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: ____/____/_____

Individual's Name _____ CON ID _____

Individual's Email _____ Individual's Phone # _____

Legal Representative (LR) _____

LR's Email _____ LR's Phone # _____

Support Coordinator (SC) _____ Core Provider _____

SC's Email _____ SC's Phone # _____

Check all that apply:

☐ SD Welcome Meeting is needed (if done, SD Agreement Date____/____/_____)

☐ A new Self-Directed arrangement

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

☐ Individual/family wants staff through a contracted Agency.

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

Additional information needed for the SD Arrangement: _____

TYPE OF SUPPORTS

Financial Management Service (FMS) Agency _____

Staffing Agency (SA) _____ Contact # _____ SA Eff. Date _____

Direct Support Professional (DSP) _____ Contact # _____

PLEASE NOTE:
Once completed above, this document must be sent by the Support Coordinator to the FMS within 3 business days of the document date.

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)
_____	Authorization to Disclose Employee Information and Release of Liability (completed once for new hires only)

	Trainings (*Required at time of hire and updated thereafter*)		
_____	First Aid (2 years)	Expiration	_____
_____	Emergency Preparedness (all, 2 years)	Expiration	_____
_____	Universal Precautions/Bloodborne Pathogens/Infection Control (Annually)	Expiration	_____
_____	Recipient Rights - New Hire (One time only face-to-face)	Expiration	_____
_____	Recipient Rights Annual Training	Expiration	_____

Required if Medication Administration is included in the 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 Start Date Direct Hire Wage $_____

(After making a conditional/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, including whether the DSP is a Qualified Provider and/or the Staffing Agency/Professional Provider is credentialed with OCHN. This information is available in the employee's record files.

_____	_____	_____
FMS Representative's Signature	Printed Name	Date

Once completed by the FMS, this document should be uploaded into ODIN within 3-5 business days.

Internal Review Only

_____	_____
MCA Reviewer Name	Review Date