



Client Name	<u>Davis, Hattie</u>	Tel: <u>(815) 962-8860</u>
Address	<u>111 W State St Apt 309 Rockford IL 61101</u>	
Emergency Contact	<u>Dorothy Young Dtr</u>	Tel: <u>7797701332</u>
Homemaker Name	<u>Adams, Brenda K</u>	Tel: <u>(815) 980-5328</u>
Date Assigned	<u>1-27-2020</u>	
Client Condition	Need assistance with 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.

Mon Tue Wed Thu Fri Sat Sun

From 10am To 2pm 4.00 Hours per week **Daily Hours**

Start Date of
Services

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

Supervisor's Signature _____ Date: _____