**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 form if you are making modifications to an existing state-approved training program.
* You must complete one program modification form per training site.
* You may type your response in the space provided.
* If you’ve submitted the following documents to the Division of Health Service Regulation (DHSR) with the same modifications, then it’s NOT necessary to submit this form.
* [Existing Training Program – Clinical Site Approval Form](https://info.ncdhhs.gov/dhsr/hcpr/nat.html#TP)
* [Existing Training Program – Clinical Site Removal Form](https://info.ncdhhs.gov/dhsr/hcpr/nat.html#TP)
* [Existing Training Program – Faculty Approval Request Form](https://info.ncdhhs.gov/dhsr/hcpr/nat.html#TP)
* [Existing Training Program – Faculty Removal Form](https://info.ncdhhs.gov/dhsr/hcpr/nat.html#TP)
* [Existing Training Program – Course Schedule and Supplemental Teaching Methodology Form (Non-Hybrid Programs)](https://info.ncdhhs.gov/dhsr/hcpr/nat.html#TP)
* [Existing Training Program – Course Schedule and Supplemental Teaching Methodology Form (Hybrid Programs)](https://info.ncdhhs.gov/dhsr/hcpr/nat.html#TP)
* If you’re considering the transition of a classroom-based course to an online format, then please contact your [Education Consultant](https://info.ncdhhs.gov/dhsr/hcpr/consultants.html) to determine if you meet the eligibility requirements and to determine the required documentation needed for approval.
* Submit the required supportive documentation with this form for review and approval, if applicable.
* Approval from DHSR is required prior to implementing any program modifications.
* The Program Coordinator must sign the document.
* Email or fax completed documents to DHSR. Incomplete forms will be denied. You must submit all pages of this form for review.
	+ Email: 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 for Review (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. **Administrative Authority:**
* Name:
* Title:
* Telephone (include area code):
* Email:
* Fax (include area code):

1. **Program Coordinator:**
* Name:
* Telephone (include area code):
* Email:
* Fax (include area code):
1. **Identify the Applicable Training Programs Numbers:**
* Nurse Aide I Training Program:
* Nurse Aide I Refresher Training Program:
* Geriatric Aide Training Program:
* Home Care Aide Training Program:

## Important Notice:

You must complete one program modification form per training site.

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 all that apply.

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

**IDENTIFY ALL PROGRAM MODIFICATIONS THAT YOU ARE**

**REQUESTING IN THIS APPLICATION BELOW.**

1. **Proposed Program Hours:**

Are you modifying the program hours of a state-approved training program?

* Yes:
* No:

If Yes, complete the information below.

* Classroom Hours:
* Online Hours:
* Laboratory Hours:
* Clinical Hours:
* Total Program Hours:

If Yes, you must submit a course schedule to identify the changes. Please select one of the forms below that applies to your program.

* [Existing Training Program – Course Schedule and Supplemental Teaching Methodology Form (Non-Hybrid Programs)](https://info.ncdhhs.gov/dhsr/hcpr/nat.html#TP)
* [Existing Training Program – Course Schedule and Supplemental Teaching Methodology Form (Hybrid Programs)](https://info.ncdhhs.gov/dhsr/hcpr/nat.html#TP)

Important Notice:

You must receive DHSR approval prior to changing the number of classroom, online, laboratory, clinical, and total hours for a training program.

1. **Course Schedule and Supplemental Teaching Methodologies:**

Are you modifying the course schedule or supplemental instructional materials used in the state-approved training program?

* Yes:
* No:

If Yes, you must submit a course schedule to identify the changes. Please select one of the forms below that applies to your program.

* [Existing Training Program – Course Schedule and Supplemental Teaching Methodology Form (Non-Hybrid Programs)](https://info.ncdhhs.gov/dhsr/hcpr/nat.html#TP)
* [Existing Training Program – Course Schedule and Supplemental Teaching Methodology Form (Hybrid Programs)](https://info.ncdhhs.gov/dhsr/hcpr/nat.html#TP)

Important Notice:

You must receive DHSR approval prior to changing instructional materials.

1. **Instructor/Student Ratios:**

Are you modifying instructor/student ratios?

* Yes:
* No:

If Yes, complete the table below:

|  |  |  |
| --- | --- | --- |
| Classroom | 1 instructor per |       students |
| Online  | 1 instructor per  |       students |
| Lab | 1 instructor per |       students |
| Clinical  | 1 instructor per |       students |

Important Notices:

* The instructor-to-student ratio for clinical cannot be greater than 1:10 per regulation [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).
* DHSR must approve each faculty member prior to instruction.
1. **Current State-Approved Classroom:**

Are you modifying a current state-approved classroom?

* Yes:
* No:

If Yes, complete the items below.

* Site Address:
* Building:
* Room:

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

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

**15. New State-Approved Classroom:**

Are you relocating to a new classroom?

* Yes:
* No:

Are you adding a new classroom?

* Yes:
* No:

If you answered Yes to either question, then complete the items below.

* Site Address:
* Building:
* Room:

If you answered Yes to either question, then attach a diagram (may be hand drawn) that includes the items listed below. All items in the drawing must be labeled.

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

**16. Current State-Approved Laboratory:**

Are you modifying an existing state-approved laboratory?

* Yes:
* No:

If Yes, complete the items below.

* Site Address:
* Building:
* Room:

If Yes, attach a diagram (may be hand drawn) that includes the items listed below. All items in the

drawing must be labeled.

* Facility name
* Site address
* Building name
* Room number
* Room dimensions (length, width, square footage)
	+ Important Notice: 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).

