

**Personal Care Orientation Evaluation District # \_\_\_\_\_**

Name of PCA \_\_\_\_\_ Service start date \_\_\_\_\_ Supervised on \_\_\_\_\_

P = Physical demonstration   O = Oral testing   W = Written testing   C = Consultation   S = Satisfactory   U = Unsatisfactory   N = Needs improvement

<b>Task/Concept</b>	<b>Demonstrated by</b>	<b>Skill level</b>	<b>Comments</b>
Dressing	P O W C	S U N	
	P O W C	S U N	
Mobility	P O W C	S U N	
Cane	P O W C	S U N	
Crutches	P O W C	S U N	
Manual wheelchair	P O W C	S U N	
Power wheelchair	P O W C	S U N	
	P O W C	S U N	
Positioning	P O W C	S U N	
Transfers	P O W C	S U N	
Pivot	P O W C	S U N	
Sliding board	P O W C	S U N	
Two-person	P O W C	S U N	
Hoyer	P O W C	S U N	
	P O W C	S U N	
Toileting	P O W C	S U N	
Bowel program	P O W C	S U N	
Bladder program	P O W C	S U N	
Catheter care	P O W C	S U N	
Foley catheter	P O W C	S U N	
Straight catheter	P O W C	S U N	
Condom catheter	P O W C	S U N	
Catheter irrigation	P O W C	S U N	
Menses	P O W C	S U N	
	P O W C	S U N	
Eating	P O W C	S U N	
Tube feeding	P O W C	S U N	
Special diet	P O W C	S U N	
Choking	P O W C	S U N	
	P O W C	S U N	
Bathing	P O W C	S U N	
Tub	P O W C	S U N	
Shower	P O W C	S U N	
Partial	P O W C	S U N	
	P O W C	S U N	
Grooming	P O W C	S U N	
Hand washing	P O W C	S U N	
Hair	P O W C	S U N	
Oral care	P O W C	S U N	
Nails	P O W C	S U N	
Deodorant	P O W C	S U N	
	P O W C	S U N	
Range of motion	P O W C	S U N	
Muscle strengthening	P O W C	S U N	
Respiratory	P O W C	S U N	
Postural drainage	P O W C	S U N	

Percussion	P	O	W	C	S	U	N	
Blow bottle	P	O	W	C	S	U	N	
Nebulizer	P	O	W	C	S	U	N	
Ventilator	P	O	W	C	S	U	N	
Oxygen	P	O	W	C	S	U	N	
Clean suction	P	O	W	C	S	U	N	
	P	O	W	C	S	U	N	
Medications	P	O	W	C	S	U	N	
Oral	P	O	W	C	S	U	N	
Topical	P	O	W	C	S	U	N	
Inhalant	P	O	W	C	S	U	N	
Drops	P	O	W	C	S	U	N	
Rectal	P	O	W	C	S	U	N	
Vaginal	P	O	W	C	S	U	N	
Psychotropic	P	O	W	C	S	U	N	
	P	O	W	C	S	U	N	
Seizures	P	O	W	C	S	U	N	
Equipment maintain/clean	P	O	W	C	S	U	N	
Skin care	P	O	W	C	S	U	N	
	P	O	W	C	S	U	N	
Wound care	P	O	W	C	S	U	N	
	P	O	W	C	S	U	N	
Behavior	P	O	W	C	S	U	N	
Self injury	P	O	W	C	S	U	N	
Injury to others	P	O	W	C	S	U	N	
Property destruction	P	O	W	C	S	U	N	
↑ vulnerability 2 <sup>nd</sup> to cognitive deficits or socially inappropriate behavior	P	O	W	C	S	U	N	
Verb. aggressive/resist care	P	O	W	C	S	U	N	
VA/child maltreatment	P	O	W	C	S	U	N	
Universal precautions	P	O	W	C	S	U	N	
Communication with student	P	O	W	C	S	U	N	
Positive behavioral practices	P	O	W	C	S	U	N	
Fraud	P	O	W	C	S	U	N	
Documentation	P	O	W	C	S	U	N	
What to ID/how to report								
Care plan reviewed with PCA		Y		N				

Based on the competencies demonstrated by **Written/Oral testing, Physical demonstration and/or Consultation** with the responsible party and/or student who can direct their own care, it is my professional opinion that the individual named above is knowledgeable about and capable to provide personal assistance services related to the care plan for \_\_\_\_\_ dated \_\_\_\_\_.

