

INDIVIDUAL SUPPORT PLAN PERSONAL CARE ASSISTANCE

Employee Name: _____

Completed by: _____ Date: _____

Outcome: Individual obtains/retains employment in an employment setting of their choice.

1. **Attach:** Identify the expected personal care needs of the employee as documented in one of the following:
 - a. Signed statement from a physician
 - b. Current Person Centered Plan developed by SLRO

2. **Directions:** In the boxes below, fill in the %Intensity+(number of times per day/week/month) and the %Duration+(number of minutes support will occur each time) representing the areas personal care supports as needed for the employee.

Type of Personal Care Support	Intensity = ____ times/day	Duration = ____ mins/occasion	Accommodations Provided
Assistance with meals			
Assistance dressing/hygiene			
Assistance in restroom			
Mobility			
Transfer			
Assistance with medication administration.			
Other:			
Other:			

Please add any additional information regarding the personal assistance needs of the employee:

Signatures:

Employee Date

Guardian (if applicable) Date

Personal Care Assistant Date

Staff completing Personal Care Plan Date

Other Date