SSA/IHA/09-001-S
Attachment aa

Local Department: _______________
Client's Name: __________________

IHAS CARE PLAN
PERSONAL CARE PLAN
(TO BE COMPLETED BY A REGISTERED NURSE OR DOCTOR)
(CHECK APPLICABLE ITEMS)

SECTION	A	A/C	C	V**	COMMENTS
1. Bath – Bed					
2. Bath – Chair					
3. Hair – Comb					
4. Hair – Shampoo					
5. Mouth Care/Denture Care					
6. Fingernails – clean					
7. Fingernails – File ____ Cut _____					
8. Toenails – Clean					
9. Toenails – File _____ Cut ____					
10. Shave*					
11. Help with Toileting					
12. Help with Dressing					
13. Help with Walking					
14. Help with Feeding					
15. Change Position					
16. Simple Range of Motion					
17. Transfer					
18. Urge Fluids					
19. Special Skin care or Dressing Specify in "Comments"					
20. Measure Intake and Output					
21. Observe Medications					
22. Other:					
23. Other:					

Is In-Home demonstration necessary for an aide to safely perform any of the personal care activities checked above?

Yes _____ Numbers ______ No _______

When should the client's need for personal care be revaluated ____
(No more than 6 months from date of this assessment)

Special precautions/comments: ____

____

____

Nurse or physician's signature ____
Date Phone #

*Physician's signature required ____
Date Phone #

Agency ____

TO BE COMPLETED BY THE IHAS

Plan for periodic nursing supervision ____

____

Date of in home demonstration by nurse if necessary

**Explanation of Code A=Function performed mostly by Aide
A/C = Function performed jointly by Aide and Client
C= Function performed mostly by Client
V= Volunteer Assistance

DHR/SSA 525-B (7/94)