**ARKANSAS DEPARTMENT OF HUMAN SERVICES**

**DIVISION OF PROVIDER SERVICES AND QUALITY ASSURANCE**

**NURSING ASSISTANT TRAINING PROGRAM**

**SLOT S405**

**P. O. BOX 8059**

**LITTLE ROCK, AR 72203-8059**

**natpcertification@dhs.arkansas.gov TDD: 501-682-6789**

**NURSING ASSISTANT TRAINING PROGRAM (NATP)**

**APPLICATION INSTRUCTIONS**

1. Review Rules for the Arkansas Long Term Care Facility Nursing Assistant Training Program. Pay special attention to Section IV. B. Implementation Requirements, C. Nursing Assistant Trainee Activities, and Section V.
2. Respond to all application items in compliance with the standards (above) and as required within instructions for each item.
3. Obtain agreements from any and all nursing facilities that will be used as clinical training or testing sites and attach a copy of each agreement. Agreements must either (a) be current, i.e. 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. Email application with original notarized signatures along with attachments to:

[natpcertification@dhs.arkansas.gov](mailto:natpcertification@dhs.arkansas.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 within 15 days of Department's 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.
* Training shall not be conducted until approval for instructors, classrooms and/or clinical sites has been received by the training program.
* Programs offered in or by nursing facilities that have been subject to one or more of the following actions will not be approved as per Arkansas Code 20-70-01 et seq.:

1. Waiver for nurse staffing requirements in excess of 48 hours during the week;
2. Extended or partial extended survey\*;
3. Assessment of civil money penalty in excess of $5000;
4. Denial of payment for new admissions for Medicare/Medicaid;
5. Appointment of temporary management;
6. Transfer of residents;
7. Termination from Medicare/Medicaid;
8. Closure of facility.

\* Extended survey is defined for this provision as a survey that includes a review of facility policy and procedures pertinent to Level A deficiencies in Resident Rights, Resident Behavior and Facility Practices, Quality of Life, or Quality of Care. Partial extended survey is defined as a survey conducted as a result of a deficiency in Level A requirements other than those listed above in the extended survey definition.

* Nursing facilities that are prohibited due to one of the actions above will not be approved as a clinical training or testing site for any nursing assistant training program. Sanctioned nursing facilities may apply for a training waiver by submitting a written request to this office.
* Public training programs MUST contact the Arkansas Department of Higher Education, 423 Main Street, Little Rock, AR 72201, 501-371-2000, to apply for a license to operate a proprietary educational program in Arkansas.

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**APPLICATION FOR NURSING ASSISTANT TRAINING PROGRAM**

|  |  |  |
| --- | --- | --- |
| **1.** | **Enter Nursing Assistant Training Program Name:** | |
|  | **If the name of the Nursing Assistant Training Program has changed, enter the new name here:** | |
| **2.** | **Check application type:** | |
|  | **NEW** | Check **NEW** for initial application or if program is not currently approved. |
|  | **RENEWAL**  NATP Code # | Check **RENEWAL** if program is currently approved and you have received ADHS Renewal notice. |
|  | **CHANGE**  NATP Code # | Check **CHANGE** if program is currently approved and you are requesting approval for program changes. Complete entries for **all** items that have changed  & certify changes by signature in Block #10 of this application. |

|  |  |
| --- | --- |
| **3.** | **Check Program Category:** |
|  | **Non-facility based** program (not offered in or by a facility) |
|  | **Facility-based program** (offered in and by a facility) |
|  | *Note: Applications under Arkansas Code 20-10-701 et seq. may not be completed by the facility that has been prohibited from training. The Department shall not approve a program offered by or in a nursing facility which, in the previous two years: a) has operated under a waiver of the nurse staffing requirements in excess of 48 hours during the week; b) has been subject to an extended (or partial extended) survey; or c) has been subject to a civil money penalty of not less than*  *$5,000, denial of payment, appointment of temporary management, closure, or transfer of residents.* |

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| --- | --- | --- | --- |
| **4.** | **Primary Instructor Name:** | | E-Mail Address: |
| Arkansas R.N. License Number: | | | Social Security Number: |
| **Yes** | **No** | **Check responses to the following questions about the Primary Instructor:** | |
|  |  | **a**. Does the Primary Instructor have at least two (2) years of nursing experience? | |
|  |  | **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? | |
|  |  | **c.** Has the Primary Instructor completed a course in teaching adults **or** have experience in teaching adults or supervising Nursing Assistants? | |

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| **5.** | **Contact/Mailing Address**: Enter a single, physical address and telephone number for the training program. All correspondence from the Department will be sent to this address and all on-site NATP surveys will be conducted at this address. | | | |
| Street | | | | |
| City | | ST | Zip Code | Phone  ( ) |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **6.** | **Additional Instructor(s):** List the name(s) and requested information below for individuals who will conduct the actual NATP training. Attach a copy of each instructor’s current Arkansas nursing license. | | | | |
| **Name:** | | **Discipline:** | | **Does Instructor have at least one (1) year of nursing experience in a long term care facility?** | |
| **RN** | **LPN** | **Yes** | **No** |
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| **7.** | **Classroom Location:** Enter a single classroom name and location. Attach additional sheets as needed. | | | |
| Name | | | | |
| Street | | | | |
| City | | ST | Zip Code | Phone  ( ) |

|  |  |  |
| --- | --- | --- |
| **8.** | **Please check responses to the following questions:** | |
| **Yes** | **No** |  |
|  |  | **a.** Does this program teach the Arkansas Curriculum for Nursing Assistants in Long Term Care Facilities? |
|  |  | **b.** Does this program exceed both the curriculum content and minimum hours indicated above? If Yes, enter the number of hours offered: Classroom: Clinical: |
|  |  | **c.** Does this program have adequate textbooks, audio-visual materials and other supplies and equipment necessary for training? |
|  |  | **d.** Do the classroom and skills training rooms provide for adequate space, cleanliness, safety, lighting and temperature controls to promote safe and effective learning? |

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| **9.** | **Clinical Training Site(s):** In the space(s) provided below, list all certified nursing facilities that will be used for the required clinical training for the NATP. (Additional sites may be listed on a separate sheet). | | | |
| **a.** | Facility Name | | | |
| Street | | | | |
| City | | ST | Zip Code | Phone  ( ) |
| **b.** | Facility Name | | | |
| Street | | | | |
| City | | ST | Zip Code | Phone  ( ) |

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| --- | --- | --- |
| **10.** | I certify that the information submitted in this application and attachments is true and correct. I agree to provide prior notification to the Department of any change in information presented in this application by submitting a Program Change Application as required. I acknowledge that failure to comply with Arkansas DHS Rules for the Arkansas Long Term Care Facility Nursing Assistant Training Program may result in withdrawal of NATP approval. | |
| Signature of Primary Instructor (MUST be signed before a notary).  Sworn and subscribed before me on this day of , 20  In County, in the State of  Notary Signature: | | (Notary Stamp/Seal): |