 **INDEPENDENT LIFE AT HOME SERVICE PLAN**

**Client Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SSN\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Client Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Client Phone Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Alternate Phone Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Family Member:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Family Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Family Phone Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Alternate Phone Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Physician Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Physician Phone Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Primary Diagnosis:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Secondary Diagnoses:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Allergy (ies): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Medically Frail/Compromised? 🞎 Yes 🞎 No**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**ILAH Representative, Title Date**

**Independent Life at Home Service Plan**

**Client Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SSN\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Functional Limitations** | | | | | |
| **Please check all that apply and provide a brief description.** | | | | | |
| **Functional Area** | | | **Describe in detail, e.g. “cannot stand or transfer unassisted or cannot hear or understand speech at normal volume”, etc.** | | |
|  | **Eating/Swallowing** | |  | | |
|  | **Receptive & Expressive Language (Speech/Hearing)** | |  | | |
|  | **Mobility/Ambulation** | |  | | |
|  | **Cognitive Function (due to Alzheimer’s, mental retardation, head trauma, etc.)** | |  | | |
|  | **Breathing** | |  | | |
|  | **Vision** | |  | | |
|  | **Behavior/Emotional** | |  | | |
|  | **Other** | |  | | |
| **Medication & Prescriptions** | | | | | |
| **Please check all that apply.** | | | | | |
|  | **Blood Thinners:** | |  | **Heart Meds:** | |
|  | **Blood Pressure:** | |  | **Cholesterol:** | |
|  | **Psychotropics:** | |  | **Insulin:** | |
|  | **Seizure:** | |  | **Other:** | |
| **Medical Support**  **Services/Treatment Required** | | **Home/Apartment** | | **Assistive Equipment** | **Prescribed Special Diet** |
| **🞎 None**  **🞎 Skin Care**  **🞎 Wound Care**  **🞎 AccuCheck**  **🞎 Peritoneal Care**  **🞎 Assistance with self-administration of Medication**  **🞎 Assistance with Foley Care**  **🞎 Other** | | **🞎 Full wheelchair accessible**  **🞎 Partially wheelchair accessible**  **🞎 Accessible means of escape**  **🞎 Located close to stores and/or public transportation**  **🞎 Individual /family vehicle available**  **🞎 Other** | | **🞎 None 🞎 Gait Belt**  **🞎 Cane/Crutches 🞎 Stair glide**  **🞎 Walker 🞎 Hearing Aid**  **🞎 Wheelchair 🞎 Glasses**  **🞎 Shower Chair 🞎 Dentures**  **🞎 Mechanical Lift (Hoyer)**  **🞎 Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | **🞎 Regular Diet**  **🞎 Low Fat 🞎 Low Salt**  **🞎 Diabetic 🞎 High Fiber**  **🞎 Low Cholesterol**  **🞎 Calorie-restricted**  **🞎 Liquid**  **🞎 Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |

**Independent Life at Home Service Plan**

**Client Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SSN\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**The following services will be provided by a Personal Care Assistant according to the schedule outlined in this plan of care. A duplicate task list will be left in the client’s home. Any changes to the task list will be reported to the Director of ILAH or designated RN who will then revise the plan of care/task list as needed.**

