



*Resource Section*

**Service Plan Summary Template: (To be completed by Case Manager)**

When you are preparing to hire a home care worker your Service Plan can be a helpful tool in determining job duties.

See *Section One: Using Your Service Plan as a Tool.*

**Client Name:** \_\_\_\_\_ **Office:** \_\_\_\_\_ **Evaluation**  
**Date:** \_\_\_\_\_

**Social Worker Name:** \_\_\_\_\_ **Employee:** \_\_\_\_\_ **Printing**  
**Date:** \_\_\_\_\_

## Service Summary

**Client Name:** \_\_\_\_\_ **Evaluation Date:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Telephone:** \_\_\_\_\_ **Ext:** \_\_\_\_\_ **Social Worker:** \_\_\_\_\_

**Gender:** \_\_\_\_\_ **Age:** \_\_\_\_\_ **Social Worker Telephone:** \_\_\_\_\_ **Ext.** \_\_\_\_\_

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**Emergency Contact:** \_\_\_\_\_ **Telephone:** \_\_\_\_\_ **Type:** \_\_\_\_\_  
( ) -

**Backup Caregiver:** \_\_\_\_\_ **Telephone:** \_\_\_\_\_ **Type:** \_\_\_\_\_  
( ) -

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**Primary Language:** \_\_\_\_\_ **Speaks English?** \_\_\_\_\_ **Interpreter**  
**required?** \_\_\_\_\_

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**Substitute for decision making:**  
**Type:** \_\_\_\_\_

**Name:** \_\_\_\_\_ **Telephone:** \_\_\_\_\_ **Type:** \_\_\_\_\_  
( ) -

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**Primary Doctor:** \_\_\_\_\_ **Telephone:** \_\_\_\_\_ **Type:** \_\_\_\_\_  
( ) -

## Service Plan Summary Template, continued

### Informal support:

Name and Lastname	Telephone

### Formal support:

Name and Lastname	Telephone

### Services

The Client is eligible for:

### Plan:

**Classification:**

**Daily Rate:**

**Hours per Month:**

**Personal Care**

Waiver #1 \_\_\_\_\_

Waiver#2 \_\_\_\_\_

Waiver#3 \_\_\_\_\_

**Total Authorized hours** \_\_\_\_\_

**The client has declined help in the following tasks:**

**These are the client's needs, who helps the client, doing what and the preferred schedule for the client:**

### Provider Information:

**Assignments:**

### Schedule:

Day	Time Period	Starting Time	Ending Time

## Service Plan Summary Template, continued

**Provider Information:**

**Assignments:**

**Schedule:**

Day	Time Period	Starting Time	Ending Time

**Provider Information:**

**Assignments:**

**Schedule:**

Day	Time Period	Starting Time	Ending Time

**Equipment:**

<i>Type</i>	<i>Who?</i>	<i>Completion Date</i>

**Client Goals**

**Short Description**

**State:**

**Who?**

**Long Description:**

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**Short Description**

**State:**

**Who?**

**Long Description:**

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**Short Description**

**State:**

**Who?**

## Service Plan Summary Template, continued

**Long Description:**

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**Short Description**

**State:**

**Who?**

**Long Description:**

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**NSA Plan:**

**NSA Description:**

**Primary CM at Assessment Creation:**

**Case Manager Name:**

**Telephone:**

**Ext:**

The role of the Case Manager is to:

1. Conduct assessments and reassessments to determine program eligibility and to authorize payment for service.
2. Develop a plan of care with participation from the client.
3. Verify that services are provided in accordance with the plan of care and to modify the plan as needed.

Clients have the right to waive case Management services other than those listed in items 1, 2, and 3 above.

**I am aware of all alternatives available to me, and I agree with the Service Plan indicated above. I authorized the Department of Social and Health Services and the Aging Network Representative to obtain and disclose the necessary information for the development of my service plan.**

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**Client Representative Signature**

**Date**

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**Provider**

**Date**

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**Social Worker/Case Manager Signature**

**Date**

### Job Description – Task List:

Job description should follow your service plan.

