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**Children's Long-Term Support (CLTS) Waiver
 Standards of Training Verification for Parent/Guardian Hired Providers (Non-licensed/certified)**

Participant Information

Participant/Child:	Parent/Guardian:	Service Coordinator:
Service Type: (Check all that Apply) <input type="checkbox"/> Respite <input type="checkbox"/> Specialized Childcare <input type="checkbox"/> Personal Supports		

Provider/Employee Information

Last:	First:	M.I.	Date of Hire:
Address:	City:	State:	Zip:

Provider named above will complete background and other service qualification requirements. Additionally, providers will receive training with participant's parent/guardian and when necessary, county waiver agency support and service coordinator (SSC), on the following requirements, to ensure provider is qualified to deliver services to the participant through CLTS Waiver funding. All provider training must be completed within 3 months of hire date.

Date of Completion	Service Provision and/or Training Requirement
1. _____	1. Provider is not listed on the Wisconsin Misconduct Caregiver Registry; does not have a substantiated finding of abuse, neglect, or misappropriation, and has not committed a crime that is substantially related to the provision of care or supervision of this service.
2. _____	2. Provider is trained to safely deliver services, so as not to endanger the participant. Additionally, provider understands how to administer first aid for the participant when necessary. Participant's safety plan is: _____ _____ _____
3. _____	3. Provider is trained to recognize and appropriately respond in the event of an emergency, including protocol for contacting local emergency response systems, and the prompt notification of the county waiver agency. Any emergency situations or incidents where the participant's health or safety may have been compromised during a session, must be immediately reported to the participant's Support and Service coordinator (SSC) SSC agency name, contact staff, and phone number: _____

<p>4. _____</p>	<p>4. Provider is trained on participant specific information, including individual needs, functional capacities, strengths, abilities, preferences, goals, and family/participant's culture. Additionally, provider has received in-depth training on the participant's individual daily living skills needs and level of assistance for bathing, grooming, toileting, eating, transfers, mobility, learning, communication, and other related tasks. If necessary, provider has also received training on using any adaptive aids or equipment the participant needs for day-to-day functions.</p> <p>Detailed Information on the participant's specific information is outlined below:</p> <p>Participants strengths, interests, and hobbies:</p> <p>_____</p> <p>_____</p> <p><i>If provider will be conducting mentoring sessions:</i> list how the participant's and provider's interests are similar and how will those interests be incorporated into sessions.</p> <p>_____</p> <p>_____</p> <p>Participant's and their family's relevant cultural needs and preferences:</p> <p>_____</p> <p>_____</p> <p>Participant's cognitive abilities and concerns:</p> <p>_____</p> <p>_____</p> <p>Participant's communication abilities, strengths, and concerns:</p> <p>_____</p> <p>_____</p> <p>Participant's grooming, bathing, toileting, and dressing strengths and concerns:</p> <p>_____</p> <p>_____</p> <p>Participant's dietary concerns, eating habits, and need for eating/feeding assistance:</p> <p>_____</p> <p>_____</p> <p>Participant's mobility strengths and concerns and need for assistance with transfers within home and community:</p> <p>_____</p> <p>_____</p> <p>Participant requires specialized equipment that will be utilized by provider during sessions <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, equipment includes:</p> <p>_____</p> <p>_____</p> <p>Participant's Goals:</p> <p><input type="checkbox"/> Provider reviewed a copy of participant's most recent CLTS Waiver Individualized Service Plan (ISP) Goals and Outcomes Page.</p>
<p>5. _____</p>	<p>5. Provider is trained on the participant's specific positive behavioral support plan so provider can safely and appropriately respond to challenging and unexpected behaviors participant may display during services.</p>

