



3949 N Pulaski Road
Chicago, IL 60641
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HEMOCARE AIDE / HOMEMAKER SERVICE ASSIGNMENT & PLAN OF CARE

Client Name Smith, Lavoyne Tel: (815) 315-5395
Address 4940 Hinsdale Ave 4 Rockford IL 61108
Emergency Contact Cameron Smith-son Tel: 815-621-9923
Homemaker Name Beeks, Janeia D Tel: (815) 721-4295
Date Assigned 7-1-2020
Client Condition Needs assistance with ADL\\S

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 _____ 17.00 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 type="checkbox"/> 3. Grooming
<input checked="" type="checkbox"/> 4. Dressing	<input checked="" type="checkbox"/> 5. Transferring	<input checked="" type="checkbox"/> 6. Incontinence
<input type="checkbox"/> 7. Managing Money	<input checked="" type="checkbox"/> 8. Telephoning	<input checked="" type="checkbox"/> 9. Preparing Meals
<input 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 checked="" type="checkbox"/> 15. Being Alone

Supervisor 's
Signature _____

Date: _____