

St. Clair County Community Mental Health Authority Staff Training/Requirement Reporting Form Primary Caseholder CAs (New Oakland and PCC)

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
Adverse Benefit Determination Notice	Initial & Annual	All Primary Caseholders	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A Note: _____	Previous _____ Current _____
CCBHC Informational Training for DCOs	Initial & Every Three Years	All Staff	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A Note: _____	Previous _____ Current _____
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: _____
Communicable Diseases	Initial & Every Two Years	All staff who have direct contact with individuals who has a SUD/COD	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A Note: _____	Previous _____ Current _____
Co-Occurring Mental Health and SUD	Initial & Every Two Years	All Staff	<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 _____
Devereux Early Childhood Assessment (DECA)	Initial & Every Two Years	Primary case holders and their supervisors who provide direct services to infants and young children, 1 month to 47 months with suspected SED.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A Note: _____	Previous _____ Current _____
Disaster Planning/Continuity of Operations	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 _____
Grievances, Appeals, and Mediation	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 _____

TRAINING REQUIREMENT	Frequency	Target Audience	Compliant	Date(s) Completed
Home-Based Safety	Initial Only	All Home-based Service Staff	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A Note: _____	Previous _____ Current _____
Implicit Bias	Initial & Annual	All Staff	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A Note: _____	Previous _____ Current _____
Level I Authorizations	Initial & Every Two Years	Staff who complete Level I Authorizations on behalf of SCCCMHA, and staff who process denials (which includes all primary caseholders)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A Note: _____	Previous _____ Current _____
Level of Care Utilization System (LOCUS)	Initial Only	Primary caseholders and their Supervisors who provide direct service to adults with primary mental illness and/or substance use disorders	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A Note: _____	Previous _____ Current _____
Limited English Proficiency	Initial & Every Three Years	N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A Note: _____	Previous _____ Current _____
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 _____
MichiCANs	Initial & Annual	All Supervisors, Coordinators, Clinicians, Case Managers, and any staff completing the MichiCANs tool with youth & families	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A Note: _____	Previous _____ Current _____
Military Culture	Initial & Annual	All Staff	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A Note: _____	Previous _____ Current _____
Older Adult Care and Culture	Initial & Annual	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
Overdose, Prevention and Response	Initial & Annual	All Staff	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A Note: _____	Previous _____ Current _____
Person Centered Planning - Advanced	Initial Only	All staff directly involved in the writing and implementation of the PCP process, which includes all primary case holders	<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 _____
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 _____
Recovery	Initial & Annual	All Staff	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A Note: _____	Previous _____ Current _____
Screening, Brief Intervention and Referral to Treatment (SBIRT)	Initial Only	All Casemanagers, Clinicians, Clinical/Program Coordinators, and Program Supervisors	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A Note: _____	Previous _____ Current _____
Targeted Case Management	Initial & Every Two Years	All Primary Caseholder	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A Note: _____	Previous _____ Current _____
Transition & Discharge Planning	Initial Only	All Primary Caseholders	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A Note: _____	Previous _____ Current _____
Trauma Informed Care	Initial & 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 _____
Zero Suicide: Introduction to Suicide Prevention	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: _____

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