NAHC

ACHC ACCREDITED

☐ PERSONAL CARE ☐ RESPITE ☐ COMPANION
☐ HOMEMAKER ☐ ESCORT
☐ OTHER:

Patient Name: _____

M.R # _____

AIDE ACTIVITY NOTE

		SUN	MON	TUES	WED	THUR	FRI	SAT
	DATE							
	REGULAR VISIT							
	REFUSE VISIT							
	TIME IN:							
	TIME OUT							
VITALS / VITALE	Temperature							
	Pulse							
	Respiration							
	Last Elimination Bowel							
	Urine							
PERSONAL CARE DUTIES	BATH-TUB/SHOWER/BED/BENCH/CHAIR							
	HAIR CARE SHAMPOO							
	HAIR CARE BRUSH							
	ORAL CARE - BRUSH/SWAB/DENTURES							
	DRESS/UNDRESS							
	SKIN CARE/FOOTCARE/(HYGIENE)							
	SHAVE/GROOM/DEODORANT							
	NAIL HYGIENE - CLEAN/FILE/REPORT							
	AMBULATION ASSIST - WC/WALKER/CANE							
	TRANSFER ACTIVITY							
	CHANGE POSITION							
	INCONTINENCE CARE							
	TOILETING ASSIT							
	RANGE OF MOTION (ROM)							
	COMODE/BED PAN ASSIST							
	MEAL PREPARATION							
	ASSIST WITH FEEDING							
	MAKE BED / CHANGE LINEN							
	LIMIT/ENCOURAGE FLUIDS							
	EMOTIONAL SUPPORT							
	CHECK PRESSURE AREA							
HOMEMAKER DUTIES	LAUNDRY							
	CLEAN BATHROOM							
	CLEAN BEDROOM							
	CLEAN KITCHEN							
	CLEAN LIVING ROOM							
	MEAL PREPARATION							
	EMPTY TRASH							
	VACUUM/SWEEP/ DUST							
	WASH DISHES							
OTHER DUTIES	RESPITE SERVICES							
	COMPANION							
	CHORES							
	ESCORT							
	SHOPPING							
	INFECTION CONTROL							
	FOLLOW UNIVERSAL PRECAUTIONS							
	SAFETY PRECAUTIONS							
	OTHER (only if is in the Care Plan):							

DATE: COMMENTS:

EMPLOYEE NUMBER _____

HHA SIGNATURE _____

WITH MY SIGNATURE, I DO CERTIFY THAT THE SERVICES MENTIONED HAVE BEEN PROVIDED BY ME AND THE CLIENT SIGNED THIS DOCUMENT ON MY PRESENCE.

TOTAL HOURS _____

AIDE/PERSONAL CARE SERVICES PLAN

www.pnsystem.com

Employee Name _____

Employee ID _____

Patient/Client Name	ID#	Patient Address / Phone:

	Every Visit	Weekly	1	2	3	4 *(visists/hrs)*
PERSONAL CARE (PC)						
BATH - TUB/SHOWER/BED/ASSIST						
HAIR CARE BRUSH/SHAMPOO						
ORAL CARE - BRUSH/SWAB/DENTURES						
DRESS/UNDRESS						
SKIN CARE/FOOTCARE/(HYGIENE)						
SHAVE/GROOM/DEODORANT						
NAIL HYGIENE - CLEAN/FILE/REPORT						
AMBULATION ASSIST - WC/WALKER/CANE						
TRANSFER ACTIVITY						
CHANGE POSITION						
INCONTINENCE CARE						
TOILETING ASSIT						
COMODE/BED PAN ASSIST						
MEAL PREP						
ASSIST WITH FEEDING						
MAKE BED / CHANGE LINEN						
LIMIT/ENCOURAGE FLUIDS						
EMOTIONAL SUPPORT						
FOLLOW UNIVERSAL PREC						
SAFETY						
INFECTION CONTROL						
HOMEMAKER (HMK)						
LAUNDRY						
CLEAN BATHROOM						
CLEAN BEDROOM						
CLEAN KITCHEN / REFRIGERATOR						
CLEAN LIVING ROOM						
MEAL PREP						
EMPTY TRASH						
VACUUM/SWEEP/ DUST						
WASH DISHES						
FOLLOW UNIVERSAL PREC						
SAFETY						
INFECTION CONTROL						
RESPITE (RSP)						
RESPITE SERVICES						
OTHER						
COMPANION						
CHORES						
ESCORT						
SHOPPING						
FOLLOW UNIVERSAL PRECAUTIONS, SAFETY MEASURES						

