DOCUMENTATION OF COMPETENCY - AGENCY QUALIFIED SERVICE PROVIDER - EMPLOYEE

DEPARTMENT OF HEALTH AND HUMAN SERVICES
MEDICAL SERVICES/HCBS
SFN 749 (5-2025)

Clear Fields

FOR AGENCY QSP USE ONLY

Instructions to complete are listed on the back of this form. Incomplete forms will not be accepted.
This form must be completed by a health care professional (see reverse side for instructions).

Failure to have an updated form on file for each employee may result in denial of payment for services provided by the employee.

QSP or QSP Applicant Agency Name	Agency Employee Full Name	Provider Number (if known)

The Documentation of Competency-Agency Qualified Service Provider-Employee must be completed or updated a minimum of one time every 5 years.

BOTH COLUMNS 3 AND 4 MUST BE COMPLETED

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

GLOBAL ENDORSEMENTS

A.	Maintenance Exercise	☐	☐	☐	☐	☐
B.	Catheter: Routine care indwelling or external	☐	☐	☐	☐	☐
C.	Medical Gases: Established routine (oxygen only)	☐	☐	☐	☐	☐
D.	Suppository: Maintain bowel program (non-prescription suppository only)	☐	☐	☐	☐	☐
E.	Cognitive/Supervision (required for companionship, respite care and supervision)	☐	☐	☐	☐	☐
F.	Taking BP; TPR	☐	☐	☐	☐	☐
G.	Compression Garment or Devices	☐	☐	☐	☐	☐
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 applicable Department of Health and 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	Email Address	Telephone Number	Comments ☐ Yes ☐ No If yes, attach additional sheet

FOR PERSON VERIFYING COMPETENCY SEE INSTRUCTIONS ON BACK

INSTRUCTIONS

The Documentation of Competency-Agency Qualified Service Provider-Employee 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 **5-26** even IF the standard doesn't apply to the specific person the individual is planning to serve.

PLEASE NOTE: COLUMNS 3 & 4 ARE REQUIRED. IF NOT COMPLETED, A NEW FORM WILL BE REQUIRED.

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

To sign the Documentation of Competency-Agency Qualified Service Provider-Employee (SFN 749) you must be one of the following health care professionals: chiropractor, 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 Health and Human Services Qualified Service Provider Handbook, Standards and allowable tasks/activities.

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 companionship, 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 Health and Human Services Qualified Service Provider Handbook.

SIGN AND PRINT NAME on bottom of page 1 of this form. YOUR CREDENTIALS AND LICENSE NUMBER MUST ALSO BE WRITTEN on bottom of page 1 of this form.