



Independent Caregiver Services Log Sheet

Return this form to HireFamily
 via email: logsheets@hirefamily.com
 via fax: 781-373-3649

via postal mail: HireFamily
 440 Totten Pond Road, Suite 301
 Waltham, MA 02451

Patient/Client Name:	Must answer the following questions regarding care during this work period: Was the Patient/Client hospitalized or in a facility this work period? <input type="checkbox"/> Yes <input type="checkbox"/> No Has the Patient/Client seen a health care professional this work period? <input type="checkbox"/> Yes <input type="checkbox"/> No Did Patient/Client have any falls or injuries this work period? <input type="checkbox"/> Yes <input type="checkbox"/> No Have Patient/Client's care needs changed this week from previous weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No	If "Yes" please list date(s) _____ _____ _____
Patient/Client Address:		
Patient/Client Phone #:		
Claim/Policy #:		

INSTRUCTIONS: Completely fill in one line of the form for each day or shift care was provided (use multiple lines for split shifts on the same day). Place an "X" in each box that describes the assistance provided for that day. Please describe all assistance provided in the Care Notes section. When complete, Caregiver and Patient/Client must each sign the bottom of the form.

Caregiver Name:			Assistance Provided With: <i>(Mark all that apply with an X)</i>							Each caregiver must use their own log sheet. If multiple caregivers provide services to patient/client, please use separate log sheets.									
Enter Date of Service <small>Example: 1/21/12 If overnight shift, use shift start date. Service week begins on Sun. and ends on Sat.</small>	Enter Time In <small>Example: 12:30 PM (Circle AM/PM)</small>	Enter Time Out <small>Example: 3:45 PM (Circle AM/PM)</small>	Bathing	Dressing	Transferring	Contingence	Toileting	Feeding	Supervision for Cognitive Impairment	Care Notes Section: Please describe all assistance provided to Patient/Client during the shift <small>(example: Sponge bath, food preparation, helped with medication, fed lunch and dinner, laundry)</small>									
	AM	AM																	
	PM	PM																	
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I certify that I have provided assistance to the Client as described above. Caregiver Signature: _____ Date: _____

I certify that the above information is true and correct. Patient/Client Signature: _____ Date: _____

If the Caregiver is also the claimant's Power of Attorney, then an additional witness signature must be included:

Notice: Witness Signature: _____ Date: _____

Any person who knowingly and with intent to defraud any insurance company or other person, files an application for insurance containing any materially false information, or conceals, for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.