Home Care
NY GUIDE

Home Care Agency Forms Bundle

Editable forms for your staff and clients

YOUR LOGO
Click to add

AGENCY NAME

LOCATION / OFFICE

Add your logo and agency name, then save a branded master copy.

Organizational templates only. Not medical, legal, or compliance advice. Verify against your state and agency requirements (incl. HIPAA).

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LOCATION / OFFICE _____ **PHONE** _____

What's Inside

GUIDE

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HOW TO USE THIS PACKET

- Open the PDF in Adobe Acrobat Reader (free). Start with "How to Add Your Logo & Agency Name," then save a branded master copy before you add any client information.
- Print the forms you need, or type into the fillable fields and save. Print extra visit notes, MARs, and timesheets for everyday use.
- These are organizational templates, not official compliance forms. Check them against your state and agency requirements, including privacy rules that apply to you.
- Completed forms may contain personal or health information. Store and share them according to your agency's policies and applicable law.

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How to Add Your Logo & Agency Name

GUIDE

1 OPEN THE FILE IN ADOBE ACROBAT READER

Download the US Letter PDF and open it in the free Adobe Acrobat Reader app on a computer. Browser and some mobile viewers may not save typed entries or accept a logo image.

2 TYPE YOUR AGENCY NAME

Click the Agency name field at the top of any form and type your agency name. In most Acrobat versions, fields that share this name will update together. Add your location or office and phone on each form if those fields do not fill automatically. Save your work.

3 ADD YOUR LOGO

Click the logo box (a dashed rectangle labeled Your Logo). In Adobe Acrobat, this should open a window so you can choose a PNG or JPG. Use a simple logo on a transparent or light background. If your reader does not let you place an image, leave the box blank and use a PDF editor to drop in your logo, or print the form and affix a logo sticker.

4 SAVE A BRANDED MASTER COPY

Use File > Save As to keep a clean master with only your logo and agency name — no client data. Make copies of that master for each new client or pay period, and keep the original blank of personal information.

5 FILL IN OR PRINT FOR STAFF

Type into the remaining fields, tick the checkboxes, and save. Or print blank copies for aides to write on. Choose “Actual size” or 100% scale. Print as many copies as you need for your claimed listing.

6 PROTECT CLIENT INFORMATION

Once a form has client details, treat it as a confidential record. Store and share it according to your agency's privacy policy and any law that applies to you, including HIPAA where it applies.

IF THE LOGO CLICK DOES NOT WORK

Some PDF apps cannot place an image in a button field. The dashed logo box is still there so you can add a logo another way: place an image in a PDF editor, print on letterhead, or tape a small logo in the box after printing. Your agency name can always be typed or written in.

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Home Care
NY GUIDE

Agency / Commercial License

LICENSE

This packet is a free resource from HomeCareNYGuide.com for licensed home care agencies that claim their listing, for the Home Care Agency Forms Bundle (fillable US Letter PDF).

WHAT YOU MAY DO

- Print and use unlimited copies with your agency's own clients and staff.
- Distribute printed or completed copies to your staff and clients for that location's work.
- Type into the fillable PDF, save a branded master copy, and keep records for your own clients at that location.

WHAT YOU MAY NOT DO

- Resell, sublicense, or redistribute the original blank digital files, even within a larger kit or as a free download.
- Share the files publicly (for example on a website, an open shared drive, or a template marketplace).
- Claim the design as your own, or remove HomeCareNY Guide credit from the template footer.
- Use the files at locations that are not part of your claimed HomeCareNYGuide.com listing.

MULTI-LOCATION AGENCIES

You may use these forms at the locations included on your claimed HomeCareNYGuide.com listing.

PLEASE ALSO NOTE

- The files are organizational templates only. They are not medical, legal, or compliance advice, and they are not official state, Medicare, Medicaid, or accreditation forms.
- Verify every form against your own state and agency requirements, including privacy rules that apply to you (such as HIPAA, where it applies).
- Completed pages may contain personal or health information. Store and share them according to your agency's policies and applicable law.
- This license does not transfer copyright. HomeCareNY Guide retains all rights to the underlying design.

