**DEPARTMENT OF HEALTH SERVICES**
Division of Medicaid Services
F-20971 (03/2017)

**STATE OF WISCONSIN**

# DOCUMENTATION OF TRAINING – SUPPORTIVE HOME CARE (SHC) / RESPITE

This is a voluntary form. If this form is not used, you must ensure that the information requested is on file in another format.

Name – County Waiver Agency

| Name – | Date – Initial Employment |
|---|---|

Name – Employer (SHC Agency or Participant)

The following information outlines the required minimum training to be completed by the person providing SHC/Respite services, based on the actual services to be provided. Check the appropriate box(s) to indicate training that was completed for the applicable services.

| | |
|---|---|
| ☐ **Personal Services – Required Training**<br>1. Orientation to County and SHC Agency Policies<br>2. Safe Provision of Services<br>3. Recognizing and Responding to Emergencies<br>4. Participant Specific Information<br>5. General Target Group Information<br>6. Working Effectively with Participants<br>7. Homemaking/Household Services | ☐ **Required Training Completed (1, 2, 3, 4)**<br>Date:<br>☐ **Training Completed (5, 6, 7)**<br>Date:<br>☐ **Training Exempted (5, 6, 7)—**Provider has previous/ comparable experience. List and attach documentation. |
| ☐ **Household/Chore Services – Required Training**<br>1. Orientation to County and SHC Agency Policies<br>2. Safe Provision of Services<br>3. Recognizing and Responding to Emergencies<br>4. Participant Specific Information | ☐ **Required Training Completed (1, 2, 3, 4)**<br>Date: |
| ☐ **Respite Services – Required Training**<br>1. Orientation to County and SHC Agency Policies<br>2. Safe Provision of Services<br>3. Recognizing and Responding to Emergencies<br>4. Participant Specific Information<br>5. General Target Group Information<br>6. Working Effectively with Participants<br>7. Homemaking/Household Services (if provided) | ☐ **Required Training Completed (1, 2, 3, 4)**<br>Date:<br>☐ **Training Completed (5, 6, 7)**<br>Date:<br>☐ **Training Exempted (5, 6, 7)—**Provider has previous/ comparable experience. List and attach documentation. |

| | |
|---|---|
| ☐ Required Caregiver Background Check completed (if applicable) | Date Completed |
| **SIGNATURE –** SHC / Respite Provider | Date Signed |
| CG | |
| **SIGNATURE** – SHC Agency Supervisor | Date Signed |
| **SIGNATURE** – Participant as Employer | Date Signed |
| M | |
| **SIGNATURE** – County Agency Care Manager | Date Signed |