

SELF DIRECTED ATTENDANT CARE

FORMS



MEMBER CHECKLIST

The following are key activities that must be completed for Self Directed Attendant Care (SDAC) participation. The member is responsible for completing each of these activities.

Mark off once completed

- Received and reviewed the Self Directed Attendant Care "Is It Right for You" brochure
- Case manager completed an initial assessment
- Reviewed Member Roles, Rights and Responsibilities with case manager
- Received and reviewed the Self Directed Attendant Care Manual
- Filled out the Self Directed Attendant Care Agreement
- Completed the Training Needs Checklist for Members and received desired training
- Worked with case manager to develop an Initial Care Plan and Backup Plan
- Contacted Fiscal Employer Agent and received all necessary paperwork
- Filled out and sent all paperwork back to the Fiscal Employer Agent
- Recruited and hired a qualified Attendant Care Worker (ACW)
- Informed ACW of all requirements of the position, including certifications, training, etc.
- Got all necessary paperwork for the ACW from the Fiscal Employer Agent and made sure all paperwork was filed out and returned in a timely manner
- Provided the ACW with an outline of duties and the ACW Roles, Rights and Responsibilities
- Signed the Self Directed Attendant Care Member/Attendant Care Worker Work Agreement and had the ACW sign it also
- Assessed the training needs of the ACW and arranged for training if needed
- Provided orientation to the ACW, including mandatory training of Universal Precautions and HIPAA, and other special considerations

- Scheduled skilled care training by a registered nurse with the case manager if ACW will do skilled nursing tasks.
- Called the case manager to report the start of services from the ACW within 14 days of the service starting

ONGOING RESPONSIBILITIES WITH THE FISCAL EMPLOYER AGENT

Mark off once completed

- Update ACW's CPR and First Aid certifications
- Turn in ACW's timesheets on time each time
- Report any changes in the ACW's duties
- Report any demographic changes of member or ACW
- Report any ACW terminations or hiring of new ACWs

ONGOING RESPONSIBILITIES WITH THE CASE MANAGER

Mark off once completed

- Report any change in needs
- Report any hospitalizations
- Report any problems with ACW not providing services

ONGOING RESPONSIBILITIES (GENERAL)

Mark off once completed

- Review monthly reports from the Fiscal Employer Agent
- Complete Member Satisfaction Surveys at six months and 12 months, and annually thereafter

Self Directed Attendant Care Agreement

I, _____, choose to participate in the Self Directed Attendant Care (SDAC) service option. I understand that I will be in charge of actively managing my own health including the following:

Initial

- _____ 1. I have received my Self Directed Attendant Care Manual. I agree to read it thoroughly and ask my case manager about any questions I may have.
- _____ 2. I have read and agree to the Member Roles, Rights and Responsibilities of the Self Directed Attendant Care service option.
- _____ 3. I will inform my case manager if I need assistance with any concerns and/or dissatisfactions with services received.
- _____ 4. I will contact the Fiscal/Employer Agent at phone number _____ within _____ days of enrolling in the Self Directed Attendant Care service option.
- _____ 5. I will make sure that my attendant care worker does not work more hours than authorized by my case manager. If I feel that additional hours of service would be beneficial to my health, I will contact my case manager and ask for a reevaluation.
- _____ 6. I agree that I will provide training on privacy and confidentiality of member's health information (HIPAA – Health Insurance Portability and Accountability Act) to my attendant care worker or ask my case manager to authorize HIPAA training from another party.
- _____ 7. I agree that if my attendant care worker is doing skilled care for me, that I will have that care assessed and trained by a registered nurse before the attendant care worker does this skilled care.
- _____ 8. I agree that I will provide Universal Precautions training to my attendant care worker or ask my case manager to authorize Universal Precautions training from another party.
- _____ 9. I have read and understand the Letting Your Attendant Worker Go section of the SDAC Manual.

I understand that additional training is available for my attendant care worker and/or me if I feel it is necessary. I understand that I also have the option to receive traditional attendant care services through an agency if I no longer wish to participate in Self-Directed Attendant Care. I understand that if I do not meet the above requirements, my Case Manager may discontinue my Self Directed Attendant Care service and enroll me in traditional agency-based services.

Case Manager Signature

Date

RATING YOUR PRIORITIES

<p>The purpose of this questionnaire is self-discovery. Use the numbers to indicate how important the following qualities are to you as you think about what you are looking for in an Attendant Care Worker.</p>	<p>1 = Essential 2 = Very Important 3 = Somewhat Important 4 = Not Important 5 = Not Sure</p>
1. Patience	
2. Neatness	
3. Ability to follow a schedule	
4. Flexibility on the job	
5. Personal appearance	
6. Calm personality	
7. Religious or spiritual beliefs	
8. Honesty and trustworthiness	
9. Empathy-able to feel for others	
10. Morality-has good moral character	
11. Good communication skills	
12. Sense of humor	
13. Punctuality-able to be on time	
14. Positive attitude	
15. Being a responsible worker	
16. Willing to learn	
17. Respect for others	

WHAT DO I NEED?

