



IDAHO DEPARTMENT OF  
**HEALTH & WELFARE**

**SERVICE AGREEMENT**

**Client Information:**

Client Name		Home Phone	
Address		Medicaid #	
City		Date Of Birth	
State		Marital Status	
Zip		Assessment Date	
Language		Admission Date	
Gender		Next Review Date	
Housing Arrangement		Facility Name	
Region		Facility Phone	
Assessment Type			

**Primary Physician:**

Physician Name		Phone	
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Goals	Outcomes

Participant Strengths:	Participant Preferences:

General information

**Preparing Meals**

<b>Assistance Required:</b> <input type="text"/>	Identify the participant's ability to prepare own food. Consider safety issues such as whether burners are left on.	<b>Available Support:</b> <input type="text"/>	<b>Unmet Needs:</b> <input type="text"/>
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**Provider Care Plan** Frequency:  Daily  Weekly  Monthly  As Needed  
 Responsible Party: \_\_\_\_\_

**Written Care Plan (Comments):**

**Eating Meals**

<b>Assistance Required:</b> <input type="text"/>	Identify the level of assistance needed to perform the activity of feeding and eating with special equipment if regularly used or special tray setup.	<b>Available Support:</b> <input type="text"/>	<b>Unmet Needs:</b> <input type="text"/>
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**Provider Care Plan** Frequency:  Daily  Weekly  Monthly  As Needed  
 Responsible Party: \_\_\_\_\_

**Written Care Plan (Comments):**

**Toileting**

<b>Assistance Required:</b> <input type="text"/>	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.	<b>Available Support:</b> <input type="text"/>	<b>Unmet Needs:</b> <input type="text"/>
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**Provider Care Plan** Frequency:  Daily  Weekly  Monthly  As Needed  
 Responsible Party: \_\_\_\_\_

**Written Care Plan (Comments):**

**Mobility**

<b>Assistance Required:</b> <input type="text"/>	Identify the participant's physical ability to get around, both inside and outside, using mechanical aids if needed.	<b>Available Support:</b> <input type="text"/>	<b>Unmet Needs:</b> <input type="text"/>
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**Provider Care Plan** Frequency: \_\_\_Daily \_\_\_Weekly \_\_\_Monthly \_\_\_As Needed  
Responsible Party: \_\_\_\_\_

**Written Care Plan (Comments):**

**Transferring**

<b>Assistance Required:</b> <input type="text"/>	Identify the participant's ability to transfer when in bed or wheelchair.	<b>Available Support:</b> <input type="text"/>	<b>Unmet Needs:</b> <input type="text"/>
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**Provider Care Plan** Frequency: \_\_\_Daily \_\_\_Weekly \_\_\_Monthly \_\_\_As Needed  
Responsible Party: \_\_\_\_\_

**Written Care Plan (Comments):**

**Personal Hygiene**

<b>Assistance Required:</b> <input type="text"/>	Identify the participant's ability to shave, care for mouth, and comb hair.	<b>Available Support:</b> <input type="text"/>	<b>Unmet Needs:</b> <input type="text"/>
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**Provider Care Plan** Frequency: \_\_\_Daily \_\_\_Weekly \_\_\_Monthly \_\_\_As Needed  
Responsible Party: \_\_\_\_\_

**Written Care Plan (Comments):**

**Dressing**

<b>Assistance Required:</b> <input type="text"/>	Identify the participant's ability to dress and undress, including selection of clean clothing or appropriate seasonal clothing.	<b>Available Support:</b> <input type="text"/>	<b>Unmet Needs:</b> <input type="text"/>
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**Provider Care Plan** Frequency: \_\_\_Daily \_\_\_Weekly \_\_\_Monthly \_\_\_As Needed  
Responsible Party: \_\_\_\_\_

**Written Care Plan (Comments):**

**Bathing**

Assistance Required: <input type="text"/>	Identify the participant's ability to bathe and wash hair.	Available Support: <input type="text"/>	Unmet Needs: <input type="text"/>
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<b>Provider Care Plan</b> Frequency: <input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> As Needed Responsible Party: _____
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<b>Written Care Plan (Comments):</b>  <div style="height: 80px;"></div>
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**Access to Transportation**

