All Heart HOME CARE

Client ID#: _____

SERVICE CARE PLAN

Name of Client: _____

Name of Client's Representative (if applicable): _____

_____

Client Street Address | City | State | Zip Code

_____

Client Home Phone No. | Cell Phone No. | Email Address

Emergency Contact 1:		Emergency Contact 2:	
Name		Name	
Relationship		Relationship	
Mobile Phone		Mobile Phone	
Other Phone		Other Phone	
Email		Email	
Preferred Method	☐ Call ☐ Text ☐ Email	Preferred Method	☐ Call ☐ Text ☐ Email

Preferred order to contact in an emergency: 1. _____ 2. _____

Care Goals: (What is most important to you and your family? Safety, remaining at home, socialization, etc.)

_____

_____

Care Coordination Notes: (Anything you want all caregivers and office staff to know – communication preferences, who to update, etc.)

_____

_____

Demographics: Care for 2 People Enter: **H** = Husband | **W** = Wife | **B** = Both			
Date of Birth		Lives With	
Height		Religion	
Weight		Attends Services	
Gender		Do Not Resuscitate	
Marital Status		Languages	
Spouse Name		Past Profession	

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Services Requested	Frequency (per request, per visit, 1x, as needed)	Services Requested	Frequency (per request, per visit, 1x week, as needed)
Instrumental Activities of Daily Living (IADLs)			
Light Housekeeping: (Limited to 20% of the Scheduled Shift) Limited to Client's Living Space			
Housework		Observation (companionship)	
Laundry (cleaning, ironing, folding, & putting away clothes		Preparing Meals (opening containers, cooking, serving & cleanup. ☐ Breakfast ☐ Lunch ☐ Dinner ☐ Snack	
Shopping (navigating a store, making selections, and paying			
Medical Conditions: List any chronic or acute conditions as well as recent hospital/skilled nursing stays			
		☐ Smoker ☐ Sensitive to Smell ☐ On Oxygen ☐ Colostomy Bag ☐ Feeding Tube	
		Functional Limitations:	
Hearing ☐ Good ☐ Poor ☐ Deaf ☐ Hearing Aid		☐ Amputation ☐ Hearing ☐ Ambulation ☐ Dyspnea with Minimal Exertion ☐ Bowel/Bladder (Incontinence) ☐ Paralysis ☐ Speech ☐ Contracture ☐ Endurance ☐ Legally Blind	
Hearing Aid Stored:			
Speech ☐ Good ☐ Poor ☐ None			
Vision ☐ Good ☐ Poor ☐ Blind ☐ Glasses			
Swallowing ☐ Good ☐ Poor ☐ None			
Mental / Behavior Conditions: Diagnosed Disorders / Medications:			
☐ Depression ☐ Lethargy ☐ Past/Current Substance Abuse		Can client be left alone?	☐ Yes ☐ No
☐ Other:		Wanderer?	☐ Yes ☐ No
		Dementia: ☐ No ☐ Forgetful ☐ Mild ☐ Moderate ☐ Severe	

Symptoms:				
☐ Frequent Mood Changes	☐ Paranoia	☐ Completing Tasks	☐ Withdrawal	☐ Sleeping Problems
☐ Short Term Memory Loss	☐ Confusion of Time/Place	☐ Misplacing Items	☐ Wandering	☐ Fear
☐ Spatial/Visual Relationships	☐ Repetition	☐ Poor Judgement	☐ Problem Solving	☐ Aggression
☐ Speaking / Conversing	☐ Comatose	☐ Agitation	☐ Sundowning	☐ Depression
☐ Anxiety	☐ Hallucinations	☐ Suspicion	☐ Poor Eating	☐ Oriented

Triggers or calming strategies caregivers should know:

Allergies:			
☐ No known Drug Allergies	☐ Drug Allergies	☐ No known Food Allergies	☐ Food/Environmental Allergies
List:		List:	
Reaction(s):		Reaction(s):	

Elimination:	
Incontinence: ☐ Urination ☐ Bowels	Wears Briefs: ☐ Accident Protection or ☐ Full Incontinence
Issues: ☐ Constipation ☐ Diarrhea ☐ Urination	Notes:

