

Client Name \_\_\_\_\_ Employee Printed Name \_\_\_\_\_, DSW

Program Service:      NOW      SIL      ROW      CC      SW      ADHC      CONTRACT

Documenting Time: Staff **MUST** check in/out using EVV. Client/Authorized Representative must sign time sheet. **Time Sheets are due on Mondays by 4pm.** If an emergency occurs, first ensure client safety then call office and document in progress notes and critical incident report. **If you are unable to clock in/out, please complete this EVV manual entry section and put reason why.**

Sunday	Date _____	Time In _____	Time Out _____	Reason _____
Monday	Date _____	Time In _____	Time Out _____	Reason _____
Tuesday	Date _____	Time In _____	Time Out _____	Reason _____
Wednesday	Date _____	Time In _____	Time Out _____	Reason _____
Thursday	Date _____	Time In _____	Time Out _____	Reason _____
Friday	Date _____	Time In _____	Time Out _____	Reason _____
Saturday	Date _____	Time In _____	Time Out _____	Reason _____

Total Hours \_\_\_\_\_

**Progress notes must be completed for each shift worked. NO WHITE OUT, must remain in home book until its due in the office**

**Sunday** Place of Service: Home      Community     

PERSONAL TASK COMPLETED: Grooming Yes / No Bath/Shower Yes / No Dressing Yes / No Oral Care Yes / No

Urination Yes / No If yes #times \_\_\_\_\_ Bowel movement Yes / No If yes #times \_\_\_\_\_ Turning/Repositioning Yes / No

TASK COMPLETED: Meal Preparation Yes / No Sweep Yes / No Mop Yes / No Vacuum Yes / No Dust Yes Kitchen Yes / No

Bedroom Yes / No Laundry Yes / No Bathroom Yes / No Grocery Shopping Yes / No

Other \_\_\_\_\_

NUTRITION/MEAL PREPARATION: Breakfast Yes/No Lunch Yes/No Dinner Yes/No Snack Yes/No Hydration Yes/No

Any changes in: Skin Condition Yes / No Health Condition Yes/No Behavior Yes/No Home Environment Yes/No (if yes call office)

Outings Shopping \_\_\_\_\_ Medical appointment \_\_\_\_\_ Other \_\_\_\_\_

PROGRESS NOTES: Write a detailed description of events that occurred on the shift, include activities, behavior issues and ISP goals.

**Monday** Place of Service: Home      Community     

PERSONAL TASK COMPLETED: Grooming Yes / No Bath/Shower Yes / No Dressing Yes / No Oral Care Yes / No

Urination Yes / No If yes #times \_\_\_\_\_ Bowel movement Yes / No If yes #times \_\_\_\_\_ Turning/Repositioning Yes / No

TASK COMPLETED: Meal Preparation Yes / No Sweep Yes / No Mop Yes / No Vacuum Yes / No Dust Yes Kitchen Yes / No

Bedroom Yes / No Laundry Yes / No Bathroom Yes / No Grocery Shopping Yes / No

Other \_\_\_\_\_

NUTRITION/MEAL PREPARATION: Breakfast Yes/No Lunch Yes/No Dinner Yes/No Snack Yes/No Hydration Yes/No

Any changes in: Skin Condition Yes / No Health Condition Yes/No Behavior Yes/No Home Environment Yes/No (if yes call office)

Outings Shopping \_\_\_\_\_ Medical appointment \_\_\_\_\_ Other \_\_\_\_\_

PROGRESS NOTES: Write a detailed description of events that occurred on the shift, include activities, behavior issues and ISP goals.

**Tuesday** Place of Service: Home      Community     

PERSONAL TASK COMPLETED: Grooming Yes / No Bath/Shower Yes / No Dressing Yes / No Oral Care Yes / No

Urination Yes / No If yes #times \_\_\_\_\_ Bowel movement Yes / No If yes #times \_\_\_\_\_ Turning/Repositioning Yes / No

TASK COMPLETED: Meal Preparation Yes / No Sweep Yes / No Mop Yes / No Vacuum Yes / No Dust Yes Kitchen Yes / No

Bedroom Yes / No Laundry Yes / No Bathroom Yes / No Grocery Shopping Yes / No

Other \_\_\_\_\_

NUTRITION/MEAL PREPARATION: Breakfast Yes/No Lunch Yes/No Dinner Yes/No Snack Yes/No Hydration Yes/No

Any changes in: Skin Condition Yes / No Health Condition Yes/No Behavior Yes/No Home Environment Yes/No (if yes call office)

Outings Shopping \_\_\_\_\_ Medical appointment \_\_\_\_\_ Other \_\_\_\_\_

PROGRESS NOTES: Write a detailed description of events that occurred on the shift, include activities, behavior issues and ISP goals.

**Wednesday** Place of Service: Home      Community     

PERSONAL TASK COMPLETED: Grooming Yes / No Bath/Shower Yes / No Dressing Yes / No Oral Care Yes / No

Urination Yes / No If yes #times \_\_\_\_\_ Bowel movement Yes / No If yes #times \_\_\_\_\_ Turning/Repositioning Yes / No

TASK COMPLETED: Meal Preparation Yes / No Sweep Yes / No Mop Yes / No Vacuum Yes / No Dust Yes Kitchen Yes / No

Bedroom Yes / No Laundry Yes / No Bathroom Yes / No Grocery Shopping Yes / No

Other \_\_\_\_\_

NUTRITION/MEAL PREPARATION: Breakfast Yes/No Lunch Yes/No Dinner Yes/No Snack Yes/No Hydration Yes/No

Any changes in: Skin Condition Yes / No Health Condition Yes/No Behavior Yes/No Home Environment Yes/No (if yes call office)

Outings Shopping \_\_\_\_\_ Medical appointment \_\_\_\_\_ Other \_\_\_\_\_

PROGRESS NOTES: Write a detailed description of events that occurred on the shift, include activities, behavior issues and ISP goals.

**Thursday** Place of Service: Home \_\_\_ Community \_\_\_\_\_

PERSONAL TASK COMPLETED: Grooming Yes / No Bath/Shower Yes / No Dressing Yes / No Oral Care Yes / No

Urination Yes / No If yes #times \_\_\_\_\_ Bowel movement Yes / No If yes #times \_\_\_\_\_ Turning/Repositioning Yes / No

TASK COMPLETED: Meal Preparation Yes / No Sweep Yes / No Mop Yes /No Vacuum Yes / No Dust Yes Kitchen Yes / No

Bedroom Yes / No Laundry Yes / No Bathroom Yes / No Grocery Shopping Yes / No

Other \_\_\_\_\_

NUTRITION/MEAL PREPARATION: Breakfast Yes/No Lunch Yes/No Dinner Yes/No Snack Yes/No Hydration Yes/No

Any changes in: Skin Condition Yes / No Health Condition Yes/No Behavior Yes/No Home Environment Yes/No (if yes call office)

Outings Shopping \_\_\_\_\_ Medical appointment \_\_\_\_\_ Other \_\_\_\_\_

PROGRESS NOTES: Write a detailed description of events that occurred on the shift, include activities, behavior issues and ISP goals.

**Friday** Place of Service: Home \_\_\_ Community \_\_\_\_\_

PERSONAL TASK COMPLETED: Grooming Yes / No Bath/Shower Yes / No Dressing Yes / No Oral Care Yes / No

Urination Yes / No If yes #times \_\_\_\_\_ Bowel movement Yes / No If yes #times \_\_\_\_\_ Turning/Repositioning Yes / No

TASK COMPLETED: Meal Preparation Yes / No Sweep Yes / No Mop Yes /No Vacuum Yes / No Dust Yes Kitchen Yes / No

Bedroom Yes / No Laundry Yes / No Bathroom Yes / No Grocery Shopping Yes / No

Other \_\_\_\_\_

NUTRITION/MEAL PREPARATION: Breakfast Yes/No Lunch Yes/No Dinner Yes/No Snack Yes/No Hydration Yes/No

Any changes in: Skin Condition Yes / No Health Condition Yes/No Behavior Yes/No Home Environment Yes/No (if yes call office)

Outings Shopping \_\_\_\_\_ Medical appointment \_\_\_\_\_ Other \_\_\_\_\_

PROGRESS NOTES: Write a detailed description of events that occurred on the shift, include activities, behavior issues and ISP goals.

**Saturday** Place of Service: Home \_\_\_ Community \_\_\_\_\_

PERSONAL TASK COMPLETED: Grooming Yes / No Bath/Shower Yes / No Dressing Yes / No Oral Care Yes / No

Urination Yes / No If yes #times \_\_\_\_\_ Bowel movement Yes / No If yes #times \_\_\_\_\_ Turning/Repositioning Yes / No

TASK COMPLETED: Meal Preparation Yes / No Sweep Yes / No Mop Yes /No Vacuum Yes / No Dust Yes Kitchen Yes / No

Bedroom Yes / No Laundry Yes / No Bathroom Yes / No Grocery Shopping Yes / No

Other \_\_\_\_\_

NUTRITION/MEAL PREPARATION: Breakfast Yes/No Lunch Yes/No Dinner Yes/No Snack Yes/No Hydration Yes/No

Any changes in: Skin Condition Yes / No Health Condition Yes/No Behavior Yes/No Home Environment Yes/No (if yes call office)

Outings Shopping \_\_\_\_\_ Medical appointment \_\_\_\_\_ Other \_\_\_\_\_

PROGRESS NOTES: Write a detailed description of events that occurred on the shift, include activities, behavior issues and ISP goals.

**Incidents:** was there a CRITICAL INCIDENT today? \_\_\_ Yes \_\_\_ No If yes, complete incident form, report to Supervisor/Agency

Check one \_\_\_ Medical \_\_\_ Behavior \_\_\_ Seizure \_\_\_ Abuse/Neglect \_\_\_ Other \_\_\_\_\_

Was participant taken to the emergency room today? \_\_\_ Yes \_\_\_ No If yes, what hospital? \_\_\_\_\_

**Medication/Health and Wellness**

New or discontinued medications/New Health Diagnosis/Other Health

Information \_\_\_\_\_

DSW Signature/Date \_\_\_\_\_

Client Signature/Authorized Representative/Date: \_\_\_\_\_

Program Representative/Date \_\_\_\_\_

**Signature verifies this client record is accurate. I understand falsifying notes and or time sheets is Medicaid fraud, punishable by law.**

**Accounts receivable \_\_\_\_\_ Accounts payable \_\_\_\_\_**