# encova
## INSURANCE

# IN-HOME NURSING/ ATTENDANT CARE LOG

Return completed form to:
Encova Insurance
P.O. Box 3151
Charleston, WV 25332-3151
Or fax to: 877-898-6980

| Claimant name | Service vendor | Vendor number |
|---|---|---|
| Claim number | Ordering physician | |
| Date submitted | Authorization number | |

| Date range of service (from/to) | Saturday | Sunday | Monday | Tuesday | Wednesday | Thursday | Friday |
|---|---|---|---|---|---|---|---|
| Time approved—daily | | | | | | | |
| Time arrived | | | | | | | |
| Time left | | | | | | | |
| Total hours | | | | | | | |
| Claimant's initials | | | | | | | |

Circle the appropriate task and place a check mark for day the task was performed.

| Tasks | Saturday | Sunday | Monday | Tuesday | Wednesday | Thursday | Friday |
|---|---|---|---|---|---|---|---|
| **ACTIVITIES OF DAILY LIVING (ADL)** | | | | | | | |
| Ambulation: walk/cane/walker/wheelchair/scooter | | | | | | | |
| Bath: total/assist/supervised/independent sponge/tub/shower | | | | | | | |
| Dressing: total/assist/supervise/independent | | | | | | | |
| Hair: total/assist/supervise/independent | | | | | | | |
| Meals: diet/breakfast/lunch/dinner plan/prep/set-up/feed/record intake | | | | | | | |
| Mouth care: total/assist/supervise/independent | | | | | | | |
| Positioning: turn every _____ hrs./up in chair | | | | | | | |
| Skin care: lotion/shaving/catheter/bedsores | | | | | | | |
| Toileting: bathroom/bedpan/bedside commode/incontinent/empty catheter bag or ostomy device/record output total/assist/supervise/independent | | | | | | | |
| **HOME CARE** | | | | | | | |
| Bathroom: sweep/mop/clean fixtures/toilet/bedpan/bedside commode or urinal/straighten/empty trash | | | | | | | |
| Bed making: hospital bed/regular bed | | | | | | | |
| Client's room: Twice weekly: straighten Weekly: vacuum/sweep/mop/dust | | | | | | | |
| Entire residence: vacuum/sweep/mop/dust/straighten | | | | | | | |
| Kitchen: vacuum/sweep/mop/countertops/dishes/straighten | | | | | | | |
| Laundry: Laundromat/in-home/apt. complex | | | | | | | |

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Circle the appropriate task and place a check mark for day the task was performed.

| | Tasks | Saturday | Sunday | Monday | Tuesday | Wednesday | Thursday | Friday |
|---|---|---|---|---|---|---|---|---|
| **HEALTH CARE** | Exercise: ROM/prescribed physical therapy total/assist/supervise/ independent | | | | | | | |
| | Medication: assist/self-administered | | | | | | | |
| | Social stimulation: companionship | | | | | | | |
| | Transportation: physician/other/ ambulance/automobile | | | | | | | |
| | Treatment: BP/pulse/respiration/ temperature/unsterile dressing/ ice pack/elevate feet/suction | | | | | | | |
| | Other: | | | | | | | |

| Claimant signature | | Date | |
|---|---|---|---|
| Caregiver signature | Date | Supervisor signature | Date |