Carefree Home Services
PCA CHOICE MONTHLY REPORT

Client Name ________________________________

This form must be filled out by the Responsible Party on the cares being performed by **each** PCA.

PCA Name ____

PCA performance	Excellent	Very Good	Good	Below Average	Comments
Supervision for Safety					
Dressing					
Grooming					
Bathing					
Eating					
Transfers					
Mobility					
Positioning					
Toileting					
Medications needs					
Maintenance Exercise					
Medical Appointments					
Skin Cares					
Prosthetics					
Medical Equipment					
Seizures					
Behaviors					
Housekeeping					

Comments____

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Signature of Client/ Responsible Party _________________________________ Date ________________