



EVALUATION FORM
Direct Care Staff

Date of Hire: _____ Name: _____ Date: _____

- A. The following categories represent the major scope of the employee’s responsibilities. Each area is to be rated by the employees supervisor. Based on the 3 items listed below, please check the rating box for each category which most closely identifies the employee’s annual performance and competency levels.
1. YES (Y): All standards/expectations are met in that Category.
 2. NO (N): None if the standards/expectations were met in that Category.
 3. INCOMPLETE (I): Some of the standards/expectations were met in that Category.

Competency Category	Y	N	I	Explanation of Rating
Employee Attendance: On time, no call offs, work attendance within policy guidelines. As evidenced by Time Sheets.				
Completes electronic & paper documentation correctly at the end of each shift. As evidenced by incomplete documentation. (unfinalized notes, unsealed forms, incomplete data on paper documentation)				
Mandatory Reporting is done on time, when required. (ie: abuse, neglect, AWOLs, etc..) As evidenced by Incident Report or Reports from internal or external parties.				
Follows all company Policies and Procedures. As evidenced by no Progressive Actions.				
Completes assignments from Management Staff. As evidenced by Home Manager or no Progressive Actions.				
Complete shift duties, including daily cleaning tasks, assists & interacts with residents and follows activities schedule. As evidenced by Progress Notes, no Progressive Actions and appearance of home.				
Prepares, implements and follows the Dietary needs of all residents. (Menus, Diet Orders) As evidenced by documentation on menus and observation of meals being served.				
Mandatory meetings and trainings attended. As evidenced by Sign-in Sheets or Training documentation.				
For assigned Residents, adheres to the Treatment and/or Behavior Plans goals and objectives. As evidenced by Progress Notes.				



EVALUATION FORM

Direct Care Staff

Strengths:

1. _____
2. _____

Areas for Development:

1. _____
2. _____

B. Please state at least two goals/objectives you would like to accomplish in the next year:

1. Goal: _____

How will I get there?: _____

2. Goal: _____

How will I get there?: _____

Are annual In-Service Trainings complete?

Yes No

If no, when are they scheduled? _____

Is TB test current (3 years)?

Yes No

If no, one needs to be scheduled immediately.

Is Annual Health Review Form current?

Yes No

If no, one needs to be filled out immediately.

Is Driver's License current/valid?

Yes No

If no, needs to be renewed immediately.

Mavis Mead

Employee Signature

Date

Evaluator's Signature

Date