NEVADA PERSONAL CARE SERVICES, INC.

PROVIDER PERSONAL CARE RECORD

Personal Care Assistant

Phone: (702) 722-6200 Fax: (702) 722-6202

Client Name: _____ Phone: _____ Medicaid Billing No: _____

Provider Name: _____ Phone: _____

Pay Period: _____ To: _____

	SU	M	T	W	TH	F	SA
DATE OF SERVICE							
TIME IN (1)							
TIME OUT							
TIME IN (2)							
TIME OUT							
TIME IN (3)							
TIME OUT							
DAILY TOTAL							
	Weekly Total						
Tasks	Total Time Allowed						
Bathing							
Dressing							
Toileting							
Grooming							
Medication Reminder							
Transferring							
Mobility/Ambulation							
Eating							
Meal Preparation							
Light Housekeeping							
Laundry							
Shopping							
Other:							
Providers Initials							
Recipients Initials							

SU	M	T	W	TH	F	SA
Weekly Total						
Total Time Allowed						

In signing, the recipient and the provider agree that all services indicated and the hours logged above have been provided and received in accordance with care plan as authorized by the Nevada Medicaid District Office. **THIS DAILY DELIVERY RECORD IS TO BE USED IN CONJUNCTION WITH THE CARE PLAN.**

Comments; _____

_____

Provider Signature: _____ Date: _____

Client Signature: _____ Date: _____

Supervisor's Signature: _____ Date: _____

6655 South Eastern Avenue Suite 130 Las Vegas, NV 89119