**Where needed, circle the correct method of delivery, e.g. give or assist, etc. Indicate Frequency as 1 x week, daily, etc.**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **SOCIAL** | **Frequency** |  | **BATHING** | **Frequency** |  | **DRESSING** | **Frequency** |
|  | **Orient time, place, person** |  |  | **Give or Assist with Tub Bath** |  |  | **Assist with Dressing** |  |
|  | **Encourage Conversation** |  |  | **Give or Assist with Tub Bath Daily** |  |  | **Assist with Undressing** |  |
|  | **Read to Client** |  |  | **Give Bed Bath Daily** |  |  | **HYGIENE** |  |
|  | **Play Cards, Games etc.** |  |  | **Assist with Shower** |  |  | **Assist with Peri-Care** |  |
|  | **GROOMING** |  |  | **Give or Assist with Sponge Bath** |  |  | **Assist with Hand Hygiene** |  |
|  | **Assist with or Shampoo Hair Weekly** |  |  | **SKIN CARE** |  |  | **Assist to Toilet** |  |
|  | **Assist or Comb/Brush Hair** |  |  | **Offer Back Rub** |  |  | **Assist to Bedside Commode (bsc)** |  |
|  | **Nail Care (file only)** |  |  | **Offer Foot Soak** |  |  | **Assist with Bedpan** |  |
|  | **Assist with or Provide Oral Care** |  |  | **Assess for Changes in Skin** |  |  | **Incontinence Care (chg diaper every 2 hrs)** |  |
|  | **Clean Dentures** |  |  | **Reposition every 2 hours** |  |  | **Empty Catheter or Colostomy Bag** |  |
|  | **Shave 🞎 Electric Razor**  **🞎Regular Razor** |  |  | **Apply Lotion 🞎feet/legs**  **🞎hands/arms 🞎back 🞎other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |  |  | **MOBILITY** |  |
|  | **ENVIRONMENT** |  |  | **Apply Powder** |  |  | **🞎Assist with Ambulation** |  |
|  | **Make Bed** |  |  | **NUTRITION** |  |  | **🞎Cane** |  |
|  | **Change Linens** |  |  | **Prepare 🞎 b’fast🞎lunch🞎dinner** |  |  | **🞎Crutches** |  |
|  | **Wash Dishes** |  |  | **Set up Meals** |  |  | **🞎Walker** |  |
|  | **Sweep/Vacuum** |  |  | **Assist or Feed Client** |  |  | **🞎Gait Belt** |  |
|  | **Mop** |  |  | **Prepare Nutritional Supplement** |  |  | **🞎Mechanical Lift (Hoyer)** |  |
|  | **Empty Trash** |  |  | **Encourage Fluids** |  |  | **🞎Upper Range of Motion** |  |
|  | **Clean Refrigerator** |  |  | **Limit Fluids** |  |  | **🞎 Lower Range of Motion** |  |
|  | **Clean Stove/Oven** |  |  | **MEDICATIONS** |  |  | **🞎Assist with Transfer** |  |
|  | **Personal Laundry** |  |  | **Reminder🞎am🞎noon🞎pm🞎bedtime** |  |  | **🞎 Assist with Wheelchair** |  |
|  |  |  |  |  |  |  |  |  |
|  | **VITAL SIGNS** | **Frequency** |  | **OTHER** | **Frequency** |  | **OTHER SPECIFIC TASKS** | **Frequency** |
|  | **Blood Pressure** |  |  | **Universal Precautions** |  |  |  |  |
|  | **Pulse** |  |  | **Transport to Appointments** |  |  |  |  |
|  | **Respirations** |  |  | **Shop for Client** |  |  |  |  |
|  | **Temperature** |  |  | **Shop with Client** |  |  |  |  |
|  | **ALLERGIES** |  |  | **EVACUATION PLAN** |  |  | **EMERGENCY PLAN** |  |
|  |  |  |  |  |  |  | **Call 911 🞎 Yes 🞎 No** |  |
|  | **SPECIAL CONDITIONS** |  |  | **Element of Service** |  |  |  |  |
|  |  |  |  | **⎕ Personal Care**  **⎕ Companion Care**  **⎕ Skilled Nursing Care** |  |  |  |  |

**Independent Life at Home Service Plan**

**Client Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SSN\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Special Instructions for Tasks to be Performed:** (If applicable, describe in full detail how the specific tasks are to be performed at the request of the client):

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Goals/Objectives of Personal Care: To provide supportive services so that the client may maintain an optimal level of independent functioning at home.**

**Discharge Plan: Client receiving services will be discharged when services are no longer desired or when client is able to function independently without assistance.**

**This plan was developed with input from the client and /or his/her family member/responsible party.**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Family Member/Responsible Party Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ILAH Supervisor/Director Date

**Independent Life at Home Service Plan**

Start time + End time = Duration Expected (how long staff will remain in home to accomplish task)

|  |  |  |  |
| --- | --- | --- | --- |
| **FREQUENCY** | **START TIME** | **END TIME** | **PERSONAL CARE; COMPANION/SITTER;**  **NURSING** |
| **Sunday** | **am** |  |  |
|  | **pm** |  |  |
| **Monday** | **am** |  |  |
|  | **pm** |  |  |
| **Tuesday** | **am** |  |  |
|  | **pm** |  |  |
| **Wednesday** | **am** |  |  |
|  | **pm** |  |  |
| **Thursday** | **am** |  |  |
|  | **pm** |  |  |
| **Friday** | **am** |  |  |
|  | **pm** |  |  |
| **Saturday** | **am** |  |  |
|  | **pm** |  |  |