**SUPPORTIVE SERVICE PLAN**

Project Name: # of Units

Contact name:

Email address:

Phone number:

Included Services (check all that apply)

[ ]  **Service Coordination** **COST**:

% of Residents receiving services Salary:

# Hours per week Benefits:

Provider Name(s) Work Comp:

 Payroll Tax:

Funding Source(s) Other: Total:

[ ]  **SASH**  **COST**:

% of Residents receiving services Salary:

# Hours per week Benefits:

Provider Name(s) Work Comp:

 Payroll Tax:

Funding Source(s) Other: Total:

[ ]  **Personal Care**  **COST**:

% of Residents receiving services Salary:

# Hours per week Benefits:

Provider Name(s) Work Comp:

 Payroll Tax:

Funding Source(s) 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: