STATE OF OKLAHOMA
OKLAHOMA HEALTH CARE AUTHORITY

Nurse Aide Training Reimbursement Program
Nursing Facility Employment Verification and Expense Reimbursement Worksheet

Employee Information (Print or Type)

Last Name	First Name	MI

Address		

City	State	Zip Code

Date of Birth (Month/Day/Year)	Social Security Number

Documentation of eligible expenses must be provided; this includes receipts for fees, textbooks and or other required course materials.
Reimbursement will be made on a pro rata basis according to the following schedule, please check appropriate box:

- ☐ Length of employment equals a minimum of three months; the eligible reimbursement amount is 1/4 of eligible expenses.
- ☐ Length of employment equals a minimum of six months; the eligible reimbursement amount is 1/2 of eligible expenses.
- ☐ Length of employment equals a minimum of nine months; the eligible reimbursement amount is 3/4 of eligible expenses.
- ☐ Length of employment equals a minimum of 12 months; the eligible reimbursement amount is full reimbursement of eligible expenses.

This form is to certify that the individual listed above has been employed by this facility within a 12-month period after completing a state approved training and/or competency evaluation program.

Long Term Care Facility Name

Oklahoma Medicaid Provider Number for Long Term Care Facility
(9 digits plus alpha location code)

Facility Administrator Signature

Employment Begin Date of Nurse Aide

Employment End Date of Nurse Aide

Nurse Aide Signature

OHCA Personnel only: Send this form along with documentation to the Finance Unit