



Client Name	<u>Mihailovic, Jovan</u>	Tel: <u>(773) 961-5927</u>
Address	<u>111 W. State Street Apt 507 Rockford IL 61101</u>	
Emergency Contact	<u>N/A</u>	Tel: <u>(</u>
Homemaker Name	<u>Johnson, Lakisa</u>	Tel: <u>(331) 643-3959</u>
Date Assigned	<u>6-21-20</u>	
Client Condition	<u>Need assistance with ADL'S / Fill-in</u>	

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 11:00 To 3:00pm 7.75 Hours per week  **Daily Hours**

Start Date of Services

<u>    </u> 1. Eating	<u>    </u> 2. Bathing	<u>  X  </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>  X  </u> 9. Preparing Meals
<u>  X  </u> 10. Laundry	<u>  X  </u> 11. Housework	<u>  X  </u> 12. Outside Home
13. Routine Health	14. Special Health	15. Being Alone

Supervisor's Signature \_\_\_\_\_ Date: \_\_\_\_\_