Homemaker/Home Health Monthly Service Report

Agency: _____ Agency Worker Name:_____

IlliniCare Health Member Name: _____ Date of Birth: _____

Services Provided: (check all that apply)

	Eating		Money Management		Outside Home		Routine Health
	Bathing		Housework		Telephoning		Special Health
	Grooming		Laundry		Dressing/Undressing		Transferring in/out of bed
	Meal Preparation		Bowel/Bladder		Supervision/Being Alone		Other*

*Please Specify Other: _____

Changes in Member's Condition (current or anticipated): _____
_____

Changes to Service Plan Recommended: _____

Services Interrupted: _____ YES _____ NO

Reason for Interruption: _____

Total hours allowed per month: _____ Total hours provided per month: _____

Reason total hours not used:_____
_____

Month/Year (noted below): _____ Please fill in calendar hours per day worked.

1.	2.	3.	4.	5.	6.	7.
8.	9.	10.	11.	12.	13.	14.
15.	16.	17.	18.	19.	20.	21.
22.	23.	24.	25.	26.	27.	28.
29.	30.	31.				

Agency Representative: _____ Date: _____