**Supportive Service Plan for**

Plan Date: Phone:

Address:

Emergency Contacts

Name Phone 1:

Relationship Phone 2:

Name Phone 1:

Relationship Phone 2:

Name Phone 1:

Relationship Phone 2:

**Section A: General Information About the Service Recipient**

1. Describe this person’s general disposition from day to day.
2. What is this person like around people he/she knows?
3. What is this person like around people he/she doesn’t know or has only met a few times?
4. What kinds of environments and situations does this person enjoy? How do you know?
5. What kinds of environments and situations are unpleasant for the individual? How do you know?
6. What does the person like to do for fun?
7. What activities does this individual not like to do? What happens when he/she participates in them?
8. Who does this person enjoy being around?
9. Who does this person avoid being around? What happens if he/she has to be around them?
10. What kinds of foods does this person like?
11. What kinds of foods does this person not like? What happens if he/she eats them?
12. What are this person’s major talents, strengths and abilities? What do people compliment this person for?

**Section B: Basic Support Needs**

1. Basic information about the individual needing services:
	1. Date of Birth
	2. Diagnoses
2. What type of support does this individual need with activities of daily living? (place an “X” next to the type of support needed for each task)

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| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Task** | **Total Physical Assistance** | **Assistive Technology** | **Hand Over Hand Assistance** | **Physical Prompts** | **Verbal Cues** | **Picture or Photo Cues** | **No Support** | **Other (describe)** |
| Bathing |  |  |  |  |  |  |  |  |
| Toileting |  |  |  |  |  |  |  |  |
| Grooming |  |  |  |  |  |  |  |  |
| Dressing |  |  |  |  |  |  |  |  |
| Eating |  |  |  |  |  |  |  |  |
| Walking |  |  |  |  |  |  |  |  |
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1. What type of support does this individual need with independent living skills? (place an “X” next to the type of support needed for each task)

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| **I need help with…** | **Total Physical Assistance** | **Assistive Technology** | **Hand Over Hand Assistance** | **Physical Prompts** | **Verbal Cues** | **Picture or Photo Cues** | **No Support** | **Other (describe)** |
| Shopping |  |  |  |  |  |  |  |  |
| Meal Preparation |  |  |  |  |  |  |  |  |
| Paying Bills |  |  |  |  |  |  |  |  |
| Reading Mail |  |  |  |  |  |  |  |  |
| Taking Medication |  |  |  |  |  |  |  |  |
| Doing Laundry |  |  |  |  |  |  |  |  |
| Housecleaning |  |  |  |  |  |  |  |  |
| Doing Dishes |  |  |  |  |  |  |  |  |
| Taking Out Trash |  |  |  |  |  |  |  |  |
| Using the Telephone |  |  |  |  |  |  |  |  |
| Calling 911 |  |  |  |  |  |  |  |  |
| Exiting Home Safely in Emergency |  |  |  |  |  |  |  |  |
| Locking Doors & Windows/Answering the Door Safely |  |  |  |  |  |  |  |  |
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1. What is the individual’s daily routine?

WEEKDAYS

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| --- | --- |
| Time Period | Activity |
| Example: 6:30 am – 7:00 am | Wake up and shower |
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WEEKENDS

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| --- | --- |
| Time Period | Activity |
| Example: 8:00 am – 8:30 am | Wake up and shower |
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**Section C: Health/Medical Supports**

1. Identify key health care contacts below.

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| **Type of Provider** | **Name** | **Phone Number** |
| Primary Care Physician |  |  |
| Dentist |  |  |
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1. List all known medical conditions below. Identify the medical professional that is treating the condition.

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| **Condition** | **Name of Treating Medical Professional** | **Phone Number** |
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1. List all current medications below.

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| --- | --- | --- |
| **Name of Medication/****Rx Number** | **Treats What Condition?** | **Dosage/Route/Frequency/Times** |
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1. List the name and phone number of the individual’s pharmacy:
2. Name of Healthcare Insurance:
	1. Policy number:
	2. Group number:
	3. Insurance phone number:
	4. Insurance address:
	5. Name of primary insured:
	6. Primary insured’s occupation:
	7. Primary insured’s birth date:
	8. Primary insured’s SSN:
	9. Primary insured’s address:
	10. Primary insured’s phone:
3. Blood Type:
4. Identify all allergies the individual has here. Include allergies to food, medication and environmental conditions (e.g., pollen, dust, animal dander, etc.).

