

ADULT DAY HEALTH CARE DAILY LOG

Recipient's Name: _____ Medicaid ID: _____

| DAY: | Monday | Tuesday | Wednesday | Thursday | Friday | Saturday | Sunday |
|------------------------|--------|---------|-----------|----------|--------|----------|--------|
| DATE (Month/Day/Year): | / / | / / | / / | / / | / / | / / | / / |
| ACTIVITY: | | | | | | | |
| Toileting | | | | | | | |
| Ambulation/Transfer | | | | | | | |
| Eating/Feeding | | | | | | | |
| Supervision | | | | | | | |
| Meals/Snacks | | | | | | | |
| Nutritional Counseling | | | | | | | |
| Administer Medication | | | | | | | |
| Health Monitoring | | | | | | | |
| Skilled Services | | | | | | | |
| Social/Rec. Activities | | | | | | | |
| Rehab. Support | | | | | | | |
| Transportation | | | | | | | |
| Other | | | | | | | |
| DAILY TIME IN | | | | | | | |
| DAILY TIME OUT | | | | | | | |
| NUMBER OF HOURS | | | | | | | |

Weekly Comments & Date: _____

Weekly Signatures:

Recipient/Family's Signature

Date

ADHC Staff Signature

Date

Printed Recipient/Family Name

Printed ADHC Staff Name: