PERSONAL SUPPORT SERVICES
SERVICE CARE PLAN

Name: _____ Date: _____

FREQUENCY OF SERVICES TO BE PROVIDED

SERVICES	EACH VISIT	WEEKLY	AS REQUESTED	OTHER (i.e. x/week)
Sweep				
Mop				
Vacuum				
Dust				
Pick Up Clutter				
Empty Garbage/Trash				
Laundry				
Change Bedding				
Make Bed				
Clean Toilets/Bathroom Sinks				
Clean Shower/Tub				
Clean Dishes				
Clean Out Refrigerator				
Clean Kitchen Counters				
Meal Prep. (Indicate B, L, and/or D)				
Medication Reminder				
Grooming Assistance				
Bathing Assistance				
Shopping				
Transportation				
Conduct Errands				
Sitter				
Pet Care				

Additional Description of Services: _____

SERVICE SCHEDULE	BEGIN TIME (am/pm)	END TIME (am/pm)	TOTAL HOURS
Monday			
Tuesday			
Wednesday			
Thursday			
Friday			
Saturday			
Sunday			

The above service care plan has been reviewed and explained to the Service Recipient and/or authorized representative and consent for services has been given.

SR/Representative Signature: _____ Date: _____

Care Plan Completed By: _____ Date: _____

Care Companion Signature: _____ Date: _____

Care Companion Signature: _____ Date: _____

6/1/06