



## **AFH-DD Plan of Daily Operation**

***Please complete the schedule below to reflect 24 hours of coverage for the operation of your AFH-DD.***

Provider: \_\_\_\_\_ Co-Provider: \_\_\_\_\_

Resident Manager: *(if applicable)*: \_\_\_\_\_

AFH-DD Address: \_\_\_\_\_ Phone: \_\_\_\_\_

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

List the scheduled hours in a typical work week for all caregivers including Providers, Resident Managers, Caregivers and Respite Caregivers.

Provider Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Co-Provider Signature: \_\_\_\_\_ Date: \_\_\_\_\_

***If the Provider or Co-Provider operates more than one AFH-DD submit the Plan of Daily Operation for each AFH-DD.***