

CARE-A-VAN Services, Inc.  
PCA Homemaker Supervisory Visit Documentation

Date \_\_\_\_\_

Consumer Name \_\_\_\_\_

Name(s) of anyone other than client present at interview.

\_\_\_\_\_

How much help has the Homemaker been?       A lot                       some                       none

Do you know your Homemaker's name?       Yes                       No

Does your Homemaker have any level authority over you?       Yes                       No

Name:

\_\_\_\_\_

Is your Homemaker cooperative       Yes                       No

Is your Homemaker punctual?       Yes                       No

Does your Homemaker stay scheduled time?       Yes                       No

Days and times your Homemaker visits

\_\_\_\_\_

When your regular Homemaker is unable to make your regular visit, would you like the agency to send someone else?       Yes                       No

Is there anything that you need done that is not being done?       Yes                       No

If yes, what

\_\_\_\_\_

Do you know that name of the agency your Homemaker works for?       Yes                       No

Can you locate the phone number?       Yes                       No

What does your Homemaker help you do?       bath \_\_\_\_\_ times weekly  
 shampoo                       cooking  
 shopping/errands                       housekeeping  
 laundry                       other

What does your Homemaker do that helps you most? \_\_\_\_\_

Do any other health care professionals visit you?       Yes                       No

If yes, name of agency

\_\_\_\_\_

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Generally, the client's health status has: remained unchanged improved  
deteriorated

Does the client's physical environment, personal appearance, and nutritional status reflect the number of units approved in the home? Yes No

Comments

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Are there any concerns regarding client's medications?

Does the client have adequate informal support? Yes No

Informal support person or persons:

Change in mental status Yes No

Alert and oriented Yes

Somewhat alert, continues to be able to function safely in home with current informal support

Not alert, unsafe to be left alone

Comments

Has the client seen his or her physician in past six months, been to the E.R., or admitted to the hospital? Yes No

Comments

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Care the services provided consistent with the care plan? Yes No

Care plan changes:

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Visit Frequency:

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Consumer Signature

Date

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QA Signature

Date