DAILY SERVICE REPORT

Month_____Year_____Service Provider_____Program Alabama Cares

Client Name_____Medical Record No._____

County_____Case Manager_____

SARCOA Area Agency on Aging

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		Day of the Week		Day of the Week	
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		Other	
Clean Refridgerator		Nail Care			
Defrost Refriderator		Shave			
Clean Stove / Oven		Dress Client		Total Service Units	
Sanitize Bathroom		Turn Client			
Straighten Living Area		In / Out Bed		**COMPANION**	
Wash / Dry Laundry		Bed to Chair		Day of the Week	
Iron / Mend Clothes		Walk Client		Date of Service	
Change Linens		Stand Client		Assist/Supervise	
Make Bed		Bowel/Bladder		Meal Planning	
Empty Garbage		Plan Meals / Snacks		Meal Prep.	
Remove Trash		Prepare Meal/Snack		Food Shopping	
Plan Meals / Snacks		Serve Meals / Snacks		Home Cleaning	
Prepare Meal/Snack		Feed Meals / Snacks		Bathing/Hygiene	
Serve Meals / Snacks		Encourage Diet		Grooming	
Feed Meals / Snacks		Essential HM Chores		Taking Meds	
Encourage Diet		Change Linens		Medical Visists	
Run Errands		Make Bed		Total Service Units	
Grocery Shopping		Laundry			
Assist Paying Bills		Wash Dishes		**OTHER:**	
Pickup Presc. Meds		Remind to Take Meds		Day of the Week	
Remind to Take Meds		Moniter Medications		Date of Service	
Assist with Telephone		Moniter CL Condition			
Letters-Read / Write		Report CL Condition			
Letters - Mail		Home Safety			
Orient to Day Events		Other			
Walk Client		Total Service Units		Total Service Units	
Moniter CL Condition		COMMENTS			
Report CL Condition					
Other					
Total Service Units					

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	Services
Time-In	Client Signature
Time-Out	Employee Signature

Reviewed by
Supervisor_____ Date_____

Reviewed by
RN Supervisor_____ Date_____