

**Ohio Department of Health
Nurse Aide Training Competency Evaluation Program (NATCEP)**

246 N. High Street, Columbus, OH 43215 • Telephone (614) 752-8285 • Fax (614) 564-2596

Report of Changes in TCEP

Effective 03/2007

Instructions: To ensure that this form is processed in a timely manner, please follow the instructions included with each section. You may fax this form to **(614) 564-2596**. **If faxing, please do not send a second copy by mail!** For questions please call (614) 752-8285. Please remember:

- ✓ Complete all applicable sections of this form, including this cover sheet.
- ✓ **Return only the portions of this form that apply to the changes you are making.**
- ✓ Include all required documentation as noted in each section.
- ✓ **The Program Coordinator's signature is required.**
- ✓ **This form must be submitted at least 10 business days prior to the planned date of change.**

You will receive a letter acknowledging your changes. If the form is not filled out correctly or proper documentation is not included, you will be contacted to provide further information. **Changes should not be implemented until you have received an approval letter from our office.**

Program Information

Program Name			Approval Number	
Street Address			County	
City	Zip	Program Office Phone ()	Fax ()	
Program Coordinator		Program Coordinator Phone ()	Cell Phone ()	
Date Submitted		Proposed Date of Change		

Please complete the sections that apply.

- A1 - To Change the Program Coordinator..... Page 2
- A2 - To Add a Primary Instructor Page 2
- A3 - To Remove a Primary Instructor..... Page 2
- B1 - To Add a Classroom Site Page 3
- B2 - To Add a Clinical Site..... Page 3
- B3 - To Remove a Classroom or Clinical Site..... Page 3
- B4 - Long-Term Care Facility Information..... Page 4
- C1 - To Change Curriculum..... Page 5
- D1 - To Change Topic Hours..... Page 5

Program Name	Approval Number
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SECTION A: Faculty Changes

A1. To Change the Program Coordinator

- ✓ Include a copy of the contract/agreement between the PC and the NFB program. [OAC 3701-18-04 (C) (3)]
- ✓ Include a copy of the train-the-trainer certificate (must include seal of the State of Ohio) and a resume to verify 2 years of nursing experience, at least one of which is in the provision of long-term care facility services. If non-facility based program, include written agreement with the Program Coordinator for provision of service. [OAC 3701-18-09]
- ✓ If the train-the-trainer certificate is more than 2 years old, submit validation of working as a PC or PI (i.e., a Trainee Report showing that the person taught or coordinated a class).
- ✓ Send verification of employment by submitting either a letter from employer or the same documentation used for admittance to the TTT program.

PC Name	
RN License Number	Expiration Date

Facility-Based Programs:

- Is this person the DON of the facility? Yes No
- Will the PC also function as a PI? Yes No

E-Mail Address of New PC	Cell Phone Number of New PC
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Former PC	Date of Resignation
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- Will the former PC remain as a PI? Yes No

A2. To Add a Primary Instructor

- ✓ Include a copy of the train-the-trainer certificate (must include seal of the State of Ohio) and a resume to verify 2 years experience caring for the elderly or chronically ill of any age.
- ✓ Send verification of employment by submitting either a letter from employer or the same documentation used for admittance to the TTT program.
- ✓ If the train-the-trainer certificate is more than 2 years old, submit validation of working as a PC or PI (i.e., a Trainee Report showing that the person taught or coordinated a class). NOTICE: The NATCEP unit does not track PC/PI work experience. You must provide the required documentation.

PI Name	
RN License Number	Expiration Date
LPN License Number	Expiration Date

- Is this person replacing a faculty member? Yes No (If yes, please complete Section A3)

A3. To Remove a Primary Instructor

- ✓ If a PI is resigning, complete this section.

Name	<input type="checkbox"/> RN <input type="checkbox"/> LPN	Date of Resignation
Name	<input type="checkbox"/> RN <input type="checkbox"/> LPN	Date of Resignation
Name	<input type="checkbox"/> RN <input type="checkbox"/> LPN	Date of Resignation

PC Signature	Date
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Program Name	Approval Number
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Section B: Classroom/Clinical Site Changes

B1. To Add a Classroom Site

✓ Include a completed copy of Section B4 on Page 4 if classroom site is a long-term care facility.

Name of site, please include room number and Medicare provider number (i.e. 365_ _ _ _) if a nursing home.			
Street Address			
City	Zip	County	Phone ()
Is classroom site a Long-Term Care Facility? <input type="checkbox"/> YES <input type="checkbox"/> NO		Room Capacity	
Is this site replacing another classroom site? <input type="checkbox"/> YES <input type="checkbox"/> NO		If yes, what site?	

