

**Service Plan for Category A Assisted Living Residents**

**Copy given to resident / legal representative: YES (date): \_\_\_\_\_**

Name: \_\_\_\_\_ Emergency Contact Name and Number: \_\_\_\_\_

Physician (name, telephone, and address): \_\_\_\_\_

Advanced Directive / Living Will / POLST / DNR (etc): NO YES Type? \_\_\_\_\_ Date included in resident file: \_\_\_\_\_

Date of Initial Service Plan: \_\_\_\_\_ 60 Day Review: \_\_\_\_\_ Annual Reviews: \_\_\_\_\_ Change of Condition Reveivs: \_\_\_\_\_

<b>What is the service to be provided?</b>	<b>Who will provide the service?</b>	<b>When will the service be provided?</b>	<b>Where and how often is the service provided?</b>	<b>Changes to the service (with date), and reasons for those changes.</b>	<b>Desired outcome (if appropriate).</b>	<b>Additional information.</b>


**Caregiver / Staff signatures**

**Additional Care Notes**

(Caregiver orientation to Service Plans may be documented here, or in the Employee File)

1. \_\_\_\_\_ Date \_\_\_\_\_
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26. \_\_\_\_\_ Date \_\_\_\_\_
27. \_\_\_\_\_ Date \_\_\_\_\_