Reset Form

APPLICATION FOR APPROVAL TO OPERATE A NURSE AIDE OR A QUALIFIED MEDICATION AIDE TRAINING PROGRAM

State Form 629 (R6 / 2-24)
INDIANA DEPARTMENT OF HEALTH
CONSUMER SERVICES AND HEALTH CARE REGULATION

INSTRUCTIONS: **This original application MUST be available upon request and/or at time of survey.*
- *Submit this application and additional required documentation electronically to IDOHLTCTrainingPrograms@health.in.gov.*
- ***Submit a separate application for each type of program requesting approval or change**. (i.e. 1 for NAT requests and 1 for QMAT requests)*

SECTION 1: Program Information

IDOH Use only

Program Name: _____
Address: _____
City: _____ State: _____ ZIP: _____
Email Address: _____
Phone: _____
Name & Title of Contact Person #1: _____
Contact Person Phone & Email: _____
Name & Title of Contact Person #2: _____
Contact Person Phone & Email: _____
Owner's Name: _____
Owner's Email: _____ Owner's Phone: _____

Please, immediately submit any changes to the information above to IDOHLTCTrainingPrograms@health.in.gov

☐ Approved
☐ Not Approved

SECTION 2: Program Approval or Renewal Request

IDOH Use only

Facility #:

REQUEST for: ☐ NAT ☐ QMAT

You must submit a SEPARATE application for each type of program requesting approval or change.

If you are requesting approval for a QMA training program, will you offer the Insulin Administration Education Module? ☐ Yes ☐ No ☐ Not Applicable

NATCEP ban dates:
N/A: _____
Exp: _____

☐ **Initial Approval** ☐ **Renewal**
Program Type: ☐ Facility Based ☐ Non-facility Based ☐ Vocational/Academic
☐ Other: _____

Training Modality: ☐ Traditional Classroom ☐ Hybrid – Online ☐ Other _____

☐ **Change(s) to Current Approved Program**
Program Changes: ☐ Classroom ☐ Clinical Sites ☐ Curriculum/Modality
☐ Address ☐ Program Director/Instructor ☐ Ownership ☐ Name

SECTION 3: Classroom Location (See Section 7 for Additional Required Documents)

IDOH Use only

☐ Add ☐ Delete ☐ Information change
Name: _____
Address: _____
City: _____ State: _____ ZIP: _____
Phone: _____

☐ Approved
☐ Not Approved

☐ Add ☐ Delete ☐ Information change
Name: _____
Address: _____
City: _____ State: _____ ZIP: _____
Phone: _____

☐ Approved
☐ Not Approved

SECTION 4: Clinical Site (if needed, use additional copies of this page)	**IDOH Use only**
☐ Add ☐ Delete ☐ Information change Name: ______ Address: ______ City: ______ State: ______ ZIP: ______ Phone: ______	☐ Approved ☐ Not Approved
☐ Add ☐ Delete ☐ Information change Name: ______ Address: ______ City: ______ State: ______ ZIP: ______ Phone: ______	☐ Approved ☐ Not Approved
☐ Add ☐ Delete ☐ Information change Name: ______ Address: ______ City: ______ State: ______ ZIP: ______ Phone: ______	☐ Approved ☐ Not Approved
☐ Add ☐ Delete ☐ Information change Name: ______ Address: ______ City: ______ State: ______ ZIP: ______ Phone: ______	☐ Approved ☐ Not Approved
☐ Add ☐ Delete ☐ Information change Name: ______ Address: ______ City: ______ State: ______ ZIP: ______ Phone: ______	☐ Approved ☐ Not Approved
☐ Add ☐ Delete ☐ Information change Name: ______ Address: ______ City: ______ State: ______ ZIP: ______ Phone: ______	☐ Approved ☐ Not Approved
☐ Add ☐ Delete ☐ Information change Name: ______ Address: ______ City: ______ State: ______ ZIP: ______ Phone: ______	☐ Approved ☐ Not Approved
☐ Add ☐ Delete ☐ Information change Name: ______ Address: ______ City: ______ State: ______ ZIP: ______ Phone: ______	☐ Approved ☐ Not Approved
☐ Add ☐ Delete ☐ Information change Name: ______ Address: ______ City: ______ State: ______ ZIP: ______ Phone: ______	☐ Approved ☐ Not Approved

SECTION 5: Program Director (PD) /Delegated Instructor (DI) /Program Instructor (PI)

IDOH Use only

Note: In order to initiate the application review process to add a NAT Program Director (must be an RN), a NAT Delegated Instructor (must be an RN or an LPN,) or a QMA Program Instructor (must be an RN), the following MUST be submitted at the same time as this application.

