

Direct Service Providers Annual 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: _____