

Ohio Department of Medicaid
HOME CARE ATTENDANT MEDICATION AUTHORIZATION

TRAINING DETAIL

CONSUMER/AUTHORIZED REPRESENTATIVE *(If applicable, please read before signing and dating)*

I agree to have the Home Care Attendant (HCA) identified below to assist me (the consumer) in the self-administration of medication.

| | | |
|---|-------------------------------------|-------------|
| Consumer Name <i>(Please print)</i> | Consumer Signature | Date Signed |
| Authorized Representative <i>(Please print)</i> | Authorized Representative Signature | Date Signed |

HOME CARE ATTENDANT *(Please read before signing and dating)*

I have received training in administering the medications listed on the Medication Profile section of this Medication Authorization and will assist the consumer in accordance with OAC Rule 5101:3-46-04.1 or 5101:3-50-04.1, as appropriate, and as trained by the consumer, authorized representative and/or trainer. I understand that I am approved to assist the consumer in the self-administration of only those medications for which I have received training in administering. By initialing each medication listed, I verify that I have been trained to assist the consumer in the self-administration of the medication.

| | | | |
|---|-------------------------------|----------|-------------|
| Home Care Attendant <i>(Please print)</i> | Home Care Attendant Signature | Initials | Date Signed |
|---|-------------------------------|----------|-------------|

TRAINER *(Please read before signing and dating)*

By initialing each medication listed, I verify that I have trained the Home Care Attendant to assist the consumer in the self-administration of medication.

| | | | |
|------------------------------------|-------------------|----------|-------------|
| Trainer Name <i>(Please print)</i> | Trainer Signature | Initials | Date Signed |
|------------------------------------|-------------------|----------|-------------|

AUTHORIZING HEALTH CARE PROFESSIONAL *(Please read before signing and dating)*

I hereby support the decision of the consumer or his/her authorized representative to direct and supervise the Home Care Attendant in assisting the consumer in the self-administration of medication.

| | | | |
|---|---|---|-------------|
| Authorizing Health Care Professional Name/Title <i>(Please print)</i> | Authorizing Health Care Professional Signature | Initials | Date Signed |
| License # | Emergency Phone Number <i>(Including Area Code)</i> | Fax Number <i>(Including Area Code)</i> | |

In the event that no physician is aware of or supports the consumer's decision to use the Home Care Attendant option, the Registered Nurse who is serving as the Authorized Healthcare Professional must be made aware of the physician's exclusion or non-support.

Consumer/Authorized Representative Initials _____ Authorized Healthcare Professional Initials _____

