CLIENT CARE LOG

Client Name: _____ **Care Provider Name**: _____

Role: RN____ LPN____ CNA____ HHA____ Companion_____ Week Ending Date: _____

Pursuant to Regulations by the Agency for Health Care Administration, it is mandatory that Care Provider document any changes in care services.

As per the direction of Client, Care Provider performed the following services:	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
PERSONAL CARE / ADL ASSISTANCE							
BATHING/SHOWER							
DRESSING							
AMBULATION							
TRANSFERRING							
RE-POSITIONING							
RANGE OF MOTION ASSISTANCE							
FEEDING							
GROOMING, SHAVING, HAIR CARE							
APPLY LOTION							
ORAL HYGIENE							
TOILETING							
INCONTINENCE CARE/DIAPER CHANGE							
ASSIST WITH OSTOMY CARE							
RECORD VITAL SIGNS							
RECORD INTAKE / OUTPUT							
RECORD WEIGHT							
OBSERVE PHYSICAL & MENTAL CHANGES							
REMIND PATIENT OF MEDICATIONS							
ASSIST PATIENT WITH SELF-ADMINISTRATION OF MEDICATION							
COMPANIONSHIP							
IADL SUPERVISION / STANDBY ASSIST							
ACCOMPANY TO APPOINTMENTS							
PREPARE MEALS							
GROCERY SHOPPING							
CHANGE BED LINEN							
LAUNDRY							
LIGHT HOUSEKEEPING							
COSMETIC ASSISTANCE							

HOURLY

DAY	DATE	TIME STARTED	DATE	TIME FINISHED	TOTAL HOURS	CHANGE IN ORIGINAL SCHEDULED HOURS	CLIENT REVIEW AND ACCEPTANCE (INITIAL)
SUN							
MON							
TUE							
WED							
THUR							
FRI							
SAT							

LIVE IN HOURS WORKED

DAY	DATE STARTED	DATE FINISHED	WORKED HOURS	CLIENT REVIEW AND ACCEPTANCE (INITIAL)
SUN				
MON				
TUE				
WED				
THUR				
FRI				
SAT				

Client Care Logs may be faxed to Administrative Services at 1-800-325-6272 or emailed to carelogs@americaninhomecare.com

By signing below I (Client) contracted with Care Provider for whom I certify performed all services noted above satisfactorily. I understand that if services were not performed as requested, I would not sign this care log. Care logs submitted without the checking of Activities of Daily Living actually performed, and required by the insurance company, may result in the patient/client being billed directly.

Signed by Client: _____

By signing below I (Care Provider) certify that this Care Log represents the actual care services requested by Client and provided by me as the Independent Care Provider for the dates listed above.

Signed by Care Provider: _____