**CMHPSM Provider Network Application & Re-Credentialing Application (7-2019) Attachment C: Aide Level Staff Training**

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| **Provider Name:** |  | **Application Date:** |  | **Initial App:** **Renewal App:** | | | |
| **Please include as many copies of Attachment C as necessary to cover all applicable staff members indicate page number(s):** | | | | **Page #:** |  | **of:** |  |

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| **Staff Information** | | | | **Staff Training Dates (Please enter date of last verified training in MM/DD/YY format.)** | | | | | | | | | | | | |
| **#** | **Last Name** | **First Name** | **Hire Date** | Initial Recipient Rights | Most Recent Recipient Rights | Due Process, Grievance & Appeals | Medicaid Integrity | Blood-borne Infectious Disease | First Aid  and CPR  (In-Person) | Limited English Proficiency | Cultural Competence | Person Centered Planning | Medication Administration | RBT Task List | AFC Licensed Req. Training | Behavior Management |
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