ADDITTIONAL INSTRUCTIONS:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Additional Instructions/orders:

_____
_____
_____
_____
_____

☐ Report Significant finding to Agency

_____ _____

Employee Preparing Plan Signature/Title Date

HOME HEALTH CARE AIDE WEEKLY RECORD

Employee Name _____

Employee No. _____

Patient/Client Name	ID#	Date
		/ /

	SUN	MON	TUE	WED	THU	FRI	SAT
PERSONAL CARE (PC)							
BATH - TUB/SHOWER/BED/ASSIST							
HAIR CARE BRUSH/SHAMPOO							
ORAL CARE - BRUSH/SWAB/DENTURES							
DRESS/UNDRESS							
SKIN CARE/FOOTCARE/(HYGIENE)							
SHAVE/GROOM/DEODORANT							
NAIL HYGIENE - CLEAN/FILE/REPORT							
AMBULATION ASSIST - WC/WALKER/CANE							
TRANSFER ACTIVITY							
CHANGE POSITION							
INCONTINENCE CARE							
TOILETING ASSIT							
COMODE/BED PAN ASSIST							
MEAL PREP							
ASSIST WITH FEEDING							
MAKE BED / CHANGE LINEN							
LIMIT/ENCOURAGE FLUIDS							
EMOTIONAL SUPPORT							
FOLLOW UNIVERSAL PREC							
SAFETY							
INFECTION CONTROL							
HOMEMAKER (HMK)							
LAUNDRY							
CLEAN BATHROOM							
CLEAN BEDROOM							
CLEAN KITCHEN / REFRIGERATOR							
CLEAN LIVING ROOM							
MEAL PREP							
EMPTY TRASH							
VACUUM/SWEEP/ DUST							
WASH DISHES							
FOLLOW UNIVERSAL PREC							
SAFETY							
INFECTION CONTROL							
RESPITE (RSP)							
RESPITE SERVICES							
OTHER							
COMPANION							
CHORES							
ESCORT							
SHOPPING							

WEEK FROM

/ /

THROUGH

/ /

		PC am		PC pm		HMK		RSP		OTHER		
DAY	DATE M/D	TIME IN	TIME OUT	TIME IN	TIME OUT	TIME IN	TIME OUT	TIME IN	TIME OUT	TIME IN	TIME OUT	TOTAL HOURS
SUN												
MON												
TUES												
WED												
THUR												
FRI												
SAT												
										TOTAL HOURS	⇨	

Employee Signature _____ Date _____

HOME HEALTH CARE
AIDE WEEKLY RECORD

Renacer Home Health Care, Inc.

Employee Name _____

Employee No. _____

Patient/Client Name	ID#	Patient/Client Signature	Date
			/ /

	SUN	MON	TUE	WED	THU	FRI	SAT
PERSONAL CARE (PC)							
BATH - TUB/SHOWER/BED/ASSIST							
HAIR CARE BRUSH/SHAMPOO							
ORAL CARE - BRUSH/SWAB/DENTURES							
DRESS/UNDRESS							
SKIN CARE/FOOTCARE/(HYGIENE)							
SHAVE/GROOM/DEODORANT							
NAIL HYGIENE - CLEAN/FILE/REPORT							
AMBULATION ASSIST - WC/WALKER/CANE							
TRANSFER ACTIVITY							
CHANGE POSITION							
INCONTINENCE CARE							
TOILETING ASSIT							
COMODE/BED PAN ASSIST							
MEAL PREP							
ASSIST WITH FEEDING							
MAKE BED / CHANGE LINEN							
LIMIT/ENCOURAGE FLUIDS							
EMOTIONAL SUPPORT							
FOLLOW UNIVERSAL PREC							
SAFETY							
INFECTION CONTROL							
HOMEMAKER (HMK)							
LAUNDRY							
CLEAN BATHROOM							
CLEAN BEDROOM							
CLEAN KITCHEN / REFRIGERATOR							
CLEAN LIVING ROOM							
MEAL PREP							
EMPTY TRASH							
VACUUM/SWEEP/ DUST							
WASH DISHES							
FOLLOW UNIVERSAL PREC							
SAFETY							
INFECTION CONTROL							
RESPITE (RSP)							
RESPITE SERVICES							
OTHER							
COMPANION							
CHORES							
ESCORT							
SHOPPING							

