



North Carolina
 Department of Health and Human Services
Division of Medical Assistance
Financial Operations/Rate Setting

1985 Umstead Drive – 2501 Mail Service Center - Raleigh, N.C. 27699-2501

Michael F. Easley, Governor
 Dempsey Benton, Secretary

William W. Lawrence, Jr., M.D. Acting Director

Registration for the 2007 Personal Care Services Cost Report Training Class

The Division of Medical Assistance (DMA) will be conducting training for the preparation of the 2007 Personal Care Service Cost Report. The new registration form, the 2007 PCS Cost Report schedules, the instruction manual, and a PowerPoint presentation will be posted on DMA’s website by May 14, 2008.

Pre-registration is required due to limited space availability. Your registration form needs to be received and confirmed at least five (5) business days prior to the training class you wish to take. Please complete the attached registration form, choosing the training date and time that is most convenient for you. Seating availability will be based on a first come, first serve basis. The training site is able to accommodate between 60-70 participants. A confirmation of your registration will be sent to you.

Please submit the registration form to Cindy.Bass@ncmail.net or fax it to 919-715-2209. In the subject line of your e-mail please reference the following: “*provider’s name* and 2007 PCS Cost Report Registration Form for *date AM PM session*”.

Training sessions are scheduled at the NCDOT Training Center, 313 Chapanoke Road, Garner, NC 27603, for the dates and times below:

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|--------------------------------|---|---|
| <i>June 10, 2008, Tuesday</i> | <input type="checkbox"/> <i>TIME: 9:00 AM to 12:00 PM</i> | <input type="checkbox"/> <i>TIME: 1:30 PM to 04:30 PM</i> |
| <i>June 19, 2008, Thursday</i> | <input type="checkbox"/> <i>TIME: 9:00 AM to 12:00 PM</i> | <input type="checkbox"/> <i>TIME: 1:30 PM to 04:30 PM</i> |
| <i>June 20, 2008, Friday</i> | <input type="checkbox"/> <i>TIME: 9:00 AM to 12:00 PM</i> | <input type="checkbox"/> <i>TIME: 1:30 PM to 04:30 PM</i> |

Tax ID#	Medicaid Provider #(s)
Provider Name	Date of Class Morning or Afternoon
Participant #1’s Name	Participant #2’s Name
Telephone #	Telephone #
Fax #	Fax #
Email Address	Email Address