

# **WORKBOOK**

## **FOR SELF DIRECTING**

**PRACTICAL FORMS, EXAMPLES AND CHECKLISTS  
TO HELP GUIDE YOU IN SELF DIRECTING**

**Part II of the Guide to Self Directing**

**Georgia Council on Developmental Disabilities  
2009**

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## **JOB RELATED FORMS AND EXAMPLES**

- A. Job Description Outline
- B. Job Description Example
- C. Sample Ad / Sample Flyer
- D. Job Application Form
- E. Reference Check Form
- F. Interview Questions
- G. Desirable Qualities / Characteristics
- H. House Rules
- I. Hiring Check List

**JOB DESCRIPTION OUTLINE**

Job Title:

Supervised by:

Job Summary:

Work Schedule:

Wages:

Total Hours Weekly:

Benefits:

Qualifications:

Duties / Responsibilities:

Working Conditions:

Reliability:

End of Services:

**This job description is subject to review or revision on an annual basis  
or when a change in job duties is required.**

I have received a copy of the job description for my records.  
I have read the entire job description and understand my responsibilities.  
I understand that this constitutes an agreement between the employer and myself, and does not guarantee employment.

\_\_\_\_\_  
Signature of the support worker

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of the employer

\_\_\_\_\_  
Date

## JOB DESCRIPTION EXAMPLE

Job Title: Personal Assistant

Supervised by: Jane Doe

Job Summary: To assist a woman with a disability throughout her daily and evening activities and routines

Work Schedule: Monday-Friday 7:00-9:00 a.m. and 9:00-11:00 p.m.  
Note: The employee must work exactly the hours that are listed above. Any additional hours will not be paid. Changes in scheduled hours may be negotiated between the employer and the employee.

Wages: Wages for this position are \$9.50 per hour

Total Hours Weekly: 20 hours

Benefits: To be determined

Qualifications: A person with a sense of humor, and someone who is a night person, punctual, female, non-smoker, and who likes pets. Must be a licensed driver in the state of Georgia and have reliable transportation. CPR and First Aid Certified.

Duties / Responsibilities: Assist with bathing, dressing, and transferring.  
Assist with meal preparation, serving meals.  
Assist with grocery shopping.  
Assist with physical exercise program.  
Accompany me to the movies, ball games, and other social events.

Working Conditions: The employee will work in the employer's home, but may need to do Tasks in other settings such as social activities, stores, and appointments

Reliability: If the employee is going to be late or absent, a phone call is expected With notice. The employee is expected to use time wisely so the service Is done in the allotted time.

End of Services: The employee agrees to give at least a two-week notice prior to resigning from this position.

**This job description is subject to review or revision on an annual basis  
or when a change in job duties is required.**

I have received a copy of the job description for my records.  
I have read the entire job description and understand my responsibilities.  
I understand that this constitutes an agreement between the employer and myself, and does not guarantee employment.

\_\_\_\_\_  
Signature of the support worker

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of the employer

\_\_\_\_\_  
Date

*Excerpt from Your Life Your Way, by the Florida Developmental Disabilities Council, Inc.*

**SAMPLE ADS/ SAMPLE FLYER**

**Personal Care Assistant**

Part-time assistant needed for woman with a disability

7-9 a.m. and 8-10 p.m.

Non-smoker, \$8-\$12 / hour  
Call (404) XXX-XXXX after 6 p.m.

**Behavioral Tech Needed**

Young man with autism needs help with personal care 6 hours a day.  
Must be familiar with Spanish Language.

Call after 6 p.m.  
(404) XXX-XXXX

**Personal Care Assistant Needed**  
**\$10 per hour**



I am looking for a dependable and compassionate personal care assistant. I have a disability and require total assistance with personal care. Position includes bathing, dressing, meal preparation, eating, light housekeeping, and community engagement supports. Lift system is available, but person must demonstrate the ability to lift 75 pounds. Reliable transportation, valid driver's license, and English language required.

Call for Interview: 404- XXX-XXXX

*Excerpt from Your Life Your Way, by the Florida Developmental Disabilities Council, Inc.*

# JOB APPLICATION

## Application for Employment

**Personal Information**

Date: \_\_\_\_\_

Name \_\_\_\_\_  
Last
First
Middle

Address \_\_\_\_\_

Phone Number \_\_\_\_\_ Social Security # \_\_\_\_\_

Position \_\_\_\_\_ Date you can start \_\_\_\_\_ Wage desired \_\_\_\_\_

Employment Eligibility: To be employed with the State of Georgia, you must meet certain State and Federal employment eligibility requirements. These include, but not limited to, United States citizenship or authorization to work in this country, and no felony convictions.

