HCBS Technology Assisted Waiver
Personal Service Attendant (PSA)Training Checklist

The PSA will receive training from the parent or legal guardian specific to the TA Waiver Recipient for whom care is provided. The PSA will provide care under the direction of the parent or legal guardian and is expected to demonstrate knowledge and proficiency in the tasks indicated below:

Name of TA waiver Recipient:			**Medicaid ID#:**
☐ Yes ☐ No	Lifting and Body Mechanics	☐ Yes ☐ No	Diapering Technique and Protocol
☐ Yes ☐ No	Transfers and Positioning	☐ Yes ☐ No	Enema/Suppository Insertion
☐ Yes ☐ No	Ambulation Techniques	☐ Yes ☐ No	Seizure Control Protocol
☐ Yes ☐ No	Bathing and Hair Care	☐ Yes ☐ No	Range of Motion exercises
☐ Yes ☐ No	Oral Care	☐ Yes ☐ No	Communication Techniques
☐ Yes ☐ No	Skin and Nail Care	☐ Yes ☐ No	Behavior Modification Techniques
☐ Yes ☐ No	Dressing Assistance	☐ Yes ☐ No	Infection Control Procedures
☐ Yes ☐ No	Hearing Impaired Assistance	☐ Yes ☐ No	CPR/First Aid
☐ Yes ☐ No	Visually Impaired Assistance	☐ Yes ☐ No	Emergency Procedures
☐ Yes ☐ No	Specialized Diet/ Nutrition Preparation	☐ Yes ☐ No	Laundry Assistance
☐ Yes ☐ No	NG/GT/NJ Feeding and Care	☐ Yes ☐ No	Room/Housekeeping Assistance
☐ Yes ☐ No	Medication Administration	☐ Yes ☐ No	Documentation/Record Keeping
☐ Yes ☐ No	Temperature Monitoring	☐ Yes ☐ No	Other (specify below)
☐ Yes ☐ No	Blood Pressure Monitoring	☐ Yes ☐ No	
☐ Yes ☐ No	Pulse Assessment	☐ Yes ☐ No	
☐ Yes ☐ No	Pulse Ox Monitoring	☐ Yes ☐ No	
☐ Yes ☐ No	Respiration Monitoring	☐ Yes ☐ No	
☐ Yes ☐ No	Oxygen Administration	☐ Yes ☐ No	
☐ Yes ☐ No	Use of Suction Machine	☐ Yes ☐ No	
☐ Yes ☐ No	Use of Glucometer	☐ Yes ☐ No	
☐ Yes ☐ No	Tracheotomy Care		
☐ Yes ☐ No	Catheter Care/ Recording Input & Output		

My signature confirms that I, _____(print name) have been trained by the parent or legal guardian to perform the delegated tasks identified in the PSA Training Checklist and that I am able to perform these tasks.

_____ Date: _____
Personal Service Attendant (PSA) Signature

My signature confirms that I, _____ (print name) as parent/legal guardian of _____ (print name) have the authority to delegate and train the PSA in the tasks identified in the above training checklist. The PSA may perform the specified tasks while providing care for _____ under my authority.

_____ Date: _____
Parent/Legal Guardian Signature

The parent or legal guardian's delegation of tasks to be provided by the PSA is limited to the term services are provided for the specific consumer in which he/she is trained to provide. Parents or legal guardian understand by delegating tasks to PSA that he/she assumes all responsibility for the action or inaction of the PSA to which authorization of tasks are given.