ACH/PC Log A

Name of Resident _____ Medicaid ID Number _____ Facility Name _____ Month _____ Year _____

PC Tasks	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
Bathing																															
Personal Hygiene/Grooming																															
Toileting																															
Dressing																															
Eating																															
Ambulation/Mobility																															
Transfers																															
Medications																															
Other PC _____																															
Other PC _____																															
Other PC _____																															

List below the names of facility staff providing personal care for the resident this month: (Aide initials task(s) performed above and records total hours of personal care provided each day to right of aide's name.)

Initials	Name of PC Aide																																Total PC Hours for Month
Initials	Name of PC Aide																																Total PC Hours for Month
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Initials	Name of PC Aide																																Total PC Hours for Month

Certification Statement: I certify that the record of personal care shown here is true and accurate, and the personal care aides identified above by initials and signatures performed the personal care tasks listed in a satisfactory manner.

_____ Signature of Facility Administrator or Designated Supervisor

_____ Date

Comments: _____

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ACH/PC Log B

Name of Resident _____ Medicaid ID Number _____

Facility Name _____ ____/____/____

TASKS PERFORMED AIDES

1st SHIFT

_____ Start Time

_____ End Time

_____ Initials PC Aide Name

_____ Initials PC Aide Name

_____ Initials PC Aide Name

_____ Initials PC Aide Name

_____ Initials PC Aide Name

____ Bath(Shower/Tub/Sponge)	____ Check Vital Signs	____ Shave/Shampoo/Grooming
____ Mouth Care	____ Assist with Eating	____ Skin Care
____ Assist w/Toileting	____ Assist w/Medications	____ Transfers
____ Turn/Position	____ Ambulation/Mobility	____ Change Non-Sterile Dressings
____ Catheter Care	____ Side Rails/Mitts/Restraints	____ Assist with Dressing
____ Other _____	____ Other _____	____ Other _____

Comments/Observations: _____

TASKS PERFORMED AIDES

2nd SHIFT

_____ Start Time

_____ End Time

_____ Initials PC Aide Name

_____ Initials PC Aide Name

_____ Initials PC Aide Name

_____ Initials PC Aide Name

_____ Initials PC Aide Name

____ Bath(Shower/Tub/Sponge)	____ Check Vital Signs	____ Shave/Shampoo/Grooming
____ Mouth Care	____ Assist with Eating	____ Skin Care
____ Assist w/Toileting	____ Assist w/Medications	____ Transfers
____ Turn/Position	____ Ambulation/Mobility	____ Change Non-Sterile Dressings
____ Catheter Care	____ Side Rails/Mitts/Restraints	____ Assist with Dressing
____ Other _____	____ Other _____	____ Other _____

Comments/Observations: _____

TASKS PERFORMED AIDES

3rd SHIFT

_____ Start Time

_____ End Time

_____ Initials PC Aide Name

_____ Initials PC Aide Name

_____ Initials PC Aide Name

_____ Initials PC Aide Name

_____ Initials PC Aide Name

____ Bath(Shower/Tub/Sponge)	____ Check Vital Signs	____ Shave/Shampoo/Grooming
____ Mouth Care	____ Assist with Eating	____ Skin Care
____ Assist w/Toileting	____ Assist w/Medications	____ Transfers
____ Turn/Position	____ Ambulation/Mobility	____ Change Non-Sterile Dressings
____ Catheter Care	____ Side Rails/Mitts/Restraints	____ Assist with Dressing
____ Other _____	____ Other _____	____ Other _____

Comments/Observations: _____

Certification Statement: I certify that the record of personal care shown here is true and accurate, and the personal care aides identified above by initials and signatures performed the personal care tasks listed in a satisfactory manner.

_____ Signature of Facility Administrator or Designated Supervisor

_____ Date

Comments: _____