**SANILAC COUNTY COMMUNITY MENTAL HEALTH AUTHORITY**

# Individual Plan of Service Inservice Verification

| | | | |
|---|---|---|---|
| **Person Served Name:** | | | Case # |
| **Reason for Training** | ☐ **IPOS**<br>☐ **Amendment**<br>☐**Periodic Review**<br>☐ **ABA Behavioral Plans** | **Effective Date:** _____ | |

## Training Provided by Qualified Staff

| | |
|---|---|
| **Qualified Staff**<br>(**Must include credentials**)<br>Case Manager, CMA, LMSW, LLSMW, LBSW, LLBSW. LLP, LP, LPC, MD/DO OT, PT, QIDP, QMHP, CMHP, BCBA, BCaBA) | |
| **Trainee Name(s) & Role/Title**<br>(Group Home Manager, Skill Building Supervisor, Case Manager, Case Manager Assistants, Clinicians) | Name:<br>Title:<br>Date Trained: |
| | Name:<br>Title:<br>Date Trained: |
| | |

_____ _____

Trainee Signature Date

_____ _____

Trainee Signature Date

_____ _____

Case Manager Signature Date

*Signatures indicate that the Trainee has been trained and understands the goals and objectives that are written in the document and is capable of running the goals and objectives.

*For Homes: The Trainee should be in a managerial position, someone who oversees direct care workers.

*For Homes: The Trainee is responsible to ensure that all new staff are trained on the goals and objectives before providing any billable service.

*** <u>The above Trainee(s) is now certified to be a Trainer on the identified document.</u> ***

| Person Served Name: | | Case # |
|---|---|---|

## SANILAC COUNTY COMMUNITY MENTAL HEALTH AUTHORITY

# Staff Training

| **Trainer Name**<br>Title/Role and Agency/Program | |
|---|---|

Trainer's Signature

Date

*A copy of this document needs to be with the provider, to ensure that trainings are kept up to date. Please keep this document in the individuals file for auditing and monitoring purposes.

| Printed Name/Job Title | Agency/Program | Signature |
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