



Client Name	<u>Yttrie, Sharon</u>	Tel: <u>(779) 772-3285</u>
Address	<u>2901 Searles Ave C109 Rockford IL 61101</u>	
Emergency Contact	<u>Chuck Yttrie</u>	Tel: <u>812 455 1310</u>
Homemaker Name	<u>McDonald, Andrea M</u>	Tel: <u>(779) 207-1604</u>
Date Assigned	<u>7/2/2020</u>	
Client Condition	needs assistance w/ ADLs	

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 4 Days a week on:

Mon	0.00	Tue	4.00	Wed	4.00	Thu	4.00	Fri	4.00	Sat	0.00	Sun	0.00
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From	9a	To	1p	16.00	Hours per week		Daily Hours	0.00
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Start Date of Services

You should provide only the following duties (checked):

<u>X</u> 1. Eating	<u> </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> </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
<u> </u> 13. Routine Health	<u> </u> 14. Special Health	<u>X</u> 15. Being Alone

Supervisor's Signature _____ Date: _____