

## P.C.A Plus Inc Log of Weekly Services / Supports & Daily Progress Notes

Individuals Name: →→→		Personal Supports	Respite (under 21)	Personal Care (under 21)																				
		Life Skills Development		Private Care																				
Staff Name: →→→→→		Week Of: _____																						
↑↑↑ I-Independently M-Modeling H-Hand Over Hand Assistance V-Verbal Prompt P-Total Physical Assistance R- Client Refused to Participate ↑↑↑																								
<b>Activities of Daily Living (ADL's)</b>	M	T	W	T	F	S	S	<b>Activities of Daily Living (ADL's)</b>	M	T	W	T	F	S	S	<b>Activities of Daily Living (ADL's)</b>	M	T	W	T	F	S	S	
Oral Care (Brush/Floss)								(Re) Positioning								Ambulation								
Bathing/Showering								Undressing								Toileting/ Diapering								
Dressing								Bedtime Assistance								Meal Preparation/Assistance								
Grooming (Nail Care/Shave)								Restroom Assistance								Scheduling Activities								
Transferring								During Night Care																
↑↑↑ Check All That Are Applicable ↑↑↑																								
<b>Health Assistance</b>	M	T	W	T	F	S	S	<b>Housekeeping</b>	M	T	W	T	F	S	S	<b>Housekeeping</b>	M	T	W	T	F	S	S	
Medication (Remind /								Change Linens								Make Bed								
Universal Precautions								Kitchen								Sweeping								
Allergy Precautions								Empty/Dispose Trash								Mopping								
Seizures/Seizure Monitoring								Laundry								Bathroom								
Behavior/ Unusual Incidents								Vacuum																
↑↑↑ Check All That Are Applicable ↑↑↑																								

Turned in behavior chart? Yes <input type="checkbox"/> No <input type="checkbox"/>	Turned in incident report? Yes <input type="checkbox"/> No <input type="checkbox"/>	Turned in seizure chart? Yes <input type="checkbox"/> No <input type="checkbox"/>	Turned in MAR? Yes <input type="checkbox"/> No <input type="checkbox"/>								
<b>Day</b>	<b>Date</b>	<b>1st In</b>	<b>1st Out</b>	<b>2nd In</b>	<b>2nd Out</b>	<b>Total Hrs</b>	<b>Total Qtr</b>	<b>Office Personnel Only:</b>			
Monday								Reviewed By: 1. _____ 2. _____ 3. _____	Billing: Date: _____ Amount: _____ Prepared By: _____		
Tuesday											
Wednesday											
Thursday											
Friday											
Saturday											
Sunday											
Total Hrs/Qtr Hrs →											

Individual/ Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Staff Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Please drop off at office or:  
 Fax: (904) 272-5097  
 Email: pcaplusinc@outlook.com

Date:

Progress made on goals:

Individuals Name: \_\_\_\_\_

<i>Monday</i>		

<i>Tuesday</i>		

<i>Wednesday</i>		

<i>Thursady</i>		

<i>Friday</i>		

<i>Saturday</i>		

<i>Sunday</i>		

What Health & Safety:

Note any Therapy, Appointments and / or Visitors during your shift:

Observation of Individuals mood/attitude: