

Client Name:

PCW Name:



MCFI Main Campus
 Harry & Jeanette Weinberg Building
 2020 West Wells Street
 Milwaukee, WI 53233

Main: 414-290-0050
 Toll-Free: 1-888-381-5696
 Payroll Fax # 414-755-7063

Payroll Email:
 hcpayroll@mcfi.net

Employee # _____

Dates	Sun	Mon	Tues	Wed	Thurs	Fri	Sat	Total Hours*
In								
Out								
In								
Out								
In								
Out								

*Example: 3.25 equals 3 hours 15 Minutes

ADL's may vary per client request with agency permission	Sun	Mon	Tues	Wed	Thurs	Fri	Sat	Notes
Advanced Personal Cares/RN Delegated Tasks Per Care Plan								
B/P, P SPO2 check/record								
Blood Glucose Checks								
Bowel Program								Were there any changes in the client's overall function? Yes/No
Catheter Care								If yes, please explain: _____
Complex Positioning								
CPAP/BIPAP								
Epi-Pen								
Medication Assistance/Remind								
Nebulizer								Were there any changes in the client's physical and/or emotional health? Yes/No
Oxygen/O2 assist/management								If yes, please explain: _____
Range of Motion								
Seizure Emergency Management								
Splints/Braces ON/OFF								
Hoyer Lift								Were there any cares assigned which were not completed? Yes/No
Sit to Stand								If yes, please explain: _____
Other:								
Other:								
	Sun	Mon	Tues	Wed	Thurs	Fri	Sat	
Personal Care/SHC Per Care Plan								
Accompany to grocery store								In case of client change of condition call MCFI Home Care Immediately, we are available by phone 24 hours a day. In case of emergencies, Call 911
Accompany to Medical Appointment								
Ambulation Assistance								
Companionship								
Clean Medical Equipment/DME								
Dress/Undress								
Glasses/Hearing Aid								
Grocery Shopping								
Grooming								
Hair Care								
Incontinent Care								RN Signature: _____
Laundry								Date: _____
Light Housekeeping/Cleaning								
Meal Preparation/Eating Assistance/Setup								
Nail Care non-diabetic								
Oral Care								
Shaving								
Shower/Tub bath/Bed bath/Sponge Bath								
Skin Care								
TED Stockings ON/OFF								
Toileting								
Transfer Simple								
Respite								
Other:								

Client or Legal Representative: My signature indicates that I attest that the worker has worked the hours stated and services have been provided in accordance with the care plan. Note: Please contact MCFI Home Care regarding any questions related to your services.

Client Signature

Date

Employee Verification: I attest that the above record of time is true and accurate in accordance with my duty sheet

Employee Signature

Date