EST. 1982
MISSOULA *aging* SERVICES
SENIOR CORPS

337 Stephens
Missoula, MT 59801
406.728.7682 office
406.728.7687 fax
www.missoulaagingservices.org

SCP Client Care Plan

Volunteer Station: _____

Volunteer Station Manager: _____ **Telephone:** _____

Senior Companion: _____ **Telephone:** _____

Client Name: _____ **B-day (month and day):** _____

Veteran or Veteran's Spouse / Widow (circle one): Yes No

Home Telephone:_____ **Cell:** _____

Address:_____
street **city** **state** **zip**

Emergency Contact Name: _____ **Relationship**:_____

Home Telephone:_____ **Work Telephone:**_____**Cell:**_____

Primary Care Physician Name: _____ **Telephone:** _____

Preferred Hospital: _____

Services Start:_____

Schedule Days: **M** _____ **T** _____ **W** _____ **Th** _____ **F**_____
Time: _____ _____ _____ _____ _____

Needs Assessment: Please check all information which applies. You are encouraged to use the space on the opposite side of this care plan/agreement for additional information.

- ☐ **Companionship:** visiting, reading, playing games assist client in arranging and/or accompanying social or recreational activities.
- ☐ **Simple Chores:** shopping, doing errands, letter writing, fill out forms, and prepare food.
- ☐ **Medical:** arrange transportation; assist in obtaining and/or accompanying clients to medical services.
- ☐ **Respite/Caregiver Relief:** provide respite for spouse or primary giver.
- ☐ **Waiver Program**

Health Needs of Client: ☐ **Diabetic** ☐ **Seizure** ☐ **Fainting** ☐ **Memory**

☐ **Uses Cane or Walker** ☐ **Difficulty Walking** ☐ **Difficulty Breathing**

☐ **Vision Impairment** ☐ **Hearing Impairment** ☐ **Developmental Disability**

☐ **Other:** _____

Please complete side two of this form

EST. 1982
MISSOULA *aging* SERVICES
SENIOR CORPS

337 Stephens
Missoula, MT 59801
406.728.7682 office
406.728.7687 fax
www.missoulaagingservices.org

Additional Information: _____

_____

_____

_____

Signature below of client, client's legal guardian or contact at physical residence provides permission: the designated Senior Companion to provide the services outlined in this care plan/agreement, the Senior Companion to release medical information of the client to emergency personnel in the event of an emergency. This care plan/agreement may be terminated at any time upon request of any of the undersigned parties. ***Copies of this care plan/agreement are to be distributed to each party.***

Volunteer Station Manager: _____ **Date:** _____

Client or Legal Guardian: _____ **Date:** _____

Senior Companion:_____ **Date:**_____

Other Case Managers involved with client: _____ **Date:** _____

_____ **Date:** _____

If not living at home:

Physical Residence: _____

Contact: _____ **Date:** _____

Contact: _____ **Date:** _____

It is our expectation that the Volunteer Station Manager will have all other responsible parties sign this document. ***The Senior Companion must be actively involved in this process***. Without the Senior Companion's active participation in the design of this Care Plan, it is very difficult for them to fulfill their role. We appreciate your help with this. Thank you.