DIVISION OF SERVICES FOR PEOPLE WITH DISABILITIES

APPLICATION FOR CERTIFICATION TO PROVIDE LIMITED SERVICES TO A PERSON UNDER THE SELF-ADMINISTERED SERVICES ACQUIRED BRAIN INJURY WAIVER

Name of Applicant: _____ Date: _____

Address: _____ Phone: _____

City: _____ State: _____ ZIP: _____

Name of Person Applicant Desires to Support: _____.

Service(s) Applicant Desires to Provide (*Circle All that Apply)*:

CH1(Q); CO1(Q); HS1(Q); RP1(Q); RP6(Q); SL1(Q); DTP

Knowledge Requirements for Certification:

Employment Agreement Date: _____

Department of Human Services Provider Code of Conduct Date: _____

Division of Services for People with Disabilities' Code of Conduct Date: _____

Emergency Contact Information Date: _____

Person's Support Book/Daily File Date: _____

Service Specific Training Date: _____

Incident Reporting Date: _____

Behavior Management *(if applicable)* Date: _____

Acquired Brain Injury Info Packet (ABI Training Manual Module I) Date: _____

SIGNATURES:

I represent that I have read and am familiar with the above-identified materials and that I have been oriented to and/or trained on all of the materials by: _____ on the dates indicated. I further represent that I both understand and will comply with the requirements identified

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in the materials in providing services to the Person and that I am capable of providing appropriate services to the Person.

_____ _____
Signature of Applicant *Date (mm/dd/yyyy)*

I,_____represent that I am the Person, the Person's Representative, or the Person's Designated Administrator of Supports, and that I am familiar with both the above-identified materials and the supports required by the Person. I further represent that I provided orientation and/or training to the Applicant on all of the above required materials on the dates indicated above. I further represent that based on the training and orientation provided to the Applicant, I am satisfied that the Applicant has the knowledge, understanding and ability to provide appropriate services to the Person.

_____ _____
Signature of Person, Representative or Designated Administrator *Date (mm/dd/yyyy)*

AWARD OF CERTIFICATION TO PROVIDE LIMITED SERVICES TO A PERSON WITH ACQUIRED BRAIN INJURY RECEIVING SELF-ADMINISTERED SERVICES

Based on the forgoing representations of the Applicant and the Person, Person's Representative, or Person's Designated Administrator of Supports, the Applicant has met the minimum requirements necessary for Certification to Provide Limited Services to the Person receiving Self-Administered Services. The Division, therefore, awards the Applicant certification to provide the following services to:_____.

Name of Person

(*Circle All that Apply)*:

CH1(Q); CO1(Q); HS1(Q); RP1(Q); RP6(Q); SL1(Q); DTP

_____ _____
Signature of Person's Support Coordinator *Date (mm/dd/yyyy)*