

Documentation of Employer Orientation By Consumer Directed Services Agency

Individual's Name:		Program Name:	
Individual's Medicaid Number:		Employer Name:	Relationship to Individual:

1. Minimum required attendance: **Employer** and **Consumer Directed Services Agency (CDSA) representative**; and the **Designated Representative (DR)** if appointed at time of orientation.
2. The training must be conducted **in the individual's residence**.
3. Training must be completed **before** initiation of Consumer Directed Services (CDS) is initiated.

Training Location:

Address:		
City:	State:	ZIP Code:

Training Session:

CDSA Representative Name:				
CDSA Name:			CDSA City:	
Begin Date:	Time: <input type="checkbox"/> AM <input type="checkbox"/> PM	End Date:	Time: <input type="checkbox"/> AM <input type="checkbox"/> PM	Length of Training Session: Hours Minutes

CDSA Contact Information:

Contact Person:	Telephone Number: ()	Fax Number: ()
Office Days:	Office Hours: From:	To:

Certification – I certify the training included, at a minimum, the topics listed in the Table of Contents of the current version of the *CDS Consumer Post-Decision Training Manual*, and also the current Chapter 41 (Consumer Directed Services Option) of the Texas Administrative Code. I also certify that the information documented on this page is correct.

Employer:

CDSA Representative:

Printed Name

Printed Name

Signature

Signature

Date

Date

Others in Attendance: (DR is required if appointed at the time of the Orientation)

Printed Name

Printed Name

Relationship to Employer

Relationship to Employer

Signature

Signature

Date

Date