



**Jazz Home, LLC**

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Dear Provider:

Please take the time to check the home health aide skills you have had experience with. DO NOT check a skill if you do not feel comfortable being placed on a client with that diagnosis. If you have a particular specialty or area of interest, please make note.

- |   |  |
|---|--|
| <input type="checkbox"/> Aids                     | <input type="checkbox"/> Hypertension          |
| <input type="checkbox"/> Arthritis                | <input type="checkbox"/> Incontinence          |
| <input type="checkbox"/> Alzheimers               | <input type="checkbox"/> Multiple Sclerosis    |
| <input type="checkbox"/> Blindness                | <input type="checkbox"/> Osteoporosis          |
| <input type="checkbox"/> Cancer                   | <input type="checkbox"/> Oxygen                |
| <input type="checkbox"/> Catheter                 | <input type="checkbox"/> Parkinsons            |
| <input type="checkbox"/> Colostomy                | <input type="checkbox"/> Psychiatric Disorders |
| <input type="checkbox"/> C.P.R.                   | <input type="checkbox"/> Respiratory Disorders |
| <input type="checkbox"/> Congestive Heart Disease | <input type="checkbox"/> Quadriplegic          |
| <input type="checkbox"/> Feeding Tube             | <input type="checkbox"/> Sliding Board         |
| <input type="checkbox"/> Diabetic                 | <input type="checkbox"/> Stroke                |
| <input type="checkbox"/> Hospice                  | <input type="checkbox"/> Total Bed Care        |
| <input type="checkbox"/> Hoyer Lift               | <input type="checkbox"/> Tracheostomy Care     |

Signature \_\_\_\_\_

Date \_\_\_\_\_

Sincerely  
Case Management Staff