Qualified Professional Visit

1027 7th Street NW unit 204 Rochester, Minnesota 55901
Phone: 507-540-0801
Email: info@rxteamhomehealthcare.com

Date of Service: _____

Agency Name: _____ **Agency Phone No.:** _____

Responsible Party Name: _____ _____	PCA(s)	1. _____ _____ _____
Recipient Name: _____ _____		2. _____ _____ _____
Recipient DOB: _____		3. _____ _____ _____
Qualified Professional Name: _____ _____		4. _____ _____ _____
		5. _____ _____ _____

PCA orientation		PCA Evaluation	
Review documentation of services (timesheets)		Abuse Plan	
Develop and review care plan			
Review month-to-month plan			
Services meeting goals of service plan		(if no, describe corrective actions) _____	
Have the needs of the recipient changed			
Satisfaction level of recipient (circle one)	Least satisfied [1 2 3 4 5 6 7 8 9 10] Most satisfied		

Notes: (Results of evaluation; actions taken to correct deficiency in work of PCA or to address recipient satisfaction)

Time In/Out

Time In:	_____
Time Out:	_____
Total Minutes:	_____

Acknowledgement and Signature

Review the completed time sheet for accuracy before signing. Your signature verifies the time and services entered above are accurate and that the services were performed as specified above.

Recipient/Responsible Party Name

_____

Qualified Professional Name

_____