



### IN-HOME SUPPORTIVE SERVICES PREPARATION WORKSHEET

Name: \_\_\_\_\_ dob: \_\_\_\_\_ ss#: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Income: \_\_\_\_\_ Source: \_\_\_\_\_

Doctor(s): \_\_\_\_\_

Medications: \_\_\_\_\_

#### SERVICES NEEDED

DOMESTIC: (MONTHLY HOURS)	_____	TRANSPORTATION: (MONTHLY)	_____
Sweep/vacuum/wash floors	_____	Number of medical visits/mo.	_____
Cleaning bathrooms	_____	Driving time for each visit	_____
Cleaning kitchen	_____	Driving to other appointments	_____
Dusting/picking up	_____		
Changing bed	_____		
TOTAL MONTHLY TIME:	_____	TOTAL MONTHLY TIME:	_____

RELATED SERVICES (WEEKLY HOURS)	_____		_____
Prepare meals	_____		
Meal cleanup	_____		
Laundry	_____	TOTAL WEEKLY TIME:	_____

NON-MEDICAL PERSONAL SERVICES (WEEKLY HOURS)	_____	PARAMEDICAL SERVICE (WEEKLY HOURS)	_____
Bowel/bladder care	_____	Gastrostomy feeding	_____
Menstrual care	_____	GT site care	_____
Oral feeding meal times/day	_____	Trach suctioning	_____
Dressing/undressing	_____	Trach cleaning	_____
Bathing (shampoo)/hygiene/teeth?	_____	Trach stoma care	_____
Bed baths	_____	Breathing	_____
Reposition/rub skin/help on and off seats	_____	Clean pulmoaide/tubing	_____
In and out of vehicle	_____	Range of motion	_____
Move in and out of bed	_____	Enema/suppository	_____
Care/assistance with braces and wheelchair	_____	Humidified oxygen	_____
Respiration assistance	_____	Medication administration	_____
TOTAL WEEKLY TIME:	_____	TOTAL WEEKLY TIME:	_____

If you believe you need protective supervision – use reverse side to describe reasons and to estimate hours.