RISE & SHINE HEALTH CARE

PLAN OF CARE

Name of Client:

Name of Client's Representative (if applicable):

Street Address | City | State | Zip Code

Emergency Contact Name | Relationship | Phone Number

Doctor's Name | Phone Number

Referred By Health Professional, self, friend, family, etc.):

Functional Limitations:

Hearing Speech Vision Mobility Swallowing Breathing

Performing Activities of Daily Living Performing Instrumental Activities of Daily Living

Cognition Special diet and /or Nutritional Needs Allergies Medications

Other: **medication, diet and insulin treatment to be handled by family members (not by R&S employees).**

Goals/Outcomes:

Services Requested	√	Frequency (per visit, per request, daily, weekly, etc.)	Services Requested	√	Frequency (per visit, per request, daily, weekly, etc.)
Homemaking/Housekeeping					
Vacuum/Sweep Floors			Clean Refrigerator (inside)		
Dust Furniture			Defrost Refrigerator		
Polish Furniture			Clean Oven/Microwave		
Clean Mirrors			Clean Bathroom Sink		
Wet Mop Floors			Clean Bathtub/Shower		
Clean Kitchen Surfaces			Clean Toilet		
Clean Inside Windows			Make Bed		
Change Bed Linen			Prepare Breakfast		

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Services Requested	√	**Frequency** (per visit, per request, daily, weekly, etc.)	Services Requested	√	**Frequency** (per visit, per request, daily, weekly, etc.)
Homemaking/Housekeeping					
Prepare Lunch			Prepare Dinner		
Prepare Food for Next Day			Laundry (Washer & Dryer)		
Laundry (Hand Wash)			Laundry(Laundromat)		
Hang Out Clothes to Dry			Other		
Companion/Sitter					
Companionship/Supervision & Overseeing of Client's Activities			Incidental Duties Including Housekeeping & Laundry		
Transportation & Escort			Socialization Activities		
Taking Client for Walk			Meal Preparation, Serving & Clean Up		
Medication Reminding			Assistance with Correspondence		
Shopping			Bill paying		
Other			Other		
Personal Care					
Assisting with Bath/Shower			Sponge Bath		
Bed Bath			Wash Hair		
Stand by For Safety			Shaving with electric razor (face, legs, underarms)		
Brush Teeth			Clean Dentures		
Clean Hearing Aid(s)			Clean Nasal Cannula		
Nail Care(Filing)			Routine Skin Care		
Dressing/Undressing			Wash Hands & Face		
Toileting-Toilet, Commode, Bedpan			Toilet Hygiene		
Assisting with Feminine Hygiene Needs			Changing Incontinency Products (i.e., Depends)		
Assistance Eating& Drinking Utensils, Adaptive Devices			Supervision/Encouragement		
Transferring			Positioning		
Assist with Walking/Wheelchair, Cane			Assist with Exercising		
Take Client for Walk					
Medication Reminding			Other		
Respite					
(List duties/tasks to be performed by support worker)					

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Services Requested	√	Frequency (per visit, per request, daily, weekly, etc.)	Services Requested	√	Frequency (per visit, per request, daily, weekly, etc.)
Friendly Reassurance/Phone Check/Home Visit					
Friendly Home Visit Check			Other		
Telephone Check/Monitor			Other		
Chores-Intermittent					
Heavy cleaning (floors, walls, carpets, rugs, exterior windows, patio, etc.)			Lawn & Garden Maintenance (cut grass, rake leaves, edging, etc.)		
Clearing sidewalks of ice, snow, etc.			Miscellaneous Handyman Tasks		
Other			Other		
Other			Other		
Miscellaneous Services					
Grocery Shopping			Errands (paying bills, pick up mail, prescriptions, etc.)		
Special Requests/Needs			Money/Financial Management		
Other:			Other:		
Other:			Other:		
Support Systems Already in Place					
Referrals					
Referrals Required: Yes: No: Referrals are specified in *Client Consent for Referral & Release* of Information Form					
Other					

Directions/Treatments/Orders:

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The Services that the Agency will be providing are (If missing from above):

1

2

3

4

5

6

7

Days & Times & Number of Hours of Service (specify AM or PM)

Day: **Time:** **Number of Hours:**

Day: **Time:** **Number of Hours:**

Day: **Time:** **Number of Hours:**

Day: **Time:** **Number of Hours:**

Day: **Time:** **Number of Hours:**

Day: **Time:** **Number of Hours:**

Service Start Date: **Service End Date: (TBD)**

Costs for Services

Service	Regular Hourly Rate	Overtime Rate	Stat Holiday Rate	Weekly Rate	
Homemaking	$	$	$	$	$
Companionship	$	$	$	$	$
Personal Care	$	$	$	$	$
Other	$	$	$	$	$

Total Cost: $30.00/hr.

Acknowledgments:

I acknowledge that:

1. I have been given a copy of the Client Handbook & Home Safety Checklist and/or information has been discussed/provided to me including, but not limited to:

Roles & Responsibilities   Code of Ethics   Costs & Billing   Service Agreement
Confidentiality of Client Information   Agency Contact Information   Client Rights
Client Access to Information   Protected Health Information   Privacy Practices
Elder Abuse   Child Abuse   Consent for Release of Information   Filing Complaints
Federal False Claims Act   Advance Directives   Home Safety   Other

2. I participated in the development of this *Plan of Care.*

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Client/Representative's Agreement or Refusal to Consent:

I DO CONSENT to accept the Non-Medical Home Services discussed and recorded in this Plan of Care. I understand that my service requests/needs will be reviewed by the Supervisor/Registered Nurse/Qualified Professional at least every 3 months or as required and, with my input, service(s) may be changed.

Client/Representative's Signature: Date

Agency Representative's Signature: Date