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| **Type of Allergy** | **Typical Reaction As a Result of Exposure to Allergen** | **Treatment** |
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1. Describe any special dietary issues the individual has here, and identify specific diets (e.g., reduced salt, sugar or fat diets) and special food preparation methods required (e.g., chopping, dicing, pureeing, chilling, etc.).

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| **Dietary Issue** | **Recommended Foods and/or Food Preparation Methods** |
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1. Does the individual have a history of seizures? ❑ YES ❑ NO
	1. If yes, describe what a support person would observe prior to, during and after the seizure.
	2. How should a support person respond to a seizure?
2. What medical equipment does the individual use to assist with feeding, eliminating or breathing (e.g., a G-tube, NG tube, ostomy, colostomy, catheter, tracheostomy, apnea monitor, etc)? What does a support person need to know? (Remember, these kinds of equipment must generally be handled by a nurse).
3. Attach the individual’s vaccination history to this care plan.
4. Hospitalization history:

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| **Dates** | **Reason** | **Outcome** |
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1. Does the individual need assistance with ambulation? ❑ YES ❑ NO
	1. If yes, describe the assistance needed to ambulate. Include a description of any mobility equipment used (e.g., walker, scooter, manual or power wheelchair), assistance needed to transfer into/out of this equipment, and assistance needed to maintain this equipment.
2. Describe any adaptive equipment or assistive technology the individual uses. Explain what the equipment is used for, how it works, and how well the individual has mastered usage.

**Section D: Communication Supports**

1. How does this individual communicate? (circle one)
	1. Verbally – clear with functional vocabulary
	2. Verbally – functional vocabulary but difficult to understand
	3. Verbally – clear but limited vocabulary
	4. Uses vocalizations (e.g., grunts, squeals, hums, clicks, cries)
	5. Sign language – clear with functional vocabulary
	6. Sign language – functional vocabulary but difficult to understand
	7. Sign language – clear but limited vocabulary
	8. Pictures or photographs
	9. Typing
	10. Blinking
	11. Other (describe):
2. Does this individual require any specialized communication devices? ❑ YES ❑ NO
	1. If yes, describe the device(s), and explain what kind of assistance the individual needs, if any, to operate and maintain these devices.

**Section E: Behavior Supports**

1. Does this individual use a positive behavior support plan at home? ❑ YES ❑ NO
	1. If yes, attach a copy of the behavior support plan to this service plan.
2. Provide the name and phone number of the primary behavior support specialist the individual works with:

**Section C: Supportive Services to Be Provided**

Caregiver’s primary role is to provide Companionship support. Companionship is defined as the provision of fellowship and protection to an individual with a disability who needs assistance in caring for him/herself. The provision of “fellowship” means to engage the person in social, physical, and mental activities, such as conversation, reading, games, crafts, accompanying the person on walks, on errands, to appointments, or to social events. The provision of “protection” means to be present with the person in their home, or to accompany the person when outside of the home, and to monitor the person’s safety and well-being. Companionship services also include the provision of care, when the care is provided attendant to and in conjunction with the provision of fellowship and protection, and does not exceed 20 percent of the total hours worked per individual and per workweek. The provision of “care” means assisting the person with:

* Activities of Daily Living (ADLs) such as dressing, grooming, feeding, bathing, toileting and transferring;

and

* Instrumental Activities of Daily Living (IADLs) which are tasks that enable a person to live independently at home, such as meal preparation, driving, light housework, managing finances, assistance with the physical taking of medications, and arranging medical care.

Caregiver is expected to perform the following types Companionship activities, in accordance with the schedule in Attachment B:

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| --- | --- |
| **General Activity** | **Specific Description** |
| Fellowship |  |
| Conversation |  |
| Reading |  |
| Games |  |
| Crafts |  |
| Walks |  |
| Errands |  |
| Appointments |  |
| Social events |  |
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| The following activities shall not exceed 20% of the total hours per workweek |
| ADLs |  |
| Dressing |  |
| Grooming |  |
| Eating/Feeding |  |
| Bathing |  |
| Toileting |  |
| Transferring |  |
| Ambulation |  |
|  |  |
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| IADLs |  |
| Meal Preparation |  |
| Driving |  |
| Light Housework |  |
| Laundry |  |
| Shopping |  |
| Budgeting |  |
| Bill Paying |  |
| Reading Mail |  |
| Assistance with Self Administration of Medications |  |
| Arranging Medical Care |  |
| Transportation |  |
| Using Phone |  |
| Home Maintenance |  |
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**ATTACHMENT B**

