

**St. Clair County Community Mental Health Authority**  
**Training/Requirement Reporting Form**  
**Non-Primary Caseholder CAs (CLS/Supported Housing/HOYO)**

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.  | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A<br>Note: _____                       | Previous _____<br>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<br><input type="checkbox"/> Progress | Hours completed current year: _____ |
| Corporate Compliance                                | Initial & Annual                                       | All Staff  | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A<br>Note: _____                       | Previous _____<br>Current _____     |
| Cultural Diversity                                  | Initial & Every Two Years                              | All Staff  | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A<br>Note: _____                       | Previous _____<br>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.  | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A<br>Note: _____                       | Previous _____<br>Current _____     |
| HIPAA   | Initial & Every Two Years                              | All Staff  | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A<br>Note: _____                       | Previous _____<br>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 | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A<br>Note: _____ | Previous<br>_____<br>Current<br>_____ |
| 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.  | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A<br>Note: _____ | Previous<br>_____<br>Current<br>_____ |
| Person Centered Planning 101                                   | Initial & Every Two Years       | All Staff  | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A<br>Note: _____ | Previous<br>_____<br>Current<br>_____ |
| Positive Behavior Supports and Prevention Strategies           | Initial & Every Two Years       | All staff who work directly with individuals receiving services.   | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A<br>Note: _____ | Previous<br>_____<br>Current<br>_____ |
| Recipient Rights   | Within 30 Days of Hire & Annual | All Staff  | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A<br>Note: _____ | Previous<br>_____<br>Current<br>_____ |
| Universal Precautions/ Bloodborne Pathogens/ Infection Control | Initial & Annual                | All Staff  | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A<br>Note: _____ | Previous<br>_____<br>Current<br>_____ |

| 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<br>e.g. ICHAT, fingerprinting, Mich Doc, etc. | After Offer of Employment but<br>Before Date of Hire/Annual | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A | _____ |
|---|---|---|-------|

|  |                          |   |       |
|--|--------------------------|---|-------|
| Driver's License/State ID<br>Age Verification: 18+ years | Before Providing Service | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A | _____ |
|--|--------------------------|---|-------|

|   |                                    |   |       |
|---|------------------------------------|---|-------|
| Driver's License Check<br>Verify Current DL and Driving Record only<br>for Staff Who Regularly Transports | Before Providing<br>Service/Annual | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A | _____ |
|---|------------------------------------|---|-------|

|   |  |   |       |
|---|--|---|-------|
| Recipient Rights Background Check<br>Office of RR Authorization To Disclose Employee<br>Information and Release of Liability form<br>New Hires Only | After Offer of Employment but<br>Before Date of Hire | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A | _____ |
|---|--|---|-------|

|  |                           |   |       |
|--|---------------------------|---|-------|
| TB Testing/Screening<br>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: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_