MCFI Home Care HOME CARE **Initial Evaluation Tool**

Name:_____

Please complete the following as your reported caregiving related experience:

Population/ Age groups: ☐ CP ☐ MS ☐ Autism ☐ Dementia ☐ Mental Health ☐ Frail Elderly ☐ Disabled ☐ Spinal Cord Injury ☐ TBI ☐ Children 18 & under ☐ COPD ☐ Children with Disabilities

☐ Other_____

Describe areas of past and/or current employment and or experience ☐ Other_____ ☐ Other_____

Employment/Experience **PLEASE BE AS DETAILED AS POSSIBLE** **Example: Grandmother or Sunny Day Group Home**	**Dates Worked or length of time** **Example: 1 year and 6 months**	**Comments (include noting experience with specific populations, such as "experience working with children with disabilities" what kind of disabilities did the children have?)Example: Assisted with toileting and meal prep, grandmother had Alzheimer's/ Dementia**

1 Direct Care Competency

Please read the skills listed in the left column and check the box if you have ever performed that skill, then indicate how long in years or months you have done that skill in the past.			INTERNAL STAFF TO COMPLETE – THESE SHADED AREAS			
Skills	**I have performed or received past training √ = yes**	**Indicate months or years**	**Skill return demo and/ or verbalizes understanding and able to explain all key concepts based on best practices. √ = yes**	**Skills return Demo Date/ Initials**	**Competent to perform √ = yes**	**Comments/ if applicable**
Simple Transfers	√	**1 yr./ 6 months**	**Internal staff to complete**	**Internal staff to complete**	√	**Example**
Gait Belt						**#9DCC**
Slide Board transfers						**#9DCC**
Positioning using side rail or transfer bar						**#9DCC**
Assist with walking with walker or cane						**#8DCC**
Assist with wheelchair mobility						**#8DCC**
Assisting in and out of bed						**#1DCC**
Assisting from chair to chair						**#8DCC**
Splints/Braces On /off						

Skills	I have performed or received past training √ = yes	Indicate months or years	Skill return demo and/ or verbalizes understanding and able to explain all key concepts based on best practices. √ = yes	Skills return Demo Date/ Initials	Competent to perform √ = yes	Comments/ if applicable
Bathing						#3DCC
Bed Bath						#3DCC
Tub Bath						#3DCC
Shower						#3DCC
Partial Bath						#3DCC
Shaving						
Dress/Undress Upper body						#6DCC
Lower body						#6DCC
Applying/removal TED Hose						#6DCC
Care of eyeglasses						#7DCC
Care of Hearing Aides						#7DCC
Eating/Feeding Assistance						#4DCC
Hair Care						
Shampoo						#3DCC
Nail Care						
Mouth Care						#4DCC

3 Direct Care Competency

Skills	I have performed or received past training √ = yes	Indicate months or years	Skill return demo and/ or verbalizes understanding and able to explain all key concepts based on best practices. √ = yes	Skills return Demo Date/ Initials	Competent to perform √ = yes	Comments/ if applicable
Toileting						#2DCC
Bedpan						#2DCC
Urinal						#2DCC
Commode						#2DCC
Incontinent Care						#2DCC
Skin care						#10DCC
Lotions						#10DCC
Barrier cream						#10DCC
Light Housekeeping						#11DCC
Laundry						#11DCC
Meal Prep						#11DCC
Equipment Cleaning						
Know when to call with change of condition of client			N/A			Please verbalize procedure & understanding.
Handwashing			N/A			Please verbalize procedure & understanding.

Other:_____						

Additional Training Received: Indicate all other training you have experience with.
Examples: ☐ **Mechanical Lift** ☐ **Catheter Care** ☐ **Bowel Program** ☐ **Memory Care**
☐ **Other (list)**

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_____

How skills verified: (i.e. Interview of staff, review of training records and/or return demonstration, etc.) _____

_____

_____

Caregiver Signature: _____ **Date:** _____

With my signature, I am verifying that the information recorded on this form is accurate, and I feel confident to perform all skills listed above.

Original to be placed in personal file with application after completion of verification.

Reviewed by:_____ **Date:**_____

Home Care Representative