Oakland Community Health Network

Developmental Disabilities • Mental Health • Substance Recovery

OCHN Self-Determination Checklist

**** Under OCHN, training expectations must align with OCHN's Required Trainings Grid to avoid nonpayment for staff services.***

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 (SD Agreement Date _____)

☐ A new Self-Directed Arrangement

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

☐ Individual/Legal Rep. wants staff from a Non-Contacted/Credentialed Provider ***(Send this document to the FMS)***

☐ Individual/Legal Representative wants staff from a Contacted Provider ***(Send this document to OCHN)***

☐ 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:
Based on the box checked above, the Support Coordinator must submit this document to the FMS or OCHN within three (3) business days of the document date.

Email: The Arc - fitimesheet@thearcoakland.org GT - referral@gtindependence.com
OCHN - selfdetermination@oaklandchn.org

THIS SECTION TO BE COMPLETED BY THE FMS FOR DIRECT HIRES

Date	Background Checks/Information
_____	Criminal Record Check (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)

Date	Trainings		
_____	First Aid (2 years)	Expiration	_____
_____	Environmental Preparedness/ Environmental Emergencies (2 years)	Expiration	_____
_____	Bloodborne Pathogens (Includes Prevention of Disease Transmission/Infection Control/Universal Precautions) (Annually)	Expiration	_____
_____	Recipient Rights-Initial (in-person, virtual, or online)	Expiration	_____
_____	Recipient Rights-Annual	Expiration	_____

Note: If Recipient Rights Training is not completed through OCHN, it can be completed through a MDHHS approved source or another CMHP. If utilizing the Improving MI Practices website, three training courses are needed to satisfy the Recipient Rights requirement: Introduction to Recipient Rights, Recipient Rights: Residential Rights, and Recipient Rights Process.

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 based on plan)

The level of training required is based on the extent to which staff are required to assist with administration.

Verification in ODIN

_____ Staffing 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 Provider is a Non-Contracted/Credentialed Provider 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