

Statewide Healthcare LLC

Compassionate Care

2130 S. Academy Blvd #103

Colorado Springs, CO 80916-2479

P (719)-434-1513 F (719)-434-8215

Client	
Caregiver	
Service Category and Description	Personal Care: Routine & repetitive activities of daily living which require non-skilled assistance for health and normal bodily functioning which would be carried out by the person receiving services if they were physically/cognitively able: includes accompanying person to appointments/ meal planning/ shopping/ money management.

Date of Service																					
Begin Time																					
End Time																					
Total Time Duration																					
Details/Goals from Service Plan																					
Indicate which Personal Care Tasks were provided today	<p style="text-align: center;">Please check all that apply</p> <table style="width: 100%; border: none;"> <tr> <td><input type="checkbox"/> Bathing</td> <td><input type="checkbox"/> Skin Care</td> <td><input type="checkbox"/> Hair Care</td> <td><input type="checkbox"/> Nair Care</td> </tr> <tr> <td><input type="checkbox"/> Oral Care</td> <td><input type="checkbox"/> Shaving</td> <td><input type="checkbox"/> Dressing</td> <td><input type="checkbox"/> Feeding</td> </tr> <tr> <td><input type="checkbox"/> Exercise</td> <td><input type="checkbox"/> Transfers</td> <td><input type="checkbox"/> Positioning</td> <td></td> </tr> <tr> <td><input type="checkbox"/> Bladder and/or Bowel Care</td> <td></td> <td><input type="checkbox"/> Medication Reminding</td> <td></td> </tr> <tr> <td><input type="checkbox"/> Assistance with Ambulation</td> <td></td> <td><input type="checkbox"/> Adaptive Equipment</td> <td></td> </tr> </table>	<input type="checkbox"/> Bathing	<input type="checkbox"/> Skin Care	<input type="checkbox"/> Hair Care	<input type="checkbox"/> Nair Care	<input type="checkbox"/> Oral Care	<input type="checkbox"/> Shaving	<input type="checkbox"/> Dressing	<input type="checkbox"/> Feeding	<input type="checkbox"/> Exercise	<input type="checkbox"/> Transfers	<input type="checkbox"/> Positioning		<input type="checkbox"/> Bladder and/or Bowel Care		<input type="checkbox"/> Medication Reminding		<input type="checkbox"/> Assistance with Ambulation		<input type="checkbox"/> Adaptive Equipment	
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Please describe how you spent your time together today providing Personal Care, what hands on, direction, cues, or verbal prompts were offered as you supported the person to work towards their goals.

Signature of Client / Client's Guardian

Date

Signature of Caregiver

Date