HEALTH UNITED TRUSTED CARE
TELE: 305-956-5151 – **FAX**: 1.888.900.8744 – **CELL**: 786.930.6548

A

CLIENT NAME: _____ Week of (SUN)_____ to (SAT)_____

Location of services: __Home __Nursing Home __ALF __RR ___Other:_____

SERVICE PROVIDED							
PERSONAL CARE ASST.		**HOMEMAKER**		**COMPANION / RESPITE**		**OTHER**	
Asst. w/ Ambulation		Bathroom		Shopping			
Bed Bath (daily)		Bedroom / change lining		Accompany to social event			
Bath (Tub/Shower) – Assist (Physical Assist) (at least 3x per week)		Kitchen		Accompany to medical appointment			
Bath (Tub/Shower) – Supervise (to look)		Prepare Meals		Emotional Support			
Dress		Living / Dining		Outing			
Hair Care (Comb / Shampoo)		Laundry					
Nail Care **(DO NOT CLIP)**		Vacuum / Sweep / Mop					
Shampoo							
Skin Care							
Shave (at least 2x per week)							
Incontinence Care							
Assist w/ Eating							
Transfer as needed							
Reposition							
Medication Reminder							
Oral Care							

NOTES:_____

_____

My signature confirms that services were provided truthfully throughout the dates indicated.

DAY OF WK	DATE	TIME IN	TIME OUT	TIME IN	TIME OUT	TOTAL HRS	CLIENT'S / SUPERVISOR SIGNATURE / Office Manager
Sunday							
Monday							
Tuesday							
Wednesday							
Thursday							
Friday							
Saturday							

TOTAL HRS.	

My signature confirms that services were provided truthfully. I also understand and agree to maintain full confidentiality of all patient and agency matters.

Worker's Printed Name: _____ Signature: _____ HHA/CNA/LPN/RN

Worker's Phone Number: _____

OFFICE ONLY:

Billed Date: _____ Software Logged: ___ Invoice #: _____	**Registry Office Initials:**
Check Deposit Date: _____	