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):

Client's Level of Function

DUTIES TO PERFORM									
Bathing	Sun	Mon	Tue	Wed	Thu	Fri	Sat	As Needed	Informational
• Shave	☐	☐	☐	☐	☐	☐	☐	☒	☐
• Shower assistance	☐	☐	☐	☐	☐	☐	☐	☒	☐
Communication	Sun	Mon	Tue	Wed	Thu	Fri	Sat	As Needed	Informational
• Keep instructions simple	☐	☐	☐	☐	☐	☐	☐	☒	☐
Dressing	Sun	Mon	Tue	Wed	Thu	Fri	Sat	As Needed	Informational
• Assistance	☐	☐	☐	☐	☐	☐	☐	☒	☐
• Set clothes out for client	☐	☐	☐	☐	☐	☐	☐	☒	☐
Meal Preparation	Sun	Mon	Tue	Wed	Thu	Fri	Sat	As Needed	Informational
• Breakfast	☐	☐	☐	☐	☐	☐	☐	☒	☐
• Lunch	☐	☐	☐	☐	☐	☐	☐	☒	☐
Miscellaneous	Sun	Mon	Tue	Wed	Thu	Fri	Sat	As Needed	Informational
• Socialization	☐	☐	☐	☐	☐	☐	☐	☒	☐
• Socialization - companionship	☐	☐	☐	☐	☐	☐	☐	☒	☐

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