Clearly state the Necessary Service Category please initial all that apply.

___ Companion Sitter ___ Personal Care Service

- Proposed Goals: :_____
- Proposed Outcomes: _____
- Barriers to Treatment: _____

If applicable please describe any special treatment necessary to accommodate the participant.

- Treatments _____
- Reason _____
- Frequency _____
- Duration _____

If applicable please indicate any pertinent nutritional needs of the participant.

Nutritional Needs

	Breakfast	Lunch	Dinner	Other
Monday				
Tuesday				
Wednesday				
Thursday				
Friday				
Saturday				
Sunday				

Tube Feeding

If applicable please list all medical equipment and special use devices necessary to accommodate the participant.

Equipment/Devices	Reason	Frequency	Duration