WEEK FROM

/ /

THROUGH

/ /

			PC am		PC pm		HMK		RSP		OTHER		
CLIENT INITIALS	DAY	DATE M/D	TIME IN	TIME OUT	TIME IN	TIME OUT	TIME IN	TIME OUT	TIME IN	TIME OUT	TIME IN	TIME OUT	TOTAL HOURS
	SUN												
	MON												
	TUES												
	WED												
	THUR												
	FRI												
	SAT												
								TOTAL HOURS	⇨				

_____ _____

PROGRESS NOTES: RESPITE CARE

Agency Staff Name:
Service Date

Name of Individual	Age
Others Present	

Location
☐ Home ☐ Daycare ☐ Community ☐ Other: _____

Consultation
☐ OT ☐ ST ☐ PT ☐ RN ☐ Other

Child/Family Update

What we did ☐ Sustain the family ☐ Sustain other primary care-giver ☐ time-limited, temporary relief from the ongoing responsibility of care giving

Focus of Today's Visit

Discuss Any Problems

Time In	Time Out
☐ a.m. ☐ p.m.	☐ a.m. ☐ p.m.

Share the Progress Note with the following program(s) ☐ N/A

1.	2.
3.	4.

Signature of Service Staff	Date	Time ☐ a.m. ☐ p.m.
Signature of Parent/Caregiver	Date	Time ☐ a.m. ☐ p.m.

SALUD HOME CARE **CHORE SERVICES NOTE**

Patient's name:	Medical record:	Visit date/Fecha:
HHA's name:	Employee #:	Time in: Time out:
HHA's signature:		Total# of hours:

CHORE SERVICES SERVICIO DE LIMPIEZA PROFUNDA		CHORE SERVICES SERVICIO DE LIMPIEZA PROFUNDA		CHORE SERVICES SERVICIO DE LIMPIEZA PROFUNDA	
Mark with an "X" in this cell ----------> if service was provided		Mark with an "X" in this cell ----------> if service was provided		Mark with an "X" in this cell ------> if service was provided	
Clean carpet Limpieza de alfombra		Assistance with relocation include: organizing, boxing, loading, moving to new location, unloading as clients request. (Assistencia con mudarse)		Others/Otros:	
Clean Kitchen / Limpieza de cocina		Wall cleaning / Limpieza de paredes			
Clean cabinets / Limpieza de gabinetes		Stair cleaning / Limpieza de escaleras			
Clean refrigerator / Limpieza refrigerador		Dishwasher cleaning / Limpieza del lavador de platos			
Clean windows/Limpieza de ventanas		Organize, clean closets Organizar, limpiar closes			
Clean floors/ Limpieza de pisos		Laundry washer, area cleaning Limpieza de lavadoras y el area			
Material removal of driveways, sidewalks, and roof Remover material de la entrada, aceras y techo		Organize, clean kitchen cabinets Organizar, limpiar gavinetes de la cocina			
Clean patio/Limpieza de jardin		Stove cleaning/ Limpieza del fogon			
Dust Services/Sacudir		Appliances cleaning/Limpieza equipos			
Assistance with clutter elimination Ayudar a eliminar deesorden		Others/Otros:			
General Home maintenance Mantenimiento general de la casa					
Clean bathroom/Limpieza de bano					
Follow universal/standard precaution Observe precauciones					
Safety Measures observed Medidas de seguridad observadas				Instructions: Report issues of confidentiality, distress signs in our aging clients, and abuse.	
Infection control/Control de infecciones				Instrucciones: reportar problemas de confidencialidad, anxiedad o abuso	
Do not transport any of our clients in your personal vehicles		No transportar clientes en carros personales		**CHORE SERVICES**	
				TOTAL # OF HOURS:	

GENERAL COMMENTS:

JOOL HOME CARE, INC.