Please answer the following questions:

- Are you employed now? \_\_\_\_\_ Yes \_\_\_\_\_ No
- Are you 18 years of age or older? \_\_\_\_\_ Yes \_\_\_\_\_ No
- Have you ever been convicted of a felony? \_\_\_\_\_ Yes \_\_\_\_\_ No
- Are you a United States citizen? \_\_\_\_\_ Yes \_\_\_\_\_ No
- Are you an alien authorized to work in the US? \_\_\_\_\_ Yes \_\_\_\_\_ No

**Education**

High School Graduate or equivalent (GED) ? \_\_\_\_\_ Yes \_\_\_\_\_ No

Vocational Business School? \_\_\_\_\_ Yes \_\_\_\_\_ No  
 If yes, Field of Study \_\_\_\_\_ # of months \_\_\_\_\_ Completion Date \_\_\_\_\_

College? \_\_\_\_\_ Graduate? \_\_\_\_\_ Yes \_\_\_\_\_ No  
 If yes, Degree \_\_\_\_\_ Date Degree completed: \_\_\_\_\_

**Former Employers**

From	To	Name	Address	Position	Reason for leaving

Name: \_\_\_\_\_

# JOB APPLICATION

## Application for Employment

### Georgia Licenses and Certifications:

Type of License / Certificate

Current Valid Drivers License	_____ Yes	_____ No
CPR Training Certificate	_____ Yes	_____ No
If yes, expiration date (mo/yr)	_____	
Basic First Aid Training Certificate	_____ Yes	_____ No
If yes, expiration date (mo/yr)	_____	
Nurse Aide Certification	_____ Yes	_____ No
If yes, expiration date (mo/yr)	_____	

You must provide a copy of your current CPR Card and Basic First Aid Care to your employer

### References

Name	Phone Number	Relationship

Briefly list reasons you should be considered for this job:

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I certify that the facts contained in this application are true and complete to the best of my knowledge. I understand that any false statement, omission, or misrepresentation on this application is sufficient cause for refusal to hire, or dismissal if employer has employed me, no matter when discovered by employer.

I authorize this potential employer to investigate all statements contained in this application, and I authorize my former employers and references to disclose information regarding my former employment, character and general reputation, without giving me prior notice of such disclosure.

I understand and agree that nothing contained in this application, or conveyed during any interview, is intended to create an employment contract. I further understand and agree that if I am hired, my employment will be "at will" and without fixed term, and may be terminated at any time, with or without cause and without prior notice, at the option of either myself or this employer. No promises regarding employment have been made to me and I understand that no such promise or guarantee is binding upon this employer unless made in writing.

**Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

Name: \_\_\_\_\_



**Reference Check Form**

**Mail-In or E-Mail Reference Form**

\_\_\_\_\_  
Insert the Date

Dear \_\_\_\_\_,  
Insert name of the reference

\_\_\_\_\_ applied for a position with me as a \_\_\_\_\_.  
Insert name of the applicant Insert the job title

This will involve the following: \_\_\_\_\_  
Write down the tasks the person will be doing for you here

\_\_\_\_\_  
\_\_\_\_\_

Please answer the following questions:

1. When did the applicant work for you? \_\_\_\_\_
2. What were his or her job title and duties? \_\_\_\_\_
3. What can you tell me about his or her job performance? \_\_\_\_\_  
\_\_\_\_\_
4. Was he or she on time to work? Were there any problems with him or her not showing up or taking too much time off? \_\_\_\_\_
5. Do you consider him or her an honest person? \_\_\_\_\_
6. How well did he or she accept supervision and criticism? \_\_\_\_\_
7. Would you recommend him or her for this job? Why or why not? \_\_\_\_\_  
\_\_\_\_\_
8. Would you re-hire this person? \_\_\_\_\_

\_\_\_\_\_  
Signature of person providing information Date

Please mail this completed form to:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

## Reference Check Questions

### Sample Employer Reference Check Questions

1. How long did \_\_\_\_\_ work for you?
2. How dependable was \_\_\_\_\_?
3. How was \_\_\_\_\_'s attendance?
4. Did \_\_\_\_\_ get along with other people at work?
5. How well did \_\_\_\_\_ work independently?
6. Why did \_\_\_\_\_ leave?
7. Would you recommend \_\_\_\_\_ for the job?

### Same Personal Reference Check Questions

1. How long have you known \_\_\_\_\_?
2. What is your relationship with \_\_\_\_\_?
3. Are there any positive or negative things about \_\_\_\_\_ that I should know before I hire him or her?
4. In your opinion, is \_\_\_\_\_ honest?
5. Would you want \_\_\_\_\_ to work for you in my situation?

# INTERVIEW QUESTIONS AND DESIRABLE QUALITIES/CHARACTERISTICS

## SAMPLE INTERVIEW QUESTIONS TO CHOOSE FROM:

1. Tell me a little about yourself.
2. What is your experience in working with people who have disabilities?
3. Why are you interested in this position?
4. Are you looking for temporary or permanent work?
5. What other jobs have you had?
6. What did you like or dislike about those jobs?
7. Why did you leave those jobs?
8. Have you had a chance to look over the job description? Are there any tasks on there that make you uncomfortable? Why?
9. What hours and days are you available?
10. Do you prefer a job that is very structured or one that is more flexible?
11. Do you have a valid driver's license?
12. How would you get to work?
13. What are 3 positive qualities that you have that you think would be important for this job?
14. How did you find out about this position?
15. What seems most challenging about this job to you?