	<p>Current Positive Behavioral Supports and Strategies for Participant: _____ _____ _____</p> <p>Participant has an active Behavior Intervention Plan through school, therapy service, or another agency. <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Provider has reviewed behavior intervention plan(s)</p>
6. _____	<p>6. Provider acknowledges and agrees that the participant may not be put into isolation or seclusion and cannot be restrained in any way during sessions. Providers are prohibited from these actions except in cases where a specific participant behavior plan has received Department of Health Services (DHS) approval. All violations of this policy must be immediately reported to the county waiver agency.</p> <p>Participant has an approved DHS Restrictive Measure Plan <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Provider has received comprehensive training on this plan by county waiver agency AND participant's parent/guardian.</p>
7. _____	<p>7. Provider is trained on county waiver agency/contract agency policies, procedures, and expectations for providers including confidentiality of participant information according to federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) privacy and security rules.</p>
8. _____	<p>8. Provider received training on billing and payment processes, record keeping, incident and mandated reporting requirements, handling complaints, and name/contact information of the county waiver agency service coordinator as well as contract agency.</p>
9. _____	<p>9. Provider will be providing transportation services to the participant <input type="checkbox"/> No <input type="checkbox"/> Yes and parent/guardian has reviewed the following and copies are on file with the county waiver agency: <input type="checkbox"/> Provider's has a valid driver's license <input type="checkbox"/> Provider has valid car insurance coverage <input type="checkbox"/> Parent/Guardian has reviewed the provider's vehicle and attests that it is in sound working order and provider will be able to provide transportation services safely and legally to the participant.</p>
10. _____	<p>10. Provider has a professional license or meets Medicaid certification for personal care services or nursing <input type="checkbox"/> No <input type="checkbox"/> Yes and a copy of the _____ license/certification has been received by the county waiver agency.</p>
11. _____	<p>11. Provider has prior training related to the participant's specific disability of _____ or general training in <input type="checkbox"/> developmental disabilities, <input type="checkbox"/> mental health, and/or <input type="checkbox"/> physical disabilities. <input type="checkbox"/> Prior training _____ _____</p> <p><input type="checkbox"/> No prior training: Parent/Guardian exempts provider from needing prior training and feels provider can safely, ethically, and appropriately deliver services to the participant. Parent/Guardian has provided provider with training on participant's specific diagnosis by sharing the following information: _____ _____</p>
12. _____	<p>12. Provider has received prior training on professional ethics and interpersonal skills as well as understanding and respecting participant direction, individuality, independence, and rights. Additionally, Provider has received prior training on how to handle conflicts and complaints with participants, respecting personal property, and understanding cultural differences and family relationships.</p>

	<input type="checkbox"/> Prior training: <hr/> <hr/> <hr/> <input type="checkbox"/> No prior training: Parent/Guardian is exempting provider from needing this training. They feel that the provider will be able to provide services safely, ethically, and appropriately to the participant due to the following reasons: <hr/> <hr/> <hr/>
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13. _____	<p>13. Provider has prior training on providing quality homemaking and household services, including understanding good nutrition, special diets, and meal planning and preparation. Provider has been trained on how to maintain a clean, safe, and healthy home environment. The provider is able to respect the participant's preferences in housekeeping, shopping and home making tasks.</p> <input type="checkbox"/> Prior training: <hr/> <hr/> <hr/> <input type="checkbox"/> No prior training: Parent/Guardian has provided training on this topic to provider as it relates to the participant's dietary needs and family's household preferences. Expectations of provider for maintaining household needs during services includes: (*Chores to be done during SHC-Chores sessions must be explained in full) <hr/> <hr/> <hr/>
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Signatures

Our signatures below indicate the named employee has met all required provider standards for this service at this time.

Signature of Employee	Date
Signature of Participant's Parent or Legal Guardian	Date
Signature of Support and Service Coordinator representing CWA	Date

Training Review

All providers must review this training information with the participant's parent/guardian every 4 years during the provider's renewal background check process. Significant changes to the participant's needs warrants a new verification of training form to be completed. Please indicate below dates of reviews and any minor updates to training that was warranted for the participant.

Date of Review	Additional Training Provided by Parent/Guardian	Initials for all parties