

# St. Clair County Community Mental Health Authority Training/Requirement Reporting Form PSAs with Direct Service

Staff Name: \_\_\_\_\_ Service: \_\_\_\_\_  
 Agency/Program: \_\_\_\_\_ Hire Date: \_\_\_\_\_  
 Position: \_\_\_\_\_ Termination Date: \_\_\_\_\_

TRAINING REQUIREMENT	Frequency	Target Audience	Compliant	Date(s) Completed
Applied Behavioral Analysis Training	Initial Only	All Paraprofessional Staff	<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: _____
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 _____
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.	
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 _____

TRAINING REQUIREMENT	Frequency	Target Audience	Compliant	Date(s) Completed
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 _____
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 _____

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: \_\_\_\_\_

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