

Consumer Directed Services
Management of Service Provider

Service Provider Name (Employee or Contractor)	Provider Type <input type="checkbox"/> Employee <input type="checkbox"/> Contractor	Today's Date
Name of Contracted Entity (if applicable)	First Day of Work	Annual Evaluation Due Date
Name of Individual Receiving Services	Name of Consumer Directed Services Employer	

Purpose of Form

Initial Orientation Ongoing Training

Evaluation
 30-Day 3-Month 6-Month Annual Other _____

Supervision
 Verbal Warning: 3-Month 6-Month Annual Other _____
 Written Warning: 3-Month 6-Month Annual Other _____

Conflict Resolution Other _____

Satisfaction

Is the **individual** satisfied with the services provided by the service provider?..... Yes No

Is the **employer** satisfied with the services provided by the service provider?..... Yes No

Employer Comments:

Service Provider Response:

Agreement/Resolution:

Action Taken/Follow-Up Scheduled:

Acknowledgement/Agreement Between Service Provider and Employer:

Effective Date of Action to be Taken: _____

Signature - Service Provider

Date

Signature - Employer or Designated Representative

Date

Signature - Witness/Other

Date