AFHTN AFH Course Hour Payment Verification Form

To be completed by the sponsoring Adult Family Home

Sponsored Individual Information

Full Name: ______________________________________

Training Program (HCA or CNA): _______________________

Training School: _________________________________

Date Training Began: ___________

Date Training Completed: ___________

Payment Details for Course Hours

Payment Date(s)	Training Dates Covered	Total Hours Paid	Hourly Rate	Payment Amount	Payment Frequency (e.g., biweekly, monthly)	Notes (if any)

*Add more rows as needed. *

Verification and Attestation

I certify that the information provided above accurately reflects payments made to the sponsored individual for completion of course hours related to their Home Care Aide (HCA) or Certified Nursing Assistant (CNA) training.

AFH Representative Name (Printed): ________________________

AFH Representative Signature: _____________________________

Title/Role: _________________________

Date: _____________