Alabama Department of Senior Services Medicaid Waiver Programs

Direct Service Providers Orientation Training Approval List

DSP Name_____ **Calendar Year** _____

To be completed by the contracting Direct Service Provider:

Signature of person completing the form: _____

Title: _____ Date of Completion_____

Please indicate the employees who will receive the training listed below:

Homemakers☐ Personal Care Workers☐ Companion Workers☐
Adult Day Health Workers☐ Unskilled Respite Workers☐ RN☐ LPN☐

Please indicate which Waiver employees will receive the training listed below:

Elderly and Disabled Waiver (E&D)☐ Alabama Community Transitions Waiver (ACT)☐

Topic	Name/Title of Trainer	Objectives	Outline of Contents	Length

To be completed by the contracting Area Agency:

The training, as listed, is approved for calendar year _____. Date: _____

Signature: _____ Title: _____

cc: QA Auditor, ADSS

MW-25A 9/2017R