

CSA 525-A	IHAS CARE PLAN AGREEMENT
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A. Client:	Client ID #:
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B. Goals for IHAS (Check applicable items)	
<input type="checkbox"/> To provide short-term care to persons who are acutely ill <input type="checkbox"/> To teach home management, self-care or caretaking skills <input type="checkbox"/> To achieve a satisfactory level of comfort and dignity during illness <input type="checkbox"/> To care for disabled adult or child when primary caregiver is absent <input type="checkbox"/> To promote a safe environment <ul style="list-style-type: none"> <input type="checkbox"/> Assisting client to limit activities <input type="checkbox"/> Teach client/caretaker to avoid frustrating/unsafe procedures 	<input type="checkbox"/> To provide long term maintenance to: <ul style="list-style-type: none"> <input type="checkbox"/> maintain client capacity <input type="checkbox"/> retard disease progression <input type="checkbox"/> prevent regression/complications <input type="checkbox"/> detect early signs of changes in client's condition <input type="checkbox"/> To promote: <ul style="list-style-type: none"> <input type="checkbox"/> Independence <input type="checkbox"/> Activity <input type="checkbox"/> Proper diet <input type="checkbox"/> Social contact
<input type="checkbox"/> Other measurable goal:	

Describe the specific results expected from the Aide Service:	Indicate the expected length of service:
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C. Specify Tasks to Be performed:	Check who performs					Instructions/Comments
	Aide	Aide& Client	Client	Volunteer	Frequency/ Week	
1. Personal Care 525B must be completed						
2. Respite Care / Supervision						
3. Make / Change bed						
4. Vacuum / sweep / mop floor						
5. Tidy living areas / empty trash						
6. Wash dishes / clean kitchen appliances						
7. Laundry / Lt. Ironing / Mending						
8. Plan/Prepare B L D S / Shop for food						
9. Assist with: budgeting / paying bills						
10. Care of Assistive Devices						
11. Transportation/Escort: Medical/Rx						
12. Trans/Escort: food, clothes, housing, job						
13. Teach (specify in comments)						
14. Other (specify in comments)						

D. To be completed by IHAS:	Date Service is expected to begin:
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The following are the maximum number of hours authorized to complete the tasks specified above:			
Task	# days/week	# hours/day	Agency

E. Client Agreement: *I agree and approve the above services. I agree to adhere to the all of the following:*

- 1. I agree to provide the aide with the equipment necessary to perform the above tasks.
- 2. I understand that IHAS is not responsible for any damage to that equipment.
- 3. I agree to be at home on the dates the aide is to perform these tasks or notify in advance: Name _____ Phone: _____
- 4. I understand that the services I am receiving will be re-evaluated periodically and that the services may be suspended or terminated with notice.
- 5. I understand that purchases services will be subject to the continued availability of funds and services. Such services may be suspended or terminated with notice if funding or service is no longer available.
- 6. I give permission to DSS to share information with other agencies, professional, when this is necessary to plan treatment or coordinate service.
- 7. I agree to pay a fee of \$____ per hour that is based on my income in accordance with the State Service Eligibility as issued by the Department.

Signatures:

Client/Caretaker: _____ Date: _____ Phone: _____

IHAS Supervisor: _____ Date: _____ Phone: _____

Case Manager: _____ Date: _____ Phone: _____