I. PERSONAL CARE	WHEN				FREQUENCY										
TASKS	MORNING	AFTERNOON	EVENING	NIGHT	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY	DAILY	WEEKLY	TWICE A WEEK	MONTHLY
E. DENTAL CARE															
1. Brushing teeth															
2. Flossing teeth															
3. Mouthwash															
4. Denture care															
5. Other															
F. DRESSING and UNDRRESSING															
1. Complete assistance															
2. Partial assistance															
G. MEDICAL AIDS															
1. Prosthetics															
2. Orthotics															
3. Support hose															
4. Assistive devices															
5. Hearing aids															
6. Glasses															
<p>All tasks listed can change at any time to best fit the member's needs. There may also be new tasks needed in the future. This list is to be used as a guide only, not as a set description of attendant duties.</p>															
SPECIAL INSTRUCTIONS:															

WHAT DO I NEED?

II. HOUSEHOLD	WHEN				FREQUENCY										
TASKS	MORNING	AFTERNOON	EVENING	NIGHT	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY	DAILY	WEEKLY	TWICE A WEEK	MONTHLY
A. Laundry															
1. Sorting clothes															
2. Washing															
3. Drying															
4. Ironing															
5. Fold clothes															
6. Put clothes away															
B. Shopping															
1. Grocery															
2. Prescriptions															
C. Housekeeping															
1. Making/changing beds															
2. Sweeping															
3. Mopping floors															
4. Vacuuming															
5. Dusting															
6. Cleaning toilet															
7. Cleaning tub and sink															
8. Emptying trash															
10. Wheelchair cleaning															
D. Miscellaneous															
1. Getting mail															
2. Writing checks															
3. Feeding pets															
4. Walking pets															
5. Other															

All tasks listed can change at any time to best fit the member's needs. There may also be new tasks needed in the future. This list is to be used as a guide only, not as a set description of attendant duties.

SPECIAL INSTRUCTIONS:

WHAT DO I NEED?

III. NUTRITION	WHEN				FREQUENCY										
	MORNING	AFTERNOON	EVENING	NIGHT	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY	DAILY	WEEKLY	TWICE A WEEK	MONTHLY
A. Meal Preparation															
1. Preparing foods															
2. Set-up (cutting up, mixing, etc.)															
3. Cooking															
4. Serving															
5. Storing and putting food away															
6. Cleaning up															
B. Eating Meals															
1. Breakfast															
2. Lunch															
3. Dinner															
4. Snacks															
C. Special Diets															
1. Low fat															
2. Low cholesterol															
3. Low sodium															
4. Diabetic															
5. Other															
D. Kitchen Chores															
1. Washing dishes															
2. Cleaning oven/stove															
3. Wiping counters															
4. Defrosting/cleaning refrigerator															
5. Empty dishwasher, put away dishes															

All tasks listed can change at any time to best fit the member's needs. There may also be new tasks needed in the future. This list is to be used as a guide only, not as a set description of attendant duties.

SPECIAL INSTRUCTIONS:

WHAT DO I NEED?

IV. MOBILITY/SAFETY	WHEN				FREQUENCY										
TASKS	MORNING	AFTERNOON	EVENING	NIGHT	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY	DAILY	WEEKLY	TWICE A WEEK	MONTHLY
A. Exercise															
1. Range of Motion exercises															
2. Walking															
3. Exercises															
B. Positioning															
1. Turning															
2. Bed															
3. Chair															
C. Transfers and Lifts															
1. Wheelchair															
2. Bed															
3. Shower or tub															
4. Toilet															
5. Hoyer Lift															
6. Car															
7. Slide Board															
D. Driving and Escorting															
1. School and/or work*															
2. Medical appointments															
3. Shopping															
4. Arrange transportation															
E. Supervision/Companionship															
<p>* K-12: If your Individual Education Plan (IEP) identifies needs to assist with education, the school district is responsible for providing Attendant Care during school hours.</p>															

All tasks listed can change at any time to best fit the member's needs. There may also be new tasks needed in the future. This list is to be used as a guide only, not as a set description of attendant duties.

SPECIAL INSTRUCTIONS:

WHAT DO I NEED?

