DOCUMENTATION OF COMPETENCY

ND DEPARTMENT OF HUMAN SERVICES
MEDICAL SERVICES/HCBS
SFN 750 (12-2014)

Clear Fields

This form needs to be completed by a Health Care Professional (see reverse side for instructions).

Applicant/Provider Name:	Provider Number (if known):

INDIVIDUAL REQUEST FOR QUALIFIED SERVICE PROVIDER

The Documentation of Competency must be completed or updated a minimum of one time every two years. Failure to have the documentation of Competency updated every two years results in automatic termination of Qualified Service Provider status.

(1)	(2)	(3) COMPETENT		(4) How Determined Standard		
	STANDARD	Yes	No	Return	Verbal	Written
5.	Proper handwashing methods					
6.	Handling of body fluids					
7.	Bathing techniques					
8.	Hair care techniques					
9.	Oral hygiene techniques					
10.	Dress/undress client					
11.	Toileting					
12.	Caring for incontinence					
13.	Feed or assist with eating					
14.	Basic meal planning and preparation					
15.	Routine eye care (non-prescription eye drops/ointment)					
16.	Care of Fingernails					
17.	Self administration of medications					
18.	Skin care (non-prescription lotions, ointments, etc.)					
19.	Turning and positioning					
20.	Transferring					
21.	Ambulation					
22.	Routine housework					
23.	Wrinkle free bed					
24.	Laundry techniques					
25.	Managing a budget					

	GLOBAL ENDORSEMENTS	COMPETENT		How Determined Standard		
		Yes	No	Return	Verbal	Written
A.	Maintenance Exercise					
B.	Catheter: routine care indwelling					
C.	Medical Gases: Established routine (oxygen only)					
D.	Suppository: Maintain bowel program (non-prescription suppository only)					
E.	Cognitive/Supervision (Required for Respite Care and Supervision)					
F.	Taking BP; TPR					
G.	Ted Socks (Surgical Stockings)					
H.	Prosthesis/Orthotics/Adaptive Devices					
I.	Hoyer lift/Mechanized bath chairs					

I certify that the above-named individual is competent in the identified standards, including those for endorsement(s), checked YES. The competency is based on the standards for direct care staff as outlined in the North Dakota Department of Human Services Qualified Service Provider Handbook.

Further, I certify that I have met the professional degree or have experience in the specialized area(s) required, explained on the back, to be qualified to sign this competency verification.

Signature of Health Care Professional:	Title:	License Number:	Date:
Printed Name of Health Care Professional:	Telephone Number:	E-Mail Address:	Comments: ☐ Yes ☐ No Attach additional sheet.

FOR PERSON VERIFYING COMPETENCY: SEE INSTRUCTIONS ON BACK

INSTRUCTIONS

The Documentation of Competency is designed to determine that an individual meets the basic standards to provide a service. For example; for personal care services competency must be determined for **all** standards **5-25** even IF the standard doesn't apply to the specific client the individual is planning to serve.

INSTRUCTIONS FOR HEALTH CARE PROFESSIONAL CERTIFYING THE INDIVIDUAL REQUESTING QUALIFIED SERVICE PROVIDER STATUS:

To sign the Documentation of Competency (SFN 750) you must be one of the following health care professionals: physician, physicians assistant, nurse practitioner, registered nurse, licensed practical nurse, physical therapist, or occupational therapist.

Column (2): **STANDARDS** Listed is a brief explanation of each. A detailed explanation of the standards and documentation required is found in the Department of Human Services Qualified Service Provider Handbook, Standards for Service Delivery (pages 11-16).

Column (3): COMPETENT You must place an X in the YES box for each standard if the individual is found competent OR you must mark NO for the standard if the individual did not meet the requirement for competency. Please do not write "N/A" as a response.

Column (4): HOW DETERMINED STANDARD You must place an X in the column that identifies how the competency was verified.
RETURN: You directly observed the demonstration/performance of the procedure by the individual.
VERBAL: A detailed verbal explanation of the procedure was given to you by the individual.
WRITTEN: A detailed written explanation of the procedure was provided to you by the individual.

Column (1): Letters A, B, C, D, E, F, G, H, I are GLOBAL ENDORSEMENTS. These are not required with the exception of Cognitive/Supervision, which is required for respite care and supervision. The competency for each task will apply to all clients for whom the provider delivers care.

See the directions above (Column 3 and Column 4) for instructions on how to complete. A detailed explanation of the global endorsements and documentation required is found in the Department of Human Services Qualified Service Provider Handbook, (pages 21-22).

SIGN AND PRINT NAME on the front of this form. YOUR CREDENTIALS AND LICENSE NUMBER MUST ALSO BE WRITTEN on the front of this form.