RFA #34349-09123 Reimbursement for Medication Aide Certification

Reimbursement Dates of February 15, 2023 through March 31, 2023

Section 1: Demographics

1. Legal Facility Name where training was attended:

   _____

2. Date training completed: _____

3. Are you currently a vendor with the State: Yes ☐ No ☐ If no, please click the link below to register for a Unique Entity ID: https://sam.gov/content/home

4. FACILITY completing this application [disregard If individual applying]:

   Name of Healthcare facility: _____

   Contact name: _____

   Mailing Address: _____

   Email Address: _____

   Phone Number: _____

   Number of licensed beds in Facility? _____

   Name of employee(s) for reimbursement:

   _____
   (Name) (Title) (Medication Certification #)

   _____
   (Name) (Title) (Medication Certification #)

   _____
   (Name) (Title) (Medication Certification #)

_____

(Name) (Title) (Medication Certification #)

Signature from Facility contact: _____

5. INDIVIDUAL completing this application [disregard if facility applying]:

   Applicant name: _____

   Mailing Address: _____

   Email Address: _____

   Phone Number: _____

   Title: _____

   Medication Certification # _____

   Name of Healthcare facility employed: _____

   Address of Healthcare facility employed: _____

   Number of licensed beds in Facility? _____

   Signature from Individual: _____

   Supervisor's Signature: _____

Section 2: Application

1. Briefly describe the facility plan once the training is completed.

2. List the benefits facilities hope to obtain from this training:

3. How will this training impact the workload at your facility?