

Agency: _____ Agency Phone Number: _____

Beneficiary Name: _____ Date of Service: _____ Overnight Shift: Yes No

Staff Printed Name	Staff Signature	*Time in	*Time out

*If EVV is used, write "EVV" in Time in/Time Out columns. If manual entry, record the exact Time in /Time out.

Location of Service: Home Other (Required for Manual Entries Only)

Check all that apply:

Relationship support/building and community connections	Family: <input type="checkbox"/> Call <input type="checkbox"/> Visit <input type="checkbox"/> Family event
	Friends: <input type="checkbox"/> Call <input type="checkbox"/> Visit <input type="checkbox"/> Event
	<input type="checkbox"/> Participated in community event <input type="checkbox"/> Community organization meeting or activity <input type="checkbox"/> Participated independently or with family/friend <input type="checkbox"/> Assistance or support provided by staff
Education, work, and social roles	<input type="checkbox"/> Assistance getting to/from location <input type="checkbox"/> Assistance in accessing/applying for opportunities
	<input type="checkbox"/> Support provided to participate <input type="checkbox"/> Individual participated with assistance from another provider
	<input type="checkbox"/> Individual participated independently or with assistance from family/friend
Appointments	<input type="checkbox"/> Doctor Visit <input type="checkbox"/> Lab or test <input type="checkbox"/> Scheduled Procedure <input type="checkbox"/> Behavioral Health Visit
	<input type="checkbox"/> Therapy or home health visit <input type="checkbox"/> Any instructions provided (see notes from MD/medical provider)
	<input type="checkbox"/> Any follow-up needed
Challenges today	<input type="checkbox"/> Medical symptoms <input type="checkbox"/> Critical incident <input type="checkbox"/> Behavioral incident <input type="checkbox"/> Medication error/problem
	<input type="checkbox"/> Plan followed and documentation available to support
	<input type="checkbox"/> Contacted supervisor or professional for assistance [Specify contact: _____]

Indicate what, if any, assistance was provided. If completed independently, provided by another person (name or role) or if assistance not provided, indicate this in the "Assistance Provided" section.

ADL/IADL area of support	Assistance provided:
Eating	
Dressing or picking out clothes	
Grooming personal hygiene	
Toileting	
Bathing or showering	
Mobility, lifting, or positioning	
Shopping or purchasing	
Cleaning my home or yard	
Managing finances	
Managing time or scheduling	
Medication or medical supports	

Progress notes, descriptions, and comments. Provide additional details of items checked above AND support towards goals included in the person's CPOC.
