HOLISTIC HOME HEALTH CARE & HOSPICE – Personal Care Worker Timesheet & Charting

PATIENT NAME & # _____ **EMPLOYEE NAME & #** _____

Address: _____ **Address:** _____

EMPLOYEE MUST FILL OUT *CHART* **AND** *TIMESHEET* **COMPLETELY**. **Write the date MM/DD/YY** *AND* ***visit time in & visit time out*** *for* ***EACH*** *shift worked*.

INCOMPLETE & NONORIGINAL TIMESHEETS MISSING ANY INFORMATION ARE NOT VALID AND WILL NOT BE ACCEPTED!

DATE:	/ /		/ /		/ /		/ /		/ /		/ /		/ /		**TOTAL**
DAY	**Sunday**		**Monday**		**Tuesday**		**Wednesday**		**Thursday**		**Friday**		**Saturday**		
	A.M.	P.M.	A.M.	P.M.	A.M.	P.M.	A.M.	P.M.	A.M.	P.M.	A.M.	P.M.	A.M.	P.M.	
Travel Start (coming)															
Travel End (coming)															
Visit Time In:															
Visit Time Out:															
Travel Start (leaving)															
Travel End (leaving)															
TOTAL VISIT															
TOTAL VISIT															

ACKNOWLEDGEMENT AND REQUIRED SIGNATURES: Review the **completed time sheet** for accuracy *before* signing.

It is a federal crime to provide false information on billings for Medical Assistance payment.

Your signature ***verifies*** the time and services entered above are ***accurate*** and that the services were performed **as specified in the Care Plan**.

EMPLOYEE SIGNATURE:	**DAY & DATE:**
CLIENT SIGNATURE:	**DAY & DATE:**

EMPLOYEE INITIAL/CHECKMARK/MARK TIME OF THE	**Sun**		**Mon**		**Tue**		**Wed**		**Thurs.**		**Fri**		**Sat**	
SERVICES PROVIDED AT THE TIME OF VISIT	**A.M.**	**P.M.**	**A.M.**	**P.M.**	**A.M.**	**P.M.**	**A.M.**	**P.M.**	**A.M.**	**P.M.**	**A.M.**	**P.M.**	**A.M.**	**P.M.**
PERSONAL CARE:														
BATH – BED/ PARTIAL/SHOWER/TUB														
ORAL HYGIENE (BRUSH TEETH/CLEAN DENTURES)														
HAIR CARE/SHAMPOO/COMBING														
SHAVE														
NAIL CARE														
PREVENTATIVE SKIN CARE														
LOTION														
ASSIST WITH DRESSING														
TEDS STOCKING														
ASSIST WITH EATING														
CHANGE POSITION/ TURN														
TRANSFER – TRANSFER BELT/HOYER LIFT														
ASSIST WITH AMBULATION: CANE/WALKER/ W/C														
RANGE OF MOTION EXERCISES (ACTIVE) (PASSIVE)														
ASSIST WITH SPLIT/BRACE														
SAFETY PRECAUTIONS														
ASSIST WITH TOILETING														
CATHETER CARE/EMPTY BAG/ PERI CARE														
BOWEL PROGRAM: YES NO														
BOWEL MOVEMENT: YES NO														
INCONTINENCE/ CHANGE DIAPERS/PERI-CARE														
ASSIST WITH MEDICATIONS														
MEDICATION REMINDER														
OTHER: _____														
HOMEMAKING:														
LINEN CHANGE														
LIGHT HOUSEKEEPING														
LAUNDRY/GROCERY SHOPPING														
MEAL PREPARATION														
OTHER: _____														
SUPPORTIVE CARE:														
SOCIAL/ RECREATION														
SHOPPING														
ERRANDS														
TRANSPORTATION														
OTHER: _____														

EMPLOYEE SIGNATURE: _____ **DAY&DATE:** _____ / / /

PATIENT SIGNATURE: _____ **DAY&DATE:** _____ / / /