

Month: _____ Year: _____

Client Name: _____

Provider Name: _____

Support Coordinator: _____

Date Mailed to Support Coordinator: _____
For Office Use Only



Attendant Care Progress Report

Draw a line through the number that corresponds with the date that each Attendant Care Task was completed.

Attendant Care Tasks:

Page 1 of 2

Showering/Bathing/Shampooing Hair

DAY OF MONTH

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
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Grooming/Combing/Styling Hair

DAY OF MONTH

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
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Dressing

DAY OF MONTH

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Toileting

DAY OF MONTH

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Transfers

DAY OF MONTH

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Positioning

DAY OF MONTH

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Eating

DAY OF MONTH

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Routine Ambulation (Walking)

DAY OF MONTH

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Nail Care (Clipping/cleaning/grooming)

DAY OF MONTH

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Skin Care to include but not limited to Lotion:

DAY OF MONTH

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Special Appliances/Prosthetic Devices

DAY OF MONTH

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Brushing Teeth

DAY OF MONTH

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Q-Tip or Clean Ears:

DAY OF MONTH

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Meal Preparation (Client Only)

DAY OF MONTH

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Clean Bathroom Floor (Client Only)

DAY OF MONTH

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Clean Tub/Shower (Client Only)

DAY OF MONTH

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Clean Toilet (Client Only)

DAY OF MONTH

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Other Bathroom Housekeeping Duties-Client Only (Specify)

DAY OF MONTH

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Clean Bedroom Floor (Client only)

DAY OF MONTH

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Change Bed Linens (Client only)

DAY OF MONTH

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Make Bed (Client Only)

DAY OF MONTH

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Dust Client Bedroom

DAY OF MONTH

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Pick up Clothing or Toys (Specify)

DAY OF MONTH

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
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Clean/Disinfect/Sanitize Toys, Therapy equipment, personal items etc. (Specify)

DAY OF MONTH

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
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By signing below, I agree that the Attendant Care tasks were completed for the dates circled. I also agree that the duties were provided in a safe manner, as authorized and according to the training the employee has received.

Provider's Signature:	Printed Name:	Date:
Parent or Guardian's Signature:	Printed Name:	Date:

Month: _____ Year: _____

Client Name: _____

Provider Name: _____

Support Coordinator: _____

Date Mailed to Support Coordinator: _____
For Office Use Only



Attendant Care Progress Report

Draw a line through the number that corresponds with the date that each Attendant Care Task was completed.

Attendant Care Tasks:

Page 2 of 2

Other Bedroom Housekeeping Duties (Specify)

DAY OF MONTH

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
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Clean Kitchen Floor

DAY OF MONTH

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Clean Kitchen Countertops

DAY OF MONTH

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Clean Outside Cabinets

DAY OF MONTH

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Wash Dishes

DAY OF MONTH

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Dry Dishes

DAY OF MONTH

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Store Dishes

DAY OF MONTH

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Clean refrigerator

DAY OF MONTH

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Other Kitchen Duties (Specify):

DAY OF MONTH

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Clean Living room / Dining Room Floor

DAY OF MONTH

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Dust Living room / Dining Room

DAY OF MONTH

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
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Other Living Room Duties (Specify):

DAY OF MONTH

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Take out Garbage (From specific rooms or to curbside)

DAY OF MONTH

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Wash Laundry

DAY OF MONTH

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Dry Laundry

DAY OF MONTH

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Fold Laundry

DAY OF MONTH

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Shopping for Food and Household Items

DAY OF MONTH

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Training Care Task (To)

DAY OF MONTH

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Stocking Personal Items (Specify Areas):

DAY OF MONTH

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Other (Specify):

DAY OF MONTH

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Other (Specify):

DAY OF MONTH

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Other (Specify):

DAY OF MONTH

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Significant changes with client or family, and any needs or concerns observed during month:

By signing below, I agree that the Attendant Care tasks were completed for the dates circled. I also agree that the duties were provided in a safe manner, as authorized and according to the training the employee has received.

Provider's Signature:	Printed Name:	Date:
Parent or Guardian's Signature:	Printed Name:	Date: