

# Executive Office on Aging

## Veteran-Directed Care (VDC) Monthly Log

**Instructions:** Effective 10/1/20, the Veteran or their designated Authorized Representative and each Employee are required to complete this log on a monthly basis. **The Veteran or Authorized Representative is required to submit a log for EACH employee, who worked during the month,** within 7 business days after the last day of the month. **Failure to comply could result in suspension or termination of services.** Please note that services through the VDC program focus on Activities of Daily Living (ADL)/personal care services. The amount of time spent on chore services should be limited.

Veteran Name: \_\_\_\_\_

Employee Name: \_\_\_\_\_

Month/Year: \_\_\_\_\_

### **I. To be completed by the Employee:**

Did you help the Veteran with any of the below tasks? (check all that apply):

- Dressing (putting clothes on)
- Grooming (brushing teeth, washing face, combing hair, shaving)
- Bathing (washing and drying body)
- Eating assistance (feeding, cutting food, grinding food up)
- Bed Mobility (assistance with positioning in bed)
- Transferring (assistance with getting in and out of bed or chair)
- Walking (assistance with walking)
- Toileting (cleaning private areas, changing briefs)
- Cooking (meal preparation)
- Cleaning/ laundry/ housework
- Transportation (driving to appointments, errands)
- Grocery Shopping
- Medication Management
- \*Special Treatment \_\_\_\_\_
- Other, please explain: \_\_\_\_\_

\***Special Treatments** include the following: Tube Feeding, IV Fluids, IV Medications, Blood Transfusions, Drainage Tubes, Symptom Control for Terminally Ill, Isolation Precautions, Hyperalimentation/Hickman Catheter, Oxygen/Respiratory Therapy/Suctioning, Ostomy/Catheter Care, Wound Care/Decubiti, and Skin Care.

**II. To be completed by the Veteran/Authorized Representative:**

Have there been any changes in the Veteran's health/functional ability over this period?  YES  NO

If yes, explain: \_\_\_\_\_

Was the Veteran hospitalized during this period?  YES  NO

If yes, dates:

From: \_\_\_\_\_ to \_\_\_\_\_

From: \_\_\_\_\_ to \_\_\_\_\_

Are you satisfied with your employee's performance?

YES  NO

Does the employee follow the care plan established (if any) or assigned tasks?

YES  NO

Does the employee require additional training to meet the needs of the Veteran?

YES  NO

Area(s) of Concern/Comments (if any):

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By initialing this monthly employee log, I am confirming that the services and supports provided by my employee are true and correct.

\_\_\_\_\_  
Veteran/Authorized Representative Initials

\_\_\_\_\_  
Date