Pay Period Start\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Pay Period Ending\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Due at the office\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Pay Date\_\_\_\_\_\_\_\_

**PERSONAL CARE SERVICE HOURS**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **Caregiver (1)** | | | | | **Caregiver (2)** | | | |
| **Please enter your name** | |  | | | |  | | | |
| **Please sign your signature** | |  | | | |  | | | |
| **Please enter your phone#** | |  | | | |  | | | |
| **Days of the Week** |  | **Service** | **Time** | | | **Service** | **Time** | | |
| **Week 1** | **Date** | Code | In | Out | Total | Code | In | Out | Total |
| **Monday** |  | **PC** |  |  |  | **PC** |  |  |  |
| **Tuesday** |  | **PC** |  |  |  | **PC** |  |  |  |
| **Wednesday** |  | **PC** |  |  |  | **PC** |  |  |  |
| **Thursday** |  | **PC** |  |  |  | **PC** |  |  |  |
| **Friday** |  | **PC** |  |  |  | **PC** |  |  |  |
| **Saturday** |  | **PC** |  |  |  | **PC** |  |  |  |
| **Sunday** |  | **PC** |  |  |  | **PC** |  |  |  |
| **End of week 1** | **TOTAL** |  |  |  | ─── |  |  |  | ─── |
| **Week 2** | **Date** | Code | In | Out | Total | Code | In | Out | Total |
| **Monday** |  | **PC** |  |  |  | **PC** |  |  |  |
| **Tuesday** |  | **PC** |  |  |  | **PC** |  |  |  |
| **Wednesday** |  | **PC** |  |  |  | **PC** |  |  |  |
| **Thursday** |  | **PC** |  |  |  | **PC** |  |  |  |
| **Friday** |  | **PC** |  |  |  | **PC** |  |  |  |
| **Saturday** |  | **PC** |  |  |  | **PC** |  |  |  |
| **Sunday** |  | **PC** |  |  |  | **PC** |  |  |  |
| **End of week 2** | **TOTAL** |  |  |  | ─── |  |  |  | ─── |
| **Two weeks GRAND totals** | |  |  | |  |  |  | |  |

Participant’s/ Representative’s Signature

Date

Date

Provider’s Signature

By signing above, the caregiver certifiesthe services rendered are in accordance with the authorized Plan of Service/Plan of Care on the above dates of service as specified in the Caregiver Service Plan and that the caregiver delivered to the participant all service hours listed on this form.

Patient Name: Signature of Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

❑ Certified Nursing Assistant ❑ Certified Medication Technician ❑ Unlicensed Aide

Name of Provider: Signature of Provider: Date:

**DAILY PERSONAL CARE PROVIDED**

**Please check task provided to patient daily. *Write “YES” or “NO" in the boxes next to the task to show what you did on each day***

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Week 1 Task** | **Mon** | Tues | Wed | Thurs | **Fri** | Sat | Sun | Comments |
| **Vital Signs** (Blood Pressure, Temperature, Respiration, Pulse) |  |  |  |  |  |  |  |  |
| **Personal Care** (Bed bath; Tub with bench; Shower with bath; Shave, Shampoo; Skin care; Peri-care; Lotion) |  |  |  |  |  |  |  |  |
| **Toileting** (Bladder; Bowel; Foley; Bed pan) |  |  |  |  |  |  |  |  |
| **Dressing** (assist with dressing and change clothes PRN) |  |  |  |  |  |  |  |  |
| **Medications** (Administration and Reminders) |  |  |  |  |  |  |  |  |
| **Diet** (Prepare and serve meals; Offer fluids; Feed patient; |  |  |  |  |  |  |  |  |
| **Mobility and Transfers** (assist with ambulation, use of assistive device) |  |  |  |  |  |  |  |  |
| **Light Housekeeping** (Light laundry; Make bed; Change linen) |  |  |  |  |  |  |  |  |
| **Errands** (light Shopping) |  |  |  |  |  |  |  |  |
| **Other** (Please Indicate type of task provided) |  |  |  |  |  |  |  |  |
| **Week 2 Task** | **Mon** | Tues | Wed | Thurs | **Fri** | Sat | Sun | Comments |
| **Vital Signs** (Blood Pressure, Temperature, Respiration, Pulse) |  |  |  |  |  |  |  |  |
| **Personal Care** (Bed bath; Tub with bench; Shower with bath; Shave, Shampoo; Skin care; Peri-care; Lotion) |  |  |  |  |  |  |  |  |
| **Toileting** (Bladder; Bowel; Foley; Bed pan) |  |  |  |  |  |  |  |  |
| **Dressing** (assist with dressing and change clothes PRN) |  |  |  |  |  |  |  |  |
| **Medications** (Administration and Reminders) |  |  |  |  |  |  |  |  |
| **Diet** (Prepare and serve meals; Offer fluids; Feed patient; |  |  |  |  |  |  |  |  |
| **Mobility and Transfers** (assist with ambulation, use of assistive device) |  |  |  |  |  |  |  |  |
| **Light Housekeeping** (Light laundry; Make bed; Change linen) |  |  |  |  |  |  |  |  |
| **Errands** (light Shopping) |  |  |  |  |  |  |  |  |
| **Other** (Please Indicate type of task provided) |  |  |  |  |  |  |  |  |

**\*\*\*\*\*Please note that all timesheets and notes are due in the office every Monday by 9:00 AM. \*\*\*\*\*\*\***