**See Section One:** Job Descriptions.

### Version One, by Task:

<b><u>HOUSEHOLD TASKS</u></b>	<b><u>FREQUENCY/COMMENTS</u></b>
<input type="checkbox"/> Sweep and mop bathroom floors	Wed. & Sat.
<input type="checkbox"/> Vacuum living room and dining room	Wed. & Sat, empty vacuum bag 1x/mo
<input type="checkbox"/> Do dishes after meal preparation	Empty dishwasher before leaving
<input type="checkbox"/> Empty and take out all garbage	Trash pick-up every Tues.
<input type="checkbox"/> Change Sheets	Every Friday
<hr/>	
<b><u>PERSONAL CARE TASKS</u></b>	<b><u>FREQUENCY/COMMENTS</u></b>
<input type="checkbox"/> Assist with foot care	Apply lotion, trim nails
<input type="checkbox"/> Transfer, stand by for bath	Help with shampoo
<input type="checkbox"/> Assist with dressing	Assist with buttons, zippers
<hr/>	
<b><u>OTHER ACTIVITIES</u></b>	<b><u>FREQUENCY/COMMENTS</u></b>
<input type="checkbox"/> Essential shopping	Use list on Refrigerator
<input type="checkbox"/> Transport to Appointments	PT every other Monday
<input type="checkbox"/> Assist with exercises	Range of motion and weights, per PT

### Version Two, by Date:

<b><u>WEDNESDAYS</u></b>
<input type="checkbox"/> Sweep and mop bathroom floors
<input type="checkbox"/> Vacuum living room and dining room
<input type="checkbox"/> Do dishes after meal preparation
<input type="checkbox"/> Assist with foot care – lotion, massages, trim nails if needed
<b><u>SATURDAYS</u></b>
<input type="checkbox"/> Sweep and mop kitchen and entryway floors
<input type="checkbox"/> Do laundry
<input type="checkbox"/> Wipe down all kitchen and bathroom counters
<input type="checkbox"/> Vacuum bedrooms
<input type="checkbox"/> Do dishes after meal preparation
<b><u>AS NEEDED</u></b>
<input type="checkbox"/> Straighten up and organize
<input type="checkbox"/> Essential shopping
<input type="checkbox"/> Transfer, stand by for bath
<input type="checkbox"/> Assist with dressing
<input type="checkbox"/> Empty and take out all garbage

**Telephone Screening Form:**

Use when prescreening applicants prior to interviewing.

**See Section One: Pre-screening Applicants.**

Name: \_\_\_\_\_ Age: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Phone: \_\_\_\_\_

Has own transportation?  Yes  No

Experience: \_\_\_\_\_

\_\_\_\_\_

Training: \_\_\_\_\_

\_\_\_\_\_

Notes: \_\_\_\_\_

\_\_\_\_\_

Currently employed?  Yes  No

Where? \_\_\_\_\_

Looking for:  Part-time Work  Full-time Work

Hours/Days Available: \_\_\_\_\_

**Interview Date:** \_\_\_\_\_ **Time:** \_\_\_\_\_

**REMINDER: Bring contact information for all employers and references**



*Please list any relevant training, education or courses you have completed (i.e., Orientation, Fundamentals of Caregiving, Safety Training, Becoming a Professional Home care worker, continuing education classes):*

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**OTHER**

Are you legally authorized to work in the U.S.?  Yes  No

Have you ever been convicted of a crime?  Yes  No  
*If yes, please provide date and details below:*

Have you ever been placed on an abuse registry?  Yes  No  
*If yes, please provide date and details below:*

Do you have any health issues that require special accommodations?  Yes  No

Hours you are willing to work: \_\_\_\_\_

**EMERGENCY CONTACT**

\_\_\_\_\_  
Name ( ) Phone Number

Address: \_\_\_\_\_  
City State Zip Code

*I authorize my previous employers be contacted for reference purposes.*

\_\_\_\_\_  
Applicant Signature Date

**Interview Questions:** Have a written list of questions so that all applicants are asked the same questions and you don't miss anything important.

**See Section One:** *Interviewing Applicants*

**Most Important Questions:**

- Tell me about yourself.
- What experience do you have with in-home services?
- Why did you leave your last job?
- Have you ever been convicted of a felony?
- Do you have any questions about the job?

