

LITTLE ANGELS SPECIAL CARE, INC.

HHA DAILY CLINICAL NOTE

Patient Name		Date of Birth	Date of Service
HHA Name	Scheduled	Clock-In	Clock-Out

CARE PROVIDED - CHECK ALL THAT APPLY

PERSONAL CARE / ADLS

- | | | | | |
|--|------------------------------------|------------------------------------|---|---|
| ☐ Bath/Shower | ☐ Oral Care | ☐ Grooming | ☐ Dressing | ☐ Skin/Perineal Care |
| ☐ Diaper/Brief Change | ☐ Toileting | ☐ Transfers | ☐ Walking/Mobility | ☐ Repositioning |

NUTRITION / FEEDING

- | | | | | |
|--|---|--|---|---|
| ☐ Meal Prepared | ☐ Snack Prepared | ☐ Feeding Assist. | ☐ Eating Supervision | ☐ Fluids Offered |
| ☐ Special Diet/Texture Followed | | | | |

Intake: ☐ 0-25% ☐ 26-50% ☐ 51-75% ☐ 76-100%

SAFETY / SUPERVISION

- | | | | |
|---|---|---|--|
| ☐ Continuous Supervision | ☐ Frequent Redirection | ☐ Fall Precautions | ☐ Elopement Precautions |
| ☐ Seizure Precautions | ☐ Behavior Monitoring | ☐ Aspiration Precautions | ☐ Poor Safety Awareness |

ACTIVITIES

- | | | | | |
|--|----------------------------------|--|-------------------------------------|----------------------------------|
| ☐ Play | ☐ Reading | ☐ Coloring/Crafts | ☐ Sensory | ☐ Outdoor |
| ☐ School/Homework | ☐ Music | ☐ Movement | ☐ Rest/Quiet | |

PATIENT STATUS

Beginning of Visit:

- | | | | | | | | |
|--------------------------------|-------------------------------|-----------------------------------|--------------------------------------|------------------------------------|-----------------------------------|--------------------------------------|------------------------------------|
| ☐ Alert | ☐ Calm | ☐ Sleeping | ☐ Cooperative | ☐ Irritable | ☐ Agitated | ☐ Hyperactive | ☐ Nonverbal |
|--------------------------------|-------------------------------|-----------------------------------|--------------------------------------|------------------------------------|-----------------------------------|--------------------------------------|------------------------------------|

Any change in condition, injury, fall, seizure, unusual behavior, or concern?

☐ No ☐ Yes

Office/Nurse notified if required?

☐ Yes ☐ No ☐ N/A

Person notified:

Time:

REQUIRED DAILY NARRATIVE - MINIMUM 25 MEANINGFUL WORDS

Describe the patient's condition, care provided, participation, safety needs, meals, toileting, behaviors, activities, and changes observed.

END OF VISIT

Patient left: ☐ Stable ☐ Calm ☐ Sleeping ☐ With Parent/Guardian ☐ Authorized Location ☐ No Change

I certify that this note accurately reflects the services I personally provided during this visit.

HHA Signature

Date

Time

Parent/Guardian Signature, if required

OFFICE USE ONLY:

- | | | | | |
|---------------------------------------|---|--|--|--|
| ☐ EVV Verified | ☐ Authorization Verified | ☐ Note Complete | ☐ Returned for Correction | ☐ Supervisor Review |
|---------------------------------------|---|--|--|--|

Complete documentation for each visit. Do not copy, backdate, or document services not provided.