



Client Name	<u>Martin, Peggy</u>	Tel: <u>(815) 381-0015</u>
Address	<u>2504 Montana Ave Rockford IL 61108</u>	
Emergency Contact	<u>Dena (dau)</u>	Tel: <u>(815) 566-1563</u>
Homemaker Name	<u>Alloway, Sandra L</u>	Tel: <u>(815) 558-7584</u>
Date Assigned	<u>6-27/28-20</u>	
Client Condition	<u>Needs assistance with ADL\\\'S/Fill-in</u>	

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.

Mon	0.00	Tue	0.00	Wed	0.00	Thu	0.00	Fri	0.00	Sat	4.00	Sun	4.00
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From SAT/SUN To 11am-3pm 8.00 Hours per week **Daily Hours**

Start Date of
Services

You should provide only the following duties (checked):

- | | | |
|---------------------------------|--------------------------|-----------------------------|
| <u>X</u> 1. Eating | <u>X</u> 2. Bathing | <u>X</u> 3. Grooming |
| <u>X</u> 4. Dressing | <u>X</u> 5. Transferring | <u>X</u> 6. Incontinence |
| <u> </u> 7. Managing Money | <u>X</u> 8. Telephoning | <u>X</u> 9. Preparing Meals |
| <u>X</u> 10. Laundry | <u>X</u> 11. Housework | <u>X</u> 12. Outside Home |
| X 13. Routine Health | 14. Special Health | X 15. Being Alone |

Supervisor's Signature _____ Date: _____