

**CERTIFICATION OF MENTORING PROGRAM COMPLETION FORM
FOR MENTEES WITH SUPPORT COORDINATOR EXPERIENCE**

This form must be completed by the Qualified Organization’s mentor and any support coordinator who has an active Medicaid Waiver Services Agreement but less than 12 months’ experience working as a support coordinator when joining a Qualified Organization. The mentee may receive credit for completing activities prior to joining the Qualified Organization if the mentor reviews documentation in the client’s central record or provided by the support coordinator to verify that these activities occurred. The mentee and mentor must sign their initials to indicate successful completion of each activity. Once completed, this form must be sent to the mentee and the Agency’s Regional Office.

Support Coordinator’s Name (Mentee):

Mentee’s Provider ID:

Mentor’s Name:

Mentor’s Provider ID:

Required Mentoring Activity		Mentee’s Initials	Mentor’s Initials																		
<p>1. The mentee participated in the mentoring program for at least 30 days.</p> <p>Date mentoring started: <u>Click</u> or tap here to <u>enter</u> text. Date mentoring ended: Click or <u>tap</u> here to enter text.</p>																					
<p>2. The mentee facilitated support plan meetings as a support coordinator or, if not, the mentee shadowed or observed support plan meetings involving the mentor or mentee’s clients.</p> <p><i>List a minimum of five (5) support plan meetings facilitated by the support coordinator.</i></p> <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th align="center">Client iConnect ID</th> <th align="center">Date of Support Plan Meeting</th> </tr> </thead> <tbody> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> </tbody> </table>	Client iConnect ID	Date of Support Plan Meeting																			
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5.	<p>The mentee facilitated or, if not, shadowed or observed the mentor in discussions to educate clients and families regarding identifying and preventing abuse, neglect, and exploitation.</p> <p><i>Provide date and client iConnect ID.</i></p> <table border="1"> <thead> <tr> <th>Client iConnect ID</th> <th>Date of Meeting</th> </tr> </thead> <tbody> <tr><td></td><td></td></tr> <tr><td></td><td></td></tr> <tr><td></td><td></td></tr> <tr><td></td><td></td></tr> <tr><td></td><td></td></tr> <tr><td></td><td></td></tr> </tbody> </table>		Client iConnect ID	Date of Meeting														
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6.	<p>The mentee instructed or, if not, shadowed or observed the mentor instruct clients and families on mandatory reporting requirements for abuse, neglect, and exploitation.</p> <p><i>Reflect the Client's iConnect ID as well as the date of meeting.</i></p> <table border="1"> <thead> <tr> <th>Client iConnect ID</th> <th>Date of Meeting</th> </tr> </thead> <tbody> <tr><td></td><td></td></tr> <tr><td></td><td></td></tr> <tr><td></td><td></td></tr> <tr><td></td><td></td></tr> <tr><td></td><td></td></tr> <tr><td></td><td></td></tr> </tbody> </table>		Client iConnect ID	Date of Meeting														
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7.	<p>The mentee used iConnect for case management activities.</p> <p><i>Provide the client's iConnect ID and the type of activity performed.</i></p> <table border="1"> <thead> <tr> <th>iConnect Client ID</th> <th>Type of Activity</th> </tr> </thead> <tbody> <tr><td></td><td></td></tr> <tr><td></td><td></td></tr> <tr><td></td><td></td></tr> </tbody> </table>		iConnect Client ID	Type of Activity														
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8.	The mentee completed a Supported Living Quarterly Meeting or, if not, shadowed or observed the mentor in the Supported Living Quarterly Meeting.																			
	<i>Provide the client's iConnect ID and date of quarterly supported living meeting.</i>																			
	<table border="1"> <thead> <tr> <th>Client iConnect ID</th> <th>Date of Supported Living Quarterly Meeting</th> </tr> </thead> <tbody> <tr><td></td><td></td></tr> <tr><td></td><td></td></tr> <tr><td></td><td></td></tr> <tr><td></td><td></td></tr> <tr><td></td><td></td></tr> <tr><td></td><td></td></tr> <tr><td></td><td></td></tr> </tbody> </table>	Client iConnect ID	Date of Supported Living Quarterly Meeting																	
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9.	Check Yes for activities that occurred during the support coordinator's prior experience or during the mentoring program or check No if no opportunities occurred.	Yes	No																	
a.	Submission of a significant additional needs request.	<input type="checkbox"/>	<input type="checkbox"/>																	
b.	Medicaid eligibility redetermination process.	<input type="checkbox"/>	<input type="checkbox"/>																	
c.	Discussion with the assessor regarding the completion of the comprehensive needs assessment.	<input type="checkbox"/>	<input type="checkbox"/>																	
d.	Updating a minimum of five (5) client cost plans and service authorizations.	<input type="checkbox"/>	<input type="checkbox"/>																	
10.	If any of the activities described in number 9.a., b., c., or d. did not occur during the support coordinator's prior experience or during the mentoring program, 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		Mentee's Initials	Mentor's Initials														
1. The mentee shadowed or observed the mentor review draft, denied, or updated purchasing plans, if applicable, or review the current purchasing plans. <table border="1" data-bbox="276 415 1133 680"> <thead> <tr> <th>Client iConnect ID</th> <th>Date of Meeting</th> </tr> </thead> <tbody> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> </tbody> </table>		Client iConnect ID	Date of Meeting														
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2. The mentee shadowed or observed the mentor submit a SAN request, if applicable, or review the most recent SAN request that was submitted. <table border="1" data-bbox="276 829 1133 1094"> <thead> <tr> <th>Client iConnect ID</th> <th>Date of Meeting</th> </tr> </thead> <tbody> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> </tbody> </table>		Client iConnect ID	Date of Meeting														
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I attest that the mentee identified on page one successfully completed the items described herein. If I did not personally observe the mentee complete any item described herein, I reviewed documentation in the client's central record or provided by the support coordinator to verify that these activities occurred.

Mentor Signature

Date

I certify that I completed the activities identified on this form.

Mentee Signature

Date