**17. New State-Approved Laboratory:**

Are you relocating to a new laboratory?

* Yes:
* No:

Are you adding a new laboratory?

* Yes:
* No:

If you answered Yes to either question, then complete the items below.

* Site Address:
* Building:
* Room:

If you answered Yes to either question, then attach a diagram (may be hand drawn) that includes the items listed below. All items in the drawing must be labeled.

* Facility name
* Site address
* Building name
* Room number
* Room dimensions (length, width, square footage)
	+ Important Notice: length x width = square footage
* Physical layout (each resident room 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).

**18. Process to Orient New Program Faculty:**

Are you modifying the process to orient new program faculty?

* Yes:
* No:

If Yes, briefly describe the new process:

**19. Process for Annual In-Service Training:**

Are you modifying the process for annual in-service training?

* Yes:
* No:

If Yes, briefly describe the new process:

**20. Monitoring (Auditing) and Maintaining Student Records:**

Are you modifying the process for monitoring and maintaining student records, including the location of the student records?

* Yes:
* No:

If Yes, briefly describe the new process and provide the location of student records:

**21. Student Grading Policy:**

Are you modifying the student grading policy?

* Yes:
* No:

If Yes, briefly describe the new process:

**22. Theory Component of Grade:**

To successfully complete the Nurse Aide I 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%.

Are you modifying the student grading policy?

* Yes:
* No:

If Yes,provide the minimum theory passing grade for the training program:

If Yes, 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 Training Program:**

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

**23. Practical Component:**

To pass the practical (laboratory and clinical) portion of the Nurse Aide I 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)).
* At a minimum, fifteen starred skills for clinical (located in [Appendix A](https://info.ncdhhs.gov/dhsr/hcpr/curriculum/pdf/appendixA.pdf)).

Are you modifying the percentage of steps that must be performed correctly for each skill?

* Yes:
* No:

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 Notice:

Students cannot perform any services to residents for which they have not been trained and found proficient by the instructor per federal regulation [42 CFR §483.152.](https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-G/part-483/subpart-D/section-483.152)

**24. Student Identification Process:**

Are you modifying the student identification process?

* Yes:
* No:

If Yes, briefly describe the new process:

**25. Attendance:**

Are you modifying the minimum number of clock hours?

* Yes:
* No:

If Yes, provide the minimum number of clock hours:

Minimum of       clock hours.

Important Notices:

* Successful completion of the program is dependent upon the student completing the minimum number of clock hours.
* The minimum number of clock hours is the total program hours minus the hours your program allows by policy for absences of instruction.

**26. Withdrawal of a Program:**

Are you withdrawing a program?

* Yes:
* No:

If Yes, provide the program number and a brief summary of the reason why you are withdrawing a program:

**27. Other Modifications:**

Describe other modifications not already identified in this form.

*
*
*
*
*

**28. Statement of Understanding:**

I certify that the information in this document, including additional forms and attachments, accurately represents the training program for which the North Carolina Division of Health Service Regulation approval is being requested.

I certify that the training program meets the requirements set forth by State and/or federal rules, regulations, and requirements.

I certify that the training program will 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 State-approved Registered Nurse per federal regulation [42 CFR §483.152](https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-G/part-483/subpart-D/section-483.152).

I certify that training program documents and student records will be kept in a secure location and made available to the North Carolina Division of Health Service Regulation upon request.

I understand that program modifications are based on our agency using the most current version of the North Carolina State-approved curriculum.

I understand that requests for training program modifications must be approved by the North Carolina Division of Health Service Regulation prior to implementation.

I understand that modifications which are required by the North Carolina Division of Health Service Regulation will be incorporated into the training program in a timely manner.

I understand that the training program must adhere to the policies and documentation submitted and approved by the North Carolina Division of Health Service Regulation.

I understand that that the training program policies must be made available to the North Carolina Division of Health Services Regulation upon request.

I understand that the North Carolina Division of Health Service Regulation may withdraw approval of a Nurse Aide I training program if it determines that the program does not meet federal or state regulations and requirements or does not adhere to the program information and documentation approved by the North Carolina Division of Health Service Regulation.

I understand that the State 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 program refuses to permit unannounced visits by the State.

I acknowledge and agree to the following:

* The information in this form is truthful, accurate and complete.
* Implement the most current version of the North Carolina State-approved curriculum.
* Establish and implement North Carolina Division of Health Service Regulation directives, policies, forms, and checklists as mandated by federal and state regulations and requirements.
* The classroom will contain instructional equipment and supplies, seating for the approved number of students as required, and adequate space to accommodate activities.
* Each laboratory will contain the items listed in the [New Training Program – Basic Equipment and Supply List](https://info.ncdhhs.gov/dhsr/hcpr/nat.html#TP) and will adhere to federal regulation [42 CFR §483.90](https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-G/part-483/subpart-B/section-483.90).
* Training objectives will be met through instructor demonstration, student practice and demonstration of proficiency.

**29. Electronic Signature Agreement:**

You acknowledge and agree to the following statements:

* I certify that I have reviewed the entire document before signing.
* Your electronic signature will have the same legal effect and enforceability as your manual signature.
* No certification authority or other third-party verification is necessary to validate your electronic signature and the lack of such certification or third-party verification will not in any way effect the enforceability of your electronic signature.

|  |
| --- |
| **Program Coordinator:**Place an X beside the correct response.I have read and agree to the Statement of Understanding and to the Electronic Signature Agreement.Yes:       No:        |

First and Last Name:

Signature:

Date (mm/dd/yyyy):