

HCBS/TBI Waiver Attendant Care Service Plan Worksheet
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SECTION I.

Consumer _____ SSN _____ Medicaid ID _____

Address _____ City _____ Zip _____ County _____

Phone _____ Emergency Contact _____ E.C. Phone _____

SECTION II.

Maximum number of hours per week _____ **Per month** _____

Estimated number of hours per day:

_____S _____M _____T _____W _____TH _____F _____S

Does the consumer have seizure activity that may effect the services needed? Yes _____ No _____

SECTION III.

Activities of Daily Living/ Instrumental Activities of Daily Living	Estimated Times	Special Instructions
<p>Personal Hygiene and Grooming</p> <p>Bathing</p> <p><input type="checkbox"/> Partial Asst. <input type="checkbox"/> Total Asst.</p> <p><input type="checkbox"/> Tub/Shower <input type="checkbox"/> Sponge</p> <p><input type="checkbox"/> Bath</p> <p>Oral Hygiene</p> <p><input type="checkbox"/> Brush Teeth or Denture Care</p> <p>Hair Care</p> <p><input type="checkbox"/> Shampoo <input type="checkbox"/> Set <input type="checkbox"/> Comb/Brush</p> <p>Skin Care</p> <p><input type="checkbox"/> Inspect Skin <input type="checkbox"/> Apply Lotion</p> <p><input type="checkbox"/> Clean Nails</p> <p>Shaving</p> <p><input type="checkbox"/> Electric <input type="checkbox"/> Non-electric</p>	<p>15-30 minutes</p> <p>5 minutes</p> <p>Average 60 minutes, total</p> <p>10 minutes</p> <p>10 minutes</p>	
<p>Dressing</p> <p><input type="checkbox"/> Partial Asst. <input type="checkbox"/> Total Asst.</p> <p>Prosthetic and Orthotic Devices</p> <p><input type="checkbox"/> Assist With Putting On and/or Removing</p>	<p>15-20 minutes</p> <p>10-15 minutes</p>	

Activities of Daily Living/ Instrumental Activities of Daily Living	Estimated Times	Special Instructions
Toileting <input type="checkbox"/> Bed Pan <input type="checkbox"/> Commode <input type="checkbox"/> Toilet <input type="checkbox"/> Empty Ostomy/Urine Bag <input type="checkbox"/> Establish/Maintain Toileting Schedule	15-30 minutes	
Transfer <input type="checkbox"/> Supervise/Minimal Assistance <input type="checkbox"/> Moderate Assistance <input type="checkbox"/> Heavy Support/Lifting <input type="checkbox"/> Special Assistive Devices (Specify) <input type="checkbox"/> Turn and Position In Bed	15-30 minutes 5-10 minutes	
Walking/Mobility <input type="checkbox"/> Supervision/Minimal Assistance <input type="checkbox"/> Moderate Assistance <input type="checkbox"/> Heavy Support/Lifting <input type="checkbox"/> Special Assistive Devices (Specify) Wheelchair Maneuvering <input type="checkbox"/> Partial Assistance <input type="checkbox"/> Complete Assistance	5 minutes 15 minutes Up to 15 minutes each	
Eating <input type="checkbox"/> Remind/Encourage <input type="checkbox"/> Assistance Such as Meat Cutting <input type="checkbox"/> Feed consumer	5 minutes 15-30 minutes	
Meal Planning/Preparation/Clean Up <input type="checkbox"/> Meals (Specify breakfast, lunch, dinner) <input type="checkbox"/> Future Meals (Prepare/Freeze) <input type="checkbox"/> Clean Up After Meals <input type="checkbox"/> Supervise for Safety <input type="checkbox"/> Partial Assist with Food Preparation <input type="checkbox"/> Special Diet (Specify) <input type="checkbox"/> Other	1 hour 15-30 minutes 1 to 1 ½ hours 15-30 minutes 1 hour	
Shopping <input type="checkbox"/> Groceries <input type="checkbox"/> Personal Items <input type="checkbox"/> Medication Pickup <input type="checkbox"/> Other	1-3 hours ½ hour ½ hour ½ hour	

Activities of Daily Living/ Instrumental Activities of Daily Living	Estimated Times	Special Instructions
Laundry/Housekeeping <input type="checkbox"/> Laundry <input type="checkbox"/> Minor Sewing and Mending <input type="checkbox"/> Other <input type="checkbox"/> Clean Toilet, Sink, Tub/Shower <input type="checkbox"/> Clean Floors, Carpets, Rugs <input type="checkbox"/> Clean Kitchen Appliances, Countertops <input type="checkbox"/> Dust <input type="checkbox"/> Make Bed &/Or Change Linens <input type="checkbox"/> Wash Dishes <input type="checkbox"/> Wash Cupboards, Walls, Throw Rugs, Curtains, Inside Windows <input type="checkbox"/> Remove Trash <input type="checkbox"/> Other	4 hours total 2 hours per week 10-15 minutes 30 minutes 30 minutes 15 minutes 10-15 minutes 5-10 minutes 10-15 minutes Once yearly 5 minutes	Defrosting & oven cleaning require additional time. or in conjunction with another task
Medications <input type="checkbox"/> Remind Consumer to Take Meds <input type="checkbox"/> Check Compliance <input type="checkbox"/> Assist in Taking Medication <input type="checkbox"/> Other	5 minutes per task	
Support of TLS		

- Supervision of consumer may be considered in determining the time needed to complete the above tasks for individuals with traumatic brain injuries.
- Time required to complete tasks may vary from day to day due to the cognitive and behavioral challenges of the individual.

Consumer Signature

Date

TBI-TCM Signature

Date