H.E.C. OPERATED AGREEMENT

-

Health Education Center, LLC
And

(Facility) _____

This agreement is executed on the _____ day of (month) _____ (year) _____ and will remain in effect until one year from the contract date, and automatically renew annually until cancelled in writing by either party.

This agreement has been developed to outline the responsibilities of both parties as it relates to online training of Nurse Aides.

Health Education Center, LLC will provide Nurse Aide Training for the above-named facility via the Kentucky Medicaid-Approved curriculum through online services and will provide the required 16 hour clinical in preparation to sit for the state competency exam.

The facility will be invoiced for services at a rate of **$450** per student and once the student is registered for the course, no refunds will be issued. This cost does not include state competency testing fees.

Health Education Center, LLC Responsibilities:

- To process the student registration and provide student access to begin the online training portion of the course.
- To maintain all student records for the required time period.
- To provide the required 16 hour clinical and skills check off at an approved clinical site.
- To provide the student with a certificate of completion on their last clinical day upon successful completion of the course.
- To communicate with nursing facilities if students fail the course or do not successfully complete the required clinical component of the course.

Nursing Facility Responsibilities:

- The nursing facility will ensure that all students registered are employed by the nursing facility.
- The nursing facility will perform the required criminal background check, abuse check and ensure that they meet the criteria for employment eligibility prior to registering students.
- The nursing facility will email student registration information to contact@healtheducationcenter.us utilizing the appropriate registration form.
- The nursing facility will provide the student with the current edition of the required textbook.
- The nursing facility will work with H.E.C. to arrange clinical dates for their students.
- The nursing facility will be responsible for assisting the student to take the state competency exam.
- The nursing facility agrees to pay **$450.00** for each student registered with Health Education Center, LLC.

This agreement is in effect as of (Date) _____ and shall remain in effect until one year from the contract date. If cancellation occurs before the contracted year, a 30 day notice in writing is required. If there is a rate change, the nursing facility will be notified in writing.

Health Education Center, LLC
39030 Vantage Place
Louisville, KY 40299
(502) 762-5151

X _____
(Authorized Signature)

Date: _____

Nursing Facility: _____
_____

Address: _____
_____

Phone: ( ) _____

X _____
(Authorized Signature)

Date: _____

Health Education Center, LLC

Nursing Facility Profile

Nursling Facility Name: _____

Complete Address: _____

Phone Number: _____

Administrator: _____

Email: _____

Please give the email where you wish to receive Invoices:

Email: _____

Do you have computer access to the internet for students? **Yes** **No**

Do you have computers available for students to complete the course? **Yes** **No**

Do you have a lab or classroom for students to practice skills? **Yes** **No**

MAP-576
(Rev. 03/21)

COMMONWEALTH OF KENTUCKY
CABINET FOR HEALTH AND FAMILY SERVICES
DEPARTMENT FOR MEDICAID SERVICES
NURSE AIDE TRAINING EXPENSE REPORT AND AUTHORIZATION FOR PAYMENT

Provider Name and Address:

_____

_____

_____

Expenses incurred are reimbursed subject to provisions of Medicaid Provider Agreement (Map – 343):
#_____
(Medicaid Provider Number)

Billing for the month of_____20____.

KY Vendor #_____

PLEASE TYPE OR PRINT ALL INFORMATION AS ILLEGIBLE REQUESTS CAN NOT BE PROCESSED

Reference #	Item Description	Units	Cost per Unit	Cost

Line A **Total Cost** _____

Line B **Enter % page 2, Line 3 (% of students employed by facility)** _____

Line C **Enter product of Line A *Line B (portion of costs related to employees)** _____

Line D **Total Medicaid Days from most recent cost report** _____

Line E **Total CNF Days from most recent cost report** _____

Line F **Line D divided by Line E (Medicaid %)** _____

Line G **Enter product of Line C *Line F (Medicaid's portion of total costs)** _____

Before Payment can be processed this certification section must be completed.

I certify that the above items represent actual costs incurred to Nurse Aide Training requirements for employees of this facility and are reimbursable under guidelines established by the Department for Medicaid Services, specifically 907 KAR 1:450. By signing and submitting this form, you are certifying you have read and agreed to the complete terms of the latest version of the **KNAT** Reimbursement contract located at https://chfs.ky.gov/agencies/dms/dpo/bpb/Pages/nursing-facilities.aspx

Date: _____

Signed: _____ (officer of administrator of facility)

Phone #

MAP-576
(Rev. 06/18)

COMMONWEALTH OF KENTUCKY
CABINET FOR HEALTH AND FAMILY SERVICES
DEPARTMENT FOR MEDICAID SERVICES

NURSE AIDE TRAINING EXPENSE REPORT AND AUTHORIZATION FOR PAYMENT

For Department for Medicaid Services Use Only

This payment report has been received and verified by: _____

Title:

This payment report is approved for payment by: _____

Title:

Column 1 Student Name	**Column 2** Facility employee? Yes or No	**Column 3** If Col. 2 is yes, enter hire date	**Column 4** Completion date of training	**Column 5** Completion date of testing

PLEASE TYPE OR PRINT ALL INFORMATION AS ILLEGIBLE REQUESTS CAN NOT BE PROCESSED

MAP-576
(Rev. 06/18)

COMMONWEALTH OF KENTUCKY
CABINET FOR HEALTH AND FAMILY SERVICES
DEPARTMENT FOR MEDICAID SERVICES
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)	