**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: