Macomb County Community Mental Health
Universal Individual Plan of Service (IPOS) Training Verification

Person Served Name:	
Case #	
IPOS Effective Date:	
IPOS Expiration Date:	
Check Reason for Training	☐ IPOS ☐ Amendment ☐ Periodic Review (if changes occurred)
Primary Provider & Agency	

TRAINING PROVIDED BY PRIMARY PROVIDER

Primary Provider Name	
Trainee Name-Person Served/Parent/Guardian/ Personal Representative	
Trainee Name, Title Program/Service	
Date Trained	

Trainee Signature _______________ Date _______________

Trainee Signature _______________ Date _______________

Primary Provider Signature _______________ Date _______________

*<u>**Trainee is now Certified to Train staff on the IPOS.**</u>

Staff Training

Trainer Name, Title Program/Service	

Trainer's Signature _______________ Date _______________

Printed Name/Job Title	Agency/Program	Signature and Date Trained

Printed Name/Job Title	Agency/Program	Signature and Date Trained

Case #___________________