Individuals Name: _____

OCHN CONID: _____

Oakland Community Health Network

Developmental Disabilities • Mental Health • Substance Recovery

OCHN Self-Determination Checklist

All training must be completed as a pre-condition for employment based on date of hire and then updated annually unless stated otherwise.

Date: _____

Support Coordinator _____ Core Provider _____

OCHN Member _____ Con ID # _____ Contact # _____

Legal Representative _____ Email Address _____

Check all that apply:

☐ SD Welcome Meeting is needed (if done, SD Agreement Date_____)

☐ A new Self-Directed arrangement

☐ Member/family wants to directly manage their staff through an individual budget.

☐ Member/family wants staff through a contracted Agency. (if checked, contact Selfdetermination@oaklandchn.org to confirm this form is needed)

☐ Member is replacing previous staff/agency ☐ Member is adding another DSP/Agency

Additional information needed for the SD Arrangement: _____

TYPE OF SUPPORTS

Financial Management Service (FMS) Agency _____

Staffing Agency _____ Contact # _____ Eff. Date _____

Direct Support Professional (DSP) _____ Contact # _____

THIS SECTION TO BE COMPLETED BY THE FMS FOR DIRECT HIRES

Date	**Background Checks/Information *(Required at time of hire* or *prior to hire)***
_____	Criminal Record Check (Prior to hire and annually)
_____	Office of Inspector General (Monthly)
_____	Michigan Driver License (Annually if transporting the person)

Trainings (*Required at time of hire and updated thereafter*)

_____	First Aid (2 years)	Expiration	_____
_____	Emergency Preparedness (all, 2 years)	Expiration	_____
_____	CPR (2 years – CWP only)	Expiration	_____
_____	Universal Precautions/Bloodborne Pathogens/Infection Control (2 Years)	Expiration	_____
_____	Recipient Rights- one time face-to-face (One time only)	Expiration	_____
	ORR updates (Annually)	Expiration	

Required if Medication administration is put in your plan (Both offered by OCHN & LIVE In-Person Training)

_____ Initial OCHN Approved Medication Administration Training (One time only)

_____ Medication Administration Competency Review Annual Training (Annually)

Verification in ODIN

_____ Backup plan verified in ODIN (Initial or if changed)

_____ Inservice/training of IPOS in ODIN (Initial and Annually)

Direct Hire _____ Direct Hire Wage $ _____

(after making a condition/contingent offer of employment to the candidate and prior to the candidate providing services to the person)

I verify that the above information is accurate and available in the employee's record files

FMS Representative's Signature	Printed Name	Date
OCHN Representative's Signature	Printed Name	Date

Internal Review Only

MCA Reviewer Name	Review Date