Client Name: _____ **Client Phone Number:** _____

Client Address: _____

	PCS/Attendent Care Services										Homemaker Services					Other							
MID#: _____	Date	Bathing	Dressing	Eating Meals	Medication	Mobility	Hygeine	Toileting	Transferring	Total Shift Minutes	Housework	Laundry	Meal Prep	Shopping	Total Shift Minutes	Transportation	Night Needs	Total Shift Minutes	Time In AM	Time Out AM	Time In PM	Time Out PM	Grand Total Hours
Saturday																							
Friday																							
Thursday																							
Wednesday																							
Tuesday																							
Monday																							
Sunday																							

Advanced Care Northwest LLC

Did client show or report signs of being sick? (Circle) Yes No
Was your client admitted to the hospital this week? (Circle) Yes No
Did your client have any falls this week? (Circle) Yes No
Did your client refuse any services this week? (Circle) Yes No
If yes, refusal must be documented in comment section.
If you answered YES to any above questions, ACNW office must be notified, via phone.

I certify that all data o this form is accurate and correct: (Circle) Yes No

PCA Signature:_____ **Date:** _____

Admin Use Only: TC:_____ Billed:_____ Audit_____

Comments:_____

Date: _____

Client Signature : _____