

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

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
Children's Diagnostic & Treatment Specific Training	Annual	* Please see end of form for specific target audience guidance	<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/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 _____
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 ongoing 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 _____
Medication Overview	Annual *	All Direct Service 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
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 _____
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 stated 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: _____			

Children's Diagnostic and Treatment Specific Training Guidance

Requirements for the 24-Clock Hour Training Requirement for Children's Diagnostic and Treatment Service Programs includes the following staff and immediate supervisors:

1. Staff who complete the initial screening, emergency evaluation, and intake evaluation within CMHSPs. This includes (a) staff completing MichiCANS assessments and (b) staff completing waiver and 1915(i) related assessments enrollment.
2. Targeted Case Managers
3. Intensive Care Coordination with Wraparound (ICCW) Care Coordinators
4. Home-Based Services Staff
5. Outpatient Therapy Staff
6. Staff for Intensive Crisis Stabilization Services and Crisis Intervention Services
7. Youth Peer Support Specialists
8. Parent Support Partners

Staff who are not required to comply with the 24-clock hour requirement

1. Psychiatrists
2. Community Living Support (CLS) Staff
3. Respite Care Staff
4. Nurses
5. Overnight Health and Safety Support Staff
6. Staff Providing Physical Therapy, Occupational Therapy, Speech Therapy, or Behavioral Health Treatment/Applied Behavioral Analysis
7. Providers of Other Waiver and 1915(i) Services Not Listed Above