Personal Care Assistance Service Support Plan

Sheltered Workshop: _____

Employee's Name: _____

Employee's SSN: _____

List of who attended the individual's personal care assistance meeting:

_____

_____

_____

Indicate documentation clearly stating the need for personal care support:

_____

Is a Person Centered Plan Available - Yes ☐ No ☐
(Attach copy of all documentation supporting need to this plan.)

1) What Personal Care Assistance/support is required for the consumer to be successfully employed?

_____

_____

_____

_____

_____

_____

_____

_____

_____

Personal Care Assistance Plan for: _____

2) Intensity/Duration of supports:
(Estimated amount of time and when supports will be provided)

_____

_____

_____

_____

_____

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_____

3) List actions/activities that should be <u>avoided</u> while providing these supports:

_____

_____

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_____

Personal Care Assistance Plan for: _____

SIGNATURE PAGE

_____
Consumer's signature Date

_____
Guardian's signature Date

_____
Personal Care Assistant's signature Date

_____
Staff completing Personal Care Plan (if different) Date

_____
Additional Attendee Date

_____
Additional Attendee Date

OFFICE USE ONLY

_____	_____	_____
Signature	Signature	Signature
_____	_____	_____
Review Date	Review Date	Review Date

IF NO CHANGES ARE REQUIRED AT YEAR END OR DURING THE PLAN YEAR THIS PLAN MAY BE EXTENDED. PLEASE REVIEW THE PLAN AND DATE. IF CHANGE(S) ARE NEEDED A NEW PLAN MUST BE WRITTEN AND NEW SIGNATURES OBTAINED.