

REQUEST FOR REPRESENTATIVE TRAINING

MVA FORM AC-4

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Purpose: The Request for Representative Training Form is used to request training for new employees or for employees requesting re-certification to assist applicants with their Medicaid applications. **Only one individual may be listed per request form.**

Prior Approval Required: **All requests for Representative Training must be approved by DHH prior to the class.** No individual will be allowed to participate in the class who has not received prior approval. Participants will be notified prior to the class of approval of their request for training.

When Should A Request for Training Be Submitted? As soon as a need to have someone trained arises, a request should be submitted to DHH for review and approval. Being able to project training needs facilitates planning for training locations and helps to establish an orderly process for setting up training classes.

Completing the Form

Each item must be completed as follows for DHH and the Medicaid Program to review and approve the individual's request for AC Representative Training. Failure to complete this information may result in the request for representative training being delayed or denied.

AC-ID#: Enter the Application Center ID#, if known.

Parish: Indicate the Parish in which the AC is located.

Application Center Information: Please print or type: the name of the AC, AC street (physical) address, and its city, state, and zip code, P.O. Box/ mailing address, and its city, state, and zip code (if different from the street address), and, the AC area code, phone number, and FAX number where the individual for whom training is being requested can be reached. Please include the AC E-Mail address.

Participant Information: Please ***print or type*** the full name of the individual for whom approval is being requested to attend a representative training class, including their first name, middle initial, and last name. Enter the participant's social security number; complete date of birth (*i.e.*, 02-13-1970) and, current education level by years (*i.e.*, High School = 12 and four years of college with a degree = 16). Enter the participant's job title; their email address, the department in which he or she works; and, a brief description of their current job duties and responsibilities.

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Participant's Signature: The form must be signed by the individual who is requesting training. Indicate date on which the request is completed.

Questions that must be answered by the Administrator/CEO or Contact Person:

This section contains two questions pertaining to the status of certified representatives in your Application Center. The answers to these questions will help DHH determine if approval will be given on the request for training and will facilitate the updating of Medicaid Program records. Failure to complete this information may result in the request for representative training being delayed or denied.

NOTE: A non-public eMail address must be provided for each person attending training. Free eMail accounts may be obtained from a variety of Internet providers. All eMail addresses will be confirmed prior to approval to attend training.

Printed or Typed Name and Signature of Administrator/CEO: The completed form must include the Administrator/CEO's signature and printed or typed name.

For DHH Use Only: This section should be left blank by Application Center.

Where to Send the Form: After the form is completed, mail or fax it to DHH. The U. S. Postal Service address, email, and Fax number are listed at the top of the form.

Failure to Attend a Scheduled Class:

Participants who cancel their attendance or fail to attend a scheduled class for any reason will be required to submit a "NEW" Request for Representative Training form to DHH for approval to attend a future class.