**FOR DHSR USE ONLY:**

* Date DHSR Received Document From Training Program (mm/dd/yyyy):
* Status Determination of Document (Approved or Denied):
* Date Status Determination Communicated to Training Program (mm/dd/yyyy):
* Review Completed By:

**INSTRUCTIONS:**

* Complete the application if the following modifications are being made to an existing State-approved training program.
* Instructor/Student Ratios
* Classroom
* Laboratory
* Faculty Orientation and In-Service
* Monitoring/Maintenance of Student Records
* Student Grading Policy
* Student Identification Process
* Attendance
* Withdrawal of a Program
* For questions and/or modifications that do not apply to the training program, please leave blank.
* Submit the required documentation with the application for review and approval.
* You may type your response in the space provided.
* Approval from the North Carolina Division of Health Service Regulation (DHSR) is required prior to modifications being implemented in the training program.
* The Program Coordinator must sign the document.
* Email or fax completed documents to DHSR. Incomplete documents will be denied. You must submit all pages of the document.
  + Email: [DHSR.EducationConsultant@dhhs.nc.gov](mailto:DHSR.EducationConsultant@dhhs.nc.gov)
  + Fax: 919-733-9764
* Contact your [Education Consultant](https://info.ncdhhs.gov/dhsr/hcpr/consultants.html) with any questions or concerns.

**PROGRAM INFORMATION:**

1. **Date Submitted to DHSR (mm/dd/yyyy):**

|  |
| --- |
| 1. **Name of School:** 2. **Name of Training Program:** |

|  |  |
| --- | --- |
| 1. **Mailing Address:** | |
| * Street: | |
| * City: * Zip Code: * County: | |
| 1. **Site Address:**  * Street: | |
| * City: * Zip Code: * County: | |

1. **Program Administrator:**

* Name:
* Title:
* Telephone (include area code):
* Email:

1. **Program Coordinator:**

* Name:
* Telephone (include area code):
* Email:
* Fax (include area code):

1. **Program Modification Type:**

Place an X beside the correct response. Select all that apply.

* Classroom:
* Laboratory:
* Instructor/Student Ratios:
* Faculty Orientation and In-Service:
* Monitoring/Maintenance of Student Records:
* Student Grading Policy:
* Student Identification Process:
* Attendance:
* Withdrawal of a Program:

1. **Training Program Number:**

Provide the training program number associated with the modification.

* Nurse Aide I Training Program:
* Nurse Aide I Refresher Training Program:
* Geriatric Aide Training Program:
* Home Care Specialty Training for Nurse Aides Program:

*Important Notice:*

Include all training program numbers associated with the modification.

1. **Program Type:**

Place an X beside the correct response.

* Community College:
* Proprietary School:
* State Mental Health Facility:
* Nursing Home:
* Hospital:
* Other:       If Selected, Please Specify the Type of Training Facility:

1. **Community College Only:**

Place an X beside the correct response.

* Continuing Education:
* Curriculum:
* Career and College Promise:

1. **Instructor/Student Ratios:**

Complete the instructor/student ratios in the table below.

|  |  |  |
| --- | --- | --- |
| Classroom | 1 instructor per | students |
| Online (if applicable) | 1 instructor per | students |
| Laboratory | 1 instructor per | students |
| Clinical | 1 instructor per | students |

*Important Notices:*

* Per [21 NCAC 36.0318](http://reports.oah.state.nc.us/ncac/title%2021%20-%20occupational%20licensing%20boards%20and%20commissions/chapter%2036%20-%20nursing/21%20ncac%2036%20.0318.pdf), the instructor-to-student ratio for clinical cannot be greater than 1:10.
* Approval from the North Carolina Division of Health Service Regulation is required prior to modifications being implemented in the training program.

1. **Classroom:**

Place an X beside all that apply.

* Modifying an existing classroom:
* Relocating to a new classroom:
* Adding a new classroom:

Complete the items below.

* Facility name:
* Room number:
* Location/Site address:
* Building:
* The classroom has tables and chairs to accommodate       students

Attach a diagram (may be hand drawn) that includes the items listed below. All items in the drawing must be labeled.

* Facility name
* Room number
* Location/Site address
* Building
* Room dimensions (length, width, square footage)
  + Note: length x width = square footage
* Physical layout (dry erase board/smart technology, tables, chairs, desks, instructor desk, audio-visual equipment, and any other furniture)

*Important Notice*:

Approval from the North Carolina Division of Health Service Regulation is required prior to modifications being implemented in the training program.

1. **Laboratory:**

Each Nurse Aide I training program laboratory must be set up similar to a resident’s room. This includes the equipment and supplies normally found in a resident’s room. This also includes the items listed in the [Existing Training Program – Basic Equipment and Supply List](https://info.ncdhhs.gov/dhsr/hcpr/nat.html#TP), to use for skills instruction, practice and return demonstration. Each laboratory must contain a minimum of 100 square feet for one bed or a minimum of 80 square feet per bed for two or more beds.

