

**WEST VIRGINIA BUREAU
OF SENIOR SERVICES**



LIGHTHOUSE PROGRAM
Policy, Procedures, Forms and Instructions

July 1, 2007
Updated May 1, 2009

WEST VIRGINIA BUREAU OF SENIOR SERVICES

LIGHTHOUSE PROGRAM Policy

I. INTRODUCTION

The Lighthouse Program was begun in 2007. Realizing the vast need for in-home assistance for seniors who did not qualify for other programs, Governor Joe Manchin III introduced legislation that was passed by the 78th Legislature of West Virginia to expand senior services throughout the state.

The Lighthouse Program is unique in that it is funded entirely by the State of West Virginia. It is administered by the West Virginia Bureau of Senior Services (the Bureau); direct services are delivered by the county aging providers (senior centers).

II. DESCRIPTION

The Lighthouse Program is designed to assist those seniors who have functional needs in their homes. Services are provided by a caregiver employed by a county aging provider after an applicant for the program has been determined medically eligible by the provider's Registered Nurse (RN) and financial eligibility has been established. Lighthouse is considered a program of last resort; other avenues of in-home services must be considered, and referrals made if indicated.

III. LIGHTHOUSE SERVICES

The Lighthouse Program provides support in four areas:

- A. **Personal Care:** Grooming, Bathing, Dressing, and Toileting
- B. **Mobility:** Transferring and Walking
- C. **Nutrition:** Meal Preparation, Feeding and/or Special Dietary Needs, and Grocery and/or Pharmacy Shopping
- D. **Environment:** Light Housecleaning, Making and Changing the Client's Bed, Dishwashing, and Client's Laundry. Environmental services must be provided in the home and cannot exceed more than 1/3 of monthly hours that client receives.

Lighthouse Policy, cont.

IV. ELIGIBILITY FOR SERVICES

There are four criteria for eligibility:

- A. **60+ years of age;**
- B. **Medically eligible** based on a functional evaluation by the provider agency's RN. Two needs must be identified under "Activities of Daily Living" on the Lighthouse Eligibility Form (LEF). A need is an ADL that requires "Much Assistance" or "Total Assistance."
- C. **Financially Eligible** based on the Lighthouse Sliding Fee Schedule. This will be based on the individual's monthly income only. The individual's assets, and other household member's income, are not to be considered. An individual's income may be determined by voluntary disclosure by the client; means tests are not required.
- D. **Resident of West Virginia** at the time service is provided.

V. HOURS OF SERVICE

A Lighthouse client could receive up to a maximum of sixty hours service per month, based on the RN's Client Assessment, resources available, and subsequent Plan of Care. Since medical eligibility is based on only two identified needs, it is anticipated that many of the clients in the program will not require the maximum hours of service per month.

VI. SERVICE PROVISION

Services will be provided by a trained caregiver employed by the provider agency. The caregiver may be any qualified individual, with the exception of the client's spouse.

All caregivers are required to have a clear Criminal Background check.

It is required that the agency RN have Lighthouse training by the Bureau staff to ensure quality of program. Director of Lighthouse Program is to be notified with any change in RN staff and required training is to be done. Registered Nurse professional level of care is expected at all times.

All persons who work with Lighthouse Program clients are required to have a signed confidentiality form in their personnel record.

Lighthouse Policy, cont.

VII. SLIDING FEE SCHEDULE

Since Lighthouse is a state-funded program there is a requirement that clients be charged based on a sliding fee schedule. All monies collected are to be used to provide additional services in the Lighthouse Program at the same hourly rate. The Bureau may change the sliding fee schedule at their discretion.

VIII. REEVALUATION

Each client shall be reevaluated for the Lighthouse Program at least annually for eligibility, through the completion of a Lighthouse Eligibility Form by the provider agency RN. Determination will be made at this time if client is still eligible, if there is a change in sliding fee schedule, and if there needs to be a referral made to another program for services.

IX. RN ASSESSMENT AND FOLLOW-UP

The RN Client Assessment, Plan of Care, and Caregiver Weekly Worksheet must be completed initially and updated at least annually by the provider agency RN. Monthly contact with the client and/or family must be made, with documentation of findings and follow-up as indicated, by the provider agency RN or a designated staff member. If there has been a change in the client's condition, a follow-up by the RN is required. Additional contacts, with documentation, may be indicated based on the client's condition and the RN's professional judgment.

