

## CAREGIVER TIME RECORD

Use Black INK

Client Name			Policy #				CareGiver Name				Hourly Rate			
Client Signature							Approval Date							
Date	/ /		/ /		/ /		/ /		/ /		/ /		/ /	
Weekday	Sunday		Monday		Tuesday		Wednesday		Thursday		Friday		Saturday	
Begin At 12:00 AM	Hour	am pm	Hour	am pm	Hour	am pm	Hour	am pm	Hour	am pm	Hour	am pm	Hour	am pm
Time In														
Time Out														
<b>Split Shift Use Below</b>														
Time In														
Time Out														
End At 11:59 PM	<b>DO NOT EXCEED 24 Hours</b>													
Daily Total Time														
Date	/ /		/ /		/ /		/ /		/ /		/ /		/ /	
Weekday	Sunday		Monday		Tuesday		Wednesday		Thursday		Friday		Saturday	
Begin At 12:00 AM	Hour	am pm	Hour	am pm	Hour	am pm	Hour	am pm	Hour	am pm	Hour	am pm	Hour	am pm
Time In														
Time Out														
<b>Split Shift Use Below</b>														
Time In														
Time Out														
End At 11:59 PM	<b>DO NOT EXCEED 24 Hours</b>													
Daily Total Time														

**Page 2 MUST accompany this page for payments to be processed**

## CAREGIVER NOTE

**Level of Assist** Choose the level that best describes the client's participation in each task on the day performed

- 7 **INDEPENDENT:** client performs task safely, with or without assistive devices - **EVERYTIME**
- 6 **SAFETY/STAND-BY/SUPERVISORY ASSISTANCE:** required from another person within arms reach for safety - **SOME OF THE TIME**
- 5 **SAFETY/STAND-BY/SUPERVISORY ASSISTANCE:** required from another person within arms reach for safety - **HALF THE TIME**
- 4 **SAFETY/STAND-BY/SUPERVISORY ASSISTANCE:** required from another person within arms reach for safety - **EVERYTIME**
- 3 **HANDS ON ASSISTANCE:** required from another person without which the client would not perform the ADL - **SOME OF THE TIME**
- 2 **HANDS ON ASSISTANCE:** required from another person without which the client would not perform the ADL - **HALF THE TIME**
- 1 **HANDS ON ASSISTANCE:** required from another person without which the client would not perform the ADL - **EVERYTIME**

### REVIEW OF PHYSICAL FUNCTIONING - ADL'S

Tasks	Sun	Mon	Tue	Wed	Thu	Fri	Sat	Sun	Mon	Tue	Wed	Thu	Fri	Sat
<b>Transferring</b>														
<b>Level of Assist 7 6 5 4 3 2 1</b>														
Getting in/out of bed														
Getting in/out of chair/wheelchair														
Walking inside or outdoors														
<b>Dressing</b>														
<b>Level of Assist 7 6 5 4 3 2 1</b>														
Selection of appropriate clothing														
Put on Take of items of clothing														
Fasten Clothing														
Put on Take of TED hose/brace														
Put on Take off socks/shoes														
<b>Bathing</b>														
<i>(circle one or more)</i> Shower Tub Sponge Bath														
<b>Level of Assist 7 6 5 4 3 2 1</b>														
Getting in/out of shower														
Washing any part of the body														
Towel dry														
<b>Eating/Feeding</b>														
<i>(circle one or more)</i> Breakfast Lunch Dinner														
<b>Level of Assist 7 6 5 4 3 2 1</b>														
Getting food from plate to mouth														
Getting fluids from cup to mouth														
Meal prep and planning														
Feeding tube of TPN use														
<b>Toileting</b>														
<i>(circle one or more)</i> Toilet Bedside Commode Bed Pan Urinal														
<b>Level of Assist 7 6 5 4 3 2 1</b>														
Getting to/from toilet/device														
Getting on/off toilet/device														
Cleaning after toileting														
<b>Incontinence Care</b>														
<i>Episodes of incontinence - how often?</i>														
<b>Level of Assist 7 6 5 4 3 2 1</b>														
Washing after accident														
Changing incontinence briefs														
Catheter care														
Colostomy or Ileostomy care														
<b>Medication Management</b>														
<b>Mark the box that applies</b>														
Independent with Medication														
Needs reminders only														
Requires physical assistance														
<b>REPORT ANY CHANGES IN THE LAST 2 WEEKS - FALLS - ILLNESS - DECLINE - IMPROVEMENT - PHYSICIAN VISITS</b>														
I certify with my signature this information is true and correct and the services marked have been performed as indicated.														
Caregiver Name										Date				