## DESIRABLE QUALITIES / CHARACTERISTICS

- \* Trustworthy
- \* Honest
- \* Sense of Humor
- \* Positive Attitude
- \* Dependable
- \* Punctual
- \* Follows Directions
- \* Good Communicator
- \* Patient
- \* Flexible
- \* Sensitive to your feelings
- \* Good listener
- \* Respectful

*Excerpts and Input from Your Life Your Way, by Florida Developmental Disabilities Council, Inc. and Institute on Human Development and Disability Community Guide Curriculum*

## HOUSE RULES

You should develop a set of house rules to share with your support workers. Have them sign a statement that says, "I have read the hours rules and I understand them." Here is a same list of house rules that you might consider.

**On time and ready to work.** You are expected to arrive at my home and be prepared to work at least by the time the shift begins.

**Absences.** You are expected to come to work when you are scheduled to work. Not coming to work and not calling me to make arrangements more than once can result in termination. Too many absences may be grounds for termination.

**Tardiness.** If you are going to be more than 15 minutes late getting to my home, you need to call and let me know. The time you write on the timesheet must be the actual time you worked. Being tardy without calling me or being tardy too many times may be grounds for termination.

**Illness.** If you are ill the day you are scheduled to work, you must notify me immediately. As the employer, I may contact you to cover another staff person's shift if he or she is ill.

**Trading shifts.** It is not acceptable to trade shifts. This should only be handled by the employer who is tracking the number of hours worked by each employee. If you know another staff person is available and willing to cover the time period, you can share this information with the employer.

**Dress code.** You should be dressed so you can do the tasks assigned to you. This means that you should wear comfortable clothing and shoes. You should not wear torn shirts or shirts with improper images. Pants should fit properly and not hang down or be too baggy or tight. Shorts and skirts should not be too short.

**Cleanliness.** You should be clean and smell clean. You should wear hair in a way that it will not interfere with your duties. You may not wear perfume or cologne.

**Alcohol and drugs.** Drinking alcohol or taking illegal drugs is not permitted in my home. Showing up for work drunk or high is not permitted. Drinking alcohol, taking illegal drugs, and showing up for work intoxicated from alcohol or drugs are grounds for termination.

**Criminal activity.** Any criminal activity is not permitted in my home. Any involvement in criminal activity is grounds for termination of employment

**Time logs.** Each worker signs in on each shift and signs out at the end of each shift. You should sign in and out in front of me. Be aware that the state of Georgia and Medicaid can charge a service provider with fraud if the agency or individual charges for work that was not completed.

**Record daily activities.** You must record daily activities in the daily activities notebook. Please keep timesheets in the notebook.

## HOUSE RULES (continued)

**Daily activities notebook.** Keep notebooks positive and objective, and do not include negative comments concerning me or other staff. Notebooks need to be restricted to information necessary for consistent support.

### **Behavior.**

- \* Staff should not talk about each other in front of me.
- \* If I express a concern about another staff, please tell me to speak with the person involved, my support coordinator, or a family member.
- \* If you have a concern about another staff, please address your concerns to me in an objective manner, remaining as positive as possible.
- \* Please avoid gossiping or complaining about other staff.
- \* Please address your concerns to me, not to other staff.

**Smoking.** Smoking is not permitted in my home or in my car. You may smoke outside. Please dispose of your cigarette butts in the can outside the door.

**Meals.** Meals are not provided. If you would like to bring your dinner, you may keep it in the refrigerator and warm it in the microwave or oven. I can provide water to drink. If you prefer something else to drink, please bring it with you. Please take any food with you that belongs to you at the end of your shift. You are responsible for clean-up.

**Using my phone.** You must ask me for permission before using my phone for personal calls. You may receive personal calls in the case of an emergency. You cannot accept phone calls while performing your duties. Absolutely no long-distance calls can be made on my phone. Making long distance phone calls on my phone is grounds for termination.

**Using my personal property.** You may not use any of my personal property for your personal use (example: washer and dryer, CD player, stereo, computer, phone, and car). That is grounds for termination.

**Using computers.** You may not use my computer for your personal use. You are not allowed to bring your personal computer to work. You are here to work for me, and I expect your individual attention.

**Using your personal phone.** You cannot use your cell phone during your work time unless there is an emergency.

**Borrowing money.** You are not to ask to borrow money from me. That is grounds for termination. You should not loan me money or have me write checks to you if you buy something for me. If you are buying something at the store for me, it is best to have me write a check to the store. Any checks on my account written to my staff can be suspected of fraud.

**Entertainment expenses.** You decide if you want to pay for staff's admission fees for community activities.

**HOUSE RULES (continued)**

**Friends and family.** You should not bring friends, boyfriends, girlfriends, spouses, significant others, or family members to work. You are here to work for me, and I expect your individual attention.

**Children.** Your child (ren) may accompany you to work only under the following conditions: (a) you have no options for day care, (b) you have notified me prior to bringing them, and (c) if they become a problem, you must make other arrangements immediately or contact another staff person to work your hours.

