CARE PROVIDER SERVICES
CLIENT CARE LOG

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

Role ☐ 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.

DATE:	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
HOURLY/ VISIT START TIME:							
HOURLY/VISIT END TIME:							
TOTAL HOURS:							
LIVE-IN START DATE:							
LIVE-IN END DATE:							
WORKED HOURS:							
DAILY CLIENT REVIEW & APPROVAL (CLIENT INITIALS)							
As per the direction of Client, the Care Provider performed the following services:							
COMPANIONSHIP/ HOMEMAKER							
IADL SUPERVISION / STANDBY ASSIST							
ACCOMPANY TO APPOINTMENTS							
GROCERY SHOPPING							
PREPARE MEALS							
CHANGE BED LINEN							
LAUNDRY							
LIGHT HOUSEKEEPING							
COSMETIC ASSISTANCE							
REPORTED INCIDENTS OR CLIENT BEHAVIORAL CHANGES							
PERSONAL CARE /ADL ASSISTANCE							
BATHING/SHOWER							
DRESSING							
AMBULATION							
TRANSFERRING							
RE-POSITIONING							
FEEDING							
GROOMING, SHAVING, HAIR CARE							
APPLY LOTION							
ORAL HYGIENE							
TOILETING							
INCONTINENCE CARE							
ASSIST WITH PRESCRIBED RANGE OF MOTION							
ASSIST WITH PRESCRIBED ICE CAP OR COLLAR							
SIMPLE URINE TEST							
MEASURE INTAKE / OUTPUT							
RECORD VITAL SIGNS							
RECORD WEIGHT							
MEDICATION REMINDERS							
OTHER CNA/ HHA TASKS: REQUIRES ADDITIONAL CLIENT CONSENT & MEDICATION LIST ON FILE							
ASSISTANCE WITH SELF- ADMINISTRATION OF MEDS							
ASSIST WITH USE OF GLUCOMETER MACHINE							
ASSIST WITH ANTI-EMBOLISM STOCKINGS							
ASSIST WITH APPLYING &/ OR REMOVING OXYGEN CANNULA							
ASSIST WITH USE OF CPAP/ BIPAP DEVICE ONLY							
MEASURED VITAL SIGNS							
ASSIST WITH COLOSTOMY BAG CHANGES							

By signing below, I (Client) contracted with Care Provider for whom I consent and certify that all services noted above within the approved dates and times were performed. 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: _____

Client Care Logs may be submitted to Financial Services via the following methods:
HHA/ CNA: Fax to 1-800-325-6272 or Email to carelogs@americaninhomecare.com