PARTICIPANT ACTIVITY TASK REPORT Month________________ Year___________

{ } HCA Participant Name________________________________ Participant Address _________________________________

{ } FHCA Homecare Aide (Worker) Name______________________________ Worker PIN: _____________ Supervisor Name ____________________

WEEK DAY	DATE	TASKS COMPLETED Please check the number for the corresponding task completed that day.															WORKER INITIALS My initials certify that I have performed the tasks specified	PARTICIPANT SIGNATURE By signing, I certify that the tasks were complete on the date below by the Homecare Aide.
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15		
Mon																		
Tue																		
Wed																		
Thu																		
Fri																		
Sat																		
Sun																		
Mon																		
Tue																		
Wed																		
Thu																		
Fri																		
Sat																		
Sun																		

TASKS LIST

(1) Eating (2) Bathing (3) Grooming
(4) Dressing (5) Transferring (6) Incontinence
(7) Managing Money (8) Telephoning (9) Preparing Meals
(10) Laundry (11) Housework (12) Outside Home
(13) Routine Health (14) Special Health (15) Being Alone

2-WAY RECEIPT

Amount GIVEN to WORKER

Date	Cash	Check	Food Stamps	Worker's Signature

Amount RETURNED to CLIENT

Date	Cash	Check	Food Stamps	Client's Signature

☐ Check this box if your client was admitted in the hospital/rehab.
Date Admitted _______________
Date Released _______________

☐ Check this box if your client refused service.
Date Refused _______________

☐ Check this box if your client had a fall.

HCA/FHCA (WORKER) SIGNATURE________________________________DATE_________ SUPERVISOR SIGNATURE ________________________________

BY SIGNING BELOW, YOU CERTIFY THAT THE ABOVE SERVICES WERE PROVIDED TO YOU IN THE DAYS INDICATED ON THIS TASK SHEET

PARTICIPANT (CLIENT)/AUTHORIZED REPRESENTATIVE SIGNATURE________________________________**DATE**____________

Rev 071119