

## **Personal Care Aide Checklist Other Equivalent Training Program**

Effective July 1, 2006, provider applicants for non-agency personal care aide services for the Ohio Home Care Waiver, Transitions MR/DD Waiver, and the Transitions Carve-Out Waiver must meet both of the following pre-enrollment training requirements:

1. **Applicant must obtain and maintain first aid certification.**
2. **Applicant must obtain training through one of the two options listed below:**

**a. Competency Evaluation Program:**

The applicant may have obtained training from either a nurse aide competency evaluation program through the Ohio Department of Health or a medicare competency evaluation program for home health aides. The provider applicant must submit a certificate of completion dated within the last 24 months of the date of application as part of the provider application packet submitted to CareStar and forwarded to BHCS.

**b. Other Equivalent Community Program:**

The applicant may obtain training from an equivalent community program. Equivalent training may be provided by existing training programs or by the consumer, the consumer's authorized representative (e.g., parent or other family member), or other qualified person.

If the training is provided by an established program, the provider applicant must submit a certificate of completion and the syllabus for the community program as part of the provider application packet submitted to CareStar. Care Star will forward the packet to BHCS for determination whether training requirements are met.

If the training is provided by the consumer, authorized representative or other qualified person, the training must include the items listed below as well as instruction about the specific care needs of the consumer. The training must include instruction about:

- Personal care aide services that assist the consumer with activities of daily living and instrumental activities of daily living impairments;
- Basic Home Safety; and
- Universal precautions for infection control, including hand-washing and proper disposal of bodily waste.

If the training is provided by the consumer, authorized representative or other qualified person, the provider applicant must submit verifying documentation using the attached check-list and Provider Enrollment Addendum: Non-Agency Personal Care Aide, Other Equivalent Training Option as part of the provider application packet submitted to CareStar. Care Star will forward the packet to BHCS for determination whether training requirements are met.

**Consumers should be aware of the need to train each new non-agency personal care aide to meet their specific requirements. All training must be documented on a separate checklist for each non-agency personal care aide.**

**Other Equivalent Training Program  
Consumer, Consumer's Representative or Qualified Trainer Checklist**

Name: \_\_\_\_\_ SSN: \_\_\_\_\_  
(Person receiving training)

The following checklist is intended to document that the provider has been successfully trained in the above activities and meets the equivalent training standards as outlined in Ohio Administrative Codes (OAC) 5101:3-46-04, 5101:3-47-04 and 5101:3-50-04.

This checklist should be completed by the consumer, the consumer's representative or a qualified trainer selected by the consumer or the consumer's representative. **Since this training is consumer-specific, only the activities that directly relate to the consumer's care need to be indicated.**

**Activities of Daily Living (Required)** (Check as appropriate)

|   |   |
|---|---|
| <input type="checkbox"/> Bathing<br><input type="checkbox"/> Dressing<br><input type="checkbox"/> Grooming<br><input type="checkbox"/> Nail Care<br><input type="checkbox"/> Hair Care<br><input type="checkbox"/> Deodorant Application<br><input type="checkbox"/> Oral Hygiene<br><input type="checkbox"/> Shaving | <input type="checkbox"/> Skin Care<br><input type="checkbox"/> Foot Care<br><input type="checkbox"/> Feeding<br><input type="checkbox"/> Toileting<br><input type="checkbox"/> Assisting with Moving Around<br><input type="checkbox"/> Transferring<br><input type="checkbox"/> Positioning in Bed<br><input type="checkbox"/> Range of Motion Exercises |
|---|---|

**Instrumental Activities of Daily Living Impairments (Required)** (Check as appropriate)

|  |   |
|--|---|
| <input type="checkbox"/> Meal Preparation and Cleanup<br><input type="checkbox"/> Laundry<br><input type="checkbox"/> Waste Disposal<br><input type="checkbox"/> Bed-Making<br><input type="checkbox"/> Dusting<br><input type="checkbox"/> Vacuuming<br><input type="checkbox"/> Washing Floors<br><input type="checkbox"/> Washing Windows<br><input type="checkbox"/> Washing Walls | <input type="checkbox"/> Accompanying or Transporting Consumer<br><input type="checkbox"/> Running Errands for Consumer<br><input type="checkbox"/> Moving Heavy Items to Provide Safe Access and Exit<br><input type="checkbox"/> Tacking Down Loose Rugs and Tiles<br><input type="checkbox"/> Assisting with Paying Bills as Directed by Consumer<br><input type="checkbox"/> Assisting with Personal Correspondence as Directed by Consumer |
|--|---|

**Consumer, Consumer's Representative or Qualified Trainer Checklist**

Name: \_\_\_\_\_

(Person receiving training)

**Basic Home Safety (Required)**

(Training to ensure consumer is safe at home. Examples include but are not limited to: Ways to avoid slips, trips and falls; fire safety; evacuations; electrical safety; etc.)

**Universal precautions of infection control (Required)**

|  |  |
|--|--|
| <input type="checkbox"/> Proper Hand-Washing             | <input type="checkbox"/> Proper sterile technique (ie. use of gloves, masks, etc.) |
| <input type="checkbox"/> Proper Disposal of Bodily Waste |  |
| <input type="checkbox"/> Other(specify)                  |  |

**Other Training** (Please specify)

(Examples: Monitoring Consumer for Skin Breakdown, Back Injury Prevention for Provider and Communication, Monitoring Intake and Output)

Date of completion of training: \_\_\_\_\_

I have trained \_\_\_\_\_ to meet the personal care aide needs identified on the All Services Plan (ASP) of Consumer:

\_\_\_\_\_.

Training Conducted by: \_\_\_\_\_

Trainer's Relationship to Consumer: \_\_\_\_\_

I verify that the above named provider has been properly trained to perform the activities as outlined in OAC as an other equivalent training program and the home health care needs as listed on the consumer's All Services Plan.

Signature: \_\_\_\_\_

Consumer OR Authorized Representative

**Provider Enrollment Addendum  
Non-Agency Personal Care Aide  
Other Equivalent Community Training Program**

Name: \_\_\_\_\_

Phone Number: \_\_\_\_\_

**Initial each item**

\_\_\_\_\_ I have received training to meet the requirements as specified in Ohio Administrative Code (OAC) 5101:3-46-04 (B) (7) (a) or 5101:3-47-04 (B) (7) (a) or 5101:3-50-04 (B) (7) (a) as Other Equivalent Training Program for Medicaid consumer:

\_\_\_\_\_ ;  
(Name of Consumer)

\_\_\_\_\_ I understand that it is my responsibility to obtain other equivalent training that is specific to the needs of all consumers that I provide services for in the future through the Ohio Department of Job and Family Services-administered Waiver Program prior to starting service delivery;

\_\_\_\_\_ I understand that a new form that documents the Other Equivalent Training Program is required for each Medicaid consumer prior to being approved by the case manager on the consumer's All Services Plan and submitting claims for reimbursement;

\_\_\_\_\_ I understand that additional training as a non-agency personal care aide can be required if I am unable to demonstrate that my skills assure the health and safety of the consumer;

\_\_\_\_\_ I understand that if I fail to comply with the above requirements and the requirements as outlined in the OAC for Other Equivalent Training, I must repay any reimbursements I have received from Medicaid through the ODJFS-administered waiver programs.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_