CHECKLIST:

- Signed agreement/contract is attached if classroom is in long-term care facility.
- Site has adequate space to accommodate all trainees.
- Site is clean, safe and meets applicable state and local building and fire code requirements.
- Site provides adequate lighting and comfortable temperatures.
- Site is equipped adequately with audio-visual equipment, appropriate teaching aids and equipment for simulating resident care, including sink and restroom.

B2. To Add a Clinical Site

✓ Include a completed copy of Section B4 on Page 4.

Name of Site and include Medicare Provider Number (i.e. 365_ _ _ _)			
Street Address			
City	Zip	County	Phone ()
Is this site replacing another clinical site? <input type="checkbox"/> YES <input type="checkbox"/> NO		If yes, what site?	

CHECKLIST:

- Signed agreement/contract is attached.
- Facility has the number of residents and variety of care needs and conditions sufficient to accommodate the trainees in meeting the learning objectives established.
- Facility ensures the clinical experience portion will not cause undue burden to the residents.
- Section B4 on Page 4 is attached.

B3. To Remove a Classroom or Clinical Site

Name of Site			<input type="checkbox"/> Class Site	<input type="checkbox"/> Clinical Site
Street Address				
City	Zip	County		

PC Signature	Date
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B4. Long-Term Care Facility Information

- ✓ Please complete this section for any long-term care facility you are adding to your program.
- ✓ This information must be provided regardless of whether the facility is being used as a classroom or clinical site.

Name of long-term care facility and include Medicare provider number (i.e. 365_ _ _ _)		
Street Address		
City	Zip	County

Ohio Administrative Code 3701-18-06: The director shall not approve a program conducted by or in a long-term care facility which during the previous two (2) years:	Yes	No	If yes, list date deficiency cited
“Had its license revoked pursuant to Chapter 3721. of the Revised Code;”			
“In the case of a long-term care facility certified as a skilled nursing facility until Title XVIII of the Social Security Act, it operated under a waiver of the Medicare nurse staffing requirements established under Title XVIII of the Social Security Act;”			
“In the case of a LTCF certified as a nursing facility under Title XIX of the Social Security Act, it operated under a waiver of the Medicaid nurse staffing requirements established under Title XIX of the Social Security Act, if the waiver was granted on the basis of a demonstration that the facility was unable to provide the nursing care required under the Medicaid requirements for a period in excess of forty-eight hours per week;”			
“The long-term care facility was subject to an extended or partial extended Medicare or Medicaid certification survey;”			
“The long-term care facility’s participation in the Medicare or Medicaid program was terminated;”			
“A civil money penalty or fine of not less than five thousand dollars was imposed upon the facility because of Medicare or Medicaid certification deficiencies;”			
“A denial of payment for Medicare or Medicaid admissions was imposed upon the facility because of Medicare or Medicaid certification deficiencies;”			
“A temporary manager or special master was appointed for the facility because of Medicare or Medicaid certification deficiencies; or”			
“The facility was closed or its residents were transferred because of Medicare or Medicaid certification deficiencies.”			

PC Signature	Date
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Section C: Curriculum Changes

C1. To Change Curriculum

- ✓ Write in the name of your current curriculum on the first line and the name of the new curriculum on the second line.
- ✓ If your new curriculum is In-House, please include a copy of the entire curriculum.

Current Curriculum	New Curriculum
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Section D: Changes in Topic Hours

D1. To Change Topic Hours

Please note that the "Required Hours" column represents the minimum number of hours required by the Ohio Administrative Code for each topic area. The total hours for Preclinical, Classroom, and Clinical hours must equal at least 75 hours.

Please do not submit with any blank spaces.

Topic Area	Required Classroom Hours	Current Classroom Hours	New Classroom Hours	Required Clinical Hours	Current Clinical Hours	New Clinical Hours	Total Hours Required	Current Total Hours	New Total Hours
I. Overview	0.5			N/A			0.5		
II. Communication and Interpersonal Skills	4.5			N/A			4.5		
III. Infection Control	2.5			N/A			2.5		
IV. Safety and Emergency Procedures	6.5			N/A			6.5		
V. Promoting Residents' Independence	1.0			N/A			1.0		
VI. Respecting Residents' Rights	1.0			N/A			1.0		
Total Preclinical Hours	16			N/A			16.0		
VII. Basic Nursing Skills	9 to 13			6 to 10			19.0		
VIII. Personal Care Skills	14.5 to 15.5			7 to 8			22.5		
IX. Mental Health and Social Services Needs	7.5 to 9.5			2 to 4			11.5		
X. Basic Restorative Services	2 to 3			1 to 2			4.0		
XI. Residents' Rights	1 to 2			0 to 1			2.0		
Subtotal Classroom and Clinical Hours	34 to 43			16 to 25			59		
Overall Total (Preclinical plus Classroom and Clinical)									

PC Signature	Date
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