

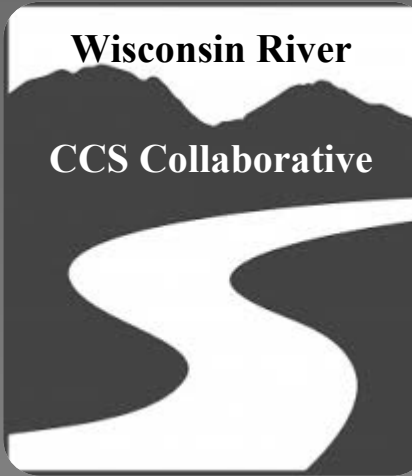
Comprehensive Community Services
Orientation Checklist

Instructions for completing the WRC CCS Orientation Checklist

- 1) All new providers must attend a county orientation training for each county that you intend to be credentialed by.
- 2) All new providers must complete the CCS Orientation Course through the UW Green Bay Behavioral Health Training Partnership and provide verification of completion. There is no cost to the provider, you will register as a contracted staff for the county entity you will be a provider for.

<https://www.uwgb.edu/behavioral-health-training-partnership/online-training/>

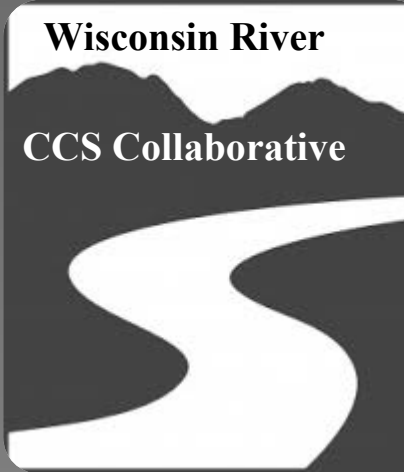
- 3) Complete and provide verification of all training with dates (Ex. training certificate, transcript or course description, name of webinar, etc.)
- 4) All trainings should have occurred within past 3 years.
- 5) You have 90 days from the time you are authorized to bill as a CCS provider to complete all the training on this checklist. If you fail to do so you will no longer be authorized to bill your county entity for CCS services you provide. Individual counties may request that the orientation checklist be completed before you are authorized to provide services.
- 6) Sign and attest your completion of training orientation checklist.
- 7) Request that the CCS county program supervisor sign your completed checklist.



**Columbia County
CCS Program
111 E. Mullett Street
P.O. Box 136
Portage, WI 53901
608-742-9227**

**Richland County
CCS Program
221 W Seminary Street
Richland Ctr. WI 53581
608-647-8821**

**Sauk County
CCS Program
505 Broadway
Baraboo, WI 53913
608-355-4200**



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Name: _____ 20 hrs. ___ 40 hrs.

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1. Parts of Chapter 36 pertinent to the services they provide.

This requirement was achieved through attending:

Name of Training _____ Type of Training _____ Date _____ Hrs. _____

2. Policies and procedures pertinent to the services they provide.

This requirement was achieved through attending:

Name of Training _____ Type of Training _____ Date _____ Hrs. _____

3. Job responsibilities for staff members and volunteers.

This requirement was achieved through attending:

Name of Training _____ Type of Training _____ Date _____ Hrs. _____

4. Applicable parts of Chapters 48, 51 and 55, Stats., and any related administrative rules.

This requirement was achieved through attending:

Name of Training _____ Type of Training _____ Date _____ Hrs. _____

5. The basic provisions of civil rights laws including The American With Disabilities Act of 1990 and The Civil Rights Act of 1964 as the laws apply to staff providing services to individuals with disabilities.

This requirement was achieved through attending:

Name of Training _____ Type of Training _____ Date _____ Hrs. _____

6. Current standards regarding documentation and the provisions of HIPAA, s. 51.30, Stats., Ch. DHS 92 and if applicable, 42 CFR Part 2 regarding confidentiality of treatment records.

This requirement was achieved through attending:

Name of Training _____ Type of Training _____ Date _____ Hrs. _____

7. The provisions of s. 51.61, Stats., and Ch. DHS 94 regarding consumer rights.

This requirement was achieved through attending:

Name of Training _____ Type of Training _____ Date _____ Hrs. _____

8. Current knowledge about mental disorders, substance use and addiction disorders, and co-occurring disabilities and treatment methods.

This requirement was achieved through attending:

Name of Training _____ Type of Training _____ Date _____ Hrs. _____

9. Recovery concepts and principles:

*Which ensure that services and supports promote consumer hope, healing, empowerment, connection to others and to the community, and

*Are provided in a manner that is respectful, culturally appropriate, collaborative between consumer and services providers, and

*Based on consumer choice and goals protective of consumer rights.

This requirement was achieved through attending:

Name of Training _____ Type of Training _____ Date _____ Hrs. _____

10. Current principles and procedures for providing services to children and adults with mental disorders, substance use, addiction disorders, and co-occurring disorders. Areas addressed shall include:

*Recovery-oriented assessment and services and person centered planning.

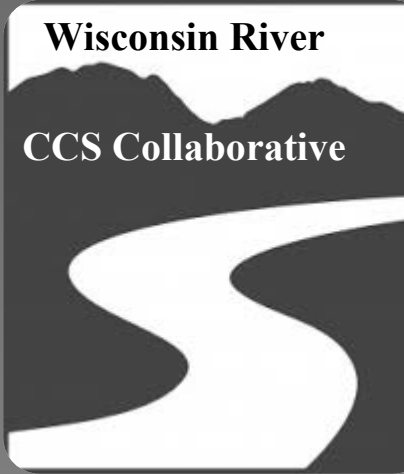
*Principles of relapse prevention,

*Psychosocial rehabilitation services,

*Age-appropriate assessments and services for individuals across the life span,

*Trauma assessment and treatment approaches, including symptom,

*The relationship between trauma and mental health and substance abuse disorders, self-



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management, and

*Culturally and linguistically appropriate services.

This requirement was achieved through attending:

Name of Training _____ Type of Training _____ Date ____ Hrs. ____

11. Techniques and procedures for providing non-violent crisis management for consumers, including:

- a. Verbal de-escalation,
- b. Methods for obtaining backup,
- c. Acceptable methods for self-protection and protection of the consumer and others in emergency situations, and
- d. Suicide assessment, prevention and management.

This requirement was achieved through attending:

Name of Training _____ Type of Training _____ Date ____ Hrs. ____

12. Ethics and Boundaries training regarding your role as a CCS provider, the scope of your authorized activities in this role, and the ethics of and professional boundaries inherent in your role.

This requirement was achieved through attending:

Name of Training _____ Type of Training _____ Date ____ Hrs. ____

13. Additional training specific to services you are providing in the CCS program, for example; substance use and dual diagnoses treatment, functional behavioral assessments, coping skills training, WRAP, cultural competence, motivational interviewing, teaming, and service facilitation.

This requirement was achieved through attending:

Name of Training _____ Type of Training _____ Date ____ Hrs. ____

This requirement was achieved through attending:

Name of Training _____ Type of Training _____ Date ____ Hrs. ____

This requirement was achieved through attending:

Name of Training _____ Type of Training _____ Date ____ Hrs. ____

Please provide a brief description of the training(s) from the areas listed above:

I attest that by signing this that I have completed all of the training I have entered on this CCS orientation Checklist.

Provider Signature Date

I approve the completion of CCS training requirements by this provider.

County Agency Signature Date

Staff Qualification Level as Determined by County Agency – Circle one

PHD MD Master Level Bachelor Level Rehabilitation Worker

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