Assistance Required: <input type="text"/>	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.	Available Support: <input type="text"/>	Unmet Needs: <input type="text"/>
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<b>Provider Care Plan</b> Frequency: <input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> As Needed Responsible Party: _____
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<b>Written Care Plan (Comments):</b>  <div style="height: 80px;"></div>
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**Shopping**

Assistance Required: <input type="text"/>	Identify the participant's ability to shop for food and personal items.	Available Support: <input type="text"/>	Unmet Needs: <input type="text"/>
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<b>Provider Care Plan</b> Frequency: <input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> As Needed Responsible Party: _____
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<b>Written Care Plan (Comments):</b>  <div style="height: 80px;"></div>
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**Laundry**

Assistance Required: <input type="text"/>	Identify the participant's ability to do own laundry either at home or at laundromat.	Available Support: <input type="text"/>	Unmet Needs: <input type="text"/>
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**Provider Care Plan** Frequency: \_\_\_Daily \_\_\_Weekly \_\_\_Monthly \_\_\_As Needed  
Responsible Party: \_\_\_\_\_

**Written Care Plan (Comments):**

**Housework**

<b>Assistance Required:</b> <input type="text"/>	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.	<b>Available Support:</b> <input type="text"/>	<b>Unmet Needs:</b> <input type="text"/>
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**Provider Care Plan** Frequency: \_\_\_Daily \_\_\_Weekly \_\_\_Monthly \_\_\_As Needed  
Responsible Party: \_\_\_\_\_

**Written Care Plan (Comments):**

**Night Needs**

<b>Assistance Required:</b> <input type="text"/>	Identify the participant's need for assistance during the night.	<b>Available Support:</b> <input type="text"/>	<b>Unmet Needs:</b> <input type="text"/>
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**Provider Care Plan** Frequency: \_\_\_Daily \_\_\_Weekly \_\_\_Monthly \_\_\_As Needed  
Responsible Party: \_\_\_\_\_

**Written Care Plan (Comments):**

**Emergency Response**

<b>Assistance Required:</b> <input type="text"/>	Identify the participant's ability to recognize the need for and to seek emergency help.	<b>Available Support:</b> <input type="text"/>	<b>Unmet Needs:</b> <input type="text"/>
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**Provider Care Plan** Frequency: \_\_\_Daily \_\_\_Weekly \_\_\_Monthly \_\_\_As Needed  
Responsible Party: \_\_\_\_\_

**Written Care Plan (Comments):**

**Medication**

<b>Assistance Required:</b> <input type="text"/>	Identify the participant's ability/willingness to administer his/her own medication.	<b>Available Support:</b> <input type="text"/>	<b>Unmet Needs:</b> <input type="text"/>
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<b>Provider Care Plan</b> Frequency: ___Daily ___Weekly ___Monthly ___As Needed Responsible Party: _____
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<b>Written Care Plan (Comments):</b>  
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**Supervision**

<b>Assistance Required:</b> <input type="text"/>	Identify the participant's ability to manage his/her life, including needs and activities.	<b>Available Support:</b> <input type="text"/>	<b>Unmet Needs:</b> <input type="text"/>
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<b>Provider Care Plan</b> Frequency: ___Daily ___Weekly ___Monthly ___As Needed Responsible Party: _____
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<b>Written Care Plan (Comments):</b>  
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**Community Supports and Other Services**

**Special Equipment:**

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

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**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.

Is there a Behavior Management Plan? *If YES please attach to the Service Plan*

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**Health & Safety Risks:**

**Intervention:**

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

**Backup Plan :**

I will accept a substitute caregiver if my caregiver is not available	
I will use informal supports if my caregiver is not available	
Name:	Phone:
Name:	Phone:
Name:	Phone:
<b>Communication Plan</b> (include detailed instructions for contacting caregiver(s) and/or informal supports and include the participant's urgent needs and any actions that are required to ensure service delivery):	

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.

**Participant**

My signature indicates that I participated in the development of my service plan, and that I agree to the delivery of services as outlined in my plan.

\_\_\_\_\_  
Participant

\_\_\_\_\_  
Date

\_\_\_\_\_  
Legal Guardian

\_\_\_\_\_  
Date

**Service Provider**

My signature indicates service will be delivered according to the service plan and consistent with home and community based requirements.

\_\_\_\_\_  
Service Provider Name

\_\_\_\_\_  
Date