I. SKILLED CARE	WHEN				FREQUENCY										
TASKS	MORNING	AFTERNOON	EVENING	NIGHT	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY	DAILY	WEEKLY	TWICE A WEEK	MONTHLY
A. Bowel Care															
1. Suppositories															
2. Enemas															
3. Manual Evacuation															
4. Digital Stimulation															
5. Other															
B. Other Skilled Tasks															
1. Bladder Catheterization (non-indwelling) that does not require a sterile procedure															
2. Wound Care (non-sterile)															
3. Glucose Monitoring															
4. Glucagon as directed by the health care provider															
5. Subcutaneous Insulin Injection															
6. Sliding scale dosing for insulin															
7. Permanent gastrostomy tube feeding															
8. Other Special Skilled Care service (must be pre-approved by AHCCCS and the Arizona State Board of Nursing):															
List: _____															
<p>IMPORANT: All tasks listed in this section require that a registered nurse visit the member and attendant care worker to assess, educate and train the member and attendant care worker regarding the specific skilled service(s) that the member requires. The registered nurse must determine that the attendant care worker understands how and demonstrates the skills to perform the processes or procedures required to provide the specific skilled service BEFORE the attendant care worker can start to do those tasks</p>															
SPECIAL INSTRUCTIONS:															

TRAINING NEEDS CHECKLIST

For Members

You will use many different kinds of skills while participating in Self Directed Attendant Care. You are the person who can best decide what kind of training you need. Your Case Manager will help you set it up. Below is a list of the skills you will use as a member in Self Directed Attendant Care. Check the box that best fits your need for training with these skills.

	I NEED A LOT OF TRAINING	I NEED SOME TRAINING	NONE
<i>Finances</i>			
Reading Monthly Reports from the Fiscal Employer Agent (for example, a bank statement)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Hiring and Managing an Attendant</i>			
Writing a Job Description for Workers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Finding Workers to Provide Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Writing a Job Application	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Screening Applicants	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Interviewing Applicants	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Checking references	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Evaluating applicants and their skills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Employment Contract or Agreement	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Training Workers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tracking Hours and Time Cards	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Communication/Inter-Personal Relationships	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Boundaries and Conflict Resolution	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

I NEED A LOT OF TRAINING	I NEED SOME TRAINING	NONE
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Maintaining Quality of Service

Assessing Quality of Services Provided by Your Workers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Supervising Your Worker	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Communicating Information with Your Workers About the Job They are Doing (Positive and Negative)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Firing Workers With Poor Job Performance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Planning for Back-Up Care or Emergency Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Understanding Services Available in Your Community	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asking Others for Help When You Need It	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Safety and Health

Body Mechanics	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Universal Precautions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Disaster Preparedness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Managing Your Own Health Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Member Signature

Date

Case Manager

Date

SELF DIRECTED ATTENDANT CARE APPLICATION FOR EMPLOYMENT

Date: _____

PERSONAL INFORMATION

Legal Name: _____

Street Address: _____

Mailing Address: _____ Apt #: _____

City: _____ State: _____ Zip: _____

How long at above address: _____

Previous Address: _____ How Long? _____

Home Phone: () _____ Work/Cell Phone: () _____

Salary Expected \$ _____ / Hour

Who should we notify in case of an emergency?

Name _____ Relationship _____

Home Phone _____ Business Phone _____

Some of the members served through the Self Directed Attendant Care option need to be lifted and transferred to and from a wheelchair, bed, toilet or shower bench. Light housekeeping is almost always required including changing linens, doing laundry, preparing meals, vacuuming and dusting. Therefore, applicants for this position may need to perform these functions. If you have any **lifting, bending, stooping, twisting, gripping** or **other physical limitations** that may affect your ability to perform these functions, please describe them below. Please note that any limitations you describe will not automatically prevent me from hiring you, and I will make reasonable accommodations to help you do this job if you are hired.

I have the following limitations: _____

Have you ever been convicted of a felony or misdemeanor, including sex related or child/adult abuse-related offenses?

Yes No If yes, please explain: _____

Do you have a probation officer? Yes No

May we have permission to contact your probation officer? Yes No

Name of probation officer: _____ Phone #: _____

Please answer the following questions:

1. What qualities do you have that would make you a successful Attendant Care Worker?

2. Why do you want to work as an Attendant Care Worker?

3. What services do you see yourself providing as an Attendant Care Worker?

EDUCATION & TRAINING

Employer reserves the right to verify education.

High School: _____ Year Graduated/GED _____

College: _____ Location (City/State) _____ Year Graduated _____

College: _____ Location (City/State) _____ Year Graduated _____

Please describe any other training you have completed: _____

Please indicate any foreign languages spoken fluently: _____

WORK HISTORY

Carefully fill in the information below. Volunteer experience may be substituted if there is no employment history. In order to process your application, you must provide complete names and phone numbers of your employers. Without this information your application cannot be processed (please list most recent employment first).

