

Hamilton County Developmental Disabilities Services Residential Worksheet

Will only be authorized when approved by Service & Support Administrator

Individual: My Plan Span Date: To Worksheet Effective Date:

SSA: Provider:

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 Ending Provider:

Re-determination Change in 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)

<input type="checkbox"/> Community Respite Number of Days:* <input type="text"/> Billing Units: <input type="checkbox"/> Full Day (24 Hour) <input type="checkbox"/> Partial Day (5-7 Hours) <input type="checkbox"/> 15 Minute Units <small>(Less than 5hrs. or more than 7hrs. & no overnights)</small>	<input type="checkbox"/> Residential Respite Number of Days:* <input type="text"/> Billing Units: <input type="checkbox"/> Institution <input type="checkbox"/> Licensed Facility <input type="checkbox"/> Residence
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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

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

Provider Signature: Date:

SSA Signature: Date: Supervisor: Date: