IN HOME SERVICE CARE/WORK PLAN

Participant: _____ **Phone:** _____

Address: _____

Emergency Contact: _____ **Phone:** _____

1. ☐ HOME DELIVERED MEALS

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday	# Per Day
Hot	☐	☐	☐	☐	☐	☐	☐	_____
Sack	☐	☐	☐	☐	☐	☐	☐	_____
Frozen	☐	☐	☐	☐	☐	☐	☐	_____
Liquid	☐	☐	☐	☐	☐	☐	☐	_____

(RN APPROVAL REQUIRED FOR LIQUID NUTRITION)

Milk: ☐ Yes ☐ No

2. ☐ HOMEMAKER

Provider: _____ **Days/Hours:** _____ **WKLY:** _____ **MO:** _____

☐ Vacuuming ☐ Laundry ☐ Sweep ☐ Dusting ☐ Mop ☐ Shopping ☐ Dishes

☐ Bedding (Participant out of Bed) ☐ Bathroom

☐ Other: _____

3. ☐ PERSONAL CARE (RN APPROVAL REQUIRED)

Provider: _____ **Days/Hours:** _____ **WKLY:** _____ **MO:** _____

☐ Grooming ☐ Hair ☐ Dressing ☐ Nails ☐ Meals ☐ Bathing

☐ Ambulation/Positioning ☐ Bed Change (Participant in Bed)

☐ Other: _____

4. ☐ RESPITE (RN APPROVAL REQUIRED)

Provider: _____ **Days/Hours:** _____ **WKLY:** _____ **MO:** _____

Tasks: _____

5. ☐ CHORE

Provider: _____ **Time Frame:** _____ **WKLY:** _____ **MO:** _____

Tasks: _____

6. ☐ SENIOR COMPANION

Provider: _____ **Days/Hours:** _____ **WKLY:** _____ **MO:** _____

Tasks: _____

7. ☐ OTHER

Provider: _____ **Days/Hours:** _____ **WKLY:** _____ **MO:** _____

Tasks: _____

Special Needs/Meals:

Directions:

IN HOME SERVICE CARE/WORK PLAN

PARTICIPANT PROBLEMS, NEEDS, STRENGTHS AND RESOURCES:

GOALS AND OBJECTIVES:

☐ Remain Living at Home ☐ Clean Environment ☐ Maintain Personal Hygiene ☐ Reduce Falls
☐ Reduce Caregiver Strain ☐ Decrease Social Isolation ☐ Maintain Nutrition Status
☐ Other: _____ ☐ Other: _____ ☐ Other: _____

METHODS AND APPROACHES TO ADDRESSING NEEDS:

COA: _____

Private Pay: _____

Informal Supports: _____

Other: _____

Other: _____

ADDITIONAL REFERRALS AND FOLLOW UP ACTIONS:

☐ Care Management ☐ MDHHS Field Office ☐ MMAP ☐ CMH

☐ Advocacy: _____ ☐ Support Groups: _____

☐ EBP: _____ ☐ Other: _____

I do hereby give my permission to receive the above services in my home.

_____ _____
Participant Signature **Date**

I agree to hold harmless the staff or volunteer for any duties performed by the staff or volunteer (except for liabilities or expenses caused by willful or negligent acts). I understand that I will not be denied services for refusal to sign.

_____ _____
Participant Signature **Date**

I have reviewed the assessment and approved the Personal Care, Respite Services and Liquid Meals

_____ _____ _____ _____
RN Signature **Date** **Assessor Signature** **Date**

_____ _____ _____ _____
RN Signature **Date** **Assessor Signature** **Date**