INDEPENDENT CAREGIVER ITEMIZED BILL & DAILY VISIT NOTE FORM



CLAIMANT NAME (PRINT):CAREGIVER'S NAME (PRINT):				POLICY NUMBER: Check where services are rendered: □ Home □ Facility				
he hired caregiver must complete this form in ink every visit.								
REQUIRED	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	
DATE (Month/Day/Year)								
Arrival Time: AM/PM								
Peparture Time: AM/PM								Totals
otal Hours Worked:								
lourly Rate:	\$	\$	\$	\$	\$	\$	\$	
otal Charge:	\$	\$	\$	\$	\$	\$	\$	\$
		Servi	ces Provided:	_				
mbulating Inside-Physically Assisted								
mbulating Inside-Standby Assist								
athing-Physically Assisted								
athing-Standby Assist								
athing-Verbal Cue or reminder								
ressing-Physically Assisted								
ressing -Standby Assist								
ressing- Verbal Cue or Reminder								
ating-Spoon Fed or Tube Fed								
ating-Verbal Cue or Reminder								
ansfer out of bed/chair-Physically Assist								
ansfer out of bed/chair-Standby Assist								
ansfer out bed/chair-Verbal Cue or Reminder								
pileting-Physically Assisted								
oileting-Standby Assist								
pileting-Verbal Cue or Reminder								
continent of bowel/bladder-Physically Assisted								
ssistance with Colostomy/Catheter Care								
rovided Continual Supervision due to Cognitive								
rovided Continual Supervision due to a Physical Functional acapacity: Cannot be left alone								
ompanion Services								
omemaking/Housekeeping-laundry, meal prep, dust, wash ishes, other:								
Vas your client hospitalized or in a facility this week?	☐ Yes ☐ No							
e cannot process this claim until this form is fully complete	_	-		-			-	services are rec
hereby certify that the information provided al	bove is a cor	mplete and ac	curate repre	sentation of t	he care provi	ded and rec	eived.	
aregiver Signature:								//
laimant or Legal Representative Signature: raud Notice: Any person who, with an intent to defraud or knowing t							Date:	//

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