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.

Auth Hours	DAY → / Date (MM/DD/YY): / ACTIVITIES	SUN Time	SUN Initial	MON Time	MON Initial	TUES Time	TUES Initial	WED Time	WED Initial	THUR Time	THUR Initial	FRI Time	FRI Initial	SAT Time	SAT Initial	Wkly Totals	Use the space below for additional issues or comments related to care provided.
	Bathing / Grooming / Nail Care / Oral Hygiene / Shave / Skin Care / Hair Care																
	Dressing / Undressing AM																
	PM																
	Toileting 1st Shift																
	2nd Shift																
	3rd Shift																
	Transfers (non-bathing or non-toileting transfers)																
	Walking / Mobility																
	Eating breakfast																
	Lunch																
	Dinner																
	Meal Preparation / Clean up Breakfast																
	Lunch																
	Dinner																
	Shopping / Money Management / Transportation (fill in time spent)																
	Housekeeping Vacuum / Mop / Dust / Trash / Bathroom / Commode / Bedmaking / Linen Change																I certify this information is correct and documented services were preformed.
	Laundry																Residents Signature:
	Management of Medication / Treatment 1st Shift																Supervisors Signature:
	2nd Shift																Last Name: _____
	3rd Shift																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 - Document time spent and initial.

Auth Hours	DAY ➡ / Date (MM/DD/YY): / ACTIVITIES	SUN Time	SUN Initial	MON Time	MON Initial	TUES Time	TUES Initial	WED Time	WED Initial	THUR Time	THUR Initial	FRI Time	FRI Initial	SAT Time	SAT Initial	Wkly Totals
	Bathing / Grooming / Nail Care / Oral Hygiene / Shave / Skin Care / Hair Care															
	Dressing / Undressing AM															
	PM															
	Toileting 1st Shift															
	2nd Shift															
	3rd Shift															
	Transfers (non-bathing or non-toileting transfers)															
	Walking / Mobility															
	Eating Breakfast															
	Lunch															
	Dinner															
	Meal Preparation / Clean up Breakfast															
	Lunch															
	Dinner															
	Shopping / Money Management / Transportation (fill in time spent)															
	Housekeeping Vacuum / Mop / Dust / Trash / Bathroom / Commode / Bedmaking / Linen Change															
	Laundry															
	Management of Medication / Treatment 1st Shift															
	2nd Shift															
	3rd Shift															
	DAILY TOTALS:															

Use the space below for additional issues or comments related to care provided.

I certify this information is correct and documented services were preformed.

Residents Signature:

Supervisors Signature:

Last Name: _____

First Name: _____

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 - Document time spent and initial.

Auth Hours	DAY → / Date (MM/DD/YY): / ACTIVITIES	SUN Time	SUN Initial	MON Time	MON Initial	TUES Time	TUES Initial	WED Time	WED Initial	THUR Time	THUR Initial	FRI Time	FRI Initial	SAT Time	SAT Initial	Wkly Totals
	Housekeeping															
	Vacuum / Mop / Dust / Trash /															
	Bathroom / Commode / Bedmaking /															
	Linen Change															
	Laundry															
	Management of Medication / Treatment															
	1st Shift															
	2nd Shift															
	3rd Shift															
	DAILY TOTALS:															

Use the space below for additional issues or comments related to care provided.

WEEKLY TOTAL:

STAFF INITIALS AND SIGNATURES:

_____

_____

_____

_____

_____

_____

I certify the information is correct and documented services were preformed.

Residents Signature: _____

Supervisors Signature: _____

Last Name: _____

First Name: _____

Apt./Rm. #: _____