



BrightPath

## Staff Orientation Record: Person-Specific

Employee name: Asho Abdulahi, IHS Specialist

Program name: BrightPath LLC. Home & Community Based Services

Before having unsupervised direct contact with persons served or for whom the staff has not previously provided direct support or any time these plans or procedures are revised, staff must review and receive instruction in the following areas as they relate to the staff's job functions for that person. \*Complete this form for all persons served to whom the staff person will be providing direct contact services.

Staff will review Support Plan, Support Plan Addendum, Self Management Assessment, and Individual Abuse Prevention Plan at orientation, and ongoing as plans are updated. Staff will review to achieve and demonstrate an understanding of the person as a unique individual and how to implement those plans. Include outcomes, behavior plans, and any document specific to the person. Other topics as determined necessary according to the person's Service and Support Plan or identified by the company will be outlined as needed.

| Orientation to Individual Service Recipient Needs |                                                                                     |                                                                |                   |                                                                                                                                                                                                                                                                                  |
|---------------------------------------------------|-------------------------------------------------------------------------------------|----------------------------------------------------------------|-------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Name of Individual Served                         | Support Plan, Support Plan Addendum, Self Management Assessment, and IAPP Reviewed? | CPR, if required by the Support Plan or Support Plan Addendum? | Hours of Training | Name of Instructor + Type of Competency                                                                                                                                                                                                                                          |
| Rachel Seltz                                      | Yes                                                                                 | N/A                                                            | .5                | Instructor Name: Jamila Whitlock, Designated Coordinator<br><br>Type of Competency:<br><input type="checkbox"/> Quiz<br><input type="checkbox"/> Discussion w/ Designated Coordinator<br><input checked="" type="checkbox"/> Self-Review<br><input type="checkbox"/> Observation |

| Name of Individual Served | Support Plan, Support Plan Addendum, Self Management Assessment, and IAPP Reviewed? | CPR, if required by the Support Plan or Support Plan Addendum? | Hours of Training | Name of Instructor + Type of Competency                                                                                                                                                                                                  |
|---------------------------|-------------------------------------------------------------------------------------|----------------------------------------------------------------|-------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                           |                                                                                     | N/A                                                            |                   | Instructor Name:<br><br>Type of Competency:<br><input type="checkbox"/> Quiz<br><input type="checkbox"/> Discussion w/ Designated Coordinator<br><input type="checkbox"/> Self-Review<br><input type="checkbox"/> Observation            |
|                           |                                                                                     | N/A                                                            |                   | Instructor Name:<br><br>Type of Competency:<br><input type="checkbox"/> Quiz<br><input type="checkbox"/> Discussion w/ Designated Coordinator<br><input type="checkbox"/> Self-Review<br><input type="checkbox"/> Observation            |
|                           |                                                                                     | N/A                                                            |                   | Instructor Name:<br><br>Type of Competency:<br><input type="checkbox"/> Quiz<br><input type="checkbox"/> Discussion w/ Designated Coordinator<br><input checked="" type="checkbox"/> Self-Review<br><input type="checkbox"/> Observation |
|                           |                                                                                     | N/A                                                            |                   | Instructor Name:<br><br>Type of Competency:<br><input type="checkbox"/> Quiz<br><input type="checkbox"/> Discussion w/ Designated Coordinator<br><input type="checkbox"/> Self-Review<br><input type="checkbox"/> Observation            |

| Name of Individual Served | Support Plan, Support Plan Addendum, Self Management Assessment, and IAPP Reviewed? | CPR, if required by the Support Plan or Support Plan Addendum? | Hours of Training | Name of Instructor + Type of Competency                                                                                                                                                                                       |
|---------------------------|-------------------------------------------------------------------------------------|----------------------------------------------------------------|-------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                           |                                                                                     | N/A                                                            |                   | Instructor Name:<br><br>Type of Competency:<br><input type="checkbox"/> Quiz<br><input type="checkbox"/> Discussion w/ Designated Coordinator<br><input type="checkbox"/> Self-Review<br><input type="checkbox"/> Observation |
| Total Training Hours:     |                                                                                     |                                                                | .5                |                                                                                                                                                                                                                               |

Signed by:

Jamila Whitlock

05A908D1BF6D4FC...

Trainer Signature

Signed by:

ASD

406C14EF00194DE...

Employee Signature

1/15/2025

Date

1/15/2025

Date

\*I understand the information I received and my responsibilities for their implementation in the care of persons served by this program.