- Copy of nursing license
- Copy of vocational license, or equivalent, if applicable
- Copy of Certified Nurse Aide or Qualified Medication Aide Train the Trainer Course Certificate
- Brief resume of long-term care and teaching experience, including locations and dates

☐ Add ☐ Delete *(Facility based program only – Director of Nursing* ☐ *Yes* ☐ *No)*
Name: _____ ☐ PD ☐ DI ☐ PI
☐ Approved ☐ Not Approved

☐ Add ☐ Delete *(Facility based program only – Director of Nursing* ☐ *Yes* ☐ *No)*
Name: _____ ☐ PD ☐ DI ☐ PI
☐ Approved ☐ Not Approved

☐ Add ☐ Delete *(Facility based program only – Director of Nursing* ☐ *Yes* ☐ *No)*
Name: _____ ☐ PD ☐ DI ☐ PI
☐ Approved ☐ Not Approved

☐ Add ☐ Delete *(Facility based program only – Director of Nursing* ☐ *Yes* ☐ *No)*
Name: _____ ☐ PD ☐DI ☐ PI
☐ Approved ☐ Not Approved

☐ Add ☐ Delete *(Facility based program only – Director of Nursing* ☐*Yes* ☐ *No)*
Name: _____ ☐ PD ☐DI ☐ PI
☐ Approved ☐ Not Approved

☐ Add ☐ Delete *(Facility based program only – Director of Nursing* ☐ *Yes* ☐ *No)*
Name: _____ ☐ PD ☐DI ☐ PI
☐ Approved ☐ Not Approved

SECTION 6: Curriculum

IDOH Use only

Curriculum: ☐ Add ☐Delete
Explanation of Change:
_____
_____
_____
☐ Approved ☐ Not Approved

Curriculum: ☐ Add ☐ Delete
Explanation of Change:
_____
_____
_____
☐ Approved ☐ Not Approved

SECTION 7: Additional Required Documentation

IDOH Use only

Initial Approval of NAT Program:
To initiate the application review process, the following information MUST be submitted at the same time as this application.

1. Pictures of classroom & clinical lab with supplies/equipment – (2-3 pictures each)
2. Copy of sample clinical agreement
3. Form(s) for classroom time record and clinical time record
4. Certificate of completion for the student – must state student's name "has successfully completed the Indiana State Department of Health 105-hour Nurse Aide Training Program," must have area for signature and date of program director and must have name and address of training entity.
5. List of items that will be kept in the student file
6. Final exam – comprehensive with all lessons
7. Signed and dated supply list
8. Outline of classroom lesson plan with day, timeframes, and content to be completed, including Core Curriculum lessons, RCPs, videos, YouTube, textbooks, handouts, and any other resources.
9. Student pre-admission math/reading assessment/test
10. Copy of the Train the Trainer certificate of completion and nursing license for each program director and/or instructor

Approved - A
Not Approved - NA
1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

Initial Approval of QMAT Program:
To initiate the application review process, the following information MUST be submitted at the same time as this application.

1. Student pre-admission math/reading assessment/test
2. Letter indicating the IDOH QMA curriculum will be followed or a copy of the program specific lesson plans
3. Supply list (signed and dated) indicating all supplies are available.
4. List of items that will be included in each student file
5. Copy of classroom time record for each student
6. Copy of clinical site agreements – NOTE: All QMA training sites MUST have clinical site approval for every clinical site used by students.
7. Picture of current drug book that will be given to each student to keep
8. Pictures of classroom and Medication cart with medications (2-3 pictures each)
9. Copy of the Train the Trainer certificate of completion and nursing license for each program director and/or instructor

Approved - A
Not Approved - NA
1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

Addition of Classroom: In order to initiate the application review process, the following information MUST be submitted at the same time as this application.

1. Letter stating the new classroom site will:
   A. Use the approved training curriculum and
   B. All the necessary supplies and equipment are available
2. Pictures of classroom and clinical lab (2-3 pictures of each.)

Approved - A
Not Approved - NA
1-A. _____
1-B. _____
2. _____

SECTION 8: Certification of NAT Program

IDOH Use only

I certify that the Nurse Aide Training Program will be conducted in accordance with 410 IAC 16.2-3.1- 14, 42 USC 1395i-3, 42 USC 1396r, 42 CFR 483.150 through 42 CFR 483.160, the Core Curriculum for the Indiana Nurse Aide Training Program, CMS State Operations Manual, Chapter 4, 4132, and any other standards for Nurse Aide Training programs established by the Indiana Department of Health. I certify that adequate records will be maintained and made available to IDOH surveyors, in order to determine compliance with those standards. I certify that all facilities listed on this application do not have a current ban on nurse aide training.

☐ Approved
☐ Not Approved

_____ _____
Signature of facility Administrator OR Director of non-facility-based program Date (month, day, year)

SECTION 9: Certification of QMAT Program

IDOH Use only

I certify the Qualified Medication Aide Training Program will be conducted in accordance with the Indiana Administrative Code requirements for QMA Training, the Core Curriculum for Indiana QMA Training Programs, and any other standards for QMA Training Programs established by the Indiana Department of Health. I certify adequate records will be maintained and made available to IDOH surveyors, in order to determine compliance with those standards. I certify the administrator of this program, as well as other personnel (including owners, officers, principals and vested partners,) have never been subject to a revocation of approval of a Qualified Medication Aide Training Program.

☐ Approved
☐ Not Approved

_____ _____
Signature of facility Administrator OR Director of non-facility-based program Date (month, day, year)

Explanation of Minimum Requirement(s) Not Met:

NOTES: