Home Health Care, Inc.
License #29992736
Fax # (352) 240-1530

LTC

DCF Genworth Staywell
Private Pay Sunshine UHC
Other - Circle one

Week ending ____/____/____

Client Name____________________________________ Caregiver Name____________________________________

Days	**Mon**	**Tue**	**Wed**	**Thu**	**Fri**	**Sat**	**Sun**
Dates	/	/	/	/	/	/	/
Universal Precautions Observed							
Bathing / Shower / Tub / Bed							
Skin / Nail / Oral Care							
Dressing							
Toileting							
Peri Care / Catheter Care							
Meal Prep / Feeding							
Medication Reminders							
Cane / Walker / WC / Mobility							
Positioning Every 2 hours							
Shopping ***							
Total PC Hrs	Hrs	Hrs	Hrs	Hrs	Hrs	Hrs	Hrs
Light Homemaking							
Shopping***							
Total HMK hours	Hrs	Hrs	Hrs	Hrs	Hrs	Hrs	Hrs
Companion / Social Interaction / Meal Prep / Medication Reminders							
Total Companion Hrs	Hrs	Hrs	Hrs	Hrs	Hrs	Hrs	Hrs
Respite							
Total Respite Hrs	Hrs	Hrs	Hrs	Hrs	Hrs	Hrs	Hrs

***Shopping – client gave aide $__________ Aide returned $__________with receipt

Type of shopping Groceries Pharmacy Misc.

CONTRACTOR VOUCHER

Client Name____________________________________ Caregiver Name____________________________________

The above-named caregiver has performed satisfactory service for the time indicated and Champion Home Health Care, Inc. is authorized to bill for such services

Date	**Day**	**Start Time**	**End Time**	**Total Hrs**	**Client Signature**	**Aide Signature**
	Mon	am/pm	am/pm			
	Tue	am/pm	am/pm			
	Wed	am/pm	am/pm			
	Thu	am/pm	am/pm			
	Fri	am/pm	am/pm			
	Sat	am/pm	am/pm			
	Sun	am/pm	am/pm			