



Client Name	<u>Rolando, Maria</u>	Tel: <u>(779) 207-2242</u>
Address	<u>111 W State St Apt 514 Rockford IL 61101</u>	
Emergency Contact	<u>Mike Rolando-son</u>	Tel: <u>(815) 988-4858</u>
Homemaker Name	<u>Hill, Beverly M</u>	Tel: <u>(815) 999-6831</u>
Date Assigned	<u>6-22-20</u>	
Client Condition	<u>Needs assistance with ADL\\\'S</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 9:45am To 1:45pm 4.00 Hours per week **Daily Hours**

Start Date of Services

<u>X</u> 1. Eating	<u>X</u> 2. Bathing	_____ 3. Grooming
<u>X</u> 4. Dressing	_____ 5. Transferring	<u>X</u> 6. Incontinence
_____ 7. Managing Money	_____ 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	X 15. Being Alone

Supervisor's Signature _____ Date: _____