

**APPLICATION FOR REIMBURSEMENT FOR LICENSED NURSING ASSISTANT  
OR MEDICATION NURSING ASSISTANT TRAINING PROGRAM AND/OR COMPETENCY TESTING  
IMPORTANT – Please complete all questions and read attached instructions**

Indicate which training program or competency test you are  
applying for reimbursement for (you must check one):

☐ License Nursing Assistant (LNA)    ☐ Medication Nursing Assistant (MNA)

**Section A - To Be Completed By Applicant (Please print clearly)**

First, Middle Initial, and Last Name \_\_\_\_\_

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

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

Nursing Assistant License Number \_\_\_\_\_

Name of Approved LNA or MNA training program and/or competency testing \_\_\_\_\_

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

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

I am applying for financial reimbursement in the amount of \$ \_\_\_\_\_, which is the amount paid for the LNA or MNA training or competency testing that was successfully completed.

**NOTE:** The following is required: a copy of an itemized receipt showing the applicant's name and, if applicable, the third-party payor, a description of the training program and/or competency testing, the amount paid for each training program and/or competency testing, and a copy of the certificate showing the date of successful completion.

**Check the box that applies and fill in the amount(s) paid:**

☐ I paid the entire cost of the training program and/or competency testing.

☐ A third-party paid the entire cost of the training program and/or competency testing.

☐ I shared the cost of the training program and/or competency testing with a third-party.

I paid \$ \_\_\_\_\_ for LNA ☐ or MNA ☐ training and/or competency testing

Third-party paid \$ \_\_\_\_\_ for LNA ☐ or MNA ☐ training and/or competency testing

Total amount paid by applicant \$ \_\_\_\_\_ Total amount paid by third-party \$ \_\_\_\_\_

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 \_\_\_\_\_

**IMPORTANT:** The third-party payor must complete Section B if seeking reimbursement

**Section B - To Be Completed By Third-Party Payor (If Applicable)**

Name of Third-Party Payor \_\_\_\_\_ Phone # \_\_\_\_\_

Address \_\_\_\_\_

I am applying for financial reimbursement in the amount of \$ \_\_\_\_\_, which is the amount paid for the LNA ☐ or MNA ☐ training program and/or competency testing for the applicant listed above. I have attached separate itemized receipts documenting payment for each training program and/or competency testing. I attest that the information provided above is accurate and that I paid the amounts listed above for the LNA or MNA training of the applicant listed above.

Signature of Third-Party Payor \_\_\_\_\_

Date \_\_\_\_\_

**Section C - To Be Completed By The NH Nursing Facility Administrator**

Applicant Name \_\_\_\_\_ Hire/Offer Date for LNA or MNA \_\_\_\_\_

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

**Applicant Status**

<input type="checkbox"/> is currently employed	<input type="checkbox"/> was employed	<input type="checkbox"/> has received an offer of employment as an LNA	<input type="checkbox"/> has received an offer of employment as an MNA
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By my signature below, I attest that the information provided above is accurate.

\_\_\_\_\_  
Name of Nursing Facility Administrator of Record

\_\_\_\_\_  
Signature of Nursing Facility Administrator of Record

\_\_\_\_\_  
Date

\_\_\_\_\_  
Phone Number

\_\_\_\_\_  
Nursing Facility License Number (Required)

**Section D - To Be Completed By Bureau of Adult & Aging Services (BAAS)**

I have verified that the LNA or MNA reimbursement competency requirements have been met for this applicant, the applicant's LNA or MNA licenses are active, and the application, BAAS Form 292, is complete.

