

3949 N Pulaski Road
Chicago, IL 60641
Phone: 773-283-0090
Fax: 773-5645-818

HOMECARE AIDE / HOMEMAKER SERVICE ASSIGNMENT & PLAN OF CARE

| | | | |
|-------------------|--|------|----------------|
| Client Name | test, sam | Tel: | (815) 713-5798 |
| Address | 5301 East State Street Rockford IL 61107 | | |
| Emergency Contact | 44444 | Tel: | (|
| Homemaker Name | Smith, Sarah | Tel: | (|
| Date Assigned | 07/23/2020 | | |
| 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 0 Days a week on:

| | | | | | | | | | | | | | |
|------|------|-----|------|------|------|----------------|------|-------------|------|------|------|-----|------|
| Mon | 0.00 | Tue | 0.00 | Wed | 0.00 | Thu | 5.00 | Fri | 5.00 | Sat | 0.00 | Sun | 0.00 |
| From | | To | | 0.00 | | Hours per week | | Daily Hours | | 0.00 | | | |

Start Date of
Services

You should provide only the following duties (checked):

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

Supervisor's Signature _____ Date: _____