HEALTH MANAGEMENT, INC.
HOME HEALTH DIVISION
1707 L Street N.W, Suite 900 Washington, DC 20036
Telephone (202) 829-1111 - Fax: (202) 829-9192

SUPERVISORY VISIT FORM

Direct Care Service: _____

Client Name: _____

Name of Aide: _____

PERSON CARE EVALUATION: 4=Excellent 3=Good 2-Fair 1=Poor N/A=Not Applicable

Bathing	_____	Meal Preparation	_____	Exercise	_____
Grooming	_____	Housekeeping	_____	Turn & reposition	___
Shaving	_____	Laundry	_____	Vital Signs	_____
Hair care	_____	Errands/Shopping	_____	Catheter care	_____
Oral Hygiene	_____	Ambulation	_____	Appointments	_____

CLIENT LIVES:

_____Alone
_____With family, but family is
___Unable to provide care
___Unavailable
___Needs assistance

Functional limitations: _____

Client and family are ( ) pleased ( ) displeased with the services of the Aide

AIDE'S PERFORMANCE:

PCA/HHA ASSIGNMENT SHEET IS IN THE HOME: ( ) YES ( ) NO
FOLLOWS THE PLAN OF CARE AND ASSIGNMENT AS OUTLINED: ( ) Yes ( ) No
FOLLOWS CDC HAND HYGIENE TECHNIQUES ( ) YES ( ) NO
ADEQUATELY DOCUMENTS THE CARE RENDERED: ( ) Yes ( ) No
NOTIFIED OFFICE OF PROBLEMS ENCOUNTERED: ( ) Yes ( ) No
DEMONSTRATED ACCOUNTABLIITY AND RESPONSIBILITY: ( ) Yes ( ) No
REPORTS TO WORK ASSIGNMENTS AS SCHEDULED: ( ) Yes ( ) No
WORKS THE ASSIGNED HOURS AS SCHEDULED: ( ) Yes ( ) No

COMMENTS:

_____
_____
_____
_____

_____ _____ _____
Supervisor's Signature/Title Date Time

I, _____, have reviewed the Individual Care Plan (ICP) with my supervising RN. I understand that I must be in compliance with the ICP at all times, and that I should contact the supervising RN with any questions and/or concerns.

_____

PCA/HHA Signature **Date**

Comment on the effectiveness of the Individual Care Plan:

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