COMMUNITY SUPPORT PROGRAM
CLIENT STATUS REPORT

Clients Name:_____ **Date:**_____

Agency Name:_____ **Care Consultant:**_____

Client or Caregiver Evaluation	**Adequate**	**Inadequate**	**Yes**	**No**
Quality of Service				
Adheres to Care Plan				
Attitude Manners				
Appearance				
Do you have unmet needs?				

COMMENTS:

Clients Signature:_____

Supervisor's Evaluation	**Adequate**	**Inadequate**	**Yes**	**No**
Quality of Service				
Adhere to Care Plan				
Professionalism				
Appearance				
Documentation				
Care Plan reviewed with client				
Is Care Plan Current?				
Current Service Schedule				

COMMENTS:

OVERALL FUNCTIONAL STATUS:

Improving_____

Describe_____

_____

Unchanged_____

Describe_____

_____

Deteriorating_____

Describe_____

_____

Medical Status:_____

Mental Status:_____

Mobility Status:_____

Nutrition Status:_____

Supervisor Signature:_____