AFH-DD Plan of Daily Operation

Please complete the information for the operation of your AFH-DD for yourself and your caregivers.

Provider: ______________________________ Co-Provider: ______________________________

Resident Manager: *(if applicable)*: ______________________________

AFH-DD Address: ______________________________ Phone: ______________________________

Who is the live in care provider: ☐ **Provider** ☐ **Co-Provider** ☐ **Resident Manager**

List all caregivers including Provider, Resident Managers, and Caregivers, and the scheduled hours of a typical work week.

Caregiver Name	Sun.	Mon.	Tues.	Wed.	Thurs.	Fri.	Sat.
Example: Sam Smith	8am-2pm	Off	Off	Off	7am-3pm	7am-3pm	8am-2pm

If provider(s) works outside of the AFH-DD, indicate work schedule *(days/hours):*

Provider/Co-Provider	Sun.	Mon.	Tues.	Wed.	Thurs.	Fri.	Sat.

Briefly describe the daily routine of the AFH-I/DD:

Meal Times: Breakfast ______________ Lunch ______________ Dinner ______________

Provider Signature: ______________________________ Date: ______________________________