RESIDENTIAL HABILITATION TRAINING/ IN-HOME SUPPORT SCHEDULE

NAME:_____ SERVICE:_____

PLAN DATE:_____ PROVIDER:_____

SCHEDULE IMPLEMENTATION/REVISION DATE:_____ LOCATION:_____

NOTE: THIS TEXT BOX IS A REMINDER TO THOSE DEVELOPING THE SCHEDULE AND IS NOT PART OF THE ACTUAL SCHEDULE. THE PURPOSE OF THIS SCHEDULE IS TO PROVIDE A GUIDELINE FOR RESIDENTIAL HABILITATION TRAINERS AND IN-HOME SUPPORT SERVICES– CONDUCTING A DESIGNED PROGRAM TO ALLOW THE INDIVIDUAL TO ACQUIRE, RETAIN, AND IMPROVE THE SELF-HELP, SOCIALIZATION, AND ADAPTIVE SKILLS NEC3ESSARY TO RESIDE SUCCESSFULLY IN THE COMMUNITY. TRAINING IS TO ADDRESS FUNCTIONAL DEFICITS IN SELF HELP, DAILY LIVING SKILLS, MOBILITY, LEARNING, COMMUNICATION, SELF-SUFFICIENCY, SURVIVIAL, REDUCTION OF MAL-ADAPTIVE BEHAVIORS, COMMUNITY ACCESS AND OTHER NECESSARY SKIILLS.

Comment [Watermark1]:

SAMPLE

Summary of Goal: Specify the goal and the measurement criteria (e.g. I will increase my level of independence by one level in the listed task.) (Base line will be determined through assessment or by the provider during my first attempt to do the task.)

Level of Independence Key:

0 = Refused to attempt
1 = Hand over hand assistance
2 = physical prompt
3= verbal prompt
4 = Initiated and completed step independently

Training Objective SCHEDULE*** DATE: MM/DD/YY							
BEGIN TIME							
OBJECTIVE #1 LAUNDRY							
1. Sort Clothing (into correct basket by using the picture card that is on basket)							
a. underclothes, socks							
b. jeans							
c. T- Shirts							
d. Towels, dish cloths, wash cloths							
2. Sets Washer Controls according to the color codes on the picture cards, located on the baskets, to the same color codes on the washer.							
3. Correctly measure detergent and fabric softener							
4, Sets dryer controls and starts dryer							
5. Cleans the lint trap							
6. Transfers clothing from washer to dryer							
7. Folds or hangs clothing up on hanger							
8. Puts clothing in appropriate place							
Measurement of level of accomplishment							
END TIME							
UNITS USED							
_____		X	X	X	X	X	X
SIGNATURE **UNITS APPROVED ____ AS OF (USE PLAN DATE HERE)** **A COPY OF THIS DOCUMENTATION AND BILLING SHEET MUST BE SUBMITTED TO THE ISC, AS PER THE PLAN OF CARE, MINIMAL AT LEAST MONTHLY** *** INCIDENT REPORTS SUBMITTED AS A SEPARATE DOCUMENT***							