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

Role: CNA__ HHA__ RN__ LPN__ Companion___ Week Ending Date (**Fridays 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:	Saturday	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday
PERSONAL CARE / ADL ASSISTANCE							
AMBULATION - TRANSFERRING							
BATHING – SHOWER - DRESSING							
FEEDING							
GROOMING – SHAVING - HAIR CARE							
INCONTINENCE CARE - BRIEFS CHANGE							
OBSERVE PHYSICAL & MENTAL							
ORAL HYGIENE							
OSTOMY CARE ASSIST							
PHYSICAL THERAPY REMINDER							
RANGE OF MOTION ASSISTANCE							
RECORD INTAKE / OUTPUT							
RECORD VITAL SIGNS/WEIGHT							
REMIND PATIENT OF MEDICATIONS							
SKIN OBSERVATION - APPLY LOTION							
TOILETING							
OTHER:							
COMPANIONSHIP							
IADL SUPERVISION - STANDBY ASSIST							
ACCOMPANY TO APPOINTMENTS							
CONVERSATION – GAMES - CARDS							
TAKE A WALK							
PREPARE AND SERVE MEALS							
GROCERY SHOPPING – ERRANDS							
LIGHT HOUSEKEEPING							
PET CARE							
RESPITE CARE							

DAY/Date	START TIME	END TIME	TOTAL HRS	CLIENT SIGNATURE
SATURDAY				
SUNDAY				
MONDAY				
TUESDAY				
WEDNESDAY				
THURSDAY				
FRIDAY				

How to Submit your Invoice for Billing

Fax: (772) 293-9850

Email: info@preferredprivatecare.com

Due at the end of Friday's shift

Invoices received after the cut-off will be processed the following week.

PREFERRED PRIVATE CARE

By signing above, 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.

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: _____ Total Hours: _____