

Kansas Department on Aging

Workforce Enhancement in Nursing Facilities - Special Project

Invoice-Summary

Grant #: _____

Grantee Name: _____

Grant Period: From _____ to _____

Title of Course /
Training Activity: _____

Billing period: From _____ to _____

Number of Individuals trained this invoice period:				
Unlicensed Staff	Licensed Staff	Total Staff	Unduplicated total # of facilities with employees attending training activity billed on this invoice	Total Amount Billed

ATTACH FORM KDOA 336a, Workforce Enhancement in Nursing Facilities - Special Project - Detail Invoice

I hereby certify:

- 1) The amount invoiced is for training of unlicensed staff currently employed by either a certified and licensed long-term care nursing facility (nursing home) or a long-term care unit of a hospital. No individuals employed in freestanding or attached Assisted Living Facilities, Residential Health Care Facilities, Home Plus Facilities, Boarding Homes, Home Health Agencies, Hospices, Hospitals and Hospital Swing Bed Units are included in this invoice.
- 2) To the best of my knowledge all training activities billed herein are in accordance with the Workforce Enhancement in Nursing Facilities, request for proposal, my agency's grant application and Notification of Grant award.

Authorized Official
Name & Title:

(Please type or print Name & Title)

Date Invoice
Submitted:

Signature of Authorized
Certifying Official:

Phone:

Contact Person:

Kansas Department on Aging

Workforce Enhancement in Nursing Facilities - Special Project

Invoice-Detail

Grant # _____

Grantee: _____

Presented by: _____

Title of Course/Training Activity: _____

Date of Session: _____

Name/Location of Facility: _____

Name/Address of Presentation: _____

	Trainee/ Attendee	Position Title *(no abbreviations)	Certificate Number	License Number	Employer	CHECK ONE		No. of YEARS IN	
						Employed in:		current position	employed in LTC
						Nursing Facility	Other		
1									
2									
3									
4									
5									
6									
7									
8									
9									
10									
11									
12									
13									
14									
15									

*May use Rn, LPN, CNA, CMA, SSD, AD. All other individuals needs to write out their position title.

KANSAS DEPARTMENT ON AGING
Workforce Enhancement in Nursing Facilities - Special Project
Program Report

Grantee: _____

COURSE / TRAINING NAME: _____

Report Period

PART I : Number of Eligible Individuals Trained by Employer

From _____ to _____

# of Individuals Trained	Employer
1	_____
2	_____
3	_____
4	_____
5	_____
6	_____
7	_____
8	_____
9	_____
10	_____
_____ TOTAL NUMBER OF INDIVIDUALS TRAINED	

KANSAS DEPARTMENT ON AGING

Workforce Enhancement in Nursing Facilities - Special Project Program Report

PART II: Summary of Grantee progress in / toward implementation of grant activity.

PART III: Identify any Challenges encounter or lessons learned in connection with the implementation of this grant activity.

KANSAS DEPARTMENT ON AGING
Workforce Enhancement in Nursing Facilities - Special Project
Program Report

PART IV: Summarize Actions taken to overcome challenges encountered in implementation of grant activity.

PART V: Summary of recommendations.