



3949 N Pulaski Road
Chicago, IL 60641
Phone: 773-283-0090
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HEMOCARE AIDE / HOMEMAKER SERVICE ASSIGNMENT & PLAN OF CARE

Client Name Lambert, Lucille Tel/Mob: (779) 210-1573
Address 2901 Searles Ave #A104 Rockford IL 61101
Emergency Contact Sheila (dau) Tel/Mob: (815) 961-1185
Homemaker Name Herring, Marilyn D Tel/Mob: (779) 221-4854
Date Assigned 2-27-2020
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 Days a week on:

Mon Tue Wed Thu Fri Sat Sun
From 10:30am To 3:30pm 25.00 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 checked="" type="checkbox"/> 3. Grooming
<input checked="" type="checkbox"/> 4. Dressing	<input checked="" type="checkbox"/> 5. Transferring	<input 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 type="checkbox"/> 15. Being Alone

Supervisor 's Signature _____ Date: _____