Medicaid/MIChild Autism Spectrum Disorder Benefit
Behavior Technician/Aide IPOS Training Acknowledgement Form

Consumer Name: ___________________ Member MH-WIN ID Number: _____________
Autism Provider Agency Name: __________________________________________________

I have received training on this specific child’s:

☐ Individualized Plan of Service (IPOS) Dated: _____________ to ________________
IPOS Case Holder Agency: _____________________________________________________
IPOS Case Holder Name: __________________________________________________________________________

☐ ABA Treatment Plan Dated: ___________________________
BCBA/Qualified Behaviorist Name: ________________________________________________
Other (specify): _________________________________________________________________________________

ABA Aide/Behavior Technician Signature                                  Parent/Guardian Name                     Date