INNOVATIVE HOUSING DEVELOPMENT CORPORATION
3051 COMMERCE DRIVE SUITE 5
FORT GRATIOT, MI 48059
(810) 385-4463

Annual Training

Group Home/Enhanced Community Support

1. Cultural Diversity
2. Corporate Compliance
3. Health/Medications
4. HIPPA/IS Security Awareness
5. Recipient Rights
6. Blood Borne Pathogens/Universal Precautions
7. Person Centered Planning

Review all IPOS's/Case #'s

_____

_____

_____

Employee signature Date

_____

Supervisor signature Date

ST. CLAIR COUNTY COMMUNITY MENTAL HEALTH

CORPORATE COMPLIANCE TRAINING ATTESTATION

Name (please print): _____

Agency Affiliation/Job Title: _____

My signature below indicates that (check all):

- ☐ I have reviewed and understand the St. Clair County Community Mental Health Policy #01-002-0020 *Corporate Compliance Complaint, Investigation & Reporting Process* on _____/_____/_____.
- ☐ I have reviewed and understand the St. Clair County Community Mental Health *Corporate Compliance Program Plan* on _____/_____/_____.
- ☐ I have reviewed and understand the St. Clair County Community Mental Health Corporate Compliance flyer on _____/_____/_____
- ☐ I have achieved functional competency in the training subject matter.
- ☐ I understand that if I have any questions regarding the training subject matter, I may contact the St. Clair County Community Mental Health Corporate Compliance Officer, Tracey Pingitore, for clarification.

Signature: _____ Date: _____

Upon completion of this training, please forward this training attestation to your organization's human resources/training representative.

3111 Electric Avenue
Port Huron, MI 48060
Phone: 810-985-8900

ST. CLAIR COUNTY COMMUNITY MENTAL HEALTH

CULTURAL DIVERSITY TRAINING ATTESTATION

Name (please print): _____

Agency Affiliation/Job Title: _____

My signature below indicates that (check all):

- ☐ I have reviewed the Cultural Diversity self-study training on _____/_____/_____.
- ☐ I have passed (scored 80% or higher) the Cultural Diversity test on _____/_____/_____.
- ☐ I have achieved functional competency in the training subject matter.
- ☐ I understand that if I have any questions regarding the training subject matter, I may contact the St. Clair County Community Mental Health Training Department for clarification.

Signature: _____ Date: _____

Upon completion of this training, please forward this training attestation to your organization's human resources/training representative.

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Phone: 810-985-8900

ST. CLAIR COUNTY COMMUNITY MENTAL HEALTH

HIPAA
TRAINING ATTESTATION

Name (please print): _____

Agency Affiliation/Job Title: _____

My signature below indicates that (check all):

- ☐ I have reviewed the HIPAA self-study training on ____/_____/_____.
- ☐ I have passed (scored 80% or higher) the HIPAA test on ____/_____/_____.
- ☐ I have reviewed and understand the St. Clair County Community Mental Health Policy #08-002-0006 *Health Care Information – Privacy & Security Measures* _____/_____/_____.
- ☐ I have reviewed and understand the St. Clair County Community Mental Health Policy #08-002-0005 *Protected Health Information – Privacy Measures* on _____/_____/_____.
- ☐ I have reviewed and understand the St. Clair County Community Mental Health Policy #08-001-0010 *Computer Information Systems Security* on _____/_____/_____.
- ☐ I understand that if I have any questions regarding the training subject matter, I may contact the St. Clair County Community Mental Health Training Department for clarification.

Signature: _____ Date: _____

Upon completion of this training, please forward this training attestation to your organization's human resources/training representative.

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Phone: 810-985-8900

ST. CLAIR COUNTY COMMUNITY MENTAL HEALTH

MEDICATION TRAINING ATTESTATION

Name (please print): _____

Agency Affiliation/Job Title: _____

My signature below indicates that (check all):

☐ I have reviewed the Seizure Types and Procedure for Administration handouts on _____/_____/_____.

☐ I have reviewed the Medication training Powerpoint on _____/_____/_____.

Signature: _____ Date: _____

Please give this completed Attestation to the SCCCMH training representative upon entering the face to face portion of Medication training. You will not be permitted to attend Medication training at SCCCMH without this documentation.

Thank you.

3111 Electric Avenue
Port Huron, MI 48060
Phone: 810-985-8900

ST. CLAIR COUNTY COMMUNITY MENTAL HEALTH

PERSON CENTERED PLANNING 101 TRAINING ATTESTATION

Name (please print): _____

Agency Affiliation/Job Title: _____

My signature below indicates that (check all):

- ☐ I have reviewed the Person Centered Planning 101 self-study training on _____/_____/_____.
- ☐ I have passed (scored 80% or higher) the Person Centered Planning 101 test on _____/_____/_____.
- ☐ I have achieved functional competency in the training subject matter.
- ☐ I understand that if I have any questions regarding the training subject matter, I may contact the St. Clair County Community Mental Health Training Department for clarification.

Signature: _____ Date: _____

Upon completion of this training, please forward this training attestation to your organization's human resources/training representative.

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Port Huron, MI 48060
Phone: 810-985-8900

ST. CLAIR COUNTY COMMUNITY MENTAL HEALTH

UNIVERSAL PRECAUTIONS/BLOODBORNE PATHOGENS/INFECTION CONTROL TRAINING ATTESTATION

Name (please print): _____

Agency Affiliation/Job Title: _____

My signature below indicates that (check all):

- ☐ I have reviewed the Universal Precautions/Bloodborne Pathogens/Infection Control self-study training on _____/_____/_____.
- ☐ I have passed (scored 80% or higher) the Universal Precautions/Bloodborne Pathogens/Infection Control test on _____/_____/_____.
- ☐ I have achieved functional competency in the training subject matter.
- ☐ I understand that if I have any questions regarding the training subject matter, I may contact the St. Clair County Community Mental Health Training Department for clarification.

Signature: _____ Date: _____

Upon completion of this training, please forward this training attestation to your organization's human resources/training representative.

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Port Huron, MI 48060
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