MSHN Mid-State Health Network

MSHN Staff Only:

Compliant: Yes No

Mid-State Health Network

CWP-HSW-SEDW Aide Staff Credentialing

WSA Case ID: _____ **MSHN Reviewer/Date Reviewed**: _____

Case Manager: _____ **PIHP/CMHSP**: _____

CWP-HSW-SEDW Aide Staff Provider Qualifications Review

2.4; 14.5.A; 15.2.C Medicaid Provider Manual: Individuals wo provide respite and CLS must: Be at least 18 years of age; Be able to practice prevention techniques to reduce transmission of any communicable diseases from themselves to others in the environment where they are providing support; Have a documented understanding and skill in implementing the individual plan of services and report on activities performed; Be in good standing with the law (i.e., not a fugitive from justice, a convicted felon, or an illegal alien); Be able to perform basic first aid and (for CWP/SEDW only) emergency procedures; Be trained in recipient rights (CWP/SEDW only) Be an employee of the CMHSP or its contract agency, or an employee of the parent who is paid through a Choice Voucher arrangement. The Choice Voucher System is the designation or set of arrangements that facilitate and support accomplishing self-determination through the use of an individual budget, a fiscal intermediary and direct consumer-providing contracting. *PLEASE NOTE: YOU MUST BE ABLE TO PROVIDE DOCUMENTED EVIDENCE DURING THE SITE REVIEW THAT SHOW YOU MEET THESE FEDERAL REQUIREMENTS.*

MSHN Confirmed	**PIHP Verified**	**Staff Name**:_____ **Employed by:** _____
Y/N	☐	☐CWP ☐HSW ☐SEDW Service Provided: _____
Y/N	☐	Date of Hire: ____/_____/_____ Date of Termination: ____/_____/_____
Y/N	☐	Date of initial & most recent Criminal Background Checks: ____/_____/_____ & ____/_____/_____ *(Please provide documentation)*
Y/N	☐	18 years of age? Date of Birth: ____/____/_____ *(Please provide Driver's License, state identification, or other documentation)*
Y/N	☐	Date of blood borne pathogen training (Infection Control/Universal precautions) (*Please provide training date ____/____/_____ & certificate with trainer's name & content of training, or other documentation)*
Y/N	☐	Date of most recent Recipient Rights training: ____/____/_____ **(CWP/SEDW only)**
Y/N	☐	Date of Emergency Procedures training: ____/____/_____ *(Please provide evidence of weather, fire, chemical, etc. emergency training)* **(CWP/SEDW only)**
Y/N	☐	Able to perform and be certified in basic First Aid procedures? *(Please provide expiration date ____/____/_____ & certificate, or other documentation)*
Y/N	☐	Received beneficiary specific IPOS/ behavioral plan of care training, including beneficiary specific emergency procedures? *(Please provide training date ____/____/_____ & certificate that includes date of training, content, trainee and trainer names, or other documentation)*