NC Medicaid
HIV Case Management

Continuing Education Training Approval Request Form

NC Medicaid Clinical Coverage Policy 12B requires HIV Case Management Supervisors and Case Managers billing Medicaid for their services complete **12 hours** of continuing education annually. Reference "**Annual Training**" in **Section 6.1.7.2 of Clinical Coverage Policy 12B** for details.

Training must be in relevant areas such as confidentiality, cultural competency, HIV disease management, ethics, the core components of HIV Case Management and care of individuals who are HIV positive. Clinically oriented training should account for 6 of the 12 required hours.

The Training Approval Request Form, found below, should be submitted for NC Medicaid approval at least 2 **weeks** prior to training. The following information should be included on the form: attendee name, date, and length of training, sponsoring organization and website, target audience, and topics to be covered. A copy of the training announcement, including presenter(s), agenda and objectives should be included with this form. It is the provider agency's responsibility to document and retain training records and certificates of completion.

To request training approval, please complete and submit this form to NC Medicaid via mail, email, or fax.

NC MEDICAID
HIV CASE MANAGEMENT

2501 MAIL SERVICE
CENTER RALEIGH, NC
27699-2501

PHONE: (919) 855-4360
FAX: (919) 715-0102
EMAIL: HIV_CASEMGT@DHHS.NC.GOV

HIV CM Continuing Education Training Approval Request Form

PROVIDER AND ATTENDEE INFORMATION

Provider's Agency Name:		**Today's Date:**
Attendee Name:	**Attendee Title:**	
Agency Phone:	**Contact Number:**	**Other:**
Email Address:		

EVENT/TRAINING INFORMATION

Name of event:			**Date(s) of Event:**
Sponsoring Organization and Website:			**Length of Training:**
Location / Address (if applicable):			
Event Format:			
In-Person: ☐		**Teleconference:** ☐	
Webinar: ☐		**Webcast:** ☐	
Target Audience:			
Topics to be Covered:			

Please confirm documents submitted with this form:

Training / Event Announcement: **yes** ☐ **No** ☐

Training / Event Agenda or Objectives: **yes** ☐ **No** ☐

Other: yes ☐ **No** ☐ **If yes, please list below:**

DETERMINATION

TO BE COMPLETED BY NC Medicaid STAFF

Training Request:	**Approved** ☐ **Denied** ☐	
Number of Hours Approved:		
Reason for Denial (if applicable):		
NC Medicaid HIV Case Management Signature:		**Date:**
Determination Sent Date:	**Method:**	

Email completed form and documentation to HIV_CaseMgt@dhhs.nc.gov