X. CAREGIVER TRAINING

New caregivers who have no training or experience must receive eight hours of basic training before caring for the client. Within twelve months of the beginning date of employment, twenty-four hours of additional training must be received. The agency RN is responsible for assuring training competency in the caregiver's skills.

Lighthouse Policy, cont.

The following are mandatory training areas for the initial eight-hour basic training:

- A. Orientation to the agency, community, and services;
- B. Personal care skills including but not limited to bathing, grooming, feeding, toileting, transferring, positioning, and ambulation;
- C. Safety and accident prevention;
- D. Occupational Safety and Health Administration (OSHA) standards related to blood-borne pathogens;
- E. Cardiopulmonary resuscitation (CPR);
- F. First aid; and
- G. How to work with the elderly, including those with physical and/or cognitive disabilities.

Other training areas must include:

- H. Body mechanics (e.g., how a caregiver can avoid self-injury while lifting, bending, etc.);
- I. Care of the home and personal belongings;
- J. Food, nutrition, and meal preparation;
- K. Confidentiality laws and regulations (HIPAA); and
- L. How to report abuse/neglect.

Caregivers must then receive at least eight hours of continuing training each year. Training may include individualized training for a special needs client. CPR and First Aid must be kept current. OSHA and HIPAA must be reviewed annually.

Ensure that training records indicate a time value to show that above policy is being followed.

XI. REPORTING

Lighthouse services must be reported to the BoSS Client Tracking Program, using Service Code 1902 and Funding Code 51. A BIF is required to enter the client into Client Tracking's computer system; Form S-1 must be completed also. (This form will automatically generate when it has been used once.) Note: Lighthouse services provided with LIFE money shall be reported under LIFE (Personal Care Service Code 1901 and Funding Code 28).

Lighthouse Policy, cont.

XII. BILLING

Services will be billed at least monthly on the Lighthouse Program Invoice provided by the Bureau. Additionally, an Invoice Attachment is required that lists the names of clients and hours served during the period covered. This information shall be submitted to the Area Agency on Aging for your region by the tenth of each month.

XIII. MONITORING

The provider of Lighthouse services will be monitored by the Bureau of Senior Services or its designee. Monitoring may include home visits to Lighthouse clients. Records regarding clients served in the Program, billing records, and records of any personnel who work with the Program shall be provided upon request.

Negative review findings may lead to a corrective action plan, payback of funds, no reimbursement, or, in severe cases, loss of privilege to provide Lighthouse services for your county.

The Bureau has the discretion to make changes to the Lighthouse Program, with ample notice to county aging providers, as the need arises.

XIV. PROGRAM RESTRICTIONS

- A. Lighthouse services cannot be used in place of Medicaid services (i.e., Medicaid Personal Care Program and/or Aged and Disabled Waiver Program), or to supplement existing Medicaid services. Lighthouse services may be used while a person's application for Medicaid services is pending determination within a reasonable time frame.
- B. The client's spouse may not be a Lighthouse caregiver.
- C. Environmental services cannot exceed more than 1/3 of monthly hours that client receives.
- D. Services may not be provided outside the State boundaries.
- E. No sub-contracting is allowed without prior approval of the Area Agency on Aging and the Bureau.

WEST VIRGINIA BUREAU OF SENIOR SERVICES

LIGHTHOUSE PROGRAM Procedures

I. REFERRAL

After a referral is received, the provider agency Registered Nurse (RN) shall determine appropriateness of the Lighthouse Program either by telephone conversation with the applicant or by home visit. At this time, all avenues of in-home services should be explored—e.g., Veterans Administration, Medicaid Personal Care, Medicaid Aged and Disabled Waiver, private insurance, and any other in-home care programs.

II. HOME VISIT; COMPLETION OF BIF, NUTRITIONAL HEALTH ASSESSMENT, AND LIGHTHOUSE ELIGIBILITY FORM; ELIGIBILITY DETERMINATION

If the applicant is determined to be appropriate for Lighthouse, the provider agency RN shall make a home visit (if initial contact has only been by telephone). The Bureau of Senior Services (the Bureau) Intake Form (BIF) and the Nutritional Health Assessment shall be completed and medical eligibility determined with the Lighthouse Eligibility Form (LEF) at time of visit. The BIF and Nutrition Assessment do not need to be completed annually. (See BIF Instructions, Nutritional Health Assessment Instructions, and LEF for further details.) If medically eligible, the applicant shall be advised at this time. If medically ineligible, the applicant shall be advised at this time, and the interview concluded. Referral to the local Aging and Disability Resource Center would then be appropriate.

