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:

<table>
<tr><th colspan="2">Required Mentoring Activity</th><th>Mentee's Initials</th><th>Mentor's Initials</th></tr>
<tr><td>1.</td><td>The mentee participated in the mentoring program for at least 30 days.

Date mentoring started: Click or tap here to enter text.
Date mentoring ended: Click or tap here to enter text.</td><td></td><td></td></tr>
<tr><td>2.</td><td>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.

List a minimum of five (5) support plan meetings facilitated by the support coordinator.

<table>
<tr><th>Client iConnect ID</th><th>Date of Support Plan Meeting</th></tr>
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3. The mentee facilitated or, if not, shadowed or observed the mentor in at least (9) face-to-face visits in a variety of settings, including meetings with clients in family homes, supported living arrangements, and licensed facilities. At least six (6) of these visits must detail the coordination of providers' supports.

List the face-to-face visits that the mentee facilitated during prior work experience as a support coordinator or, if not, shadowed or observed the mentor during the mentoring program. Indicate those six meetings that involved coordination of provider supports.

Client iConnect ID	Date of Face-to-Face Visit	Brief Description of Meeting's Purpose	Living Setting of Client

4. The mentee attended meetings (support coordinator monthly meetings / webinars) hosted by APD that occurred prior to joining the Qualified Organization or during the mentoring program.

List a minimum of three (3) meeting dates and topic addressed.

Date of Meeting	Topic of Meeting

5.	**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.** *Provide date and client iConnect ID.* **Client iConnect ID** / **Date of Meeting**			
6.	**The mentee instructed or, if not, shadowed or observed the mentor instruct clients and families on mandatory reporting requirements for abuse, neglect, and exploitation.** *Reflect the Client's iConnect ID as well as the date of meeting.* **Client iConnect ID** / **Date of Meeting**			
7.	**The mentee used iConnect for case management activities.** *Provide the client's iConnect ID and the type of activity performed.* **iConnect Client ID** / **Type of Activity**			

8.	**The mentee completed a Supported Living Quarterly Meeting or, if not, shadowed or observed the mentor in the Supported Living Quarterly Meeting.** *Provide the client's iConnect ID and date of quarterly supported living meeting.*				
	Client iConnect ID	**Date of Supported Living Quarterly Meeting**			
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.**		☐	☐	
b.	**Medicaid eligibility redetermination process.**		☐	☐	
c.	**Discussion with the assessor regarding the completion of the comprehensive needs assessment.**		☐	☐	
d.	**Updating a minimum of five (5) client cost plans and service authorizations.**		☐	☐	
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.

<table>
<tr><th colspan="2">Required Mentoring Activity for the CDC+ Program</th><th>Mentee's Initials</th><th>Mentor's Initials</th></tr>
<tr><td>1.</td><td>The mentee shadowed or observed the mentor review draft, denied, or updated purchasing plans, if applicable, or review the current purchasing plans.

<table><tr><th>Client iConnect ID</th><th>Date of Meeting</th></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></table></td><td></td><td></td></tr>
<tr><td>2.</td><td>The mentee shadowed or observed the mentor submit a SAN request, if applicable, or review the most recent SAN request that was submitted.

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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