



STATE OF NEW HAMPSHIRE  
 DEPARTMENT OF HEALTH & HUMAN SERVICES  
 DIVISION OF LONG TERM SUPPORTS AND SERVICES  
**BUREAU OF ELDERLY & ADULT SERVICES**

BEAS 292  
 Rev. 09/2020

**APPLICATION FOR REIMBURSEMENT FOR NURSING ASSISTANT  
 TRAINING AND COMPETENCY TESTING  
 IMPORTANT – Please Read Attached Instructions**

**To Be Completed By Applicant- Section A**

First, Middle Initial, and Last Name (Print): \_\_\_\_\_

Date of Birth (Required): \_\_\_\_\_ Phone # \_\_\_\_\_ Cell Phone # \_\_\_\_\_

Mailing Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Name of Approved Nursing Assistant (NA) Training Program \_\_\_\_\_

Start Date \_\_\_\_\_ End Date \_\_\_\_\_ Test Date \_\_\_\_\_

Name of New Hampshire Nursing Facility where you are, were, or will be employed: \_\_\_\_\_

I am applying for financial reimbursement in the amount of \$\_\_\_\_\_, which is the amount I and/or a third party paid for the Nursing Assistant Program and/or competency testing that I successfully completed. I have attached a receipt to this application documenting payment for the Nursing Assistant Program and/or competency testing.

**Check the box that applies:**  I paid for the entire course and/or competency testing entirely from my own funds.  
 I shared the cost of the course and/or competency testing with a 3<sup>rd</sup> party. I paid: \$\_\_\_\_\_ 3<sup>rd</sup> Party Paid: \$\_\_\_\_\_  
 (The 3<sup>rd</sup> party payer must complete section B if they are seeking reimbursement)

**I attest that the information provided above is accurate and that I am, have been, or will be employed by the Nursing Facility named above. Signature of Applicant \_\_\_\_\_ Date \_\_\_\_\_**

**To Be Completed by Third Party Payer if Applicable Section B**

Name of Source of Payment: \_\_\_\_\_ Phone #: \_\_\_\_\_

Address: \_\_\_\_\_ I am applying for financial reimbursement in the amount of \$\_\_\_\_\_, which is the amount I paid for the Nursing Assistant Program and/or competency testing for the applicant listed above. I have attached a receipt documenting payment for the training.

**I attest that the information provided above is accurate and that I paid the amount listed above for nursing assistant training of the applicant listed above.**

**Signature of Third Party Payer \_\_\_\_\_ Date: \_\_\_\_\_**

**To Be Completed By the NH Nursing Facility Administrator- Section C**  
*(The Administrator of Record must sign this section).*

Applicant Name: \_\_\_\_\_ Hire/Offer Date: \_\_\_\_\_

Name of NH Nursing Facility: \_\_\_\_\_

Applicant (please circle) is currently employed was employed has received an offer of employment as a Nursing Assistant at this facility.

Nursing Facility Administrator's Name (please print): \_\_\_\_\_

By my signature below, I attest that the information provided above is accurate.

Signature of Nursing Facility Administrator: \_\_\_\_\_ Date: \_\_\_\_\_

Phone #: \_\_\_\_\_ Nursing Facility License Number (Required): \_\_\_\_\_

**To Be Completed By The NH Board of Nursing- Section D**

The NH Board of Nursing Nurse Aide Registry confirms that the records indicate the above named applicant has successfully completed an approved nursing assistant training program and/or competency testing within 12 months prior to the date of hire or offer of employment.

