

# St. Clair County Community Mental Health Authority Staff Training/Requirement Reporting Form

Non-Primary Caseholder CAs (Community Enterprise, Goodwill, Life Skills, Lotus Cafe, Creative Empowerment, RSA)

Legal Name: \_\_\_\_\_ Previous/Preferred Name: \_\_\_\_\_ (Aliases, Maiden, etc.)  
PROOF of Legal Name (i.e. Driver's License/State ID if following Date of Hire)

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 Note: _____	_____ Previous _____ Current _____
Corporate Compliance	Initial & Annual	All Staff	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A Note: _____	_____ Previous _____ Current _____
Cultural Diversity/Competency	Initial & Annual	All Staff	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A Note: _____	_____ Previous _____ Current _____
Emergency Preparedness	Initial & Annual	All Staff	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A Note: _____	_____ Previous _____ 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 Note: _____	_____ Previous _____ Current _____
HIPAA	Within 30 Days of Hire & Annual	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 through Utilization Management reviews	
Medication Administration	Initial & Every Three Years	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 or assigned by CMH Nurse when medication errors suggest re-training would be beneficial. 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 SCCCMHA	<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
Medication Overview	Annual *	All Direct Service Staff	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A Note: _____	Previous _____ Current _____
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 and any contracted behavioral home.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A Note: _____	Previous _____ Current _____
Person Centered Planning - Basic	Within 60 days of hire & Annual"	All Staff	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A Note: _____	Previous _____ Current _____
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 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 _____
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 (unless noted otherwise in frequency)  
 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	_____
MDHHS Central Registry Only required (prior to start date ) if working with individuals under 18	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 (Form 02-0250)	After Offer of Employment but Before Date of Hire	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	_____

Authorized Signer: \_\_\_\_\_ Date: \_\_\_\_\_  
 Other Comments: \_\_\_\_\_  
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