

Consumer Name _____ Date _____

Ohio Home Care Program

NEEDS CHECKLIST

Daily Weekly Monthly Other

Personal Care:

Tub/Bed/Bath

Shower

Transfer

 Pivot

 Slid Board

 Hoyer Lift

Dressing

Oral Hygiene

Hair Care

Nail Care

Assistance with Meds

Positioning

Other

Other

Other

Meal Preparation

Assistance With

Eating

Housekeeping

 Dusting

 Vacuuming

 Kitchen Area

 Bathroom Area

 Bedroom Area

 Laundry

 Other

 Other

 Other

Grocery Shopping

Driving

Keeping

Appointments

Other

Other