



Shift Log

Client Last Name

Client First Name

Caregiver Last Name

Caregiver First Name

Dec	Shift 1				Shift 2				Total Daily Hours*	Calendar Week Hours	COVID PROTOCOL			
	Service Type	Time In	Circle AM or PM	Time Out	Circle AM or PM	Service Type	Time In	Circle AM or PM			Time Out	Circle AM or PM	Initial each box	
1	Sun			am pm				am pm				I wash my hands frequently during my shift and assist the client I am working with to do so.	I screened myself and each client for COVID-19 symptoms at the start of each shift.	I have my mask and know that I am required to wear it during each shift.
2	Mon			am pm				am pm						
3	Tue			am pm				am pm						
4	Wed			am pm				am pm						
5	Thu			am pm				am pm						
6	Fri			am pm				am pm						
7	Sat			am pm				am pm						
8	Sun			am pm				am pm						
9	Mon			am pm				am pm						
10	Tue			am pm				am pm						
11	Wed			am pm				am pm						
12	Thu			am pm				am pm						
13	Fri			am pm				am pm						
14	Sat			am pm				am pm						
15	Sun			am pm				am pm						
16	Mon			am pm				am pm						
17	Tue			am pm				am pm						
18	Wed			am pm				am pm						
19	Thu			am pm				am pm						
20	Fri			am pm				am pm						
21	Sat			am pm				am pm						
22	Sun			am pm				am pm						
23	Mon			am pm				am pm						
24	Tue			am pm				am pm						
25	Wed			am pm				am pm						
26	Thu			am pm				am pm						
27	Fri			am pm				am pm						
28	Sat			am pm				am pm						
29	Sun			am pm				am pm						
30	Mon			am pm				am pm						
31	Tue			am pm				am pm						

of hours allocated to _____ is _____
 Service Type _____
 # of hours allocated to _____ is _____
 Service Type _____

Caregiver Signature _____

Client/Family Signature _____

Service Type Examples: Personal Care, Respite, Private Pay

Total Daily Hours in quarter hour increments only.
 (.00, .25, .50 or .75)

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Authorized Tasks														Adult Tasks Only		FAMILY INITIALS		
1-A	1-B	2	3	4	5	6	7	8	15	16	17	10	11	12	13		14	Respite
Locomotion In	Locomotion Out	Bed Mobility	Transfers	Eating	Toileting	Dressing	Personal Hygiene	Bathing	Walk in Room	Telephone Use	Skin Care/Foot Care	Meal Prep	House Work	Essential Shopping	Transportation	Medication Reminder		

Monthly Schedules: Please note that schedules for the month are due to the supervisor at least five business days before the month starts. Example: If you are working with a client in December 2024, please submit your entire December schedule by November 22, 2024 to your supervisor. This will help to ensure supervisors are aware of when staff are working, if we are within the amount of hours authorized by the state, and allow time to offer more services to the client/family or the caregiver before the month begins. Please note that clocking in and out of Therap is mandatory for EVV compliance. If your schedule changes, please alert your supervisor immediately so Therap is up to date and has a scheduled slot for you to clock in and out of.

Shift Log: Please note that your shift logs are due weekly. They should be sent directly to your supervisor. Please also note that you are paid for the hours that are clocked in and out in Therap. It is the staff's responsibility to ensure that their clock in/out's are accurate. Staff should be checking their clock in/out's in Therap daily & weekly and requesting changes to their supervisor ASAP. If changes are not made prior to payroll, this could cause discrepancies in pay. Staff should not be relying on supervisors cross referencing their shift logs with Therap.

COVID-19 Protocols: Three statements are included on the shift log for HCA's to initial every shift. The screening questions to ask yourself and the client are listed on the SAILS Washington Home Care COVID – 19 Screening Questions form. You should also be taking your temperature prior to starting every shift, wearing your mask throughout your shift, and washing your hands prior to starting and frequently throughout the day. If you do not have a mask or your mask is worn out, SAILS Washington has a stock of masks and PPE available for all employees, free of charge.

SAILS Washington Home Care COVID – 19 Screening Questions:

Staff and Client Screening Questions:

- 1 Do you have any of these symptoms that are not caused by another condition? Fever, chills, cough, shortness of breath, difficulty breathing, fatigue, muscle or body aches, headache, recent loss of taste or smell, sore throat, congestion, nausea, vomiting, or diarrhea.
- 2 Within the past 14 days have you been in close contact with anyone that you know had COVID-19 or COVID-like symptoms?
- 3 Have you had a positive COVID-19 test for active virus in the past 10 days, or are you awaiting results of a COVID-19 test?
- 4 Have you traveled outside of Washington State in the past 14 days?
- 5 Within the past 14 days, has another employer, public health or medical professional told you to self-monitor, self-isolate, or self-quarantine because of concerns about COVID-19 infection?
- 6 Have you worked with a client at another agency, have a coworker at another agency or have someone close to you that has symptoms of COVID 19 or has had a positive test result?

** If you have answered yes to any of these questions please return to your automobile contact your supervisor immediately. If your client answers yes to any of the questions above, contact your supervisor immediately.