HOME HEALTH CARE
AIDE WEEKLY VISIT RECORD

Employee Name: _____ Week From: _____/_____/_____

Employee No.: _____ Through: _____/_____/_____

Patient/Client Name	ID#	Patient/Client Signature	Date
			/ /

	SUN	MON	TUE	WED	THU	FRI	SAT
PERSONAL CARE (PC)							
BATH - TUB/SHOWER/BED/ASSIST							
HAIR CARE BRUSH/SHAMPOO							
ORAL CARE - BRUSH/SWAB/DENTURES							
DRESS/UNDRESS							
SKIN CARE/FOOT CARE (HYGIENE)							
SHAVE/GROOM/DEODORANT							
NAIL HYGIENE - CLEAN/FILE/REPORT							
AMBULATION ASSIST - WC/WALKER/CANE							
TRANSFER ACTIVITY							
CHANGE POSITION							
INCONTINENCE CARE							
TOILETING ASSIST							
COMMODE/BED PAN ASSIST							
MEAL PREP							
ASSIST WITH FEEDING							
MAKE BED/CHANGE LINEN							
LIMIT/ENCOURAGE FLUIDS							
EMOTIONAL SUPPORT							
FOLLOW UNIVERSAL PREC.							
SAFETY							
INFECTION CONTROL							
COMMENTS:							

			PC	am	PC	am	PC	am	PC	am	PC	am	
CLIENT INITIALS	DAY	DATE M/D	TIME IN	TIME OUT	TIME IN	TIME OUT	TIME IN	TIME OUT	TIME IN	TIME OUT	TIME IN	TIME OUT	TOTAL HOURS
	SUN												
	MON												
	TUE												
	WED												
	THU												
	FRI												
	SAT												
											TOTAL HOURS ➜		

Employee Signature _____ Date _____

JOOL HOME CARE, INC.

HOME HEALTH CARE
AIDE WEEKLY VISIT RECORD

Employee Name: _____ Week From: _____/_____/_____

Employee No.: _____ Through: _____/_____/_____

Patient/Client Name	ID#	Patient/Client Signature	Date
			/ /

	SUN	MON	TUE	WED	THU	FRI	SAT
HOMEMAKER (HMK)							
LAUNDRY							
CLEAN BATHROOM							
CLEAN BEDROOM							
CLEAN KITCHEN / REFRIGERATOR							
CLEAN LIVING ROOM							
MEAL PREP.							
EMPTY TRASH							
VACUUM / SWEEP / DUST							
WASH DISHES							
FOLLOW UNIVERSAL PREC.							
SAFETY							
INFECTION CONTROL							
RESPITE (RSP)							
RESPITE SERVICES							
OTHER							
COMPANION							
CHORES							
ESCORT							
SHOPPING							
COMMENTS:							

			PC	am	PC	am	PC	am	PC	am	PC	am	
CLIENT INITIALS	DAY	DATE M/D	TIME IN	TIME OUT	TIME IN	TIME OUT	TIME IN	TIME OUT	TIME IN	TIME OUT	TIME IN	TIME OUT	TOTAL HOURS
	SUN												
	MON												
	TUE												
	WED												
	THU												
	FRI												
	SAT												
											TOTAL HOURS ➜		

_____ _____

Employee Signature Date

JOOL HOME CARE, INC.

HOME HEALTH CARE
AIDE WEEKLY VISIT RECORD

Employee Name: _____ Week From: _____/_____/_____

Employee No.: _____ Through: _____/_____/_____

Patient/Client Name	ID#	Patient/Client Signature	Date
			/ /

	SUN	MON	TUE	WED	THU	FRI	SAT
COMPANION SERVICES							
STS MEETING							
OTHER MEETING							
MATH							
SHOPPING							
PARK							
GROCERY SHOPPING							
MEDICATION PICK-UP							
BEAUTY SALON							
MALL							
MAIL PICK-UP							
EMPTY TRASH							
MEDICAL APPOINTMENT							
DENTAL APPOINTMENT							
OTHERS							
COMMENTS:							

			PC	am	PC	am	PC	am	PC	am	PC	am	
CLIENT INITIALS	DAY	DATE M/D	TIME IN	TIME OUT	TIME IN	TIME OUT	TIME IN	TIME OUT	TIME IN	TIME OUT	TIME IN	TIME OUT	TOTAL HOURS
	SUN												
	MON												
	TUE												
	WED												
	THU												
	FRI												
	SAT												
											TOTAL HOURS ➜		

Employee Signature _____ Date _____

First Quality Home Care, Inc.

