

Illinois Department of Public Health – Nursing Assistant Training & Competency Evaluation Program (NATCEP)  
**BASIC NURSING ASSISTANT TRAINING PROGRAM**  
**NEW PROGRAM SUBMISSION CHECKLIST**

Programs may NOT begin classes until Department approval is granted.

Programs submitting student test applications without a program approval number or with an invalid or inactive program number will have those applications returned and the students will not be permitted to test.

**Submit all information requested in the order shown to expedite the review process.**

MAIL TO: Illinois Department of Public Health  
 Education and Training Section  
 525 W Jefferson, 4<sup>th</sup> Floor  
 Springfield, IL 62761

Program Sponsor/Organization \_\_\_\_\_ Address – Street/City/State/Zip \_\_\_\_\_

Theory Site Name/Address/Phone if different than Program Sponsor \_\_\_\_\_

Program Coordinator \_\_\_\_\_ Phone Number \_\_\_\_\_ Fax Number \_\_\_\_\_ E-mail Address (required) \_\_\_\_\_

Program Status (Check one):  New Program  Reactivation NOTE: If requesting reactivation, list your program code number: \_\_\_\_\_

Date Received (IDPH Office Use): \_\_\_\_\_ Date Returned, if incomplete (IDPH Office Use): \_\_\_\_\_

For application procedure, refer to [www.nurseaidetesting.com](http://www.nurseaidetesting.com) → Program Coordinators & Instructors → Forms, *Program Coordinator Toolbox*.

<p>Check the boxes below to indicate that the requested information is enclosed in the submission packet.</p> <p><b>INCOMPLETE SUBMISSIONS WILL BE RETURNED.</b></p>	<p>In accordance with regulations, the Department has 90 days to advise new program sponsors whether or not the program has been approved, denied or to request additional information. Prior to submission, direct questions to either <a href="mailto:Jennifer.Kempiners@illinois.gov">Jennifer.Kempiners@illinois.gov</a>, 217-785-5569, or <a href="mailto:Cindy.Colwell@illinois.gov">Cindy.Colwell@illinois.gov</a>, 217-785-5132.</p>
<p><b>Program Summary</b></p> <p><input type="checkbox"/> Submit a brief <b>summary</b> of the sponsoring agency, the program rationale and purpose. An agency brochure may be included.</p> <p><input type="checkbox"/> Indicate the <b>type of program</b>. Types are <u>Facility</u>, <u>College</u>, <u>Secondary</u>, <u>Hospital</u>, <u>Home Health</u>, or <u>Vocational (private business and vocational school) programs</u>.</p> <p><input type="checkbox"/> Submit <b>credentialing documentation</b>, if required, as stated below:</p> <ul style="list-style-type: none"> <li>• Home Health Agency submit copy of current license.</li> <li>• Private Business and Vocational Schools submit copy of Certificate of Approval from IBHE.</li> <li>• Facility, Home Health and/or Hospital submit copy of Certificate of Approval from IBHE if admitting students other than their employees.</li> <li>• Secondary School submit copy of Certificate of Approval from ISBE. Secondary program instructor needs to consult with high school administration about provisional teaching certificate.</li> </ul>	<p><b>Corporations and individuals do not qualify for sponsorship.</b> For example, if application is for a facility-based program then each individual facility needs to apply rather than a corporate affiliate applying for a number to be used at more than one location or site.</p> <p>Each different theory site and different program type must have its own program number even if the Program Sponsor is the same. Program Types are defined in the <i>Program Coordinator Toolbox</i>.</p> <p><b>Not charging (This applies to only facility-based programs).</b> Facility-based programs must comply with Federal Regulations which govern the reimbursement for Nurse Aide Training in accordance with 42 CFR Section 483.152 (c). This reimbursement process is tracked. For questions contact 217-524-7237.</p> <p>Contact the Illinois Board of Higher Education (IBHE) at 217-557-7384.</p> <p>Contact the Illinois State Board of Education (ISBE) at 217-782-2948.</p>
<p><b>Objectives and Content</b></p> <p><input type="checkbox"/> Submit a statement indicating that the Department’s <b>model program</b> will be used;  <b>OR,</b>          Submit your own curriculum that complies with all curriculum requirements.</p> <p><input type="checkbox"/> Submit a <b>syllabus</b> which includes methodology, content, objectives and Attendance Policy. Your <b>attendance policy</b> must include a statement on how many absences are allowed and how students will make up time missed.</p> <p><input type="checkbox"/> <b>Allocation of BNAT Program Hours</b></p>	<p><b>Review the regulations that govern BNATP operation.</b> Forms, documents, links and guidelines are located on <a href="http://www.nurseaidetesting.com">www.nurseaidetesting.com</a>.</p> <p><b>State Regulations:</b> <a href="http://www.idph.state.il.us">www.idph.state.il.us</a>. IL Admin Code 77, Part 395, Part 955 and Part 300. Curriculum requirements are in Section 395.300.</p> <p><b>Federal Requirements:</b> <a href="http://www.cms.hhs.gov">www.cms.hhs.gov</a>. 42 CFR 483.75, 483.151, 483.152, and 483.154.</p> <p>The Allocation of BNAT Program Hours identifies the minimum number of theory hours to be allotted per module. The total number of theory hours on your Master Schedule must match the total number of theory hours on your Allocation of BNAT Program Hours worksheet and for which the BNATP will be/is approved.</p>

