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/Guaranto	or/POA/	Conserv	ator –	Include	e phone	e/emai	ls		
Emergency Contact(s):									
Client's Level of Function									
OUTIES TO PERFORM									
Bathing	Sun	Mon	Tue	Wed	Thu	Fri	Sat	As Needed	Informational
Shave								x	
Shower assistance								X	
Communication	Sun	Mon	Tue	Wed	Thu	Fri	Sat	As Needed	<u>Informational</u>
 Keep instructions simple 								X	
Dressing	Sun	Mon	Tue	Wed	Thu	Fri	Sat	As Needed	Informational
Assistance								X	
 Set clothes out for client 								X	
Meal Preparation	Sun	Mon	Tue	Wed	<u>Thu</u>	Fri	Sat	As Needed	Informational
Breakfast								X	
• Lunch								X	
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							