**General Questions to Ask:**

- Why do you want to be a home care worker?
- What would your co-workers say about you?
- What would your last consumer say is your strongest point?
- How long do you expect to work with me?
- Have you ever been asked to leave a position?
- Why do you think you will do well at this job?
- What part of this job would be the most difficult?
- Tell me about a problem you had with a past supervisor and how you handled the problem.
- What would you do if you had a disagreement about any job responsibility?
- Tell me how you would know if you were doing a good job.
- What was your favorite and least favorite jobs and why?

**Reference Check Release Form:**

To be completed along with Application.

**See Section One:** *Conducting Reference Checks*

TO: \_\_\_\_\_  
(Name of Reference)

I, \_\_\_\_\_,  
(Name of Applicant)

have applied for a position as an home care worker for

\_\_\_\_\_  
(Name of Potential Consumer)

and have given your name as a reference. I would appreciate it if you would supply him/her or his/her designee with information regarding my character, dependability and/or performance.

Thank you,

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Date

**Employment Reference Checklist:**

Use to track responses from applicants prior employers.

**See Section One:** *Checking Employment History*

Date: \_\_\_\_\_

Name of Reference: \_\_\_\_\_

Reference Phone Number: \_\_\_\_\_

Relationship to Applicant: \_\_\_\_\_

Dates of Employment: \_\_\_\_\_

Job Title: \_\_\_\_\_

Duties: \_\_\_\_\_

Reason for Termination: \_\_\_\_\_

Attendance: \_\_\_\_\_ Punctuality: \_\_\_\_\_

Relationships with supervisor and co-workers: \_\_\_\_\_

Dependability: \_\_\_\_\_

Job performance: \_\_\_\_\_

Ability to learn new tasks: \_\_\_\_\_

Ability to follow directions: \_\_\_\_\_

Honesty: \_\_\_\_\_

Responsibility: \_\_\_\_\_

Would You Hire Again?: \_\_\_\_\_

Other Comments: \_\_\_\_\_

**AGING AND DISABILITY SERVICES ADMINISTRATION  
INDIVIDUAL PROVIDER TIME SHEET**

**Time Sheet:** Be sure to verify hours before signing time sheet.  
**See Section Two: Time Sheets**

CLIENT/EMPLOYER NAME					INDIVIDUAL PROVIDER'S NAME							MONTH			YEAR					
Day of Month					1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
A	TIME SERVICE																			
B	TIME SERVICE																			
C	TOTAL HOURS																			
D	MILEAGE																			
Day of Month					17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	TOTALS
A	TIME SERVICE																			
B	TIME SERVICE																			
C	TOTAL HOURS																			
D	MILEAGE																			
CHECK TASKS PERFORMED DURING MONTH																				
<input checked="" type="checkbox"/> Meal Preparation		<input type="checkbox"/> Dressing		<input type="checkbox"/> Walking/Locomotion		<input type="checkbox"/> Bathing		<input type="checkbox"/> Housework		<input type="checkbox"/> Essential Shopping										
<input type="checkbox"/> Eating		<input type="checkbox"/> Personal Hygiene		<input type="checkbox"/> Transfer		<input type="checkbox"/> Toileting		<input type="checkbox"/> Wood Supply		<input type="checkbox"/> Medication										
<input type="checkbox"/> Escort/Transport to Medical		<input type="checkbox"/> Bed Mobility/ Positioning		<input type="checkbox"/> Application of Lotion/Ointment		<input type="checkbox"/> Toenails Trimmed		<input type="checkbox"/> Dry Bandage Change		<input type="checkbox"/> Passive Range of Motion Treatment										
INSTRUCTIONS																				
A. Enter time service began – indicate AM or PM as appropriate.										C. Enter total hours worked each day.										
B. Enter time service ended – indicate AM or PM as appropriate. SSPS.										D. Mileage: All miles traveled transporting or shopping for a client when authorized per SSPS.										
<b>DO NOT send these time sheets to Case Managers. Keep completed time sheets in our records for two (2) years. Copies will be requested by Case Managers at the time of reassessment.</b>																				
CLIENT'S SIGNATURE										INDIVIDUAL PROVIDER'S SIGNATURE										

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COPIES TO: Individual Provider; Client/Employer

SAMPLE

**Emergency Contact List:**

Consumer and employee should develop this plan and post next to all phones  
**See Section Two: Planning Ahead - Your Emergency Action Plan**

**911**  
dial 911 first

**Emergency Contact List**

created on: \_\_\_/\_\_\_/\_\_\_  
. . . . .

