

INDEPENDENT CAREGIVER ITEMIZED BILL & DAILY VISIT NOTE FORM

CLAIMANT NAME (PRINT): _____ POLICY NUMBER: _____
 CAREGIVER'S NAME (PRINT): _____ Check where services are rendered: Home Facility

Caregiver is a (check one): Certified Home Health Aide C.N.A. RN LPN/LVN Personal Care Attendant (PCA) Companion/Homemaker
 The hired caregiver must complete this form in ink every visit. Return originals only. Retain a copy for your records. Under each date of service, please check services provided.

REQUIRED	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
DATE (Month/Day/Year)							
Arrival Time: AM/PM							
Departure Time: AM/PM							
Total Hours Worked:							Totals
Hourly Rate:	\$	\$	\$	\$	\$	\$	\$
Total Charge:	\$	\$	\$	\$	\$	\$	\$
Services Provided:							
Ambulating Inside-Physically Assisted							
Ambulating Inside-Standby Assist							
Bathing-Physically Assisted							
Bathing-Standby Assist							
Bathing-Verbal Cue or reminder							
Dressing-Physically Assisted							
Dressing -Standby Assist							
Dressing- Verbal Cue or Reminder							
Eating-Spoon Fed or Tube Fed							
Eating-Verbal Cue or Reminder							
Transfer out of bed/chair-Physically Assist							
Transfer out of bed/chair-Standby Assist							
Transfer out bed/chair-Verbal Cue or Reminder							
Toileting-Physically Assisted							
Toileting-Standby Assist							
Toileting-Verbal Cue or Reminder							
Incontinent of bowel/bladder-Physically Assisted							
Assistance with Colostomy/Catheter Care							
Provided Continual Supervision due to Cognitive Impairment: Cannot be left alone							
Provided Continual Supervision due to a Physical Functional Incapacity: Cannot be left alone							
Companion Services							
Homemaking/Housekeeping-laundry, meal prep, dust, wash dishes, other:							

Was your client hospitalized or in a facility this week? Yes No

We cannot process this claim until this form is fully completed. Both signatures are required. The form should not be signed until the work week has concluded and all weekly services are recorded. I hereby certify that the information provided above is a complete and accurate representation of the care provided and received.

Caregiver Signature: _____ Date: ____/____/____
 Claimant or Legal Representative Signature: _____ Date: ____/____/____

Fraud Notice: Any person who, with an intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud and may be subject to criminal and civil penalties. Please refer to enclosed state variation sheet for state specific wording regarding this fraud notice.