The LEF must be completed annually to determine continuing eligibility for the Program.

III. SLIDING FEE SCHEDULE

If medically eligible, the sliding fee schedule and the provider agency's policy for payment shall be discussed with applicant. (Note: Only the applicant's income is to be counted when determining payment by client. Household income is not considered. Individual's assets are not considered).

The sliding fee schedule will be determined annually.

Lighthouse Procedures, cont.

IV. RN CLIENT ASSESSMENT

The RN Client Assessment should be completed at the time of the initial home visit. The Assessment should be detailed enough to determine Plan of Care needs. (See RN Client Assessment Instructions for further details.)

The RN Client Assessment must then be completed at least annually and when there are any client changes that the RN thinks warrants a new complete assessment. Log notes may be more appropriate for some client changes.

V. PLAN OF CARE

The Plan of Care shall be completed based on the RN Client Assessment, using the RN's professional judgment, to determine tasks needed and times needed for each task to be done. No tasks can be provided outside the service definitions. The Plan of Care may be completed at the time of the RN Client Assessment or soon thereafter. (See Plan of Care Instructions for further details.) Plan of Care specifics must be discussed with the client. (Since a client must pay according to the Sliding Fee Schedule, it is possible that he may wish to limit the number of hours of service provided.) A copy of the Plan of Care must be subsequently left in the home for the provider agency's caregiver to utilize, and the original must be kept in the client's file.

The POC must be completed at least annually with the annual RN Client Assessment. Other changes to the POC must have adequate documentation to determine tasks needed and times needed for each task to be done. The RN documentation, either in the RN Client Assessment or in log notes, must validate the tasks and times on the POC.

VI. CAREGIVER WORKSHEET

The client caregiver must indicate time of their arrival and departure, and initial on the Caregiver Weekly Worksheet only the tasks completed daily. The Worksheet directly reflects the Plan of Care, a copy of which is kept in the client's home for the caregiver to utilize. Photocopies of the Worksheet may be used. The Worksheet must be turned in at least weekly to the RN after the client and caregiver have signed; the RN then signs and begins the billing process. (See Caregiver Weekly Worksheet Instructions for further details.)

Lighthouse Procedures, cont.

The provider agency RN is responsible for review of the completed Caregiver Worksheet to ensure that the POC is being followed. If any discrepancy is found then follow-up is expected with documentation in the client record. The RN signature indicates that he/she has reviewed the Caregiver Worksheet and either agrees the POC has been followed or is providing follow-up due to any discrepancy.

Bureau of Senior Services
LIGHTHOUSE PROGRAM
Lighthouse Eligibility Form

Instructions

- 1) Lighthouse Eligibility Form must be completed in full initially, annually, and more often if the client's condition warrants, by the provider agency RN.**
- 2) Medical eligibility is determined by the "Activities of Daily Living" section. If at least two of the Activities of Daily Living indicate "Much Assistance" or "Total Assistance," applicant is medically eligible.**
- 3) Financial Sliding Fee Schedule will be based on the monthly income information collected. The individual's assets and other household member's income are not to be considered. An individual's income may be determined by voluntary disclosure; means tests are not required. If applicant does not want to share this information, then 100% fee may be charged.**
- 4) RN should determine if referral to another program is indicated with the completion of the LEF and the RN Client Assessment Form.**
- 5) RN signature will determine eligibility for the Lighthouse Program.**

Lighthouse Eligibility Form

Client name: _____

Date of Birth: _____ Gender: _____ Marital Status: _____

Address:

Street: _____ City: _____ Zip: _____

County of Residence: _____ Phone number: _____

Monthly Income: _____ Assets greater than \$2000? _____

Informal Support's name: _____

Relationship: _____ Phone Number: _____

Medicaid Number (if applicable) _____ QMB? _____

Living conditions:

Activities of Daily Living:

Determine need for each ADL. Must be level 3 or 4 in two areas to qualify for program.

1- Independent 2- Some Assistance 3 – Much Assistance 4 – Total Assistance

Grooming _____

Feeding _____

Bathing _____

Meal Prep _____

Dressing _____

Transferring _____

Toileting _____

Walking _____

Eligibility must be determined by Registered Nurse. Signature below signifies that determination.

Client **has not** been determined eligible for the Lighthouse Program.

_____ RN Date: _____

RN signature

Client **has** been determined eligible for the Lighthouse Program.

_____ RN Date: _____

RN signature

Bureau of Senior Services

BIF and Nutritional Health Assessment

Instructions for LIGHTHOUSE PROGRAM

- 1) BIF and Nutritional Health Assessment must be completed in full at the time of the initial visit. (It does not need to be completed annually unless there are demographic changes.) Be sure every block is completed. Every Lighthouse client must have a BIF in the BoSS Client Tracking Program.**
- 2) If applicant is an existing client, use current Client Number.**
- 3) Income can be determined by voluntary disclosure; means tests are not required.**

BoSS Intake Form

04/08

ACTION: <input type="checkbox"/> 1= Add <input type="checkbox"/> 2= Change <input type="checkbox"/> 3= Delete <input type="checkbox"/> 4= Inactive				Client Number: _____			
Date of Intake: _____			Type of Contact:		Worker:		
Provider Number: _____			<input type="checkbox"/> In Office <input type="checkbox"/> In Field <input type="checkbox"/> By Telephone				
Client Name: Last: _____		First: _____		MI: _____			
Date of Birth: ____/____/____		Gender: <input type="checkbox"/> Female <input type="checkbox"/> Male		Eligibility: <input type="checkbox"/> Spouse <input type="checkbox"/> Volunteer <input type="checkbox"/> Handicapped <input type="checkbox"/> III-E Caregiver <input type="checkbox"/> FAIR Caregiver <input type="checkbox"/> Lighthouse			
If FAIR/III-E Caregiver, Relationship to Client:				<input type="checkbox"/> 1= Husband <input type="checkbox"/> 2= Wife			
<input type="checkbox"/> 3= Son/Son-in-Law		<input type="checkbox"/> 4= Daughter/Daughter-in-Law		<input type="checkbox"/> 5= Other relative <input type="checkbox"/> 6= Non relative			
Address: Street _____		City _____		State _____ Zip _____			
Telephone: (____) _____ - _____			Speaks English: <input type="checkbox"/> Yes <input type="checkbox"/> No				
Language Limitations: <input type="checkbox"/> 1=Does Not Read <input type="checkbox"/> 2=Reads Only <input type="checkbox"/> 3=Writes Only <input type="checkbox"/> 4=Reading/Writing Limited							
Marital Status: <input type="checkbox"/> 1=Married <input type="checkbox"/> 2=Single <input type="checkbox"/> 3=Widowed <input type="checkbox"/> 4=Separated							
Race: <input type="checkbox"/> 1=White, Non-Hispanic <input type="checkbox"/> 2=White, Hispanic <input type="checkbox"/> 3=American Indian/Alaskan Native <input type="checkbox"/> 4=Asian <input type="checkbox"/> 5=Black or African American <input type="checkbox"/> 6=Native Hawaiian or other Pacific Islander <input type="checkbox"/> 7=Other							
Ethnicity: <input type="checkbox"/> 1= Hispanic or Latino <input type="checkbox"/> 2=Not Hispanic or Latino							
Household Composition - Lives: <input type="checkbox"/> Alone <input type="checkbox"/> W/Spouse <input type="checkbox"/> W/Child <input type="checkbox"/> W/Relative <input type="checkbox"/> W/Non-Relative							
Income Range:		<input type="checkbox"/> 1=\$0 - \$867 <input type="checkbox"/> 2=\$868 - \$1167 <input type="checkbox"/> 3=\$1168 - \$1467 <input type="checkbox"/> 4=\$1468 - \$1767		<input type="checkbox"/> 5=\$1768 - \$2067 <input type="checkbox"/> 6=\$2068 - \$2367 <input type="checkbox"/> 7=\$2368 - \$2667 <input type="checkbox"/> 8=\$2668 - \$2967			
Number in Household: _____			G.E.N.: <input type="checkbox"/> Yes <input type="checkbox"/> No				
Transportation: <input type="checkbox"/> 1. Have Car <input type="checkbox"/> 2. Public <input type="checkbox"/> 3. Senior Citizens Transportation <input type="checkbox"/> 4. Family/Friends <input type="checkbox"/> 5. None							
Rural: <input type="checkbox"/> Yes <input type="checkbox"/> No		<input checked="" type="checkbox"/> =Yes: <input type="checkbox"/> GSN <input type="checkbox"/> Low Income Minority <input type="checkbox"/> At Risk					
Activities of Daily Living: Circle One For Each <small>1=No Assistance, 2=Some Assistance, 3=Much Assistance, 4=Cannot Perform</small>			Instruments of Daily Living: Circle One For Each <small>1=No Assistance, 2=Some Assistance, 3=Much Assistance, 4=Cannot Perform</small>				
Bathing	1 2 3 4	Transferring		Cooking	1 2 3 4		
Dressing	1 2 3 4	in/out of bed	1 2 3 4	Heavy Housework	1 2 3 4		
Eating	1 2 3 4	Getting Places	1 2 3 4	Use of Telephone	1 2 3 4		
Walking	1 2 3 4	Toileting	1 2 3 4	Medication			
				Business Affairs	1 2 3 4		
				Management	1 2 3 4		
REMARKS: 							
Total Score (ADL's and IADL's) _____			Total Score (NUTRITIONAL HEALTH ASSESSMENT) _____				