Place an X beside all that apply.

* Modifying an existing laboratory:
* Relocating to a new laboratory:
* Adding a new laboratory:

Complete the items below.

* Facility name:
* Room number:
* Location/Site address:
* Building:
* Number of beds:

Attach a diagram (may be hand drawn) that includes the items listed below. All items in the drawing must be labeled.

* Facility name
* Room number
* Location/Site address
* Building
* Room dimensions (length, width, square footage)
  + Note: length x width = square footage
* Physical layout (each resident area must include a resident bed, bedside table, over-bed table, chair, non-functioning call signal, wastebasket, privacy curtain hung from the ceiling that surrounds the area and provides 100% privacy, sink, and any other furniture deemed necessary).

*Important Notices*:

* A laboratory for a Home Care Specialty Training for Nurse Aides Program must closely resemble a home environment.
* Approval from the North Carolina Division of Health Service Regulation is required prior to modifications being implemented in the training program.

1. **Faculty Orientation and In-Service:**

Briefly describe the new process:

*Important Notice:*

Approval from the North Carolina Division of Health Service Regulation is required prior to modifications being implemented in the training program.

1. **Monitoring/Maintenance of Student Records:**

Briefly describe the new process and provide the location of student records:

*Important Notice:*

Approval from the North Carolina Division of Health Service Regulation is required prior to modifications being implemented in the training program.

1. **Student Grading Policy:**

Theory Component

To successfully complete the training program, students must achieve a minimum passing grade of 75 in the theory component. Derivation of the theory grade may consist of tests, a comprehensive exam, quizzes, homework/activities, a project, etc. Each component must include a weighted percentage and when totaled, the percentage must equal 100%.

Provide the minimum theory passing grade for the training program:

List each item which contributes to the theory component grade. Refer to the example below.

**Example Only:**

|  |  |
| --- | --- |
| Theory Component: 5 Quizzes (Each Quiz Equals 4%) | Weight: 20 % |

**To Be Completed By The Training Program:**

|  |  |
| --- | --- |
| Theory Component: | Weight:       % |
| Theory Component: | Weight:       % |
| Theory Component: | Weight:       % |
| Theory Component: | Weight:       % |
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| Theory Component: | Weight:       % |
| Theory Component: | Weight:       % |
| **Total Weight** | **100%** |

Practical Component

To pass the practical (laboratory and clinical) portion of the training program, students must be proficient in demonstrating skills.

* At a minimum, each starred skill for laboratory (located in [Appendix A](https://info.ncdhhs.gov/dhsr/hcpr/curriculum/pdf/appendixA.pdf) in the state-approved curriculum).
* At a minimum, fifteen (15) starred skills for clinical (located in [Appendix A](https://info.ncdhhs.gov/dhsr/hcpr/curriculum/pdf/appendixA.pdf) in the state-approved curriculum).

Proficiency is defined as the ability to perform a skill in a competent and safe manner.

In order to be deemed proficient, the student must perform      % of steps correctly for each required skill. In addition, students must correctly perform each predetermined critical step for each required skill.

Laboratory and clinical components are graded as pass/fail, based on the program’s definition of proficiency and student performance on skills.

Provide additional criteria for demonstration of proficiency (if applicable):

*Important Notices:*

* Per [42 CFR §483.152,](https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-G/part-483/subpart-D/section-483.152) students cannot perform any services to residents for which they have not been trained and found proficient by the Instructor.
* Approval from the North Carolina Division of Health Service Regulation is required prior to modifications being implemented in the training program.

1. **Student Identification Process:**

Briefly describe the new process:

Refer to the [North Carolina Board of Nursing](https://www.ncbon.com/badge-lawlicense-required-exceptions) for more information.

*Important Notice:*

Approval from the North Carolina Division of Health Service Regulation is required prior to modifications being implemented in the training program.

1. **Attendance:**

Successful completion of the training program is dependent upon the student completing a minimum of       clock hours (your total program hours minus the hours your program allows by policy for absences) of instruction.

All missed classroom, laboratory and clinical experiences must be completed in order for the student to successfully complete the training program and take the North Carolina State-approved competency evaluation.

*Important Notice*:

Approval from the North Carolina Division of Health Service Regulation is required prior to modifications being implemented in the training program.

1. **Withdrawal of a Program:**

List the training program number(s) being withdrawn:

Please provide the reason for the withdrawal of the training program:

1. **Other Modifications:**

Complete the documents below if the following modifications are being made to an existing State-approved training program.

