Ohio Department of Developmental Disabilities
Non-Agency Personal Care Training Verification Form

Provider's name: _____ **Provider SSN:** _____

Individual's name: _____ **Individual's Medicaid #** _____

Non-agency personal care aides must verify receipt of all required training and disclosure of any convictions that have not been sealed by initialling in the space provided and signing below. The signature of the individual to be served is required prior to the provider's being added to the individual's service plan.

_____ I have received training specific to the individual named above in the areas of:

- Activities of daily living (bathing, dressing, grooming, toileting assistance, eating, positioning, etc.)
- Instrumental activities of daily living (meal preparation, household chores, assisting with bill-payment, etc.)
- Basic home safety (avoiding slips/falls, fire safety, evacuations, weather safety, etc.)
- Universal precautions (hand-washing, disposal of bodily fluids, sterile techniques, etc.)

Individual-specific training provided by: _____

Relationship of trainer to individual served: _____

Date of training: _____

_____ I have received training regarding definitions and reporting procedures for incidents adversely impacting health and safety (MUIs) in accordance with Ohio Administrative Code 5123:2-17-02.

_____ I have received training regarding the rights of individuals with developmental disabilities as outlined in Ohio Revised Code 5123.62.

_____ I have disclosed to the individual to be served and his/her legal guardian any convictions for any offense that has not been sealed.

_____ _____
Provider's signature **Date**

I am requesting to receive services from the provider listed above. The provider has received training related to my needs.

_____ _____
Individual's signature **Date**

_____ _____
Guardian/Representative signature **Date**