VETERANS
At Home Care

4480 General Degaulle Dr.
Ste. 208
New Orleans, LA 70131
Office: (504) 354-8111
Fax: (504) 354-8017

FACILITATOR WEEKLY PROGRESS REPORT

Consumer's Name: _____
Week of: _____ through _____
Facilitator Name: _____

Weekly contacts (1 Face-to-Face & 2 telephone contacts per week) Minimum Requirement

1. _____ _____ _____ Contact: Face-to-Face ☐ Phone ☐
   Date Beginning Time Ending Time

Area of Discussion:
_____
_____
_____

Is there any change in the consumer's medication? Yes ☐ No ☐ If "yes" list changes:
_____
_____
_____

2. _____ _____ _____ Contact: Face-to-Face ☐ Phone ☐
   Date Beginning Time Ending Time

Area of Discussion: _____
_____
_____

Is there any change in the consumer's medication? Yes ☐ No ☐ If "yes" list changes:
_____
_____
_____

3. _____ _____ _____ Contact: Face-to-Face ☐ Phone ☐
   Date Beginning Time Ending Time

Area of Discussion: _____
_____
_____

Is there any change in the consumer's medication? Yes ☐ No ☐ If "yes" list changes:
_____
_____
_____

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QUARTERLY WALK THROUGH
SUPERVISORY VISIT

1. Name of Direct Support Worker (DSW) on duty: _____
2. Is the DSW at work according to approved schedule: ☐ Yes ☐ No
   If "no", brief explanation: _____
3. Is the DSW staff appropriately dressed and neat in appearance: ☐ Yes ☐ No
   If "no", brief explanation:

_____

4. Consumer Home Assessment: Are the following areas neat and clean in appearance?

- Consumer bedroom: Yes: _____ No:_____
  If "no", brief explanation: _____
- Consumer bathroom: Yes: _____ No: _____
  If "no", brief explanation: _____
- Consumer living room area: Yes: _____ No: _____
  If "no", brief explanation: _____
- Consumer kitchen area: Yes: _____ No: _____
  If "no", brief explanation: _____

5. On a scale of 1-4 (1=excellent 2=good 3=satisfactory 4=poor) how would you rate the overall appearance of the Consumer's home?

☐ 1=excellent ☐ 2=good ☐ 3=satisfactory ☐ 4=poor

Brief explanation if below satisfactory rating:

_____

_____

Area of deficiencies: _____
Action implemented to correct deficiencies: _____
_____
_____

Reviewed by: _____/Title: _____Date: _____

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CONSUMER SURVEY

Consumer Name: _____ Phone #: (_____) _____-_____

Address: _____

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1. Does your staff arrive to work as scheduled (on time)? ____ Yes ____ No
2. Is your staff arriving to work late every day? ____ Yes ____ No
3. Is your staff courteous at all times? ____ Yes ____ No
4. Are you afraid, intimidated in any way by your staff? ____ Yes ____ No
5. Are there any grievances at this time? ____ Yes ____ No
   If "yes" brief description: _____
6. While delivering hands on support, does your staff talk on his/her cell phone? ___ Yes___ No
7. Does your staff leave for long extended periods of time without notifying you? ___ Yes ___ No
8. Are you satisfied with your current PCA Provider, Veterans at Home Care? ___ Yes ___ No
   If "no" brief description: _____
9. Is there any area of the Agency you could improve, what would be that area and why?
   _____
10. What grade would you give your DSW? 1 being the lowest and 10 being the highest?

1 2 3 4 5 6 7 8 9 10

Additional Comments: _____

_____

Face-to-Face Contact: ☐ Telephone Contact: ☐

_____ _____
Consumer Signature **Date**

_____ _____
Legal Guardian Signature (If Applicable) **Date**

_____ _____
VAHC Representative Signature **Date**