NUTRITIONAL HEALTH ASSESSMENT

Client Name: _____

Date of Birth: _____

Date Completed: _____

Do you have an illness or condition that makes you change the foods you eat?	YES = 2	NO = 0
Do you eat at least two times every day?	YES = 0	NO = 3
Do you eat some fruits and vegetables every day?	YES = 0	NO = 1
Do you have some milk products every day?	YES = 0	NO = 1
Do you have 2–3 or more drinks of beer, wine or liquor almost every day?	YES = 2	NO = 0
Do you have any problems with your teeth, mouth or throat that makes it hard for you to eat or swallow?	YES = 2	NO = 0
Do you eat alone most of the time?	YES = 1	NO = 0
Do you take 3 or more pills each day?	YES = 1	NO = 0
Are you always physically able to get around to shop, cook and/or feed yourself?	YES = 0	NO = 2
Without trying, have you lost or gained 10 pounds in the last six months?	YES = 2	NO = 0
Do you have enough money to buy the foods you need?	YES = 0	NO = 4

TOTAL NUMBER OF POINTS: _____

0–2 points is Good

3–5 points indicates Moderate Nutritional Risk

6+ points indicates High Nutritional Risk

Bureau of Senior Services
LIGHTHOUSE PROGRAM
Sliding Fee Schedule

Instructions

- 1) An individual's income may be determined by voluntary disclosure by the client; means tests are not required. If client does not want to disclose income, then 100% fee may be charged.**
- 2) Only the applicant's income is to be counted when determining payment by client. All taxable income is to be considered. Neither client assets nor other household income is to be considered.**
- 3) The Sliding Fee Schedule and provider agency's policy for payment shall be discussed with the applicant at the time of eligibility determination.**
- 4) The fees collected are to be used to provide additional services in the Lighthouse Program at the same hourly rate.**

LIGHTHOUSE PROGRAM
Sliding Fee Schedule

Sliding Fee Schedule Effective February 1, 2009

Sliding Fee %	Fee per Hour	Individual's Annual Income	Individual's Monthly Income
Minimum	\$1.00	Up to \$20,220	Up to \$1,685
25%	\$4.00	\$20,221 to \$30,220	\$1,685 to \$2,518
50%	\$8.00	\$30,221 to \$40,220	\$2,518 to \$3,351
75%	\$12.00	\$40,221 to \$50,220	\$3,351 to \$4,185
100%	\$16.00	\$50,221 and up	\$4,185 and up

Bureau of Senior Services
LIGHTHOUSE PROGRAM
RN Client Assessment

Instructions

- 1) RN Client Assessment must be completed in full by the provider agency RN, and must include a narrative which includes client's living conditions, medical history, medications, diagnoses, and ability to perform personal care, mobility, nutritional, and environmental tasks.**
- 2) This Assessment is used to develop the client's Plan of Care; therefore, as much detail as possible must be included (additional pages may be attached as necessary). The documentation should paint a picture and validate the tasks and time frames on the POC.**
- 3) Assessment must be completed at least every 12 months, or more often, at RN's discretion, if client's needs change.**
- 4) Provider agency RN must sign and date Assessment.**
- 5) Original copy of Assessment must be kept in client's file.**

Date: _____

Lighthouse Program RN Client Assessment Form

Client Name: _____ Date of Birth: _____

Describe client's living conditions:

Narrative: Include medical history, current diagnoses available, medications, allergies and current conditions:

Describe client's ability to perform Personal Care Tasks:

Grooming:

Bathing:

Dressing:

Toileting:

Client Name: _____

Describe the client's ability to perform mobility tasks.

