TEXAS Health and Human Services

Form 3597
June 2002-E

Community Living Assistance and Support Services (CLASS)

Habilitation Training Plan

Participant	Medicaid No.	Date
ISP Effective Period (mm/dd/yyyy) **From:**	**To:**	
Habilitation Training Goal:		
Why is this goal important to you?		
How is goal integrated with other CLASS services?		
Habilitation Trainer(s)		
Frequency of Training (number hours)	Duration (estimated time for development of skill)	
Task(s) to be trained:		

Signature - Participant/Guardian	Date	Signature - DSA Representative	Date

Quarterly Summary of Habilitation Training

Participant	Habilitation Trainer

Quarter: ☐ **1st** ☐ **2nd** ☐ **3rd** ☐ **4th**

Evaluation of Progress Towards Habilitation Training Goal:

Is Participant Independent in Identified Task(s)? ☐ **Yes** ☐ **No** If marked No, explain if more training is required:

Is Habilitation Training Goal Met? ☐ **Yes** ☐ **No** If marked Yes, date met: _____

Evolving Needs (if applicable):

Revised Plans (if applicable):

Signature - Participant/Guardian	Date	Signature - DSA Representative	Date