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YOUR LOGO
Click to add

AGENCY NAME _____

LOCATION / OFFICE _____ PHONE _____

Client Intake & Profile

INTAKE

INTAKE DATE _____ REQUESTED START DATE _____ REFERRAL SOURCE _____

CLIENT

LEGAL NAME _____ PREFERRED NAME _____ DATE OF BIRTH _____

PHONE _____ EMAIL _____ PREFERRED LANGUAGE _____

STREET ADDRESS _____ CITY _____ STATE _____ ZIP / POSTAL _____

LIVES ☐ Alone ☐ With spouse / partner ☐ With family ☐ With roommate ☐ Other

IF OTHER / NOTES ON LIVING SITUATION _____

EMERGENCY & AUTHORIZED CONTACTS

NAME	RELATIONSHIP	PHONE	EMAIL / OTHER	EMERGENCY	AUTHORIZED to discuss
				☐	☐
				☐	☐
				☐	☐

RESPONSIBLE PARTY / LEGAL REPRESENTATIVE (IF ANY) _____ PHONE _____

PHYSICIAN, PHARMACY & HOSPITAL

PRIMARY PHYSICIAN _____ PHONE _____ PREFERRED HOSPITAL _____

PHARMACY _____ PHONE _____ OTHER SPECIALISTS (OPTIONAL) _____

PAYER / INSURANCE (AS PROVIDED — NOT A BILLING FORM)

PAYER TYPE ☐ Private pay ☐ Long-term care insurance ☐ Medicaid waiver ☐ Medicare (if applicable) ☐ Other

PLAN / PROGRAM NAME _____ MEMBER / ID (LAST 4 ONLY IF PREFERRED) _____ GROUP # _____

INTAKE NOTES (AVAILABILITY, ACCESS, PETS, PARKING, OTHER)

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AGENCY NAME

LOCATION / OFFICE PHONE

Client Intake & Profile

INTAKE

CLIENT DATE

HEALTH INFORMATION AS REPORTED

Record what the client or family provides. This is not a medical assessment.

CONDITIONS, DIAGNOSES, OR RELEVANT HISTORY AS REPORTED

ALLERGIES / REACTIONS PRIMARY PHARMACY (IF NOT ON P.1)

CURRENT MEDICATIONS (OR WRITE "SEE MEDICATION RECORD")

DEVICES / SUPPORTS ☐ Walker ☐ Cane ☐ Wheelchair ☐ Hospital bed ☐ Oxygen ☐ Hearing aids ☐ Glasses ☐ Dentures ☐ Incontinence suppli ☐ Other

OTHER EQUIPMENT OR SUPPLIES

ADVANCE DIRECTIVES ON FILE? ☐ Yes — location noted below ☐ No / unknown ☐ Client declined to discuss

IF YES, TYPE AND WHERE THE DOCUMENT IS KEPT

SERVICES REQUESTED & PREFERENCES

SERVICES ☐ Personal care ☐ Companionship ☐ Meal prep ☐ Light housekeeping ☐ Errands / shopping ☐ Transportation ☐ Medication reminders ☐ Respite ☐ Overnight ☐ Other

PREFERRED DAYS / TIMES SCHEDULE NOTES

HOW THE CLIENT PREFERS TO BE ASSISTED · ROUTINES, LIKES, DISLIKES, COMMUNICATION TIPS

INFORMATION PROVIDED BY

NAME RELATIONSHIP PHONE

CLIENT OR REPRESENTATIVE SIGNATURE DATE INTAKE COORDINATOR DATE

Information is recorded as provided. Not a medical, legal, or financial assessment.

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AGENCY NAME _____

LOCATION / OFFICE _____ PHONE _____

Client Emergency Information

EMERGENCY

CLIENT _____ DATE OF BIRTH _____ DATE UPDATED _____

AT A GLANCE

PREFERRED NAME _____ PRIMARY LANGUAGE _____ BLOOD TYPE (IF KNOWN) _____

KNOWN CONDITIONS (AS REPORTED)

ALLERGIES / REACTIONS _____ CODE STATUS / DIRECTIVES (AS DOCUMENTED) _____

DEVICES / ALERTS

- ☐ Fall risk
- ☐ Oxygen
- ☐ Pacemaker
- ☐ Hearing aids
- ☐ Walker / wheelchair
- ☐ Cognitive impairment
- ☐ Diabetes
- ☐ Other

WHO TO CALL

ROLE	NAME	PHONE	NOTES
Emergency contact 1			
Emergency contact 2			
Physician			
Agency on-call			
Other			

PREFERRED HOSPITAL _____ PHARMACY _____ PHARMACY PHONE _____

ADVANCE DIRECTIVES & ACCESS

DNR / POLST / PROXY / LIVING WILL — TYPE AND WHERE KEPT _____ GATE / KEY / ACCESS NOTES _____

WHAT RESPONDERS OR COVERING AIDES SHOULD KNOW FIRST

Organizational templates only. Not medical, legal, or compliance advice. Verify against your state and agency requirements (incl. HIPAA).

YOUR LOGO
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AGENCY NAME

LOCATION / OFFICE PHONE

Care Plan Summary

CARE PLAN

CLIENT PLAN DATE REVIEW BY COORDINATOR

REASON FOR SERVICES & GOALS

A working summary for your team — not an official state or payer plan of care.

