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HEMOCARE AIDE / HOMEMAKER SERVICE ASSIGNMENT & PLAN OF CARE

Client Name Anderson, Kathryn Tel/Mob: (815) 222-6834
Address 2122 Sheffield Ct Apt 4 Freeport IL 61032
Emergency Contact Elizabeth Anderson Tel/Mob: (815) 978-9652
Homemaker Name Knutson, Lana J Tel/Mob: (815) 275-2235
Date Assigned 07/28/2020
Client Condition _____

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 Days a week on:

Mon Tue Wed Thu Fri Sat Sun
From _____ To _____ Hours per week **Daily Hours**

Start Date of Services _____

You should provide only the following duties (checked):

<input type="checkbox"/> 1. Eating	<input checked="" type="checkbox"/> 2. Bathing	<input type="checkbox"/> 3. Grooming
<input checked="" type="checkbox"/> 4. Dressing	<input checked="" type="checkbox"/> 5. Transferring	<input checked="" type="checkbox"/> 6. Incontinence
<input type="checkbox"/> 7. Managing Money	<input checked="" 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 checked="" type="checkbox"/> 13. Routine Health	<input type="checkbox"/> 14. Special Health	<input checked="" type="checkbox"/> 15. Being Alone

Supervisor 's Signature _____ Date: _____