TEXAS Health and Human Services

Form 6518
February 2023

Deaf Blind with Multiple Disabilities (DBMD)

Record of Completion for Individual Specific Training

Individual's Name:	Date Training Completed:
Name of Service Provider:	Name of Trainer:

Service Provider Type *(check one or more)*:

- ☐ Community First Choice PAS/Hab
- ☐ Employment Assistance
- ☐ Individualized Skills and Socialization
- ☐ Intervener, I, II, III
- ☐ Licensed Assisted Living (18 or 24 Hour)
- ☐ Licensed Home Health Assisted Living
- ☐ Respite (In-Home and Out-of-Home)
- ☐ Supported Employment
- ☐ Transportation – Residential Habilitation

Completed in the Individual's Home? ◯ Yes ◯ No

Complete Physical Address of the Training Site:

Reason for Training *(choose one)*:

◯ Initial Training ◯ Annual Renewal ◯ Individual's Needs Changed

Training included the full participation of the:

☐ Individual ☐ Individual's Legally Authorized Representative ☐ Actively Involved Person

Training must be completed before providing services to the individual at least annually, and if the individual's needs change.

Section 1: Specific Needs

Training was provided to the above-named service provider on the specific needs of the individual, including:

☐ Methods of communication. Describe:

☐ Specific visual and audiological loss. Describe:

☐ Adaptive aids *(if applicable)*. List *(if any)*:

Managing challenging behavior, including training in: ☐ De-escalation techniques ☐ Prevention of aggressive behavior

Individual has a Behavioral Support Plan (BSP)? ◯ Yes ◯ No

Section 2: Protective Devices

☐ Training on the individual's protective device(s) has been completed (if any).

List the protective device:

Use of a protective device must be reported to:

☐ I understand that protective devices must not be used to modify or control an individual's behavior or for disciplinary purposes or for convenience or as a substitute for an effective, less restrictive method.

☐ Not Applicable *(check if the individual does not use a protective device)*.

Section 3: Restraints

☐ Training on restraints has been completed, including usage and reporting requirements.

List the authorized restraint(s):

Use of a restraint must be reported to:

☐ Training includes the following documentation requirements:

- The use of the restraint.
- Time and date the restraint was used.
- Name of the person administering the restraint.
- Type of restraint and duration used.
- If used in a behavioral emergency:
  - Events preceding the use of the restraint.
  - Actions taken after the use of the restraint.
  - Types of interventions attempted before use of the restraint.

☐ I understand that restraints must not be used for disciplinary purposes, retaliation, coercion, retribution, for the convenience of myself or another service provider or as a substitute for an effective, less restrictive method.

☐ Not Applicable *(check if the individual does not have a physician's order for a restraint)*.

Section 4: Delegated Tasks

Training on delegated tasks has been completed by _____ on _____ and competency was verified. Documentation of the delegated training is maintained in the individual's record and is available for review upon request.

Section 5: Individual's Needs Changes

The following changes must be reported as soon as possible:

- Individual is hospitalized.
- Changes in the individual's needs and changes in behavior.
- Individual is absent from the home or moved.

These changes should be reported to: _____

Section 6: Additional Information

If this training is being conducted as the result of a change in the individual's needs, document the change(s):

Additional concerns (if any):

Additional comments (if any):

My signature confirms that I have received specific training and can demonstrate competency.

_____ _____
Signature of Service Provider **Date**

My signature confirms that I have provided instruction on the specific needs of the individual.

_____ _____
Signature of Trainer **Date**