Hamilton County Developmental Disabilities Services
Residential Worksheet

Will only be authorized when approved by Service & Support Administrator

Individual: ______ My Plan Span Date: ______ To ______

SSA: ______ Provider: ______

Worksheet Effective Date: ______

Funding Source/Worksheet Purpose - To Be Completed by SSA Only

FUNDING: ☐ I/O Waiver ☐ L1 Waiver ☐ L1 Emergency Funds ☐ Local/Levy Dollars

☐ Initial Services ☐ Change in Services

☐ Re-determination ☐ Change in Provider

☐ **Ending Provider:**

Provider: ______ Date ended: ______

Shared Living (IO Waiver ONLY)

RATIO:

☐ 1 to 1

☐ 1 to 2

☐ 1 to 3

1. Is direct support staff related to individual? ☐ YES ☐ NO

2. If you answered "Yes" to question #1: Is the family member doing 20% or more of the total assessed services? ☐ YES ☐ NO ☐ N/A

3. Select One: ☐ Adult (18+) ☐ Child (Under 18)*

(HPC 15 minute unit max rate/day - Adult Foster Care Rate)*

4. Are others served living in the home? ☐ YES ☐ NO

Comments: ______

Homemaker Personal Care (HPC)

Typical HPC Hours

Total HPC Hours*: ______ Per: ______

Ratios: (*Break down the total number of HPC hours listed above*)

1:1 ______ 1:2 ______ 1:3 ______ 1:4 ______

**Live Alone Household Schedule Must Be Attached For More Than 15 Hours/Week*

Exception Days

1. Medical, Dental, Other Appointments: HPC Hours Per Span: ______
2. Sick Days (Off Work): Days Per Span: ______
3. Snow Days/Workplace Closings: Days Per Span: ______

Respite (IO/L1)

☐ Community Respite

Number of Days:* ______ *(* 60 Day Max)*

Billing Units:

☐ Full Day (24 Hour)

☐ Partial Day (5-7 Hours)

☐ 15 Minute Units (Less than 5hrs. or more than 7hrs. & no overnights)

☐ Residential Respite

Number of Days:* ______ *(* 90 Day Max)*

Billing Units:

☐ Institution

☐ Licensed Facility

☐ Residence

Mileage

1:1 ______ ☐ Per Month ☐ Per Span

1:2 ______ ☐ Per Month ☐ Per Span

1:3 ______ ☐ Per Month ☐ Per Span

1:4 ______ ☐ Per Month ☐ Per Span

Does this person require the use of a wheelchair equipped vehicle? ◯ Yes ◯ No

Comments (Including On-Site/ On-Call Information): ______

Provider Signature: ______ Date: ______

SSA Signature: ______ Date: ______ Supervisor: ______ Date: ______