

EMS Tuition Reimbursement Program Instruction

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

ELIGIBILITY

In order for an individual to be eligible for reimbursement for an INITIAL or a REINSTATEMENT course, they must hold an active (not temporary) Nebraska EMS license at the level that they are requesting reimbursement for.

Providers requesting INITIAL course reimbursement for the EMR to EMT Bridge, must have been a Nebraska licensed EMR during the course and at the time that they were granted an EMT license. Providers requesting INITIAL course reimbursement for the "Nurse Bridge" courses must have been a Nebraska licensed practical nurse or registered nurse during the course and at the time they were granted an EMS license.

REINSTATEMENT requests are only for those persons that previously held a Nebraska EMS provider license at the level that they reinstated and are requesting reimbursement. Providers that were not expired/lapsed during their refresher course are NOT eligible for reimbursement.

INITIAL and REINSTATEMENT reimbursement payments are tiered according to the number of days between course completion date and the date the completed application packet is received by the department. Consideration may be given if a delay in licensing is caused due to the background check process. See table below for reimbursement amounts. Requests for reimbursement must be submitted within one (1) calendar year of course completion. Reimbursement funds are limited and will be paid on a first come, first served basis. The Office of Emergency Health Systems reserves the right to reimburse less than or deny reimbursement based on funding limitations. EHS reserves the right to ask for proof of payment for initial or reinstatement tuition fees. Reimbursement amount will not exceed total tuition fee.

REQUESTING REIMBURSEMENT

Requests for INITIAL or REINSTATEMENT reimbursement must be on the request form. **Supporting documents listed on the request form must also accompany the request.** Completed form and supporting documentation must be saved or scanned and sent as an attachment to the email address noted on the form. **Requests will not be accepted if mailed, faxed, or emailed to EHS staff.**

A W-9/ACH form and copy of a blank or voided check **must** be completed by the student if the student is being reimbursed or by the agency if the agency is being reimbursed. **Incomplete reimbursements will not be processed until completed and may be denied if documentation is not received.**

Email completed form with the required documentation or questions to: dhhs.sp.EHSContinuingED@nebraska.gov

EMS REIMBURSEMENT AMOUNTS

INITIAL EDUCATION COURSES (amounts are per eligible provider)

Course Completion to Request Date	Within 60 Days	61-120 Days	121-180 Days	181-270 Days
Emergency Medical Responder (EMR) Course	\$265.00	\$230.00	\$190.00	\$75.00
Emergency Medical Technician (EMT) Course	\$620.00	\$530.00	\$440.00	\$175.00
Advanced Emergency Medical Technician (AEMT) Course	\$1,100.00	\$940.00	\$780.00	\$315.00
Paramedic Course	\$3,900.00	\$3300.00	\$2800.00	\$1100.00
Pre-Hospital Emergency Care Course Nurse to EMT Bridge Course	\$350.00	\$300.00	\$255.00	\$100.00
Pre-Hospital Emergency Care Course Nurse to Paramedic Bridge Course	\$2,100.00	\$1,800.00	\$1,500.00	\$600.00
EMR to EMT Bridge Course	\$390.00	\$335.00	\$280.00	\$110.00

REINSTATEMENT COURSES (amounts are per eligible provider)

Course Completion to Request Date	Within 60 Days	61-120 Days	121-180 Days	181-270 Days
Emergency Medical Responder Refresher Course	\$115.00	\$100.00	\$80.00	\$30.00
Emergency Medical Technician Refresher Course	\$150.00	\$130.00	\$110.00	\$45.00
Advanced Emergency Medical Technician Refresher Course	\$210.00	\$180.00	\$150.00	\$60.00
Paramedic Refresher Course	\$220.00	\$190.00	\$160.00	\$65.00



Office of Emergency Health Systems Initial Education Course / Licensure Reinstatement Refresher Reimbursement Request

Reimbursement Requirements

PLEASE FILL OUT FORMS ELECTRONICALLY. With this form, you **MUST** include copies of (NOTE: The W-9/ACH forms are filled out by the student or service who is being reimbursed):



- A copy of Course Completion Certificate issued by training agency
- The attached W-9/ACH form **AND** a copy of a blank or voided check

SECTION A	
Are you licensed as a State of Nebraska out-of-hospital emergency care provider at the level that you are requesting reimbursement for? <input type="checkbox"/> YES <input type="checkbox"/> NO	
IF YOU ANSWERED YES TO THE QUESTION ABOVE, CONTINUE BELOW. IF YOU ANSWERED NO, YOU ARE <u>NOT</u> ELIGIBLE FOR REIMBURSEMENT.	
Student Name:	Nebraska EMS License #:
Student Phone Number:	Student Email:
What course did you complete? <input type="checkbox"/> EMR <input type="checkbox"/> EMT <input type="checkbox"/> AEMT <input type="checkbox"/> Paramedic <input type="checkbox"/> EMR to EMT BRIDGE <input type="checkbox"/> Nurse to EMT BRIDGE <input type="checkbox"/> Nurse to Paramedic BRIDGE	
Please mark: <input type="checkbox"/> Initial <input type="checkbox"/> Refresher (Reinstatement Only)	
What training agency offered your course? If Other, Specify	
Course Location:	Date of Course Completion:

SECTION B	
EMS Agency Name or Employer:	
Signature of person or agency being reimbursed:	Reimbursement to go to: <input type="checkbox"/> Student <input type="checkbox"/> Agency



Email completed form with the required documentation to: dhhs.sp.EHSContinuingED@nebraska.gov

<i>For DHHS use only</i>		
<i>Date Application Received:</i>	<i>License Verified:</i>	<i>Service Roster Verified:</i>
<i>Within # of Days:</i>	<i>Amount approved to be paid:</i>	
<i>Approved By:</i>	<i>Date Approved:</i>	<i>On Base Enter Date:</i>
<i>Requestor #:</i>	<i>AB#:</i>	
<i>Comments:</i>		

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: *	<input type="checkbox"/> Check here if the bank is outside of the United States.
Address:	Depositor Account Number:	Prior Account Number: *	<input type="checkbox"/> 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: <input type="checkbox"/> Checking <input type="checkbox"/> 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:	
Title:	
Date	

Internal Use Only: