Client Assistance Plan

(formerly Plan of Care)

Washington Home Care LLC P.O. Box 1244 Washington, CT 06793 203-577-8979



Client: Address:

First Active: Gender: Birthday:

Contact information/Guarantor/POA/Conservator – Include phone/emails									
Emergency Contact(s):									
S 2									
Client's Level of Function									
DUTIES TO PERFORM									
Bathing	Sun	Mon	Tue	Wed	Thu	Fri	Sat	As Needed	Informational
• Shave			_				_	X	
Shower assistance								X	H
- Shower assistance	_			_				_	
Communication	Sun	Mon	Tue	Wed	Thu	Fri	Sat	As Needed	Informational
 Keep instructions simple 								X	
Dressing	Sun	Mon	Tue	Wed	Thu	Fri	Sat	As Needed	Informational
Assistance								X	
Set clothes out for client								X	ñ
	Sun	Mon	Tue	Wed	Thu	Fri	Sat	As Needed	Informational
Meal Preparation						_			Informational
Breakfast								x	
• Lunch								X	Ш
Miscellaneous	Sun	Mon	Tue	Wed	Thu	Fri	Sat	As Needed	Informational
 Socialization 								x	
Socialization - companionship								x	

AT :
Notes:
Duties to Perform
Service Provider Name:
Please list any other:
Clean the Residence
Light housekeeping
Ambulation
Assistance dressing
Meal Preparation
Transportation to/from appointments, shopping
Assist with shower and dressing
Make bed and vacuum rooms
Empty garbage throughout residence
Laundry
Assist with med reminders
Authorization (if required) – Physician – Sign and date
Authorization – (if any) Guardian/POA/Conservator (Please specify) – Sign and date
Authorization – Guarantor – Sign and date