



3949 N Pulaski Road
Chicago, IL 60641
Phone: 773-283-0090
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HEMOCARE AIDE / HOMEMAKER SERVICE ASSIGNMENT & PLAN OF CARE

Client Name test, sam Tel: (815) 713-5798
Address 5301 East State Street Rockford IL 61107
Emergency Contact 44444 Tel: (
Homemaker Name Omalley, William Tel: (815) 713-5798
Date Assigned _____
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 checked="" type="checkbox"/> 1. Eating | <input type="checkbox"/> 2. Bathing | <input type="checkbox"/> 3. Grooming |
| <input checked="" type="checkbox"/> 4. Dressing | <input type="checkbox"/> 5. Transferring | <input type="checkbox"/> 6. Incontinence |
| <input checked="" type="checkbox"/> 7. Managing Money | <input type="checkbox"/> 8. Telephoning | <input type="checkbox"/> 9. Preparing Meals |
| <input checked="" type="checkbox"/> 10. Laundry | <input type="checkbox"/> 11. Housework | <input type="checkbox"/> 12. Outside Home |
| <input checked="" type="checkbox"/> 13. Routine Health | <input type="checkbox"/> 14. Special Health | <input type="checkbox"/> 15. Being Alone |

Supervisor 's _____ Date: _____
Signature _____