<p><b>Methodology</b></p> <input type="checkbox"/> List what methods of teaching will be utilized. <input type="checkbox"/> Provide textbook information. <input type="checkbox"/> List names and length of time for each Multi-media resource. <input type="checkbox"/> Submit a completed <b>BNATP Facility &amp; Equipment/Supplies Form</b> .	<p>Examples include, but not limited to, Lecture, Demonstration, Return Demonstration, and Audio-Visual/Multi-media. Some information may be a repeat from syllabus.</p> <p>BNATP Facility &amp; Equipment/Supplies Form is located on <a href="http://www.nurseaidetesting.com">www.nurseaidetesting.com</a>.</p>
<p><b>Instructor(s)</b></p> <input type="checkbox"/> See instructor requirements found in IL Administrative Code 77, Section 395.160 (a, b, e, f). <input type="checkbox"/> Submit documentation for each BNATP instructor according to Procedure to Request Instructor Approval. Only Department-approved Theory, Clinical, Alzheimer's, Special Content and CPR instructor(s) shall be used in a BNATP. <p><b>Approved Evaluator(s)</b></p> <input type="checkbox"/> See Approved Evaluator requirements found in IL Administrative Code 77, Section 395.162. <input type="checkbox"/> List the Approved Evaluator(s). Facility-based programs must also identify and use an Approved Outside Evaluator(s) who shall have no fiduciary connection, within 30 days before or after the evaluation, with the facility at which the student is employed or will be employed.	<p>The Procedure to Request Instructor Approval found in the <i>Program Coordinator Toolbox</i> is the same for initial instructor approval with a new program application and for a new instructor approval request for an existing program.</p> <p>NOTE: In-service instruction/education does not meet the requirement of formal teaching experience.</p> <p>Each student must be deemed competent to perform the 21 mandated skills by the Approved Evaluator(s) in accordance with the established standards and guidelines.</p> <p>Instructor(s) and Approved Evaluator(s) may only sign the Official Class Roster at the end of class if all students listed have successfully completed the program in accordance with Section 395.173.</p> <p>NOTE: Submit for instructor codes according to Obtaining an Instructor Code Procedure found in the <i>Program Coordinator Toolbox</i>.</p>
<p><b>Evaluation Tools</b></p> <input type="checkbox"/> Submit the following Instruction/Program Evaluation Form(s): <ul style="list-style-type: none"> <li><input type="checkbox"/> 1) Written Final Exam and the answer key</li> <li><input type="checkbox"/> 2) Clinical Skills Checklist</li> <li><input type="checkbox"/> 3) Evaluation of Student's Clinical Performance form</li> <li><input type="checkbox"/> 4) Other evaluation tools to be used</li> </ul>	<ol style="list-style-type: none"> <li>1) Submit a copy of the tool(s) students will use to evaluate the instructor(s) and/or the program.</li> <li>2) The Final Exam must be comprehensive with a balance of questions covering all portions of the training program curriculum. Include the answer key.</li> <li>3) Clinical Skills Checklist must list the nursing assistant skills, <b>in addition to the required 21 Performance Skills</b>, that will be evaluated by the Clinical Instructor/Approved Evaluator.</li> <li>4) The student's clinical performance evaluation form should be an objective tool.</li> </ol>
<p><b>Clinical Site Agreement</b></p> <input type="checkbox"/> Submit a signed and dated Clinical Site Agreement for each facility to be used as a clinical site.	<p>The Clinical Site Agreement is a contract that is signed and dated by the owner or operator of the clinical site and the program sponsor representative which grants written permission for the use of the facility and/or equipment not owned or operated by the program sponsor.</p>
<p><input type="checkbox"/> <b>Master Schedule with Dates and Locations</b> completed in detail. Revision of this initially proposed Master Schedule may be necessary based on date of program approval.</p> <p><b>NOTE:</b> The Department has set an 8:1 student to instructor ratio for clinical instruction. A Master Schedule should be submitted for each group of 8 students.</p>	<p>Follow the <i>Master Schedule Completion Guidelines</i> to prepare a proposed Master Schedule. Put PENDING in the space provided for Program Number, NA#____. Instructors and evaluators must be identified. The hours must be calculated to allow for breaks and other exclusions.</p> <p><b>NOTE:</b> In accordance with Federal (42 CFR 483.152 (b)) and State (Section 395.150 (a)(6)) Regulations, the curriculum of the BNATP must include a minimum of 16 hours of training in specific areas prior to any direct contact with a resident.</p>

Programs must counsel their students on the Health Care Worker Background Check Act and the Health Care Worker Background Check Code in accordance with 77 Illinois Administrative Code, Section 395.171 and Part 955. All programs are required to initiate a fingerprint-based criminal history records check (FEE\_APP) prior to entry of an individual into the training program.

### REQUIRED SIGNATURES

**I have read and understood this program submission checklist in its entirety and hereby agree to be in full compliance with all rules, requirements and regulations governing the Nurse Aide Training and Competency Evaluation Program.**

\_\_\_\_\_  
**Program Coordinator – Print legibly**

\_\_\_\_\_  
**Signature**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Administrator (facility-based only) – Print legibly**

\_\_\_\_\_  
**Signature**

\_\_\_\_\_  
**Date**