Additional Skills Reimbursement Program

The Office of Emergency Health Systems

Please note changes to reimbursement program

The Nebraska Legislature has set aside money to reimburse EMS providers and services for EMS education.

ELIGIBILITY

EMS providers are only eligible to take **ADDITIONAL SKILLS MODULE** courses **IF** they are a Nebraska licensed EMS provider (at the respective level for the module) at the time they attended the class.

Requests for additional skills module reimbursement must be made within **30 days** of course completion. Failure to submit the reimbursement request within 30 days may result in denial of reimbursement. Reimbursement funds are limited and will be paid on a first come, first served basis.

The additional skills module reimbursement is to be submitted by the licensed EMS service or licensed EMS provider that received the training or by the training agency.

REQUESTING REIMBURSEMENT

- Requests for additional skill modules reimbursement **MUST** be on the request form.
- Each reimbursement request **MUST** include the completed the **Emergency Health Systems Additional Skills Module Roster – REIMBURSEMENT Classes**. Failure to provide this roster form may result in denial of payment.
- **MUST** submit a copy of the Training Agency invoice for module course(s) held if reimbursement is submitted by the service or provider.
- Eligible reimbursement amounts not to exceed $30 per student per module. Not to exceed $180 per student for Intravenous Access and Monitoring module.
- Training course with multiple modules taught can be submitted on one request form.
- Add-on module courses taken for continuing education is not eligible for this reimbursement. See Continuing Education Reimbursement guidelines.
- Email completed form and all required documentation or questions to dhhs.sp.EHSContinuingED@nebraska.gov Please fill form out electronically.

ADDITIONAL SKILLS MODULES

EMR	
Aspirin & Epinephrine Administration	Patient Transport
Patient Transport Devices	Spinal & Extremity Immobilization

EMT	
Glucometer	Intravenous Fluid Monitoring
Peripheral Intravenous Access & Monitoring	Impedance Threshold Device
Non-Visualized Advanced Airway	Albuterol & Epinephrine Administration

Emergency Medical Services Additional Skills Module Reimbursement Request

Email completed form with **ALL** required documentation within ***30*** days of course completion to:
dhhs.sp.EHSContinuingED@nebraska.gov

Fill in number of students that attended for all that apply:

	# of Students
a. EMR - Aspirin & Epinephrine Administration	0
b. EMR - Patient Transport	0
c. EMR - Patient Transport Devices	0
d. EMR - Spinal & Extremity Immobilization	0
e. EMT - Glucometer	0
f. EMT - Peripheral Intravenous Access & Monitoring	0
g. EMT - Intravenous Fluid Monitoring	0
h. EMT - Impedance Threshold Device	0
i. EMT - Non-Visualized Advanced Airway	0
j. EMT - Albuterol & Epinephrine Administration	0

What date(s) and times was the course(s) held?

Who was the module instructor and Training Agency affiliation?

Total reimbursement funds requested: $ $ 0.00

SECTION B

EMS Service, EMS Provider, or Training Agency Submitting for Reimbursement:

Your signature below is requesting tuition reimbursement for the EMR or EMT Additional Skills Module. With this form, you must include a copy of the Training Agency Invoice and completed course roster(s) supplied by EHS. The roster(s) must also contain the Training Agency's name, Instructor's name, the course title, and course completion date. The Office of Emergency Health Systems reserves the right to deny payment based on funding and/or requirements.

Typing your name below constitutes a legal electronic signature.

EMS Service Officer or Training Agency Representative Signature:

Phone Number: e-mail:

For DHHS use only		
Date Reimbursement Received:	*Date Entered/PD:*	*On Base Date:*
Licenses Verified:	*AB #:*	*Requestor #:*
Approved by:	*Date approved:*	*Amount approved to be paid:*
Comments:		

Revised 1/4/19

Click Here to Save AFTER Reimbursement & ACH forms are COMPLETE

Clear Form

STATE OF NEBRASKA W-9 & ACH ENROLLMENT FORM

PLEASE SUBMIT FORM TO INVOICED AGENCY

1 Name (as shown on your income tax return). Name is required on this line; do not leave this line blank.

2 Business name/disregarded entity name, if different from above

3 Check appropriate box for federal tax classification; check only **one** of the following boxes:

☐ Individual ☐ Sole proprietor ☐ C Corporation ☐ S Corporation ☐ Partnership ☐ Trust/Estate

☐ Non-Profit Entity ☐ Government (Local, State or Federal)

☐ Limited Liability Company. Enter the tax classification (C = C Corporation, S = S Corporation, P = Partnership) ____

☐ Other (see instructions) _____

Note: Enter the owner's name on line 1 and mark the appropriate federal tax classification box for disregarded entities.

4 Exemptions (see instructions): Exempt payee code (if any) _____ Exemption from FATCA reporting code (if any) _____

5 Address:

Remit Address (if different):

6 City, state, and ZIP code

City, state, and ZIP code

Taxpayer Identification Number (TIN):

Social Security Number (SSN): _____-_____-_____ **OR** Employer Identification Number (EIN): _____-_____

Certification:

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), and
2. I am not subject to backup withholding due to failure to report interest and dividend income, and
3. I am a U.S. citizen or other U.S. person (defined in the instructions), and
4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

For additional instructions please refer to http://www.irs.gov/pub/irs-pdf/fw9.pdf to obtain a copy of the IRS Form W-9 General Instructions.

Signature of US Person:_____ Date: _____

Printed Name: _____ Contact Phone:_____

Comments or Business/Entity Notes:

ACH Enrollment: (Rev. December 2014) ☐ Initial Setup ☐ Change ☐ Close Account

This information is REQUIRED to process ACH payments. Without this information, your payment may be delayed.

Financial Institution Name:	Nine Digit Routing Number:	Prior Routing Number: *	☐ Check here if the bank is outside of the United States.
Address:	Depositor Account Number:	Prior Account Number: *	☐ Check here if our payments to you are being forwarded from a U.S. financial institution to a financial institution in another country
City, state and ZIP code:	Type of Account: ☐ Checking ☐ Savings	* Prior ACH instructions are required to be completed if changing/updating your ACH instructions with the State of Nebraska.	

This account will be used for all payments by the State of Nebraska unless specified here: _____

E-mail:_____

(Used for ACH payment notifications.)

Authorized Individual or Entity Signature:	**Attachment Required!** (Select and attach **one** of the following items for verification):
Printed Name:	☐ Blank check (voided) or ☐ Photocopy of a cleared check
Title:	☐ Letter or statement from your financial institution
Date	☐ Vendor invoice or letter which contains printed ACH instructions

Internal Use Only:

Funding for this class has been provided by the

Nebraska Department of Health & Human Services
Office of Emergency Health Systems
Additional Skills Module Roster – REIMBURSEMENT Classes

ADD-ON MODULE(S): _____ DATE(S): _____

INSTRUCTOR: _____ CE HOURS: _____

TRAINING AGENCY: _____ LOCATION HELD: _____

Legal Name (please print **LEGIBLY**)	**Organization / Department**	**EMS License Level**	**Signature**	**P / F**
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