INDIVIDUAL PLAN OF SERVICE PROOF OF TRAINING
Ancillary / Specialized Residential / Aide Level Staff

Individual Served: _____ **Case Number:** _____

Effective date of Plan: _____ **Type of Plan** ☐ Initial / Annual ☐ Addendum ☐ Behavior Support Plan ☐ Protocol

Provider Agency: _____ **Location:** _____

IPOS training shall be provided by the case manager or other qualified staff / independent facilitator that are responsible for monitoring the IPOS and are not providers of any other service to that individual and by each specialized professional within the scope of their practice, as appropriate (see IPOS In Service form). The identified staff/trainer either received IPOS training during the Person Centered Planning (PCP) meeting **or** has received training from the Primary Clinician outside of the PCP meeting. Please indicate the appropriate training received below:

Training/PCP Meeting Date	Staff Name (please print)	Staff Signature	Name of Primary Clinician	IPOS Training (select one below)
				☐ Yes: received training during the PCP Meeting ☐ No: attest to receiving training outside of PCP Mtg
				☐ Yes: received training during the PCP Meeting ☐ No: attest to receiving training outside of PCP Mtg

Indicate below the completed training information provided to staff and have staff print, sign and date. Please note that each **date of training** must be completed separately.

Training information:

Date of Training: _____

Trainer Printed Name: _____

Trainer Signature: _____

Staff Name (please print)	Staff Signature	Signature Date

Training information:

Date of Training: _____

Trainer Printed Name: _____

Trainer Signature: _____

Staff Name (please print)	Staff Signature	Signature Date

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Training information:

Date of Training: _____

Trainer Printed Name: _____

Trainer Signature: _____

Staff Name (please print)	Staff Signature	Signature Date

Training information:

Date of Training: _____

Trainer Printed Name: _____

Trainer Signature: _____

Staff Name (please print)	Staff Signature	Signature Date