New Jersey Department of Health
Division of HIV, STD and TB Services
HIV Home Care Program

_____ / _____
Client ID *Month/Year*

MONTHLY ACTIVITY REPORT

Refer to the "Instructions for Completion of the Monthly Activity Report."

Name of Agency		County
Name of Case Manager		Date
Enrollment Date _____ / _____ / _____	Date of Birth _____ / _____ / _____	Discharge Date _____ / _____ / _____

Reason for Discharge

☐ Improved Health ☐ ACCAP ☐ Medicaid ☐ Nursing Facility ☐ Hospital ☐ Hospice

☐ Expired - Date of Expiration: ____ / ____ / ____ Where did Client expire? ☐ Hospital ☐ Home

☐ Other (specify): _____

Linkage with Long-Term Reimbursement Systems:

	Application Date	Approval Date	Denial Date
SSI			
SSD			
ACCAP			
Medicaid			
Other (Specify): _____			

Client Condition

☐ Good ☐ Fair ☐ Poor ☐ Guarded ☐ Wasting ☐ Cognitive Impairment

Has client been hospitalized since last monthly report? ☐ Yes ☐ No If Yes, provide hospital dates:	Admission Date ____ / ____ / ____	Discharge Date ____ / ____ / ____

Justify the utilization of home care services based upon client's medical and nursing needs, such as wound care, new diagnoses and treatment modalities, ADL and IADL deficits, etc.

NURSING SERVICES	**Date of Visit(s)**	**Payer**	**Drug Adherence # Minutes**
Skilled RN			
Skilled RN			
Skilled RN			
Skilled RN			
Skilled RN			
Skilled RN			
Skilled RN			
Skilled RN for HHA/PCA Supervision			
Skilled RN for Dedicated Drug Adherence			
Skilled RN for IV Administration			
Skilled RN for Respiratory Therapy			
LPN			

CASE MANAGEMENT	**Date of Visit**	**Payer**
Initial Visit		
Monthly Visit		

Client ID

MONTHLY ACTIVITY REPORT
Continued

/
Month/Year

PARAPROFESSIONAL SERVICES	Number of Hours	Payer
Homemaker/Home Health Aide		
Personal Care Attendant		
REHABILITATION	**Date of Visit(s)**	**Payer**
Occupational Therapy		
Physical Therapy		
Speech Therapy		
MENTAL HEALTH	**Date of Visit(s)**	**Payer**
Counselor		
Medical Social Worker		
Psychiatric Nurse		
NUTRITIONAL COUNSELING	**Date of Visits**	**Payer**
Registered Dietician		
Registered Nurse		
IV THERAPY	**Date of Treatment(s)**	**Payer**
IV Medications		
IV Equipment and Supplies		
RESPIRATORY CARE	**Date of Treatment(s)**	**Payer**
Respiratory Therapist		
Aerosolized Medications		

Cost Per Day:	**$**	X Number of Days		= Total Cost	**$**

DIAGNOSTIC TESTING	**Date**	**Payer**
Diagnostic/Lab Tests		
Diagnostic Equipment and Supplies		
Skilled RN/Phlebotomist		
DURABLE MEDICAL EQUIPMENT (DME), MATERIALS AND SUPPLIES Equipment Item(s)	**Monthly Rental or Purchase Cost**	**Payer**

NUTRITIONAL SUPPLEMENTS

Cost Per Can:	**$**	X No. of Cans		= Total Cost	**$**	Payer:	

ESCORT SERVICE	Date of Visit(s):		Payer:	
MEDICAL DAY CARE	Number of Days:		Payer:	

BILLING FEE:	**$20.00**	X Number of Service Categories:		= Total Cost	**$**

Comments:

Case Manager Supervisor Signature	Date