Texas Department of Aging
and Disability Services

Form 1732
January 2007-E

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