whenever possible facilities are encouraged to support CNAs by paying costs that could be an obstacle to a trainee in completing the certification process. Eligible expenses must be based on the actual cost associated with supporting and training the specific CNA trainee named on this form.

Facility/Trainee Information:

Name of participating facility: ____

Mailing address: ____

Name of CNA trainee: ____

Dates of participation: ____

Eligible Expenses:

List eligible expenses on a per student basis - ***a separate reimbursement request must be submitted for each CNA trainee.*** Please provide the amount of each eligible expense, the total of all expenses, and also the total reimbursement requested (maximum of $4000 per CNA trainee). Receipts are not required to be submitted, but AHHA reserves the right to request detailed accounting and receipts. For costs shared among multiple CNA trainees, calculate a per student cost.

CNA Trainee wages/benefits _______
Training:
  In-house CNA training (per student cost) _______
  External CNA training program tuition & fees _______
CNA training supplies per student (stethoscope, blood pressure cuff, etc.) _______
Training textbook/workbooks _______
BLS/CPR training _______
Background check/fingerprinting/drug screen _______
Certification license and exam fees _______

Total Expenses: __________
Total Reimbursement Requested (up to $4,000) __________

Current Status of CNA Trainee:

Check all milestones met by CNA trainee so far:

___ Enrolled in CNA training
___ Completed CNA training
___ Paperwork submitted for certification exam/licensing
___ Taken CNA exam
___ Passed CNA exam
___ Employed at facility as CNA
___ Other ____________________

Training Report/Success Story:

Please provide a few sentences on CNA trainee's experience and success with the program.

I certify/attest that the above expenses were incurred and paid by our facility and, if requested, I will provide back-up documentation.

____
Signature of facility representative

____
Print Name of facility representative

____
Title

____
Date

Submit this completed form to:

AHHA, Attention: Sara Bloom
1049 W 5th Ave, Ste 200, Anchorage, AK 99501
sbloom@alaskahha.org
Phone: 907-646-1444 /Fax: 907- 646-3964