Aetna Better Health® of Illinois
3200 Highland Avenue, MC F648
Downers Grove, IL 60515

Homemaker/Home Health Monthly Service Report

Agency:_______________________________ Agency Worker Name:__________________________________

Member Name:____Date of Birth: ___________________

Services Provided: (check all that apply)

	Eating		Money Management		Outside Home		Routine Health
	Bathing		Housework		Telephoning		Special Health
	Grooming		Laundry		Dressing/Undressing		Transferring in/out of bed
	Meal Preparation		Bowel/Bladder		Supervision/Being Alone		Other*

*Please Specify Other: ____

Changes in Member's Condition (current or anticipated): ____

____

Changes to Service Plan Recommended: ____

Services Interrupted: _________YES _________NO

Reason for Interruption: ____

Total hours allowed per month:______________ Total hours provided per month: _____________

Reason total hours not used:____

____

Month/Year (noted below):___________________ Please fill in calendar hours per day worked.

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.				

Agency Representative:____Date: ______________________

Please email form to <CM> at: <CM e-mail address>

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