RESIDENT SERVICE PLAN FOR ASSISTIVE CARE SERVICES

FACILITY:	DATE:
RESIDENT NAME:	MEDICAID #:
Beginning Date of Service Plan _____	Ending Date of Service Plan_____

ASSISTANCE WITH ACTIVITIES OF DAILY LIVING (ADLs)

ACTIVITY	SERVICE NEED	
AMBULATION	☐ Independent ☐ Provide Assistance ☐ Assist with Ambulatory Device ☐ Wheelchair ☐ Walker ☐ Cane	
Expected Outcome of Service: _____ Comments: _____		
BATHING	☐ Independent ☐ Provide Supervision ☐ Provide Assistance ☐ Provide Total Help	☐ Tub ☐ Shower ☐ Morning ☐ Evening
Expected Outcome of Service: _____ Comments: _____		
DRESSING	Choose attire / Put on shoes / Dress/ Undress ☐ ☐ ☐ Independent ☐ ☐ ☐ Provide Supervision ☐ ☐ ☐ Provide Assistance ☐ ☐ ☐ Provide Total Help	
Expected Outcome of Service: _____ Comments: _____		
TOILETING	☐ Independent ☐ Supervision/Prompting ☐ Provide Assistance ☐ Incontinent: ☐ Bladder ☐ Bowel	☐ Adult Brief ☐ Catheter Care ☐ Ostomy Assistance
Expected Outcome of Service: _____ Comments: _____		
EATING	☐ Independent ☐ Provide Supervision ☐ Provide Assistance ☐ Provide Total Help	☐ Hand Guidance ☐ Cutting Food ☐ Opening Packages
Special diet: ☐ Regular ☐ Diabetic ☐ No added salt ☐ Low fat/Low cholesterol Other _____ Expected Outcome: _____ Comments: _____		

GROOMING	☐ Independent ☐ Provide Supervision ☐ Provide Assistance ☐ Provide Total Help	☐ Teeth ☐ Hair ☐ Nails Other_____
Expected Outcome of Service: _____ Comments: _____		
TRANSFERRING	☐ Independent ☐ Provide Supervision ☐ Provide Assistance	☐ Provide Total Help
Expected Outcome of Service: _____ Comments: _____		

ASSISTANCE WITH SELF-ADMINISTERED MEDICATION		
ACTIVITY	SERVICE NEED	**PROVIDER**
MEDICATIONS	☐ Independent ☐ Provide Daily Supervision or Assistance ☐ Provide Administration	☐ Facility Non-Nursing Staff ☐ Facility Nursing Staff
Expected Outcome of Service: _____ Comments: _____		

ASSISTANCE WITH INSTRUMENTAL ACTIVITIES OF DAILY LIVING (IADLs)	
ACTIVITY	SERVICE NEED
MAKING A TELEPHONE CALL	☐ Independent ☐ Supervision/ Prompting ☐ Dial Number
Expected Outcome of Service: _____ Comments: _____	
MANAGING MONEY	☐ Independent ☐ Provide Assistance ☐ Representative Payee or Power of Attorney
Expected Outcome of Service: _____ Comments: _____	
SHOPPING FOR PERSONAL ITEMS	☐ Independent ☐ Provide Supervision ☐ Provide Total Help
Expected Outcome of Service: _____ Comments: _____	

USING AVAILABLE TRANSPORTATION	☐ Independent ☐ Provide Supervision ☐ Provide Assistance or Escort
Expected Outcome of Service: _____ Comments: _____	

HEALTH SUPPORT	
ACTIVITY	SERVICE NEED
REMINDING RESIDENT OF IMPORTANT TASKS	☐ Independent ☐ Appointments ☐ Daily Tasks ☐ Other _____
Expected Outcome of Service: _____ Comments: _____	
OBSERVING RESIDENT'S APPEARANCE AND WELL-BEING	☐ Weekly or Less ☐ Daily ☐ Other _____
Expected Outcome of Service: _____ Comments: _____	

OTHER SERVICES	
ACTIVITY	SERVICE NEED
Expected Outcome of Service: _____ Comments: _____	
Expected Outcome of Service: _____ Comments: _____	

RESIDENT COMMENTS: _____

Facility Administrator or Designee	**DATE**	**Resident or Representative**	**DATE**