**Payments for gas.** I do not pay for gas. If you work for an agency service provider, the agency will pay you for mileage. If you are an independent service provider, you can keep track of your mileage and use it for a tax deduction at the end of the year.

**Confidentiality.** All issues related to me are to be handled in a confidential manner. Do not discuss my affairs with anyone without my consent. Staff may share with each other only that information needed to carry out their duties and training activities on a need-to-know basis. Breaking confidentiality may be grounds for termination.

I have read the House Rules and agree to follow them.

\_\_\_\_\_  
(Print) Employee's Name

\_\_\_\_\_  
Employee's Signature

\_\_\_\_\_  
Date

## HIRING CHECK LIST

Document:	Obtained:
1 Pre-employment Screening	
2 Applications for Employment	
3 Copy of Social Security Card,	
4 Copy of Driver License	
5 First Aid and CPR Certification	
6 Certifications, Licenses, or Records of Specialized Training	
7 School Transcripts	
8 W-4	
9 G-4 Tax Forms	
10 I-9	
11 Pay Selection Option for Employee	
12 Background Check	
13 References	
14 House Rules	
15 Wage Agreement Form	
16 Confidentiality Agreements	
17 Employee Handbooks	

## **EMPLOYEE FILES**

- A. Training Log
- B. Confidentiality
- C. Evaluation of Performance
- D. Employee File Checklist





## CONFIDENTIALITY

Health and educational information is protected by law. Confidentiality is a serious matter.

We want to respect the PRIVACY of people we are supporting.

We want to build TRUST with the person, their family, and the community.

We are trying to BUILD RELATIONSHIPS.

What does CONFIDENTIALITY mean?

- \* Containing information, the unauthorized disclosure of which can pose a threat or harm to another.
  
- \* Entrusted with the confidence of another, indicating confidence and intimacy.

It may seem harmless, but what people share with you is THEIR business so unless there is DANGER in not sharing, you should keep information to yourself.

If you are unsure what should be kept quiet, you should always error on the side of caution. When people share confidences with you, it is a sign of trust and respect. It is easier to lose trust than it is to gain it.

Think while you are Listening....Is this information:

- Something I need to know?
- Something I need to share?
- Making me uncomfortable?
- Something I have permission to know?
- Something I need to say?
- Something I need to tell?
- Something I have permission to share with others?

# EVALUATION OF PERFORMANCE

## Evaluation Form

Date: \_\_\_\_\_

Use the following rating scale from 1 to 5 to rate the employee's work performance.

<b>1. Attendance</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>
	poor		average		superior
Follows work schedule					
Reports to work on time					
Has no excessive absences					
Gives appropriate notice for absences					
<b>2. Performance</b>	1	2	3	4	5
	poor		average		superior
Knows job					
Follows instructions					
Works with minimal supervision					
Performs job duties well					
<b>3. Behavior</b>	1	2	3	4	5
	poor		average		superior
Is trustworthy					
Is open to suggestions					
Communicates well					
Has a positive attitude					
Is willing to learn					

4. In what areas does the employee need more training?
5. What changes does the employee need to make in work, attitude, or behavior?
6. What changes do we need to make to improve our working relationship?
7. List any ideas or concerns the employee wants to talk about.

Comments:

Date of next evaluation: \_\_\_\_\_

\_\_\_\_\_  
Employee's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Employer's Signature

## EMPLOYEE FILES CHECKLIST

You should have an employee file for each of your employees. Personnel Files are considered confidential; access to the information should be limited to the employee, employer, employee's legal representative, and auditing agencies. This file should contain information and all paperwork required By the financial support services provider such as:

- \_\_\_\_\_ Completed Job Application
- \_\_\_\_\_ Their Resume
- \_\_\_\_\_ Reference Checks
- \_\_\_\_\_ Copy of Social Security Card
- \_\_\_\_\_ Copy of Driver's License
- \_\_\_\_\_ Training Log
- \_\_\_\_\_ House Rules - Signed off on
- \_\_\_\_\_ Criminal Background Check
- \_\_\_\_\_ Performance Evaluations
- \_\_\_\_\_ Any Disciplinary Actions
- \_\_\_\_\_ Copy of the Job Description
- \_\_\_\_\_ Copies of Time sheets
- \_\_\_\_\_ I-9 Form
- \_\_\_\_\_ W-2 Form

## **SERVICE DELIVERY**

- A. Service Delivery Log
- B. Progress Note
- C. Tracking Sheet
- D. Calendar
- E. Weekly Schedule
- F. Individual Service Plan Goals
- G. Communication Log
- H. Monthly Checklists

# SERVICE DELIVERY LOG

## Service Delivery Record

Consumer (client) name: \_\_\_\_\_

Address: \_\_\_\_\_  
 \_\_\_\_\_

Medicaid Number: \_\_\_\_\_

MHID Number: \_\_\_\_\_

Month/Year: \_\_\_\_\_ / \_\_\_\_\_

Day	Time In/Out-Staff Initials
1	
2	
3	
4	
5	
6	
7	
8	
9	
10	
11	
12	
13	
14	
15	
16	
17	
18	
19	
20	
21	
22	
23	
24	
25	
26	
27	
28	
29	
30	
31	

