ELITE CARE AT HOME

CLIENT NAME: _____

CHECK ONE:
☐ HOME MAKING/CMP. ☐ NURSE VISIT
☐ PERSONAL CARE ☐ THERAPY VISIT

DATE	DAY	IN	OUT	IN	OUT	TOTAL HOURS WORKED	MILEAGE	CLIENT SIGNATURE (TO BE SIGNED DAILY)
	MONDAY							
	TUESDAY							
	WEDNESDAY							
	THURSDAY							
	FRIDAY							
	SATURDAY							
	SUNDAY							
TOTAL HOURS WORKED/BILLABLE FOR THE WEEK								

Important Information for Client: By signing this form, client certifies that hours shown are correct and work was done satisfactory.

ACTIVITIES	MON	TUES	WED	THUR	FRI	SAT	SUN	Comments With Date
Personal Care:								
Bathing								
Dressing								
Ambulation								
Transfers								
Feeding								
Toileting								
Incontinence								
Shampoo								
Oral Care								
Hair Care								
Skin Care								
Hand/Foot Care								
Shave								
Assist With Meals								
Positioning								
ROM Exercise								
Vital Signs								
Companionship/Homemaker Services:								
Companionship								
Remind Medications								
Meal Preparations								
Linen Changes								
Bed Making								
Laundry								
Vacuum								
Dusting								
Mop/Sweep								
Clean Bathroom								
Clean Kitchen								
Shopping/Errands								

I have reported to management all injuries and illnesses arising from this assignment and I have not been subject to harassment in the workplace.

HHA / CNA / LPN / RN / PT / OT / ST (Please Circle One)

Print Employee Name: _____ Employee Signature: _____ ____/____/____