Transferring:

Walking:

Describe the client's ability to perform Nutritional tasks:

Meal Preparation:

Feeding and/or special dietary needs:

Shopping:

Describe the client's ability to perform environmental tasks:

Light housecleaning:

Dishwashing:

Making/Changing client's bed:

Client's laundry:

RN signature

Date of assessment

Bureau of Senior Services
LIGHTHOUSE PROGRAM
Plan of Care
Instructions

- 1) **Plan of Care must be completed in full by the provider agency RN based on the RN Client Assessment. No tasks can be provided outside the service definitions.**
- 2) **Plan of Care must be completed initially and annually or as indicated with any documented change in client condition.**
- 3) **Time in minutes is to be entered for each task. RN is to use professional judgment for times needed for each task to be completed. Excessive time for tasks must have thorough documentation. Times indicated will be averages and are used to determine a block of time.**
- 4) **Indicate the “time to begin” and “time to end” for every day of service. This time must correlate with the total times indicated under tasks for each day of service.**
- 5) **Environmental tasks are incidental to the other tasks and cannot exceed 1/3 of the total monthly hours that the client receives.**
- 6) **RN should include in “Comments” section any instructions to caregiver. Always include the number of meals to be prepared under “meal preparation.”**
- 7) **Plan of Care must be discussed in detail with client. Since client will be paying for services, he/she may want to restrict the hours of service provided. Any POC change must have documentation that it was reviewed with client and/or family.**
- 8) **RN must sign and date Plan of Care.**
- 9) **A copy of the Plan of Care must be kept at client’s home to be utilized by the provider agency caregiver, and original copy of Plan of Care must be kept in client’s file.**

**LIGHTHOUSE PROGRAM
PLAN OF CARE**

Client Name:
Client Address:

Days of the Week:								Comments
	Mon	Tues	Wed	Thurs	Fri	Sat	Sun	
Date:								
Time to begin:								
Time to end:								
PERSONAL CARE								
A. Grooming								
B. Bathing								
C. Dressing								
D. Toileting								
MOBILITY								
A. Transferring								
B. Walking								
NUTRITIONAL SUPPORT								
A. Meal Preparation								
B. Feeding/Special Dietary Needs								
C. Grocery/Pharmacy Shopping								
ENVIRONMENTAL								
A. Light Housecleaning								
B. Dishwashing								
C. Making/Changing Bed								
D. Client's Laundry								
TOTAL MINUTES								

NOTE: Environmental Tasks cannot exceed 1/3 of total time.

RN Signature: _____ RN

Date: _____

Bureau of Senior Services
LIGHTHOUSE PROGRAM
Caregiver Weekly Worksheet

Instructions

- 1) The Caregiver Weekly Worksheet must reflect the Plan of Care, a copy of which must be in the client's home.**
- 2) Caregiver is to indicate time of arrival and departure each day of service.**
- 3) Caregiver is to initial each task done on each day of service. They must not initial if task not completed. Time spent on each service is not to be entered.**
- 4) Any reasons that a task is not performed (e.g., client does not feel well enough for a bath) should be reported in the "Comments" section.**
- 5) Client must sign and date the Worksheet at the end of the week verifying that he/she received services as initialed.**
- 6) Caregiver must sign and date the Worksheet at the end of the week to verify service delivery.**
- 7) Worksheet is subsequently given to RN for approval, who then signs and dates. Provider Agency RN has responsibility to ensure that POC is being followed. Follow-up must be done and documented for any discrepancies. Worksheet must be approved by RN prior to billing.**
- 8) Each signed Caregiver Weekly Worksheet is to be kept in client's file. Additionally, client must be given a copy of the Worksheet upon request.**

LIGHTHOUSE PROGRAM CAREGIVER WEEKLY WORKSHEET

Client Name: _____

Client Address: _____

	Day of Week:	Daily Planned Task							Comments
		Mon	Tues	Wed	Thurs	Fri	Sat	Sun	
	Date:								
	Beginning Time:								
	Ending Time:								
PERSONAL CARE									
	A. Grooming								
	B. Bathing								
	C. Dressing								
	D. Toileting								
MOBILITY									
	A. Transferring								
	B. Walking								
NUTRITIONAL SUPPORT									
	A. Meal Preparation								
	B. Feeding/Special Dietary Needs								
	C. Grocery/Pharmacy Shopping								
ENVIRONMENTAL									
	A. Light Housecleaning								
	B. Dishwashing								
	C. Making/Changing Bed								
	D. Client's Laundry								

Caregiver must initial each task performed daily. Do not initial if task not completed.

I have received the services as initialed above. _____, Client	Date: _____
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I have provided the services as initialed above. _____, Caregiver	Date: _____
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I have reviewed this worksheet and verify that it is correct. _____, RN	Date: _____
--	--------------------