

### Summit Pointe IPOS In Service Log Form

Customer Name: \_\_\_\_\_ Customer SPOT ID#: \_\_\_\_\_

Treatment Plan Effective Date: \_\_\_\_\_

Case Manager: \_\_\_\_\_

Delegated CSM to complete In Service: \_\_\_\_\_

Date that Delegated CSM was trained by Author: \_\_\_\_\_

☐ CB CLS Provider    ☐ Spec Res Provider    ☐ Skill Building Provider    ☐ SIL/In Home CLS Provider

Lead Staff Trained Name and Title: \_\_\_\_\_

Provider Name: \_\_\_\_\_

| Date Lead Staff Trained: | Staff Initials | Lead Staff Trained Signature: | Signature of Case Manager: |
|--------------------------|----------------|-------------------------------|----------------------------|
|                          |                |                               |                            |
|                          |                |                               |                            |
|                          |                |                               |                            |
|                          |                |                               |                            |
| Date Staff Trained:      | Staff Initials | Staff Signature:              | Signature of Trainer:      |
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\*Signatures indicate that Lead Staff/Staff have been trained on the goals and objectives written in the IPOS by the case manager, and are capable of running the goals and objectives as written.

\*Lead Staff should be anyone in a managerial position who oversees direct care workers.

\*Lead staff are responsible to ensure that all new staff are trained on IPOS goals and objectives before running any treatment plans.

\*A copy of this document needs to be with the provider, to ensure that trainings are kept up to date. Please keep this document in the customer's file for auditing and monitoring purposes.