

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

State Form 629 (R7 / 5-25)
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 <a href="mailto:aidetraining@health.in.gov">aidetraining@health.in.gov</a>.
- **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  Program Name: Address: City: 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:  Owner's Phone:
Address: State: ZIP: Not Approved Not Approved Not Approved Not Approved Not Approved Not Approved Name & Title of Contact Person #1: Contact Person Phone & Email:
Email Address:
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:
Name & Title of Contact Person #2:  Contact Person Phone & Email:  Owner's Name:
Name & Title of Contact Person #2:  Contact Person Phone & Email:  Owner's Name:
Contact Person Phone & Email: Owner's Name:
Contact Person Phone & Email: Owner's Name:
Owner's Name:
Ourser's Presil
Owner's Email: Owner's Phone:
Owner's Email:
Please, immediately submit any changes to the information above to aidetraining@health.in.gov
SECTION 2: Program Approval or Renewal Request IDOH Use only
REQUEST for:
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:
□ Initial Approval □ Renewal N/A:
Program Type: ☐ Facility Based ☐ Non-facility Based ☐ Vocational/Academic
Other:
Training Modality:   Traditional Classroom Hybrid – Online Other  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)
☐ Add ☐ Delete ☐ Information change
Name: Approved Not Approved
Address:
City:State:ZIP:
Phone:
☐ Add ☐ Delete ☐ Information change
Name: Approved
Address: Not Approved
City:State:ZIP:
Phone:

SECTIO	ON 4: Clini	cal Site (if needed, use additional	copies of this page)	IDOH Use only
☐ Add Name:	☐ Delete	☐ Information change		□ Approved □ Not Approved
City:		State:	ZIP:	
Name:		☐ Information change		□ Approved □ Not Approved
City:		State:	ZIP:	
Name:		☐ Information change		□ Approved □ Not Approved
City:		State:	ZIP:	
Name:		☐ Information change	_	□ Approved □ Not Approved
City:		State:	ZIP:	Thet/pproved
Name:		☐ Information change		□ Approved
Address: City:		State:	ZIP:	□ Not Approved
		☐ Information change		□ Approved
Address: City:		State:		□ Not Approved
		☐ Information change		□ Approved
Address: City:		State:	ZIP:	□ Not Approved
□ Add	☐ Delete	☐ Information change		Ammanyad
Address: City:		State:	ZIP:	□ Approved □ Not Approved
□ Add	☐ Delete	☐ Information change		□ Approved
City:		State:	ZIP:	□ Not Approved

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

SECTION 7: Additional Required Documentation	IDOH Use only
<ul> <li>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 &amp; 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</li> </ul>	Approved - A Not Approved - NA 1 2 3 4 5 6 7 8 9 10
<ul> <li>Initial Approval of QMAT Program: To initiate the application review process, the following information MUST be submitted at the same time as this application. <ol> <li>Student pre-admission math/reading assessment/test</li> <li>Letter indicating the IDOH QMA curriculum will be followed or a copy of the program specific lesson plans</li> <li>Supply list (signed and dated) indicating all supplies are available.</li> <li>List of items that will be included in each student file</li> <li>Copy of classroom time record for each student</li> <li>Copy of clinical site agreements – NOTE: All QMA training sites MUST have clinical site approval for every clinical site used by students.</li> <li>Picture of current drug book that will be given to each student to keep</li> <li>Pictures of classroom and Medication cart with medications (2-3 pictures each)</li> <li>Copy of the Train the Trainer certificate of completion and nursing license for each program director and/or instructor</li> </ol> </li> </ul>	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.  Signature of facility Administrator OR Director of non-facility-based program Date (month, day, year)	□ Approved □ Not Approved
Explanation of Minimum Requirement(s) Not Met:	
NOTES:	