



Passport Supervisory Report Form

| Client Name | | | | | Date | | | | | |
|--|-----------|------|---------|------|----------------------|--|-----------|----------|---------|----------|
| Primary Diagnosis | | | | | | | | | | |
| HM/HHA Services | Excellent | Good | Average | Poor | Comments | Functional Status | Unchanged | Improved | Changed | Comments |
| Adherence to Care Plan | | | | | | Medical | | | | |
| Recording/Reporting | | | | | | Mental Status | | | | |
| Problems/Changes | | | | | | Mobility | | | | |
| Dress Code | | | | | | Nutrition | | | | |
| promptness | | | | | | Skin | | | | |
| Attendance | | | | | | Nursing Care Plan Reviewed with Client/Caregiver and HHA/HM _____ | | | | |
| Personal Care | | | | | | | | | | |
| Quality of Service | | | | | | Service Care Plan Reviewed with Client/Caregiver and HHA/HM _____ | | | | |
| List Type of Service (HHA/HM/RSP) and Service Schedule: | | | | | HHA Present | | | | | |
| HM/HHA(Name) : | | | | | Title | | | | | |
| COMMENTS : (Problems, Plans, Unmet Needs, Safety Hazards, Changes in Informal Caregiver Status, Client Teaching, Contacts with Case Manager.) | | | | | | | | | | |
| Client/Caregiver Signature | | | | | Supervisor Signature | | | | | |