Name and title of person who completed evaluation: \_\_\_\_\_

Signature of person who completed evaluation: \_\_\_\_\_ Date \_\_\_\_\_

Evaluation(s) completed on the dates times below:

Date: \_\_\_\_\_ Time: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_

Notes:

## Supervision of Personal Care Assistance Services

School District # \_\_\_\_\_ Building \_\_\_\_\_

*When new staff/contractor is assigned to provide personal care services and those services will be billed to Minnesota Health Care Programs (MHCP), supervision of that individual must occur within 14 days of the start of assignment. Use the Orientation form. When personal care services are provided for a child/student and those services will be billed to MHCP, the service must be supervised at least every 90 days during the first year of service and every 120 days thereafter.*

Supervision provided by:  RN    Mental Health Professional    Other Qualified Professional

Student Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

PCA #1 \_\_\_\_\_ Last Name \_\_\_\_\_    PCA #2 \_\_\_\_\_ Last Name \_\_\_\_\_    PCA #3 \_\_\_\_\_ Last Name \_\_\_\_\_  
 PCA #4 \_\_\_\_\_ Last Name \_\_\_\_\_    PCA #5 \_\_\_\_\_ Last Name \_\_\_\_\_    PCA #6 \_\_\_\_\_ Last Name \_\_\_\_\_

Task	90/120 Date: Time:	PCA #	90/120 Date: Time:	PCA#	90/120 Date: Time:	PCA#	90/120 Date: Time:
Plan of care compliance	S I N	1 2 3 4 5 6	S I N	1 2 3 4 5 6	S I N	1 2 3 4 5 6	S I N
Dressing	S I N	1 2 3 4 5 6	S I N	1 2 3 4 5 6	S I N	1 2 3 4 5 6	S I N
Mobility	S I N	1 2 3 4 5 6	S I N	1 2 3 4 5 6	S I N	1 2 3 4 5 6	S I N
Positioning	S I N	1 2 3 4 5 6	S I N	1 2 3 4 5 6	S I N	1 2 3 4 5 6	S I N
Toileting	S I N	1 2 3 4 5 6	S I N	1 2 3 4 5 6	S I N	1 2 3 4 5 6	S I N
Transfers	S I N	1 2 3 4 5 6	S I N	1 2 3 4 5 6	S I N	1 2 3 4 5 6	S I N
Eating	S I N	1 2 3 4 5 6	S I N	1 2 3 4 5 6	S I N	1 2 3 4 5 6	S I N
Bathing	S I N	1 2 3 4 5 6	S I N	1 2 3 4 5 6	S I N	1 2 3 4 5 6	S I N
Grooming	S I N	1 2 3 4 5 6	S I N	1 2 3 4 5 6	S I N	1 2 3 4 5 6	S I N
Range of motion	S I N	1 2 3 4 5 6	S I N	1 2 3 4 5 6	S I N	1 2 3 4 5 6	S I N
Strengthening exercises	S I N	1 2 3 4 5 6	S I N	1 2 3 4 5 6	S I N	1 2 3 4 5 6	S I N
Medications	S I N	1 2 3 4 5 6	S I N	1 2 3 4 5 6	S I N	1 2 3 4 5 6	S I N
Respiratory	S I N	1 2 3 4 5 6	S I N	1 2 3 4 5 6	S I N	1 2 3 4 5 6	S I N
Seizures	S I N	1 2 3 4 5 6	S I N	1 2 3 4 5 6	S I N	1 2 3 4 5 6	S I N
Skin care	S I N	1 2 3 4 5 6	S I N	1 2 3 4 5 6	S I N	1 2 3 4 5 6	S I N
Behavior	S I N	1 2 3 4 5 6	S I N	1 2 3 4 5 6	S I N	1 2 3 4 5 6	S I N
Maintain/clean equip.	S I N	1 2 3 4 5 6	S I N	1 2 3 4 5 6	S I N	1 2 3 4 5 6	S I N
Integral homemaking	S I N	1 2 3 4 5 6	S I N	1 2 3 4 5 6	S I N	1 2 3 4 5 6	S I N
	S I N	1 2 3 4 5 6	S I N	1 2 3 4 5 6	S I N	1 2 3 4 5 6	S I N
	S I N	1 2 3 4 5 6	S I N	1 2 3 4 5 6	S I N	1 2 3 4 5 6	S I N
	S I N	1 2 3 4 5 6	S I N	1 2 3 4 5 6	S I N	1 2 3 4 5 6	S I N
Satisfaction level	NS S VS		NS S VS		NS S VS		NS S VS
Documentation reviewed	Y N		Y N		Y N		Y N
Care plan reviewed	Y N C/NC		Y N C/NC		Y N C/NC		Y N C/NC

**S** = Satisfactory    **I** = Instruction given    **N** = Not satisfactory  
**NS** = Not Satisfied    **S** = Satisfied    **VS** = Very Satisfied  
**Y** = Yes    **N** = No    **C** = Changed    **NC** = No change

Supervision was direct \_\_\_Yes \_\_\_No    If "No", supervision was done by consulting with: \_\_\_\_\_  
Name/title of responsible party or student consulted

Outcomes or plans based on findings:

Signature and title of supervising healthcare professional: \_\_\_\_\_ Date: \_\_\_\_\_