Your Name: \_\_\_\_\_ Date of Birth \_\_\_/\_\_\_/\_\_\_

<b>Home Telephone Number</b>	( ) ___ - ____
<b>Street Address</b> include street, apartment, numbers, zip code	_____ -
<b>Nearest Cross Streets</b> landmarks, apartment complex name	_____ -
<b>Physician and Hospital</b> names and phone numbers	Physician: _____ Hospital: _____ ( ) ___ - ____ ( ) ___ - ____ _____
<b>Case Manager</b> Name:	Phone: Cell/Pager: ( ) ___ - ____ ( ) ___ - ____
<b>Contact Persons</b> names and phone numbers	Name/Relationship:      Name/Relationship: ( ) ___ - ____      ( ) ___ - ____

**Keep a copy at every phone**

**Hazard Assessment Check Sheet:**

Use this Check Sheet to help identify and reduce potential for accidents and injuries in your home. **See Section Two: Workplace Safety**

- Emergency Plan - Emergency Contact List complete
- Adequate Protective Equipment  
(gloves, leak proof apron, disposable towels, leak proof containers, etc...)
- Outside walkways are well lit, cleared of debris/material
- Inside floors are cleared of furniture, debris
- Stairs have handrails and are well lit
- Rug edges are non-frayed and tacked down
- Throw rugs are removed or non skid mat in place
- No exposed electrical wires
- Extension cords are not frayed and do not pose a tripping hazard
- Used needles are placed in sharps or closed durable container
- Sharp objects are padded (bed frames etc.)
- Oxygen hoses are out of walkway
- Medical equipment stored properly
- No smoking or open flames with oxygen use
- Liquids such as water, ice, snow, grease are cleaned up immediately
- Materials are stored at proper height and safely
- Proper lighting
- Home is free of infestation and animal waste
- Animals are controlled
- Medications and chemicals are labeled and stored correctly
- Fire Extinguishers are readily available and serviced
- Smoke alarms are in working condition
- Lifting and moving objects are kept to a minimum



## *Frequently Asked Questions About the Referral Registry*

*For more information contact the Home Care Referral Registry Center in your area at:  
1-800-970-5456*

### ***What is the Referral Registry?***

The Referral Registry is a web-based service, used to match those who need in-home long-term care services with pre-qualified, pre-screened individual providers that are ready to work.

### ***How does it work?***

- ✓ **Individual Providers** can visit or call their local Home Care Referral Registry (HCRR) center to submit an application specifying personal care tasks they are willing to do, availability and clientele they are willing to serve.
- ✓ **Consumers-employers** and/or their Case Manager/Social Worker can call the local HCRR center to start the referral request process.
- ✓ **The Referral Registry** generates a list of individual provider names that best match the referral request. The list is sent to the employer-consumer who is responsible for interviewing and selecting their Individual Provider!

### ***Who can use the Referral Registry?***

- ✓ Consumer-employers who are receiving COPES or Medicaid Personal Care services through DSHS
- ✓ A person representing the employer-consumer
- ✓ Individual Providers
- ✓ Case Managers/Social Workers

### ***Why should I use the Referral Registry?***

- There are more options for choosing a provider
- Each provider has been screened with up-to-date information
- Providers have more opportunities for employment

### ***What's the next step?***

Request an application and information on how to enroll on, or request a referral from, the Registry by contacting your local Home Care Referral Registry at 800-970-5456.

### Additional Resources

The following materials are available through the Home Care Referral Registry. Please call 1-800-970-5456 to request your copies.

- **SAFETY TIPS**  
for Home Care Recipients (brochure)
- **STAY RIGHT WHERE YOU ARE**  
Resources for Seniors and Adults with Disabilities Living at Home in Washington State (booklet)
- **YOUR CHOICE – Part One**  
How to Hire the Right Individual Provider (DVD)
- **YOUR CHOICE – Part Two**  
Supervising Your Individual Provider (DVD)
- **Becoming a Professional Individual Provider**  
An Introduction to In-Home Care Work (booklet)

