

HOUSEHOLD SERVICES DISABILITY CHECKLIST

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| <input type="checkbox"/> Vacuuming | <input type="checkbox"/> Laundry | <input type="checkbox"/> Driving |
| <input type="checkbox"/> Changing Linens | <input type="checkbox"/> Dusting | <input type="checkbox"/> Cooking |
| <input type="checkbox"/> Running Errands | <input type="checkbox"/> Dishwashing | <input type="checkbox"/> Ironing |
| <input type="checkbox"/> Snow Shoveling | <input type="checkbox"/> Grass Cutting | <input type="checkbox"/> Child Care |
| <input type="checkbox"/> Grocery Shopping | <input type="checkbox"/> Home Repair | <input type="checkbox"/> Bed Making |
| <input type="checkbox"/> Window Washing | <input type="checkbox"/> Trash Removal | |
| <input type="checkbox"/> Other (please specify): | | |

No Need for Assistance

My patient is unable to perform these activities _____ times per week for the period of _____ to _____.

My patient is unable to work from _____ to _____ because he/she cannot perform (please list specific duties)

Physician's signature: _____ Date: _____

Address: _____

Phone: _____ Tax ID#: _____