



OKLAHOMA DEPARTMENT OF HUMAN SERVICES



Personal Care Aide (PCA) Supervisor Visit



	Date	County
Client name	Case number	
Agency	PCA present? <input type="checkbox"/> Yes <input type="checkbox"/> No	

- How much help has the PCA been? a lot some none
- Do you know your PCA's name? Yes No
Does your PCA have any legal authority over you? Yes No
Name: _____
- Is your PCA: Cooperative? Yes No Punctual? Yes No
Does your PCA stay scheduled time? Yes No
Days and times your PCA visits: _____
When your regular PCA is unable to make your regular visit, does the agency send someone else? Yes No
Is there anything that you need done that is not being done?

Comments: _____

- Do you know the name of the agency your PCA works for? Yes No
Can you locate the phone number? Yes No
- What does your PCA help you do?
 bath _____ times a week shampoo cooking
 shopping/errands housekeeping
 laundry - in home out of home other _____
- What does your PCA do that helps you the most? _____
- Do any other health care professionals visit you?
 Yes No Don't know
Name of agency: _____
Services provided: _____
- Generally, the client's health status has:
 remained unchanged
 improved: _____
 deteriorated: _____

9. Does the client's physical environment, personal appearance, and nutritional status reflect the number of units approved in the home? Yes No

Comments: _____

10. Are there any concerns regarding client's medications? Yes No

Current medications: _____

11. Does the client have adequate informal support? Yes No

Informal support person or persons:

What do they do and how often?

12. Mobility: ambulatory wheelchair other _____

13. Changes in mental status? Yes No

Alert and oriented.

Somewhat alert, continues to be able to function safely in home with current informal support.

Not alert, unsafe to be left alone.

Comments: _____

14. Has the client seen his or her physician in past six months, been to the E.R., or admitted to the hospital? Yes No

Comments: _____

15. Are the services provided consistent with the care plan? Yes No

Comments: _____

16. Care plan changes: Yes No Increase Decrease

Comments: _____

17. Visit frequency: _____

Healthcare management nurse signature

Copy sent to agency on date _____ Mailed Faxed