By my daily initials I certify that the above named consumer/client was served: \_\_\_\_\_

<u>Initials:</u>	<u>Signature:</u>	<u>Print Name:</u>	<u>Title:</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

# PROGRESS NOTES

## PROGRESS NOTES

CONSUMER NAME: \_\_\_\_\_

PRINT:

STAFF NAME \_\_\_\_\_ CREDENTIALS \_\_\_\_\_ TITLE \_\_\_\_\_ INITIALS: \_\_\_\_\_  
 STAFF NAME \_\_\_\_\_ CREDENTIALS/ \_\_\_\_\_ TITLE \_\_\_\_\_ INITIALS: \_\_\_\_\_

Date & Time	ISP GOAL #	NOTES - Each entry must be dated and signed with name and position. (Initials may be used by staff listing name & title on each sheet)

# TRACKING SHEET

NAME: \_\_\_\_\_

CODE: I-Independent

V-Verbal Cue

Beginning Date: \_\_\_\_\_

F-Full Guidance

G-Gesture

ISP Start Date: \_\_\_\_\_

P-Partial Guidance

R- Refused

ISP Meeting Date: \_\_\_\_\_

N-Not worked on

H-Home Visit

DESIRED OUTCOME:

Goal:

Objective

Date	M	T	W	T	F	S	S	Comments
	/	/	/	/	/	/	/	
	/	/	/	/	/	/	/	
	/	/	/	/	/	/	/	
	/	/	/	/	/	/	/	
	/	/	/	/	/	/	/	
	/	/	/	/	/	/	/	

Staff Signature and Initials: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_



# TRACKING SHEET EXAMPLE

NAME: Brandon CODE: I-Independent V-Verbal Cue  
 F-Full Guidance G-Gesture  
 Beg. Date: 11/27/08 P-Partial Guidance R-Refused  
 N-Not worked on H-Home Visit  
 ISP Start Date: 11/27/08 ISP Meeting Date: 10/20/08

**DESIRED OUTCOME:**

Goal (E) Brandon will demonstrate independent living skills.  
 1. Brandon will make a shopping list of personal items assisted as needed by personal support aides. Goal will be met when Brandon makes purchases independently for 6 months.

**1x monthly**

Date	M	T	W	T	F	S	S	Comments
	/	/	/	/	/	/	/	
	/	/	/	/	/	/	/	
	/	/	/	/	/	/	/	
	/	/	/	/	/	/	/	
	/	/	/	/	/	/	/	
	/	/	/	/	/	/	/	
	/	/	/	/	/	/	/	

2. Brandon will choose appropriate clothes daily for activity chosen, assisted by personal support aide. Goal will be met when Brandon independently choose appropriate clothes daily for 12 months

**5 x weekly/**

Date	M	T	W	T	F	S	S	Comments
	/	/	/	/	/	/	/	
	/	/	/	/	/	/	/	
	/	/	/	/	/	/	/	
	/	/	/	/	/	/	/	
	/	/	/	/	/	/	/	
	/	/	/	/	/	/	/	
	/	/	/	/	/	/	/	

Staff Signature and Initials: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

# CALENDARS

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
					1	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	28	29	30

Monthly Calendars are a good way to have the big picture look at your schedule. You can color code each staff member’s name, hours, and the service that they delivered. You can also mark down key dates, like “time sheets due.”

One parent gave the tip that she keeps the monthly schedule on their refrigerator so that everyone can see it and have a reminder.

# WEEKLY TRACKING SCHEDULES

## Monthly Tracking & Data

NAME: \_\_\_\_\_

Prompt: I-Independent      V-Verbal Cue

F-Full Guidance      M-Modeled

Beg. Date: \_\_\_\_\_

P-Partial Guidance      G-Gesture

N-Not Worked On      R-Refused

ISP Start Date: \_\_\_\_\_ ISP Meeting Date: \_\_\_\_\_

RP-Role Play

Goal (A) \_\_\_\_\_ will demonstrate appropriate social skills in all environments.

1. \_\_\_\_\_ will participate in group discussions about social skills (interpreting people facial expressions, spitting frequently, and respecting other people speech patterns/words) instructions and role play by personal support aides. Goal will be met when \_\_\_\_\_ decreases spitting frequency to 4x per hour daily for 6 consecutive months. (3x weekly)

<b>Date</b>	<b>M</b>	<b>T</b>	<b>W</b>	<b>TH</b>	<b>F</b>	<b>S</b>	<b>S</b>
<b>Total</b>							

**Monthly Total of Prompts:**

**I-** \_\_\_\_    **V-** \_\_\_\_    **F-** \_\_\_\_    **G-** \_\_\_\_    **P-** \_\_\_\_

**R-** \_\_\_\_    **N-** \_\_\_\_    **M-** \_\_\_\_    **RP-** \_\_\_\_

**Comment:**

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**Staff Signature and Initials:** \_\_\_\_\_ / \_\_\_\_\_

**Staff Signature and Initials:** \_\_\_\_\_ / \_\_\_\_\_

# INDIVIDUAL SERVICE PLAN GOALS AND OBJECTIVES

Goals and objectives should be written so that they are measurable. It is important to have a goal for each of the services that the person is receiving. Some sample goals that were shared by different families include the following:

**Community Access Individual:**

Mary Anne will participate in recreational activities of her choice 1x per month.

