REQUEST FOR AUTHORIZATION

Department of Medical Assistance Services
40-Hour PCA Training Program

Provider Name: _____ Provider #: _____

PCA Training Program Name: _____
Contact Name: _____ Phone #: _____
RN Instructor(s): _____
Address [Location(s) of Training] _____
1. _____
2. _____
3. _____

Special Notes or conditions concerning your program to be kept on file at DMAS:

_____
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Instructions:

1. Complete this form in its entirety.
2. Attach a copy of your training program's certificate of completion/graduation.
3. Mail to: The Department of Medical Assistance Services
   Waiver Services Unit
   600 East Broad Street
   Suite 1300
   Richmond, VA 23219
4. You will receive a letter of authorization with an effective date to begin the PCA training program from the Waiver Services Unit.
5. The Waiver Services Unit can be reached for questions at: (804) 786-1465.

Students cannot provide nursing aide services to Medicaid recipients until after they have successfully completed a minimum of 40 hours of nursing aide training and teaching.

This form contains patient-identifiable information and is intended for review and use of no one except authorized parties. Misuse or disclosure of this information is prohibited by State and Federal Laws. If you have obtained this form by mistake, please send it to: DMAS, 600 East Broad Street, Suite 1300, Richmond, VA 23219