

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 (2 Years)	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