



Client Name	Thomas, India	Tel: (815) 968-2129
Address	410 S Henrietta Ave Rockford IL 61102	
Emergency Contact	Sharon	Tel: (815) 971-3502
Homemaker Name	HCP Havens, Elizabeth	Tel: () -
Date Assigned	7-9-20	
Client Condition	Need assistance with ADL'S / Fill-in	

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	0.00	Sun	0.00
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From Thursday To 11-1pm 2.00 Hours per week ☐ **Daily Hours**

Start Date of  
Services

You should provide only the following duties (checked):

<u>    </u> 1. Eating	<u>X</u> 2. Bathing	<u>X</u> 3. Grooming
<u>X</u> 4. Dressing	<u>X</u> 5. Transferring	<u>    </u> 6. Incontinence
<u>    </u> 7. Managing Money	<u>X</u> 8. Telephoning	<u>    </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: \_\_\_\_\_