IDAHO DEPARTMENT OF HEALTH & WELFARE

Service Agreement

RESIDENT INFORMATION

Client Name		Medicaid #	
Address		City	
Home Phone		Date of Birth	
State		Zip	
Assessment Date		Next Review Date	
Region		Assessment Type	

PRIMARY PHYSICIAN

Name	Phone

GENERAL INFORMATION

Health monitoring (blood level checks, oxygen, etc.), special diets, etc. Medical appointments including dental, vision, general medical and medical specialty appointments. Identify medical transportation.

Goals	Outcomes

Resident Strengths	**Resident** Preferences

ATTENDANT CARE ACTIVITIES OF DAILY LIVING (ADL)

Bathing Identify the participant's ability to bathe and wash hair.	Assistance Required: <Select>	Available Support:	Unmet Needs:
Risks & Interventions			
Frequency ☐ Daily	☐ Weekly	☐ Monthly	☐ As Needed
Responsible Party:			
Written Care Plan:			

Dressing Identify the participant's ability to dress and undress, including selection of clean clothing or appropriate seasonal clothing.	Assistance Required: <Select>	Available Support:	Unmet Needs:
Risks & Interventions			
Frequency ☐ Daily	☐ Weekly	☐ Monthly	☐ As Needed
Responsible Party:			
Written Care Plan:			

Eating Meals Identify the level of assistance needed to perform the activity of feeding and eating with special equipment if regularly used or special tray setup.	Assistance Required: <Select>	Available Support:	Unmet Needs:
Risks & Interventions			
Frequency ☐ Daily	☐ Weekly	☐ Monthly	☐ As Needed
Responsible Party:			
Written Care Plan:			

Emergency Response Identify the participant's ability to recognize the need for and to seek emergency help.	Assistance Required: <Select>	Available Support:	Unmet Needs:

Risks & Interventions				
Frequency	☐ Daily	☐ Weekly	☐ Monthly	☐ As Needed
Responsible Party:				
Written Care Plan:				

Medication Identify the participant's ability/willingness to administer his/her own medication.	Assistance Required: <Select>	Available Support:	Unmet Needs:

Risks & Interventions				
Frequency	☐ Daily	☐ Weekly	☐ Monthly	☐ As Needed
Responsible Party:				
Written Care Plan:				

Mobility Identify the participant's physical ability to get around, both inside and outside, using mechanical aids if needed.	Assistance Required: <Select>	Available Support:	Unmet Needs:

Risks & Interventions				
Frequency	☐ Daily	☐ Weekly	☐ Monthly	☐ As Needed
Responsible Party:				
Written Care Plan:				

Night Needs Identify the participant's need for assistance during the night.	Assistance Required: <Select>	Available Support:	Unmet Needs:
Risks & Interventions			
Frequency	☐ Daily	☐ Weekly	☐ Monthly ☐ As Needed
Responsible Party:			
Written Care Plan:			

Personal Hygiene Identify the participant's ability to shave, care for mouth, and comb hair.	Assistance Required: <Select>	Available Support:	Unmet Needs:
Risks & Interventions			
Frequency	☐ Daily	☐ Weekly	☐ Monthly ☐ As Needed
Responsible Party:			
Written Care Plan:			

Toileting Identify the participant's ability to get to and from the toilet (including commode, bedpan, and urinal), manage colostomy or other devices, to cleanse after eliminating, and to adjust clothing.	Assistance Required: <Select>	Available Support:	Unmet Needs:
Risks & Interventions			
Frequency	☐ Daily	☐ Weekly	☐ Monthly ☐ As Needed
Responsible Party:			
Written Care Plan:			

Transferring Identify the participant's ability to transfer when in bed or wheelchair.	Assistance Required: <Select>	Available Support:	Unmet Needs:
Risks & Interventions			
Frequency	☐ Daily	☐ Weekly	☐ Monthly ☐ As Needed
Responsible Party:			
Written Care Plan:			

