

St. Clair County Community Mental Health Authority Training/Requirement Reporting Form Independent Facilitators

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

TRAINING REQUIREMENT	Frequency	Target Audience	Compliant	Date(s) Completed
Corporate Compliance	Initial & Annual	All Staff	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A Note: _____	Previous _____ Current _____
Cultural Diversity	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 _____
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 _____
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 _____

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	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	_____
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	_____
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	_____
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	_____
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	_____

Contract Manager: _____ Date: _____
 Other Comments: _____