



## 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.

### CONSUMER/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 5101:3-46-04.1, 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 consumer, HCA, and Authorized Health Care Professional.

Name <i>(Please print)</i>	Signature	Initials	Date Signed
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### 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 5101:3-46-94.1 or 5101:3-50-04.1, as appropriate, and as trained by the consumer, authorized representative and/or trainer. I understand that I am approved to perform on the listed task(s) for this consumer and that ODJFS 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 Consumer, CMA Case Manager, Trainer, and Authorized Health Care Professional.

Name <i>(Please print)</i>	Signature	Initials	Date Signed
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### 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 <i>(Please print)</i>	Trainer Signature	Initials	Date Signed
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### AUTHORIZING HEALTH CARE PROFESSIONAL AND TRAINER *(Please read before signing and dating)*

I, the undersigned, approve the consumer'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 Consumer/Authorized Representative, CMA Case Manager, and Trainer.

Name <i>(Please print)</i>	Signature	Initials
Date Signed	Emergency Phone Number <i>(Including Area Code)</i>	Fax Number <i>(Including Area Code)</i>

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

Customer/Authorized Representative (Initials) \_\_\_\_\_  
 Authorized Healthcare Professional (Initials) \_\_\_\_\_

## SKILLED TASK TRAINING DETAIL

Consumer 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 consumer. 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 consumer/authorized representative is the trainer, the consumer/authorized representative will complete this section.)*

Name of Task

Date Training Completed

Task Training Detail

Check here if CONTINUED on next page

### **Authorized Healthcare 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)** \_\_\_\_\_