ONE-TO-ONE PROGRAM/INDIVIDUAL JOB ASSIGNMENT PLAN

INSTRUCTIONS: This form has been designed as an instruction sheet to aid in the communication process and documentation of one-to-one program plans and individualized work/service plans. Indicate the type of plan and complete the remainder of the form in as much detail as possible to ensure that the person providing assistance (one-to-one) or the resident (job assignment) understands exactly what is to be done, how it is to be done, what the desired outcome is and how to document the outcomes.

○ **One-to-one program plan:** Primary one-to-one assistant(s)

○ **Individual job assignment plan:** If this is checked you must complete the following:

My signature below verifies the fact that this work or service is being done voluntarily.

   ○ I understand I will not receive any wages/salary for my performance of the work described.

   ○ I understand that I will be paid for this work/service.

I understand that I have the right to refuse to participate in this work/service plan at any time.

Resident/Resident Representative Signature: _____ **Date:** _____

If not signed by resident, record title of signer: _____

PLAN DESCRIPTION

Statement of work/service plan: _____

_____

Level of ability/limitations: _____

_____

_____

Purpose (benefit to resident): _____

_____

Instructions for carrying out plan (include adaptations): _____

_____

_____

_____

_____

_____

Location of supplies needed: _____

_____

Contact person - staff (for questions, assistance, concerns): _____

_____

Date work/service plan started: _____

Care plan reflects nature of work/service, resident's desire to participate and objectives of arrangement:

○ **Yes**   ○ **No, why not?** _____

Care plan reflects that work/service is voluntary or paid:

○ **Yes**   ○ **No, why not?** _____

NAME–Last	First	Middle	Attending Physician	Record No.	Room/Bed

BRIGGSHealthcare®

ONE-TO-ONE/JOB ASSIGNMENT PLAN
❏ Continued on Reverse

ONE-TO-ONE PROGRAM/INDIVIDUAL JOB ASSIGNMENT PLAN

DATE	COMMENTS (Record significant events and outcomes here)	SIGNATURE/TITLE

NAME–Last	First	Middle	Attending Physician	Record No.	Room/Bed

ONE-TO-ONE/JOB ASSIGNMENT PLAN   **BRiGGS** Healthcare®