**Community Living:**

With physical assistance from staff, Mary Anne will help prepare a meal 1x per week.

With physical assistance from staff, Mary Anne will learn to do household chores (cleaning or laundry) 1x per week.

**Specialized Medical Supplies:**

With physical assistance from staff, Mary Anne will maintain good hygiene related to eating, bathing and toileting.

**Community Access Group:**

Mary Anne will participate in recreational activities in a group setting in the community.

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**Goal B:** Brandon will demonstrate emotional growth and stability.

**Objective 1:** Brandon will recognize his feelings of frustration independently and in a positive manner will choose a calming activity and ask to take a break. Goal will be met when Brandon independently calms himself for six consecutive months (track 7 x weekly).

**Goal C:** Brandon will demonstrate marketable job skills.

**Objective 1:** Brandon will maintain a professional appearance and attitude when working as evidenced by staying focused on his job task and by showing respect to co-workers and by following work place rules. Staff will use social stories, role play, and video tapes as a way to help Brandon see his interactions. Goal will be met when Brandon demonstrates a professional appearance and attitude four times weekly for 12 consecutive months.

## COMMUNICATION LOG

The Communication Log can be a spiral notebook. It should be kept in an easy to access location where staff can take a few minutes to write notes back and forth to each other. This log helps with the continuity of support. It can alert a staff person coming to work what has been happening earlier that day. It should become a habit for staff to write in and read the Communication log.

### SAMPLE COMMUNICATION ENTRY

**August 30, 2009** Arrived at work at 10:00 and Sam seemed quiet and not as active as usual. He didn't want lunch and complained that his stomach hurt. Was able to get him to drink some fruit juice. Around 3:00 he spent about 30 minutes in the bathroom and said he had "pooped." Seemed to be feeling better afterwards. Marsha Reed

**August 30, 2009** When I came in at 6:00, Sam was really hungry. He kept going to the refrigerator wanting snacks. I gave him the choice of eating earlier since he hadn't eaten much at lunch. I also tried to make sure that he drank more fluids this evening. He ate well at supertime after choosing left over pot roast for his dinner.  
Cindy Smith

# MONTHLY SUMMARY

Month: \_\_\_\_\_ Client: \_\_\_\_\_ Location: \_\_\_\_\_

CLIENT BEHAVIORS: (note general trends, number of outbursts, etc.)

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FAMILY CONTACT: (note increase, decrease, etc.)

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MEDICAL REPORT: (note major illnesses, visits to doctor, etc.)

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ISP GOALS: (note progress, lack of progress)

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RECREATIONAL ACTIVITIES: (increase, decrease, enjoyed, refused to participate)

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NUMBER OF BEHAVIOR & UNUSUAL INCIDENTS: \_\_\_\_\_

AMOUNT OF TIME IN COMMUNITY: \_\_\_\_\_

FIRST AID INSPECTION: date \_\_\_\_\_ pass/fail

FIRE DRILL/SMOKE DETECTOR CHECK: date \_\_\_\_\_ pass/fail

SPECIAL PROBLEMS: \_\_\_\_\_

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STAFF \_\_\_\_\_

DATE \_\_\_\_\_

SUPPORT COORDINATOR \_\_\_\_\_

DATE \_\_\_\_\_

BEHAVIOR SPECIALIST \_\_\_\_\_

DATE \_\_\_\_\_

FAMILY \_\_\_\_\_

DATE \_\_\_\_\_

# MONTHLY PAPERWORK CHECKLIST

Consumer/Client: \_\_\_\_\_

Month: \_\_\_\_\_ Year: \_\_\_\_\_

1. Progress Notes Complete \_\_\_\_\_ Progress Note Summary \_\_\_\_\_
2. Tracking Sheets \_\_\_\_\_ Tracking Sheet Summary \_\_\_\_\_
3. Support Coordinator Notes \_\_\_\_\_ Date(s) of visit(s) \_\_\_\_\_
4. Behavior Consult Notes \_\_\_\_\_ Reports \_\_\_\_\_ Date(s) \_\_\_\_\_
5. Monthly Calendar \_\_\_\_\_
6. Staff Training \_\_\_\_\_
7. Medical Appointment \_\_\_\_\_ Date \_\_\_\_\_ Doctor/Dental \_\_\_\_\_  
    Any Changes \_\_\_\_\_
8. Service Delivery Record \_\_\_\_\_
9. Fire Drills \_\_\_\_\_ completed within 3 minutes \_\_\_\_\_ Night Drill ( \_\_\_\_\_ Oct & \_\_\_\_\_ Feb)  
    \_\_\_\_\_ Batteries replaced ( \_\_\_\_\_ Oct & \_\_\_\_\_ Feb)
10. Disaster Drill \_\_\_\_\_ (every 3 months: \_\_\_\_\_ Mar \_\_\_\_\_ Jun \_\_\_\_\_ Sep & \_\_\_\_\_ Dec)
11. First Aid Kit Inspection \_\_\_\_\_ (every 3 months: \_\_\_\_\_ Mar \_\_\_\_\_ Jun \_\_\_\_\_ Sep & \_\_\_\_\_ Dec)
12. Other \_\_\_\_\_

Staff Signature \_\_\_\_\_ Title \_\_\_\_\_ Date \_\_\_\_\_

Family \_\_\_\_\_ Date \_\_\_\_\_

Consumer/Client \_\_\_\_\_ Date \_\_\_\_\_

Behavior Consult \_\_\_\_\_ Date \_\_\_\_\_

Support Coordinator \_\_\_\_\_ Date \_\_\_\_\_

## **MEDICAL AND EMERGENCY INFORMATION**

- A. Medication Administration Record
- B. Permission to Treat
- C. Appointment Log
- D. Emergency Contact Forms
- E. Emergency Preparedness Supply Checklist
- F. Behavioral Incident Report
- G. Non-Behavioral Incident Report





**REASON MEDICATION NOT ADMINISTERED**

- 1 = Home
  - 2 = Work/ADT
  - 3 = ER/Hospital
  - 4 = Refused
  - 5 = Medication not available – explain ↔
  - 6 = Held by MD – explain ↔
  - 7 = Other – explain ↔
- Time, date, and initial each explanation.

Sign and initial at the bottom of the form.

Name: \_\_\_\_\_

Record medication administration notes below. For medication not administered, use the codes in the box at the left, including appropriate dates, comments, and explanations.


SIGNATURE	INITIALS	SIGNATURE	INITIALS	SIGNATURE	INITIALS

# PERMISSION TO TREAT

## Power of Attorney for Consent to Medical Care for a Minor

By signing this form, I (we) hereby authorize \_\_\_\_\_ to consent to any medical care and treatment for \_\_\_\_\_ (Child) that is recommended by a licensed healthcare provider to whom the Child is presented for treatment. In order to ensure that the Child receives prompt medical care and treatment when necessary, I (we) hereby release any licensed health care provider providing medical care to the Child in reliance of this form from liability relating to such provider's acceptance of my (our) substitute care giver's consent.

This Power of Attorney is dated \_\_\_\_\_, \_\_\_\_\_ and is valid for one year.

\_\_\_\_\_  
 Parent's Signature Date Second Parent's Signature (optional) Date

\_\_\_\_\_  
 Dated Signature - Notary Public My commission expires

**Medical History**

(Failure to complete any of the following does not impair the validity of this Power of Attorney for consent to medical care for a minor.)

Child's Name	Child's Birth Date	Allergies
Religion	Blood Type	Date of Last Tetanus Shot
Previous Hospitalizations and Major Illnesses		Current Medications
Pediatrician Telephone		Other Important Information

**Other Information**

Father's Name	Home Phone	Home Address
Place of Employment	Work Phone	
Insurance Company	Policy Number	
Mother's Name	Home Phone	Home Address
Place of Employment	Work Phone	
Insurance Company	Policy Number	

**APPOINTMENT LOG**

**Appointment Log**

<b>Date</b>	<b>With Whom</b>	<b>Where</b>	<b>Outcome</b>	<b>Signature / Title</b>

**EMERGENCY CONTACTS**

**Doctor**

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone: \_\_\_\_\_

**Medical Insurance**

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone: \_\_\_\_\_

**Hospital**

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone: \_\_\_\_\_

**Contact Family Member**

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone: \_\_\_\_\_

**Contact Friend**

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone: \_\_\_\_\_

**Important Medical Information**

Allergies: \_\_\_\_\_  
Medical Conditions: \_\_\_\_\_  
\_\_\_\_\_

**Other Information:**

Police Department Phone Number \_\_\_\_\_  
Fire Department Phone Number \_\_\_\_\_  
Poison Control Phone Number \_\_\_\_\_  
Utility Company (gas and electric) Phone Number \_\_\_\_\_  
Landlord's Phone Number \_\_\_\_\_

Put copies of Maps or Directions to Doctor Offices, Hospital, Pharmacy, Dentist or other key places where someone might need to go in an emergency.

*Excerpt from Your Life Your Way, by the Florida Developmental Disabilities Council, Inc. and Parent Recommendation*

**EMERGENCY PROCEDURES**

**Disability Related Emergency:**

Who to Call: \_\_\_\_\_  
Phone Number \_\_\_\_\_  
Important Information and Plan:

**Non-Disability Related Emergency:**

Who to Call: \_\_\_\_\_  
Phone Number: \_\_\_\_\_  
Important Information and Plan:

**Severe Weather or Natural Disaster**

Who to Call: \_\_\_\_\_  
Phone Number: \_\_\_\_\_  
Important Information and Plan:

**Power Outage**

Who to Call: \_\_\_\_\_  
Phone Number: \_\_\_\_\_  
Important Information and Plan:

**List Any Allergies**

Who to Call: \_\_\_\_\_  
Phone Number: \_\_\_\_\_  
Important Information and Plan:

## EMERGENCY PREPAREDNESS SUPPLY CHECKLIST

Assemble Supplies you might need in an emergency. Store them in an easy to carry Container such as a back pack. Include the following:

- \_\_\_\_\_ A supply of water (one gallon per person per day)  
Store water in sealed, unbreakable containers.  
Replace every six months.
- \_\_\_\_\_ A supply of non-perishable packaged or canned food and  
A non-electric can opener.
- \_\_\_\_\_ A change of clothing, rain gear and sturdy shoes.
- \_\_\_\_\_ Blankets or a sleeping bag.
- \_\_\_\_\_ A first aid kit and prescription medications.
- \_\_\_\_\_ An extra pair of glasses.
- \_\_\_\_\_ A battery powered radio, flashlight, and plenty of  
extra batteries. Hand crank radios that do not require  
Batteries are also available.
- \_\_\_\_\_ Credit cards and cash.
- \_\_\_\_\_ An extra set of car and house keys.
- \_\_\_\_\_ A list of family physicians.
- \_\_\_\_\_ A list of important family information.
- \_\_\_\_\_ A list of the style and serial number of medical devices  
such as pacemakers.
- \_\_\_\_\_ Special items for infants, elderly and family members who  
have disabilities.

*Excerpt from Your Life Your Way, by Florida Developmental Disabilities Council, Inc.*

# BEHAVIORAL INCIDENT REPORTS

Client/Staff Injury

## BEHAVIOR INCIDENT RECORD

Client: \_\_\_\_\_  
Date: \_\_\_\_\_  
Time Incident Began: \_\_\_\_\_ Time Incident Ended: \_\_\_\_\_ Total Time: \_\_\_\_\_  
Place of Occurrence: \_\_\_\_\_ Number of staff required to manage incident: \_\_\_\_\_

**ANTECEDENT CONDITIONS** – (What was happening just prior to the behavior. What was the client doing and what was going on around him?)

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**BEHAVIOR** – (Describe the actual behavior of the client.)

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**CONSEQUENCES** – (Describe what followed the behavior.)

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**CLIENT'S REACTION** – (Describe what the client did after your action.)

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Description of any injuries sustained by client(s) and/or staff. Medical treatment provided?

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Administrative Comments:

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Guardian or Family Notified: \_\_\_\_\_ Yes \_\_\_\_\_ No      Date Notified: \_\_\_\_\_

Staff Person Handling the Incident: \_\_\_\_\_

	Signature	Title	Date
Support Coordinator: _____	_____	_____	_____

	Signature	Date
Behavior Specialist: _____	_____	_____

	Signature	Date
Program Coordinator: _____	_____	_____



# NON-BEHAVIORAL INCIDENT REPORTS

Unusual Incident

Accident

Medical

Injury

Date: \_\_\_\_\_

Time: \_\_\_\_\_

Home: \_\_\_\_\_

Persons involved: \_\_\_\_\_  
\_\_\_\_\_

Other persons present: \_\_\_\_\_  
\_\_\_\_\_

Describe the incident in specific terms: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Describe the action taken: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Behavior consult contact and action: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Staff Signature

\_\_\_\_\_  
Date

Requires Regional Board Notification  
Administrative action, if needed:

Client/Staff Injury

Time Program Coordinator notified: \_\_\_\_\_

\_\_\_\_\_  
Behavior Consult

\_\_\_\_\_  
Date

\_\_\_\_\_  
Support Coordinator

\_\_\_\_\_  
Date

\_\_\_\_\_  
Family

\_\_\_\_\_  
Date

Sent to Regional Board \_\_\_\_\_

\_\_\_\_\_  
Date

Not Applicable

## BIBLIOGRAPHY

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Community Guide Curriculum, Institute on Human Development and Disability,  
850 College Station Rd., Athens, GA.

Developing and Implementing Self-Direction Programs and Policies, A Handbook,  
Robert Wood Johnson Foundation.

Domestic Employer Info, Self Determination Resources, Inc. (SDRI)  
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Domestic Employee Policy Handbook, Self Determination Resources, Inc. (SDRI)  
[http://www.sdri-pdx.org/customers/Content\\_DomesticEmployerInfo.html](http://www.sdri-pdx.org/customers/Content_DomesticEmployerInfo.html)

HR Pro File Employment Screening, 8506 Beechmont Ave., Cincinnati, OH 45255.

NOW and COMP Waiver Policies and Procedures Manuals,  
<https://www.ghp.georgia.gov>

Personal Assistance Training Manual, Shepherd Center, 2020 Peachtree Rd, NW  
Atlanta, Georgia 30309.

The New Mexico MI VIA Program Concept Paper, New Mexico Aging and Long  
Term Services Department, New Mexico Department of Health.

The Yellow Book, Implementing Choice, 2nd Edition, Dane County Department of  
Human Services, 1202 Northport Drive, Madison, WI 53704

Your Life Your Way, Florida Developmental Disabilities Council, Inc., Mary  
Hayden, 58 Inner Drive, St. Paul, MN 55116