

**Ohio Department of Job and Family Services
Ohio Home Care Program**

Consumer Service Request for a Provider

Consumer Name
Medicaid ID Number (Ohio Medicaid 12 digit Billing Number)
Case Manager

I am requesting _____ to become my Medicaid provider.
(Print Provider's Name)

The provider meets eligibility requirements for a provider serving a consumer as specified in OAC 5101:3-46-04, 5101:3-47-04 and 5101:3-50-04.

I have informed my case manager, who has acknowledged my request and has given their approval. I understand that I am responsible for training my providers and for reporting incidents as outlined in the ODJFS-administered waiver rules.

(Signature of Consumer or Authorized Representative)

(Date)

To be Completed by the Applicant

I can attest to the fact that above name consumer has selected me to provide services as a non-agency personal care aide through the consumer directed option. I also understand that I jeopardize my enrollment as a Medicaid Provider if any of the information here or in my application is not true.

(Signature of Provider Applicant)

(Date)

Ohio Department of Job and Family Services
OTHER EQUIVALENT TRAINING PROGRAM
CONSUMER, CONSUMER'S REPRESENTATIVE OR QUALIFIED TRAINER
VERIFICATION AND PROVIDER ENROLLMENT ADDENDUM NON-AGENCY
PERSONAL CARE AIDE

Provider Name	SSN (<i>person receiving training</i>)
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My signature below serves as verification that the above name individual has been properly trained to perform the activities as outlined in OAC as an other equivalent training program as outlined in Ohio Administrative Codes (OAC) 5101:3-46-04, 5101:3-47-04 and 5101:3-50-04 and the home health care needs as listed on the consumer's All Services Plan.

This training has included:

Activities of Daily Living

Examples include but are not limited to: bathing, dressing, grooming, nail care, oral hygiene, shaving, skin care, foot care toileting, transferring positioning in bed, etc.

Instrumental Activities of Daily Living Impairments

Examples include but are not limited to: meal preparation and cleanup, laundry, waste disposal, bed-making, dusting, vacuuming, washing floor, transporting consumer, providing a safe exit, assisting consumer with paying bill, etc.

Basic Home Safety

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

Examples include but are not limited to: proper hand-washing, proper disposal of bodily waste, proper sterile technique, etc.

Consumer Name
Date Training Completed
Trainer's Name
Trainer's Relationship to Consumer
Consumer or Authorized Representative Signature

Note: 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.

***Provider Enrollment Addendum
Non-Agency Personal Care Aide***

Provider Name	Provider Phone Number
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My signature below serves as verification that the following statements are true and I agree to be bound by this agreement.

- 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.
- 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 reimbursement I have received from Medicaid through the ODJFS-administered waiver programs.

Signature of Provider	Date
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Mail to:
Bureau of Community Services Policy
Attn: Application Coordinator
P.O. Box 182709, 5th Floor
Columbus, Ohio 43218