Self-Determination

STAFF/PROVIDER TREATMENT PLAN REVIEW & ACKNOWLEDGEMENT FORM

CUSTOMER:_____ SUMMIT POINTE ID#:_____

SUPPORTS COORDINATOR/CARE MANAGER:_____

ACKNOWLEDGEMENT: I, Care Provider, acknowledge that I have reviewed the Customer's current treatment plan effective_____and that I fully understand my role in providing community living supports and/or respite care supports.

I also acknowlege that I have been informed of the required **initial and annual training expectations** as a service provider for the community living supports and/or respite care services as well as the documentation expectations.

Provider:_____ Date:_____
(Print Name Here:_____)

Participant:_____ Date:_____
(Participant/Gaurdian Signature)