



BlueCare Tennessee is an Independent Licensee of the BlueCross BlueShield Association.

Member: _____ DOB: _____ Date: _____

MCO Name	Phone Number	Fax Number
BlueCare Tennessee	1-888-423-0131	(423) 535-5254
UnitedHealthcare	1-800-690-1606	1-800-743-6829
Amerigroup	1-800-454-3730	1-877-297-5003/1-866-920-6003

Recertification Member/Caregiver Training Checklist

This form is to be completed with each recertification to continue or increase Private Duty Nursing (PDN) and/or home health services after the initial admission and initial member/caregiver training checklist has been completed. **Do not complete this form unless the Initial Training Checklist has been completed.** Also, complete this form with any new training of the primary caregiver or new/additional backup caregivers and annually once all training has been successfully completed.

The training checklist below is used to document the training offered and provided by agency staff to the member/member's primary caregiver and the designated backup plan caregivers.

The purpose of this training is to provide support to the primary caregiver and backup caregivers to foster independence and confidence in caring for the member and/or support member self-care. The checklist can be used to monitor progress toward identified short-term and long-term goals and to identify any barriers that require intervention.

Check the appropriate box(s):

- Initial member/caregiver training checklist reviewed. **Please review the initial checklist with each caregiver and backup caregiver before proceeding further.**

Date: _____

- New skills training provided to member and/or caregiver

Date: _____

Complete the Member/Caregiver Training Checklist (pp.2) indicating the skills taught or reviewed.

- New skills taught to member and caregivers. Please complete page 2.
- Reviewed previously learned skills. Please list on page 2 and complete.
- No new skills or additional training requested

Checklist for Additional Caregiver Evaluation and Training

Agency staff is to date and initial the applicable care task(s) and mark an X in the appropriate column indicating the following codes to monitor progress toward successful demonstration by the member/caregiver:

- Member/Caregiver observes caregiving task(s): O
- Member/Caregiver discusses and explains caregiving task(s): E
- Member/Caregiver successfully provides (demonstrates) caregiving task(s): D
- If a skill is not applicable, indicate by N/A

Member: _____ DOB: _____ Date: _____

SKILLS

Skill	Date	Code				Comments	Initials
		O	E	D	N/A		

Member/Caregiver/Agency Signature Page

Yes No – I need additional training.
If yes, please list specific training needed:

Member/Primary Caregiver Signature: _____ Date: _____

Yes No – I need additional training.
If yes, please list specific training needed:

Backup Caregiver Signature: _____ Date: _____

Yes No – I need additional training.
If yes, please list specific training needed:

Backup Caregiver Signature: _____ Date: _____

Yes No – Additional training scheduled – Date: _____

Agency Staff Signature & Degree: _____ Date: _____