

Department of Health and Welfare
Agency Registered Nurse Supervisor Visit

Participant Name: _____ Medicaid Number: _____

Zip Code _____

Check (√) Current UAI Unmet Needs	Any Changes in Function		Comments
	Yes	No	
Preparing Meals			
Eating Meals			
Toileting			
Mobility			
Transferring			
Personal Hygiene			
Dressing			
Bathing			
Transportation			
Finances			
Shopping			
Laundry			
Housework			
Wood/Coal Supply			
Night Needs			
Emergency Needs			
Medication			
Supervision (Mental/Behavioral)			

1. Was the Plan of Care updated during the visit? Yes _____ No _____
2. Does the Plan of Care require a Significant Change? Yes _____ No _____
3. Are the current progress notes present with Time in/Time out information, caregiver/participant signatures and dates, do the tasks match UAI/unmet needs, and is appropriate written documentation included? Yes _____ No _____
Comment: _____
4. Was on the spot training given to the Caregiver/Participant designee? Yes _____ No _____
Comment: _____
5. Did the condition of the home/participant reflect adequate performance of care task?
Yes _____ No _____
6. Was the participant satisfied with the care received? Yes _____ No _____
Comment: _____
7. List contact(s) made as a result of the visit: _____
Comment: _____

Agency RN Signature

Date