

# HOME SUPPORT PLAN

YOU MUST INFORM THE AGENCY IF YOU ARE UNABLE TO ACCEPT THE HOMESUPPORT AT THE ARRANGED TIME,  
OTHERWISE YOU MAY BE CHARGED FOR THE HOMEMAKER VISIT.

NAME					CLIENT #			HOME SUPP. HOURS/WEEK			
HOME SUPPORT AGENCY				PHONE		HOME SUPPORT SUPERVISOR					
<b>PERSONAL ASSISTANCE</b>		SELF	FAM.	HSW	FREQUENCY		SELF	FAM.	HSW	FREQUENCY	
	TUB BATH					GROOMING					
	SPONGE BATH					DRESSING					
	SHOWER					TRANFERRING					
	HAIRWASHING					TOILETING					
	SHAVE					WALKING					
	MOUTH CARE					MED. REMINDER					
	SKIN CARE					OTHER					
COMMENTS / INSTRUCTIONS											
<b>PERSONAL ASSISTANCE GUIDELINES</b>		HSW			FREQUENCY			HSW		FREQUENCY	
	DUTY 1						DUTY 3				
	DUTY 2						DUTY 4				
	COMMENTS										
<b>ADDITIONAL SERVICES</b>		SELF	FAM.	HSW	FREQUENCY		SELF	FAM.	HSW	FREQUENCY	
	MEAL PREP.					PREP. MEALS AHEAD					
	RESPIRE					PREP. FOR ADC					
	OTHER					OTHER					
COMMENTS / INSTRUCTIONS											
<b>COMMUNITY SUPPORT</b>	FAMILY/ FRIENDS					ADULT DAY CARE					
	HOME CARE NURSE					MEALS-ON-WHEELS					
	REHAB. THERAPIST					VOLUNTEER VISITOR					
	NUTRITIONIST					SENIORS OUTREACH					
	LIFELINE					OTHER					
REVIEW DATE											

I UNDERSTAND AND AGREE TO THIS PLAN. INFORMATION PROVIDED BY ME TO THE CASE MANAGER MAY BE RELEASED TO SERVICE PROVIDERS.

CLIENT SIGNATURE

CASE MANAGER SIGNATURE

TELEPHONE

DATE