



Member: _____ DOB: ____/____/____ Date: ____/____/____

MCO Name	Phone Number	Fax Number
BlueCare Tennessee	1-888-423-0131	1-800-292-5311
UnitedHealthCare	1-800-690-1606	1-800-743-6829
Wellpoint	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

Member: _____ DOB: ____/____/____ Date: ____/____/____

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 – I need additional training.

If yes, please list specific training needed:

Agency Staff Signature & Degree: _____

Date: ____/____/____