

St. Clair County Community Mental Health Authority
Training/Requirement Reporting Form
Primary Caseholder CAs (PCC, NorServ)

Staff Name: _____ Service: _____
 Agency/Program: _____ Hire Date: _____
 Position: _____ Termination Date: _____

TRAINING REQUIREMENT	Frequency	Target Audience	Compliant	Date(s) Completed
Adverse Benefit Determination Notice	Initial Only	All Primary Caseholders	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A Note: _____	Previous _____ Current _____
Child and Adolescent Functional Assessment Scale (CAFAS)	Initial & Every Two Years	Primary case holders and their supervisors who provide direct service to children/adolescents with SED.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A Note: _____	Previous _____ Current _____
Children's Diagnostic & Treatment Specific Training	Annual	Child Mental Health professionals must have 24 Hours annually of specialized training specifically related to the diagnosis and/or treatment of children. This is also required for staff providing services in children's Residential Homes, staff providing CLS/Respite for children, and Home-Based Aides in Children's Programs.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/> In Progress	Hours completed current year: _____
Communicable Diseases	Initial & Every Two Years	All staff who have direct contact with individuals who has a SUD/COD.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A Note: _____	Previous _____ Current _____
Corporate Compliance	Initial & Annual	All Staff	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A Note: _____	Previous _____ Current _____
Cultural Diversity/Competency	Initial & Every Two Years	All Staff	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A Note: _____	Previous _____ Current _____
HIPAA	Initial & Every Two Years	All Staff	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A Note: _____	Previous _____ Current _____
Home-based Safety	Initial Only	All Home-based Service Staff	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A Note: _____	Previous _____ Current _____
Level I Authorizations	Initial & Every Two Years	Individuals who complete Level I Authorizations on behalf of SCCCMHA, and staff who process denials (which includes all primary case holders and Access clinicians).	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A Note: _____	Previous _____ Current _____
Level of Care Utilization System (LOCUS)	Initial & Annual	Primary caseholders and their Supervisors who provide direct service to adults with primary mental illness and/or substance use disorders.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A Note: _____	Previous _____ Current _____

TRAINING REQUIREMENT	Frequency	Target Audience	Compliant	Date(s) Completed
Medication	Initial & Annual	Medication training is required under many circumstances, including AFC licensing rules, accreditation requirements, or if medication assistance is identified as a need within the Individual Plan of Service (IPOS). Additionally, medication training may be included as part of a corrective action plan. It is the contract agency's responsibility to comply with all regulatory body rules and requirements and the individual's IPOS. Evidence of applicable medication training must be available if requested by	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A Note: _____	Previous _____ Current _____
Person Centered Planning 101	Initial & Every Two Years	All Staff	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A Note: _____	Previous _____ Current _____
Person Centered Planning 301	Initial Only	All staff directly involved in the writing and implementation of the PCP process, which includes all primary case holders.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A Note: _____	Previous _____ Current _____
Pre-School and Early Childhood Functional Assessment Scale (PECFAS)	Initial & Every Two Years	Required for all primary case holders, and their supervisors, providing direct service to children with SED.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A Note: _____	Previous _____ Current _____
Recipient Rights	Within 30 Days of Hire & Annual	All Staff	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A Note: _____	Previous _____ Current _____
Transition & Discharge Planning	Initial Only	All Primary Caseholders	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A Note: _____	Previous _____ Current _____
Universal Precautions/ Bloodborne Pathogens/ Infection Control	Initial & Annual	All Staff	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A Note: _____	Previous _____ Current _____

TRAINING REQUIREMENT	Frequency	Target Audience	Compliant	Date(s) Completed
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Initial = Within 90 Days of Hire
 Note: There is a 30 day grace period for recertifications and re-trainings.

PERSONNEL REQUIREMENT	Frequency	Compliant	Date(s) Completed
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Criminal Background Check e.g. ICHAT, fingerprinting, Mich Doc, etc.	After Offer of Employment but Before Date of Hire/Annual	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	_____
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DHHS Central Registry	After Offer of Employment but Before Date of Hire/Annual	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	_____
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Driver's License/State ID Age Verification: 18+ years	Before Providing Service	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	_____
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Driver's License Check Verify Current DL and Driving Record only for Staff Who Regularly Transports	Before Providing Service/Annual	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	_____
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Recipient Rights Background Check Office of RR Authorization To Disclose Employee Information and Release of Liability form New Hires Only	After Offer of Employment but Before Date of Hire	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	_____
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TB Testing/Screening Reporting Required for SED Waiver Providers Only	Before Providing Services	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	_____
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Contract Manager: _____ Date: _____

Other Comments: _____