PLAN OF CARE

Date:_____

Patient's Name:	Medical Record Number:	Patient's Signature:
Home Health Aide's Name:	Employee Number:	Home Health Aide's Signature

A: HOME MAKER TRABAJO DOMESTICO		B: PCA TRABAJO CUIDADO SONALPERS		C: CHORE LIMPIEZA GENERAL FUERTE	
Total Number of Hours:		Total Number of Hourrs:		Total Numbers of Hours	
LAUNDRY LAVADO DE ROPA		CHANGE LINEN CAMBIAR ROPA DE CAMA		CLEAN CARPET LIMPIEZA DE ALFOMBRA	
MAKE BED/CHANGE OF LINEN HACER/CAMBIAR ROPA DE CAMA		BED BATH BAÑO EN LA CAMA		CLEAN KITCHEN LIMPIEZA DE COCINA	
ERRANDS MANDADOS		TUB BATH/SHOWER BAÑO BAÑADERA/ DUCHA		CLEAN CABINETS LIMPIEZA DE GABINETES	
GROCERY SHOPING COMPRA DE COMESTIBLES		BATHING SUPERVISION ASISTIR CON EL BAÑO		CLEAN REFRIGERATOR LIMPIEZA DE REFRIGERADOR	
LIGHT HOUSE KEEPING LIMPIEZA LIGERA		ORAL HYGIENE CUIDADO BUCAL		CLEAN WINDOWS LIMPIEZA DE VENTANAS	
CLEAN BATHROOM LIMPIEZA DE BAÑO		NAIL/FOOT CARE (DO NOT CLIP) CUIDADO DE UÑAS/PIES (NO CORTAR)		CLEAN FLOORS LIMPIEZA DE PISOS	
CLEAN KITCHEN/WASH DISHES LIMPIEZA DE COCINA/FREGAR		DRESS VESTIR		CLEAN BATHROOM LIMPIEZA DE BAÑO	
CLEAN BEDROOM LIMPIEZA DE DORMITORIO		SHAMPOO LAVAR EL CABELLO		CLEAN PATIO LIMPIEZA DE PATIO	
MEAL PREPARATION PREPARACIO DE COMIDA		HAVE AFEITAR		YARD CLEANUP LIMPIEZA DE JARDIN	
WASH DISHES LAVAR LOS PLATOS		SKIN CARE CUIDADO DE LA PIEL		OTHER: OTROS:	
DUST (PATIENT'S AREAS ONLY) SACUDIR (SOLO AREAS DEL PACIENTE)		ASSIST WITH TOILETING ASISTIR EN EL SERVICIO SANITARIO			
SOCIALICE / COMMUNICATE SOCIALIZAR/COMUNICARSE		BED SIDE COMMODE ASISTIR CON EL ORINAL			
FOLLOW UNIVERSAL PRECAUTION OBSERVE PRECAUCIONES GENERALES		BED PAN / URINAL RETRETE / ORINAL-URINARIO			
SAFETY SEGURIDAD		EMPTY CATHETER BAG VACIAR BOLSA DE CATETER			
INFECTION CONTROL CONTROL DE INFECCIONES		TRANSFER AS NEEDED TRASLADAR CUANDO ES NECESARIO			
EMTIONAL SUPPORT APOYO EMOCIONAL		AMBULATE AS NEEDED ASISTIR CON AMBULACION			
		FEEDING DARLE LA COMIDA AL PACIENTE			

C: RESPITE / RESPIRO	D: COMPANION/ ACOMPAÑAR	E: ESCORT / ESCOSTAR
Total Number of Hours:	Total number of Hours:	Total Number of Hours

Monday/Lunes	Tuesday/Martes	Wednesday/Miércoles	Thursday/Jueves	Friday/ Viernes	Saturday / Sábado	Sunday / Domingo

General Comments:_____

First Quality Home Care, Inc.

