PATHWAYS TREATMENT PLAN TRAINING DOCUMENTATION FORM

Recipient Name: _____ MCO#: _____

IPOS/Amendment/Specialty Plan Effective Date: _____ to _____

Trainer(s) & Title: _____ Location/Worksite: _____

TRAINING CATEGORY: Check 1 or more: (Include applicable goals, objectives, & data sheet/s)

- ☐ IPOS - training on entire IPOS
- ☐ IPOS Amendment
- ☐ ABA Applied Behavioral Analysis (Autism Benefit)
- ☐ Behavioral Treatment Plan
- ☐ Dietary Plan
- ☐ Health Care Plan
- ☐ Physical Therapy Plan
- ☐ Speech Therapy Plan
- ☐ Supported Employment Plan
- ☐ Occupational Therapy Plan
- ☐ Vocational Plan
- ☐ Other: _____

PRINTED NAME	SIGNATURE	DATE TRAINED	TIME / LENGTH OF TRAINING	INITIALS OF TRAINER

Trainer Comments: _____

_____

Case Manager/Specialty Staff has trained _____ and s/he agrees to train additional staff that is required to be trained.

_____ (*Signature of Home Manager/Assistant Manager/Supervisor*) I have been properly trained by Pathways staff and have agreed to train remaining staff that need to be trained.

Trainer Signature(s): _____ _____

NC_v.2015-10-14 (4-16 ad) (4-16-18 JL) PWY #534

Form must be faxed to Pathways Medical Records after obtaining signatures, unless person is a new hire, and maintained on site for auditing purposes.