WHY SERVICES WERE REQUESTED / CURRENT SITUATION

SERVICE GOALS (WHAT SUCCESS LOOKS LIKE FOR THIS CLIENT AND FAMILY)

SCHEDULED SERVICES

SERVICE / TASK	DAYS	TIME WINDOW	HOURS / VISIT	NOTES

SUPPORT NEEDS & SAFETY

MOBILITY, TRANSFERS, AND PERSONAL-CARE NOTES

SAFETY, HOME ACCESS, AND WHAT TO WATCH FOR

PREFERENCES & SPECIAL INSTRUCTIONS

ROUTINES, COMMUNICATION, FOOD, CULTURAL OR PERSONAL PREFERENCES

FAMILY / RESPONSIBLE PARTY TO KEEP UPDATED PHONE

COORDINATOR SIGNATURE DATE CLIENT OR REPRESENTATIVE (OPTIONAL) DATE

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AGENCY NAME _____

LOCATION / OFFICE _____ PHONE _____

ADL / IADL Checklist

ASSESSMENT

CLIENT _____ DATE _____ COMPLETED BY _____

ACTIVITIES OF DAILY LIVING (ADLS)

Mark the usual level of help at the time of this review. Not a clinical assessment.

ACTIVITY	INDEPENDENT	SOME assistance	FULL assistance	NOT NEEDED / not asked	NOTES
Bathing / showering	☐	☐	☐	☐	
Dressing / undressing	☐	☐	☐	☐	
Grooming / hygiene	☐	☐	☐	☐	
Toileting	☐	☐	☐	☐	
Transferring (bed / chair)	☐	☐	☐	☐	
Walking / mobility	☐	☐	☐	☐	
Eating	☐	☐	☐	☐	
Continence care	☐	☐	☐	☐	

INSTRUMENTAL ACTIVITIES (IADLS)

ACTIVITY	INDEPENDENT	SOME assistance	FULL assistance	NOT NEEDED / not asked	NOTES
Meal preparation	☐	☐	☐	☐	
Housekeeping / laundry	☐	☐	☐	☐	
Shopping / errands	☐	☐	☐	☐	
Transportation	☐	☐	☐	☐	
Medication reminders	☐	☐	☐	☐	
Using the telephone	☐	☐	☐	☐	
Managing appointments	☐	☐	☐	☐	
Managing money / bills (if asked)	☐	☐	☐	☐	

SUMMARY AND RECOMMENDATIONS FOR THE CARE PLAN (FOR INTERNAL PLANNING ONLY)

REVIEWER SIGNATURE _____ DATE _____

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AGENCY NAME _____

LOCATION / OFFICE _____ PHONE _____

Aide Daily Visit / Shift Note

VISIT NOTE

CLIENT _____ AIDE _____ DATE _____

TIME IN _____ TIME OUT _____ SHIFT / VISIT TYPE _____ MILEAGE (IF USED) _____

TASKS COMPLETED

Check what was done this visit. Follow the care plan and your agency's instructions.

- ☐ Bathing
- ☐ Dressing
- ☐ Grooming
- ☐ Toileting / incontinence care
- ☐ Transfers / mobility
- ☐ Meal prep / feeding
- ☐ Medication reminder
- ☐ Light housekeeping
- ☐ Laundry
- ☐ Errands / shopping
- ☐ Companionship
- ☐ Range of motion / walking
- ☐ Vitals (if assigned)
- ☐ Other

OTHER TASKS _____

MEALS, FLUIDS & OBSERVATIONS

MEAL / TIME	WHAT WAS OFFERED / EATEN	AMOUNT	FLUIDS	NOTES

MOOD / HOW THE CLIENT SEEMED _____ PAIN OR DISCOMFORT MENTIONED _____

VITALS IF ASSIGNED (BP / PULSE / TEMP / SPO2 / BG) _____ INITIALS _____

HANDOFF

CHANGES, CONCERNS, OR ANYTHING THE NEXT AIDE OR OFFICE SHOULD KNOW

OFFICE NOTIFIED?

- ☐ No issue to report
- ☐ Left a message
- ☐ Spoke with office / supervisor
- ☐ Family updated

AIDE SIGNATURE _____ TIME _____ CLIENT OR FAMILY INITIALS (OPTIONAL) _____ TIME _____

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AGENCY NAME _____

Medication Administration Record

MEDICATIONS

MONTH / YEAR _____ CLIENT _____ ALLERGIES _____

MEDICATION / DOSE / ROUTE	TIME	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31

HOW TO USE Write initials when a dose is given. One row per dose time. Codes: R = refused H = held (per prescriber or agency policy) N = not available A = away S = asleep X = not scheduled. Explain any code or missed dose in your visit note or incident process. Follow the pharmacy label, the prescriber's instructions, and your agency's medication policy. This chart is a template, not a requir

STAFF INITIALS KEY (INITIALS = PRINTED NAME) _____ SUPERVISOR REVIEW (OPTIONAL) _____ DATE _____

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Click to add

AGENCY NAME _____

LOCATION / OFFICE _____ PHONE _____

Incident Report

INCIDENT

REPORT # (OPTIONAL) _____ DATE OF INCIDENT _____ TIME _____ DATE REPORTED _____

CLIENT _____ LOCATION _____ STAFF PRESENT _____

TYPE OF INCIDENT

Use this template alongside your agency's incident and reporting policy.

