Ohio Department of Medicaid

HOME CARE ATTENDANT (HCA) SKILLED TASK AUTHORIZATION

Individual Name *(Please print)*			Medicaid Billing #
Individual Street Address	**City**	**State**	**Zip Code**

SKILLED TASKS TRAINING LIST

INSTRUCTIONS FOR TRAINER

Enter the medically necessary skilled task(s) the Home Care Attendant has successfully completed training to perform. Draw a single line through any unused boxes.

INSTRUCTIONS FOR AUTHORIZING HEALTH CARE PROFESSIONAL (AHP)

Place initials in the box for each approved task(s).

TASK	AHP INITIALS	TASK	AHP INITIALS

SKILLED TASKS APPROVAL

DIRECTIONS

Each team member shown below must complete the section that applies to her/his role. The HCA is not approved to perform the listed task(s) until though AHP has initialed the "Training Detail" page.

INDIVIDUAL/AUTHORIZED REPRESENTATIVE

I, the undersigned have received the necessary training and am electing to select, instruct and direct the Home Care Attendant (HCA) to perform the task(s) set forth on this form. I will ensure that the HCA performs the task(s) consistent with her/his training and in accordance with OAC Rule 5160-46-04.1, as appropriate. I understand that this authorization may be revoked at any time by my authorizing health care professional. I am responsible for reporting any changes in my health or circumstances to the Case Management Agency (CMA) Case Manager, Trainer (if other than individual, HCA, and Authorizing Health Care Professional.

Name *(Please print)*	Signature	Initials	Date Signed

HOME CARE ATTENDANT

I, the undersigned have received training in task(s) set forth on this form, and will perform the task(s) in accordance with OAC Rule 5160-46-04.1, as appropriate, and as trained by the individual, authorized representative and/or trainer. I understand that I am approved to perform on the listed task(s) for this individual and that ODM may revoke that approval at any time if deemed necessary. I understand I am responsible for reporting any changes in my ability to perform the task(s) to the Individual, CMA Case Manager, Trainer, and Authorizing Health Care Professional.

Name *(Please print)*	Signature	Initials	Date Signed

TRAINER *(Please read before signing and dating)*

I, the undersigned, verify that I have successfully trained the Home Care Attendant to perform the task(s) set forth on this form.

Trainer Name *(Please print)*	Signature	Initials	Date Signed

AUTHORIZING HEALTH CARE PROFESSIONAL AND TRAINER *(Please read before signing and dating)*

I, the undersigned, approve the individual's decision to select, instruct and direct the Home Care Attendant in the performance of the task(s) set forth on this form. I understand that I may revoke approval at any time, if deemed necessary, by notifying the Individual/Authorized Representative, CMA Case Manager, and Trainer.

Name *(Please print)*	Signature	Initials

Date Signed	Emergency Phone Number *(Including Area Code)*	Fax Number *(Including Area Code)*

In the event that no physician is aware of or supports the individual's decision to use the Home Care Attendant option, the Registered Nurse who is serving as the Authorizing Health Care Professional must be made aware of the physician's exclusion or non-support.

Customer/Authorized Representative (Initials) ____________

Authorizing Health Care Professional (Initials) ____________

SKILLED TASK TRAINING DETAIL

Individual Name *(Please print)*	Effective Period *(not to exceed 12 months)*
Trainer Name *(Please print)*	Start Date: ______________________ End Date: _____________________

DIRECTIONS

Trainer – Enter the name of the medically necessary skilled task required by the individual. Enter the date the Home Care Attendant (HCA) completed training to successfully perform the skilled task. Write a detailed description of how HCA will perform the task, including times or intervals. (If the individual/authorized representative is the trainer, the individual/authorized representative will complete this section.)

Name of Task	Date Training Completed

Task Training Detail

☐ Check here if CONTINUED on next page

Authorizing Health Care Professional

My initials indicate approval of this task to be performed by the Home Care Attendant and that the Home Care Attendant has demonstrated the ability to perform the task.

(Initial here) ___________