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## HEMOCARE AIDE / HOMEMAKER SERVICE ASSIGNMENT & PLAN OF CARE

Client Name Mcallister, Denise Tel: (815) 995-9512  
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  
Signature \_\_\_\_\_

Date: \_\_\_\_\_