CERTIFICATION OF MENTORING PROGRAM COMPLETION FORM FOR NEW SUPPORT COORDINATORS

This form must be completed by the Qualified Organization's mentor to document a mentee's completion of all required activities in an approved mentoring program. Once completed, this form must be sent to the mentee and the Agency's Regional Office.

Prospective Support Coordinator Name (Mentee):

Mentor's Name: **Mentor's Provider ID:** Mentor's **Required Mentoring Activity** Initials Indicating Completion The mentee shadowed or observed work of the mentor for at least 90 days. Date mentoring started: Date mentoring ended: 2. The mentee shadowed or observed support plan meetings involving the mentor or mentee's clients. List a minimum of five (5) support plan meetings in which the mentee participated during the mentoring period. Client iConnect ID **Date of Support Plan Meeting**

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3.	The mentee shadowed or observed the mentor in at least
	nine (9) face-to-face visits in a variety of settings, including
	meetings with clients in family homes, supported living
	arrangements, and licensed facilities. At least six (6) of
	these visits must detail the coordination of providers'
	supports.

List the face-to-face visits that the mentee participated in during the mentoring period and indicate visits that detail coordination of providers' supports. Include a description of the activities in each client's case notes.

Client iConnect ID	Date of Face-To Face Visit	Brief Description of Meeting's Purpose	Living Setting of Client	

4.	The mentee a occurred whi program.			
	List the date o			
	Date of Meeting			
				_
5.	The mentee shadowed or observed the mentor in discussions to educate clients and families regarding identifying and preventing abuse, neglect, and exploitation. Provide the client's iConnect ID and the date of each meeting.			n.
	Client iCo	nnect ID	Date of Meeting	
6.	clients and fa	milies on m	r observed the mentor instruct nandatory reporting requirements	
	for abuse, ne Reflect the Cli			
	Client iCo	nnect ID	Date of Meeting	

	of iConnect for case Provide the client's iCo			
	performed.			
	Client iConnect ID	Type of Activity		
8.	The mentee shadowe Supported Living Qu	ed or observed the mentor in the arterly Meeting.		
	Provide the client's iConnect ID and date of quarterly supported living meeting with a minimum of one meeting.			
	Client iConnect ID	Date of Supported Living Quarterly Meeting		
9.		ies that occurred or check N/A if no ed during the mentoring period.	Yes	N/A
a.		ificant additional needs request.		
b.	Medicaid eligibility re	pility redetermination process.		
C.	Discussion with the assessor regarding the completion of the comprehensive needs assessment.			
d.	Submission of a minimum of five (5) client cost plans and service authorizations.			
10.	If any of the activities described in number 9.a., b., c., and d. did not occur, the mentor reviewed those processes, including documentation in a client's central record, with the mentee.			

If the Qualified Organization has been approved by the Agency to provide consultation services under the CDC+ program, please complete the following in addition to the requirements stated above if the mentee will provide consultation services. If the Qualified Organization or mentee will not provide consultation services, skip this section.

	Required Mentoring	Activity for the CDC+ Program	Mentor's Initials Indicating Completion
1.		r observed the mentor review purchasing plans, if applicable, or asing plans.	-
	Client iConnect ID	Date of Meeting	
2.	2. The mentee shadowed or observed the mentor submit a SAN request, if applicable, or review the most recent SAN request that was submitted. Client iConnect ID Date of Meeting		
		Date of Meeting	
	that the mentee identified oned herein.	on page one successfully completed th	e items
Mentor	Signature	Date	
l attest	that I completed the activit	ies identified on this form.	
Mente	e Signature	Date	