COMMENT SHEET AND TIME RECORD

Patient's Name:	Medical Record Number:	Visit Date: _____ Regular Visit:_____
Home Health Aide's Name:	Employee Number:	Time In: Tiime Out:
Home Health. Aide's Signature	Patient's Signature:_____ ___	Total Number of Hours:

A: HOME CARE TRABAJO DOMESTICO		B: PCA TRABAJO CUIDADO PERSONA		C: CHORE LIMPIEZA GENERAL FUERTE	
Total Number of Hours:		Total Number of Hours:		Total Number of Hour:	
LAUNDRY LAVADO DE ROPA		CHANGE LINEN CAMBIAR ROPA DE CAMA		CLEAN CARPET LIMPIEZA DE ALFOMBRA	
MAKE BED / CHANGE OF LINEN HACER / CAMBIAR ROPA DE CAMA		BED BATH BAÑO EN LA CAMA		CLEAN KITCHEN LIMPIEZA DE COCINA	
ERRANDS MANDADOS		TUB BATH / SHOWER BAÑO BAÑADERA / DUCHA		CLEAN CABINETS LIMPIEZA DE GABINETES	
GROCERY SHOPPING COMPRA DE COMESTIBLES		BATHING SUPERVISION ASISTIR CON EL BAÑO		CLEAN REFRIGERATOR LIMPIEZA DE REFRIGERADOR	
LIGHT HOUSEKEEPING LIMPIEZA LIGERA		ORAL HYGIENE CUIDADO BUCAL		CLEAN WINDOWS LIMPIEZA DE VENTANAS	
CLEAN BATHROOM LIMPIEZA DE BAÑO		NAIL / FOOT CARE (DO NOT CLIP) CIDADOS DE UÑAS / PIES (NO CORTAR)		CLEAN FLOORS LIMPIEZA DE PISOS	
CLEAN KITCHEN / WASH DISHES LIMPIEZA DE COCINA / FREGAR		DRESS VESTIR		CLEAN BATHROOM LIMPIEZA BAÑOS	
CLEAN BEDROOM LIMPIEZA DE DORMITORIO		CHAMPOO LAVAR EL CABELLO		CLEAN PATIO LIMPIEZA DE PATIO	
MEAL PREPARATION PREPARACION DE COMIDA		SHAVE AFEITAR		YARD CLEANUP LIMPIEZA DE JARDIN	
WASH DISHES LAVAR LOS PLATOS		SKIN CARE CUIDADO DE LA PIEL		OTHER: OTROS:	
DUST (PATIENT'S AREA ONLY) SACUDIR (SOLO AREAS DEL PACIENTE		ASSIST WITH TOILETING ASISTIR EN EL SERVICIO SANITARIO			
SOCIALIZE / COMMUNICATE SOCIALIZAR / COMUNICARSE		BED SIDE COMMODE ASISTIR CON EL ORINAL			
FOLLOW UNIVERSITY PRECAUTION OBSERVE PRECAUCIONES GENERALES		BED PAN /URINAL RETRETE / ORINAL-URINARIO			
SAFETY SEGURIDAD		EMPTY CATHETER BAG VACIAR BOLSA DE CATETER			
INFECTION CONTROL CONTROL DE INFECCIONES		TRANSFER AS NEEDER TRASLADAR CUANDO SEA NECESARIO			
EMOTIONAL SUPPORT APOYO EMOCIONAL		AMBULATE AS NEEDED ASSISTIR CON AMBULACION			
		FEEDING DARLE COMIDA AL PACIENTE			

C. RESPITE / RESPIRO	D. COMPANION / ACOMPAÑAR	E. ESCORT / ESCORTAR
Total Number of Hours:	Total Number of Hours:	Total Number of Hours

Geneal comments:_____

SERVICE PROVISION PLAN

Service Care Plan for _____ Effective Date _____

- Any changes that occur in your cares need to be documented on the care plan
- This care plan must be updated at as needed, but at least every 90 days.

Activities of Daily Living: Identify the amount of help needed to complete daily tasks. Make comments about any special needs, including physical limitations, precautions, and need for reminders.

Dressing, Grooming Comments:
Shooping for food, Meal Preparation, Eating – includes nutritional concerns/special diets/assistance with eating. Example cutting food, risk of choking/need for fluids **Comments:**
Bathing, Toileting Comments:
Transfers, Mobility, Positioning – Comments:

Health Related Care Needs Identify the special health needs, and how will be provided. This could include cares such as: wound cares; non-sterile respiratory cares; monitoring and safety precautions for seizures; or therapy programs such as range of motion exercises, ambulation, pool therapy or strengthening exercises. Use extra pages if needed.
Your doctor or a qualified professional need to help give directions to the Agency for these cares.

