# DOCUMENTATION FOR SERVICES PROVIDED: PROCEDURE CODE- 00001 & S5136, Family Home Care & Family Personal Care (Daily Rate)

**Client Name:**_____ **Client ID:**_____ **Provider:** _____ **Provider #:** _____

**MM/DD/YYYY of Service:**_____ **Service Location** _____

**Time In:**_____ **Time Out:**_____ **Total Units:**_____

☐ **00001 – Family Home Care**
☐ **S5136 – Family Personal Care**

**CHECK TASKS PROVIDED:**

| | | | |
|---|---|---|---|
| ☐ APNEA MONITOR | ☐ FEEDING | ☐ MEDICATION | ☐ SKIN |
| ☐ BATHING | ☐ FINGERNAIL | ☐ MOBILITY INSIDE | ☐ SUPPOSITORY |
| ☐ CATHETER | ☐ HAIR/SHAVING | ☐ MOBILITY OUTSIDE | ☐ TED SOCKS |
| ☐ COGNITIVE SUPERVISION | ☐ HOYER LIFT | ☐ OSTOMY | ☐ TEETH/MOUTH/DENTURE |
| ☐ DRESSING | ☐ INCONTINENCE | ☐ POSTURAL/BRONCHIAL DRAINAGE | ☐ TEMP/PULSE/RESPIRATION/BLOOD PRESSURE |
| ☐ EXERCISE | ☐ JOBST STOCKINGS | ☐ PROTHESIS/ORTHOTICS | ☐ TOILETING |
| ☐ EYE | ☐ MEDICAL GASES | ☐ RIK BED | ☐ TRANSFER/POSITIONING |
| ☐ COMMUNICATION | ☐ HOUSEWORK | ☐ LAUNDRY | ☐ MONEY MANAGEMENT |
| ☐ MEAL | ☐ SHOPPING | | |

**RESPITE CARE PROVIDED**

**Time In:**_____ **Time Out:**_____

**CLIENT HOSPITALIZATION/OUT OF HOME**

**Date Left:**_____ **Date Left:**_____ **Date Left:**_____ **Date Left:**_____

**Date Returned:** _____ **Date Returned:**_____ **Date Returned:**_____ **Date Returned:**_____

**COMMENTS:**