* Program (Clock) Hours, Course Schedule, or Supplemental Teaching Methodology (Instructional Resource):
  + [Existing Training Program – Course Schedule and Supplemental Teaching Methodology Form](https://test.ncdhhs.gov/dhsr/hcpr/nat.html#TP).
* Faculty:
  + [Existing Training Program – Faculty Approval Request Form](https://test.ncdhhs.gov/dhsr/hcpr/nat.html#TP).
  + [Existing Training Program – Faculty Removal Form](https://test.ncdhhs.gov/dhsr/hcpr/nat.html#TP).
* Clinical Site:
  + [Existing Training Program – Clinical Site Approval Form](https://test.ncdhhs.gov/dhsr/hcpr/nat.html#TP).
  + [Existing Training Program – Clinical Site Removal Form](https://test.ncdhhs.gov/dhsr/hcpr/nat.html#TP).

1. **Statement of Understanding:**

* I understand that the training program must meet the requirements set forth by federal and state rules, regulations, and requirements.
* I understand, per [42 CFR §483.152](https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-G/part-483/subpart-D/section-483.152), that students cannot perform any services to residents for which they have not been trained and found proficient by the Instructor.
* I understand, per [42 CFR §483.151](https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-G/part-483/subpart-D/section-483.151), that the approval of the training program must be renewed by the North Carolina Division of Health Service Regulation every two (2) years.
* I understand, per [42 CFR §483.152](https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-G/part-483/subpart-D/section-483.152), that the training program must use the current version of the North Carolina State-approved curriculum and adhere to the policies and procedures approved by the North Carolina Division of Health Service Regulation.
* I understand, per [42 CFR §483.151](https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-G/part-483/subpart-D/section-483.151) and [42 CFR §483.152](https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-G/part-483/subpart-D/section-483.152), that the training program faculty and clinical sites must be approved by the North Carolina Division of Health Service Regulation prior to implementation and the enrollment of students.
* I understand, per [42 CFR §483.151](https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-G/part-483/subpart-D/section-483.151), that modifications to the training program must be approved by the North Carolina Division of Health Service Regulation prior to implementation.
* I understand modifications to the training program required by the North Carolina Division of Health Service Regulation must be made in a timely manner.
* I understand, per [42 CFR §483.152](https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-G/part-483/subpart-D/section-483.152), that the training program must provide supervised practical training to ensure students demonstrate the knowledge and skills required to perform nurse aide tasks and provide care under the direct supervision of a North Carolina Division of Health Service Regulation approved Registered Nurse.
* I understand the training program must incorporate innovative instructional strategies that enable students to deliver quality, compassionate, and consistent basic nursing care. I further understand the training program must ensure objectives are met through instructor demonstration, student practice and demonstration of proficiency.
* I understand the classroom must contain instructional equipment and supplies, seating for the approved number of students as required, and adequate space to accommodate activities.
* I understand, per [42 CFR §483.152](https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-G/part-483/subpart-D/section-483.152), that each Nurse Aide I training program laboratory must be designed, equipped, and contain a sufficient quantity of supplies as shown in the [Existing Training Program – Basic Equipment and Supply List](https://test.ncdhhs.gov/dhsr/hcpr/nat.html#TP).
* I understand, per [42 CFR §483.151](https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-G/part-483/subpart-D/section-483.151), that the policies for the training program must be made available to the North Carolina Division of Health Service Regulation upon request.
* I understand, per [42 CFR §483.151](https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-G/part-483/subpart-D/section-483.151), that the training program is required to maintain student records for a minimum of three (3) years. I further understand student records must be kept onsite, kept in a locked file cabinet, kept in a locked area, and made available for review by the North Carolina Division of Health Service Regulation upon request.
* I understand, per [42 CFR §483.151](https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-G/part-483/subpart-D/section-483.151), that the North Carolina Division of Health Service Regulation may withdraw approval of a training program if it determines that the training program does not meet federal or state rules, regulations, and requirements.
* I understand, per [42 CFR §483.151](https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-G/part-483/subpart-D/section-483.151), that the North Carolina Division of Health Service Regulation may withdraw approval of a training program if it determines that the training program is not adhering to program documentation approved by the North Carolina Division of Health Service Regulation.
* I understand, per [42 CFR §483.151](https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-G/part-483/subpart-D/section-483.151), that the North Carolina Division of Health Service Regulation must withdraw approval of a Nurse Aide I training and competency evaluation program or a Nurse Aide I competency evaluation program if the entity administering the Nurse Aide I training program refuses to permit unannounced visits by the North Carolina Division of Health Service Regulation.

1. **Attestation:**

|  |
| --- |
| * I have read and agree to the Statement of Understanding. * I certify that the information in this application, and in the documentation submitted with the application, is truthful, accurate, and complete. * I certify that the information in this application, and in the documentation submitted with the application, accurately represents the training program for which the North Carolina Division of Health Service Regulation approval is being requested. * I will implement directives, policies, forms, and checklists as mandated by federal and state regulations and the North Carolina Division of Health Service Regulation.   **Program Coordinator:** |

First Name:

Last Name:

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date (mm/dd/yyyy):

*Note: The North Carolina Division of Health Service Regulation will not accept an electronic signature. However, you may type your First Name, Last Name, and the Date.*