Direct Care Competency (DCC) Training Program Application

“Train the Trainer for Personal Care Workers”

Date: ☐ Phone Number: ☐ e-mail ☐

Agency Name: ☐

Street: ☐ PO Box: ☐

City: ☐ County: ☐ ☐ Other: ☐

Zip: ☐ How many years has your agency been in business? ☐

Is the agency you represent currently a DCC participant? ☐ Yes ☐ No If yes, stop here.

Are you a certified or licensed provider?: ☐ Yes ☐ No Private Duty Agency? ☐ Yes ☐ No

If so please check :

☐ MA-PC ☐ HH Agency ☐ CBRF ☐ Other-specify ☐

Name of Counties served: ☐

Are you currently working with Family Care? ☐ Yes ☐ No Partnership? ☐ Yes ☐ No

IRIS participants? ☐ Yes ☐ No MA participants? ☐ Yes ☐ No

If yes, please list MCOs:

☐

Please list the names of those who will be attending:

☐

What is the background of your recommended trainer? ☐ CNA ☐ PCW ☐ LPN ☐ RN

Other-explain:

☐

Date of Training: ☐