\_\_\_\_\_  
Name & Title of BAAS Representative

\_\_\_\_\_  
Signature of BAAS Representative

\_\_\_\_\_  
Date

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

Please process for payment in the amount of:

Total to applicant \$ _____	LNA payment portion \$ _____	MNA payment portion \$ _____
Total to a third party \$ _____	LNA payment portion \$ _____	MNA payment portion \$ _____

Check Date \_\_\_\_\_ Check Number \_\_\_\_\_

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

\_\_\_\_\_  
Name & Title of Finance Representative

\_\_\_\_\_  
Signature of Finance Representative

\_\_\_\_\_  
Date

**Mail completed application with required attachments to:**

Department of Health and Human Services  
Bureau of Adult and Aging Services  
Attn: Nursing Assistant Reimbursement  
105 Pleasant Street, Concord, NH 03301-3857

If you have any questions or need help completing this form, please call  
BAAS at 603-271-9203 or 1-800-852-3345 Ext.19203.

*This institution is an equal opportunity provider and employer.*



**INSTRUCTIONS TO BAAS FORM 292  
“APPLICATION FOR REIMBURSEMENT FOR LICENSED NURSING ASSISTANT OR MEDICATION NURSING  
ASSISTANT TRAINING PROGRAM AND/OR COMPETENCY TESTING”**

**Purpose**

BAAS Form 292 is used by individuals and/or third-party payors to apply for financial reimbursement from the Bureau of Adult and Aging Services (BAAS) for Licensed Nursing Assistant (LNA) or Medication Nursing Assistant (MNA) training program and/or competency testing. Financial reimbursement is available to an LNA or MNA who:

- Has completed an LNA or MNA training program and/or successfully passed the competency test approved by the NH Board of Nursing;
- Has completed the required training program and/or competency testing no more than 12 months prior to the date of hire at the nursing facility; and
- **Is, was, or will be employed by a licensed nursing facility as an LNA or MNA.**

**Note:** 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 are not eligible for reimbursement.

Third-party payors are eligible for reimbursement if they paid for the training of an LNA or MNA who meets the criteria listed above.

**Authority/Legal Basis**

He-E 804 Licensed Nursing Assistant Training and Medication Nursing Assistant Training Reimbursement; RSA 161:4-a, IX; 42 USC1396r.

**Instructions**

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

In order to receive reimbursement, the applicant shall only complete Section A and then provide the application to the nursing facility administrator where the applicant is, was, or will be employed, or to a third-party payor, if applicable.

- 1. Itemized receipt(s) must be attached to the document showing the amount that the LNA, MNA, and/or third-party paid for the training program and/or competency testing.**
  - The receipt must have the training program and/or competency testing facility's name and address imprinted on it. Only costs associated with attending the training program and/or competency testing that the LNA or MNA paid out of the LNA's or MNA's personal funds are eligible for reimbursement.
  - Costs for criminal records background checks, uniforms, pins, etc. are not reimbursable.
  - The itemized receipt verifying payment for the training program and/or competency testing may be one of the following: a one-page statement that shows the amount charged and the amount paid by the LNA or MNA, a receipt for a cash payment, copies of both sides of a check used to make payment and proof that the payment has cleared the bank, or a copy of a credit card payment.
- 2. A certificate of successful completion of the training program and/or competency testing must be attached. The certificate must include the date the LNA or MNA successfully completed the training program and/or competency testing.**

**Section B: Third-Party Payor (if applicable)**

If a third-party paid for the training program or competency testing and wishes to be reimbursed, the third-party payor must complete Section B of the application.

Itemized receipt(s) must be attached to the application that shows the cost that the third-party paid for the training program and/or competency testing.

**Section C: NH Nursing Facility Administrator**

The nursing facility administrator completes Section C of the application to certify that the applicant is, was, or will be employed by the facility as an LNA or MNA and mails the completed application with the required itemized receipt(s) and certificate of completion to:

**Department of Health and Human Services  
Bureau of Adult and Aging Services  
Attn: Nursing Assistant Reimbursement  
105 Pleasant Street, Concord, NH 03301-3857**

**Retention**

A copy of BAAS Form 292 is retained by both the Office of Finance and BAAS for 3 years from completion date (3YC).