Maximum Home Support – FLOW SHEET	

CLIENT NAME:____**MONTH**____ **YEAR**____________________

Personal Care Duties	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**13**	**14**	**15**	**16**
Bath/Shower/Bed Bath																
Brush teeth/dentures																
Clean Hearing Aid																
Nail Care (If not diabetic)																
Dressing/undressing																
Toileting needs/hygiene																
Assist with eating/drinking																
Medication reminders																
Range of motion exercise																
Housekeeping																
Light Vacuum or sweep																
Dust																
Wet Mop floors (ONLY)																
Wipe kitchen surfaces																
Dishes																
Clean stove (not ovens)																
Clean refrigerator (inside)																
Laundry																
Clean Bathroom																
Change bed linen																
Make bed																
Prepare/serve meal(s)																
Spot clean walls (only)																
Other:																
Respite Care (as approved in service authorization)																
Shopping																
Running errands																
Attend appointments																
Recreational activities																
Other:																

HSW Name:______________________________ Initial:________ HSW Name:_____________________________ Initial:_________

HSW Name:______________________________ Initial:________ HSW Name:_____________________________ Initial:_________

Maximum Home Support – FLOW SHEET

CLIENT NAME:____**MONTH**__________________________________**YEAR**__________________

SEE REVERSE SIDE OF THIS PAGE FOR REMAINDER OF THE MONTH

Personal Care Duties	**17**	**18**	**19**	**20**	**21**	**22**	**23**	**24**	**25**	**26**	**27**	**28**	**29**	**30**	**31**
Bath/Shower/Bed Bath															
Brush teeth/dentures															
Clean Hearing Aid															
Nail Care (If not diabetic)															
Dressing/undressing															
Toileting needs/hygiene															
Assist with eating/drinking															
Medication reminders															
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Make bed															
Prepare/serve meal(s)															
Spot clean walls (only)															
Other:															
Respite Care (as approved in service authorization)															
Shopping															
Running errands															
Attend appointments															
Recreational activities															

Property of Maximum Home Support. Please return to Area Supervisor or call your nearest office for pick up. Request additional sheets if required. All information is considered confidential and must remain at the client's home

HSW Name:______________________________ Initial:________ HSW Name:_____________________________ Initial:_________

HSW Name:______________________________ Initial:________ HSW Name:_____________________________ Initial:_________

Maximum Home Support – FLOW SHEET	

CLIENT NAME:______________________________**MONTH**______________________________ **YEAR**________________

Other:																

HSW Name:_____________________________ Initial:________ HSW Name:_____________________________ Initial:_________

HSW Name:_____________________________ Initial:________ HSW Name:_____________________________ Initial:_________