DEPARTMENT OF HEALTH SERVICES
Division of Quality Assurance
F-62688 (11/08)

STATE OF WISCONSIN
HFS 129, Wis. Admin. Code

FEEDING ASSISTANT TRAINING PROGRAM TRAINER APPLICATION

- The U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS) authorizes the Department of Health Services to review and determine eligibility for feeding assistant program trainers under the requirements of the Medicare and Medicaid programs. Completion of this form is voluntary; however, the information collected on this form is used to determine if federal and state program trainer eligibility requirements have been met.
- Providing the program trainer's social security number is voluntary; however, social security numbers are one of the unique identifiers used to prevent incorrect identity mismatches; e.g., the Department of Justice uses social security numbers, names, gender, race, and date of birth to prevent incorrect matches of persons with criminal convictions.
- Provide the requested information for all trainers. Add any information that you believe is pertinent. (Submit additional pages, if necessary.)
- Submit completed application and materials to**:** **Wisconsin Nurse Aide Training Consultant**
  Office of Caregiver Quality
  P.O. Box 2969
  Madison, WI 53701-2969
- If you have questions about completing this form, call **(608) 261-8319.**
- **Print neatly in BLACK INK or type.**

I. PERSONAL INFORMATION

- Provide a copy of your Social Security card and a form of identification to verify your current name.
- Provide a copy of your current applicable Wisconsin license.
- Provide a copy of completed BID, DOJ, and DHS Responses if you will be participating in clinicals with the students.

Note: To be approved as a program trainer, state and federal regulations require that you have a minimum of one year of experience in the area in which you will provide training.

Full Name (Last, First, MI) ***(DO NOT USE NICKNAMES.)***	Title	Social Security Number
Name - Program		Sex ☐ Female ☐ Male

II. EDUCATION

Name – School / College	Years Attended	Year of Graduation
Diploma or Degree		Year Received

Street Address	City	State	Zip Code

III. WORK EXPERIENCE

Name – Employer

Street Address	City	State	Zip Code

Position Held	Start Date (mm/dd/yyyy)	End Date (mm/dd/yyyy)

IV. LICENSURE *(Attach additional pages, if necessary.)*

Type of License *(Attach copy of license.)*	State of Issuance	Issuance Date (mm/dd/yyyy)	Expiration Date (mm/dd/yyyy)

DHS OFFICE USE ONLY

☐ Program Trainer Approved ☐ Approval Pending; Information Needed ☐ Program Trainer Denied

Reason for Denial

Name – Reviewer	Title	Date Reviewed