Ontario
Health atHome

Assessment and Service Plan Authorization
Private School / In-Home School Student Health Needs

Name: _____ DOB: _____ (dd/mm/yy)

District: _____ School: _____

Date Assessed: _____ (dd/mm/yy) ☐ Initial ☐ Reassessment

Score: 0=NA (Independent with/without aids) 1=Needs Assistance 2=Dependent

Personal Support Activities	Score (0 1 2)	Time		Frequency		Total	Equipment
☐ Dressing/Undressing			X		=		
☐ Toileting/Personal Hygiene			X		=		
☐ Incontinence Care/Catheterization			X		=		
☐ Feeding			X		=		
☐ Transfer/positioning (non mobile)			X		=		
☐ Mobility			X		=		
☐ OT Educational Training			X		=		
☐ PT Educational Training			X		=		
☐ SLP Educational Training			X		=		
☐ Other (e.g., shallow suctioning)			X		=		
TOTAL	0	0	X	0	=	Min./Day Hrs/Day	

Personal Support Plan: _____ hours per day _____ hours per week

Part A – Personal Service Plan:

Time Period	Hours					Total Hours Per Week
	Monday	Tuesday	Wednesday	Thursday	Friday	

Part B – Professional Service Plan:

Service	Maximum Number Of Visits	Planned End Date
Occupational Therapy		
Physiotherapy		
Speech Language Pathology		
Nursing		
Nutritional Counselling		

Care Coordinator Signature/Title _____ Print Name _____ Date _____

Copy: School