Hawaii Life & Disability Insurance Guaranty Association
1003 Bishop Street
Suite 2030
Honolulu, HI 96813

tel. (808)749-4919
penntreatyaloha@hilifega.org

Weekly Care Certification

Policyholder and Provider Information

1. Policyholder Name: _____Policy: _____
2. Provider Name: _____
   Tel: _____ Fax: _____

	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Date of Service (MM/DD)							
Time In/Time Out (AM/PM)							
Total Hours							
Rate							
Total Charge							

Activities of Daily Living (ADLs)	**Caregiver:** Document any assistance provided by using the letter below to indicate the level of assistance **I**- Independent **S**- Supervision **A**- Stand-by Assistance **H**- Hands On Assistance						
Bathing/ Showering							
Indoor Mobility/Walking							
Getting in/out of bed/chair							
Continence Care							
Eating							
Toileting							
Dressing							
Medication							

IADLs	**Caregiver:** Document any assistance provided with ✓. Leave blank if no assistance was provided.						
Housekeeping							
Meal Preparation							
Shopping							
Transportation							
Managing Medicines							
Laundry							

By signing below, I certify that the information provided on this form is a true and accurate accounting of the services provided for these dates.
For your protection, state insurance laws require the following to appear on this form: Any person who knowingly presents a false or fraudulent claim for payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Caregiver Signature _____ Date: _____

Policyholder Signature _____ Date: _____