



3949 N Pulaski Road
Chicago, IL 60641
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HEMOCARE AIDE / HOMEMAKER SERVICE ASSIGNMENT & PLAN OF CARE

Client Name Nelson, Matthew Tel: (815) 977-4546
Address 3303 E State St. Apt. 1218 Rockford IL 61108
Emergency Contact _____ Tel: _____
Homemaker Name Ross, Paulette E Tel: (608) 312-3509
Date Assigned 5-22-2020
Client Condition Needs assistance with ADL\\S

This Plan of Care has to be followed by the Homecare Aide/Homemaker for the above named Client. The Plan of Care is designed to meet the Client's individual needs. It is mandatory to follow the Plan of Care so the Client can best receive the services the State has assigned for him/her. If you cannot adhere to this Plan of Care for the Client, please call your Supervisor and discuss the matter.

The above named Client is to be seen 2 Days a week on:

Mon 0.00 Tue 3.00 Wed 0.00 Thu 3.00 Fri 0.00 Sat 0.00 Sun 0.00

From 12:45pm To 5:30pm 14.25 Hours per week ☐ **Daily Hours** 0.00

Start Date of Services _____

You should provide only the following duties (checked):

<input type="checkbox"/> 1. Eating	<input checked="" type="checkbox"/> 2. Bathing	<input checked="" type="checkbox"/> 3. Grooming
<input checked="" type="checkbox"/> 4. Dressing	<input type="checkbox"/> 5. Transferring	<input checked="" type="checkbox"/> 6. Incontinence
<input type="checkbox"/> 7. Managing Money	<input type="checkbox"/> 8. Telephoning	<input checked="" type="checkbox"/> 9. Preparing Meals
<input checked="" type="checkbox"/> 10. Laundry	<input checked="" type="checkbox"/> 11. Housework	<input checked="" type="checkbox"/> 12. Outside Home
<input type="checkbox"/> 13. Routine Health	<input type="checkbox"/> 14. Special Health	<input type="checkbox"/> 15. Being Alone

Supervisor's Signature _____ Date: _____