

## Direct Support Professional Provider Attestation Statement

Individual Served Name: \_\_\_\_\_

Direct Support Professional Name: \_\_\_\_\_

\_\_\_\_ I acknowledge that I have reviewed and understand the individual's Individual Support Plan (ISP).

\_\_\_\_ I acknowledge that I have reviewed and understand the individual's treatment plan, including the Provider Plan/Short Term Goals.

I acknowledge that in regards to administering medication:

\_\_\_\_ I will not be administering medication.

\_\_\_\_ I will only administer medication to the individual after I have notified EOR and have obtained a current non-expired certificate in Medication Administration training.

I acknowledge that in regards to providing transportation:

\_\_\_\_ I will not be providing transportation.

\_\_\_\_ I will only provide transportation to the individual after I have notified EOR, have provided evidence of appropriate automobile liability insurance, have provided a copy of my valid driver's license, and have passed a driving record review conducted by Acumen.

\_\_\_\_ I acknowledge that I have reviewed and understand the Person Centered Thinking Training.

\_\_\_\_ I acknowledge that I have reviewed and understand the Confidentiality Training.

\_\_\_\_ I acknowledge that I have reviewed and understand the Bloodborne Pathogens and Universal Precautions Training.

I attest that I will comply with the above mentioned requirements. I understand that these requirements must be continuously adhered to.

DSP Printed Name: \_\_\_\_\_

DSP Signature: \_\_\_\_\_ Date: \_\_\_\_\_

EOR Signature: \_\_\_\_\_ Date: \_\_\_\_\_