PCG Public Partnerships
Supporting Choice. Managing Costs.™

West Virginia Personal Options
TRAUMATIC BRAIN INJURY WAIVER PROGRAM
Annual Training Verification Form

All Personal Options employees must complete all of the following areas before providing services for payment:

- **Adult (or Child if applicable) Cardiopulmonary Resuscitation (CPR) and First Aid** – a copy of the CPR and First Aid cards must be submitted to PPL and must be maintained current as defined by the terms of the certifying agency
  - Must be provided by a certified trainer from the American Heart Association, American Red Cross, American Health and Safety Institute, American CPR. Skills must be demonstrated.
  - Online courses will not be accepted unless accommodated with a statement from the provider indicating that skills are demonstrated.
- **Infectious Disease Control:** hand washing, food safety, use of Personal Protective Equipment (PPE), and blood borne pathogen
- **Abuse/Neglect/Exploitation Identification** – reporting suspected Abuse/Neglect/Exploitation, definition of Abuse/Neglect/Exploitation, signs of abuse, neglect, exploitation, common risk factors and how to address them
- **HIPAA** – Medicaid's policy and procedure of HIPAA and the importance of using social media appropriately

Training Topic	Date	Start Time	Stop Time	Location of Training	Source
Infectious Disease Control (30 minutes)					PPL Training Packet
Abuse, Neglect, and Exploitation (1 hour)					PPL Training Packet
HIPAA (30 minutes)					PPL Training Packet

- **4 hours of training focusing on enhancing direct care services delivery knowledge and skills. Specific on-the-job training with the participant can be counted toward this requirement:**

Training Topic	Date	Start Time	Stop Time	Duration	Location of Training	Source

By signing below, the participant (or their representative) confirmed that the training topics above were provided to the employee listed below, and that he/she has completed those training topics.

_____

Participant Name **Participant or Representative Signature** **Date**

_____

Employee Name **Employee Signature** **Date**

Resource Consultant Name: _____

Please submit the completed test and verification form to your Resource Consultant or fax it to 304-296-1932 Revised 4.2017