Texas Department of Aging
and Disability Services

Form 1732
January 2007

Consumer Directed Services

Management of Service Provider

Service Provider Name (Employee or Contractor):	Provider Type: ☐ Employee ☐ 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 _____