St. Clair County Community Mental Health

Individual Plan of Service (IPOS) Training Log

Name: _____ **Case #:** _____

Plan Effective Date: _____ **Plan Expires On:** _____

Plan Type: ☐ IPOS ☐ Amendment ☐ Periodic Review **Goal #:** ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 **Objective(s):** ☐ A ☐ B ☐ C ☐ D ☐ E ☐ F

If OT, RN, or any other Clinical Goals were written in the IPOS, that Professional Staff MUST provide the training instead.

Initial Training – Complete only once for the initial training & then submit for scanning.

CMH Staff: _____ provided treatment planning training to
(Printed Staff Name, Credentials, & Job Title)

Trained Staff: _____ on the following date _____.
(Printed Staff Name, Credentials, Job Title, & Organization/Program) (Month/Day/Year)

_____ _____
Trained Staff Signature **Date**

Additional Staff Training – Complete for training of support staff & then submit for scanning.

I, _____ , who is **CERTIFIED** to **TRAIN** staff on the Individual Plan of Service (IPOS), has provided training to the staff listed below on the following date: _____.
(Printed Staff Name, Credentials, Job Title, & Organization/Program) (Month/Day/Year)

Printed Staff Name	Job Title	Organization/Program	Signature	Training Date

Clinical Form: #03-0146
Date Revised: 8/16/2024
Admin Procedure Ref: #02-003-0011, #03-001-0005, #03-001-0025, #03-001-0050
EHR: Services, Individual Plan of Service, Meeting/Treatment Plan (Attach to Corresponding IPOS Date)