Required DOH & Waiver Training

Employee Name: ____ **Date:** _______________

Reason for Training: □ **New Hire** □ **Annual Evaluation** □ **Other** __________________

Area of Review/Training	Employee Competent In Training Area	
	YES	**NO**
Emergency Disaster Response Plan		
Responding to individual health and behavioral emergencies or crises		
Dealing with people with difficult behaviors		
Understanding and Implementing the ISP or Care Plan		
Identifying ISP or Care Plan Outcomes		
Ensuring that individuals have access to their home/setting/community with respect to individual needs, mobility, hearing and vision		
Proper documentation of services provided		
Staff receive annual incident management training on preventing, recognizing, reporting, and responding to incidents, and assuring that a participant is safe		
Abuse, Neglect and Exploitation Identification and Prevention		
HIPAA/Confidentiality		
Workplace safety including risk mitigation, infection control, & proper restrictive procedures		
Knowledgeable of Agency's Quality Management Plan		
Understanding and implementing agency's complaint/grievance policy		
Knowledgeable in implementing ODP mission, principles and values		
Competent in appropriate program bulletins, info memos, & regulations issued this year		
Fraud and Financial Abuse Prevention		
Competent in additional DOH required subject areas including: *Confidentiality, Consumer Control & the Independent Living Philosophy, Instrumental ADLs, Recognizing changes in the consumer condition that need to be addressed, Infection Control, Universal Precautions, Handling Emergencies, Dealing with difficult behaviors, Bathing/Shaving/Grooming/Dressing, Hair/Skin/Mouth Care, Assist with Ambulation/Transfers, Meal Prep and feeding, Toileting, Assistance with self-administered medications.*		
Other:		

Consumer specific training was conducted regarding the below consumers.
This training included a thorough review of the consumer's ISP/care plan, likes/dislikes, risk mitigation strategies, accessibility to home and community through needs/mobility/hearing/vision, preferred modes of communication, supporting the individual with equipment/adaptations, and special requirements & restrictions:

Participant/Consumer Name(s): ____________________________ ____________________________

____________________________ ____________________________

Individual Support Plan (ISP)/ Care Plan Development Statement:
By signing below, the employee and supervisor attest that they have had the opportunity to be involved in the development of the current and approved ISP/Care Plan of the above listed consumer(s).

By signing below, both the employee and supervisory attest that the above information is true and accurate. If further training is needed, contact your local office and additional training will be provided.

____ ___________________

Employee Signature Date

____ ___________________

Supervisor/Surrogate Signature Date