



HELPING HANDS OF FLAGLER COUNTY, LLC.  
 License # 299994524  
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**LTC SERVICE FOR THIS WEEK: RESPITE – IN HOME Service Note**  
*(Separate timesheet per service/per week Friday to Thursday)*  
 Insurance Company: **(Circle One)** Sunshine, Humana, United

Service Recipient Name: \_\_\_\_\_ C.N.A. or HHA Name: \_\_\_\_\_

<b>ADD COMMENT NEXT TO SERVICE PERFORMED</b>	<b>FRI</b>	<b>SAT</b>	<b>SUN</b>	<b>MON</b>	<b>TUES</b>	<b>WED</b>	<b>THURS</b>
<b>DATE:</b>							
<b>TIME IN:</b>							
<b>TIME OUT:</b>							
<b>TOTAL HOURS ON EACH DAY:</b>							

\*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							
<b>INCONTINENT – CHANGE BRIEFS</b>							
<b>CHANGE POSITION ___TURN</b>							
<b>RANGE OF MOTION</b>							
<b>*CLEANING – ONLY INCIDENTAL TO SERVICE:</b>							
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 / ASSIST – What did he/she eat and Status of Appetite?							
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**HEALTH-SAFETY-WELLBEING CAREGIVER COMMENTS---**

Status of Physical Health / Emotional Health / Behavior this week:

Any Safety issues need addressing:

Any Medical Appts – Date/Physician/Outcome:

Other Comments:

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.