



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

Client Name Mcallister, Denise Tel: (815) 601-0643
Address 4337 Eastridge Dr Rockford IL 61107
Emergency Contact _____ Tel: _____
Homemaker Name English, Melissa A Tel: () -
Date Assigned 07/16/2020
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 checked="" type="checkbox"/> 3. Grooming |
| <input checked="" type="checkbox"/> 4. Dressing | <input type="checkbox"/> 5. Transferring | <input 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 _____ Date: _____
Signature _____