SUPPORTIVE SERVICE PLAN

Project Name: ____ # of Units __________

Contact name: ___________________________
Email address: ___________________________
Phone number: ___________________________

Included Services (check all that apply)

☐ **Service Coordination**
% of Residents receiving services ______________
# Hours per week ______________
Provider Name(s) ____________________________
____
Funding Source(s) ____________________________
____

COST:
Salary: ______________
Benefits: ______________
Work Comp: ______________
Payroll Tax: ______________
Other: ______________
Total: ______________

☐ **SASH**
% of Residents receiving services ______________
# Hours per week ______________
Provider Name(s) ____________________________
____
Funding Source(s) ____________________________
____

COST:
Salary: ______________
Benefits: ______________
Work Comp: ______________
Payroll Tax: ______________
Other: ______________
Total: ______________

☐ **Personal Care**
% of Residents receiving services ______________
# Hours per week ______________
Provider Name(s) ____________________________
____
Funding Source(s) ____________________________
____

COST:
Salary: ______________
Benefits: ______________
Work Comp: ______________
Payroll Tax: ______________
Other: ______________
Total: ______________

☐ **Case Management**		**COST**:	
% of Residents receiving services	____________	Salary:	____________
# Hours per week	____________	Benefits:	____________
Provider Name(s)	________________________	Work Comp:	____________
	________________________	Payroll Tax:	____________
Funding Source(s)	________________________	Other:	____________
	________________________	Total:	____________

☐ **Nursing / Wellness Nurse**		**COST**:	
% of Residents receiving services	____________	Salary:	____________
# Hours per week	____________	Benefits:	____________
Provider Name(s)	________________________	Work Comp:	____________
	________________________	Payroll Tax:	____________
Funding Source(s)	________________________	Other:	____________
	________________________	Total:	____________

☐ **Meals**		**COST**:	
% of Residents receiving services	____________	Salary:	____________
# Hours per week	____________	Benefits:	____________
Provider Name(s)	________________________	Work Comp:	____________
	________________________	Payroll Tax:	____________
Funding Source(s)	________________________	Other:	____________
	________________________	Total:	____________

☐ **Housekeeping**		**COST**:	
% of Residents receiving services	____________	Salary:	____________
# Hours per week	____________	Benefits:	____________
Provider Name(s)	________________________	Work Comp:	____________
	________________________	Payroll Tax:	____________
Funding Source(s)	________________________	Other:	____________
	________________________	Total:	____________

☐ **Transportation**		**COST**:	
% of Residents receiving services	____________	Salary:	____________
# Hours per week	____________	Benefits:	____________
Provider Name(s)	________________________	Work Comp:	____________
	________________________	Payroll Tax:	____________
Funding Source(s)	________________________	Other:	____________
	________________________	Total:	____________