**IPOS Training Verification Form**

|  |  |  |  |
| --- | --- | --- | --- |
| Client Name: | | CMHSP: | |
| CMHSP ID#: | WSA ID#: | | Annual IPOS  Amendment  Date of Document: |

The staff person(s) identified below were trained on the Individual Plan of Service/Crisis Prevention or Amended Plan of Service, for the service recipient identified above. The staff was provided an opportunity to review the IPOS/Amendment document containing the plan that will be implemented, and to ask questions/receive clarification as needed. If any questions/concerns develop related to the IPOS, Crisis Prevention and/or Amended Plan, they are to be brought to the attention of the Supports Coordinator, Care Manager, Wrap Around Facilitator, and/or ABA Supervisor.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Training Date: | Printed Name of Trainee | Trainee Signature | Trainer | Trainer Credentials/Title | Trainer Signature |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |

ADDITIONAL STAFF TRAINING: Use this section for new hires and staff not available at the initial training and who were trained by a staff/parent/guardian who was previously trained in the IPOS.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Training Date: | Printed Name of Trainee | Trainee Signature | Trainer | Trainer Credentials/Title | Trainer Signature |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |

\*\*\*If additional signature lines are needed, make copies of this page.