Thompson Home Health Team LLC **Advance Personal Care Training Waiver**

To: ____Fax #:______________________

Attention: _______________________________________ Title_______________________

From:______________________________________ **Thompson Home Health Team, LLC**

Fax # (314) 371-1551 **Phone (314) 371-1550**

Applicant's Signature: ____ Date: _________

Applicant's Name: ____

Print Clearly

I have applied to Thompson Home Health Team, LLC for a position of Home Health Aide and have given you as a reference. I hereby release the company or person name above from all liability and authorization to release all information regarding my employment history.

Name of representative: ________________________Title: ___________________

Company's Name: ____

Address: _______________________________ _____________ _________________

City State Zip

Fax number: ( ) _______- __________ Phone: ( ) _________-_______________

____, stated that your

Applicant's Name

company____ was contracted with the Missouri

Company's name

Medicaid Audit and Compliance in-home service program, he ☐ she ☐ received advance personal care training and was employed as an advance personal care aide within the last six months.

Is this True? Yes ☐ or No ☐ if yes please provide the following information.

1. **Date of classroom training _________________________________**
2. **Date of task training _____________________________________**
3. **Position as an ___________________________________**
4. **As an advance personal care aide how long was aide employed**
   From ___________________________ to __________________________

Is documentation of classroom training and task training available, yes ☐ or no ☐, if yes please provide information.

____________________________ ___________________________ ____________

Name of Authorized Representative *Signature of Authorized Representative* Date

TRAINING WAIVER JUSTIFICATION

☐ 12 hours of the personal care aide's basic training was waived

Reason- The employee has received similar training during the current or preceding state fiscal year, or has been employed as an aide in an in - home or home health agency at least half time for six months or more within the current or preceding state fiscal year.

I, ____/______/______acknowledge that

Applicant's signature *Date*

12 hours of personal care basic training was waived. I understand and acknowledge that I must receive 8 hours of advance personal care training including 2hours of Thompson Home Health Team, LLC's orientation, and 4 hours of task training in which will be performed in the client's home under the supervision of a Registered Nurse.

Office Use Only	
Has documentation of registered nurse, licensed practical nurse, or certified nurse aide been verified and place in personnel files Yes ☐ or No ☐ Date verified and filed ________/_________/_________	Signature of Authorized Representative: ______________________________

☐ All basic training and task training was waived

REASON- documentation provided in personnel record that the aide is a

☐ **R**egistered **N**urse, ☐ **L**icensed **P**ractical Nurse, or ☐ **C**ertified **N**urse **A**ide.

I ____/________/______acknowledge that

Applicant's signature *Date*

all training was waived except two hour Thompson Home Health Team, LLC orientation which will be provided before client contact.

Office Use Only	
Has documentation of registered nurse, licensed practical nurse, or certified nurse aide been verified and place in personnel files Yes ☐ or No ☐ Date verified and filed ________/_________/_________	Signature of Authorized Representative: ______________________________

______________________________ ______________________________ ____________

Name of Authorized Representative *Signature of Authorized Representative* Date