St. Clair County Community Mental Health Authority

Training/Requirement Reporting Form

Group/Specialized AFC Homes

Staff Name: _____ Service: _____

Agency/Program: _____ Hire Date: _____

Position: _____ Termination Date: _____

TRAINING REQUIREMENT	Frequency	Target Audience	Compliant	Date(s) Completed
Cardio-Pulmonary Resuscitation (CPR)	Certification must be current at all times	All staff who provide CLS, skill building, or respite services; ABA Technicians; other staff as identified by Supervisor.	☐ Yes ☐ No ☐ 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.	☐ Yes ☐ No ☐ N/A ☐ In Progress	Hours completed current year:
Corporate Compliance	Initial & Annual	All Staff	☐ Yes ☐ No ☐ N/A Note:	Previous Current
Cultural Diversity	Initial & Every Two Years	All Staff	☐ Yes ☐ No ☐ N/A Note:	Previous Current
First Aid	Certification must be current at all times	All staff who provide CLS, skill building, or respite services; ABA Technicians; other staff as identified by Supervisor.	☐ Yes ☐ No ☐ N/A Note:	Previous Current
HIPAA	Initial & Every Two Years	All Staff	☐ Yes ☐ No ☐ N/A Note:	Previous Current
Individual Specific IPOS Training	Initial, Annual and Any time there is a change in IPOS	All Direct Service Staff	Compliance is monitored ongoing through Utilization Management reviews.	

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 SCCCMHA.	☐ Yes ☐ No ☐ N/A Note:	Previous Current
Nonviolent Crisis Intervention (CPI)	Initial & Every Two Years	All staff who provide direct service to individuals with challenging behaviors, as assigned by agency/supervisor. Minimally this includes homes housing individuals served at Hayes, Roehl, Springborn, Wells, Colorado, Stone Creek, Abbottsford, Lincoln, Scott, Oak, private home.	☐ Yes ☐ No ☐ N/A Note:	Previous Current
Person Centered Planning 101	Initial & Every Two Years	All Staff	☐ Yes ☐ No ☐ N/A Note:	Previous Current
Positive Behavior Supports and Prevention Strategies	Initial & Every Two Years	All staff who work directly with individuals receiving services.	☐ Yes ☐ No ☐ N/A Note:	Previous Current
Recipient Rights	Within 30 Days of Hire & Annual	All Staff	☐ Yes ☐ No ☐ N/A Note:	Previous Current
Universal Precautions/ Bloodborne Pathogens/ Infection Control	Initial & Annual	All Staff	☐ Yes ☐ No ☐ N/A Note:	Previous Current

TRAINING REQUIREMENT	Frequency	Target Audience	Compliant	Date(s) Completed

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
Criminal Background Check *e.g. ICHAT, fingerprinting, Mich Doc, etc.*	After Offer of Employment but Before Date of Hire/Annual	☐ Yes ☐ No ☐ N/A	
Driver's License/State ID *Age Verification: 18+ years*	Before Providing Service	☐ Yes ☐ No ☐ N/A	
Driver's License Check *Verify Current DL and Driving Record only for Staff Who Regularly Transports*	Before Providing Service/Annual	☐ Yes ☐ No ☐ N/A	
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	☐ Yes ☐ No ☐ N/A	
TB Testing/Screening *Reporting Required for SED Waiver Providers Only*	Before Providing Services	☐ Yes ☐ No ☐ N/A	

Contract Manager: _____ Date: _____

Other Comments: _____