

WEEKLY SERVICE REPORT



Month _____ Year _____ Service Provider _____ Program _____

Client Name _____ Medical Record No. _____

County _____ Case Manager _____ A Southern AL Regional Council on Aging Program

Place a **check** in the box for each day a task is performed. Write an **N** in each box assigned but **NOT** needed that day.

HOMEMAKER								PERSONAL CARE								UNSKILLED RESPITE							
Day of the Week	SA	S	M	T	W	TH	F	Day of the Week	SA	S	M	T	W	TH	F	Day of the Week	SA	S	M	T	W	TH	F
Date of Service								Date of Service								Date of Service							
Vacuum / Sweep								Bathe Client								Personal Care							
Mop (damp)								Skin Care								Homemaker							
Dust								Shampoo Hair								Supervise							
Clean Kitchen								Comb Hair								Support							
Wash Dishes								Oral Care															
Clean Refridgerator								Nail Care															
Defrost Refriderator								Shave								Total Service Units							
Clean Stove / Oven								Dress Client															
Sanitize Bathroom								Turn Client								COMPANION							
Straighten Living Area								In/Out Bed								Day of the Week	SA	S	M	T	W	TH	F
Wash / Dry Laundry								Bed to Chair								Date of Service							
Iron / Mend Clothes								Walk Client								Assist/Supervise							
Change Linens								Stand Client								Meal Planning							
Make Bed								Bowel/Bladder								Meal Prep.							
Empty / Remove Garbage								Plan Meals / Snacks								Food Shopping							
Plan Meals / Snacks								Prepare Meal/Snack								Home Cleaning							
Prepare Meal/Snack								Serve Meals / Snacks								Bathing/Hygiene							
Serve Meals / Snacks								Feed Meals / Snacks								Grooming							
Feed Meals / Snacks								Encourage Diet								Taking Meds							
Encourage Diet								Essential HM Chores								Medical Visits							
Grocery Shopping								Change Linens								Total Service Units							
Assist Paying Bills								Make Bed															
Pickup Presc. Meds								Laundry								OTHER:							
Remind to Take Meds								Wash Dishes								Day of the Week	SA	S	M	T	W	TH	F
Assist with Telephone								Remind to Take Meds								Date of Service							
Mail - Read / Write								Monitor Medications															
Orient to Day Events								Monitor CL Condition															
Walk Client								Report CL Condition															
Monitor/ReportCondition								Home Safety															
Total Service Units								Total Service Units								Total Service Units							

COMMENTS:

List services below as: **HM** = homemaker **PC** = personal care **UR** = unskilled respite **C** = companion **O** = other(specify)

This is to certify that the information on this form is true, accurate and complete. I understand that I am certifying that I have received the services listed on the dates specified.

Day of Service	Time-In	Time-out	Services	Client Signature	Employee Signature
Saturday					
Sunday					
Monday					
Tuesday					
Wednesday					
Thursday					
Friday					

Reviewed by
Supervisor _____

Date _____

Reviewed by
RN Supervisor _____

Date _____