HARBOR REGIONAL CENTER

IN-HOME SUPPORTIVE SERVICES PREPARATION WORKSHEET

Name: _____ DOB: _____

Address: _____

Phone: _____ Income: _____ Source: _____

Doctor(s): _____

_____

Medications: _____

_____

SERVICES NEEDED

DOMESTIC: (monthly hours)

- Sweep/vacuum/wash floors _____
- Cleaning bathrooms _____
- Cleaning kitchen _____
- Dusting/picking up _____
- Changing bed _____

TOTAL MONTHLY TIME: _____

TRANSPORTATION: (monthly hours)

- Number of medical visits/mo _____
- Driving/waiting time for visit _____
- Driving to other errands/medical _____

TOTAL MONTHLY TIME: _____

RELATED SERVICES: (weekly hours)

- Prepare meals _____
- Meal clean up _____
- Laundry _____

TOTAL WEEKLY TIME: _____

NON-MEDICAL PERSONAL SERVICES: (weekly hours)

- Bowel/bladder care _____
- Menstrual care _____
- Oral feeding meal times/day _____
- Dressing/undressing _____
- Bathing (shampoo)/hygiene/teeth _____
- Bed baths _____
- Reposition/rub skin/help on/off seats _____
- In and out of vehicle _____
- Move in & out of bed _____
- Care/assistance with braces and wheelchair _____
- Respiration assistance _____

TOTAL WEEKLY TIME: _____

PARAMEDICAL SERVICE: (weekly hours)

- Gastrostomy feeding _____
- GT site care _____
- Trach suctioning _____
- Trach cleaning _____
- Trach stoma care _____
- Breathing treatments _____
- Clean pulmoaide/tubing _____
- Range of motion _____
- Enema/suppository _____
- Humidified oxygen _____
- Medication administration _____

TOTAL WEEKLY TIME: _____

If you believe you/your family member needs Protective Supervision – use reverse side to describe reasons and safety concerns. It may be helpful to keep a log for 5-7 days of incidents to document risks and frequency.