



HELPING HANDS OF FLAGLER COUNTY, LLC.

50 Cypress Point Pkwy, Ste. B-4, Palm Coast FL 32164
 Office 386-313-1239 Cell 386-931-8001 Fax 386-206-3236
 e-mail: denisewilliams150@gmail.com

LTC SERVICE FOR THIS WEEK: PCA (Personal Care Assistance) Service Note (Separate timesheet per service/per week Friday to Thursday)

Service Recipient Name: _____ **C.N.A. or HHA Name:** _____

ADD COMMENT NEXT TO SERVICE PERFORMED	FRI	SAT	SUN	MON	TUES	WED	THURS
DATE:							
TIME IN:							
TIME OUT:							
TOTAL HOURS ON EACH DAY:							
*Services When Specified in Plan of Care, Required, and/or Essential to the Health, Welfare, Comfort of service recipient.							
OBSERVE / URGE BATHING – Comment weekly summary report on overall hygiene:							
BED BATH ___ Partial ___ Completed							
ASSIST WITH ___ SHOWER ___ TUB							
ASSIST WITH GROOMING (Comment with what)							
Clothing Hair Shaving Personal Effects							
ASSIST WITH MOUTHCARE ___ Dentures							
ASSIST WITH AMBULATION (WALKING)							
ASSIST WITH TRANSFER: (Get out of ___ Bed / ___ Chair / ___ Wheelchair)							
ASSIST WITH TOILETING – Comment weekly summary report:							
Assist To and From Bathroom							
Uses a Bedside Commode							
Uses a Bedpan / Urinal							
Empty Catheter Drainage Bag							
INCONTINENT – CHANGE BRIEFS							
CHANGE POSITION ___ TURN							
RANGE OF MOTION							
*CLEANING – ONLY INCIDENTAL TO SERVICE:							
Clean Affected Floor							
Empty Affected Trash							
Change Bed Linen if Soiled							
Pick-Up / Organize pertaining to Personal Care							
FOOD / NUTRITION / DIET ACTIVITIES – Comment Weekly Summary Report:							
MEAL PREPARATION / SERVE – What is it?							
Offer Fluids							
Assist with Eating							
What % Was Eaten	%	%	%	%	%	%	%
HEALTH-SAFETY-WELLBEING CAREGIVER COMMENTS:							
Physical Health this week:							
Emotional Health this week:							
Behavior this week:							
Safety issues need addressing:							
Medical Appts – Date/Physician/Outcome:							

Service Recipient Designee Signature: _____ **Caregiver Signature:** _____ **Date:** _____

Service Recipient (Patient)/Designee: I certify that the caregiver listed on this time slip worked the times indicated and the work was performed in a satisfactory manner. I agree to the times regarding this time slip.