State of Illinois
Department of Human Services

Homemaker/Home Health Monthly Service Report

Agency: _____

Worker's Name: _____

Customer's Name: _____

Services Provided: (Check all that apply)

Case Number: _____

	Eating		**Money Management**		**Outside Home**		**Teaching Skills**
	Bathing		**Housework**		**Telephoning**		**Other***
	Grooming		**Laundry**		**Dressing & Undressing**		**Routine Health**
	Meal Preparation		**Bowel/Bladder**		**Supervision**		**Special Health**

* Please Specify: _____

Changes in Customer's Condition (Current or Anticipated)

Changes to HSP Service Plan Recommended

Services Interrupted ☐ Yes ☐ No

Reason for Interruption: _____

Record of Contacts in Hours

Month/Year: _____

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.				

Vendor Signature: _____ Date: _____

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