

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.*** Provide the amount of reimbursement requested for each eligible expense and the total reimbursement (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	_____
CNA Coordinator/Navigator (per students cost)	_____
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:	 _____

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