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Medications and Supplements Reminder:			
Needs medication / supplement reminders?	☐Yes ☐ No	Is there a separate medication / supplement schedule sheet?	☐Yes ☐ No
Who manages medications / supplements?		Number of medications / supplements?	
Medications / supplements set up in pill box?	☐Yes ☐ No	Notes:	
How many weeks are set up?			
What time is the medication / supplement administered?			
☐ first thing in the morning ☐ with breakfast ☐ with lunch ☐ with dinner ☐ at bedtime ☐ before breakfast ☐ before lunch ☐ before diner ☐ once a day ☐ once a week ☐ once a month Specific times of day: _____ _____ _____ _____			
Ambulation:			
Aids:		Fall Risk:	
☐ Cane ☐ Walker ☐ Wheelchair ☐ Geri-Chair ☐ Scooter		☐ Fall Risk ☐ No History ☐ Poor Balance	
Notes:		Use of Arms / Hands ☐ Left ☐ Right	
Transfers:			
Transfer Types:		Aids: ☐ Gait Belt ☐ Hoyer ☐ Other:	
Transfer Risks:		Notes:	
Bathing, Grooming & Dressing:			
☐ Resists Bathing		☐ Uses Shower Bench	
Method: ☐ Shower ☐ Bath ☐ Sponge bath		Hygiene: ☐ Dental / Dentures Care ☐ Skin Care	
Bathing Frequency:		☐ Other:	
Dressing:		Notes:	
☐ Dresses Self ☐ Light Assistance ☐ Heavy Assistance ☐ Total Assistance			
Meals:			
Assistance: ☐ Cooking ☐ Preparation ☐ Feeding		Appetite: ☐ Good ☐ Poor	
Diet: ☐ Poor Nutrition ☐ Desires Improved Nutrition ☐ Special Diet		Special Diet:	
Times: ☐ Breakfast: _____ ☐ Lunch: _____ ☐ Dinner: _____ ☐ Snacks: _____			
Other: ☐ Swallowing Issues ☐ Encourage Liquids		Notes:	
Favorite Foods:			
Breakfast:			
Lunch:			
Snack:			
Driving:			
Vehicle: ☐ Client Drives ☐ Needs Caregiver to: ☐ Client's Car ☐ Aide's Car ☐ Driving is Not Required			
Other: ☐ Errands:		☐ Doctor's Appointment(s):	
Where can the caregiver park their vehicle?			
Is a parking permit required? ☐ YES ☐ NO			

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Exercise:			
Importance: ☐ 1 (least) ☐ 2 ☐ 3 ☐ 4 ☐ 5 (most)		☐ Does the client have specific exercise/rehab regimen?	
☐ Encourage exercises?		Notes:	
Sleep Patterns:			
Goes to Bed at:		Wakes Up at:	
☐ Sleeps through night ☐ Frequently awakens ☐ Gets up for toileting ☐ Difficulty returning to sleep			
☐ Needs assistance at night from caregiver? ☐ Naps during day: Time: Duration:			
Equipment / Environment:			
☐ Bedrails ☐ Hospital Bed ☐ Bed Commode ☐ Grab Bars ☐ Lift Chair ☐ Raised Toilet Seat ☐ Shower Bench ☐ Handheld Showerhead ☐ Has Lifeline Pendant (or equivalent)			
Gate / Access Instructions:			
Gate Code:	Lockbox Code:		
Are there cameras installed in the home? ☐ YES ☐ NO		If YES, do the cameras record or monitor audio? ☐ YES ☐ NO ☐ N/A	
If YES, a warning sign is required to be posted at the front door. Is there a sign posted? ☐ YES ☐ NO ☐ N/A			
If YES, where are the cameras located?			
Pet Care:			
☐ Cat ☐ Cat Litter Box ☐ Dog ☐ Feeding ☐ Walk Dog ☐ Other:			
If a dog is present, has it ever bitten or physically attacked someone? ☐ YES ☐ NO			
Notes:			
Daily Routine:			
Activities Permitted: (check all that apply)			
☐ Complete Bedrest	☐ Bedrest BRP	☐ Up as Tolerated	
☐ Transfer Bed/Chair	☐ Exercises Prescribed	☐ Partial Weight Bearing	
☐ Independent at Home	☐ Crutches	☐ Cane	
☐ Wheelchair	☐ Walker	☐ No Restrictions	
Morning Routine:			
Afternoon Routine:			
Evening Routine:			
Activities:			
Activities at home: (e.g. reading, board games, hobbies, music):			
Activities away from home: (e.g. parks, gardens, outings, lunches, etc.):			
Favorite restaurants / shops:			
Family / friends / neighbors:			

Services Home Care Organizations and Home Care Aides MAY NOT provide:

Home Care Organizations are prohibited from arranging for medical services and Home Care Aides cannot provide any medical services to clients. There is no waiver or any other type of consent that removes this prohibition as medical services may only be administered and provided by an authorized medical professional. The following list contains examples of services, but is not an all-inclusive list, that Home Care Aides **cannot provide**:

- Diabetic Insulin Shots
- Catheter Care
- Bed Sore Treatment
- Physical Therapy
- Glucose Reading
- Tracheostomy Care
- Tube Feedings and Care
- IV Insertions
- Blood Pressure
- Ventilator Dependent Care
- Colostomy Bag Care
- Enemas
- Vital Signs
- Post-surgery Wound Care
- Full Assist
- Single Caregiver Hoyer Lift Assistance
- Medication Assistance*

*Home Care Aides (HCA) may assist with medication that a client self-administers; however, HCAs are not authorized to assist with medication that requires administration or oversight by a licensed medical professional. For example, a HCA may remind clients to take their medication; however, they may not directly provide it to the client. An HCA may instruct clients to fill a pillbox per their physician's instructions but cannot fill the pillbox for them. There is no "medication waiver" that will allow the Home Care Organization or HCA legal authority to assist with or provide medication.

Date Service Plan Prepared: _____ Service Start Date: _____

Name of Individual Preparing Service Plan: _____

Please Note: **The service plan is subject to change based on adequate notice between Client and All Heart Home Care. Contact the All Heart Home Care office at 619-736-4677 for any modifications to the service plan. Any additions to the Service Plan must be reviewed and approved by the CEO.**

_____ _____

Client/Client's Representative's Signature **Date**

_____ _____

Agency Authorized Signature & Position **Date**