HOMEMAKER ACTIVITIES OF DAILY LIVING (ADL)

Access to Transportation Identify the participant's ability to get to and from stores, medical facilities, and other community activities, considering the ability both to access and use transportation.	Assistance Required: <Select>	Available Support:	Unmet Needs:
Risks & Interventions			
Frequency	☐ Daily	☐ Weekly	☐ Monthly ☐ As Needed
Responsible Party:			
Written Care Plan:			

Housework Identify the participant's ability to clean surfaces and furnishings in his/her living quarters, including dishes, floors and bathroom fixtures and disposing of household garbage.	Assistance Required: <Select>	Available Support:	Unmet Needs:
Risks & Interventions			
Frequency	☐ Daily	☐ Weekly	☐ Monthly ☐ As Needed
Responsible Party:			
Written Care Plan:			

Laundry Identify the participant's ability to do own laundry either at home or at laundromat.	Assistance Required: <Select>	Available Support:	Unmet Needs:
Risks & Interventions			
Frequency	☐ Daily	☐ Weekly	☐ Monthly ☐ As Needed
Responsible Party:			
Written Care Plan:			

Preparing Meals Identify the participant's ability to prepare own food. Consider safety issues such as whether burners are left on.	Assistance Required: <Select>	Available Support:	Unmet Needs:
Risks & Interventions			
Frequency	☐ Daily	☐ Weekly	☐ Monthly ☐ As Needed
Responsible Party:			
Written Care Plan:			

Shopping Identify the participant's ability to shop for food and personal items.	Assistance Required: <Select>	Available Support:	Unmet Needs:
Risks & Interventions			
Frequency	☐ Daily	☐ Weekly	☐ Monthly ☐ As Needed
Responsible Party:			
Written Care Plan:			

Note: Supervision is not a discrete care task. The Unmet Needs score for Supervision drives the amount of time allocated for Activities of Daily Living included under Attendant and Homemaker services. *Supervision is intended to be incorporated into each identified care task as appropriate.*

Supervision Identify the participant's ability to manage his/her life, including needs and activities.	Assistance Required: <Select>	Available Support:	Unmet Needs:

Risks & Interventions				
Frequency	☐ Daily	☐ Weekly	☐ Monthly	☐ As Needed
Responsible Party:				
Written Care Plan:				

SPECIAL EQUIPMENT

Equipment to meet the special needs for physical/emotional disability or impairment. Equipment may include; wheelchairs, walkers, canes, hearing aids, orthopedic supports, glasses, contacts, etc.

COMMUNITY SUPPORTS / BEHAVIOR MANAGEMENT

Use of community services such as day treatment, workshop programs, financial or legal services, vocational training, case management, targeted service coordination, transportation, etc. Please include family support, physicians, attorneys, social workers, etc. If there is a Behavior Management Plan, please attach to this Service Plan.

HEALTH AND SAFETY RISKS AND INTERVENTION

Risk	Intervention
Identify health & safety risks such as falling, memory/cognitive impairment, behavioral issues that present a risk to the resident or others.	Identify intervention need to address each health or safety risk during service delivery.

BACKUP PLAN

I will accept a substitute caregiver if my caregiver is not available:	☐ YES	☐ NO
I will use the informal supports listed below if my caregiver is not available:		
Name:	Relationship:	Phone:
Name:	Relationship:	Phone:
Name:	Relationship:	Phone:
Communication Plan: Include detailed instructions for contacting caregiver(s) and/or informal supports and include the participants urgent needs and any actions that are required to ensure service delivery.		

SIGNATURES

The signers have read and agree to the provisions of this document. Each has retained a copy for their records. If there is any disagreement, such should be noted. Attach any signed and dated physician's orders, admission records, and documentation concerning special needs.

Each signer acknowledges that this Service Plan was developed with input from the resident and is the plan to be followed in delivering care.	
Resident Signature:	Date:
Legal Representative:	Date:
Service Provider Name:	Date:
Service Provider Signature:	Date: