## HCBS/FE PERSONAL CARE SERVICES WEEKLY CARE LOG Facility Name: \_\_\_\_\_

**Supervisor** - Indicate HCBS hours in the Authorized Hours column. If item is separated by slashes, circle applicable activity. **Staff** - Document time spent and initial.

	DAY DAY	SUN		MON		TUES		WED		THUR		FR	I	SAT			Use the space below for additional
Auth																Wkly	issues or comments related to care
Hours		Time	Initial	Time	Initial	Time	Initial	Time	Initial	Time	Initial	Time	Initial	Time	Initial	Totals	provided.
	Bathing / Grooming / Nail Care / Oral Hygiene / Shave / Skin Care / Hair Care																
	Dressing / Undressing AM					1											
	РМ																
	Toileting 1st Shift					1											
	2nd Shift					1											
	3rd Shift																
	Transfers (non-bathing or non-toileting transfers)																
	Walking / Mobility																
	Eating breakfast Lunch					<b> </b>											
<b> </b>	Dinner Meal Preparation / Clean up Breakfast	<b> </b>				<b> </b>		<b>—</b>								<b> </b>	
	Lunch	L				-		1									
	Shopping / Money Management /																
	Transportation (fill in time spent)					1											
	Housekeeping Vacuum / Mop / Dust / Trash / Bathroom / Commode / Bedmaking /																I certify this information is correct and documented services were preformed.
	Linen Change Laundry	┣──				┨────		┣──		<sup> </sup>							Residents Signature:
	Management of Medication / Treatment	├──				┣──		├──		'							Supervisors Signature:
	1st Shift																
	2nd Shift																
		┣───		<b> </b>		<u> </u>		<u> </u>		<u> </u>							Last Name:
	3rd Shift																First Name:
	DAILY TOTALS:								J !				l				Apt./Rm. #:
	STAFF INITIALS AND SIGNATURES:				-									WEEKLY	TOTAL:	L	l

## **HCBS/FE PERSONAL CARE SERVICES WEEKLY CARE LOG**

Facility Name:

Resident Name:

 Supervisor - Indicate HCBS hours in the Authorized Hours column. If item is separated by slashes, circle applicable activity.

 Staff - Document time approximation of initial

Juli	Document time spent and initial.	SUN		MO	N	TUES		WED		THUR		FRI		SAT			Use the space below for additional
Auth	Date (MM/DD/YY):															Wkly	issues or comments related to care
Hours	ACTIVITIES	Time	Initial	Time	Initial	Time	Initial	Time	Initial	Time	Initial	Time	Initial	Time	Initial	Totals	provided.
	Bathing / Grooming /							1									
	Nail Care / Oral Hygiene / Shave / Skin Care / Hair Care			1				1									
	Dressing / Undressing AM							-									
	PM																
			<b></b>	<b> </b>			<u> </u>	┣───									
	Toileting 1st Shift			1				1									
	2nd Shift							1								1	
	3rd Shift						<u> </u>	┢────									
	Ju Shit							•									
	Transfers			. · ·				-		-				_			
	(non-bathing or non-toileting transfers) Walking / Mobility		╂───┦	┟────┤			┢────	┣───					<u> </u>		<u> </u>		
								·						1			
	Eating Breakfast Lunch		╉───┦	┫━━━━┛	'		<b> </b> '	──	┣───	<b> </b>							
	Dinner		┨───┦	┨────┤													
	Meal Preparation / Clean up Breakfast							1									
	Lunch Dinner			1 I				-									
	Shopping /																
	Money Management /			<b> </b>				1		-							
	Transportation (fill in time spent)			4				1									
	Housekeeping							j									I certify this information is correct and
	Vacuum / Mop / Dust / Trash /			1				-		-							documented services were preformed.
	Bathroom / Commode / Bedmaking / Linen Change			1				1	<u> </u>								Residents Signature:
	Laundry																
	Management of Medication / Treatment		┟───┦	┟────┘	'		<b> </b> '	┣───	<u> </u>	<u> </u>							Supervisors Signature:
	1st Shift							1									Supervisors Signature.
				<b> </b> '				┣───									
	2nd Shift			1				4									
																	Last Name:
	2 161 18			1				-		-							
	3rd Shift	r		1				1									First Name:
	DAILY TOTALS:																Apt./Rm. #:
	STAFF INITIALS AND SIGNATURES:		•		-		-		-			WEEKLY	TOTAL:				
					_								-				-
					_								-				

## **HCBS/FE PERSONAL CARE SERVICES WEEKLY CARE LOG**

Facility Name:

Resident Name:

Supervisor - Indicate HCBS hours in the Authorized Hours column. If item is separated by slashes, circle applicable activity.

Staff - L	Document time spent and initial.															
	DAY	SUN MC				TUES	S	WED		THUR		FRI		SAT		
Auth	Date (MM/DD/YY):															Wkly
Hours	ACTIVITIES	Time	Initial	Time	Initial	Time	Initial	Time	Initial	Time	Initial	Time	Initial	Time	Initial	Totals
	Housekeeping												T			
	Vacuum / Mop / Dust / Trash /			1		1				1						
	Bathroom / Commode / Bedmaking /															
	Linen Change															
	Laundry															
	Management of Medication / Treatment													]		
	1st Shift													_		
	2nd Shift															
						1				1		1		1		
												┢────	╉────	╉────		
						4		-		4		4		_		-
	3rd Shift															
														1		
	DAILY TOTALS:												1	1	1	<u>8</u>
Use the space below for additional issues or comments related to care provided. WEEKLY TOTAL													TOTAL:			
	1	ł														1
	STAFF INITIALS AND SIGNATURES:	1					I certify	the infor	mation is	correct a	and docu	nented se	ervices w	ere prefo	rmed.	
							Resider	nts Signa	ture:							
					_			-								
		_		Supervisors Signature:												
		-									•					
		_		Last Name:								•				
					_		First Na	me:								_
					_		Apt./Rm	n. #:								-
					_											•