**CAREGIVER WORK SCHEDULE**

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| --- | --- | --- | --- |
| https://www.care.com/img/cms/web/content/articlephotos/2013/09-sep/check-box.png  Sat | Begin: \_\_\_\_\_\_ am/pm  | End: \_\_\_\_\_\_ am/pm  |   |
|   | Begin: \_\_\_\_\_\_ am/pm | End: \_\_\_\_\_\_ am/pm | Daily Hours \_\_\_ |
| https://www.care.com/img/cms/web/content/articlephotos/2013/09-sep/check-box.png  Sun | Begin: \_\_\_\_\_\_ am/pm | End: \_\_\_\_\_\_ am/pm |   |
|   | Begin: \_\_\_\_\_\_ am/pm | End: \_\_\_\_\_\_ am/pm | Daily Hours \_\_\_ |
| https://www.care.com/img/cms/web/content/articlephotos/2013/09-sep/check-box.png  Mon | Begin: \_\_\_\_\_\_ am/pm | End: \_\_\_\_\_\_ am/pm |   |
|   | Begin: \_\_\_\_\_\_ am/pm | End: \_\_\_\_\_\_ am/pm | Daily Hours \_\_\_ |
| https://www.care.com/img/cms/web/content/articlephotos/2013/09-sep/check-box.png  Tue | Begin: \_\_\_\_\_\_ am/pm | End: \_\_\_\_\_\_ am/pm |   |
|   | Begin: \_\_\_\_\_\_ am/pm | End: \_\_\_\_\_\_ am/pm | Daily Hours \_\_\_ |
| https://www.care.com/img/cms/web/content/articlephotos/2013/09-sep/check-box.png  Wed | Begin: \_\_\_\_\_\_ am/pm | End: \_\_\_\_\_\_ am/pm |   |
|   | Begin: \_\_\_\_\_\_ am/pm | End: \_\_\_\_\_\_ am/pm | Daily Hours \_\_\_ |
| https://www.care.com/img/cms/web/content/articlephotos/2013/09-sep/check-box.png  Thurs   | Begin: \_\_\_\_\_\_ am/pm | End: \_\_\_\_\_\_ am/pm |   |
|   | Begin: \_\_\_\_\_\_ am/pm | End: \_\_\_\_\_\_ am/pm | Daily Hours \_\_\_ |
| https://www.care.com/img/cms/web/content/articlephotos/2013/09-sep/check-box.png  Fri | Begin: \_\_\_\_\_\_ am/pm | End: \_\_\_\_\_\_ am/pm |   |
|   | Begin: \_\_\_\_\_\_ am/pm | End: \_\_\_\_\_\_ am/pm | Daily Hours \_\_\_ |
|   |   |   |  |

WeeklyFlex Hours (e.g., for nighttime wake up calls)

 Total Weekly Hours \_\_\_\_\_

**ATTACHMENT C**

Lodging and Board Calculation

Service Recipient Lease

Property Rules and Regulations

The lodging and board calculation is based on an estimated monthly fair value of the prorated cost of rent, utilities, Internet, cable and food for the live-in caregiver:

|  |  |
| --- | --- |
| Full Monthly Rent for the Unit | $ |
| Utilities | $ |
| Average Electric/Month | $ |
| Average Gas/Month | $ |
| Average Water/Month | $ |
| Average Trash/Month | $ |
| Average Oil/Month | $ |
| Average Internet/Month | $ |
| Average Cable/Month | $ |
| Average Food for Household/Month | $ |
| TOTAL | $ |
| Prorated cost (divide total by number of persons in the household, including the caregiver, and multiply by one) | $ |

U.S. Department of Labor, “Paying Minimum Wage and Overtime to Homecare Workers” (<https://www.dol.gov/whd/homecare/homecare_guide.pdf>) indicates records regarding the cost to the employer of providing the housing should show how much money the employer spends on the housing, such as proof of mortgage or rental payments and/or utility bills. **With respect to *live-in domestic service employees only*, an employer that does not provide such records may claim a certain amount—up to seven and one-half times the statutory minimum hourly wage for each week lodging is furnished, currently $54.38 (7.5 x $7.25)—toward wages rather than the reasonable cost or fair value of the housing provided.**