- ☐ Fall (no apparent injury)
- ☐ Fall with injury
- ☐ Other injury
- ☐ Medication-related
- ☐ Behavioral / safety concern
- ☐ Property / missing item
- ☐ Delayed or missed visit
- ☐ Other

IF OTHER, DESCRIBE _____

WHAT HAPPENED (FACTS ONLY, AS OBSERVED OR REPORTED)

INJURIES, SYMPTOMS, OR PROPERTY INVOLVED · IMMEDIATE ACTION TAKEN

WHO WAS NOTIFIED

WHO	NAME	METHOD	DATE / TIME	NOTES
Supervisor / office				
Family / responsible party				
Physician / 911 / other				
Other				

FOLLOW-UP NEEDED AND WHO IS RESPONSIBLE

PERSON COMPLETING THIS REPORT _____ SIGNATURE _____ DATE _____

SUPERVISOR REVIEW _____ SIGNATURE _____ DATE _____

Follow your agency's incident, fall, and mandatory-reporting procedures. This page is not a substitute for required state or insurance forms.

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AGENCY NAME _____

LOCATION / OFFICE _____ **PHONE** _____

Caregiver Timesheet / Visit Verification

TIMESHEET

EMPLOYEE _____ **PAY PERIOD START** _____ **PAY PERIOD END** _____

VISITS THIS PERIOD

For internal timekeeping. Verify hours against your payroll, contracts, and EVV rules if they apply.

DATE	CLIENT	TIME IN	TIME OUT	HOURS	SERVICE / VISIT TYPE	CLIENT OR FAMILY initials	EMPLOYEE initials

TOTAL HOURS THIS PERIOD _____ **MILEAGE TOTAL (IF USED)** _____ **OFFICE NOTES** _____

EXCEPTIONS (OVERTIME, CANCELLED VISITS, SPLIT SHIFTS, ON-CALL — AS YOUR POLICY REQUIRES)

EMPLOYEE SIGNATURE _____ **DATE** _____ **SUPERVISOR / OFFICE APPROVAL** _____ **DATE** _____

A client initial verifies the visit was made, not a legal waiver. Follow your agency's payroll and documentation rules.

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AGENCY NAME _____

LOCATION / OFFICE _____ PHONE _____

Supervisory Visit Log

SUPERVISION

CLIENT _____ SUPERVISOR _____ DATE _____ TIME IN / OUT _____

AIDE / CAREGIVER OBSERVED _____ IN PERSON / PHONE / VIDEO / OTHER _____

VISIT TYPE
- ☐ Routine supervisory
- ☐ New client / start of care
- ☐ Follow-up after incident
- ☐ Quality review
- ☐ Other

ITEMS REVIEWED

Check what you looked at this visit. Adapt to your agency's supervision policy.

- ☐ Care plan / assignment followed
- ☐ Documentation complete and timely
- ☐ Medication reminders / MAR (if used)
- ☐ Client or family feedback
- ☐ Client appearance & comfort
- ☐ Home safety observations
- ☐ Infection-control practices
- ☐ Aide competency / coaching needs

OTHER ITEMS REVIEWED _____

OBSERVATIONS

WHAT WENT WELL, ISSUES NOTED, AND CLIENT OR FAMILY COMMENTS

COACHING, FOLLOW-UP, OR CHANGES TO THE ASSIGNMENT

FOLLOW-UP NEEDED?
- ☐ None at this time
- ☐ Coach aide
- ☐ Update care plan summary
- ☐ Office follow-up
- ☐ Another visit

SUPERVISOR SIGNATURE _____ DATE _____ AIDE SIGNATURE (IF PRESENT) _____ DATE _____

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AGENCY NAME

LOCATION / OFFICE PHONE

Family Communication Log

COMMUNICATION

CLIENT PRIMARY FAMILY / CONTACT PHONE

CONTACTS THIS PERIOD

A running log of calls, visits, and messages so the office and aides share one record.

DATE	TIME	WHO WAS CONTACTED	METHOD (phone, in person, email, VM)	SUMMARY / REASON	FOLLOW-UP NEEDED	STAFF initials

OPEN FOLLOW-UPS AND WHO IS RESPONSIBLE

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