

REQUESTER NAME: \_\_\_\_\_

DATE OF SUBMISSION: \_\_\_\_\_  
(MUST BE 3 WEEKS PRIOR TO EVENT)

**NORTH CAROLINA  
DIVISION OF MEDICAL ASSISTANCE  
HIV CASE MANAGEMENT**

**CONTACT HOURS APPROVAL REQUEST FORM**

The Division of Medical Assistance's Clinical Coverage Policy 12B requires completion of **20 hours of contact hours**/continuing education annually by HIV Case Management Supervisors and Case Managers for recertification of HIV Case Management provider agencies. Reference "**Annual Training**" in **Section 6.4.2 of Clinical Coverage Policy 12B**.

Training must be in relevant areas such as the nature and course of HIV disease, confidentiality, ethics, case management, community resource development, substance abuse issues as they relate to HIV disease, and issues of death and dying.

A provider should submit a request for approval of training at least **3 weeks** prior to the training. The request should include the following information/documentation: name, date, and length of training, sponsoring organization, target audience, and topics to be covered all of which can be included on this form. A copy of the training announcement should be attached. Participation in training should be documented and kept on file.

\*Approval is not needed for trainings sponsored by the Division of Medical Assistance and the Carolinas Center for Medical Excellence (CCME).

The Division of Medical Assistance requires that a CV or resume of the presenters also be included when requesting approval of training(s). In addition a copy of the training agenda/objectives should be included with this form.

To request approval of training, please complete this form or provide this information via another format and submit to Victoria Landes, HIV Program Consultant. Requests may be submitted via mail, email or fax.

**VICTORIA LANDES  
HIV PROGRAM CONSULTANT  
DIVISION OF MEDICAL ASSISTANCE  
2501 MAIL SERVICE CENTER  
RALEIGH, NC 27699-2501  
PHONE: (919) 855-4389  
FAX: (919) 715-2372  
E-MAIL: VICTORIA.LANDES@DHHS.NC.GOV**

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PROVIDER/REQUESTER INFORMATION		
AGENCY NAME:		
REQUESTER'S NAME:	REQUESTER'S POSITION:	
ADDRESS:		
CITY:	COUNTY:	ZIP:
AGENCY PHONE:	REQUESTER'S PHONE/EXT:	OTHER:
EMAIL ADDRESS:		

EVENT/TRAINING INFORMATION	
NAME OF EVENT:	DATE(S) OF EVENT:
SPONSORING ORGANIZATION:	LENGTH OF TRAINING:
LOCATION /ADDRESS(IF APPLICABLE):	
EVENT FORMAT :	
IN-PERSON : <input type="checkbox"/>	TELECONFERENCE: <input type="checkbox"/>
WEBINAR: <input type="checkbox"/>	WEBCAST: <input type="checkbox"/>
TARGET AUDIENCE:	
TOPICS TO BE COVERED:	
PLEASE CONFIRM DOCUMENTS ATTACHED TO THIS FORM FOR APPROVAL:	
PRESENTER(S) RESUME/CURRICULUM VITAE: YES <input type="checkbox"/> NO <input type="checkbox"/>	
TRAINING/EVENT AGENDA: YES <input type="checkbox"/> NO <input type="checkbox"/>	
TRAINING/EVENT ANNOUNCEMENT: YES <input type="checkbox"/> NO <input type="checkbox"/>	
OTHER: YES <input type="checkbox"/> NO <input type="checkbox"/> IF YES, PLEASE LIST BELOW:	

APPROVAL DECISION	
*TO BE COMPLETED BY DMA STAFF*	
CONTACT HOURS APPROVED: YES <input type="checkbox"/> NO <input type="checkbox"/>	
HOURS APPROVED:	
REASON FOR DENIAL (IF APPLICABLE):	

REQUESTER SIGNATURE: \_\_\_\_\_

DATE: \_\_\_\_\_