

## MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES

CWP-HSW-SEDW Aide Staff Credentialing

**MDHHS Staff Only:** 

Compliant: Yes No

WSA Case ID:		MDHHS 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 and Application for 1915 (c) HCBS Waiver: Individuals we 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, as evidenced by completion of first aid training course and be able to perform emergency procedures, as evidenced by completion of emergency procedures training course; 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. <i>PLEASE NOTE: YOU MUST BE ABLE TO PROVIDE DOCUMENTED EVIDENCE DURING THE SITE REVIEW THAT SHOW YOU MEET THESE FEDERAL REQUIREMENTS.</i>		
<u>MDHHS</u> <u>Confirmed</u>	<u>PIHP</u> Verified	Staff Name: Employed by:
Y/N		CWP HSW Service Provided:
Y/N		Date of Hire:/
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://
Y/N		Date of Emergency Procedures training:/ (Please provide evidence of weather, fire, chemical, etc. emergency training)
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)