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

Title: \_\_\_\_\_ Registry Number: \_\_\_\_\_

**To Be Completed By the DHHS Office of Finance- Section E**

Please process for payment in the amount of: Total:\$ \_\_\_\_\_ Applicant:\$ \_\_\_\_\_ 3<sup>rd</sup> Party:\$ \_\_\_\_\_

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

Amount Paid \$ \_\_\_\_\_ Date: \_\_\_\_\_ Check Number: \_\_\_\_\_

Second Check Info (if applicable) Date: \_\_\_\_\_ Check Number \_\_\_\_\_



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BEAS 292(i)  
Rev. 09/2020

**INSTRUCTIONS TO BEAS 292**  
**“APPLICATION FOR FINANCIAL REIMBURSEMENT**  
**FOR NURSING ASSISTANT TRAINING AND COMPETENCY TESTING”**

**PURPOSE:**

BEAS 292 is used by Nursing Assistants (NA) and third parties to apply for financial reimbursement from the NH Department of Health and Human Services (DHHS), Bureau of Elderly and Adult Services (BEAS) for nursing assistant training and/or competency testing, pursuant to He-E 804. Financial reimbursement for training or competency testing is available to an NA who:

- Has completed an NA training program approved by the NH Board of Nursing and/or successfully passed the competency test;
- Has completed the required training course and/or competency testing no more than 12 months prior to the date of hire at the facility; and
- **Is, was, or will be employed by a licensed nursing facility** since being placed on the NH Board of Nursing Nurse Aide Registry (**employment in other types of health care settings, including but not limited to: assisted living, residential care facilities, hospice programs, hospitals, and home health agencies is not eligible for reimbursement**).

Third parties are eligible for reimbursement if they paid for the training of a NA who meets the above criteria.

**INSTRUCTIONS**

**Section A: Applicant – Please read thoroughly:**

The applicant completes Section A only and sends the document to the administrator of the nursing facility where the applicant is/was employed. Or to a third party if a third party other than the nursing facility paid for the nursing assistant's training and is seeking reimbursement. **A receipt(s) must be attached to the document that shows the cost that the NA and/or third party paid for the training and/or competency testing. The receipt must have the training/testing facility's name and address imprinted on it. Only costs associated with taking the course and/or testing that the NA paid out of his or her own personal funds are eligible for reimbursement. Costs for criminal records background checks, uniforms, pins, etc. are not reimbursable. The receipt for payment may be: a one-page statement that shows the amount charged for the training and/or testing and the amount paid by the NA, a receipt for a cash payment, copies of both sides of a check used to make payment, or a copy of a credit card payment made to the training/testing site.**

**Section B: Third Party Payer if applicable**

If a third party other than the nursing assistant paid for the nursing assistant's training and wishes to be reimbursed, the third party must complete section B. **A receipt(s) must be attached to the document that shows the cost that the NA and/or third party paid for the training and/or competency testing if the applicant did not already attach one.**

**Section C: NH Nursing Facility Administrator**

The nursing facility administrator completes Section C of BEAS 292 to certify that the applicant is, was, or will be employed by the facility and sends the document, **with the attached receipt(s)**, to the New Hampshire Board of Nursing Nurse Aide Registry, 7 Eagle Square, Concord, NH 03301-2431.

**Section D: NH Board of Nursing**

The NH Board of Nursing Nurse Aide Registry completes Section D of BEAS 292 to certify that the applicant successfully completed an approved nursing assistant training program and/or competency testing within 12 months prior to the date of the applicant's date of hire. The Registry sends the original application, with the attached receipts, to the Department of Health and Human Services, Office of Finance, 105 Pleasant Street, Concord, NH 03301-3857.

**Section E: DHHS Office of Finance**

The DHHS Office of Finance, Accounts Payable completes Section E, verifies that the document is completed correctly and that the appropriate receipts are attached, and then approves or denies the reimbursement. If reimbursement is denied, BEAS notifies the applicant in writing of the reason(s) for denial and what steps, if any, the applicant may take to receive reimbursement. If reimbursement is approved the Office of Finance indicates the amount of reimbursement to be made, and signs and dates the request for reimbursement. Office of Finance retains a copy of BEAS 292 and the applicant's receipt(s), sends a copy of the approved application to the NH Board of Nursing Nurse Aide Registry.

**RETENTION**

The DHHS Office of Finance and Bureau of Elderly and Adult Services each retain a copy of BEAS 292 for three years.