

**Appendix E**

Department of Health and Human Services' Office of Adult Mental Health Services  
and The Center for Learning

*This form may be copied.*

**MHRT/COMMUNITY TUITION REIMBURSEMENT REQUEST**

**Application must be mailed at least 30 days before the start of the class.  
Funds are very limited. Applicants are cautioned to not make coursework plans based on an  
assumption of reimbursement.**

**A. - IDENTIFICATION:** (NOTE: All information MUST be filled in for this section in order for your request to be processed.)  
**PLEASE PRINT CLEARLY! Illegible or incomplete requests will be returned unprocessed.**

Name: \_\_\_\_\_ Work Tel: \_\_\_\_\_ SS.#: \_\_\_\_\_  
Your Home Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_  
Agency (Full Name): \_\_\_\_\_  
Agency Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Address reimbursement check is being mailed to: **(Circle One)** HOME AGENCY

**B. - ELIGIBILITY:** (A response is needed to each question in this section. A "yes" answer is required for each question. "No" answers and/or false statements will result in denial of tuition reimbursement)

- 1) My position is funded by a DHHS contract ..... Yes \_\_\_ No \_\_\_
- 2) My position is DHHS funded for 20 hours (half-time) or more..... Yes \_\_\_ No \_\_\_
- 3) The applicant has a Provisional MHRT/Community Level B Certification on file with the Center for Learning ..... Yes \_\_\_ No \_\_\_
- 4) The course(s) identified are required for applicant's present position and for MHRT/Community Certification..... Yes \_\_\_ No \_\_\_

**C. - COURSE IDENTIFICATION:** (Please enter cost of tuition for the class: \$ \_\_\_\_\_)

School, Campus & Location: \_\_\_\_\_  
(Note: Please list the name of the institution you will be attending in the above information)

Course Title: \_\_\_\_\_  
(Note: A separate request sheet must be made out for each course.)

Reimbursement to: **(Circle One)** SELF AGENCY Undergraduate Course \_\_\_ Graduate Course \_\_\_

**D. - SEMESTER:** Please list the Semester/Year of the course here: \_\_\_\_\_

**E. - APPROVAL:** Supervisor's Name: \_\_\_\_\_ Date: \_\_\_\_\_  
(Please Print Clearly)

\_\_\_\_\_  
(Supervisor Signature)\* (Applicant Signature)

**\*NOTE:** Supervisor's signature indicates that all Eligibility Statements are accurate and that individual is authorized to submit this request.

**BOTH STUDENT & SUPERVISOR SIGNATURES ARE REQUIRED**

Completed form must be returned to: **The Center For Learning, 45 Commerce Dr. Suite 11, Augusta, ME 04330**  
**Attn: Tuition Reimbursement or faxed to 626-5022.** The DHHS Office of Adult Mental Health Services will reimburse **only the actual tuition costs** for the course (up to a maximum tuition rate for an undergraduate 3 credit course at USM). Students understand they are responsible for books and fees. Reimbursement will be made after receipt of an official transcript for the course with a grade of "C" or better. Students must submit the transcript directly to the Center For Learning for reimbursement. Grades must be mailed within 30 days of close of class. There is a limit of three classes per fiscal year (July 1 through June 30).