

New York State Medicaid Fee-for-Service Program Private Duty Nursing Trained Caregiver Form

Instructions

- This form must be completed by the trained caregiver.
- At least one trained adult caregiver is required and cannot be a provider servicing the case (submit a separate form for any additional trained caregivers).
- This form must be submitted with new PDN cases and with 12 -month documentation renewal requests, along with the required documentations detailed in **Section 6.1** of the PDN Policy Manual.
- This form is required any time there has been a change to the information provided, submitted via change request to eMedNY, per **Section 9.1** of the PDN Policy Manual.
- The form must be dated no more than 90 days before the prior approval start date.
- Incomplete forms will not be accepted and may delay the prior approval process.

Member Information

Name _____

Medicaid ID Number _____

Trained Caregiver Information

Name _____

Age _____

Relationship to Member _____

Training Statement

I, _____, the trained caregiver, have been fully trained in all skilled tasks required to care for the member and will be responsible for providing care to the member when a private duty nurse is not available.

Employment Information

YES NO I, the trained caregiver, am employed.

If YES, answer the following:

- Total commute time per day to/from work _____
- If self-employed, indicate your work schedule including days and start/stop times below

- If not self-employed, separately submit your work schedule on employer letterhead, including days of the week and start/end times of the workday. It must be signed and dated by the employer per **Section 6.12** of the PDN Policy Manual.

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College Information

NO YES I, the trained caregiver, attend college.

If YES, answer the following:

- Total commute time per day to/from college _____
- Separately submit college schedule on school letterhead as described in **Section 6.12** of the PDN Policy Manual.

Household Information

YES NO I, the trained caregiver, reside in the same home as the member.

If NO, answer the following:

- Distance from the member's residence _____

YES NO The member resides alone.

Indicate who resides in the home with the member (attach separate sheet if needed)

Name	Age	Relationship

I attest I am the member's trained caregiver and all information provided is accurate.

Trained Caregiver Name _____

Date _____

Questions may be directed to the Bureau of Medical Review, PDN Prior Approval Unit at:
1(800) 342-3005, Option 4 or PDNDirectory@health.ny.gov