

OCHN Self-Determination Checklist

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

Individual's Name	_____	CON ID	_____	Date	_____
Individual's Email	_____	Individual's Phone #	_____		
Legal Representative (LR)	_____				
LR's Email	_____	LR's Phone #	_____		
Support Coordinator (SC)	_____	Core Provider	Select One		
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 Representative wants staff from a Non-Contracted Provider (**Send this document to the FMS**)
- ☐ 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	Select One	
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 HR Alliance - fmsdocuments@hragroup.net

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	Expiration
_____	First Aid (2 years)	_____
_____	Environmental Preparedness/	Expiration _____
_____	Environmental Emergencies (2 years)	_____
_____	Bloodborne Pathogens (Includes Prevention of Disease	Expiration _____
_____	Transmission/Infection Control/Universal Precautions) (Annually)	_____
_____	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