Special health care need(s):
Instructions for assistance:

Other Living Supports

Instrumental Activities of Daily Living (IADLs). Check the tasks that needs support and write out how the staff can assist the patient.

Laundry for the recipient Light housekeeping/essential household chores
Accompany to medical appointments, other community appointments or activities:
Other

Behavior, Mental Status

Identify any behaviors that might affect the ability to function at home and in the community and write down how our staff will help. Use extra paper if needed.

Describe behavior to look for and what the staff needs to know about observing and redirecting

Functional Limitations, Activities permitted:

_____

_____

_____

_____

Discipline ordered, frequency, duration:

_____ _____

_____ _____

_____ _____

_____ _____

GOALS:

_____

_____

_____

_____

RN or quilified designeed completed Plan:(name/title) _____

Signature: _____ **Date:** _____

A & A Health Service, Inc.

HOME HEALTH AIDE WEEKLY VISIT RECORD
ELDERCARE PLAN / EVERCARE PLAN

Patient's Last Name	First Name	Medical Record #

ACTIVITIES	SUN	MON	TUE	WED	THU	FRI	SAT
PERSONAL CARE							
HOMEMAKER							
RESPITE							
ESCORT							

MONTH/DATE	TIME IN	TIME OUT	TOTAL HOURS	PATIENT'S SIGNATURE
SUNDAY				
MONDAY				
TUESDAY				
WEDNESDAY				
THURSDAY				
FRIDAY				
SATURDAY				

Comments/Observations: _____

_____

_____

_____

_____

_____

_____

EMPLOYEE SIGNATURE _____ EMPLOYEE # _____

EMPLOYEE PINT NAME AS SIGNED _____

A & A Health Service, Inc.

Employee Daily Hourly Report

Employee Name & #:_____ Week of _____ to _____

Agency Codes: Medicare: MC Medicaid: MA American Eldercare: AE Evercare: EV Channeling: CH

PATIENT #	AGENCY	SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	TOTAL HOURS
						GRAND TOTAL OF HOURS PER WEEK			

Comments:

_____

_____

_____

Employee Signature:_____ Date: ____/____/____

A & A Health Service, Inc.

Channeling Services Report

DATE	PERSONAL CARE	BATH BED SHOWER	HAIR COMB. SHAMPOO	SHAVE	NAIL CARE	SKIN CARE	ASSIST DRESSING	ELIMINATION TOILET BED PAN COMMODE	TRANSFERS BED TO CHAIR LIFT	ASSISTAMBULATION	MEAL PREPARATION	FEEDING	LIGHT CLEANING	LINEN CHANGE	PATIENT'S ROOM	BATHROOM	LAUNDRY	LIGHT GROCERY SHOP	RESPITE	COMPANION	ESCORT	TIME	PATIENT'S SIGNATURE
Sunday																							
Monday																							
Tuesday																							
Wednesday																							
Thursday																							
Friday																							
Saturday																							

HHA Name: _____ HHA SIGNATURE: _____

A & A Health Service, Inc.

SERVICE REPORT

Patient Name:_____ **Patient Number:**_____ **HHA Name:**_____

DATE	PERSONAL CARE	BATH		HAIR		SHAVE	NAIL CARE	SKIN CARE	ASSIST WITH DRESSING	ELIMINATION			TRANSFERS		ASSIST WITH AMBULATION	MEAL PREPARATION	FEEDING	LIGHT CLEANING	BATHROOM	PATIENT'S ROOM	LINEN CHANGE	LAUNDRY	LIGHT GROCERY SHOPPING	RESPITE	COMPANION	ESCORT	TIME			PATIENT SIGNATURE
		BED	SHOWER	COMB	SHAMPOO					TOILET	BED PAN	COMMODE	BED TO CHAIR	LIFT													In	Out	Total	
SUNDAY																														
MONDAY																														
TUESDAY																														
WEDNESDAY																														
THURSDAY																														
FRIDAY																														
SATURDAY																														
																												TOTAL HOURS		

HHA Signature:_____