

TA WAIVER ONLY

**You will only complete this form if you are working for a client on the TA waiver.
This must be completed and submitted BEFORE you can begin working.**

HCBS Technology Assisted Waiver Personal Service Attendant (PSA) Training Checklist

The PSA will receive training from the parent or legal guardian specific to the TA Waiver Recipient for whom care is provided. The PSA will provide care under the direction of the parent or legal guardian and is expected to demonstrate knowledge and proficiency in the tasks indicated below:

Name of TA waiver Recipient:		Medicaid ID#:
<input type="checkbox"/> Yes <input type="checkbox"/> No	Lifting and Body Mechanics	<input type="checkbox"/> Yes <input type="checkbox"/> No Diapering Technique and Protocol
<input type="checkbox"/> Yes <input type="checkbox"/> No	Transfers and Positioning	<input type="checkbox"/> Yes <input type="checkbox"/> No Enema/Suppository Insertion
<input type="checkbox"/> Yes <input type="checkbox"/> No	Ambulation Techniques	<input type="checkbox"/> Yes <input type="checkbox"/> No Seizure Control Protocol
<input type="checkbox"/> Yes <input type="checkbox"/> No	Bathing and Hair Care	<input type="checkbox"/> Yes <input type="checkbox"/> No Range of Motion exercises
<input type="checkbox"/> Yes <input type="checkbox"/> No	Oral Care	<input type="checkbox"/> Yes <input type="checkbox"/> No Communication Techniques
<input type="checkbox"/> Yes <input type="checkbox"/> No	Skin and Nail Care	<input type="checkbox"/> Yes <input type="checkbox"/> No Behavior Modification Techniques
<input type="checkbox"/> Yes <input type="checkbox"/> No	Dressing Assistance	<input type="checkbox"/> Yes <input type="checkbox"/> No Infection Control Procedures
<input type="checkbox"/> Yes <input type="checkbox"/> No	Hearing Impaired Assistance	<input type="checkbox"/> Yes <input type="checkbox"/> No CPR/First Aid
<input type="checkbox"/> Yes <input type="checkbox"/> No	Visually Impaired Assistance	<input type="checkbox"/> Yes <input type="checkbox"/> No Emergency Procedures
<input type="checkbox"/> Yes <input type="checkbox"/> No	Specialized Diet/ Nutrition Preparation	<input type="checkbox"/> Yes <input type="checkbox"/> No Laundry Assistance
<input type="checkbox"/> Yes <input type="checkbox"/> No	NG/GT/NJ Feeding and Care	<input type="checkbox"/> Yes <input type="checkbox"/> No Room/Housekeeping Assistance
<input type="checkbox"/> Yes <input type="checkbox"/> No	Medication Administration	<input type="checkbox"/> Yes <input type="checkbox"/> No Documentation/Record Keeping
<input type="checkbox"/> Yes <input type="checkbox"/> No	Temperature Monitoring	<input type="checkbox"/> Yes <input type="checkbox"/> No Other (specify below)
<input type="checkbox"/> Yes <input type="checkbox"/> No	Blood Pressure Monitoring	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Yes <input type="checkbox"/> No	Pulse Assessment	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Yes <input type="checkbox"/> No	Pulse Ox Monitoring	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Yes <input type="checkbox"/> No	Respiration Monitoring	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Yes <input type="checkbox"/> No	Oxygen Administration	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Yes <input type="checkbox"/> No	Use of Suction Machine	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Yes <input type="checkbox"/> No	Use of Glucometer	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Yes <input type="checkbox"/> No	Tracheotomy Care	
<input type="checkbox"/> Yes <input type="checkbox"/> No	Catheter Care/ Recording Input & Output	

My signature confirms that I, _____ (print name) have been trained by the parent or legal guardian to perform the delegated tasks identified in the PSA Training Checklist and that I am able to perform these tasks.

Date: _____

Personal Service Attendant (PSA) Signature

My signature confirms that I, _____ (print name) as parent/legal guardian of _____ (print name) have the authority to delegate and train the PSA in the tasks identified in the above training checklist. The PSA may perform the specified tasks while providing care for _____ under my authority.

Date: _____

Parent/Legal Guardian Signature

The parent or legal guardian's delegation of tasks to be provided by the PSA is limited to the term services are provided for the specific consumer in which he/she is trained to provide. Parents or legal guardian understand by delegating tasks to PSA that he/she assumes all responsibility for the action or inaction of the PSA to which authorization of tasks are given.