Name of Employer: _____ Supervisor: _____

Address: _____ Dates of Employment: _____

City: _____ State: _____ Zip: _____ Telephone: _____

Name of Employer: _____ Supervisor: _____

Address: _____ Dates of Employment: _____

City: _____ State: _____ Zip: _____ Telephone: _____

Name of Employer: _____ Supervisor: _____

Address: _____ Dates of Employment: _____

City: _____ State: _____ Zip: _____ Telephone: _____

Personal References

Carefully fill out the information below. In order to process your application you must provide the complete names and phone numbers of three personal references. These are people who are not relatives and who you have known at least one year.

Name: _____ Relationship: _____

Phone Number: _____ Length of Acquaintance: _____

Name: _____ Relationship: _____

Phone Number: _____ Length of Acquaintance: _____

Name: _____ Relationship: _____

Phone Number: _____ Length of Acquaintance: _____

I hereby state the above information is correct to the best of my knowledge and authorize investigation and verification of all statements contained in this application. I understand that misrepresentation or omission of facts may render me ineligible for consideration. I authorize my references to disclose any information about me, including information on employment, and release and hold my references harmless from all liability arising from information disclosed.

SIGNATURE _____ **DATE:** _____

Self Directed Attendant Care Skills Checklist

Attendant Care Worker (ACW) _____ has demonstrated the knowledge and ability to provide safe and appropriate care for member: _____.

ACW Initials	Member Initials	
		Universal Precautions (cleaning of equipment, proper disposal of waste, hand washing, and protection from germs spread through the air, bodily fluids and direct contact) <i>Mandatory Training</i>
		HIPAA and confidentiality of member information <i>Mandatory Training</i>
		Skilled care assessment and training (as applicable for member's needs) completed by a registered nurse.
		An understanding of the member's conditions, which are: _____ _____ _____
		An understanding of the member's wishes regarding advance directives, which are: _____ _____
		Appropriate communication and conflict resolution skills
		Maintaining a clean, safe environment for the member
		Safe and appropriate bathing and personal hygiene for the member
		Safe and appropriate assistance with member transfers using the following assistive devices: _____ _____
		Safe ACW body positioning and movement during all tasks
		Other knowledge and/or tasks specific to the member: _____ _____

ACW Signature: _____

Date: _____

Member Signature: _____

Date: _____

SELF DIRECTED ATTENDANT CARE MEMBER/ATTENDANT CARE WORKER WORK AGREEMENT

This is a work agreement between _____ and _____
(Employer/Member)
_____, who will be an Attendant Care Worker.
(Employee/Attendant Care Worker)

Attendant Care Worker Start Date: ____ / ____ / ____

Total Number of Hours Per Week: _____

Pay Rate: _____ (subject to change)

WORK SCHEDULE

The Attendant Care Worker's work schedule will be as follows:

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday

Please Initial:

_____ I have received a copy of the employer's task list. I understand that I will be assisting my employer with those tasks. If additional tasks arise, I understand that the employer may change my job tasks to better reflect his/her needs.

_____ I have received a copy of the Attendant Care Worker Role, Rights and Responsibilities and I agree to adhere to all of the requirements of the Attendant Care Worker position.

Employee Signature

Date

Employer/Member Signature

Date

cc: Fiscal Employer Agent

EVALUATION FORM

Name: _____ Date: _____

Rate Attendant Care Worker Performance by Checking the Box:

Assigned Task	Excellent	Acceptable	Needs Improvement	Unacceptable
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

Comments:

Plan:

Attendant Care Worker

Employer

Date: _____

EMERGENCY PHONE NUMBERS AND EMERGENCY PLAN

EMERGENCY PHONE NUMBERS

**If there is a medical emergency, immediately call:
911**

Medical Providers:

Doctor Name: _____ Phone: _____

Pharmacy Name: _____ Phone: _____

Transportation Service Provider: _____ Phone: _____

Medical Power of Attorney:

Name: _____ Phone: _____

Close Relatives or Friends:

Name: _____ Phone: _____

Name: _____ Phone: _____

Name: _____ Phone: _____

Case Manager:

Name: _____ Phone: _____

Other:

Name: _____ Phone: _____

Name: _____ Phone: _____

EMERGENCY PLAN

1. What to do in case of a fire: _____

2. What to do in case of a medical emergency: _____

3. What medications I am allergic to: _____

4. My medications and medical supplies are located: _____

5. In case of an emergency, please contact: _____

SELF DIRECTED ATTENDANT CARE REPORTING FORM

Member Name: _____ Phone Number: _____

Member AHCCCS ID (if available): _____

Address: _____

City: _____ State: _____ Zip: _____

Person completing report: _____ Phone #: _____

Date of Concern: _____

Time of Concern: _____

Explain the Concern (include who, what, where, when, how and why) and the Action Taken:

Have you notified the Case Manager: Yes No

CM Name: _____

Phone Number: _____

Date/Time Contacted: _____

Please check here if you would like a copy of this report returned to you.

