

Mid-State Health Network
CWP-HSW-SEDW Aide Staff Qualifications

WSA Case ID: _____

MSHN Reviewer/Date Reviewed: _____

Case Manager: _____

CMHSP: _____

CWP-HSW-SEDW Aide Staff Provider Qualifications Review

2.4; 14.5.A; 15.2.C Medicaid Provider Manual: Individuals who 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, emergency procedures (for CWP/SEDW only); Be trained in recipient rights 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	<input type="checkbox"/>	<input type="checkbox"/> CWP <input type="checkbox"/> HSW <input type="checkbox"/> SEDW Service Provided: _____
Y/N	<input type="checkbox"/>	Date of Hire: ____/____/____ Date of Termination: ____/____/____
Y/N	<input type="checkbox"/>	Date of initial & most recent Criminal Background Checks: ____/____/____ & ____/____/____ (Please provide documentation)
Y/N	<input type="checkbox"/>	18 years of age? Date of Birth: ____/____/____ (Please provide Driver's License, state identification, or other documentation)
Y/N	<input type="checkbox"/>	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	<input type="checkbox"/>	Date of most recent Recipient Rights training: ____/____/____
Y/N	<input type="checkbox"/>	Date of Emergency Procedures training: ____/____/____ (Please provide evidence of weather, fire, chemical, etc. emergency training) (CWP/SEDW only)
Y/N	<input type="checkbox"/>	Able to perform and be certified in basic First Aid procedures? (Please provide expiration date ____/____/____ & certificate, or other documentation)
Y/N	<input type="checkbox"/>	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)