SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES

Healthy Connections MEDICAID

South Carolina Nurse Aide Training Program Application

Instructions

PROCEDURE

1. Complete the Nurse Aide Training Program Application below.
2. Attach a resume for the primary instructor listed on the Nurse Aide Training Program application Instructors (must have Inclusive dates of work and educational experience).
3. Obtain agreements from any and all nursing facilities that will be used as clinical training sites and attach a copy of each agreement. Agreements must either (a) be current that is, signed by facility authority within the past six months or (b) specify the time period for which the agreement is valid. Facility authority is the facility administrator or corporate officer who is a designated authority.
4. Classroom and Clinical Schedule (to include dates and times).
5. Copy of Sled report
6. An addendum to the South Carolina Nurse Aide Curriculum if additional information is to be taught in the program
7. Class policies procedures (attendance, grading, uniforms, confidentiality, etc.).
8. Please Ensure Application is Signed by School Official
9. Private based programs must contact the South Carolina Commission on Higher Education at 803-737-3918. Please forward a copy of your license from the Commission or a letter stating that the license is in process or letter of exemption.
10. E-Mail application along with attachments, to: SCNAR@scdhhs.gov

YOU NEED TO KNOW

- Incomplete applications will be returned, which will delay the approval of your program.
- If the application contains errors or discrepancies, you will be notified by the Department of Health and Human Services receipt of the application and you will be given an opportunity to make corrections. This may delay the date of approval of your program.
- You should allow at least 20 days from the date you mail your application before inquiring about the status of the application.
- Programs offered in or by nursing facilities that have been subject to one or more of the following actions will not be approved,
    - waiver for nursing services;
    - extended or partially extended survey;
    - assessment of civil money penalty in excess of $10,314;
    - denial of payment for new admissions for Medicare/Medicaid;
    - trustee appointment for resident safety;
    - termination from Medicare/Medicaid; and/or
    - closure of facility.

Direct questions to:SCNAR@scdhhs.gov

Nurse Aide Training Program Name:	
If the name of the Nurse Aide Training Program is different from above enter name here:	
Check Application Type: ☐ **New** ☐ **Renewal** Program Code_____ ☐ **Change** Program Code _____	• Check **NEW** for initial application or if program is not currently approved. • Check **RENEWAL** if program is currently approved and you have received DHHS renewal notice. • Check **CHANGE** if program is currently approved and you are requesting approval for program changes. Completed entries for all items that have changed and certify changes by signature administrative authority.

Check Program Category:
☐ High School ☐ Community College ☐ Private ☐ Nursing Facility

Contact/Mailing Address: Enter the single, physical address and telephone number for the training program. All correspondence from SCDHHS and will be sent to this address and all SCDHHS onsite Nurse Aide Training & Competency Evaluation Program (NATCEP) surveys will be conducted at this address.

Street:		
City	State:	Zip code
Contact #:		Fax #:

Classroom Location: Enter a single classroom name and location. If different from contact/mailing address

Name:		
Street		
City	State	Zip Code

Check responses to the following questions:

a.	Does this program teach SC Curriculum for Nurse Aides in Long Term Care Facilities?	Yes ☐ No ☐
b.	Does this program include a minimum of 60 hours of classroom and skills training that does not involve direct care of residents by trainees?	Yes ☐ No ☐
c.	Does this program include a minimum of 40 hours of clinical training defined as hands-on care of residents by trainees under the direct supervision of a licensed nurse?	Yes ☐ No ☐
d.	Does this program exceed **both** the curriculum content and minimum hours indicated above? If Yes, enter total number of hours offered:	Yes ☐ No ☐
e.	Does this program have adequate textbooks, audio-visual materials and other supplies and equipment necessary for training?	Yes ☐ No ☐

f.	Do the classroom and skills training rooms provide for adequate space, cleanliness, safety, lighting and temperature controls to promote safe and effective learning?	Yes ☐ No ☐

Clinical Training Site(s): In the space(s) provided below, list all certified nursing facilities that will be used for the required 40 hours of clinical training for the NATCEP. Complete this section even if the clinical site is already listed in the Mailing Address and Classroom Location. **Note:** You must attach a current agreement letter for each facility listed **and** all clinical training and testing must be conducted at a facility listed on this application. (Additional sites may be listed on a separate sheet.)

Facility Name:			Facility ID:
Street			
City	State	Zip Code	Contact #

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Street			
City	State	Zip Code	Contact #

Administrative Authority: Enter the name of the individual who will have administrative authority for the program. This may be an administrator of the facility or school or the designated program director. This individual must sign all correspondence from SCDHHS will be directed to this individual. **Ex. DON, High School principal/administrator**.

Name:	Title:
Telephone #:	E-mail Address:
Primary Instructor:	
Name	E-mail Address:
SC RN License #	

Check responses to the following questions about the program director (please attach resume):

a	Does the primary instructor have at least two (2) years of nursing experience?	Yes ☐ No ☐
b	Is at least one (1) year of the required nursing experience in the provision of long-term care facility services in a nursing facility or skilled nursing facility?	Yes ☐ No ☐
c	Has the primary instructor completed a course in teaching adults or have experience in teaching adults or supervising nurse aides?	Yes ☐ No ☐
d	NATCEPs must ensure that trainees meet the requirements listed in the South Carolina Nurse Aide Candidate Handbook. Trainees may not be listed on the NAR in revoked status or have been found to have a conviction of a criminal offense. By signing this statement I am acknowledging that I am aware of this requirement.	Yes ☐ No ☐

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Signature- **Administrative Authority**

Program Instructor(s) List the name(s) and requested information below for individuals who will conduct the actual NATCEP training. Please attach resume.		
Names :	Discipline: RN/LPN/LVN License #	Does the Instructor have at least one year of nursing experience in a LTC Facility?

Attestation

I certify that the following is true:

a) Our program follows the South Carolina Commission of Education Nurse Aide Training Curriculum Model.
b) There is sufficient space available for training and is environmentally controlled.
c) Equipment and supplies are available to ensure that each student has the ability to meet course objectives.
d) The program is in compliance with Federal and State requirements.
e) The information included in this application is complete and true.

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Signature- **Administrative Authority**

South Carolina Department of Health and Human Services
Nurse Aide Training Program
Community and Facility Services
P.O. Box 8206
Columbia, SC 29202
SCNAR@scdhhs.gov