TDNT Counseling Services Companionship Attendant Care Log

Document services provided at TDNT Counseling Services' Companionship Care Services. Please complete and sign this log. We will retain a copy on file. For questions, please contact us anytime: tdntcounseling@tdntsocialservices.org.

* Indicates required question

TDNT Social Services, Inc. (*TDNT Counseling Services Program*)

Companionship Caregiver Daily Activity Log

Please complete this Care Log for In-Home & Remote Companionship Attendant Services with TDNT Counseling Services Program at TDNT Social Services, Inc. Review the Client Service Agreement as well as more information at https://tdntsocialservices.org/companionship-care. Simply complete and submit this form Online. Or save and email this form as a PDF file to tdntcounseling@tdntsocialservices.org. You can also print and mail to PO Box 2213, Belle Glade, FL 33430 or turn this form in in-person.

1. Companionship Caregiver Notes for [Client/Patient name] *

2. Patient/Client ID *

3. Date of Service *

Example: January 7, 2019

4. Shift Start Time *

_____

Example: 8:30 AM

5. Shift End Time *

_____

Example: 8:30 AM

6. Written & Submitted by [Caregiver/Companionship Attendant] *

_____

7. Date Written/Submitted *

_____

Example: January 7, 2019

8. 1. Daily Activities *

Check all that apply.

- [ ] Walks
- [ ] Reading
- [ ] Games
- [ ] Watching TV
- [ ] Attending Events
- [ ] Other: _____

9. Notes & Observations [Comments] *

10. 2. Daily Interactions *

Check all that apply.

- [ ] Conversations
- [ ] Social Visits
- [ ] Phone Calls
- [ ] Other: _____

11. Notes & Observations [Comments] *

12. 3. Mood & Behavior *

Check all that apply.

- [ ] Mood Changes
- [ ] Energy Levels
- [ ] Unusual Behaviors
- [ ] Other: _____

13. Notes & Observations [Comments] *

14. 4. Activities & Interests *

15. 5. Notes, Recommendations & Reminders [Plans] for Daily Companionship Activities *

16. 6. Medications Taken [List the medication names, prescribed or over the counter (OTC), dosage and time taken] *

17. Notes & Observations [Comments] *

18. 7. Toileting Information *

Check all that apply.

- [ ] Urinate
- [ ] Bowel Movement [BM]
- [ ] Other: _____

19. Notes & Observations [Comments - include time for each toileting event (urinate or BM)] *

20. 8. Meal *

Check all that apply.

- [ ] Breakfast
- [ ] Lunch
- [ ] Dinner
- [ ] Snacks
- [ ] Drinks
- [ ] Water [>8oz recommended]
- [ ] Other: _____

21. Notes & Observations [Comments - include amount of water client/patient drinks each time] *

_____

_____

_____

_____

_____

22. 9. Sleeping & Grooming *

Check all that apply.

- [ ] Wake Up
- [ ] Nap
- [ ] Bed Time
- [ ] Sleep (hours)
- [ ] Shower/Washed
- [ ] Other: _____

23. Notes & Observations [Comments - include total hours of sleep each time, include time for each activity] *

24. 10. General *

Check all that apply.

- [ ] Appointments
- [ ] Health Concerns
- [ ] Supplies Needed Soon
- [ ] Pain Level
- [ ] Plans for Tomorrow
- [ ] Other: _____

25. Notes & Observations [Comments - include appointments completed in the shift and scheduled appointments, health concerns, supplies needed, pain level (if any) and any plans patient/client has for tomorrow regardless if you have that shift or not] *

26. 11. Service Type Provided *

Check all that apply.

- [ ] 8 hour Shift Care
- [ ] 12 Hour Shift Care
- [ ] 4 to 7 Hour Shift Care
- [ ] 2 to 3 hour Shift Care
- [ ] 12/24 Hour Shift Care
- [ ] Elderly Care
- [ ] Daily Caregiver
- [ ] Other: _____

27. 12. Service Hours (Shift Schedule for this date of service)

Check all that apply.

	Mon	Tue	Wed	Thu	Fri	Sat	Sun
4-HR SHIFT	☐	☐	☐	☐	☐	☐	☐
1:00 am - 5:00 am	☐	☐	☐	☐	☐	☐	☐
5:00 am - 9:00 am	☐	☐	☐	☐	☐	☐	☐
9:00 am - 1:00 pm	☐	☐	☐	☐	☐	☐	☐
1:00 pm - 5:00 pm	☐	☐	☐	☐	☐	☐	☐
5:00 pm - 9:00 pm	☐	☐	☐	☐	☐	☐	☐
9:00 pm - 1:00 am	☐	☐	☐	☐	☐	☐	☐
Other 4hr (Comments)	☐	☐	☐	☐	☐	☐	☐
8-HR SHIFT	☐	☐	☐	☐	☐	☐	☐
1:00 am - 9:00 am	☐	☐	☐	☐	☐	☐	☐
9:00 am - 5:00 pm	☐	☐	☐	☐	☐	☐	☐
5:00 pm - 1:00 am	☐	☐	☐	☐	☐	☐	☐
Other 8hr (Comments)	☐	☐	☐	☐	☐	☐	☐
12-HR SHIFT	☐	☐	☐	☐	☐	☐	☐
1:00 am - 1:00 pm	☐	☐	☐	☐	☐	☐	☐

5:00 am - 5:00 pm	☐	☐	☐	☐	☐	☐	☐
9:00 am - 9:00 pm	☐	☐	☐	☐	☐	☐	☐
1:00 pm - 1:00 am	☐	☐	☐	☐	☐	☐	☐
5:00 pm - 5:00 am	☐	☐	☐	☐	☐	☐	☐
9:00 pm - 9:00 am	☐	☐	☐	☐	☐	☐	☐
Other 12hr (Comments)	☐	☐	☐	☐	☐	☐	☐
24-HR SHIFT	☐	☐	☐	☐	☐	☐	☐
1:00 am - 1:00 am	☐	☐	☐	☐	☐	☐	☐
5:00 am - 5:00 am	☐	☐	☐	☐	☐	☐	☐
9:00 am - 9:00 am	☐	☐	☐	☐	☐	☐	☐
1:00 pm - 1:00 pm	☐	☐	☐	☐	☐	☐	☐
5:00 pm - 5:00 pm	☐	☐	☐	☐	☐	☐	☐
9:00 pm - 9:00 pm	☐	☐	☐	☐	☐	☐	☐
Other 24hr (Comments)	☐	☐	☐	☐	☐	☐	☐
2-HR SHIFT Type hours in Comments	☐	☐	☐	☐	☐	☐	☐

28. Comments on Shift Schedule [Include exact time you attended] *

29. 13. Services Provided: *

Check all that apply.

- [ ] Standard Companionship Attendant Service (conversation, play games, support in activities, taking walks together, eating meals together, etc)
- [ ] Light Meal Preparation (taking food from refrigerator to hand to Client; time spent together during meals; mixing, serving, and heating up drink or food in the microwave or on the stove, etc)
- [ ] Light Tidying of living spaces where providing services as needed (wiping counters or tables where Attendant provided services, where Client will be eating during the Shift; straightening out the bed sheets or table cloth where Client is currently lying down or eating; placing/removing clothes in/from the washing machine/dryer to be washed/dried; etc)
- [ ] Light Errands (pick up medications from the drug store; pick up food from restaurant or store; drop mail in outgoing mailbox; pick up mail; etc)
- [ ] Shopping (grocery shopping together or alone, light shopping for clothes and shoes, etc)
- [ ] Other: _____

30. 14. Any changes in client/patient information? (phone, emergency contact, email, payment card info). Enter any changes here; if payment info changed, please tell us here and have the client/patient complete a new service agreement form or have the client pay using the payment card device we gave to you. *

31. 15. Did the client/patient pay for services in-person during the shift with you? *

Mark only one oval.

- Yes
- No

32. 16. If the Client/Patient paid for services during the shift, please indicate if the payment was Cash, Check or credit/debit card using a device we provided. *

Mark only one oval.

- Cash
- Check
- Credit/Debit Card
- Other: _____

33. 17. How much did the Client/Patient pay in-person during the shift? Enter the dollar amount (ex: $52.08). *

34. If the Client/Patient paid for services during the shift in Cash or Checks made payable to your name (not recommended), you may owe us a portion of this amount in fees. You must pay the amount which we will invoice you or we will deduct from your reimbursement payments. We recommend if paying in Checks for the Client to make the checks payable to "TDNT Social Services Inc" and you or the Client/Patient must either mail it to PO Box 2213, Belle Glade, FL 33430 or bring us the check in person. We will reimburse you as contracted. *

Mark only one oval.

- ◯ I understand and agree to pay fees I owe to TDNT Social Services Inc if the Client/Patient pays me directly for services; or I will bring the payment to TDNT Social Services Inc in person or by mail for checks.

35. I agree to email tdntcounseling@tdntsocialservices.org to give at least a 72-hour notice should I not be able to cover a shift, whenever possible. Should I not be able to give this notice, I will be sure to reach out immediately or at least 4 hours before my shift. *

Mark only one oval.

- ◯ I understand and consent.

36. I, the assigned companionship attendant at TDNT Social Services Inc, attest to having provided Companionship Attendant Services according to the services listed above and according to the description of services on the Client Service Agreement as follow: *

4. DESCRIPTION OF SERVICES. The Service Provider shall provide a Certified Nursing Assistant (CNA), Certified Medical Assistant (CMA), a Home Health Aide (HHA) or a credentialed Sitter to attend the Client.

The CNA, CMA, HHA or Sitter provided by the Service Provider shall have the power to:

- Administer medications when appropriate as shown below under Medication Instructions. This task is limited to Companionship Attendants credentialed and holding proper licensure as CNA's and CMA's Only.

- Provide emotional care, social engagement, emotional support, meaningful activities, companionship, assistance or support with general daily living needs, and related duties or tasks.

-

_____

_____

_____

_____

Service Provider or its representative will assist Client to live at home and to have as much control over the home environment and life as possible.

Apart from performing the above tasks the Service Provider shall do similar related tasks to be mutually agreed upon by the parties.

Mark only one oval.

I so attest.

37. Companionship Attendant Signature & Date *

38. Companionship Attendant ID, Email & Phone *

39. Executive Officer/Secretary Signature & Date (https://tdntsocialservices.org/companionship-care 954-324-7843 tdntcounseling@tdntsocialservices.org)

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40. **Donate to Help us Support Community Members & Earn Incentives**

Check all that apply.

- [ ] $1 Donor
- [ ] $10 Anytime Sporadic Blessings (Bronze)
- [ ] $10 per month My Heart's Desire (Silver)
- [ ] $20 per month Start Small (Gold)
- [ ] $50 per month Philanthropist (Platinum)
- [ ] $1000 per year Patronus Honoris (Diamond)
- [ ] $5000 per year Honore Patronis (Titanium)
- [ ] Other: _____