

**SUPPORTIVE HOME CARE/PERSONAL ASSISTANT SERVICES SCHEDULE**

**Recipient Name:** \_\_\_\_\_ **Social Security #:** \_\_\_\_\_

<b>TIME</b>	<b>WEEKDAYS</b>	<b>WEEKENDS</b>	<b>DETAILS OF WHAT WORKER WILL BE DOING</b>
12:00 AM			
1:00 AM			
2:00 AM			
3:00 AM			
4:00 AM			
5:00 AM			
6:00 AM			
7:00 AM			
8:00 AM			
9:00 AM			
10:00 AM			
11:00 AM			
12:00 PM			
1:00 PM			
2:00 PM			
3:00 PM			
4:00 PM			
5:00 PM			
6:00 PM			
7:00 PM			
8:00 PM			
9:00 PM			
10:00 PM			
11:00 PM			

**# Non-related people living in household:** \_\_\_\_\_ **Are any HCBS/MR recipients?** \_\_\_\_\_

**This schedule is to be completed and submitted with the Plan of Care when requesting Supportive Home Care or Personal Assistant Services. Indicated under weekdays the days that the worker is need and during what hours. (Ex: M-F, M-Th, M-W-F; etc.) Please provide details as to what the worker will be doing during the hours you are requesting. Provide the number, if any, of unrelated people living in the household and if they are HCBS/MR waiver recipients.**